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QI Boxset: How QI can improve practice culture

Mark Turner and Pam Mosedale

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Pam Mosedale

Hi everyone. Today, as part of the QI Boxset, I'm going to talk to Mark Turner about practice culture. Mark is a practicing small animal vet. He already has a Master's in patient safety culture and is currently studying for another Master's in organisational psychology. So, I can't think of anybody better to talk with about this subject. So hi, Mark.

Mark Turner

Hi Pam, how are you? I'm very good, thanks.

Pam Mosedale

Good thank you how are you? So, practice culture I've seen quite a lot in in the veterinary press recently, people talking about practice culture. What is culture?

Mark Turner

Yeah, so it's a really good question, and something that, of course, I find very interesting personally. I thought I'd give you one definition to start off with and perhaps expand it from there. But I have a book here by Daniel Coyle called The Culture Code. It's a really good read, very accessible for anybody new to the subject. He says that "a group culture is one of the most powerful forces on the planet. We sense its presence inside successful businesses, championship teams, and thriving families. We sense when it's absent or even toxic too. We can measure its impact on the bottom line." And it gives us a statistic here. A strong culture increases net incomes 765 % over 10 years, according to a Harvard study of more than 200 companies. Yet the inner workings of culture remain mysterious. We all want a strong culture in our organisation. We all think that we know how it works. But how do we go about implementing it?

So that's one definition from, as I say, Daniel Coyle. If I can go back a few years, Edgar Schein is another academic in the field. He described organisational culture as being made up of three layers, and so, if we think for a moment about an iceberg, a big iceberg, he said that the most superficial layer is above the waterline, and then the other two layers remain somewhat hidden below the surface.

So, he said that there are three layers, as I say, the most superficial one that's called the artefacts. So, they're indicators of an organisation's culture. Things like posters, uniforms and job titles give us some sense of what our culture is like. The second layer just below the waterline, he called these espoused values. He said that these are deeper indicators of a culture than artefacts, but shallower than underlying beliefs. Espoused values are things like an organisation's values or a mission statement, for example.

Then the third layer, the deepest layer, the underlying beliefs he called these, the underlying beliefs held by members of an organisation are more profound indicators of an organisation's culture. They reflect the way that the organisation really works on the inside. Underlying beliefs include assumptions about how staff think they should work with each other and what is and isn't okay to say. The underlying beliefs include beliefs about what staff really think will lead to success or failure in their job role. Yeah, so just two definitions there of culture, just to give us some sense of what we're talking about.

Pam Mosedale

That's really interesting. Thank you, Mark. Loads to think about there for a start-up on your first definition. I'd never really thought of culture when it came to families. That's interesting too, isn't it? And your other one with the iceberg example. Yeah, I think that's really important. I mean, from from my very simplistic point of view, as you know, I used to be a Practice Standards Assessor. So I've been to lots and lots of veterinary practices and I've sometimes had assumptions about some places that I thought would be absolutely brilliant because they're in a lovely new building with lots of shiny kit. I've done the assessment, and they've passed everything on Practice Standards, but I've come away thinking, hmm, not sure I'd like to work there. And I've been at other places where it's a little bit basic, maybe, you know, clean, tidy, but a bit more basic. Again, they’ve passed what level they were at or there were a few things to do, but I've come away thinking that's a really nice practice, I'd love to work there and I think I thought similar things when I was locuming. I don't think it's about stuff like the physical kit and even posters on the wall. It's about how people talk to each other, and you get a feeling of that. Do you agree?

Mark Turner

Yeah, absolutely. This is the challenge, I suppose, isn't it, when we're talking about culture, that it’s difficult sometimes to measure, but it's still undeniably a really powerful force. And I like this short definition. So, if we start thinking about culture in terms of healthcare organisations, this definition by Professors Russell Mannion and Hugh Davis in an article for the BMJ a few years ago, in healthcare organisational culture, they said, “We can think of it as a metaphor for some of the softer, less visible aspects of healthcare service organisations and how these become manifest in patterns of care”. So, I guess they're there making the link between these almost invisible aspects of care, but how they have a very powerful influence on the really tangible outcomes of what we do as healthcare professionals and in healthcare organisations. It's something that takes some teasing apart, doesn't it?

