IMPLEMENTING THE “IDEAL” MODEL - CHANGE MANAGEMENT

Introducing a changed model of patient care, or making any other change in hospitals, involves all the ‘usual’ challenges of change management. This is becoming a sizeable body of knowledge and a new ‘industry’, with specialist practitioners available (at cost) to consult and manage the ‘change process’. The health sector has its own particular challenges, and the complexity of change increases dramatically with the size of the system being changed. These are ‘generic’ issues concerning change management, and will not be dealt with further.

There are multiple strategies that are used to manage change and redesign. Many of these have been developed in the settings of other industries, and are used by management consulting groups as a framework for their work in the healthcare setting. Examples include Continuous Quality Improvement, Six Sigma, the Fifth Discipline, Lean Thinking, and Accelerated Implementation Methodology. It is unclear which or if any of these methodologies are superior in the healthcare setting. All external management experts bring new skills and knowledge, but these need to be used together with the existing workforce to adapt the methods for their own purposes.

All change management depends on ongoing work over a long time to be sustained. It also requires ongoing engagement at all levels of the organisation. This means the workers at the ‘coal-face’, the middle management, and the executive. In the healthcare setting, the ‘coal-face’ engagement should include both clinicians of all disciplines, and patients as active participants in redesign and change.

COMMON CONTROVERSIES ENCOUNTERED IN CHANGING PREOPERATIVE SYSTEMS

As discussed at the beginning of this chapter, despite the wide variation between hospitals, health systems, nations and cultures, a number of common themes or focal points of controversy and variation can be identified with regard to new systems of peri-operative patient care. These are the issues that can be considered to be the particularly difficult challenges of implementing the new model of care.

All change is accompanied by controversy and disputation. Where there is a clear ‘answer’ or ‘solution’ this will usually become obvious reasonably promptly, although implementation may be delayed because of the cost or power implications of the proposed solution. If there is sustained controversy, it may be presumed that there is no ‘right’ answer. The best solution will vary between institutions and settings, and will be strongly influenced by local factors. Hence, although the same controversial issues may be encountered, a local debate must deal with the issue to develop an appropriate local solution. Some of the common controversial themes arising from the challenge of new preoperative care systems include:

- A shift from discipline-specific work practices to multidisciplinary teamwork. The most obvious manifestation of this change is shared clinical records, and a breakdown of the traditional division of both clinical tasks and decision-making. Where this change is simple ‘workforce substitution’ (e.g. training nurses to perform tasks traditionally performed by medical staff), there may be cost savings, or evidence may be produced showing equivalence of care (but rarely both together). The real opportunity for improvement is in using the shift to multidisciplinary teamwork as an opportunity for true process redesign.
• The question is not if worker A can substitute for worker B; rather we should first define what work needs to be done. This implies a labour-intensive process-mapping exercise, which must involve all stakeholders in the process. The inevitable involvement of external facilitators, long committee meetings, and use of jargon can make engagement of clinicians problematic!

• Implementation of a multidisciplinary model of care requires changes in supervision and responsibility – the traditional professional ‘silos’ dividing nurses, doctors and other health professionals must be broken down. Staff working within the preoperative service may be comfortable with this, if only because of a self-selection process. However, breakdown of professional silos may threaten the power structures of more senior management, and thus be resisted or sabotaged. For example, ‘senior’ medical, nurse, or clerical management may not accept ‘their’ junior staff being supervised by a different discipline.

• Staffing of the Preoperative (Perioperative) Service has been a source of conflict in some hospitals. At initial stages of change, when only ‘screening’ preoperative assessment and basic preparation is undertaken, a ‘simple’ service with nurses working independently may be effective. As process redesign develops, a single-discipline service will become constrained in scope due to limited capacity and ability to interact with all health professionals involved in perioperative care. In order to achieve profound and ongoing clinical process change, both medical and nursing involvement in the service must occur. This should be augmented by other health professionals such as para-clinical staff, pharmacists, and allied health services.

• Leadership of the Perioperative Service is also controversial. Advanced nursing training provides skills and abilities in service management, so this position is most appropriately filled by a nurse (although allied health professionals and others have filled the role). A designated medical leader/director is necessary as the function of the service expands to deal with more complex patients, takes a more active role in clinical decision-making and investigations, and initiates therapeutic interventions. While this role need not be discipline-specific, it is difficult to imagine any medical specialist other than an anaesthetist filling this role successfully.

