When reform becomes the norm: celebrating a culture of learning in one Tasmanian rural site

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Beth Smith and Karyn Parker comprise the management team (DoN and NUM respectively) within a small (15-bed) acute/sub-acute rural inpatient facility 52 km from Launceston in northern Tasmania. Their combined health care and management experience in both rural and urban settings is broad. Since training in the 1970s, Beth has worked in both general nursing and specialty areas including palliative care, adolescent health, sexual health, Telehealth and health promotion, with Karyn's specialisation being 'all things renal'. The past 5 years have seen this duo change the culture of their team and they build on their strong advocacy of rural and remote health care by sharing their story with whomever will listen!

'Extract from the abstract'

In contemporary Australia, an emphasis on quality and safety is mandatory in all health service organisations. Achieving a sustainable culture focused on quality and safety, however, is not a simple enterprise no matter what size the organisation. It requires broad acceptance and a high level of commitment on the part of staff first to establish this culture and then to maintain it. Multiple disciplines exist in small rural inpatient facilities just as they do in large metropolitan services: however, with smaller teams, there is an even greater need to move away from illness and task-oriented paradigms of care to primary health care-focused learning cultures.

This case study reports the multi-faceted approach taken at one small rural inpatient facility following a review where the site came up short in many areas. This approach enabled all staff and the community to engage and stay enthused, and in just 5 years, this small 15-bed acute care rural hospital in northern Tasmania underwent a transformation. The changes ranged from the physical environment (from the original 1950s building to a state of the art facility) through to staff discovering the merits of being a part of a cohesive contemporaneous health care team with shared goals. This case study illustrates that the trials and tribulations inherent in system changes, with resultant emergence from dated past practices cannot be glossed over. Rather, they need to be captured and used as foci for reflection to guide and maintain momentum.

The way we were

In 2005 this small rural inpatient facility faced the aftermath of two Health Complaints Commission (HCC) Complaints, and the subsequent customary review resulted in most of the 44 benchmarked standards rated as unmet. There were many recommendations relating to organisational functions and clinical practice, as well as several issues resulting from the1954 building.

Key person dependency existed at a management level with that person responsible for rostering, all stock and supply management and oversight and all decisions regarding clinical practice. No evidence-based practices were obvious.

There was an **inconsistent work ethic** between staff, an example being the use of the tea room. It was located via a short corridor off the main ward and staff tended to use it as a base in preference to the Nurse Station. The argument was put to the new Director of Nursing (DoN) that they 'could see the front door/main corridor and hear the bells' from there. In fact both HCC complaints made reference to patients and carers being unable to find staff as they 'were all in the tea room'. The tea room itself was symbolic of the team ethos at that time. For example the room contained two tables—one table would have only one hotel services staff member seated there, while the other 'nurses table' had several crowded around it. These seating arrangements were a powerful symbol of division.

A **poor reputation/image** existed, and anecdotally other visiting service providers would recount experiencing an 'unwelcoming atmosphere' on arrival at the facility, with both current and previous staff noting factionalism and a 'favoured few' mentality.

There were **poorly defined registered nurse (RN) and enrolled nurse (EN) roles.** This manifested as no patient allocation: typically the ENs undertook the bulk if not all of the hygiene care, and even if ENs were medication-endorsed, the RN administered the medications. Clinical handovers consisted of one bed (patient ward) plan on a clipboard being 'talked to' between handing-over RNs, whilst the oncoming EN had little to no input.

There were **poor quality and safety systems** with observations not routinely done; documentation standards were subjective/limited in information; and there was no recording of incidents.

Where to begin

The shortcomings of the site and recommendations of the review were so numerous and daunting, it was hard to know where to start! The recommendations were prioritised and the first major area to be tackled was the development of systems at an operational level, for patient management and to reduce key person dependence.

Agency or Primary Health policy became a reference point for discussions and meetings about current issues. The relevant policy was clearly displayed and linked to the seriousness of the initial HCC report and the requirement to act. The policy enable the management team to de-personalise the call to action—'this is not **my** idea … more contemporary best practice'. At that time there were many new policies being generated state-wide such that at one stage we called a moratorium for our site regarding any new policies unless legislative-based. This request was supported by the rationale that our focus **had** to be on ensuring minimum standards of care were being met without 'muddying the waters' with an overload of new policies that may not be relevant to site priorities.

