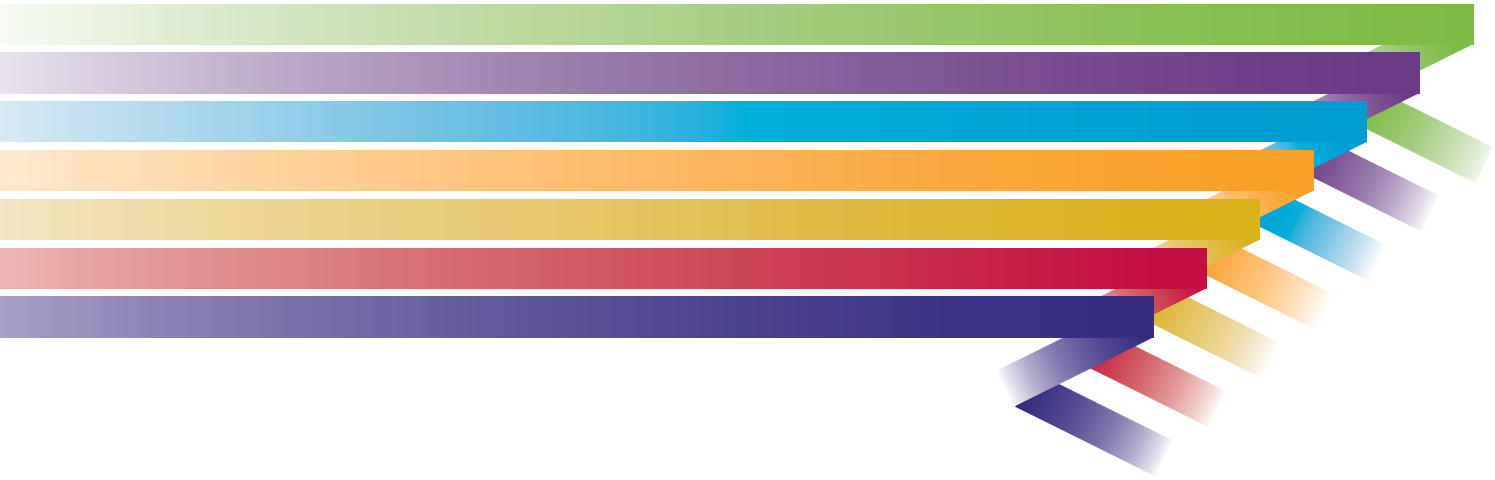

Executive Summary

Provincial Evaluation of the Releasing Time to Care and Productive Operating Theatre Programs

British Columbia, 2012-2017

BC PATIENT SAFETY & QUALITY COUNCIL
Working Together. Accelerating Improvement.

EXECUTIVE SUMMARY

Originally developed in 2007 by the National Health Service (NHS) in England, The Productive Series encompasses module-based improvement programs in various areas, including Releasing Time to Care (RT2C) for acute, mental health, residential care, and community-based settings, and The Productive Operating Theatre (TPOT) for operating room teams.

Using a grassroots, self-directed approach, RT2C has yielded impressive results. The key to its success is that improvements are driven by multi-disciplinary teams working at the point of care. It empowers staff and physicians to ask difficult questions about practice and to re-design and streamline the way they work by focusing on four core areas: safety and reliability of care, value and efficiency, team performance and staff well-being, and patient experience and outcomes.

Prior to implementation in Canada, early observations of the Productive Series' impacts in England were promising for its application in international health care settings. It had been shown to improve teamwork, communication, and culture, leading to improved health outcomes for patients, lower costs for the organization, and lower staff absence and turnover rates as a result of more engaged and productive teams.[1] [2] Inspired by this success, the program first came to BC in 2012 and was implemented by four acute demonstration units in Vancouver Coastal Health. Once it became evident the program could succeed here, the Council began supporting the spread of RT2C throughout BC in 2014. There are now 53 teams actively implementing RT2C across 28 sites and 8 organizations throughout the province.

