Standardization as a Key to Quality

COMMENTARY

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ABSTRACT

The increasing attention to healthcare-associated infections is essential and long overdue. The authors of the lead article point out that standardization is a key dimension of quality. We, as healthcare providers, must leave behind the historical approach of "accommodating" broad clinical variation in practice, tolerance of low compliance in applying clear evidence that enhances outcome, and accommodating intransigent, colleagues who reject infection control practices. We know from the behavioural literature that unless an issue affects "me," buy-in is significantly limited; clearly, we must help each person in the chain of care feel an impact. There is much we can do, and each of us must demand change.

Few topics have resonated with consumers, policy makers and providers alike as has the patient safety agenda. Within this agenda, increasing attention to healthcare-associated infections (HAIs) is essential and long overdue, as is well pointed out by the authors of the lead paper. A number of compelling themes emerge from their article.

Those of us in healthcare need to recognize that, to a great degree, autonomy is grossly overrated and, in fact, results in poorer quality of care. The authors point out that standardization is a key dimension of quality, and we, as healthcare providers, must leave behind the historical approach of "accommodating" those who believe otherwise. Governments unprecedent investment in information technology infrastructure is a key enabler to realize system transformation with respect to safety and quality and will permit providers to better understand their performance and results. Boards, management and clinicians must be given

the tools and the clear direction to get on the standardization bandwagon.

The article, however, might more forcefully encourage us to push back on those few, but intransigent, colleagues who reject the infection control practices based on their view that inadequate randomized control trials have taken place. If we were to apply this standard to all that we do in healthcare, we would do very little of what has become standard practice. Rather than acquiescing to the naysayers, the solution may lie in turning the table such that the onus shifts to the non-compliant. Should you choose to reject the literature that supports handwashing, for example, then it is incumbent on you as a practitioner to craft and pursue funding for a study that supports your null hypothesis. In the absence of undertaking that work, naysayers are no longer welcome! Wash your hands!

The issue of HAIs must be viewed as a component of system capacity, flow and affordability. The agenda of governments across the Western world places access and wait times as key political and policy platforms. Increased lengths of stay, increased drug costs and increased costs due to sick time resulting from HAIs threaten this shared agenda and put political leaders at some considerable risk. In fact, if we do not address this in a systemic way, the costs – both human and fiscal – will put the model of care and appropriate autonomy and innovation at risk. We must be mindful that we affect over 200,000 people each year with nosocomial infections. We make them sick. By any standard, this is unacceptable and unaffordable.

Sadly, there remains a pervasive view that this is a "cost of doing business," and the authors clearly point out that it need not be. When one sees the Scandinavian experience of reducing methicillin-resistant *Staphylococcus aureus* from 30 to 1%, it is clear that our performance can and must change now. The lead article reminds each leader in the healthcare system to question how much time our boards, executive teams, medical advisory committees, professional advisory committees and other decision-making bodies spend both understanding and implementing solutions to the complex issues of HAIs. I believe most would confess to too little.

The authors also remind us that the governing bodies of healthcare organizations have an important role to play in improving patient safety. Has the board adequately defined preventable events and made them part of its consistent board goals and deliverables? Is the board holding management appropriately accountable and similarly the Medical Advisory Committee, Professional Advisory Committee? Does this figure into the pay-for-results agenda of the organization? Has the board focused on consequences to individuals and the broader organization for poor performance? As an example, do staff and medical staff orientation and re-credentialing adequately reflect the importance of patient safety and HAIs?

While Accreditation Canada has moved to improved required organizational practices, should one consider the more active involvement of the "regulator," be it the Ministry of Health or the professional colleges? Do the colleges see patient safety initiatives as a component of competence? Should repeat offenders risk the loss of their license? Similarly, should funders openly declare that they simply will not pay for bad quality – whether to the institution or the individual provider? Such has become the case with Medicare/Medicaid in the United States. Clearly, the behaviourists would promote such a model.

We know from the behavioural literature, and it is reinforced by these authors, unless an issue affects "me," buy-in is significantly limited. To that end, we must increasingly tell

the individual story, the sad, often tragic story of the patient unnecessarily lost to a HAI, and similarly and increasingly tell of the risks and outcomes for healthcare providers. Rarely does one get the opportunity to quote Stalin in a positive light; however, he asserted that one million deaths is a statistic; one death is a tragedy. Perhaps we must focus more on telling the story of the tragedies than the statistics in order to capture the hearts and minds of healthcare providers and our role in contributing to these tragedies. Bring out the marketers!

We remain without fee schedules and funding formulas that are aligned with expected behaviours and outcomes. Clearly, we must help each person in the chain of care feel an impact, both with significant rewards for outstanding performance and negative reinforcement for poor compliance. Might we be wise to ask each organization to make clear how many jobs are lost or beds are closed due to the costs associated with HAIs? If we were to express these costs in terms of the number of nurses laid off because of poor compliance and its resulting costs, we would likely begin a lively debate.

Not unlike the Green Initiative, which bubbled up by a new generation of activist young people, might we see HAIs in a similar way – can we empower those currently in training and education? These authors remind us that learners are most affected in patient safety interventions by their senior mentors. Not only are we harming patients of today but very likely contributing to the harm of future generations. Through the curricula and faculty development programming of health professional schools, we could, however, make the next generation of providers the poster children for safer healthcare. The current programming in most health professional programs are inadequate in responding to HAIs. This article offers a challenge to each academic health science centre and the key clinical leaders to right this wrong.

The bright lights in HAI control appear to be patients. Numerous studies have demonstrated that those who most frequently comply with handwashing in hospitals are patients and visitors. That being the case, we must encourage a more demanding consumer. The democratization of information will help drive this change. The next generation of consumers will have less hesitancy in asking professionals about patient safety issues or in comparing publically available data. It appears clear that embarrassment is, sadly, a necessary variable in the equation. Perhaps to remind ourselves of the simplest yet most impactful intervention, we should emblazon on patient gowns the motto, "Don't touch me until I see you wash your hands." For if we don't, patients may bring their own stickers!

Last and certainly not least, the authors remind us that a number of policy directions are inconsistent with patient safety – the most obvious and perhaps timely being the construction of single rooms and the re-use of equipment. We are seeing unprecedented redevelopment in healthcare facilities across North America. Surely the time has come to declare unequivocally the use of single rooms as a best practice standard. Similarly, we must revisit the use of equipment and the safe sharing of equipment. Is it possible that one would consider nominal fees for the use of disposable instruments as a component in the arsenal of infection control?

While one must always guard against the view that we can make healthcare a zero-risk environment, the authors point out that we are a great distance from that point. There is much we can do and, in fact, we lag behind much of the world in preventing ill health in our patients and our staff. The article is a call for leadership for each of us to demand this change and ensure consequences for a lack thereof.