April 18, 2024

Leading With Purpose

8 Strategies for Engaging Your Careforce

amda The Society For Post-Acute And Long-Term Care Medicine™

The John A. Hartford Foundation

Jewish Healthcare Foundation

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)

Porter, L. (2022, April 15). *We need a careforce, not just a workforce*. McKnight's Long-Term Care News. https://www.mcknights.com/blogs/guest-columns/we-need-a-careforce-not-just-a-workforce

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:

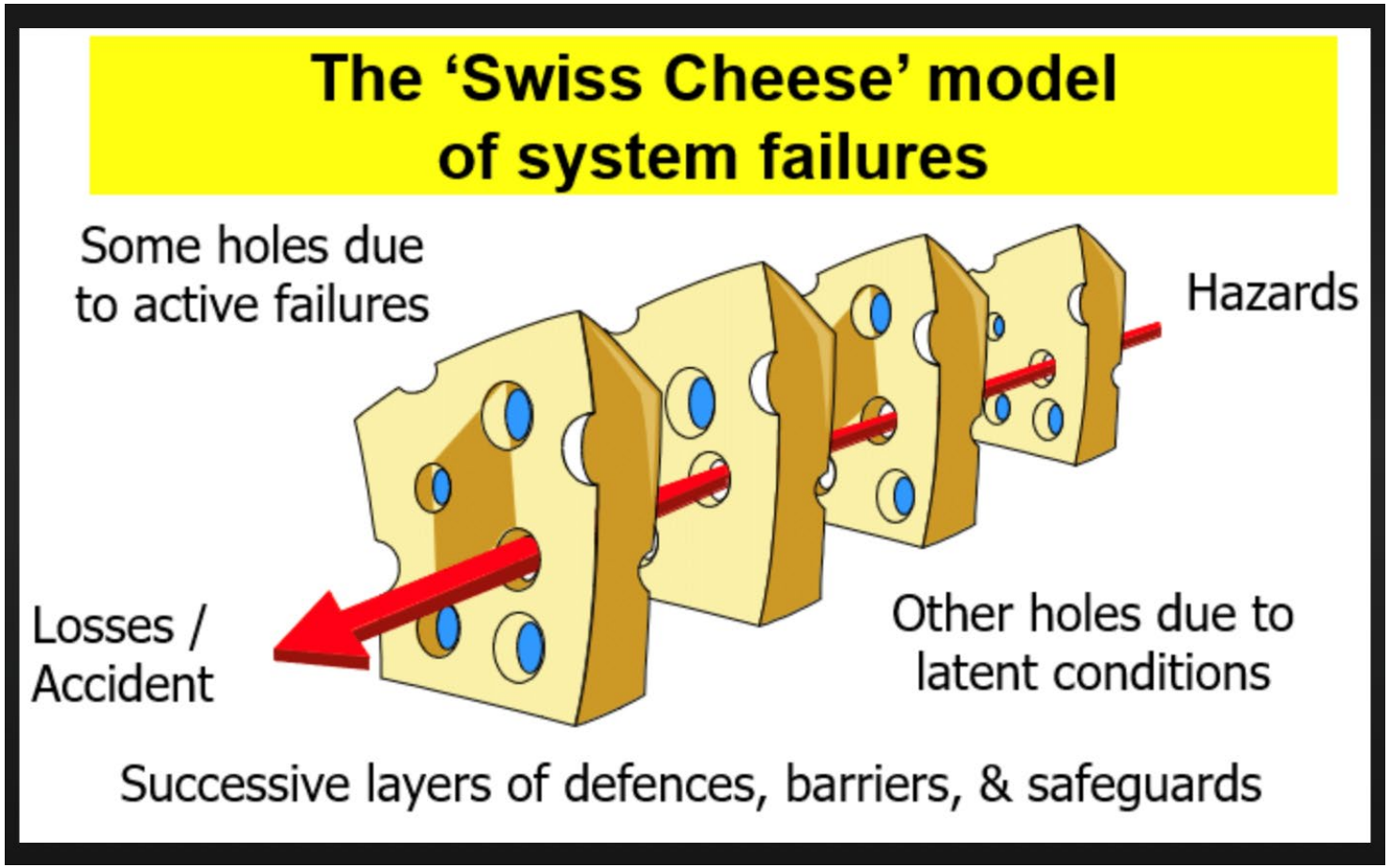
- Produce substantially better outcomes
- Treat customers better and attract new ones
- Are more likely to remain with their organization than those who are less engaged
- Are healthier and less likely to experience burnout.

Harter, J. K., Schmidt, F.L., & Agrawal, S., et al. (2020). *The relationship between engagement at work and organizational outcomes. Gallup.*

Chat in….

