Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Quality Improvement Division

QI TALK TIME

Building an Irish Network of Quality Improvers

Leading for Quality

Speaker: Peter Lachman ISQua CEO

21st Nov 2017

Connect **Improve** **Innovate**

Speaker

- **Peter Lachman - M.D. MPH. M.B.B.Ch., FRCPCH, FCP (SA), FRCPI**

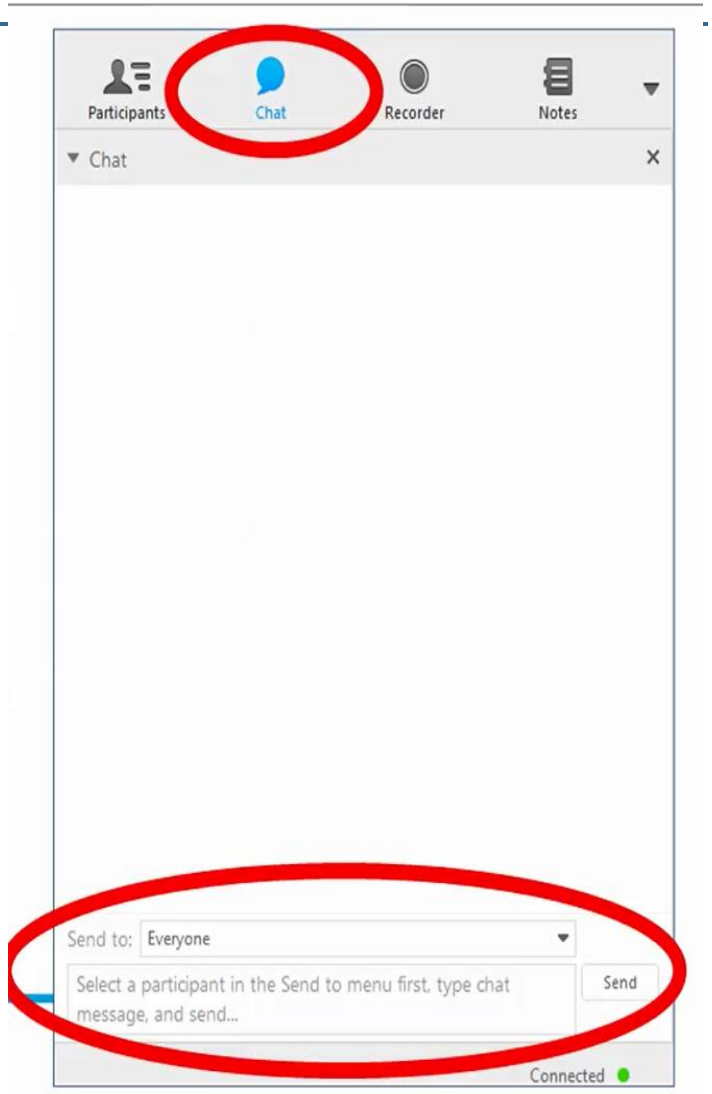
- Assumed the position of ISQua Chief Executive Officer on 1st May 2016. He has great experience as a clinician and leader in QI and patient safety.

- Dr Lachman was a Health Foundation QI Fellow at IHI in 2005-2006, and developed the QI programme at Great Ormond Street Hospital where he was the Deputy Medical Director with the lead for Patient Safety. Prior to joining ISQua, Peter was also a Consultant Paediatrician at the Royal Free Hospital in London specialising in the challenge of long term conditions for children.

- He has been the National Clinical Lead for SAFE, a Heath Foundation funded RCPCH programme which aims to improve situation awareness in clinical teams. In Ireland leads International Faculty at the RCPI in Dublin, where he co-directs the Leadership and Quality programme to develop clinical leaders in QI. He is co-founder and Chairperson of PIPSQC, the Paediatric International Patient Safety and Quality Community.

Instructions

- Interactive
- Sound
- Chat box function
  - Comments/Ideas
  - Questions
- Q&A at the end
- **Twitter: @QITalktime**



Leading for Quality

Peter Lachman, ISQua CEO

Inspiring and driving improvement in the quality and safety of healthcare worldwide through education and knowledge sharing, external evaluation, supporting health systems and connecting people through global networks.

Networking Events

External Evaluation (Accreditation) Network

IAP Global Presence

66 Organisations

In 34 Countries

Learning and Knowledge Network

Key benefits for ISQua Fellowship Participants and Graduates

Entry into **exclusive events** at the ISQua International Conference

Access to a **vast library** of ISQua and partner resources

Free registration to **partner online e-learning** courses

Introduction to global experts in your field who can **mentor** and guide you in your future career.

Prospect of an **Internship** with a leading organisation in the healthcare quality and safety arena.

Opportunity to **share your research** with an international audience.

ORIGINAL ARTICLE

Effectively leading for quality

Peter Lachman, MD, MPH, MMed, MBBCh, BA, FRCPCH, FRCPI, FCP(SA)[1] and Wendy Nicklin, RN, BN, MSc(A), CHE, FACHE, FISQUA, ICD.D.[1]

