

Present & Future Challenges of Quality & Safety in Healthcare

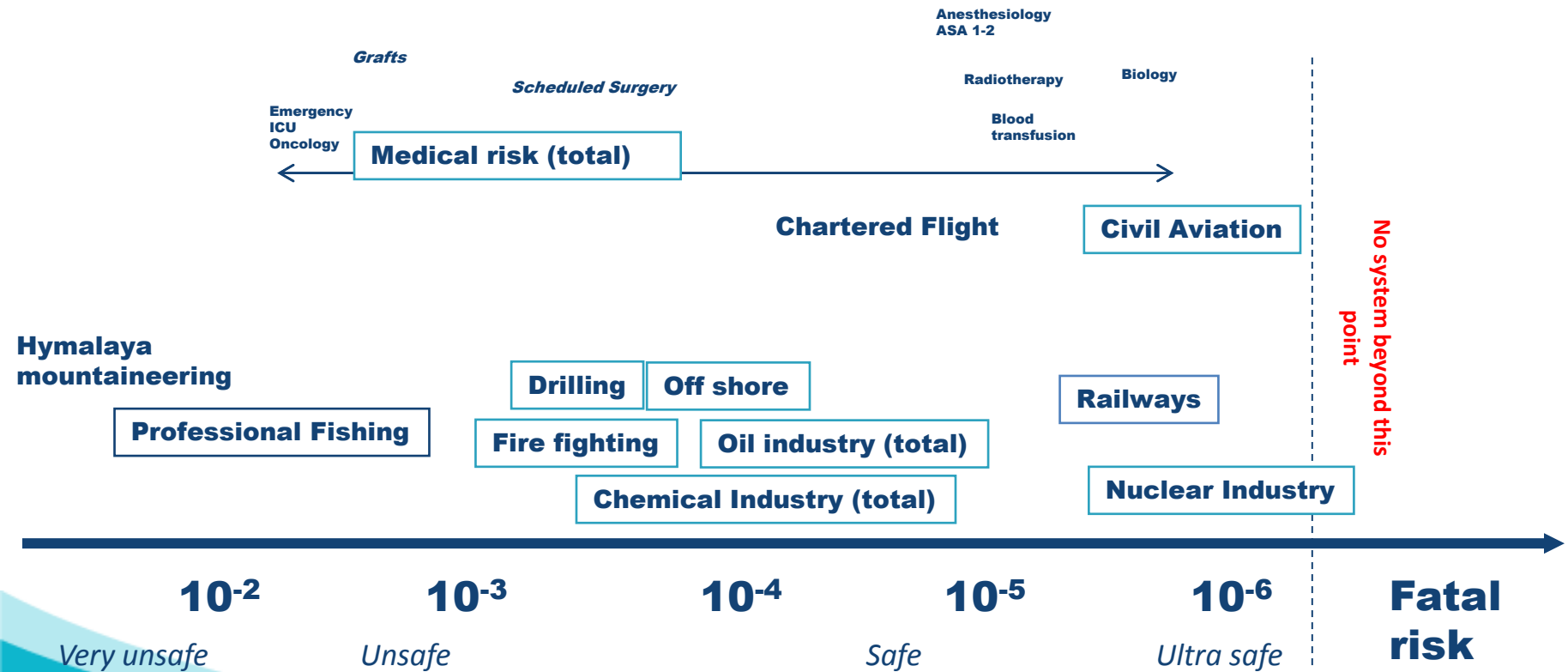
Engaging Patients in their care and safety

