



Advanced Quality Improvement: Mindfulness and High Reliability Healthcare

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1:00-4:00 PM

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Proposed Agenda

- 1:00-1:05 Welcome and Introductions (PK – S1-3)
- 1:05-1:10 Getting Oriented (CB S4-10)
- 1:10-1:30 A Shared Experience! (PK S11-13)
- 1:30-2:00 The Promise, Challenge and Requirements for Mindfulness (PK S14-26)
- 2:00-2:10 Discussion (CB S28)
- 2:10-2:20 A Mindful Break
- 2:20-2:50 Applying Mindfulness to Tough Problems (PK S29-44)
- 2:50-3:10 Discussion (CB S45)
- 3:10-3:25 A Mindful Exercise/Bio-Break (CB)
- 3:25-3:50 Tools and Discussion(PK S46-68)
- 3:50-4:00 Resources (CB S69) and Wrap-Up (PK S70-78)

Our Humble and Auspicious Goal

- Introduce mindfulness concepts and resources
- Demonstrate relevance to safety and quality improvement –creating “high reliability” healthcare
- Start a dialogue and launch a new frontier of effective collaborative efforts
- Have some fun together!

Why This Workshop?

Motivating Observations

#1: Research demonstrates that humans are the weakest link and source of most errors.

The missing link:

“human technology”

#2: Healthcare is a highly complex system requiring mindful methods to ensure quality and safety.

The missing link:

Systemic, emergent and participatory approaches

The bottom line of “human technology” issues

Devoting Attention

Small moments of inattention or misperception can escalate into serious adverse events.

