Towards Better Outcomes

Triona Fortune

MD, Fortune Quality Accreditation Services

11th November 2019

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Agenda

- Quality Improvement
- Patient Safety

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John Ruskin 1819-1900

Quality is never an accident. It is always the result of high intention, sincere effort, intelligent direction and skilled execution.

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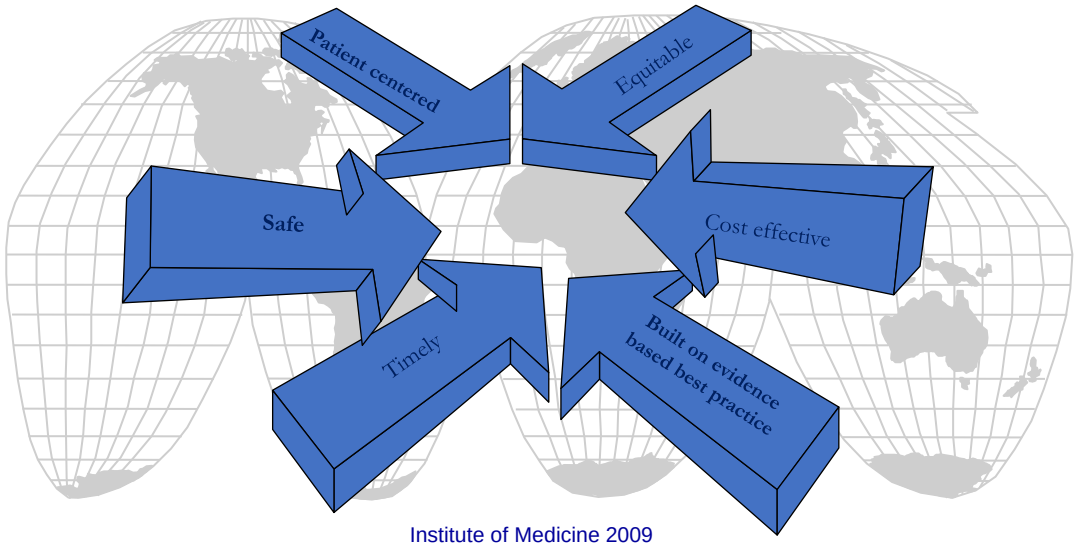
Quality Dimensions



Institute of Medicine 2009

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Prof. John Ovretveit 2008

Patient

- Listen to patient / client

Professional

- Best practice / Research based guidelines

Management

- Value for money
- Effective/efficient use of limited resources

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Quality

Who is responsible?

What are the components of a healthcare quality framework?

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Everybody's responsibility

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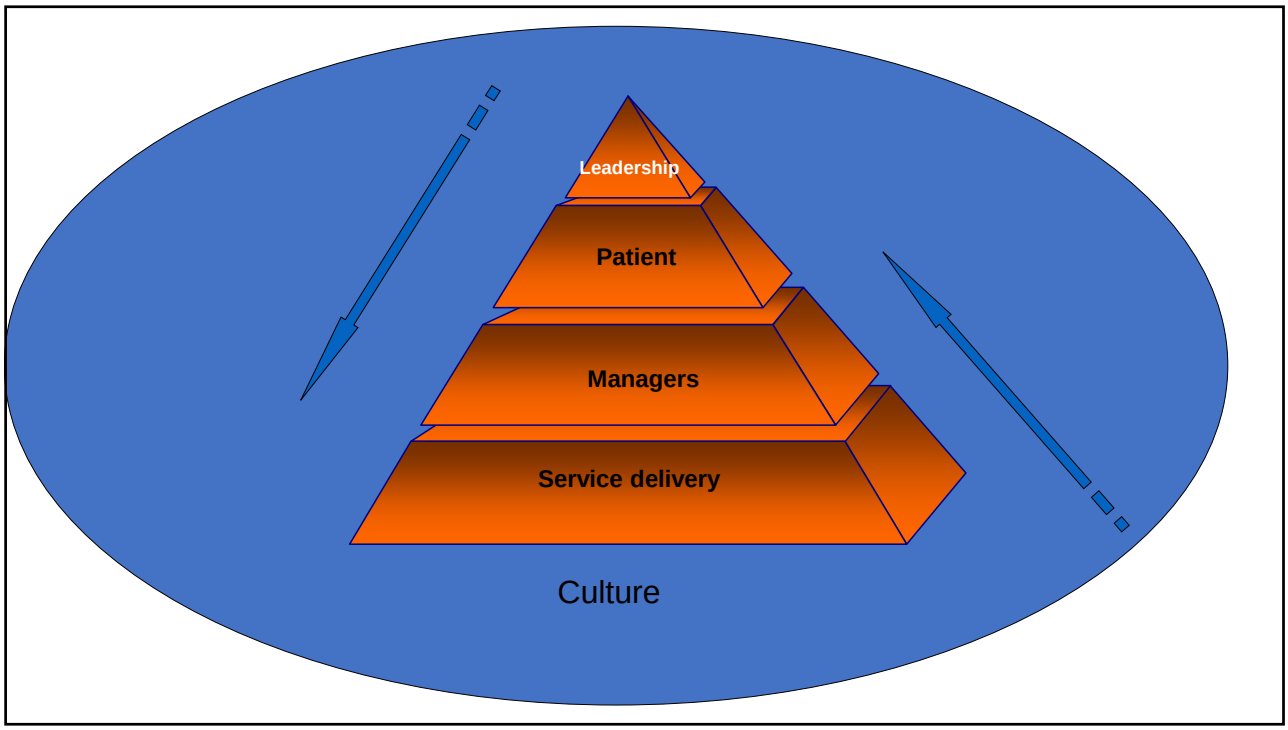
Leadership
Patient
Managers
Service delivery
Culture

