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Five Essential Skills for 21st Century Quality Professionals in Health and Human Service Organisations

Cathy Balding

*Qualityworks P/L and La Trobe University
Australia*

1. Introduction

Society's demand for quality in all spheres has never been higher. In health and human services industries in particular, consumers and funding bodies demand both technical excellence and outstanding customer service. Industries such as health, aged care and community services are struggling to meet these challenges, as the numbers of consumers grow, technology adds new a layer of complexity that solves some problems and creates others, and staff are expected to provide excellent customer service as well as technically effective services. The role of the quality improvement professional in these organizations is expanding in line with these growing expectations and has never been more important. Traditional quality systems focused on compliance and monitoring are no longer sufficient to create an excellent consumer experience, and quality managers need to add to their skills base to effectively support their organizations in this rapidly evolving environment. This chapter proposes five essential skills for quality professionals in the new millennium that build on, and go beyond, those associated with traditional monitoring and improvement, and are essential for taking organizations beyond compliance to transformation of the consumer experience. The five essential skills for 21st century quality managers discussed in this chapter are:

1. Support robust quality governance
2. Work effectively in complex systems
3. Develop a balance of rule based and proactive approaches to quality
4. Develop strategic quality plans
5. Create impact and improve outcomes through sustained systems change

The content is derived from the literature and from the author's 20 years experience working as a quality manager and with quality managers in health and aged care.

2. Support robust quality governance

Transforming the consumer experience cannot be achieved without effective governance for quality. We now need quality governance and systems that address the impact we have on our consumers – not just the outcomes we achieve. People across the organisation, from the

boardroom to the customer interface, need to be clear on their individual responsibility for the quality of the services they provide and supported to enact it. Quality managers must be able to work with governing bodies and executives to design and develop systems that support staff to fulfil their responsibilities. This section discusses the governance systems required to enable and empower personnel across the organisation to enact their role in creating high quality services every day.

2.1 Understanding and implementing quality governance

The concept of quality governance is a relatively recent phenomenon. When the author started working as a quality manager in the 1980s, we thought that if we were accredited, doing some auditing and clinical review and engaging staff in quality projects then we were doing well. We knew that leadership was important, but we didn't know how important it was or indeed how best to lead. It took various studies and inquiries into suboptimal care and adverse events in healthcare to demonstrate that safe and high-quality care in a complex environment requires more than good staff trying hard. Clinical governance largely emerged from the findings of public inquiries into poor care that found that the majority of these organisations were not the victims of deliberately negligent practitioners. What they lacked were systems: for including consumers in their care, for supporting staff to provide quality care, for clarify accountabilities and for measurement and improvement. Nor did they exhibit consumer and safety-oriented cultures, with 'blame and shame' the common response to adverse events and passive response to data indicating suboptimal results. (Hindle et al., 2006)

Of course, quality care can't be achieved without good staff doing their best. But to create great care consistently, healthcare staff also need sturdy organisational supports behind them. Staff are 'front of house' – out there working with the customers. Governance is 'back of house' – the behind-the-scenes systems that support staff and enable them to provide a great consumer experience. To make the components of great care happen for every consumer, every day you'll need to ask:

- What do we currently have in place that supports great care as we've defined it?
- What do we need to enhance/change to achieve our quality goals?
- What new processes/supports do we need that we don't currently have?

Providing safe, quality care and guarding against organisational weaknesses that allow poor care requires commitment and accountability to be embedded in the organisational structures and culture, but also requires a targeted plan. Setting goals and targets for the quality of care your organisation wants to deliver, and implementing strategies to achieve them is part of the governance of any health or aged care organisation. The emergence of clinical governance over the past decade has been healthcare's approach to providing this accountability, planning and support. In aged and primary care, this can be reframed using more appropriate terms such as 'quality governance' or 'care governance'. The key components of governance can be organised into four generic cornerstones:

- strategic leadership, planning and culture
- consumer participation
- effective and accountable workforce
- quality and risk systems.

The importance of a quality governance system cannot be overstated; it provides the foundation for the myriad pieces of a quality system and gives people a role in that system, which in turn makes the implementation of the various governance systems easier.

2.1.1 Clarifying accountabilities for creating safe, quality care

The concept of governance arose from the need to ensure greater and clearer accountability for the quality and safety of care experienced by the consumer. This is still a work in progress in healthcare. There are many health service organisations in which individuals are not aware of the clear, specific, personal responsibility they have for the quality of care and services they provide. This makes it difficult for staff to carry out their responsibilities, and even harder to create a consistently safe, quality experience for consumers. Governance is where the governing body, executives and managers play their critical role in creating safe, quality care. The executive must translate the strategic quality goals into operational plans and strategies to facilitate their implementation as part of organisational business. Those on the frontline of care create the consumer experience, but the organisational supports for this must come from the top, as staff require leadership, policy, systems and an investment of time and resources to implement the strategies. And, of course, the quality manager provides technical support across the organisation to enable staff to fulfil their responsibilities. An example of generic governance roles for quality care is described in Table 1.

