Winnipeg Regional Health Authority | Office régional de la santé de Winnipeg
Caring for Health | À l'écoute de notre santé

Winnipeg Regional Health Authority | Office régional de la santé de Winnipeg

Presented by: WRHA Quality, Patient Safety, & Accreditation (QPSA)

Introduction to Quality and Patient Safety

QUALITY IMPROVEMENT & PATIENT SAFETY

QUALITY IMPROVEMENT & PATIENT SAFETY

Ethics Honesty Leadership Transparency Kindness Respect Trustworthiness

Resilience Compassion Quality Fairness Perserverance Adaptive Motivated Flexible

Humility Community Dignity Integrity Excellent Patient Care Accountability Knowledge

WHAT WE DO

Client Relations	Receiving and responding to feedback from clients and families.
Patient Safety	Managing of patient safety events and critical incidents to enhance patient care.
Clinical Audits	Examines evidence based standards through collection and analysis of data to guide clinical practice.
Accreditation	An independent review of the quality and safety of services provided.
RL	Web based software for the submission and management of feedback and patient safety events.
Education & Workshops	Provides training to staff around patient safety and quality improvement.
Communications	We would love to hear from you! If you have any suggestions or feedback on this newsletter or quality and patient safety, please contact us at qipscommunication@wrha.mb.ca

For more information, please visit our QIPS site at http://home.wrha.mb.ca/quality/index.php

Professionalism Collaboration Compassion Innovation Empathy Safety

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About Us

http://home.wrha.mb.ca/quality/

Q 1 - I have been involved/have experience with:

- Quality Improvement
- Lean or Six Sigma
- Accreditation
- Project Management
- Patient Safety or Safety initiatives
- Client Relations or Patient Representative work

Objectives

The participants will increase their awareness about:

Quality

- *Quality in Healthcare*
- *Culture of Quality & Safety*
- *Quality Frameworks including Accreditation and PDSA*

Patient Safety

- *Types of patient safety events*
- *Learning from patient safety events*

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Quality Improvement

What is Quality in Healthcare?

Words come to mind when you think of a high-quality health care system?

Who Is Involved In Quality Improvement?

Why is Quality in Healthcare Important?

WRHA Mission: To coordinate and deliver QUALITY, caring services that promote HEALTH & well-being

VALUES

DIGNITY - as a reflection of the self-worth of every person

CARE - as an unwavering expectation of every person

RESPECT - as a measure of the importance of every person

EQUITY - promote conditions in which every person can achieve their

STRATEGIC DIRECTION

Quality & Safety are goal & expectation

Quality & Patient Safety Plan
One Focused Initiative includes:

- The WRHA has set a target of 100% for hand hygiene compliance.
- Sites/sectors are responsible for identifying opportunities to improve hand hygiene, equipment cleaning, and environmental cleaning to achieve regional targets and reduce all HAI's including MRSA.

Group Discussion:

What happens if we don't get it right?

What are some of the costs of poor quality in healthcare?

TIPs:

- Consider the complexity of the health care
- Look at what we do, ask how can we make it better, include others in the process – what is our purpose?
- Include the client/patient

Q 2 - What are some of the costs of poor quality in healthcare?

Which of the following could be an outcome of poor quality healthcare? Select all that apply.

A. Harm or Injury to patient, potential life lost or disability incurred
B. Increase healthcare resources to manage 'fix' the harm or injury to patient
C. Negative patient satisfaction scores
D. Impaired staff morale

Q 3 - Which resource(s) might be required to respond to an event where there was harm or injury to a patient?

A. More medical staff for the patient
B. Increased Time in the healthcare system
C. More Supplies e.g medication, diagnostics
D. Client relations / Patient Representative support
E. Legal representative involvement

A Culture of Quality & Safety:

Not an add-on

Q 4 - Have you heard of the Culture of Safety Survey?

