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COVID-19 Management

The Impact of the COVID-19 Pandemic on the Future of Healthcare Leadership

Three Critical Components for Safe Patient Care

Creating and nurturing a culture of safety that is aligned with a holistic, continuous improvement process and sustained through effective communication and education is no longer a choice; it is now a requirement of all healthcare leaders, from the boardroom to the bedside.

We are well aware of the impact that the COVID-19 pandemic has had on frontline healthcare workers. They have been challenged with an ongoing lack of supplies and staff while trying to manage tremendous surges in patient volume for months. Many have been 'repurposed' and asked to work in roles and departments previously unfamiliar to them. We hear about these stories on the news daily, but healthcare leaders have also been quite challenged during this time. There is little talk on the news about the tremendous impact this pandemic has had, and will continue to have, on leadership moving forward.

We have an opportunity to make the next 20 years in healthcare quality and safety different than before. For the past two decades, since the publication of the IHI's *To Err is Human*, healthcare leaders, clinicians and patient advocates across the globe have worked diligently to uncover the root causes of harm in healthcare and improve them. Unfortunately, medical error remains the third leading cause of death in the U.S. and the 14th globally. Although healthcare *has* improved tremendously over the past 20 years, we still have a very long way to go.

This pandemic has highlighted the gaps in safety that still exist in hospitals. Patient falls, pressure ulcers and

communication errors have increased significantly over the past several months. Though the demographics may be different, social disparity and health inequity exist in every country, and are evident in the COVID-19 death toll. This is happening because, in most organisations, the processes implemented to improve those outcomes were never truly hardwired, and so they break down easily during a crisis. This indicates that a change in behaviour didn't occur, which is the most difficult component of improvement.

Over the next 20 years, leaders must learn how to change the hearts and minds of the people who do the work. This requires a shift in organisational thinking that begins with the governing body and executive leadership. There must be alignment across the organisation, and agreement at all levels of leadership, that harm from preventable medical error is unacceptable.

There are three critical components to transforming safety in such a way. Organisations, which are committed to eliminating harm from medical error, have alignment across:

1. A culture of safety
2. A holistic, continuous improvement process
3. A development approach that results in effective sustainment.

Most organisations do not have such alignment, and the COVID-19 pandemic has highlighted how a crisis can quickly disable an organisation without a foundation of safety. The Patient Safety Movement Foundation provides resources that can assist you in your journey to transforming safety. Our Actionable Patient Safety Solutions (APSS) provide an evidence-based summary of 18 of the leading safety challenges, including establishing a culture of safety, and are available free of charge on our website. Refer to these APSS to help your organisation align the three critical components of transforming safety.

Culture of Safety

Achieving a culture of safety requires transformational change, a data-rich environment, and a focus on respect and transparency. It is critical to create trust, establish accountability, and make it easy for people to identify unsafe conditions. Leaders must ensure that everyone in the organisation feels safe reporting issues and near misses and establish a blame-free culture that focuses on strengthening the system rather than blaming the individual. Organisations, which are successful at minimising harm because they have created such a culture, are said to be a high reliability organisation (HRO). This has been optional in the past and is a status that only a few healthcare systems have had the resources and the capacity to do well, but the COVID-19 pandemic has clearly shown us that all healthcare organisations should be HROs.

Holistic, Continuous Improvement

Every hospital has a quality department that oversees improvement of identified issues, but often the work of these departments is not aligned with all of the improvement projects that are occurring across a hospital or a system. This creates waste and inefficiency. It is critical that the improvement system is approached in a holistic manner, and that leaders assess the risks and actual problems in an organisation as a whole, so that priorities can be established and improvement can be allowed to progress unimpeded. Healthcare administrators have a responsibility to lead improvement efforts by ensuring that the right team is established, that their work is supported and that barriers are removed.

Sustainability

Every healthcare organisation struggles with sustaining hard-won change. A structured, organisational development approach that aligns with the holistic improvement process and culture of safety is the third critical component of transformation. This includes creating a simple process for communication and education. Healthcare workers are inundated with constant changes in policies, procedures, protocols, pathways and many other documents that are supposed to guide their practice. Leaders must ensure that it is easy for the frontline to know what to do, and that managers are well equipped to effectively facilitate change by understanding and applying the principles of human factors.

Conclusion

COVID-19 is reshaping the narrative about healthcare safety and has shifted the responsibilities of future healthcare leaders. Creating and nurturing a culture of safety that is aligned with a holistic, continuous improvement process and sustained through effective communication and education is no longer a choice; it is now a requirement of all healthcare leaders, from the boardroom to the bedside. We have seen the gaps shown to us by this pandemic, and as leaders, we cannot just turn away. We have the responsibility, as well as the opportunity, to truly make patient care safer in the future. Let's embrace it. ■

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Key Points

- The COVID-19 pandemic has highlighted the gaps in safety that still exist in hospitals.
- These gaps exist because leaders have not yet become proficient at changing behaviour.
- The three critical components required to transform safety include aligning a culture of safety with a holistic, continuous improvement process and a development approach that results in effective sustainment.
- The Patient Safety Movement Foundation provides free resources to assist healthcare leaders in transforming patient safety.