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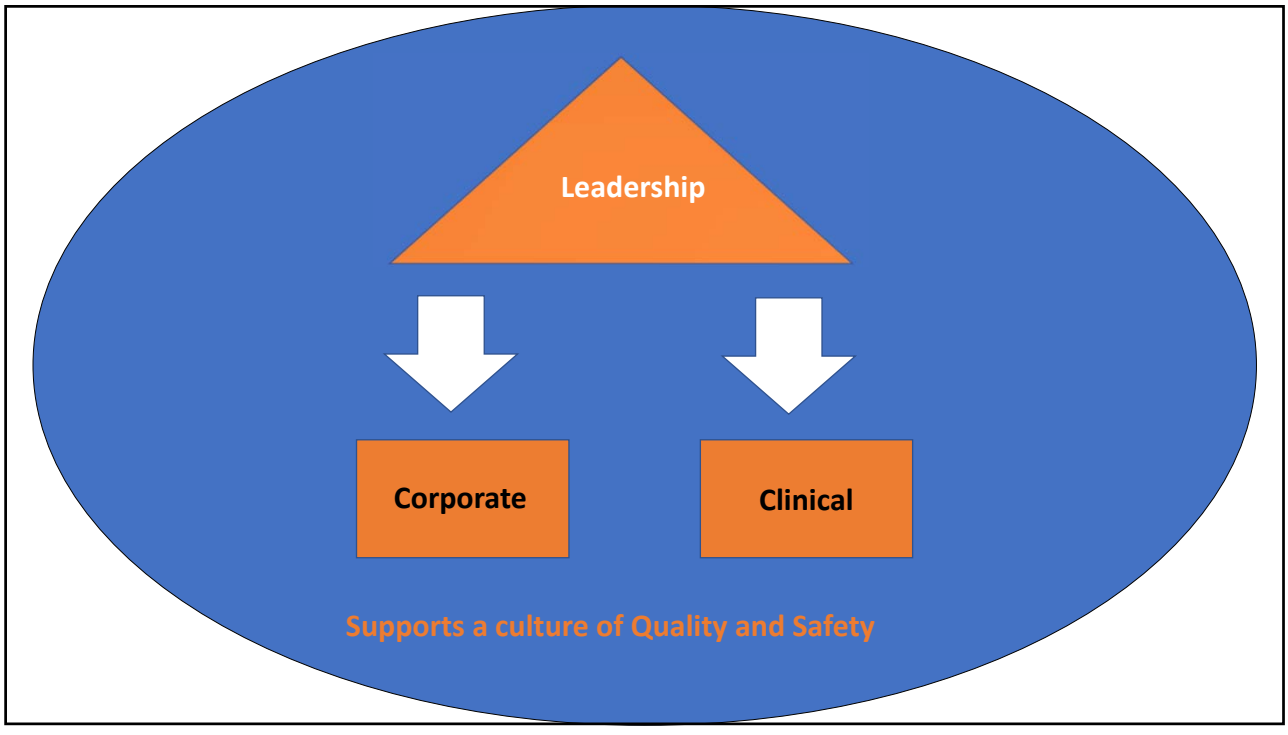
Leadership
Corporate
Clinical
Supports a culture of Quality and Safety

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Clinical Governance

A framework through which organisations are accountable for continually improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish

- high standards of care
- transparent responsibility and accountability for those standards, and a
- constant dynamic of improvement.

NHS 1995

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Governance of Quality

Corporate ⟷ **Clinical**

- Governing Body & Deed
- Executive
- Strategic plan -MVV
- Legal
- Delegated management
- Operational plan
- Financial control
- Effectiveness measures

- Standards / Guidelines / PPG's
- Safety & Risk Management
  - Proactive & Reactive
- Partnership with patients
  - Proactive & Reactive
- Audit
- Effectiveness measures

Responsibility and Accountability

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Quality Framework

Structure

- Leadership
- Competent Human Resources
- Strategic & Organisational plans

Process

- Policies, Procedures & Guidelines
- S&RM
- PCC
- Audits

Outcome

- KPI's
- PROM's

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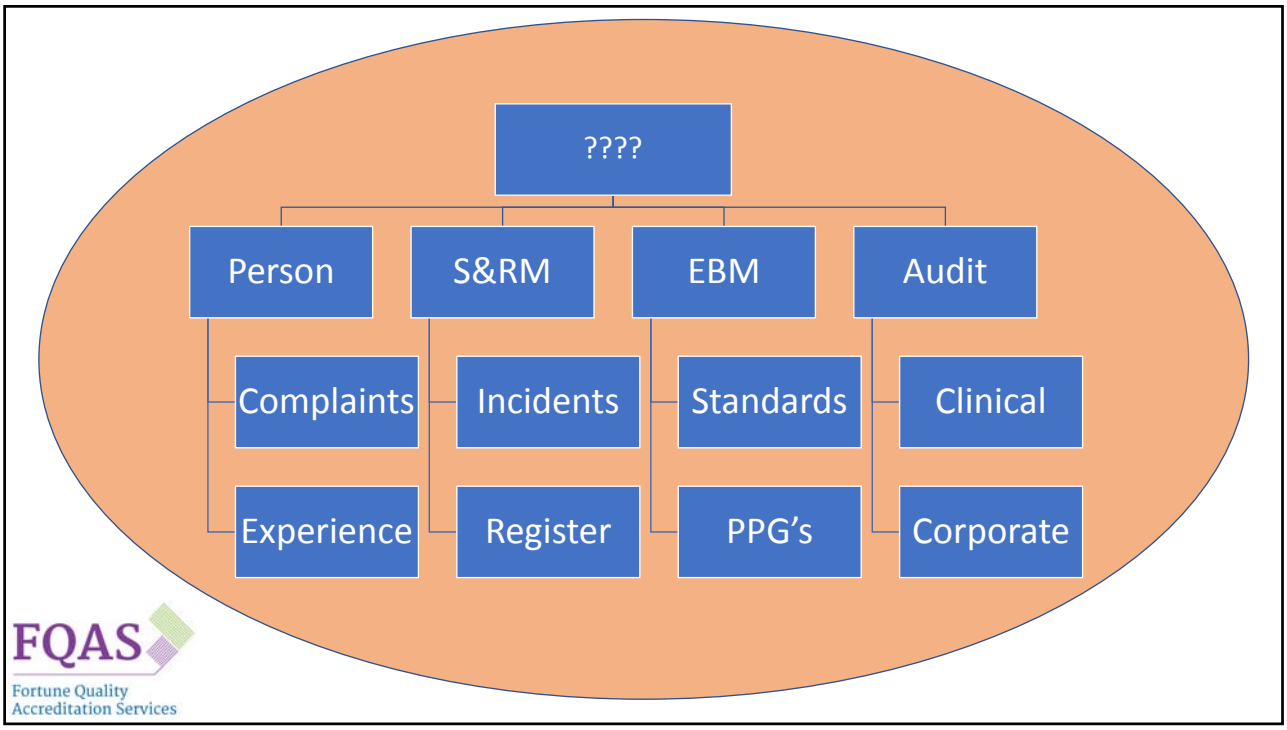

