Navigating Change to Achieve High Reliability: The Role of Leadership
(An ACHE Qualified Category II Education)

Erin DuPree, MD, FACOG
Chief Medical Officer and Vice President
Joint Commission Center for Transforming Healthcare

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President, Houston Health Innovations, LLC

INSIGHTS FOR HEALTHCARE PROFESSIONALS
(A partnership with Medical World Americas)
Learning Objectives

• Articulate the need for high reliability in healthcare.

• Understand that healthcare management and clinical leadership are key to successful change to high reliability.

• Describe leadership commitment action to navigate change.
Biography

Erin S. DuPree, M.D., FACOG, is the Chief Medical Officer and Vice President for the Joint Commission Center for Transforming Healthcare. She leads the efforts of the Center to transform the health care industry into a high reliability industry. She has expertise in performance improvement and information technology. Prior to assuming her role, Dr. DuPree practiced obstetrics/gynecology and was Chief Medical Officer and Senior Vice President for Medical Affairs at The Mount Sinai Medical Center in New York City. During her eight years at Mount Sinai in a progression of leadership roles, she steered efforts to improve safety culture, evidence-based care, and critical processes that impact patient care. Dr. DuPree has a bachelor of arts in biochemistry and molecular biology from the University of California, Berkeley, and received her M.D. from Columbia University, College of Physicians and Surgeons in New York City.
Biography

Anne-Claire France, PhD, CPHQ, FACHE, is President/Owner of Houston Health Innovations, LLC (HHI), an organization specializing in improving performance in healthcare systems using Robust Process Improvement methodologies. Dr. France has trained and coached over 150 Master Black Belts, Black Belts and Green Belts in Lean Six Sigma. Before becoming a Lean Six Sigma professional, she served as Director of the Center for Healthcare Improvement at Memorial Hermann Health System, where she actualized the process improvement ideas of front line clinical staff. Her focus within the healthcare system was the improvement of patient safety, clinical outcomes, customer and staff satisfaction and significant cost savings. Anne-Claire's twenty-five years of healthcare experience include twenty years in applied research and process improvement. Her primary clients include the pharmaceutical industry, small rural hospitals, multi-hospital healthcare systems, physician organizations and group practices. Before founding Houston Health Innovations LLC in 2001, Anne-Claire held a number of leadership positions in healthcare organizations. She has taught applied research, statistics, and psychology. She served as Adjunct Faculty at the Center for Health Studies, Houston Baptist University as well as academic appointments at the University of Texas Health Science Center at Houston Schools of Medicine and Nursing and Northern Illinois University. In addition to certification as a Six Sigma Master Black Belt, in Health Care Administration, and as a Healthcare Quality Professional, Anne-Claire holds a B.A. from the University of Colorado (Boulder), a M.A. and a Ph.D. from Vanderbilt University, and a Post Doctoral Fellowship from the University of Texas Health Science Center at Houston Medical School.
CHANGE AGENTS

Ignaz Philipp Semmelweis  Ernest Amory Codman
CHANGE AGENTS

South Carolina Safe Care Commitment

MANE HEALTH
We're in this together.

BAPTIST EASLEY HOSPITAL
caring is our calling

Beaufort Memorial Hospital

ROPE ST. FRANCIS
Creating highly skilled health professionals

MUSC Health

GEORG TOWN
Hospital System

+RMC
the Regional Medical Center

ROPE ST. FRANCIS

GREENVILLE HEALTH SYSTEM

ROPE ST. FRANCIS

PAMETTO HEALTH

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“Change is good. You go first.”

— Dilbert
456 Piedmont patients warned about improperly cleaned devices

Posted: 6:06 p.m. Tuesday, April 30, 2013

456 patients notified
SSM Health Care apologizes for brain-surgery error

SSM Health Care acknowledged Tuesday that its neurosurgeon and medical staff recently operated on the wrong side of a St. Louis-area woman’s brain and skull.

