

Leading in Crisis: Lessons for Safety Leaders

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Objective: The National Quality Forum (NQF) Safe Practices are a group of 34 evidence-based Safe Practices that should be universally used to reduce the risk of harm to patients. Four of these practices specifically address leadership. A recently published book, *7 Lessons for Leading in Crisis*, offers practical advice on how to lead in crisis. An analysis of how concepts from the 7 lessons could be applied to the Safe Practices was presented nationally by webinar to assess the audience's reaction to the information. The objective of this article was to present the information and the audience's reaction to it.

Method: Recommendations for direct actions that health care leaders can take to accelerate adoption of NQF Safe Practices were presented to health care leaders, followed by an immediate direct survey that used Reichheld's "Net Promoter Score" to assess whether the concepts presented were considered applicable and valuable to the audience. In a separate presentation, the challenges and crises facing nursing leaders were addressed by nursing leaders.

Results: Six hundred seventy-four hospitals, with an average of 4.5 participants per hospital, participated in the webinar. A total of 272 safety leaders responded to a survey immediately after the webinar. A Net Promoter Score assessment revealed that 58% of those surveyed rated the value of the information at 10, and 91% scored the value of the webinar to be between 8 and 10, where 10 is considered a strong recommendation that those voting would recommend this program to others.

Conclusions: The overwhelmingly high score indicated that the principles presented were important and valuable to this national audience of health care leadership. The 2010 environment of uncertainty and shrinking financial resources poses significant risk to patients and new challenges for leaders at all levels. A values-grounded focus on personal accountability for leading in crisis situations strongly resonates with those interested in or leading patient safety initiatives.

Key Words: patient safety, safe practices, health care leadership

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The global financial downturn, unknown impact of health care reform, and shrinking revenue per unit of care delivered have put most leadership teams into "crisis mode." Investment in most areas, and especially in patient safety, has been put on hold in many hospitals. These cutbacks significantly increase risk of harm to patients. In many organizations, cutbacks in nurse staffing, infection control, quality improvement, and education have been undertaken, even in the face of major stakeholders telling us that safety issues have to be a national priority.^{1–3} Patient safety officers have been put in a crucible, having to ask for more resources that are dramatically shrinking. Pharmacy leaders are experiencing cutbacks in budget

allocations that would have addressed safety. Lilee Gelinas, RN, Vice President and Chief Nursing Officer for VHA, Inc., reports that "Chief Nursing Officer positions have even been folded under other executives, ever widening the distance between the boardroom and the bedside" (oral communication, December 8, 2009).

Governance, administrative, and medical leaders have been given much air time in many venues because they control the purse strings and are at the seat of power. Studies reveal, however, that many are out of touch with how their organizations are doing in quality. For instance, Jha and Epstein⁴ surveyed a nationally representative sample of board chairs of 1000 U.S. hospitals to understand their expertise, perspectives, and activities in clinical quality. Fewer than half of the boards rated quality of care as 1 of their 2 top priorities, and only a minority reported receiving training in quality. The authors felt that the large differences seen in board activities between high-performing and low-performing hospitals suggested that governing boards may be an important intervention target for policymakers hoping to improve care in the United States. Among the low-performing hospitals, which were found to be in the bottom decile of quality in the nation, no respondent reported that their hospital's performance was worse or much worse than that of the typical U.S. hospital, whereas 58% of this group reported their hospital's performance to be better or much better, reflecting a clear lack of awareness of their hospital's performance gaps.⁴ Are they receiving sanitized information from administrators, are they suffering from optimism bias, or are they just plain in denial? Their quality-blindness and lack of information flow is critical to future resource allocation; however, pivotal to safety in the immediate term is the leadership of midlevel and upper management during the current crisis.

