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

Zuneera Khurshid, Aoife DeBrun, Gemma Moore, Michael Carton, Jennifer Martin, Philip Crowley & Eilish McAuliffe.

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?"

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

Root Cause Analysis

Measuring and understanding the key features of a safety culture and a structure. The impact is being tested on the knowledge to measure, identify, control and overcome errors.

A robust measurement system should be in place with well-defined measures.

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.

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

- 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

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.