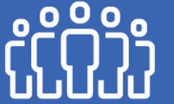
Collective Leadership and Safety Cultures (Co-Lead)

UCD School of Nursing, Midwifery and Health Systems

COLLECTIVE LEADERSHIP AND SAFETY CULTURES

COLLECTIVE LEADERSHIP FOR SAFETY SKILLS

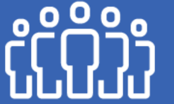
Co-Lead



Collective responsibility

- **Collective responsibility** is the notion that if each individual in a team can effect the team's results, we can attribute the successes and failures of the team to every individual.
- **Collective responsibility** asserts that if an error occurs or a patient is harmed each individual involved—including patients, healthcare professionals and managers—is responsible for that failure.
- This sense of **collective responsibility** improves patient safety and helps to build a culture of safety in healthcare systems.

Collectively Identifying the causes of errors



Biases in seeking causes

People have cognitive biases that prevent them from seeing causes.

Some examples:

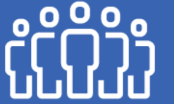
- *Confirmation bias* prefers causes that agree with our initial assumptions.
- *Ingroup bias* prefers causes that implicate people outside our close associates.
- *Sunk cost bias* shuns causes that involve expensive investments.
- *Recency illusion* can prefer causes that have become recently visible, but were present and hidden before.
- *The bandwagon effect* prefers causes that other people mention.

T-shaped professionals

- Collective responsibility motivates the development of broadly skilled colleagues.

- The concept of T-shaped professionals or T-shaped skills is one where the vertical bar on the *T* represents the depth of related skills and expertise in a single field or discipline, whereas the horizontal bar is the ability to collaborate across disciplines with experts in other areas and to apply knowledge in areas of expertise other than one's own.

- T-shaped professionals have well-developed specialty skills and broad capabilities in other areas. Broader skills in a group are important for taking collective responsibility



Safety Skills and Competencies

The Six Domains of Safety Competencies
1. Contribute to a culture of patient safety 2. Work in teams for patient safety 3. Communicate effectively for patient safety 4. Manage safety risks 5. Optimise human and environmental factors 6. Recognise, respond to and disclose adverse events

Ref: Ginsburg L, Castel E, Tregunno D*, et al.* The H-PEPSS: an instrument to measure health professionals' perceptions of patient safety competence at entry into practice. *BMJ Qual Saf* 2012;**21:**676-684.

Factor	Item	Team skills (1-10)	Team priority ranking
Working in teams with other professionals	Managing inter-professional conflict		
	Sharing authority, leadership and decision-making		
	Encouraging team members to speak up, question, challenge, advocate and be accountable as appropriate to address safety issues		
Communicating effectively	Enhancing patient safety through clear and consistent communication with patients		
	Enhancing patient safety through effective communication with other healthcare providers		
	Effective verbal and nonverbal communication abilities to prevent adverse events		
Managing Safety risks	Recognising routine situations in which safety problems may arise		
	Identifying and implementing safety solutions		
	Anticipating and managing high risk situations		
Understanding Human and Environmental factors	Understanding the role of human factors, such as fatigue, which effect patient safety		
	Understanding the role of environmental factors such as work flow, ergonomics and resources, which effect patient safety		
Recognise and respond to reduce harm	Recognising an adverse event or close call		
	Reducing harm by addressing immediate risks for patients and others involved		
Culture of Safety	Taking a questioning attitude and speaking up when I see things that may be unsafe		
	Creating a supportive environment that encourages patients and providers to speak up when they have concerns about safety		
	Understanding the nature of systems (e.g., aspects of the organisation, management or the work environment including policies, resources, communication and other processes) and system failures and their role in adverse events		

Outcome template

PRIORITY RANKING	SAFETY SKILL	AGREED ACTIONS TO DEVELOP THIS SKILL WITHIN OUR TEAM	RESPONSIBLE PERSON(S)	DATE TO REVIEW PROGRESS
1				
2				
3				
4				
5				