



# Spørsmål til en leder:

1. Bruk for briller?
2. Hvordan forestiller du deg arbeidet?
3. Bruker dere de riktige data riktig?
4. Kan dine folk dette?
5. Tørr de si fra?
6. Prosjektitis eller plan?
7. Hvordan leder du (egentlig)?

# Hvordan har du ledet / opplevt ledelsen af kvalitetsforbedringer?



Bruk for  
briller?

# den Kopf in den Sand stecken



ein Problem ignorieren;  
sich weigern, die Realität wahrzunehmen

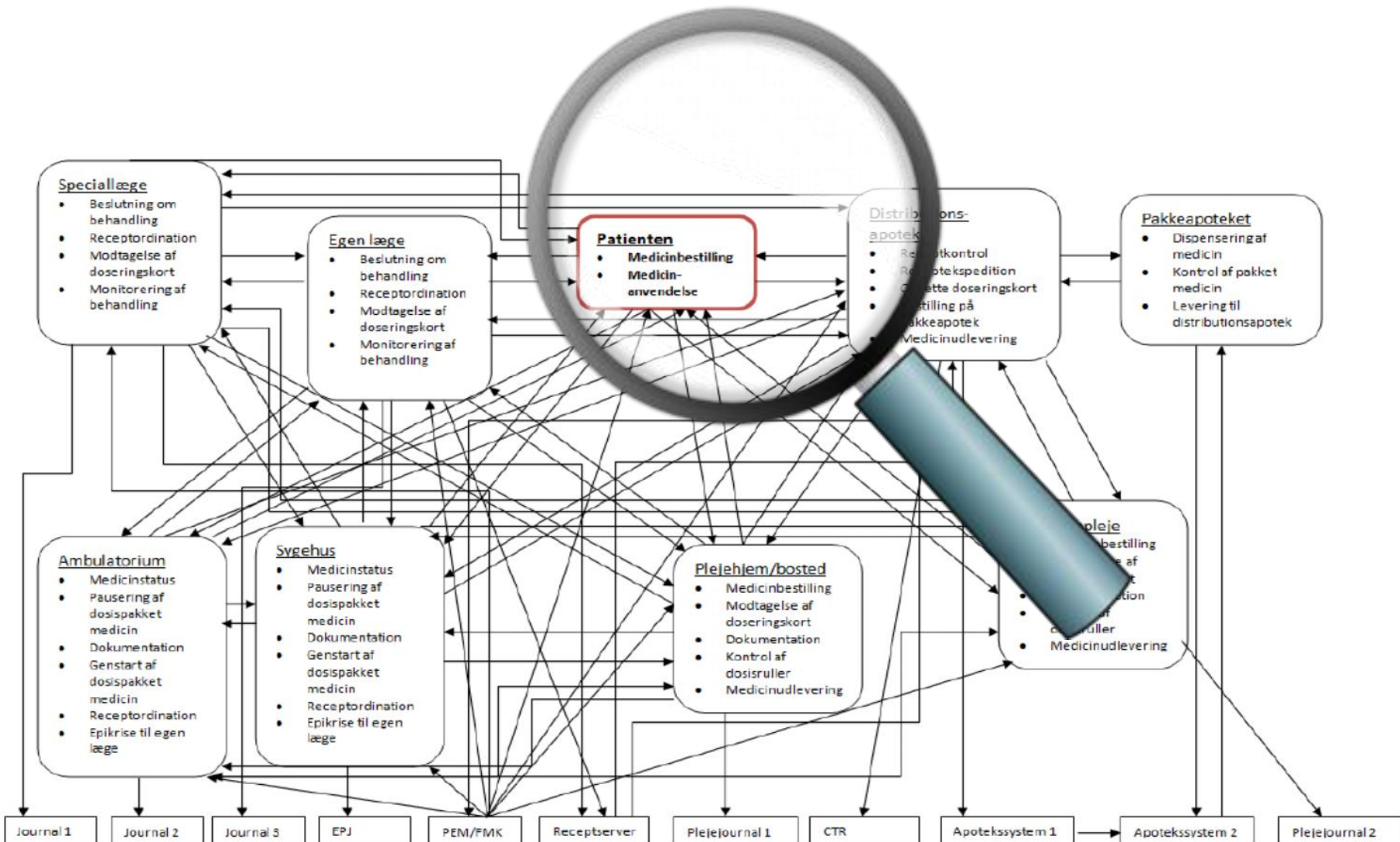




”Every problem seems to cry out in its own language”


