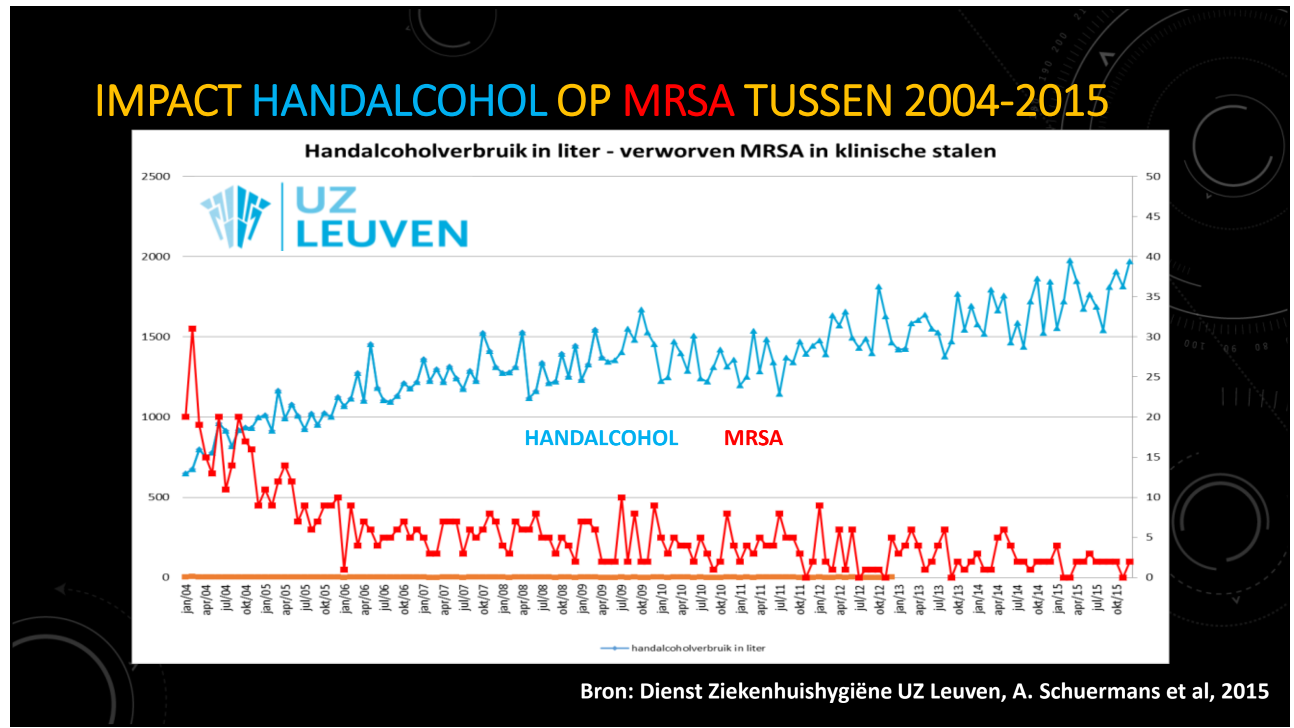
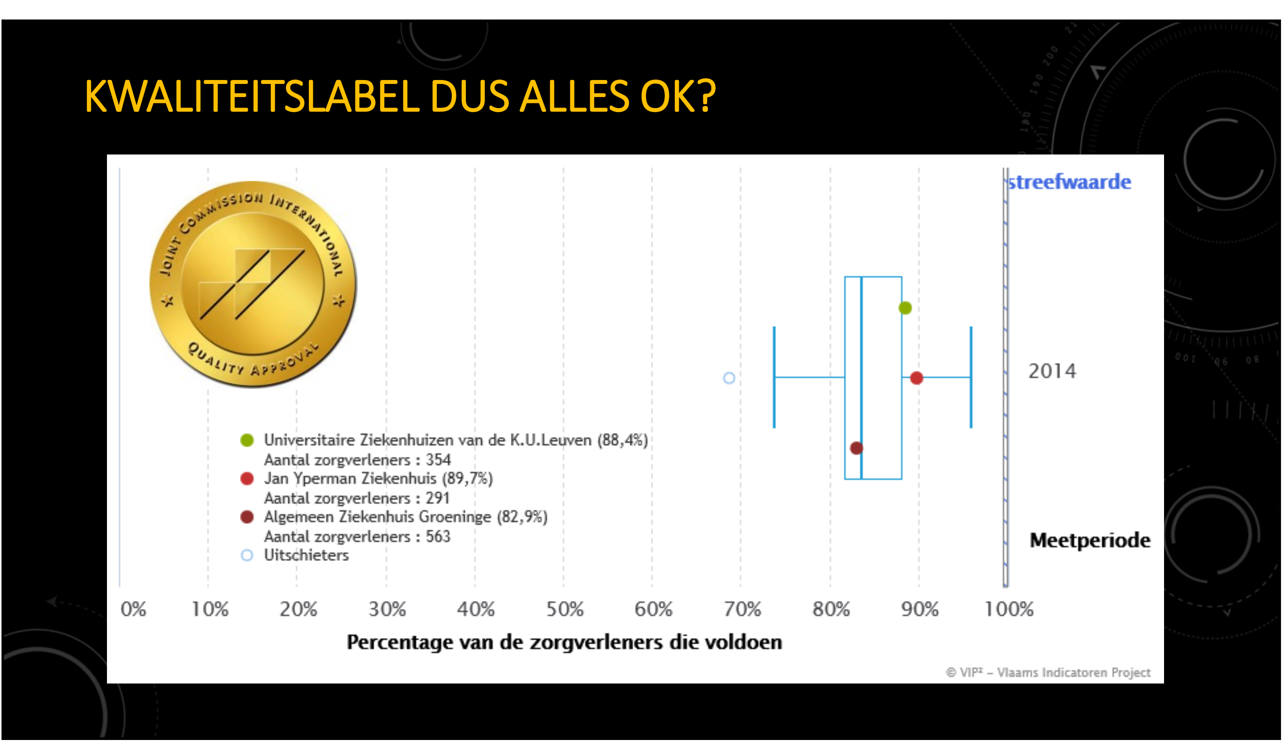
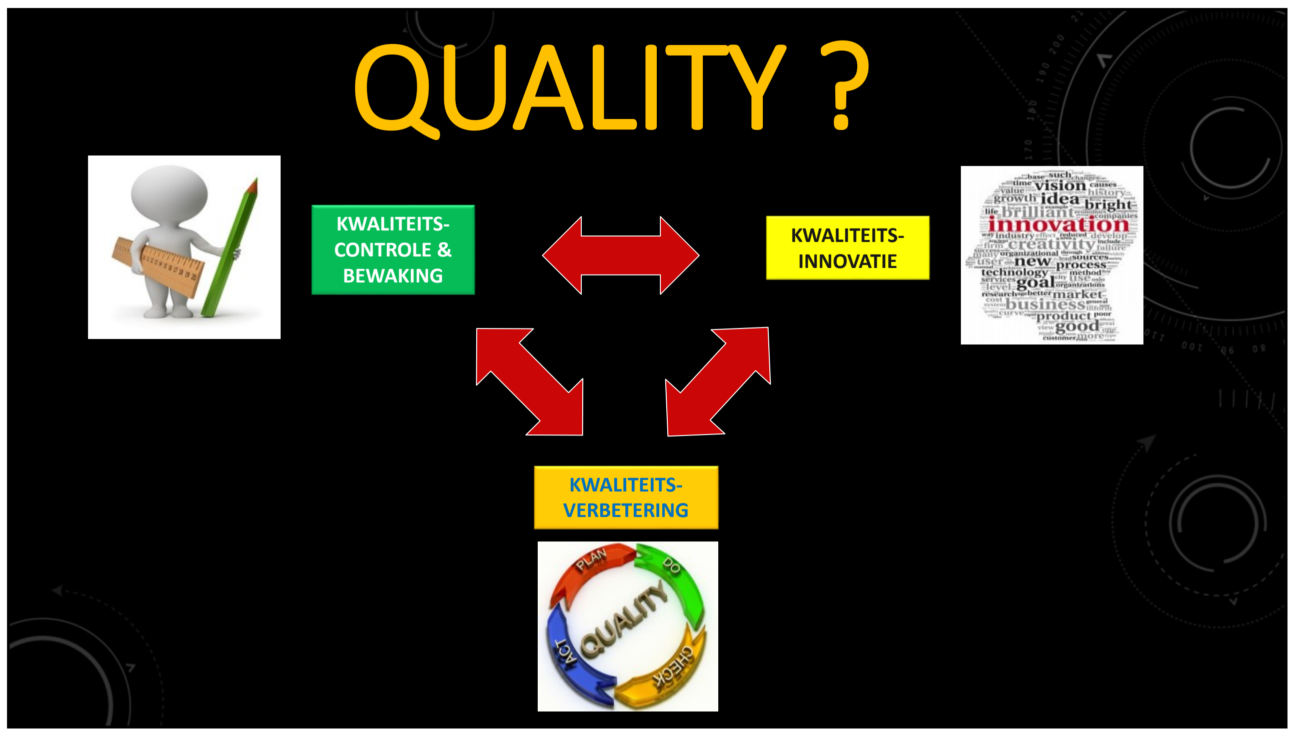
KU LEUVEN
LEUVENS INSTITUUT VOOR GEZONDHEIDSZORGBELEID
@krisvanhaecht
UZ LEUVEN
MANAGEMENT VERSUS LEIDERSCHAP
OM ZORGVERLENERS TE STEUNEN
IN HET GEVAL VAN ZORGINFECTIES
PROF. DR. KRIS VANHAECHT
LEUVENS INSTITUUT GEZONDHEIDSZORGBELEID-KU LEUVEN
DIENST KWALITEIT – UZ LEUVEN

