# Patient Safety and Quality Improvement 301

GLOBAL HEALTH CONFERENCE

NOVEMBER 2020

# Objectives

- To understand the components of an effective patient safety program

- To understand how an "A3" can facilitate both administrative as well as clinical quality improvement projects

- To understand a healthcare Board's role in Patient Safety and Quality Improvement

# Patient Safety  - Reliability

- What if your hospital has an 80-90% institutional success rate? "Great"?
  - No, from an individual patients' standpoint, it is unacceptable

- For the individual patient, reliability is an "all-or-none" matter


- Optimal Patient Safety requires a framework for improving reliability - standardized protocols for care that are evidence-based and widely agreed upon is essential

# Patient Safety / Quality Improvement = Culture Change

Culture: "The set of values, norms, mores and behaviors which create formal and informal networks within an organization"

Practical Definition: The way we "do things" around here

Remember, "Culture eats (QI) Change every day"

# Cultural Transformation: Business as Usual

**Leadership: Powerful few. Make decisions about how work is done**
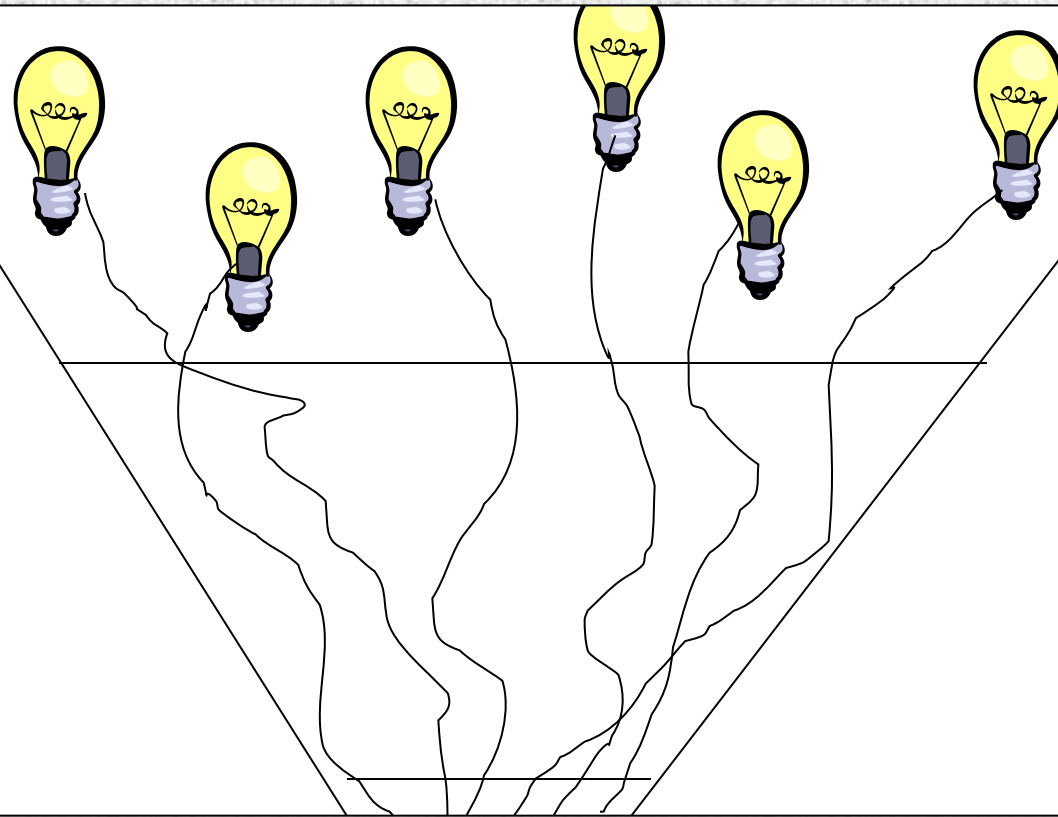
**Middle Management: Implement decisions**

*Front-line workers – many, experts at the work they do: carry out decisions, rarely engaged in deciding HOW work is done*

# After Culture Transformation – Everybody Contributes!

*Font-line Workers: experts at the work they do; decide HOW to do the work*

*Leadership and middle managers support and filter ideas; and remove barriers for implementation of practices for front-line workers*

# Common Patient Safety Challenges

- Diagnostic Errors: When a patient is not provided with a timely and correct diagnosis

- Medication Errors: can occur from the time the prescription is written to time of administration (it may or may not result in harm)

- Transition Errors: Change between inpatient and outpatient care (also between hospital units)

# Diagnostic Errors (DE)

- A DE is present when there was a missed opportunity to make the correct diagnosis

- The rate of DE is about 10% - most patient will be subject to DE at sometime in their life

- DE are the leading cause of malpractice claims against most MDs

- DE's are multifactorial in origin with flawed cognitive clinical processes and Systems Issues both contributing

# Diagnostic Error Examples

- **Premature Closure**: accepting a Dx and discontinuing the diagnostic process before the data necessary to establish the Dx have been obtained

- **Diagnostic Momentum**: when a Dx is suggested early in the Dx process –and the process continues even if the data do not support it

- **Confirmation Bias**: the predisposition to seek evidence to confirm a suspected Dx without looking for evidence to disprove it

- **Faulty application of knowledge**: the clinician does not posses the underlying knowledge necessary to make the Dx- or does not apply the knowledge properly

# Medication Errors

Adverse drug event: harm experienced by a Pt as a result of exposure to a medication

- ◦ >100,000 hospitalizations per year
- ◦ Can be secondary to an accepted risk or the result of a Medication Error

Risk Factors for Medication Errors:

- ◦ Polypharmacy
- ◦ Advanced Pt Age
- ◦ Impaired renal or liver function
- ◦ Illegible handwriting
- ◦ Use of non-standard abbreviations
- ◦ "Look-alike" or "Sound-alike" names
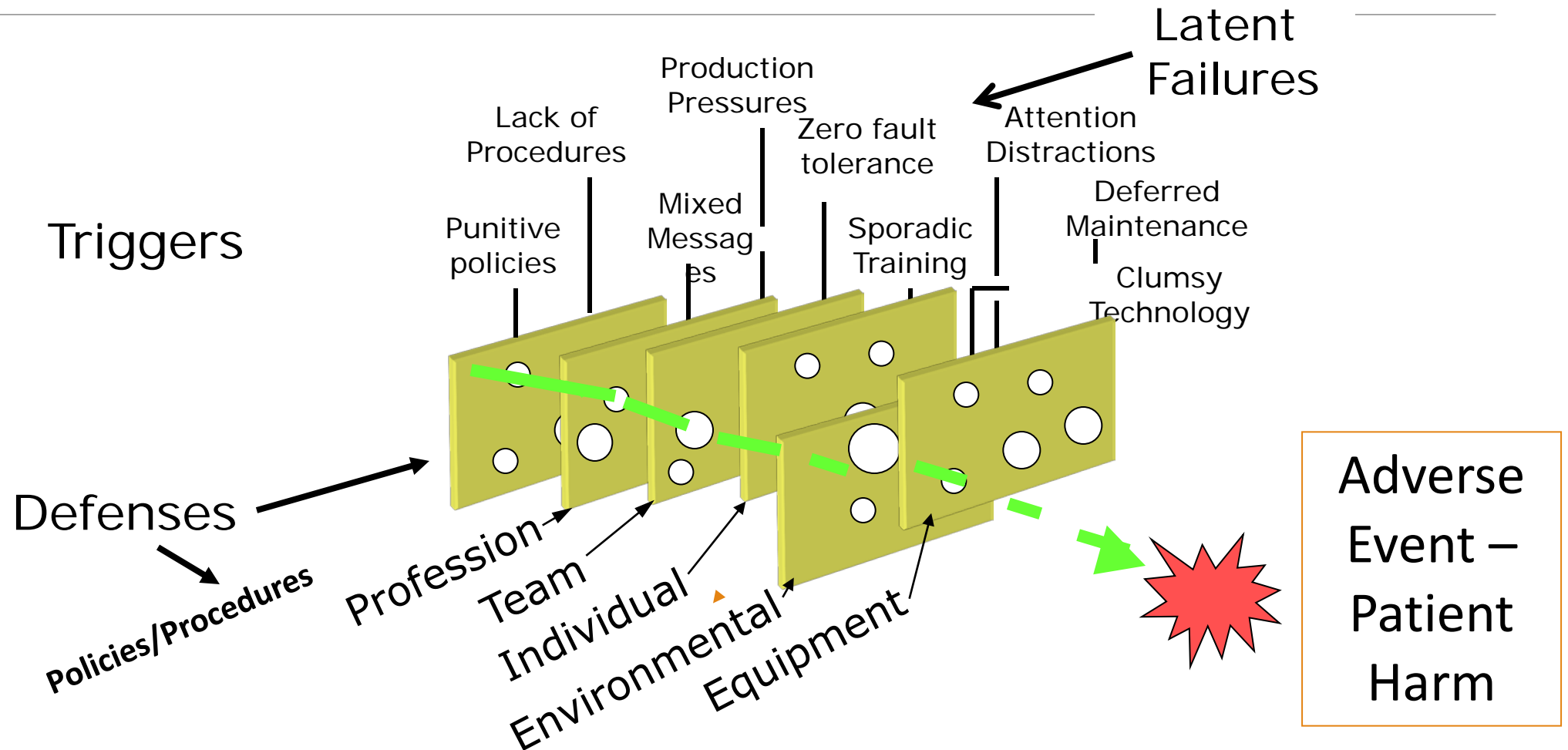
# Measures to Reduce Medication Errors