The purpose of this article was to provide leaders with concepts that can be applied to adoption of the Safe Practices from a recent book entitled *7 Lessons for Leading in Crisis*⁵ and presented in a national webinar, hosted by Texas Medical Institute of Technology (TMIT) and the National Quality Forum (NQF) on August 25, 2009.⁶ At the end of the webinar, the value of the information was measured through surveying a group of webinar participants using the "Net Promoter Score" introduced by Reichheld as a method of discovering the value of a product or organization.⁷ There was an extraordinarily positive response by 272 safety leaders, representing a large sample of the 674 hospitals that participated in the webinar, with approximately 4.5 participants per hospital. The survey sample results confirmed that the safety leaders, pharmacy, and nursing leader webinar participants felt that they are in crisis, that they have a real thirst for leadership advice, and that the information presented was valuable.

A separate workshop of nursing leaders took place on August 12, 2009, and reviewed the challenges in nursing to confirm that nursing leaders are facing what they believe are crisis conditions. This meeting provided context to the 7 lessons as they relate to the nursing workforce.

The NQF *Safe Practices for Better Healthcare — 2009 Update and — 2010 Update*,^{8,9} now being updated on an annual

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basis, is increasingly being tied to transparency, compliance, and payment drivers of certifying, quality, and purchasing organizations. Leadership has become a major thrust of the Safe Practices, with emphasis on governance, administrative, and clinical leadership accountability. Individual Safe Practices specifically address nursing, pharmacy, and direct caregiver leadership and call for direct input from them and interactive dialog with administrative and governance leaders. Safe Practice 1—Leadership Structures and Systems, is a roadmap for governance and administrative leadership. It is hardwired to 3 specific leadership practices: Safe Practice 9—Nursing Workforce, and Safe Practice 10 — Direct Caregivers, and Safe Practice 18 — Pharmacist Leadership Structure and Systems. However, more than information sharing, the practices demand action. The leadership practice for pharmacists was new in 2009 and those for nursing and direct caregivers are leadership-centric. Table 1 provides the text from the 4 Safe Practices that address leadership.

The question of this study was whether we could explore how the *7 Lessons for Leading in Crisis* can be applied to the “4A Model of Innovation Adoption” used in the framework of the practices. The 4A Model uses awareness, accountability, ability, and action (4 A’s) for adoption of new clinical practices and technology innovation.¹⁰ In Table 2, the 7 leadership lessons have been cross-walked to the NQF *Safe Practices for Better Healthcare — 2009 Update*⁸ and the 4A Model of Innovation Adoption of the Safe Practices as they pertain to the role of midlevel and upper-level leaders of health care organizations.

Below, we summarize the webinar presentation, which addresses the *7 Lessons for Leading in Crisis*; then we address

the 4A Model of Innovation Adoption used in the Safe Practices; and we close with the actions that hospitals leaders can take, using these tools to mitigate crisis situations.

7 LESSONS FOR LEADING IN CRISIS

The following section represents a summary of the webinar content pertaining to the *7 Lessons for Leading in Crisis* presented by the author, Bill George. The webinar is now available as streaming content over the Internet.⁶

We have a noticeable gap in the number of authentic leaders, trained in clinical health care, who understand the complexities of our health care system.^{11,12} Now is the time for a new generation of health care leaders to step forward into important leadership roles. The country needs nurses,^{13,14} pharmacists,¹⁵ and other health care workers who can step into leadership roles to guide us through this crisis.

Health care, at its essence, is a local endeavor, based on relationships between patients and their health care teams. Accounting for one-sixth of the U.S. economy, it is far too complex and diverse to attempt to apply a “one-size-fits-all” strategy on a national basis, as many policymakers and politicians are attempting to do.¹⁶ To fill the leadership gaps, hundreds, if not thousands, of health care leaders are needed to address immediate problems in local geographic areas.

We need clinically-trained health care leaders at the local level who can address the 4 critical macro-areas of insurance, cost, quality, and lifestyle in their service areas and who can develop integrated solutions. Without the emergence of such leaders, health care will lurch from one crisis to the next, with limited forward progress. Those leading within the microsystems in hospitals are in critical positions that can prevent harm today.

Crisis is the ultimate test for any leader. It is far easier to lead in stable situations than to lead in a crisis; and leading in good times does not provide an adequate test of how leaders will cope in crisis. An old English proverb says, “A smooth sea never made a skilled mariner.”¹⁷ In our current crisis, we are finding out who the skilled mariners of our health care system are. Leading in crisis is the best way, not only to test leaders, but also to develop them, so they will be prepared for the larger crises that may present themselves.