In addition to the use of policy as a reference point, changing out-dated practices was also facilitated by **bringing in a credible external resource person.** For example the cleaning practices determined by one long-standing full-time cleaner were not consistent with contemporary occupational health and safety standards (OH&S), (mopping across whole corridor; inadequate changes of water/mop heads etc). This issue was resolved by an external OH&S consultant who observed their/the whole cleaning team's methods and task lists, and submitted a report to management with recommendations which were supportive in the push to implement change. By developing clear task lists; communication mechanisms; regularly observing the mopping practices; and performance managing the individual, eventually correct methods were adopted.

The patient management system required many changes. **Patient Allocation was implemented** and this was embraced by the ENs who enjoyed the challenge of managing all aspects of their patients' care. It also equally shared the workload between the nurses on duty.

Systems-based reporting was introduced and encouraged the nurses to think 'whole body system' when completing their shift reports

The DoN assumed responsibility for the rostering; and closer monitoring of all general medical and surgical consumables and pharmacy supplies orders

Credible clinical leadership complementary to the senior management role is vital. To sustain momentum, there has to be a strong person/s sharing the vision for a safety and quality framework in a site. Twelve months post the initial investigation, the DoN sought a follow-up review as there were still identifiable gaps in clinical practice that seemed hard to resolve. The second review report found that while there was a significant improvement in the operational management of human, physical and financial resources, serious clinical gaps remained. These findings were critical to providing the impetus to achieve changes in patient care. An **acting Nurse Unit Manager (NUM) was appointed** to progress that clinical mentoring role 'on the floor'. The acting NUM and DoN then began the following strategies: a process of **performance management** (clearly articulating expectations as soon as concerns arise and following up with monitoring and documented meetings); **sound recruitment and selection practices** (either or both of them continue to be on every selection panel for all levels of staffing); **consultative decision making** involving the team (through meetings and individually); and importantly a **celebration of a learning culture** became embedded (for example a mature-aged EN undertaking her medication endorsement, EN bridging to RN, three ENs upgrading to Diploma, and two Aides training to be ENs). The NUM role has proven to be pivotal leading to creation of a permanent position.

Team building started from commencement of the new DoN, when a variety of communication methods were adopted in order to best meet the needs of all the disciplines within the team. These communication strategies included:

- An introductory letter sent to each staff member from the DoN in the week preceding her arrival outlining her professional background and personal family details. This proved valuable in that it served as an icebreaker/common ground when first meeting a team member plus offered some credibility and confidence in the experience of the new manager;

- Individual interviews/chats were held with every staff member over initial weeks in an effort to elicit their satisfaction levels and future plans;

- Actively demonstrating an 'open door/reflective listening' attitude; frequently interacting on the ward assisting with patients and dining with staff *(espousing positive role modelling and visible and active clinical leadership)*

- Holding frequent meetings with agendas and action-based minutes clearly displayed. For example, the Medical Advisory Committee was re-energised with increased attendance by all GPs; Hotel Services Team meetings established; Whole of Team meetings; Community Nursing and (Acute Ward) Nurse Team meetings regularly scheduled;

- Staff Newsletter developed and used as a tool for celebration; safety and quality updates; social events and staff movements;

- 'Just a Note to Say' is an informal handwritten tool used by management to individual team members about individual issues e.g. arranging meetings/roster and leave queries; and

- A mix of quick win and long term management of issues where the team could see results which were effective in proving management is 'not the enemy'.

In April 2006 the demolition of the old hospital and **rebuilding of the new one started**. This occurred on the same block of land, and bed numbers were reduced from 15 to 9 while the hospital stayed functioning throughout the rebuild. So the rebuild resulted in **change management about the physical environment as well as the cultural**. We used it to team build: involving staff in sub-committees eg art selection; soft furnishings; cleaners chose equipment; kitchen team toured other new facilities; and the Infection Control Nurse (newly designated portfolio taken up with enthusiasm by an EN) determined modifications to sink/hand hygiene placements. All of this culminated in a celebratory day where all staff received personalised mugs.

