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Qmentum Quarterly: Quality in Health Care is an avenue for sharing expertise, innovation, and leading practices across Canada. The publication provides a forum for health and social services organizations that are committed to learning about improving quality and patient safety.

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Erratum: Qmentum Quarterly, Vol. 6, No.1, page 31 (summer issue 2013): The authors have requested a revision to the opening statement.
Original: “Sunnybrook Health Sciences Centre has developed a new initiative to improve after-care for patients who have had a stroke.”
Corrected: “Sunnybrook Health Sciences Centre has recently implemented a new initiative to improve after-care for patients who have had a stroke.”
The error was made near the time of initial release and has since been corrected in the online version.
Organizational culture has received increasing attention in recent years, as its connection to the quality of health care service delivery becomes better understood. The quality of this delivery is affected by an organization’s willingness to change, innovate, and openly discuss issues around process and quality. Leadership and ownership around challenges play a significant role in an organization’s culture and greatly affect the capacity for organizational change.

While an organization’s culture is intangible, it has highly tangible results in terms of patient safety and care delivery. An organization’s culture of care is closely tied to its people; progress toward a healthy, open, and dynamic culture results from strong leadership and an engaged staff who know they will be supported. The alternative is a stagnant culture where those involved are unwilling to take ownership of systemic problems and necessary improvements.

In this issue, our authors explore the ways in which they are helping to create healthier cultures, including Positive Deviance, a Sustainable Patient Safety Culture, and patient involvement in improvement processes.

Michael Gardam and Leah Gitterman talk about how they developed the “Front-Line Ownership” method, an approach that uses innovative ideas to support positive culture and encourage behavioural change.

Reece Bearnes, Gail Blackmore, Susan Dunn, and Karen Webb-Anderson are helping Capital Health in Nova Scotia move to a more patient-centred culture of care, with 60+ interdisciplinary Quality and Patient Safety teams working to integrate patients, the public, and other stakeholders into processes that address quality health provision.

Carole Estabrooks and Peter Norton focus on having health care aides lead quality improvement initiatives that address bedside care in residential long-term care facilities. Initiatives in this area have not typically been led by this group of health care professionals; Carole and Peter’s pilot program suggests this should change.

Stephanie Carpenter discusses the importance of organizational culture and socio-cultural traditions when delivering health services in remote and isolated geographical areas, and elaborates on how culture and tradition informed the development of the Accreditation Canada Remote/Isolated Health Services Standards.

Majdah Shugdar, Eleri Jones, John Gunson, and Adel Ibrahim have been working to change staff attitudes and behaviours at King Fahd Hospital in Jeddah, Saudi Arabia. Their Sustainable Patient Safety Culture model is leading to positive results in several areas of care.

For their efforts, these authors are seeing improvements in organizational culture and an impact on the quality of care at the facilities in which they work or with whom they partner. I expect that some of the lessons learned outlined in these articles are ones that have relevance for you in your efforts to improve patient outcomes.

With kind regards,

Wendy Nicklin
If you don’t succeed the first 20 times, *please* try something different...
After becoming frustrated with endless unsuccessful cycles of education and reminders to change behaviour in health care facilities, we began searching for other approaches. We discovered that success was tied in large part to people feeling ownership for the solutions that were being implemented in their facility or unit. We devised a new approach and called it “Front-Line Ownership.” We have had great success in getting people to address the common problems that still plague most facilities.

Does this scenario seem familiar? Let’s imagine that a few years ago you were assigned to prevent patient falls at your facility. You began by creating a working group that identified the risk factors for falls and then you developed checklists and other tools for staff. Unfortunately, you didn’t see much of an improvement, largely because you had difficulty getting people interested in the problem and using the tools. Recently, you attended a conference where you heard about one facility’s success in falls prevention and you excitedly got a copy of their best practice document to use at your facility. Rather than sharing your enthusiasm for this document however, your frontline staff shot down the practices and told you why they wouldn’t work. Undeterred, you tried to roll out these best practices across your organization but uptake was slow. Now you’re frustrated and unable to understand why something seemingly as straightforward as falls prevention is such a challenge.

In the patient safety and quality world we talk a lot about sharing and implementing best practices to improve patient safety, yet in our real experience, success is often elusive. We’ve previously written that health care workers largely know what actions they need to take to prevent adverse events, but for whatever reason, they often don’t seem to take them (Gardam, Reason, and Rykert, 2010). Indeed, when we’ve conducted exercises in reverse engineering by provocatively asking frontline staff how they would efficiently spread C. difficile, make sure patients fall, or consistently give patients the wrong medications, they easily proved that they knew which practice lapses cause harm, and they affirmed that many of these lapses actually occur. There are undoubtedly many reasons for poor compliance with best practices including a perceived lack of time, or program design to name a few. We have also argued that staff members are often disengaged and may not see these issues as ones that should concern them or that they have the power to change.
Positive Deviance

Several years ago we became very frustrated with endless, unsuccessful cycles of education and reminders to influence behaviour in infection prevention and control and began searching for other approaches. Through work with Safer Healthcare Now! we met practitioners of a decades-old approach to improving seemingly intractable problems such as malnutrition in developing countries. It was called Positive Deviance.

The basis of this approach is that solutions are best identified and implemented by the people who are “touching the problem” (i.e., not outside experts, but people who will be most affected by the changes) (Positive Deviance Initiative, 2013). Individuals or groups that have managed to perform better despite being in the same situation as everyone else are identified as “positive deviants” or “outliers.” Others are encouraged to learn from positive deviants’ behaviours, and to retain ownership over solutions by tailoring them to their own community’s needs. Encouraged by early American success in using Positive Deviance to prevent the spread of the hospital superbug methicillin-resistant Staphylococcus aureus (MRSA) (Elligson et al., 2011), we started using Positive Deviance methodologies in our own facilities at the University Health Network in 2009. After some success, we invited five Canadian hospitals to participate in a study using this approach to prevent the spread of antibiotic-resistant organisms. While we were ultimately successful in decreasing infection rates by half at these hospitals, we also learned that using this approach fundamentally changed how staff approached problems and how they interacted with one another. Simply put, the patient safety culture had shifted on the wards that used the Positive Deviance approach (Zimmerman et. al., 2013). Specifically, we found that teams took more time to think about problems before acting, leaders often stepped back to allow others to lead, relationships and communication became more important in the eyes of staff, and social proof (i.e., seeing things with your own eyes) became as important as data in motivating staff to change.

