Morale among doctors [illegible]

"I have to admit, [in] the atmosphere which pressured permanent staff [illegible]

Talking quality improvement . . . Visiting Boston University Prof Alan Cohen outside Dunedin Hospital this week. PHOTO: JANE DAWBER

Quality improvement matter of investment

By ELSPETH McLEAN

LACK of money to invest in quality improvement can be a serious barrier to achieving a high-performing hospital, executive director of the Boston University Health Policy Institute Prof Alan Cohen says.

High-performing hospitals needed to have physicians and nurses really involved with quality improvement.

If, for instance, nurses felt put upon with a high workload and no compensatory time off for additional tasks and responsibilities related to quality improvement, they would become dissatisfied with their jobs and see improvement as a burden.

That situation was not healthy for an organisation.

If money was limited, hospitals had to do the best they could by allocating resources strategically.

They could concentrate on improving one particular aspect, such as diabetes care.

By targeting that area and involving staff from all levels, the organisation could then build on success there and apply it to other disease conditions.

Transforming a hospital into a high-performing organisation devoted to quality improvement could take up to 10 years.

Progression was not linear, either. Hospital managers in the United States surveyed on the subject showed it was a matter of "two steps forward and one step back".

In the first year of the transformation process, managers optimistically considered they were 50% along the journey, but three years later that perception reduced to between 15% and 20%.

The more work they did on quality improvement, the more they discovered was still to be done, he said.

The first and foremost difference between high-performing hospitals and those which were average was leadership and commitment to quality improvement.

Without support from leadership, it was unlikely any organisation could embrace quality improvement.

Organisational culture was the next important factor, with the need for every staff member, clinical and non-clinical, to feel part of the whole strategy for quality improvement.

There also had to be the infrastructure to support improvement with ongoing training for staff in quality improvement methods, and good information technology.

Prof Cohen, a William Evans Fellow who has been visiting the University of Otago this month, said the competitive health environment in the United States had generally supported better incident reporting.

Rather than hospitals being concerned they would be open to litigation, they saw having good quality services as a selling point and a recruitment tool.

The "no blame" culture where staff were encouraged to report potential adverse events in a bid to improve overall systems had now moved on to an emphasis on a "just culture".

This involved fixing the systemic issues, but also recognising that in some cases people needed to be held accountable for their actions, but that it needed to be done in a fair and equitable and just way.

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