2.1.2 Developing dynamic quality committees

Another aspect of accountability is the way in which committees support the quality system. Driving the achievement of the quality plan through line management will generally occur in partnership with working groups or committees, particularly where implementation requires cooperation across staff groups or services. When committees are action focused they are invaluable in tracking and driving progress with the quality goals. When committees are just information recipients, staff will have difficulty understanding their purpose – and may try to avoid them. Quality managers need to be alert to directionless committees – and get them on track before they erode the credibility of the quality system. Committees should take an active role in quality goal monitoring and action at the local department/service level (where they might take responsibility for driving one component of a goal) right through to board committee level (which monitors progress with achieving the quality goals). Committees that have an explicit responsibility for achieving a quality goal are more likely to be proactive decision makers and less likely to be passive recipients of information.

To be useful, committees need a clear purpose and something that they are responsible for so they can make decisions and take action. Giving a quality committee responsibility for driving and monitoring a quality goal, objective, strategy or governance support will add some life and energy to proceedings. A clear purpose also helps determine a committee's agenda and membership. Quality committee agendas can be structured according to the quality goals and their objectives and components, which makes it easier to see how data monitoring and improvement activities link to the achievement of great care. All reporting should help a committee determine if progress is being made towards implementing governance cornerstones or achieving the relevant quality goals. Committee membership is

always tricky to get right. Members can be invited on the basis of who has to be on this committee – there will always be political and relationship imperatives in a complex system – and who you need on the committee to fulfil its purpose. Some members may need to be there because they are decision makers and have formal power. Depending on the committee’s role, you may also want people with informal power – the influencers. If the committee is responsible for addressing improvement in a particular area of the organisation, you will need some who have a deep understanding of the relevant systems, relationships and mental maps. Everyone on a quality-related committee should understand its purpose and exactly what each of their roles is – be it sharing their knowledge, experience or influence – and be invited to contribute to discussions and decisions on that basis.

Organisational level	Quality Governance Responsibilities
Governing Body Accountable for the quality of care, services and consumer experience	<ul style="list-style-type: none">• Make the achievement of great care a priority• Set strategic direction and the line in the sand for the quality of care and services to be achieved• Lead a just, proactive culture• Ensure management provides the necessary system supports and staff development to provide great care for each consumer, and monitors progress towards achieving the strategic quality goals
Chief Executive and Executives Accountable for and lead great care and services	<ul style="list-style-type: none">• Make the achievement of great care a priority• Set strategic goals for great care and operationalise them through effective governance, resources, data, plans, systems, support, tools, policy and people development• Monitor and drive progress towards the strategic quality goals• Develop a thinking organisation and a just culture, wherein staff are supported to take a proactive approach to achieving safe, quality care and services
Directors and Managers Responsible for the quality of care in each service	<ul style="list-style-type: none">• Make the achievement of great care a priority and take a proactive approach to achieving it• Operationalise the strategic quality goals by translating them into local initiatives• Understand the key organisational safety and quality issues and the broader quality agenda• Monitor and drive progress by implementing the drivers of great care within their services• Develop staff and systems to create quality care and services for each consumer• Make the right thing easy for staff to do
Clinicians and Staff Responsible for quality of care at point of care	<ul style="list-style-type: none">• Make evaluation and improvement a routine part of care• Develop, implement and evaluate initiatives to contribute to the organisational quality goals• Support and enable all staff to create great care• Create a great experience for each consumer through positive behaviours and attitudes and a proactive approach

Table 1. Examples of governance roles in creating quality care (Australian Commission on Safety and Quality in Healthcare [ACSQHC], 2010; Victorian Quality Council [VQC], 2003)

2.2 Work effectively in complex systems

Organizations providing human services are complex systems. They have a large number of inputs and processes, and are continually exposed to outside pressures and influences. It is imperative that quality managers working in these environments understand how these systems work to be successful. This section explains what complex systems are, how they work and, most importantly, why these things are important for quality managers, because of the way they directly impact on the pursuit of high quality services in an organisation. Working in a complex system, but treating it as if it is a simple or complicated system, makes it difficult to achieve consistently high quality services. Change and improvement in complex systems require a particular approach, tailored to the unique characteristics of the complex environment.

2.2.1 An overview of some key complex systems characteristics

Complex systems operate according to distinctive and often counter-intuitive rules. It is important that quality managers understand these rules and, in particular, their implications for creating change and improving safety and quality. Traditional, production line approaches to quality are only half the story in a complex environment such as a health or aged care service.