Healthcare Management Forum
1-4

DOI: 10.1177/0840470417706705
journals.sagepub.com/home/hmf

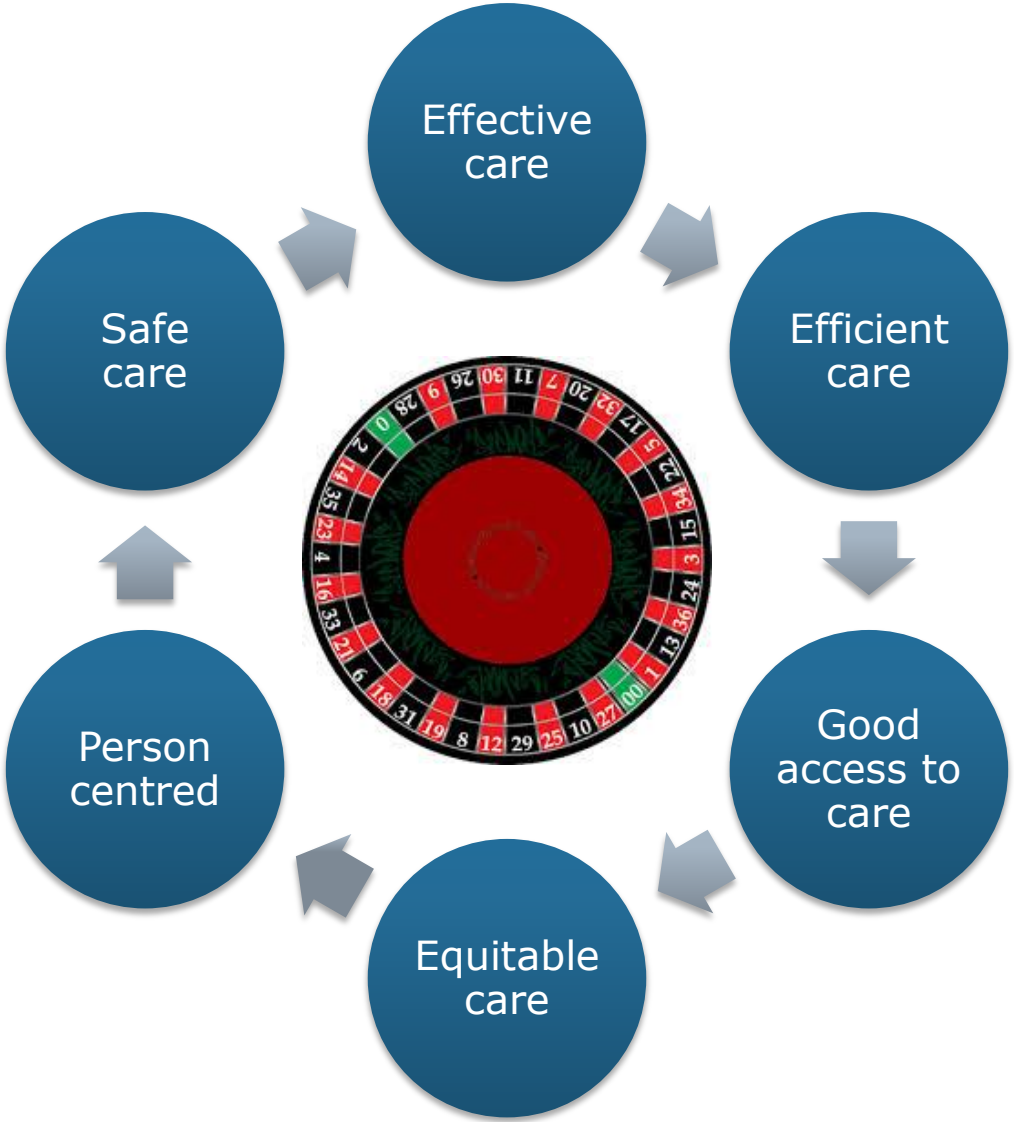
Abstract

Although significant advances have occurred in medical and related sciences, the quality improvement and patient safety movements have been slow to gain traction. There are many "pockets" of progress around the globe; however, the scale and spread has been slow. Stimulating culture and system change in healthcare requires a definitive change in leadership style and approach. Health leaders of today must commit to the critical success factors and demonstrate the attributes necessary to create change and raise the bar for quality improvement and safety.

1

Quantifying effective healthcare leadership

The roulette wheel of quality & safety



Move from Risk Management to Safer care

- Defending against harm
- National Reporting and Learning Systems
- Investigation of sentinel events
- Reporting adverse events
- Alerts

Risk Management
Quality Assurance

- Tackling improvement
- Identifying and measuring harm
- Setting strategic goals
- Identifying drivers and process changes
- Small scale test of change
- System level improvement
- Innovation
- Culture

Patient Safety and
Quality Improvement

“Safety” (and Quality) is the ability of a system to sustain required operations under both expected and unexpected conditions.

Hollnagel et al.

Theoretical approach to explore

- Culture
  - Individual and system
- Individual processes
  - Human factors
- System issues
  - Complex adaptive systems
  - Clinical complexity

Are we generative?

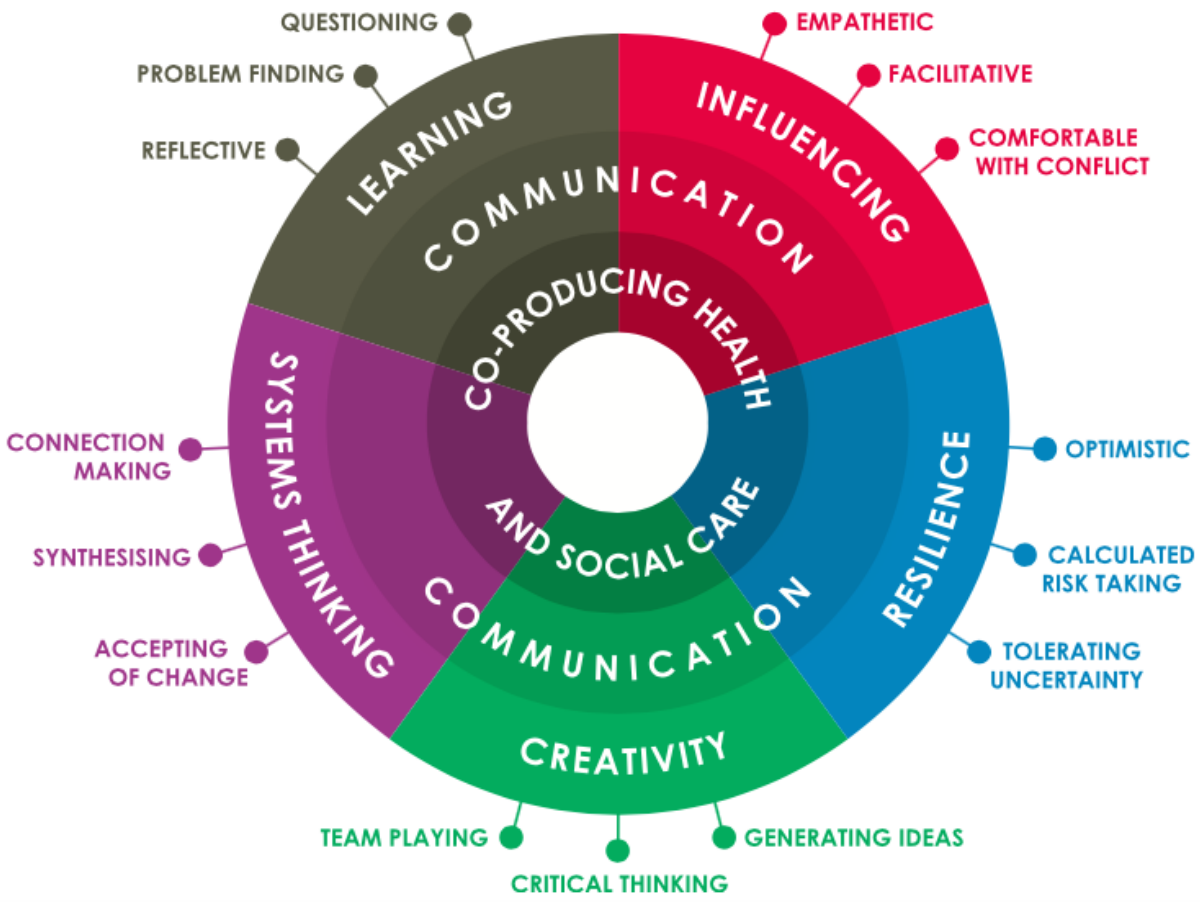
is

Safety and Quality

how we deliver healthcare?

Do we have the habits of safety & quality?