- Computerized physician order entry (CPOE) systems

- Medication reconciliation

- Better Labeling of meds with similar names

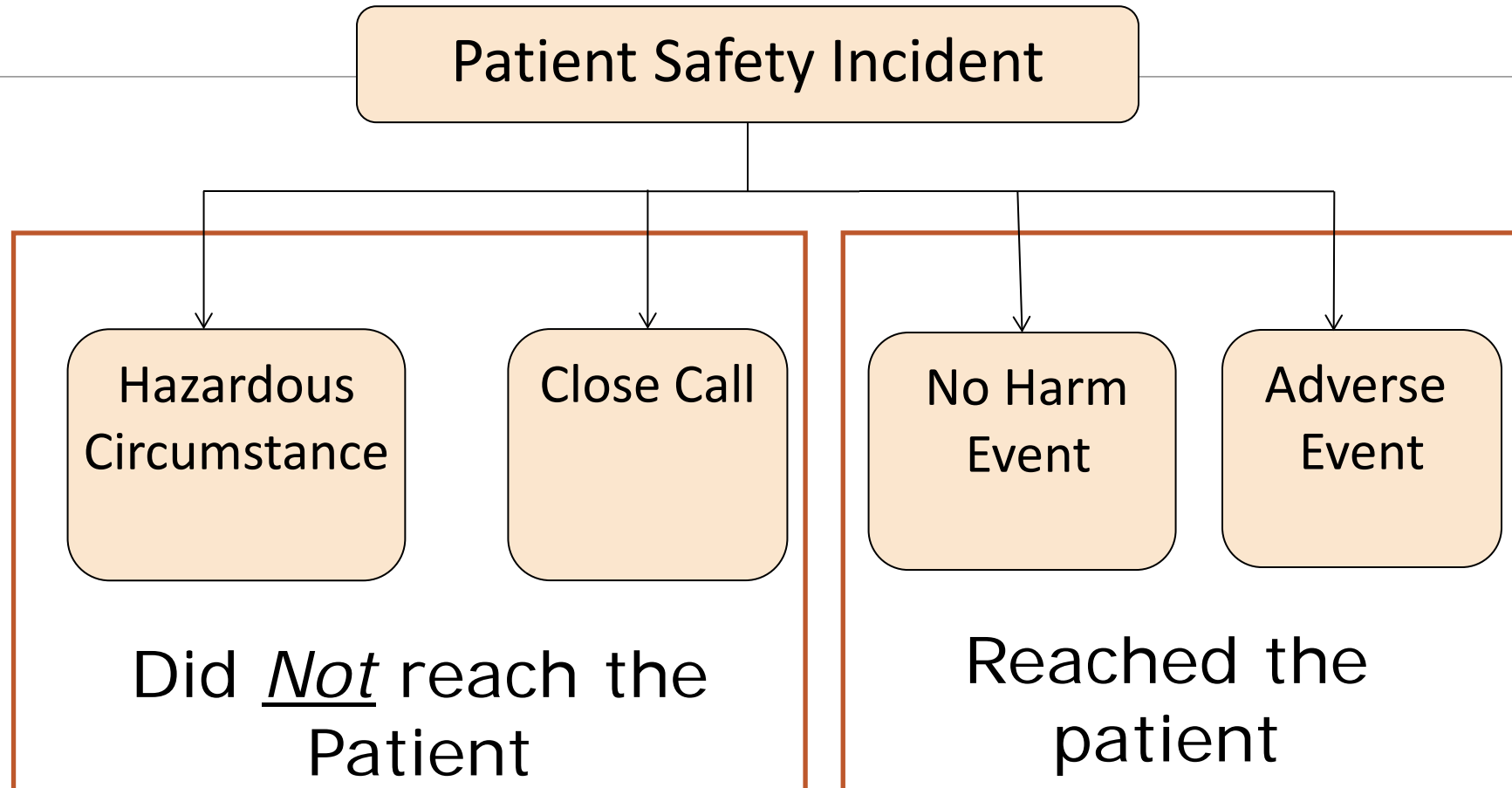- Barcode-Assisted medication administration (BCMA)

# "Human Error" =
## *Modus Operandi* in Current System

- Medicine has traditionally viewed errors as failings for which the individual at fault should be found and blame affixed

- "Train and Blame" methodology

- Nursing Training has emphasized rules

- Physician Training has emphasized knowledge

- Corrective actions have thus historically focused on the individual not the system

# The *Swiss Cheese* Model (Reason, 1991)

# Defining a Patient Safety Incident

Patient Safety Incident

Hazardous Circumstance

Close Call

No Harm Event

Adverse Event

Did *Not* reach the Patient

Reached the patient

# Our Knee-Jerk (unthinking) Reaction?

- Go to the Sharp edge of action:
  - The young staff member; the surgical team; the residents….
  - Don't follow an unconscious protocol…

- However, a better way is to not automatically blame the caregiver(s)

- Thoroughly investigate the incident
  - Begin a "Root Cause Analysis"
    - A defined process that seeks to explore all of the possible factors associated with an incident by asking what happened, why it happened, and what can be done to prevent it from happening again

# Basics of a Root Cause Analysis

- Start with a prompt investigation – complete in a specific time
  - Establish a timeline  - what happened? Who involved? Etc.
    - Review the Medical Record
    - Interview those involved
  - Discuss Timeline findings with your multi-disciplinary RCA team
    - Do not settle for an easy answer
    - Ask Why?  (the 5 why's) – Goal: find the root cause of the incident
  - End with a short document:   [To be signed by CEO]
    - Issue and Actions to be taken to ensure it doesn't happen again
      - Who will do the action and Date each action to be completed

# Why do Staff not Follow Policies/Procedures?

Because they…

◦ **Don't know** them (knowledge deficit)?

◦ **Can't find** them (P&P not readily available)?

◦ Staff don't have the **time**?

◦ **Can get away with** not following them?

◦ Are **careless** and/or **reckless**?

# Just Culture

"How can you justly **deal with the individual** who was involved, while also ensuring that your **organization learns** as much as it can from the event?" Sidney Dekker

How will you balance accountability with learning?

**Learning**: **Studying harmful events** (or **near misses**) so as to make **improvements** that lead to a **safer** healthcare environment.

If you come down hard on people…

- Staff *may* **be** more **careful**.
- They will **certainly** be **less willing to report** instances of harm or even near misses

However, if you have no sanctions…

- Staff who are in the '**wrong seat**' may persist.
- Other employees may believe "**anything goes**."

# Basic Pt Safety Structure & Function

- Implementing and Managing an **incident report system**

- Understanding and analyzing **data**

- **Connecting** leadership with front line staff

- Implement **frontline activity** to improve patient safety

- Analyzing **major errors** and sentinel events to prevent reoccurrence

- **Qualifications** and **training** of the **Patient Safety Officer**

- The role of the **patient safety committee**

- **Engaging physicians** in patient safety

- **Board engagement** in patient safety

# Patient Safety Measurement

- The 'basics' include:
  - Data from **voluntary incident report** system
  - Data from **trigger tools** (and results of chart review)
  - **Real time surveillance**: e.g., CLABSI, CAUTI
  - **Key outcome** data: e.g., risk-adjusted mortality
  - Key **process/structural** data: e.g., CPOE use
  - **NQF** serious **reportable** events
  - **Malpractice** claims and payouts
  - **Accreditation/licensing** data from areas of concern
  - Serious **patient complaints**
  - Data from **M & M** conferences
  - Results from **patient experience** surveys
  - Results from **safety culture** surveys
  - Data from **executive walk-rounds**/focus groups

What do I do with data once I have it?

Not very many people really know how to use data.

# The Importance of Patient Safety

Healthcare is safe for the vast majority of people the vast majority of time, **but it could and should be safer**.

The vast majority of healthcare harm events are **systems issues, not people issues**.

Approach to patient safety

◦ Just culture/unsafe acts algorithm

◦ Normalization of deviance

◦ Root cause analysis

- The balance between creating a **learning** environment and **accountability** (**a 'just culture'**) **is difficult to define, create and maintain**.
- **Normalization of deviance is inevitable human behavior**, the 'path of least resistance.'
- The *process* for investigating harm (e.g., RCA) must be **well-defined and consistent**; if it is, people will be **more likely accept the result even if they don't like it**.

## How does this work?

By the best methods we know of to measure harm (i.e., trigger tools) *not well*; the fault of **intervention**, **dissemination**, or **measurement**?

- On thinking of different approaches:

  – Teamwork and communication

  A root cause of about **80% of harm events**. **Good teamwork and communication cannot be assumed** in complex environments.

  – Human factors

  Physical, cognitive and macro human factors **considered by many to be the number one systematic cause of patient harm**.
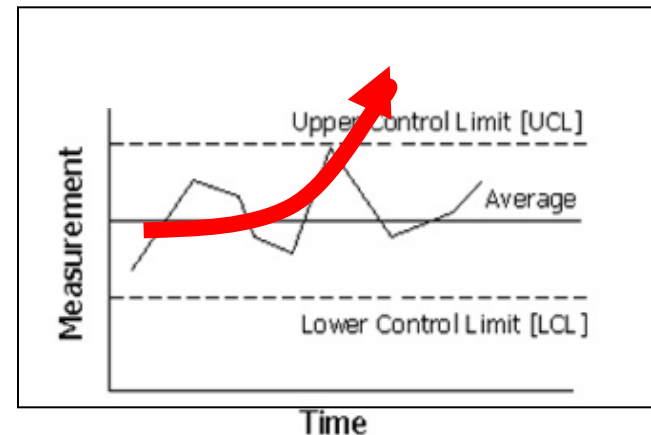
# Why "Quality Improvement" not "Quality Assurance" Activities?