Pam Mosedale

Yeah, it's complex, isn't it? So, every practice will have some sort of culture. How do they go about making sure it's the kind of culture they want or establishing a... we hear these terms banded around like ‘just culture’ and things like this.

Mark Turner

Yeah, so I mean, of course, it’s a massive, massive subject, and there are lots of different components to it. Of course, it can seem a bit overwhelming at times to think about culture and adjusting our culture in our practice or organisation. How do we go about it? I mean, perhaps another way to just think about changing culture is to go back to some work done by Amy Edmondson about 25 years ago now. So, Professor Amy Edmondson, she may be familiar to some of our listeners, but she's a Professor at Harvard Business School and has done a lot of work into the importance of things like psychological safety. But she studied healthcare cultures in some depth, and if I can read you another passage slightly longer this time, forgive me. But again, going back to Daniel Coyle's excellent book, he describes this piece of research that Amy Edmondson did back about 25 years ago, as I say. He says that one of the best measures of any group's culture is its learning velocity. So, that is how quickly it improves the performance of a new skill. So just using a new skill as an example of the strength of an organisation's or a healthcare organisation's culture. In 1998, a team of Harvard researchers led by Amy Edmondson tracked the learning velocity of 16 surgical teams learning to perform a new heart surgery technique called MICS. So minimally invasive cardiac surgery. Of course, a human cardiac surgery technique involved just a small chest incision as opposed to a much larger thoracotomy. Each of the 16 teams was studied, as I understand it, for quite a long time. They were studied during the three-day training program, which was identical for all of them.

And they were studied when they were turned to their hospitals and started performing the procedure.

This is all in the context of Amy's interest in the power of organisational or healthcare organisational culture for how effectively, in this example, these teams learned a new procedure, but also, what were their results? What were their stats like at the end of the day? He goes on to say that at the outset, a large teaching hospital, for example, Chelsea Hospital might have been expected to come out on top. I should say that these aren't real names of the hospitals involved, so it wasn't the Chelsea and Westminster Hospital.

This hospital was an elite centre led by a very eminent surgeon, we'll call him Dr C. So it was their proposition that it would be one of these large hospitals that would come out on top at the very end of the study. It was thought that a more provincial hospital like Mountain Medical Centre, a much smaller non-teaching institution, would fare worse in final results. It was led by Dr. M, a young surgeon who had relatively little experience.

But they found that actually, Chelsea's team didn't win. On the contrary, it was slower to learn its skill, plateaued after 10 procedures in terms of its results, and, wincingly, the team members weren't happy. In interviews afterwards, they reported feeling dissatisfied. And after six months, Chelsea ranked 10th out of 16 teams. Meanwhile, the Mountain Medical team, on the other hand, learned fast and well. By the fifth surgery, its members were already faster than Chelsea's top mark, and by the 20th procedure, Mountain Medical was completing successful surgeries a full hour faster than Chelsea.

Pam Mosedale

Wow. Wow. Yeah.

Mark Turner

Just one example there of the power, and she goes on to explain, or I should say Daniel goes on to explain that Amy's study found that there were powerful underlying cultural factors at work to explain the very tangible results of the study.

Pam Mosedale

Yeah, that's amazing, Mark, because actually quite often with all this kind of thing, people say, well, you know, what's this got any relevance to what we do clinically? But that example really shows, doesn't it, that it absolutely does have a lot of relevance to the outcomes we get. Yeah,

that's really interesting. And I think having a learning culture where you learn from everything that happens in the practice is important too, isn't it?

Mark Turner

Yeah, and that's a perfect segue into what he goes on to say about what she discovered, was the difference, what made the difference between the results of Chelsea Hospital and Mountain Medical Centre. She listed five really powerful behaviours that Mountain Medical Centre was doing and that perhaps Chelsea wasn't doing quite so well. The first of those then was something called framing. So, the most successful teams in the study conceptualized MICS, the surgical technique, as a learning experience that would benefit patients and the hospital. The second finding was the importance of clear roles. Successful teams were explicitly told by the team leader why their individual and collective skills were important for the team's success.

