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The Newsletter for Quality Leaders

October/November 2015

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The latest Australian case of poor, unsafe healthcare - what does the Djerriwarrh case tell us that we don't already know?

Free access to my online 'Lead a strategic quality governance system' overview module.

Hello!

Last month I flagged that this month I'd talk more about 'Always Events'. But the best laid plans...

The past few days have brought sombre news for Australian healthcare - another health service inquiry into poor care. It's caused me to reflect again about what's at the heart of our failure to guarantee safe, quality care for our consumers, so always events - although not unrelated - can wait until next time.

Why? How? - in 2015?

An extract from the 16/10/15 health service media release states: 'A comprehensive, independent investigation of 11 cases at DjHS between 2013 and early this year found a series of failures and deficiencies may have contributed to the deaths of up to seven babies...Djerriwarrh has, in consultation with the Victorian Department of Health and Human

Services, initiated all possible measures to reinforce the safety of its maternity and newborn services.'

A new case, with old themes that we've seen in public inquiries around the world: poor care over a prolonged period (during which babies died unnecessarily), 'everyone' knew but no-one wanted to know, and distressed staff leaving the hospital in frustration, their reports ignored. Where were clinical guidelines? Where was the risk management system? Where were the case reviews? Where was speaking up for safety? Where were the board and executive?

As someone who works with health services every day on their safety, quality and governance, my feelings are mixed, to say the least. Anger, disappointment, frustration; and sadness for the families involved. Empathy for the health service staff trying to do the right thing, caught up in a poor culture, ineffective governance and absent leadership; and who for the foreseeable future will be the face of the 'latest' healthcare safety catastrophe.

If I feel like this, I can't imagine how those involved - on both sides - are feeling. And no doubt clinicians and executives all over Australia are mentally checking in with their clinical governance systems - 'how well would we have detected and responded to this situation?' (If you think this is a good time to perform a stocktake on your current quality governance system, I'm providing a free online module for the next week to help you do just that - see below.)

How could this happen more than a decade after the advent of clinical governance? Obviously no-one in the organisation planned for babies to die. But did they - more specifically - the board and executive, take enough action for it *not* to happen?

What do I mean by this? Healthcare is a complex, high risk industry. There's a few other things in the mix that make it tough to assure safe, high quality care: endless demand, severely capped resources, multiple sub cultures, many managers with limited management training, independent contractors providing high risk services, complicated technology - and human beings, to name just a few. It's a jungle in there!

None of this is new, however. We know that healthcare and aged care are complex, and hard to get consistently right. There are many precedents and lessons to draw on - both what and what not to do - for guidance. Previous public inquiries into poor care have taught us that good people trying hard is not enough to guarantee good care within this environment. It's no secret that most of these lessons have highlighted weak leadership and governance at the core of poor performance. And, I believe, a dearth of understanding of the levers for driving safe care.

Creating and maintaining consistently safe, high quality care requires an understanding of complexity, and the mix of interconnected organisational factors required: great people supported by great systems, led from the top, based on a relentless pursuit of excellence. But - we haven't yet achieved universal acceptance that this is what it takes. The belief that point of care is fundamentally clinician's business is buried in our healthcare DNA; an unconscious attitude that drives a hands off approach to clinical governance in still too many health, community and aged care services.

So - there's a step before all the action. And that's the step that many health services miss: fostering a non-negotiable safety mindset that addresses this deeply held belief head on. I see ‘excellence’ everywhere in mission statements and strategic plans. But it doesn't take much to scratch the surface and realise that in too many cases, these words are about image, not substance. The way we'd like to be perceived, rather than the way we really are. As if saying it will somehow make it a reality. But saying it is just the beginning.