Health care has vastly underestimated the importance of developing its own leaders. All too often, health systems turn to support industries like consulting and accounting to find leaders. The problem with this approach is that many of these outside leaders have a deep understanding of business processes and financial realities, but little or no experience in the all-important clinical side of medicine.

There is a major shortage of physician leaders, as well as nursing leaders and pharmacy leaders, who are prepared to take on important leadership roles. A concerted effort is required to develop leaders with deep backgrounds in these fields. Today there are few in-depth programs to prepare midcareer leaders from these professions.

*7 Lessons for Leading in Crisis*⁵ was written to propose some universal lessons that all health care leaders can use to guide their organizations through crises, or to avoid crises altogether if possible. The 7 lessons are:

1. Face reality, starting with yourself
2. Don’t be Atlas; Get the world off your shoulders
3. Dig deep for the root cause
4. Get ready for the long haul
5. Never waste a good crisis
6. You’re in the spotlight: follow your true north
7. Go on offense; focus on winning now

TABLE 1. Four Safe Practices for Leadership

Safe Practice 1: Leadership Structures and Systems

Leadership structures and systems must be established to ensure that there is organization-wide awareness of patient safety performance gaps, direct accountability of leaders for those gaps, and adequate investment in performance improvement abilities, and that actions are taken to ensure safe care of every patient served.

Safe Practice 9: Nursing Workforce

Implement critical components of a well-designed nursing workforce that mutually reinforce patient safeguards, including the following:

- A nurse staffing plan with evidence that it is adequately resourced and actively managed and that its effectiveness is regularly evaluated with respect to patient safety.
- Senior administrative nursing leaders, such as a chief nursing officer, as part of the hospital senior management team.
- Governance boards and senior administrative leaders that take accountability for reducing patient safety risks related to nurse staffing decisions and the provision of financial resources for nursing services.
- Provision of budgetary resources to support nursing staff in the ongoing acquisition and maintenance of professional knowledge and skills.

Safe Practice 10: Direct Caregivers

Ensure that non-nursing direct care staffing levels are adequate, that the staff members are competent, and that they have had adequate orientation, training, and education to perform their assigned direct care duties.

Safe Practice 18: Pharmacist Leadership Structures and Systems

Pharmacy leaders should have an active role on the administrative leadership team that reflects their authority and accountability for medication systems performance across the organization.

