The Patient Safety Education Program™
CANADA

Module 8: Leadership: Everybody's Job

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The PSEP – Canada curriculum received editorial contributions from Phil Hassen, International Society for Quality Assurance in Health Care, John Wade, Winnipeg Regional Health Authority, Paula Beard, Canadian Patient Safety Institute, Marie Owen, Canadian Patient Safety Institute, Julie Barré, Canadian Patient Safety Institute, Gordon Wallace, Canadian Medical Protectorate Society, Carolyn Hoffman, Alberta Health Services, Deborah Danoff, Canadian Medical Protectorate Society, Linda Hunter, The Ottawa Hospital, Jane Mann, Fraser Health, Wayne Millar, Eastern Health, Sherissa Microys, The Ottawa Hospital, Donna Davis, Patients for Patient Safety Canada, Elinor Caplan, Patients for Patient Safety Canada, Hugh MacLeod, Canadian Patient Safety Institute, Redouane Bouali, The Ottawa Hospital, Alan Baxter, The Ottawa Hospital, Lisa Calder, The Ottawa Hospital, Craig Bosenburg, Vancouver Island Health Authority, Susan MacKnak, Regina Qu'apelle Regional Health Authority, Annamarie Fuchs, Consultant, Anne Bialachowski, Community and Hospital Infection Control Association-Canada, Joanne Habib, Community and Hospital Infection Control Association-Canada, Deborah Simmons, University of Texas Health Science Center at Houston, and Lisa Little, Consultant.

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Contact PSEP – Canada by e-mail at **PSEPCanada@cpsi-icsp.ca**

[Revised 2017]

PSEP – Canada Objectives	Related CPSI Safety Competencies
The knowledge elements include an understanding of: • The characteristics of learning organizations • The roles of individuals in a learning organization • How to create change using facilitative and distributed team leadership skills The performance elements include the ability to: • Practice facilitative and distributed team leadership in the workplace • Implement patient safety initiatives in the workplace	**Domain: Contribute to a culture of patient safety** *1. Health care professionals who commit to patient and provider safety through safe, competent, high-quality daily practice:* 1.1. Are able to articulate their role as individuals, as professionals, and as health care system employees in providing safe patient care 1.2. Act as role models and champion patient-safety behaviours 1.3. Recognize personal limitations and ask for assistance when required 1.4. Demonstrate knowledge of policies and procedures as they relate to patient and provider safety, including disclosure 1.5. Report unsafe processes within the health care system 1.6. Participate actively in event and close call reporting, event analyses and process improvement initiatives 1.7. Exchange feedback with colleagues on safety issues on an ongoing basis in an open manner 1.8. Integrate safety practices into daily activities (e.g., hand hygiene) 1.9. Recognize clinical situations that may be unsafe and support the empowerment of all staff to resolve unsafe situations 1.10. Demonstrate a commitment to a just culture, promoting fair approaches to dealing with adverse events 1.11. Advocate for improvements in system processes to support professional practice standards and the best patient care *3. Health care professionals who maintain and enhance patient safety practices through ongoing learning:* 3.1. Identify opportunities for continuous learning and improvement for patient safety

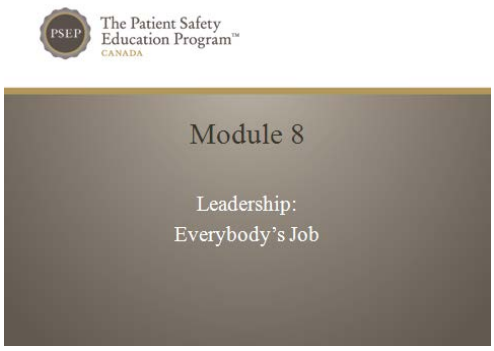
	3.2. Reflect on actions and decisions continuously, with self-awareness and using self-evaluation, to improve knowledge and skills in patient safety 3.3. Analyze a patient safety event and give examples on how future events can be avoided 3.4. Participate in patient and health care professional safety education 3.5. Share information on adaptations to practices and procedures that increase safety for specific individuals or situations 3.6. Contribute to the creation, dissemination, application, and translation of new health care system safety knowledge and practice 3.7. Participate in self- and peer assessments reflecting on practice and patient outcomes *4. Health care professionals who demonstrate a questioning attitude as a fundamental aspect of safe professional practice and patient care:* 4.1. Recognize that continuous improvement in patient care may require them to challenge existing methods 4.2. Identify existing procedures or policies that may be unsafe or are inconsistent with best practices and take action to address those concerns 4.3. Re-examine simplistic explanations for adverse events to facilitate optimal changes to care 4.4. Demonstrate openness to change **Domain: Work in teams for patient safety** *1. Health care professionals who participate effectively and appropriately in an interprofessional health care team to optimize patient safety are able to:* 1.5. Identify and act on safety issues, priorities and adverse events in the context of team practice 1.8. Contribute to a defined process for introducing new and emerging evidence into team-based care *3. Health care professionals who appropriately share authority, leadership, and decision-making for safer care:*

	3.1. Explain their role in patient care to team members and patients 3.2. Collaboratively consult with, delegate tasks to, supervise and support team members 3.3. Accept delegated tasks 3.4. Ask for support when appropriate 3.5. Encourage team members to speak up, question, challenge, advocate and be accountable to address safety issues and risks inherent in the system 3.6. Demonstrate leadership techniques appropriate to clinical situations **Domain: Manage safety risks** *1. Health care professionals who recognize routine situations and settings in which safety problems may arise:* 1.1. Demonstrate situational awareness by continually observing the whole environment, thinking ahead and reviewing potential options and consequences 1.2. Recognize safety problems in real-time and respond to correct them, preventing them from reaching the patient 1.3. Employ, as appropriate, techniques such as diligent information-gathering, cross-checking of information using checklists, and investigating mismatches between the current situation and the expected state *2. Health care professionals who systematically identify, implement, and evaluate context-specific safety solutions:* 2.1. Critically appraise the literature to identify evidence-informed and emerging safety solutions 2.2. Learn from local successes and experiences, assessing their appropriateness to a work setting 2.3. Select the most appropriate solution for a given context, taking into account quality, resources, practicality and patient preferences 2.4. Reflect on the impact of an individual intervention, including the potentially harmful or unintended

	consequences of a safety intervention 2.5. Evaluate the ongoing success of a safety intervention by incorporating lessons learned 2.6. Adjust policies and procedures to reflect established guidelines, if applicable *3. Health care professionals who anticipate, identify and manage high-risk situations:* 3.1. Recognize health care settings that may lead to high-risk situations 3.2. Respond effectively by means of efficient task and process management, crisis team functioning, and dynamic decision-making 3.3. Participate in ongoing training, such as simulations to enhance abilities to manage high-risk situations **Domain: Recognize, respond to and disclose adverse events** *5. Health care professionals who participate in timely event analysis, reflective practice, and planning for the prevention of recurrence:* 5.1. Engage in personal and professional reflection regarding the adverse event 5.2. Recognize the importance of monitoring the outcome of event analysis 5.3. Apply lessons learned from the event analysis 5.4. Advocate for system change as warranted 5.5. Recognize the need for information exchange across health care organizations and as mandated by provincial/territorial legislation

Abstract

Slide 1



The nature of healthcare delivery and the nature of the environment within which we work presents unique challenges for healthcare organizations across the continuum of care and at all organizational levels looking to support and implement changes to improve safety and quality. All individuals within the organization, are leaders at certain times, whether 1:1 with a colleague or within a team.