The admission — and a lengthy public apology — followed a Post-Dispatch story in Tuesday’s paper about a lawsuit filed Friday on behalf of Regina Turner of St. Ann.

“SSM Health Care and SSM St. Clare Health Center sincerely apologize for the wrong-site surgery in our operating room,” Chris Howard, president and chief executive of SSM Health Care-St. Louis, said in a written statement.
Operating-Room Fire at Hospital Burns Patient, Prompts Changes

FirstHealth of the Carolinas officials should know by the end of the month whether they have taken adequate corrective steps to prevent operating room fires like the one recently that burned the neck and shoulders of a patient during an emergency surgery at Moore Regional Hospital.

The N.C. Division of Health Service Regulation placed Moore Regional on “immediate jeopardy” status following an
Five Principles of High Reliability Organizations

Anticipation - “Stay Out of Trouble”
- 1. Preoccupation with failure
- 2. Sensitivity to operations
- 3. Reluctance to simplify

Containment - “Get Out of Trouble”
- 4. Commitment to resilience
- 5. Deference to expertise
Is Health Care Different?

• Patients, not machines
• One person at a time
• Workforce mobility
• Definition of harm
Reliability is failure free operation over time from the viewpoint of the patient.

-R. Resar, Institute for Healthcare Improvement
High-Reliability Health Care: Getting There from Here

MARK R. CHASSIN and JEROD M. LOEB

The Joint Commission

Context: Despite serious and widespread efforts to improve the quality of health care, many patients still suffer preventable harm every day. Hospitals find improvement difficult to sustain, and they suffer “project fatigue” because so many problems need attention. No hospitals or health systems have achieved consistent excellence throughout their institutions. High-reliability science is
Leadership

Safety Culture

Robust Process Improvement®
MANAGING CHANGE

VS

LEADING CHANGE
US Safety Board Determines Crash Was Failure of Both Track and Safety Culture

By Robert Charette
Posted 29 Jul 2010 | 16:07 GMT

VITERBI JOINS WITH METROLINK TO CREATE SAFETY CULTURE

USC professors help 50 high-level Southern California commuter rail leaders study the histories of past rail disasters to prevent future ones

Metro-North railroad has 'deficient safety culture' government says after fatal derailment

BP Oil Spill: Engineering Experts Attack Industry Safety Culture

By SETH BORENSTEIN | 12/14/11 01:35 PM ET | AP
Culture is Predictive: A Leading Indicator

1. Medication errors
2. Back injuries
3. Patient satisfaction
4. Nurse turnover
5. AHRQ Patient Safety Indicators
6. Nurse satisfaction
7. Urinary tract infections
8. Malpractice claims

• Hofmann & Mark (2006) • Katz-Navon et al. (2005)
• Vogus & Sutcliffe (2007)
Evolution of Safety Culture

Today: React after adverse events

Close Calls

Unsafe conditions

Proactive assessment of safety systems
Behaviors that undermine a culture of safety

Intimidating and disruptive behaviors can foster medical errors,(1,2,3) contribute to poor patient satisfaction and to preventable adverse outcomes,(4,5) increase the cost of care,(4,5) and cause qualified clinicians, administrators and managers to seek new positions in more professional environments. (6) Safety and quality of patient care is dependent on teamwork, communication, and a collaborative work environment. To assure quality and to promote a culture of safety, health care organizations must address the problem of behaviors that threaten the performance of the health care team.
ROBUST PROCESS IMPROVEMENT®

Facilitating Change

Lean

Six Sigma

ACCEPTANCE & ACCOUNTABILITY

REMOVES WASTE
FLOW

REDUCES VARIATION
ACCURACY

FOCUS IS ON THE PATIENT
FACILITATING CHANGE

Plan
Inspire People
Launch
Support the Change

Facilitating Change

2015 ACHE-SETC Conference on Healthcare Leadership

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A Systematic Approach for Complex Problem Solving