***"Quality Assurance"*** will support best outcome <u>within</u> current system design
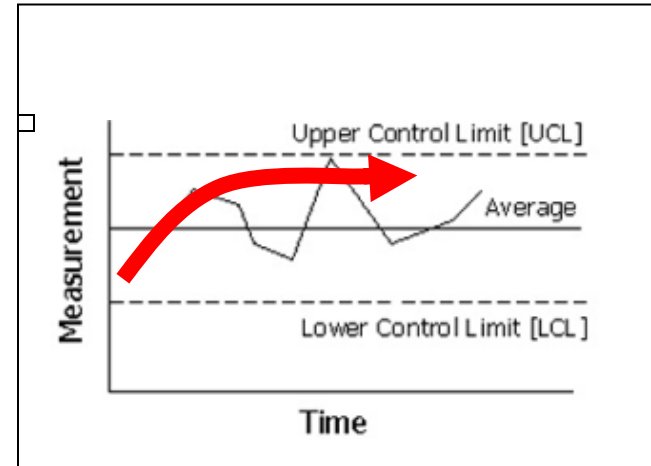
**QA**

***"Quality Improvement"*** will <u>transcend</u> current best design specifications

**Q I**

# Basis for "Quality Improvement"

- The key element in the "Quality Improvement" is the premise that **quality** is a **system** property

- Therefore, what primarily determines the level of performance is the **design** of the healthcare **system**

# Overuse/Overtreatment

- **Definition**: Patients receiving services from which they will not benefit

- **Example**: Giving Antibiotics for "colds"/URI [>30% of children receive excessive antibiotics for ear infections]

- **Why a Problem**: exposed to the risk of adverse effects of this treatment without the possibility of benefit

# Underuse/Undertreatment

- **Definition**: Patients not receiving services from which they would benefit

- **Example**: Heart Failure patients not treated with ACE inhibitors

- **Why a Problem**: desired outcome is reduced because they do not realize the health benefits of these treatments

# Misuse

- Definition:  Appropriate health services are provided ineptly [~ 7% of hospital patients experience a serious medication error]

- Example: patients with renal insufficiency who require aminoglycoside antibiotics but receive doses that are not reduced to match their renal function

- Why a Problem: the probability of a good outcome is diminished by the added risk of avoidable complications

# "Community of Scientists"

The Basic Sciences of Quality/Pt Safety

Use Evidence-Based **Management** Principles (HC Delivery) to Improve Healthcare Organizations as "Systems"

Change from the <span style="color:red">"Why"</span> do this to

<span style="color:red">"How"</span> to do it!

# System Attributes

- "We must accept human error as inevitable – and design around that fact." - Don Berwick, M.D.

- "The Search for zero error rates is doomed from the start"

- If You Want a New Level of Performance?

# Design a New System!

## Apply a
## "Quality Improvement" Methodology

To Improve (Change) Your HC Delivery System

"The Science of Improving Healthcare Delivery"

[Evidence-Based HC Management]

# A Transformed [*Highly Reliable*] Healthcare System

["A Place where you want to be…"]        A Framework

1. No Needless Deaths                        [Safety]

2. No Needless Pain                          [Effectiveness]

3. No Helplessness                           [Person-Centered]

4. No Unwanted Waiting                       [Timeliness]

5. No Waste                                  [Efficiency]

6. No Unfairness                             [Equity]

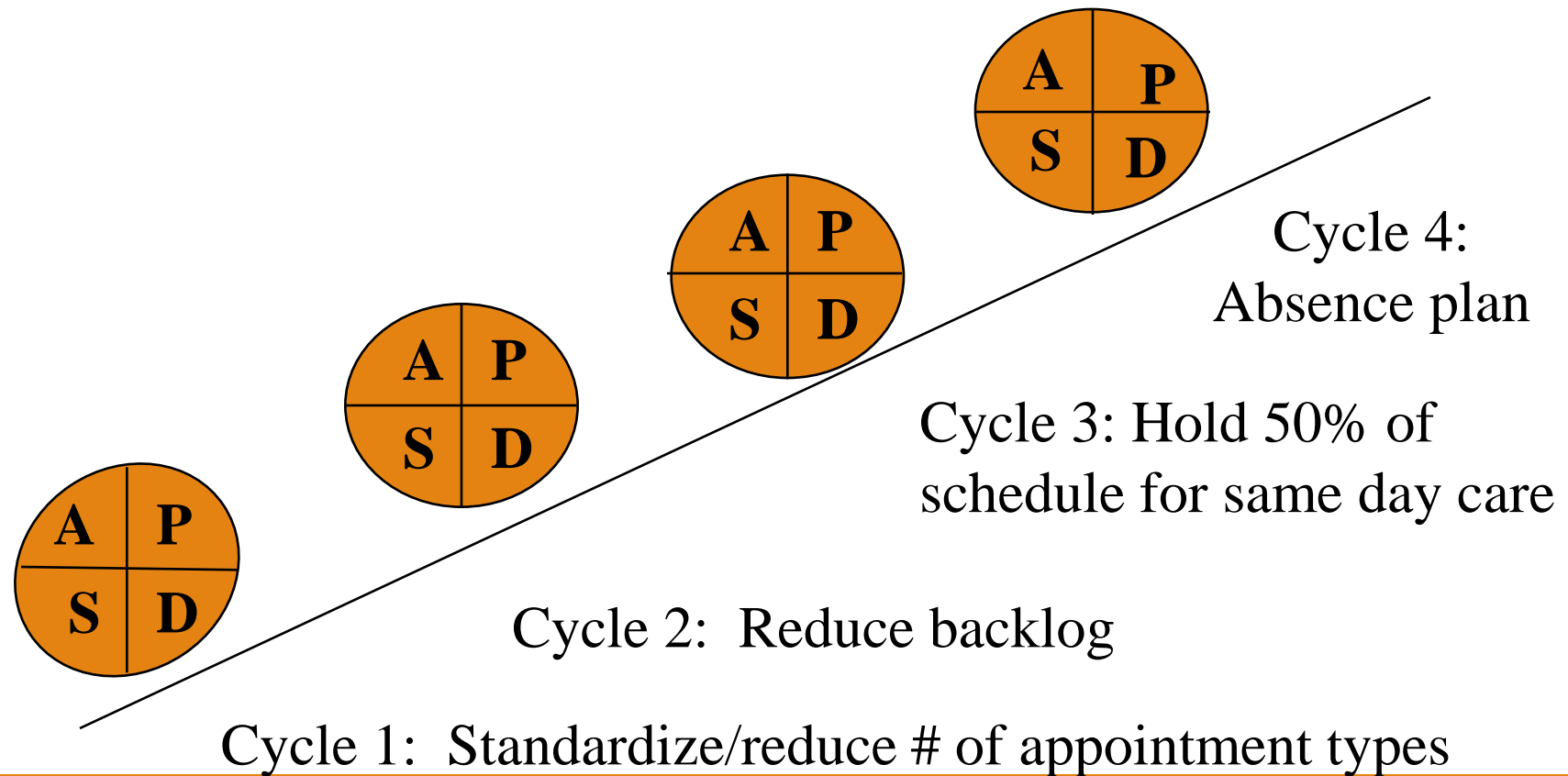# Model for Improvement – IHI [model A]

**The model has two parts**:

I.    Three Fundamental Questions:
   1. Setting **Aims**: What are we trying to accomplish?
   2. Establishing **Measures**:  How will we know that a change is an improvement?   [Measurement]
   3. Selecting **Change**:  What changes can we make that will result in improvement?

