LEADERSHIP TODAY

A Matter of Life and Death

Applying organisational psychology in time-critical, high-risk leadership environments

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LEADERSHIP TODAY

OUR GOALS FOR THIS “HOW TO” SESSION

01

Analyse

frontline healthcare leadership challenges

02

Apply

organisational psychology to real scenarios

03

Evaluate

leadership development within a health context

04

Design

a leadership intervention for a frontline challenge

LEADERSHIP TODAY

THE SAME PRESSURES EXIST BEYOND HEALTHCARE

Healthcare is our example, but these approaches apply in any high-pace, high-risk setting



OUR EXAMPLE

FRONTLINE HEALTHCARE

Shift-based teams making life-and-death decisions amid constant change and stretched resources



EMERGENCY SERVICES

Police, fire and ambulance crews making rapid calls



AVIATION

Flight and ground crews where small errors carry high stakes



MINING AND RESOURCES

Remote, shift-based teams managing constant safety risk



CONSTRUCTION

Site leaders balancing deadlines, contractors and safety



DEFENCE

Teams leading through uncertainty, fatigue and high consequence



ENERGY AND UTILITIES

Crews keeping critical services running around the clock

‘God bless this joint’: Inside our emergency departments

LEADERSHIP TODAY

Melissa Cunningham

It has just gone 4pm when the hostile man shows his true colours inside a busy Melbourne hospital.

He is erratic, groaning and dishevelled with a wild, dark beard. There is dried vomit over his ankles and feet and blood dripping from his right hand.

Police have escorted the man into St Vincent’s Hospital’s emergency department (ED) after he violently attacked a stranger, a woman walking down a nearby street in Fitzroy.

A doctor and team of nurses calmly assess the man, who is dressed in scrubs, grey tracksuit pants and a long-sleeved fluoro shirt, and in the grips of psychosis.

They calm him before giving him a mix of antianxiety and antipsychotic medications. To their relief, he swallows the medication without much resistance.

Minutes later, he is attacked once deep and quietly snoring, surrounded by a sea of patients in various states of consciousness.

It is just another night inside the busy ED in the hospital on the edge of Melbourne’s CBD, where staff are caring for a record number of acutely unwell and injured Victorians every day.

Another young man is wheeled in on a stretcher by two paramedics. He last tested positive for opiates – ice – and the party drug GHB. He was found shirtless on the side of the road. The combination of drugs has triggered a life-threatening spike in blood toxicity known as metabolic acidosis. He is coming back to consciousness, thrashing about and screaming incoherently.

“Just try and relax, mate.” Dr Ben Gleeson reassures him. “It’s OK. You’re all right, mate. You’re in the emergency department.”

In the stretcher next to him, a woman in her 90s, with grey, clammy skin and lips that are tinged blue is sitting upright as she struggles to breathe. She is being given oxygen and showing all the grim hallmarks of heart failure.

The director of emergency services at St Vincent’s Hospital, Dr Jonty Karro, says some elderly who arrive have several co-existing chronic conditions, making diagnosis and treatment more complex and time-consuming.

“They’ve got diabetes, high blood pressure, heart failure, they may have cancer or kidney failure. They come in with shortness of breath or abdominal pain we have to work out what is going on, what’s causing the symptoms and then what is the best treatment.”

Between January and October this year, the hospital’s ED treated 33,171 patients, 1,000 more than in the same period in 2016. Earlier this month, the Australasian College of Emergency Medicine warned that the rise in elderly patients meant patients were being left in hospital corridors to deteriorate as they waited for a bed.

The college’s Victorian chairman, Associate Professor Mark Pelland, warned the system is at tipping point and more urgent action is taken now, the worst is yet to come.

Data from the Victorian Agency for Health Information shows more than half of patients are waiting more than four hours to be treated.

Ambulance ramping is a problem. The acting secretary of the Victorian Ambulance Union, Olga Bermack, says: “Paramedics are being told they’re not going to be able to get their patient off the stretcher for anywhere between two and eight hours.”

Today the state government will unveil an additional $1.5 billion plan to slash emergency department wait times by up to 30 per cent.

The government says if it is re-elected it will expand 12 hospital emergency departments by 22 per cent, including the state’s major trauma centre, The Alfred hospital.

It plans to hire 1,000 health workers, including 750 nurses, and deliver 250 more beds over the next four years.

But Karro believes much of the pressure on the system cannot not only from a lack of staffing and ED beds, but also from delays in being able to discharge people.

“The problem is a bottleneck at the other end,” he says. “It’s getting people out of hospital beds and into residential aged care or getting them NDIS supports. You can’t get people out of the hospital until they have somewhere to go.”