• Preoperative processes can be based on ‘generic’ patients, or based on surgical sub-specialty. Traditional organisation of surgical care focuses on the specialised issues related to the particular operation the patient is having. In high-volume or low-variation specialities such as short day-stay procedures, cataracts or cardiac surgery this may be appropriate, but can lead to uncoordinated surgical ‘empires’ with unnecessarily different work practices within the same institution. Alternatively, all patients can be managed by a common system with expertise for most patients having most operations, backed up by highly specialised expertise on an ‘as needs’ basis for ‘problem’ cases. The latter model appears to offer greatest potential for ‘whole of hospital’ system improvements, process flexibility, and efficiency of staff time. In both systems, active management is necessary to balance these conflicting advantages and disadvantages. A possible compromise can be a generic preoperative service with specialised clinical streams managed by designated staff.
• Appropriate standardisation. Any Clinical System Redesign program (such as perioperative systems) will raise expectations of standardisation of clinical infrastructure (e.g. forms, terminology, workforce, work practices) as well as clinical care itself (e.g. standard clinical guidelines, protocols etc). But at what level? In the same specialty, why should Doctor A treat her patients different to Doctor B? In the same hospital, why should specialty X have a different fasting protocol to specialty Y? Why doesn’t St Elsewhere’s Hospital use the same paperwork as the Royal General? Why can’t there be an agreed national definition of theatre start time, or funding standards? External imposition of standardisation, particularly in clinical care, can be unproductively divisive. Most of the benefits of standardisation can be achieved at the simple and basic level, and can be achieved ‘under the radar’ if more controversial areas of variation in practice are allowed to continue. In this area of controversy, change advocates frequently fall into the trap of trying to fix everything rather than ‘just’ 80%, and end up fixing nothing.

• The appropriate organisational role of the Anaesthetist in supervising the preoperative patient care process continues to evolve. The process may presume that the anaesthetist must see every patient as an early preoperative consultation (as has been mandated in France). If the preoperative process includes a selective consultation system, then patients must be triaged to varying levels of preoperative care. This triaging can be based on a defined process that is designed, supervised and managed by anaesthetists. Alternatively, anaesthetists may be involved as ‘passive’ recipients, consulting when requested by others (such as the surgical team or advanced nurses) for occasional or complex cases. In situations where anaesthetists are seen as a technical service provider (“bag-squeezer”), are in relatively short supply, or if funding depends on time in theatre, the appropriateness of anaesthetists working in out-of-theatre settings will be challenged. The interest & enthusiasm of the local individuals and clinical specialty groups or disciplines is a major determinant of this development. This issue may become manifest as a ‘political’ turf war about whether the preoperative service should be surgeon, nurse or anaesthetist led.

• The scope of the preoperative assessment service’s involvement in patient care varies in ‘depth’. Preoperative processes can be seen as limited to assessment - checking the quality of preparation performed by others (a “gatekeeper”), or may be both assessment and preparation - actively involved in organising investigations, optimising the patient’s health, and planning care (a ‘road-maker’).

  o For all staff, but particularly nurses, a preparation rather than screening role implies a more activist and ongoing involvement in patient care during the preoperative period. This may require ongoing attention to a particular ‘problem patient’ over days or weeks. Care processes need to be appropriately designed to assure ongoing preoperative care, particularly to accommodate job-sharing or part-time work. Similarly, anaesthetists taking on the role of ‘perioperative physician’ must be prepared to provide a service that is not ‘just’ pre-anaesthetic assessment – they may need to become involved in explaining surgical procedures, discussing broader medical issues, and leading discussion of risk/benefits of anaesthesia and surgery. That said, enthusiasts may need to be restrained from becoming too involved in long-term patient care issues encountered incidentally which are better managed by their primary care provider. This can include opportunistic preventative health care; involvement in
• The scope of the Perioperative service/system also varies in ‘breadth’ or duration. When does the perioperative period start and finish? The perioperative period can be thought of as commencing at the time a decision is made that the patient should have an operation, and finishing when the patient has recovered to their stable postoperative health status. Ideally, the patient care should be an integrated sequence of steps that are planned and coordinated to produce optimal quality and efficiency of care. In reality, every hospital includes a collection of different groups jealousy guarding their own ‘empires’, and subverting efforts to integrate patient care.