Thomas Transtrømer





**“I call it cruel, perhaps the root of all cruelty to know what occurs, but not recognize the fact.”**

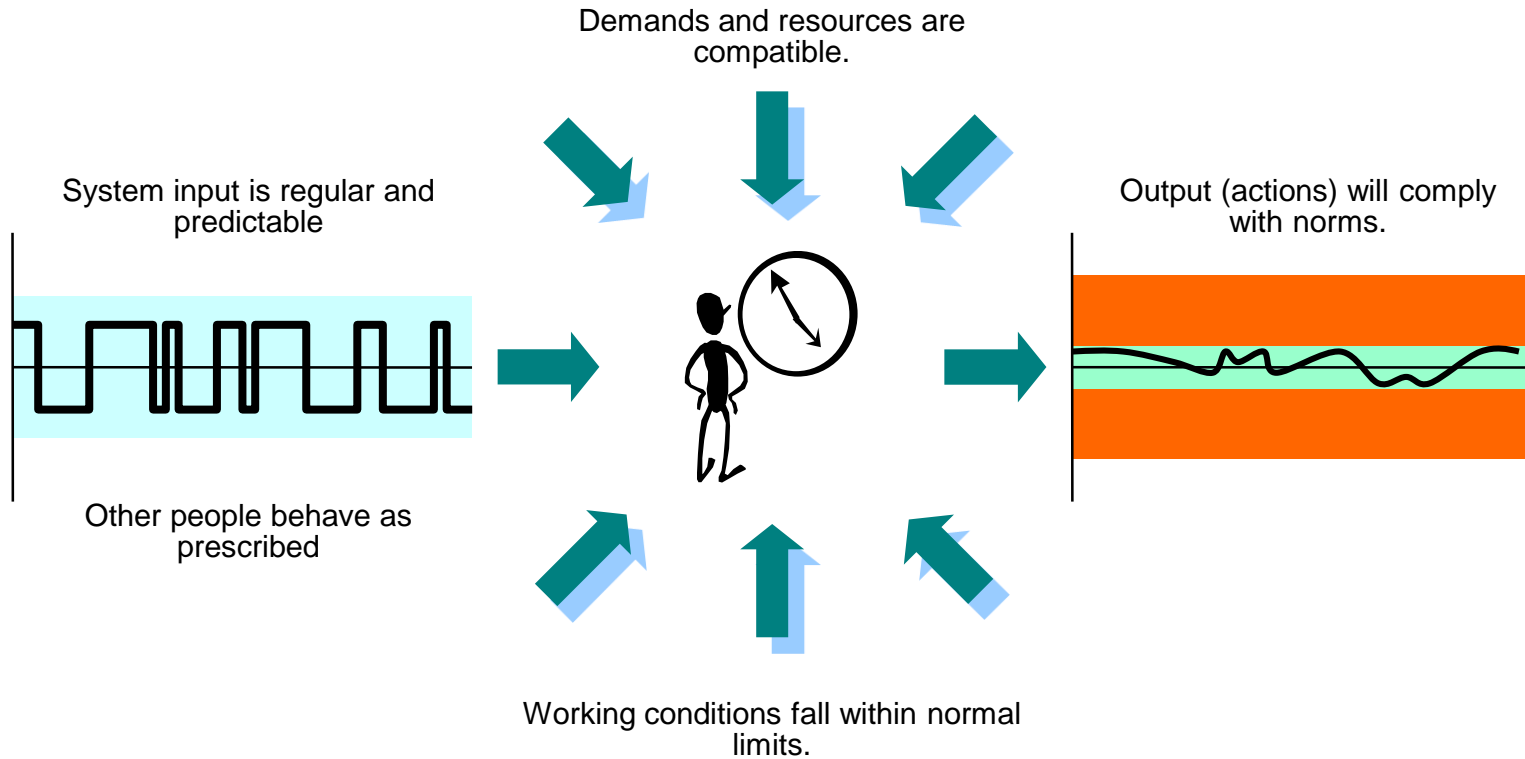
William Stafford



Hvordan  
forestiller  
du deg  
arbeidet?

bruk for  
briller?

