Role of Measurement for Improvement Training and Curriculum in Improving Patient Safety

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Measurement for Improvement and Patient Safety

Developing and implementing measurement for improvement systems is not an end in itself, rather it should be viewed as a means to an end

A good measurement for improvement system should enable learning and improvement at all levels

Essential components of a safety measurement system**(1)**:
- Adverse event reporting
- Routinely collected data
- Patient reported measures

The Challenge!!!!!

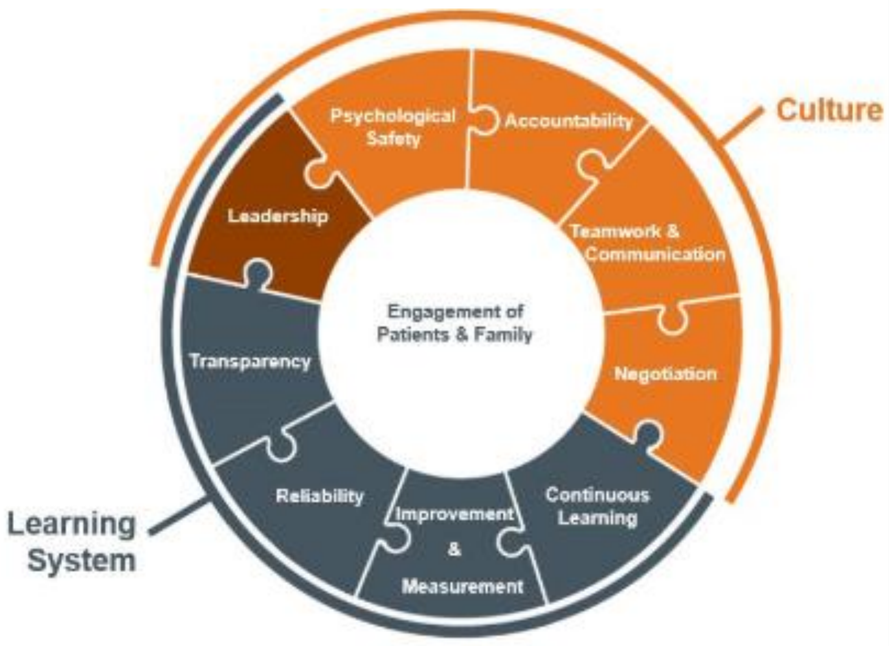
Focus is on measurement of harm as opposed to measurement for improvement	Healthcare organizations have limited capacity to analyse, monitor and learn from safety & quality information
Accurate and reliable measurement of errors and adverse events	Agreement on definitions for example what is "preventable"

Shift from harm reduction to proactive prevention

Elements of Proactive Prevention(2)

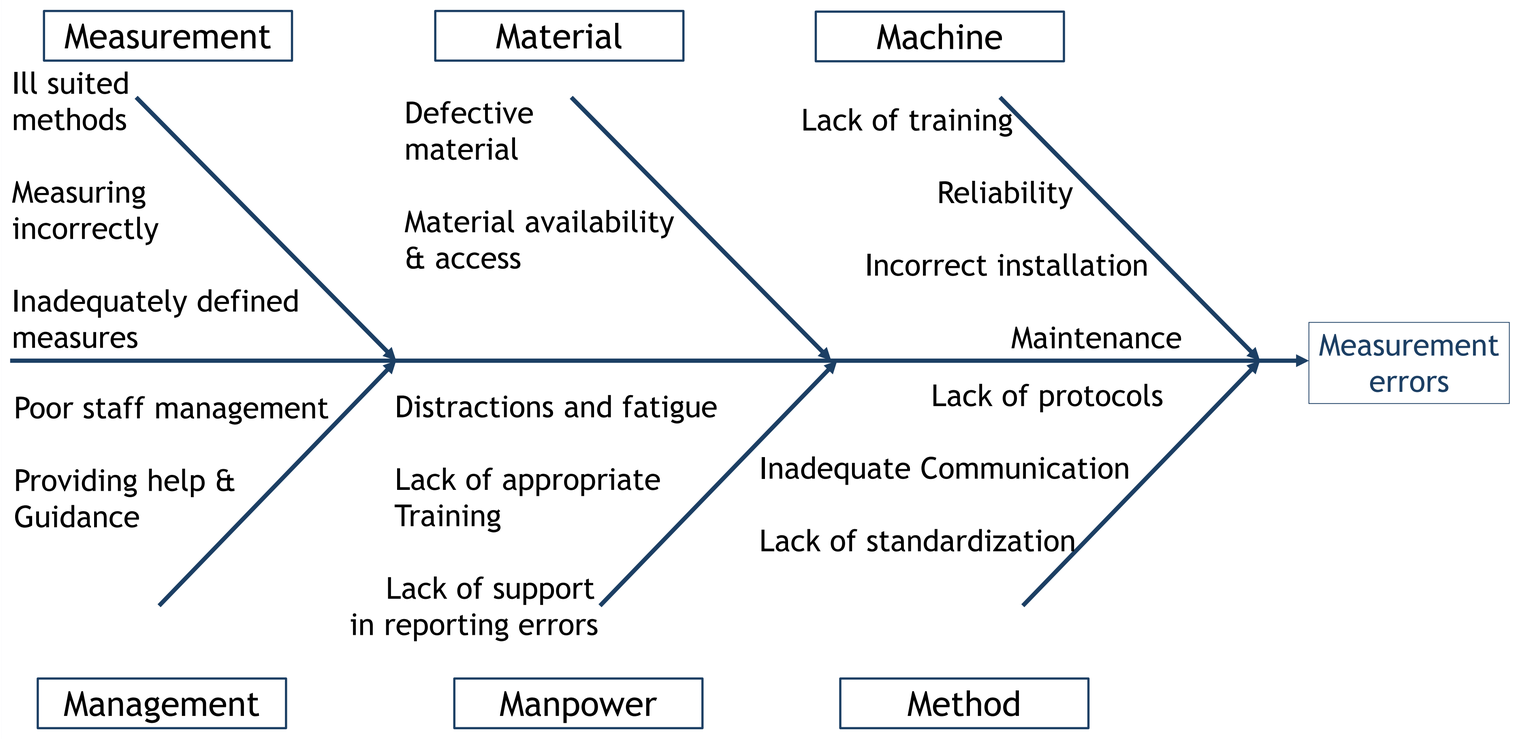
- Create a learning system
- Use diagnostic tools and data for understanding
- Build capacity and capability to improve
- Collective leadership responsibility