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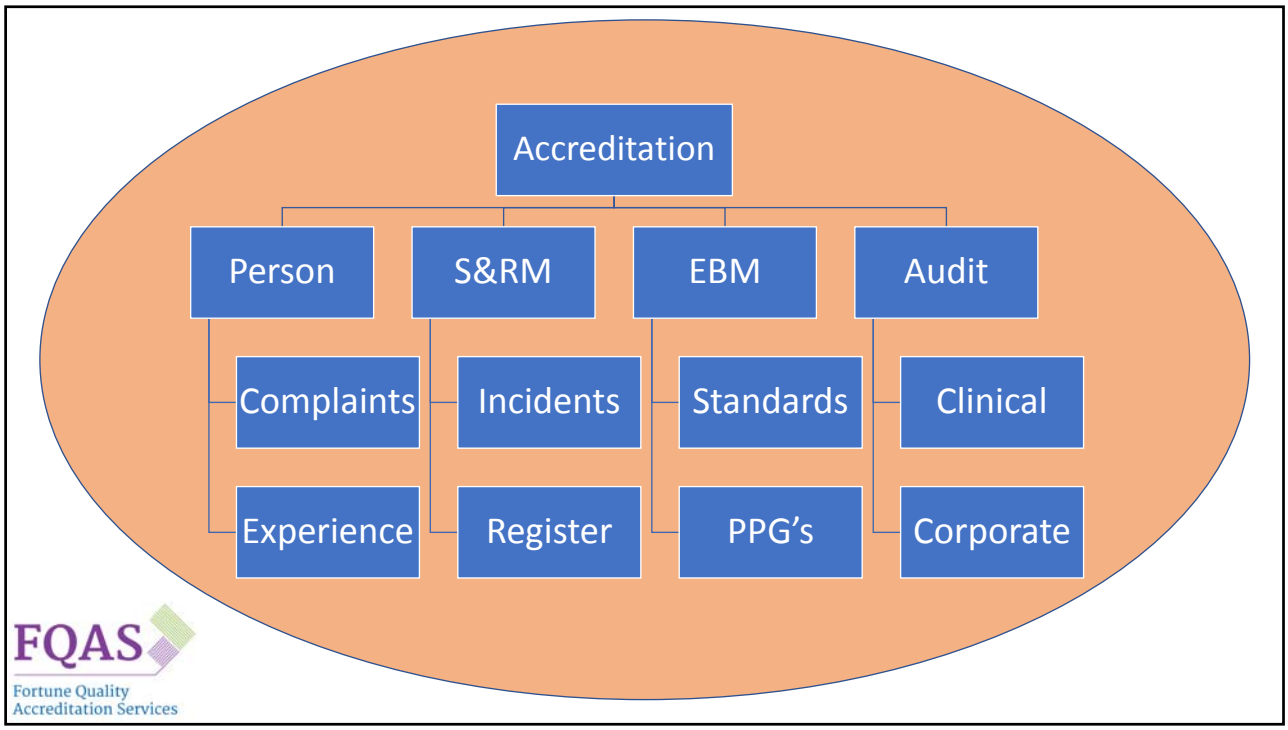

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Accreditation

Corporate

- Governing Body & Deed
- Executive
- Strategic plan -MVV
- Legal
- Delegated management
- Operational plan
- Financial control
- Effectiveness measured

Clinical

- Standards / Guidelines / PPG's
- Safety & Risk Management
  - Proactive & Reactive
- Partnership with patients
  - Proactive & Reactive
- Education & Research
- Effectiveness measured

A Quality Improvement Framework

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Accreditation or Regulation?

17

What we need is Carrot Sticks!

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International Journal for Quality in Health Care, 2017, 1–3
doi: 10.1093/intqhc/mzx010
Perspectives on Quality

ISQua

OXFORD

Perspectives on Quality

Leveraging the full value and impact of accreditation

WENDY NICKLIN, TRIONA FORTUNE, PAUL VAN OSTENBERG, ELAINE O'CONNOR, and NICOLA MCCAULEY

International Society for Quality in Health Care, 7-8 Upper Mount Street, Dublin 2, D02 FT59, Ireland

Address reprint requests to: Triona Fortune, International Society for Quality in Health Care, 7-8 Upper Mount Street, Dublin 2, D02 FT59, Ireland. Tel: +35316706750; E-mail: tfortune@isqua.org

Editorial Decision 16 January 2017; Accepted 23 January 2017

Abstract

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Safety & Risk Management

Reactive

- Reporting system- simple & accessible
- Track & correlate – all reports
- Root cause analysis – isolated

Proactive

- Risk register
- Risk mitigation plan
- FMEA – complicated
- Risk matrix – simple

Culture of No Blame, Feedback, Board Reports, informs Strategic & Operational Plans