- Yes
- No

QUALITY IMPROVEMENT & PATIENT SAFETY

Culture of Safety

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Strong committed **leadership**

Working Conditions
CULTURAL SAFETY · TRUST · just culture
patients as partners
Teamwork & Communication
Safety Climate · Transparency
Organizational fairness
Psychological Safety

Engaged committed **employees**

Share

Policies & practices that **enable** the pursuit of safety

Do

Frontline **enact** to improve patient safety

Learn

Elaborate learning practices to reinforce safe behaviors

Let's take a 3 minute break

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Quality

Frameworks: Tools

Quality Framework/Methodology Examples

- ***Health Standards Organization (HSO)and Accreditation***
- ***PDSA (Plan Do Study Act)***
- Model for Improvement
- Quality Improvement / and TQM
- Lean/ Six Sigma

Σ

Have several tools in the toolbox

QUALITY
IMPROVEMENT &
PATIENT
SAFETY

Accreditation Process in WRHA

Updated: January 27, 2020

Q 5 - Accreditation

How have you been involved in WRHA Accreditation process?

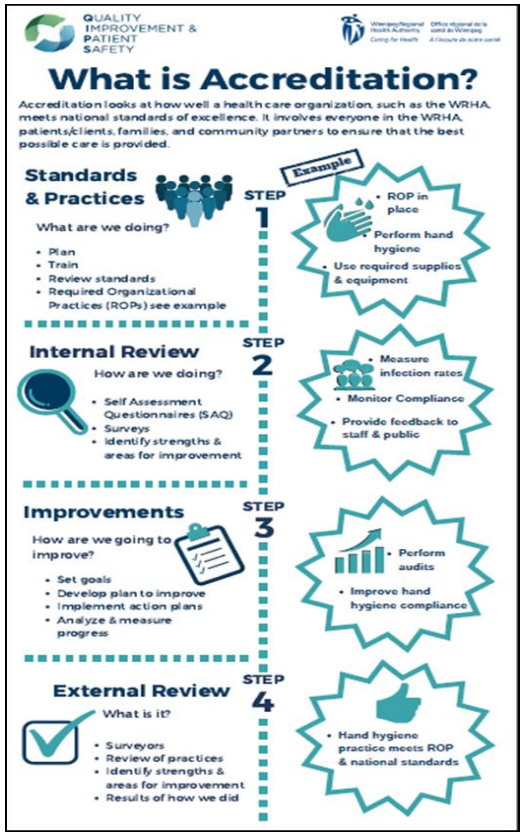
A. I have **never** been involved
B. I am aware of it as a **staff** member at a site/program
C. I have participated as a **member** of our site/program Accreditation/ Quality/Safety team
D. I am a site/program Accreditation/Quality/Safety **Lead**
E. I have participated as part of **Leadership** at our site/program
F. Other

Accreditation in Healthcare:

What Is Accreditation?

Why Do We Participate?

Accreditation as a Quality Framework



The Accreditation Process guides our Quality activities

What is Accreditation?

http://home.wrha.mb.ca/quality/regional-accreditation.php

Last WRHA Accreditation Survey Visit occurred:

Virtual – February 8-12, 2021

On site – September 26 – October 1, 2021

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What is Accreditation?

Accreditation looks at how well a health care organization, such as the WRHA, meets national standards of excellence. It involves everyone in the WRHA, patients/clients, families, and community partners to ensure that the best possible care is provided.

Standards & Practices

STEP 1

What are we doing?

- Plan
- Train
- Review standards
- Required Organizational Practices (ROPs) see example

Example

- ROP in place
- Perform hand hygiene
- Use required supplies & equipment

Internal Review

STEP 2

How are we doing?

- Self Assessment Questionnaires (SAQ)
- Surveys
- Identify strengths & areas for improvement

- Measure infection rates
- Monitor Compliance
- Provide feedback to staff & public

Improvements

STEP 3

How are we going to improve?

- Set goals
- Develop plan to improve
- Implement action plans
- Analyze & measure progress

- Perform audits
- Improve hand hygiene compliance

External Review

STEP 4

What is it?

