Mitigating Burnout / Enhancing Resilience

Michael Leonard, MD
Cultural Maturity Model

**UNMINDFUL**
Who cares as long as we’re not caught
*Chronically Complacent*

**REACTIVE**
Safety is important. We do a lot every time we have an accident

**SYSTEMATIC**
We have systems in place to manage all hazards

**PROACTIVE**
Anticipating and preventing problems before they occur; Comfort speaking up

**GENERATIVE**
Safety is how we do business around here
*Constantly Vigilant and Transparent*

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*Adapted from Safeskies 2001, “Aviation Safety Culture,” Patrick Hudson, Centre for Safety Science, Leiden University*
Leadership & Psychological Safety

Allan Frankel, MD
Michael Leonard, MD
Leadership

Leaders create high degrees of psych safety and accountability.

Leaders model the desired behaviors to drive culture of safety.

Training and support exists for building clinical leadership.

Episodic, completely dependent on the individual clinician.

Absent for the most part.

**GENERATIVE**
Organization wired for safety

**PROACTIVE**
Playing offense – anticipating

**SYSTEMATIC**
Systems in place

**REACTIVE**
Playing defense – reacting to events

**UNMINDFUL**
No awareness of safety culture
Where is Your Leadership?

What are the strengths of your leadership - both senior and clinical

Where do you have opportunity?

How would you measure and sustain this work?
Effective Leadership

Set a positive active tone

Think out loud to share the plan – common mental model

Continuously invite people into the conversation for their expertise and concern

Use their names
A Surgical Safety Checklist to Reduce Morbidity and Mortality in a Global Population


ABSTRACT

BACKGROUND

Surgery has become an integral part of global health care, with an estimated 234 million operations performed yearly. Surgical complications are common and often preventable. We hypothesized that a program to implement a 19-item surgical safety checklist designed to improve team communication and consistency of care would reduce complications and deaths associated with surgery.

METHODS

Between October 2007 and September 2008, eight hospitals in eight cities (Toronto, Canada; New Delhi, India; Amman, Jordan; Auckland, New Zealand; Manila, Philippines; Ibadan, Tanzania; London, England; and Seattle, WA) representing a variety of economic circumstances and diverse populations of patients participated in the World Health Organization’s Safe Surgery Saves Lives program. We prospectively collected data on clinical processes and outcomes from 3,733 consecutively enrolled patients 15 years of age or older who were undergoing noncardiac surgery. We subsequently collected data on 3,995 consecutively enrolled patients after the introduction of the Surgical Safety Checklist. The primary end point was the rate of complications, including deaths, during hospitalization within the first 30 days after the operation.

RESULTS

The rate of death was 1.9% before the checklist was introduced and declined to 0.8% afterward (P < 0.001). Inpatient complications occurred in 11.0% of patients at baseline and in 7.0% after introduction of the checklist (P = 0.001).

CONCLUSIONS

Implementation of the checklist was associated with concomitant reductions in the rates of death and complications among patients at least 16 years of age who were undergoing noncardiac surgery in a diverse group of hospitals.

Introduction of Surgical Safety Checklists in Ontario, Canada

David R. Urbach, M.D., AnandGovindarajan, M.D., Rekif Saksin, M.Sc., Andrew S. Wilton, M.Sc., and Nancy N. Baxter, M.D., Ph.D.

ABSTRACT

BACKGROUND

Evidence from observational studies that the use of surgical safety checklists results in striking improvements in surgical outcomes led to the rapid adoption of such checklists worldwide. However, the effect of mandatory adoption of surgical safety checklists is unclear. A policy encouraging the universal adoption of checklists by hospitals in Ontario, Canada, provided a natural experiment to assess the effectiveness of checklists in typical practice settings.

METHODS

We surveyed all acute care hospitals in Ontario to determine when surgical safety checklists were adopted. Using administrative health data, we compared operative mortality, rate of surgical complications, length of hospital stay, and rates of hospital readmission and emergency department visits within 30 days after discharge among patients undergoing a variety of surgical procedures before and after adoption of a checklist.

