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Managing Quality in Healthcare:

The challenges for hospitals in Europe

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CPSSQ
Centre for Patient Safety & Service Quality

NHS
National Institute for
Health Research

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CPSSQ
Centre for Patient Safety & Service Quality

Based in the Dept of Surgery & Cancer at Imperial College Healthcare NHS Trust

20+ researchers - doctors, nurses, psychologists, managers

Translational research themes:

- Emergency Medicine
- Care of Older People
- Infection prevention
- Medication safety
- Surgery
- Cancer
- Primary Care

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Cross-cutting research themes:

- Patients and families
- Safety and quality information
- Design and technology
- Teamwork and skills
- Organisation and health systems

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Managing Quality in Healthcare:

The challenges for hospitals in Europe

- Defining QUALITY in healthcare

- Patient Safety

  – Examples of what can go wrong

  – Why things go wrong

  – What is needed for patients to be safe

- QUASER research in 5 European countries

  – Emerging findings about managing quality

- The challenges for hospital leaders

How to define QUALITY in healthcare?

- Safe

- Effective

- Patient Centred

- Timely

- Efficient

- Equitable

Institute for Healthcare Improvement USA definition

Patient Safety

Wrong patient had knee surgery

- 1 set of records for 2 patients with similar names

- 4 different hospital numbers in the records, more than one GP and several different addresses

- Patient identifier labels replicated mistakes

- Translator not always available when each person came to an appointment

- Consent form and assessment forms not properly completed

- Both patients had knee pain on the same day although one was being treated for a dermatological condition, not orthopaedic

Spinal surgery on the wrong side

- Washable ink pen used to mark site – washed off by skin prep

- Consultant late for theatre – having attended management meeting

- Different theatre being used to normal one

- Image intensifier in demand so taken away after needle inserted to mark L3/4 disc

- WHO surgical safety checklist completed whilst surgeon was scrubbing – couldn't hear what was being said – trainee surgeon went to scrub as surgeon returned

- Trainee who had consented the patient was scrubbing when surgeon wrongly marked the side and started the operation.

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Common factors

- Environmental factors – tables, theatres, screens

- Time pressures

- Lack of leadership

- Staff changes, interruptions, distractions

- Patients notes, computer records, coding, abbreviations

- Taking a timeout

- Using the checklist properly

- Marking the site

Active Failures

- **Knowledge based**
  - Experienced doctor unable to operate new equipment
- **Rule based**
  - Clerical person performing technical tasks
- **Skill based**
  - Pressed wrong key on computer
- **Violations**
  - Short cuts, work arounds

Latent Conditions:

Types of organisational problems:

1. Tight finances = vacancy freeze = temporary staff

2. Hospitals merge = patients have multiple hospital records

3. Some departments computerise = parallel computer and paper based systems

4. Different waiting times in departments = can't ensure all tests are completed before the next appointment

5. ....

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For patients to be safe – all these need to be right

- Leadership

- Culture

- Communication

- Organisation

- Equipment

- Information and records

- Jobs, tasks, protocols

- Environment

- Work design

Background to the QUASER Research:

Right of patients to seek healthcare in another Member State

Directive on safe, high quality and efficient cross-border healthcare (2008) – one of main goals:

> "Patients should be confident that the quality and safety standards of the treatment they will receive in another Member State are regularly monitored and based on good medical practices"

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Background

❖ Good understanding of types of quality improvement strategies such as:

  ✓ Lean, Six Sigma, Risk management

  ✓ Specific tools and strategies

      PDSA cycles

      Surgery checklist

      Standardised care pathways

❖ Less understanding of the human & social components

  ✓ The factors that increase effectiveness of implementation such as leadership & culture

Background: EU 7ᵗʰ Framework Programme Call on Quality and Safety

"Study the relationship of organisational quality management and culture, professionals' involvement, and patient empowerment with the quality of hospital care, including clinical effectiveness, patient safety and patient involvement.

Identify organisational and cultural characteristics of hospitals and professional- and patient-related tools that are associated with better quality of care.

This research should serve to guide hospitals to develop their own effective safety and quality improvement programmes and provide the basis for assessing hospital quality of care by purchasers and national and local governments."