- Surveyors
- Review of practices
- Identify strengths & areas for improvement
- Results of how we did

- Hand hygiene practice meets ROP & national standards

Standards & Practices

STEP 1

What are we doing?

Internal Review

STEP 2

How are we doing?

Improvements

STEP 3

How are we going to

External Review

STEP 4

What is it?

- Surveyors
- Review of practices
- Identify strengths & areas for improvement
- Results of how we did

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QUALITY IMPROVEMENT & PATIENT SAFETY

WRHA QUALITY IMPROVEMENT PLAN

REPORTING PERIOD: APRIL 1, 2019 TO MARCH 31, 2020

PROGRAM/ SITE NAME:	
DATE OF SUBMISSION:	
NAME OF LEAD(S):	

QUALITY ISSUE (WHY)	OBJECTIVES (OUTCOMES WE ARE LOOKING FOR)	PLAN OF ACTION (WHAT WILL BE DONE, AND WHO WILL DO IT)	BY WHEN (WHEN)	SUCCESS/ EFFECTIVENESS CRITERIA (HOW)	PROGRESS (WHERE WE ARE AT)	DATE COMPLE-TED
Why are the changes needed? Linked to what Quality Dimension(s)? Is it an ROP or AC Recommendation? Was it flagged on the SAQ?	Identify what team intends to accomplish by when Be SMART: Specific, Measurable, Achievable, Realistic, Time-Based	Describe in detail step(s) to be taken, and who will carry them out	List target completion date for each step	Describe what you will measure to determine success/effectiveness	Progress to date	
Champion for Initiative: **Quality Issue:** **Quality Dimension(s):** ☐ Population Focus ☐ Accessibility ☐ Safety ☐ Worklife ☐ Client-Centered Services ☐ Continuity ☐ Appropriateness ☐ Efficiency ☐ **ROP or High Priority Criteria** ☐ **Evidence Submission (AC)** ☐ **Recommendation (AC)** ☐ **SAQ Flag**						

Video 1 - Dr Mike Evans

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PDSA: Plan-Do-Study-Act

- PDSA is a good tool for your toolbox

TIPs to get you Started: Quality Improvement

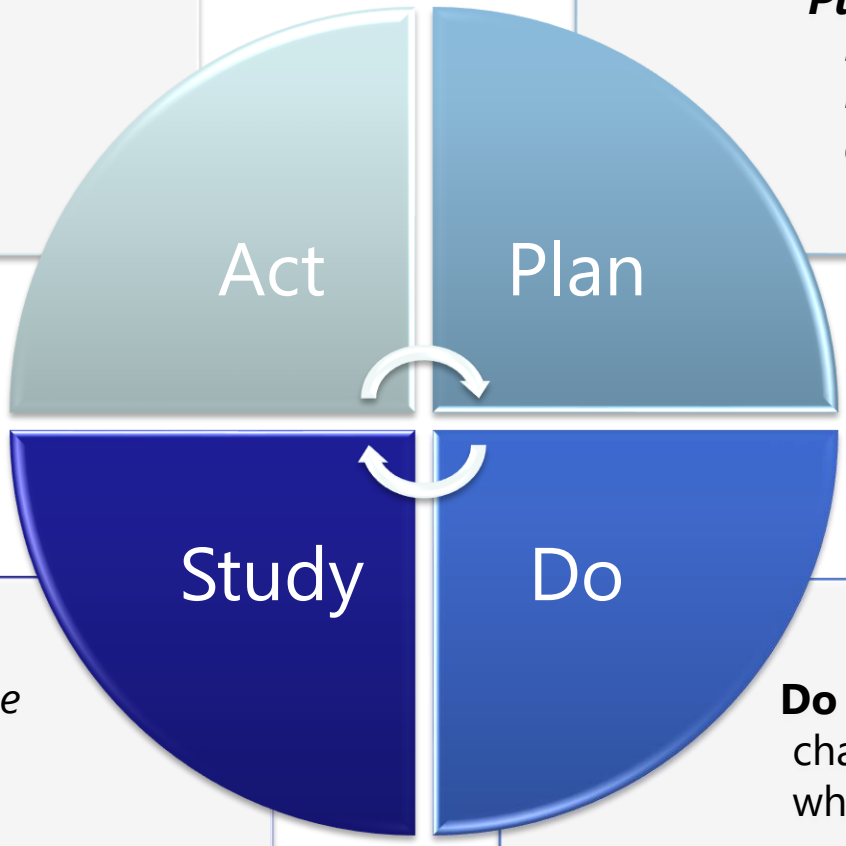
- **What** are we trying to change
- **Why?**
- What change can we make which will result in improvement? **Why**
- **Who** needs to be part of this? Who will this impact?
- **How** will we know the change is an improvement