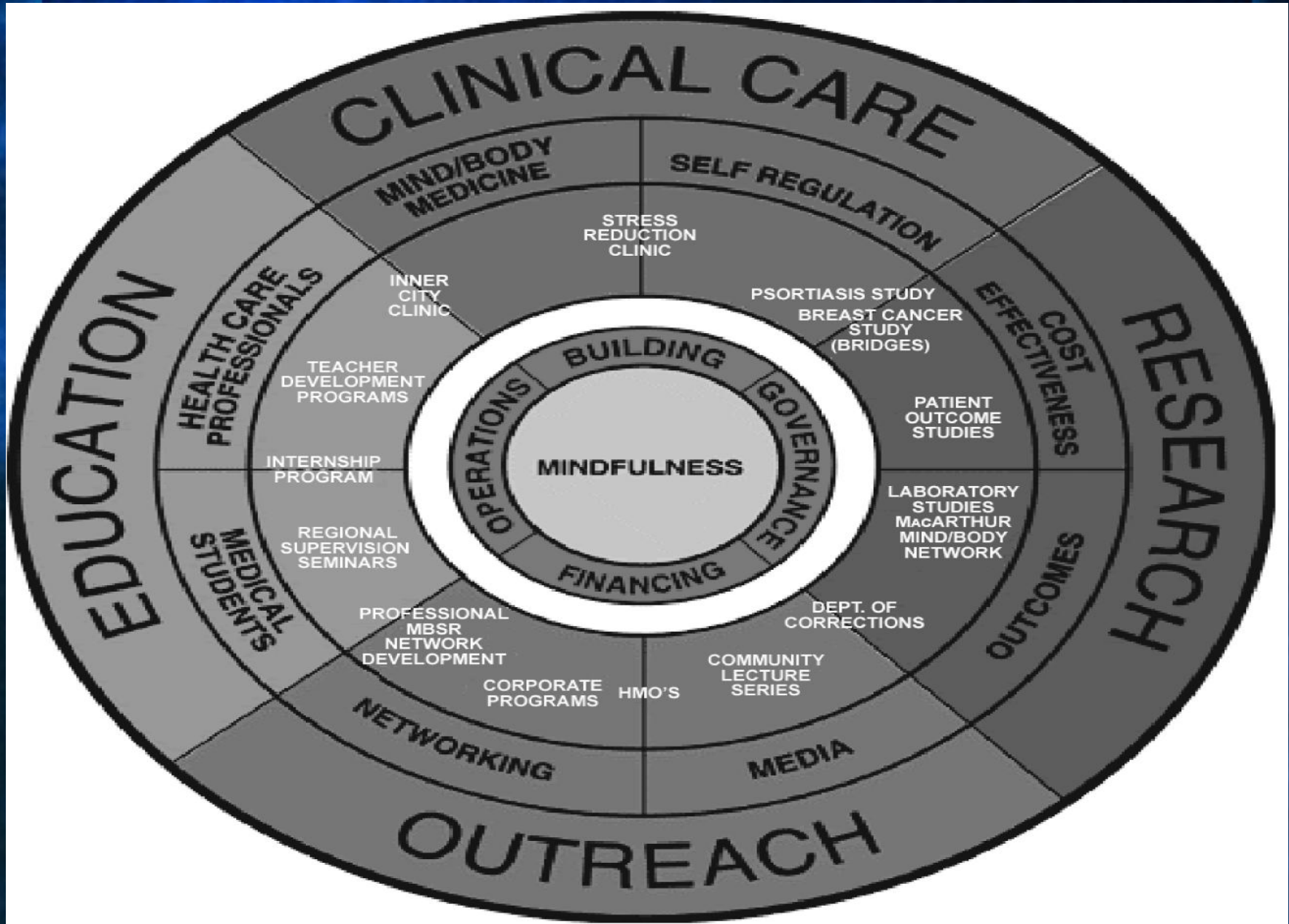
Communication

- Relating-to self and others

Mindfulness: The Thousands Year Old Cutting Edge of Human Technology

- Mindfulness principles and practices are a common denominator in transformational and sustainable models of organizational excellence
- **Terms we hear:**
 - Mindful Systems
 - Living Systems
 - Whole Systems
 - Social Presencing

Mindfulness in Healthcare



Mindfulness At Work



Insight cannot be taught or learned, but the consciousness that gives rise to insight can be developed. Trying to teach insight without transforming consciousness is like trying to create apples without growing apple trees.

Robert Kegan

The Blind Spot of Leadership

Results:

What



Process:

How



Source:

Who

Blind Spot: Inner place
from where we operate

Mindfulness and the High Reliability Organizations-In a Nut Shell

- Culture of respectful interaction
- Desire to continually update situational awareness
- Regular and standardized communication
- Competence via education and training

Mindfulness

Mindfulness is moment-to-moment nonreactive, nonjudgmental awareness. To develop fuller mindfulness, people need to learn both where to focus attention and how to focus attention

*Allow your mind to be seduced, and you will make mistakes.
Proverbs-Soloman*

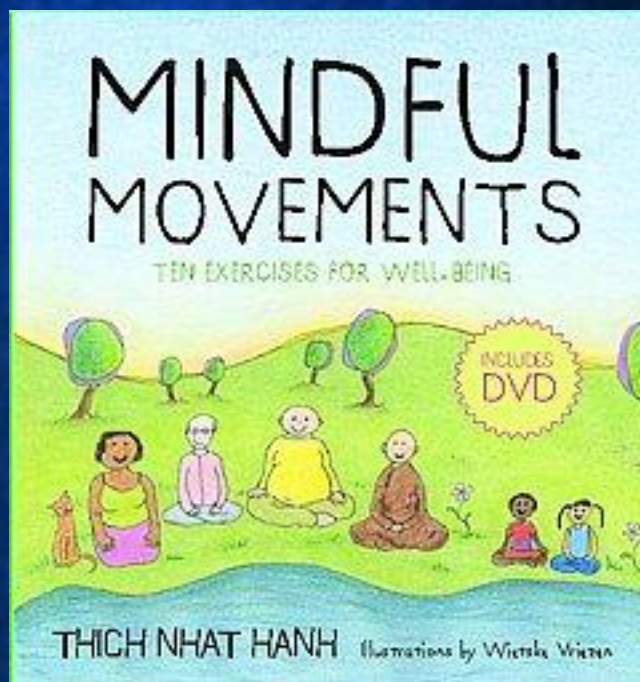
“Be where you are with all your mind”

New York Central Railroad: Machine Shop



Experience First!

Mindfulness Starts with Somatic Sensing and Setting a Positive Intention



Mindfulness Concepts and Relevance to Healthcare Safety and Quality

- Definition, concepts and characteristics
- Operationalizing mindfulness
- Applying mindfulness

Thich Nhat Hanh

“ Mindfulness is our ability to be aware of what is going on both inside us and around us. It is the continuous awareness of our bodies, emotions and thoughts. Through mindfulness we avoid injuring ourselves and others, and we can work wonders.”