To deal with this, St Vincent’s and the Austin hospitals both have dedicated teams of geriatricians working alongside emergency department clinicians to assess older patients and safely divert them to their homes, aged care facilities or rehabilitation services.

Health, including overcrowded emergency departments, has emerged as a political flashpoint in the upcoming state election.

In September, there was public outrage after *The Age* revealed 20 new emergency beds at the Royal Children’s Hospital would be left empty even after a long-awaited $60m–$80m redevelopment is completed in November because it lacks the staff to use them.

Weeks later, in an attempt to kill the controversy before the November election, the government committed an extra $66 million to staff the 20 beds.

Australian Medical Association Victoria president Simon Judkin says a recent snapshot of patients languishing in the state’s emergency departments for more than 24 hours and more put into chairs overnight were in corridors.

“Politicians need to start being honest about the state of the healthcare system,” he says.

The most recent data available showed that between April and June this year almost 2700 people were in an ED for longer than 24 hours, up from 1558 in the previous quarter.

Judkin says healthcare workers are arriving for night shifts with 80 patients already in waiting rooms and most ED cubicles full.

In one recent case, Judkin says, a patient stayed five days in a Melbourne ED waiting for disability and mental support.

“There’s no time for breaks any more,” the emergency physician says. “You constantly hear the stories of staff just working through a whole shift without a break.”

Back at St Vincent’s, there is a purpose-built, sealed-off mental health, alcohol and other drugs hub, with six short-stay beds, where people in the throes of an acute mental health crisis often withdraw from drugs or alcohol.

“The most important thing is we try to provide the least restrictive care we can,” Karro says.

Many have myriad complex circumstances, including addiction and homelessness.

On this night all the beds are full in the hub, while six ambulances are ramped outside.

In one of the rooms, a man wearing black glasses is repeatedly packing and unpacking his clothes and obsessively making his bed. He has been brought in by his family and is withdrawing from alcohol.

“He is very unwell and suffering from delirium,” Karro says. “This is the safest place for him right now.”

People often arrive like this man in a heightened state: agitated, anxious, intoxicated.

In the main area of the mental health hub, there is an artificial sky light in the form of a bright blue skies and white clouds to create a calm environment.

Karro says the first steps in helping people safe and ensuring them all take notice. “There are people coming to us now in absolute crisis.”

Karro’s colleague, emergency physician Dr Joanne Emery, is at the short-stay unit, where all the beds are full. She says staff see between 150 and 200 patients each shift, compared with about 100 a day in past years. “It is quite a big difference,” she says.

Among Emery’s patients is Corriane Kenyon, who arrived at the hospital with a crippling abdominal pain 10 hours ago.

“The staff here have been wonderful,” Kenyon says as a calm hum, an announcement for a medical emergency, rings out in the background. “They have put me at ease while I wait to get my scans.”

About 11 kilometres away in the Austin Hospital’s emergency department, the waiting room is overflowing and the workload unrelenting. It has just gone 11pm.

Two women in light-coloured hands as they wait in plastic chairs. A man next to them is shivering, wrapped in a white hospital blanket.

A woman dressed in pale blue pyjamas collapses. Her daughter-in-law sits in a nurse, who runs over with a device. They put the woman in the recovery position while she vomits on the floor, before they wheel her away on a stretcher.

Only days before, The Age visited earlier this month, staff were inundated by the highest number of patients reported in a single day since the catastrophic thunderstorm asthma event that left 10 Victorians dead a decade ago.

More than 900 sick and injured people presented to the ED. Some opted to go across the road to Waverley Private Hospital, paying hundreds of dollars to be seen sooner. Staff there treated almost double the number of patients they typically see.

Victoria’s opposition health spokeswoman, Georgie Crozier, says the health system is not breaking point. “More than 68,000 Victorians are waiting for vital surgery, graduate nurses can’t get a job, and it takes longer to get an ambulance than it did a decade ago,” she says.

If elected, the Coalition has pledged to fund more beds, upgrade hospitals including the Mildura Base Public Hospital, and put 50 more Protective Services Officers in EDs. The Coalition has also made a $1.25 billion pledge to halve Victoria’s public elective surgery waitlist by diverting patients to private hospitals.

Austin Health’s director of emergency, Dr Jocelyn Howell, says the sudden surge in patients, about 20 per cent more than staff would see on a typical day, could not be attributed to any single trend. Instead, it reflected a broader pattern of more seriously ill and complex patients going to EDs.

The hospital has become known to the state’s geriatric trauma centre. Nils and his partner were increasingly concerned, along with dangerous bleeds on the brain, a risk amplified by blood thinners.

Howell says that while clinical ED services such as urgent care clinics are easing the load, patients are sicker than she has ever treated before.