Plan-Do-Study-Act (PDSA)

A structured trial of a process change

Act *– Identify next steps based on the analysis*

Plan *- Plan your process, includes creating measures or data collection plan*



Study *- Analyze the data and results*

Do - A time to try the change and observe what happens

Team uses and links small PDSA cycles until ready for larger scale implementation

The PDSA cycle will naturally lead to the Plan step of a subsequent cycle

S M A R T Goals

S	Specific
M	Measurable
A	Achievable
R	Realistic
T	Time Sensitive

Q 6 - Which is the best SMART goal statement?

A. To improve hand hygiene compliance on unit 2 by 100 % by December 31st, 2020
B. Make compliance to hand hygiene successful
C. To provide hand hygiene education to unit 2 staff by October 31st, 2020
D. Staff will improve health associated infections by washing hands
E. None of the above

Let's Try a PDSA

Hand Hygiene

- Let’s walk through the PDSA cycle for HH

To improve hand hygiene compliance by 100 % by December 31st 2020

- What are we changing – hand washing practice on unit two
- Why – staff, family feedback, increased HAIs
- What will we do? add more hand sanitizer stations
- Who should we consult with? Include?
- How will we measure it? Amount of product used per month? Audit of behavior? Survey Staff?
- What happened? How much product was used? Audit findings?
- Change did not meet goal – revise. Place hand sanitizer stations on BP machine, Pyxis, Bedside

Where/How can I use QI Results?

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Break

10 minute break

Recognizing

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Reporting

Responding

.....Reviewing

patient safety events

..... Learning ...

PS Video 1

Recognizing & Reporting Patient Safety Events

Patients may experience unintended harm, this is known as a Patient Safety Event. It is important to know how to recognize & report events to ensure safe patient care.

1. Recognize

What Happened?

Types of Events:

- Near Miss
- Occurence
- Critical Incident

2. Respond

Is the Patient Safe?

- Assess & treat the patient
- Notify the care team

Communicate

- Huddle with the care team
- Support patient & family
- Evaluate need for staff support

Equipment

- Secure equipment & environment

3. Report

RL

- Submit report in RL6
- Notify leadership

When you report a patient safety event you make it safer for everyone.

http://home.wrha.mb.ca/quality/files/InitialManagement.pdf

But not all of the time……

UHN
Toronto General
Toronto Western
Princess Margaret
Toronto Rehab
COURAGE LIVES HERE

Canadian Adverse Event Study
(CMAJ, 2004)

Beyond the Quick Fix
(2015) Institute of Health Policy, Management and Evaluation, University of Toronto

What is a PSE - Recognizing

An event, situ stance that resulted or co ed in an unintended ar tcome such as an inju

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Types of Patient Safety Events

Near Miss

An event or situation that took place, and could have resulted in an unintended outcome, but was 'caught' before adversely impacting the Patient

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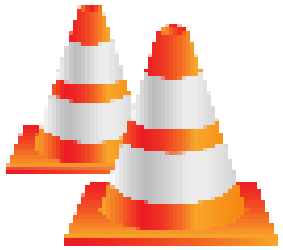
An event or circumstance that resulted in an unintended and undesired outcome such as an injury to a patient that did not meet the definition of a critical incident

2. Respond



Is the Patient Safe?