World Health Organization
Clean Care is Safer Care
SAVE LIVES: Clean Your Hands - WHO's global annual call to action for health workers
Safety Starts Here.
KWALITEITSINDICATOREN VOOR ZIEKENHUISHYGIËNE IN ACUTE ZIEKENHUIZEN
JAARRAPPORT - DATA 2013
AUTEURS
Dr Marie-Laurence Lambert
Dr Boudewijn Catry
.be
Zorginfecties
Handhygiëne
Wat kan ik doen ?
De ziekenhuizen
Voor kinderen
Hoesthygiëne
Ontdek jouw rol in het vermijden van infecties!
Wat kan ik doen ?
VLAAMS Indicatoren project
DE KWALITEIT VAN DE VLAAMSE ZIEKENHUIZEN IN KAART GEBRACHT


IMPACT HANDALCOHOL OP MRSA TUSSEN 2004-2015
Handalcoholverbruik in liter - verworven MRSA in klinische stalen
UZ LEUVEN
HANDALCOHOL
MRSA
handalcoholverbruik in liter
Bron: Dienst Ziekenhuishygiëne UZ Leuven, A. Schuermans et al, 2015


KWALITEITSLABEL DUS ALLES OK?
Joint Commission International
Quality Approval
streefwaarde
2014
Meetperiode
Universitaire Ziekenhuizen van de K.U.Leuven (88,4%)
Aantal zorgverleners : 354
Jan Yperman Ziekenhuis (89,7%)
Aantal zorgverleners : 291
Algemeen Ziekenhuis Groeninge (82,9%)
Aantal zorgverleners : 563
Uitschieters
Percentage van de zorgverleners die voldoen
© VIP² – Vlaams Indicatoren Project



JAPAN

JAPAN

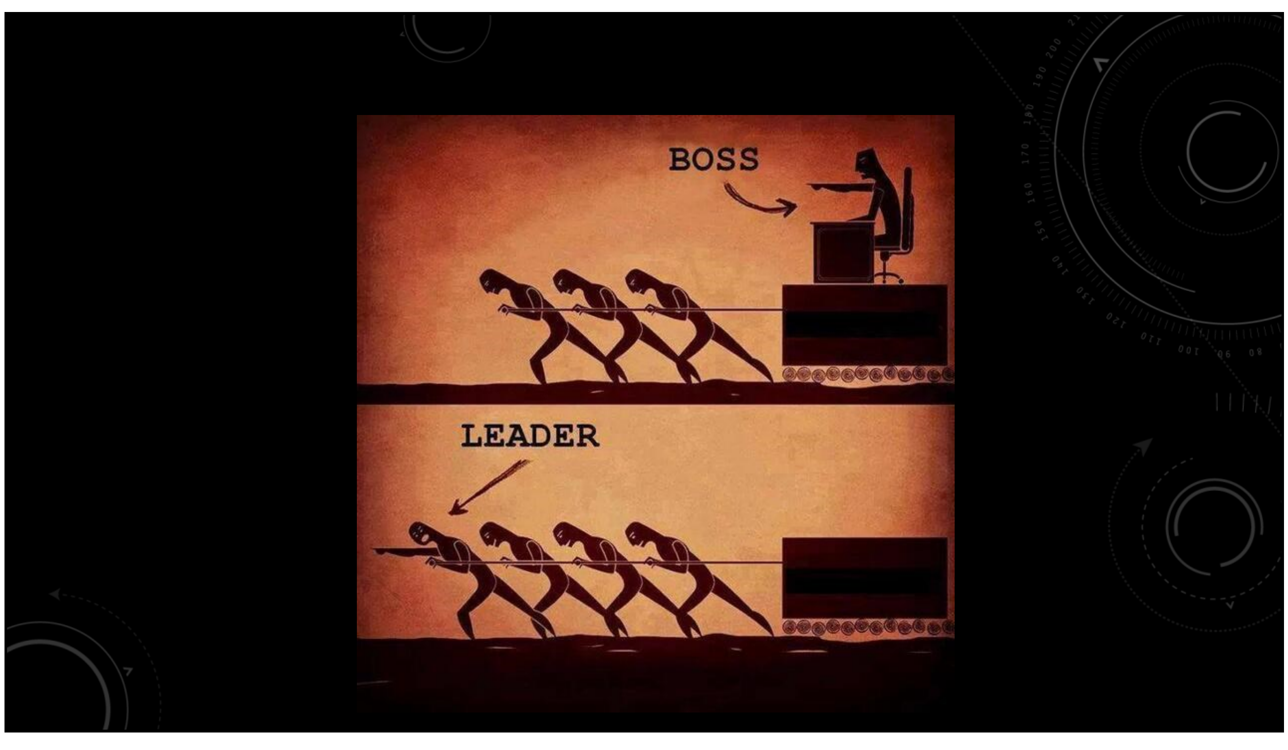
JAPAN: RULE NUMBER 1 IS … YOU BREAK NO RULE

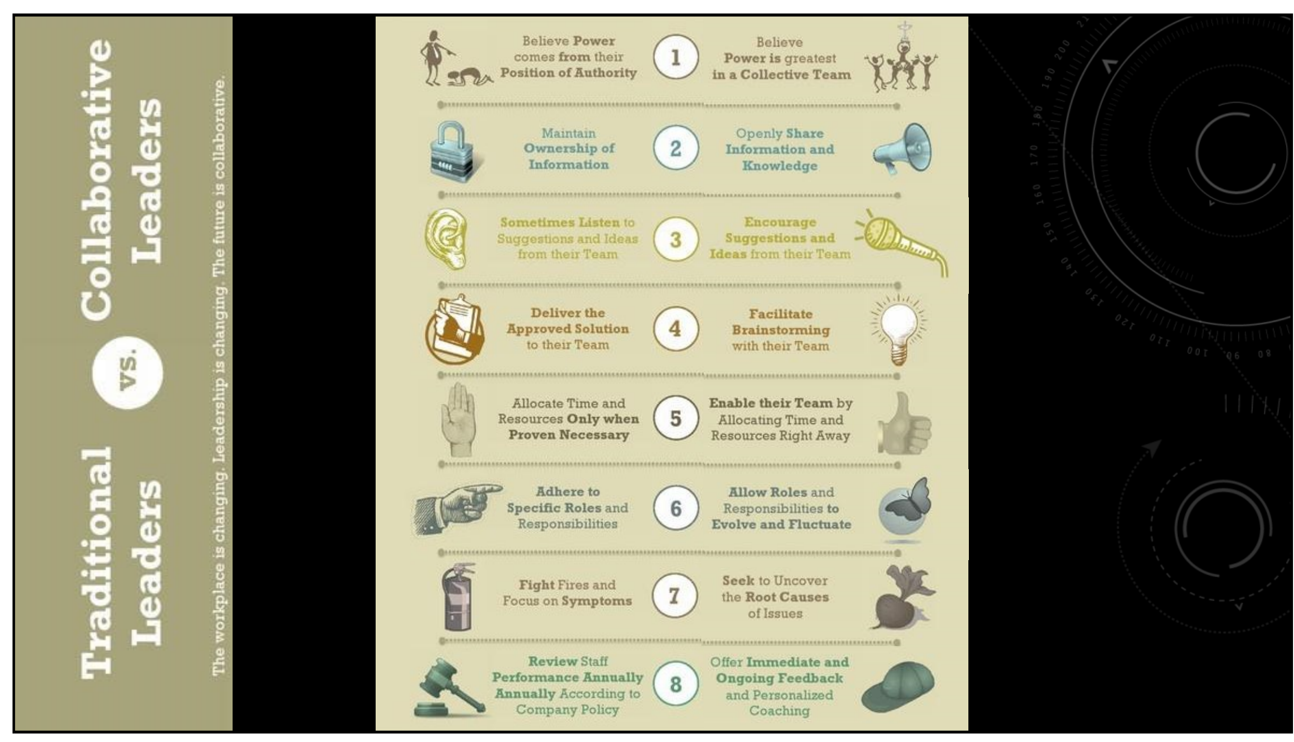
Hand Hygiene Adherence Among Health Care Workers at Japanese Hospitals: A Multicenter Observational Study in Japan