“Our patients are so much more complex, they have a much higher acuity and they are taking us much longer to deal with,” she says.

There has also been a worrying spike in young people in severe mental distress. “We are seeing really high numbers of all sorts of adolescent and young adult mental health patients,” Howell says, adding that rates of eating disorders, depression, anxiety, self-harm and suicidality are all soaring.

Inside the nearby fast-track area, emergency physician Dr Andrew Howell and a team of nurse practitioners and physiotherapists are tending to a never-ending stream of patients being assessed, treated, sent off for scans, and either discharged or admitted.









Clockwise from main and above: Another busy night shift in the emergency department of St Vincent’s Hospital, a patient brought in by police steps in the ED after being given anti-psychotic medication. Austin Hospital emergency physician Dr Andrew Howell checks on Nicole Miller, whose nose had been bleeding a second officially. Photos: Simon Schluter



‘You are able to help people on their worst day.’

Nurse Julia Schwarz



‘You can’t get people out … until they have somewhere to go.’

Dr Jonty Karro, St Vincent’s emergency department director

Howell lists some of the patients of the day: a girl, 11, with a dislocated shoulder; a young man with a fractured ankle that needed to be plastered; a woman unable to walk due to an injured disc; depression; etc.

The Austin Hospital’s executive nurse unit manager Ellen Bradbury cannot remember a time in her 30-year career where the emergency department has been so stretched.

“Most days, we don’t even have time to get to the toilet or take breaks.”

Bradbury says many patients cannot afford the cost of seeing their GP, which has blown out, wait times and leads to longer ED stays. The Austin now has a dedicated ambulance officer area to mind the amount of time paramedics are spending there.

Bradbury still finds her job rewarding. “It’s a very, very hard job to see, and that’s also why the ED nursing staffing cohort has such a high turnover,” she reflects says.

Despite the relentless pressure, the violence, the never-ending flow of stretchers and patients, it is quiet, sense of purpose that keeps emergency staff coming back shift after shift.

“You really see everyone, every facet of life,” St Vincent’s nurse Julia Schwarz says.

“That’s what I like about this job. It takes you out of your bubble. You are able to help people on their worst day.”

One of Howell’s patients is Nicole Miller, whose nose was bleeding uncontrollably for hours before she was brought in by ambulance.

She is sitting up in the bed in the short-stay unit as Howell leans over her, explaining what the next steps are.

“Looks like it’s finally stopped,” he says with wide smile. “I notice finally able to eat and drink again. Let’s get you some cordial.”

“Thank God for these guys,” Miller says her voice cracking with emotion and eyes filling with tears.

“I really freaked out this morning. I had a heart attack four years ago. These guys looked after me then, too. God bless this joint.”



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What are the biggest leadership challenges facing frontline healthcare leaders?



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FIVE COMMON FRONTLINE LEADERSHIP CHALLENGES

Austin Health Frontline Leadership Program



STEP UP AND LET GO

Making the transition from team member to team leader in behaviour and mindset



BE CLEAR TO BE KIND

Undertaking important conversations around performance and expectations



BUILD HIGH PERFORMING TEAMS

Building individual and team capability, performance and engagement in busy environments



NAVIGATE CHANGE

Navigating change and encouraging continuous improvement at a frontline level



LEAD ACROSS THE ORGANISATION

Influencing and leading across a complex organisation



THE PERSONAL EXPERIENCE OF LEADERSHIP: confidence, emotional demands, isolation, workload and sustaining energy

LEADERSHIP TODAY

You have five workshop days available spread over five months.

