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Conferences, tablecloths and cupboards: How to understand the situatedness of quality improvements in long-term care

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ABSTRACT

Long term care needs improvement, but still little is known how quality improvement works in practice. A better, in-depth, understanding of the content and complexities of quality improvement is necessary because of the still limited theoretical and empirical grounds underlying its approach. This article draws on empirical material from Care for Better, a national quality improvement collaborative (QIC) for the long-term care sector in the Netherlands that took place from 2005 until 2012. Following a project on prevention of malnutrition, we analyzed the complex and ongoing processes of embedding improvements. The guiding question for our research was: what must be accomplished to enable and sustain improvements to occur in the everyday life of care organizations? In our analysis, we linked ethnographic findings to Actor Network Theory. We found that different kinds of work had to be done by both human and non-human actors to displace improvements into specific organizational situations. We conceptualized this work as the activity of translation. Moreover, the concept of inscription offers a perspective to reveal how improvements are made durable. Inscriptions are translations of values into texts, behavior or materialities that steer action in a specific way. We analyzed three different modes of inscription: gathering, materializing and training. We analyzed how one specific value, patient choice, became inscribed in different ways, configuring the actors in specific ways, with diverging consequences for how patient choice comes about.

Introduction

What must be accomplished to enable and sustain improvements to occur in the daily life of long term care organizations? Quality improvement collaboratives (QICs) are expected to close the gap between best practices and actual practices in health care by bringing organizations and different types of expertise together in order to create a learning laboratory to enhance quality of care (Strating, Nieboer, Zuiderent-Jerak, & Bal, 2011). A better understanding of the processes and content of quality improvements is necessary because of the still limited theoretical and empirical grounds underlying the approach of QIC's; theory driven and qualitative 'process based' research is particularly lacking (Dixon-Woods, Bosk, Aveling, Goeschel, & Pronovost, 2011; Greenhalgh, Robert, Macfarlane, Bate, & Kyriakidou, 2004; Mittman, 2004; Øvretveit, 2009; Schouten, Hulscher, Huijsman, & Grol, 2008; Walshe 2009). In-depth knowledge and descriptions of actual interventions and ongoing processes within such programs are important (Dixon-Woods et al. 2011; Greenhalgh, Russell, Ashcroft, & Parsons, 2011; Øvretveit, 2009; Øvretveit et al., 2002; Walshe & Freeman, 2002) and alternative conceptualization could help to redefine practices of quality improvement (Zuiderent-Jerak, Strating, Nieboer, & Bal, 2009). To achieve additional, deeper, more detailed (Greenhalgh et al., 2004, 2011) and richer (Mol, 2010) understanding of how change occurs and can be sustained, it is necessary to enter the situation where change is taking place. Ethnographic research is particularly suited to do just that.

In 2005 the Dutch Ministry of Health launched Care for Better (CfB), a comprehensive quality improvement program for the long-term care sector. CfB is aimed at stimulating sustainable quality improvements in long-term care organizations throughout the Netherlands. In CfB, care organizations from all over the country formed improvement teams that came together at working conferences where evidence based and expert knowledge was shared and improvement processes were guided in so called 'breakthrough projects' (Langley, Nolan, Norman, & Provost, 1996; Øvretveit et al., 2002: 346; Strating, Zuiderent-Jerak, Nieboer, & Bal, 2008). QICs were constructed around various themes such as the prevention of malnutrition, prevention of decubitus ulcers, fall prevention, patient autonomy, behavioral problems and the prevention of sexual abuse.

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We were interested in the kind of work required to improve and sustain the quality of care throughout the program and in the daily life of organizations. Getting a grasp on how this is done is the aim of this paper. In this paper, we focus on one of the QICs in the program, the Eating & Drinking (E&D) project aimed at prevention of malnutrition in long term care. We looked into the enactment of one specific value: patient choice. Previous research has shown that patients do eat better – it may come as no surprise – when they like the food that is being served. Nevertheless, patients in long term care rarely have the ability to prepare their own meals; each day they have to wait and see what will be served. The E&D project therefore reintroduces the concept of client autonomy and the inherent value of patient choice. Patients should be given more choice in what they prefer to eat. Organizing patients' choice of their own food is one of the leading themes at the E&D working conferences. Struhkamp (2005) beautifully describes how patient autonomy and choice is realized in the concrete activities of day-to-day health care, in the material context of care, and in arrangements of health care institutions. We therefore focused our research question: What kind of work has to be provided on different levels and places to make 'choice' happen in the context of the prevention of malnutrition? In this paper, we link ethnographic research not only to theories of organizational innovation and change (Ciborra & Braa, 2000; Øvretveit et al., 2002) but, in order to reconceptualize the complexity of improving work practices, to actor network theory (ANT) as well (Broer, Nieboer, & Bal 2010; Latour, 2005; Law, 1986; Law & Hassard, 1999; Mol, 2010).

