Quality – Improving services

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How quality is assessed & regulated in healthcare

- Care Quality Commission (CQC)
- Medicines & Healthcare products Regulation Agency (MHRA)
- Professional bodies (GMC, NMC, HPC)
- “Quality Accounts” – produced b y NHS providers
- Local Involvement Networks (& other patient groups)
- Complaints procedures
- Parliamentary scrutiny (Health Select Committee)
- National Audit Office, etc.

None of these make any connection with the issue of quality ***improvement***. All are ***retrospective.***

Most people would like to *‘do something about quality*’ but they don't have the time.

They are too busy dealing with complaints, correcting mistakes, re-doing things that are wrong, and doing what they do twice.

paraphrased from Øvretveit 1992

There are 2,231 words meaning drunk …

but only **one** word for quality

Quality does **not n**ecessarily mean *excellence …*

Quality means:

fit for the purpose.

6 components of Quality

1. Access
2. Relevance to need
3. Effectiveness
4. Equity
5. Acceptability
6. Efficiency

(Maxwell 1984)

(Lister's 7th component of Quality)

7. Humanity

The ‘Productive Ward’

- Developed by the NHS Institute for Innovation and Improvement,

  e.g.

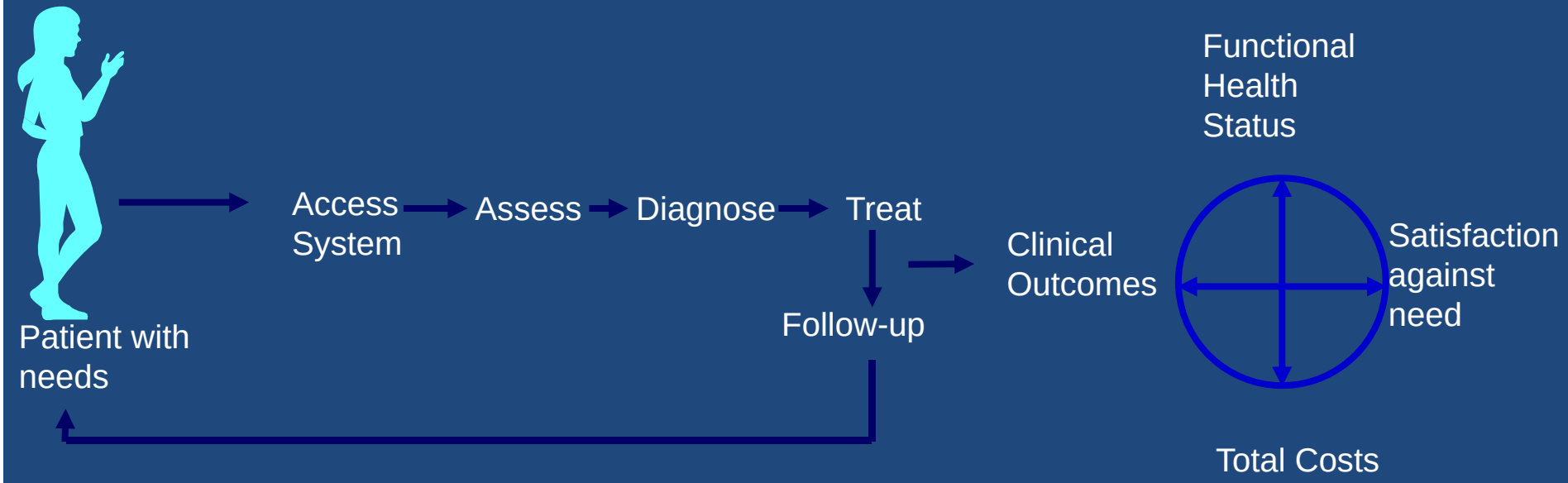
  “***Releasing time to care*** - The Productive Ward focuses on improving ward processes and environments to help nurses and therapists spend more time on patient care thereby improving safety and efficiency.”

Others in the ‘Productive Series’

- The Productive Community Hospital
- Productive Community Services
- Productive General Practice
- The Productive Leader
- The Productive Mental Health Ward
- The Productive Operating Theatre
- The Productive Ward

(NHS Institute for Innovation & Improvement)