All complex systems have a goal, which may be as simple as survival, or maintaining the current situation. Be prepared for push back from the system if you interfere with it achieving its goal. Systems enjoy their status quo and strive to maintain it. If you change one part of the system, this will result in resistance from the other parts of the system it is linked to because it means they will have to change as well. The more parts of the system there are and the more possible connections between them, the harder it is to change and the easier it is to create chaos (Meadows, 2008). So whenever you take action within a complex system, there will be side effects. These may be positive or negative, depending on your perspective. In our health services, we usually expect that effect will follow cause. This is production line thinking. We recognise these as false conclusions when we can't then replicate the same result in another part of the organisation. The result may have been due to the natural variation inherent in every system. Or it may have been due to your intervention – but this intervention won't work the same way in another part of the system. Generally speaking, real change in complex systems requires a lot of different parts of the system to be working towards the same change.

A complex system acts like a web of elastic bands so that when you pull one piece out of position it will stay there only for as long as you exert force on it. When you let go, you may be surprised and annoyed that it springs back to where it was before. In addition, a complex system may or may not be stable. Stable complex systems that have not been subject to a lot of change become more resistant to change as time goes on. All of us have experienced this in organisations, where one service or department has somehow escaped the force of change experienced by other parts of the organisation. When their turn comes, they find change very difficult. In an unstable system, however, pressure to make changes can cause the system to burst like a balloon. If the system is under a lot of pressure routinely, this may only take a small trigger, just as a small crack in a dam can lead to its collapse because of the constant pressure of water behind it. So if you put an unstable system under enough pressure for long enough, it can suddenly disintegrate.

Despite these characteristics, complex systems work because people make them work. But to do this, processes in the system are often changed as the system evolves, and then the relationships between the processes have to change to keep the system working. The relationship between different parts of the system determines how the system overall works, so each process change, however minor, can affect the behaviour of the whole. This is an important point! All processes in a system are interdependent and they all interact. The key to change is not to just focus on one process in isolation, but to look at how it relates to the other processes in the system. Systems can also become self-organising and can generate their own hierarchies of power and influence. These hierarchies may not be the same as those seen on your organisational chart. Each person, wherever they sit in the system, has the power to affect the way the system behaves. Relationships within each subsystem are denser and stronger than relationships between subsystems. For example, there are likely to be more interdependencies and networks up and down a silo in a health service than across and between silos. Interaction within the silos occurs mainly between members of the same professional group: nurses interacting with nurses, and doctors interacting with doctors. These tribes give the people within them an important sense of belonging but it can be hard to break down the walls and build bridges between them (Braithwaite, 2010).

Complex systems do not necessarily operate according to the policies of the organisation. On the contrary, complex systems can be exceedingly policy resistant. This resistance particularly arises when an introduced change threatens the goal of the system or when policies are implemented that are not based on the reality and unwritten rules of those having to implement them. We've all experienced policies developed on the run, or even painstakingly over a long period, that have only been partially adhered to by those they were designed for. If there is too great a mismatch between the policy requirements and the way that things really get done or the goals of the system, the policy will generally fail. At worst, people will disregard it; at best, they will work around it to meet their goals of getting their work done in the most effective, efficient and easiest way – a way that has probably been crafted over time and is protected by and embedded in the way the system operates and the unwritten beliefs of those who work within it. The way in which policy is implemented can also influence the degree to which it is enacted as intended. Poor implementation opens up a policy to all sorts of change and interpretation by those using it. This may drive policy enactment to drift away from the original intention.

The importance of quality professionals being able to adjust to and deal with these characteristics cannot be underestimated. It can mean the difference between the creation of consistently safe and quality services, and implementing monitoring and improvement with few gains. The implications of these complex systems characteristics are discussed throughout the remainder of this chapter.

2.3 Develop a balance of rule based and proactive approaches to quality

Human services have traditionally relied on rules to enforce standards and ways of working. But, as we can see from the characteristics of complex systems, more than traditional approaches are required to create consistently safe and high quality health and human services. Of course some rules and standardization are important, but too many rules can do as much damage as too few. Staff work around rules that are not a good fit for their environment and all systems and procedures gradually erode in complex systems,

where they are open to a myriad of influences and changing circumstances. What is required is a balance of rules, systems and thinking, proactive staff.

Improving reliability through systems that force and guide safe decisions, provide backups, remind staff of preferred behaviour and catch fallible humans when they make a mistake, are key aspects of creating safety. In fact, their use is in its infancy in healthcare – compared to other high-risk industries – and there would probably be significant benefit in fast-tracking the implementation of proven safety systems. Rule-based decision making, such as the use of protocols and checklists is also extremely useful in many situations; for example, by inexperienced practitioners who are learning standard procedures for frequent high-risk situations. Standard procedures can be useful for experts as well – particularly if they find themselves in a situation that they do not often experience (Flin et al, 2008). Not all aspects of standardisation and reliability are foolproof, however, and there is danger in thinking that they are a set and forget solution to safety. There are many reasons for this in a complex system. Remember the ‘policy resistant’ aspect of complex systems? Complex systems – and the people working within them – do not always respond well to overly restrictive rules, and they may react in unexpected ways. Creating a standardized approach, unless based on a forcing function, does not guarantee that it will be followed. And forcing functions, while useful in creating safety, can give rise to complacency and a lack of staff alertness. So standardisation is *one* answer to improving safety and quality, but not the *only* answer.

