

April 18, 2024

Leading With Purpose



8 Strategies for Engaging Your Careforce



Our Work Together

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What the 8-Part Series Will Deliver

By participating in this series of 8, 30-minute sessions, you will:

- Assess your strengths and your organization's strengths and build on those;
 - Lead change through small tests over time,
 - Cultivate a positive work culture, and
 - Ultimately, grow and retain your *Careforce*
(Porter, 2022)



Quick Debrief on Session 3, Feedback that Works -

In Session 3, we ...



Discussed leader practices to improve communication and engagement



Applied SBI-I to deliver timely, authentic, actionable feedback



Considered where and how you can apply feedback and feed forward “by next Tuesday”!

On Deck for Today!

Crowdsourcing the Collective Intelligence of Your Team!

In this session we will....



Discuss leader practices to engage front line team members



Reflect on the impact of positive and punitive cultures



Consider methods for sharing governance

Team members with higher levels of engagement:

- Produce substantially better outcomes
- Treat customers better and attract new ones
- Are more likely to remain with their organization than those who are less engaged
- Are healthier and less likely to experience burnout.

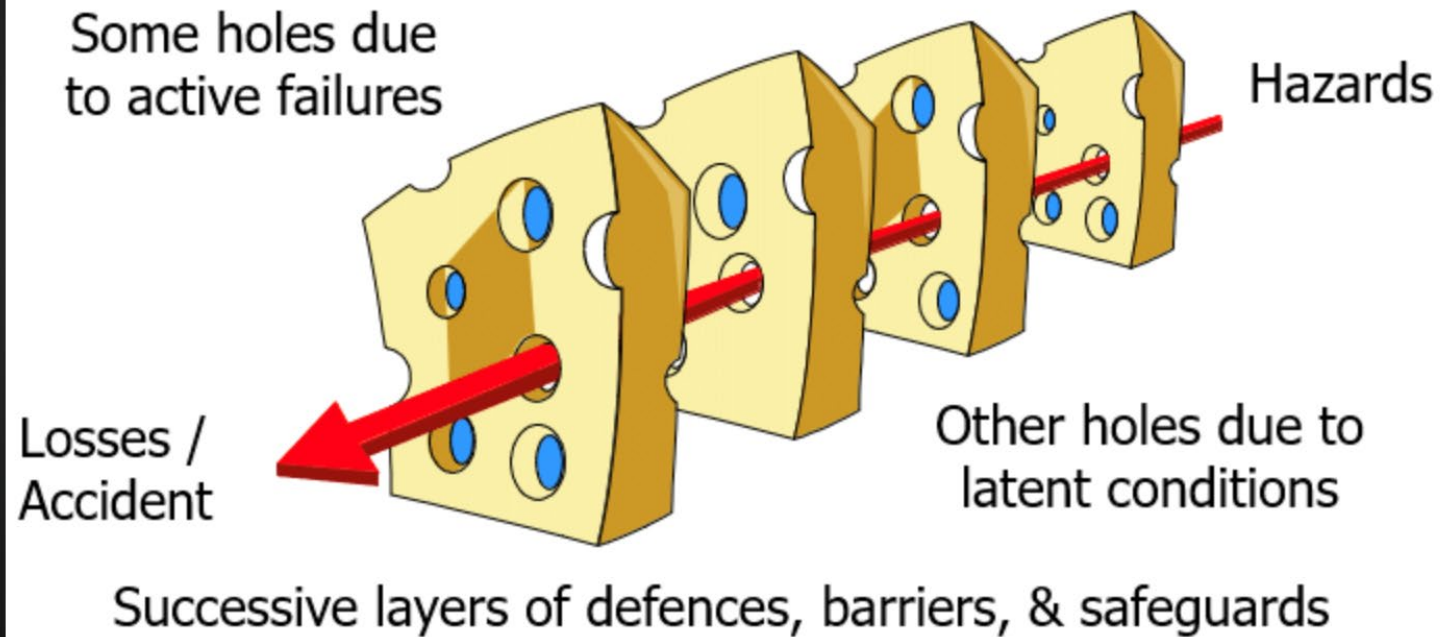


Chat in....

What is the top cause of accidents and incidents in PALTC?

How should team member errors resulting in harm be handled?

The 'Swiss Cheese' model of system failures



Reason, J. (1990). *Human error*. Cambridge University Press.

Wiegmann, D. A., Wood, L. J., Cohen, T. N., & Shappell, S. A. (2022). Understanding the "Swiss Cheese Model" and Its Application to Patient Safety. *Journal of patient safety*, 18(2), 119–123. <https://doi.org/10.1097/PTS.0000000000000810>