- Assess & treat the patient
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Communicate

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- Support patient & family
- Evaluate need for staff support

Equipment

- Secure equipment & environment

What is the importance of reporting PSEs

- document what happened
- accountability and learning
- promote a supportive environment

To improve the safety and quality of care for our patients

Let's take a 3 minute break

Q 7 - Have you been involved in the review of a patient safety event?

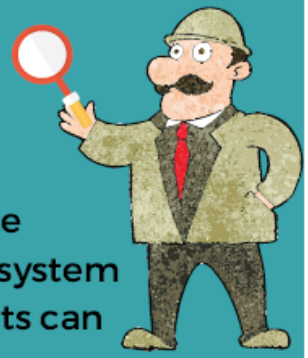
- Yes
- No

QUALITY IMPROVEMENT & PATIENT SAFETY

Reviewing & Learning from Patient Safety Events

Every reported patient safety event is an opportunity to learn and improve the care we deliver to patients & families.

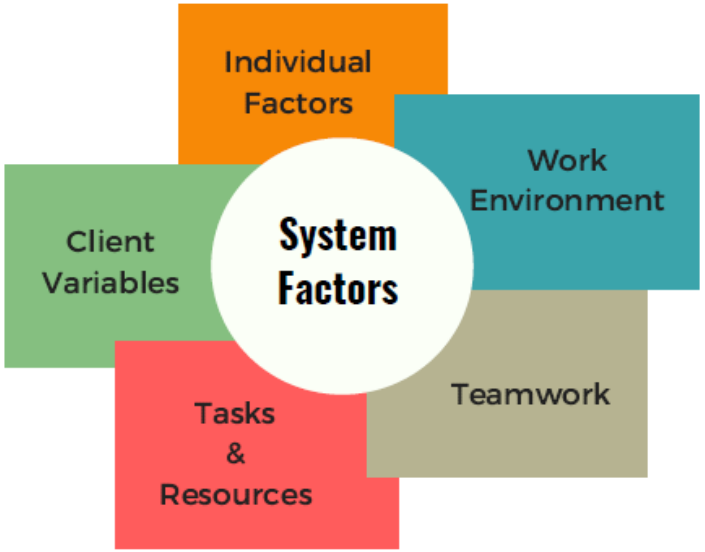
Reviewing



What happened?

- Explore processes in place
- Focus on the gaps in the system
- Identify how similar events can be prevented

fair & just culture



Learning

What will we do to improve?

- Collaborate with patients, families & other care providers
- Identify improvements
- Implement changes to enhance patient safety

SHARE

REVIEWING AND LEARNING

Near Miss/Good Catch & Occurrence	• Program/Unit Manager
Critical Incident	• Critical Incident Review Commitee(CIRC)