Define & measure the impact of the problem

Discover specific causes

Solutions are targeted to each specific cause

DEFINE & MEASURE

ANALYZE

IMPROVE & CONTROL
<table>
<thead>
<tr>
<th>Main Causes of Failure to Clean Hands</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>F</th>
<th>G</th>
<th>H</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ineffective placement of dispensers or sinks</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Hand hygiene compliance data are not collected or reported accurately or frequently</td>
<td></td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Lack of accountability and just-in-time coaching</td>
<td></td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Safety culture does not stress hand hygiene at all levels</td>
<td></td>
<td></td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Ineffective or insufficient education</td>
<td></td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Hands full</td>
<td></td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Wearing gloves interferes with process</td>
<td></td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Perception that hand hygiene is not needed if wearing gloves</td>
<td></td>
<td></td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Health care workers forget</td>
<td></td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td></td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Distractions</td>
<td></td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
</tbody>
</table>

Note that not all of the main causes of failure appear in every hospital. The chart above represents the validation of the root causes across hospitals. This underscores the importance of understanding hospital-specific root causes so that appropriate solutions can be targeted.
Sustaining and Spreading Improvement in Hand Hygiene Compliance

Features
Infection Prevention and Control
- Editorial: Toward More Reliable Processes in Health Care
- Improving Hand Hygiene at Eight Hospitals in the United States by Targeting Specific Causes of Noncompliance
- Beyond the Collaborative: Spreading Effective Improvement in Hand Hygiene Compliance

"If other quality and safety problems exhibit the same characteristics as hand hygiene noncompliance, attempting to address them everywhere with exactly the
CHANGE AGENTS

South Carolina Safe Care Commitment

- ANMED Health
- Baptist Easley Hospital
- Beaufort Memorial Hospital
- Roper St. Francis

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Memorial Hermann Health System

- Total Hospitals: 12 (9 Acute, 2 Rehab, 1 Children’s)
- Ambulatory Surgery Centers: 18
- Heart & Vascular Institutes: 3
- Imaging Centers: 21
- Breast Care Centers: 9
- Sports Medicine & Rehab Centers: 32
- Diagnostic Laboratories: 21
- Retirement/Nursing Center: 1
- Home Health Branches: 3
- Cancer Centers: 7

- Adjusted Admissions: 256,175
- Annual Emergency Visits: 450,010
- Annual Deliveries: 23,111
- Employees: 20,241
- Beds (acute licensed): 3,147
- Medical Staff Members: 5,790
- Physicians in Training: 1,694
- Annual Labor Cost: $1.191 billion
Journey to Cultural Transformation

August 14, 2006

A Call to Action on Patient Safety

Transfusion Errors
Serious Safety Events
Red Arm Band Task Force

Red Arm Band task force with representation from all hospitals and divisions

Developed

- Policies and Procedures
  - System
  - Local

- Implementation Plan
  - Communication Plans
  - Education Plans
  - Monitoring Plans
  - Roll out schedules

Go Live - September 5th, 2006
Board Commitment

Provide leadership for high reliability, safety & quality initiatives

Ensure the Board receives quality & safety results information it needs

Provide guidance for the System Quality Committee

Provide support for safety & quality initiatives, including financial support
Journey to Cultural Transformation

Leadership Commitment to “safety first”

Partner with Healthcare Performance Improvement

Diagnostic assessment to determine readiness

Gaps in communication, critical thinking, knowledge, attention to task, and compliance
Safety Culture Training

Step 1: Set Behavior Expectations
Define Safety Behaviors & Error Prevention Tools proven to help reduce human error

Step 2: Educate
Educate our staff and medical staff about the Safety Behaviors and Error Prevention Tools

Step 3: Reinforce & Build Accountability
Practice the Safety Behaviors and make them our personal work habits

Take Action.
Make Patient Safety Your Priority.