While there are many programs that focus on individual leadership skills, this module focuses on the leadership skills necessary for culture change necessary for successfully implementing patient safety improvements within their unit or program.

Respect and an understanding for the contribution of all levels of leadership in an organization is essential from the board through to the front line. It is important to note that many view change as a criticism of the past when in fact change is necessary to prepare us for the future. The module concludes with practical activities that leaders can consider implementing to improve patient safety in their local environments.

Keywords

Leadership, learning organization, change, culture, corporate leadership, clinical leadership, work life, quality of work life

Teaching methods

Interactive lecture, role play

Objectives

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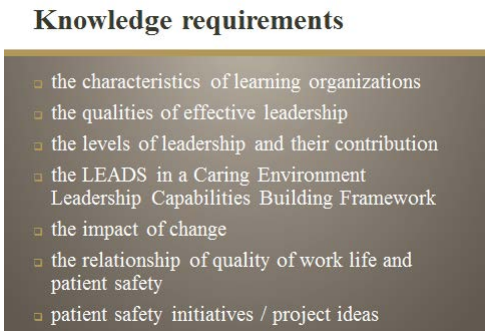

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The objectives of this module are to understand how middle level managers and healthcare providers can facilitate change in the workplace and contribute to creating a learning organization that values patient safety.

Knowledge requirements

The knowledge elements include an understanding of:

- the characteristics of learning organizations;
- the qualities of effective leadership;
- the levels of leadership and their contribution;
- the LEADS in a Caring Environment Leadership Capabilities Building Framework
- the impact of change;
- the relationship of quality of work life and patient safety; and
- patient safety initiatives / project ideas

Performance requirements

The performance elements include the ability to:

- discuss and understand effective leadership qualities;
- discuss the ‘layers’ of leadership within an organization; and
- identify and implement patient safety initiatives

Clinical case on trigger tape

Slide 4

A hospital administrator is doing an executive walkaround with a group of residents, demonstrating the institution’s commitment to patient safety and keeping in touch with what’s happening with frontline staff. The team stops at a nurses’ station to speak with a clinician.

Introduction

Slide 5

It is now well recognized that improving safety and quality in healthcare requires modification through to possibly radical changes in both the decision-making, the practice of healthcare delivery and the organizational culture. Identifying the need for, and enacting such changes in any healthcare organization presents considerable

challenges and barriers. There are many reasons for these challenges/barriers including: discord between clinical and corporate leadership; the intensely hierarchical nature of healthcare organizations; lack of incentive for individuals to take on a leadership role; lack of organizational responsiveness to the need for change; fear of change; the 'silo' nature of healthcare delivery; and the failure to reward success/progress. In addition, change is sometimes seen as a criticism of the past when in fact it is about positioning the team, organization or care in order to deal with today and the future. These realities may result in lack of motivation or buy-in to participate in the new directions.

Over the last decade there has been considerable focus on the role of the leader in healthcare improvement and reform; thus, leadership development is now a central component in the redevelopment of most healthcare systems around the world. However, leaders can only be effective in organizations that support and cultivate leadership throughout the organization such that it does not rest in the hands of a few. Successful change and improvement relies on effective leadership throughout an organization.

This module focuses on understanding the leadership skills and strategies needed to foster the development, implementation and sustainability of patient safety initiatives throughout an organization. Leadership is key to success, key to improving the safety of care and improving patient outcomes. This module will provide references to some activities that middle level managers can undertake to support the development of this culture.

Learning organizations

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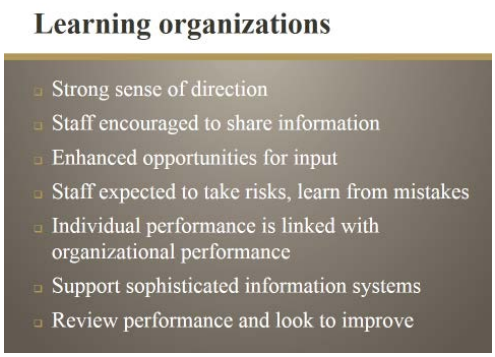

One of the great challenges facing healthcare organizations has been their inability to respond to a changing environment and increasing pressure for reform. In contrast, other industries have developed a more dynamic approach to dealing with their environment. These organizations are called 'learning organizations'.

The term learning organization has been applied to organizations that can quickly learn and innovate their work practices and services in response to an increasingly and constantly changing environment. By adopting the characteristics of a learning

organization, healthcare organizations may be better equipped to implement change for improvement, as well as foster leadership skills in their employees.

Key characteristics of learning organizations include:

- everyone having a strong sense of direction;
- staff who are encouraged to acquire, process and share information;
- staff who are expected to risk failure and learn from mistakes;
- individual performance is linked with organizational performance;
- information systems exist that facilitate rapid acquisition and sharing of complex information, enabling effective knowledge management;
- managerial structures and practices that enhance opportunities for employee and consumer involvement in the organization; and
- the capacity to review its performance and look towards further improvement.

PSEP – Canada Module 1: Systems Thinking: Moving Beyond Blame to Safety covers the components of a high reliability organization (HRO), which is an example of a highly functioning learning organization.

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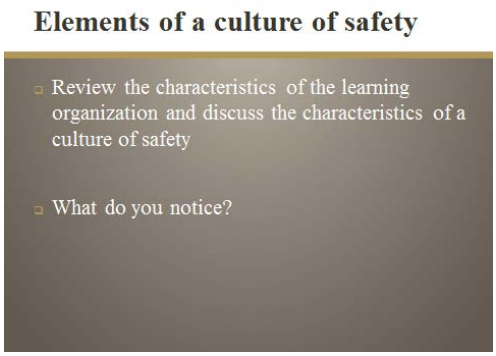

Some of the key characteristics of a learning organization are also key elements of a culture of safety. The characteristics of the learning organization are foundational and essential to that culture of safety and enabling improvements. PSEP – Canada Module 5: Organization and Culture discusses the characteristics of a culture of safety and recommended organizational practices.