Why is this? We often find that there is such a strong emphasis on procedures, checklists and protocols that organisations attempt to write one for every eventuality. But it is almost impossible for a procedure to be written for every situation in a complex system, and unlikely that staff will refer to all procedures if there are too many of them (Amalberti et al, 2006). Reliability in high reliability organisations is accomplished by standardisation and simplification of as many processes as possible. But your health service is a dynamic organism with a high level of variability, production pressure, professional autonomy and rapid creation of new knowledge. Not everything can be fixed and standardised so when trying to reduce variability and improve reliability, it is better to focus on the variation that is creating real problems, rather than variation more broadly. All safety policies have a natural lifespan as the context around them is constantly changing. The challenge of creating and maintaining safety within this context requires a mix of standardisation and proactive, flexible, thinking solutions.

Over reliance on rule-based decision making is another flaw in mechanistic approaches to safety and quality in health services. It may cause a degree of skill decay; if an unexpected and unfamiliar situation arises and no rule exists, will the person making the decisions be able to formulate an effective course of action? (Flin et al, 2008). Protocols too may reduce or discourage the ability of people to be proactive, practice situational awareness, identify deviations from normal situations – in short, to think for themselves (Dekker, 2005). Bad decisions can also occur in rule based situations if the wrong rule or protocol is selected. It is human nature to prefer a familiar rule, whether or not it is the right one to match the situation in which the decision maker finds themselves. A mechanistic rule-based approach to safety is based on the premise that safety is the result of people following procedures, but staff work around rules and procedures that do not meet their needs for efficiency and streamlining. Developing checklists and protocols in response to risks may provide a sense of action having been taken, but can send the message that reliable, safe care requires

nothing more than insisting upon routine standardised procedures. Nothing threatens safety like the belief that the problem is solved (Bosk et al, 2009).

2.3.1 Moving beyond standardisation to create safety and quality

When developing safety policies and protocols, it is better to give staff fewer rules that can be reliably followed around the clock than to write 'perfect' protocols based on ideal conditions that require workarounds to fit the situation at 11pm on a Saturday night. Try to resist the pressure to develop a new rule in response to every adverse event or root cause analysis finding because you'll end up with a mix of 'should follow' and 'must follow' rules that will muddy the safety waters. 'Should follow' rules that have little credibility or apparent consequence are unlikely to be followed in a messy, high-risk, high-stress environment, so why bother? Erosion of compliance with 'should follow' rules can, in turn, negatively influence compliance with the more important 'must follow' rules. When people are violating a protocol, find out why! It may be for a good reason and may give you an insight into what's going on in practice – and what's required to improve. Use observation and discussion to work out what's really happening. And when introducing a new protocol to reduce a risk, do the troubleshooting around whether or not it's likely to be followed, before people's lives depend on it. Quality managers who understand and can explain the value of not constraining the system any more than necessary, and who encourage challenging a new protocol with 'why won't it work?' and 'how are people likely to work around it?' are more likely to effect positive change in their organisation's approach to safety and quality than those obsessed with rules and compliance.

Another strategy for creating safety and quality in complex organizations is to develop the resilience of the staff. Resilience engineering is a concept derived from human factors engineering – the discipline that studies the interface between machines and systems and human beings, and improves design so that humans can operate safely and effectively. From a human factors perspective, resilience refers to the ability, within complex and high-risk organisations, to understand how failure is avoided and how to design for success. It describes how people learn and adapt to create safety in settings that are fraught with gaps, hazards, tradeoffs and multiple goals. Resilience can be described as a property of both individuals and teams within their workplace (Jeffcott et al, 2009). It fits well with James Reason's observation that his 'Swiss Cheese Model of Accident Causation' (Reason, 2008). requires another slice of cheese – cheddar, not Swiss – at the end of the line. This slice represents humans as the final barrier and defence against unsafe situations turning into harm, when all other systems fail. Practising resilience requires organizations to investigate how individuals, teams and organisations monitor, adapt and act effectively to cope with system failures in high-risk situations, and to apply and develop these lessons.

In the end, rules don't create safety – people do. Quality care and services are created by systems and standardisation, and also by proactive staff working in partnership with consumers to create the organisation's vision for great care. Building resilience is a component of this approach that combines elements of creating safety, human factors, high performing teams, job satisfaction and empowerment in a way that may assist with winning the hearts and minds of the staff at point of care. These are the staff we ultimately depend on to create and deliver the safety and quality of care we want our consumers to experience every day.

We cannot expect to eliminate human error and systems failure, but we can develop organisations that are more resistant to their adverse effects. Achieving this balance within a high-risk and ever changing environment is a critical challenge for healthcare managers and staff. But this approach reflects more realistically the environment within which we work every day. An environment that cultivates both systems and people not only supports the creation of a safer environment, but improved quality of care and services more broadly.

