Institute for Healthcare Improvement

What does it take to establish a reliable quality system?

A safety conversation

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D4 Wed 22nd June 11am – 12.15pm

Faculty

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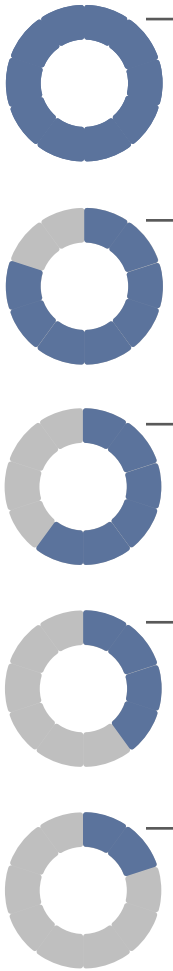
Institute for Healthcare Improvement

Objectives for this session

We will aim to help you:

- Describe the components and elements of a framework to improve and advance patient safety in your area of responsibility
- Discuss how culture and learning system interact to drive patient safety
- Identify two components where you will begin to work or address an identified gap

Where is your organisation?



Innovation trailblazer

Widely recognised as improvement and innovation leaders.
Clear, measurable signs of strong improvement culture. High performing organisation.

Improvement leaders

Consistent organisation-wide improvement plan and approach.
Evidence of improvement planning and delivery. Improvement across a range of access, quality and safety indicators

Gaining improvement momentum

Developing consistent organisation-wide improvement approach.
Support needed and further development to refine capability

High potential for improvement

Evidence of improvement plans and capability in some areas.
No consistency across the organisation

Limited improvement capability

Improvement not supporting strategic priorities.
Little improvement capability

Advanced	5
Consolidating	4
Refining	3
Building	2
Foundational	1

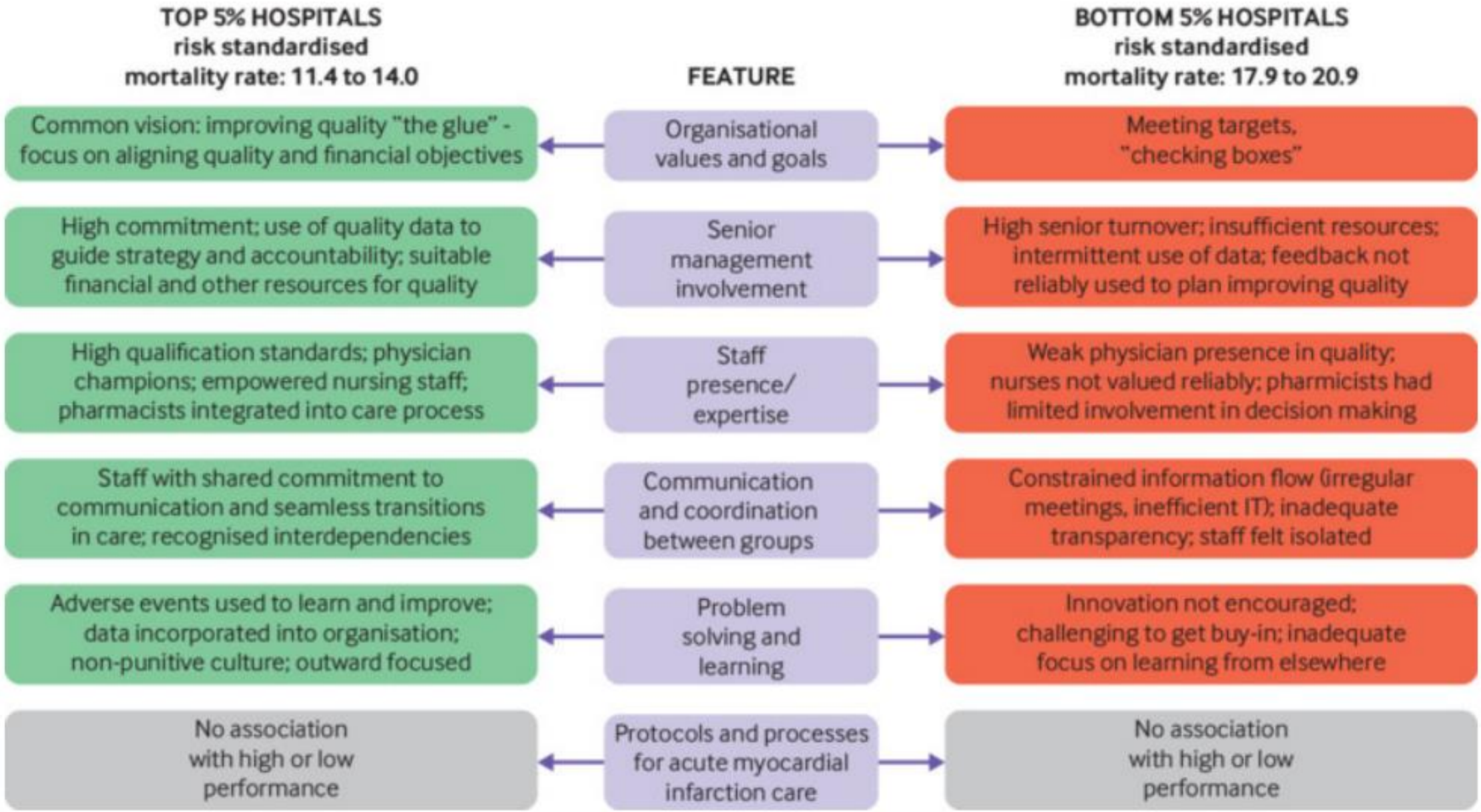
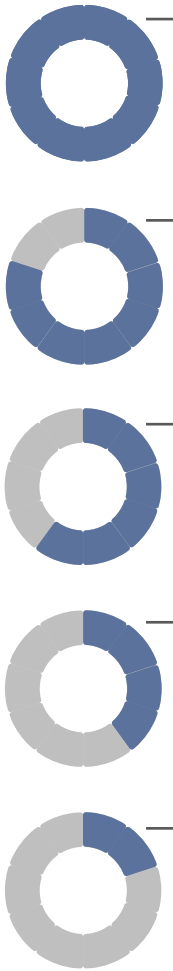


Fig 3 Contrasting organisational approaches in US healthcare organisations with the top and bottom 5% risk standardised mortality for acute myocardial infarction in 2017[8]

What's our ambition?



Innovation trailblazer — Advanced — 5

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Improvement leaders — Consolidating — 4

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Quality System Paradigm

Traditional way	Quality into the future
Quality is about compliance.	Quality is about continuous, systematic improvement.
Quality is a function of governance.	Quality is a shared responsibility.
Leadership creates standards.	Leadership creates culture.
Power is concentrated (in the hands of the checkers).	Power is distributed to patients and staff at the point of care.
Data is for assessment.	Data is for rapid adjustment.

The Quality Cycle - A Quality Management System

Quality Planning

Integrated Medium Term Plans – IMTP

Wellbeing of Future Generations Act

with patient experience and needs of communities at the centre

Quality Improvement

Transformational, organisational wide change

Connected planning, measurement and Improvement teams

for results at scale

Quality Control

Monitoring and managing quality at the point of service delivery

Staff with ability to standardise and maintain safe effective and reliable daily work

Quality Assurance

Qualitative and quantitative evidence of performance from across the system

Providing assurance to the board and regulatory bodies

Quality and Safety Framework: learning and Improving., Welsh Government, 2021

It takes more than improvement….

Improvement Philosophy

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Managing Quality

The way we manage our collective efforts to do the right work to meet the needs of NHS Wales:

