

*Sign up to Safety
Drivers and Measurement*

Sign up to
.....
SAFETY
LISTEN LEARN ACT



*Expert Partner
Nicola Davey*



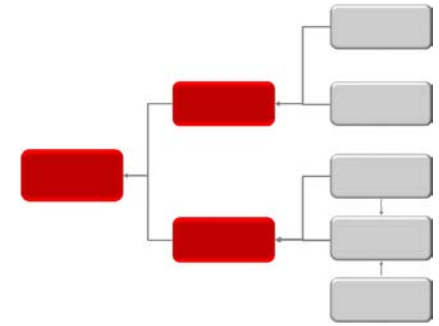
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Topics for today



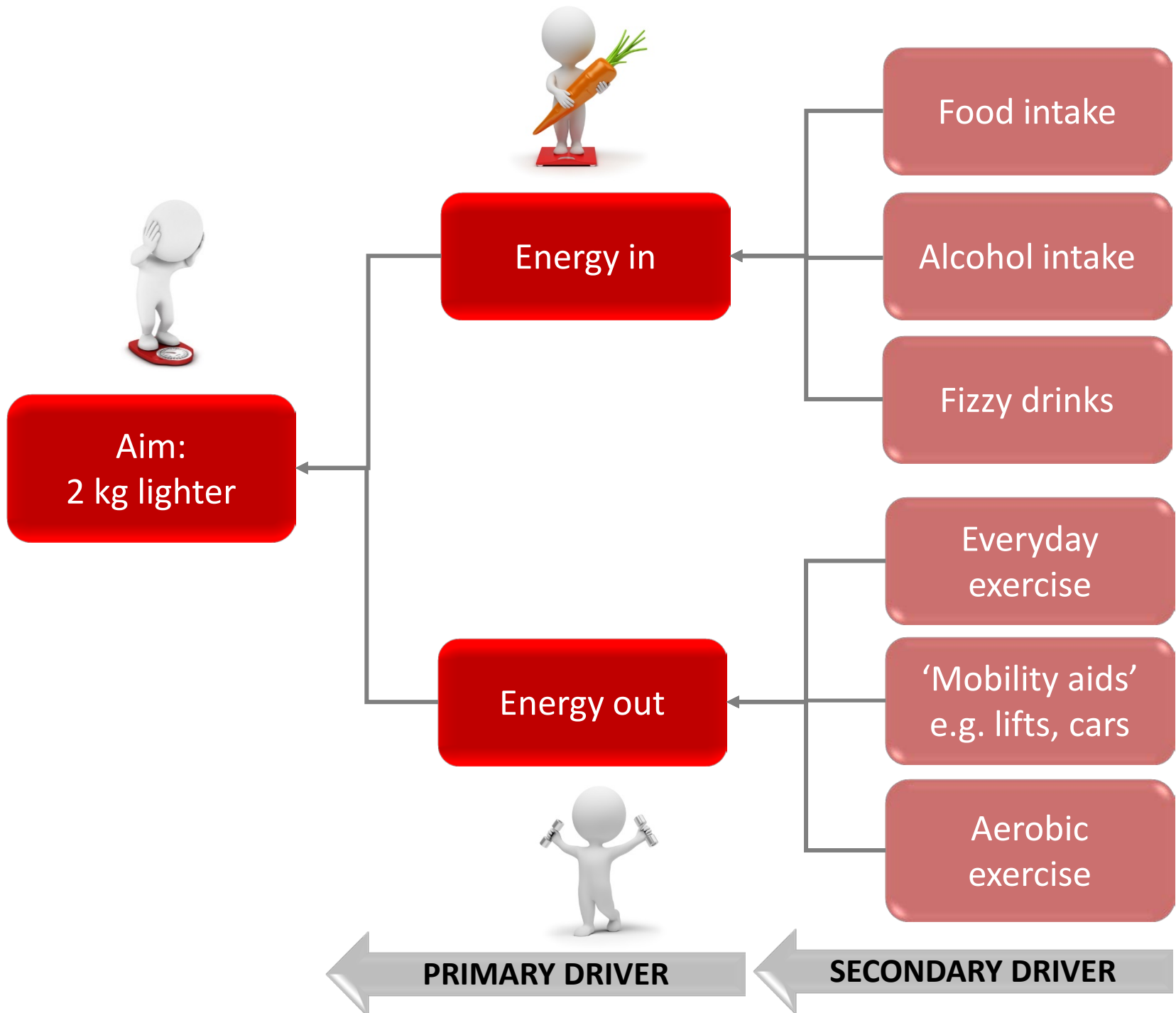
- *Driver diagrams*

- Linking improvement aims to strategic objectives
- Generating simple improvement measures

- *Measures*

- Process, outcome measures from clinical, managerial and patient perspectives
- Balancing measures





Have I achieved my goal?



Aim:
2 kg lighter



Energy in

Reduce food intake

Reduce alcohol intake

Reduce high sugar drinks

Increase everyday exercise

Reduce reliance on aids

Increase aerobic exercise

Energy out



MEASUREMENT

Have I achieved my goal?



Aim:
2 kg lighter

Weight

Energy in

Calories

Calories

Energy out



Reduce food intake

Calories

Reduce alcohol intake

Units

Reduce high sugar drinks

No of drinks

Increase everyday exercise

Steps/Miles

Reduce reliance on aids

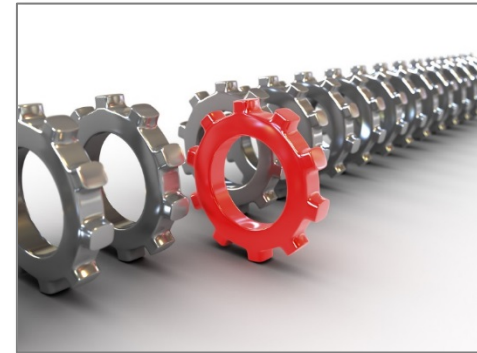
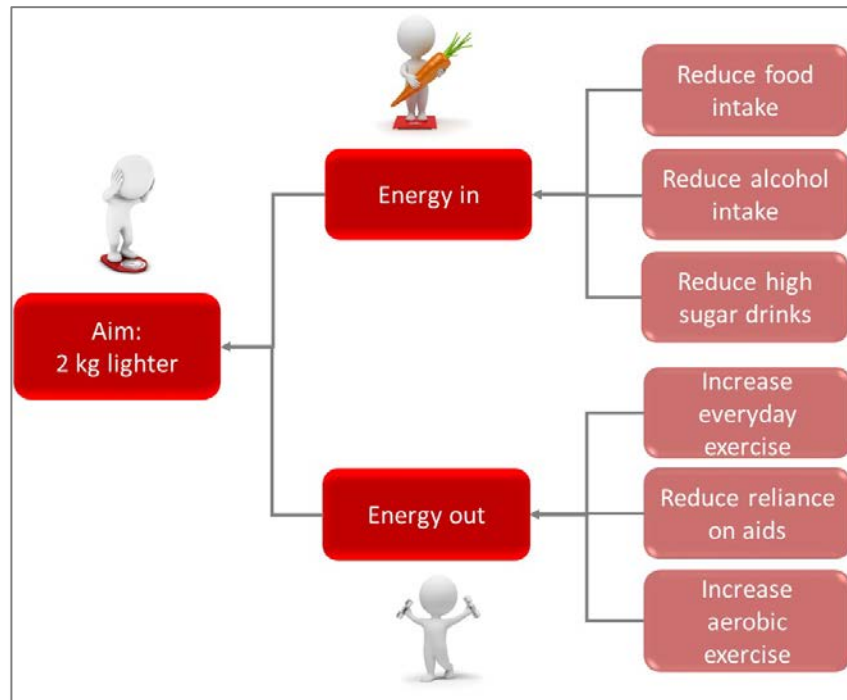
Times used