1. Attention to Detail
   Self-Check with STAR
   - Stop: Pause for one to two seconds
   - Think: Focus on the act
   - Act: Perform the act

3. Questioning Attitude
   - Qualify: Is the source reliable?
   - Validate: Consistent with my knowledge?
   - 1. What is typical or expected?
   - 2. What is outside of the norm?

6. Support Each Other
   - Be a Safety Partner
     - Look out for each other
     - Positively reinforce safe and productive behaviors (XS)
     - Correct unsafe behaviors in a helpful manner
   - Speak Up ARCC and CUSS Words
     - Ask a question
     - Request a change
     - Concern, state your concern using the safe word
     - Chain of command
     - CUSS words
       - I am concerned
       - I am uncomfortable
       - This is for safety
       - Stand Up and Stand Together
MHHS Safety Culture Training
2007-2008

Hospital Training Complete

>15,000 Employees Trained

>1,000 Physicians Trained

>540 Safety Coaches Trained

>$18M Expense
200% Accountability

I am 100% accountable for the behavior and results of my Unit(s).

My Unit is also 100% accountable for their behavior and results.

“The measure of success is not whether you have a tough problem to deal with, but whether it is the same problem you had last year.”

- John Foster Dulles
   US statesman
Leaders: Rounding with a Purpose

Connect with front-line staff, patients & physicians
  – Understand the front line perspective
  – Engage with our people
  – Identify problems impacting operations

Reinforce safety & service performance expectations
  – Understand employee’s knowledge
  – Reward and recognize
  – Provide feedback and coaching
  – Support blame-free variance & possible event reporting
Red Rules
Absolute Compliance

1. Patient Identification
   - Verify with two patient identifiers before acting
2. ‘Time Out’ before invasive and high-risk procedures
3. ‘Two-Provider Check’ before administration of blood, blood products and high-risk medication

1. Patient Identification
2. Time Out
3. Two Provider Check
Performance Management Decision Guide
Adapted from James Reason’s Decision Tree for Determining the Culpability of Unsafe Acts and the Incident Decision Tree of the National Patient Safety Agency (United Kingdom National Health Service)

Start

**Deliberate Act Test**
- D1: Did the individual intend the act?
  - Yes
  - No

**Impairment Test**
- I1: Is there suspicion of ill health (either mental or physical) or substance abuse?
  - Yes
  - No

**Compliance Test**
- C1: Did the individual depart from policies, procedures, protocols, or generally accepted performance expectations?
  - Yes
  - No

**Substitution Test**
- S1: Would individuals in the same profession and with comparable knowledge, skills, and experience act the same under similar circumstances?
  - Yes
  - No

**Substitution Test**
- S2: Were there any deficiencies in related training, experience, or supervision?
  - Yes
  - No

**Suspected Medical Condition and/or Substance Abuse**
- If illness or medical condition: Was the individual aware of the illness or medical condition?
  - Yes
  - No

**Possible Reckless or Negligent Behavior**
- Is there evidence that the individual chose to take an unacceptable risk or has a history of poor performance or decision making?
  - Yes
  - No

**Possible Unintended Human Error**
- Were there significant mitigating circumstances that support the act in this case?
  - Yes
  - No

**Possible System Induced Error**
- Were there any deficiencies in related training, experience, or supervision?
  - Yes
  - No

**Actions to Consider**
- Malevolent or Willful Misconduct
  - Consult Human Resources
  - Disciplinary action
  - Report to professional group or regulatory body
  - Law enforcement referral

**Actions to Consider**
- Suspected Medical Condition and/or Substance Abuse
  - Consult Human Resources
  - Disciplinary action
  - Occupational health referral
  - Leave of absence if substance abuse
  - Substance abuse testing
  - Disciplinary action

**Actions to Consider**
- Possible Reckless or Negligent Behavior
  - Consult Human Resources
  - Disciplinary action
  - Job-fit consideration

**Actions to Consider**
- Possible Unintended Human Error
  - Consult Human Resources
  - Disciplinary action
  - Console and/or Coach the individual
  - Find & Fix Process Problems

**Actions to Consider**
- Possible System Induced Error
  - Consult Human Resources
  - Disciplinary action
  - Console
  - Coaching
  - Mentor assignment
  - Increased supervision
  - Performance improvement plan
  - Adjustment of duties

Identify Contributing System Factors
2010 Change in Focus: Journey to High Reliability

• We’ve come a long way since 2006
• We’ve got a long way to go
• We have to do something different to get a different result
• Enlightened leadership is the key
• The staff is primed to follow your lead
## Take Action.
Make Patient Safety Your Priority.