René Amalberti, Prof, MD, PhD
ISQUA & HAS, France





Risks in human activities



Gaps in Hospital Discharge Planning and Transitional Care

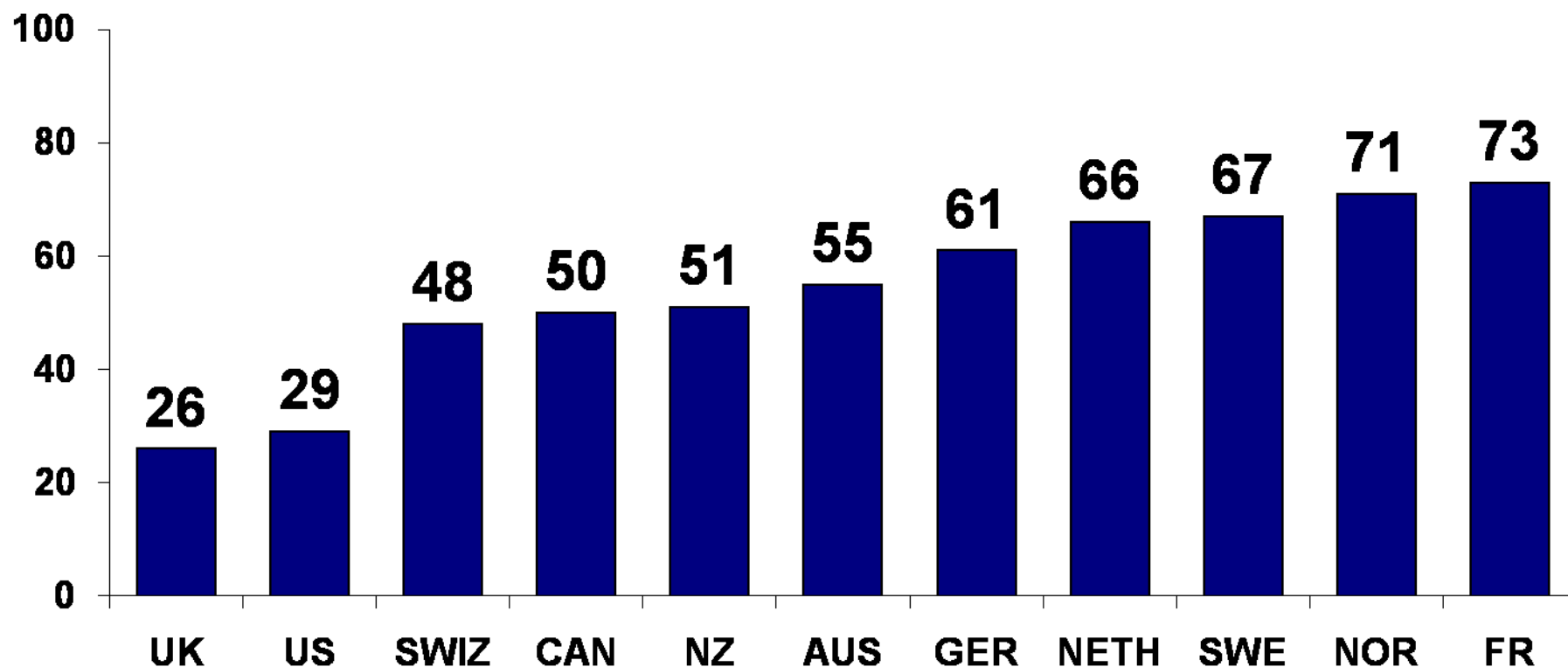
Base: Adults with any chronic condition who were hospitalized in past 2 years

Percent	AUS	CAN	FR	GER	NETH	NZ	UK	US
Did <i>not</i> receive instructions about symptoms and when to seek further care	25	20	37	29	24	28	26	12
Did <i>not</i> know who to contact for questions about condition or treatment	15	11	16	11	13	14	17	8
Hospital did <i>not</i> provide written plan for care after discharge	43	29	39	40	37	31	32	9
Hospital did <i>not</i> make arrangements for follow-up visits with any doctor	38	32	40	35	21	32	27	28
<i>Any of the above discharge gaps</i>	61	50	71	61	51	53	50	38

Gaps in Hospital or Surgery Discharge in Past Two Years



Percent



* Last time hospitalized or had surgery, did NOT: 1) receive instructions about symptoms and when to seek further care; 2) know who to contact for questions about condition or treatment; 3) receive written plan for care after discharge; 4) have arrangements made for follow-up visits; and/or 5) receive very clear instructions about what medicines you should be taking.

Medical, Medication, or Lab Test Errors in Past Two Years (percent)



Percent reported:	AUS	CAN	FR	GER	NETH	NZ	NOR	SWE	SWIZ	UK	US
Wrong medication or dose	4	5	6	8	6	7	8	5	2	2	8
Medical mistake in treatment	10	11	6	8	11	13	17	11	4	4	11
Incorrect diagnostic/ lab test results*	4	5	3	2	6	5	4	3	3	2	5
Delays in abnormal test results*	7	11	3	5	5	8	10	9	5	4	10
<i>Any medical, medication, or lab errors</i>	19	21	13	16	20	22	25	20	9	8	22

* Base: Had blood test, x-rays, or other tests in past two years.