Mindfulness

"Paying attention in a particular way: on purpose, in the present moment, and nonjudgmentally." Jon Kabat Zin

Mindfulness Basics

- First focus attention on internal processes
 - Breathing, somatic sensing, creating “spaciousness”
 - Presence, willingness & ability to be with what is in self and others
 - Calmness and capacity to respond vs. react
 - Set emotional intention and affirm “loving-kindness”
- Then, employ real-time methods reinforce internal state & not lose attention
 - Minimize distraction, wandering attention, associative thinking, explaining away or rejecting.
 - Reduce “in the moment” confusion and forgetfulness

“The success of an intervention depends on the interior condition of the intervenor.”

William O'Brien,
former CEO of the Hanover Insurance Company

The Primacy of Context in Change: If You've Seen 1 NICU.....

If context is as critical as the science explains, then nothing really transfers; everything is always new and different and unique to each of us. We must engage with each other and experiment to find what works best for us.

Margaret Wheatley

The Promise

Mindful Individuals

Mindful Teams and
Microsystems,
Including Active
Participation of
Patients

Curious, Dynamic,
Creative Problem
Solving and High
Reliability Healthcare

Barriers to Mindfulness

- **Automatic Pilot and Past Experience**
 - People act less mindfully when they **rely on past categories**, act on automatic pilot and fixate on a single perspective without awareness that things could be otherwise.
 - Increasing mindfulness promotes **discrimination of subtle cues** that had gone unnoticed before. When these cues are noted, routines that had been unfolding mindlessly are interrupted (check list adherence, time-outs, stop-the-line).

The Reality We Deal With

“When an ever increasing amount of information has to be squeezed into the relatively constant amount of time each of us has at our disposal, the span of attention necessarily decreases”

social anthropologist Thomas Eriksen

The Catch-22 Mindfulness Helps Resolve

We must (and do) filter information:

- Every observation is preceded by a choice of what to observe (and what not). We find what we are looking for and miss out on much more.

And open to all that is present:

- However, it takes a broad array of data and views and interpretations to make meaningful sense of things.

