International Forum on
QUALITY & SAFETY
in HEALTHCARE
LONDON

10-12 April 2024

Together to Regenerate Health and Care

@QualityForum #Quality2024

Institute *for* Healthcare Improvement

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International Forum on QUALITY & SAFETY in HEALTHCARE LONDON

CHRIS JONES

CEO, BMJ

@QualityForum #Quality2024

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PENNY PEREIRA

Managing Director, Q

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Academy


Academy

“The most important single change in the NHS […] would be for it to become […] a system devoted to continual learning and improvement of patient care, top to bottom and end to end.”

Don Berwick

A promise to learn - a commitment to act, 2013

Together, to improve health and care

The Health Foundation

Q is led by the Health Foundation and supported by partners across the UK and Ireland

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Reflection and learning canvas

Setting intentions

My goal for the conference is...

Surfacing insights

What ideas have inspired or surprised me?

Main takeaways and action planning

What?

What are my main takeaways from the conference?

Now what?

How can I bring these into my work? What will I do and when?

So what?

Why are these important to me?

How?

What do I need to consider? Who do I need to engage? How will I know if I've succeeded?

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GABBY MATHEWS, AMY EDMONDSON, DON BERWICK

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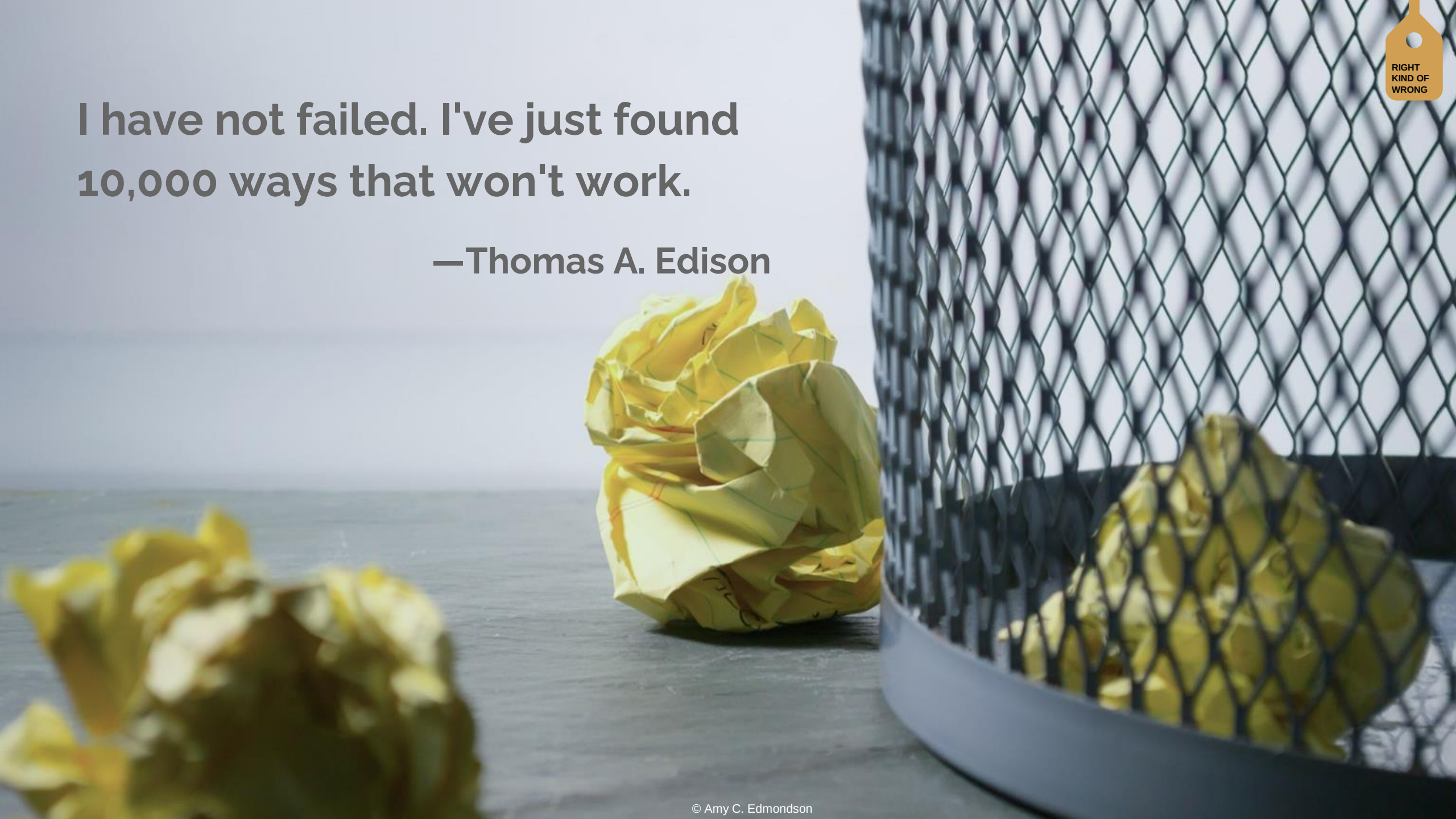
RIGHT KIND OF WRONG