I. A GLANCE OF HISTORY

1. The naïve enthusiasm of pioneers, 1995-2003



- **Q&S interventions situated within the tradition of Epidemiology and Continuous Quality Improvement (CQI)**
- **Prevalent idea simple enough**
 - Identifying, counting, preventing Adverse events
- **Deceptive results : little or no improvement after 5 years**
- **Diagnosis**
 - lack of specific professionalism in Quality and Safety, lack of basic tools including IT's



- **Recruitment of Quality and Patient Safety Officers (QPSO)**
- **Prevalent idea**
 - Risk management (imported from Industry) is at the core of the success
 - Address causes instead of symptoms
- **Still quite deceptive results**
- **Diagnosis :**
 - efforts capsulated to happy few specialists.
 - hierarchical positioning of QPSO proved being much too low

- **Improving safety culture as a Gospel**
- **Prevalent idea**
 - Safety culture as a prerequisite of any improvement in safety
 - Crucial component in learning from failures
- **Need time to see results : Generation shift??**

4. New challenges coming, 2010-continue



System changes

- Technical innovations (day surgery is only one example) all leading to a drastic and rapid reduction of the average length of stay.
- Sociological changes (population aging, acute diseases becoming chronic, patients becoming experts)
- More public transparency required
- More supervision by authorities via administrative and medical databases

Leading to new challenges

- Shift from safer medical acts to safer patient's journey
- Much greater participation of patients not a choice



II. ENGAGING PATIENTS IN THEIR CARE AND SAFETY



Donabedian domains – consumer role in quality

- Contributors
- Targets
- Reformers

1. Donabedian A. Quality assurance in health care: the consumer's role. *Quality in Health Care* 1992;1:247-251.



Contributors

- Defining safety
 - What is important to patients – e.g. surveys show HAI critical
 - Setting standards based on expectations
- Evaluating safety
 - Assess organisational safety?
- Informants = Experience of care
 - Complaints/suggestions
 - Reporting incidents



Targets: co-production

- Concordance
- Shared decision making
- Expert patient



Reformers

- Asking challenging questions
 - “Have you washed your hands?”
 - Marking surgical site
- Patient choice of provider: not unproblematic
- Patient safety champions



Examples of relevant survey questions (1)

- Beforehand, did a member of staff explain the risks and benefits of the operation or procedure in a way you could understand?
- Were you involved as much as you wanted to be in decisions about your care and treatment?
- Sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you?



Examples of relevant survey questions (2)

- As far as you know, did doctors [nurses] wash or clean their hands between touching patients?
- Did a member of staff tell you about medication side-effects to watch for when you went home?
- Before you left hospital, were you given any written or printed information about what you should or should not do after leaving hospital?



Evidence-based information, excellent communication, patient engagement





Common causes of errors in medicine-taking

- Failure to elicit patients' preferences and beliefs
- Failure to explain why drug is prescribed and how it's supposed to work
- Poor communication about contra-indications and side-effects
- Poor communication about how and when to take medicines



Talking with Patients & Families

Always:

- Use Plain Language.
- Slow down.
- Break it down into short statements.
- Focus on the 2 or 3 most important concepts.
- Check for understanding using **teach-back**.



Asking for a Teach-back

Ask patients to demonstrate understanding,
using their own words:

- “I want to be sure I explained everything clearly. Can you please explain it back to me so I can be sure I did?”
- “What will you tell your husband about the changes we made to your blood pressure medicines today?”
- “We’ ve gone over a lot of information, a lot of things you can do to get more exercise in your day. In your own words, please review what we talked about. How will you make it work at home?”



Why it matters

- “Effective ways to help people follow medical treatments could have far larger effects on health than any treatment itself.”

Haynes et al, Cochrane Review, 2008

- “Non-adherence should not be considered the patient’s problem. Rather, it usually results from a failure to fully agree the prescription with the patient in the first place and to support the patient once the medicine has been dispensed.”