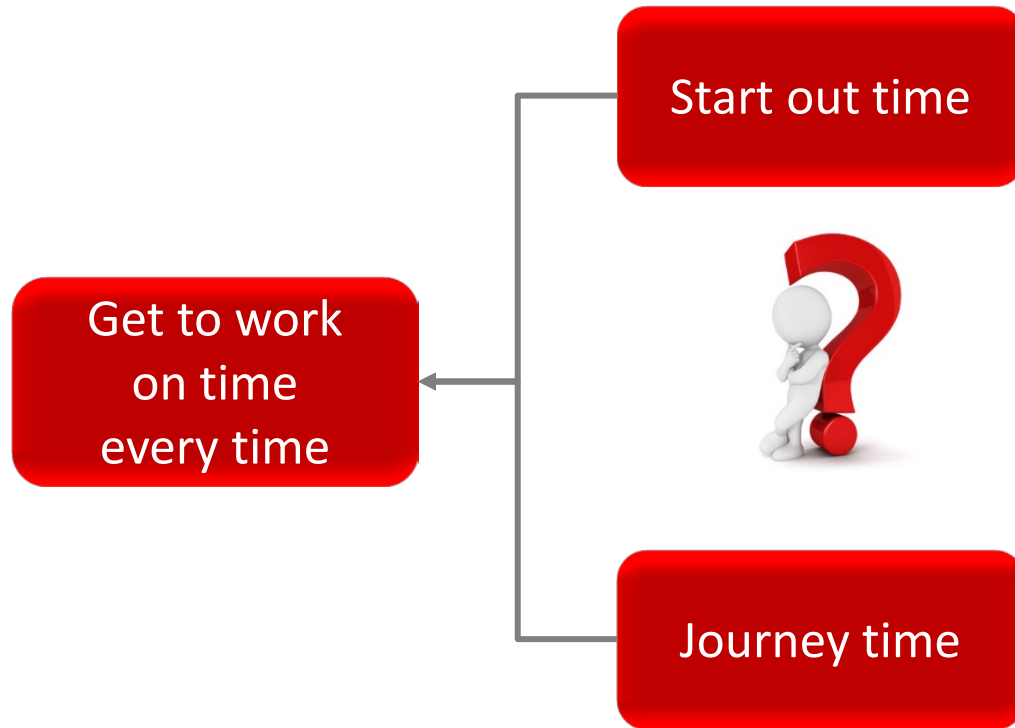
Increase aerobic exercise

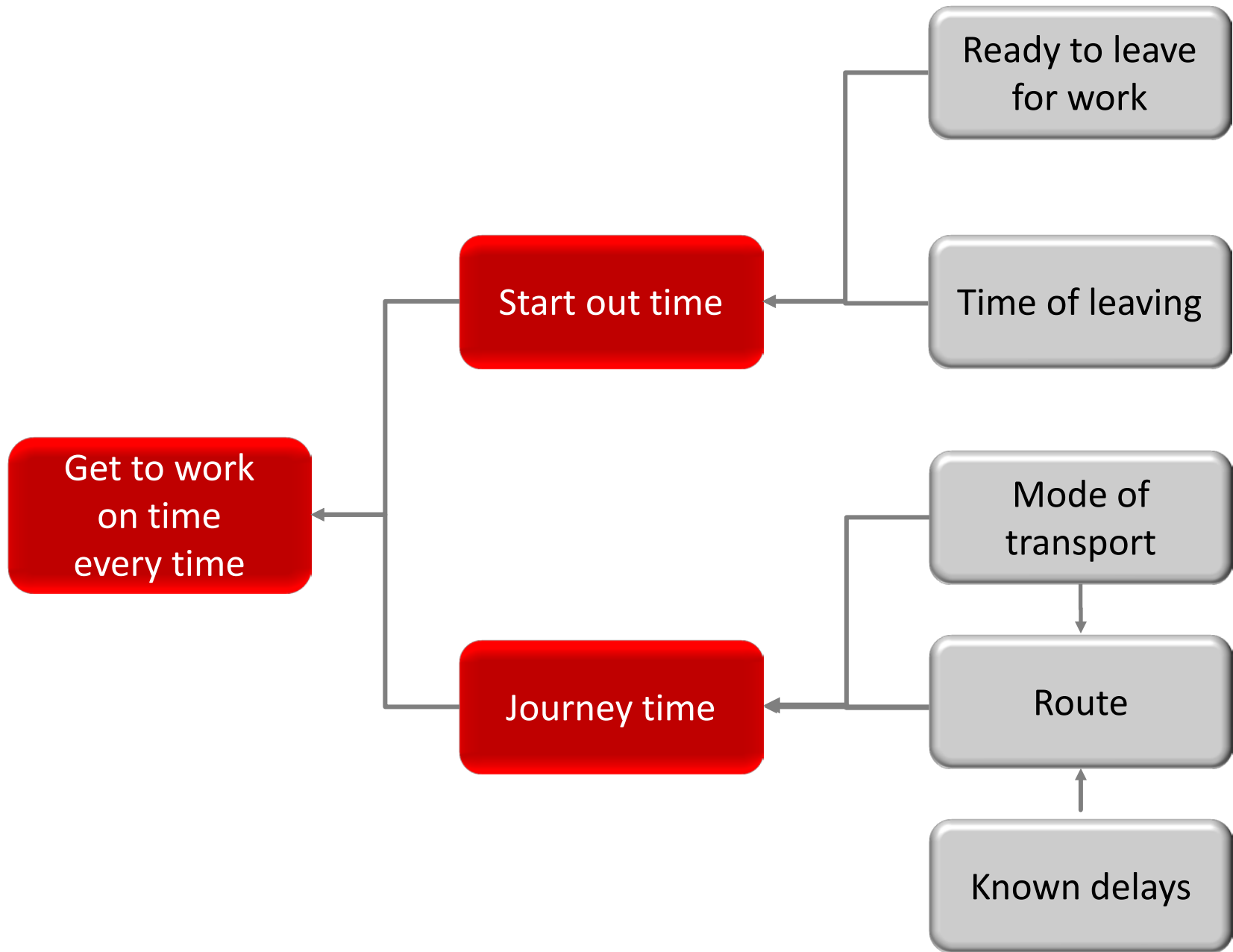
Exercise sessions

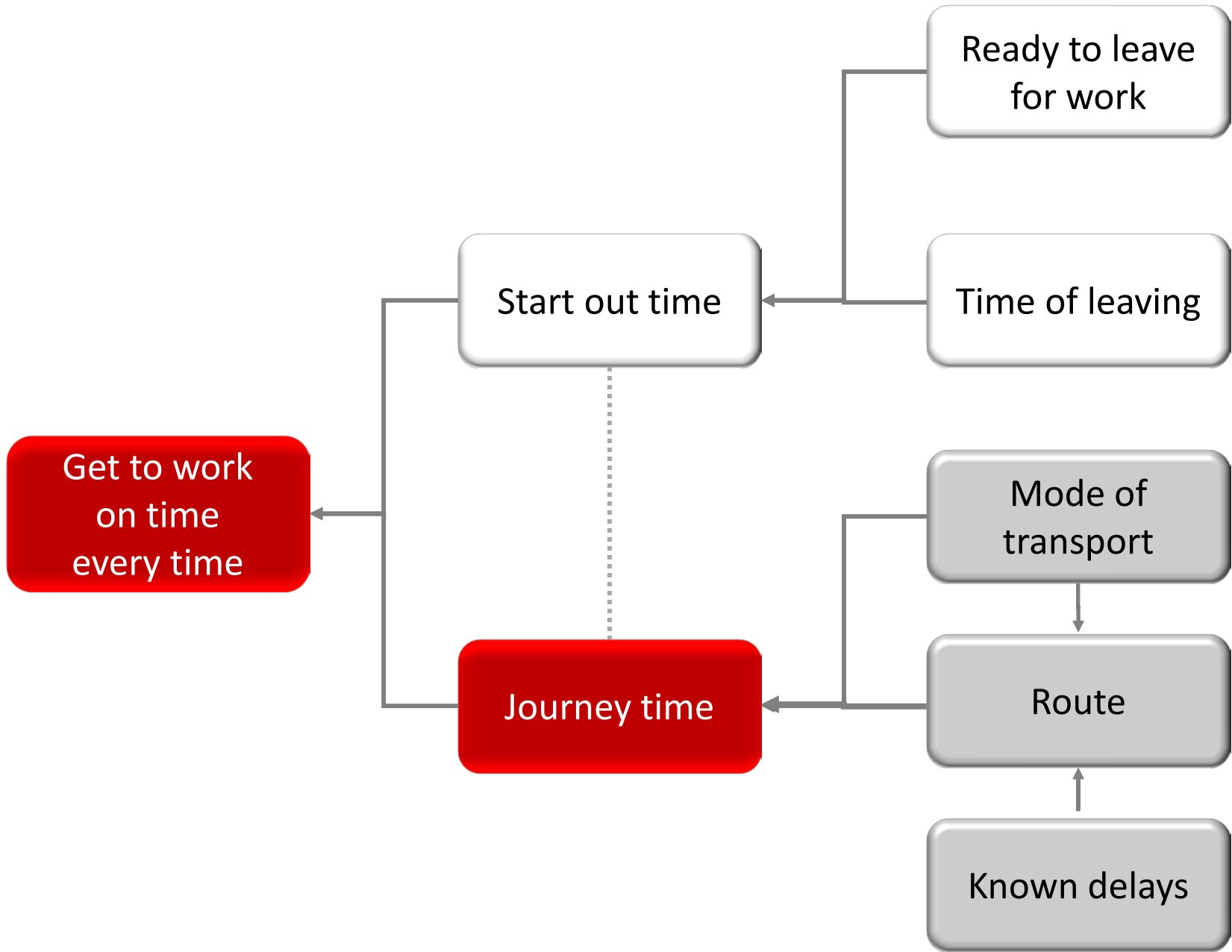