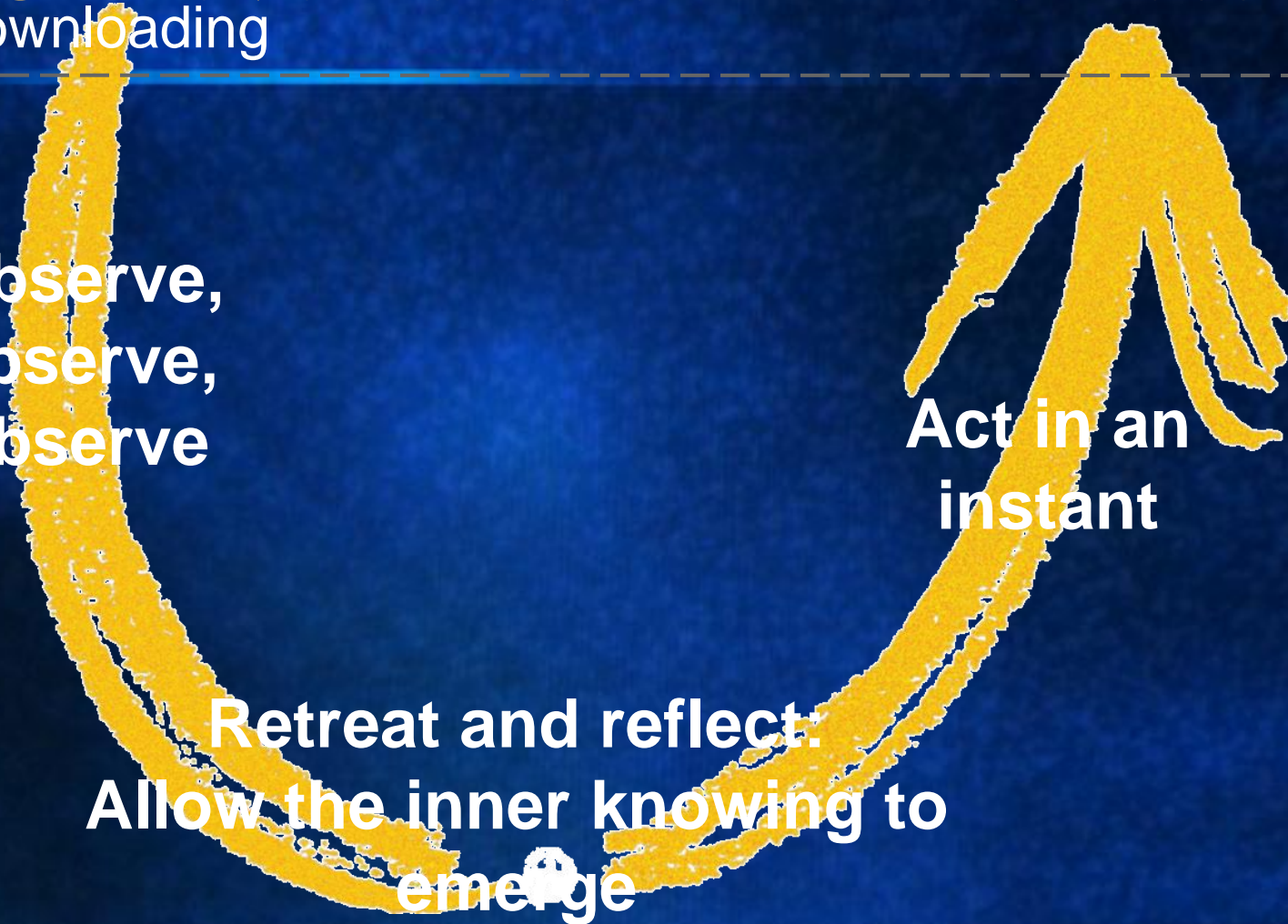
3 Movements of Mindfulness

Downloading

Observe,
observe,
observe

Act in an
instant

Retreat and reflect:
Allow the inner knowing to
emerge



Levels of Listening

LISTENING 1:
from habits

*Automatic Pilot;
Confirming the Past*

reconfirming old
opinions & judgments

LISTENING 2:
from outside

*Open
Mind*

Noticing
differences;
disconfirming
[new] data

LISTENING 3:
from within

*Open
Heart*

seeing through
another person's eyes
emotional connection

LISTENING 4:
from Source

*Open
Will*

connecting to an
emerging future whole;
shift in identity and self

How to Operationalize Mindfulness In Organizations

- Culture of Noticing
 - Organize (build structures and processes) in such a way that we are better able to notice the unexpected in the making and halt its development (probabilities, prevent, *identify*, mitigate)
- Culture of Learning
 - Key difference of mindful with usual organizations is the early detection of often weak signals of trouble (audits/checklists). Mindfulness allows us to see meaning in weak signals and give strong response to weak signals.
- Normalize Change

Operational Mindfulness

- **Attention to Failure:** Mindful organizations catch the unexpected earlier, when it is smaller, comprehend its potential importance despite the small size of the disruption, and remove, contain, and rebound from the effects of the unexpected
- **Active Humility:** Mindful organizations are always aware that they don't know what they don't know (how do we keep this question in front of us)

Group Questions

- Do you currently use the concept of mindfulness in your work?
- How might we apply mindfulness to improve processes of care?
- How would we teach mindfulness to ourselves and others?

Q: Upon What Will We Focus Our
Mindfulness?

A: Tough Problems

Tough Problems

- 1) Dynamic complexity is low if cause and effect are close together in space and time. High complexity problems can only be understood *systemically*, taking account of the interrelationships among the pieces and the functioning of the system as a whole.

$$Q_t = Q_1 + Q_2 + \dots$$

Systemic Approach

David Bohm: the universe is whole but we mistakenly see it as fragmented

Implications: Systemic

Focus equally on descriptions of specific tasks AND on how to manage the needed change and foster the emergence of new processes. ‘Teach a man to fish’

For people and microsystems with the ability and capacity to change, the need for change is not necessarily a fearsome opponent.

Change: A Fearsome Opponent

- People don't want to change because they don't know how to behave differently and they think there can be a status quo with stability. But all things change.
- People need to hear that even if there is a status quo, the current one is not good enough and there really isn't stability so we must learn to manage continuous change.