II.   The Plan-Do-Study-Act (**PDSA**) cycle to test and implement changes in <u>real work settings</u>

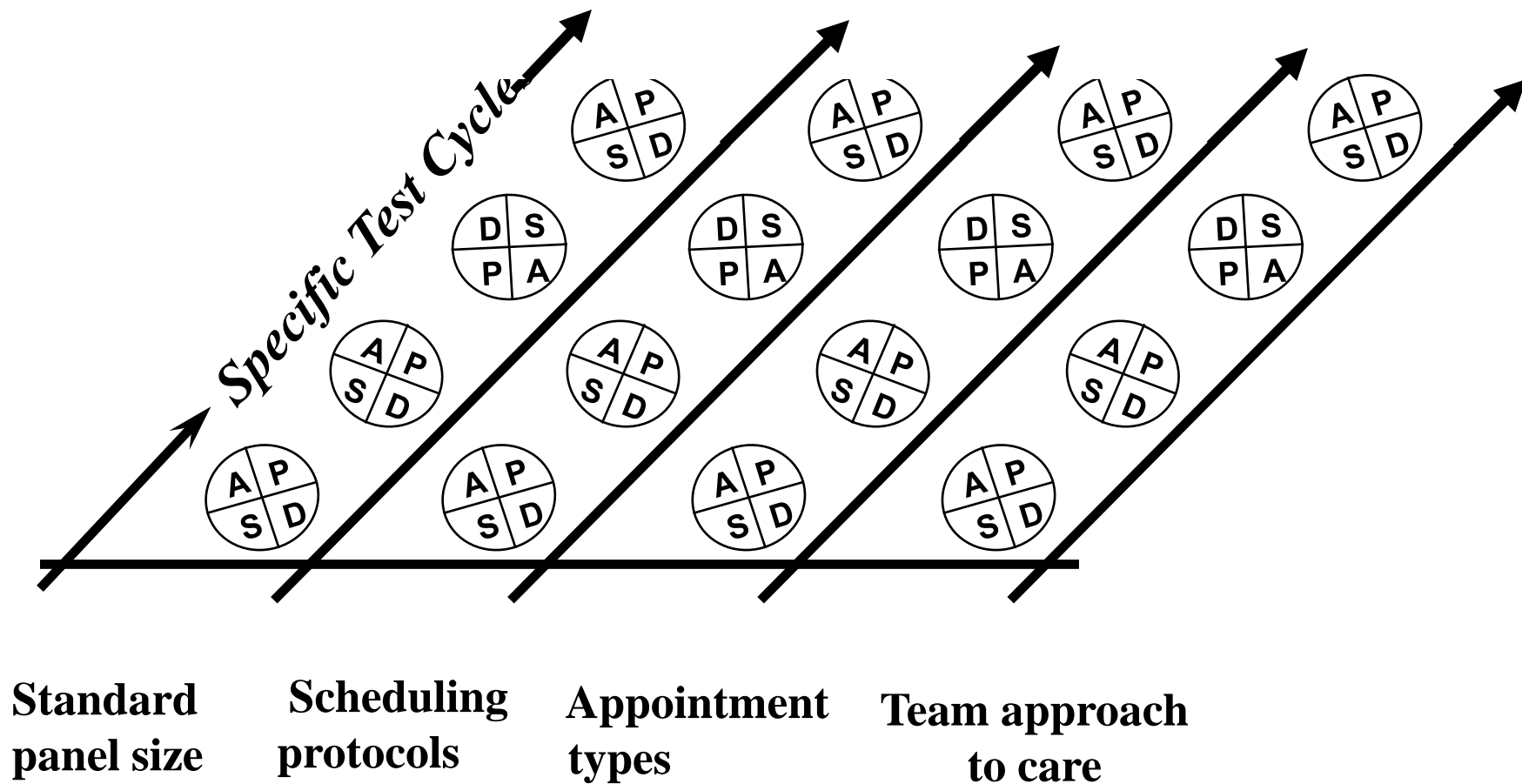Rapid Cycle Improvement (RCI) = multiple small tests (PDSAs) of change

Berwick D. A primer on leading the Improvement of systems.  BMJ; 312:619622. 9 March 1996

# Testing…testing…Aim:
## Next Available Appointment < 7 days



Cycle 4: Absence plan

Cycle 3: Hold 50% of schedule for same day care

Cycle 2: Reduce backlog

Cycle 1: Standardize/reduce # of appointment types

# Rapid Cycle Improvement (Many PDSA Cycles)



**Standard panel size**

**Scheduling protocols**

**Appointment types**

**Team approach to care**

# What is Lean Thinking?

*"The endless transformation of waste into value from the customer's perspective"*

The Culture change in lean thinking is as important as the actual tools or methodologies

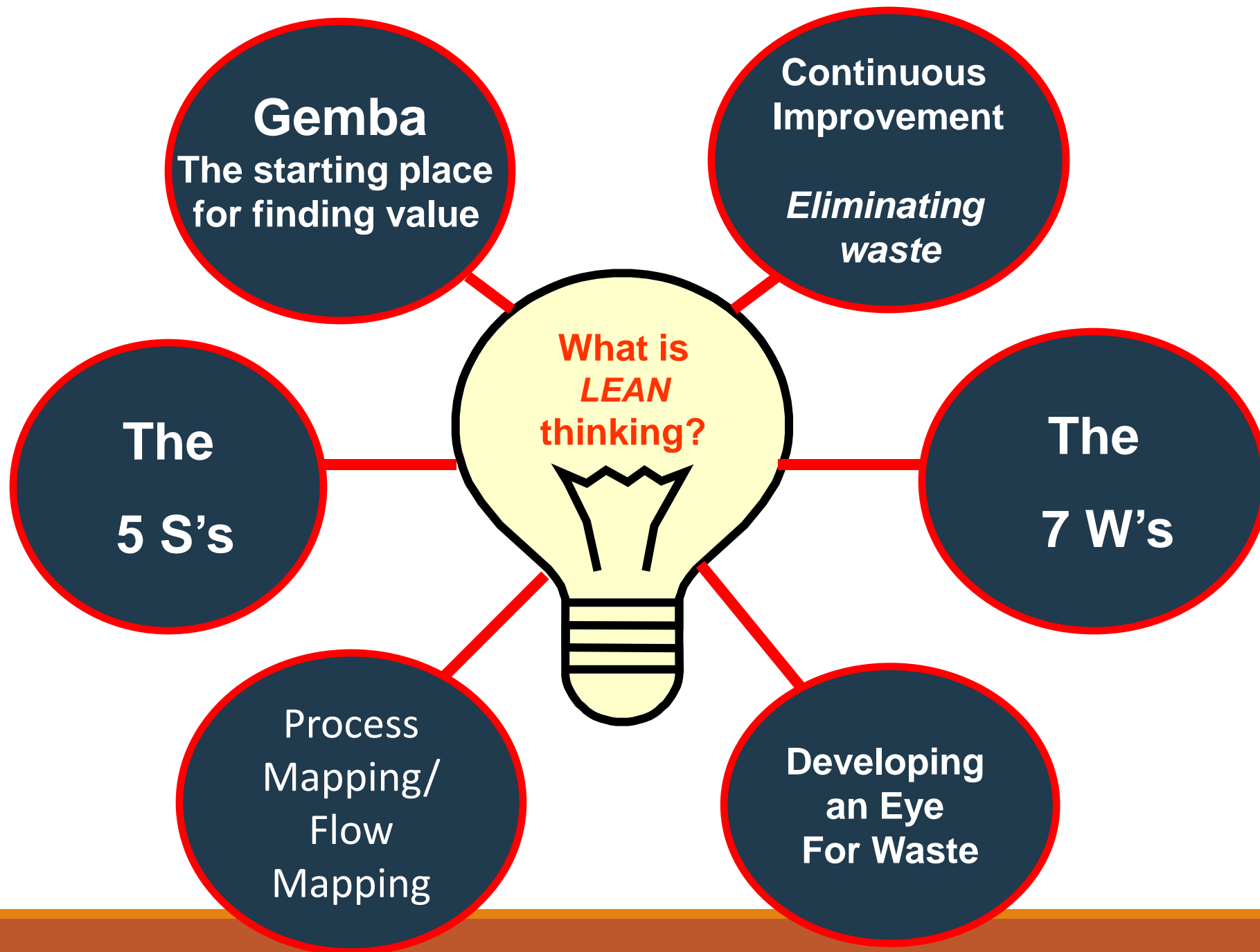# How to Determine the Value You Provide to Your Patients:

$$\text{VALUE} = \frac{\text{Outcome}}{\text{Cost}}$$

$$\text{VALUE} = \text{"A"} \times \frac{\text{Access + Technical + Functional + Satisfac.}}{\text{COST}}$$

"Delight Index"

"A" = Appropriateness
If "A" = zero, don't do process
If "A" = 1, appropriate care

# 5 S:
## Sort, Set in Order, Shine, Standardize, Systematize

5 S: an organized, never ending, effort to

- Remove all physical waste out of the work place that is not required for doing work in that area
- Setting things in order
- Identify, label, allocate a place to store it so that it can be easily found, retrieved and put away

## Lean Six Sigma: 5S

5S is a workplace organization technique composed for five primary phases: Sort, Set In Order, Shine, Standardize, and Systematize.

**SORT**
Keep only necessary items in the workplace.

**SET IN ORDER**
Arrange items to promote efficient workflow.

**SHINE**
Clean the work area so it is neat and tidy.

**STANDARDIZE**
Set standards for a consistently organized workplace.

**SYSTEMATIZE**
Maintain and review standards.

# 5 S Results:

**Before 5S**

**After 5S**

# Waste "Pre / Post- "5 S"



Unit 1. Basement   (Before) and (After)

# Stabilizing Equipment Availability

5-S Techniques:
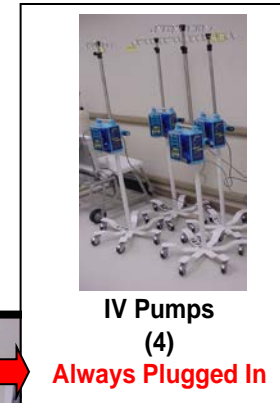
*Sort*

*Set in order*

*Standardize*

*Shine*

*Sustain*

**BEFORE**

**IV Pumps
(4)**
**Always Plugged In**

Benefits

*Clean equipment =
pathogen vector*

*Saves frustration,
searching*

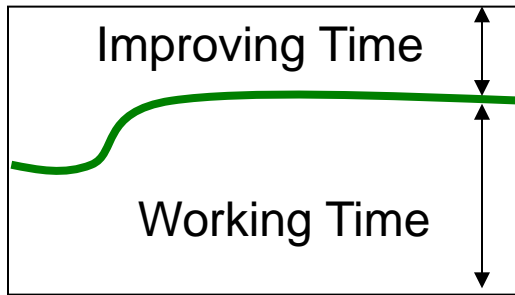*Freed up $20K-worth of
unused equipment for
use elsewhere*