- Quality Planning
- Quality Control
- Quality Improvement

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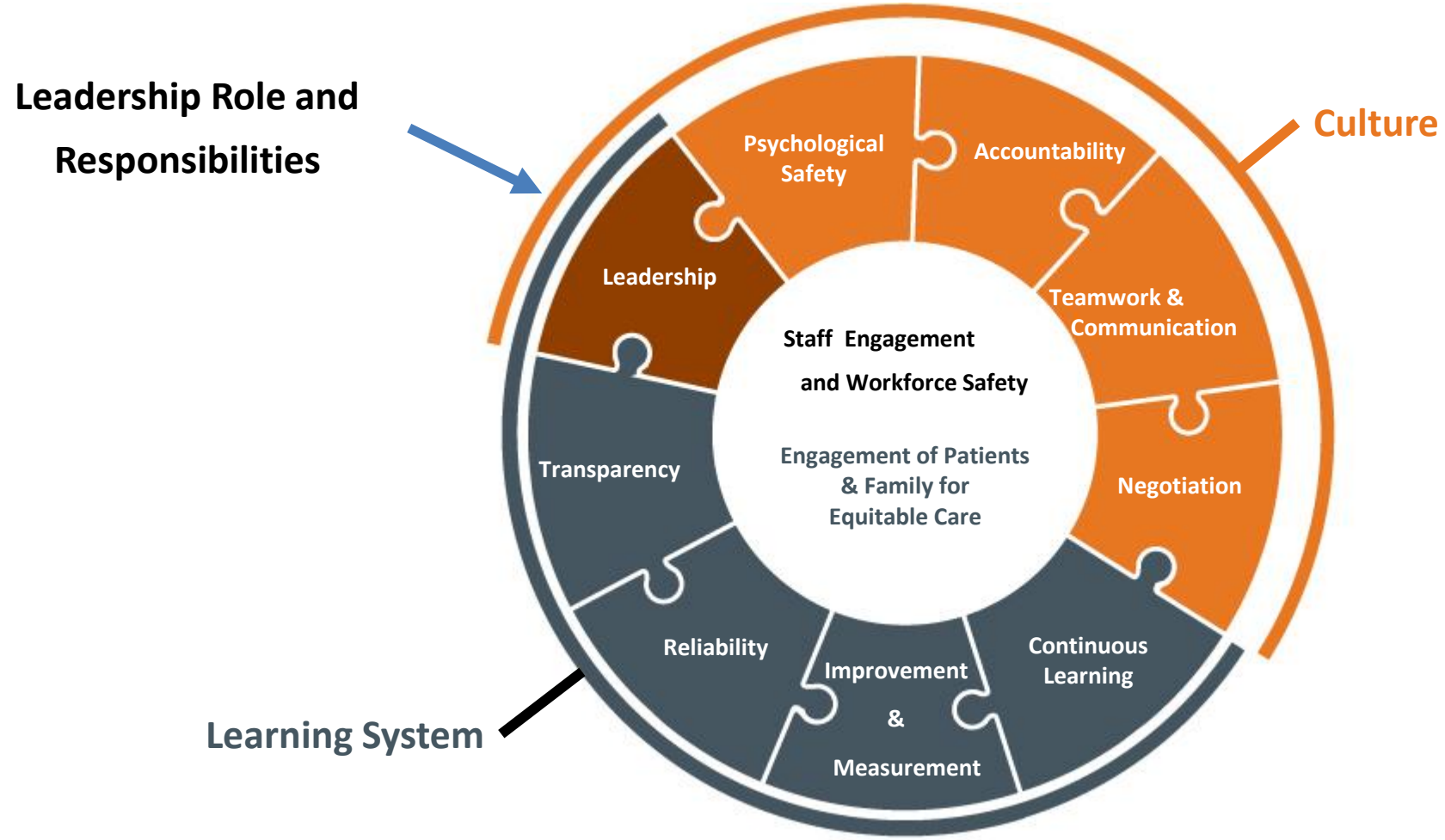
High performing system

Leadership Principles for Quality

Principle	Definition
Build a shared sense of purpose	Co-production of a cohesive and unified vision for the desired future state of the organisation
Practice systems thinking	See the interconnectedness of the system elements, distinguishing patterns and relationships
Engage in collective learning and dialogue	Inquiry, dialogue and co-production to progress towards shared vision
Practice personal inquiry and reflection	Self reflection, unearthing deeply held beliefs, understanding influence on behaviours

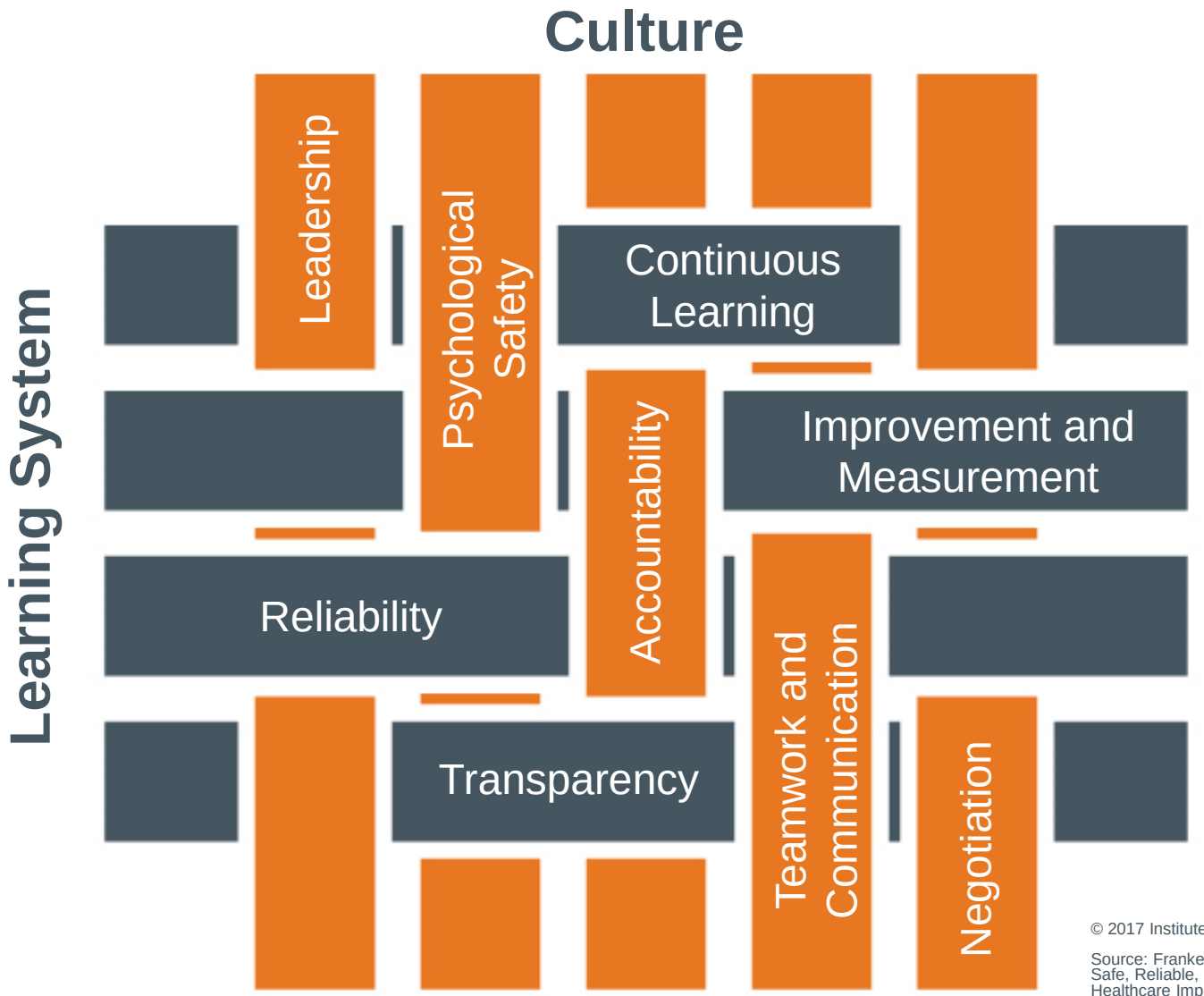
http://www.ihi.org/resources/Pages/IHIWhitePapers/whole-system-quality.aspx