Qualities of leadership

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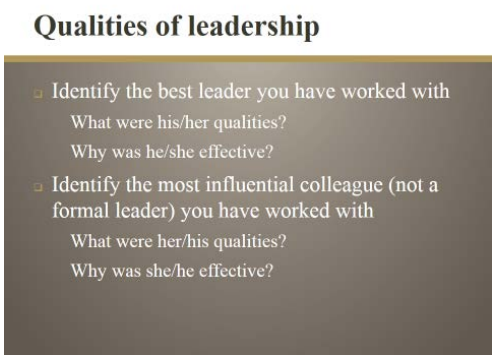

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The qualities of an effective leader include being an excellent communicator, humble, a listener, motivating, inspiring, sensitive to others, visible, ethical, confident, hands-on, and respectful. Effective leaders also take risks, go first, empower others, build trust, recognize contributions, celebrate successes, foster collaboration, has a vision, sets direction, and is a role model for others.

One of the roles of a leader is to focus on enabling others to learn and develop skills and to grow both personally and professionally. Leaders have the responsibility to live/breathe the qualities of a culture of safety and to act as a role model for honesty, transparency, no-blame and respect.

What is leadership?

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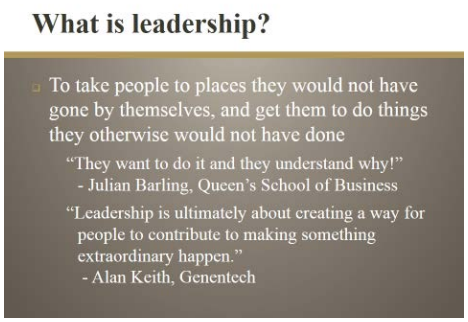

Leadership is taking people to places they would not have gone by themselves, and getting them to do things they otherwise would not have done.

> "They want to do it and they understand why!" - Julian Barling, Queen's School of Business
>
> "Leadership is ultimately about creating a way for people to contribute to making something extraordinary happen." - Alan Keith, Genentech

Leadership is not about personality, it is about behaviour. Leaders can seize the opportunities to bring out the best in others and guide them on the journey to accomplishing exceptionally challenging goals. (Kouzes & Posner)

Key points

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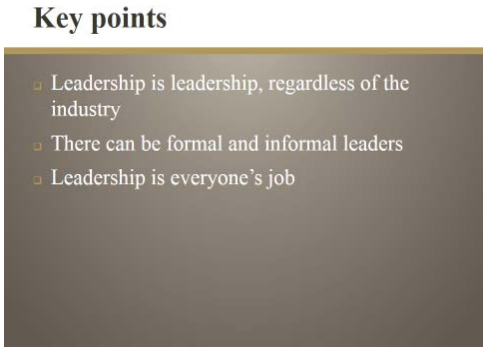

The qualities of an effective leader are generally the same whether in healthcare, banking or other industries.

Formal leaders are designate by their titles and have line responsibility – including the responsibility to hire and fire. That being said, it is critical to also know who the informal leaders are within any team or organization. The informal leaders can assume an extremely powerful role. Those informal leaders are important to the success or demise of any project – they should be identified and become important members of the team for any initiative.

Those often with the greatest influence are the informal leaders, the champions. It is up to an organization to recognize and cultivate those leaders to enable the effectiveness of the patient safety plan.

Learning and leadership

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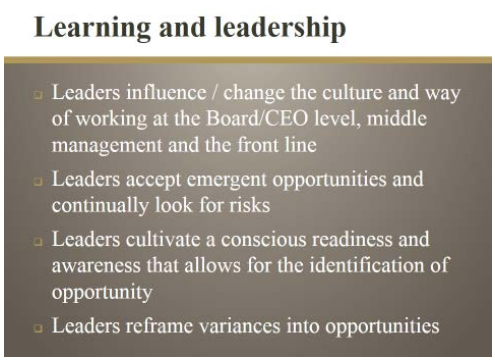

The most effective leadership addresses issues at three levels: the executives, the management, and the front-line. Leaders accept emergent opportunities and continually look for trouble, as well as reframe variances into opportunities. Leaders cultivate a conscious readiness and awareness that allows for the identification of opportunity.

Levels of formal leadership

Slide 13

While informal leadership is critical, the formal lines of leadership must be respected and utilized to enable effective implementation of any strategy. It is also important to remember that the CEO and the Board work in partnership as well as the CEO and the Senior Leadership Team.

Roles and responsibilities

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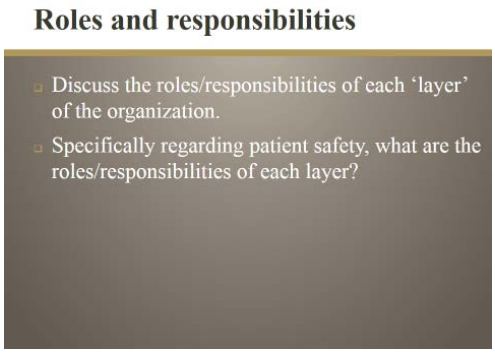


When looking at the roles and responsibilities of each formal leadership layer of the organization there are many factors to consider.

The board level must have a 5 to 10 year vision for the organization and should consider the following:

- must identify with the population it serves and understand their needs
- must carry out its fiduciary responsibilities
- sets the mission, vision and strategic directions - with the input of stakeholders – of the organization
- oversees and ensures financial viability; resource allocation
- receives performance measure reports – to enable monitoring of progress
- plays a key role in overseeing quality and patient safety
- hires, evaluates and if necessary, terminates the CEO
- ensure that the board and senior leadership are working collaboratively to create an environment focused on patient safety and quality of work life

The CEO of an organization also needs to have a 5 to 10 year vision for the organization and should act on the following:

- maintain responsibility for the operations of the organization and ensure that the strategic directions of the organization are achieved
- with the board, set the 'tone'/ culture of the organization – ensuring strategies are in place to enable that culture to flourish, e.g. for patient safety – a just culture of openness and transparency is cultivated
- develop a Leadership team to ensure effective leadership throughout the organization
- develop an organizational structure that enables effective management
- ensure the existence and implementation of a quality and patient safety plan for the organization and the ongoing monitoring of its effectiveness

The Chief of Staff in a hospital setting typically reports directly to the board and not to the CEO, and generally has a key role to play regarding the quality of care. The Chief of Staff guides the board in its quality of care decisions and should play a key role in the quality/patient safety plan for the organization.

The Vice Presidents and Chief Nursing Executives of organizations should have a 3 to 5 year vision for the organization and their roles and responsibilities include:

- having the quality and patient safety departments reporting to them and thus ensuring the quality and patient safety programs are sound and being implemented successfully
- keeping the CEO informed regarding the quality and patient safety initiatives of the organization
- monitoring the organization-wide plan and ensuring effective impact on the system/organization

The Director level of an organization should have a 3 year vision and is responsible for:

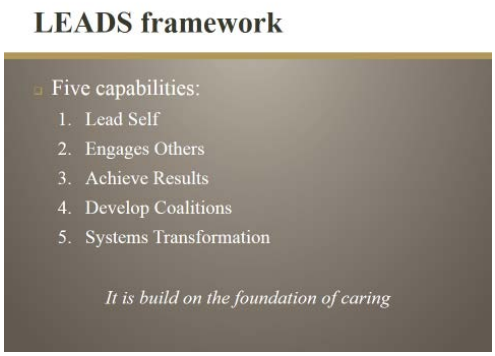
- overseeing the implementation of the quality and safety plan, and its effective application at the program/unit level

The Manager level of an organization is concerned for today to one year in the future and will be, with the input of their staff, interdisciplinary team, and champions focusing on:

- ensuring areas of focus are identified and aligned with priorities,
- actively participating in quality and patient safety programs,
- ensuring timelines are met,
- monitoring the impact and results of initiatives

LEADS framework

Slide 15



In 2009 *The LEADS in a Caring Environment Leadership Capabilities Building Framework* was adopted by the Canadian Health Leadership Network (CHLNet), the Canadian College of Health Services Executives and the Health Care Leaders Association of British Colombia (HCLABC) Leaders for Life program as the standards

for the development of leadership in Canada's health sector. The *LEADS in a Caring Environment Leadership Capabilities Building Framework* was developed by researches from Royal Roads University in British Colombia.