So really identifying the importance and the value of each individual person in the surgical team and the role that they played wasn't just down to the surgeon, in other words. Rehearsal was another important behaviour. Successful teams in the study did elaborate dry runs of the procedure, preparing in detail, explaining the new protocols, and talking about the importance of communication. So, they were talking to one another about the value of these softer skills for the outcome of the surgical technique. Again, it wasn't just down to one individual. The results were never going to be down to the finesse of the surgeon or the anaesthetist. Everybody played a role. The fourth point, really interesting this, is explicit encouragement to speak up. Successful teams were told by team leaders to speak up if they saw a problem. They were actively coached through the feedback process. The leaders of unsuccessful teams, meanwhile, did little coaching. As a result, team members were hesitant to speak up. So that was a very important behavioural or interpersonal behaviour that had a tangible impact on the final results. Then finally, he talks about active reflection. So having debriefs after each surgery to understand what went well and what they might learn to do better next time.

So, I guess there in summary, five really important cultural elements of the hospital or organisation that had a very tangible impact on a surgical technique and on their results.

Pam Mosedale

That sort of resonates with me with some of the Quality Improvement activities that we suggest for practices. Practices that are open to measure what they do and see if it needs improving. But also things in QI like having huddles and communication, which was obviously a really important thing there, and not having so much hierarchy and allowing people to speak up. I

think there's at least one paper where if you're using surgical safety checklists, as an example of QI activity, if using surgical safety checklists, if they've been read out, vocalised, then people in the room are much more likely to speak up if something goes wrong during the surgery.

Mark Turner

Yeah, it's given everybody a voice, isn't it? And understanding that perhaps traditional aspects of the profession and steep hierarchies aren't always congruent with good outcomes because ultimately what we do is a team-based activity.

Again, I guess that's another really important part of successful healthcare cultures, understanding the power of teamwork and understanding that sometimes giving away power, if you like, to the surgeon or the medical practitioner isn't always going to give us the best outcomes because of course, as I say, it is fundamentally a team-based activity. And so, it's important, as in any team, that people feel able to contribute and speak openly with one another, sometimes quite candidly, to get things done and get things done in the best possible way for the patient.

Pam Mosedale

So, do you think a practice getting involved in some of the QI activities might help culture a little bit?

Mark Turner

Yeah, I think sometimes the most important thing to do is remember that we're all human. We are all liable to make mistakes occasionally just because of our cognitive limitations as human beings. And so really embracing the power of having more than one set of eyes on a patient or procedure or more than one set of eyes, you know, in the ward or the prep area and understanding that allowing people to give you feedback, comment on cases, pick up on mistakes and that we may have missed is a really powerful way of avoiding the mistakes that we're all liable to make from impacting patient care. That principle for me is really powerful. It's a compassionate way of thinking about ourselves, understanding that we're all trying to do our best and we're incredibly diligent and committed vets and veterinary nurses. But occasionally we will make a mistake and that's okay to accept in ourselves and it's okay to understand that other people will make mistakes too and that they are still very skilled, diligent professionals.

Pam Mosedale

It's about how practices deal with those things once they've happened though, isn't it Mark? When something's happened in the practice it's about how it's dealt with, because it can go one way or the other can't it? It can go down the road of blaming people or it can go down a much more positive road of trying to look at what happened and see if we can learn from it.

Mark Turner

Yeah, and I guess another really powerful concept is systems. Again, our listeners may be familiar with the system's approach to healthcare and healthcare accidents. But again, for me, it's been really powerful to take a step back and understand that my job and the role of a veterinary surgeon in a veterinary practice is one part of a much larger system and that outcomes of veterinary care are fundamentally about the proficiency not just of individual vets and veterinary nurses, but of the system. And so, when the system has a blip and there's a mishap, sitting down together as a team to understand that there will always be a very powerful system component to the mistake that somebody's made or the accident that's occurred.

So again, if we can shift our perspective just a little bit, understand the power of this concept of systems, it becomes a lot easier to start routinely viewing accidents and near misses as opportunities to look at the system and see what we can change or finesse a little bit so that the same accident won't happen in the future because fundamentally that accident has occurred because we work in a beautiful system, a beautiful imperfect system. An imperfect system which furthermore is incredibly complex and can be nudged off course by seemingly very minor events. Perhaps a phone call at the wrong moment. Somebody being distracted on a day when they haven't had quite as much sleep as they would normally have and they lose something off their mental checklist. The number of permutations, the number of possible explanations for this event is almost endless. But seeing that we operate in systems then allows us to sit down as I say, in a team and use an adverse event auditing tool to see what we can do differently next time.