1. **Attention to Detail**
   - Stop
   - Think
   - Act
   - Review

2. **Communication**
   - Three-way Repeat
     - Sender initiates communication
     - Receiver repeats back
     - Sender acknowledges by saying, “That’s correct” or “That’s not correct”

3. **Questioning Attitude**

## Make Every Day a Safe Day.
Patient Safety Is Our Core Value.

1. **Attention to Detail**
2. **Questioning Attitude**

### 5. Support Each Other

#### Be a Safety Partner
- Look out for each other
- Positively reinforce safe and productive behaviors (XS)
- Correct unsafe behaviors in a helpful manner

#### Speak Up: ARCC and CUSS Words
**Ask a question**
- **Situation**: What is the problem, patient, or project?
- **Background**: What is important to know?
- **Assessment**: What is your concern?
- **Request/Recommend**: What action do you need?

**CUSS words**
- I am concerned
- I am uncomfortable
- This is for safety
- Stand up and stand together

**Ask Questions**
- Ask one or two clarifying questions when in high-risk situations or when information is incomplete and/or ambiguous.

### Phonetic & Numeric Clarifications
Say the letters and say the numbers.

**SBAR (Quick, To the Point)**

<table>
<thead>
<tr>
<th>Situation</th>
<th>Ask a question</th>
</tr>
</thead>
<tbody>
<tr>
<td>Background</td>
<td>Request a change</td>
</tr>
<tr>
<td>Assessment</td>
<td>Concern, state your concern using the safe word</td>
</tr>
<tr>
<td>Request</td>
<td>Chain of command</td>
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</table>

**CUSS Words**
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### 5. Support Each Other

#### Be a Safety Partner
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#### Speak Up: Use ARCC and CUSS Words
**Ask a question**
- **Situation**: What is the problem, patient, or project?
- **Background**: What is important to know?
- **Assessment**: What is your thought?
- **Request/Recommend**: What action do you need?

**CUSS Words**
- I am concerned
- I am uncomfortable
- This is for safety
- Stand up and stand together

### Protect Patients from Harm
- Absolute compliance with Red Rules
- Perform hand hygiene
- Prevent falls
- Activate Rapid Response
## System-Wide Strategies

**Quality & Safety**

*Lead healthcare to superior patient outcomes through creation of a high reliability culture with evidence-based quality and patient safety as our core value*

<table>
<thead>
<tr>
<th>Patients</th>
<th>Create strong customer loyalty by providing exceptional experiences for all patients.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians</td>
<td>Build sustainable, trusting &amp; collaborative relationships to advance our respective quality and economic objectives.</td>
</tr>
<tr>
<td>People</td>
<td>Recruit, develop, &amp; retain top performing employees.</td>
</tr>
<tr>
<td>Operational Excellence</td>
<td>Achieve financial operating performance to fund capital needs and strengthen the balance sheet.</td>
</tr>
<tr>
<td>Growth</td>
<td>Strategically grow services to meet the expanding needs of the Greater Houston community.</td>
</tr>
</tbody>
</table>
Understanding Failure

The question is not:

– What mistake was made?
– Why didn’t they notice what we find important now?