Framework for Safe, Reliable, and Effective Care



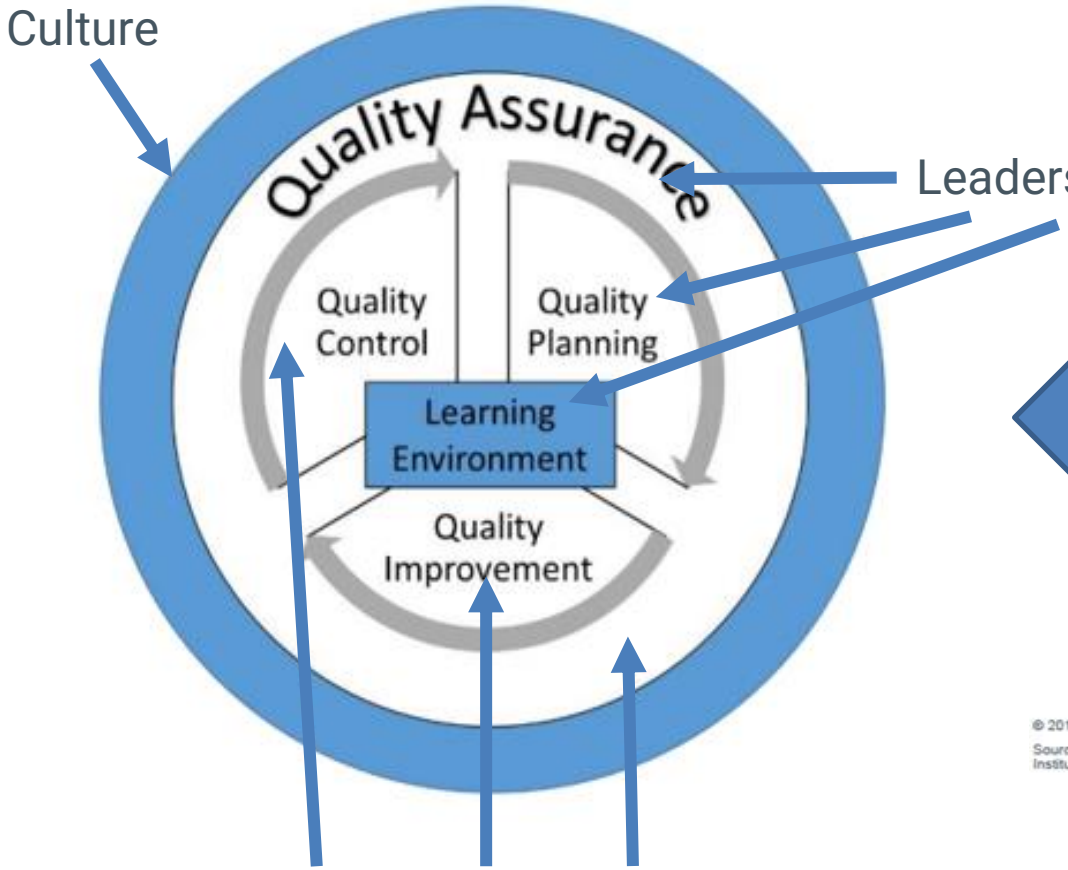
Source: Frankel A, Haraden C, Federico F, Lenoci-Edwards J. *A Framework for Safe, Reliable, and Effective Care.* White Paper. Cambridge, MA: Institute for Healthcare Improvement and Safe & Reliable Healthcare; 2017. (Available at ihi.org)

Framework for Clinical Excellence

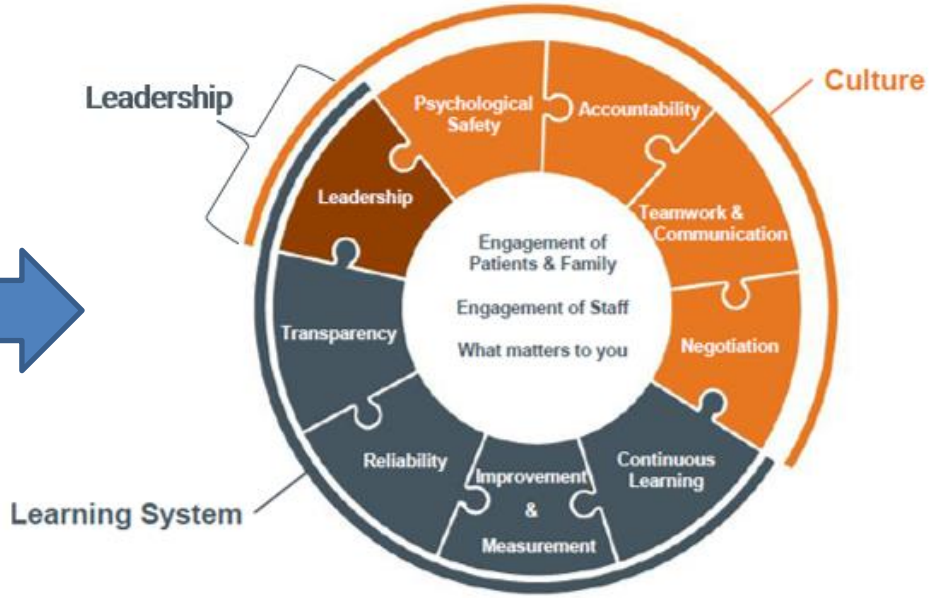


Source: Frankel A, Haraden C, Federico F, Lenoci-Edwards J. A Framework for Safe, Reliable, and Effective Care. White Paper. Cambridge, MA: Institute for Healthcare Improvement and Safe & Reliable Healthcare; 2017. (Available at ihi.org)

The Quality and Safety Framework and the Framework for Safe, Reliable and Effective Care – how they align and come together in practical work



Quality and Safety Framework: learning and Improving., Welsh Government, 2021



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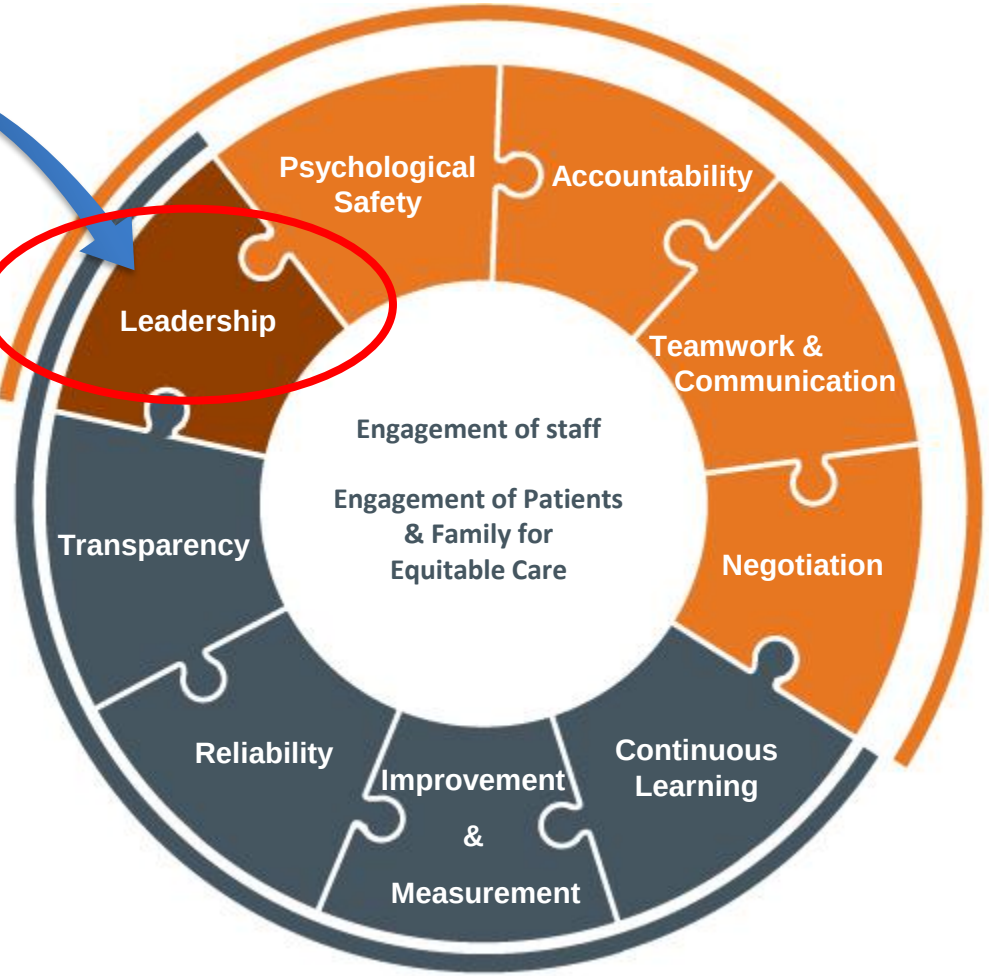
Framework for Clinical Excellence

Facilitating and mentoring teamwork, improvement, respect and psychological safety.