The framework identifies the leadership and management capabilities required for individuals to effectively create change in the modern Canadian health care environment (Dickson, 2010). There are five capability domains identified in the framework: Lead Self, Engages Others, Achieve Results, Develop Coalitions and Systems Transformation.

The Lead Self domain consists of four capabilities that a leader should be able to demonstrate namely:

- Self-aware – which includes being emotionally self-aware, being aware of perceptions and assumptions and being aware of values and principles
- Manages Self – this refers to managing emotions, exhibiting personal mastery and generating life balance
- Develops Self – which includes developing soft skills such as emotional and social intelligence, confidence, team management
- Demonstrates Character – this includes acting with integrity and exhibiting emotional resiliency

The Engage Others domain includes the following four capabilities:

- Foster development in others
- Contribute to the creation of healthy organizations
- Communicate effectively
- Build effective teams

The Achieve Results domain includes the following four capabilities:

- Set direction
- Strategically align decisions with vision, values and evidence
- Take action to implement decisions
- Assess and evaluate

The Develop Coalitions domain includes the following four capabilities:

- Purposefully build partnerships and networks to create results
- Demonstrate a commitment to customers and service
- Mobilize knowledge
- Navigate socio-political environments

The last capability domain in the *LEADS in a Caring Environment Leadership Capabilities Building Framework* is Systems Transformation and includes:

- Demonstrates systems/critical thinking
- Encourages and supports innovation
- Orients themselves strategically to the future
- Champions and orchestrates change

Leadership and change

Patient safety initiatives

Slide 16

Not everyone is on board with change even if the intent and direction is absolutely clear and correct. It is important for the leader to be sensitive to this reality, to identify strategies to help get people 'on board'. Look for the informal leaders and champions, (refer to the PSEP – Canada Module 15: Capacity Building: Transferring PSEP – Canada Knowledge to your Organization for more information on Change Management).

Patients and families as partners

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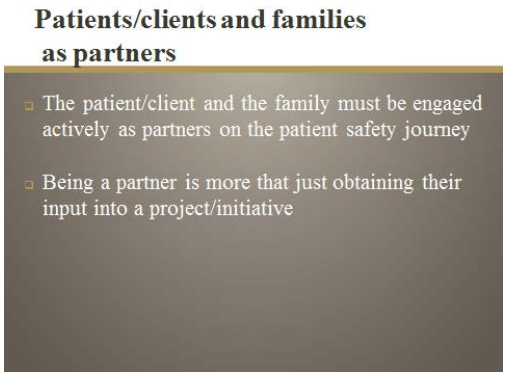

The patient/client and the family must be engaged actively as partners on the patient safety journey. Being a partner is more that just obtaining their input into a project/initiative. What does being a partner truly mean? More information on this

subject can be found in PSEP – Canada Module 7: Patients as Partners: Engaging Patients and Families.

Quality of work life

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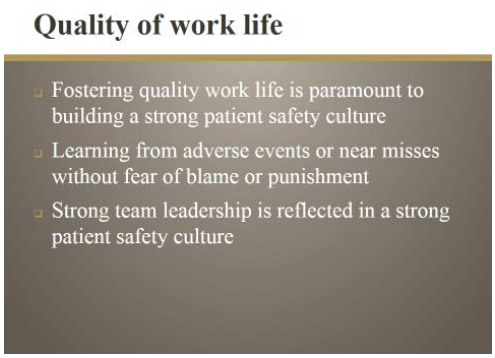

It is important for leaders to focus on the staff ensuring that their quality of work life supports the work to be accomplished. The leaders should listen to the staff, empower staff, work with interdisciplinary teams discussing with staff on a regular basis what is going well and what might be improved to enable the staff to provide high quality care.

Staff, volunteers, physicians and all involved in health care provision will do a better job when they work in a truly caring environment, with leaders who actively demonstrate a caring attitude towards staff.

How can leaders support patient safety initiatives?

Integrating initiatives

Slide 19

To ensure safe patient care all healthcare organizations should develop, implement and monitor a quality/patient safety plan. The quality/patient safety plan should be aligned with the strategic priorities of the organization and include goals, outcomes and performance measures which are regularly reported to the leadership of the organization.

Implementing a unit/program patient safety initiative necessitates that the approach is linked to the organization's overall plan to ensure it is supported and effective. The Leadership of an organization plays a key role in ensuring that all levels of the organization are aware of the overall quality patient safety plan.

Identifying the participants

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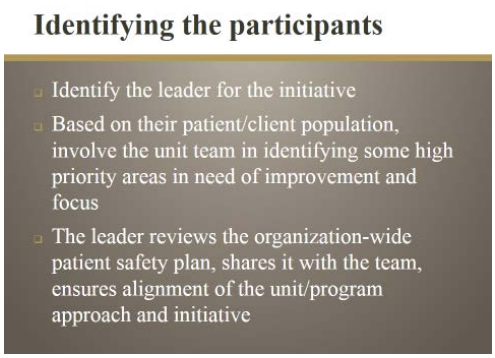

Leaders must be cognizant of the organization-wide plan for quality improvement and patient safety. Narrowly focusing an initiative on the unit without recognition of the organization-wide plan may result in difficulty sustaining the unit plan and lack of support for any resources required. An organization-wide plan may provide the infrastructure, support, tools, knowledge, motivation and support from the unit through to the board

When seeking possible project areas, ask staff what is their greatest concern regarding patient safety - this may assist in identifying an area of priority for focus. Choose something manageable and something measurable.

Each unit/program success, within the overall organization plan, will also potentially provide system-wide impacts across the organization. Other units/programs may benefit from the success of one initiative and magnify that impact dramatically.

While teams are essential for success – there must be a designated leader, someone in the charge of the team to ensure a plan is in place, resources are available and goals are met.