Goal is to have a Safety Culture focused on System Learning

Reviewing Events in RL

quality improvement & PATIENT SAFETY

QUALITY IMPROVEMENT & PATIENT SAFETY UNIT

Vision, Mission, Values

Communications

Workshops & Education

AREAS OF PRACTICE/SPECIALTY

Client Relations

Patient Safety

Accreditation

Clinical Audits

Patient Safety -Standard Operating Procedures

Initial event management

CI review process

Recommendation development

Escalation process

Privileged and Confidential Information

Second Party Requests for Information

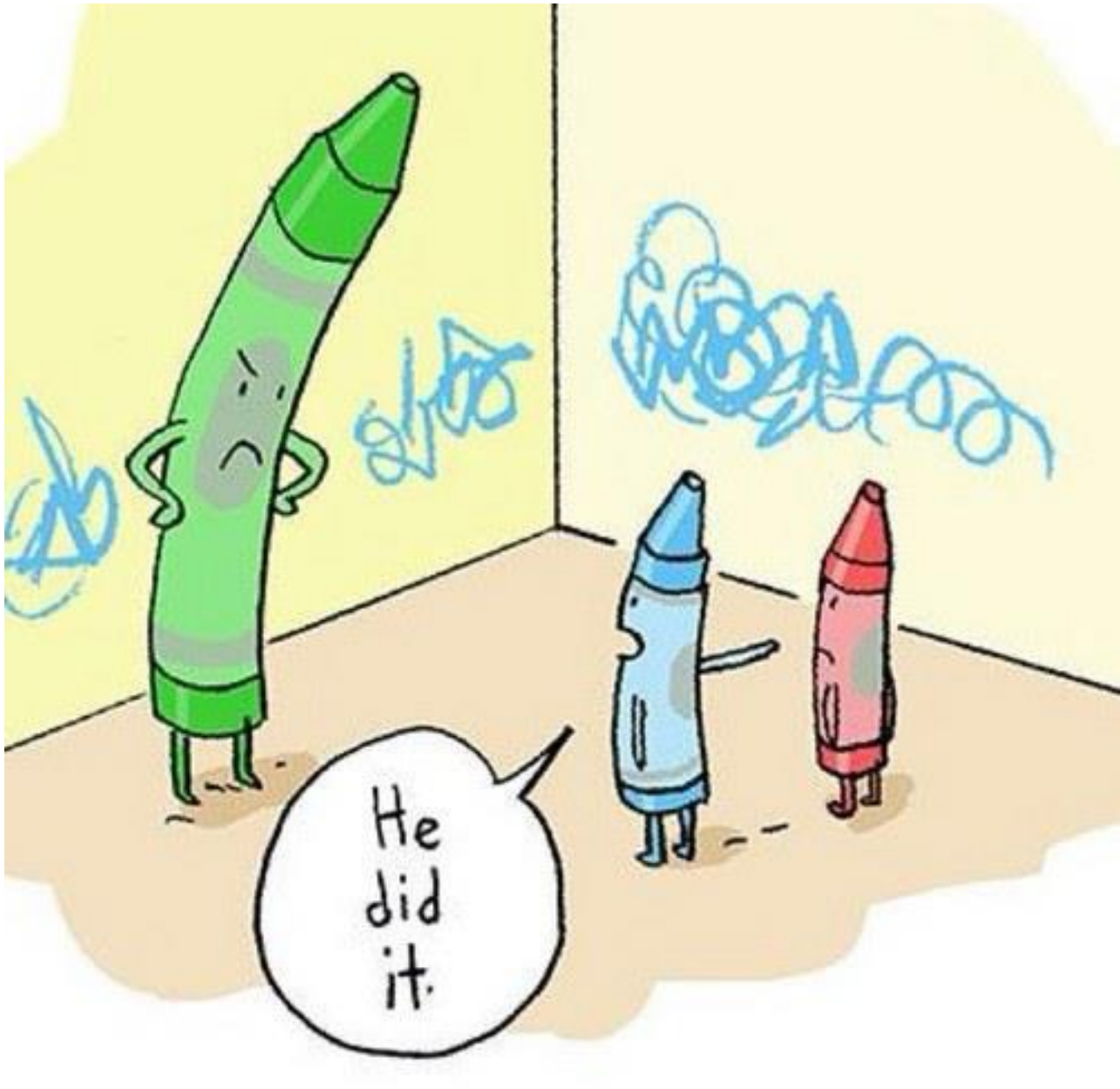
Patient Safety Learning Advisory