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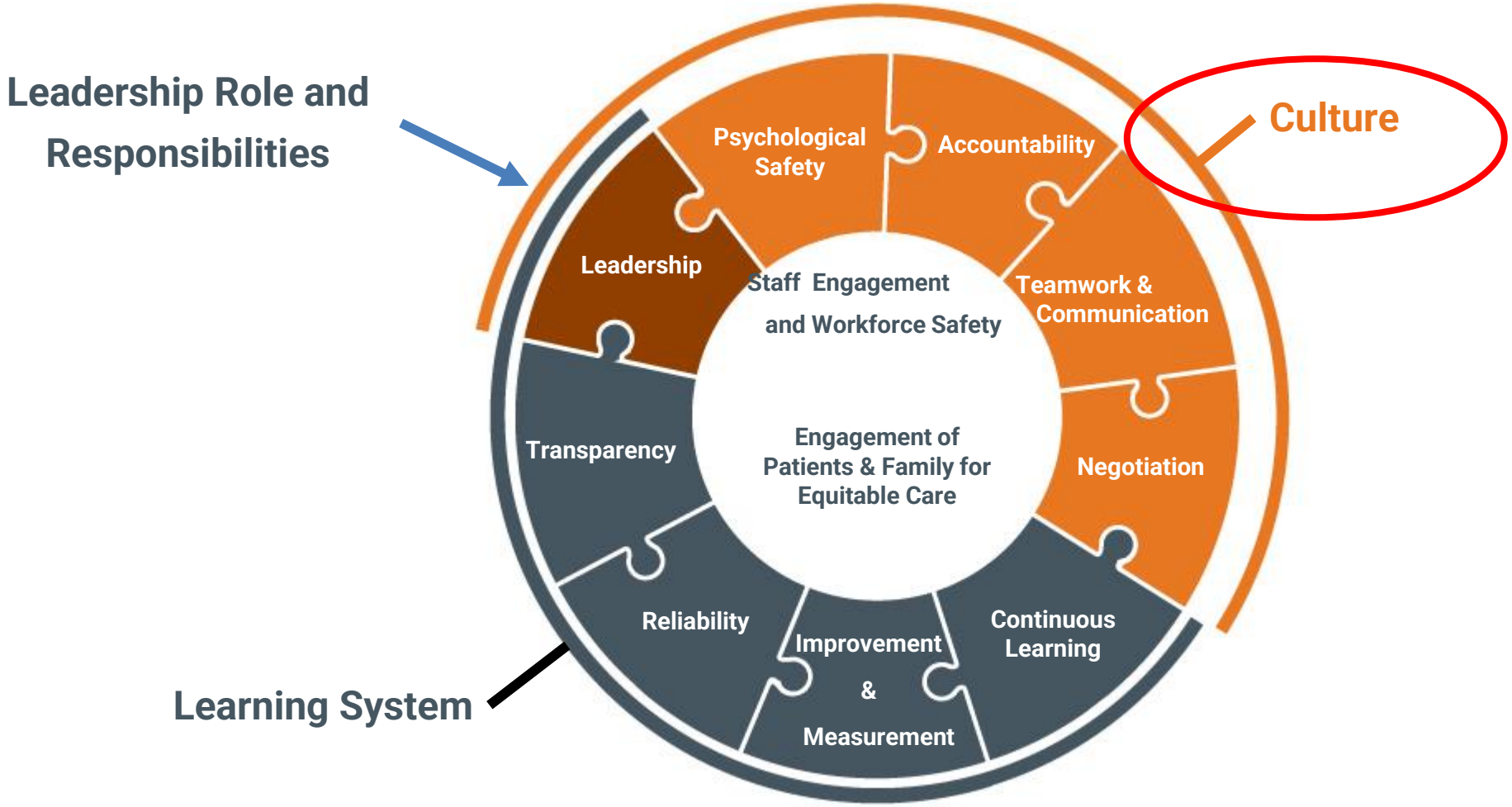
Leadership Actions

- Clearly define the vision for all to understand and visualise the future, and the implications of not making changes
- Set compelling, but realistic, expectations
  - Set goals that reflect the care that patients should receive
  - Set goals for workforce safety
- Shape the Desired Culture – non-negotiable behaviours
  - Respect is not optional
- Provide Resources
- Monitor Progress and Results – build a learning system
- Build Will & Encourage the Heart –emotional intelligence

Framework for Safe, Reliable, and Effective Care



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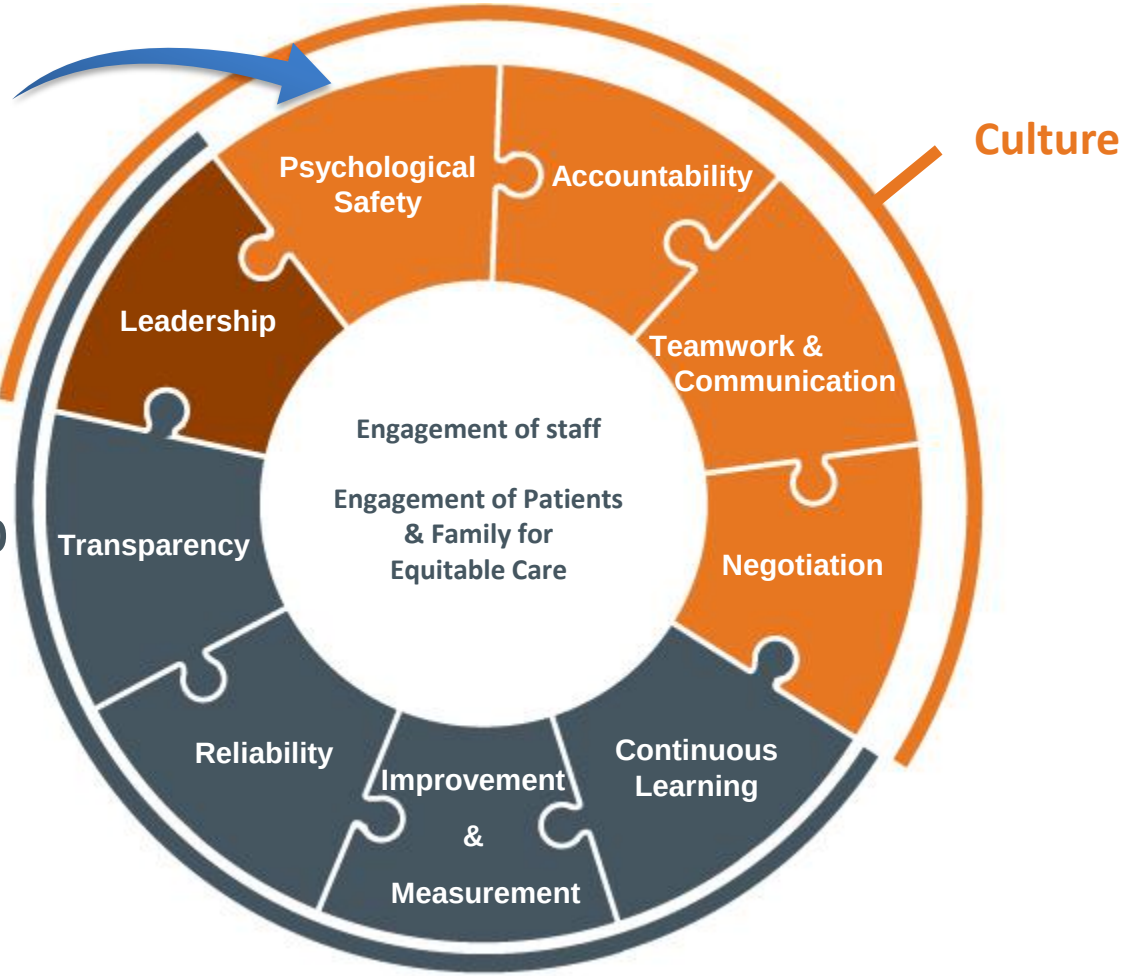
When you think about culture in health care, what is important to you?

Culture

Creating an environment where people feel comfortable and have opportunities to raise concerns or ask questions.



Source: Frankel A, Haraden C, Federico F, Lenoci-Edwards J. A Framework for Safe, Reliable, and Effective Care. White Paper. Cambridge, MA: Institute for Healthcare Improvement and Safe & Reliable Healthcare; 2017. (Available at ihi.org)

“Psychological safety is a belief that one will not be punished or humiliated for speaking up with ideas, questions, concerns, or mistakes.”

Amy Edmondson 1999

Psychological safety reduces “a person’s anxiety about being basically accepted and worthwhile”.

Schein and Bennis 1965

“Drive out fear, so that everyone may work effectively for the company”. **Deming 1982**

“Psychological safety is being able to show and employ one’s self without fear of negative consequences of self-image, status or career…..the shared belief that the team is safe for interpersonal risk taking…..”

