Clinical Leadership Challenges
(Quality and Safety Leads it all)

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Leadership

What model?
What style?
Who is your mentor?
Who is sharing this with you?

It's about a culture.

It's lonely.

It's about self management and emotional intelligence.
The Right Traits

Resilience
Patience
Trust
Respect
Knowledge or the ability to get it
Humility
Strength
Loyalty
Commitment
Know Your Stuff

Your data
Your workforce
Your incidents
Your resources

Be available
Be visible
Be consistent
Say sorry
Its about our patients

Quality and Safety is a Leadership Model in itself. Make it your culture
Keep every body safe all of the time
Make quality your aim with everything
Workforce
Equipment
Care
Education
Defining Quality and Safety

The language comes from other High Reliability Organisations that want to measure sustain and enhance performance.

**Safety** = free from harm

**Quality** = Excellence

Establishing and maintaining a culture of Quality and Safety is a constant challenge in the face of dynamic Health Care Policy and the changing Face of Population Health
2012 Release of National Standards
2011-2012 Australian Institute Of Health and Welfare reports 6.1% of public hospital admissions associated with adverse event.

Should we be perfect?

So many resources, reports and measures?

Why still so challenging?

Ownership of Role/Portfolio
External Drivers

- National Health Budget
- State Health - priorities
- ACSQHC
- ABF
- Infrastructure
- Increasing chronicity
- Ageing population
- Increasing ED activity
- Complex treatments
Internal Drivers

• Workforce:
  o Scope of Practice
  o Workforce behaviours
  o Training needs of tomorrows’ workforce
  o Multiple disciplines
  o Multiple skill sets
  o Skill set variance
  o Managing it – recruitment - retention
Internal Drivers

- Clinical Practice:
  - New practice
  - Old practice
  - Variance
  - Guidelines – helpful or not
  - Standards
  - Safety and Quality Tools – BTF/Pathways/Handover
WHO RUNS THINGS?
WHO DECIDES?
Leadership

- Direction
- Vision
- Support
- Clarity
- Purpose
- Feedback
Competence

- Did skilled people assess with expert eyes?
- Did the right diagnostics get ordered, completed and interpreted by skilled people?
- Did the right treatment get ordered?
- Did treatment commence?
- Did monitoring continue?
Our patients

• Was the patient informed along the way?
• Was the patient included in the decision making?
• Was the patient the focus of their journey?
• Were compassion and empathy visible and constant?
• They are the public face of safe quality healthcare
FOUNDATION TRUST KILLED OUR LOVED ONES
WHERE NEXT
WHY HAS IT TAKEN SO LONG
400 DEATHS
Lack of general pain relief

Joan Giles
40 years young
Rosedale Nursing Home 14th January 2000

Ellen Linstead
25-7-1930 - 15-12-2006

Peter Darlington
February 2005
Deceased Patient

Emma Peachey
Died in Pain 2005
The photos of all these people who died need to be taken down.

Kate McHarg
20-1-1935 - 10-7-2007

Emergency Care Institute
NEW SOUTH WALES
Why still such a Challenge?

Why so different in the emergency department?

- Its unpredictable
- Its unplanned
- Its dynamic
- Its after hours
- Its workforce is not consistent 24/7 – skill or numbers
- Its cradle to the grave
- Its crowded
- Cognitive load
- Interruptions and distractions
Unique factors

A unique feature in the ED is the high density of clinical decision making.

Limited time and limited information.

Factors like fatigue and sleep debt and cognitive overload can and do threaten the quality of decision making.

Safety in the ED is linked to thinking and skills.

(issues identified by International Federation for Emergency Medicine 2012)
More Challenges

- Its unspecialised in a world of increasingly specialised medicine
- Its loaded with time-based KPI’s
- Its consumers have high expectations and high anxiety
- Risk is a constant
- Change is a constant
What does it look like?

It looks different to:

• The patient
• The relative
• The doctor
• The nurse
• The administrator
• The executive
Culture is over arching solution

- Leaders that lead
- Clarity regarding product
- Clarity regarding role
- Education at every level for everybody
- Minimal variance
- Adequate resources
- Make peoples work visible
- Measure and display what reflects safety and quality in your department
People – our greatest resource

- Make them accountable
- Respect them
- Delegate to them
- Trust them
- Value, incite, experience and compassion
- Communicate

**Tell everyone everything every time!!**
Solutions

• Make it part of everything everyday.
• A “just culture” - balance no blame with appropriate accountability
• Not everything is good for everybody – local modification of models of care/safety tools/processes (CERS)
• Collect data that means something – then make it available to the people it matters to
• Network and share and support.
• Influence – Whole of Hospital Strategies
• Celebrate the consumer commentary
Solutions

- Measure “CARE” – do we have a measure?
- Listen and engage our product – Patients and Families
  - “Your most unhappy customers are your greatest source of learning” Bill Gates
- Influence and control what you can
- Use data – we now know what errors happen, when and why.
- Value knowledge and experience
- Consider the value of Soft Systems – The Relationships (Hugh MacLeod and Dr. Mary Ditton)
Survival and Satisfaction

Learn how to preserve you
Learn how to celebrate the wins
Share the load
Network
Liase
Talk to other NUMs/NM
Nurture the babies
Make everyone accountable for their roles
Transparency
Of course i am their Leader I am following them .......
The one free thing! Empathy/touch/
Dear Secretary of State

Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry

As you know, I was appointed by your predecessor to chair a public inquiry under the Inquiries Act 2005 into the serious failings at the Mid Staffordshire NHS Foundation Trust. Under the Terms of Reference of the Inquiry, I now submit to you the final report.

Building on the report of the first inquiry, the story tells is first and foremost of appalling suffering of many patients. This was primarily caused by a serious failure on the part of a provider Trust Board. It did not listen sufficiently to its patients and staff or ensure the correction of deficiencies brought to the Trust’s attention. Above all, it failed to tackle an insidious negative culture involving a tolerance of poor standards and a disengagement from managerial and leadership responsibilities. This failure was in part the consequence of allowing a focus on reaching national access targets, achieving financial balance and seeking foundation trust status to be at the cost of delivering acceptable standards of care.

The story would be bad enough if it ended there, but it did not. The NHS system includes many checks and balances which should have prevented serious systemic failure of this sort. There were and are a plethora of agencies, scrutiny groups, commissioners, regulators and professional bodies, all of whom might have been expected by patients and the public to detect and do something effective to remedy non-compliance with acceptable standards of care. For years that did not occur, and even