Figure 2 – The habits of improvers

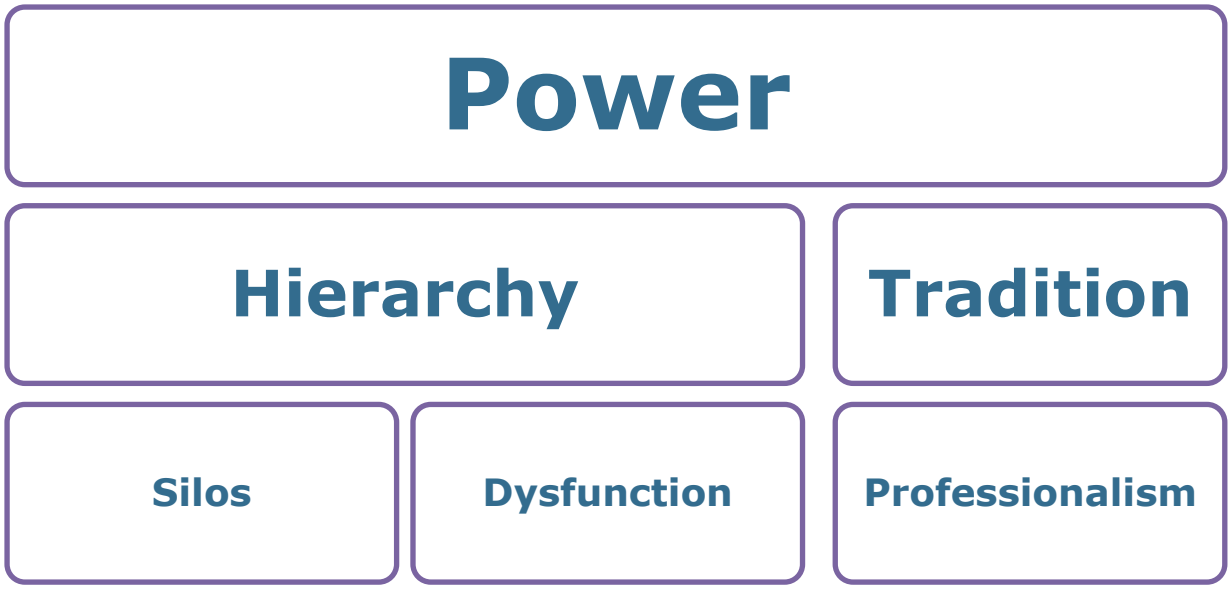


http://www.health.org.uk/publication/habits-improver

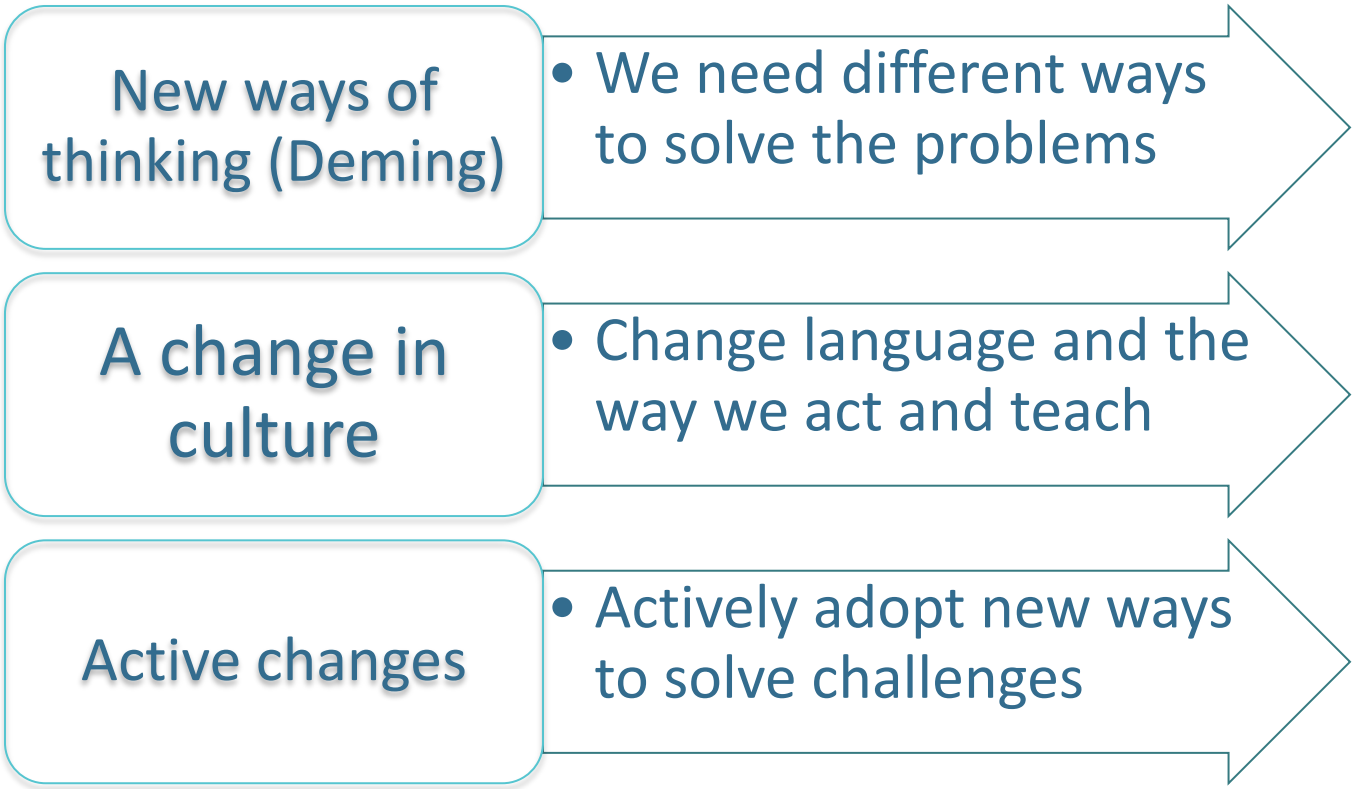
2

Critical factors for leaders in healthcare

Why change can be difficult



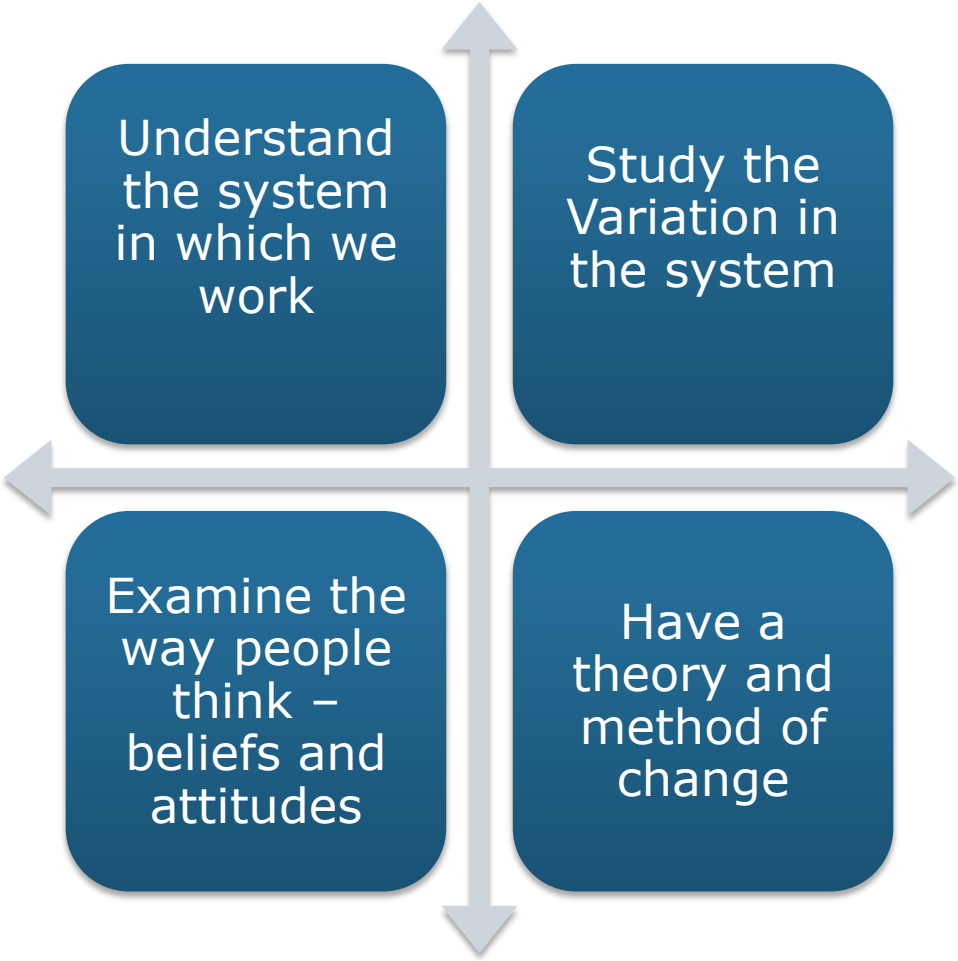
To achieve this, work as usual does not work