PRACTICING THE SCIENCE OF FAILING WELL IN AN UNCERTAIN WORLD

Amy C. Edmondson, PhD
Harvard Business School

We’re going to fail all day.

—Jen Heemstra

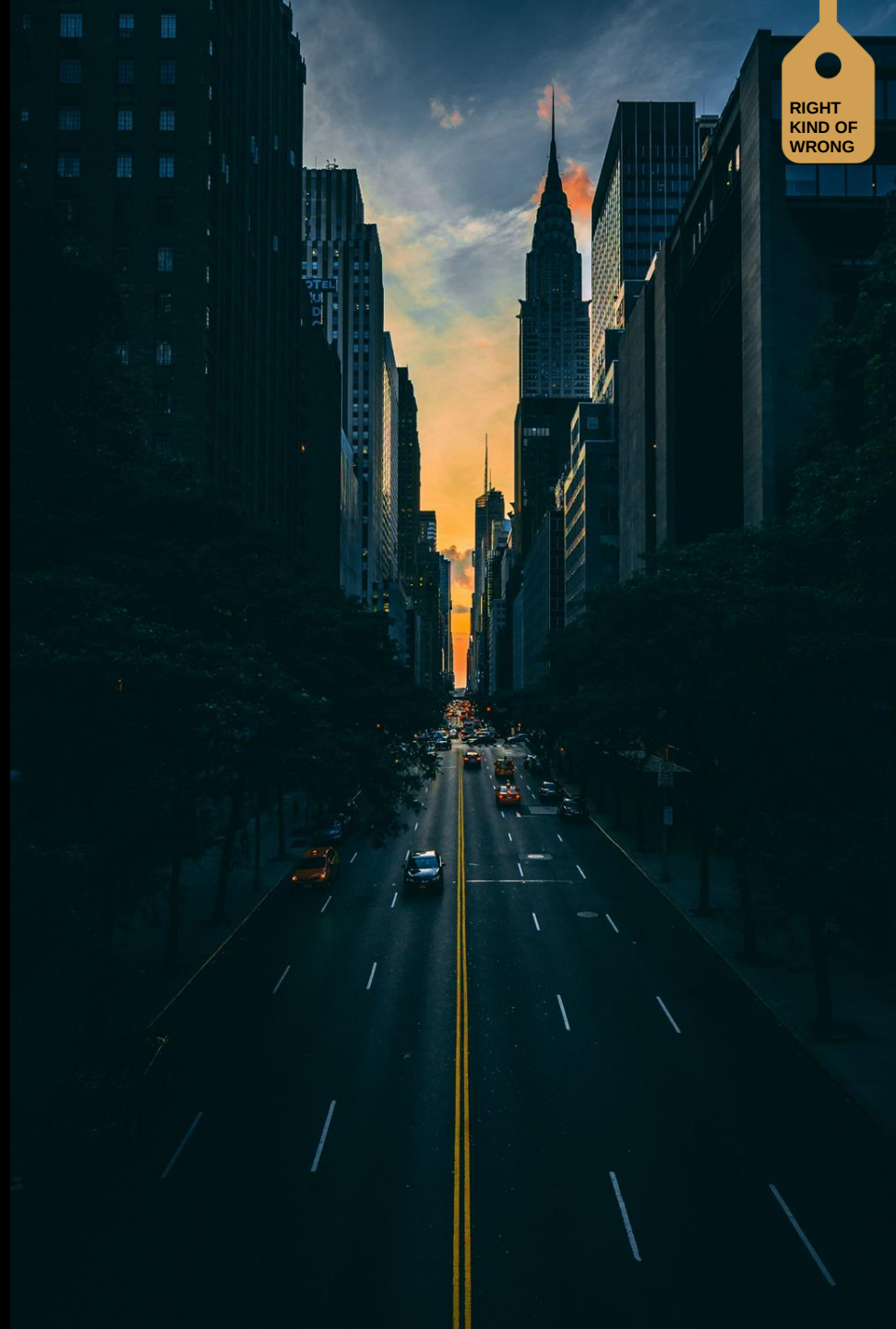


THE PROBLEM WITH THE FAILURE FAD

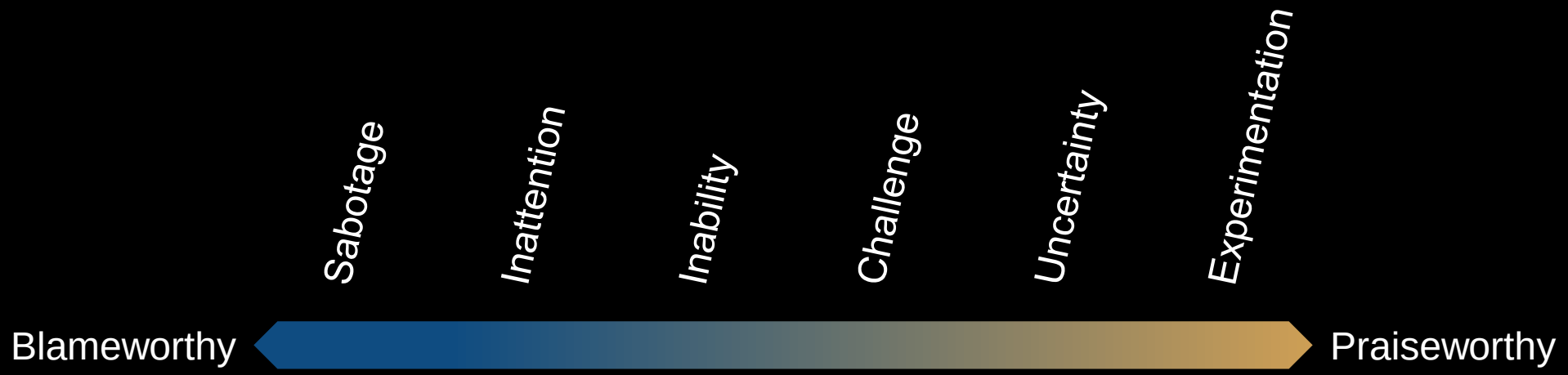
RIGHT KIND OF WRONG

We know deep in our hearts: failure is bad!

When failure is “off limits”



HYPOTHETICAL CAUSES OF FAILURE



- Question: What **percent** of failures in your organization are caused by blameworthy acts?

- Question: What **percent** of failures in your organization get *treated* as if caused by blameworthy acts?

RIGHT KIND OF WRONG

1

Basic Failures

2

Complex Failures

3

Intelligent Failures

The right kind of wrong

Air Florida Flight 90: January 13, 1982

RIGHT KIND OF WRONG

First Officer: Pitot heat.
Captain: On.
First Officer: Anti-ice.
Captain: Off.
First Officer: APU.
Captain: Running.
First Officer: Start levers.
Captain: Idle.

BASIC ≠ SMALL

AN INNOVATION DECISION AT "TELCO"

RIGHT KIND OF WRONG

- Excellent provider of local and long-distance telephony.
- Executive team debate about the launch of "NewTech" in major metropolitan city market.
- Small, well-staffed, successful suburban pilot.
- Decision made to go for a full-scale launch.
- **Colossal service failure…**

RIGHT
KIND OF
WRONG

Why didn't the pilot prevent the fiasco?

