Back-to-Front and Upside-Down

Is top-down command and control working for anyone?

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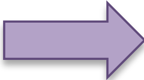
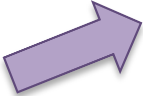
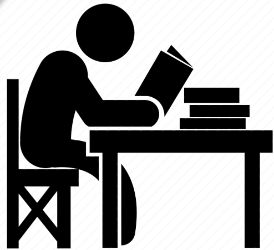
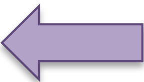
My journey to where I am from where I started









Take-home messages from my journey

1. My perspective is grounded in the scientific method.

The Scientific Method

An empirical method of acquiring knowledge that involves development of an hypothesis, testing the hypothesis through various means (i.e. data collection) and then modifying the hypothesis on the basis of the outcomes of the tests (i.e. data analysis and interpretation).

Take-home messages from my journey

1. My perspective is grounded in the scientific method.
2. I am an “outsider” in the safety/quality/risk domain.
3. I understand process pathways.

Quality
improvement

Safety and risk
management

How I got into…

Clinical Learning Environment

A learning environment in a clinical context, that enables and supports work-based experiential placements for health professional and other learners.

Best Practice Clinical Learning Environment Framework

Six key elements of a high quality clinical learning environment

Best Practice Clinical Learning Environment

1 An organisational culture that values learning

- Education is valued
- Educators are valued
- Learners are valued
- A career structure for educators
- Education is included in all aspects of planning
- Use of facilities and resources are optimised for all educational purposes

2 Best practice clinical practice

- Organisational commitment to quality of care and continuous quality improvement
- Clinical staff are highly skilled, knowledgeable and competent
- Organisation adopts best evidence into practice

3 A positive learning environment

- The environment is welcoming and safe
- Appropriate learning opportunities take place
- Clarity about educational objectives
- Clinical education staff are high quality
- Learners are well prepared
- Appropriate ratios of learners to educators and patients
- Structured learning programs and assessment

4 An effective health service-education provider relationship

- Open communication occurs at all levels of the partner organisations
- Mutual respect and understanding exists between the partners
- The partners assist each other to optimise their contribution to the training of health professionals
- Relationship agreements codify expectations and responsibilities of the partners

5 Effective communication processes

- Communication is not taken for granted
- Communication informs actions, behaviours and decision-making
- Communication facilitates feedback
- Communication facilitates improved teaching and learning

6 Appropriate resources and facilities

- Learners and staff have access to the facilities and materials needed to optimise the clinical learning experience