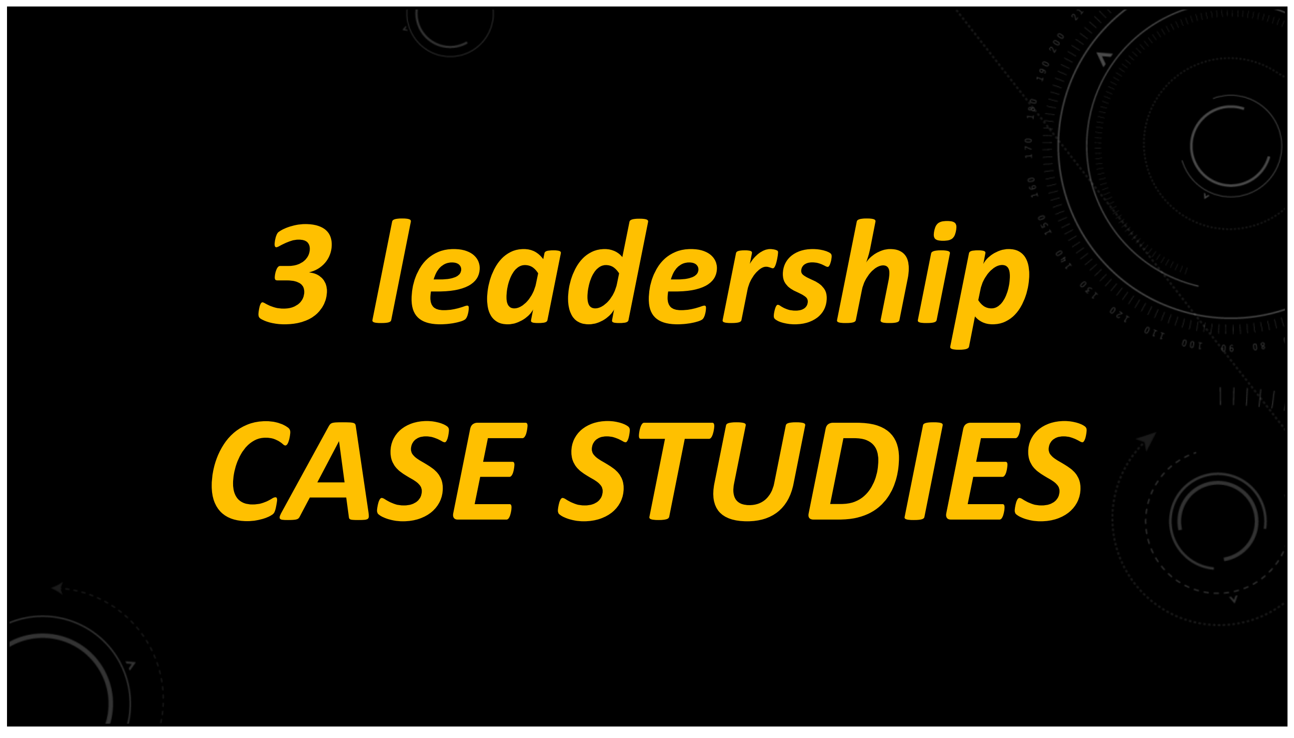
Tomoko Sakihama, RN, CNIC, MSN, Hitoshi Honda, MD,† Sanjay Saint, MD, MPH,‡§ Karen E. Fowler, MPH,‡ Taro Shimizu, MD, MPH,|| Toru Kamiya, MD,¶ Yumiko Sato, RN, CNIC,# Soichi Arakawa, MD, PhD,** Jong Ja Lee, RN, CNIC,** Kentaro Iwata, MD, MSc,†† Mutsuko Mihashi, RN, PhD,‡‡ and Yasuharu Tokuda, MD, MPH||*

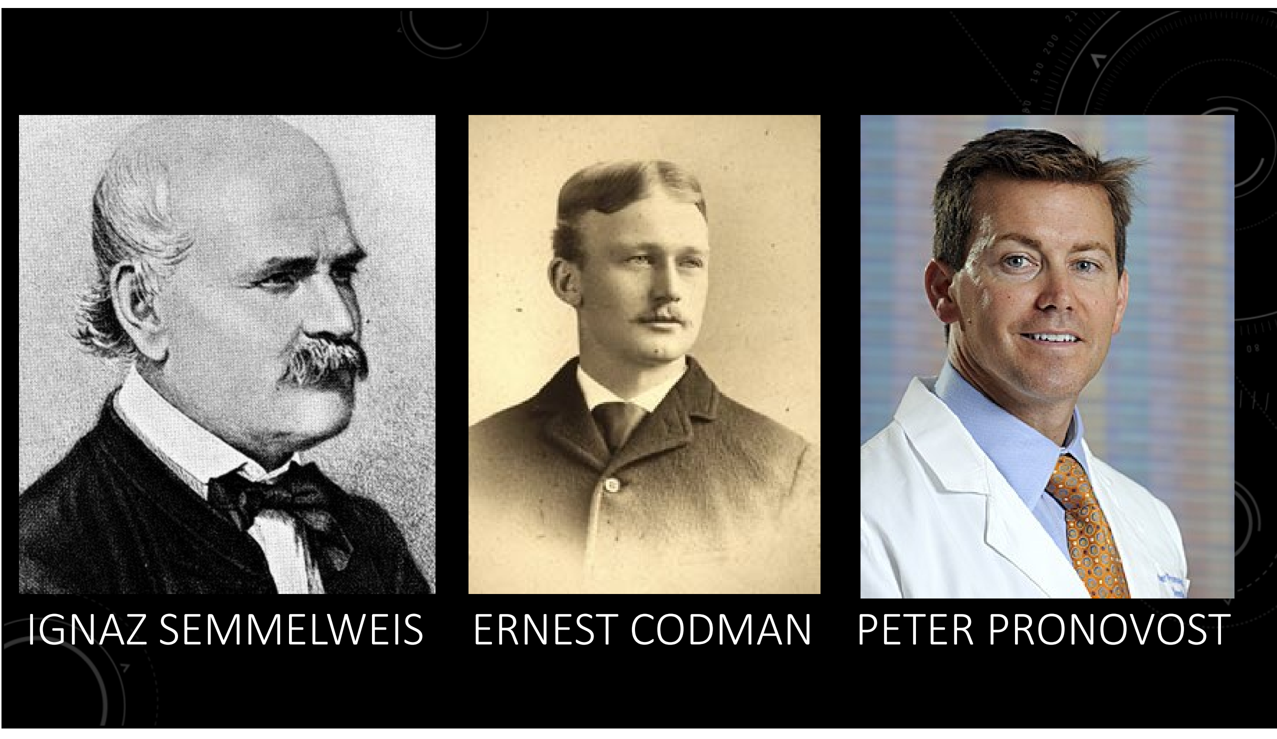
Conclusions: The hand hygiene adherence in Japanese teaching hospitals in our sample was low, even lower than reported mean values from other international studies. Greater adherence to hand hygiene should be encouraged in Japan. 15% artsen – 23% verpleegkundigen

Maybe
IT IS
TOO EASY

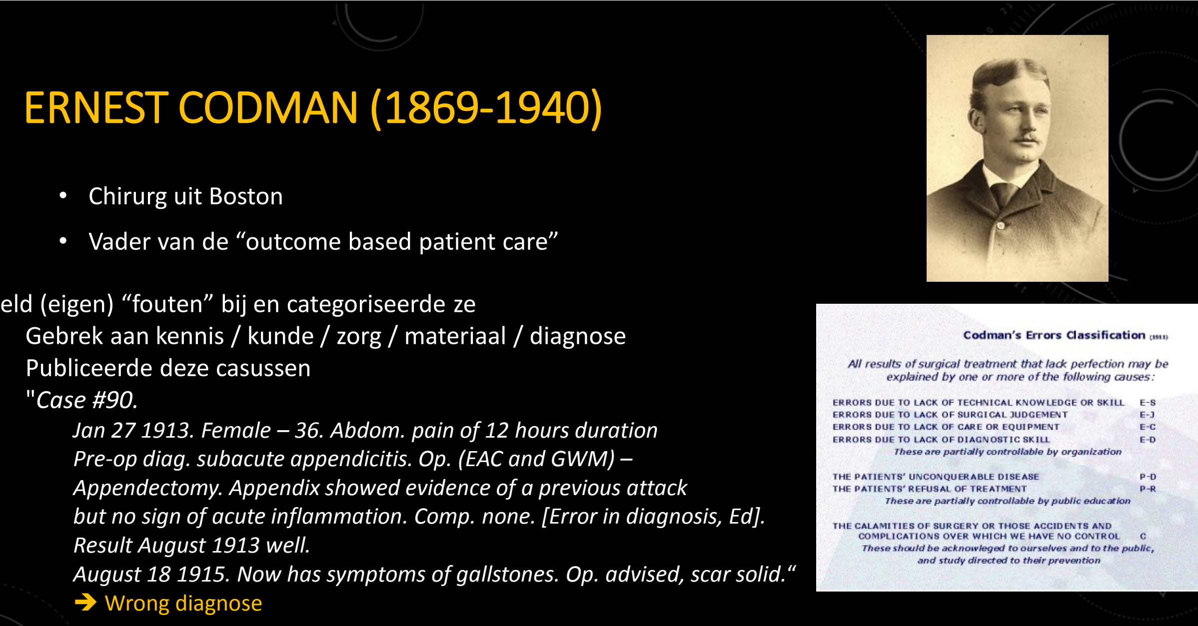

BOSS
LEADER


Traditional Leaders
vs.
Collaborative Leaders
The workplace is changing. Leadership is changing. The future is collaborative.
Believe Power comes from their Position of Authority
1
Believe Power is greatest in a Collective Team
Maintain Ownership of Information
2
Openly Share Information and Knowledge
Sometimes Listen to Suggestions and Ideas from their Team
3
Encourage Suggestions and Ideas from their Team
Deliver the Approved Solution to their Team
4
Facilitate Brainstorming with their Team
Allocate Time and Resources Only when Proven Necessary
5
Enable their Team by Allocating Time and Resources Right Away
Adhere to Specific Roles and Responsibilities
6
Allow Roles and Responsibilities to Evolve and Fluctuate
Fight Fires and Focus on Symptoms
7
Seek to Uncover the Root Causes of Issues
Review Staff Performance Annually Annually According to Company Policy
8
Offer Immediate and Ongoing Feedback and Personalized Coaching