TABLE 2. Integration of the 4 A's and 7 Lessons for Leading in Crisis

4 A's	7 Lessons	Leader Activities by Safe Practice
Awareness	<ul style="list-style-type: none"> • Face reality, starting with yourself • Dig deep for the root cause 	<ul style="list-style-type: none"> • Governance/Administrative Leaders: Awareness is a critical issue for governance leaders. They recognize their roles as the corporate conscience of the organization. They must ask the right questions, identify the real performance gaps, and “own” the issues of resource allocation. Quality and safety cannot be delegated away. Administrators must not protect past performance—new safety risks are continually being recognized. Awareness programs must be coupled to rapid administrative response processes to address the dynamics of the ever-changing safety risks that evolve across the organization. Change is a given. • Nursing Leaders: Nursing leaders must battle the “learned helplessness” that can set in with lack of control and cost constraint pressures. They are the neurosensory apparatus of the organization. The NQF Safe Practice 9 for nursing provides a means of having a new voice at the leadership table. They can identify risk areas that can be addressed to improve clinical, operational, and financial performance. • Pharmacy Leaders: The hospital pharmacy should no longer be considered a silo service. The pharmacy and its leaders have reach that extends far beyond the walls of their operation—they can help identify problem areas. If they do not help identify areas for harm reduction, they are failing the mission of the organization. • Direct Caregiver Leaders: Leaders of non-nursing direct care can have less opportunity to affect performance than even nursing; yet imaging, laboratory, and other services that affect patients can help identify risk and bring it to the leadership table.
Accountability	<ul style="list-style-type: none"> • You're in the spotlight: follow your True North 	<ul style="list-style-type: none"> • Governance/Administrative Leaders: Leaders drive values, values drive behaviors, and behaviors drive performance. Governance and administrative leaders must do everything they can to ensure that the values of the organization are painted by the behaviors of the leaders, and that every incentive is created to encourage them and that disincentive is created to prevent migration away from them. This responsibility is defined in the Safe Practice for leadership and should not be taken lightly. Crisis provides a perfect opportunity for setting an example. • Nursing Leaders: Nurses represent the final common pathway of the majority of care delivered. The nursing leadership practice sets forth requirements for orientation and competency. In the current crisis conditions, nursing leaders can impress on those new to the organization, temporary staff, float pool nurses, contract staff, and temporarily assigned nurses, the importance of getting back to the core values of compassionate care. • Pharmacy Leaders: The precision and responsibility that is required of pharmacists is a given requirement of the position; however, pharmacy leaders now have a real opportunity to exhibit values-driven and principle-grounded behavior as leaders with direct access to their senior leadership. This will require courage to create budgets that support an organizational medication safety program and will require crucial conversations with administrators. • Direct Caregiver Leaders: Leaders of those services interacting with patients that are not nursing services have even less voice in typical organizations than nursing leaders. Here it will be a real challenge for leaders to make sure to maintain behaviors reflecting true north core values. Personal accountability for risk assessments and voicing safety concerns will require leadership by example.
Ability	<ul style="list-style-type: none"> • Never waste a good crisis • Don't be Atlas; get the world off your shoulders 	<ul style="list-style-type: none"> • Governance/Administrative Leaders: The current health care crisis provides governance and administrative leaders with the opportunity to help break the surface tension and inertia that is the greatest barrier to overcome. Capacity, resources, and competency are critical to the ability of organizations to implement changes in their culture and in patient safety performance. Systematic and regular assessment of resource allocations to key systems should be undertaken to ensure performance in patient safety. This will be difficult. Crisis provides a perfect time for governance and administrative leaders to call on medical leaders—informal and formal. The leadership practice calls for regular, periodic assessment of adequacy of resource allocations with appropriate adjustments to ensure that patient safety is adequately funded. Patient safety budgets for people systems, quality systems, and technology systems should be maintained and documented. Again, this will require courage and teamwork. • Nursing Leaders: Nursing leaders tend to be and feel isolated from the performance improvement infrastructure. However, they must put into place and document performance improvement programs that include the elements of education, skill building, measurement, reporting, and process improvement, and provide evidence of the actions taken to close patient safety gaps related to nursing services. Herein lies a crisis-driven opportunity for nurses to help others, including clinicians, to become engaged in identifying risks to patient safety and the development of solutions to mitigate the potential for harm.

(Continued on next page)

TABLE 2. (Continued)

4 A's	7 Lessons	Leader Activities by Safe Practice
Action	<ul style="list-style-type: none"> • Go on offense; focus on winning now • Get ready for the long haul 	<ul style="list-style-type: none"> • Pharmacy Leaders: Pharmacy leaders must use logical arguments, grounded in fact, and financial projections to get adequate funding to maintain the ability to close performance gaps. Teaming up with nursing and medical leaders is key to being successful. The new pharmacy leadership practice provides a channel for communication; however, a team-developed message will likely be most successful. • Direct Caregiver Leaders: Managers of non-nursing direct caregivers must develop staffing plans that are adequately resourced and actively managed. This is difficult with financial cutbacks. The effectiveness of such programs needs to be regularly evaluated with respect to patient safety, and must provide the ability to the direct caregivers to monitor and take care of potential problems. In today's financial situation, these risks must be tied to evidence-based and validated costs. • Governance/Administrative Leaders: The leadership practice sets forth that structures and systems should be put in place to ensure that leaders take direct and specific actions, including performance improvement programs, regular actions of governance, basic teamwork training and interventions briefings, and governance board competency in patient safety. In crisis conditions, the temptation is to cut back on these activities; however, the forces of transparency and pay-for-performance will definitely favor those who increase spending on quality and especially safety, which is the pain-point for federal and private payers. • Nursing Leaders: Now is the time for nurses to step up with honest arguments for support of improving discharge management, transitions of care management, prevention of infections, and improved handling of test results. These are all Safe Practices that tie directly to staffing, competency, and education, specifically in the nursing practice. Although challenging, the direct action of nursing today on safety issues will save the organizations tomorrow. • Pharmacy Leaders: Safe medication management and delivery will be a daunting challenge for some time to come. Pharmacy leaders will have a long haul ahead; however, investment in the right training, right people, and right technologies will pay handsomely in improved care and reduced costs related to harm. Again, the path of least resistance is the path of failure. • Direct Caregiver Leaders: The good news for non-nursing-related service lines is that there is more and more recognition of their importance to enterprise-wide systems performance. It is critical that midlevel managers in this area stay the course on performance improvement. Episode of care and outcomes-related transparency programs will uncover the value of high-performance imaging, laboratory, and other services.