Ideas to consider

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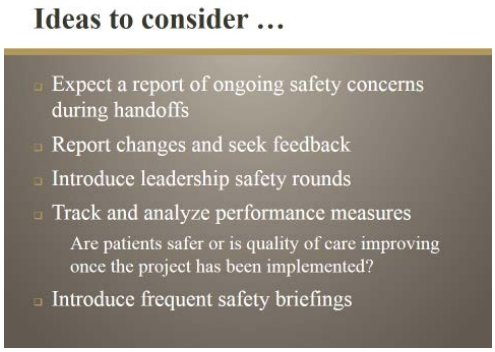


Report ongoing safety concerns during handoffs

A significant leadership competence, which will improve patient safety, lies with individual members of the healthcare team reporting hazards and system breakdowns that have occurred. One way to ensure this reporting is to add some of these systemic safety issues in a sign-out report to oncoming teams. When implemented as a routine procedure, this will increase the awareness of the unit's entire staff of ongoing safety concerns.

Another way to ensure safe patient care after hand off is to develop and test a protocol. If none exist, any member of the team can suggest that one be developed and tested to see if it results in better quality and complete information exchange with the team taking over the care of the patients.

Report changes and seek feedback

To truly have an impact on an organization's safety culture and have staff observations become part of the learning process, staff must ask for feedback on any reports provided to management. Staff should also be prepared to report on any changes they have made to either systems or procedures and how those have affected safety outcomes. When performed on a routine basis, this technique will enable the healthcare organization to become a true learning organization. Effective reporting can only be performed if the team tracks the changes and benchmarks against past performance and national standards.

Introduce leadership safety rounds

An active way to engage senior leaders in the work staff performs is to invite them onto the unit to participate in routine safety rounds. If senior managers do not hold safety walk rounds you could suggest it in the next forum available to staff. If no such forums occur, you could make suggestions to management by giving them details of successful safety walk rounds in other institutions. The benefit of inviting senior management to visit or join a meeting of the team is that it will increase their awareness of the risks and hazards

staff face, and it will also demonstrate staff's commitment to providing a safer environment for patients.

At the unit level seek to institute a routine practice of weekly safety rounds where the entire healthcare team can discuss and seek resolutions to problems identified by the team. This practice would include adverse events and near misses associated with system breakdowns and equipment failures. For example, the team might want to examine the stocking of look-alike and sound-alike medicines or the presence of multiple types of IV pumps on the unit.

Track and analyze performance measures

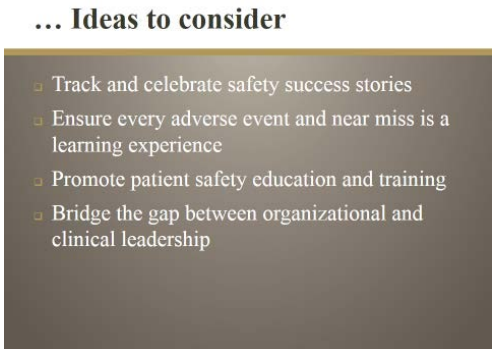
It is important to report and analyze "near misses." These reports should be made in a systematic and routine fashion and be part of the weekly unit safety rounds. Using these reports to create awareness among the ranks of middle and senior leaders is also a critical factor in the success of a safety program. Communicating your observations—and an expectation that there will be a response to them—enables your senior leaders to take your concerns seriously and to incorporate them into a system-wide improvement effort.

Hazard surveillance cannot be limited to tracking a few adverse events and risks. In addition to weekly unit safety rounds, unit-specific performance measures addressing both patient and worker safety should be added to the list of clinical performance metrics already in place. Trending and displaying data for the team to view is an important way to heighten patient safety awareness and to track progress of patient safety initiatives or clinical practice improvement projects. Trend data should relate to misses and near misses, as well as adherence to, or deviation from, existing guidelines or protocols (behavioural norms).

Introduce frequent safety briefings in your setting

Ignorance is not bliss. All team members have a role in raising awareness and fostering a culture of safety. Patient safety is everyone's business and leadership can be demonstrated by any member of the team by being watchful and mindful of patients while they are in the hands of your team. A number of institutions have introduced frequent safety briefings into their daily or weekly activities as a way to encourage input from all team members. Safety briefings provide a short, structured and non-punitive framework to discuss and address potential safety issues within the unit. The Institute for Healthcare Improvement provides a tool for implementing safety briefings which is included in the resources in this module. In the PSEP – Canada Module 4: Teamwork: Being an Effective Team Member, there are examples of other strategies such as huddles, checklists, debriefs and briefs to enhance patient safety vigilance.

Slide 22



Track and celebrate safety success stories

All patient safety initiatives should be well documented so that a record is kept about what did and did not work. High turnover of staff in some units may mean that important historical information is lost. Keeping a record of improvement projects can assist new staff and also clearly shows that your unit is participating in patient safety initiatives. Another important reason is to enable celebration of patient safety success stories. This boosts individual and team morale and keeps the momentum for improving patient safety.

Patient safety and quality improvement departments should be made aware of the progress made on initiatives, so they can communicate information about these improvements across the organization. This process facilitates the sharing of learnings and improvement throughout the organization. It will also increase organizational leadership support as lessons are shared across units leading to systemic level organizational improvement.

Ensure every adverse event is a learning experience

Despite increased mindfulness about the situation and widening the perception of unanticipated events, adverse events or failures of planned actions that cause patient safety incidents will still occur. Once they have occurred, however, a major responsibility of the care team is to limit the harm from this event. Learning how to become resilient and responsive in the face of an adverse event is a critical leadership trait in minimizing harmful incidents. Being resilient and responsive involves understanding when the adverse event has occurred and what its potential harm may be. Learning lessons from the experiences of others as well as from one's own experience in "putting out fires," is central to developing and maintaining a culture of safety.

Understanding this concept of resilience also requires the leader and the team to be able to respond quickly to the adverse event without losing focus. A critically important skill is the ability to mentally simulate different possibilities from different actions in response to the event. This ability to simulate can be further enhanced by having team members and leaders participate in regular training involving simulated scenarios so that people

understand what their roles and responsibilities are in a crisis situation. Simulation training can be key to developing resilience.

In a true learning organization, every adverse event, every situation of real harm and every clinical crisis becomes an opportunity to learn, improve and develop the appropriate behaviours to deal with the next clinical crisis.

Promote patient safety education and training

The focus of professional development on the technical skills of individual clinicians places an imperative for front line managers to ensure staff are supported and encouraged to gain education and training in areas such as human factors engineering and clinical practice improvement that would not normally be included in an individuals professional development planning.

Though education in patient safety science is not often a priority of busy clinicians, it is important as a leader to encourage and support members to participate in learning activities around improving patient safety. Invite known experts to join a team meeting or arrange for a lunch time education session. If patient safety education is lacking in your organization you can request management to invest in education and training for all staff.