2.4 Develop strategic quality plans

Health services have traditionally measured inputs and outputs, and to a lesser extent outcomes, as valid and reliable outcome data can be difficult to obtain. They have been less concerned with measuring and addressing their impact on the consumer experience. We often see quality systems focused on compliance and small scale improvement, resulting in task focused programs with little purpose or direction. Like a jigsaw puzzle without the picture, there are many pieces, but no one is quite sure how to put it together. Yet engaging staff in playing their part in quality requires an inspiring vision of the service quality the organisation is committed to provide for each consumer, and a clear pathway to get there. Creating consistently high quality consumer experiences in complex organisations requires a strategic approach. Quality professionals must be able to work with their executives and managers to create a blueprint wherein goals, strategies, leadership and governance converge on a specific target: great technical care and customer service. Strategic quality planning and implementation within complex healthcare environments is a key skill for quality managers in the 21st century.

So, what is goal-based quality planning – and why do we need it? Staff involved in health and aged care quality systems are often frustrated because they don't understand why they are being asked to collect data, develop new processes or go to meetings. Simply, they can't see how these efforts fit into the bigger picture. All they see are tasks that interfere with their capacity to do 'real' work. A goal based quality plan is the blueprint for how the quality system components work together to achieve a quality consumer experience. A clear, strategically focused quality plan can help quality professionals to clarify and fulfil their role and support managers and staff to better understand their part in achieving quality care. It also demonstrates that participation in the quality system is about a lot more than achieving accreditation, as the focus of the quality system becomes the impact of monitoring and improvement activities on consumers, rather than fulfilling accreditation requirements. And this is of much more interest to clinicians and staff.

There are three key aspects to a quality system in health and aged care:

- Maintenance – minimise risk, maintain processes and standards of care, detect problems, monitor compliance
- Improvement – identify and drive operational improvements in processes designed to solve problems and improve consumer experiences and outcomes
- Transformation – develop and pursue a strategic view of consistently 'great' care for every consumer (Balding, 2011).

Most quality systems address maintenance and improvement, but too few use their quality and governance structures and processes to pursue transformation. So how does goal-based

quality planning address this? More importantly, how does it address this in a complex environment? Your quality plan and system are only as good as the extent to which they impact on the care the consumer receives – supporting it to be good today, and driving it to be great over the long term. Helping managers and staff understand this, and their role in it, is a key responsibility of the quality manager. And it's not just the managers and staff who need to understand it; a quality manager will often have to explain it to the organisation's executive and governing body. When it comes to quality, governing bodies need something tangible to govern and leaders need something concrete to lead.

The strategic approach to quality planning and creating great care in this chapter is based on the characteristics of successful strategic planning processes used in healthcare and other industries, and is a good fit with complex systems characteristics. They include:

- the use of vision statements that inspire and stretch the organisation
- the development of revolutionary goals to achieve the vision
- a horizontal approach to the planning process where input and participation are equalised across the organisation
- using learning, information and rewards to increase the strategic view of the entire organisation
- encouragement and the cultivation of strategic thinking and culture change at all levels of the organisation
- having strategic decision making driven down to all levels of the organisation so that achieving the strategic direction becomes part of everyone's job. (Zuckerman, 2005).

Organisations using this dynamic approach develop their quality plan as the platform for achieving the organisational strategic vision for quality. The strategic planning process is managed centrally or corporately and the leaders, managers and staff who are closest to the consumer are the key implementers. A dynamic quality plan is a map and a vehicle for reaching a destination. That means that a strategic approach to maintaining, improving and transforming great care and services requires you to know the where (where are we now and where do we want to go?), the why and what (why are we doing this and what do we want to achieve?) and the how (how will we get there?).

2.4.1 Setting goals is key to success

One of the most valuable skills a quality manager can offer an organisation is the development of clear and measurable goals. Do you really know what your organisation is trying to achieve? What do you want to be known for in terms of the quality of care and services you provide? Where do you stand in terms of the key quality and safety issues in your industry?

The research points to the need for a shared purpose if real change is to be made. Engaging people's hearts and minds in a common purpose requires us to paint a rich, specific picture of what they will gain if they participate and what the end result will look like. This is a staple of effective strategic planning. But it is still rare to see health services with a specific vision for the quality of care and services they wish to provide for their consumers. The pressures of short-term budget cycles and political and corporate demands do not lend themselves to a comprehensive, longer-term approach. However, stretch goals can have a

transformational effect on an organisation. A strategic approach should be designed to take your organisation somewhere better than it is now, and that requires a quality plan based on the vision of care that your organisation wants to move towards. It must also be based on current reality, achievable enough so that people can believe it can happen and enough of an improvement that it is worth pursuing. If you want people to lay the quality bricks, you have to engage them in developing a rich picture of what the finished house will look like.