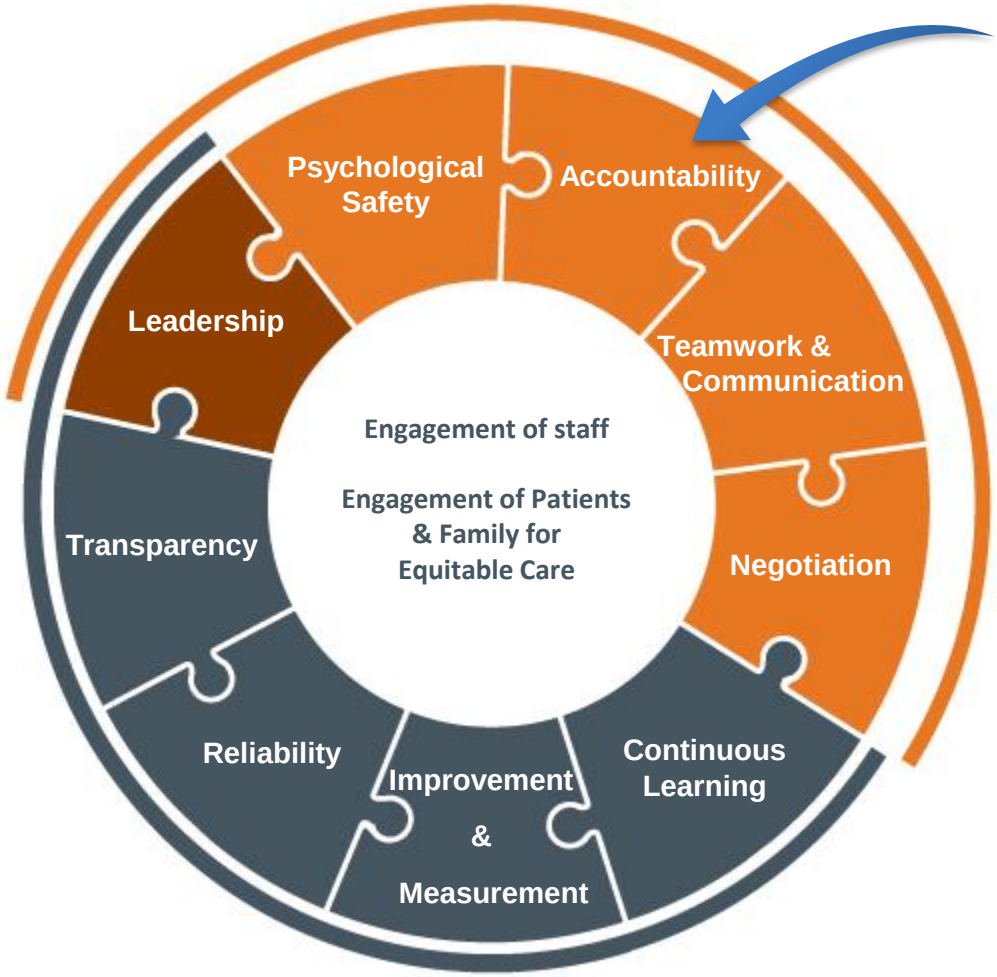
William Kahn 1990

Barriers to Psychological Safety

Hierarchy: higher ranking physicians were valued more (organisational level)
Lack of knowledge: lack of awareness of cases being discussed (team level)
Authoritarian leadership: leaders devaluing ideas from team members (team level)
Personality: dominant personalities overpowering conversations, or overly shy team members (individual level)

Source: Annual Perspective: Psychological Safety of Healthcare Staff

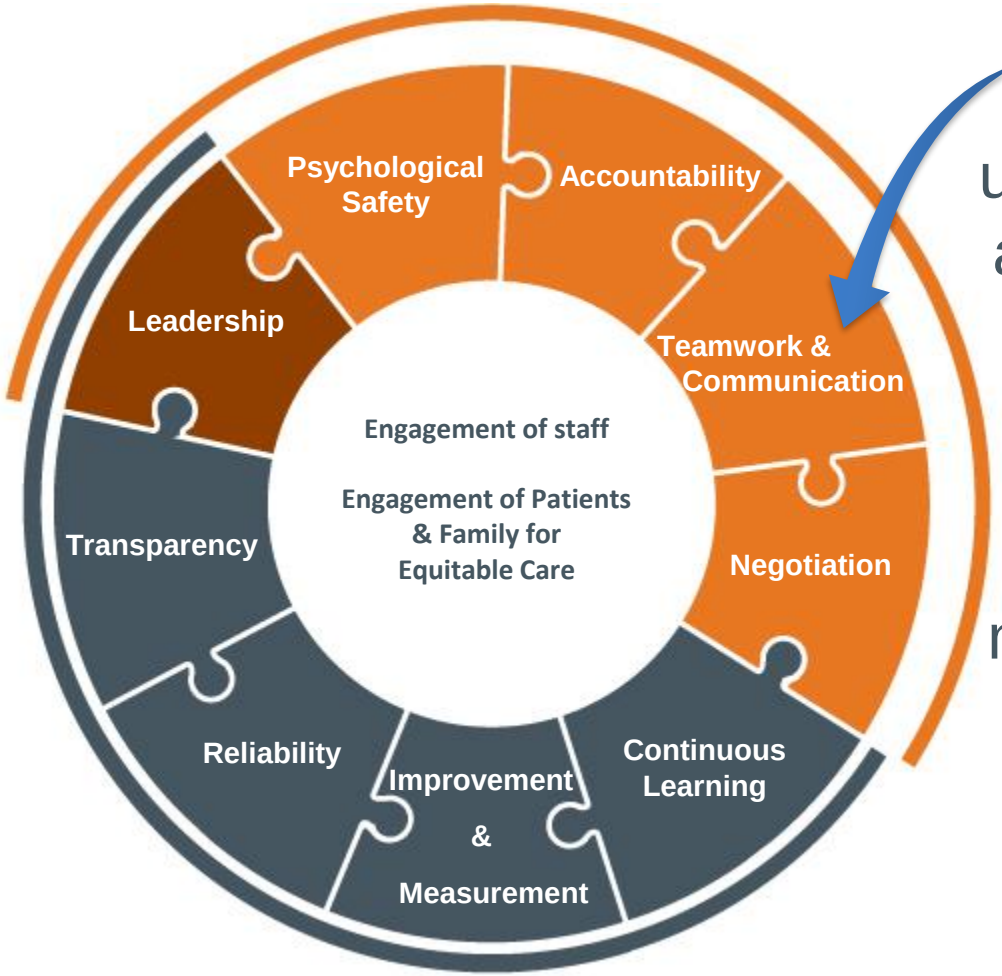
Culture



Being held to act in a safe and respectful manner given the training and support to do so.

Source: Frankel A, Haraden C, Federico F, Lenoci-Edwards J. A Framework for Safe, Reliable, and Effective Care. White Paper. Cambridge, MA: Institute for Healthcare Improvement and Safe & Reliable Healthcare; 2017. (Available at ihi.org)

Culture



Developing a shared understanding, anticipation of needs and problems, agreed methods to manage these as well as conflict situations

Source: Frankel A, Haraden C, Federico F, Lenoci-Edwards J. A Framework for Safe, Reliable, and Effective Care. White Paper. Cambridge, MA: Institute for Healthcare Improvement and Safe & Reliable Healthcare; 2017. (Available at ihi.org)

Teamwork and Communication

- Team training is a cultural intervention and dependent upon leadership support at all levels
- Team training is best paired with other methods of improving teamwork
- Team training is a solution to patient safety, not the solution
- Measurement driven feedback drives improvement
- Becoming an expert team player is a career-long journey
- Sustainability is essential

Effective Teams

- Brief - Plan forward
- Debrief – Reflect back
- Huddle – Manage risk
- Communicate clearly – use tools such as SBAR, open ended questions, respectful listening, ensure all have opportunity to contribute – psychological safety
- Hold each other accountable across a flat hierarchy
- Agree on norms of conduct and hold each other accountable when necessary

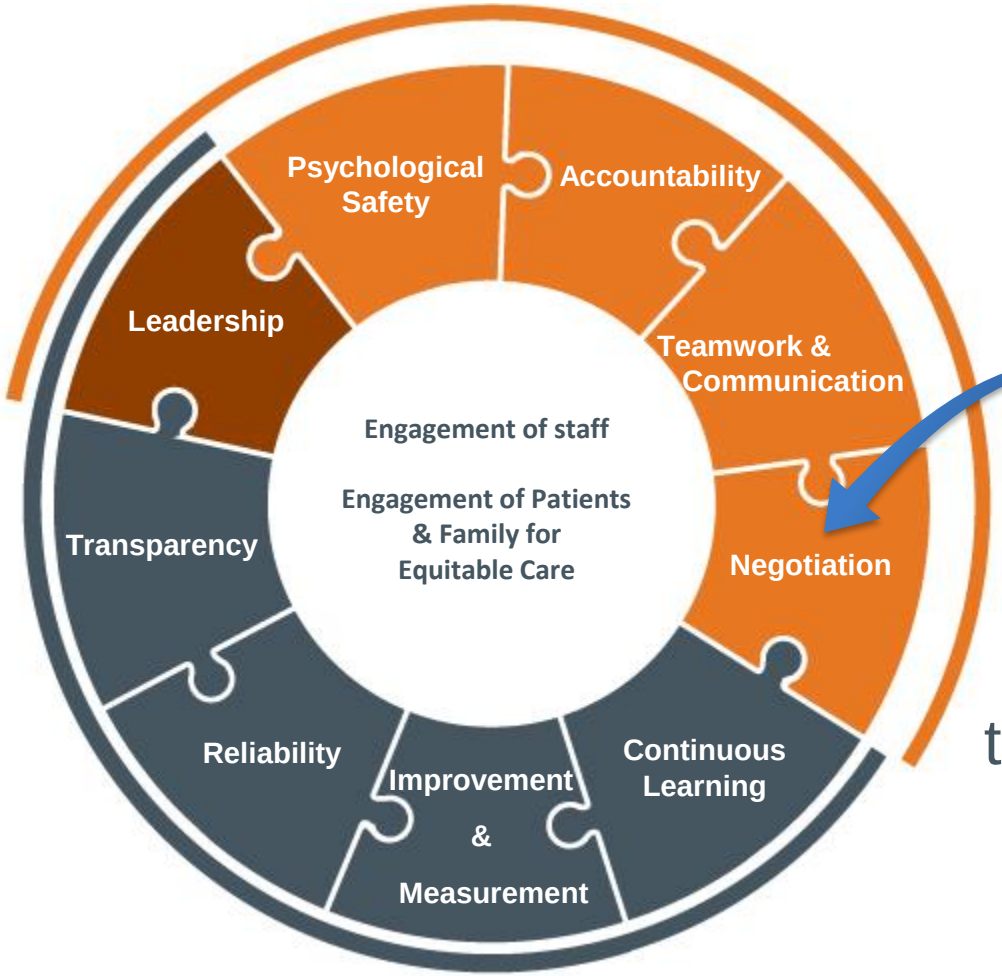
“The single biggest problem in communication is the illusion that it has taken place.”

