A large part of what exemplary leaders do is to manage the unforeseen, the potential surprises, and the unexpected in organizations. We can see great strategic plans, but if we can’t see the weak signals in the environment that are trying to tell us we need to change course, we will fail. Surprises and unanticipated events are part of our everyday lives in health care. However, early warning signals can often foretell an untoward incident. One of the competencies of a great leader is the ability to spot those weak signals, pay attention to them, and act upon them. The corporate soul of an organization reflects its shared values.

The ability of a culture to spot and act upon weak signals is one of the hallmarks of a culture of safety. Leadership is a continuous learning process not only for oneself, but also for one’s organization. In the case of patient safety, the stakes are high. We have the opportunity of stopping the preventable deaths and injuries if we lead differently. If we ignore the research, we must be accountable for the many mishaps and bad outcomes that will happen because of our inability to lead effectively. Patient safety must be a shared value of a successful organization. Creating these cultures, and making sure that a part of that culture is the ability to read and act upon weak signals, is vital for the leader and the organization.

**Patient Safety and High-Reliability Organizations**

The corporate soul of an organization reflects the shared values of that organization. The most important thing a leader can do is to develop a culture that creates a shared value of creating a safe environment where mistakes can be examined and learning can take place. Through this process, an organization can create an environment that creates a high-reliability organization. In health care, our challenge is to create that high level of reliability so that patients can trust us as a reliable organization and where they will never undergo wrong surgery, medication, or fall out of bed. High-reliability organizations are built only with a lot of very hard, intense work.

When investigating the Columbia shuttle disaster, the commission referenced high-reliability theory to provide insights into the failure of what should be a high-reliability organization (Columbia Accident Investigation Board, 2003). According to Weick and Sutcliffe (2001), high-reliability organizations are characterized by:

- A preoccupation with failure.
- Reluctance to simplify interpretations.
- Sensitivity to operations.
- Commitment to resilience.
- Deference to expertise.

These authors also note that high-reliability organizations recognize ear-
lier and respond to weak signals faster than unreliable organizations. And when they respond, they do not respond with a weak intervention. Instead, they respond strongly and aggressively.

This concept is similar to the failure to rescue concept in nursing. The novice nurse does not recognize the weak signals of a patient’s deteriorating condition, and once recognized, does not initiate a strong enough intervention to rescue the patient. The expert nurse, by contrast, recognizes weak signals and responds immediately, rescuing the patient. Culturally, an organization with a well-developed safety system recognizes weak signals and takes action. A high-reliability organization is preoccupied with the chance of failure, and is sensitive to the front-line people who have the opportunity to see disaster before it hits other parts of the organization. All of us can tell stories about something that happened with a patient that in retrospect indicated we overlooked or simplified the situation, and the patient suffered. A nurse who walks by a room and senses that there is something wrong with the way the patient looks, but simplifies the situation to “he just looks tired” when the patient in actuality is deteriorating rapidly, is an example.

Recognizing Weak Signals

Teaching an organization to recognize and act upon weak signals is a challenge for a leader. Organizations work very hard at silencing people. In the analysis of the shuttle disaster, the commission recommended that “Strategies must increase the clarity, strength and presence of signals that challenge assumptions about risk” (Columbia Accident Investigation Board, 2003, p. 203). They also stated, “It is obvious but worth acknowledging that people who are marginal and powerless in organizations may have useful information or opinions that they don’t express” (p. 203). Weick and Sutcliffe (2001) described the concept of “normalization of abnormalities” that describes the tendency we all have of noting a discontinuity in our observations, but explaining it away as normal rather than focusing on the fact that this might mean trouble. We have to balance between false-positive errors and false alarms and celebrate the person who calls an alarm even if it proves to be untrue.

In the Columbia shuttle disaster, there were many examples of the corporate nod that precluded an in-depth examination of the weak signals that were present. Scott (2002) describes the corporate nod as “when the echo or learning from the past event is not heard in the present.” Weick and Sutcliffe (2001) offer interventions such as creating an awareness of vulnerability, encouraging alternate frames of reference, seeking out bad news, developing humility, and creating an error-free learning culture as ways to help the organization detect and act on weak signals earlier. The Columbia Accident Investigation Board (2003) also recommended that reports should not only represent the consensus of the majority, but from dissenters as well.

Willingness to Have the Fierce Conversations

It is one thing for nurse leaders to believe in these principles, but how can we initiate substantive change? Scott (2002) reminds us that the world is changed one conversation at a time and that we must be willing to have fierce conversations which she describes as ones in which “…we come out from behind ourselves into the conversation and make it real” (p. 7). In unreal conversations, Scott (2002) states we should be scared to death. Scott (2002) notes that in organizations we often give the “corporate nod” to issues instead of listening and investigating, which is an example of an unreal conversation. She likens this to the look of a cat in the litter box “…sort of far away as if to indicate that he is not really here and neither are you” (p. 17).

In the Columbia shuttle disaster, there were many examples of the corporate nod that precluded an in-depth examination of the weak signals that were present. Scott (2002) explains that our instincts are like an intelligence agent who is sending you information constantly. She cautions us to obey our instincts and recognize and collect those weak signals. If a problem is named, it can be solved, but it eludes us until that weak signal can be recognized and discussed.

In fierce conversation, reality is interrogated, and everybody’s reality is out on the table so it can be interrogated. Recognizing and dealing with weak signals will be ruined by mechanisms such as the corporate nod and fear of reprisal. We should participate as if it matters, because it does. There is no greater need for intense participation than attending to weak signals in our environment.

Summary

Halveron and Isham (2003) quote sources that report the accidental death rate of simply being in a hospital is “…four hundred times more likely than your risk of death from traveling by train, forty times higher than driving a car, and twenty times higher than flying in a commercial aircraft” (p. 13). High-reliability organizations such as nuclear power plants and aircraft carriers have been pioneers in the business of recognizing weak signals. Weike and Sutcliffe (2001) note that high-reliability organizations distinguish themselves from others because of their mindfulness which enables them to see the significance of weak signals and to give strong interventions to weak signals. To act mindfully, these organizations have an underlying mental model of continuously updating, anticipating, and focusing the possibility of failure using the intelligence that weak signals provides. Much of what happens is unexpected in health care. However, with a culture that is continuously looking for weak signals, and intervenes and rescues when these signals are detected, the unexpected happens less often. This is the epiphany of how leaders can build a culture of safety that focuses on recognizing the weak signals to manage the unforeseen.$

REFERENCES