**AFTER**

# System Paradox: Does QI mean – Work "Harder"?
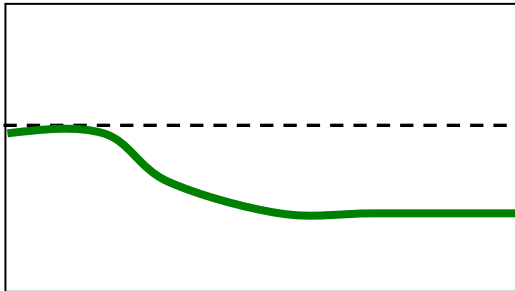
## Effort

Improving Time

Working Time

## Capability

## Actual Performance

Time →

Repenning, NP and Sterman, JD: Nobody Ever Gets Credit for Fixing Problems that Never Happened www.webmit.edu

# System Paradox: Work "Smarter"
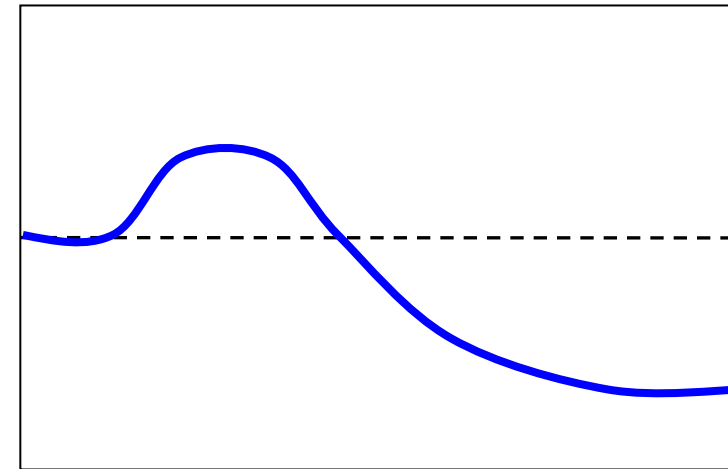
### Effort

Improving Time

Working Time

### Capability

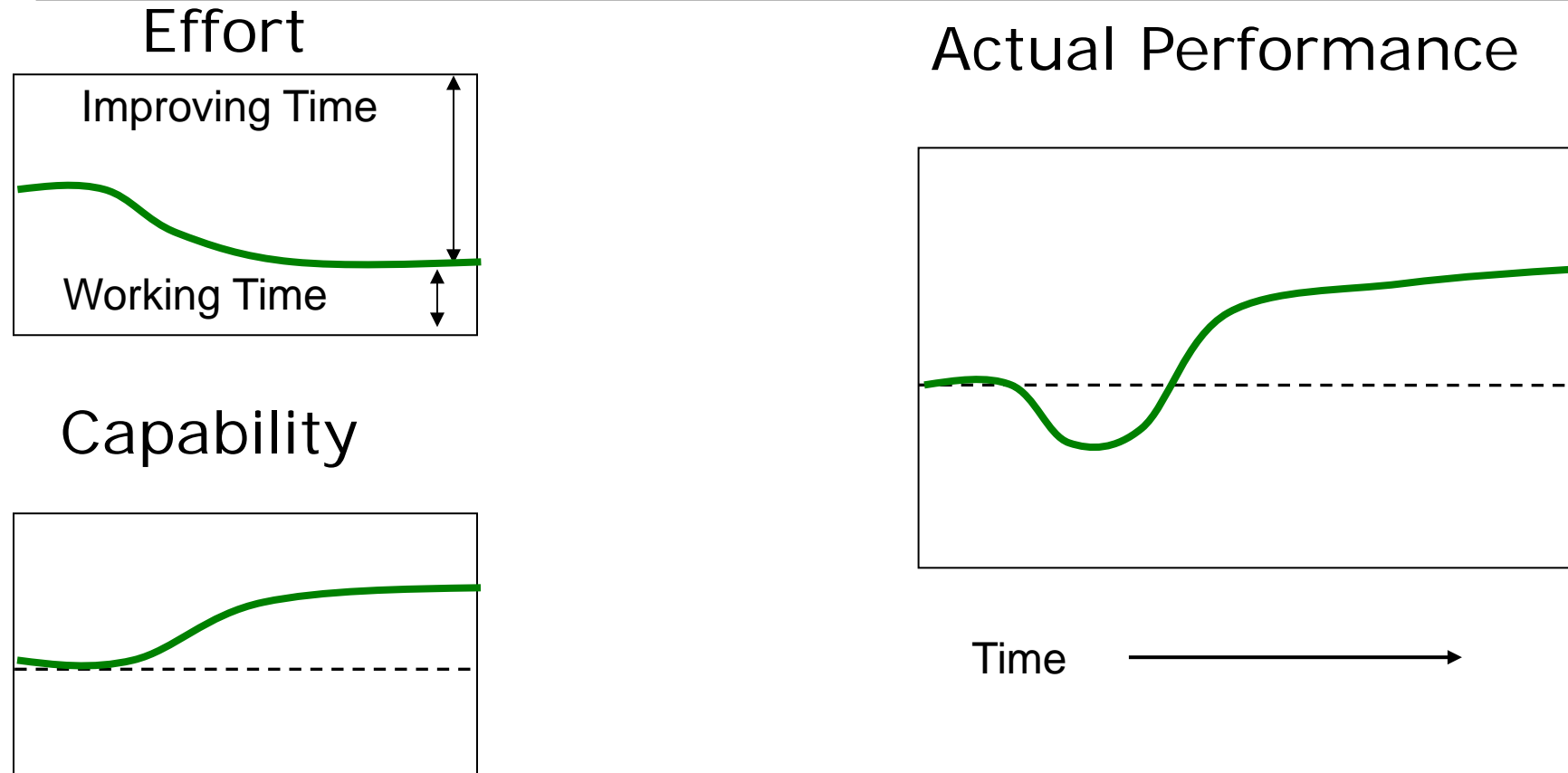### Actual Performance
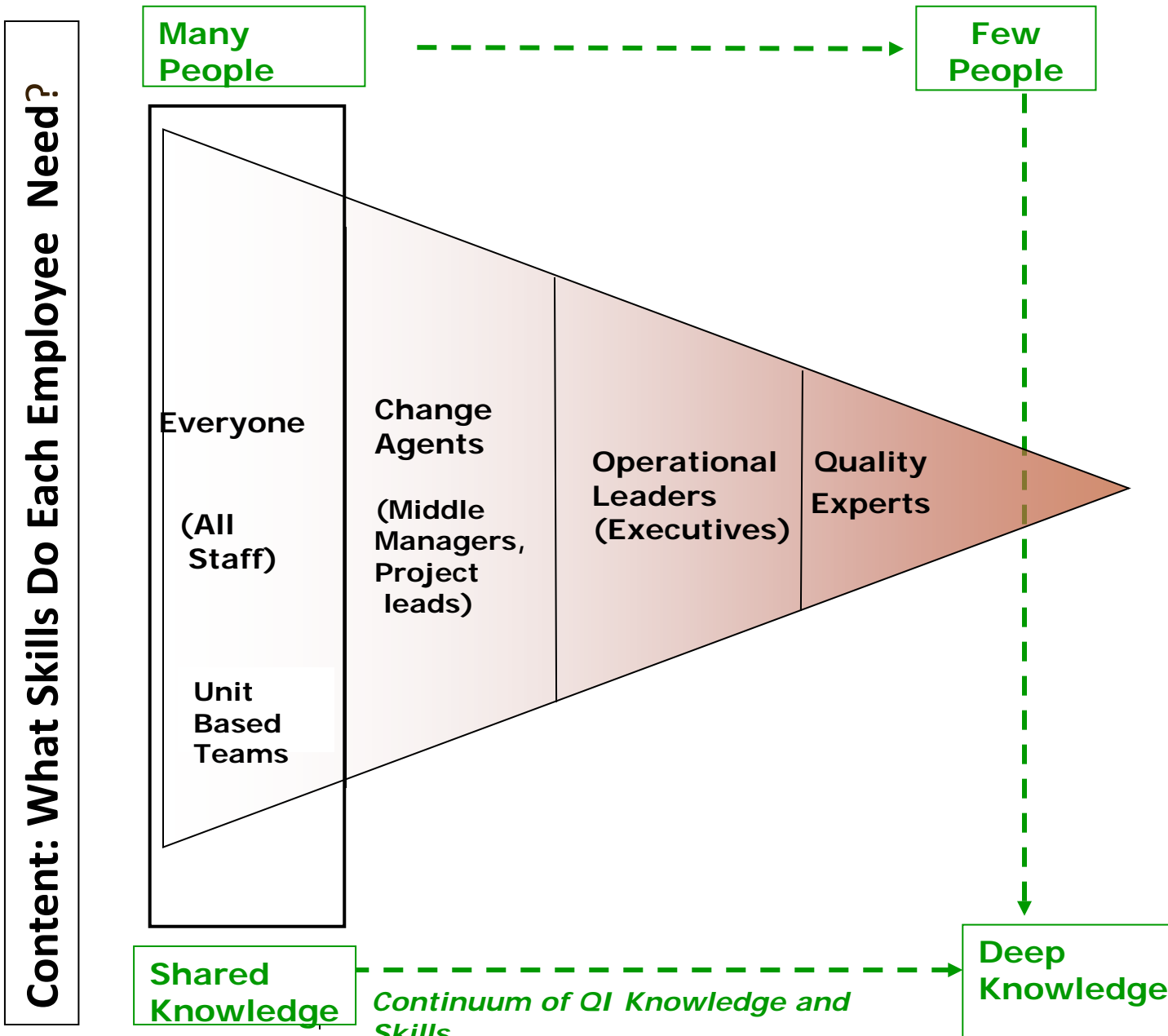
Time →