Getting Ready for Change

- Adaptability comes from actively seeking new information including disturbing information, and then circulating that information widely for broad interpretation. (including parents?)
- Keep the system alert to the fact that it might need to change and how to do so

Five F.A.C.E.S of Mindfulness

Flexible, Adaptable, Coherent, Energized, Systemic

Tough Problems

2) Generative complexity is low if the future is familiar and predictable. High complexity problems need to be worked out as the situation unfolds. Talk not only about options that worked in the past, but also about those *emerging* now

Tough Problems

3) Social complexity is low if people have common assumptions, values, rationales, and objectives. High complexity problems, when people involved see things very differently, cannot be peaceably settled by authorities from on high. The people involved must *participate* in creating and implementing solutions. Talk not only with people who see things the same way but especially with those who see things differently, even those we don't like

Tough Problems

High complexity problems can only be solved using processes that are *systemic, emergent, and participatory*

Solving Tough Problems

Tough Simple

Dynamic

Systemic

Fragmented

Generative

Emergent

Reflective

Social

Participatory

Dictatorial

Solving Tough Problems

Collaboratives have both an exchange of learning and relational components. The strength of our connections makes the emergence of new solutions much more likely

Community of Practice

- Collegiality, friendliness, respect, broad participation
- Openness and fast trust
- Context: every effort is new and needs to be created locally
- Its all about the kids
- Willingness to try new things
- Monitor ourselves
- Discover new approaches/knowledge
- Educate and train current/future members

Solving Tough Problems

Ground rules: to ‘call things by their name’, to express differences without irony, to assume the good faith of others, to be tolerant, disciplined, and punctual, to be concrete and concise, to keep confidences

Solving Tough Problems

Reflectiveness: without being able to see how what we are doing or not doing is contributing to things being the way they are, there is no leverage for change. We must recognize our role, by omission or commission, in creating the situation

If we want to change the systems we are part of - we must also see and change ourselves

Solving Tough Problems

If you're not part of the problem, then you can't be part of the solution (who needs to be in the room)

Reflectiveness

All change results from a change in meaning.
Work of change always the same. We need
to find ways to get people's attention, we
need to find what's meaningful to them.
Meaning matters

Group Questions

- Are the issues we face complex? In all dimensions?
- Are our approaches systemic, emergent, and participatory? This takes more time and effort, will it be worth it?

Tools to Tackle Tough Problems

Vision

Culture

Committed Actions

High Reliability

Every system is perfectly designed to get the results it gets, if you don't like the result, change the system.

- Change the system

- by changing the culture
- by changing behavior patterns
- by changing individual actions
- by changing the interior habits of individuals
- by changing the system.



Vision Is a Living System

- Vision is more than a destination. It is an intention that helps inform and shape behavior

Margaret J. Wheatley

Self-fulfilling Prophecy

...an unconditional expectation about a future situation such that had it not been made, the future situation envisaged would not have occurred, but because it was made, *alterations in behavior* are produced which bring about that envisioned situation...

Robert Merton

Vision

- Safety is a *dynamic non-event*. What produces this stable outcome is constant change rather than continuous repetition. When one system changes others must adapt/compensate. This takes respectful interaction, communication, trust, attentiveness, familiarity with one another's roles, and experience.
- Safety, quality, and reliability are *dynamic non-events*.

Culture

Culture is what we expect around here

Culture eats strategy for lunch

Culture

If Culture is what we expect around here, when everyone feels strongly about the importance of a behavior, there is little latitude for deviation, and slight deviations from the norm are dealt with swiftly and harshly

Culture

Culture influences the safety and quality of care. Culture influences attitudes towards change. A culture can be objectively **observed** as:

The way **we do** things around here

Committed Actions

- Public
- Volitional
- Irrevocable

Committed actions by leaders are often symbolic and can lead to wanted or unwanted behavior patterns (positive feedback loop)

What's Your Default Position

- No news is good news?
- No news is bad news?
- No news is no news?

- For a High Reliability Organizations, no news is worrisome

Changing Behavior

Anything that disturbs the system (data, comparative results) plays a crucial role in helping the organism (microsystem) self-organize into a new form. Whenever there is new information, the system chooses whether to accept that provocation and respond. If the information creates a large enough disturbance and the system can no longer ignore it, then real change is at hand

Changing Behavior

Sustaining high quality and safe care requires a culture *attentive* to fulfilling its self-prophecies by:

- 1) Supporting and enabling appropriate public behavior patterns. *Make it easy to do the right thing.*
- 2) Supporting and enabling the mindful, committed actions of individuals. *Make it easy to make the right choice.*

High Reliability Organizations

Where no one in health care has gone before

H.R.O.