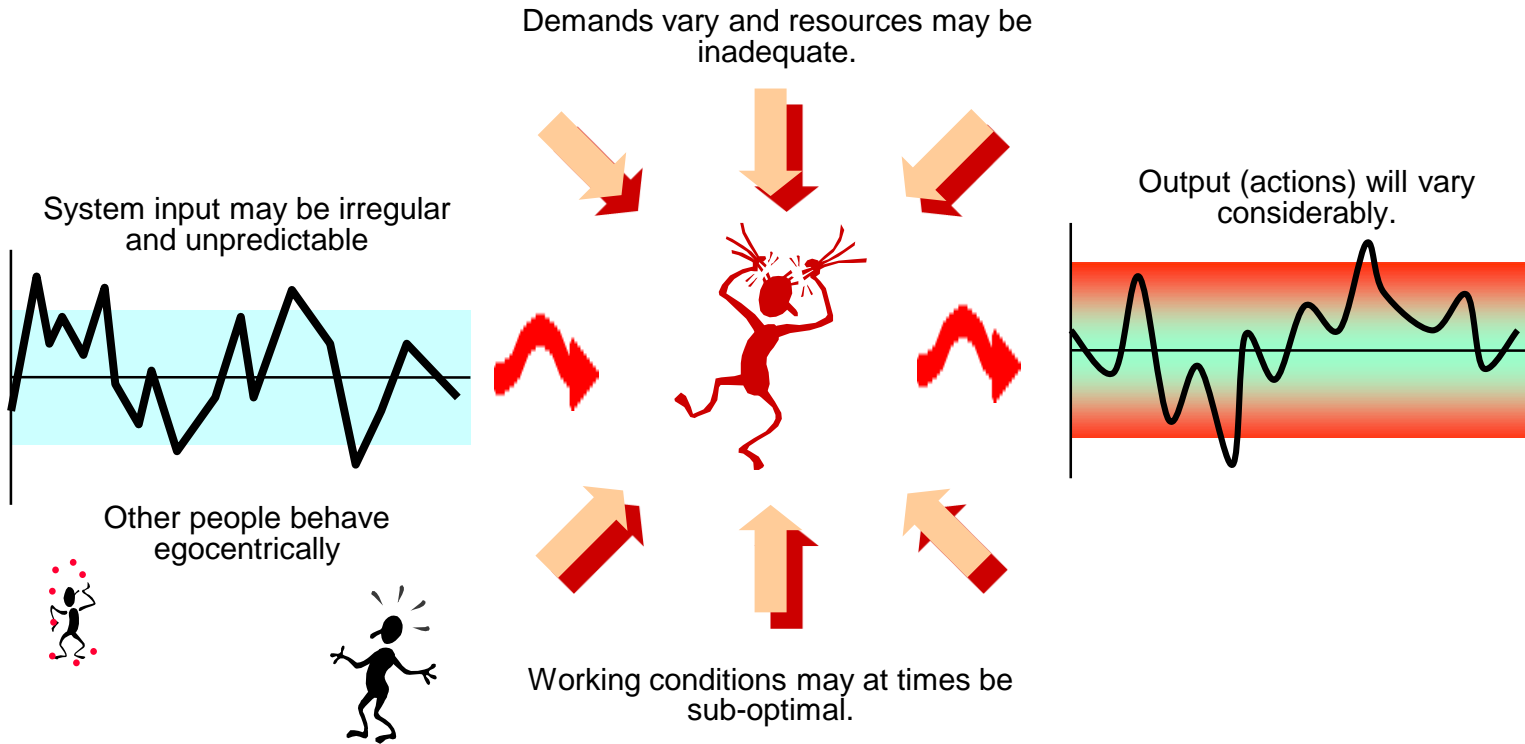
# Work as imagined – nominal work



... no need to make adjustments

©Erik Hollnagel 2015

# Work as done – actual work



... necessary to make local adjustments  
Efficiency-Thoroughness Trade-Off (ETTO)

©Erik Hollnagel 2015

# Efficiency-Thoroughness Trade-Off

**Thoroughness: Time to think**  
Recognising situation.  
Choosing and planning.

If thoroughness dominates,  
there may be too little time to  
carry out the actions.

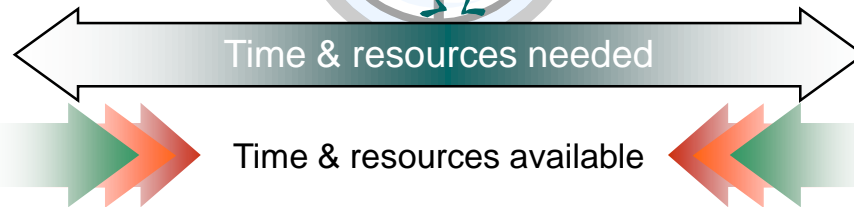
Neglect pending actions  
Miss new events



**Efficiency: Time to do**  
Implementing plans.  
Executing actions.

If efficiency dominates,  
actions may be badly  
prepared or wrong

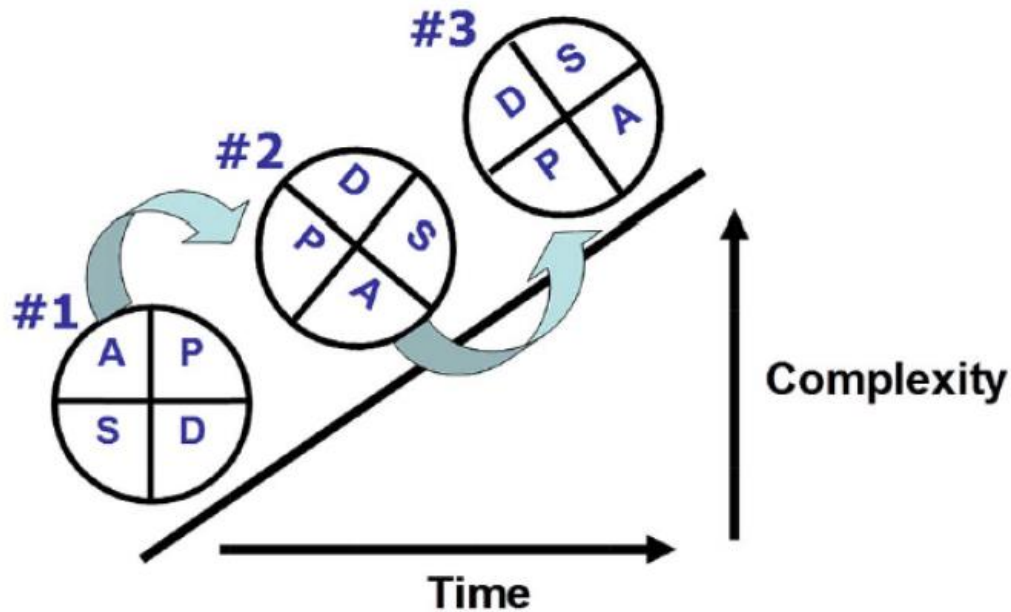
Miss pre-conditions  
Look for expected results