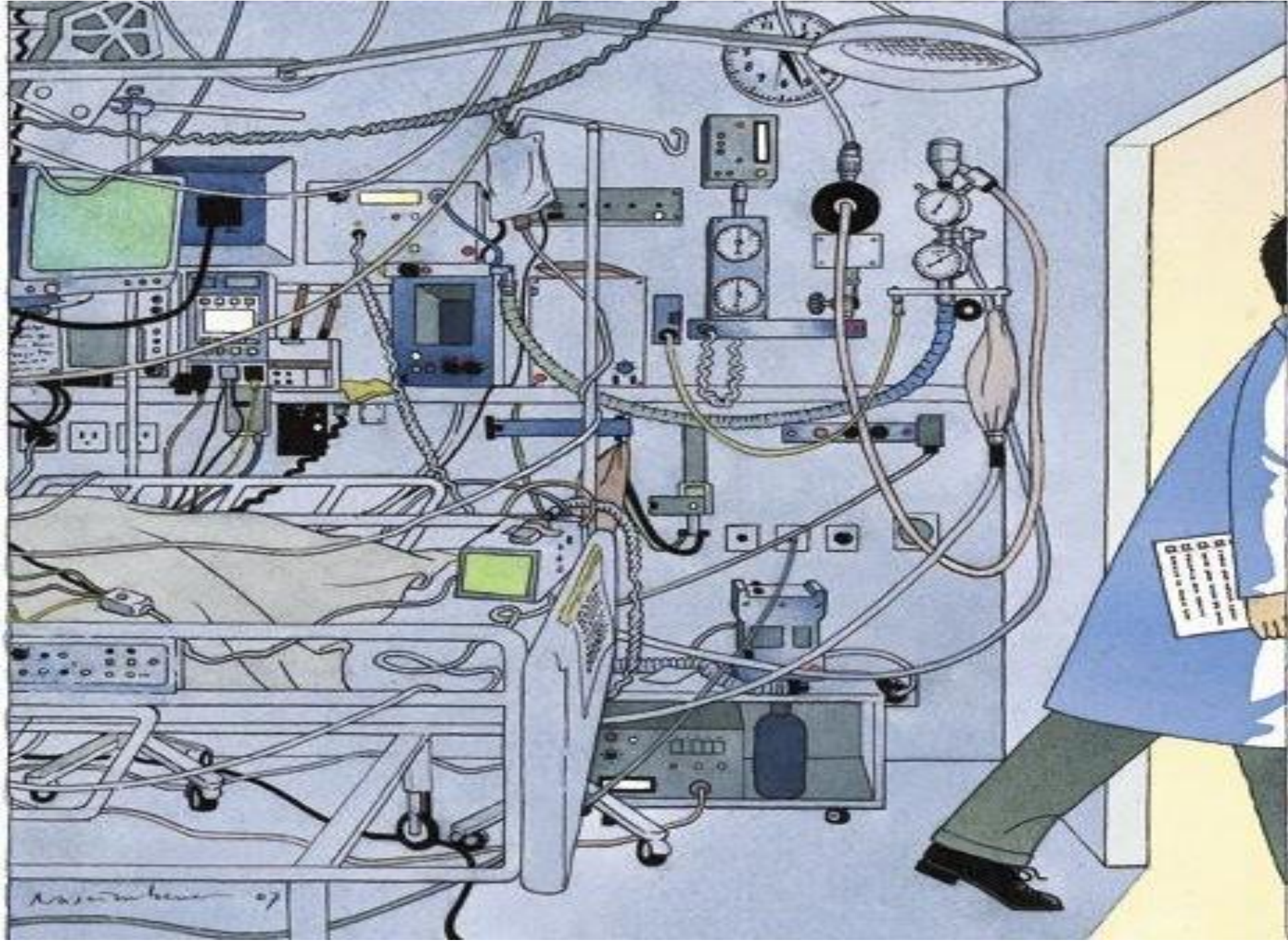
- https://home.wrha.mb.ca/quality/SOPs.php

How to do a Review

Focus on learning, not blame

Inquire about why the decisions and actions made sense to staff at the time.





System Factors to Consider

The phenomenal power of the human mind:

Aoccdrnig to rscheearch at Cmabrigde Uinervtisy, it deosn’t mttaer in waht oredr the ltteers in a wrod are,

the olny iprmoent tihng is that the frist and lsat ltteer be at the rghit pclae. The rset can be a tatol mses and you can sitll raed it wouthit a porbelm.

This is bcuseae the huamn mnid deos not raed ervey

lteter by istlef, but the wrod as a wlohe.

Amzanig huh?