Where to start?

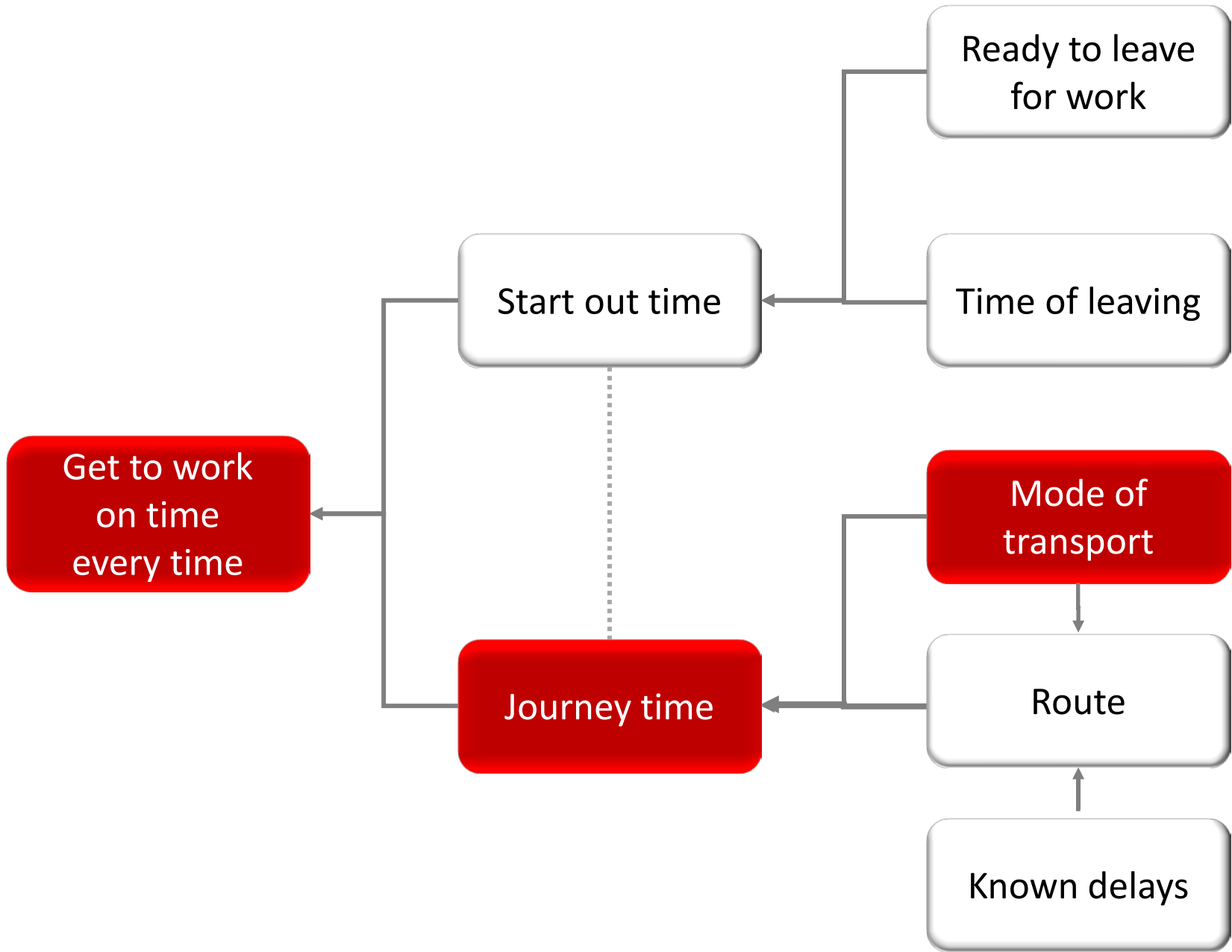
Priorities and dependencies











Any questions



How do change ideas connect to strategic aims?