Map-Enabled Experiential Review

= MEER

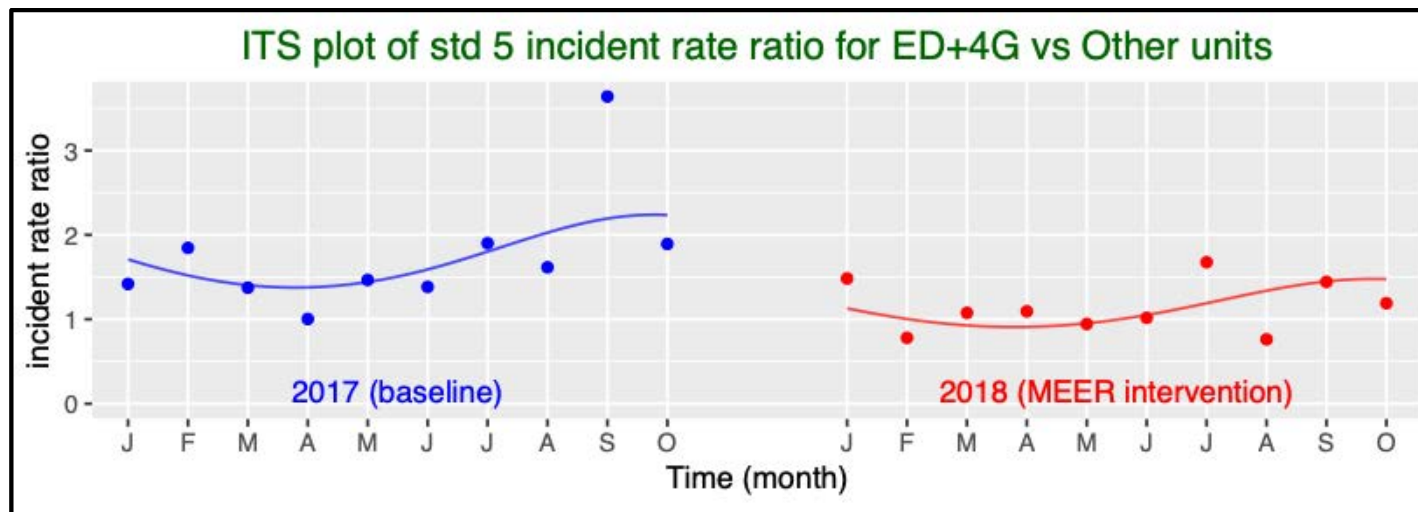
MEERQAT

Quality Assessment Tools

The first use of MEER

MEER improves indicators of patient harm
Adverse incident data from the hospital trial

A **34% statistically significant decrease** in the incident rates of the two participating units relative to the rest of the hospital.



Relative Risk (RR) = 0.66

(0.52 – 0.84 95% confidence interval)

p = 0.00056

BMJ Open Quality

Novel team-based approach to quality improvement effectively engages staff and reduces adverse events in healthcare settings

Annie Gabrielle Curtin [1] Vitas Anderson,[2] Fran Brockhus,[3] Donna Ruth Cohen[4]

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ABSTRACT

Background Despite significant attention to safety and quality in healthcare over two decades, patient harm in hospitals remains a challenge. There is now growing emphasis on continuous quality improvement, with approaches that engage front-line staff. Our objective was to determine whether a novel approach to reviewing routine clinical practice through structured conversations—*map-enabled experiential review*—could improve engagement of front-line staff in quality improvement activities and drive improvements in indicators of patient harm.

Methods Once a week over a 10-month period, front-line staff were engaged in 35 min team-based conversations about routine practices relating to five national safety standards. Structure for the conversations was provided by interactive graphical logic maps representing each standard. Staff awareness of—and attitudes to—quality improvement, as well as their perceptions of the

To address this problem, in 2011 the Australian Commission on Safety and Quality in Health Care introduced mandatory National Safety and Quality in Health Service (NSQHS) standards against which hospitals are periodically accredited, together with indicators for benchmarking performance. The standards and indicators have generally been well received by health services.[4] However, there are now many calls for a shift away from compliance-driven regimes towards concepts of continuous quality improvement (CQI).[1 5–9] This includes: a focus on processes rather than on individuals; engaging and valuing the contribution of all staff; adopting team-based, systematic and ongoing approaches and promoting a culture in which quality is everyone's business.[5 8 10–12]

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Targeting zero

Supporting the Victorian hospital system to eliminate avoidable harm and strengthen quality of care

Report of the Review of Hospital Safety and Quality Assurance in Victoria

Healthcare and aviation: twins separated at birth

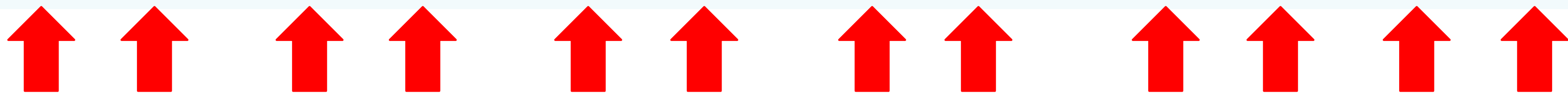
- ✓ Adverse events in both sectors have the potential to result in loss of life.
- ✓ Adverse events tend to reflect system-level issues, not individual-specific issues.
- ✓ Both sectors require structured ongoing training for professionals.
- ✓ Both systems have systems for reporting adverse events and near misses.