3 leadership
CASE STUDIES


IGNAZ SEMMELWEIS
ERNEST CODMAN
PETER PRONOVOST

IGNAZ SEMMELWEIS (1818-1865)
• Kraamvrouwenkoorts
• Vroedvrouwenafdeling
• Medische afdeling
• Handen in bleekwater wassen
• Spectaculaire daling infecties & sterftes
• 1847 → daling sterfte van 10% naar 1-2%
• 1948: ontslag wegens "politiek-liberaal"
• Echte reden was rancune
• Hij had "de club" in diskrediet gebracht
Hij was "ne lastige"
Inaz Phillipp Semmelweis July 1,1918 - August 13,1865



• "The End Result"

"The common sense notion that *every* hospital should follow *every* patient it treats, long enough to determine whether or not the treatment has been successful, and then to inquire, 'If not, why not?' with a view to preventing similar failures in the future" (italics from Codman). While obviously not today a controversial position, it is obvious few hospitals or medical practices in fact follow patients as he advocated, and in Codman's day the suggestion was particularly inflammatory since he decided the system should be used to judge surgeons and determine promotions (rather than seniority).

• The first registry (osteosarcoma)

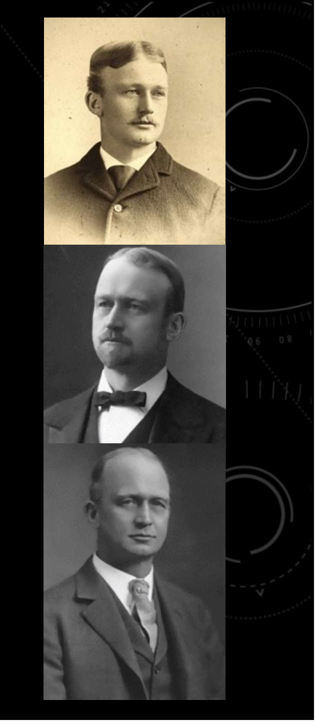
Closely related to his idea of an End Result System, Codman developed the first registry. In two papers we republish here [1, 2], Codman described a way to follow patients nationally. His registry on bone sarcoma became practical in 1920 with a gift of $1000 from the family of a

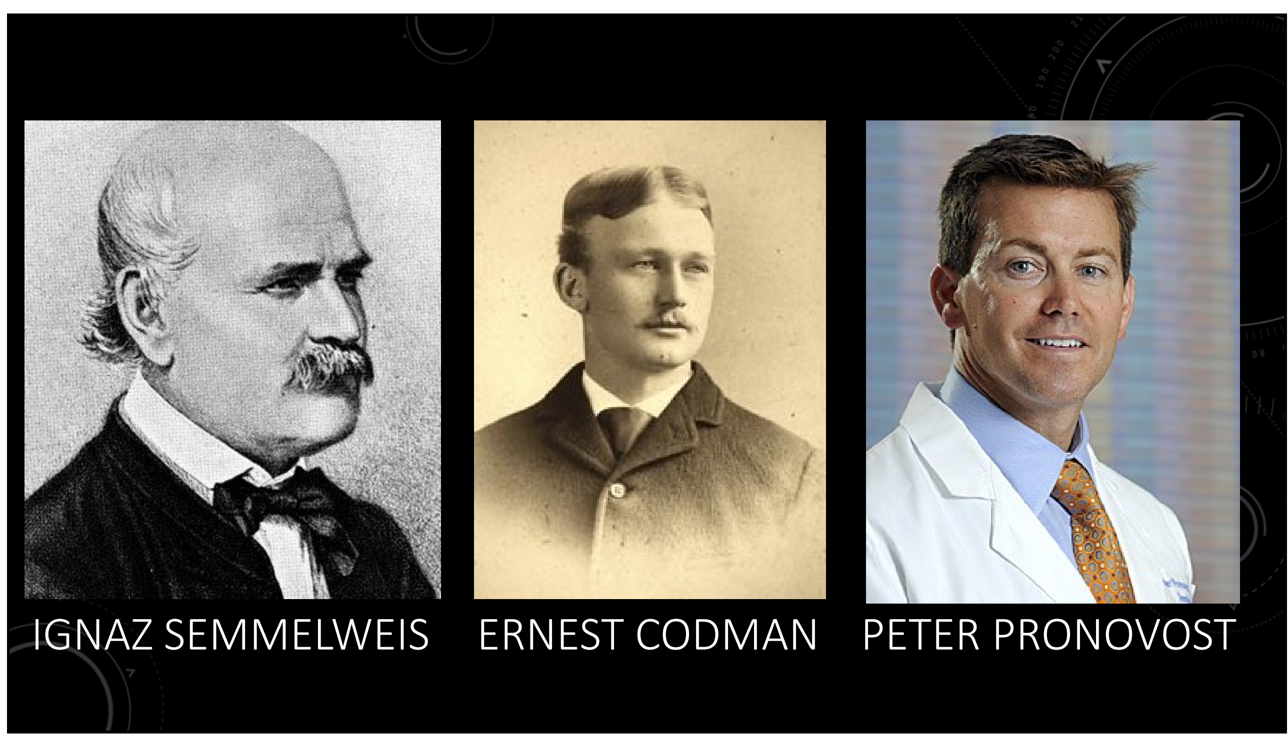
• Standardization & Accreditation

Washington, D.C., in 1913. He was intimately involved with early attempts to standardize hospitals. However, perhaps owing to his insistent nature, he often irritated his colleagues. One of them, Dr. Edward Martin, wrote to Codman in 1914:

"Dear Codman:
God bless you! I suppose I should hate you if I lived in the same town, but my feeling, being remote, is quite other. Indeed the very enemies who lurk in second story windows with muffled rifles are waiting your passing, are the ones who take off their hats in deepest respect as your cold, but beautiful, corpse is carried away" [4].

Hij was ook "ne lastige"





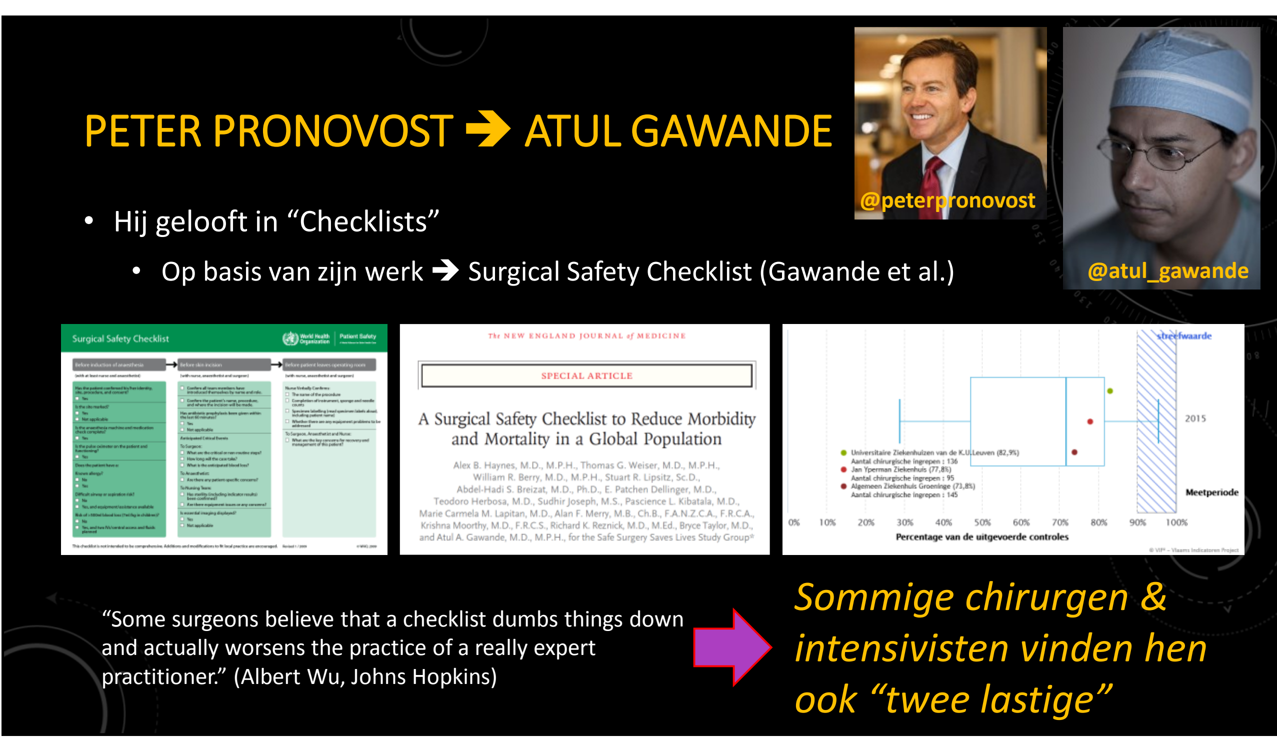
PETER PRONOVOST

@peterpronovost

- Directeur Armstrong Institute for Patient Safety and Quality at Johns Hopkins
- Central line infections op Intensieve Zorgen in Michigan
  - 1500 levens redden per jaar
  - 100 miljoen $ sparen per jaar