At first glance, several of the lessons sound rather obvious. Does not everyone believe in “facing reality?” Yet in studying how many seemingly successful leaders fail to follow these lessons during crises, it becomes apparent that deeper study is required to understand why leaders repeat the same mistakes crisis after crisis.

When Bill George, one of the authors of this article, joined Medtronic as chief executive officer in 1989, he knew a lot about high-tech businesses but very little about health care. He often felt he was carrying the weight of the world on his shoulders and that 1 mistake in design or software coding could potentially harm thousands of patients. So he relied heavily on medical doctors, scientists, and engineers who had far greater knowledge of medicine than he. He also gowned up and witnessed 1000 procedures in his 12-year reign at Medtronic, as a way of learning from highly-skilled physicians. He developed a deep understanding that the core values of each individual need to be the “true north” that will drive the direction of leadership.

Lesson No. 1: “Face Reality, Starting With Yourself”

Until you acknowledge the reality of the crisis and its potential implications, you cannot overcome the problems. In health care, many people believe we only have an access problem and we do not acknowledge the quality crisis and how it contributes to the cost crisis. Perhaps the largest crisis of all is

that of patient empowerment and lifestyles, something few are willing to speak about openly.

It is hard to avoid organizational denial until leaders admit their mistakes. When leaders refuse to face their own realities, things only get worse.

Lesson No. 2: “Don’t Be Atlas; Get the World Off Your Shoulders”

There is a real danger in leaders who turn inward when crisis happens. They disappear into their offices and think they can solve the problem by themselves. As the pressures mount, they become more isolated.

It is highly important to build a diverse, skilled team and listen closely to their opinions, especially when they conflict with your own. Sometimes you will have to make a lonely decision to go against their advice, but at least you have heard it. You also need an external reference point against which to test your judgments. It starts with having one or more people—your spouse, best friends, or mentors—whom you can trust implicitly.

Lesson No. 3: “Dig Deep for the Root Cause”

How many times has medicine treated symptoms and not the root cause of the disease? The phrase “Trust, but verify” applies here. You need to trust the people you work with, but you have to verify their opinions with hard data. This means bringing together a team of knowledgeable people drawn from

both inside and outside the company to get into the root cause, because it may not be apparent at first.

How do you know when you have identified the root cause? You have to keep testing to verify that a solution has been found and will not create additional problems. One of the reasons people fear digging deeper is they are afraid that things may be much worse than they thought. That is why it is so important for leaders to keep digging into the root cause.

Lesson No. 4: "Get Ready for the Long Haul"

Health care crises that have festered for a long time cannot be resolved quickly. All too often, leaders look for quick-fix solutions without understanding how intractable these problems can be, or without recognizing that things may get worse before they get better. Modest actions will not correct long-standing problems. Decisive actions are required, but many health care leaders have failed to take them. Health care reform, even if it embodies insurance reform, will at first have increasing pressure of transparency with respect to performance improvement, quality, and safety. Leaders at all levels are going to have new accountability and should prepare for a long haul.