Repenning, NP and Sterman, JD: Nobody Ever Gets Credit for Fixing Problems that Never Happened www.webmit.edu

**Content: What Skills Do Each Employee Need?**

**Many People** ⇢ **Few People**

Everyone

(All Staff)

Unit Based Teams

Change Agents

(Middle Managers, Project leads)

Operational Leaders (Executives)

Quality Experts

A key operating assumption of building capacity is that different groups of people will have different levels of need for QI knowledge and skill

Important to make sure that each group receives the knowledge and skill sets they need when they need them and in the appropriate amounts

**Shared Knowledge** ⇢ **Deep Knowledge**

*Continuum of QI Knowledge and Skills*

# Data

# Information
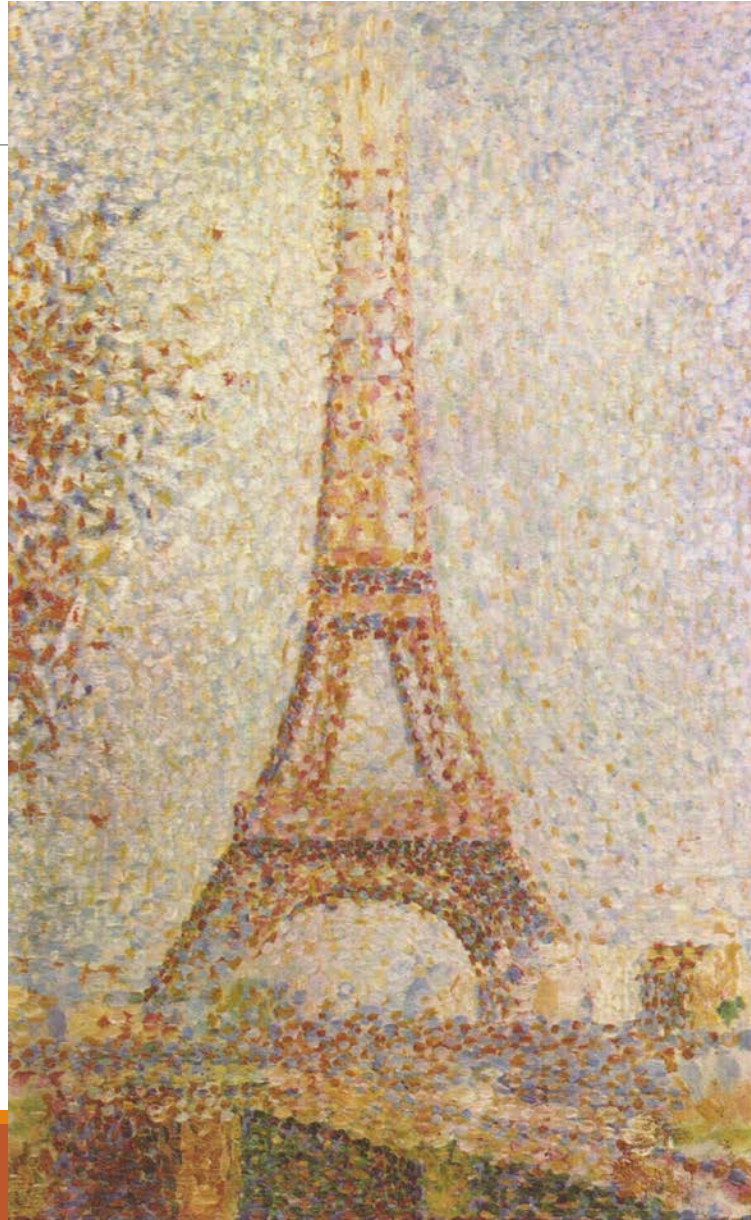
# Now this is where it gets a little complicated
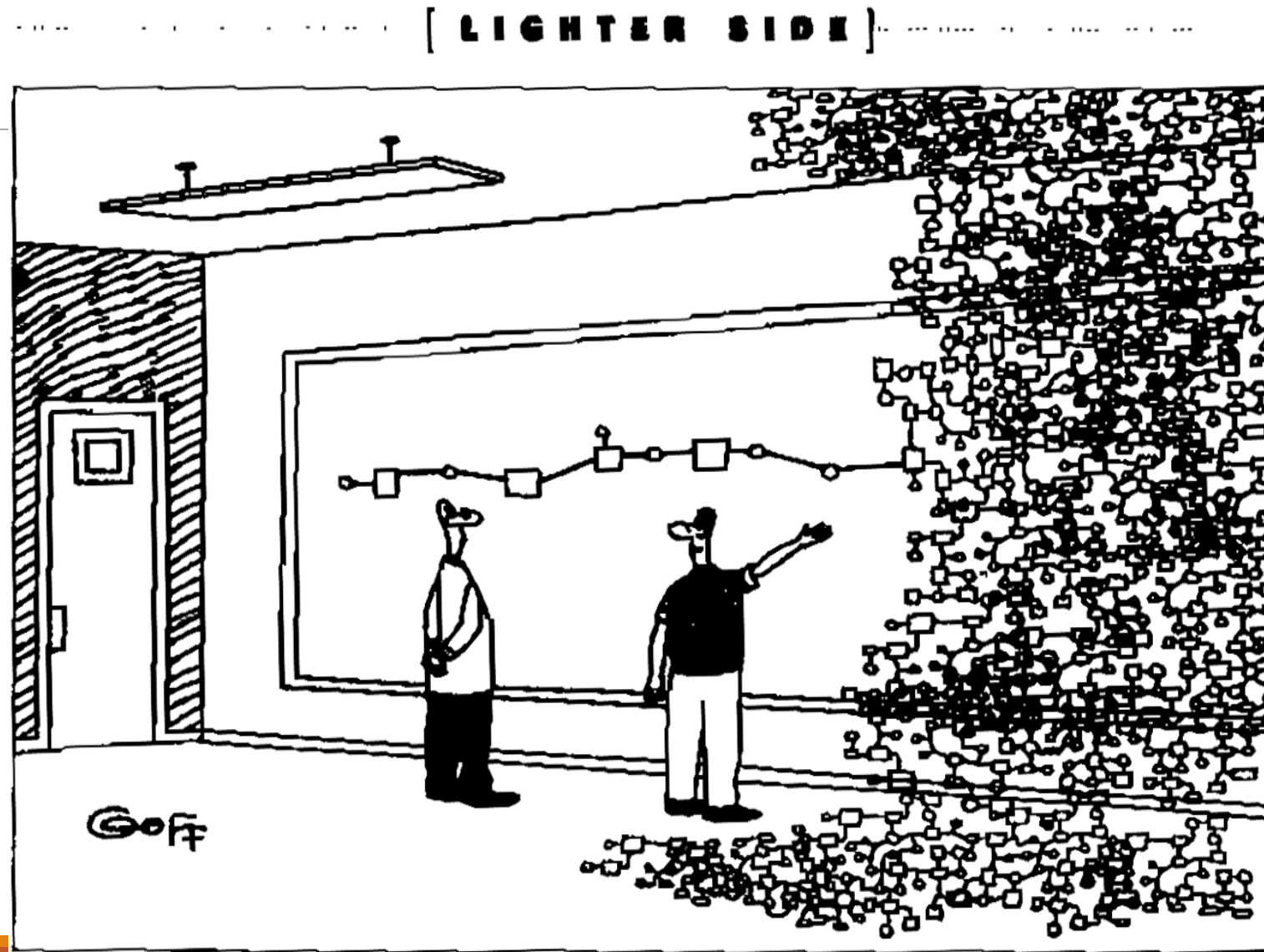
# Why A3 "Protocol"/Thinking?

- A structured cycle of improvement

- A framework for organizing thinking
  - Can be used for any type of problem
  - Individual and teams (and systems) – a living, dynamic document

- Eliminates the waste of debating method

- Reveals the issues, problems and previous ways of thinking

- Makes problem solving visual

- Tells a Story

**A Key tool in becoming a High Reliability Organization**

# LEAN   A3

| 1. **Reason for Action:**<br>**VISION / Analysis**<br>**Team and AIM** | 4. **Gap Analysis:**<br>**Change** | 7. **Completion Plan:**<br>**Sustain new process**<br>**Spread** |
|---|---|---|
| 2.   Current State:<br>Map Process<br>Baseline measurement | 5.   Solution Approach:<br>Change Ideas | 8.   Confirmed State:<br>Sustain & Spread |
| 3.   Target (or Future) State:<br>Map Ideal/Target State<br>Measure | 6.   Rapid Experiments (PDSA<br>Cycles =RCI)<br>Change | 9.   Insights:<br>Ideas to help sustain and<br>spread |

# A3 - Box 1 Reason for Action

What is the problem statement?

What is the scope of the problem?

What are the boundaries you will set?

| Reason for Action | Gap Analysis | Completion Plan |
|---|---|---|
| 1 | 4 | 7 |
| Current State | Solution Approach | Confirmed State |
| 2 | 5 | 8 |
| Target (Future) State | Rapid Experiments | Insights |
| 3 | 6 | 9 |

# A3 – Box 2  Current State

## What does the organization look like right now?

◦ Data/Business case for need:
◦ What are the current/upcoming changes you wish to initiate?
◦ Have you personally visited the site you want to change?
  ◦ Gemba Walk
◦ Identify what are the core process?
◦ Flow Map the core processes
  ◦ Identify (high-level) major issues (Kapowie's)

| Reason for Action | Gap Analysis | Completion Plan |
|---|---|---|
| 1 | 4 | 7 |
| Current State 2 | Solution Approach 5 | Confirmed State 8 |
| Target (Future) State 3 | Rapid Experiments 6 | Insights 9 |

# A3 – Box 3  Future (Target) State

What do we want the organization to look like at:
- 1 year
- 3 years
- 5 years from now?