Back-to-Front and Upside-Down

Is top-down command and control working for anyone?

CEO/General Manager

Frontline workforce



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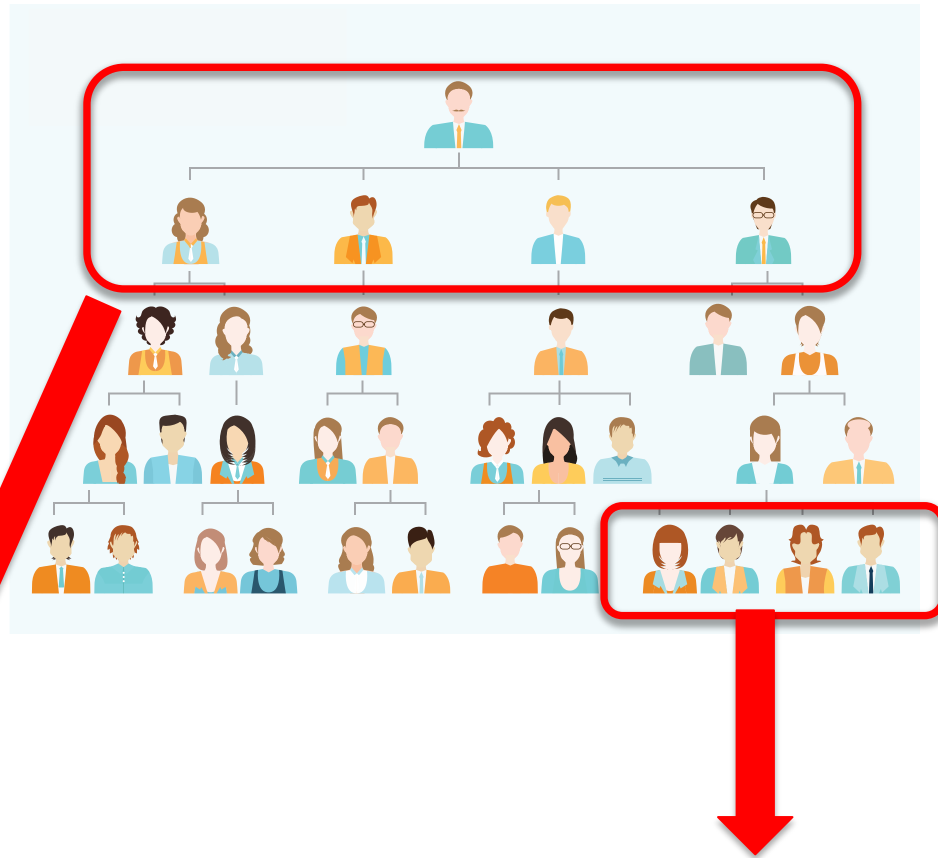
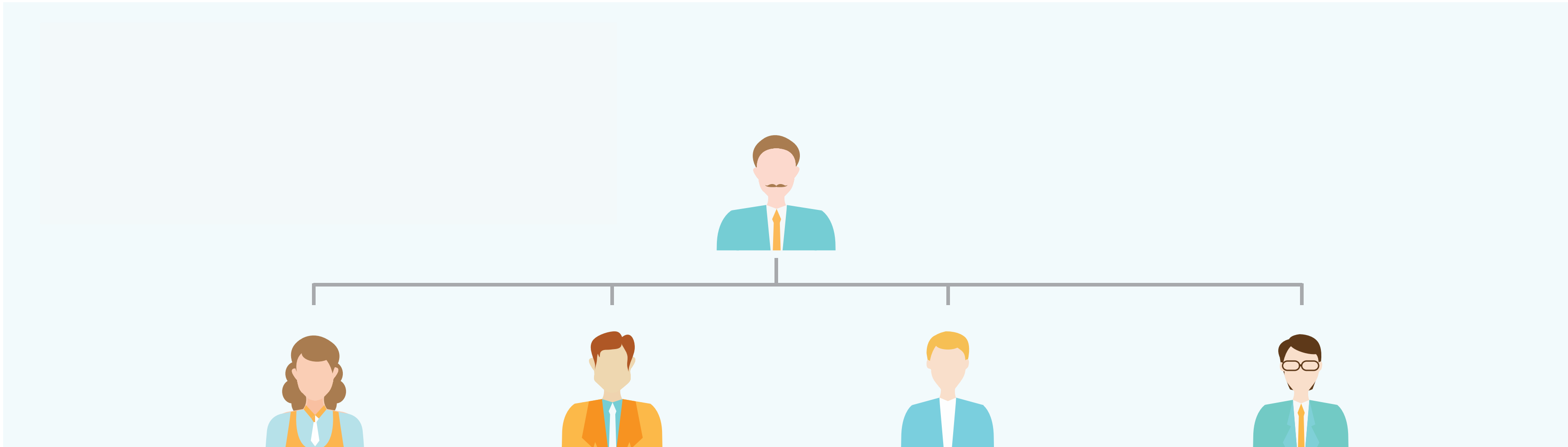