Part of our research involved interviewing hospital staff. During this process, a housekeeper told
us that in her 25 years of work, no one had ever asked for her opinion about how to clean a room. She had ideas about how to improve processes, yet given the rigid hierarchy in health care, she felt she might get in trouble if she spoke up. We have subsequently heard similar comments from nurses, volunteers, ward clerks, students, and even physicians. Prior to using a Positive Deviance approach, they often felt they were told what to do, with little to no input into what was being done, or how it was being done. As they became empowered to create and lead their own solutions, we witnessed increasing enthusiasm, ownership, and most importantly, real improvements. These had all been missing from our previous approaches.

In effect, teams often need to “rebuild the wheel,” a process that is often discouraged as inefficient, yet is vital to a group owning a solution.

The FLO approach

To help ignite the engagement process, we began to use simple yet powerful techniques termed “liberating structures” to help us hear from everyone who needed to be involved in changes/improvements; we wanted to unleash their ideas (McCandless and Lipmanowicz, 2013). We termed the combination of Positive Deviance and Liberating Structures simply, “Front-Line Ownership” (FLO) (Zimmerman et al., 2013).

These approaches are firmly based in the field of complexity science, which teaches that fundamental change can be realized through multiple, seemingly small improvements that interact with one another in often unpredictable and hard-to-measure ways. While more traditional improvement models assume there is a linear association between actions and outcomes (e.g., if we implement a falls checklist, falls will decrease) complexity science suggests that engagement and relationships are actually more important than what a group chooses to work on. Furthermore, the direction taken by a group will be highly influenced by their local conditions. Using a FLO approach, different teams working on the same problem will likely come up with different solutions that ultimately address the same issue. For example, we are currently working with seven American hospitals on falls prevention and each is following a different approach that will ultimately lead to the same outcome of fewer falls. In effect, teams often need to “rebuild the wheel,” a process that is often discouraged as inefficient, yet is vital to a group owning a solution. While sharing best practices makes sense, how one achieves best practices must to be locally owned and driven to achieve sustainable change.

Central to the FLO approach is a set of principles that guide the work (see Table 1).

Table 1 - Principles of the FLO approach

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<tr>
<td>1.</td>
<td>Go slow to go fast</td>
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<td>2.</td>
<td>Invite the unusual suspects</td>
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<td>3.</td>
<td>Work with those who want to work with you</td>
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<td>4.</td>
<td>Participation is voluntary</td>
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<tr>
<td>5.</td>
<td>Nothing about me without me</td>
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<tr>
<td>6.</td>
<td>Change can spread bottom up, top down, and sideways</td>
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<tr>
<td>7.</td>
<td>Make the invisible visible</td>
</tr>
<tr>
<td>8.</td>
<td>Act your way into a new way of thinking</td>
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1. While it is acceptable for organizational leadership to set parameters around when change needs to occur, teams need to take time to understand what it is they need and want to do (“go slow to go fast”). Driving change on a tight deadline can often backfire.

2. It is important to invite everyone and encourage them all to participate. This includes “the unusual suspects.” We have found that hospital improvement activities often revolve around clinical staff (frequently nurses), yet some of the most remarkable ideas have come from non-clinical staff. For example, we must recognize that someone working in housekeeping can provide meaningful, insightful ideas about falls prevention.

3. Prior to changing our practice, we would frequently try to do quality improvement (QI) work on the biggest problems rather than with people who wanted to work with us on smaller issues. As we gained experience, we learned that working with people who want to work with us goes a long way toward creating winning conditions that bring about change.

4. Today, we don’t impose projects on those who aren’t interested in working with us. We have found that they eventually want to work with us when they see the success others are having. Participation needs to be voluntary if we want people to be engaged and own their work.

5. “Nothing about me without me” refers to the frequent stumbling block of group members naming people who are not present as the reason things do not improve. For example, we often hear non-medical staff say that doctors don’t wash their hands, so it is pointless to talk to nurses about improving their compliance and so on. One can imagine that if no doctors are present during the conversation, it can quickly get derailed. When this occurs, we park the conversation and ask the group to invite a doctor to the next meeting so we can continue.

6. We have learned that change can occur in an infinite number of ways. While we have seen QI led by senior teams in a top-down approach, other organizations prefer to have the senior team step aside to allow frontline staff to lead in a bottom-up approach. In some organizations, QI spreads virally from ward to ward, with seemingly no one leading the process in a sideways approach. This said, the FLO approach is most effective when the organizational culture, led by leadership, embraces change that comes from the front lines. For example, at our hospital, hand-hygiene compliance improvement strategies spread virally from ward to ward but the impetus for change clearly came from the senior leadership team. Over the past four years we have seen our health care workers’ hand-hygiene compliance increase from 30% to just over 90%.

7. Human behaviour is frequently driven by unspoken and often unconscious rules that may hamper QI efforts. For example, we recently gave a workshop involving two distinct groups of hospital employees. When the two groups came into the room they sat in two perfectly isolated groups—not a single person from one group mixed with the other. We drew attention to this behaviour, and in doing so, made the silos that were invisible (unconscious) suddenly visible. For the rest of the workshop, we expected the groups to intermingle.
The FLO approach does not require us to win over health care workers’ hearts and minds. We are not trying to make others understand our point of view or motivate them through education. Rather, we empower them to come up with and implement their own solutions, suitable to their context and reality. As staff begin to act differently (e.g., by answering call bells more frequently to prevent patient falls) their attitudes and mindfulness about adverse events begins to change.