What does a "Good" future look like?

How will we know when we have made an impact?

| Reason for Action | Gap Analysis | Completion Plan |
|---|---|---|
| 1 | 4 | 7 |
| Current State | Solution Approach | Confirmed State |
| 2 | 5 | 8 |
| Target (Future) State | Rapid Experiments | Insights |
| 3 | 6 | 9 |

# A3 – Box 4 "Gap Analysis"

What are the big differences (gaps to be closed) between the current and future state?

What impact do these gaps have on our ability to be successful or reach our target state?

How much control / influence do we have over these gaps?

What are some of the potential root causes of the gaps?

| Reason for Action | Gap Analysis | Completion Plan |
|---|---|---|
| 1 | 4 | 7 |
| Current State | Solution Approach | Confirmed State |
| 2 | 5 | 8 |
| Target (Future) State | Rapid Experiments | Insights |
| 3 | 6 | 9 |

# A3- Box 5 Ideas (Solutions) Approach

What ideas / strategies do we have for closing the gap?

Which of the core processes have the most potential to close gaps (attain target)

What have others done to close the gaps?

How easy or difficult are the solutions being proposed?

| Reason for Action | Gap Analysis | Completion Plan |
|---|---|---|
| 1 | 4 | 7 |
| Current State 2 | Solution Approach 5 | Confirmed State 8 |
| Target (Future) State 3 | Rapid Experiments 6 | Insights 9 |

# A3 – Box 6  Rapid Experiments

Proposed countermeasures to address each root cause

Predicted results for each countermeasure

Do multiple PDSAs

Assessment Q:
◦ Are there clear countermeasure steps identified?
◦ Do the countermeasures link to the Root Cause of the prob.?
◦ Who is responsible for what, by when (5 whys)
◦ Will these action items prevent recurrence of the problem?

| Reason for Action | Gap Analysis | Completion Plan |
|---|---|---|
| 1 | 4 | 7 |
| Current State | Solution Approach | Confirmed State |
| 2 | 5 | 8 |
| Target (Future) State | Rapid Experiments | Insights |
| 3 | 6 | 9 |

# A3 – Box 7 "Implementation"

Table to document how you will do the different PDSA cycles you do in closing the gaps

◦ Who  (who leads task)

◦ What   (task)

◦ When   (completion date)

◦ Where

Learn and improve as you go

| Reason for Action | Gap Analysis | Completion Plan |
|---|---|---|
| 1 | 4 | 7 |
| Current State | Solution Approach | Confirmed State |
| 2 | 5 | 8 |
| Target (Future) State | Rapid Experiments | Insights |
| 3 | 6 | 9 |

# A3 – Box 8 "Confirmed State"

Accomplishments

Metrics (data)
◦ run charts, control charts, etc.
◦ Document quantified change (% improvement or % no longer happening, etc.)

| Reason for Action | Gap Analysis | Completion Plan |
|---|---|---|
| 1 | 4 | 7 |
| Current State | Solution Approach | Confirmed State |
| 2 | 5 | 8 |
| Target (Future) State | Rapid Experiments | Insight / Reflection |
| 3 | 6 | 9 |

# A3 – Box 9 "Insights"

What have you learned from this process?

How can we make it better next time?

Summary

| Reason for Action 1 | Gap Analysis 4 | Completion Plan 7 |
|---|---|---|
| Current State 2 | Solution Approach 5 | Confirmed State 8 |
| Target (Future) State 3 | Rapid Experiments 6 | Insights / Reflection 9 |

**PROJECT Title: NICU Discharge Planning: Obtaining Riverside CCS SAR's**     **Team : (Leader–Christy Hollis), Manuel Cota, Aiko Liang, Meenu Singh**

**Facilitator: Bernice Chapman-Stewart**     **A3**

## 1. Reasons for action:

**Problem statement**
NICU patients are delayed in being seen at specialty clincs after discharge date due to no authorization by CCS

CM staff in NICU and core office spending extra time investigating the status of CCS referrals which are initated by a parents phone call when they are unable to

There is vaulable time being wasted, by extra steps, reworking of the process which results in delays of service and low customer satisfication.

**Scope**
process start 04-2016    in scope: LLUCH CM, Riverside CCS
process end 11-2016    out of scope: other departments, S.B. CCS

## 4. Gap Analysis:
Five Whys

1. • Parents unable to schedule FU appointments after discharge
2. • The SAR not found by clinic personal in LLEAP
3. • SAR has not been processed
4. • CCS has not reviewed or authorized referral yet
5. • D/C summary and referral are sent to CCS after patient discharged

## 7. Completion Plans:

| Action | Who | when |
|---|---|---|
| Notify Manual Cota UM Coordinator of DC referral needs | NICU case manager | After weekly Multidisciplinary team meeting |
| Referral made to Riverside CCS | Manual Cota | As soon as possible. |
| f/u at CCS website | Manual Cota | 1-2 weeks after referral request was made and then weekly |

## 2. Initial State:

Initially there were up to 7 decision points in addition to 10 steps. Referral went out with d/c summary at time of discharge.



NICU Discharge Planning for CCS referrals

## 5. Solution Approach:

Data was collected from April thru July from RV county prior to starting the New Process and from August thru November with the new process in place and was compared to see if the process change is successful

| Days Pre /post DC | # of days until SAR was Obtained for RV county april-july | % April-July |
|---|---|---|
| 6 or more days post DC | 27 | 58% |
| 1-5 days post DC | 10 | 21% |
| 0-5 days prior to DC | 8 | 17% |
| 6 or more days prior to DC | 2 | 4% |

| Days Pre /post DC | # of days until SAR was Obtained for RV county August-nov | % Aug-Nov |
|---|---|---|
| 6 or more days post DC | 46 | 43% |
| 1-5 days post DC | 38 | 36% |
| 0-5 days prior to DC | 13 | 12% |
| 6 or more days prior to DC | 9 | 9% |

## 8. Confirmed State:

Manual Cota CCS coordinator and NICU discharge planner Aiko Liang will continue to follow up on Riverside county patient to make sure the new process is working smoothly and NICU patients have their speciality clinic appoinmtents scheduled within reasonable time frame.

**Current state**



- 6 or more days post DC
- 1-5 days post DC
- 0-5 days prior to DC
- 6 or more days prior to DC

## 3. Target State:



NICU Discharge Planning for CCS referrals: Target State Process Map

Target is to have speciality appointment scheduled by the time patient is discharged from NICU. The decision points decreased to 3 with a maximum of 6 steps.
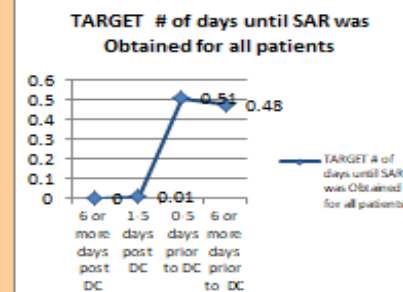
## 6. Rapid Experiments:



- # of days until SAR was Obtained for RV county August- nov
- # of days until SAR was Obtained for RV county april-july
- Target

| Days Pre /post DC | # of days until SAR was Obtained for RV county August-nov | # of days until SAR was Obtained for RV county april-july | Target |
|---|---|---|---|
| 6 or more days post DC | 43% | 58% | 0% |
| 1-5 days post DC | 36% | 21% | 1% |
| 0-5 days prior to DC | 12% | 17% | 49% |
| 6 or more days prior to DC | 9% | 4% | 50% |

## 9. Insights:

Planning to role out the same process with San Bernardino county from January 2017.
We will continue to do routine checsk/audits to make sure referral request are made on timely manner and NICU patients has the authorizations for the follow up appointments 0-5 days prior to discharge.

**TARGET # of days until SAR was Obtained for all patients**



- TARGET # of days until SAR was Obtained for all patients

Sidebar labels: Team/Aim | Map/Measure | Map/Measure | Change | Change | Change | Sustain | Sustain | Sustain

# Trystorming

- Rapid Tests of Change (RCI = Multiple PDSA cycles)

# SDSA Cycle

- PDSA: focuses on experimentation

- SDSA: focuses on Standardization/Sustainability

- Once you have run many PDSA cycles (RCI) and have achieve a desired level of performance – you want to maintain this gain
  - Adopt new a new **s**tandard method (till you need to make new improvements)

- SDSA cycle is how you *hold the gain*

"Don't be afraid of learning too much;


it will never happen!"