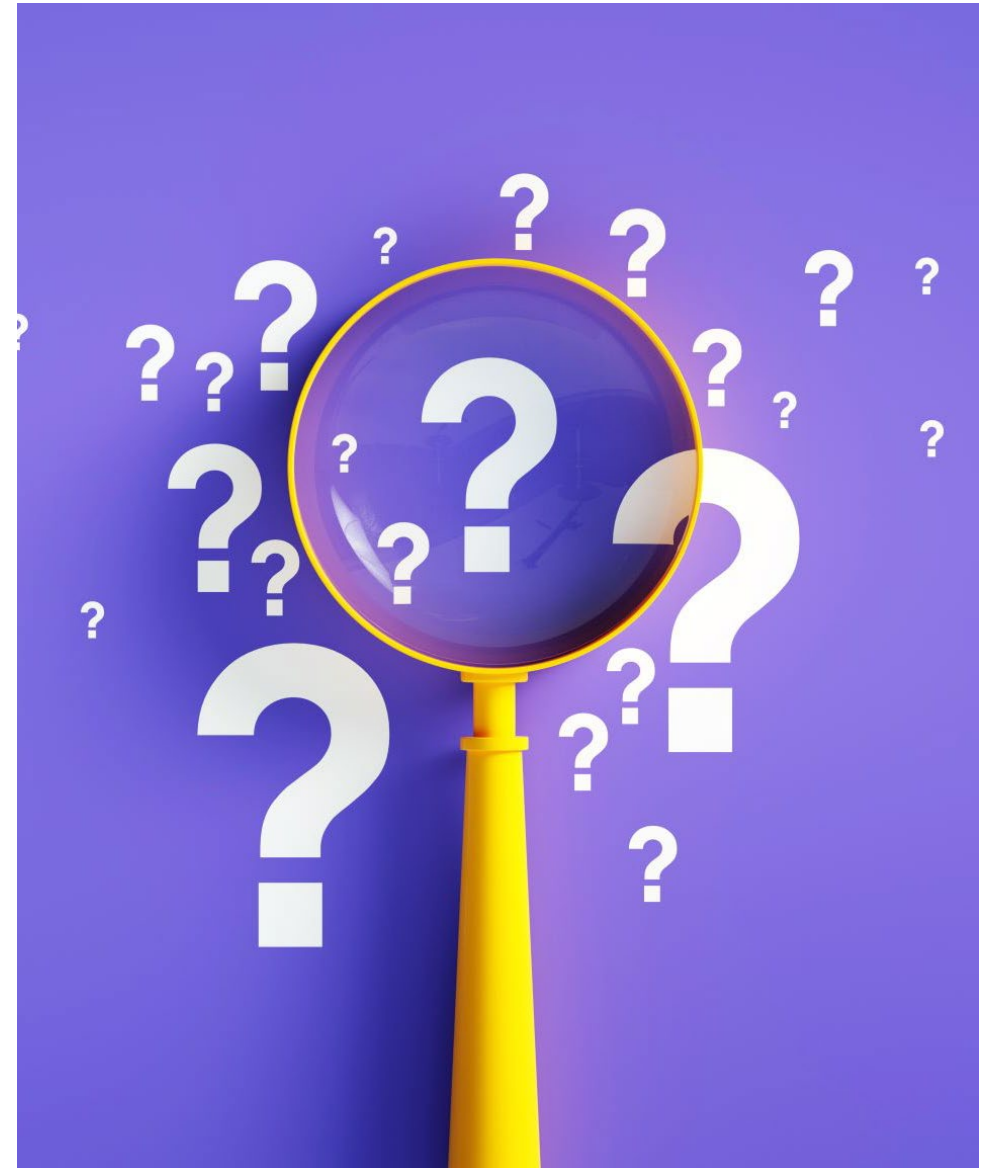
The single greatest impediment to error prevention in the medical industry is “that we punish people for making mistakes.”

Lucian Leape
Harvard School of Public Health
Testimony before Congress on Health Care
Quality Improvement

Poll Question

Which category of errors accounts for the greatest proportion of errors in healthcare?

- Human error
- At-risk behavior
- Reckless behavior



What are the causes of errors in systems?



Human Error

Consolable Behavior

Human error, inadvertent mistake, slip or lapse (Just Culture: human error)

Product of Our Current System Design and Behavioral Choices

Manage through changes in:

- Choices
- Processes
- Procedures
- Training
- Design
- Environment



At-Risk Behavior

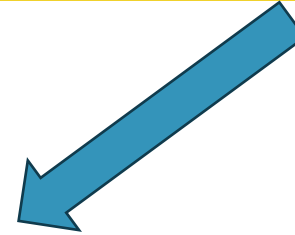
Coachable Behavior

minimization of or failure to recognize risk resulting in deviation from process, policy or system (Just Culture: risky behavior)

A Choice: Risk Believed Insignificant or Justified

Manage through:

- Removing incentives for at-risk behaviors
- Creating incentives for healthy behaviors
- Increasing situational awareness



Reckless Behavior

Punishable Behavior

Intentional violation of process, policy or system.

Conscious Disregard of Substantial and Unjustifiable Risk

Manage through:

- Remedial action
- Punitive action

What is Just Culture?



1. Environmental structures and processes
2. Perceptions and attitudes of individuals
3. Behaviors of individuals, and
4. Buy-in and support from all levels of the administration.



Takeaway – what could a leader do “by next Tuesday?”



What steps can we take?