Bernard Shaw

Communications

- Failure to communicate most common contributing factor to adverse event
- Impacted by
  - Hierarchy
  - Language/words
  - Bias
  - Expectations
  - Environmental design
  - Distractions/noise
  - Multi-lingual work force

Culture



Gaining genuine agreement on matters of importance to team members, patients and families.

Source: Frankel A, Haraden C, Federico F, Lenoci-Edwards J. A Framework for Safe, Reliable, and Effective Care. White Paper. Cambridge, MA: Institute for Healthcare Improvement and Safe & Reliable Healthcare; 2017. (Available at ihi.org)

Discussion:
What does the culture look and feel like in your workplace today?

Psychological safety

Accountability

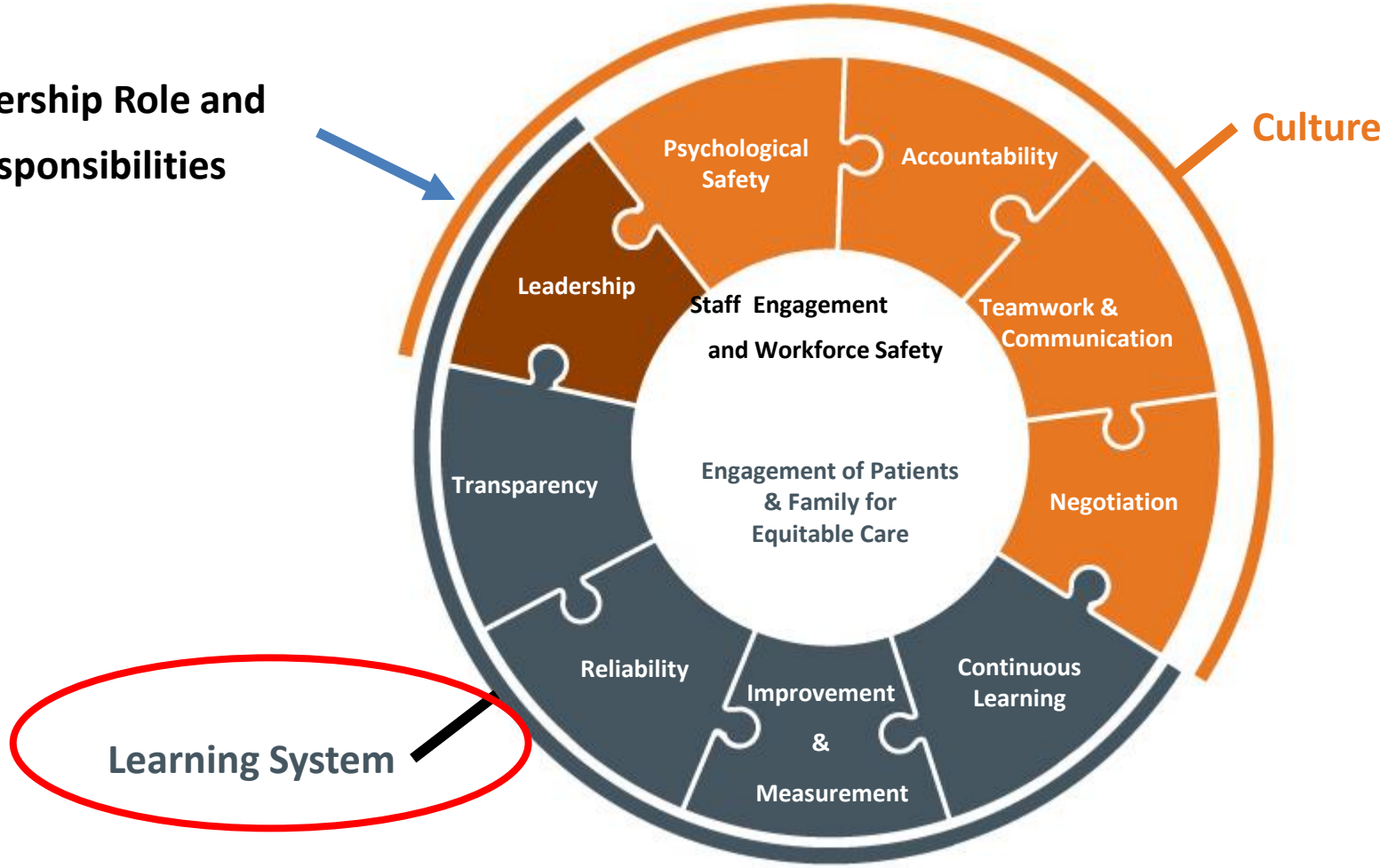
Teamwork and communication

Negotiation

Shaping the Culture

- Behave in ways that reinforce a safe environment to speak up
- Do not tolerate behaviours that undermine the culture you want to build
- Recognise those that speak up
- Hold each other accountable/responsible to behaviours and meeting expectations

Learning System



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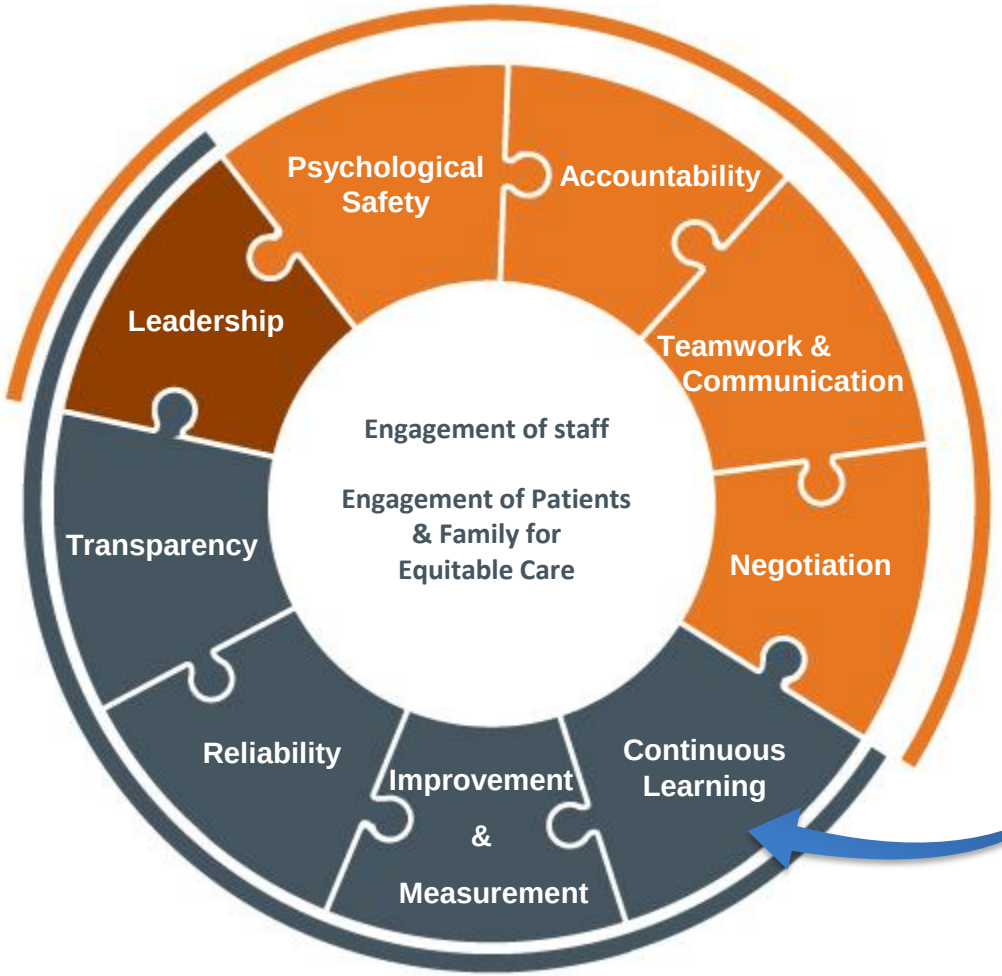
What does the term learning system mean to you and your work?