NICE guidance CG76, 2009



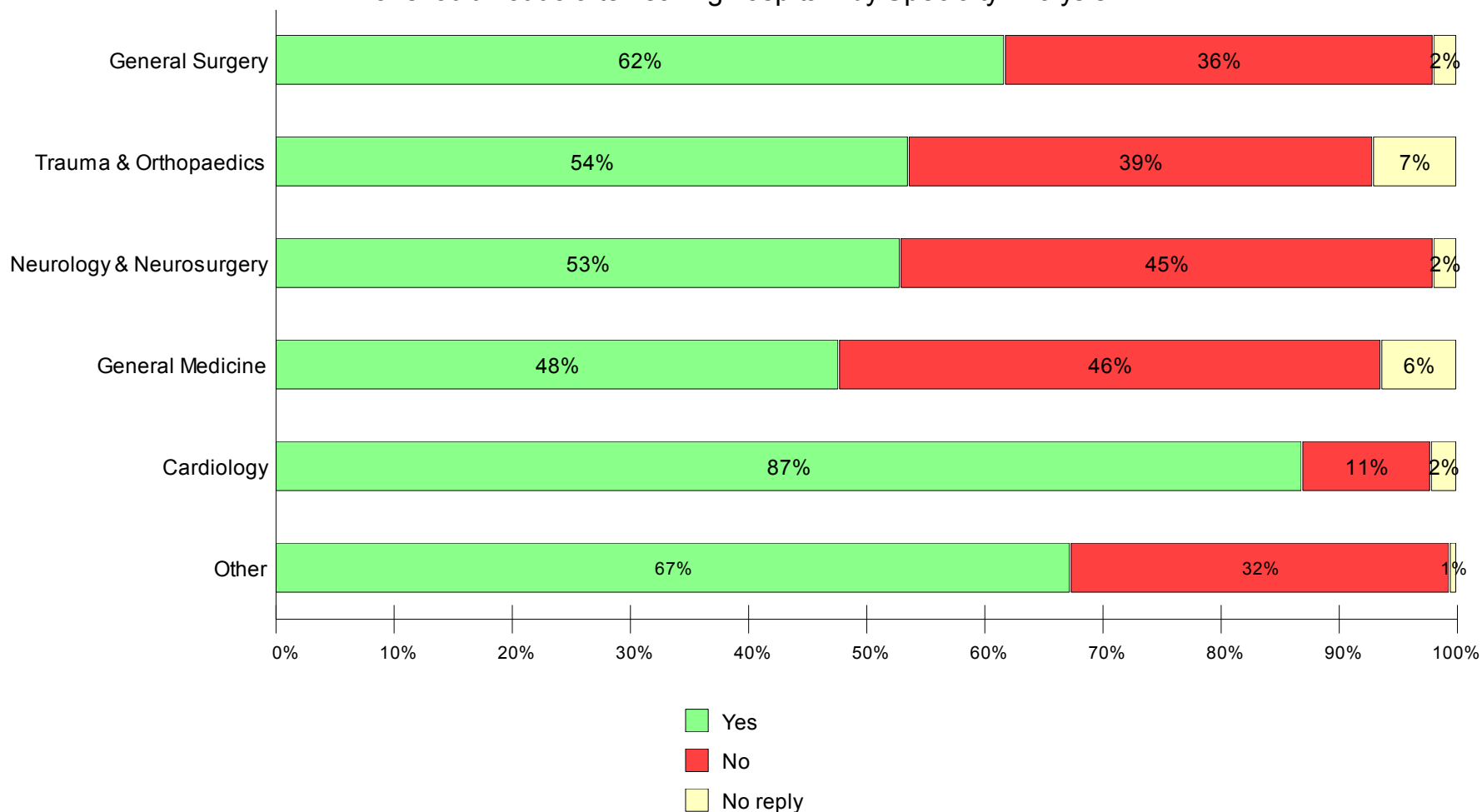
Use patient survey data

- To identify problem areas
- To identify pressure points on the patient journey
- To compare results over time
- For external benchmarking
- For internal benchmarking



Survey data can be used for internal benchmarking

G5. Before you left hospital, were you given any written or printed information about what you should or should not do after leaving hospital? by Specialty Analysis





Survey data can be used for external benchmarking

Your care and treatment

Did a member of staff say one thing and another say something different?