Dr Stephen Miles

# Healthcare QI Board Responsibilities

- Ensure your HC Board has "Quality & Patient Safety" as part of its agenda – should be ~25% of agenda - Larger facilities: "Q & PS" Board Subcommittee

- Keep your "Board" appraised of "Q and PS" status

- Establish a "Just Culture"

- Select a Quality Improvement (QI) Methodology

- Include QI/PS goals in your CEO's Performance Evaluation

- Continually communicate QI results to all stakeholders staff (tell "stories")

# "Ideal" Board Structure
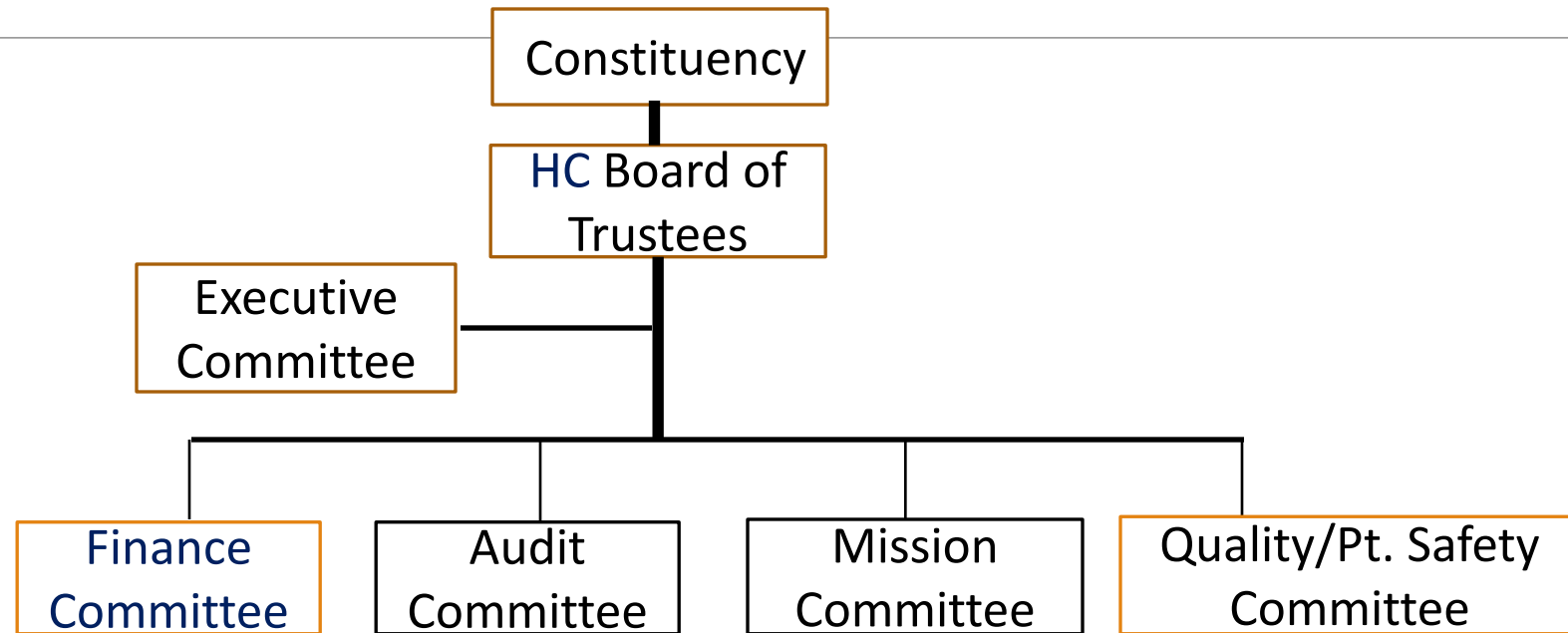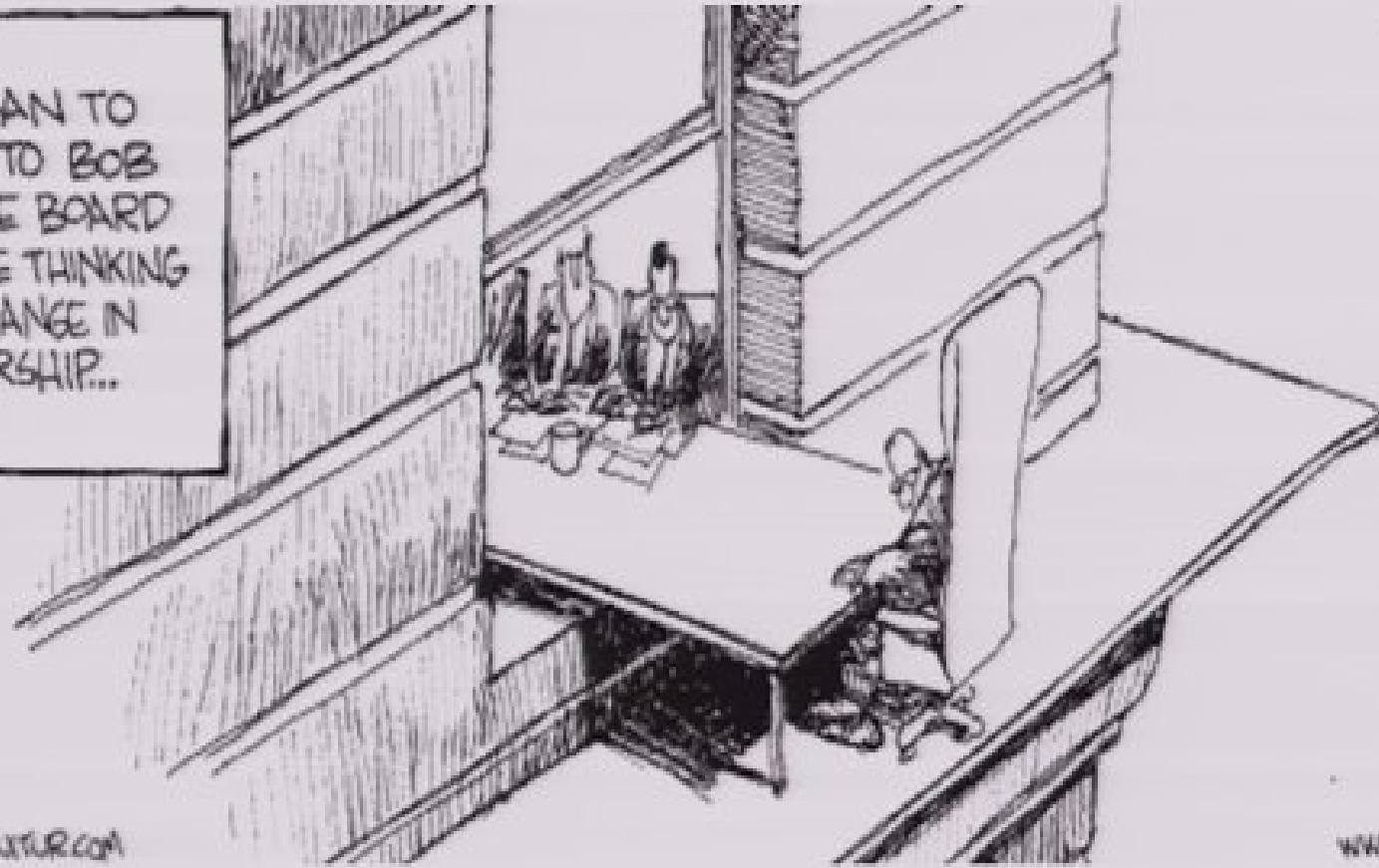
# 21ˢᵗ Century Health Care System

The Healthcare workplace of the future is:

1. A desirable place to work

2. An efficient place to work

3. Has a Culture of Continuous Systems (Quality) Improvement **-"Improving My Work Is My Work"**

   Every employee has two jobs:
   - Their given "job description"
   - Daily Improving **how** they do their "job"

# 21st Century Health Care System

4. Staff work in multi-disciplinary teams:
- Teams that are peers, empowered and have data about:
  - Cost, Quality, Access
- Teams have ability to select high priority challenges (those that are important to them) to improve
- Teams that receive formal QI training

# 21st Century Health Care System

5. Teams have dedicated time to:
- Do change (PDSA cycles = Rapid Cycle Improvement)
- Evaluate change

6. Teams choose tasks that are aligned with the organization's values and culture

7. Every Employee has a Safe Forum to raise Questions

# Quality Improvement Concepts

1. Serious gaps in quality exist –shared aims are helpful
2. The people of your workforce are good
3. Trying harder is the worst plan
4. All improvement is change
5. Skills for improvement are not common –yet
6. Strong QI Methodology (concepts) are essential

# Quality Improvement Concepts

7. Measurement helps learning

8. Local adaptation makes concepts work properly – without it, they won't

9. "All Teach – All Learn"

10. Improving for an individual staff member:

   **"Improving my work is my work"**

# Caution

- QI Principles are <u>Tools</u> to change your local system…. Not the actual work to make needed change

  - Goal: improved Efficiency, Quality and Patient Safety in your facility

- Unless many PDSA test cycles occur, you won't get any change / improvement

- "QI" principles cannot be implemented by Senior Management mandate – instead, it comes from front-line teams

- Different sites using same "QI" principles may lead to different processes in different places (freedom to innovate)

# Quality Improvement Themes:

- Soon is not a Time!

- Some is not a Number!

- Hope is not a Plan!

- Caring is not Whole Person Care!
  - Compassion without science is well-intentioned kindness; it needs to be combined with evidence-based medicine, evidence-based HC management
  - "This life is full of gracious opportunities, which you can improve in the exercise of your God-given abilities to bless others.  YI, Dec. 15, 1886.

# What then is Quality?

- Quality is a way of **thinking** about work

- Quality is how you **approach** work every day for yourself personally and for those you serve

- Quality is not about a staff title or using the latest catchy phrase

# PS/QI = "The Science of Improvement"

Creating a culture of continuous quality improvement in a "Just Culture"

## "Improving my work is my work"

"Remember that what is worth doing at all is worth doing well"

YI, Sept. 29,1892

# Institute for Healthcare Improvement

## IHI's Open School

http://www.ihi.org/education/ihiopenschool/overview/Pages/default.aspx