Slide concept based on IHI White Paper

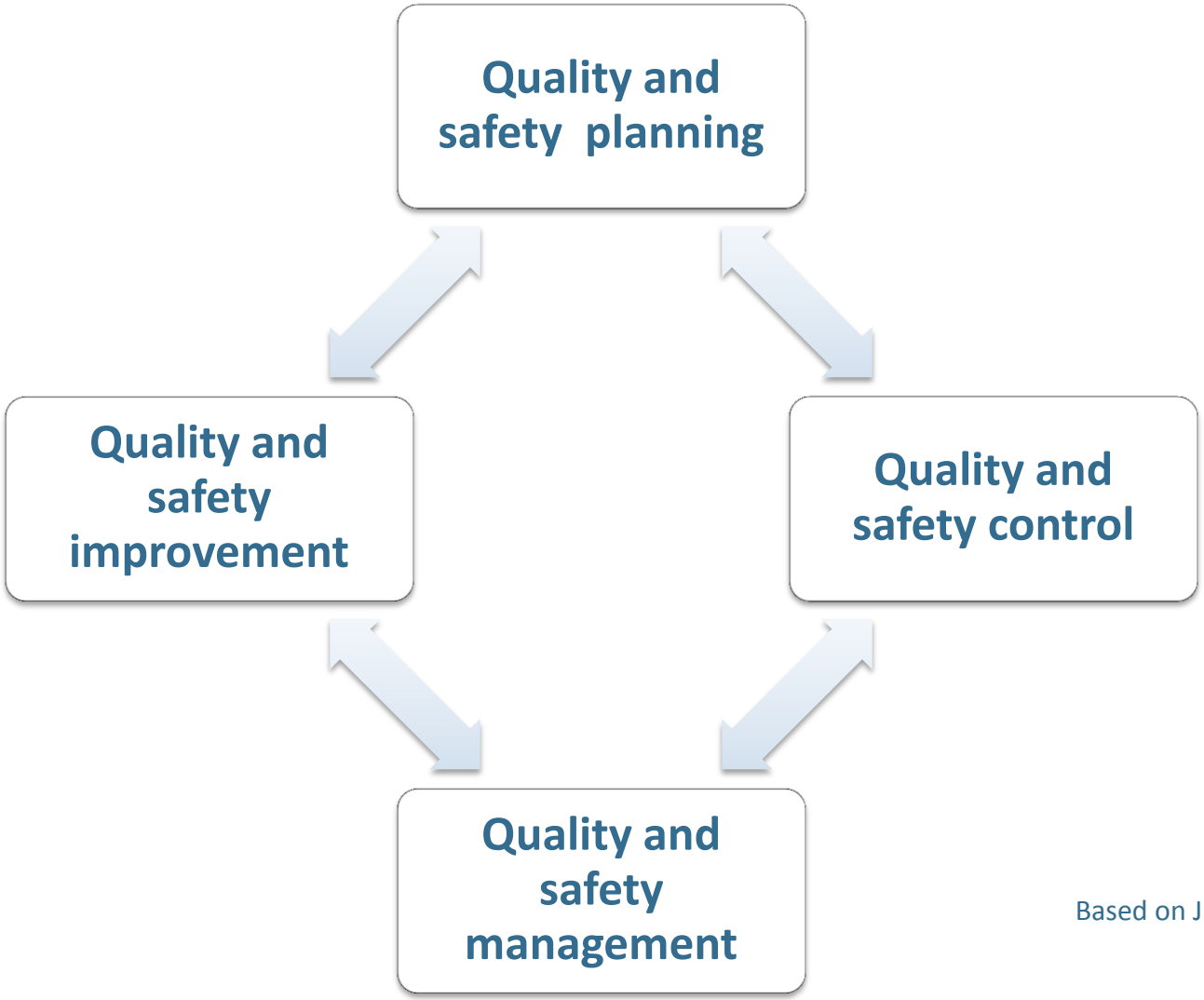
Understanding Systems

System thinking



Based on Deming

Quality and safety need to be planned



Based on Juran

Safety is a daily question

Source: Vincent C, Burnett S, Carthey J. *The measurement and monitoring of safety.* The Health Foundation, 2013. www.health.org.uk/publications/the-measurement-and-monitoring-of-safety

Person-centred care

Patient Provider

Start with the provider

Medical error: the second victim

The doctor who makes the mistake needs help too

When I was a house officer another resident failed to identify the electrocardiographic signs of the pericardial tamponade that would rush the patient to the operating room late that night. The news spread rapidly, the case tried repeatedly before an incredulous jury of peers, who returned a improvements that could decrease errors. Many errors are built into existing routines and devices, setting up the unwitting physician and patient for disaster. And, although patients are the first and obvious victims of medical mistakes, doctors are wounded by the same errors: they are the second victims.

Personal view
p 812

Start with the provider

What is a second victim?

A 'second victim' is a healthcare professional perceived responsible by oneself or others for an unanticipated patient safety incident.
Although the stress-response and coping strategy in the aftermath of this event can vary, the healthcare professional is to some extent affected by this event.

Source: Van Gerven, E., Sermeus, W., Euwema, M. Vanhaecht, K. (2016). PhD dissertation KULeuven.

