Skeleton Keys & Unexpected Allies

Carl Horsley & Tony Williams
Middlemore Critical Care Complex
Auckland, New Zealand
Healthcare Faces Many Problems
Your Hospital

to follow all the rules
Healthcare Worker
Safety through Constraint
We Make Usual Success Harder?

$10^{-4} = 1$ failure in 10,000 events

$1 - 10^{-4} = 9,999$ non-failure in 10,000 events
Zero or -1?

Normal functioning (compliance) → “Nothing to see here”

Unwanted transition (sudden or gradual)

Malfunctioning (non-compliance) → “I can’t believe you did that”

Hollnagel E. *Safety-I and Safety-II; the past and future of safety management* 2014
Resilient actions remain invisible and unvalued
Staff Burnout and Disengagement
Quadruple Aim

Better Health for the Population

Improved Provider Satisfaction

Better Care for Individuals

Lower Cost Through Improvement
Upgrade the Components

• Mindfulness
• Empathy training
• Patient Centred Care courses
• Team 2.0

Leanne has been staring at this beautiful tree for five hours.

She was meant to be in the office. Tomorrow she will be fired.

In this way, mindfulness has solved her work-related stress.
The Waterfall

What You Pay Attention To

How You Design Your System

How We Feel
Safety II – the skeleton key?
Create conditions for success

Are you making failure less likely?

Or usual success more likely?
MIND THE GAP
Learn from all events

Why did that seem the right thing to do at the time?

Dekker A Field Guide to Understanding Human Error 2014
Build the Resilience Potential in Teams and Systems

Anticipation
- Knowing what to EXPECT
- Knowing what to LOOK FOR

Response
- Knowing what to DO
- Knowing what has HAPPENED

Monitoring

Learning
Unexpected Allies
New Models of Leadership

Intent Based Leadership
Create an environment for people to contribute so that they feel valued and reach their potential.
The Law of Requisite Variety

“The greater the variety of responses, the greater the variety of conditions the system can cope with”

First Law of Cybernetics: Ashby, 1956
"In complex environments, resilience often spells success, while even the most brilliantly engineered fixed solutions are often insufficient or counterproductive."

Gen Stanley McChrystal *Team of Teams* 2015
Psychological safety

A shared belief held by the team that the team is safe for interpersonal risk taking

Google “Project Aristotle”
Improved Psychological Safety

More effective
More engaged
Safer

(Edmondson 1999, Nembhard and Edmondson 2006)
Lean

I’m coming to “Lean” you
The Forgotten Parts

• Respect for the frontline view
• The waste in failing to use the abilities of people
• Creating a context that supports success
• A continuous process not an “event”

• Staff led adaptations of work

IHI Framework for Improving Joy in Work

Close, but...
What Have We Seen?

- High levels of engagement
- High reported patient and family satisfaction
- Low turnover and sick leave
- Staff driven improvement
“The whole culture has changed and I think it has become a really focused group effort department with everyone looking out for each other and working for each other and with each other.”

(Nurse, CCC)
It is unrealistic to expect extraordinary effort and performance without creating an environment where people feel extraordinarily valued.

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