Bridge the gap between organizational and clinical leadership

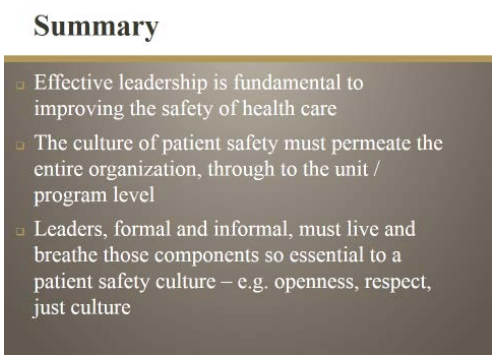
The unique and complex hierarchical structures and responsibilities in healthcare present challenges at all levels of management. The level of control and autonomy exerted by health professionals can bring them into constant conflict with organizational leadership who operate within an environment of increased accountability and the need for healthcare to be practiced within a managed framework.

The bureaucracy of healthcare management is often far removed from patient care, a situation that can be frustrating to individual teams and staff. Healthcare leadership is generally focusing on budgets and cost control. Because of this disconnect between clinicians and management, there have been many attempts to improve understanding between these two groups. These attempts have had varying levels of success.

To bridge this gap, clinicians should be encouraged to gain leadership and managerial skills and non-clinical managers must learn how to gain the support of clinicians to implement reform. Facilitative leadership can encourage and support understanding between clinical and organizational hierarchies. Facilitative leadership is a type of leadership that is non-authoritative and invites open suggestions and constructive feedback from the floor so that everyone involved gets to share their thoughts and opinions.

Summary

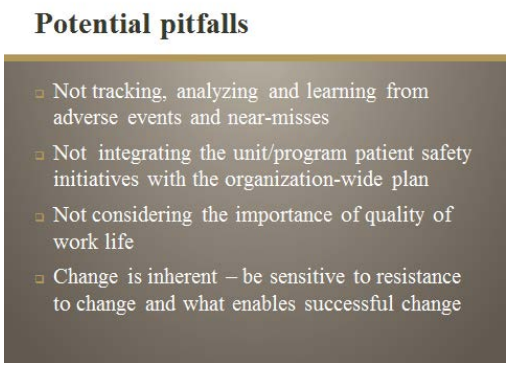
Slide 23



Effective leadership is fundamental to improving the safety of health care. The leadership must come from all levels, so that the culture of patient safety permeates the entire organization, from the Board and CEO level right through to the unit / program level. Leaders, formal and informal, must live and breathe those components so essential to a patient safety culture, e.g., openness, respect, and just culture.

Potential pitfalls

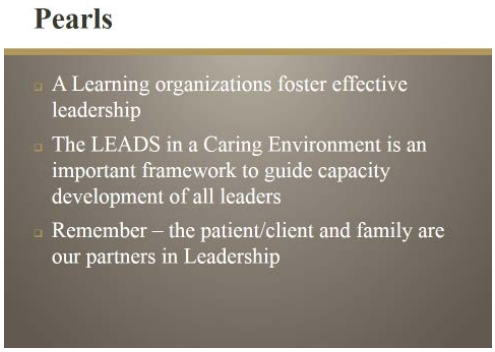
Slide 24



1. Not tracking, analyzing and learning from adverse events and near-misses
2. Not integrating the unit/program patient safety initiatives with the organization-wide plan
3. Not considering the importance of quality of work life
4. Change is inherent – be sensitive to resistance to change and what enables successful change

Pearls

Slide 25



1. A Learning organizations foster effective leadership

2. The LEADS in a Caring Environment Leadership Capabilities Building Framework is an important framework to guide capacity development of all leaders

3. Remember – the patient/client and family are our partners in Leadership

Toolkits & outcome measures

- **Effective Governance for Quality and Patient Safety: A Toolkit for Healthcare Board Members and Senior Leaders**: The Effective Governance for Quality and Patient Safety Toolkit leverages the commissioned research led by Dr. G. Ross Baker (2010), "*Effective Governance for Quality and Patient Safety in Canadian Healthcare Organizations*", which identified a number of key elements or 'drivers' that enable boards to fulfill their responsibilities for quality and patient safety. http://www.patientsafetyinstitute.ca/English/toolsResources/GovernancePatient Safety/Pages/default.aspx http://www.patientsafetyinstitute.ca/french/toolsresources/governancepatientsafety/pages/default.aspx
- **Strategies for Leadership: Hospital Executives and their Role in Patient Safety**: Dana-Farber Cancer Institute, Boston, Massachusetts, USA http://www.ihi.org/IHI/Topics/PatientSafety/SafetyGeneral/Tools/StrategiesforLeadershipHospitalExecutivesandTheirRoleinPatientSafety.htm
- **Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies; Volume 1: Series Overview and Methodology**: University of California, San Francisco-Stanford Evidence-based Practice Center (EPC) – Academic Institution Agency for Healthcare Research and Quality – Federal

Government Agency
[U.S.] http://www.ahrq.gov/downloads/pub/evidence/pdf/qualgap1/qualgap1.pdf

- **Engaging physicians in a shared quality agenda**: Reinertsen JL, Gosfield AG, Rupp W, Whittington JW. Engaging Physicians in a Shared Quality Agenda. IHI Innovation Series white paper. Cambridge, Massachusetts: Institute for Healthcare Improvement;
  2007. http://www.ihi.org/IHI/Topics/Improvement/ImprovementMethods/Literature/EngagingPhysiciansinaSharedQualityAgenda.htm
- **Patient Safety Leadership WalkRounds™**: Frankel A, Graydon-Baker E, Neppl C, Simmonds T, Gustafson M, Gandhi T. Patient safety leadership walkrounds. Joint Commission Journal on Quality Improvement. 2003;29(1):16-
  26. http://www.ihi.org/IHI/Topics/LeadingSystemImprovement/Leadership/Tools/Patient+Safety+Leadership+WalkRounds™+%28IHI+Tool%29.htm
- **Project Initiative Tool: Clinical Manager Workbook (IHI Tool)**: Institute for Healthcare Improvement (in conjunction with Lynn Spragens and the Robert Wood Johnson Foundation) Cambridge, Massachusetts,
  USA http://www.ihi.org/IHI/Topics/LeadingSystemImprovement/Leadership/Tools/ProjectInitiativeToolClinicalManagerImpactWorkbook.htm
- **Innovation Quality Project Summary Sheet Multi-Project Tracking Tool (IHI Tool)**: Institute for Healthcare Improvement (in conjunction with Lynn Spragens and the Robert Wood Johnson Foundation)Cambridge, Massachusetts, USA http://www.ihi.org/IHI/Topics/LeadingSystemImprovement/Leadership/Tools/InnovationQualityProjectSummarySheetMultiProjectTrackingTool.htm
- **Business Tools to Support Clinical Project Evaluation (IHI Tool)**: Institute for Healthcare Improvement (in conjunction with Lynn Spragens and the Robert Wood Johnson Foundation) Cambridge, Massachusetts,
  USA http://www.ihi.org/IHI/Topics/LeadingSystemImprovement/Leadership/Tools/BusinessToolstoSupportClinicalProjectEvaluation.htm
- **Strategies for Leadership: An Organizational Approach to Patient Safety**: VHA 2000 http://www.ihatoday.org/issues/safety/tools/vhatoolfinal.pdf
- **University of Michigan Health System Patient Safety Toolkit**: University of Michigan Health
  System http://www.med.umich.edu/patientsafetytoolkit/index.htm
- **Project Tracking Tool: Project Tracking Summary and Strategic Quality Goals (IHI Tool)**: Institute for Healthcare Improvement (in conjunction with Lynn Spragens and the Robert Wood Johnson Foundation)Cambridge, Massachusetts,
  USA http://www.ihi.org/IHI/Topics/LeadingSystemImprovement/Leadership/Tools/ProjectTrackingToolProjectSummaryandStrategicQualityGoals.htm
- **TeamSTEPPS: Strategies and tools to enhance performance and patient safety**: Department of Defense (DoD) in collaboration with the Agency for Healthcare Research and Quality (AHRQ). http://www.ahrq.gov/qual/teamstepps/