Joy at work

Figure 2. IHI Framework for Improving Joy in Work

Perlo J, Balik B, Swensen S, Kabcenell A, Landsman J, Feeley D. *IHI Framework for Improving Joy in Work.* IHI White Paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2017. (Available at ihi.org)

Safety and quality must be viewed from
the eyes of the patient

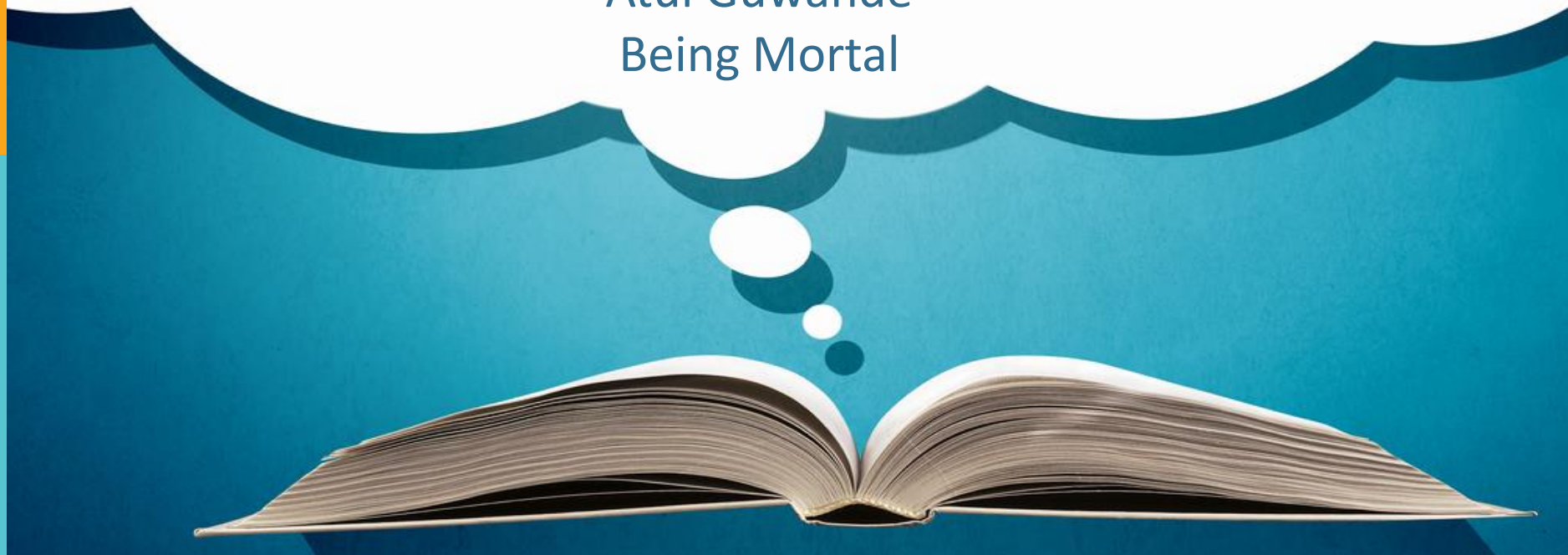
…and then the provider

Listen to stories

Patient and provider stories will bring reality to the work we do to keep patients safe

“For human beings, life is meaningful because it is a story. A story has a sense of a whole, and its arc is determined by the significant moments, the ones where something happens.”

