Children's Hospital

WEXNER LEADERSHIP SUMMIT

PROFESSOR MONICA HIGGINS

Agenda

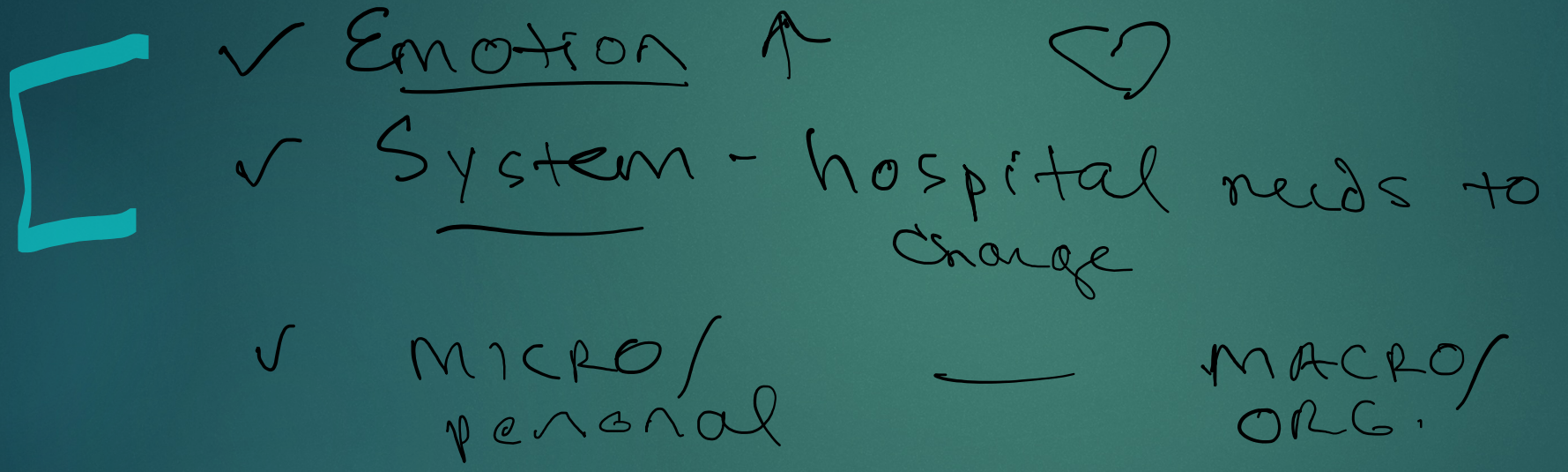
- Intro/Set Stage re Problem
- Action
- Diagnosis
  - Patient Safety Initiative
  - Julie Morath & Organizational Change
- Translation/Implications
  - Reflections
  - Wrap/Update
  - New Research

Action Question: What would you do? Imagine you are Julie Morath…

Prep for meeting with Matthew's Parents

Q: How will you start the meeting?

Why is this conversation so difficult?



Patient Safety Initiative: what's she trying to accomplish?

Opportunities

✓ change culture
from Shame/blame →
open + honest culture
✓ find root causes
⇒ INQUISITIVE

Challenges

? Take responsibility ?
⇒ TIPS ?!
? complexity
✓ must have consistent messaging


ACCOUNTABILITY
BLAME-FREE REPORTING

Leading the Change Process

Taking Charge

Interviews with CEO and Board; uses interview process to communicate ideas

Presents data

Invites others to share via focus groups

Creates Patient Safety Steering Committee (10)

Planning the Initiative

Strategic Plan (SAFE)

Clear goals established (short term and long term)

Secures support from BOD re disclosure policy

New protocol for focused event studies

Develops blameless reporting, new safety reports, new language

Plans for medication administration project

Implementation

Institutes safety action teams, good catch logs

Tracks # safety reports & average patient satisfaction

Hires Dr. Knox

Adds members to PSSC (19)

(Deals with Matthew situation)

Themes & Implications for you in your work? (break out groups with note catcher slides to fill in)