- **Safety Briefings (IHI Tool)**: Institute for Healthcare Improvement; Boston, Massachusetts, USA (2004) http://www.ihi.org/IHI/Topics/PatientSafety/MedicationSystems/Tools/Safety%20Briefings%20(IHI%20Tool)
- **Patient Safety Culture Surveys**: April 2007. Agency for Healthcare Research and Quality. Rockville, MD. http://psnet.ahrq.gov/resource.aspx?resourceID=5333
- **Example of a Health Care Failure Mode and Effects Analysis for IV Patient Controlled Analgesia (PCA)**: Institute for Safe Medication Practices (ISMP). 2005. http://www.ismp.org/Tools/FMEAofPCA.pdf
- **Using Health Care Failure Mode and Effect Analysis**: DeRosier J, et al. The VA National Center for Patient Safety Prospective Risk Analysis System (2002). *Joint Commission Journal for Quality Improvement* 28:248-67. http://www.va.gov/ncps/SafetyTopics/HFMEA/HFMEA_JQI.html

Resources

- **Patient Safety Culture Improvement Tool**: Fleming M, Wentzell N (2008) "Patient Safety Culture Improvement Tool: Development and Guidelines for Use" Healthcare Quarterly 11 (Special Edition):10-15. http://www.longwoods.com/content/19604
- **Patient Safety Culture Measurement and Improvement: A 'How To' Guide**: Fleming M (2005) "Patient Safety Culture Measurement and Improvement: A 'How To' Guide" Healthcare Quarterly 8(Special Edition):14-19. http://www.longwoods.com/content/17656#loopBack
- **Modified Stanford Instrument (MSI) Patient Safety Culture Survey**: Ginsburg LR (n.d.). *Patient safety culture research at York University.* http://www.atkinson.yorku.ca/~safetyculture/questionnaire.htm
- **Canadian Root Cause Analysis Framework**: In 2006, the Canadian Patient Safety Institute partnered with Saskatchewan Health and the Institute for Safe Medication Practices Canada (ISMP Canada) to co-author the Canadian Root Cause Analysis Framework. http://www.patientsafetyinstitute.ca/English/toolsResources/rca/Pages/default.aspx http://www.patientsafetyinstitute.ca/french/toolsresources/rca/pages/default.aspx
- **Canadian Failure Mode and Effects Analysis Framework©**: ISMP Canada. (2006, December 23). *Failure Mode and Effects Analysis: Proactively Identifying Risk in Healthcare*. ISMP Canada Bulletin 2006;6(8). http://www.ismp-canada.org/fmea.htm

- **Leadership intervention and resources**: National Patient Safety Agency (UK). http://www.patientsafetyfirst.nhs.uk/Content.aspx?path=/interventions/Leadership/
- **Learning Organizations – a self assessment resource pack**: Social Care Institute for Excellence. October 2004. http://www.scie.org.uk/publications/learningorgs/index.asp
- **Building a business case for Patient Safety**: Patrick Walz & Barb Averyt. Nov. 2005. Safe and Sound, an Arizona Patient Safety Initiative through the Arizona Hospital and Healthcare Association. http://www.ihi.org/IHI/Topics/LeadingSystemImprovement/Leadership/Tools/BuildingaBusinessCaseforPatientSafety.htm
- **Executive Review of Improvement Projects (IHI Tool)**: Institute for Health Care Improvement, Boston, Massachusetts, USA. Developed by Jim Reinertsen, MD, Michael Pugh, Tom Nolan, PhD. http://www.ihi.org/IHI/Topics/Improvement/ImprovementMethods/Tools/ExecutiveReviewofProjectsIHI+Tool.htm
- **Glossary of Frequently Used Financial Terms**: Institute for Healthcare Improvement (in conjunction with Lynn Spragens and the Robert Wood Johnson Foundation)Cambridge, Massachusetts, USA http://www.ihi.org/IHI/Topics/LeadingSystemImprovement/Leadership/Tools/GlossaryofFrequentlyUsedFinancialTerms.htm

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Module 8 Trainer's Notes

Principal message

The single most important message your audience should come away with is that everyone involved in the provision of health care – from board members to managers, *clinicians and support staff have a leadership role in patient safety*. There are many skills and competencies necessary to be an effective leader. The participant should come away recognizing that to improve patient safety everyone must be 'on board' as a team.

Module overview

Effective leadership is key to enacting change to improve safety in healthcare delivery. This leadership comes for the Board and executives, managers and healthcare providers. Leadership is exercised on an ongoing basis within an organization committed to quality improvement. For change to be effective, leadership skills must be fostered. This includes empowerment of staff; a culture that encourages openness and transparency in order to share areas of concern and solutions. Leadership is not about titles – it's about taking initiative to make a difference, to work effectively within groups with a common focus and goal. Healthcare organizations must function as learning organizations, adapting and responding in a nimble and effective manner to their changing environments. It is clear that the element of a culture of safety, of a learning environment, and those necessary for quality of work life are all similar and must be considered.

This module focuses on leadership and leading; how to recognize your own leadership qualities and nurture those that need strengthening, understanding the contribution of the leadership 'layers' in an organization. The module outlines the LEADS in a Caring Environment Leadership Capabilities Building Framework – an excellent mechanism to enable leaders to further develop themselves and others. Finally an approach to identifying, developing and implementing unit or program-specific patient safety initiatives is discuss, with some practical examples included.

Preparing for a presentation

1. Assess the needs of your audience

Choose from the material provided in the syllabus according to the needs of your expected participants. It is better for participants to come away with a few new pieces of information, well learned, than to come away with a deluge of information from which they can remember little or nothing.

2. Presentation timing

Allow sufficient time to collect participants' demographic data and complete the pre-test.

The suggested timing for each part of this module is:

Introduction	2-3 minutes
Presentation & discussion	40 minutes
DVD trigger tape & discussion	5-7 minutes
Debrief about teaching methods	5 minutes
Summary	2-3 minutes
Post-test & Evaluation	5 minutes
Total	49-53 minutes

3. Number of slides: 25

4. Preparing your presentation

The text in the syllabus was not designed to be used as a prepared speech. Instead, the text provides material you may want to use. The slides have been designed to support and prompt ideas for your presentation. Although the slides closely follow the text of the syllabus, they do not contain all of the content. Their use presumes that you have mastered the content. The bibliography is current.