Learning System

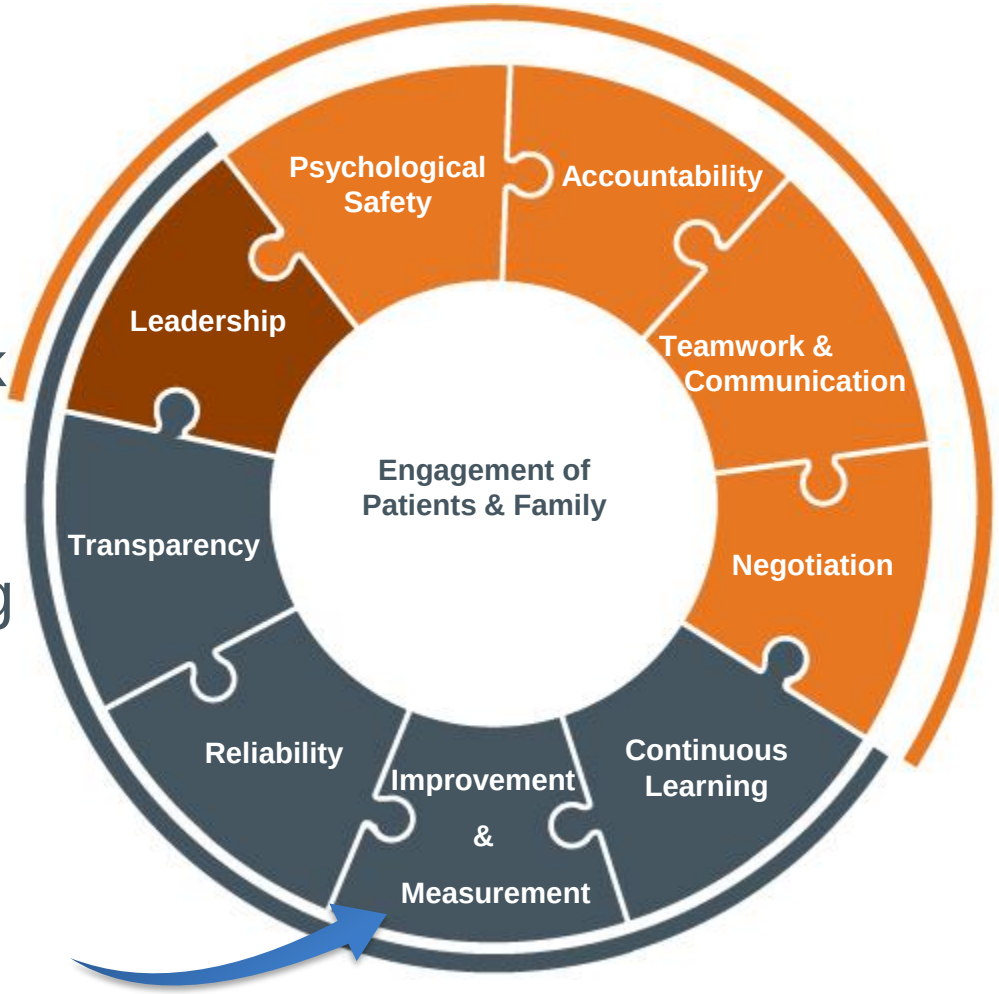


Regularly collecting and learning from defects and successes.

Source: Frankel A, Haraden C, Federico F, Lenoci-Edwards J. A Framework for Safe, Reliable, and Effective Care. White Paper. Cambridge, MA: Institute for Healthcare Improvement and Safe & Reliable Healthcare; 2017. (Available at ihi.org)

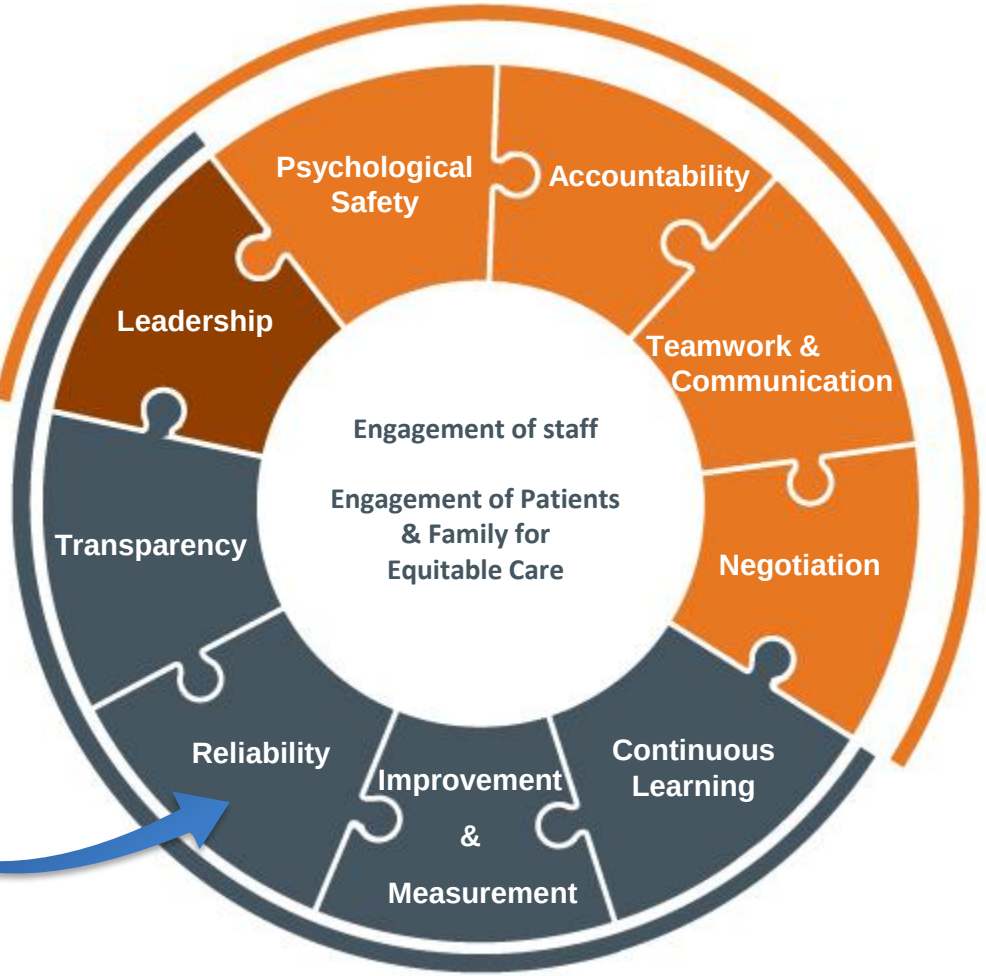
Learning System

Improving work processes and patient outcomes using standard improvement tools including measurements over time.



Learning System

Applying best evidence and minimising non-patient specific variation with the goal of failure free operation over time.



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Think of a time when a safety initiative or change was implemented in your organisation?

Did it stick ?

If it did what do you think made it stick?

If it didn’t, what do you think prevented this from happening?

Improvement Sequence

- **Testing**: Trying and adapting ideas to learn what works in your system
- **Implementation**: Making a change a permanent part of the day-to-day operation of the system
- **Sustainability**: A plan for holding the gains from all that has been accomplished!

Expectations when testing and implementing a change

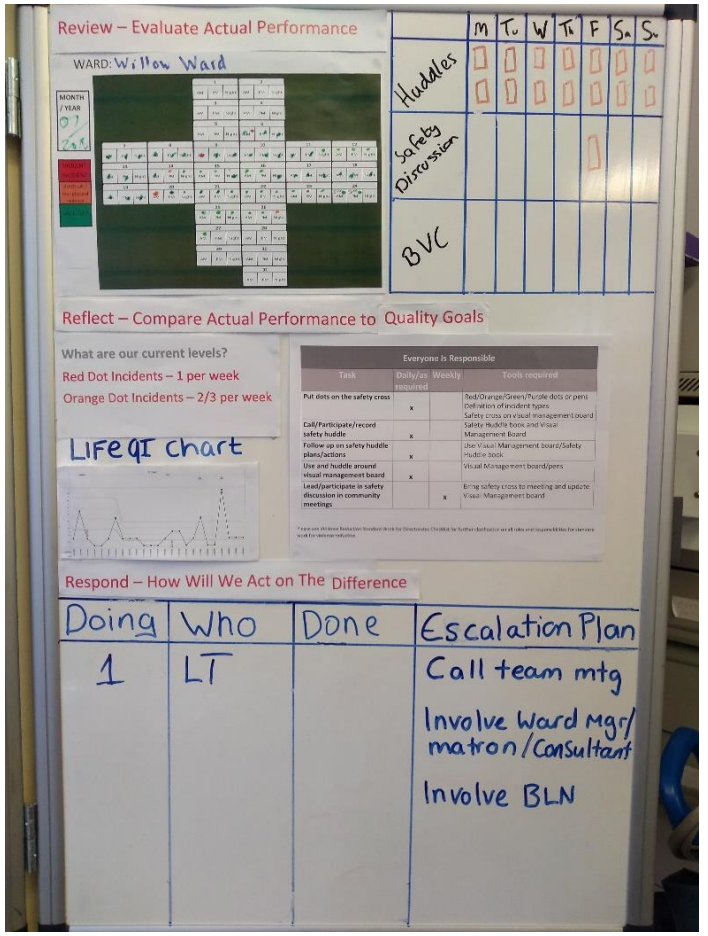
Expectation for…	Testing	Implementation
Failure	20–25% Good! Failure = learning!	<5% Bad! Failure = setback
Surprises and learning	High	Low
Number of people affected	Few	Many
Resistance	Low	High
Support infrastructure	Informal, on the fly	Formal and systematic
Redesign of existing processes (e.g., job descriptions)	No	Yes
New resources needed	No	Yes
Duration	Temporary	Permanent, until next upgrade
Speed	Fast(er)	Slow(er)