©Erik Hollnagel 2015



# Plan-Do-Study-Act cirkler [1]



**Figure 1** Traditional view of successive plan–do–study–act (PDSA) cycles over time depicted as a linear process. Each preceding PDSA informs the next one. As time goes on, the complexity of each intervention and trial often increases.<sup>2</sup>

## Building knowledge, asking questions

Greg Ogrinc and Kaveh G Shojania

*BMJ Qual Saf* 2014; 23: 265–267 originally published online December 23, 2013



# Plan-Do-Study-Act cirkler [2]



Building knowledge, asking questions

Greg Ogrinc and Kaveh G Shojania

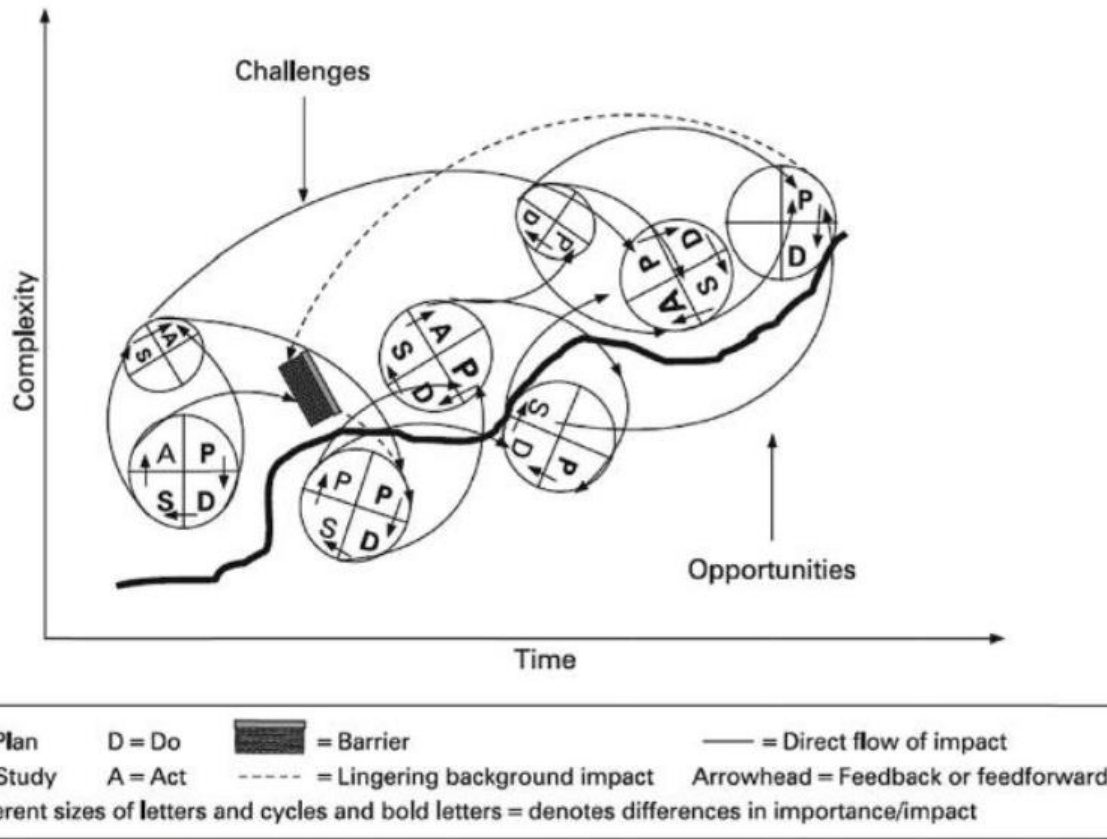


Figure 2 Revised conceptual model of plan-do-study-act (PDSA) methodology.<sup>4</sup>