Lesson No. 5: "Never Waste a Good Crisis"

This phrase comes from Machiavelli. A crisis is the best opportunity to make fundamental changes in organizations because people recognize that dramatic action is required to fix the situation. Leaders cannot just hunker down until the storm passes. They must anticipate what lies ahead, and sometimes even create a crisis to get on top of potential problems immediately. The focus on the failure of our health care system has broken surface tension of the status quo. The initial inertia that is so hard to overcome has been shifted. Leaders at all levels can leverage the crisis to focus on the true calling of health care.

Lesson No. 6: "You're in the Spotlight: Follow Your True North"

How often is health care-related harm in the spotlight these days? Pick up any newspaper, and you will find it is all over the papers. Someone gets harmed; then it is published on the Web and there is no hiding. You cannot duck it, or the external stories and rumors will gain greater credence than the facts of the case.

These days, internal and external communications have morphed into one. Everything that is communicated internally gets outside, no matter what you do. Often, what is communicated in the media, on the Internet, or on blog sites has more credibility with employees and patients than internal messages. In this environment, the only way to be credible is by being fully transparent and openly communicating the known facts of the situation.

To know what is going on, you need to create a culture of candor and surround yourself with people who will tell you the whole truth. When you do not know the root cause of the problem, you still have to be candid and forthcoming, as well as taking public responsibility for problems.

Being in the spotlight is the real test of your "True North." Will you stay true to who you are and what you believe?

The Final Lesson, No. 7: "Go on Offense; Focus on Winning Now"

Crises represent both danger and opportunity. You cannot just get through the crisis; rather, you need to see how you can use the crisis to create positive opportunities for your organization.

Anthropologist Margaret Mead once said, "Never doubt the power of a small group of people to change the world.

Indeed, it is the only thing that ever has."¹⁸ It is easy to feel overwhelmed by the challenges of health care. None of us can solve the national health care problem by ourselves, but we can work with a small group of people to make a lasting difference in our local communities. The current crises in health care may provide defining moments for health care leaders to step up to leadership that makes a lasting difference. The sum of all these efforts can build a health care system that works well for everyone.

Survey Results

The concepts above were addressed for patient safety, pharmacy, and nursing leaders. At the end of the webinar, a survey of participants was performed.⁶ Two hundred seventy-two respondents were surveyed using Reichheld's "Net Promoter Score" approach as presented in his book, *The Ultimate Question*,⁷ to assess the value of information presented to hospital safety leaders. By subtracting the detractors, or people who would not recommend the information as useful to others in their field, from the promoters, who would recommend the information, Reichheld has provided a very reliable method for assessing value, the Net Promoter Score. The survey results of the value of utilizing concepts from *7 Lessons for Leading in Crisis*, as applied to use of the NQF Safe Practices, were that that 91% of the respondents had scores between 8 and 10, where 10 is a top recommendation score. More than half the respondents (58%) scored the information a 10. This surveyed group, which represented an estimated 25% of the approximately 1200 total participants, felt that the program provided very useful information.

APPLYING THE 7 LESSONS TO THE 4 A'S OF INNOVATION ADOPTION

The 4 A's, Awareness, Ability, Accountability, and Action, represent an operational framework which was incorporated into certain NQF Safe Practices, to which the 7 lessons of leading in crisis can be applied.¹⁰

The NQF Safe Practice 1 (Leadership Structures and Systems) states that "leadership structures and systems must be established to ensure that there is organization-wide awareness of patient safety performance gaps, direct accountability of leaders for those gaps, and adequate investment in performance improvement abilities, and that actions are taken to ensure safe care of every patient served."^{8,9,19} The activities by governance, administrative, and clinical leaders have been organized using the 4A Model of Innovation Adoption.