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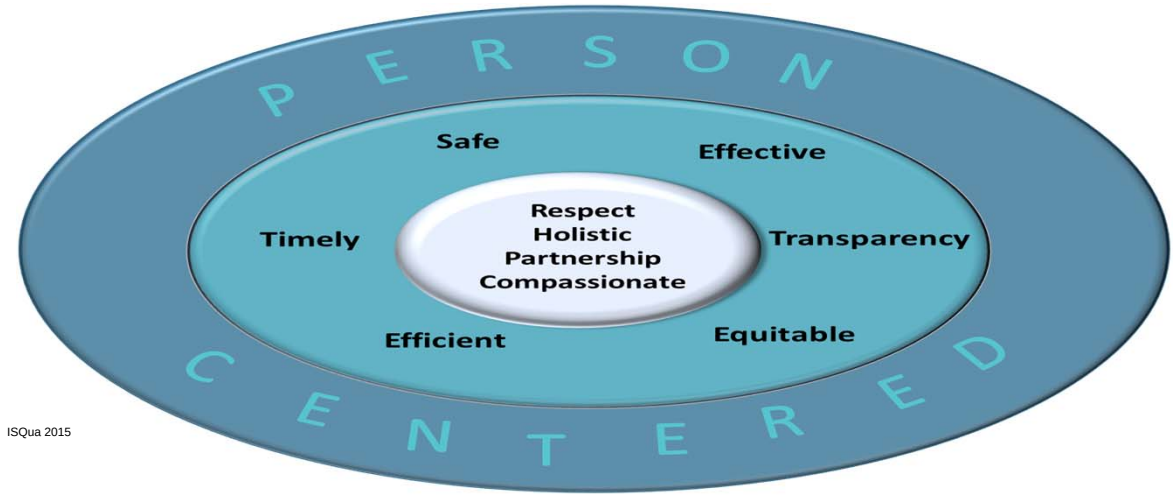
Person Centred Care is the care given in accordance with the Values and Principles of…..



ISQua 2015

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Values

Partnership:	**Is the process of mutual agreement between the health care professional, the person and their significant others on a decision or care treatment plan.**
Holistic:	Is the process of the putting each person, and their individual needs at the core of the healthcare delivery process.
Respectful:	Is care delivered in a manner, that is respectful of each individual`s dignity, culture, beliefs, values and preferences.
Compassionate	Is care delivered with humanity, kindness and warmth

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Person centered

Reactive
- Complaints
- Investigations

Proactive
- Satisfaction
- Experience
- PROMs
- PREMs
- PAMs

Culture of No Blame, Feedback, Board Reports, informs Strategic & Operational Plans

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What does patient-centered mean to HCAC ?


Dignity and respect


Information sharing


Participation


Continuity

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The evidence

- Decreases mortality
- Decreases rates of HAI's
- Decreases surgical complications
- Improves clinical outcomes
- Supports compliance with medication safety
- Produces higher levels of staff satisfaction and retention
- Decreases malpractice claims

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Do we always include the patient?

1004 clinicians in DK, US, UK & Israel – 2009

- 90% - important to ask patients
- 16% - actually did
- 20% - nurses vs 11% doctors

What would make a difference?

- Leadership support

CLINICIANS' ATTITUDES AND SELF PERCEPTIONS TOWARDS MANAGING PATIENT EXPECTATIONS AND PATIENT SATISFACTION: AN INTERNATIONAL SURVEY R. Rozenblum et al, ISQua 2010

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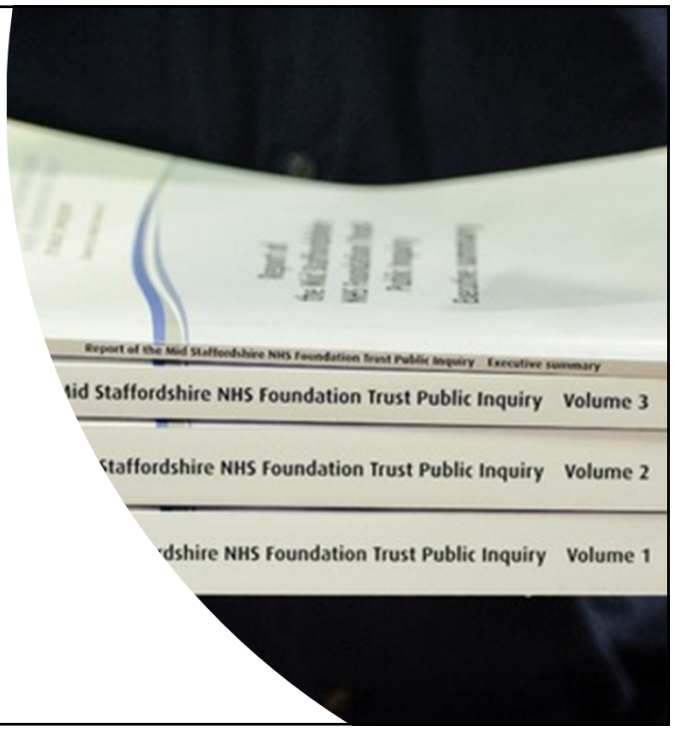
Measurement / Audits

- Schedule
- Clear roles
- Burden
- Validated instruments / measures
- Aligned with other data
- Act



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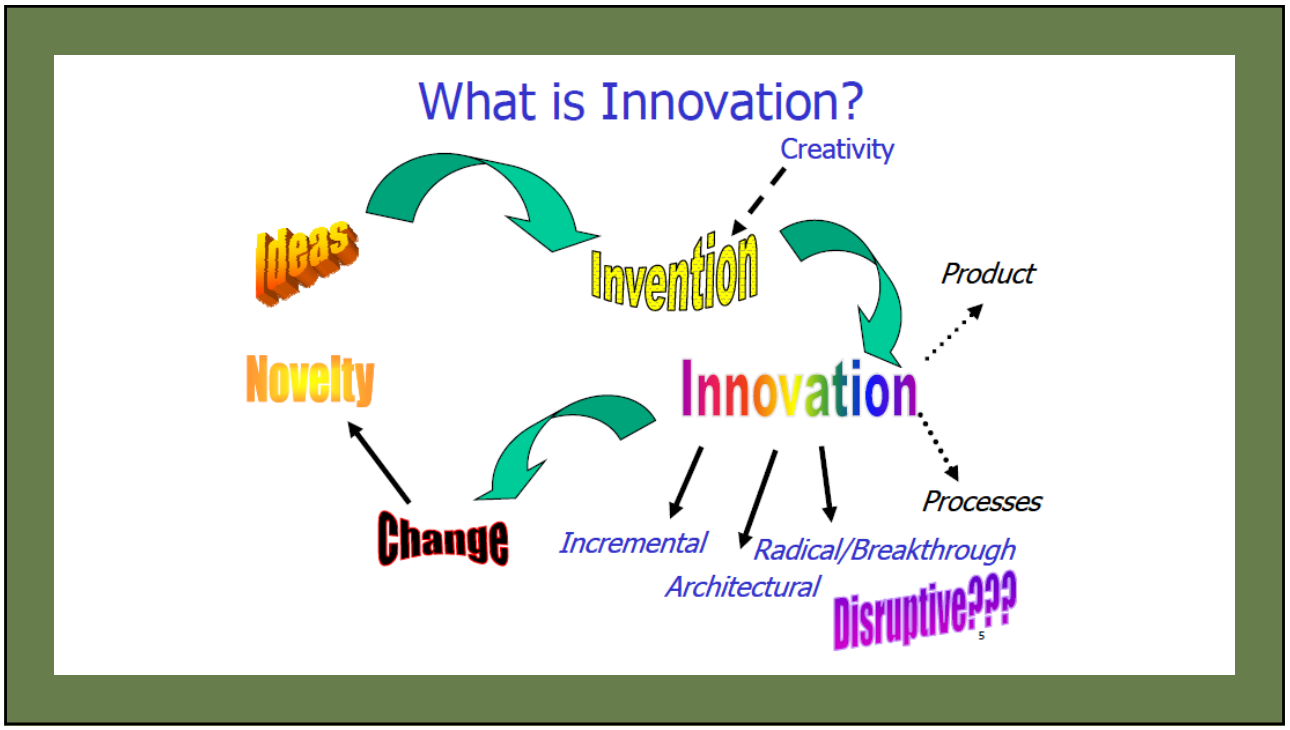