- Table adapted from Kevin Little, Ph.D. Informing Ecological Design, LLC based on chapters 7 & 8, G. Langley et al., The Improvement Guide, 2nd edition (2009), Jossey-Bass, San Francisco).

Standard work: The who, when, where, how and what

Everyone's Responsibilities					
Task	**Daily**	**Weekly**	**Monthly**	**As required**	**Tools required**
Put dots on the safety cross as an incident happen on the ward	X				Red/Orange/Green/Purple dots or pens Definition of incident types (colour dots)
Change the safety cross (frequency depends on type of safety cross used by the ward)	X		X		Printed copies for daily or monthly safety crosses
Call/Participate/record safety huddle at least twice a day	X				Safety Huddle book
Follow up on safety huddle plans/actions	X				
Active/Lead/Guide/participate in safety discussion in community meetings		X			Bring safety cross to meeting
Participate in patient led safety huddles		X			
Have access to LifeQI for violence reduction data		X			LifeQi log ins
Induct new starters				X	Welcome packs

Specific Responsibilities					
Modern Matrons/Ward Managers					
Allocate who will input LifeQi data		X			
Present and interpret data to MDT/community meetings			X		LifeQi log ins
Allocate time in away days to discuss performance (review), compare to standards (reflect), and any actions required (react) to prevent detorioration			X		Data
Service Users					
Participate in Service User led safety huddle		X			
Induct new service users to the ward				X	Welcome pack



Learning System

Openly sharing data and other information concerning safe, respectful and reliable care with staff and partners and families.

Source: Frankel A, Haraden C, Federico F, Lenoci-Edwards J. A Framework for Safe, Reliable, and Effective Care. White Paper. Cambridge, MA: Institute for Healthcare Improvement and Safe & Reliable Healthcare; 2017. (Available at ihi.org)

Transparency Implies

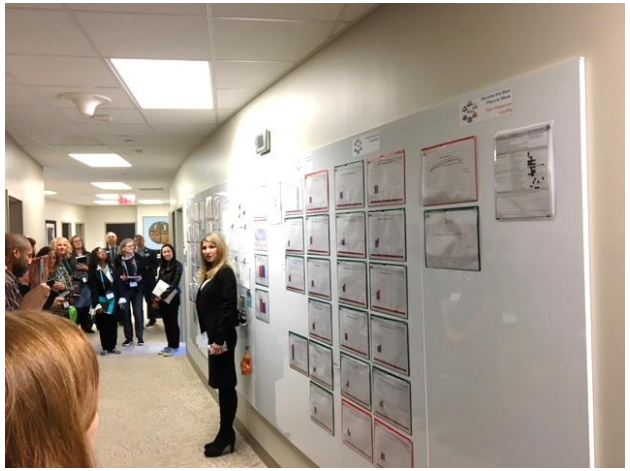
- Openness
- Communication
- Accountability/ Ownership

Application of Transparency

- Transparency in display of data
- Transparency among clinicians
- Transparency with patients
- Transparency among organisations
- Transparency with the community

Transparency Among Practitioners

- There is no fear of giving suggestions, pointing out problems, or providing feedback
- Sharing and displaying data about performance
- Using learning boards to share progress
- Communications across all layers of the organisation



Transparency With Patients and Their Families

- From start to finish, extreme honesty:
- Performance data
- Communication after an adverse event
- Shared decision making
- Fully informed consent before treatment,
- Free and open communication during the pro

Transparency Among Organisations

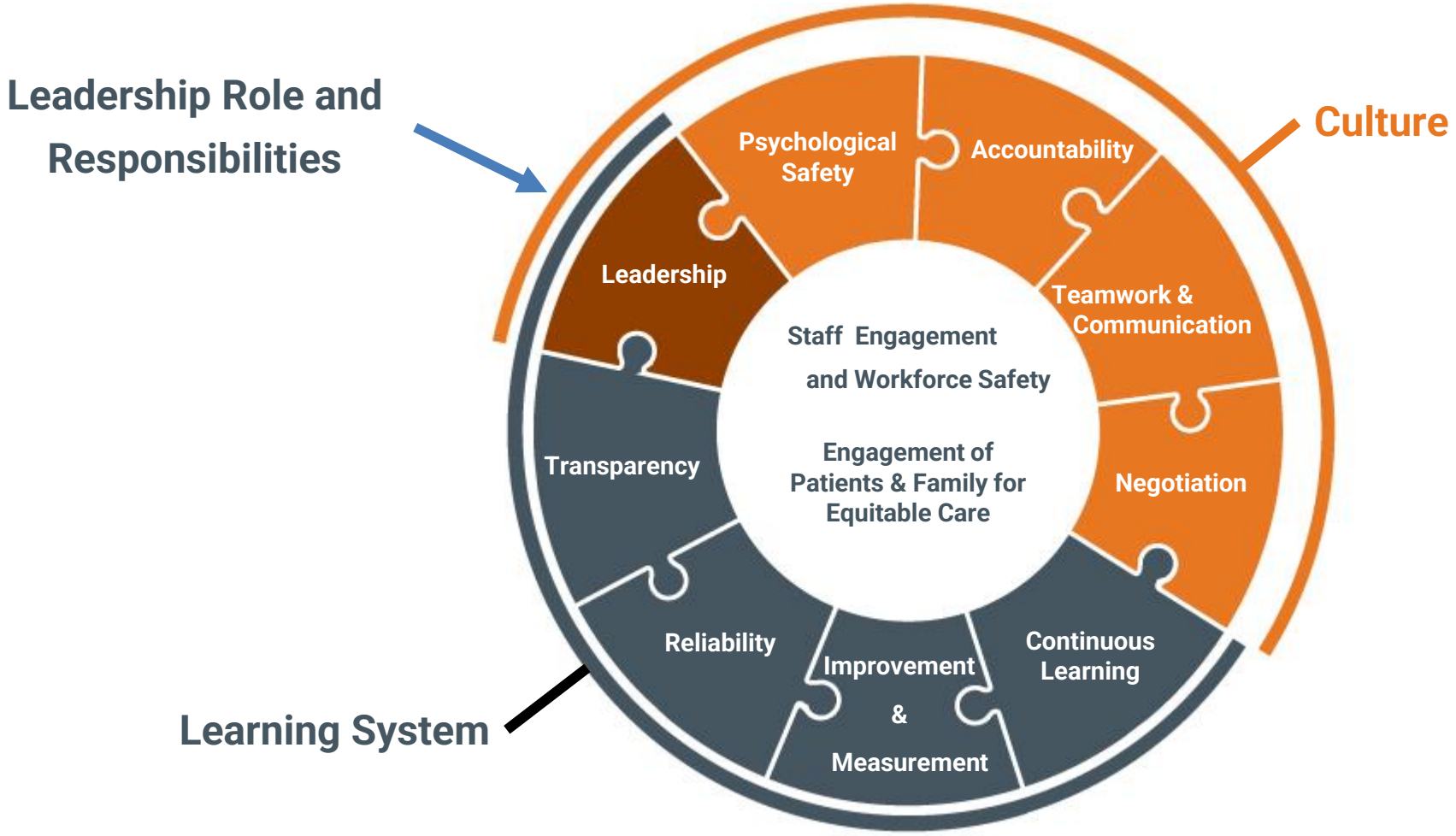
- Sharing good practices
- Lessons learned
- Defects that contribute to patient harr

Discussion:

Does your current learning system meet the needs of safe reliable and effective care?

- Continuous learning
- Improvement and measurement
- Reliability
- Transparency

Where will you begin your safety conversations now?



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Thank you

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