As with any improvement work, it is important to collect and review data to understand whether the program is achieving intended results. RT2C is now well established in BC, and it was time to undertake a province-wide evaluation to answer the following questions:

1. Is RT2C improving quality in BC's health care system?
2. What are the key factors for success with the program?
3. Does RT2C contribute to improving workplace culture for participating teams?
4. How effective is this program in supporting improvement in the four core areas of focus?
5. What impacts are we seeing on direct patient care as a result of the program?

The evaluation approach was co-created with input from the RT2C Provincial Leadership Committee, executive sponsors, point-of-care team members, and the provincial faculty network. In total, it included analysis of 229 unique quantitative datasets from 41 teams, interviews with 19 individuals from seven teams, a provincial online survey in September 2016 (response rate = 74/300, 25%), and a review of anecdotal qualitative feedback received directly from teams over the past five years. Data were shared voluntarily, as teams are not required to submit results to the Council on a regular basis. In turn, the evaluation is somewhat limited and does not provide a comprehensive summary of all of the RT2C-related work happening throughout the province. All data were mapped against the four core areas of program focus and seven dimensions of BC's Health Quality Matrix.[3]

Of the quantitative data received, 84 datasets (37%) met the criteria for improvement, 27 (12%) did not, and 118 (51%) did not include sufficient data to reach a conclusion one way or another. There may be a variety of reasons for which so many datasets were inconclusive, including: shifting priorities, changes in staffing or leadership, teams having begun tracking a measure quite recently, teams having discontinued measurement prematurely, teams being too young (those that began in 2016 or later may not yet have had enough time to achieve results; 23 active teams fall into this category), or other unknown variables. Of the teams submitting data, 27 of 41 (66%) have seen improvement on at least one measure, and 21 of those 27 teams (78%) shared data showing improvement on multiple measures. Seven teams (17%) did not submit any data showing improvement, while the remaining seven (17%) did not submit sufficient data to say one way or another.

Promisingly, the evaluation revealed improvements in all four areas of program focus (though it is important to note that progress is not consistent across all teams; some have excelled and accomplished a great deal, while others struggle to establish regular program practices or consistently collect and analyze data). The most commonly collected measures across teams were: patient experience and satisfaction, direct care time, Clostridium difficile incidence, staff satisfaction, Methicillin-resistant Staphylococcus aureus incidence, and falls. The range of success varied widely depending on the measure. For instance, 0% of teams collecting data on unplanned absence and overtime have sufficient data to confirm positive results, while 100% of teams collecting data on pneumonia, hand hygiene, unnecessary motion, and staff satisfaction have seen improvement. The qualitative portion of this evaluation revealed clear support for the program and a strong belief in its ability to improve staff well-being, in particular. Impacts in this area relate to staff engagement, empowerment, team culture, and professional development.

Qualitative feedback also validated previous findings on important factors for success with the program. These include: protected time for staff, a balanced and complementary team, project leader and facilitator support, constant communication, leadership visibility and support, patience and ongoing commitment, alignment with organizational strategic direction, and focus on a balanced set of measures. Teams are hindered by paying insufficient attention to these key areas, as well as by additional barriers, such as: resistance and change fatigue, turnover and unplanned absence, workload, and resource constraints.

The evaluation identified four primary ways in which the Council will focus its efforts moving forward. These include: helping teams to increase attention on measurement (particularly direct care time), supporting greater access to standard collected measures, enhancing education and skills-development for teams, and developing relevant resources for the provincial network.

NOTES

1 NHS Institute for Innovation and Improvement. (2011). Rapid impact assessment of the productive ward: Releasing time to care. Retrieved from: https://bcpsqc.ca/documents/2017/07/Rapid-Impact-Assessment-of-the-PW-2011.pdf

2 NHS Institute for Innovation and Improvement. (2012). Calculating the financial benefit of the productive ward: Releasing time to care. Retrieved from: https://bcpsqc.ca/documents/2017/07/Calculating-the-financial-benefit-of-The-Productive-Ward-2012.pdf

3 BC Patient Safety & Quality Council. (2012). BC health quality matrix handbook. Retrieved from: https://bcpsqc.ca/documents/2012/09/BCPSQC-Health-Quality-Matrix-February2017.pdf