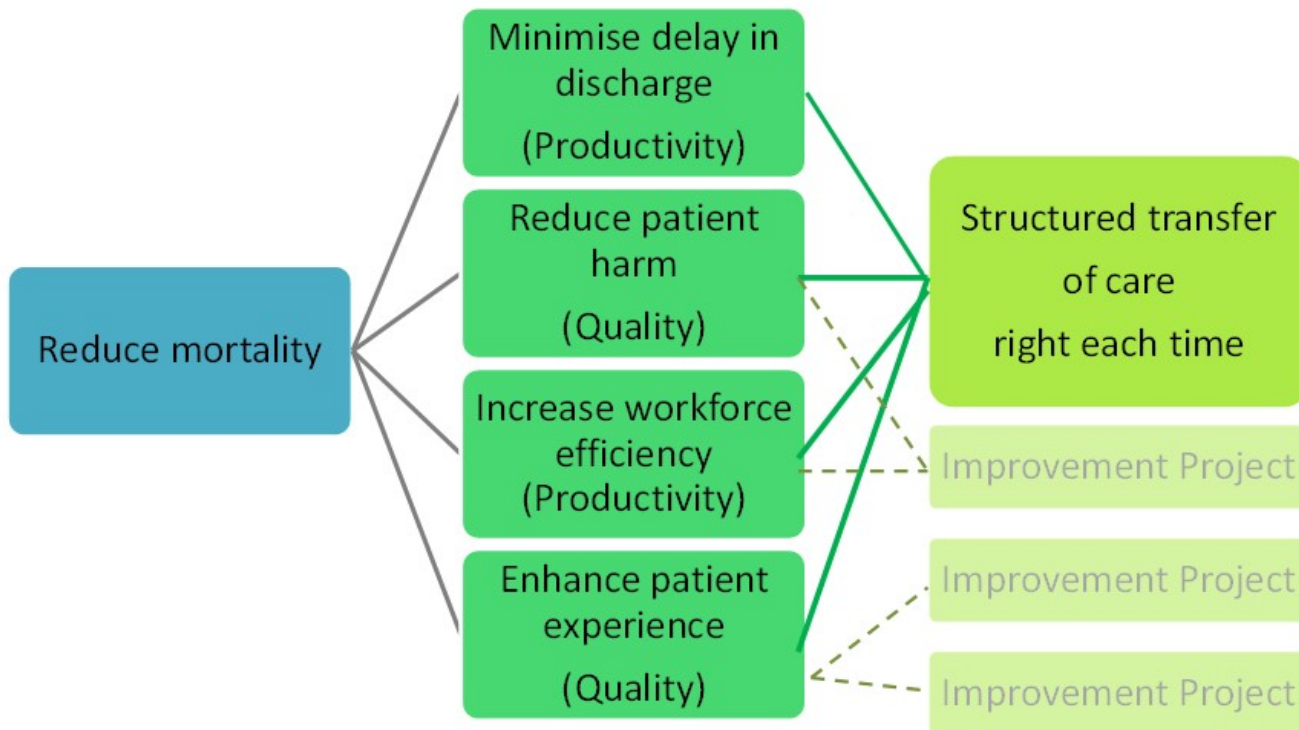


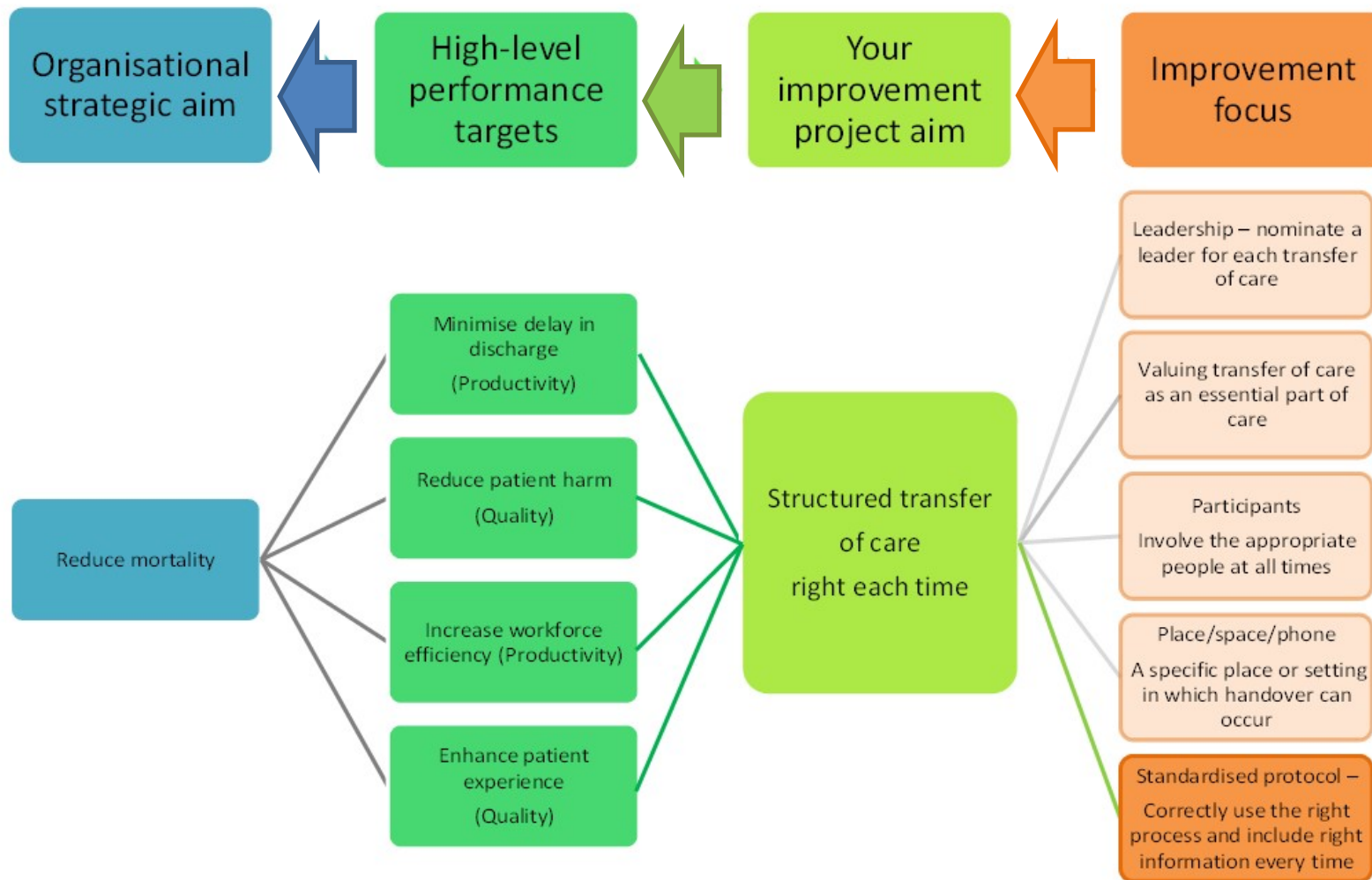
BIG DOT little dot DRIVER™

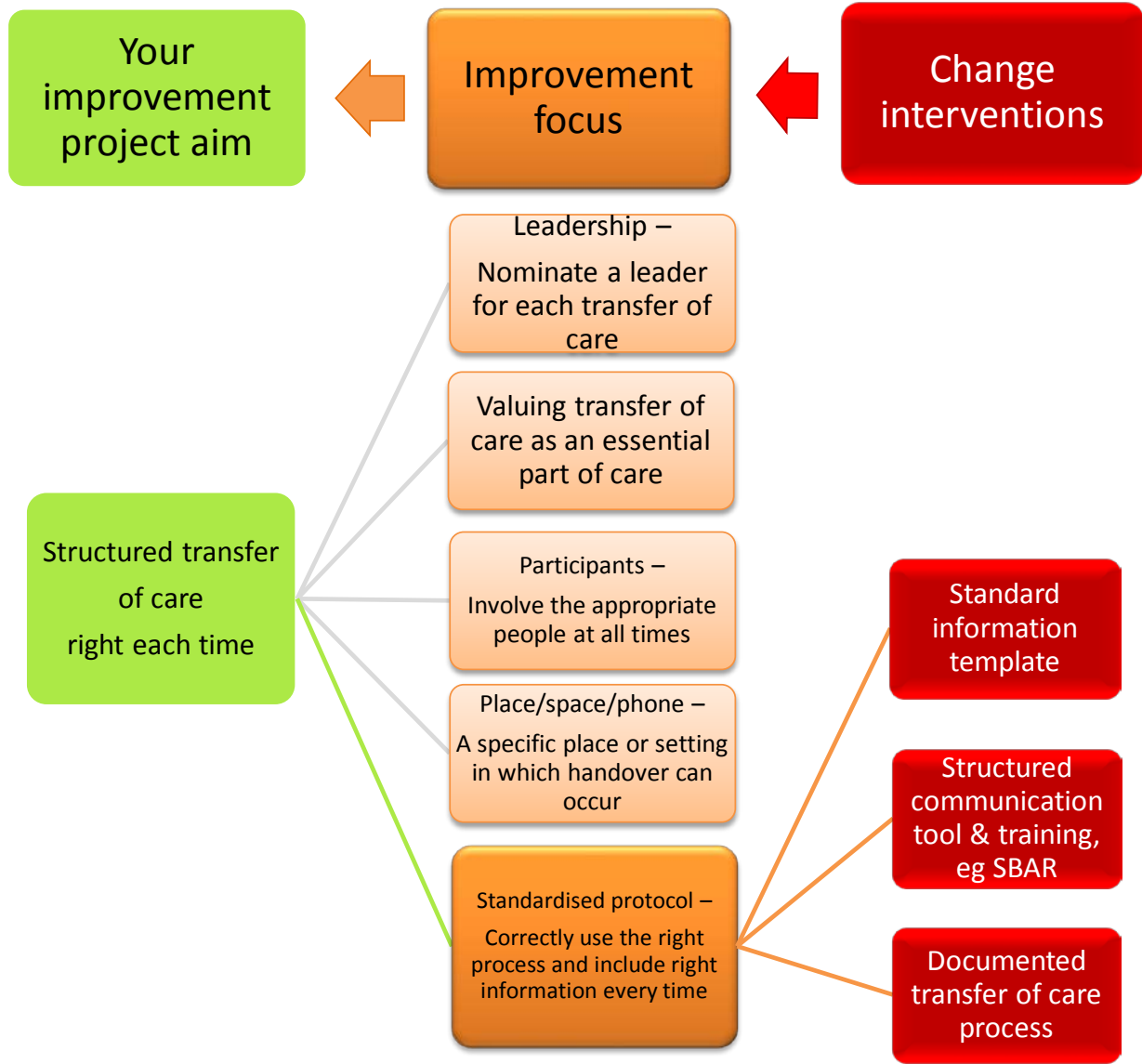
Aligning organisational strategic aims to change ideas at the front line

&..

Connecting you to your sponsor!