- **Commit** to the journey
- **Do a self-assessment** – survey widely across the organization
- **Model and teach non-punitive management approaches**
- **Empower employees** to have a **questioning attitude on safety issues**
- **Enact objectives** for directly improving safety in each manager’s unit
- Have a genuine **interest** in safety improvements and **recognizing** those who achieve them in the organization
- **Review** safety of the organization on a regularly scheduled basis and identify short-term and long-term safety goals
- **Encourage reporting** by assuring non-punitive responses

Session 1 - Culture!
Session 2 – Communal Agreements
Session 3- Feedback

Take the Quiz - <https://www.justculture.healthcare/stages-of-just-culture-quiz/>

How “Just” is your organization’s culture?

- Errors are often not reported due to fear of reprisal or punishment
- Your org is primarily reactive to safety issues rather than preventative.
- Individuals who make mistakes are blamed for the error and reprimanded.
- Leadership is focused on rules and expects an error free organization.
- Individuals largely try to hide their mistakes from management.
- Management encourages reporting of errors by creating an environment of trust.
- Errors are seen as a learning opportunity.
- When errors occur your org focuses on what can be improved in the system to avoid the same error recurring.
- Clinicians report most errors but don’t usually report near misses.
- Managers seldom report errors and near misses up the organizational hierarchy.
- The org accepts that errors happen and works proactively to prevent them.
- Clinicians report all errors and near misses so that the org can improve systems
- The culture of your org is fair and clinicians feel a shared accountability with management to improve safety.
- Individuals are rewarded for reporting errors and system issues they notice.
- Your error reporting system allows for anonymous reports or protects the identifiable information of the reporter.

How “Just” is your organization’s culture?





Takeaway – what could a leader do “by next Tuesday?”

“Breaking the Rules” – tapping into your staff’s collective intelligence

If you could break or change one rule in service of a better care experience for patients or staff, what would it be and why?

Alternatives:

- What would you like to see us do differently?”
- “What would you change to provide a better experience for patients and/or staff at [Name of Organization]?”
- “What is one wish you would make to deliver better care for patients or staff?”
- (For patients/families) “Is there anything our organization has done during your stay that has gotten in the way of your family member’s care?”
- (For patients) “What do we do routinely that has made things more challenging for you?”



3:00 PM

Takeaways - Lightening Round

What was of value?



Question





References

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Find the Recordings of *More of a Good Thing* and *Leading with Purpose* (this series) ... Along with Other Resources

<https://paltc.org/goodthing>



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THE SOCIETY FOR POST-ACUTE AND LONG-TERM CARE MEDICINE™



More of a Good Thing



Leading With Purpose

8 Strategies for Engaging Your Careforce

More of a Good Thing: A Framework to Grow and Strengthen the PALTC Careforce

More of a Good Thing expands upon the already successful, evidence-based 4Ms Framework of the Age-Friendly Health System to address the needs and well-being of staff. In 2022, AMDA convened a series of six virtual roundtable discussions guided by the themes of the 4Ms for Staff: What Matters (facility culture and respect), Medication (health promotion and workplace safety), Mentation (mental health and emotional well-being of staff), Mobility (opportunities for personal growth, ongoing education, and career advancement).

With generous funding support from the Jewish Healthcare Foundation and The Foundation for Post-Acute and Long-Term Care Medicine, AMDA is building upon its previous work with new sessions that highlight how nursing home leadership can positively impact facility culture and develop effective policies to help grow and strengthen the PALTC Careforce from within.

Leading with Purpose: 8 Strategies for Engaging Your Careforce

To complement the *More of a Good Thing* discussions, JoAnne Reifsnnyder, PhD, MSN, MBA, FAAN, Professor of Health Services Leadership and Management at the University of Maryland School of Nursing, and former Executive Vice President and Chief Nursing Officer for Genesis Healthcare will lead a series of **eight 30-minute virtual sessions on leadership strategies** that can help facility leaders assess their strengths, lead change, cultivate a positive work culture, and ultimately retain and recruit new members to their teams. The monthly sessions will begin on **January 18, 2024**.

Access recordings and slides from previous virtual discussions below.

More of a Good Thing Meeting Archives & Tools

Developing Leaders Within Your Organization | January 11, 2024

Partnership in Leadership: An Administrator and DON Share Their Success Stories and Lessons Learned | December 14, 2023

New Nursing Home-Value Business Model | November 9, 2023

Save The Date

More of a Good Thing Monthly Roundtable Discussions

The National Dementia Workforce Study: Insights on How to Care for Those Caring for People with Dementia

Date: Thursday, February 8, 2024

Time: 4:00 - 4:45 PM Eastern

Fee: Free

Register Now

Leading With Purpose: 8 Strategies for Engaging Your Careforce

Setting Your Course: How to Jump Start Your Workforce Plan

Date: Thursday, January 18, 2024

Time: 4:30-5:00 PM Eastern

Fee: Free

Register Now

Stay Connected to More of a Good Thing

Sign up for email notifications about future More of a Good Thing programming and resources.

Join Our Email List

Questions?

Contact AMDA's Director of Clinical Affairs and Education: Erin O'Brien, MA,

Next Session!

May 16th (Thursday) at 4:30 EDT

***Creating
psychologically safe
workplaces
(...and why it matters)***