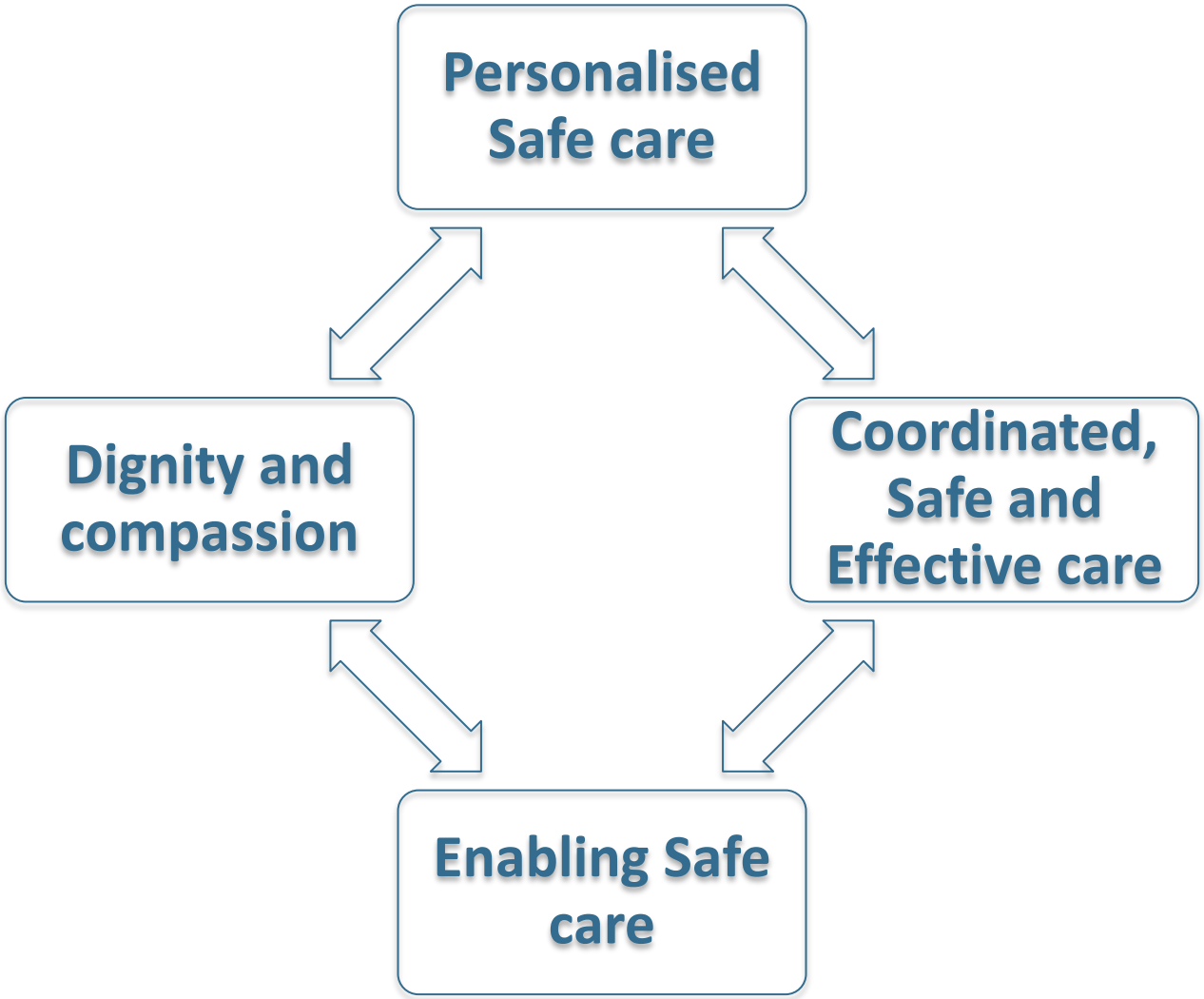
Atul Guwande
Being Mortal



Person-centred care

Consider what matters to **caregivers** and **patients**

Safety is about what really matters for people



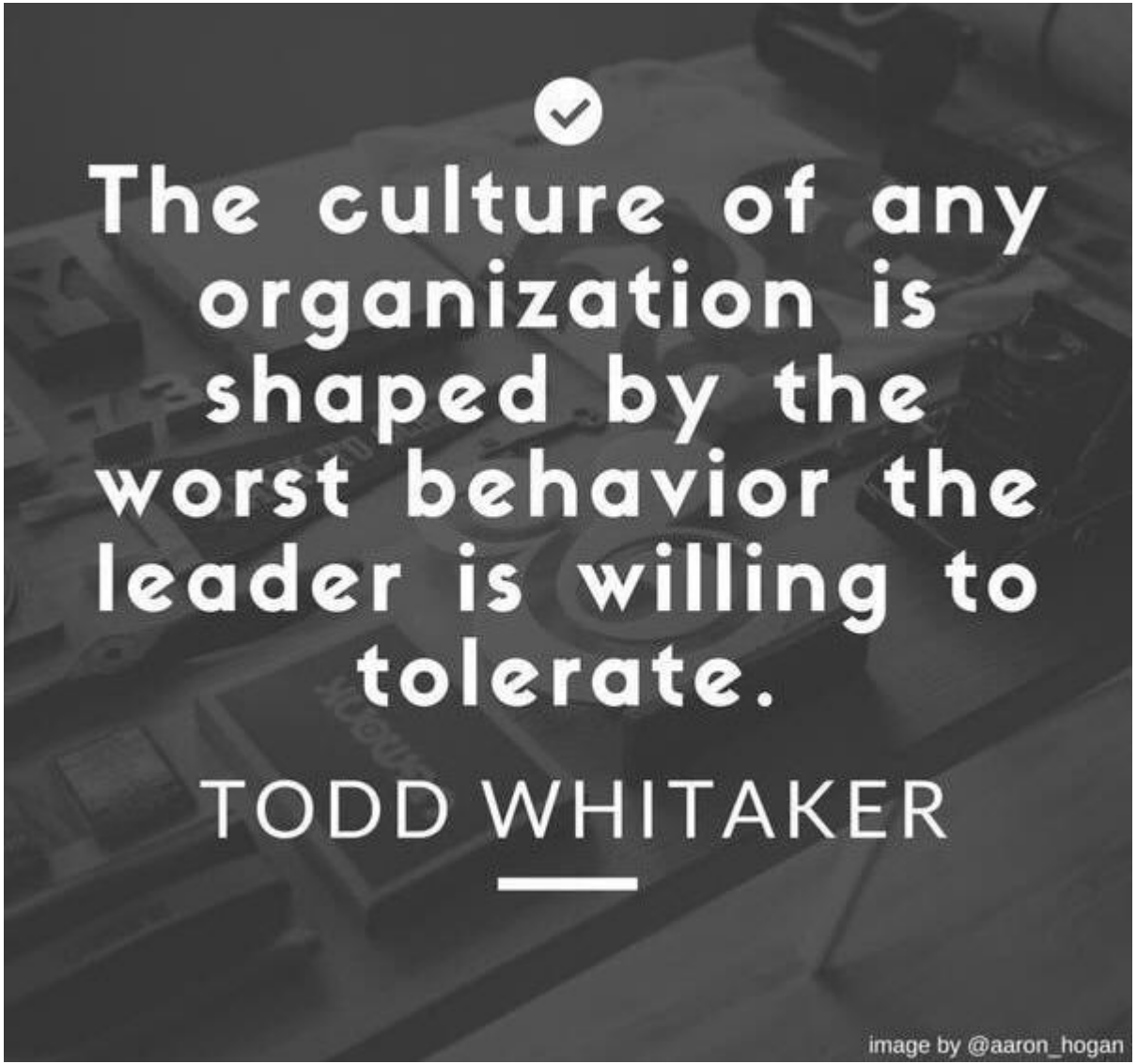
http://www.health.org.uk/public/cms/75/76/313/4772/Measuring%20what%20really%20matters.pdf?realName=GuxZKx.pdf

4

Reliable care

From the System and Individual

WHAT WE PERMIT, WE PROMOTE

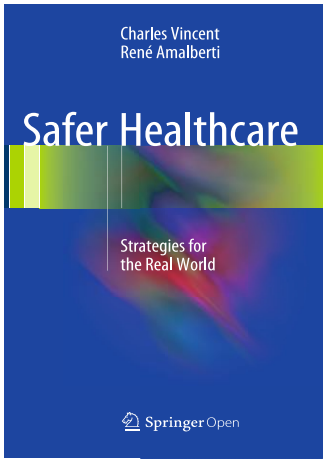


Why do we accept our inability to deliver the right care at the right time every time?

Why do highly performing individuals accept unsafe care in areas under our own clinical control ?

Prescribing
Hand hygiene
Poor medical records
Incomplete handover
Not following agreed protocols
Etc.

Is your care reliable?