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

How should team member errors resulting in harm be handled?



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

Taylor, L.M. (2022). Just culture in healthcare. Available at: https://www.justculture.healthcare

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.

Taylor, L.M. (2022). Just culture in healthcare. Available at: https://www.justculture.healthcare

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.

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

How "Just" is your organization's culture?

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"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?"

https://www.ihi.org/sites/default/files/2023-12/IHI-Leadership-Alliance_Breaking-the-Rules-for-Better-Care-Resource-Guide.pdf

Takeaways - Lightening Round

What was of value?


Questio

References

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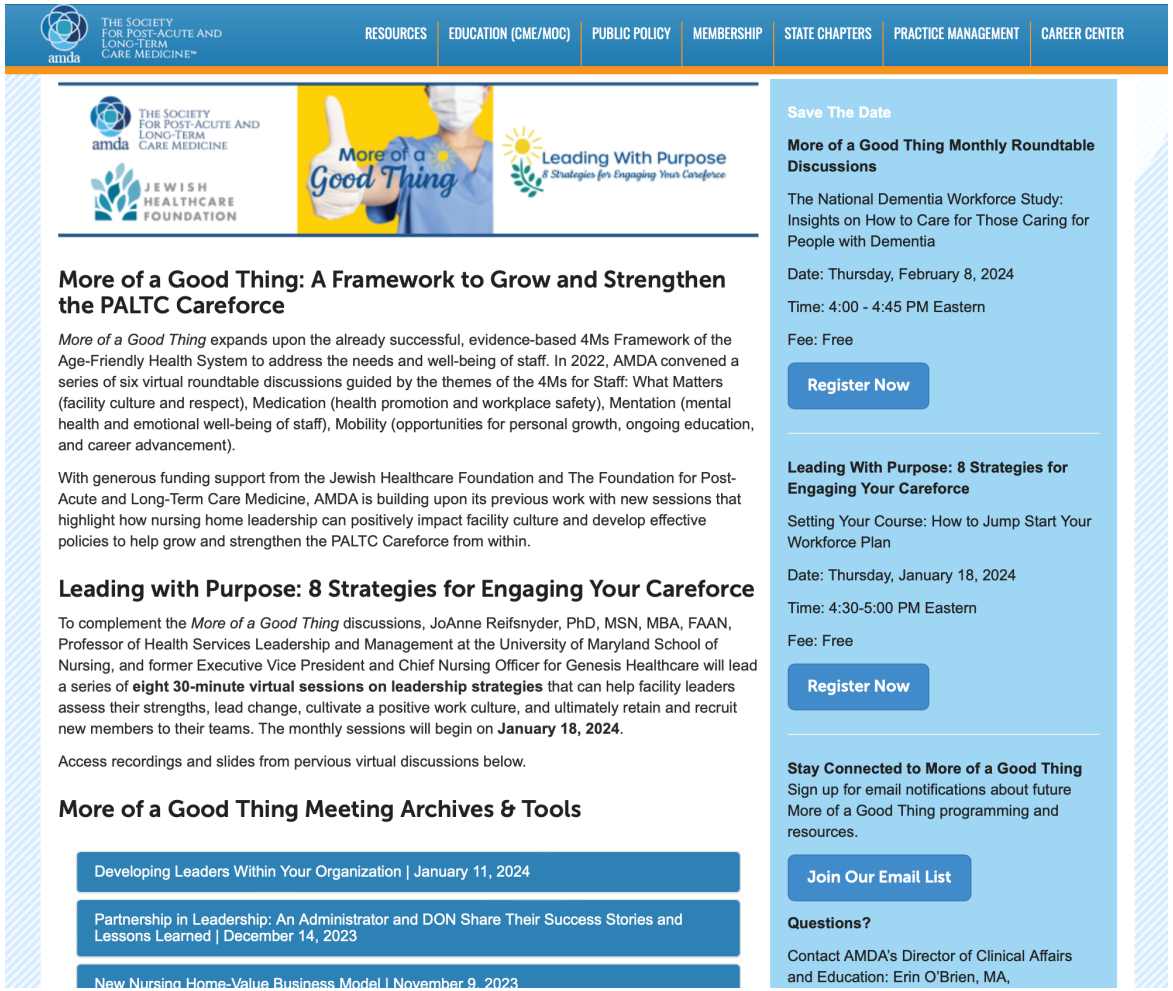
Find the Recordings of *More of a Good Thing* and *Leading with Purpose* (this series) … Along with Other Resources

https://paltc.org/goodthing



Next Session!
May 16th (Thursday) at 4:30 EDT

Creating
psychologically safe
workplaces

(…and why it matters)