RESULTS

During 3-month periods before and after adoption of a surgical safety checklist, a total of 103 hospitals performed 109,341 and 106,370 procedures, respectively. The adjusted risk of death during a hospital stay or within 30 days after surgery was 0.77% (95% confidence interval [CI], 0.66 to 0.76) before implementation of a surgical checklist and 0.65% (95% CI, 0.60 to 0.70) afterward (odds ratio, 0.91; 95% CI, 0.80 to 1.03; P = 0.13). The adjusted risk of surgical complications was 3.86% (95% CI, 3.76 to 3.96) before implementation and 3.82% (95% CI, 3.71 to 3.92) afterward (odds ratio, 0.97; 95% CI, 0.90 to 1.03; P = 0.29).

CONCLUSIONS

Implementation of surgical safety checklists in Ontario, Canada, was not associated with significant reductions in operative mortality or complications. (Funded by the Canadian Institutes of Health Research.)
Psychological Safety

**GENERATIVE**
HRO - wired for safety and

**PROACTIVE**
Playing offense - anticipating,

**SYSTEMATIC**
Systems in place to manage hazards

**REACTIVE**
Playing defense – reacting to events

**UNMINDFUL**
No awareness of safety culture

- Primary responsibility of leaders, continuously modeled everywhere.
- Leaders model and expect the behaviors that promote psychological safety.
- In some units it feels safe to speak up and voice a concern.
- Personality dependent – it depends who I’m working with.
- Fear based – keep your head down and stay out of trouble.
Psychological Safety

What are the things that make it hard to speak up here?

What are the 1-2 things we can do to make it better? Describe them in a way that they are actionable, visible and measurable.
We are our own image consultants and best image protectors.

Psychological Safety changes this paradigm.

To protect one’s image, if you don’t want to look:

- STUPID: Don’t ask questions
- INCOMPETENT: Don’t ask for feedback
- NEGATIVE: Don’t be doubtful or criticize
- DISRUPTIVE: Don’t suggest anything innovative

Source: Amy Edmondson
Google

Laszlo Bock

Culture is imminently measurable

Julia Rozovsky

Two attributes of great teams:

1. Everyone speaks up in equal amounts
2. Team members are attuned to how others on the team feel and respond with “emotional intelligence”.

Safe & Reliable Healthcare
BURNOUT / RESILIENCE
Building Resilience / Reducing Burnout

• We need a Framework
• We need tools to enhance resilience
• We need a Learning System
• We need to make positivity visible and capture it
Burnout / Resilience

What percentage of physicians in America are reporting symptoms of burnout?

Is this getting better or worse?

What do you think contributes to burnout? Resilience?

Why is this important?

Tait D. Shanafelt, MD; Omar Hasan, MBBS, MPH; Lotte N. Dyrbye, MD, MPH; Christine Sinsky, MD; Daniel Satele, MS; Jeff Sloan, PhD; and Colin P. West, MD, PhD

Abstract

Objective: To evaluate the prevalence of burnout and satisfaction with work-life balance in physicians and US workers in 2014 relative to 2011.

Patients and Methods: From August 28, 2014, to October 6, 2014, we surveyed both US physicians and a probability-based sample of the general US population using the methods and measures used in our 2011 study. Burnout was measured using validated metrics, and satisfaction with work-life balance was assessed using standard tools.

Results: Of the 35,922 physicians who received an invitation to participate, 6880 (19.2%) completed surveys. When assessed using the Maslach Burnout Inventory, 34.4% (n = 3680) of the physicians reported at least 1 symptom of burnout in 2014 compared with 45.5% (n = 3310) in 2011 (P < .001). Satisfaction with work-life balance also declined in physicians between 2011 and 2014 (45.8% vs 40.9%; P < .001). Substantial differences in rates of burnout and satisfaction with work-life balance were observed by specialty. In contrast to the trends in physicians, minimal changes in burnout or satisfaction with work-life balance were observed between 2011 and 2014 in probability-based samples of working US adults, resulting in an increasing disparity in burnout and satisfaction with work-life balance in physicians relative to the general US working population. After pooled multivariate analysis adjusting for age, sex, relationship status, and hours worked per week, physicians remained at an increased risk of burnout (odds ratio, 1.97; 95% CI, 1.80-2.16; P < .001) and were less likely to be satisfied with work-life balance (odds ratio, 0.68; 95% CI, 0.62-0.75; P < .001).

Conclusion: Burnout and satisfaction with work-life balance in US physicians worsened from 2011 to 2014. More than half of US physicians are now experiencing professional burnout.

For editorial comment, see page 1595; for a related article, see page 1596.