The question should be:

Why did it make sense to do what they did?
A collective examination of past events for “common causes” (not common outcomes)

Event (E): a condition that results from a deviation from practice expectations or standard of care

Inappropriate Act (IA): a human error that violates performance expectations or takes a task outside acceptable limits

Analyze by: Profession, Organization, Key Process, Key Activity, System Failure Mode, Individual Failure Mode, Human Error Type

Common Causes
Investigating Individual Failures (IFM)

Individual failures are beyond the person that got caught. It’s all of the people with the same practice shaping the culture that caused the error.

The question is: “Why did it make sense to do what they did?”

It requires a hard look at the expectations we have placed on the staff and their understanding of those expectations.
Investigating System Failures (SFM)

System failures are weaknesses in the current culture, processes and safeguards.

Reconstruct the world in which individuals found themselves at the time.

The question is: Why don’t we have thoughtful and reliable use of safety behaviors? Or if we do, why did they fail?

What can we do to increase the reliability in the process?
Hospital Acquired Infections, Conditions and Patient Safety Indicators

Central Line Associated Bloodstream Infections
Ventilator Associated Pneumononias
Surgical Site Infections
Retained Foreign Bodies
Iatrogenic Pneumothorax
Accidental Punctures and Lacerations
Pressure Ulcers Stages III & IV
Hospital Associated Injuries
Deep Vein Thrombosis and/or Pulmonary Embolism
Deaths Among Surgical Inpatients with Serious Treatable Complications
Birth Traumas
Serious Safety Events
Hospital Acquired Infections, Conditions and Patient Safety Indicators

Central Line Associated Bloodstream Infections
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- Central Line Associated Bloodstream Infections
- Ventilator Associated Pneumonias
- Surgical Site Infections
- Retained Foreign Bodies
- Iatrogenic Pneumothorax
- Accidental Punctures and Lacerations
- Pressure Ulcers Stages III & IV
- Hospital Associated Injuries
- Deep Vein Thrombosis and/or Pulmonary Embolism
- Deaths Among Surgical Inpatients with Serious Treatable Complications
- Birth Traumas
- Serious Safety Events
High Reliability
Certified Zero Award

1. Zero Events

2. 12 Consecutive Months

3. Certified Zero Category
High Reliability 2011-15
Certified Zero Awards

ICU Central Line Associated Bloodstream Infections (13)
ICU Catheter Associated Urinary Tract Infections
Hospital-Wide Central Line Associated Bloodstream Infections (3)
Ventilator Associated Pneumonias (23)
Surgical Site Infections
Retained Foreign Bodies (33)
Iatrogenic Pneumothorax (17)
Accidental Punctures and Lacerations (3)
Pressure Ulcers Stages III & IV (25)
Hospital Associated Injuries (5)
Deep Vein Thrombosis and/or Pulmonary Embolism (1)
Deaths Among Surgical Inpatients with Serious Treatable Complications
Birth Traumas (12)
Serious Safety Events 1 & 2 (9)
All Serious Safety Events (1)
Early Elective Deliveries (1)
Manifestations of Poor Glycemic Control (14)
**Leadership – An Evolution in Perspective**

“If you do the things you’ve always done, you’ll get the results you’ve always gotten.”

<table>
<thead>
<tr>
<th>From…</th>
<th>To…</th>
</tr>
</thead>
<tbody>
<tr>
<td>Externally driven safety focus (e.g. Joint Commission, CMS)</td>
<td><strong>Internally driven</strong> safety focus (First, Do No Harm – it’s the right thing to do)</td>
</tr>
<tr>
<td>Safety is a priority</td>
<td>Safety is a <strong>core value</strong> that cannot be compromised</td>
</tr>
<tr>
<td>We are creating a safety culture</td>
<td>We are shaping a <strong>reliability culture</strong> that creates safety</td>
</tr>
<tr>
<td>The board and senior leader support culture change</td>
<td>The board and senior leaders <strong>own and manage</strong> the culture</td>
</tr>
<tr>
<td>Medical staff support culture change</td>
<td>Medical staff <strong>own and promote</strong> safety culture</td>
</tr>
</tbody>
</table>
Attention is the currency of leadership.

Ronald Heifetz