It is important to define quality care from both the consumer and provider perspectives. One without the other is only half the story. It is not an easy undertaking to pull the threads of your organisation together to achieve a common vision for the quality of care your organisation wants to provide. And it is likely to be nearly impossible unless it is clearly defined, ruthlessly prioritised and pursued with laser-like focus. It also needs to fit with existing system goals. To achieve all of this, plans should not contain too many ingredients and focus on achieving the essentials of great care for every consumer, every time. This means that these essentials must be defined. Engaging people across the organisation, including consumers and the governing body, is a good way to ensure this picture of quality care is both aspirational and achievable. Frontline staff and ‘frequent flyer’ consumers are central to this process. No one understands the difference between great and unacceptable care like those engaged in the care and service delivery transaction. The conversation around developing the vision might go something like this:

- How would we like each of our consumers to experience our care and services in three years time?
- How would we like to describe our care and services?
- How would we like our consumers to feel about our services and describe their experience with us?
- What would we like the media to be saying about us – or not saying?

Consumers, staff, executives and the governing body can - and should – contribute to these conversations. But it is not always easy to take the next step and turn this rich picture of quality care into concrete, strategic goals. This is where many organisations falter. Without goals, your quality plan may look like a long to-do list with no specific purpose. The vision for the care you want to provide must be rich, and also translated into concrete goals to describe the way things could be. Goals must be attractive and describe real, desirable, achievable changes, as seen in Table 2.

<p>Our strategic goals for the care and services each of our consumers will experience by the end of 20XX are:</p> <ul style="list-style-type: none">• Care and services are designed and delivered to create the best possible experience for each individual (person-centred).• Care and services are designed and delivered to minimise the risk of harm (safe).• Care is based around the consumer as an individual, and is designed to achieve optimal outcomes (effective and appropriate).• Consumers are provided with, and experience, care and services in a logical, clear and streamlined flow (continuous, accessible, efficient)

Table 2. Examples of strategic goals for an organisation’s quality of care (Balding, 2011).

People are attracted to ideas they feel they are involved in generating. Involving the staff affected in developing the goals for change can help create both buy-in, and the goal clarity that people need before deciding if and how they will participate. Goal clarity appears to be another problem area in creating change. If you aim at nothing in particular – or something ambiguous – that's probably what you'll hit. And yet it is not uncommon to see changes and improvements implemented with only a vague idea of what they will achieve and no clear objectives against which to measure success. The goals for your change must be SMART: specific, measurable, achievable, realistic and time-bound. Goals are about turning your vision into something achievable. Goals are not tasks; goals describe the desired future achievement. A SMART goal will encompass: How well? By when? How will we know? These are then broken down into objectives and the key tasks or stepping stones that have to be traversed, depending on where you're starting from, to achieve the final goal.

2.4.2 Select priorities carefully

A traditional problem with quality plans is that they are over ambitious. But it's far better to do fewer things and get them right. That's why any good plan has short, medium and long-term goals. Developing an annual Quality Action Plan, derived from the strategic quality plan, is a good way to keep the strategic quality plan current and dynamic. The annual plan contains the priorities to be achieved over the coming 12 months. It ensures the strategic quality plan can evolve with changing external and internal circumstances, while maintaining the overall direction towards achieving the quality goals over the longer term.

So what should be done in the first year of the plan? The selection of your first year objectives will be based on the activities that:

- have the greatest impact in creating a positive experience for each consumer
- maximise safety
- address components of great care that are currently suboptimal – or non existent
- minimise and eliminate the things that shouldn't happen
- solve significant problems and manage key risks
- meet legislative, policy and accreditation requirements
- get something going that will take a long time to achieve
- cover a lot of the quality plan's intent, using the 80:20 principle.

The 'first among equals' priority for consumers is safety and this requires robust processes across all services to reduce risk in key areas. Priorities may also be selected based on safety and indicator data, consumer and staff feedback and identified problems in specific areas. Policy, funding issues and key risks must also be addressed as priorities – that's a reality. If compliance and safety issues are at the head of your quality priorities queue, try to also include some aspirational objectives for improving the consumer experience from other dimensions of quality on the Year One list, or you may lose the momentum and energy created by the planning process. Internally, you will already have many activities in place that will help you achieve your goals. You could start by conducting a gap analysis to ascertain where current quality activities are or are not addressing or supporting the key priorities. Other organisations can also supply ideas for achieving your quality goals. Above all, don't get caught up in the detail of planning to the extent that you lose sight of your purpose. Keep the care you want every consumer to experience at the centre of your activities.

2.5 Create impact and improve outcomes through sustained systems change

Once high quality care and services are achieved, they must be embedded in everyday work. This is one of the most challenging aspects of a quality system, particularly in complex, dynamic organizations, and effective change skills are pivotal to the quality role. Quality managers often underestimate the difficulties of achieving sustained change in this environment, resulting in re-work and waste as changes that don't 'take' are re-implemented. Lasting change to effect improvement requires both systems and people change.