Were you involved as much as you wanted to be in decisions about your care?

How much information about your condition or treatment was given to you?

Did your family or someone close to you have enough opportunity to talk to a doctor?

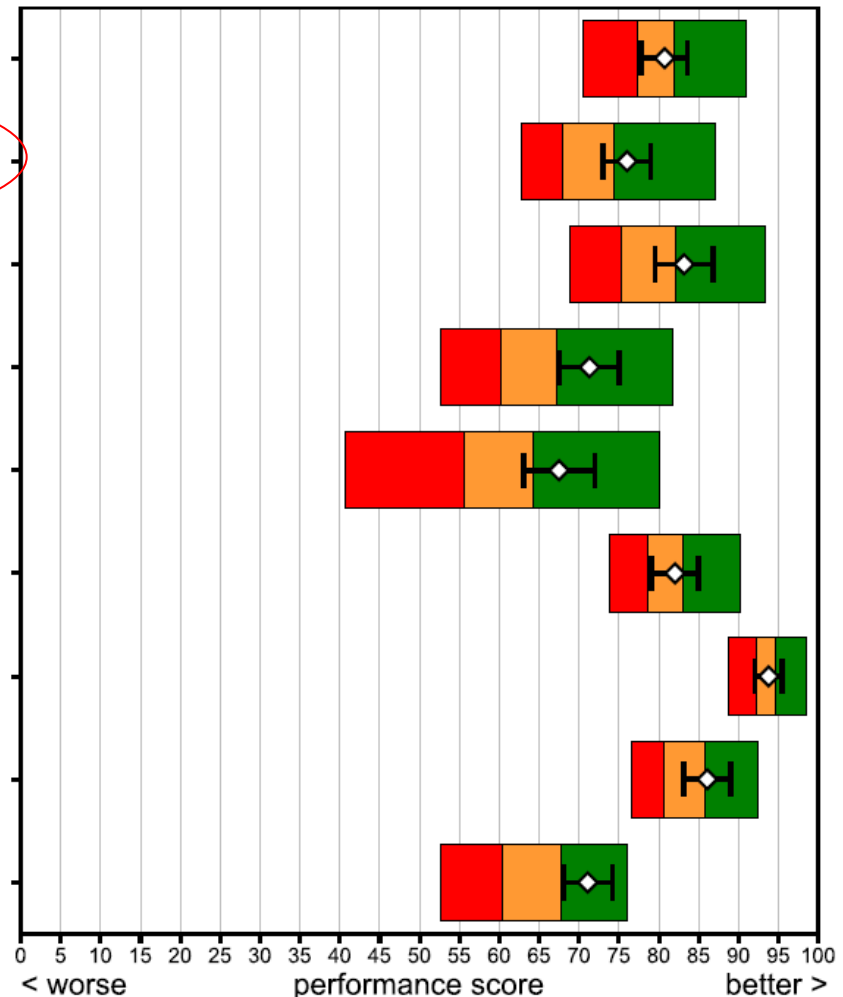
Did you find someone on the hospital staff to talk to about your worries and fears?

Were you given enough privacy when discussing your condition or treatment?

Were you given enough privacy when being examined or treated?

Do you think the hospital staff did everything they could to help control your pain?

After you used the call button, how long did it usually take before you got help?