We have seen remarkable success when groups use the FLO approach. Following our research work, we led two national collaboratives with Safer Healthcare Now! from 2011 to 2013, which focused on preventing health care-associated infections and improving hand-hygiene compliance. More recently, we used FLO to address other patient safety issues including pressure ulcer prevention, bedside report, falls, and staff morale at our own hospital as well as in many others. We have seen sustainable success with the FLO approach in both Canada and the United States.

If the hypothetical scenario in our opening paragraph resonated with you, we encourage you to try a different approach. This work is immensely rewarding for everyone involved! Q

Michael Gardam

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Leah Gitterman

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References


Care aides leading quality improvement
Health care aides—unregulated health care providers who deliver 80% of the direct care in Canadian nursing homes—have high degrees of burnout. We believed that a strategy to empower this workforce might reduce cynicism and tap into their high levels of job efficacy (the belief that one’s work is important). Our pilot study showed that successful care aide-led interventions are feasible; 50% of the teams working in each clinical area of our pilot showed improvement. This approach empowers care aides to contribute measurably to leading enhancements in bedside care, and can also help address issues around burnout and empowerment.

Safer Care for Older Persons (in residential) Environments (SCOPE) (Cranley et al., 2011) is a component of Translating Research in Elder Care (TREC), a longitudinal research program in Western Canadian provinces (Estabrooks, Hutchinson et al., 2009; Estabrooks, Squires et al., 2009; Roycroft-Malone et al., 2009). TREC was established to determine how residential long-term care facilities (nursing homes) could increase the use of best practices and improve quality and safety. A longitudinal measurement system was set up using a representative sample of more than 40 nursing homes. With this system and its validated instruments, we assessed organizational context, the self-reported use of best practices, and worklife quality (e.g., job satisfaction, burnout). The survey data indicated that health care aides—unregulated health care providers who deliver 80% of the direct care in Canadian nursing homes—have high degrees of burnout (i.e., emotional exhaustion and cynicism). Yet, they also have unusually high levels of job efficacy (the belief that their work is important) (Maslach et al., 1996; Poghosyan et al., 2009).

We believed that a strategy to empower the health care aide workforce might reduce their cynicism, tap into the high levels of job efficacy, and lead to improved patient care. Health Canada agreed to fund a pilot project under its health care workforce initiative.

We aimed to determine the feasibility of implementing care aide-led quality improvement (QI) teams in nursing homes. This was considered
particularly relevant given the constraints posed by having small numbers of staff and traditional decision-making hierarchies in nursing homes. Additionally, implementing care aide-led teams is a relatively inexpensive step.

... few teams are led by health care aides. Yet these aides ... are the staff most likely to observe, interpret, and respond to residents’ daily care needs.

We established QI teams in 10 units in seven nursing homes in Edmonton, Calgary, and the Interior Health (Okanagan) region of BC. These teams, led by health care aides, had four to six members each. SCOPE research staff facilitated the QI teams in carrying out rapid-cycle changes using the Plan-Do-Study-Act method to test for bedside change. Research staff used day-to-day troubleshooting and monthly teleconferences to facilitate learning about tools, undertake local measurement, understand Resident Assessment Instrument–Minimum Data Set 2.0 (RAI-MDS) data reports, and form learning networks across the 10 units. A senior sponsor, such as a Director of Care or higher, supported each QI team, provided the required resources, removed barriers, and shared success stories with senior management.

The literature on collaboratives and QI initiatives in nursing homes reports that few teams are led by health care aides. Yet these aides are pivotal to the health care team as well as to the quality and safety of care in nursing homes. They are the staff most likely to observe, interpret, and respond to residents’ daily care needs (Boockvar et al., 2000; Kontos et al., 2011); their decisions and actions directly impact residents’ care.

Importantly, studies have revealed the following:

- Strategies such as empowering work teams can strengthen staff performance and resident care (Barry et al., 2005; Yeatts & Cready, 2007).
- Health care aides who feel empowered report experiencing less burnout and feeling more committed to and satisfied with their job (Cready et al., 2008).
- Staff engagement (i.e., involvement and commitment) and initiatives that improve communication among nursing home staff members are associated with an improved quality of care (Castle & Engberg, 2007; Hamelin Brabant et al., 2007; Scott-Cawiezell et al., 2004).
- The use of best practices also improves the quality of care—both the processes and the outcomes (Grimshaw et al., 2004).
- Succeeding with best practices requires the capacity to apply complex knowledge, work as a team, and maintain clear communication among staff members (Janes et al., 2008).
- While implementing these practices is sometimes complicated, care aides have demonstrated their ability to translate best practice knowledge into care (Janes et al., 2008).

**Methods**

SCOPE required time and support so that QI team members could attend a minimum of one monthly teleconference, regular team huddles, meetings with senior decision makers, four face-to-face meetings during the intervention (with at least
two team members, including one care aide), and prepare data and presentations. Estimating that this would require the release of at least 5% of a full-time equivalent health care aide position over the 12-month project, we offered a modest grant to each participating facility to offset costs.

A consensus exercise (Cranley et al., 2012) among decision makers, care aides, registered nurses/care coordinators, and managers/educators provided strong agreement on the top three clinical areas of focus for QI teams: skin care, managing behavioural issues, and pain control. Each team selected one area for its QI work.

