Potential Strategies to Overcome Common Barriers to Improvement
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Ineffective Teams
- Focus on common goal/aim
- Use project charter as a guide
- Clear roles and responsibilities
- Instead of minutes, use action log…assign tasks to, date task to be completed and action to be taken…
- Celebrate successes
- Increased people, decreased productivity
- Identify the problem/issue
- Team senior leadership
- Invitation to change role or set aside, if resistance
- Communication – considering bringing in outside expert/coach to help build the team
- Do meeting debrief to outline what worked, didn’t work at end of every meeting
- Force round table feedback, call on everyone to speak
- Openness to other’s professional knowledge and roles

Lack of Buy-in Physicians or Others
- Presenting evidence that your idea may work (e.g. data, literature)
- Find the champion and find the innovator
- Make it meaningful for them on level of patient care
- Use the physician network (physician to physician, peer to peer)
- Research, publications – use data
- Identify problem (focused)
- Be sensitive to the generation
- Seek input early
- Quality improvement vs. Research – acknowledgement for QI that they receive for research
- Seek their assistance and input to solving new problems
- Dedicated physician lead, even a small part time role can make a big difference
- Include in medical curriculum and orientation

Lack Time and Other Resources
- Dedicated FTE’s
- Dedicated workspace, computers and resources to do the job
- Alignment to organizational goals
- Buy in from upper administration
- Incorporate into daily routine
- Ok for CEO to do it need to draw up plan, specifying resources needed to fulfill goals
- Think outside box to change practice

Resistance to Change (territorialism, lack ownership)
- Not a project, this is process change – not going to end, use different language
- Do pre and post data to show improvement over time
- Don’t come to them with defined solutions – listen to their solutions
• Patient focus – about patient’s best interests, not about you
• Make it real – give stories about how infections affect real people, e.g. person died from infection
• Show what is in it for them
• Involve people in working groups
• Involvement in decisions
• Listen to staff, capitalize on segmentation e.g. early adopters
• Increased workload
• Confusion from mixed messages
• Keep it simple, make it easy
• If one thing added, take one thing away
• Share data, celebrate successes

**Lack Senior Leader Support**
• Ownership
• What are their priorities? Drivers? Include a business case
• Speak their language
• Annotated run chart is gold – say it on one page
• Present data, complete and simple
• Vary approach with different groups – segmentation
• Approach influencers
• Invite as member of improvement team
• Education from front line workers
• Physician involvement on team
• Education – not QI experts, need support realistic expectations
• Team share human factors with leadership
• Help with dinosaur in the room, unable to get past them
• Find other organizations that have support and succeeded
• Share actual patient stories, patient relations department
• Integrate QI principles and values into senior leader goals and objectives

**Communication**
• Getting information out – involve corporate communications department
• Choose “right” person to communication the message e.g. physician to physician
• Simplify – one slide only – annotated run charts are gold!
• Don’t/can’t read email
• Media publicity
• Launch to create attention and excitement
• Team kick off celebration
• Closing loop – keep team updated
• Incentives for meetings
• Meeting people where they are
• Prioritize communication strategy to what’s important to audience
• Create a “buzz”, make it fun, what to be at an event, paid, dedicated time for education event
• Praise, encouragement and acknowledgement
• Face to face
• Website including results (QI/safety section)
• Newsletter for staff
• Keep everyone informed of success – brief and fun
• Leadership engagement at the front line
• Make sure data/results get back to front line and leadership (close the loop)

Turnover of Team Member or Team Leaders
• Shared ownership of leading (distributed learning)
• Rotating roles (e.g. take turns with minutes)
• Keep physicians and senior leadership roles more consultative so their commitment is smaller but more sustainable
• Make it appealing (incentives)
• Dedicated FTE
• Set up mentoring program for new clinicians
• Leaders to share knowledge amongst team so not disabling when one leaves
• Promoting conference presentations and publications
• Admin financial support up front
• Recognize efforts to maintain motivation
• “team” approach vs. “team leader”
• Spread the workload around
• Use tools to decrease work e.g. check sheets
• Build the “work” into daily practice so it becomes what we do

Lack of QI Infrastructure
• Integrate quality resources – must be dedicated support and back-up from clinical champion leading improvement (everyday work)
• Alignment of clinical and local priorities with senior leadership priorities, the big things
• The improvement triad
  o Operational Lead – keen decision maker
  o QI Consultant – how to expertise
  o Clinical Champion – street credibility
• Pay clinical nurse to come in on their own time and replace them from their other duties
• Vibrant unit CQI Committees
• Build measurement into regular indicator trending for department
• Create organizational plan at regional level set priorities based on three year plan
• Give work back to the people who know how to do it (before government gets involved)
• Look to other clinical professionals to do the work instead of just nurses, RT’s, physio, others

QI as add-on, Year End Money, Side of Desk Activity
• Use business case
• Board level commitment – standing item on their agenda
• Presentation of data to all levels of organization
• Inclusion in strategic plans, link to mission
• Communication of solutions to leadership
• Use year end money for celebrations of success, perks, etc
• Learn from baseline data, focus on a few interventions or components and do them well
• Ensure QI as line item on budget at clinical level
• Clear linkages with 3 year plans
• QI as organizational goal at all levels and strategic plans

Saturation/Overload
• Timelines – prioritization of QI initiatives
• Identify potential successor to allow respite
• Prepare successor, celebrate previous successes
• Clarify expectations, realistic vs. perfection
• Define roles and responsibilities (delegate)
• Rotate project lead under one champion leader
• Refocus scope
• Combine projects
• Set deadlines
• Set achievable goals, limited goals
• Engage more front line staff
• Share the work, share the ideas
• Don’t reinvent the wheel, look at previous data

QI Burnout
• Keep simple, fun
• Reduce documentation
• Rewards/incentives for attending meetings
• Positive feedback
• So many initiatives – piggyback to other groups working on same things

Lack of Good Data
• Use patient stories, process of events, data needs to “speak”, must be meaningful
• Consider sample size and small tests (e.g. 10 charts)
• Start small (1 patient, 1 day, one unit)
• Build data collection into adverse event experience so that it gets captured and communication follow through
• Increase ADE reporting and analysis
• Use data from other centres – benchmark
• Explore what data is currently collected
• Build data collection into electronic clinical documentation system
• Develop and test data collection tools and processes
• Integrate into current forms and databases
• Use action research cycles

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