- **Awareness:** Leaders must be aware of performance gaps before anything can be achieved. Awareness requires that adequate information be provided to leaders at all levels. The practice requires that structures and systems be in place to provide a continuous flow of information to leaders from multiple sources about the risks, hazards, and performance gaps that contribute to patient safety issues. Leaders at any level need a clear understanding of performance shortfalls to act. Lesson 1, "Face reality, starting with yourself," and Lesson 2, "Don't be Atlas; get the world off your shoulders," have applicability to the dimension of awareness of performance gaps.
- **Accountability:** Accountability of leaders to closing performance gaps is a key success factor—someone needs to "own" the changes that must be made to processes, systems, and expectations of staff. Owing to the slow but critical transformation from the legacy "command and control" accountability structures to "team-based" approaches, few leaders are directly accountable for specific and measurable patient safety

performance gaps. High-performing organizations have seen the light and have teamed clinical with administrative leaders with joint goals. Lesson 6, “You’re in the spotlight: follow your true north,” has applicability to the dimension of accountability for closing performance gaps.

- **Ability:** A team or unit may be aware of gaps, and may be accountable for those gaps. However, if they are not able to make changes, change will not occur. Worse, “learned helplessness” can set in, galvanizing the troops to the status quo. The dimension of ability may be measured as capacity for change. It requires investment in knowledge, skills, compensated staff time, and the “dark green dollars” of line-item budget allocations. Preliminary results from the TMIT Research Test Bed, which is studying the impact of patient safety practices and solutions in hundreds of community hospitals, indicate that few hospitals have made adequate investments in patient safety. Lesson 5, “Never waste a good crisis,” and Lesson 2, “Don’t be Atlas; get the world off your shoulders,” have direct applicability to creating the ability to close performance gaps.
- **Action:** Finally, to accelerate innovation adoption, organizations need to take explicit actions toward line-of-sight targets that close performance gaps, that can be easily measured, and that can generate early wins. Multiple objectives that can be achieved by direct action must be designed into an improvement program, improvement that can be easily scored. Lesson 7, “Go on offense; focus on winning now,” and Lesson 4, “Get ready for the long haul,” have direct applicability to taking the direct action to close performance gaps.

Barriers exist along each of these dimensions. Such barriers can often be converted into accelerators by specific interventions.¹⁰

NQF Safe Practices

The NQF Safe Practices have been thoroughly updated for 2010 with reference to citations and implementation recommendations; however, the endorsed specifications for leadership, as presented in Table 1, have not changed from the 2009 version. Safe Practice 1, which addresses governance, administrative, medical, and safety leadership, is like a central hub of information transfer and is intended to serve leaders by integrating information flow to them and direction from them. In this time of crisis, it will serve as a structural blueprint for action. The real crisis, however, is at the bedside and is the domain of mid- and upper-level managers who face the reality of resource constraints. Without their energies focused now in a time of crisis, real harm can come to the patients being served. Pharmacy leaders have a practice specifically designed to enhance and frame their leadership role in medication management systems. Leaders of nursing and direct caregivers have practices that are more subtly designed to emphasize their leadership role with less tactical specifics. All 3 are now in crisis, and the 7 lessons can serve them well.

Governance and Administrative Leadership

Governance and administrative leaders represent lynchpins to success. Safe Practice 1 provides a blueprint to help such boards hardwire information, power, and resource flow. Activities to be undertaken by boards are organized by the 4 A’s as presented in Table 2, and can be placed in a customized checklist for governance and administrative teams. Table 2 also provides specific application of the 7 *Lessons for Leading in Crisis* concepts.

The transformation needed for health care reform and pay-for-performance must occur from the top down. Crisis pro-

vides a wonderful opportunity to do away with “sacred cows” like entrenched policies that put patients at risk. Remember, sometimes sacred cows make the best hamburger.

Pharmacy Leadership

The frequency of adverse drug events (ADEs) is very high, with 1 ADE occurring in every 10 patients.²⁰ ADEs are cited as the leading cause of medical harm. Safe Practice 18 for Pharmacy Leaders⁸ was intentionally designed to put pharmacy leaders into more prominent roles and recognize the dramatic reduction in medication management errors that can be achieved with their impact on improvement of the systems of care. The *NQF Safe Practices for Better Healthcare — 2010 Update*⁹ is unchanged with respect to pharmacy leadership specifications; however, the evidentiary support has been refreshed. The practice sets forth the principle that pharmacy leaders should have an active role on the administrative leadership team of health care organizations that reflects their authority and accountability for medication systems across the organization. Additional specifications address key action areas that integrate former Safe Practices to cover the systems issues that stretch beyond the walls of the pharmacy.