The teams included a project manager, a quality advisor, and a research assistant. They planned SCOPE around these core principles:

- Care aides are expert care givers working on the front lines
- Empowering care aides to implement changes could improve the quality of care and the aides’ worklife quality
- Projects must fit the realities of working life in nursing homes
- Team progress must be monitored and learning needs assessments must be conducted regularly to allow education and coaching support to be tailored appropriately
- Senior leaders and frontline teams are both critical to a program’s success

We combined data from short surveys, observations, short interviews, and field notes with simple measures of engagement in SCOPE (e.g., the frequency of submitting monthly reports,
attendance at learning sessions, attendance at teleconferences, QI team-initiated calls to SCOPE staff). The quality of worklife measures included job satisfaction, burnout, and health status (QualityMetric Incorporated, 1999). We developed a short scale to collect measures of informal communication between care aides and other nursing home staff, as well as best practice use (Squires et al., 2011). Risk-adjusted quality indicators derived from RAI-MDS 2.0 data characterized the effect of bedside quality of care. We analysed the RAI-MDS quality indicators for each clinical area of focus using statistical process control methods (Thor et al., 2007).

Results
The SCOPE pilot studied whether successful care aide-led interventions are feasible and effective; the answer is yes. We classified SCOPE areas as improved if they showed clinical improvement in a majority of their control charts for appropriate RAI quality indicators. Using this rule, 50% of the teams working in each clinical area (skin care, behavioural issues, pain control) showed improvement. Using statistical process control methods, we saw positive and significant improvement for pressure ulcers in the two units addressing skin care (see Figure 1).

Discussion
Our pilot study results are encouraging. QI work in nursing homes is primarily led by registered health care providers who commonly direct care aides to implement new protocols (Abel et al., 2005; Buhr & White, 2006; Morley, 2008; Ouslander, 2007). We showed that QI teams led by care aides can carry out QI in a collaborative environment. We are now developing a full-scale implementation and evaluation of the SCOPE model that addresses sustainability and scalability.

Figure 1: SCOPE units working on skin care

UCL = upper control limit
Stage 2+ PU = stage 2 or greater pressure ulcer
*Note the lower control limit (LCL) is negative and the UCL and LCL are symmetrical around the mean; when this happens and it does not make sense, commonly only the UCL is shown. In this case, the variation will be from 0 to 8.4% unless the system changes.

Given our small sample and the relatively short time we followed outcomes, we were surprised that in 50% of the nursing home teams, unit-level RAI quality indicators showed measurable improvement in the clinical area of focus. Some changes were substantial. For example, prior to SCOPE, 4% of residents on one unit had moderate to severe daily pain. Eighteen months after initiating SCOPE, this incidence had fallen to less than 1%. Some participants were sceptical at the first learning session, but SCOPE received significant across-the-board enthusiasm and support by the final session. We believe that SCOPE leveraged an untapped sense of job efficacy.
SCOPE’s success may also have arisen from positive deviance (Bradley et al., 2009; Marsh et al., 2004)—the concept that organizations already contain knowledge about what works. In Western Canadian nursing homes, where care aides deliver 80% or more of direct bedside care, aides hold much of this tacit knowledge. Given the opportunity, the language and tools of QI, and the support of a senior sponsor, aides mobilized this embedded knowledge and effectively changed bedside practice.

We demonstrated that care aides can engage in successful bedside QI initiatives. Nonetheless, three aspects require careful attention:

- Providing sufficient support to care aides—especially during the early stages of an intervention—so they can complete their regular workload and lead teams
- Engaging managers and senior sponsors meaningfully in supporting the QI process; attending to their learning needs, as well as those of the frontline staff
- Planning early in the process to sustain the initiative

Health care aides can master the QI model, how to measure for improvement, and the Plan-Do-Study-Act method. To do so, they require a thoughtfully planned program that includes information, coaching, networking, and the concrete support of senior sponsors. Given the opportunity, health care aides can contribute measurably to leading improvements in bedside care. Q

Carole Estabrooks

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References


The importance of culture in delivering remote/isolated health services
Remote/isolated health service providers in Canada face unique challenges. At Accreditation Canada, we aim to support them by creating standards that address their needs in a culturally relevant way (most such providers serve Aboriginal communities). To this end, *Remote/Isolated Health Services Standards* for the Qmentum program will be released early in 2014; they address the culture of community and partnerships, team culture, socio-cultural practices.

Every health care setting has unique challenges. Health care facilities in remote or isolated environments have the difficult task of offering a large range of services to a small community or to a number of small communities that are typically spread over a large area.

The definition of remote/isolated varies. At Accreditation Canada, it is defined as an area with limited access to an acute care hospital, where health care is provided by general practitioners or non-physician providers and/or where specialist support is either limited or not immediately available. Such communities may be inaccessible at certain times of the year and require fly-in access; this includes remote nursing stations and health centres. According to Health Canada, there are 76 remote nursing stations and more than 195 health centres providing care to over 600 Aboriginal communities in remote and isolated areas of Canada (Health Canada, 2013). These numbers do not reflect organizations providing care north of the 60th parallel, which, according to a 2006 study, represent almost 17% of Canada’s Aboriginal nurses (University of Saskatchewan, 2006) and 0.2% of the total nursing workforce in Canada (Canadian Institute for Health Information, 2011). According to the same report, 6.1% of Canadian nurses work in remote areas.

Add to this reality the other challenges of a remote setting—the limited availability of physical and human resources, restricted access to other health care services (e.g., acute care organizations, specialists, pharmacy, physicians, and other health care providers), and the ever-present complications of geographic access and weather—and health care provision may seem almost impossible. But these organizations endure. They rise to the challenges and provide quality care.

**Recognizing cultural differences**

To help address these challenges, Accreditation Canada has been working since 1999 with representatives of remote health services organizations, particularly Aboriginal health services, to develop accreditation programs focused...
on community health, primary care, community-based mental health, and substance misuse services.

Accreditation Canada’s Remote/Isolated Health Services Standards for the Qmentum program will be released early in 2014. These standards provide an integrated approach to service delivery by addressing the blend of acute, community, and public health services that remote/isolated health care organizations provide. More specifically, the standards focus on emergency, urgent, and primary care, as well as public health through community health programs, health promotion, and disease prevention. An associated set of standards—Medication Management for Remote/Isolated Health Services—is also available. These standards address medication safety in the remote service environment. Remote/isolated health services-specific content for the Accreditation Primer will also be available for organizations that are new to accreditation.

