

Challenges in sustaining safety standards in high performing health care services

Mr Michael Giuliano

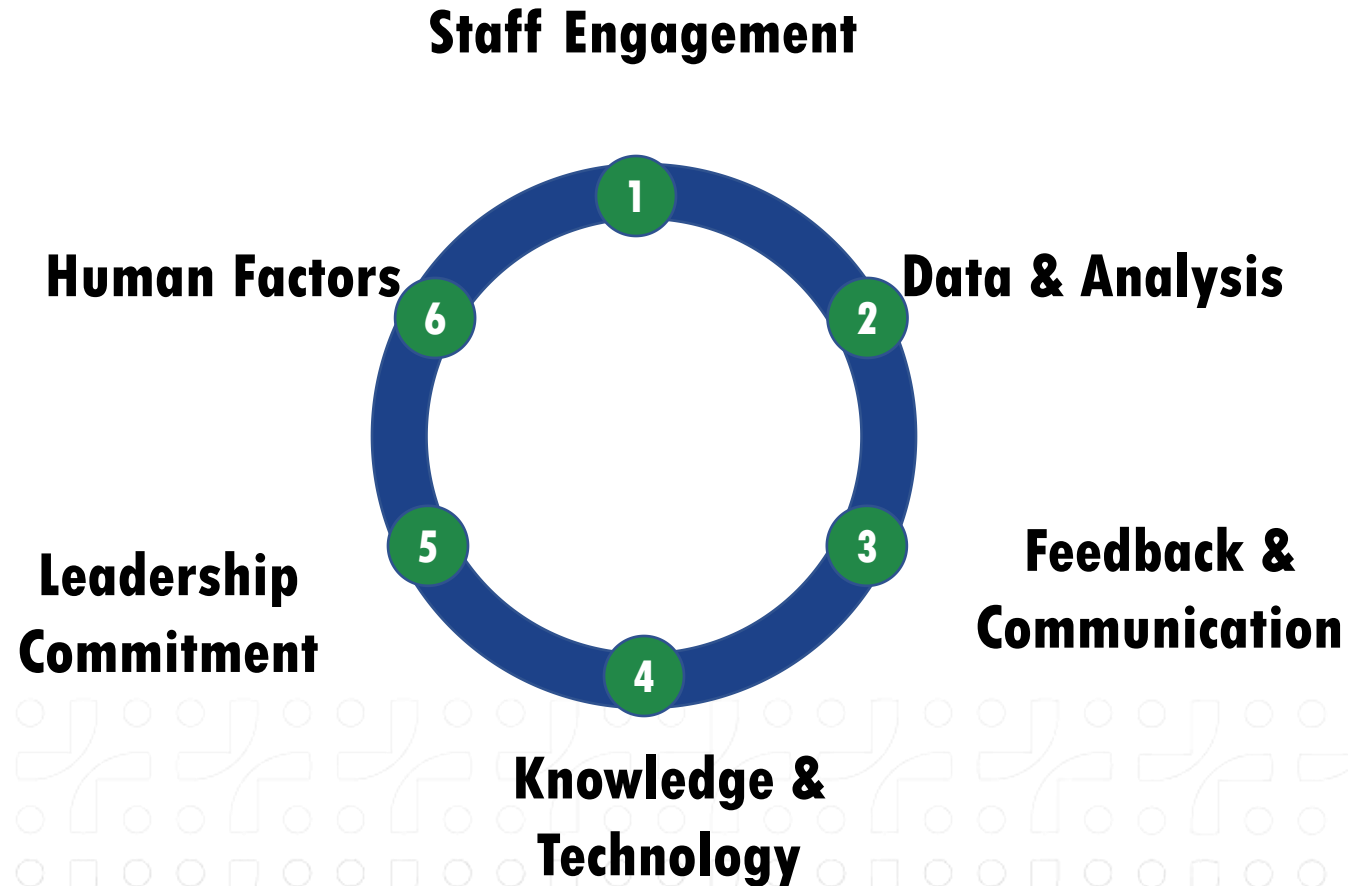
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CAHOCON Kochi – 2 April 2022

Sustainable Consistency



Challenges Overview



1 – Staff Engagement



Subsidiarity

“giving real power and responsibility to employees within an organisation, with the entire organisation having an understanding of, and a respect for, the common good”