Because the pilot was a success!

Your pilots should fail. (Yes, fail)

<u>Essential diagnostic questions</u>

1. Is the pilot being tested under **typical** circumstances?
2. Is the goal of the pilot to **learn** as much as possible?
3. Is it clear that compensation and performance reviews are not based on a successful outcome of the ***pilot***?
4. Were explicit **changes** made as a result of the pilot?

The new service launch fiasco was <u>not</u> the right kind of wrong.

FOUR AND A HALF ATTRIBUTES OF INTELLIGENT FAILURE

RIGHT KIND OF WRONG

It takes place in new territory

With a credible opportunity to advance toward a desired goal

Informed by available knowledge; (hypothesis-driven)

The failure is no larger than needed to gain the new knowledge

Bonus: The failure's lessons are identified, shared, & used

RIGHT
KIND OF
WRONG

Diagnosing Telco

A preventable complex failure...

RIGHT KIND OF WRONG

2

Basic Failures

Complex Failures

Intelligent Failures

The right kind of wrong

TORREY CANYON 1967

RIGHT KIND OF WRONG

"Many little things added up to one big disaster…"

1. time pressure
2. missing copy of standard maritime manual
3. the Captain had stayed up late
4. ocean currents and wind pushed the ship slightly off course overnight
5. first officer changed course without permission
6. two lobster boats suddenly appeared out of …
7. the fog
8. a mechanical problem in the steering wheel inhibited full rudder responsiveness

AN ADVERSE DRUG EVENT AT "CHILDRENS"

RIGHT KIND OF WRONG

"Many little things added up to one big disaster…"

1) Overflow conditions in the ICU – the post surgical patient is transferred to a regular medical unit, with less specialized staff.
2) A newly graduated nurse on duty programmed the electronic infusion pump,
3) located in a dark corner of the room, to release the prescribed amount of morphine.
4) Unfamiliar with the device, the nurse asked a colleague for help.
5) The colleague, an experienced nurse, in a rush, stopped to help,
6) The concentration listed on the drug's label was partly obscured by the label being printed in the pharmacy in a way that wrapped around the cassette.
7) The experienced nurse used the visible information to calculate and program the machine with what she believed was the correct concentration.
8) The first nurse looked over the shoulder of the second to check the numbers, rather than independently carrying out his own calculations.

TAKING THE INTELLIGENCE OF INTELLIGENT FAILURE TO HEART

RIGHT KIND OF WRONG

In new territory, the only way to make progress is through trial and failure

Intelligent failures are not preventable

(but they are avoidable)

RETHINKING EXCELLENCE FOR AN UNCERTAIN WORLD

RIGHT KIND OF WRONG

1

Minimize basic failures

2

Anticipate and mitigate complex failures

3

Promote and celebrate intelligent failures

Excellence means error awareness—**catching and correcting error**—all the way through a process or project, along with a willingness to **experiment**. This requires **psychological safety** – to make it easier for people to speak up, to take smart risks, and to shut down failing initiatives in a timely way.