THE “BIG ISSUES” AND THE “LITTLE PROBLEMS”

The shift towards a multidisciplinary, team-based and protocolised perioperative model of patient care gives rise to ongoing ‘big issues’ and challenges associated with change in hospitals.

• Achieving the right balance in patient care between a ‘sausage machine’ (inappropriately rigid clinical protocols) and clinical freedom/anarchy.
• Maintaining staff satisfaction in a more ‘disciplined’ work environment.
• Achieving adequate levels of trust in the system of preoperative preparation so that (say) the procedural anaesthetist will accept assessment & preparation by a different anaesthetist or other health professional. This must be achieved while not developing an entire abdication of responsibility to others.
• Maintaining Surgeon’s “sense of involvement” with managing patient care, and keeping the best features of the traditional hierarchical model of surgical care. Surgeons must not become surgical technicians.
• Recognising the skills and building the contribution of clerical (or ‘para-clinical’) staff in the peri-operative team.
• Recognising the potential for skills- and task-transfer between different disciplines of health professionals, whilst accepting the important differences between them.
• Maintaining the momentum for change without underestimating the complexity and difficulty of achieving it.

There are also the myriad ‘little problems’ as well. These are the ‘little’ issues that seem to recur ubiquitously, and become flashpoints for disputation or difficulties in managing change. Examples include legible completion of hospital forms, the process for obtaining documented consent, responsibility for writing up medication, timing of patient arrival on the day of surgery, patients arriving after commencement of surgical lists, administrators undervaluing clerical staff, managing ‘standby’ patients, arguments about paperwork, Doctor/Nurse issues, authorisation for test ordering, and ICU/HDU/Ward bed allocation problems. Despite their apparent ‘triviality’, these ‘little’ problems can become major stumbling blocks to implementation. Even with the help of highly paid external consultants, experts in ‘change management’, nothing can avoid the requirement for tediously working through all the little challenges (and ‘little victories’) of process change.
Future Developments

Existing ‘high-functioning’ comprehensive pre-operative systems already include preparation for postoperative care and discharge. A logical development of this process would therefore be the integration of both the preoperative and postoperative phases of care into a multidisciplinary perioperative service. This could be achieved by integration of the pre-operative service with post-operative services such as the acute pain service. Extension of the pre-operative service’s role into involvement with non-elective patients (particularly complex sub-acute patients such as orthogeriatrics) would also be an appropriate development. The role of advanced practice nurses and anaesthetists in this model of care yet to be defined. The potential exists for evolution into perioperative clinicians, building on skills and knowledge developed from current involvement in ICU/HDU, acute pain services, Medical Emergency Teams, and preoperative assessment & preparation. Integration of this clinical service with the routine collection of outcome data provides the basis for integration of patient risk factors obtained preoperatively with patient outcomes, so that quality assurance, risk management and audit becomes internalised within the perioperative process.

Further development of preoperative assessment and preparation may also provide a platform for institutional risk management. Early assessment of the patient’s health status and their perioperative risk can be used to make an appropriate decision as to whether the institution wishes to accept the risk of providing the proposed surgical or other procedure for the particular patient. In hospital settings providing ‘free’ surgical care, it may then become realistic to deny the patient surgery (such as a knee replacement) until the patient has lost weight or stopped smoking. Alternatively, high-risk patients may be diverted from surgical interventions at an early stage rather than after expectations have developed.

Around the world, medico-legal and general risk is being disseminated from individual practitioners to institutions. Adverse outcomes can no longer be blamed on a rogue practitioner. When a patient has an operation, it is not ‘just’ the surgeon providing the service – it is provided by the health care institution. By being ‘proactive’, the decision by the institution to provide a clinical procedure can be made at the time of booking the patient, rather than after the patient has been waiting in expectation of having surgery for some time. This is much more likely to be accepted by the patient, their family and the community. From an institutional or health system point of view, better systems for early preoperative assessment and preparation provide a better platform for managing the institutional, as well as the patient’s, risk.

The development of better and more integrated systems and processes for preoperative assessment and preparation, and delivery of perioperative patient care will continue to evolve. While there will be ongoing differences, these general developments will result in systems and processes that will be better for the patient, better for the staff and ultimately better for the organisation delivering the care.