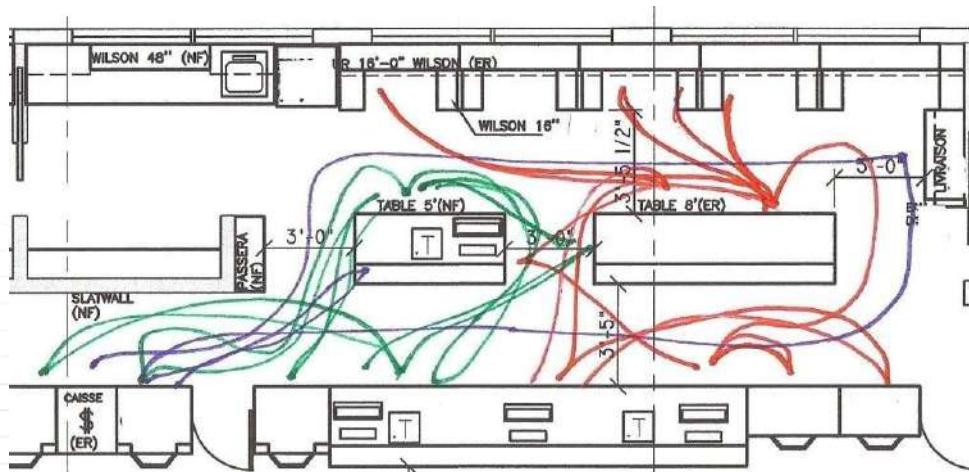
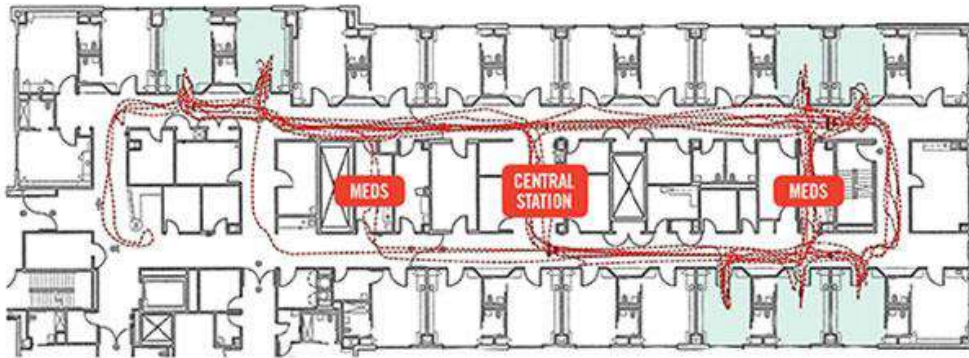
Allow people affected by change design and lead the change

Going to Gemba

Lean and Kaizen principle to ‘visit the shop floor’ to understand, learn, and ask questions of how actual processes are delivered

The Real Place

Nurse Led Change



42% to 67%

2 – Data & Analysis



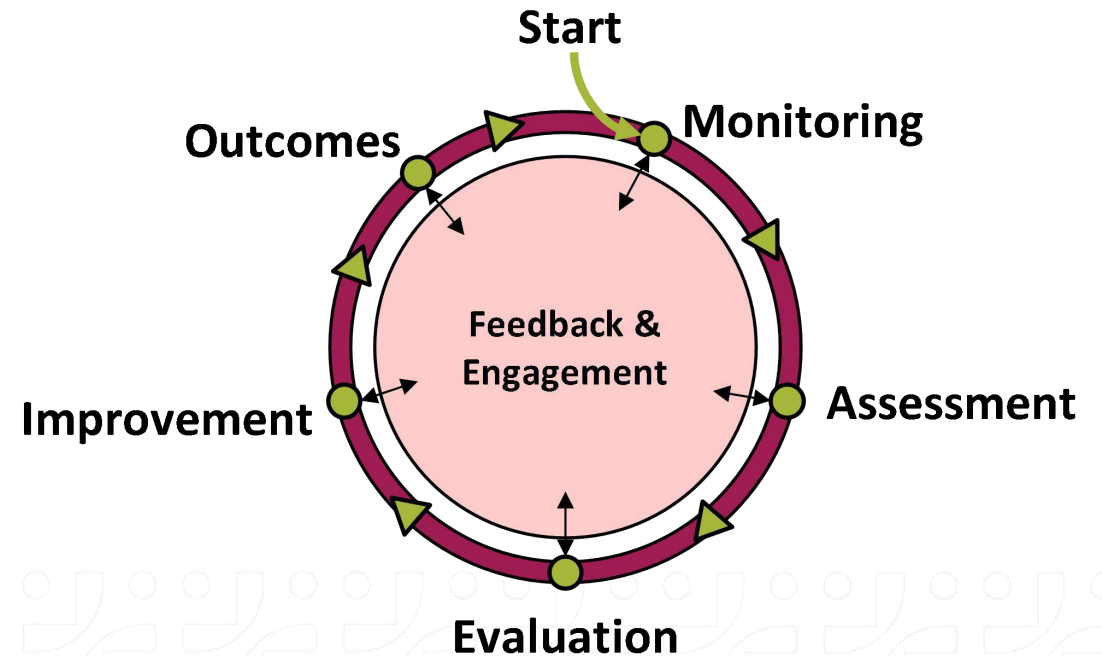
- Data collection difficulties – paper based records, retrospective
- Standardised collection – e.g., core body temp measurement post recovery
- No capacity / capability to collect, analyse, and interrogate data
- Drowning in data, but starved for knowledge – analysis paralysis
- Does measuring really ensure patient safety? (Provonost)
- Assumptions that monitoring, performance management or intervention is the responsibility of someone else (Mid Staffs)