Nursing Leadership

Typically, more than 50% of a hospital workforce is made up of nurses. Front-line nurses, nursing leaders, and nursing membership organization leaders believe that the profession is definitely in a state of crisis. Recognizing that nursing offers a terrific opportunity to improve care, a two-day national workshop was hosted by TMIT on August 12, 2009, with leaders of several major nursing organizations, including the Association of Perioperative Registered Nurses, the American Association of Critical Care Nurses, nursing leaders, front-line nurses, experts in talent development, advanced leadership fellows, and national patient safety leaders to address the current nursing crisis. Challenges of nursing leadership addressed at this meeting were issues such as the ongoing industry crises of hospital budget cuts, changes in nursing practice, communication issues within hospitals, transition from staff to management, responsibility without authority, staff management, recruitment and retention, multiple hospital stakeholders, quality issues, budget/financial management, time management, and the need for nurse self-development.²¹

As a final note on nursing, there is currently a well-known shortage of nurses, and this shortage is expected to be as high as 1 million by the year 2020. Yet there are nursing school graduates who cannot find jobs. Why is this? Because, due to online education, there are more nursing graduates. Also, the retirement-age workforce is postponing retirement because of the economy, and the industry prefers experienced nurses who are specialty-trained.²² Dall et al²³ found that the economic value to society of improved quality of care can be achieved through higher nurse staffing levels. So, although reducing staffing seems to cut costs on the bottom line, in the long run, it does not. There are crises building at both ends of the nurse staffing spectrum. In a recent white paper, the Hodes Health Care Group suggests that we need a positive, proactive approach to the transition of nursing leaders from the current generations to the cohort of new nurses who are coming aboard today.²⁴

CROSSWALK OF 7 LESSONS TO 4A ADOPTION MODEL AND NQF SAFE PRACTICES

The lessons for leading in crisis have practical relevance to the actions that governance/administrative, nursing, pharmacy, and non-nursing leaders need to take to be in compliance with the requirements of the NQF Safe Practices. To make the

insights of the 7 lessons practically applicable to the NQF Safe Practices, and to breathe life into the dry specifications, we have organized advisory content into Table 2. Although activities embedded in the table are not an exhaustive and detailed crosswalk, and linkages were not undertaken down to the specification level, high-level concepts have been applied and example activities have been addressed. Suffice it to say that the lessons provide guidance for implementation of the practices.

Governance and administrative leaders are a center of gravity for resource allocation and transformation of a health care enterprise. Engagement of them is critical. The effectiveness of midlevel managers is directly correlated to their engagement.

CONCLUSIONS

Health care reform will bring in new forces, new realities, and new crises. There are stormy seas ahead, extending beyond the horizon. All of our leaders from governance down to front-line servant leaders will be mariners who will need new skills to safely make their voyage to safe care. It is clear that those skill sets will have to include applied leadership, people systems areas such as recruitment, retention, and rewards, a deeper understanding of hospital systems beyond their immediate domain, and new know-how in the science and art of improvement.

The 7 lessons provide a roadmap to use of the well-developed and evidence-based Safe Practices. The most difficult lesson to learn is to face reality and own our roles in safety issues; however, this is the critical beginning necessary to survive crisis. We must leverage our teams and those around us and truly get the world off our shoulders. In a field where we have been trained to operate more independently than to work as teams and collaborative groups across an organization, we must embrace the discipline to do so. In a world where we try to reduce problems and issues to the simplest form, it is very important to dig more deeply to find the root cause for systems failures and not just treat systems. We must get ready for the long haul, because health care will be in turbulent times for years. Finally, we can leverage the current crisis because people are worried and ready to seek change, and the inertia can be moved. We must fall back on our core values for our compass heading, and rather than be buffeted by sea change, we must set our course for safe care, and go on offense.

The 4A Model provides a means of organizing tactics and the Safe Practices provide the what, when, how, and why for action. The rest is up to us. There will be no safe harbor for inaction. It is time to grasp the helm, set the course, and declare the destination.

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