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QMS

Quality Management System

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Example of an accreditation standard
1.0 An effective system of document control is in place for both electronic and paper based documents/records that ensures the appropriate versions are accessed, used and available to staff, clients, and other stakeholders.

Guidance
The document control system could include:

i. a document control policy and/or procedure;
ii. a register (electronic or paper based) being maintained of all documents with the respective issue or amendment status, the authorising person and the distribution list/procedure identified;
iii. the distribution of all accreditation or certification related documents being controlled to ensure that only current, appropriate documentation is used;
iv. new or revised documents being reviewed and approved for adequacy by appropriately authorised and competent personnel prior to them being issued and implemented;

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Patient Safety

Triona Fortune
MD, FQAS
10 Nov 2019

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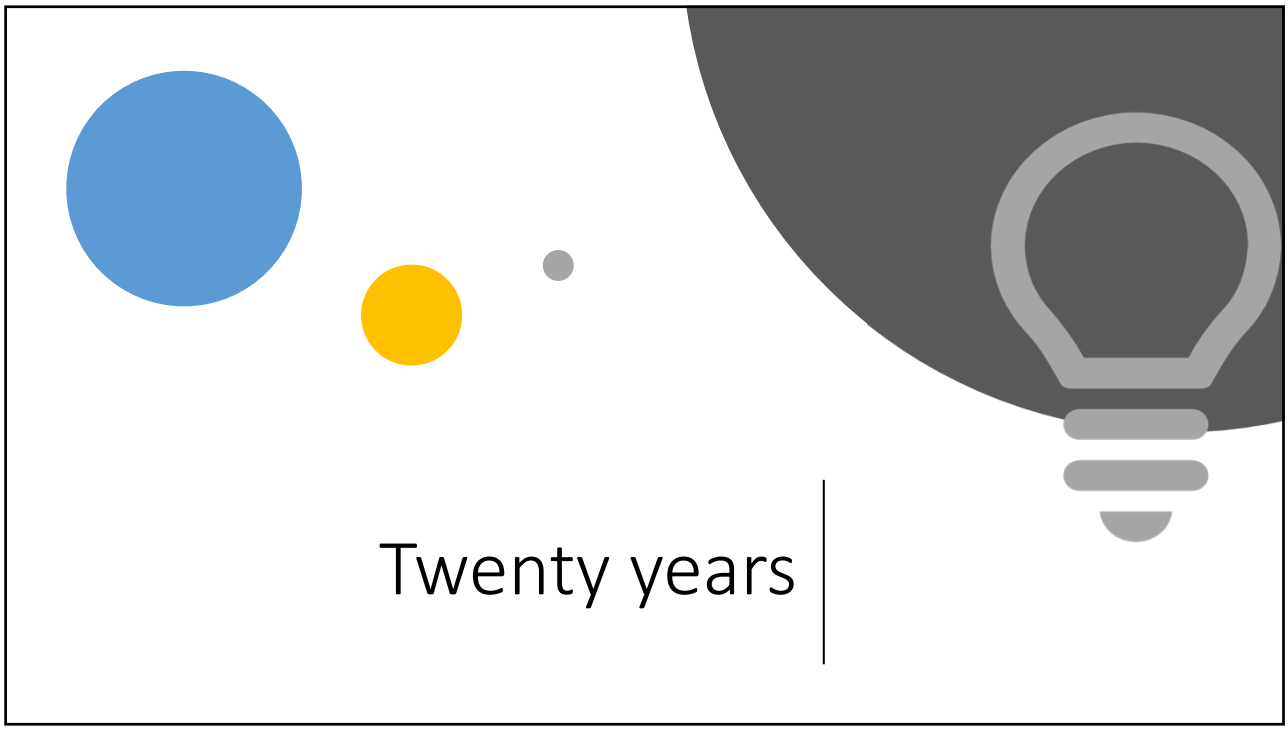

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Why

HSE apologises to woman's family over death during 'routine' surgery

3,000 more patients have died needlessly in hospital

More than 3,000 people may have died unnecessarily at five NHS trusts in a crisis that could dwarf the horrors at Mid Staffordshire, which were detailed in a devastating report on Wednesday.