3 – Feedback & Communication



“What gets measured gets done,
What gets measured and **fed back** is done well,
What gets **rewarded** gets repeated”

- John E. Jones III



4 – Knowledge & Technology



Year	Time to Double
1950	50 years
1980	7 years
2010	3.5 years
2020	73 days
2022+	?



**Clinical Decision Support Tools
Change Management**

5 – Leadership Commitment



- Visible leadership
- Active listening
- Questioning attitude
- Resource redirection
- Non-Hierarchical Decision Making
- Constrained Improvisation



6 – Human Factors



Human factors recognise that the workplace needs to be **designed and organised** to minimize the likelihood of errors occurring and the impact of errors when they do occur.

Blame culture > individual

Just culture > environment



Other Barriers



Unrealistic expectations of clinical perfection

Healthcare professionals should not make mistakes

Litigation and regulation

Individuals the focus as source of error

= shame, reluctance to report

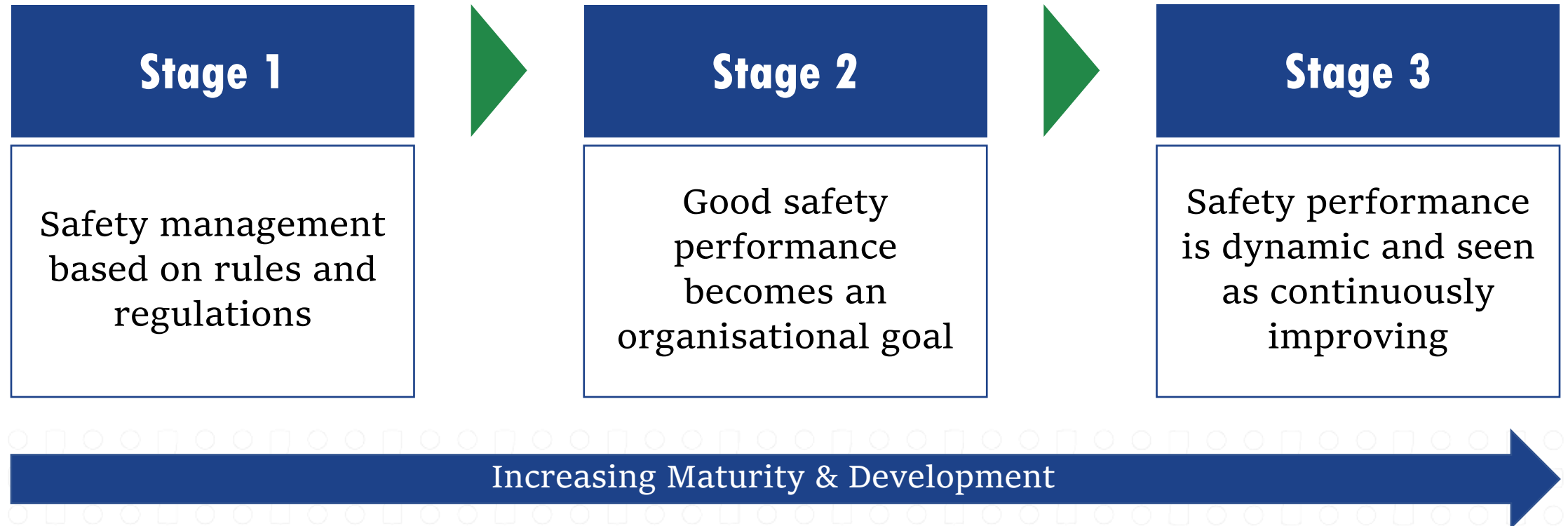
Types of culture model

1. Culture of Blame +
2. Culture of Blame
3. Culture of Reaction
4. Culture of Consolidation
5. Culture of Ambition
6. Culture of Success



Source – BPA Analytics 'Type of Culture' Model

Long Term Journey



Source – Carnino (undated), International Atomic Energy Agency



Thank You & Enjoy CAHOCON

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