- Appropriate hand hygiene
- Use chlorhexidine for skin preparation
- Use full-barrier precautions during central venous catheter insertion
- Subclavian vein placement as the preferred site
- Review and remove unnecessary CVCs

Rate Per 1,000 Central Line Days
0 0.5 1 1.5 2 2.5 3
2004 2005 2006 2007 2008 2009 2010 2011 2012 2013

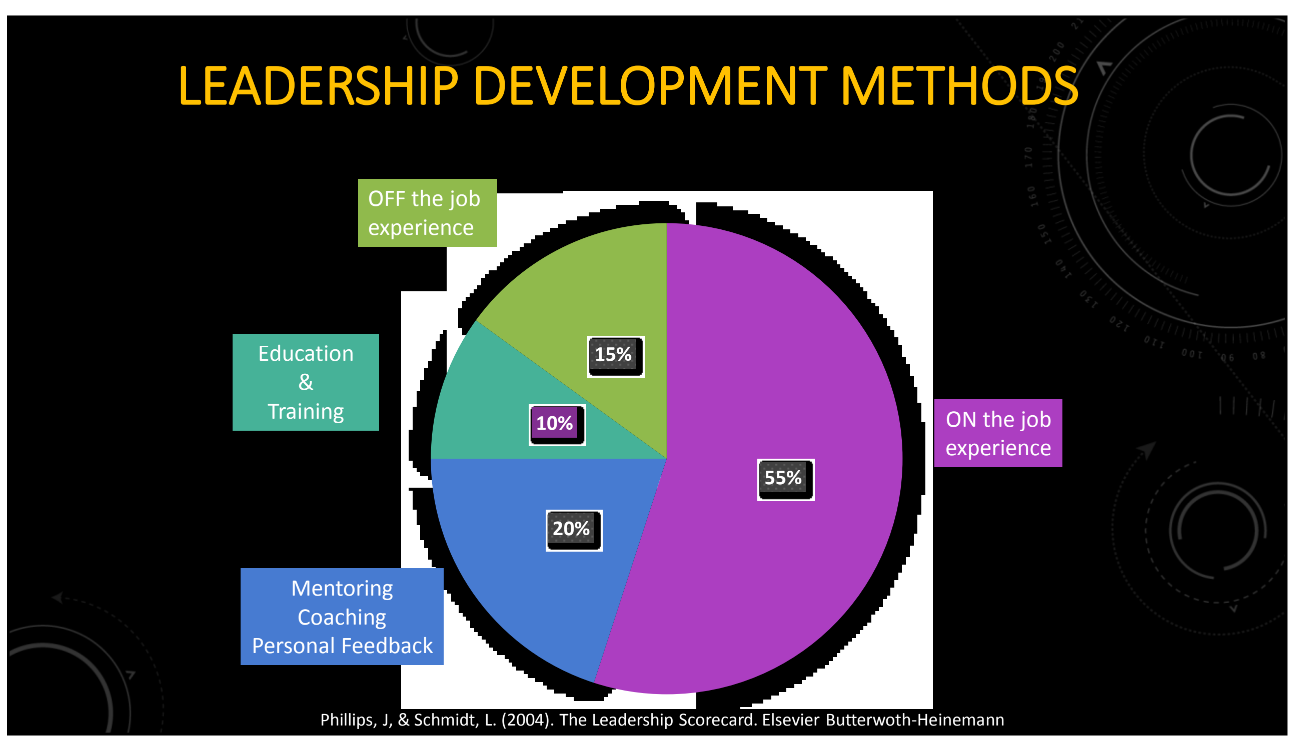

PETER PRONOVOST → ATUL GAWANDE
@peterpronovost
@atul_gawande
• Hij gelooft in "Checklists"
• Op basis van zijn werk → Surgical Safety Checklist (Gawande et al.)
Surgical Safety Checklist
The NEW ENGLAND JOURNAL of MEDICINE
SPECIAL ARTICLE
A Surgical Safety Checklist to Reduce Morbidity and Mortality in a Global Population
streefwaarde
2015
Meetperiode
Percentage van de uitgevoerde controles
"Some surgeons believe that a checklist dumbs things down and actually worsens the practice of a really expert practitioner." (Albert Wu, Johns Hopkins)
Sommige chirurgen & intensivisten vinden hen ook "twee lastige"

LESSONS FROM 3 CASE STUDIES
1. Geen "éénvoudige mensen" → noemen we hen wel eens "lastig"?
2. Wel "éénvoudige interventies" → zijn de interventies misschien té éénvoudig?
3. Duurt wel heel lang vooraleer we willen inzien dat zoiets werkt
DUS MOETEN WE VERDER INZETTEN
OP KWALITEITSVERBETERING
ÉN ZULLEN ONZE LEIDERS
HUN VERANTWOORDELIJKHEID MOETEN OPNEMEN

SO WHAT ABOUT QUALITY & LEADERSHIP

5 LEVELS OF LEADERSHIP (JOHN MAXWELL)

Level		
RESPECT	They follow you because of who you are	*They like you because … you know that leadership is an ongoing process*
PEOPLE DEVELOPMENT	They follow you because you understand that the most valuable product of your company is your team	*They like you because … You recruite people & give them a position in which they shine*
RESULTS	They follow you because you are effective & produce results	*They like you because … you are credible & attract others to do the same*
RELATION	They want to follow you because you have a good relation	*They like you because … you listen, observe & learn*
POSITION	They have to follow you because you are the boss	*They don't like you …*