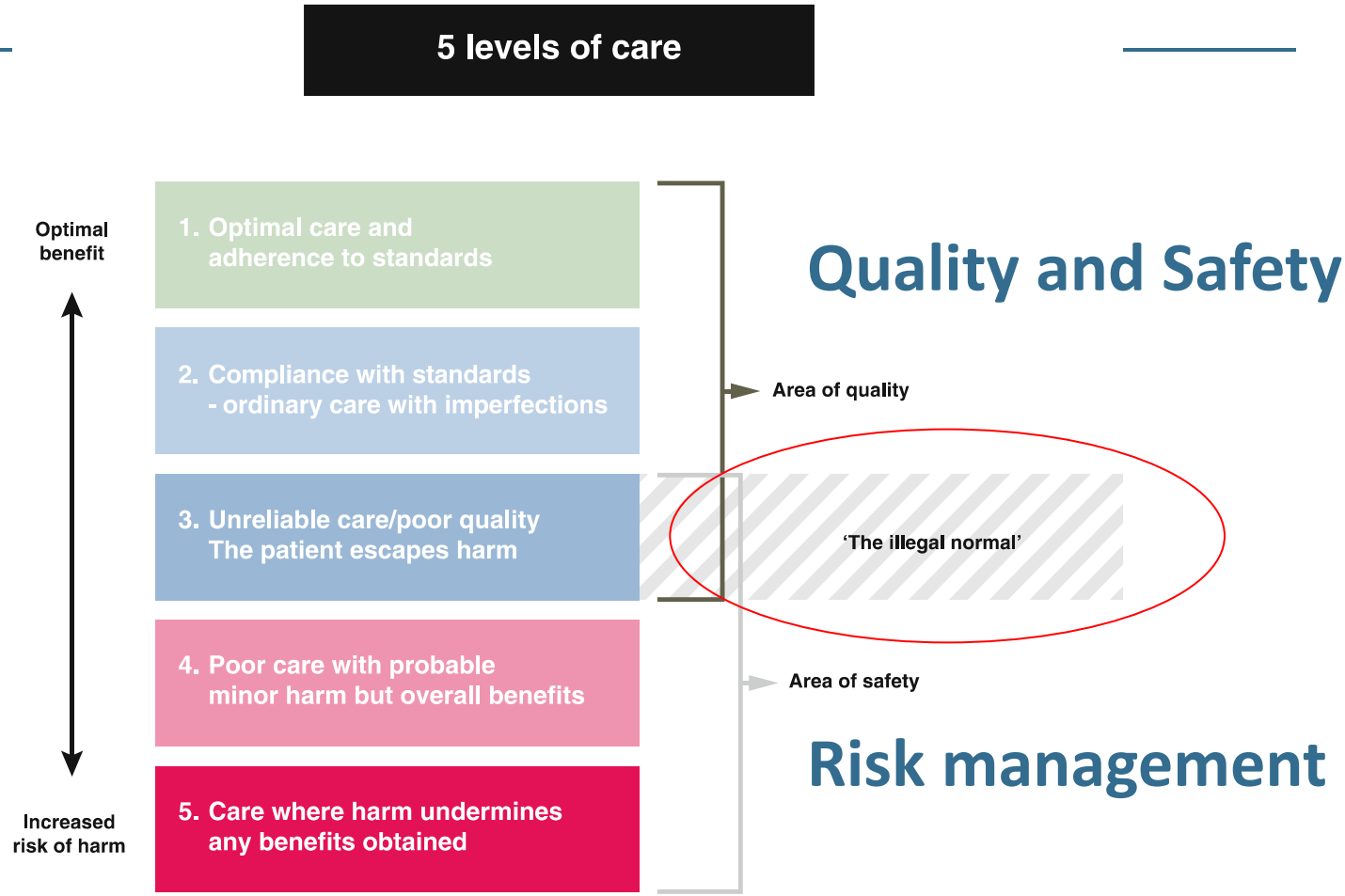


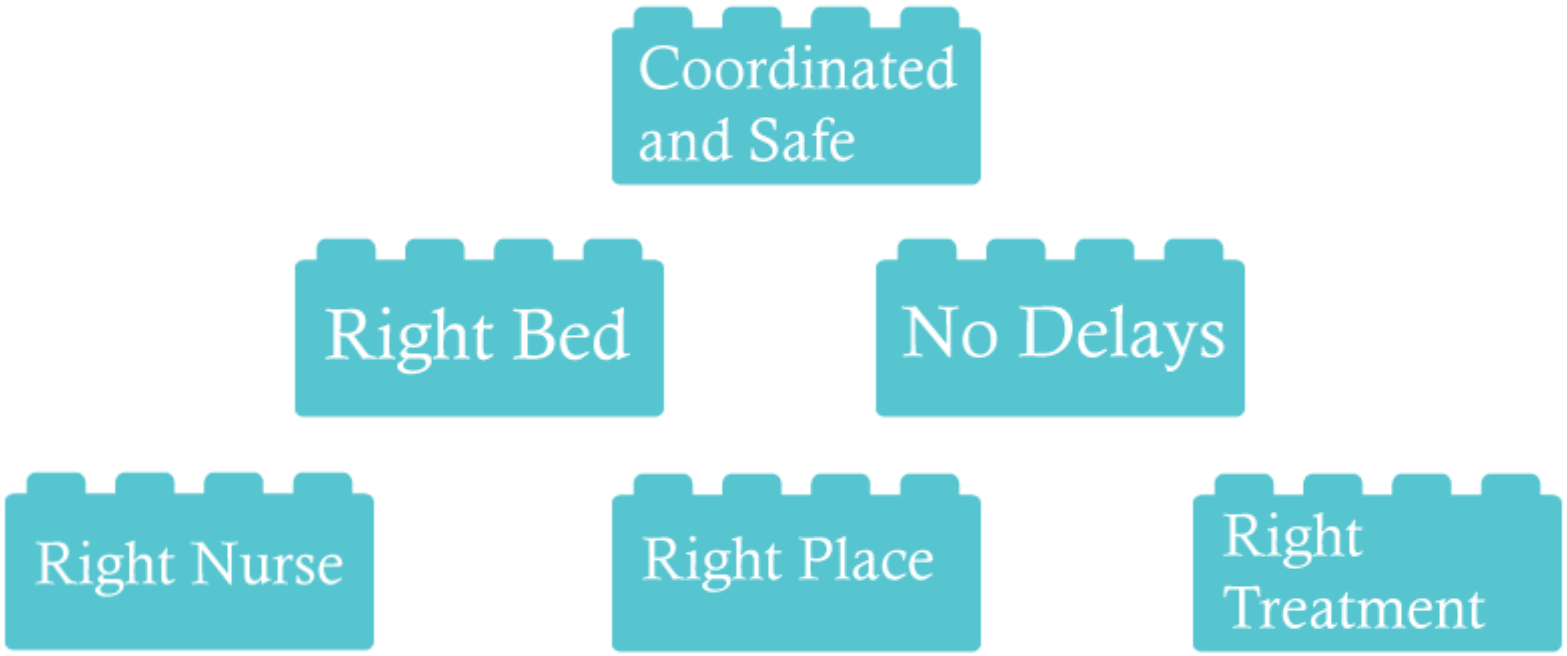
Fig. 2.1 Five levels of care

Charles Vincent Rene Amalberti Safer Healthcare Strategies for the Real World

https://link.springer.com/content/pdf/10.1007%2F978-3-319-25559-0.pdf

Reliable person centred care

The person receives the right care, the first time, every time



Improve safety with something you can achieve

- Handover
- Medical records
- Hand hygiene
- Apply what works
- Prescribing and drug administration

Change in education

We can’t continue educating as we currently do

Objectives of Quality Healthcare Education

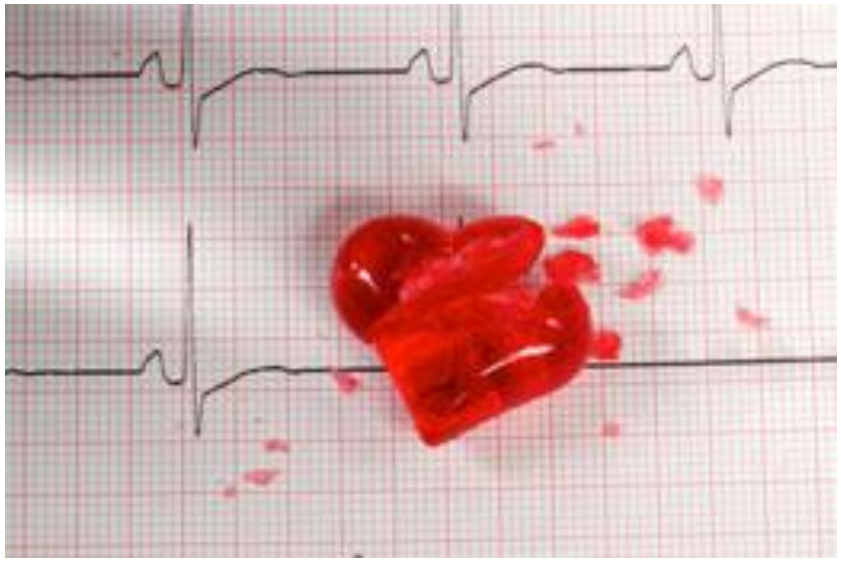
What If High-Quality Care Drove Medical Education? A Multi- attribute Approach
David P. Sklar, MD, and Robert Lee, MS

Business case for quality


THE ECONOMICS OF PATIENT SAFETY
Strengthening a value-based approach to reducing patient harm at national level
Luke Slawomirski, Ane Auraaen and Niek Klazinga
MARCH 2017
OECD
BETTER POLICIES FOR BETTER LIVES

Cost of failure

Estimating the costs of lapses in patient safety. Costs are quantified in terms of disease burden (morbidity and mortality), and financial and resource impact on the healthcare system.