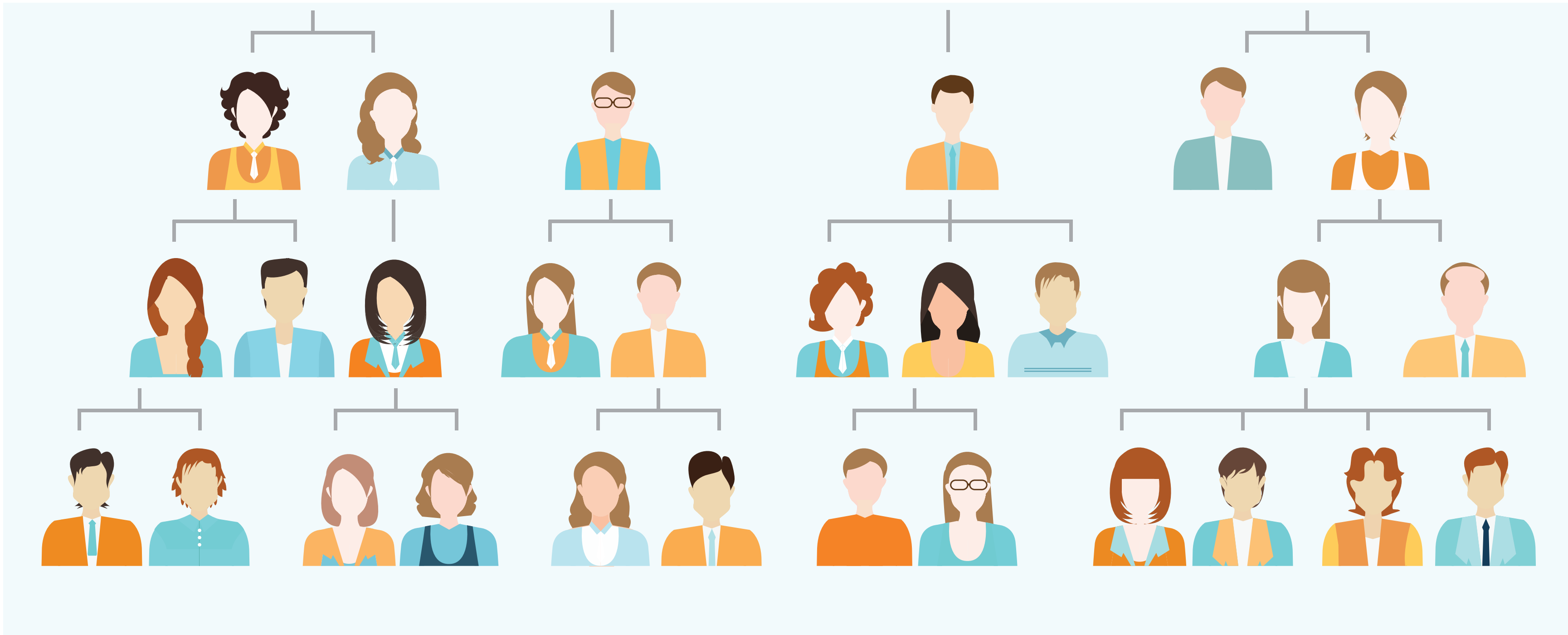
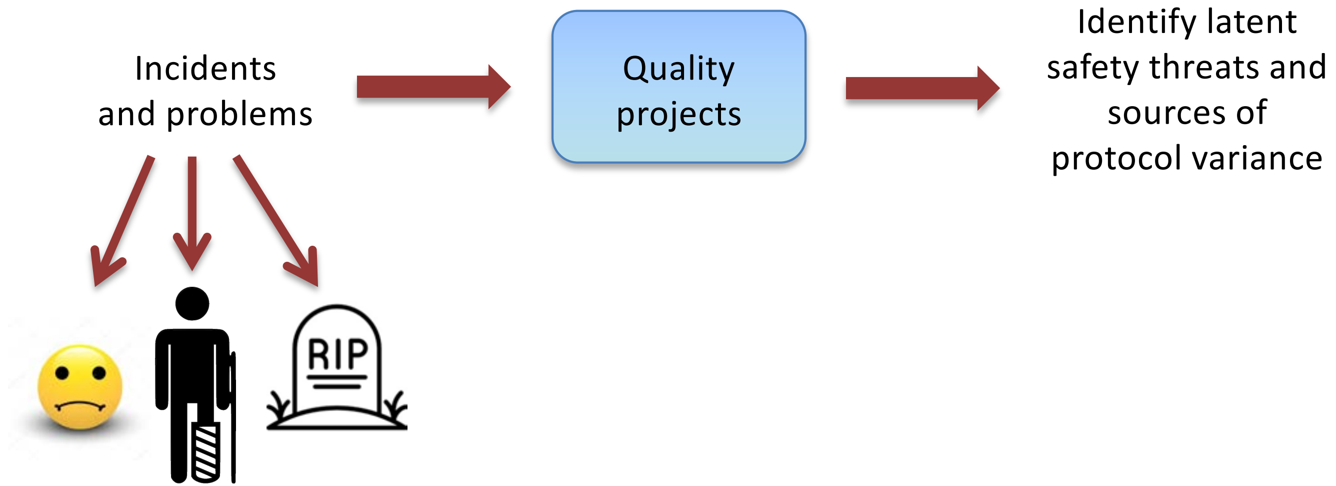
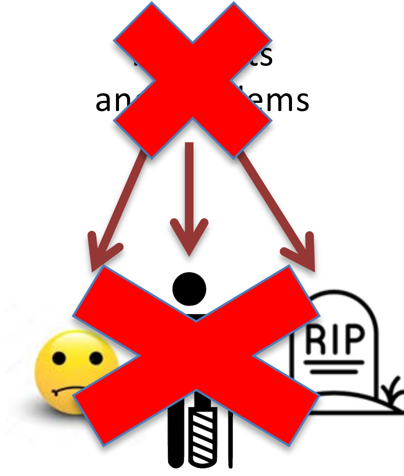