LEIDERSCHAPSSTIJLEN

BOVEN - leiden

Gedrag

Relatiewens

Kijk eens hoe goed ik ben

Luister naar mij

Wees bang voor mij

Wij mogen elkaar

CONCUR-REREND

LEIDEND

OFFENSIEF

HELPEND

Roos van LEARY

OPSTANDIG

MEEWERKEND

TERUG-GETROKKEN

AFHAN-KELIJK

Minacht me maar

Ik doe wat jij wilt

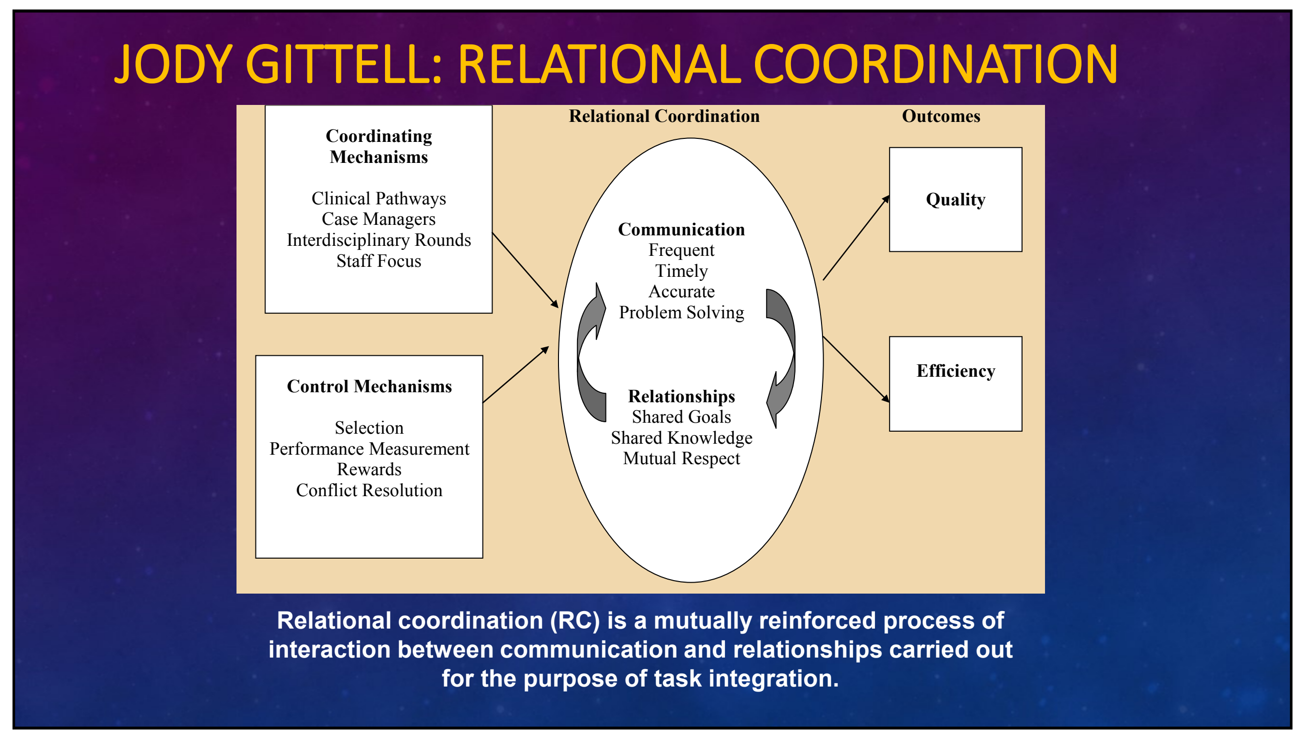
Laat me maar met rust

Help me

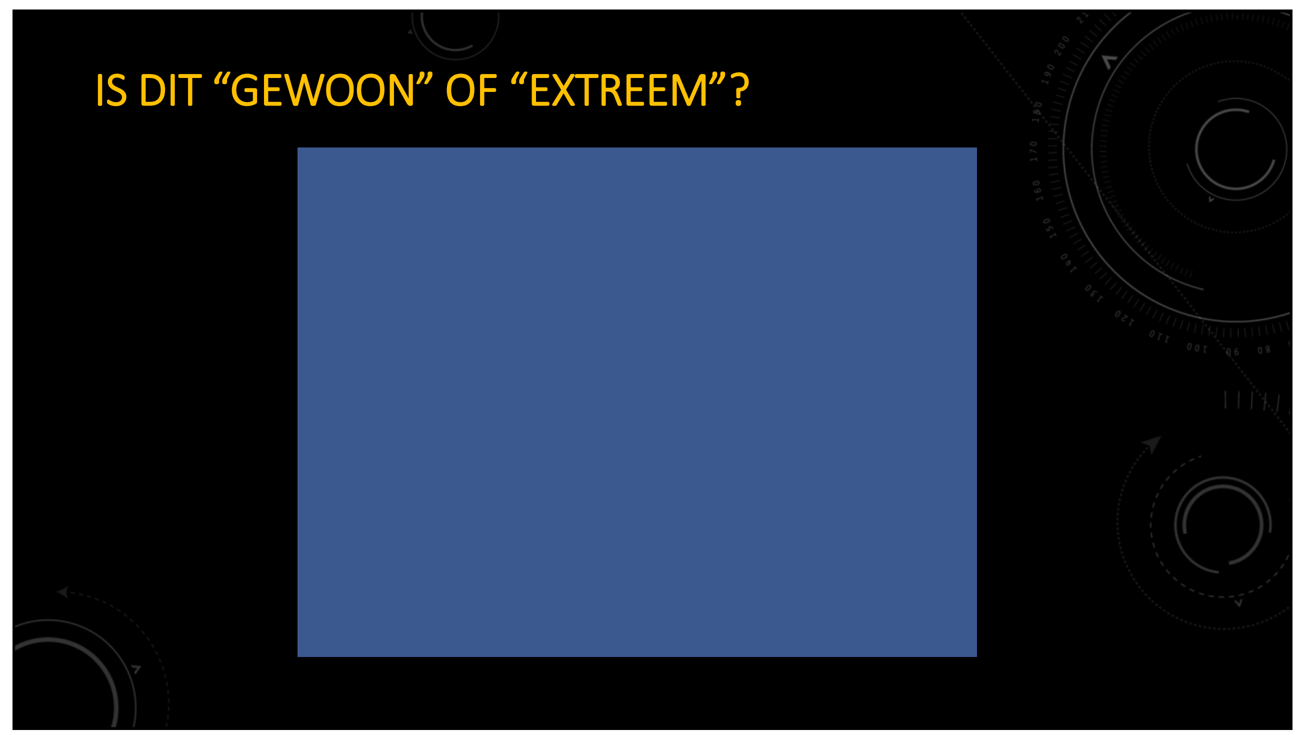
TEGEN eigen belang

SAMEN andermans belang
samen-gedrag roept samen-gedrag op

ONDER - volgen


JODY GITTELL: RELATIONAL COORDINATION
Coordinating Mechanisms
Clinical Pathways
Case Managers
Interdisciplinary Rounds
Staff Focus
Control Mechanisms
Selection
Performance Measurement
Rewards
Conflict Resolution
Relational Coordination
Communication
Frequent
Timely
Accurate
Problem Solving
Relationships
Shared Goals
Shared Knowledge
Mutual Respect
Outcomes
Quality
Efficiency
Relational coordination (RC) is a mutually reinforced process of interaction between communication and relationships carried out for the purpose of task integration.

KEUZEVRIJHEID VAN EEN WERKNEMER
DE KEUZEVRIJHEID VAN EEN WERKNEMER
Prikkelende creativiteit
Oprechte betrokkenheid
Positief samenwerken
Volgzaamheid
Kwaadwillende gehoorzaamheid
Rebellie of stoppen



MANAGEMENT GRID

(Low) Concern for People (High)									
	1,9								9,9 ← Best
	1,8								
	1,7								
	1,6								
	1,5				5,5				
	1,4								
	1,3								
	1,2								
	1,1	2,1	3,1	4,1	5,1	6,1	7,1	8,1	9,1

(Low) Concern for Production (High)

WAT IS LEADERSHIP VOLGENS KOUZES & POSNER?

Modelling the way: geeft aan in welke mate jij vanuit je waardenprofiel **voorbeeldgedrag** stelt. Hoe laat jij je medewerkers weten wat je belangrijk vindt, wat voor jou de 'standaard' is ? Hoe duidelijk ben je in hierin ? In welke mate doe je zelf wat je van anderen verwacht ?

Inspiring a shared vision: geeft aan in welke mate je in staat bent je medewerkers te inspireren om **samen een visie te ontwikkelen**, samen doelen te bepalen voor de toekomst. Slaag je er in om je medewerkers doen in te zien dat ze door inbreng 'verschil maken' (toegevoegde waarde hebben); slaag je er in om hoopvol en positief over de toekomst te praten en medewerkers doen na te denken over uitdagingen, mogelijkheden ?

Challenging the process: geeft aan in welke mate je op zoek gaat naar opportuniteiten voor **verandering en innovatie** om de organisatie te verbeteren. Durf je te experimenteren (nieuwe voorstellen uitproberen), durf je risico te nemen ? Kun je ontgoochelingen ombuigen tot leerervaringen ?

Enabling others to act: geeft aan in welke mate je **samenwerking en persoonlijke ontwikkeling faciliteert**. Wat doe jij om teamspirit te verbeteren, om samenwerking optimaal te maken zowel binnen het team als met andere afdelingen ? Hoe creëer jij een omgeving van vertrouwen en respect ? Wat doe je om medewerkers sterker te maken en het gevoel te geven dat zij werkelijk betekenis hebben voor de afdeling ?

Encouraging the heart: geeft aan in welke mate jij de de bijdrage van medewerkers erkent, mensen laten delen in succes en realisaties viert. Hoe geef je feedback ? Kan er een schouderklop af ? Op welke manier zorg jij dat het team te weten komt **dat ze goed bezig zijn** ?