84 Children Are Killed by Medicine in Nigeria

HSE Apologies for Medical Negligence Which Caused Death of Baby

INFOGRAPHIC: U.S. Hospitals Are Hazardous, Germ-Infested Places

Old people 'not safe' in Scottish hospitals, nurses say

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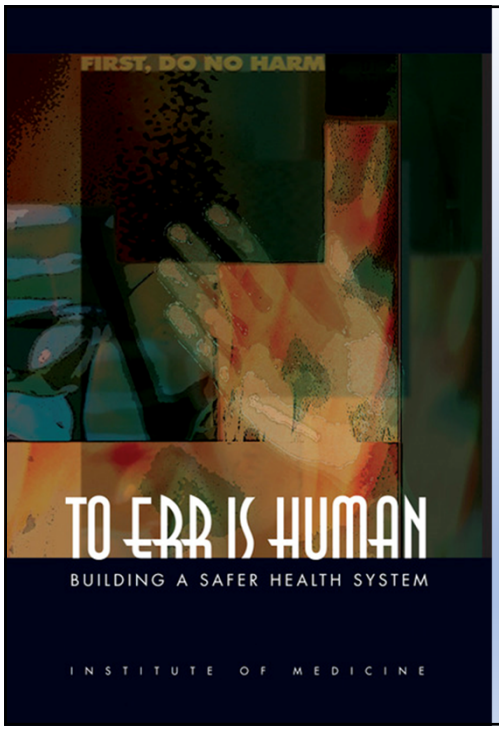

Reducing medical errors by 50% in 5 years

- National goals for patient safety
- Mandatory into voluntary reporting, legislating confidentiality no-blame
- Role of Accreditation & Consumers
- Commit to patient safety by
  - providing leadership,
  - incorporating proven safety principles from others and
  - commence with medication.

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Lucien Leape

To make health care safe, we have to change the culture

The most important culture changes we need are:

- To learn to work in multidisciplinary teams
- To develop more effective systems of accountability

Neither will happen without strong leadership

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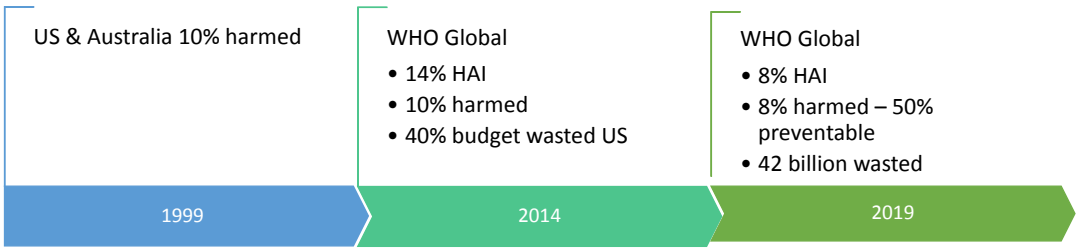
Crude statistics



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Lessons learned

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Peter Pronovost's - Bundle of Care

1 ICU in 2001 replicated in 50 ICU's in Michigan

- Checklist to prevent central line infections
- Results: 66% reduction in infections, saving 2000 lives
- Conclusion: standardisation of performance is effective, but only in case of support by leaders, improved team work and physicians who accept advice from nurses

Pronovost et al NEJM 2001

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Pronovost 2010

- Barrier medical hierarchy
- Any practice guideline could be a checklist
  - But adapted to local context by MDT
  - Dedicated time

Safe Patients, Smart Hospitals, 2010

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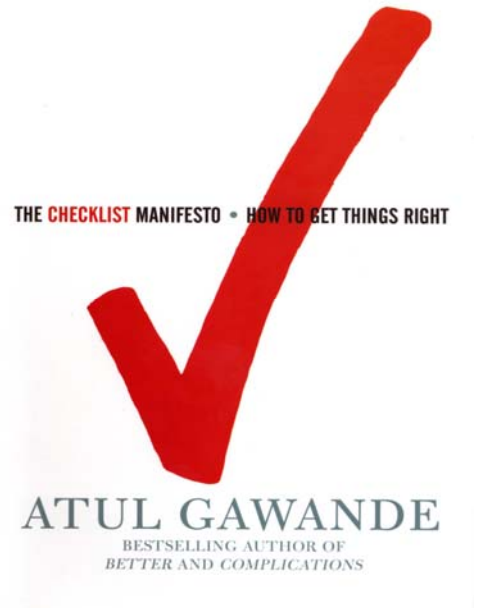
2009

ICU 1 patient 178 actions per day = 2% error

Teamwork, Control & Checklist



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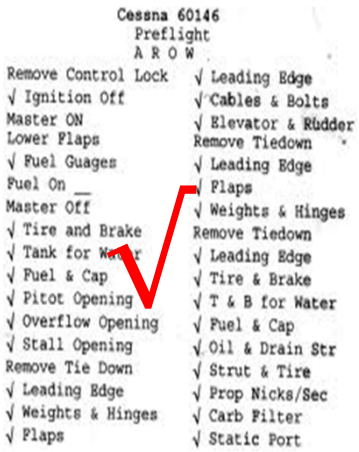
Checklists



Cessna 60146
Preflight
A R O W

Remove Control Lock	√ Leading Edge
√ Ignition Off	√ Cables & Bolts
Master ON	√ Elevator & Rudder
Lower Flaps	Remove Tiedown
√ Fuel Guages	√ Leading Edge
Fuel On __	√ Flaps
Master Off	√ Weights & Hinges
√ Tire and Brake	Remove Tiedown
√ Tank for Water	√ Leading Edge
√ Fuel & Cap	√ Tire & Brake
√ Pitot Opening	√ T & B for Water
√ Overflow Opening	√ Fuel & Cap
√ Stall Opening	√ Oil & Drain Str
Remove Tie Down	√ Strut & Tire
√ Leading Edge	√ Prop Nicks/Sec
√ Weights & Hinges	√ Carb Filter
√ Flaps	√ Static Port