Partners/Countries

5 Countries

- England

- Netherlands

- Norway

- Portugal

- Sweden

7 Partners

1.   University College London, UK

2.   Erasmus University, Netherlands

3.   Jönköping County Council, Sweden

4.   Centre for Patient Safety and Service Quality, Imperial College London, UK

5.   King's College London, UK

6.   ISCTE, Portugal

7.   University of Stavanger, Norway

Translational stakeholder group

- Spain
- Romania
- Turkey
- Denmark
- Poland
- England
- Portugal
- Belgium

- Estonia
- Norway
- Netherlands
- Sweden
- Denmark
- Finland
- Lithuania
- Italy
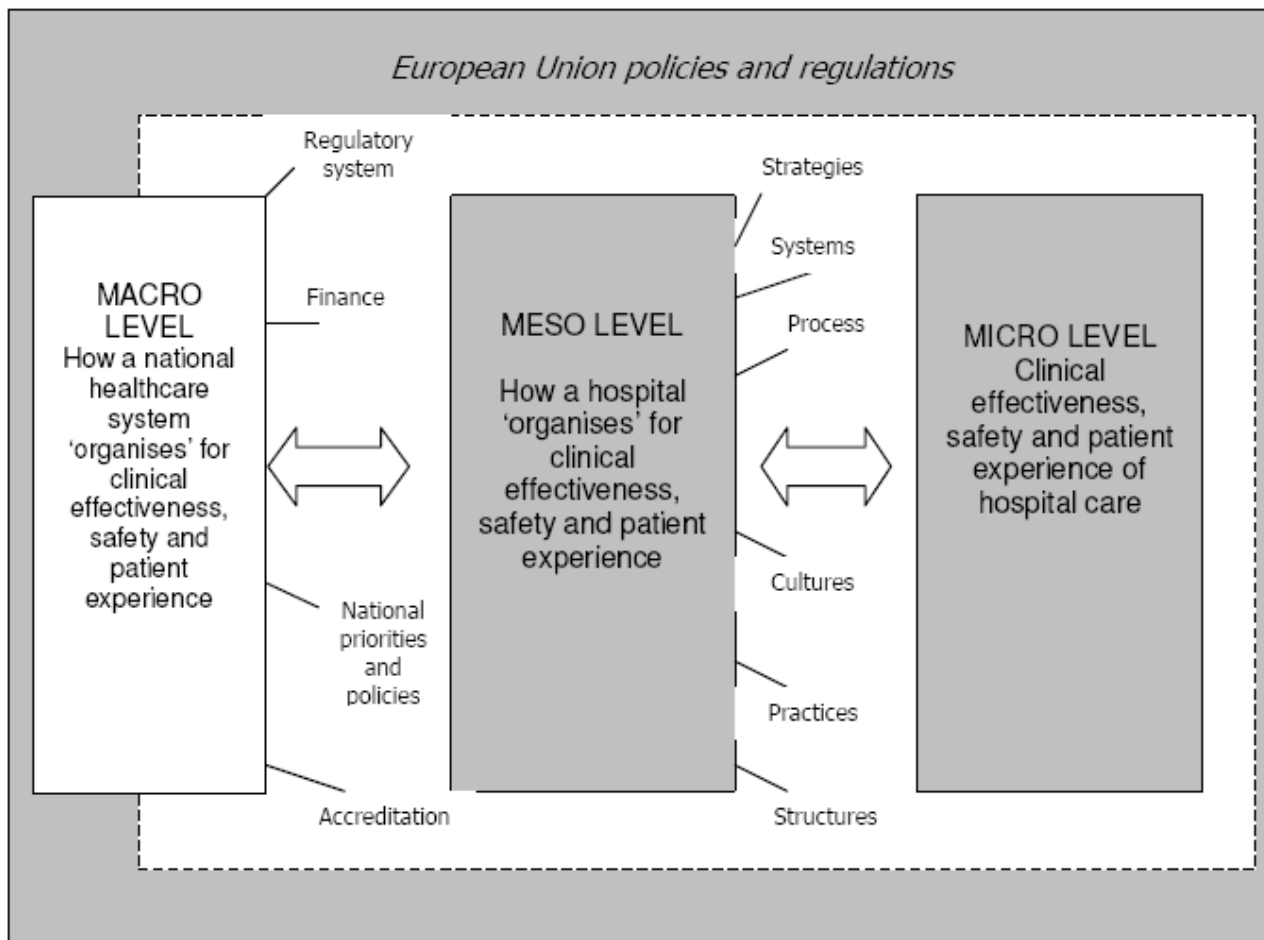
Key questions

- How is Quality Improvement work structured, planned and co-ordinated? (structural)
- How is Quality led in the hospital? (leadership)
- How are the politics of change negotiated? (political)
- How are shared understandings & commitment to quality built? (cultural)
- How do staff learn about quality and quality improvement? (educational)
- How are individual and collective enthusiasm for quality and quality improvement engendered and supported? (emotional)
- How is the physical, informational and technological infrastructure used to support quality and quality improvement? (physical & technological)

What the respective roles of the macro-, meso- and micro-system levels are in terms of (a) the successful implementation and spread of quality improvement, and (b) sustained quality? How do the levels inter-relate?

The research

- Analysis of the national context in each country

- 10 general hospitals studied (2 in each country)
- 10-15 interviews with Senior Leaders x2
- 2 clinical micro systems studied in each country
- Healthcare Acquired Infection project studied

- 387 semi-structured interviews
- 780 hours observation
- Over a one year period

- Common interview questions across countries
- Common framework for analysing the findings

Initial findings (1)

- Quality improvement work is largely at the margins of hospital priorities and routines

- Hospital approaches to Quality Improvement is dominated by a 'project by project' mentality, rather than large-scale, system-wide;

- The formal, rational 'science' of quality improvement (with its focus on systems, tools and data) predominates over the informal, political 'art' (with its focus on changing attitudes, behaviours and cultures)

Initial findings (2)

- Governance, compliance and accountability are key drivers rather than learning and cultural change

- There is limited patient and public involvement in QI

- QI is largely enacted through professional groups;

- There is a wide variation in the nature of managerial and clinical relations in the five countries

- There are pockets of high quality services - multi-level and hospital-wide leadership systems for QI are rare but vitally important

Managing Quality in Healthcare:
The challenges for hospital leaders in the EU

1. **Structural** - structuring, planning and co-ordinating quality efforts
2. **Political** - addressing the politics and negotiating the buy-in, conflict and relationships of change surrounding any quality improvement effort
3. **Cultural** - giving 'quality' a shared, collective meaning, value and significance within the organization
4. **Educational** - creating and nurturing a learning process that supports continuous improvement
5. **Emotional** - inspiring, energizing, and mobilizing people for the quality improvement effort
6. **Physical & technological** - designing physical systems and technological infrastructures that support improvement and quality of care.
7. **Leadership** - providing clear, strategic direction – aligning goals
8. **External demands** - responding to broader social, political and contextual factors

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