Importance of Measurement and Monitoring in Patient Safety Frameworks



IHI's Framework of safe, reliable and effective care lists measurement and continuous learning as core elements (3)

Root Cause Analysis



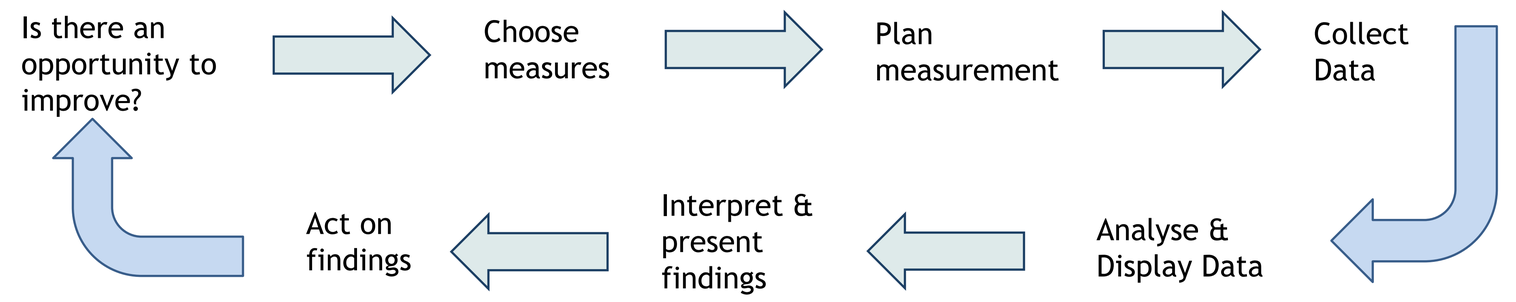
Co-lead

This research is being conducted as part of the UCD Co-lead programme and in collaboration with HSE QID

A collective leadership intervention has been developed and its impact is being tested on safety culture, requires an understanding of the key features of a safety cultures and a shared approach to measurement

Measurement for Improvement Curriculum

As one of the six drivers in Framework for Improving Quality, it is important for all healthcare staff to value measurement and understand its importance



Research Objective

Assessing the effectiveness of measurement for improvement in collaboration with the Quality Improvement Division (QID) of the Health Service Executive (HSE) Ireland.

Exploring curriculum design and delivery elements for patient safety

Research Process

Systematic review to identify critical elements for an effective measurement for improvement curriculum intervention and a co-design process

Intervention content and delivery methods will be refined iteratively over a period of one year

Research Output

A model to assess measurement for improvement curriculum and training effectiveness which can be applied to other QID framework areas and contribute towards improving patient safety cultures

Benefits and Outcomes

- Evaluating the effectiveness of the curriculum at individual, team and organization level
- Ascertaining how and what to teach
- Enabling Irish healthcare organizations to present, interpret, analyze, monitor, control and learn from the information collected
- Sustainability, knowledge spread and network formation of trained resources

Originality and Value

- Focusing on effectiveness of curriculum and training in addition to content and delivery so that sustainable results can be achieved
- Developing an evidence-based curriculum that addresses the implementation and sustainability problems in building capacity
- Input for design and implementation of other QI initiatives

- A robust measurement system should be in place with well-trained individuals who possess the skills and knowledge to measure, identify, control and overcome errors
- This research is being supported by HSE QID

1) OECD, Better policies for better lives, (2018). Measuring patient safety, Opening the black box. Available at https://www.oecd.org/health/health-systems/Measuring-Patient-Safety-April-2018.pdf
2) Haraden, C.,(2014). Patient Safety: Moving from Defect Reduction to Proactive Prevention, Institute for Healthcare Improvement.