The structure of this paper is as follows. Below we first discuss how the often used theoretical framing of improvement processes – diffusion and dissemination – disconnects from our empirical findings. Accordingly, we first outline another theoretical perspective on improvement processes in order to create a more fitting theoretical frame to present our empirical data. For this, we mainly focus on Actor Network Theory (ANT) and especially use this theory's central concepts of translation and inscription. Second, we describe our research methods. Third, we set the stage of our empirical analysis by sketching the aims and effects of the E&D project. In the fourth section, we present our data to show the different kinds of work that has been accomplished on several locations: the QIC and two participating long term care organizations. In the Conclusion section we pay special attention to three processes that played crucial roles in the observed change practices. We reveal three different modes of inscription that we have labeled: gathering, materializing and training.

Theoretical perspectives on quality improvement processes

The central question of this paper is: what must be accomplished to enable and sustain improvements to occur in the everyday life of care organizations? Theories about implementation of innovations and quality improvements in health care describe improvement processes either as naturally occurring and smoothly passing processes of diffusion, or as planned, top-down initiated processes of dissemination (Greenhalgh et al., 2004). Not just improvement programs but also improvement process studies are often based on Rogers' diffusion of innovations theory (Rogers, 1995 [1962]). In this theory the innovation—in cases of quality improvement often the 'best practice'—is an unchangeable entity. The result of the diffusion or dissemination of the innovation is the adoption (or not) of the best practice by the relevant professionals. They are expected to act either as innovators who embrace and copy the innovation, or as laggards who resist change, or somewhere in between.

The diffusion theory forms a normative and rather compelling perspective (May & Finch, 2009). The assumptions of diffusionism are deeply embedded both in research and in practice, according to McMaster and Wastell (2005). Diffusion 'entirely depends on the idea that there are unique sources of innovation and that others are capable only of imitation' (McMaster & Wastell, 2005. 388). It is an idea they believe that should be critically examined. Rogers describes diffusion as a rather linear 'process by which an innovation is communicated through channels over time among the members of a social system' (1983, quoted in McMaster, Vidgen, & Wastell, 1997, p. 65).

Diffusionism is also the underlying theory of the QIC. In all conferences that we visited, Rogers' model of innovators – with its cast of characters such as early adopters, early or late majority and laggards – was shown and discussed. A typical QIC conference starts with a kick-off meeting, where teams familiarize themselves with the principles of the 'breakthrough method', developed by the Institute of Healthcare Improvement in 1995 (IHI, 2003). This method aims to create advances in quality of care through rapid cycles of improvement and feedback aimed at specific issues, such as malnutrition. Three fundamental issues are involved in the preparation of the QIC: selecting best practices, setting goals, and establishing measures. The improvement process is structured according to the Nolan model that consists of those three fundamental issues and introduces an improvement device: the plan–do–study–act (PDSA) cycle (Langley et al., 1996; Øvretveit et al., 2002: 346; Strating et al., 2008). The PDSA cycle fits perfectly into Rogers' diffusion of innovations theory (Rogers, 1995 [1962]). Its starting point is not the comparison of best practices with the routines at home, but rather starts with planning: adopting best practices full stop.

In our observations of the daily practices of health care organizations however, the improvement processes turned out to be more complicated (cf. May, 2006). It is in daily care practice that improvement teams meet implementation problems and work hard to make implementation happen. During our research it became obvious that, first, the contents of the improvements were not always clear or unchangeable, and moreover, often had to be reinvented and negotiated on the spot. Instead of simply implementing a best practice, teams were involved in processes of trial and error, as well as creativity, and they simply had to 'work' to make the best practice fit in their organization. Professionals were not just copying the innovation, but they actively and creatively shaped it to make it fit into their own situation. Secondly, changes did not occur as streamlined as the concept of diffusion presupposes. On the contrary, after following the improvement projects at the working conferences organized by the quality collaborative and the teams back on their home ground, the impression obtained was not a linear 'communicating through channels' but more like a confusing puzzle of people, systems, materials and processes.

In order to be able to bring the analysis of the improvement processes one step further, we used Actor Network Theory (ANT). Central to ANT is the concept of translation. Translation can be understood as the activity of changing something into another form and as an activity of displacement. In this regard displacement is comparable with diffusion: innovations travel or spread toward other places. However, in ANT, innovations are perceived to be both outcome and starting point of a process of negotiation between people, contexts and materials. The innovation is never completely developed, as it is in diffusion theory, but it is constantly translated as it becomes embedded in new networks. From the perspective of ANT there can be no spread of innovations without translation, since innovations are transformed to fit the actors involved. At the same time, the innovations transform the practices in which they are embedded. The social and the material are thus mutually shaped through *processes of translation*, entailing that neither of them can form an explanation for the outcomes of the translation