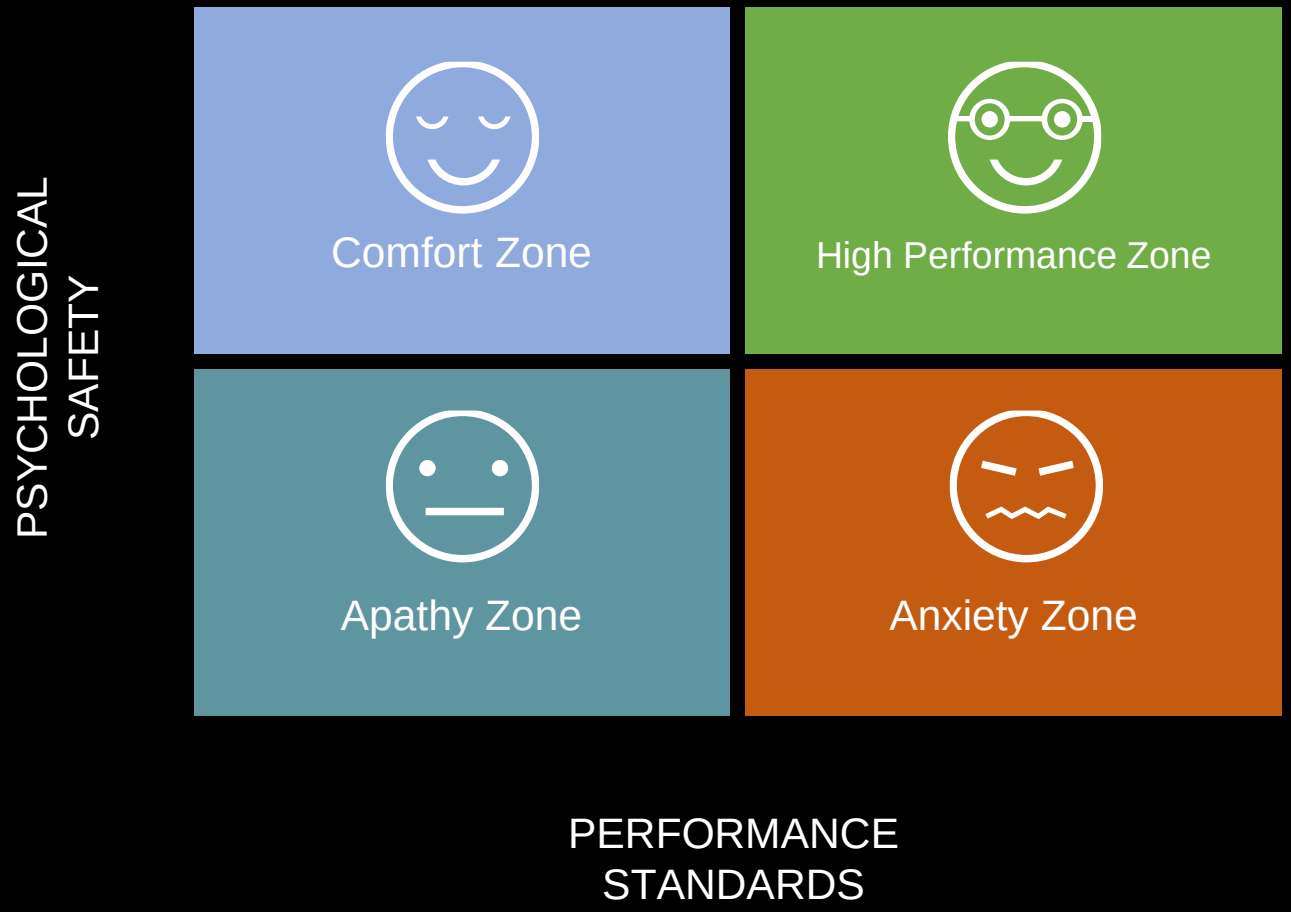
PSYCHOLOGICAL SAFETY

A belief that the context is safe for interpersonal risks – that speaking up with ideas, questions, concerns, or failures will be welcomed and valued

PSYCHOLOGICAL SAFETY

is NOT:
Being Nice
Being Comfortable
Job Security
Lowering Standards

NO TRADEOFF BETWEEN HIGH STANDARDS AND PSYCHOLOGICAL SAFETY



RIGHT KIND OF WRONG

CHECK YOUR RATIOS!

RIGHT KIND OF WRONG

WHAT PERCENT OF WHAT YOU HEAR IS…

This?	Compared to this?
GOOD NEWS	BAD NEWS
AGREEMENT	DISSENT
PROGRESS	PROBLEMS
ALL'S WELL	REQUESTS FOR HELP
SUCCESS	**FAILURE**

If you're hearing a lot of green and not much red, beware!
Red is surely happening. (And it's also part of innovation)