As the Remote/Isolated Health Services Standards were being developed, “culture” was a predominant theme that emerged during the literature review, in discussions with the Standards Working Group, and via feedback from client organizations. The culture of community and partnerships in remote communities, the culture within which their health teams operate, and the integration of socio-cultural traditions into care are all vital to delivering quality remote health services.

The culture of community and partnerships

Although the actual service area may be large, the population is relatively small and the number of staff working in remote health organizations is limited. This means staff members often provide care to friends, neighbours, and family members. Although there are benefits to having close ties with clients and the broader community, this also poses challenges. The professional anonymity often found in urban centres is lost in remote areas and confidentiality can become a much more complex issue (Canadian Association for Rural and Remote Nurses, 2008).

Partnerships are an important aspect of any effective health care organization. In an environment where resources and access to other services are limited, they are essential. Organizations must have established partnerships with other health care providers who fly in to provide on-site care (e.g., physicians, specialists, dentists), with community groups and leaders (e.g., Band Council, Elder groups, community advisory groups), emergency supports (e.g., RCMP, Emergency Medical Services), and transportation providers. With these partnerships, remote/isolated organizations are able to provide communities with a full range of health and community services. To ensure the best care is delivered, especially in an urgent situation, partnerships and technology (e.g., telehealth) must be well-established and efficiently organized.

Team culture

Remote/isolated care has unique recruitment and retention issues. Conditions are different from urban communities; remote communities can often be insular due to their location. As they are largely in the Canadian North, health care service providers also experience a harsh environmental reality (Canadian Association for Rural and Remote Nurses, 2008).
Health care practitioners may wish to work in these environments for any number of reasons, including having roots in the community, being drawn to the service environment, or wishing to experience new areas of health care, including a different scope of practice.

In some jurisdictions, remote health nurses have an expanded scope of practice from those working in other remote areas of Canada (College of Registered Nurses of British Columbia, 2013). Working to the full scope of one’s practice has a positive impact on staff retention and recruitment (Canadian Health Services Research Foundation, 2010). Although care is supported by education and practice setting requirements, there are additional pressures on those who work in remote communities.

In remote/isolated health care organizations, for example, nurses provide care that, in an urban area, would be overseen by a general practitioner or provided by other professionals (e.g., pharmacy, respiratory therapy, diagnosis). Remote health care professionals are required to provide routine daily care (e.g., take blood pressure, aid with medication administration, deliver community programs) as well as be poised to respond to an urgent or emergency situation or a complicated health issue that requires intervention from partners or other health care providers outside the organization.

Socio-cultural practices

Most remote health organizations serve largely Aboriginal populations. To be effective, it is crucial that these organizations engage their clients and deliver services that are meaningful and culturally relevant. In Aboriginal communities, this means incorporating traditional teachings, medicines, and healing practices into care. It also means training staff members to be culturally aware and sensitive when working with clients.

When a community’s connections to its health services improve, clients are better able to understand and engage in their own care. This happens when the health service makes the effort to assess community needs, evaluate how the organization is meeting those needs, identify areas for improvement, and actively pursue the participation of the people it serves.
A health care team must operate smoothly for care to be delivered effectively and safely. Effective team functioning is dependent on solid communication, feelings of trust, and working together to deliver care, address challenges, and work toward quality improvement (Canadian Patient Safety Institute, 2011).

Summary

The Qmentum Remote/Isolated Health Services Standards can be used to foster a culture of quality improvement in organizations that often struggle to meet day-to-day challenges. By strengthening the internal team culture, professionals can work together to deliver safe, quality, and relevant services to their clients. The standards also incorporate aspects of Aboriginal culture into health services delivery, which is an integral part of strengthening how health services are delivered in remote/isolated areas. Respecting Aboriginal culture and ensuring that its uniqueness is integrated within the standards helps engender pride in the health services provided in remote/isolated communities.

Stephanie Carpenter

Stephanie Carpenter, MA, is an Accreditation Product Development Specialist at Accreditation Canada. She is the lead Product Development Specialist for the Aboriginal Health Services market which includes the Remote/Isolated Health Services Standards, Aboriginal Substance Misuse Services Standards, Aboriginal Community Health and Wellness Standards, and the Aboriginal Integrated Primary Care Standards. In addition to her work on Aboriginal health, her projects include Ambulatory Systemic Cancer Therapy Services Standards, Cancer Care and Oncology Services Standards, Emergency Department Standards, and standards for Spinal Cord Injury Services. She holds a Master of Arts from the University of Western Ontario and a Bachelor of Arts from McMaster University.

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Key lessons in engagement: Creating a culture of care
Capital Health (Nova Scotia) works with patients, partners, and the public to exchange information, make decisions, act together, and share responsibility for improving health and well-being. To facilitate meaningful participation, we developed an engagement policy and established over 60 interdisciplinary Quality and Patient Safety (Q&PS) teams. Stakeholder engagement is integral to ensuring a high-quality, patient-centred culture of care at Capital Health.

Health care systems are undergoing significant changes in the face of increasing demands and strained resources. Advancing technology, treatments, and innovations in clinical practices all influence patients’, families’, and providers’ perceptions of health care and their experiences. Despite the many organizational changes we continue to undergo, Capital Health remains grounded in its values; we are committed to engaging with those we serve and to improving our culture of care.

The Accreditation Canada standards specify that health care organizations engage with communities to understand their needs, establish priorities, and plan the appropriate delivery of services (Accreditation Canada, 2012). Capital Health is committed to doing this by engaging patients, families, and communities in a way that is meaningful and sustainable.