Your improvement project aim



Improvement focus



Change interventions

Structured transfer of care right each time



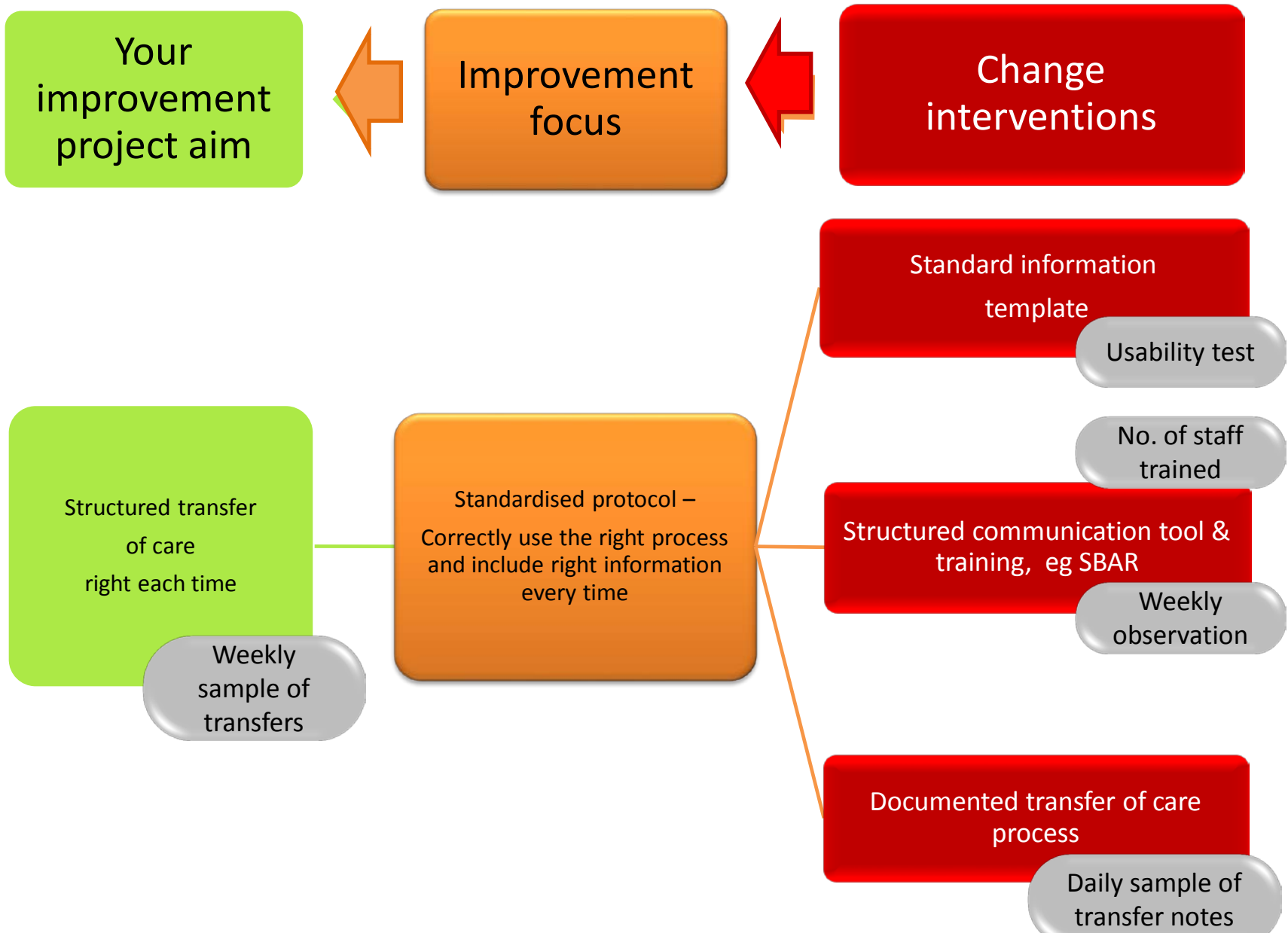
Standardised protocol –
Correctly use the right process
and include right information
every time

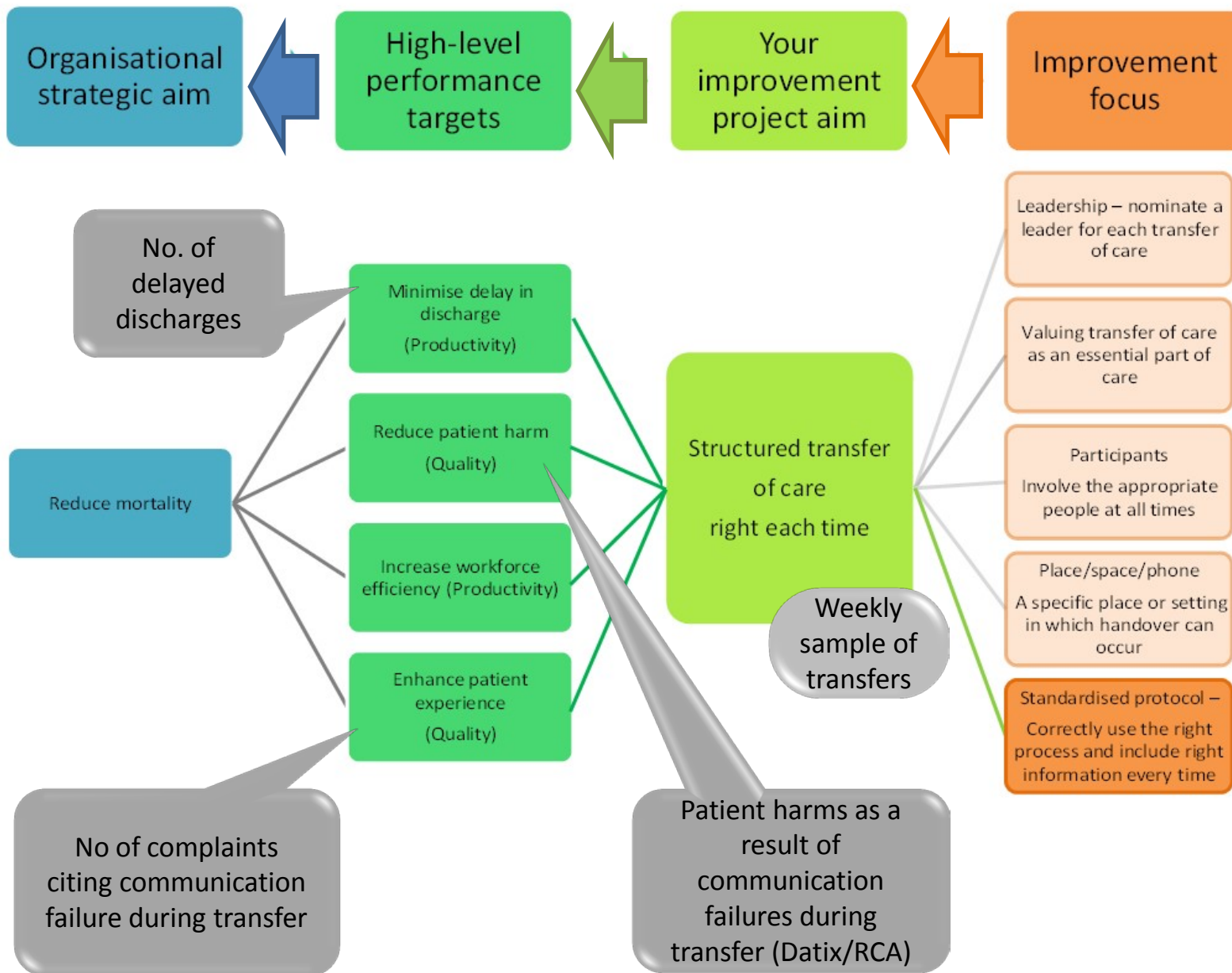


Standard information template

Structured communication tool & training, eg SBAR

Documented transfer of care process





Any questions



Model for Improvement

AIM

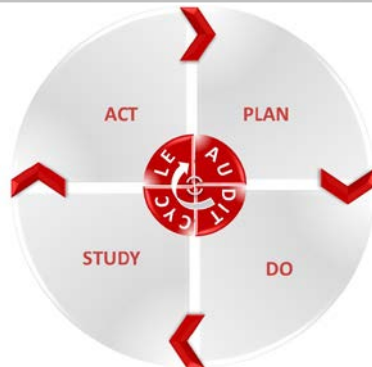
← **What are we trying to achieve?**

MEASURES

← **How will we know the change is an improvement?**

**INTERVENTIONS
(Changes)**

← **What change can we make that will result in the improvement we seek?**



← **How do I test my idea?**

Developing a SMART improvement aim

Specific

Measurable

Achievable

Results focused

Time-bound



Driver Diagram: Patient Safety Implementation Plan 2014/17



Aim

Our aim is to reduce avoidable harm in our organisation by 50% by 2017 through delivery of improvement in 6 Trust high priority areas