Bron: M. Verschueren, KULeuven-UZLeuven, 2013

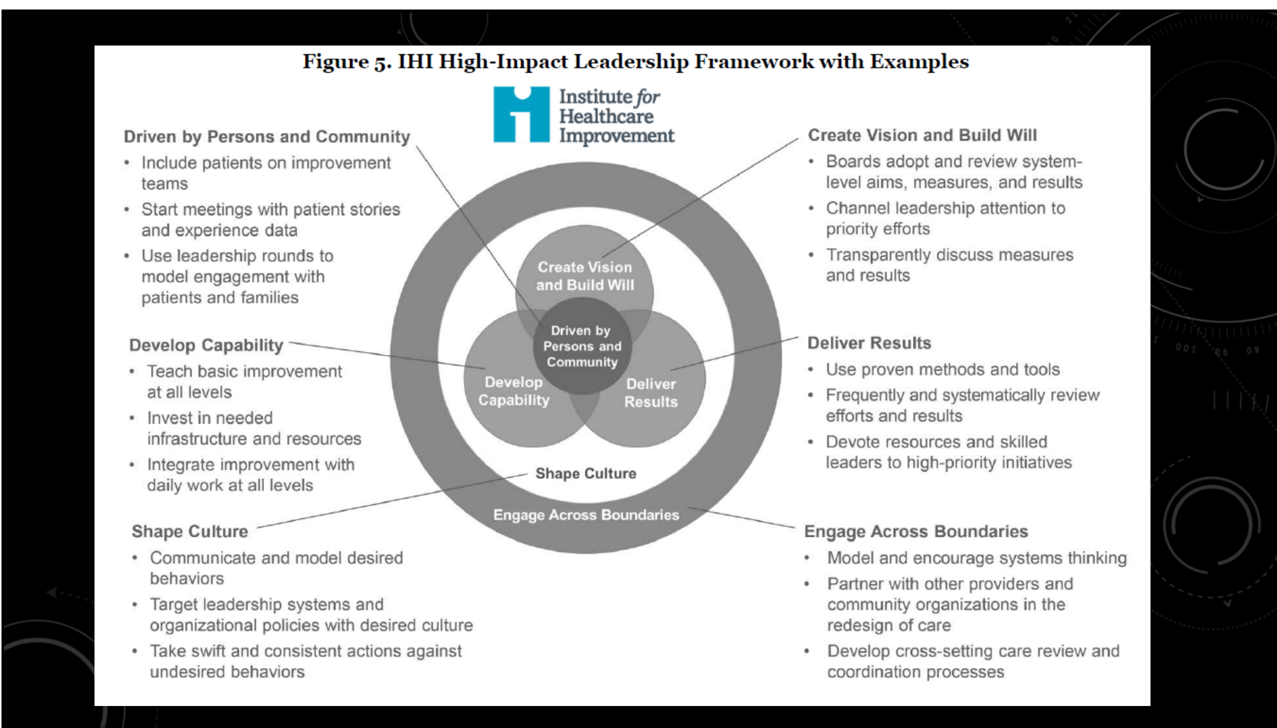


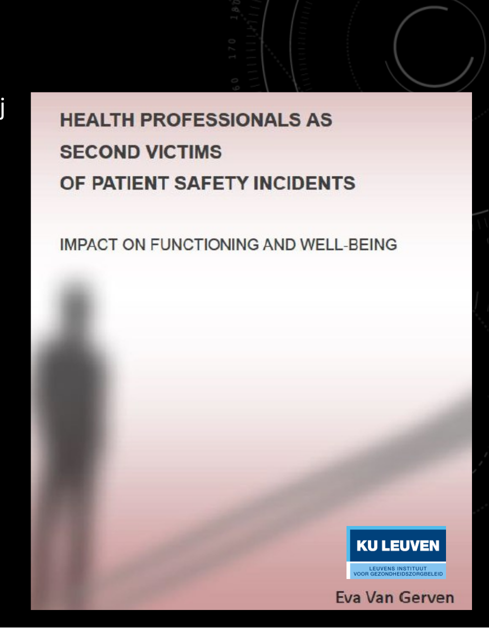
Figure 5. IHI High-Impact Leadership Framework with Examples
Institute for Healthcare Improvement
Driven by Persons and Community
• Include patients on improvement teams
• Start meetings with patient stories and experience data
• Use leadership rounds to model engagement with patients and families
Develop Capability
• Teach basic improvement at all levels
• Invest in needed infrastructure and resources
• Integrate improvement with daily work at all levels
Shape Culture
• Communicate and model desired behaviors
• Target leadership systems and organizational policies with desired culture
• Take swift and consistent actions against undesired behaviors
Create Vision and Build Will
• Boards adopt and review system-level aims, measures, and results
• Channel leadership attention to priority efforts
• Transparently discuss measures and results
Deliver Results
• Use proven methods and tools
• Frequently and systematically review efforts and results
• Devote resources and skilled leaders to high-priority initiatives
Engage Across Boundaries
• Model and encourage systems thinking
• Partner with other providers and community organizations in the redesign of care
• Develop cross-setting care review and coordination processes
Create Vision and Build Will
Driven by Persons and Community
Develop Capability
Deliver Results
Shape Culture
Engage Across Boundaries

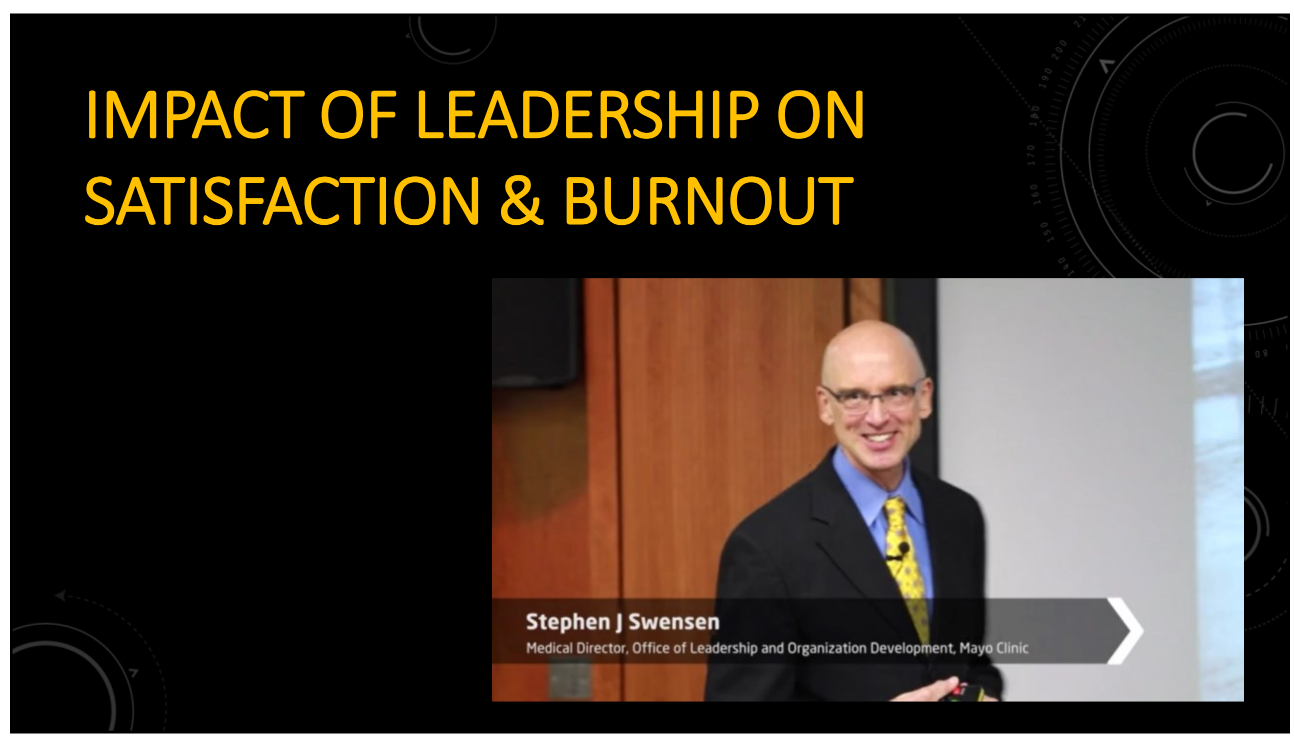
The FIVE DYSFUNCTIONS of a TEAM
PATRICK LENCIONI
Inattention to Results
Avoidance of Accountability
Lack of Commitment
Fear of Conflict
Absence of Trust
#1: Absence of Trust
The fear of being vulnerable with team members prevents the building of trust within the team.
#2: Fear of Conflict
The desire to preserve artificial harmony stifles the occurrence of productive, ideological conflict.
#3: Lack of Commitment
The lack of clarity or buy-in prevents team members from making decisions they will stick to.
#4: Avoidance of Accountability
The need to avoid interpersonal discomfort prevents team members from holding one another accountable for their behaviors and performance.
#5: Inattention to Results
The pursuit of individual goals and personal status erodes the focus on collective success.

IMPACT ADVERSE EVENTS

- Onderzoek (met o.a. de steun van FOD) gaf aan:
  - 1 op 10 hulpverleners in de voorbije 6 maand betrokken bij patiëntveiligheidsincident (adverse events)
    - Significant hogere kans hebben op burn-out
    - Significant meer problematisch medicatiegebruik
    - Significant meer interferentie tussen werk & privé
    - Significant meer kans om job te verlaten
    - Symptomen vertonen als
      - Angst, Twijfel, Slapeloosheid, Frustratie, …
- Ondersteuning nodig!
- Bespreken Morbidity & Mortality Meetings
- Uitvoeren Root Cause Analyse