Over the last six years, Capital Health’s approach to community and stakeholder engagement has truly matured. In 2007, we began our journey by launching Strategic Quest, a strategic planning exercise to shape the organization’s future direction. During this process, we listened to staff, physicians, and the community, after asking them what a new model of care delivery might look like. We heard from thousands of people and uncovered some uncomfortable truths within our system. This feedback ultimately helped shape the development of a new strategic plan called Our Promise.
As set out in our strategic plan, our mission is “To be a world-leading haven for people-centered health, healing, and learning.” The organization focused on five key strategies to achieve this, one of which is Citizen and Stakeholder Engagement and Accountability. In 2012, we invited hundreds of patients, employees, physicians, and stakeholders to a district-wide consultation to review our strategic plan with a focus on implementation. Through this process, we renewed our commitment to Our Promise, identified 14 Areas of Focus, and launched, Our Promise in Action.

Engagement and accountability

The principle underlying the Citizen and Stakeholder Engagement and Accountability plan is information sharing between the patient, the family, and the health care provider. With patients, partners, and the public, we exchange information, make decisions, act together, and share responsibility for improving health and well-being. This is the participatory foundation upon which our culture of caring for people is built.

In keeping with recommendations from Accreditation Canada, a variety of approaches are used to encourage and engage the public in planning around our services. Dialogue is encouraged through team participation; focus groups; town hall meetings; and surveys or feedback requests on policy development, care delivery services, and daily operations.

By listening to and learning from patients and families, we create and sustain a caring culture within our organization. This culture of listening and learning involves patients, families, and stakeholders in decision making for organizational priorities and services. “This approach helps to integrate identified needs into the plan of care for patients and families, and in doing so, focuses on providing quality, safe, patient-centered care. Through shared decision-making, the patient and family collaborate with providers to improve health care experiences for themselves and one another,” says Chris Power, President and CEO of Capital Health.

Our approach to patient and public engagement

To facilitate meaningful participation by patients and the public, we developed an engagement policy with input from staff, physicians, the public, and community health boards. Capital Health then established over 60 interdisciplinary Quality and Patient Safety (Q&PS) teams. The goal was to build a district-wide structure to engage patients, families, and clients who could bring their experiences to bear with the teams. The teams’ participation takes many forms, including involvement in projects and initiatives of strategic importance, such as business planning and facilities renewal planning processes.

Recruitment

To successfully recruit patients, families, and the public, a multi-faceted strategy was developed and implemented. Recruitment activities included placing invitational postcards in strategic locations throughout the organization, using social media, contacting people who had previously expressed interest, and word-of-mouth. To ensure the most meaningful experience possible, people were then assigned to Q&PS teams that matched their area of interest.
Education

In order to support meaningful engagement for both participants and staff, we recognized the importance of sharing information and providing education. For patients and the public, we provided an overview of the organization, basic principles of engagement, and an opportunity to discuss and clarify respective roles. The sessions were meaningful for participants, enhancing their function within the Q&PS teams. We educated patients and interested members of the public about what was expected of members of the quality and patient safety teams and specifically about the unique value their participation can bring. Specifically, we provided an orientation session, which further described expectations around the participant role. The second session explained how participant involvement is integral to quality health care, as reflected in accreditation. The sessions were meaningful experiences for both the participants and the Q&PS teams. We will continue to offer education sessions to meet the needs of our participants, as well as workshops for staff highlighting the key components of engagement, best practices, and other practical suggestions around quality improvement (QI).

Networking and support

Our goal was to sustain patient, family, and public involvement in QI and build meaningful experiences through participation on the Q&PS teams. By bringing participants together and providing opportunities for facilitated conversations, we enabled participants to build
networks, share experiences, and enhance their skills around QI work. This has brought a valuable perspective to Q&PS team discussions related to improving patient care processes and outcomes.

**Key organizational lessons**

This commitment to community/public/patient engagement has brought a number of key lessons to the foreground:

- Exploring and sharing patient stories is not always easy for participants or teams in general.
- Engagement needs to be meaningful for both the organization and the participants in order to build trust-based relationships.
- Logistical planning for successful engagement requires a significant time commitment.
- It is essential that Q&PS teams invest time in ongoing education, orientation, and mentoring for participants.
- Ensuring that all team participants are clear on engagement objectives, role clarity, and expectations is critical.

**Impactful insights**

We heard a number of valuable messages and insights from patients, families, and the public during this journey:

- Patients and families want to give back to our health care system, and want their input to make a difference.
- Participants gained a greater understanding of the systemic challenges in health care.
- Participating on the Q&PS teams provided participants with an opportunity to identify QI solutions.
- Participants articulated their desire to help shape the future direction of services to ensure their quality and sustainability into the future.
Our journey continues

Despite the significant changes health care continues to undergo, practices that encourage and support citizen and stakeholder engagement are integral to ensuring a high-quality, patient-centred culture of care. We will continue to evaluate the impact of our ongoing efforts to engage patients, families and the public. Organizationally, Our Promise in Action will be evaluated through measures of the 14 identified Areas of Focus. Capital Health puts those it serves—patients, families, and communities—at the centre of everything it does. Participating in the Accreditation Canada Qmentum program has helped move Capital Health forward in achieving its mission to become “… a world-leading haven for people-centered health, healing and learning.”

Gredi Patrick
Gredi Patrick, BScN, MN, MHSA, is a Quality and Patient Safety Leader with Performance Excellence at Capital Health. Her background includes critical care nursing, clinical educator, research assistant, and Research Ethics Board co-Chair. Her research interest is patient engagement through shared decision making. Gredi obtained her BScN and Master’s in Health Service Administration and Nursing at Dalhousie University. She is a member of the International Association of Public Participation and is enrolled in the Canadian College of Health Leaders CHE program.

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Reece D. Bearnes, BSc, MHA, CHE, is Quality and Patient Safety Leader at Capital Health. He was the inaugural recipient of a one-year postgraduate Executive Fellowship in Health Administration. He has led the development and implementation of a co-Leadership Accountability Framework for directors and physicians, was selected to help lead the renewal of Capital Health’s strategic plan, and has championed systematic efforts to improve the patient experience.