As part of our commitment to the Sign Up for Safety campaign:

We pledge to:
 Put patient safety first
 Be transparent
 Collaborate
 Continually learn
 Support our staff to do so

Primary Drivers

- Never Events**
Reduce incidence of Never Events by 50% by 31st December 2017.
- Sepsis**
Reduce mortality from sepsis by 50% by 2017
- Acute Kidney Injury**
Reduce hospital and community acquired AKI by 20% by 2017
- Medication Errors;**
Reduce avoidable harm from medication errors by 50% by 2017
- Right information**
Reduce avoidable harm from poor information by 50% by 2017
- Clinical Claims**
Reduce avoidable clinical claims by 20% by 2017
- Patient & Staff involvement**
Recruit 50 volunteers and 50 Safety Ambassadors by 2017

Secondary Drivers

- Safety culture: Implementation Theatre Patient Safety strategy
 Promote reporting: Increase trainee incident reporting pilot
 Promote learning: Team debrief implementation
 Best Practice: Technical and non-technical skills team training
 Patient and staff involvement: Patient safety briefings implementation – patient leaders
 Leadership: Bespoke Leadership programme
- Sepsis ~~workstream~~ implementation: Sepsis 6 on admission and in-patient
 Prevention UTI ~~workstream~~
 Prevention HAP and aspiration pneumonia ~~workstream~~
 Patient Safety Federation ~~workstream~~ – sepsis scorecards
 Patient Safety Academy ~~workstream~~ – surgical site infection
 Emergency ~~workstream~~ pathway full implementation
- Identification: AKI alerts primary and secondary care
 Prevention: Polypharmacy in high risk patients in primary care
 Prevention: Care planning in primary care
 Management: AKI care bundles primary and secondary care
 Outcomes: DFI AKI mini Goal International collaboration; sustainability of healthcare resource with Centre for Sustainable Healthcare; Patient Safety Collaborative AKI ~~workstream~~
 Hydration Matters: ~~workstream~~
- Safety thermometer medication tool implementation
 Adopt Patient Safety Federation Safe Medicines ~~workstream~~ learning
 Adopt antibiotic safe prescribing P&F ~~workstream~~ learning
- Medical records improvement programme
 Safe handover on discharge
 Safe handover at hand-offs
 Care bundles and care pathways programme
- Improvement implementation plans in 4 high cost claim areas
 - Obstetrics
 - Neurology
 - Haematology
 - Casualty/emergency department
- ~~Trustwide~~ QI team support & training to facilitate all staff & patients to develop capability & resilience to improve
 Communication strategy
 Volunteer recruitment
 Safety (QI) Ambassadors
 Patient Leader Programme

Example

Driver Diagram: Patient Safety Implementation Plan 2014/17



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Reduce avoidable clinical claims by 20% by 2017

Secondary Drivers

- Sepsis workstream implementation: Sepsis 6 on admission and in-patient
- Prevention UTI workstream
- Prevention HAP and aspiration pneumonia workstream
- Patient Safety Federation workstream – sepsis scorecards
- Patient Safety Academy workstream – surgical site infection
- Emergency laparotomy pathway full implementation
- Antibiotic prescribing stewardship to prevent CDT

Our aim is to reduce avoidable harm in our organisation by 50% by 2017 through delivery of improvement in 6 Trust high priority areas

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Put patient safety first

Be transparent

Collaborate

Continually learn

Support our staff to do so

Sepsis
Reduce mortality from sepsis by 50% by 2017

Sepsis 6 **implemented** on admission and in-patient

Routine use of Sepsis Score cards

UTI Prevention Improvement Plan **implemented**

HAP and aspiration pneumonia improvement plan **implemented**

Surgical site infection **reduced**

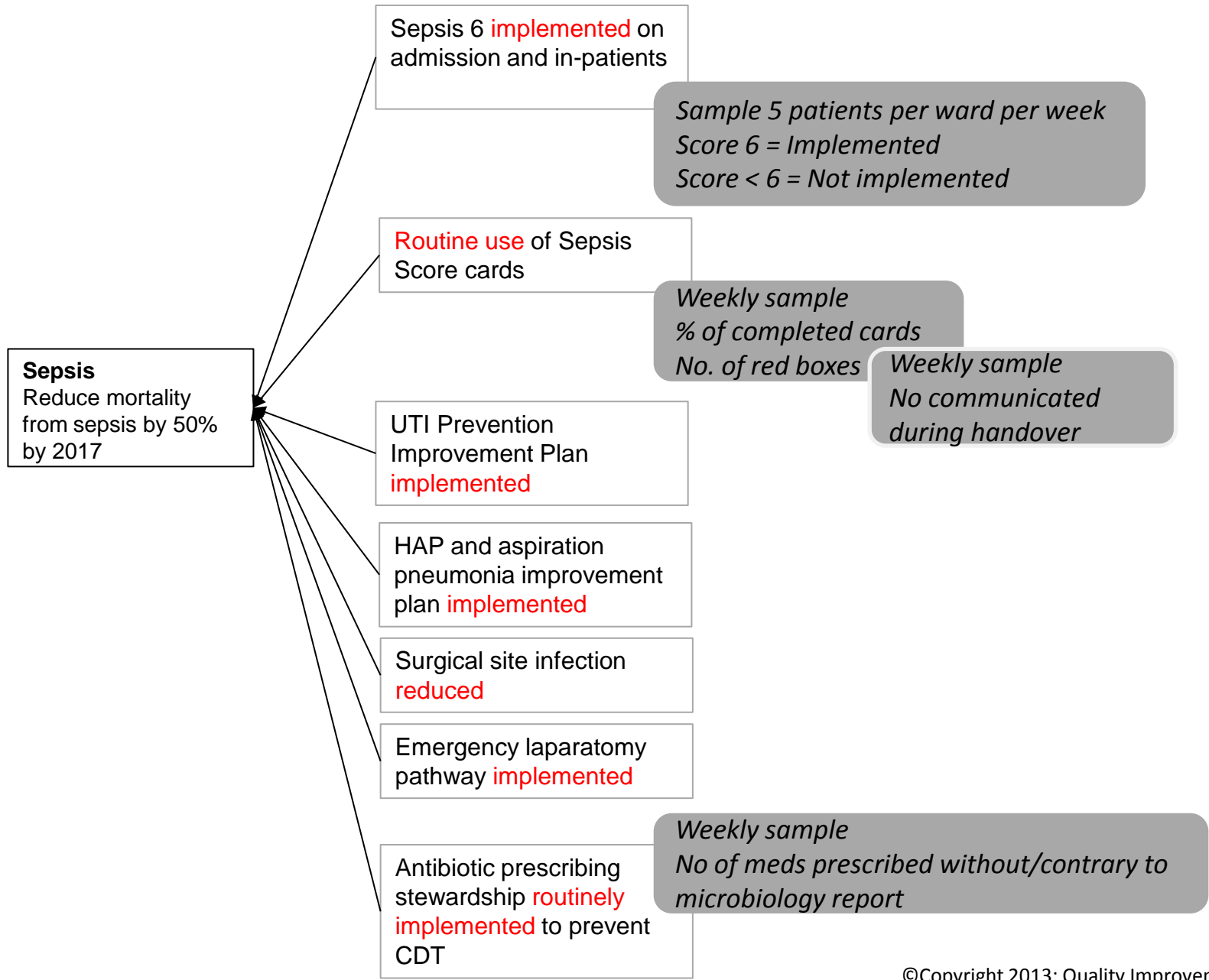
Emergency laparotomy pathway **implemented**

Antibiotic prescribing stewardship **routinely implemented** to prevent CDT

Measurement for improvement checklist

- **Easy**
 - quick to do on regular basis
- **Reliable**
 - same if someone else did the measurement
- **Reproducible**
 - can measure same on many occasions
- **Meaningful**
 - Understand what I can learn from this measurement
- **Informing**
 - It will help me decide what to do next





System alignment...