FIGURE 1. Burnout (A) and satisfaction with WLB (B) by specialty 2011 vs 2014. For 1A and 1B, specialty discipline is shown on the y axis and burnout (A) and satisfaction with WLB (B) are shown on the x axis. For 1C, satisfaction with WLB is shown on the y axis and burnout on the x axis. GIM = general internal medicine; OB/GYN = obstetrics and gynecology; IM/RIA = internal medicine and radiology; Prev = Preventive medicine, occupational medicine, or environmental medicine; WLB = work-life balance. © 2015 Mayo Foundation for Medical Education and Research.
Major article

Nurse staffing, burnout, and health care—associated infection

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\textbf{Background:} Each year, nearly 7 million hospitalized patients acquire infections while being treated for other conditions. Nurse staffing has been implicated in the spread of infection within hospitals, yet little evidence is available to explain this association.

\textbf{Methods:} We linked nurse survey data to the Pennsylvania Health Care Cost Containment Council report on hospital infections and the American Hospital Association Annual Survey. We examined urinary tract and surgical site infection, the most prevalent infections reported and those likely to be acquired on any unit within a hospital. Linear regression was used to estimate the effect of nurse and hospital characteristics on health care—associated infections.

\textbf{Results:} There was a significant association between patient-to-nurse ratio and urinary tract infection ($0.86; \ P = .02$) and surgical site infection ($0.93; \ P = .04$). In a multivariate model controlling for patient severity and nurse and hospital characteristics, only nurse burnout remained significantly associated with urinary tract infection ($0.82; \ P = .03$) and surgical site infection ($1.56; \ P < .01$) infection. Hospitals in which burnout was reduced by 30% had a total of 6,239 fewer infections, for an annual cost saving of up to $68 million.

\textbf{Conclusions:} We provide a plausible explanation for the association between nurse staffing and health care—associated infections. Reducing burnout in registered nurses is a promising strategy to help control infections in acute care facilities.
34% of nurses in the US regarded themselves to be burnt out.
NOTE: LOWER IS BETTER
Burnout Climate by Position

- Registered Practical Nurse (RPN) (5) - 100%
- Nurse (RN) (34) - 91%
- Therapist (RT, PT, OT, Speech) (6) - 83%
- Other (26) - 81%
- Midwife (5) - 80%
- Physician: Attending/Staff - Obstetrics/Gynecology (10) - 70%
- Physician: Attending/Staff - Anesthesiology (7) - 57%
- Physician: Attending/Staff - Pediatrics (6) - 50%

Source Data: Jan 2017
Personal Burnout Domain

Events in this work setting affect my life in an emotionally unhealthy way. (99)

I feel I am working too hard on my job. (99)

I feel frustrated by my job. (99)

I feel burned out from my work. (99)

I feel fatigued when I get up in the morning and have to face another day on the job. (99)
Burnout Domain – By Facility

Note: Lower is better
Burnout Domain – By Position

Note: Lower is better
Burnout Domain Item

People in this work setting are burned out from their work.

Note: Lower is better

Benchmarks: 2017 Q1
25th: 55% 50th: 48% 75th: 40%
Percent Negative Percentiles
n = 162319 responses
From 106 hospitals/facilities
Burnout Domain Item

People in this work setting are burned out from their work.

Note: Lower is better

Benchmarks: 2017 Q1
25th: 55% 50th: 48% 75th: 40%
Percent Negative Percentiles
n = 162319 responses
From 106 hospitals/facilities
Influencing Factors in Burnout / Resilience

• Do I feel valued by the organization?
• Do I have a voice?
• Do I feel supported in the work I do?
• Do I have the tools and resources to do my job?
Recent data analyses reveal the disturbing decline in well-being of contemporary US physicians. This trend has captured the attention of not only affected physicians and researchers but also physicians’ patients and the general public. For example, the September 7, 2015, issue of TIME Magazine featured an article titled “Life/Support: Inside the Movement to Save the Mental Health of America’s Doctors.”

Burnout increased significantly, rising from 45.5% in 2011 to 54.4% in 2014 (P<.001). Furthermore, this burnout was apparent in all 24 medical specialties studied, and 9 of the 24 specialties showed a relative increase in burnout of more than 10%. In the work-life balance portion of the study, the incidence of physician satisfaction decreased from 48.5% to 40.9% overall (P<.001), and a decline in satisfaction...
Three Good Things – the power of focusing on how we make a difference.