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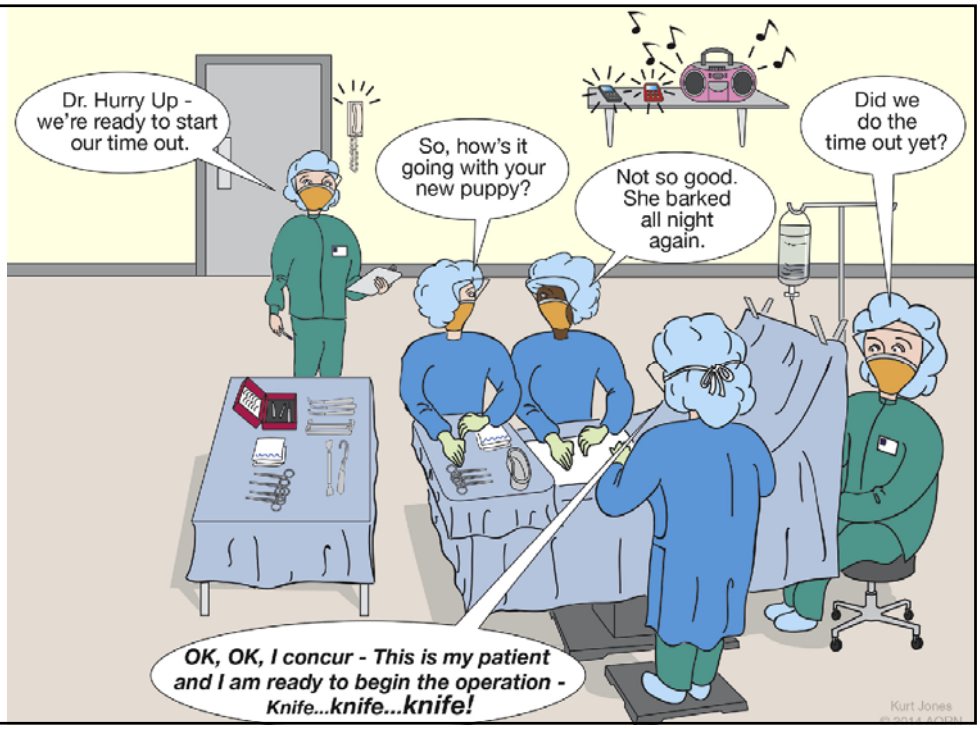

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Evidence of success

Haynes AB, Weiser TG, Berry WB, et al. A surgical safety checklist to reduce morbidity and mortality in a global population. New England Journal of Medicine. 2009

Ten years of the Surgical Safety Checklist

T. G. Weiser[1,2] and A. B. Haynes[3,4]

[1]Department of Clinical Surgery, Royal Infirmary of Edinburgh, University of Edinburgh, Edinburgh, UK, [2]Department of Surgery, Stanford University, Stanford, California, [3]Department of Surgery, Massachusetts General Hospital, Harvard Medical School, and [4]Safe Surgery Program, Ariadne Labs, Harvard TH Chan School of Public Health and Brigham and Women's Hospital, Boston, Massachusetts, USA (e-mail: thomas.weiser@cd.ac.uk; @tgweiser, @safersurgery, @stanfordsurgery, @edinsurg)

Published online in Wiley Online Library (www.bjs.co.uk). **DOI:** 10.1002/bjs.10907

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WHO Patient Safety Solutions

2007

- Look-alike, sound-alike
- ID
- Patient hand-overs
- Performance of correct procedure at correct body site
- Control of concentrated electrolyte
- Assuring medication accuracy at transitions in care
- Catheter and tubing misconnections
- Single use of injection devices; and
- Hand hygiene

To date

- Hand Hygiene 2007
- Safe Surgery Saves Lives 2008
- Medication without Harm 2017
- Patient Safety Day Sept. 27th

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MEDICATION WITHOUT HARM
Global Patient Safety Challenge

World Health Organization

5 Moments for Medication Safety

Starting a medication
- What is the name of this medication and what is it for?
- What are the risks and possible side-effects?

Taking my medication
- When should I take this medication and how much should I take each time?
- What should I do if I have side-effects?

Adding a medication
- Do I really need any other medication?
- Can this medication interact with my other medications?

Reviewing my medication
- How long should I take each medication?
- Am I taking any medications I no longer need?

Stopping my medication
- When should I stop each medication?
- If I have to stop my medication due to an unwanted effect, where should I report this?

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Doing it differently

Insanity is doing the same things the same way and expecting different results

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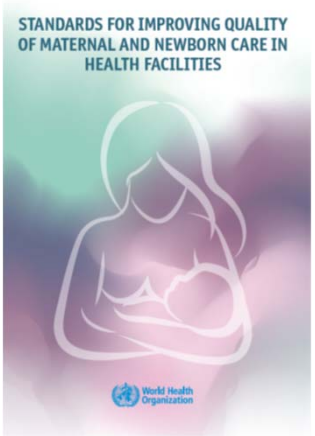
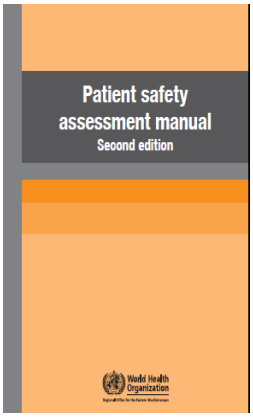
Cultural Context

Ministry of Public Health





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The future of healthcare

- 17 Sustainable Development Goals (SDGs) - UHC
- Refugees
- Moving away from
  - Illness to health
  - Acute to community
- Ageing population
- Limited resources, 30% Cheaper, Medical Tourism
- Technology
- Environmentally friendly - Climate change

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2014

- Safety along ICP
- with patient
- constantly changing context
-revised objectives & language
-educate everybody.

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Safety 2

- From Safety-I to Safety-II: A White Paper (2015) Hollnagel et al.
- Improvement Science

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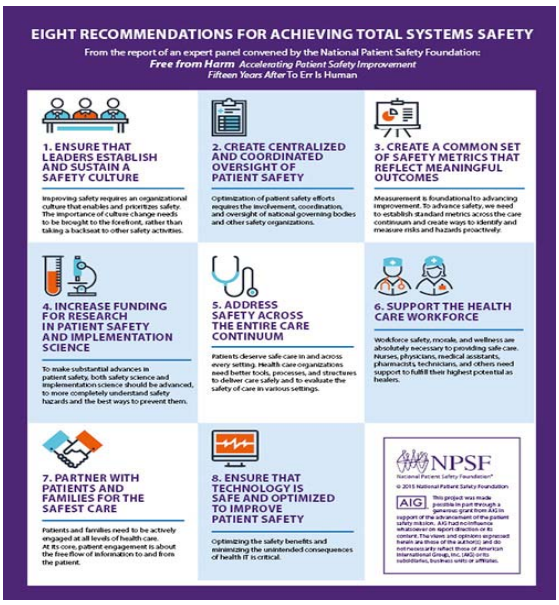
15 years