Culture change—a challenge for a few

The staff at the site responded in various ways to the changes that were occurring. The **few resistors ramped up their actions incrementally as the pressure for change increased**. This manifested in both overt (eg eye rolling and open criticism in meetings) and covert ways (eg unsigned notes on noticeboards and comments written across memos, and a Suggestion Box with not-so-appropriate suggestions!). In the first few months of her appointment, the DoN arrived one Monday morning to find the main corridor walls lined with flyers advertising an ANF meeting due to the 'low morale at (our facility)'. In fact not only the halls were lined but also the toilet door and even the toilet seat! The 'phantom poster-placers' were very keen to let all and sundry know of their discontent. From the resistors there was blame attached to the 2005 HCC report—some dismissing it as '**only** based on aged care standards so not relevant to us' (our premise was that these should be at the very least minimum standards so—if **these** are not met it isn't good) or trivialising the original complaints themselves.

There was recognition by the management team though, that the majority of the team was suffering some shell shock after the damaging HCC report so a gently supportive growth and development process was called for.

HR Advice was critical for management with the message to stay calm in the face of adversity and 'stand up to the resistors with a constant message' based on fairness and equity for all.

In order to circumvent any industrial action, a **Workforce Reference Group was formed** (along the lines of an industrial consultative committee) which connoted a less adversarial role. This group still exists and is a useful forum for the airing of any concerns between unions and management. Unions were kept informed throughout the change process and prior to any innovation in policies which may have resulted in a grievance being claimed. The **roster review was an example** of this consultative HR process where separate RN and EN meetings were held to discuss options for a rotational roster including nights. The emphasis on equitable sharing of the night shift roster was a given (previously it had been left to 4 nurses) but the team could choose **how** they wanted it to work. The end result was that the RNs chose an 8 week rotation and ENs chose a 12 week rotation. When 10 hour nights were introduced across the state in the next year—our team had a seamless transition without any industrial consequences which was **not** the case in several other sites.

And now?

Throughout the past 5 years, the application of quality and safety and clinical governance frameworks became de-mystified and contextualised. Scott et al [1] attested to this imperative when writing of addressing any existing cultural deficiencies that it demands not just 'a change **in** culture but… a fundamental change **of** culture'. The paradigm shift from illness and task-orientation to a more primary health-focused culture is demonstrated daily on-site.

These changes are evidenced by:

- the adoption of clinical portfolios eg Infection Control, Diabetes, Palliative Care and Wound Care
- the instigation of OH&S and Infection Control Committees
- regular audits for example of: documentation; medication charts; Emergency Health Records (therefore reviewing clinical performance, a cyclical process of improving quality of care)
- embracing of the risk management/GP communication model DANGERS for every admission. (DANGERS is an observation and reporting system whereby all admissions regardless of diagnosis/initial acuity must have 4 hourly observations taken and if these are outside set parameters then the GP must be alerted and importantly respond immediately)
- innovative policies emerging from incident reporting (rationalising the policy change) eg admission criteria (subsequently rolled out to every rural inpatient facility in Tasmania)
- openness and transparency with open disclosure in place
- use of a Journey Board whereby every inpatient's clinical trajectory is clearly charted from admission to discharge
- an emphasis on patient-centred care eg pilot site for bedside handover trial whereby patient feedback indicates increased satisfaction in 'being involved in (their) care'
- was one of the first rural Tasmanian sites to be totally smoke free in buildings and grounds
- branching out into the broader community with a health-promoting message eg monthly radio sessions on local community radio station *'Hospital Happenings'*; media coverage ++ with only positive messages about the facility and benefits of preventing illness.

In conclusion, this paper has attempted to demonstrate how a management team maintaining its central philosophy and practice of enabling and facilitating critical reflection, has resulted in a site that has become renowned for excellence. Sashkin & Kiser stated that organisations which 'push for constant, continuous improvement and (engender) an institutionalised belief that 'we can always do better' are deemed innovative, cited in Detert et al [2].

Take home messages

- Communicate in whatever way you can
- A little humour goes a long way
- Champion the change
- Listen to good trusted advice
- Document everything!
- Back up change with good policy
- Be visible and available

> It must be remembered that there is nothing more difficult to plan, more doubtful of success, nor more dangerous to manage than the creation of a new system. For the initiator has the enmity of all who would profit by the preservation of an old institution and merely lukewarm defenders in those who would gain by the new ones
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> Machiavelli., Niccolo 1532

It is important to never forget the vagaries of the past, however in this instance Machiavelli would instead witness a 'strong and passionate defence' of the new system that now exists in the George Town Hospital & Community Centre.

Thank you

References

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