Reducing harm effectively & efficiently

Exploring a value-based approach to investing in patient safety in a resource-constrained context.

The relative costs and impact of various interventions (and combinations thereof) targeting patient harm across healthcare systems are estimated using a snapshot survey of international patient safety experts and policy makers.

Key message

Preventability cost is less than the cost of the harm and adverse events

ISQua

Choosing Wisely®

An initiative of the ABIM Foundation

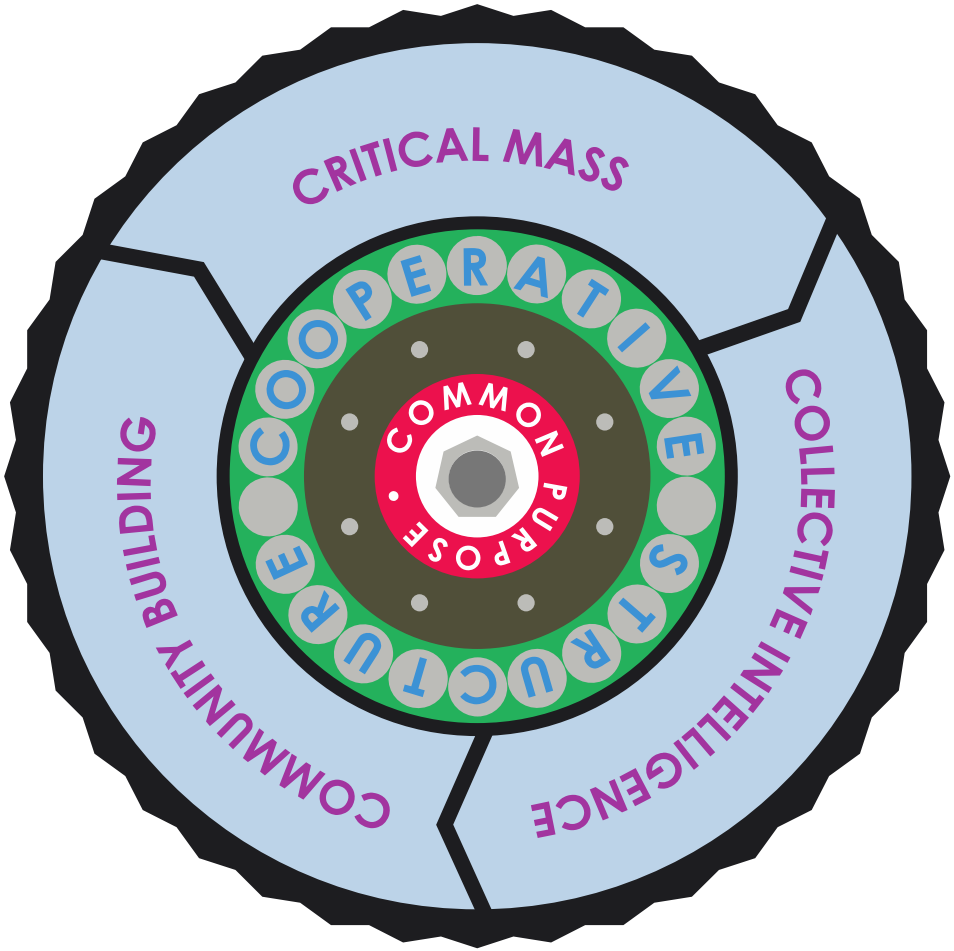
- *Choosing Wisely* aims to promote conversations between clinicians and patients by helping patients choose care that is:
- Supported by evidence
- Not duplicative of other tests or procedures already received
- Free from harm
- Truly necessary

ISQua

Network learning

Functions of networks

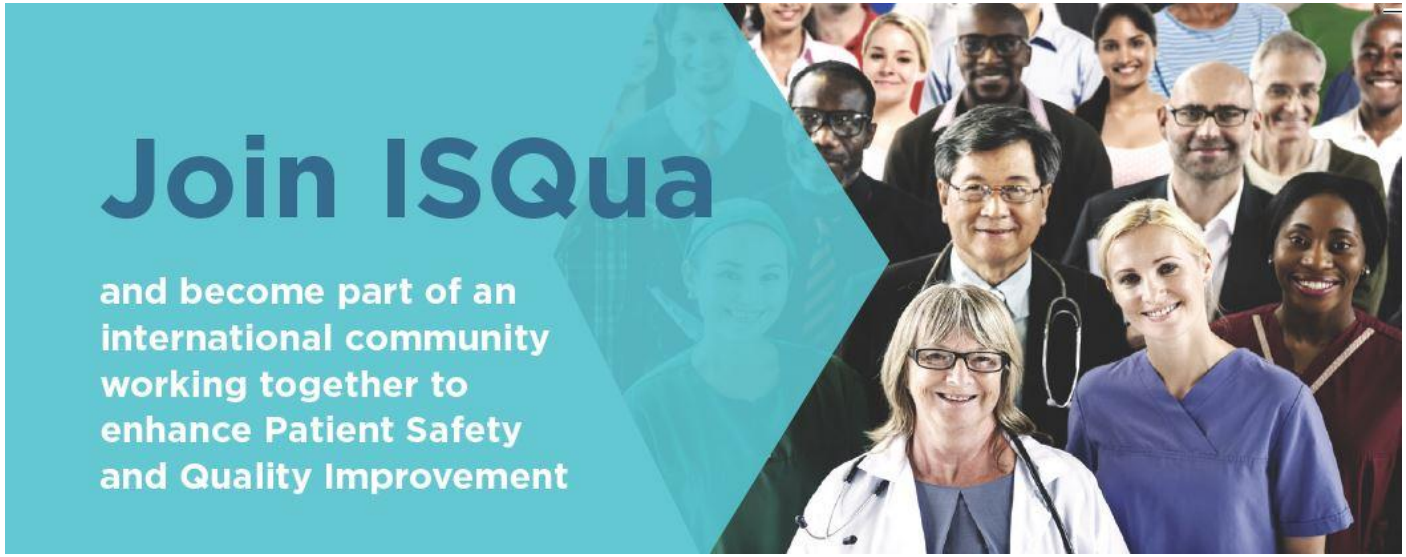
- Community building
- Filtering
- Amplifying
- Facilitating
- Investing or providing
- Convening



http://www.health.org.uk/sites/health/files/LeadingNetworksInHealthcare.pdf

ISQua Network

Membership Network



Essential leader attributes for leading change

Essential Attributes

“Quality and Safety are never an accident; they are always the result of high intention, sincere effort, intelligent direction and skillful execution; they represents the wise choice of many alternatives"

Adapted from William A. Foster

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peterlachman

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Group - ISQua


www.youtube.com/user/ISQuaEducation


www.instagram.com/isquaconference/

Helpful links

Framework for Improving quality
www.qualityimprovement.ie

Improvement Knowledge and Skills Guide

http://www.hse.ie/eng/about/Who/QID/aboutQID/

Follow us on Twitter @QITalktime

Watch recorded webinars at your convenience on HSEQID QITalktime page

Next Webex –5th December
Dr Rob Cunney & Juanita Guidera:
Frontline ownership techniques

QI TALK TIME

Building an Irish Network of Quality Improvers

Thank you from all the team @QITalktime
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