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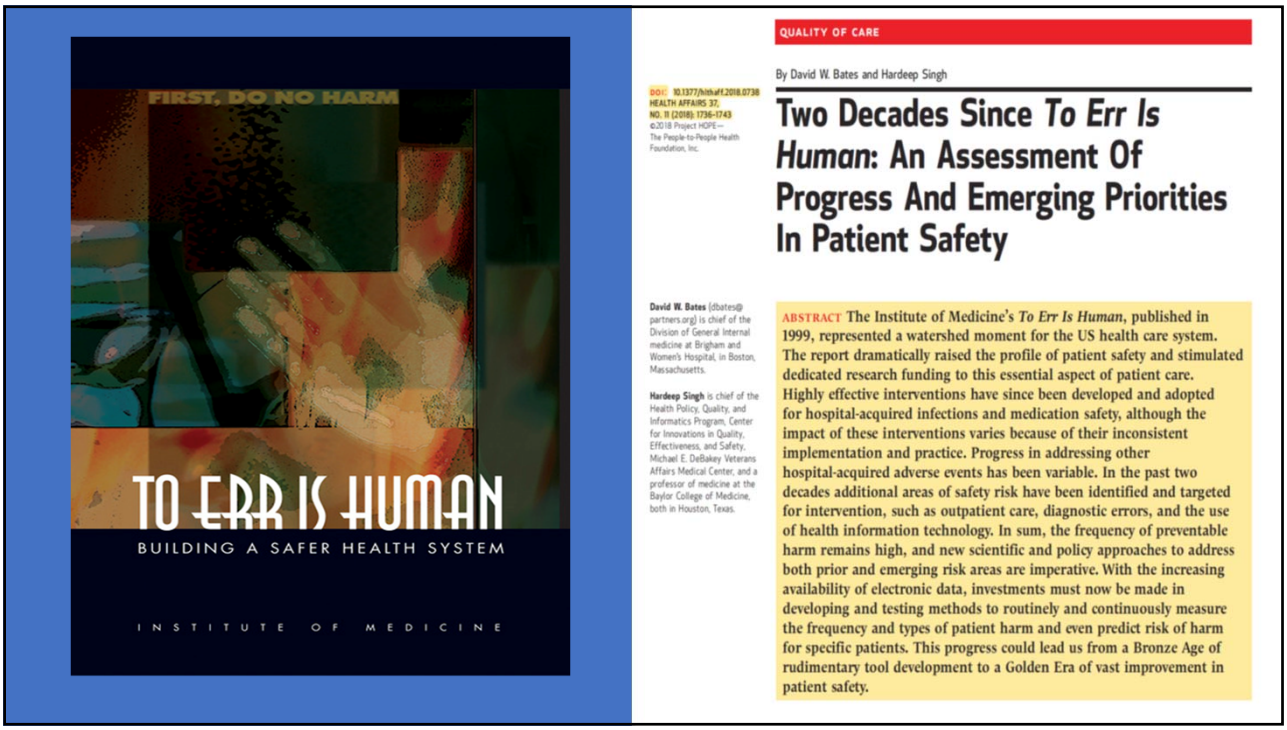

QUALITY OF CARE

DOI: 10.1377/hlthaff.2018.0738
HEALTH AFFAIRS 37,
NO. 11 (2018): 1736–1743

By David W. Bates and Hardeep Singh

Two Decades Since *To Err Is Human*: An Assessment Of Progress And Emerging Priorities In Patient Safety

David W. Bates (dbates@partners.org) is chief of the Division of General Internal medicine at Brigham and Women's Hospital, in Boston, Massachusetts.

Hardeep Singh is chief of the Health Policy, Quality, and Informatics Program, Center for Innovations in Quality, Effectiveness, and Safety, Michael E. DeBakey Veterans Affairs Medical Center, and a professor of medicine at the Baylor College of Medicine, both in Houston, Texas.

ABSTRACT The Institute of Medicine's *To Err Is Human*, published in 1999, represented a watershed moment for the US health care system. The report dramatically raised the profile of patient safety and stimulated dedicated research funding to this essential aspect of patient care. Highly effective interventions have since been developed and adopted for hospital-acquired infections and medication safety, although the impact of these interventions varies because of their inconsistent implementation and practice. Progress in addressing other hospital-acquired adverse events has been variable. In the past two decades additional areas of safety risk have been identified and targeted for intervention, such as outpatient care, diagnostic errors, and the use of health information technology. In sum, the frequency of preventable harm remains high, and new scientific and policy approaches to address both prior and emerging risk areas are imperative. With the increasing availability of electronic data, investments must now be made in developing and testing methods to routinely and continuously measure the frequency and types of patient harm and even predict risk of harm for specific patients. This progress could lead us from a Bronze Age of rudimentary tool development to a Golden Era of vast improvement in patient safety.

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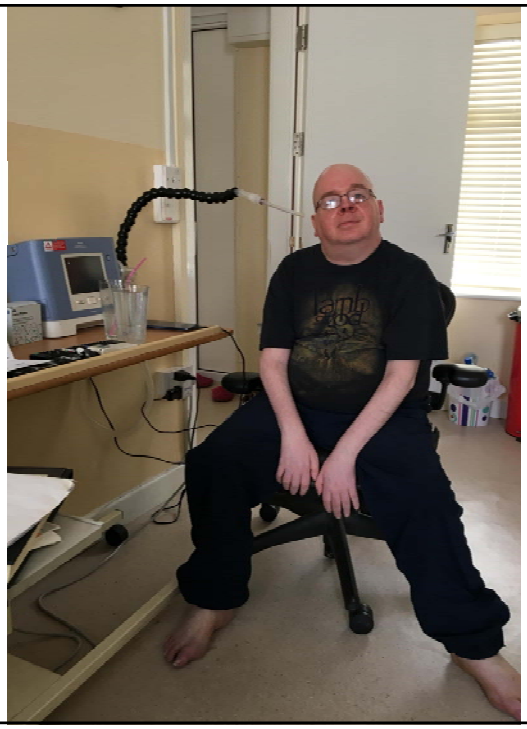
Safety or Quality ?

Who's your person?



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Thank-you

Triona Fortune
www.fqas.ie
tfortune@fqas.ie

@trionafortune

triona-fortune

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