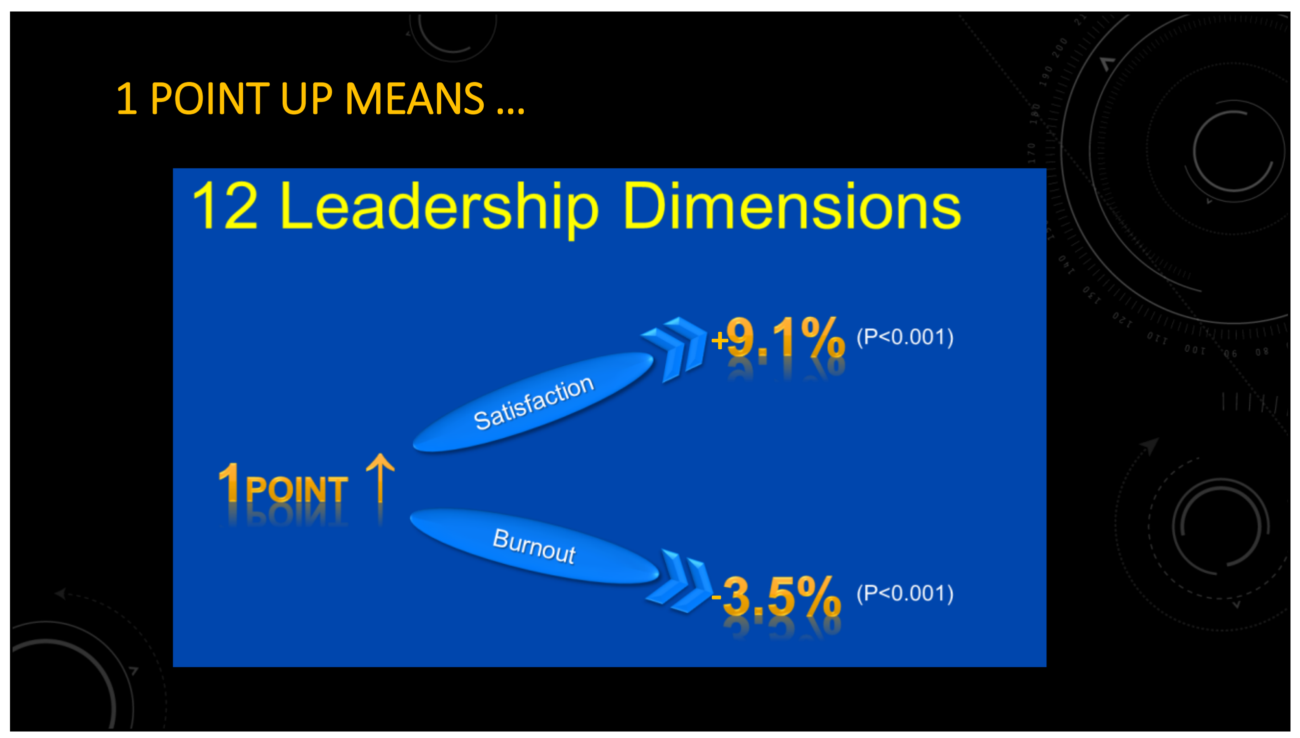
➔ LEREN en GOED VOOR JEZELF





LEADERSHIP SCALE MAYO CLINICS (SHANAFELT & SWENSEN)

Holds career development conversations with me	Strongly Disagree	Disagree	Neither Agr nor disagr	Agree	Strongly Agree
Inspires me to do my best	Strongly Disagree	Disagree	Neither Agr nor disagr	Agree	Strongly Agree
Empowers me to do my job	Strongly Disagree	Disagree	Neither Agr nor disagr	Agree	Strongly Agree
Is interested in my opinion	Strongly Disagree	Disagree	Neither Agr nor disagr	Agree	Strongly Agree
Encourages employees to suggest ideas for improvement	Strongly Disagree	Disagree	Neither Agr nor disagr	Agree	Strongly Agree
Treats me with respect and dignity	Strongly Disagree	Disagree	Neither Agr nor disagr	Agree	Strongly Agree
Provides helpful feedback and coaching on my performance	Strongly Disagree	Disagree	Neither Agr nor disagr	Agree	Strongly Agree
Recognizes me for a job well done	Strongly Disagree	Disagree	Neither Agr nor disagr	Agree	Strongly Agree
Keeps me informed about changes taking place at Mayo Clinic	Strongly Disagree	Disagree	Neither Agr nor disagr	Agree	Strongly Agree
Encourages me to develop my talents and skills	Strongly Disagree	Disagree	Neither Agr nor disagr	Agree	Strongly Agree
I would recommend working for (name of immediate supervisor)	Strongly Disagree	Disagree	Neither Agr nor disagr	Agree	Strongly Agree
Overall, how satisfied are you with (name of immediate supervisor)	Very dissatisfied	Dissatisfied	Neither Sat or Dissat	Satisfied	Very Satisfied



MEER TEVREDEN EN MINDER BURNOUT IS GOED VOOR JEZELF ÉN DE PATIËNT

Forbes / Pharma & Healthcare

BY PETER PRONOVOST

FEB 22, 2016 @ 09:14 AM 2,879 VIEWS

Five Lessons Healthcare Leaders Are Learning From An Unlikely Source: Nuclear Power

1. Het management moet zijn verantwoordelijkheid nemen

   (als iets fout gaat, moet je het onderzoeken én verantwoordelijkheid dragen)

2. Focus op uitkomsten

   (organiseer je processen hoe je wil, maar zorg ervoor dat je outcomes in orde zijn)

3. Als medewerkers spreken, dan luistert het management

   (kom niet steeds onmiddellijk met een antwoord maar laat hen het antwoord formuleren)

4. Er bestaan geen alleenstaande incidenten

   (ga dus voor elk incident op zoek naar de aanpassing van het systeem, en dat is jouw rol)

5. Streef naar perfectie

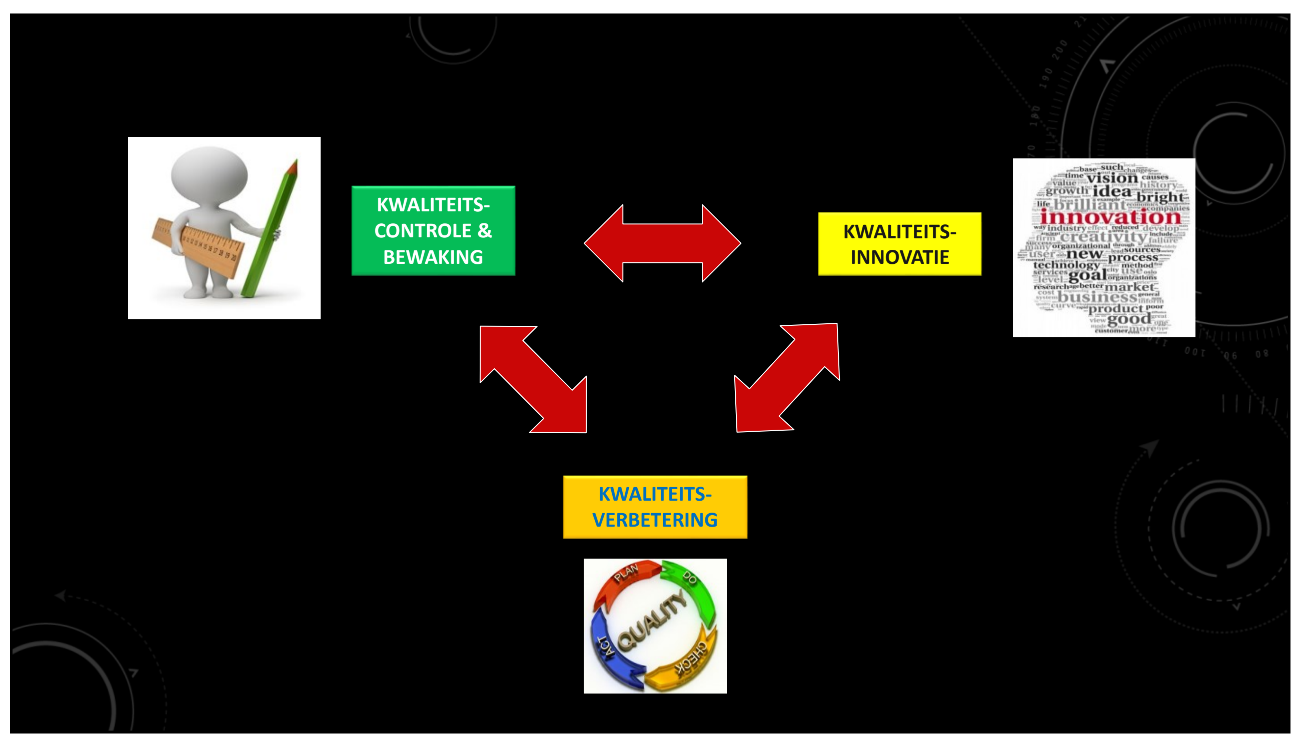
   (de enige maatstaf voor kwaliteit is "zero-defects", je aanvaardt enkel dat kwaliteitsniveau binnen je ziekenhuis dat je zelf als patiënt zou aanvaarden)

ZERO DEFECTS ?
BELGIË GOED BEZIG ?

KCE:	2635 overlijdens door nosocomiale infecties/jaar
FOD:	3000 overlijdens door adverse events/jaar
TOTAAL=	5635 overlijdens per jaar
	15 overlijdens per dag

CONCLUSIE
MANAGEMENT
VS
LEADERSHIP

LEADERSHIP NA DEELNAME AAN IMAGINE CL TRAJECT
Ambities-waarmaken
Willen-is-kunnen
Conflicten-voorkomen
Transparant
Inspireren
Confronteren
Doen-wat-je-predikt
Meenemen
Vanuit-de-helicopter
Open-staan
Hulp-durven-inroepen
Verbinder
Bewust-zijn
Betrouwbaar
Kwetsbaarheid
LEADERSHIP
Ervaring-delen
Authentiek
Visie
Geduld
Delegeren
Incasseringsvermogen
Stimuleren
Enthousiasmeren
Kwetsbaar
Voorbeeldrol
Observeren
Moed
Introduceren
Transformeren
Niet-van-bovenaf
Echt
Betrokken-krijgen



CONCLUSIE: HET IS EEN KWESTIE VAN EVENWICHT

BOSS OR LEADER

Boss

LEADER