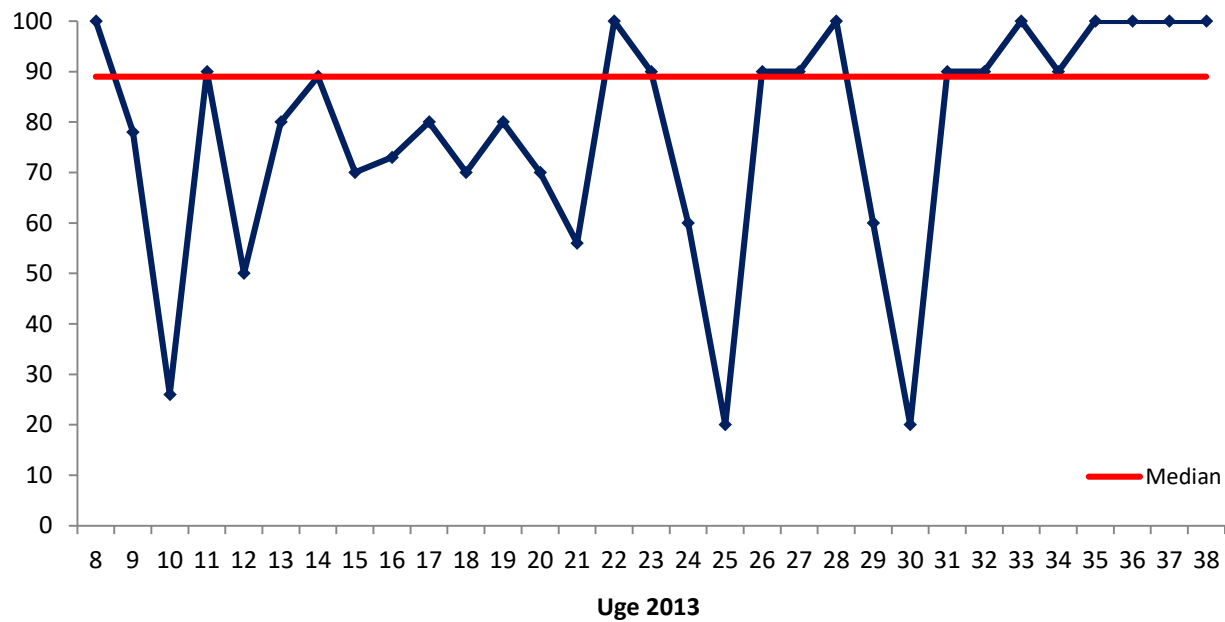


Hvordan  
forestiller  
du deg  
arbeidet?

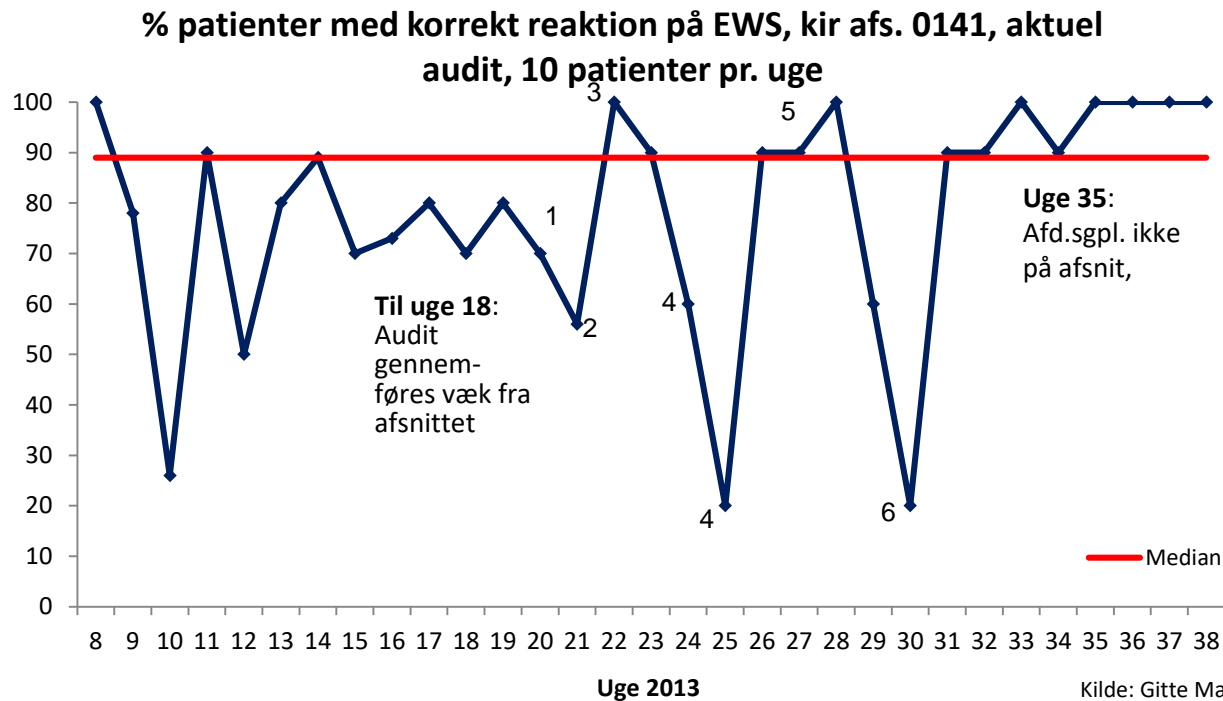
Bruk for  
briller?