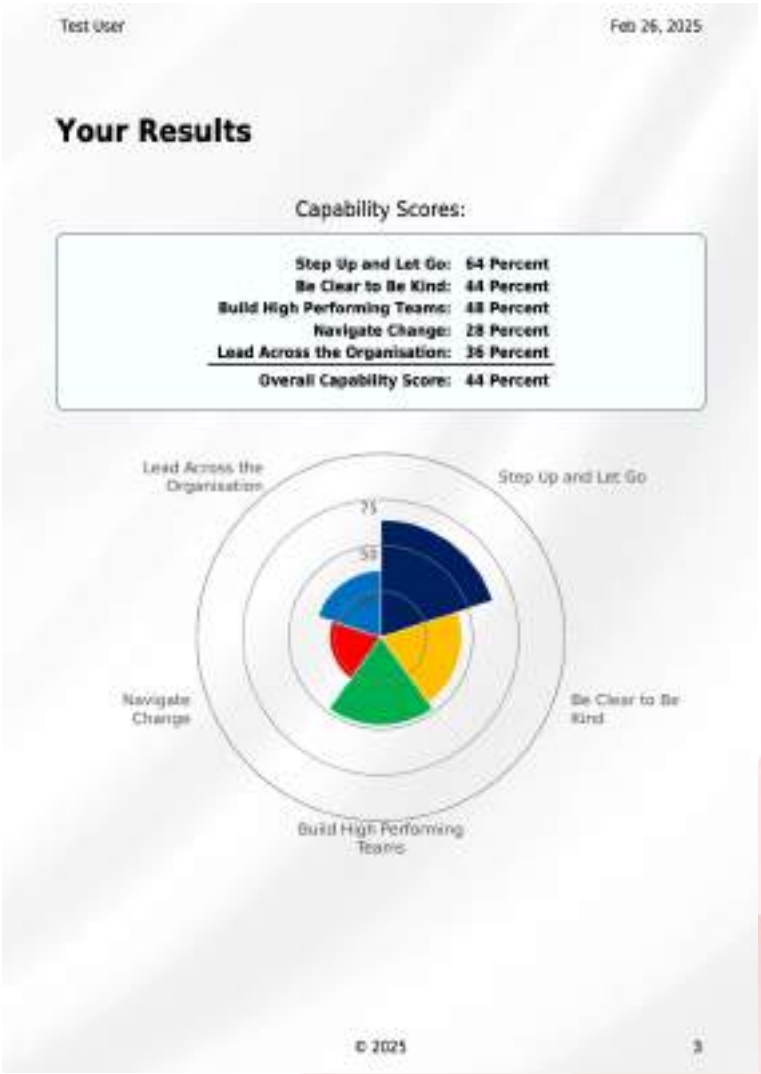
What is one development area you would address and how?

Elect a spokesperson



PRE-PROGRAM SELF-ASSESSMENT







LEADERSHIP TODAY

FOUR ELEMENTS OF EFFECTIVE LEADERSHIP DEVELOPMENT

Our Approach to Design



CHALLENGE

Real frontline problems that stretch leaders beyond their comfort zone



FRAMEWORKS

Practical models that give leaders a shared language for leading people

LEADERSHIP DEVELOPMENT



ACTIVITIES

Hands-on exercises, scenarios and peer discussion that build skills



APPLICATION

Putting new skills to work in the team, with reflection and follow-up

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FRAMEWORK: WHAT MOTIVATES PEOPLE?

Deci & Ryan (2017) – Self-Determination Theory Basic Psychological needs in Motivation, Development and Wellbeing

SENSE OF MEANING AND PURPOSE



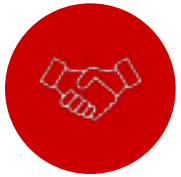
AUTONOMY

Feeling freedom & control



COMPETENCE

Feeling confident & effective



RELATEDNESS

Feeling cared for, caring for & belonging

ACTIVITIES

Leadership Practices Card Sort and Water Works Emergency Water Filter











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APPLICATION

Austin Health Emerging and Frontline Leadership Programs

INDIVIDUAL APPLICATION SPRINT

1. Select a challenge from your own work
2. Choose a program framework to tackle it
3. Apply it on the job throughout the program
4. Reflect and share lessons with peers
5. Refine your approach, keep what works

GROUP INNOVATION SPRINT

1. Select three real workplace challenges
2. In groups explore one problem and who it affects
3. Generate potential solutions, pick one to focus on
4. Present findings and next steps to senior leaders
5. Brief provided to CEO & Senior Executive

SCALE THE IMPACT

LEADERSHIP MASTERCLASSES







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YOU'VE JUST APPLIED DESIGN THINKING...

Hasso Plattner Institute of Design at Stanford

> *Design thinking is a mindset and approach to problem-solving and innovation anchored around human-centered design.*
>
> Esther Han, Harvard Business Review, 2022

01 ► 02 ► 03 ► 04 ► 05

EMPATHISE

Research your users' needs

DEFINE

State your users' needs and problems

IDEATE

Challenge assumptions and create ideas

PROTOTYPE

Start to create solutions

TEST

Try your solutions out

LEADERSHIP TODAY

REASONS WHY CLIENTS LOVE ORGANISATIONAL PSYCHOLOGY



EVIDENCE-BASED

Grounded in decades of research on how leaders learn and change



PRACTICAL

Tools leaders can use on the job the next day, not just theory



TAILORED

Built around each organisation's culture, challenges and goals



HOLISTIC

Develops the whole leader, from skills to wellbeing and resilience



MEASURABLE IMPACT

Validated tools track behaviour change and results



SYSTEMIC

Links individual growth to team performance and organisational outcomes



LASTING CHANGE

Reflection, practice and coaching make new habits stick

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What's one key learning or action you will take as a result of today?



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