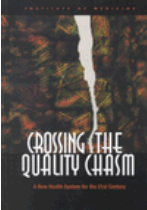


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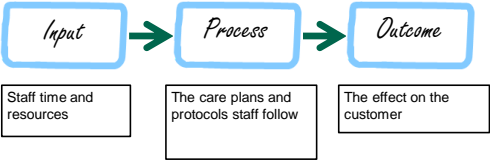
The Goal...Towards perfect healthcare...

- no needless death or disease
- no needless pain
- no feelings of helplessness amongst users and staff
- no unwanted delay
- no waste
- no inequality in service delivery



4

Systems thinking



Source: "Evaluating the Quality of Medical Care", Donabedian A, 1966

5

Types of measure

Outcome measure	Outcome measures show the impact on the patient
Process measure	Process measures show how well we do what we say we do
Input measure	Input measures track the level of resource we use
Balancing measure	Balancing measures show any unintended consequences

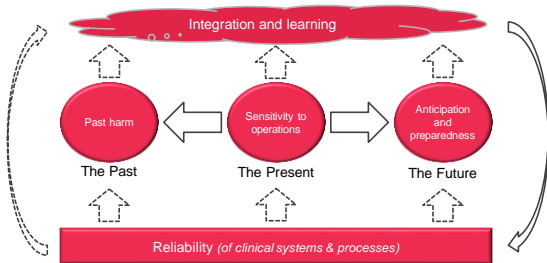
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THE 5 DIMENSIONS OF SAFETY MEASUREMENT

7

The Framework



8

Past harm

Has patient care been safe in the past?

- As a by-product of Treatment
 - *adverse drug reactions, surgical complications, wrong site surgery and the adverse effects of chemotherapy*
- Through over treatment
 - *through error (a drug overdose) or from well intended but excessive intervention (overuse)*
- General healthcare related
 - *Hospital-acquired infections, falls, delirium*
- Failure to provide appropriate treatment
 - *rapid thrombolytic treatment for stroke, rapid and effective treatment for MI, prophylactic antibiotics before surgery*
- Delayed or inadequate diagnosis
- Psychological harm and feeling unsafe
 - *Clinical depression after cancer surgery*

Outcome measures

9

Integration & learning Are we responding and improving?

- How to integrate the wealth of patient safety information and analyse it in a meaningful way?
 - *Clinical teams* *Board level*
- How can that be supported to support organisational learning and sustainable improvements?
 - *Procedures*

6 principles of mortality review



1. Do the review
Reviews must be undertaken at an agreed frequency, involving relevant people in a way that is sustainable.
2. Do it intelligently
There should be an agreed process for selecting cases that either covers all deaths, or a properly representative sample.
3. Get some learning
The review process must be structured in a way that allows identification of system issues.
4. Share that learning
The review process should produce timely feedback to Clinicians, service leaders and Quality & Safety Committee.
5. Report comprehensively
Reporting should highlight learning about clinical system issues and also the review process itself.
6. Feed learning into strategy
There must be a process for ensuring that Health Board strategy on avoidable death and harm reflects the outcomes of the review process



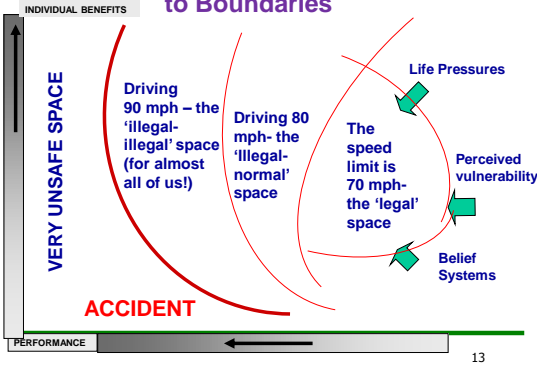
Reliability

Are our clinical systems and processes reliable?

- 'failure-free operation over time'
- Apply to those processes that benefit from standardisation
 - *Basic Clinical processes*
 - *Care bundles*
 - *Administrative processes*
- Beware 'Tick the box' measurement



Systemic Migration to Boundaries



Avoiding the migration – Standard work

“By documenting the current best practice, standardised work forms the baseline for kaizen or continuous improvement. As the standard is improved, the new standard becomes the baseline for further improvements, and so on. Improving standardised work is a never-ending process.”