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Susan Dunn
Susan Dunn is an Advisor on Patient and Public Engagement at Capital Health. She is a member of the International Association of Public Participation. Before joining Capital Health six years ago, she worked in broadcasting and adult education.

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References
Developing a sustainable patient safety culture in Saudi Arabia
Researchers at the King Fahd Hospital in Jeddah (KFHJ) created and implemented a project to change staff attitudes and behaviours. They aimed to promote an enhanced patient safety culture among hospital staff to help reduce medical errors. In general, there was a positive correlation between the implementation of their Sustainable Patient Safety Culture (SPSC) model and the enhancement of staff attitudes around patient safety.

Despite advances on many fronts in health care (e.g., improved physician skills, enhanced infrastructure, higher levels of patient education), many patients are still injured or die because of medical errors (Kizer and Blum, 2005).

A culture that promotes patient safety is likely to lead to a reduced number of medical errors.

Causing no harm is one of the most important goals of any health care provider. This goal necessitates a system that proactively detects and prevents errors (Cooper et al., 2000). A culture that promotes patient safety is likely to lead to a reduced number of medical errors.

To this end, we developed and implemented a project to change staff attitudes and behaviours and promote an enhanced patient safety culture among hospital staff using an action research approach (Coghlan and Brannick, 2009). The project was undertaken in the KFHJ, the second largest public hospital in the western region of Saudi Arabia.

The expected project outcomes were three-fold:

1. Create a SPSC model and toolkit
2. Achieve an enhanced score on the Hospital Patient Safety Culture Assessment (HOPSCA) (Agency for Healthcare Research and Quality, 2001) which was adopted by the Saudi Ministry of Health
3. Attain an enhanced accreditation score on the Saudi national accreditation standards administered by the Central Board of Accreditation of Healthcare Institutions (CBAHI)

Our research question was “How can [we] change staff attitudes and behaviours through the accreditation process to promote a SPSC in a hospital environment?” The conceptual framework developed to guide the study was based
on a thorough literature review and the notion of embedding patient safety practices into the hospital accreditation process.

**Research milestones**

Research milestones were set while the first HOPSCA was administered (see Table 1) (Ketring and White, 2002) to assess the baseline scores of the patient safety culture dimensions. Following an eight-month application of the SPSC change model, a second HOPSCA was conducted prior to the formal CBAHI accreditation survey.

Analyzing the patient safety culture indicators in the HOPSCA confirmed that the SPSC model positively affected the culture in some dimensions. The following improvements were identified:

- 100% increase in Organizational Learning, Continuous Improvements, and Communication Openness
- 75% increase in Feedback and Communication about Errors
- 75% increase in Non-Punitive Response to Error
- 50% increase in Supervisor/Manager Expectations and Actions Promoting Safety, Teamwork within Hospital Units, and Staffing

After the SPSC intervention, the hospital accreditation scores also increased by almost 10% in all areas. The SPSC model was therefore an effective tool for enhancing quality at the hospital, leading to high accreditation scores and improvements in staff performance.

The results led to refinements in the SPSC model so it could be applied to other organizations seeking accreditation, to help them to avoid the pitfalls that occurred during this research. The main challenge was transforming a punitive culture, and attaining more leadership support around resource provision.

<table>
<thead>
<tr>
<th>Table 1: HOPSCA patient safety culture dimensions</th>
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<tbody>
<tr>
<td>1. Teamwork within units (four items)</td>
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<tr>
<td>2. Supervisor/manager expectations and actions promoting patient safety (four items)</td>
</tr>
<tr>
<td>3. Organizational learning: continuous improvement (three items)</td>
</tr>
<tr>
<td>4. Management support for patient safety (three items)</td>
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<tr>
<td>5. Perceptions of patient safety (four items)</td>
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<tr>
<td>6. Feedback and communication about errors (three items)</td>
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<td>7. Communication openness (three items)</td>
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<tr>
<td>8. Frequency of events reported (three items)</td>
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<tr>
<td>9. Teamwork across units (four items)</td>
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<td>10. Staffing (four items)</td>
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<td>11. Handoffs and transitions (four items)</td>
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<tr>
<td>12. Non-punitive response to errors (Cronbach’s four items)</td>
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</table>

**The SPSC model**

We began with some updates at the hospital level, ensuring appropriate planning in terms of staff numbers and specialties, and adopting safe and advanced technologies. Some organizational systems also needed to be put in place, including an infection control and medication management plan. The complexity of human behaviour was also considered, given that Saudi Arabia employs health care workers of approximately 40 different nationalities, all with differing languages, beliefs, and attitudes.
Once we were ready to roll out the SPSC model, we followed a clearly defined process. There were 12 steps in the model we used at KFHJ, as outlined below.

Step 1: Leadership Momentum
The hospital’s executives declared that improved accreditation scores were a predetermined objective of the project, and led the kick-off to get the process underway. This included hosting meetings and educational sessions with staff from departments across the hospital.

Step 2: Formation of the Accreditation Steering Committee (ASC)
The ASC was a multi-disciplinary committee of key stakeholders and departmental leaders who guided the accreditation process. It was chaired by the hospital’s General Director and consisted of seven team leaders, representing the medical, administrative, nursing, safety, pharmacy, laboratory, facility management and safety, and infection control departments. The Committee was responsible for the nomination of teams, team leaders, and members based on predetermined selection criteria. In collaboration with the quality department, the Committee created the SPSC Toolkit, which was distributed once the accreditation teams were officially appointed.

Step 3: The Accreditation Teams
The ASC assigned tasks to seven accreditation teams (e.g., the Continuous Quality Improvement Team, the Patient Safety Team). These teams used the CBAHI standards to identify the necessary resources, documents, and committees for this project.

Step 4: Team Vision
The teams and the Committee adopted a new vision to drive the SPSC efforts with a uniform approach that was aligned with the hospital’s vision.