Everyone wants to be excellent, but not everyone wants to do the hard work, including attitudinal change - to get there. Some boards and executives don't want to achieve excellence enough to seek a deep understanding of what it takes to create it consistently, and to formulate the concrete and strategic plans for achieving it at point of care. They are not determined and committed enough to take a strong, clear leadership stand to make it happen. They don't address the difficult challenge of sorting out concrete roles and responsibilities for safe care between clinicians and managers. In the absence of these vital levers for change the 'hope' mindset rules: 'oh well, we've got great people ...and we measure lots of things... and we don't have many

complaints...and we're accredited...so we hope all that means that our care is excellent/the best/second to none'. This is when, as Sir Bruce Keogh puts it so well: 'some boards use data simply for reassurance, rather than the forensic, sometimes uncomfortable, pursuit of improvement.' And this is a path to failure: for consumers, communities and staff.

Beyond 'hope' to safe, great care

High performing boards and executives are propelled by many things - but 'hope' is not one of them. They know that the complexity of the environment means that quality of care and services is not linear, or set and forget. It waxes and wanes and requires vigilance and focus. To paraphrase Brendon Burchard, if you knock on the door to excellence, hard work answers! And the hard work begins with acknowledging that achieving great care is not easy - and it's also non-negotiable. This is the safety mindset for success - understanding that providing consistently safe, high quality care is a tough challenge, and it's what healthcare/ aged care/ community care is all about.

Successful organisations view this challenge as both a matter of pride and viability. For them it's core business. They draw a line in the sand between acceptable and non-acceptable care, and go after it as if lives depend on it. They embrace the fact that this challenge must be faced every day. Like a round the world voyage, great care must be defined, charted and led, meticulously and strategically, and driven from the top through line management to point of care. Everyone must know their specific and personal role in achieving it - and be supported to perform that role every day. The best people must be on the job of providing monitoring, reporting and implementation support. Frequent review and course corrections will be required in response to data, to navigate safe passage and the best route to the destination. And even then, within the risk and complexity, there are no guarantees. Things will go wrong. But the down times will not be prolonged, nor unaddressed.

If this shared mindset can be achieved across your organisation - in itself not an easy task - you're halfway there. The rest is about the 'how'. In the absence of this mindset, however, the 'how' can become the thing. Without a focused and strategic platform of purpose and

accountability, 'doing quality' can too easily become a series of tasks ticked off for accreditation and compliance, rather than the means to great care for every person, every time. Getting this focus wrong creates a performance fog that many organisations don't know they're in. Complicated, paper-based quality systems with weak links to point of care obscure, rather than clarify, what's really happening for consumers. Standards can slip, poor practice flies under the radar, slack attitudes go unnoticed and hope rules. Until it's too late.

A big part of what I do these days is helping organisations to shift this mindset. Clearly - we've still got a long way to go before this is universally achieved. So, in light of the DJHS case, I'd like to do something more about this today.

I have a seven module online course: 'Lead a strategic quality governance system', which covers the basics of leading, planning, implementing and monitoring a strategic system for pursuing safe, high quality care in acute, community and aged care services. For the next week, in the interests of reinforcing the safety governance message, I'll provide the Overview Module for free. The module touches on all the key components of a strategic quality governance system, and includes discussion points and quizzes that you/your board/your executive can do together as a group, or separately. As a minimum, you can refresh the basics, perform a health check of your current quality and safety governance and plan a more proactive way forward to greater rigour and achievement.

Do you have doubts about the clarity, focus and robustness of your quality and governance systems? Would it detect and deal with a Djerriwarrh situation early? Is what you have in place now doing the job for you and your consumers in terms of monitoring, pursuing and creating great care? Are you fulfilling your role in this? Are you leading it in such a way that staff are both motivated and equipped to play their roles?

Click on this **link** to access 'Lead a strategic quality governance system' Overview Module. Using this complimentary link you and your health service board/executive/ whoever else can access and download the Overview Module to use in your organisation as many times as you like. The link will be available until cob Monday 26 October 2015.

Let's clear the fog and spread the right mindset for consumer safety and great care, once and for all.

And - let's wish the Djerriwarrh Health Services new leadership our goodwill and support for the journey they're now undertaking to mend a broken system and restore the faith of consumers, community and staff.

Reference

Keogh B. Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report. NHS, 2013.

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(A big thankyou to those who've already purchased - welcome to the Qualityclass community of organisations going after great care and services - as if their consumer's lives depend on it.)

And - check out 'Mini Qualityclasses': free videos on key quality concepts.

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