The evidence

How to make this easier
Douglas and Walter, two University of Pennsylvania MBA graduates, were laid off by their Wall Street companies 18 months ago. Both went into a tailspin: They were sad, listless, indecisive, and anxious about the future. For Douglas, the mood was transient. After two weeks he told himself, "This is my crisis, I can weather this storm."

On the other hand, Walter

Duke Patient Safety Center:

Training, Research and Implementation for Patient Safety and Quality

Duke Patient Safety Center Mission:

To help individuals, clinical areas, hospitals, ambulatory centers and others who want to improve quality and patient safety. We aim to:

1. Spread best practices inside and outside Duke University Health System
2. Generate new knowledge
3. Bring joy back to work

We work to develop and support quality and safety related roles, committees, training, tools, research, strategies, data and other resources through our interdisciplinary team. We strive to balance the clinical, administrative, psychological, spiritual and service needs of our organization, our frontline workers and the patients that we serve.

SAVE THE DATE
12th Annual Duke Health System Patient Safety & Quality Conference
March 23, 2017
Click here to enroll in One Good Talk March 23 - 30th
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To enroll 2017 cohorts please select one of the following:

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May 22 - June 5
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Nov 13 - 27

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Want to learn how to be more Resilient with WISER:

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Learning

Build organization trust through identifying and resolving defects

Make learning visible – feedback is key

This requires ownership and infrastructure

We always want to move toward higher order problem solving
BACKGROUND

Is celebrating successes and recognizing individuals that excel in patient-centered care linked to the well-being of healthcare workers?

Safety rounding, in which leaders visit work settings to surface and resolve patient safety related deficits, has been associated with better safety culture and lower rates of burnout (Sexton et al., 2014).

Positive rounding, which is a new variant of safety rounding, involves leaders intentionally acknowledging what is going well in units and recognizing workers who go above and beyond.

To date, there is a paucity of evidence assessing associations between positive rounding and worker well-being.

If positive rounding is linked to lower worker burnout, it could be a relatively low-cost intervention to increase worker well-being and improve clinical and operational outcomes.

To evaluate associations between healthcare worker (HCW) well-being (i.e., burnout climate, personal burnout, and work-life balance), and exposure to positive rounding: Did leaders ask for information about what is going well in this work setting (e.g., people who deserve special recognition for going above and beyond, celebration of successes, etc.)?

Hypothesis 1: HCWs who report being exposed to positive rounding will report lower burnout climate, personal burnout and higher levels of work life balance.

Hypothesis 2: Both positive rounding and senior leader rounding will independently predict greater HCW well-being.

AIMS AND HYPOTHESES

10,496 Duke University Healthcare System workers (78% response rate) were surveyed with measures of burnout (emotional exhaustion), burnout climate, and work-life balance as well items on whether or not they experienced positive and/or senior leader rounding.

RESULTS

DUHS workers (and work settings) who reported experiencing positive rounding (62%), compared to workers who did not, reported:
1) Lower burnout climate, \( (8,765) = -24.14, p < .001 \)
2) Lower personal burnout, \( (8,778) = -25.11, p < .001 \)
3) Higher work-life balance, \( (8,647) = 17.87, p < .001 \)

SUMMARY OF RESULTS

Positive rounding is associated with lower HCW and work-setting levels of burnout climate and personal burnout, and higher levels of work-life balance. Positive rounding is as powerful as safety rounding and it uniquely contributes to these outcomes.

LESSONS LEARNED

• The initial aim of positive rounding was to enhance employee engagement, however these findings suggest that it merits a closer look as an intervention to reduce burnout and improve the well-being of healthcare workers.

• Burnout has been linked to poor clinical outcomes, (e.g., medication errors; Fahrenkopf, et al., 2008; higher standardized mortality ratios; Aiken et al., 2002), and negative organizational outcomes (e.g., turnover; Sung et al., 2012). Thus, the current study suggests that positive rounding could be a low-cost, high-yield intervention to increase patient safety and HCW retention.

• Examine associations between positive leader rounding and additional outcomes (e.g., teamwork, turnover, SRS reporting).

• Test for changes in HCW well-being and outcomes before and after positive rounding is initiated across various units.

• Investigate whether combining positive rounding and safety rounding with feedback leads to superior outcomes.

• Develop a plan for recruiting senior leaders to participate in positive rounding, as well as measure roll-out efforts, adherence, and feedback on this initiative.