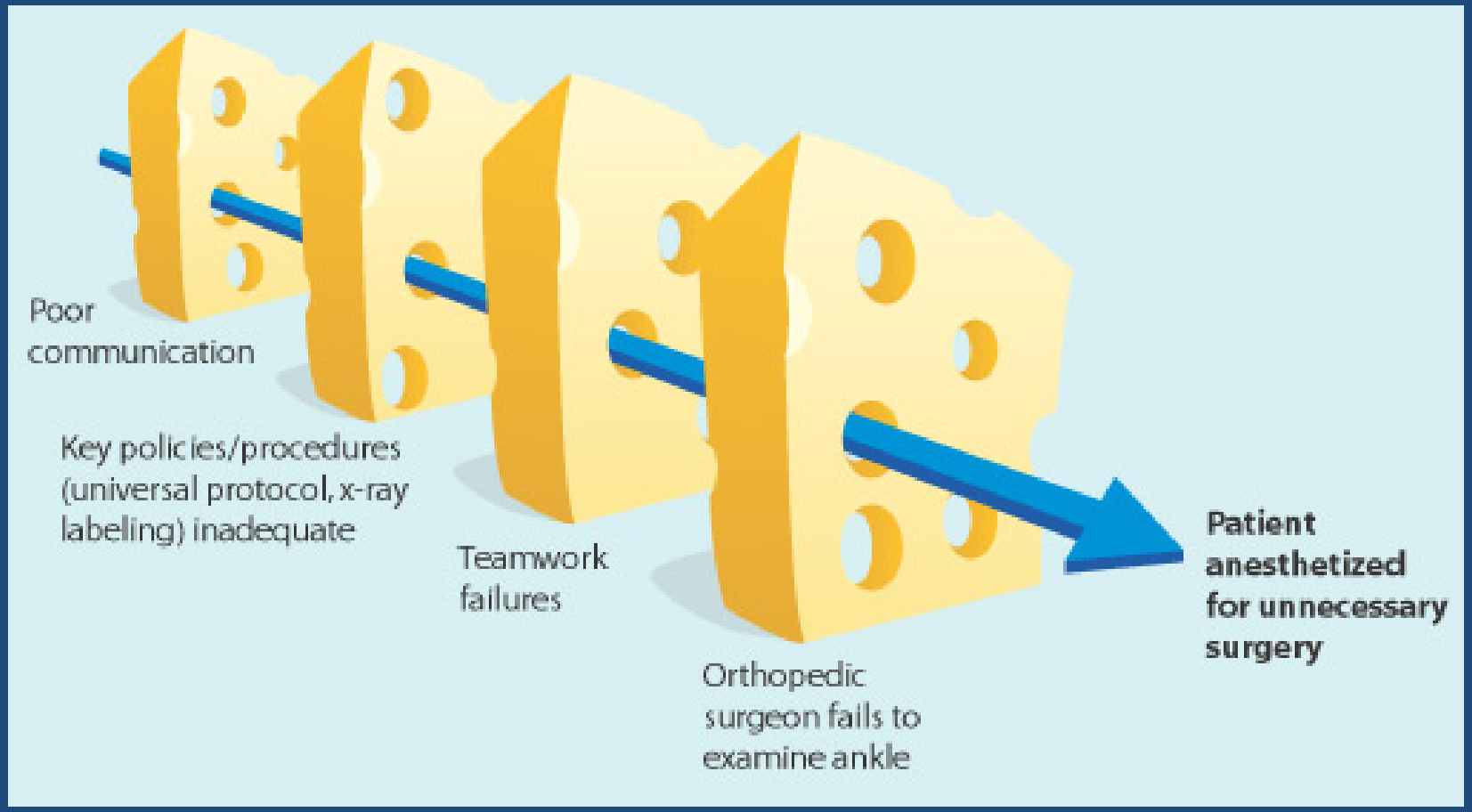
The Model for Providing Care



Balanced measure of care

Nelson *et al* (1996)

The Swiss cheese model of management



It’s the system …

Every system is perfectly designed to produce the outcome it achieves*!*

paraphrased from Berwick (1996)

Check-lists

"We have accumulated stupendous know-how. … Nonetheless, that know-how is often unmanageable.

Avoidable failures are common and persistent. …

And the reason is increasingly evident:

> the volume and complexity of what we know has exceeded our individual ability to deliver its benefits correctly, safely, or reliably."

(Gawande 2010)

An example from Gawande (2010)

They monitored whether doctors undertook 5 infection prevention steps to when inserting a central line;

1. hand washing
2. cleaning patient's skin with chlorhexidine
3. covering the entire patient with sterile drapes
4. wearing a mask, hat, sterile gown and gloves
5. once the line is in, covering the insertion site with a sterile dressing

It was found that at least 1 step was missed in a third of patients.

This resulted in the check list being introduced, to actually be ‘checked’.

The doctors were no longer only observed, they were reminded (by a nurse) if they didn’t follow all 5 actions.

Within a year the infection rate dropped from 11% to **Zero**.

Thus preventing;

- 43 infections,
- 8 deaths

  and
- saving $2 million.

WHO ‘Surgical Safety Checklist’

- For operating theatres world wide in order to reduce medical errors.

  e.g. ‘has antibiotic prophylaxis been given within the last 60 minutes?’

  ‘are instrument, sponge and needle counts correct’

- Wherever it has been introduced it has prevented mistakes.

(World Alliance for Patient Safety 2008)

Comparisons to other industries

- Would you get on a plane if pilot said,

  "I'm the pilot that doesn't believe in checklists" ?

- Watch Formula 1

The health service has many heroes … the staff who work harder, predict problems and compensate for short comings.

Heroic thoroughness may make patients lives a little safer, but a real improvement in the quality of care provided to patients is not created by heroes who compensate for the flawed processes.

The real heroes are those who change the system to remove the flaws!

Organisations that can provide information/support

IHI & IHI Open School: International resource offering free online courses

http://www.ihi.org/offerings/ihiopenschool/Pages/default.aspx

NHS Institute for Innovation & Improvement

http://www.institute.nhs.uk/

1000 lives plus, NHS Wales

http://www.1000livesplus.wales.nhs.uk/

Scottish Patient Safety Programme

http://www.scottishpatientsafetyprogramme.scot.nhs.uk/programme

Lessons for journalists …

Don’t look for the frontline staff to blame – it is destructive

Ask the hospital management the following …

- *What have you done to stop this happening again?*
- *What service improvement initiatives are you undertaking?*
- *What are the staffing levels?*
- *How many temporary staff are you dependant on?*
- *Have issues of behaviour been identified? And if so has there been training for the staff involved?*
- *Are the managers responsible covered by professional codes of conduct? If so how is this being addressed?*

Ask those who commission and/or monitor the service why they hadn’t identified any problems.

So when things go wrong …

Don’t ask …

“Who should we blame?”

Ask …

“What have you done to stop this happening again?

References

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Maxwell RJ (1984) Quality assessment in health. *British Medical Journal*; 288: 1470-2

Nelson G, Batalden P, Plume S, Mohr J (1996) Improving Health Care Part 2 - A Clinical Improvement Worksheet and Users' Manual. *The Joint Commission Journal on Quality Improvement*. 22 (8) 531-548

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