Implementing change based on local or national clinical audit findings
How we implement change based on clinical audit

For a success you have experienced —

- What is the process for acting on clinical audit findings?
- Who is responsible for carrying out the process?
- Who is accountable for the process being done successfully?
Types of actions healthcare organizations can take

WEAK ACTIONS

- Raise staff awareness
- Remind staff
- Provide training
- Write a new policy

Hughes D. Root cause analysis: bridging the gap between ideas and execution. National Center for Patient Safety Topics in Patient Safety 2006;6(5):1–2
‘After conducting an RCA, healthcare workers are left to their own devices in generating … plans …. They experience significant difficulty in generating and implementing … recommendations, and those they produce are often not consistent with best practice. Indeed, some of the most popular … strategies in healthcare (training and education) may do more harm than good’
‘The effect of audit and feedback on professional behaviour and on patient outcomes ranges from little or no effect to a substantial effect.... The effect may be influenced by the type of behaviour it is targeting...’

What contributes to success in achieving improvements?

For a success you have experienced —

- Did people see what improvement is needed?
- What were the drivers for acting?
- Was there commitment to achieving improvement?
- Who was responsible and accountable?
Why don’t they do what we expect them to do
They don’t **want** to

- It’s not worth it
- What’s in it for me
- It’s more work
- It goes against the grain
- I don’t see the point

*People don’t believe in the change*
I don’t know how
I don’t have what I need
It doesn’t match ‘the system’
My manager says to ignore it

I don’t really know what you want

People don’t have what it takes to make the change
People need —

<table>
<thead>
<tr>
<th>Scientific evidence of what is the right or best way</th>
</tr>
</thead>
<tbody>
<tr>
<td>Belief in the evidence</td>
</tr>
<tr>
<td>Good systems to implement the evidence</td>
</tr>
</tbody>
</table>
*Implementation science* (knowledge translation) is the study of the processes and methods for implementing evidence-based practice, that is, getting the findings of research into everyday clinical practice through focusing on identifying the processes and methods that work best under what circumstances to achieve effective and sustained implementation with sufficient fidelity.
# Human factors engineering

## Types of work and causes of individual failures

<table>
<thead>
<tr>
<th>Nature of task</th>
<th>Nature of behaviour</th>
<th>Type of quality failure</th>
<th>Type of cause</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performed on autopilot</td>
<td>Schematic</td>
<td>Slips and lapses</td>
<td>Failure to concentrate, distracted, tired</td>
</tr>
<tr>
<td>Require planning and problem solving</td>
<td>Attentional</td>
<td>Mistakes</td>
<td>Lack of experience or training</td>
</tr>
</tbody>
</table>

Identify the IMPROVEMENT

Identify opinion to favour the improvement — and overcome barriers

Prepare for a new way — strategies and tactics

Redesign the way things work now

Operate the new way — on a pilot basis

Verify that the new way works

Eliminate unwanted variation in the new way

Stabilize the new way
Identify the improvement

- What should happen …
- For how many patients

The exact outcome to be achieved … in comparison to what’s happening now
<table>
<thead>
<tr>
<th>Agree on the shortcomings in care revealed by the final clinical audit findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Find the root causes of the shortcomings</td>
</tr>
<tr>
<td>Decide on the actions that will be effective in removing or minimizing the causes of the shortcomings</td>
</tr>
<tr>
<td>Implement the actions</td>
</tr>
<tr>
<td><strong>A shortcoming</strong> in care is current actual practice that does not represent good practice or is not acceptable</td>
</tr>
</tbody>
</table>
Mould opinion

Are people ready?

- Use discussion, focus groups, force field analysis or an opinion leader
- Find selling points and obstacles

Pros ...

Cons ...
Prepare a strategy for change

- Reaffirm or amend the improvement and benefits
- State benefits and barriers and investigate barriers
- Reaffirm or amend who will be involved — all the stakeholders in the improvement
- Reaffirm or amend the types of changes needed — attitudes, values, behaviours, processes or systems
Possible strategies

- Feedback
- Education
- Clinical guideline
- Consensus-building
- Reminder system
- Opinion leader or outreach visit
- Patient education
- Process or system redesign
- Organizational change
- Team building and/or leadership
- Financial or regulatory incentives

Use as many strategies as possible
Redesign current practice

**What**
- are the behaviours, processes or systems needed for the improvement?

**Who**
- is involved in the change?
- is assuming responsibility for managing the change?

**How**
- will the attitudes, values, behaviours, processes or systems be changed?

**When**
- will the attitudes, values, behaviour, process or system be changed?
STRONG ACTIONS

Remove barriers to doing the work effectively
Redesigning the work
Monitor and feed back
Supervise
Use IT or technology

Hughes D. Root cause analysis: bridging the gap between ideas and execution. *National Center for Patient Safety Topics in Patient Safety* 2006;6(5):1–2
A practical hint — setting priorities among actions using the Commercial Aviation Safety Team (CAST) model —

Make a list of actions to address the shortcomings in the quality of patient care

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
</tr>
</thead>
</table>
| 1    | Use a 7–point scale to rate —  
- How effective will the action be in addressing the cause of the shortcoming in quality  
- How strongly do you believe that the action can be implemented in your organization |
| 2    | Multiply the ratings |
| 3    | Find and implement the priority actions (top priority = 49) |
Operate the new way

Have a formal pilot —

Plan the implementation of change
Implement the change
Measure the effects of the change
Make adjustments as needed
**Verify that the new way works**

Use data to evaluate —

<table>
<thead>
<tr>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is the change working?</td>
</tr>
<tr>
<td>If not, why not?</td>
</tr>
<tr>
<td>If yes, is it working consistently?</td>
</tr>
<tr>
<td>Are there any unintended side effects?</td>
</tr>
</tbody>
</table>
Eliminate unwanted variation

Is there variation demonstrated in the implementation of the change and its effects?

Decide on the type of variation — common or special cause — using run charts or control charts

Take actions accordingly

Continue to monitor
Plan full implementation
Continue measuring the effects
Provide feedback to all those involved
Continue to make adjustments as needed

Identify the IMPROVEMENT

Mould opinion to favour the improvement — and overcome barriers

Prepare for a new way — strategies and tactics

Redesign the way things work now

Operate the new way — on a pilot basis

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Eliminate unwanted variation in the new way

Stabilize the new way
Action planning and managing change are *PROCESSES*

Achieving improvement is an *OUTCOME*