You may want to make notes on the slide summary pages to help you prepare your talk in more detail and provide you with notes to follow during your presentation.

Remember that you can adjust the slides to suit your presentation content, your style, and to make it feel fully familiar and your own.

Practice your presentation using the slides you have chosen, and speaking to yourself in the kind of language you expect to use, until it is smooth and interesting and takes the right amount of time. The most accomplished presenters and teachers still practice prior to a presentation; don't miss this step.

5. Preparing a handout for participants

The syllabus text and slides in the **Participant's Handbook** were designed to be reproduced and provided to participants as a handout. Take the portion you need; they can be used in their entirety, module by module, or for just one specific topic. Please include the following in each set of handouts:

- **PSEP – Canada Front Cover Page**;

- **PSEP – Canada Acknowledgment Pages** (to acknowledge the source of the material);
- syllabus and slides for **your topic**; and
- appendix material as relevant.

6. Equipment needs

- Projector and screen
- Computer and monitor
- Flipchart and markers for recording discussion points

Test your equipment beforehand to ensure that it works.

Review your video segments to assess which trigger tapes or portions you would like to use.

Have a back-up plan so that if there is any equipment failure you can move without panic to your back-up plan. For instance, have in mind that:

- if the video fails, you can read the vignette of the trigger tape story;
- if the slides cannot be shown, you can refer to the hand out slides; and
- if flipcharts and markers are not available, you can have participants list items on their hand outs that you would have written up for all to see.

Making the presentation

1. Introduce yourself

If you have not already done so, introduce yourself. Include your name, title, and the organization(s) you work for. Briefly describe your professional experience related to the information you will be presenting.

2. Introduce the topic

Show the title slide for the module. To establish the context for the session, make a few broad statements about the importance of topic as a patient safety matter. Tell participants the format and time you will take to present the session. Identify the teaching styles that you intend to use.

3. Review the session objectives

Show the slide with the session objectives listed. Read each objective and indicate those that you are planning to emphasize.

4. Present the material

Recommended style: interactive lecture

An interactive lecture will permit you to engage your audience, yet cover your chosen material within the time. You can use as your interactive components the trigger tape stimulated discussion and an interactive exercise.

Alternative style: role play

Ensure that the overall goals of the module can be obtained in using this approach.

Using materials for Case #1 or Case #2 included with these Trainer's Notes, role-play the Quality Improvement Officer making the case to the CEO to implement an intervention that has been through several PDSA cycles and implemented successfully in a defined area. The goal is to:

- get the intervention implemented throughout the hospital, and
- get quality indicators established as part of the hospital's routine continuous quality improvement process.

The role play can be conducted as a fishbowl, where two participants perform the role play in front of everyone, or within small groups. After completing the role play, facilitate discussion among the group. Possible questions include:

- To actors: What did you find difficult about your role?
- To group: What aspects went well and what didn't? How would you have handled a similar situation?
- To everyone: Do you feel you could be an effective advocate in your organization?

Materials

Case # 1

1. Run chart for pain control in the ER
2. Propose new best practice protocol for rapid pain management
3. Relevant current best practice paper on rapid pain management
4. Calculation on cost-benefit
5. Example of proposed quality indicator and how/when to gather the data

Case # 2

1. Run chart for hand washing and MRSA bacteremia
2. Calculation on cost-benefit for adding hand sanitizer to every room
3. Example of proposed quality indicators and how/when to gather the data

5 Show the trigger tape if time permits (as an example of one of the strategies mentioned.)

After the full presentation, show the trigger tape. It has been designed to provide you with one example of an important initiative, to engage the participants and provide an appropriate clinical context for the session. It was not designed to demonstrate an ideal interaction, but to "trigger" discussion.

Trigger tape content

David Bates, MD, speaks about the importance of having a patient safety team led by a clinician that can address safety issues within the hospital. He also discusses the impact of implementing executive walkarounds. In the video, a patient safety team stops at a nurse's station to discuss issues with new computer technology.

Keep in mind that the facilitator may choose to use any one of the trigger tapes. Since the vignettes are rich and overlap in their teaching points, it may make sense to do this, for instance if an audience has seen the trigger tape already or if a trigger tape from another module is easier for the audience to identify with.

A teachable moment: discussion after the trigger tape

After the trigger tape, ask the participants for their comments about the issues and the interaction they have just seen. To affirm what they contribute, consider recording the important points on a flipchart or overhead projector.

If the discussion is slow to start, you may want to ask more direct questions, like:

- Have you seen patient safety team or executive walkarounds in your organization? Does your organization have a patient safety team?
- Would you want executives in your organization to do this? If not, why not? What would you do differently?
- What role can you as frontline staff and middle level managers play in leading patient safety improvement within your organization?
- What characteristics make a successful leader?

Use the discussion to set the stage for the material to follow. Do not let the discussion focus on a critique of the technical quality of the DVD or how "real" the players seemed. If the participants do not like something that was said or done in the DVD, acknowledge that there is always room for improvement and ask them how they would do it themselves.

Setting limits to discussion time

It is usually best to limit discussion of the video to no more than **five** minutes, then move on to the conclusion / key take home points. To help move on if the discussion is very engaged, try saying something like:

- let’s hear two last points before we move on, and
- now that you have raised many of the tough questions, let’s see how many practical answers we can find.

For the more advanced facilitator who is very confident of both the patient safety material and his or her pedagogic skills, it is possible to use the trigger tape as a form of case-based teaching and to facilitate the discussion to draw out the teaching points of the module. The hazard of this approach is that the discussion will not yield the desired teaching points. Feel free to return to the slides if this happens. If this approach is used, it is essential to write up the points on a flip chart as they arise, to fill in any gaps and to summarize at the end. Again, use this method with caution and only if you are really ready.

6. Key take-home points

1. Effective leadership is fundamental to improving the safety of health care.
2. The culture of patient safety must permeate the entire organization, through to the unit/program level.
3. Leaders, formal and informal, must live and breathe those components so essential to this culture – openness, respect, just culture
4. Ensure alignment of the unit/program patient safety initiatives with the organization-wide program to ensure optimal success
5. Remember the critical role of the patient/client and family.
6. Focus on the work environment, the staff, physicians, support workers, volunteers – remembering the linkage of quality of work life and patient safety.

7. Summarize the discussion

Briefly, review each part of the presentation. Recap two or three of the most important points that were discussed.

8. Debrief about the teaching method

Tell the group that it is time to consider the teaching method used, how it worked and what its limitations were. Ask them what other methods might work, and what methods would work best *for the topic* in their home institutions. Ask them to consider what method would work best *for themselves as facilitators* and for their *target audience*.

9. Post-test/evaluation

Ask the participants to complete the post-test questions for this module and evaluate the session.