Bruker  
dere de  
riktige data  
riktig?

% patienter med korrekt reaktion på EWS, audit 10 patienter pr. uge



Kilde: Gitte Madsen, Nordsjællands Hospital



Kilde: Gitte Madsen, Nordsjællands Hospital

**Indtil uge 18:** audit blev gennemført af UKK, afd.sgpl ikke involveret

**1:** Personalemøde, principper for EWS gennemgået, EWS skal vises på alle ptt. på tavlen

**2:** Ugl audit v/ UKK og afd.sgpl. Kriterier for EWS og reaktion på score gennemgås v/ tavlen ud fra pt. case

**3:** EWS audit gennemføres ved UKK og afd.sgpl – sammen med personalet på aktuelle ptt

**4:** Ferie, i uge 25 gentaget formål med EWS: det er et fælles sprog, monofagligt og tværfagligt

**5:** Kommentarer fra personalet:

'Nu ser jeg betydningen i brug af EWS som et fælles sprog, tidligere (maj) syntes jeg at vi gjorde dobbeltdokumentation

'Jeg vil gerne at vi gennemgår denne pt., jeg mener at lægeordination med kroniske værdier er farlige for patienten'

**6:** Gentaget principper for EWS og algoritmen – de næste punkter taler for sig selv



ELSEVIER

Contents lists available at [ScienceDirect](#)

## Social Science & Medicine

journal homepage: [www.elsevier.com/locate/socscimed](http://www.elsevier.com/locate/socscimed)



# Beyond metrics? Utilizing ‘soft intelligence’ for healthcare quality and safety



Graham P. Martin <sup>a,\*</sup>, Lorna McKee <sup>b</sup>, Mary Dixon-Woods <sup>a</sup>

<sup>a</sup> *University of Leicester, United Kingdom*

<sup>b</sup> *Aberdeen University, United Kingdom*



Sammenhæng



Data

Informasjon

Viten

Visdom

Menneskelig interaksjon /intervensjon



Forståelse

Etter Ackoff



Hvordan  
forestiller  
du deg  
arbeidet?

Kan dine  
folk  
dette?

Bruker  
dere de  
riktige data  
riktig?

bruk for  
Briller?



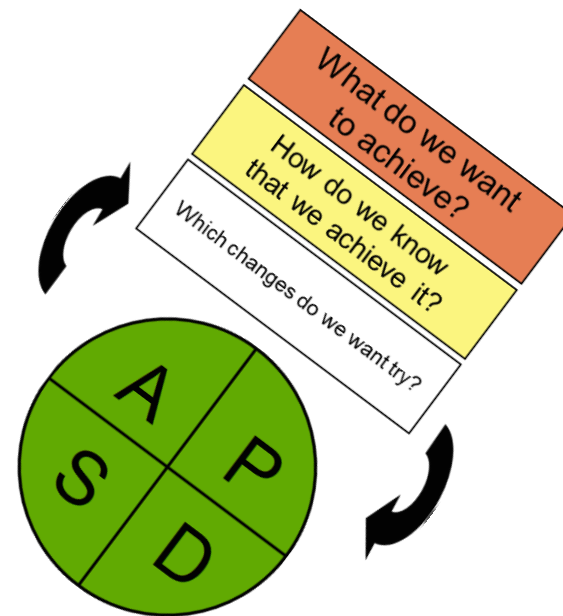
Helsefaglig  
viten

Viten om  
kvalitets-  
utvikling

Helsefaglig

vit

Viten om  
kvalitets-  
utvikling



# Antal medarbeidere per nivå

	Alle ansatte	Praktikere (klinikkere)	Forandrings- agenter mellem- og prosjektledere	Avdelings- ledere, direksjon	Ekspertter
Cincinnati Childrens'	12.600	/	440	70	(Faculty 640)
Tayside	14.000	1200	400	70	40
Hillerød	4000	300	100	40	10



Hvordan  
forestiller  
du deg  
arbeidet?

Kan dine  
folk  
dette?

Bruker  
dere de  
riktige data  
riktigt?