CONCLUSIONS



The key position of managers

Seven principles for leadership

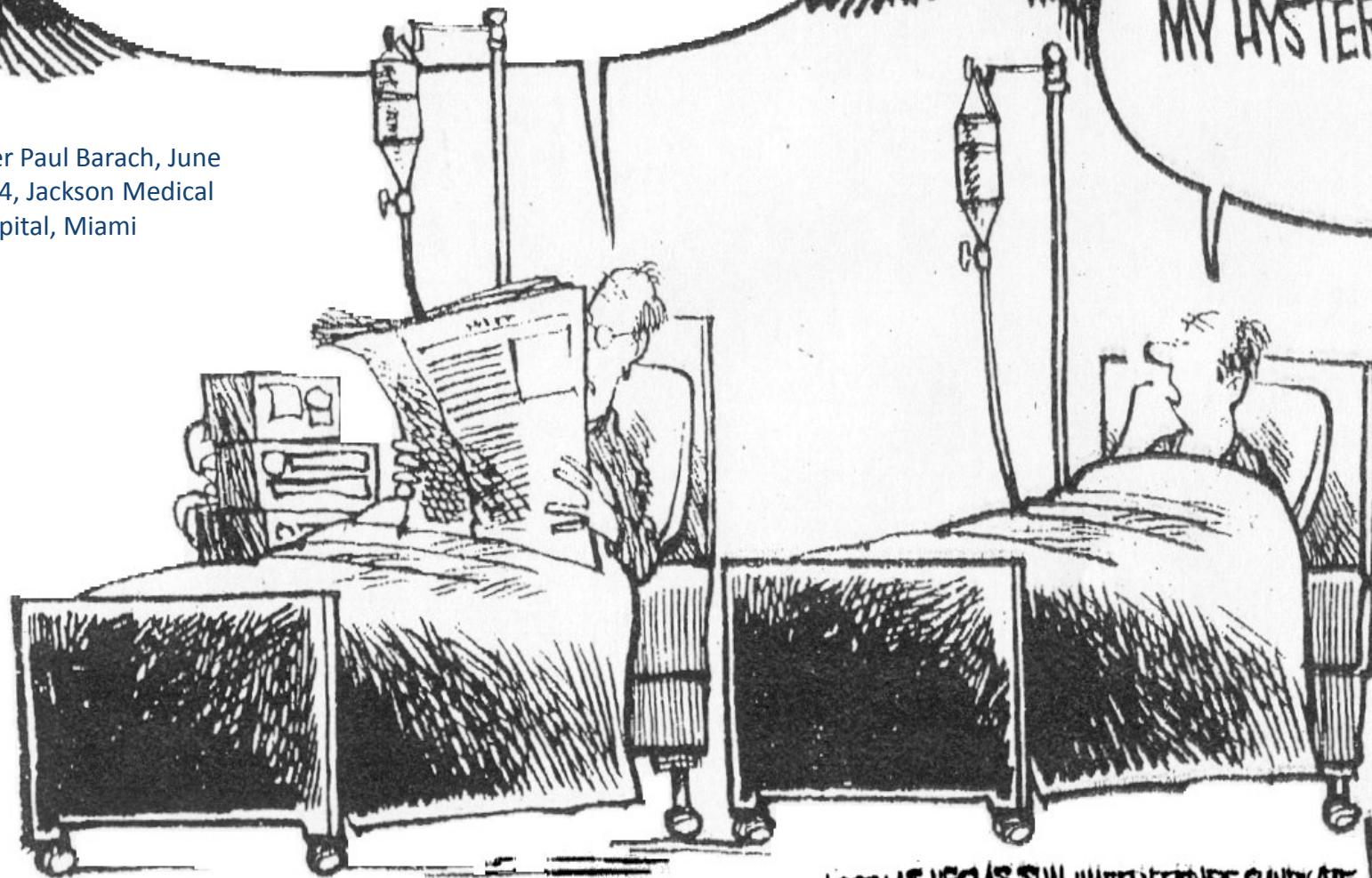
- Doing well what has been decided in the safety plan
 - Make recs applied to normal and acceptable conditions
 - Engage patients
 - Prevent conditions of non compliance
- Knowing well what has been sacrificed and not covered by the safety plan
 - Explain fragilities to professionals
 - Plan effective strategies for degraded conditions
 - Enforce recovery strategies

Principle 1	Create the safety vision (which must be coherent with the management's values and principles). Be explicit on a minimum bar (no go conditions)
Principle 2	Give safety the place it deserves in the organisation and in the management, and guide it in everyday practice
Principle 3	Ensure the safety vision is shared: influence, persuade and promote information feedback
Principle 4	Be credible: exemplary behaviour and coherence
Principle 5	Promote team spirit and cooperation across the organisation
Principle 6	Maintain a presence on the ground to observe, listen and communicate effectively, consider adaptation to degraded conditions
Principle 7	Recognise good practices and apply sanctions justly

IT SAYS HERE THAT THE RATE OF
MEDICAL ERRORS IS STUNNINGLY
HIGH.

THAT EXPLAINS
MY HYSTERECTOMY.

After Paul Barach, June
2004, Jackson Medical
Hospital, Miami



LAS VEGAS SUN UNITED FEATURE SYNDICATE