Step 5: Education and Training
This step involved promoting learning throughout the organization; we wanted staff at all levels to acquire new skills. The work of Kegan and Leahey (2001) in *The Real Reason People Won’t Change* was a significant factor in our approach to education. They pointed to competing commitments, assumptions, and one’s actions/inactions around a given goal as areas that need to be addressed to create a true learning environment.

Step 6: SPSC Toolkit
The SPSC Toolkit provided the hospital with a standardized process for document preparation, including formatting for policies and procedures, job descriptions, committee-management forms, training needs assessments, information needs assessments. This was done across the hospital through a hospital-wide workshop called “How to prepare your department.” The Toolkit identified training sessions that needed to be conducted for various staff groups, based on the CBAHI standards.

Step 7: Continuous Quality Improvement
The Continuous Quality Improvement Team, the Accreditation Teams, and the Patient Safety Teams agreed on a process for critically analyzing problems and determining realistic solutions within the available resources.
Step 8: Staff Communication and Awareness Team

This team engaged and enabled the whole organization by using many communication channels to distribute the appropriate information at the right time. For example, a poster about confidentiality reminded staff that patient information should not be discussed in public areas such as elevators or the waiting area.

Step 9: Facilitate

The Accreditation Steering Committee Chairperson held regular monthly meetings with the accreditation teams to support them with the necessary resources and decisions and help them overcome obstacles.

Step 10: Celebrate Quick Wins

An internal audit of short term wins in the SPSC model was created. It was intended to inspire teams before the final accreditation survey.

Step 11: Continuous Quality Improvement

See step number seven. This step took place after the quick-wins audit and before the formal CBAHI survey.

Step 12: Sustain–Adopt Hospital-Wide Projects

This step came after the final CBAHI survey and after the hospital had achieved accreditation. It was created to promote sustainability and a cooperative environment via the hospital-wide adoption of a continuous quality improvement project.
Results

Primary data were collected using the HOPSCA, which was completed by physicians, nurses, and technicians. Secondary data was collected by the CBAHI surveyors, using survey process tools from the CBAHI database.

After the SPSC intervention, the overall differences in the mean scores of agreement on safety dimensions were significantly higher for physicians than for the other two groups (Figure 1).

Figure 1: Changes in the overall mean scores of agreement on safety dimensions

Significant increases were seen in the mean scores of agreement after interventions on items grouped around the safety culture dimensions (Figure 2). The greatest differences in the mean scores were for the “organizational learning/continuous improvements” and “communication openness” dimensions. However, mean scores for four dimensions did not change. There was a slight drop in “non-punitive response to error” because it was difficult to introduce a shift from a punitive culture—with a focus on personal/individual blame—to a non-punitive culture, focusing on rectifying systemic issues.

Figure 2: Changes in patient safety culture dimensions after intervention

Figure 3: Changes in each unit’s score after intervention
Higher percentages were achieved during the accreditation survey after the SPSC intervention was introduced (Figure 3). The greatest improvements were in the specialized areas (42.4%), followed by facility management and safety (32.9%), patient and family education and rights (31%), and finally, in the laboratory (23.3%). A few areas actually experienced a negative impact after the intervention. One of the reasons was the variation in the surveyors’ interpretations. Relicensing was an issue they identified, but it was outside the control of the hospital administration as it is done centrally by the Saudi Commission for Healthcare Specialists, which did not respond in a timely fashion to ensure that everyone’s licenses were updated. Other reasons included poor communication between the pharmacy and the medical staff around antibiotic guidelines. The lower score in the ICU was the result of having a poor staffing plan for nursing care, which was not based on patient volume and acuity.

**Summary**

In general, there was a positive correlation between the implementation of the SPSC model and the enhancement of the KFHJ accreditation score. This resulted from enhancing staff attitudes around patient safety (Figure 4). Some patient safety dimensions still need further work, which will likely include research around team work and leadership support for the SPSC.

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References


Health care providers can exercise a significant amount of influence over the culture in their organizations. With the right leadership, support, and openness, organizations can shift their culture to improve patient outcomes. Thank you to the authors here in Canada and around the world for sharing their efforts, which are clearly having a positive impact in their organizations.

Our next issue of Qmentum Quarterly will focus on partnerships to improve care outcomes. Partnerships are vital in leveraging the work of various individuals and organizations in contributing to quality and patient safety and they are an important part of our work at Accreditation Canada. Partnerships increase the capacity of the system to address Canadian health care challenges in a unified manner across sectors and organizations. Our ongoing efforts to improve patient safety via collaboration always have the ultimate goal of improving the overall standard of health care in Canada.

To support your quality improvement efforts, we have a number of upcoming webcasts and workshops you might find interesting. We will have webcasts featuring Aboriginal health service organizations sharing stories around how they implemented plans and frameworks to improve care, including risk-management plans designed to help them meet the Qmentum program criteria.

Our Lean training sessions are in high demand, and new sessions are offered as follows:

- **Green belt 15-day training session in Ottawa, ON**:
  - 20-24 January 2014 • 3-7 March 2014 • 14-18 April 2014

- **Yellow belt 4-day training session in Ottawa, ON**: 4-7 November 2014

Two workshops on ethics will be offered in November 2013: “Ethics at the Frontline” on the 13-14th and “Ethics for Leaders” on the 15th.

Two new webinars for Accreditation Coordinators are now available. “Getting Started with Qmentum” is hosted by an Accreditation Specialist who will walk you through the client organization portal. A guest Accreditation Coordinator will also share experiences and tips for success in accreditation. “Preparing for the On-site Survey” will give you an opportunity to hear from an Accreditation Canada surveyor who will provide an overview of the tracer methodology; discuss what surveyors are looking for in tracers; and clarify the accreditation decision, report, and follow-up processes.

Save the date now for the 2014 Quality Conference on April 10 and 11 at the Hilton Lac-Leamy in Gatineau, Quebec. Our 2013 Quality Conference was a huge success! Read about it [here](#).

I encourage you to take advantage of some of these opportunities as we move ahead together to ensure quality and safety in health care.

Together in quality and safety,