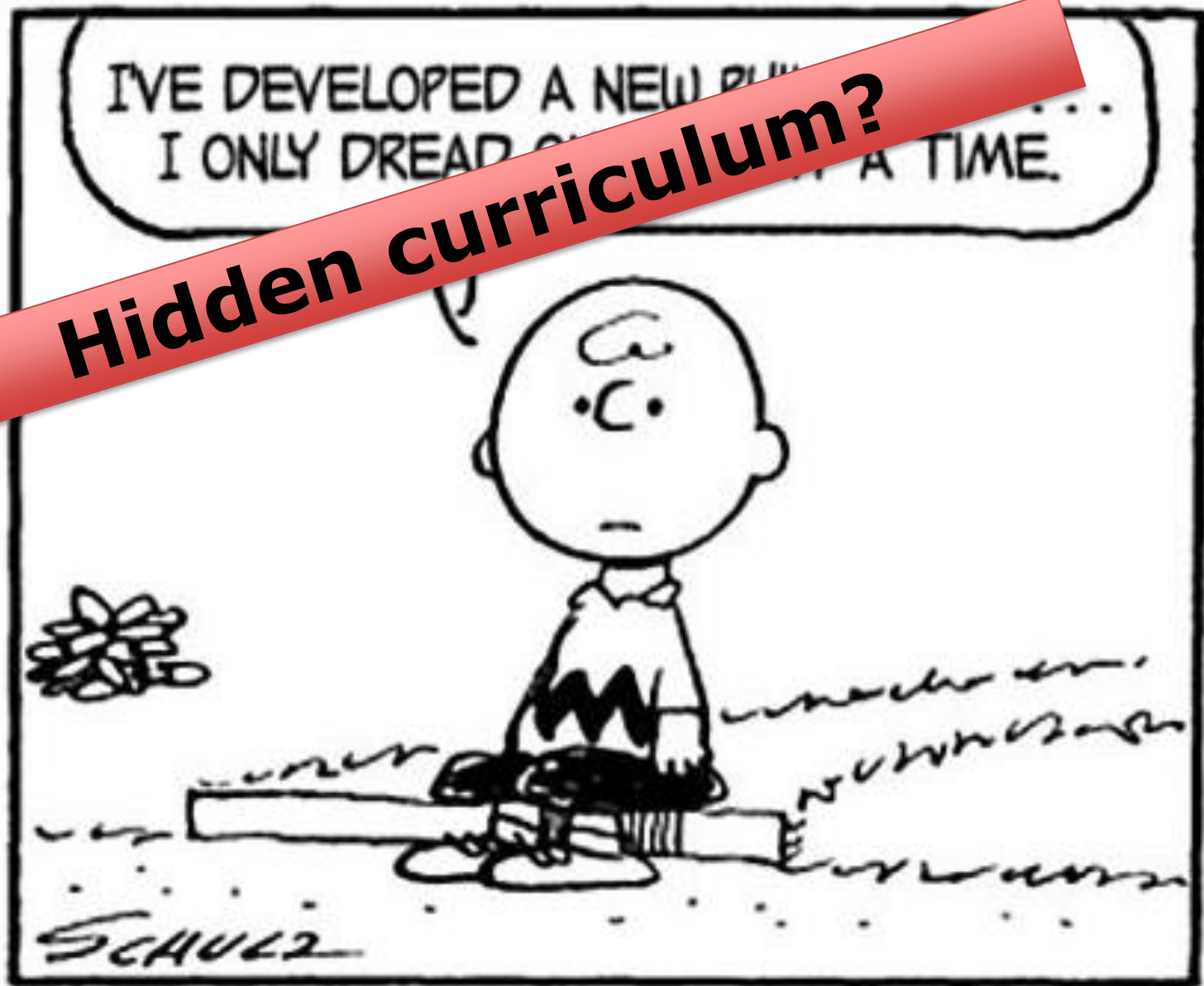
Tørr de  
si fra?

Bruk for  
briller?

“Fear is toxic to both safety and improvement.”

NHS: A commitment to learn—a promise to act

**Hidden curriculum?**







Hvordan  
forestiller  
du deg  
arbeidet?

Kan dine  
folk  
dette?

Prosjekt-  
titis eller  
plan?

Tørr de  
si fra?

Bruker  
dere de  
riktige data  
riktigt?

Bruk for  
briller?



An impressive *firework* of ongoing quality improvement initiatives in the Danish healthcare system



Too much of a good thing...?

Gerdes, U. Centre for Quality

**Projects**



**Campaigns**



**Microsystem - based change**



**Mesosystem & Macrosystem-based change**



**Whole system transformation**

Nelson EC, Institute for Healthcare Improvement, Dartmouth Medical School & Dartmouth-Hitchcock Medical Center, presented at ISQua, London October 23, 2006



Hvordan forestiller du deg arbeidet?

Bruk for briller?

Kan dine folk dette?

Bruker dere de riktige data riktig?