2.5.1 Understand the current system before you try to change it

In a complex system you need to understand what drives current processes before you can achieve a sustained impact and improvement in outcomes. Observe the humans in their natural systems environment. This may be the most important of all the 'change basics' steps – and one of the least practised. With the goal of determining organisational fit and readiness for change, you can look for systems factors such as:

- the degree to which the system participants perceive the change as beneficial
- who and what drives the current system
- the key relationships between processes and people
- the degree of fit between the goals of the system and the goals of the change
- the timing and context of the change. What else is changing or happening in this system?
- the perception of the need for change
- personal attitudes towards change generally, and past experiences with change in the organisation
- the social and values anchors that are important to the change targets and that maintain the status quo. Which of these are non-negotiable?
- aspects of the current situation that the change targets don't like. Can these be eliminated or improved as part of the change?
- driving and restraining forces for change and the degree to which it looks like the drivers outweigh the restraints (NHS 2002, 2004).

This should help you build an informative picture of the current situation. What has to change to achieve your vision? Work policies and practices? Physical surrounds? Emotional ties? Cultural norms? Understanding and working with the current culture is critical to success – even if that culture is the very thing you want to change. Use your mud map of the current situation to assess, identify and build on what currently works. 'Appreciative inquiry' is a process of identifying something that works consistently well within a system and finding out how this happens (NHS, 2002). Have you ever performed a root cause analysis on something that works to find out why it works well? This makes a nice change from looking at things that don't work well, which is a more common approach in healthcare. Tools such as process mapping, direct observation and conversations with the various players are useful here to tease out the positive characteristics of the current system that will help anchor the changed system. Not only will this help inform your preplanning, but you will be laying a foundation for buy in.

2.5.2 Develop your strategies for change – And impact

Your strategies for change will be based on your mud map of the current situation, particularly the anchors keeping the current situation in place, and represent the flight plan for how to get to your goals from where you are. Where possible, learn from others who have introduced the same or similar changes, whilst adapting their strategies to your own environment. There is no guarantee that strategies that have been successful elsewhere will work as well in your organisation due to the many layers of interactions that make your system unique. Change, transformation and improvement cannot be delivered through the adoption of an imported recipe or formula without adapting it to the current environment. If you introduce a new procedure, software system, data collection or form on a Monday morning without investing in preparing and equipping the people who will use the innovation, it is unlikely to be automatically adopted. The process may have changed, but the people haven't – they are the same as they were on Friday afternoon. Process change is not the same as people change. Process change is transactional and concrete. People change is transitional and involves a psychological process to come to terms with a new situation and change behaviour to enable the new situation to occur. Unless this transition is well managed, change will not work and things can get stuck. Even with obviously positive changes, there are transitions that begin with having to let go of something and there will be push back because your change adds to the staff 'to do' list and new behaviours take longer, both of which result in lost time. At worst, staff are losing something they are strongly wedded to and may actively resist or get stuck in a neutral zone where they are aware of the change but not actively engaged – a sort of change no man's land (Bridges, 1997).

It is important to remember that all staff feel that they are doing their best for each patient. Change for improvement should always be presented as something that helps good practitioners achieve even more. They may maintain that their only desired benefit of change is improved patient outcomes and these, of course, are likely to take some time to become apparent after the initial change. So what are some of the short-term benefits of change you can use to get people's attention? This is where you have to talk about impact as well as outcome. Impact what we are trying to achieve by change, for both consumers and for staff. It's not only about trying to improve the results of care. It's about consumers feeling the impact of your change through a different, more positive experience. Does the change mean that staff are more active listeners – so consumers feel heard? Is it that the change can form part of an action research project and that you can assist staff to write it up for a journal or a conference paper? Will it help both consumers and staff feel more informed and in control of what's going on? Can a process be made more efficient and simpler as part of the change? Can you save them time and money? (Frankel et al, 2011).

Within this framework, as far as possible, give staff as much freedom as possible to devise their own ways of achieving the goals, based on their intimate knowledge of their own systems. But empowering people to create change is not just saying 'make it so' and then being disappointed when they don't achieve the desired result. Empowering people to change in complex systems is not straightforward. But there are some common actions that have been shown to be essential in assisting people to take ownership of a task or change: direction, knowledge, resources and support – the DKRS model of empowerment (Balding, 2011). For the DKRS model to succeed, each of these four components must be present to

fully enable people to take ownership of the task or a change. We often see one or two of these employed in healthcare change but it is unusual to see an individual or team supplied with all four (Balding, 2009). Empowerment does not mean abandonment. Giving people permission to do something differently is not helpful if they are unable to do it. That permission just sets them up to fail. Setting the context for change means preparing the players, understanding what they know and don't know, working with them, watching their performance, giving them feedback and creating an ongoing dialogue with them (Meadows, 2008). It may be more effort at the front end of a change to work with staff to ensure they have all four components, but it will save you a lot of time and trouble at the back end of the change if they are able to embrace, own and run with the change in their local environment.