The ability to deal with a crisis situation is largely dependent on structures that have been developed before the chaos began. The event is an abrupt and brutal audit. At a moment's notice everything that was left unprepared becomes a complex problem and every weakness comes rushing to the forefront

High Reliability Organizations

- Preoccupation with failure
- Reluctance to simplify interpretations
- Sensitivity to operations
- Resilience
- Deference to expertise

| Mindfulness strategy | Examples of mindlessness | Prescription for mindfulness |
|--|--|--|
| <i>Anticipate the unexpected by:</i> Preoccupation with failure | Funded programs irrespective of meeting objectives | Heavy emphasis on LBW or PTB as failure and reporting of these; require case reviews; continue holding national conferences with emphasis on prevention of LBW and PTB |
| Reluctance to simplify | Increasingly long list of outcome indicators; shorter list of models to choose | Insist on complex inter-dependent program elements that address the complex human needs and responses |
| Sensitivity to operations | No measures of process or implementation | Flexibility and tailoring to local and individual client conditions, responses, and changes |
| <i>Containing the unexpected by:</i> Commitment to resilience | Long lag times between action, reports and feedback | Use real-time reporting, especially of LBW, PTB, and infant mortality; require real-time reporting of changes to programmatic interventions in response to failures |
| Deference to expertise | Used own staff to develop program and give oversight | Use more outside experts on a more frequent and consistent basis; decentralize authority in response to failures |

Preoccupation with Failure

- Any lapse is a symptom of system vulnerability
- All errors and near misses are reported and used as learning opportunities

Reluctance to Simplify

Our environment and patients are complex, we need more complete and nuanced understanding of the situation (error rates in July)

Sensitivity to Operations

- “Latent failures” or loopholes in any system’s defenses will always occur because we are human
- Discover latent failures in the course of normal operations before a failure occurs.
- Attentive to the front line where the real work gets done
- Culture: open, speak-up

Sensitivity to Operations

Maintaining explicit and communicated situational awareness (pre and post shift briefing sessions). What/who are we worried about; what went well; what could have gone better. Real time information permits early identification and action

Resilience

Errors will always occur (we are human). Being resilient is to be mindful about errors that have already occurred and to correct them before they worsen and cause more serious harm. Structures and processes to detect early, interpret, and act

Detect the unexpected in a robust, stable manner and react to the unexpected in a variable manner (deference to expertise, etc)(expect nothing, be ready for anything)

Deference to Expertise

- Push decision making down to the front line
- Decisions migrate to the person with most specific knowledge of the situation

How can we use mindfulness to forestall catastrophic outcomes through mindful attention?

- How do we maintain continuing mindfulness?
- How do we learn what we don't know?
- How do we continually question our assumptions?
- Do you currently use/teach processes of HROs?

Review of Resources and References Handout

Wrap-Up: Mindlessness

Mindlessness is more likely when people are distracted, hurried, or overloaded. To deal with production pressures people ignore discrepant clues and cut corners

Mindlessness also occurs when people feel they can not act upon their concerns (how easy is it to question a practice in the unit?)

H.R.O.

The unexpected is uncomfortable and people normalize events over time. H.R.O.s stay with discomfort because fear of missing something is greater

Mindlessness leads to false comfort with P&P (have plans in place for the ideal situation not reality). Need to update information, expectations and actions

HRO Learning Culture

- Use unexpected events for learning, especially if they are rare events
- Treat small lapses as weak signals that other parts of the system may be at risk. Look deep inside the system.

Support New Behaviors

- What vision and what self-prophesizing can draw out the wanted behaviors?
- What committed actions are needed to support the new behavior patterns?
More than new policies and procedures.
- What new structures are needed to support and sustain the new behaviors?
- What new training, education, meetings, communications are needed for staff to perform and interact appropriately

Supporting and Sustaining Skillful Behaviors

- Sustaining gains = Maintaining organizational awareness and attention.
- Positive feedback is needed for proactive, continuous change e.g. new information and knowledge. Small actions can have large impact.
- Negative feedback (audits, checklists) is needed to compare actual to expected behavior. This feedback is positive when process and outcome expectations are met/exceeded.

Context

One mistake the arts would never make is to presume that a part or role can be exactly specified independent of the performer, yet this is the idea that has dominated work organizations for most of the 20th century

Peter B. Vail *Managing as a Performing Art*: 1989

Where to Start?

Practice mindfulness in everyday life to become skillful at managing attention **before** a severely stressful event occurs

Final Thoughts

Change only comes from the margins. The real trick is to stay in the work long enough to really see it move to the center. Remain marginal until something emerges.

Wheatley

Final Thoughts

No problem can be solved from the same consciousness that created it

Einstein