Incidents
and problems
Quality
projects
Identify latent
safety threats and
sources of
protocol variance
RIP



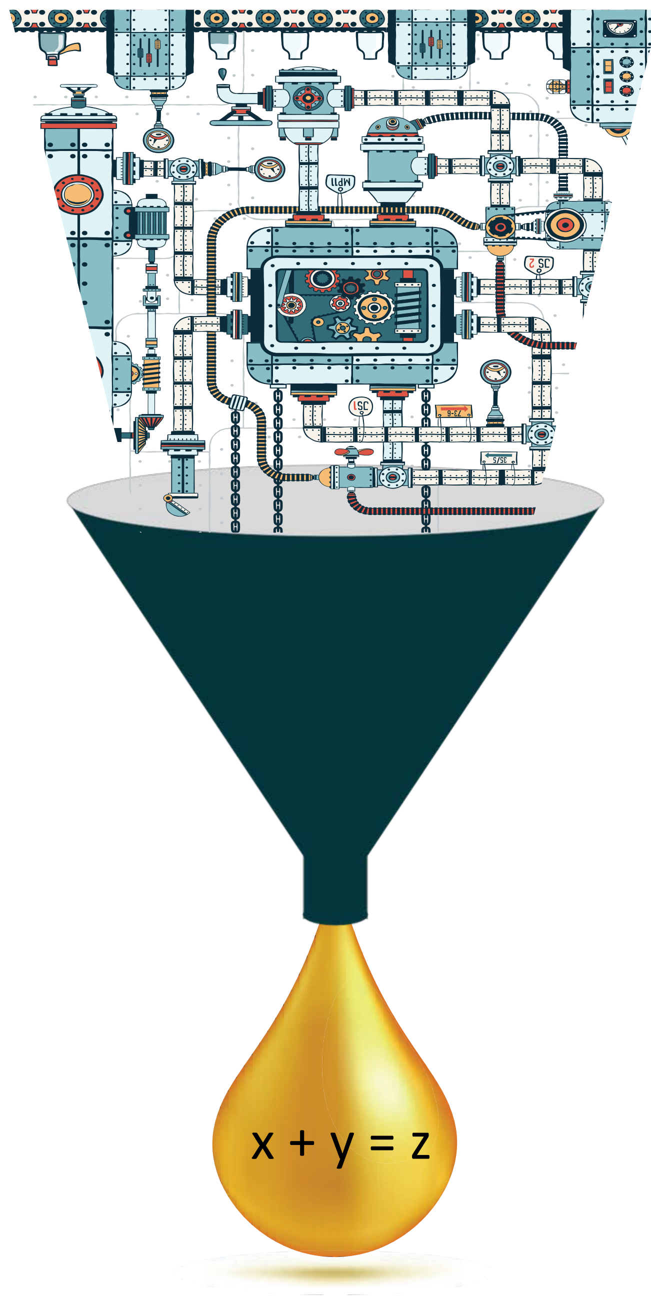
Quality projects

Identify latent safety threats and sources of protocol variance

What drives the back-to-front approach?

- ✓ A focus on compliance
- ✓ Misplaced faith in accreditation and performance indicators
  - ✓ Accreditation doesn't guarantee fidelity of implementation
  - ✓ Indicators are not always an accurate reflection of service delivery
  - ✓ Indicator benchmarks can drive perverse behaviours

How
can
we
do
this
better
?


x + y = z

"For every complex problem there is an answer that is clear, simple and wrong."

– H. L. Mencken

Not everything that is important can be measured by an indicator.

AND…

Not everything that can be measured by an indicator is important.

It’s about the frontline

Support

Facilitate

Enable

Validate

Potential hurdles

1. Managers may feel threatened by having to defer to staff below them in the organisation chart
2. Staff may be reluctant to engage

"I wondered if the nurses had a few suggestions on how to make our jobs easier, so I put up a suggestion box. Apparently, they do."

Potential hurdles

1. Managers may feel threatened by having to defer to staff below them in the organisation chart
2. Staff may be reluctant to engage
3. Workplans have no room for new activities
4. The prevailing attitude to risk management
5. The separation of “quality” from everyday work

"The definition of insanity
is doing the same thing over and over again,
but expecting different results."