Lean Enterprise Institute
www.lean.org

14

Sensitivity to operations Is care safe today?

Early identification of issues and prompt response by:

- Safety walk-ros
- Patient Safety
- Operational
- Briefings and debriefing
- Day to day conversations
- Patient interviews

Input & Process measures (some Qualitative)

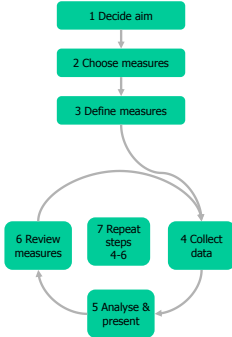
15

Anticipation & preparedness *Will care be safe in the future?*

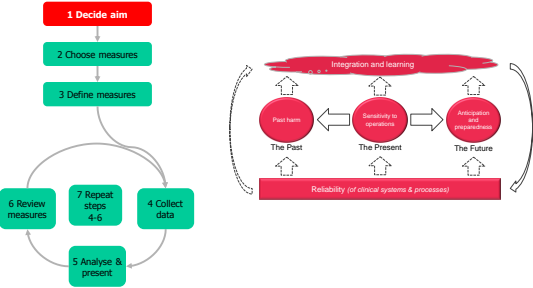
- Personal: Predict possible risks and have strategies for dealing
 - *Driving Test Theory*
 - *WHO Checklist* prepare for possible
- Process: Hur...
- Organisational: Safety culture
 - *Surveys, sickness rates, mandatory training*

Mixed measures:
surveys, checklists

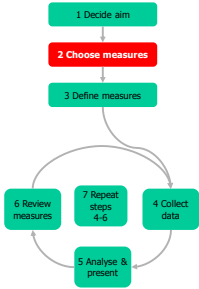
The 7 steps to effective measurement



What's the question?

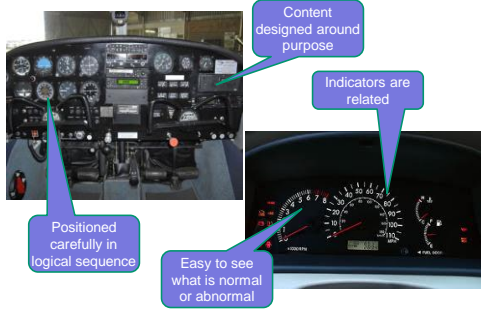


Choose measures



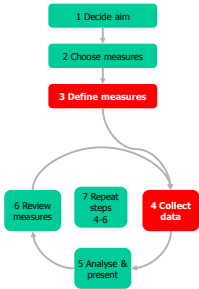
19 19

Some proper dashboards



20 20

Define & collect



How do you define a fall?

An operational definition is a description, in quantifiable terms, of what to measure and the steps to follow to measure it consistently

21 21

Analyse and present

The flowchart shows the following steps:

- 1 Decide aim
- 2 Choose measures
- 3 Define measures
- 4 Collect data
- 5 Analyse & present
- 6 Review measures
- 7 Repeat steps 4-6

Next to the flowchart is a screenshot of a BBC News article titled "Shark attacks rose in 2010 to highest in decade". The article text includes: "Sharks launched 19 unprovoked attacks on humans in 2010, the highest number in a decade, US researchers have found. Six people died from unprovoked attacks, up from an average of 2.6 over the past 10 years, University of Florida scientists said. Thirty-two attacks occurred in North American waters, 14 off Australia and eight in South Africa on waters. During peak months 18-30 million to 70 million sharks per year, the researchers said."

In summary ...

The summary includes two diagrams:

Logic-Process-Outcome:

- Logic:** Staff time and resources
- Process:** The data plans and protocols staff follow
- Outcome:** The effect on the customer

Feedback Loop:

- Central cycle: Forecast (The Past) → Review measures (The Present) → Repeat studies (The Future)
- Top: Integration and learning
- Bottom: Reliability of data system & personnel

A small version of the research process flowchart with steps 1-7.