Pam Mosedale

So looking at improving systems rather than looking at individuals and blaming individuals, that's the important thing, isn't it?

Mark Turner

Yeah, as we said, we are all human. We all fundamentally have very similar brains, and that brain has a limit, has limitations. Again, another really interesting part of the psychology of all

of this, is that the limitations of our brain are influenced by a number of factors, as I say, it could be a lack of sleep, could be that we've missed a lunch break, it could be that we're feeling stressed for some reason outside of work, it could be that we're feeling a little bit stressed about something inside of work, maybe the quality of communication, maybe the quality of our relationships with our teammates aren't quite what they could be. These all have influences. This is the fundamental point, these all have influences on our cognition, on our brain's ability to think clearly, sometimes when the day is very busy. So really doubling down, particularly on the controllables, for example, the quality of our relationships with our colleagues, the quality of our tea breaks, the quality of our sleep, the quality of our relationships with our line managers. These all have influences on our ability to do our particular job, whether that's a vet, a nurse, a receptionist or a manager.

Pam Mosedale

Yeah, and so culture has got to be for the whole team, hasn't it? It can't just one person can't decide I'm going to just change the practice culture. It's got to be a whole team activity.

Mark Turner

Yeah, we all have a very important role to play. Yeah, fundamentally, we all influence the people around us. I know that this can sound a bit overwhelming that, 'oh my God, I've not just got to think about the case in front of me and the client in front of me in the consulting room, I've got to think about my relationships and self-care and so on'. But I don't mean to make it sound overwhelming. It's just something that can powerfully affect…well, going back to our discussion about auditing events, it can help us see these events post hoc, if you like, in a very different way. It can give us an opportunity to maybe change things in the future. We're all of us, of course, learning all of the time as we go through life. An adverse event audit is a really nice opportunity just to take stock of where we are at the moment and what might help us do our job better in the future.

Pam Mosedale

Yeah, absolutely. I'm a huge fan of a tea break and chatting things through. So just to kind of finish with, a practice then has thought about all this, hopefully, and the culture's improved and the way they're looking at errors has improved and the way they talk to each other, and they have a learning culture. But, you know, from my experience of years in practice, culture can change when there are changes in personnel and changes in leaders and so on. How do you maintain this good practice culture once you have it, you say, Mark? Any tips on that?

Mark Turner

Yeah, you make me think about something I was reading yesterday in preparation. The quality of a culture isn't so much down to one or two really powerful motivational talks. It's more about regularly reminding the team about just a few principles that are really important at work. So, maintaining just a steady drip, drip message about why we're here, about what makes for really good teamwork and what helps us improve the chances of having reliable, good quality outcomes at work.

I mean, you know, none of us are, or no practice or veterinary organisation is ever going to be perfect. It's just about understanding that there are things that can help us in striving for the highest possible levels of care quality and doing those things as often as we can. So, for example, having little huddles at the beginning of the day. Maybe occasionally we'll miss having a huddle at the beginning of every single day because, you know, just events get in the way and maybe an emergency turns up first thing. But that's okay too. But maybe have a huddle once the emergency has been stabilized and then that may present you with an opportunity to go back to your team and talk about the other things on the ops list.

So, I guess what I'm saying is understanding that communicating with our team, having mini huddles just to maintain our situational awareness as a team is a really powerful... one really powerful way, just one really powerful way of keeping the team functioning optimally, which is, as we've said, teamwork being a very important part of modern healthcare and a good modern healthcare culture.

Pam Mosedale

That's excellent advice, Mark, for any practice, I think. Communication is just so important, isn't it? It’s been that's been so insightful. Thank you so much. It really shows how thinking about these things can, not just improve your working day and make everyone happier, hopefully, but also improve outcomes and improve care for our patients.

Mark Turner

Yeah, absolutely. And one final comment maybe, if I can slip it in, is that another way of thinking about culture is to think of the T's and C's. So, the T's and C's, as I call them, of culture. There are three T's and three C's just to try and remember. I'm just going to pull them up now.

So, if we're thinking about the T's and C's of healthcare culture, the T's are Truth, Trust, and Teamwork. And the C's are Compassion, Civility, and Collaboration.

Pam Mosedale

Brilliant. Thank you, Mark. Excellent.

Mark Turner

Thanks, Pam.

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