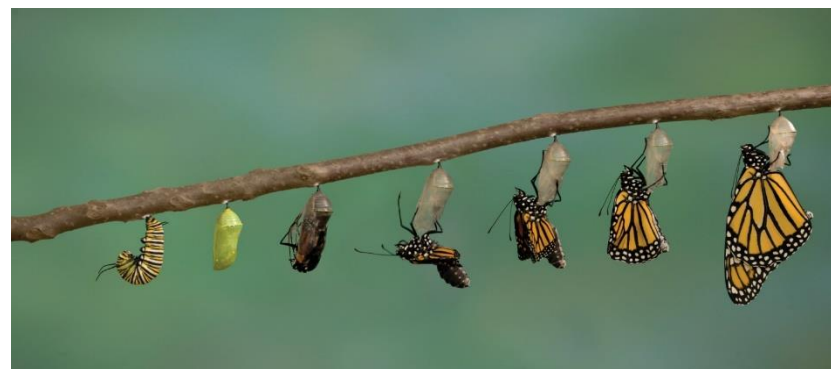
Prosjekt-titis eller plan?

Tørr de si fra?

Hvordan leder du?



# MOTIVASJON



**“While there are many definitions of leadership, one of the most useful is to think of leadership as an ongoing conversation among people who care deeply about something of great importance.”**

**(Kouzes and Posner 1988).**

Hvordan passer dette til mine  
erfaringer?

Er det noe jeg vil gjøre  
annerledes?





WAI—WAD

Observer og  
følg op!

Skap kompe-  
tanser!

Bruk data som  
vindu til  
virkeligheten

Skap  
sammenheng!

Skap  
trygghet!

Kombiner  
transfor-  
matorisk og  
transaksjonel  
ledelse

# Litteraturliste

- Batalden, P: Leading the improvement of health care, a one page book, [her](#)
- Botwinick L et al (2006). Leadership Guide to Patient Safety. IHI Innovation Series white paper. Cambridge, Massachusetts: Institute for Healthcare Improvement. (Available on [www.IHI.org](http://www.IHI.org))
- Deming WE: 14 points for management, <https://deming.org/explore/fourteen-points>
- Detert GR, Buris E (2016): Can your employees really speak freely? Harvard Business Review, Jan-Feb
- Ferlie EB, Shortell SM (2001): Improving the quality of health care in the United Kingdom and the United States. Milbank Quarterly, 79,2
- Hardace et al (2011): What's leadership got to do with it? Exploring links between quality improvement and leadership in the NHS. The Health Foundation.
- Helsefirektoratet 2005: Og bedre skal det bli – Nasjonal strategi for kvalitetsforbedring i sosial- og helsetjenesten 2005–2015
- Hollnagel E. et al (2015): From Safety-I to Safety-II: A White Paper. The Resilient Health Care Net: Published simultaneously by the University of Southern Denmark, University of Florida, USA, and Macquarie University, Australia.
- Institute of Medicine (IOM). Crossing the Quality Chasm: A New Health System for the 21st Century. Washington, D.C: National Academy Press; 2001.
- Kozes IM, Posner BZ (1988): The leadership challenge: How to get extraordinary things done in organizations. San Francisco: Jossey-Bass
- Joshua M. Liao JM et al (2014) Speaking Up About The Dangers Of The Hidden Curriculum. *Health Affairs*, 33, 1: 168-171
- National Advisory Group on the Safety of Patients in England (2013): A promise to learn—a commitment to act
- Pronovost Peter J, Berenholtz Sean M, Needham Dale M. Translating evidence into practice: a model for large scale knowledge translation BMJ 2008; 337 :a1714
- Reinertsen JL et al (2008): Seven Leadership Leverage Points for Organization-Level. Improvement in Health Care (Second Edition). Cambridge, Massachusetts: Institute for Healthcare Improvement. (Available on [www.ihl.org](http://www.ihl.org))
- Stafford W: A ritual to read to each other
- Swensen S et al (2013): High-Impact Leadership: Improve Care, Improve the Health of Populations, and Reduce Costs. IHI White Paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2013. (Available at [ihl.org](http://ihl.org))
- Thude B et al (2018): Staff acting resiliently at two hospitals. Paper three of PhD thesis Leadership at Danish Hospitals. Submitted to Leadership in Health Services
- Wears B (2015): Improvement and evaluation. QSHC, 24: 92-94
- Weiner BJ et al (1997): Promoting clinical involvement in hospital quality improvement efforts: The effects of top management, board and physician leadership. Health Services Research, 32, 4
- Wiig S et al (2014) Talking about quality: Exploring how quality is conceptualized across hospitals and health care systems. BMC Health Services Research

## Christian von Plessen, MD ph.d.

Director/research lead  
Centre for Quality



Associate Professor  
Institute for Regional Health Research



T: +45 2482 2165

[christian.von.plessen@rsyd.dk](mailto:christian.von.plessen@rsyd.dk)

P.V. Tuxensvej 5, 5500 Middelfart,  
Denmark

- **Internist & Respiratory Care Physician**
- **Leader of Safety Campaign**
- **Research in Quality and Patient Safety**

No conflicts of interest