DO YOU RECOGNIZE

these potential 'blindspots' that impede lasting change and continuous improvement



BLINDSPOT

Communication is critical.

Actions are even more critical. Communication is necessary, but insufficient. If you ask the organization to change, yet you don't, that's a barrier. Your team and associates throughout your organization pay as much attention (possibly more) to what you do (and do not do) as they do to what you say. If you say you want the organization to learn from failure, but you find failure unacceptable, they won't learn. Feeling change often happens first.

ACTIONS

Lead the culture change by actions and words.

Ultimately, your work will succeed you—a culture change that is leader-led, but not solely dependent on you.

Data will motivate change.

- * Develop staff.
- * Provide clear organizational direction.
- * Create milestones to track progress.
- * Memorialize stories of frontline change.

BLINDSPOT

We need to focus on the big problems.

Most big problems are an aggregation of lots of small problems. Quarterly data can be directional, but it cannot provide enough information for improvement efforts. In fact, gathering lots of data to understand the magnitude of related problems may have an inverse effect on staff's perception and satisfaction with management's support and focus on improvement

ACTIONS

- * Act your way to a new way of thinking.
- * Narrow the gap between problem identification and problem resolutions.

Act in
'Big' Ways
& then roll
it out.

- * Tackle small problems when they occur.
- * Adopt a "small is big" philosophy.
- * Protect time on your calendar regularly for improvement learning at the frontline.

 Small regular doses are better than infrequent larger blocks.

BLINDSPOT

Being certain.

However, we know things are unpredictable. Map out future predictions. Realize roadblocks are inevitable. Learn from them. • Healthcare is complex; learn from problems that occur. 🔸 Exploit the power of uncertainty and be opportunistic. • If you think you know, you tend to not pay attention any more.

ACTIONS

- Be curious, no one person has all the answers.
- Cede decision rights to those closest to the problem.
- Don't assume your data is telling the whole truth.

Мy

'Dashboard'

is my Best

Setting a clear direction for ideal patient care is critical.

Friend. Leaders need to know where to find answers &/or how to discover the answers

- Leaders are responsible for the system, not the solutions.
 - If you spend time learning about improvement throughout your organization, the 'answers' you seek become self-realized.
 - A learning organization learns from problems. Make opportunities to learn every day.
 - Improvement cannot be sustained by leaders & executives even if they spent 24/7 on it.
- Go to the workplace to see how the work actually happens and what problems occur. Develop this habit in your direct reports.

BLINDSPOT

We just need the right people.

Empower and train people to act as change agents. 🔸 We need the right people with the right skills. • Leaders must build capacity for continuous organizational improvement (a community of scientists)

Create the environment to make this happen by those who do the work everyday through training, coaching, and mentoring in order to improve care processes and improve culture. 🔸 Would you classify your institution as a 'learning organization' whereby the focus is on learning from from successes as well as errors?

ACTIONS

- Hire for values & provide skills development.
- Build your direct reports ability to coach and teach problem solving in the course of work—a true learning organization.

We just

need to

hold people

accountable

- Nuture the values & coach the skills to improve in daily work.
- Ask people to "show" you problems instead of "telling" you about them. Ask folks how do they know about problems. Have they seen them?
- Make trips to the frontline to learn about how their work happens and what problems they encounter.

BLINDSPOT

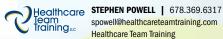
Change is an event.

Within a year, progress can be made, however, for sustainable change, you need to invest over a longer time horizon.

ACTIONS

- * Provide clear organizational direction, create milestones, so you and your team can feel and see progress.and set expectations that this is a multi-year endeavor.
- * Remember Data alone will feeling change motivate often happens change. first, so memorialize stories of how the change is feeling on the frontline close to patients.

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Schein, E. (1999). The Corporate Culture Survival Guide: Sense & Nonsense about Culture Change. San Francisco: Jossey-Bass

Balik, B., Gilbert, J. (2010) The Heart of Leadership: Inspiration & Practical Guidance for Transforming Your Health Care Organization. Chicago: AHA Press.

Braaten, J, Bellhouse, D. Improving Patient Care by Making Small Sustainable Changes. Nursing Economics, May-June 2007, Vol 25, No. 3, 162-66.

Collins, J. (2009). How the Mighty Fall. NY: Harper Collins

Collins, J. (2001). Good to Great, NY: Harper Business

Heifetz, R., Grashow, A., Linsky, M. (2009). The Practice of Adaptive Leadership. Boston: Harvard Business Press.

Kenagy, J. (2009). Designed to Adapt. Second River Publishing.

Kouzes, J., Posner, B. (2002). The Leadership Challenge. San Francisco: Jossey-Bass.

Kouzes, J., Posner, B. (2003). Encouraging the Heart: A Leader's Guide to Rewarding & Recognizing Others. San Francisco: Jossey-Bass

Keroack, M., Youngbird, B., Cerese, J., Krsek, C., Prellwitz, L., Trevelyan, E. Organizational factors associated with high performance in quality & safety in academic medical centers. Academic Medicine 82: 1178-1186, December 2007

Rother, M. (2010). Toyota Kata: Managing People for Improvement, Adaptiveness, and Superior Results, NY: McGraw Hill.

Senge, P., Kleiner, A., Roberts, C., Ross, R., Roth, G., Smith, B., (1999). The Dance of Change: The Challenges of Sustaining Momentum in Learning Organizations. New York: Doubleday.

Spear, S. (2010). The High Velocity Edge. New York: McGraw Hill.

Balik, B., Gilbert, J. (2010). The Beautiful Lie. Illinois: AHA Press.

Homicide By Example? Jim Womack, Lean Enterprise Institute e-letter 07.13.10

Going Through the Motions: An Empirical Test of Management Involvement in Process Improvement, Anita Tucker & Sara Singer HBS working paper 2009.

Why Hospitals Don't Learn From Failure, Anita Tucker & Amy Edmondson, California Mangement Review, Winter 2003

Dr. Ellen Langer, Professor, Harvard University, videoblog excerpt from "The Biggest Mistake a Leader Can Make, Insights from Imagining the Future of Leadership, A Harvard Business School Symposium, August, 31, 2010.

Our Iceberg is Melting, John Kotter, 2005, St. Martins Press

Decoding the DNA of the Toyota Production System, Steven Spear & H. Kent Bowen, Harvard Busness Review September-October 1999

Fixing Healthcare From The Inside, Today, Steven Spear, Harvard Business Review, September 2005