..for measures too!

Clinical
Managerial
AND
Patient Focused!

Clinical Examples



Clinical Process measures

Surgical checklist completed



Clinical outcome measures

Successful operations

VTE checklist completed



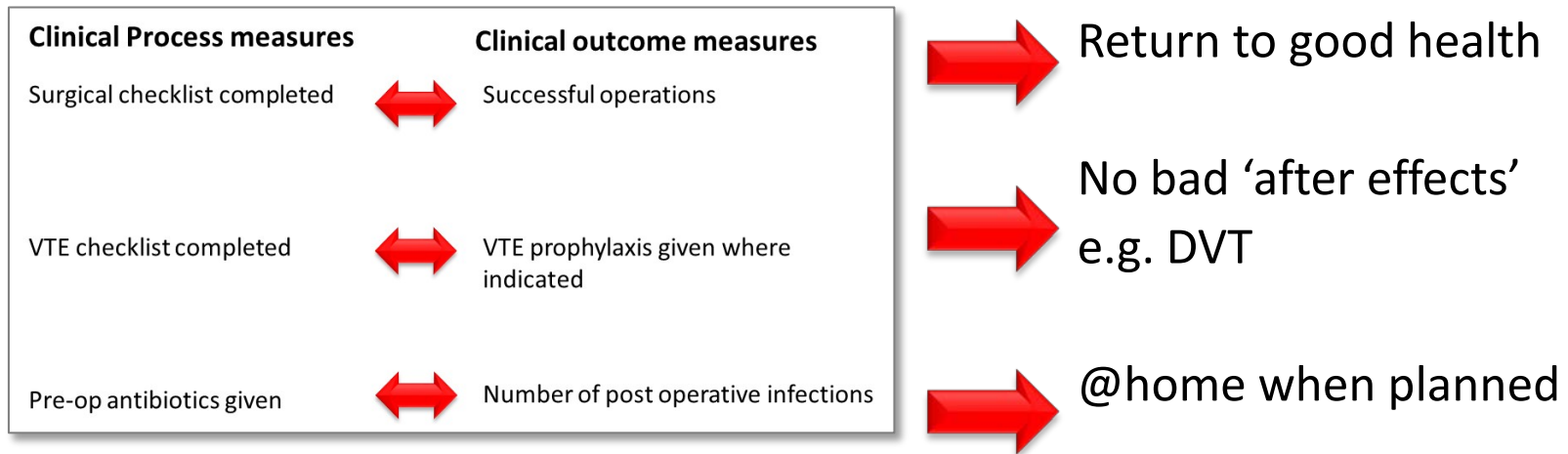
VTE prophylaxis given where indicated

Pre-op antibiotics given



Number of post operative infections

Patient outcomes



Managerial Examples



Managerial Process measures

Enough beds to meet demand



Number of VTE assessments being completed



Number of MRSA infections



Number of complaints satisfactorily resolved



Managerial outcome measures

Reduced length of stay

CQUIN payments received

National MRSA target met

Friends and family score

Patient outcomes



Managerial Process measures

Managerial outcome measures

Enough beds to meet demand



Reduced length of stay

Number of VTE assessments being completed



CQUIN payments received

Number of MRSA infections



National MRSA target met

Number of complaints satisfactorily resolved



Friends and family score



Return to good health



No bad 'after effects'
e.g. DVT or infections



Confidence in local service

A perfect synergy...
clinical & managerial AND patient
process & outcome measures



Clinical Process measures

VTE checklist completed



Clinical outcome measures

VTE prophylaxis given where indicated

Managerial Process measures

Number of VTE assessments being completed



Managerial outcome measures

CQUIN payments received

No bad
'after effects'
From surgery
e.g. deep vein
thrombosis

Balancing measures

Unanticipated and/or unwanted impact of planned improvement



Process/outcome measures

Balancing measures

Reduced Length of Stay



Increase in readmissions

Reduction in medicines toxicity/overdose



Increase in instances of sub therapeutic dose

Adherence to sepsis bundle



Increased admissions for infections suitable for non-acute management

Increased access to diagnostics



Number of non essential interventions

Any questions



Resources – driver diagrams



Driver diagrams, Bob Lloyd , IHI Open School

<http://www.ihl.org/offerings/IHIOpenSchool/resources/Pages/BobLloydWhiteboard.aspx#4>

OR

Youtube

<https://www.youtube.com/watch?v=A2491BJcyXA>



Driver Diagrams

Handbook of Quality and Service Improvement Tools, NHS Institute for innovation and Improvement

http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/driver_diagrams.html

Resources - Measurement



Run Charts, Bob Lloyd, IHI Open School

<http://www.ihl.org/education/IHIOpenSchool/resources/Pages/BobLloydWhiteboard.aspx#5>

OR

Youtube

<http://youtu.be/YQd1QoMHYwU>

Seven steps to measurement, Mike Davidge on Measurement for Improvement

<http://www.youtube.com/watch?v=Za1o77jAnbw>

Measurement for improvement, QI Bitesize03 - Emma Donaldson and Tickle

<http://www.youtube.com/watch?v=Nnh86wulHFs>



PDSA, Handbook of Quality and Service Improvement Tools, NHS Institute for Innovation and Improvement

www.institute.nhs.uk/spc

Measuring for Improvement, Improvement Leaders Guide, NHS Institute for Innovation and Improvement (NHS staff LOGIN, Others via Quality Improvement Clinic)

http://www.institute.nhs.uk/index.php?option=com_joomcart&Itemid=194&main_page=document_product_info&cPath=65&products_id=301



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THE MEASUREMENT AND MONITORING OF SAFETY, *The Health Foundation, Spotlight 2013*



Past harm: this encompasses both psychological and physical measures

Reliability: this encompasses measures of behaviour and systems

Sensitivity to operations: the information and capacity to monitor safety on an hour or daily basis

Anticipation and preparedness: the ability to anticipate, and be prepared for, problems

Integration and learning: the ability to respond to, and improve from, safety information