PROMOTE PSYCHOLOGICAL SAFETY

Frame the Work

Call attention to **Attributes of the Work** that require mutual learning

Invite Participation

Lean in to Inquiry; Make voice easy

Respond Productively

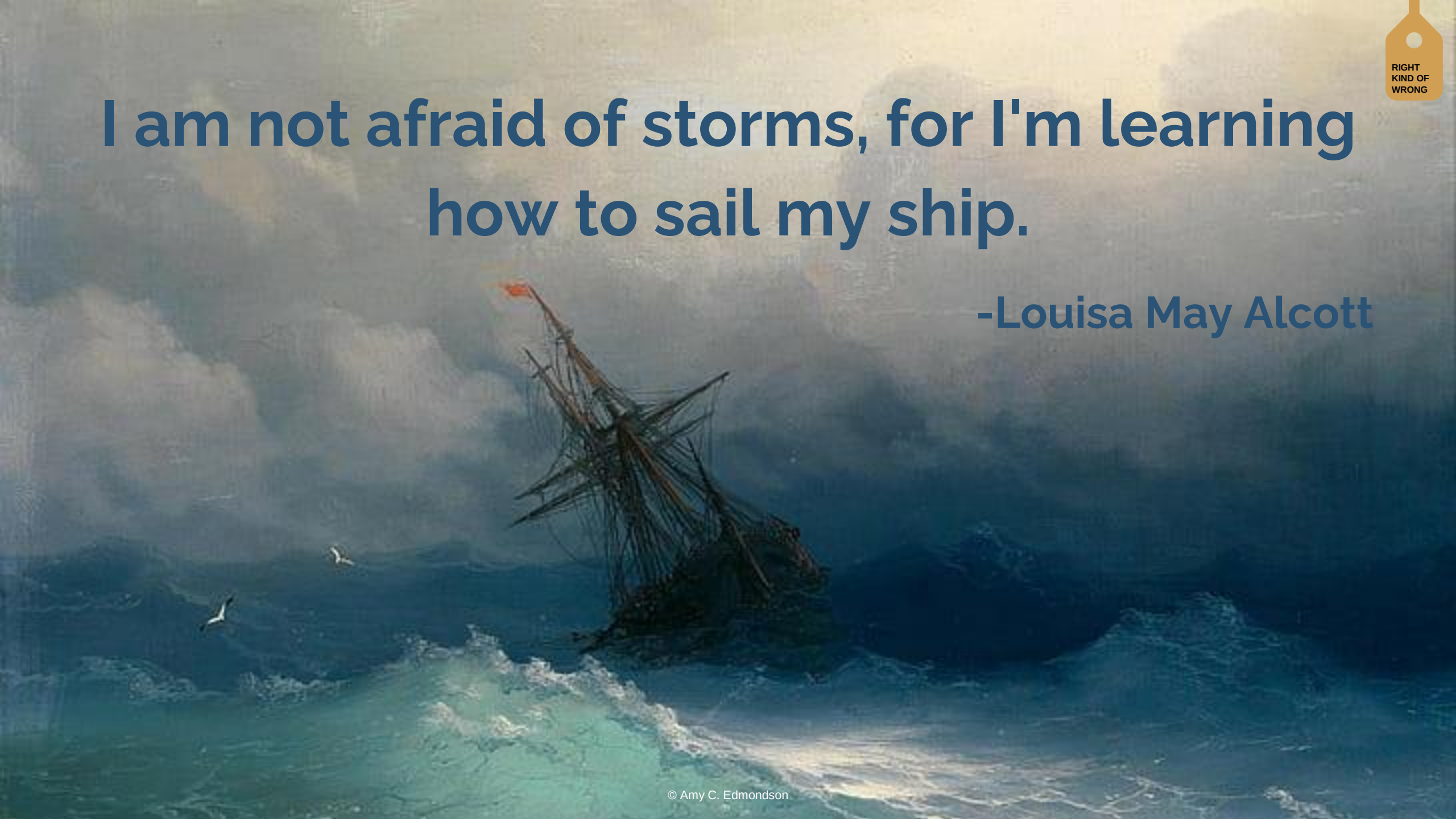
Express Appreciation, **Destigmatize Failure**, Sanction Clear Violations

FRAMING THE WORK: HIGH STAKES IN A VARIABLE CONTEXT

RIGHT KIND OF WRONG

**“I've never flown a perfect flight –
and it won’t happen today either.
I need to hear from you.**

Captain Ben Berman reframing the work with the cockpit crew



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