2.5.3 Test and implement the changes

Rapid cycle piloting of change using the Plan Do Study Act (PDSA) cycle is a useful approach to change in a complex system. PDSA fits the changeable and adaptable nature of complex systems and enables you to test ideas under a variety of circumstances (Reason, 2008). It's also a good way to pick up on the feedback and side effects of your change. This model also includes the possibility that the change being tested will not be successful, but because these tests are done on a small scale the risk of failure can be kept to a level that's manageable. PDSA also helps achieve quick wins, even if small, that are integral to gaining stakeholder acceptance of change. Success on a small scale builds confidence, which allows larger risks and changes. Pilot projects work best under the following circumstances:

- Pilots are limited to small samples and short cycles of change with the people who want to be involved
- They use solutions that have worked for others, but are adapted to fit the local situation
- The easiest change with the most leverage for the biggest impact is made
- An action learning process is used to frequently review progress and the change leader stops to ask: 'how did we go?', 'what did we learn?', 'what were the unintended consequences and side effects?' and 'how should we do it differently in the next cycle?'
- Participants are not afraid to stop a test change that's clearly not working. This is part of change in complex systems (Haines, 1998; Reason, 2008).

Staff involved in the pilot will be watching, judging and weighing up whether or not to hitch their wagon to the new way. It is imperative that your process has credibility. When you pilot a change, use a simple but rigorous project management approach and do exactly what you have promised. If you want to change people's beliefs about how things should be done, you must change what they see. A memo or an email about doing something differently will not make it happen. If you want people to believe that changing their behaviour will result in a certain positive outcome, that outcome must occur. If you commit the leadership group to behaving in a different way, they must behave in that way. This is where many change initiatives break down: we make the plan and say what will happen, but don't follow through.

Early wins are required to show that change is possible and can have positive outcomes. Action sends a strong message, more than any memo ever could. Don't be surprised by unexpected or negative outcomes, and don't expect a linear cause followed by effect chain with your change. Look for the unintended negative side effect of your change. For example, if you have streamlined the new consumer registration process, does this leave clients feeling that they have been hurried and not heard? Don't ignore or downplay these negative side effects – they are not failure, but the way of the world in complex systems.

2.5.4 Reinforce, embed and spread the change

Creating buy-in is one thing. 'Stay in' is something else altogether. Systems need a constant supply of new energy to survive and, until your new change starts to create its own energy, it requires yours! Sustainability is a process, not an ending (NHS, 2002). Many managers want to get everything up and running on auto pilot as soon as possible, but this is the antithesis of what actually sustains change.

In complex systems, sustainability and spread are dynamic processes that need focus and attention. So, define sustainability. What do you mean by it? What do you want to still be happening in one/three/six months from now? People need to be reminded of the goal and the vision, and the way in which these are achieved requires monitoring and course correction in a shifting complex environment. Involve people in developing solutions to overcome the unexpected problems that arise, ensure they are equipped for their role in the change and reinforce where their contribution to the change makes things better for patients. Use the sceptics to help you identify the problems and the roadblocks and show you value their input. Arguing with them will not change their mind and you may lose valuable information (Haines, 1998).

If you've done a good job of your change process by giving the participants a positive experience, ensuring the change is an improvement for patients and staff and finding those quick wins, the initiative should have its ownership and should just about spread itself. This is the 'tipping point' concept, which provides a useful summary of spread (Gladwell, 2002). The 'law of the few' and the 'stickiness factor' are tipping point concepts, which provide us with direction on how to go about reaching the point where the change takes on a life of its own. The law of the few means that a few influential, popular people can effectively spread a message, so use the people who have influence – the 'players' in your complex system – and also the people who just get around and talk a lot. Stickiness means that a message has impact: you can't get it out of your head, it sticks in your memory. Are your messages 'sticky' or dull and forgettable? (Gladwell, 2002). Are they presented in the language of the people – or in complex bureaucratese?

Once you've got the change right, embed it in job descriptions, policies and procedures, competencies and performance reviews. Reinforce it. Remove the old way – if you don't, people will cling to it because it's familiar, and it will make the new way seem like an extra, rather than a replacement. Keep the change on meeting agendas as a specific review item for at least six to twelve months, depending on the size of the change. Appoint a 'keeper' of the change – someone influential whose job it is to keep an eye on the new way of doing things and the people involved, and to identify regression and unintended side effects. Ensure it continues to be linked to broader organisational initiatives.

3. Conclusion

As the pressure on our health and aged care services grows, so too do the demands on the quality professional. Continuing to increase the efficiency and quality of healthcare will require new knowledge and savvier ways of working. To meet these challenges, quality professionals will need to expand their role beyond traditional compliance, measurement and improvement skills and tasks. They will be required to understand their workplaces as complex systems and be experts in supporting their complex organisations to create high quality care. To do this they will support and lead their organisations to develop robust governance, to create safety through a mix of effective systems and resilient people and to achieve sustainable change that positively impacts the consumer experience as well as improving outcomes. These are the new skills for 21st century quality managers.

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