System Design & Human Factors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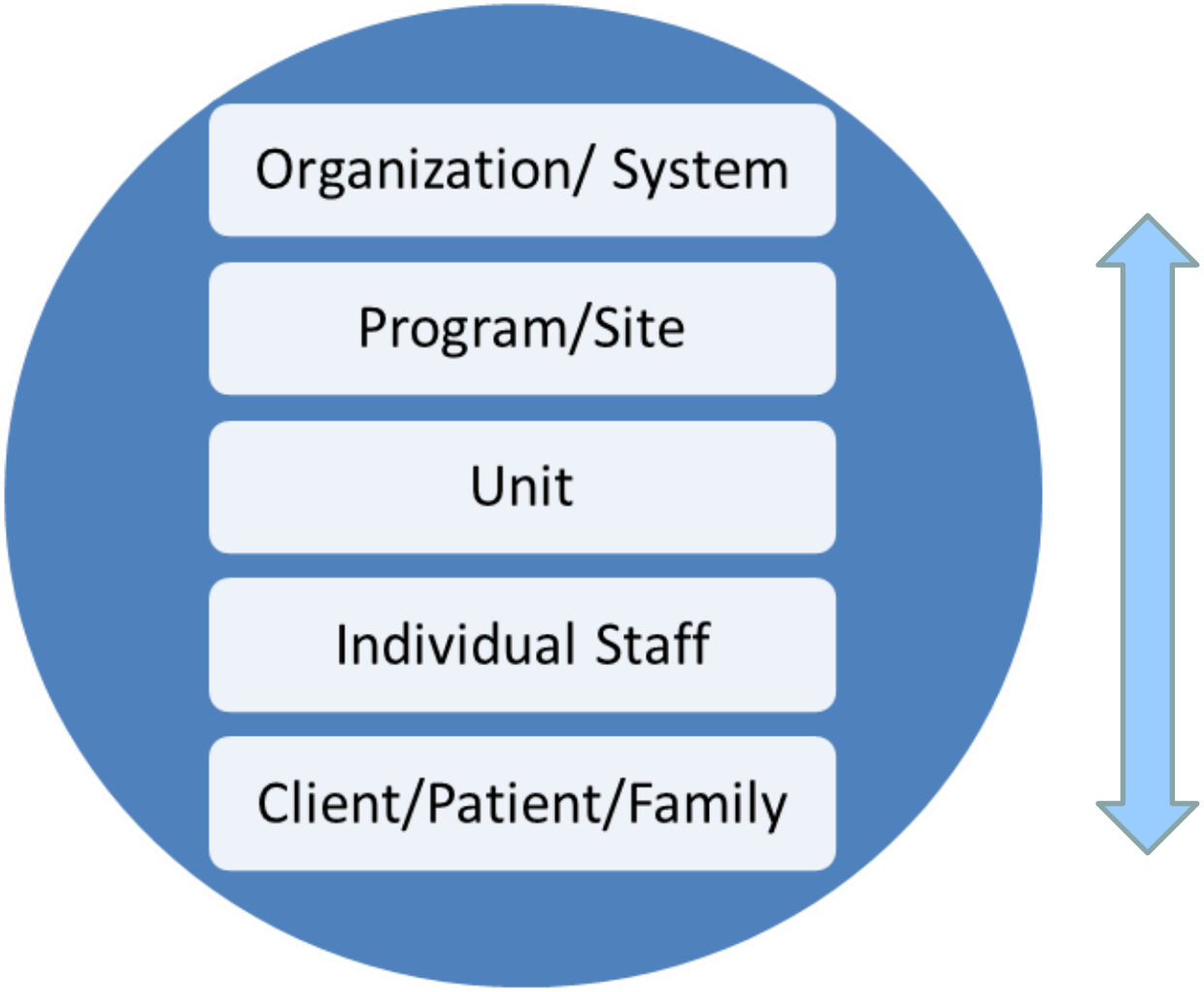
Learning from PSEs

Target for Improvement/Learning: Scope

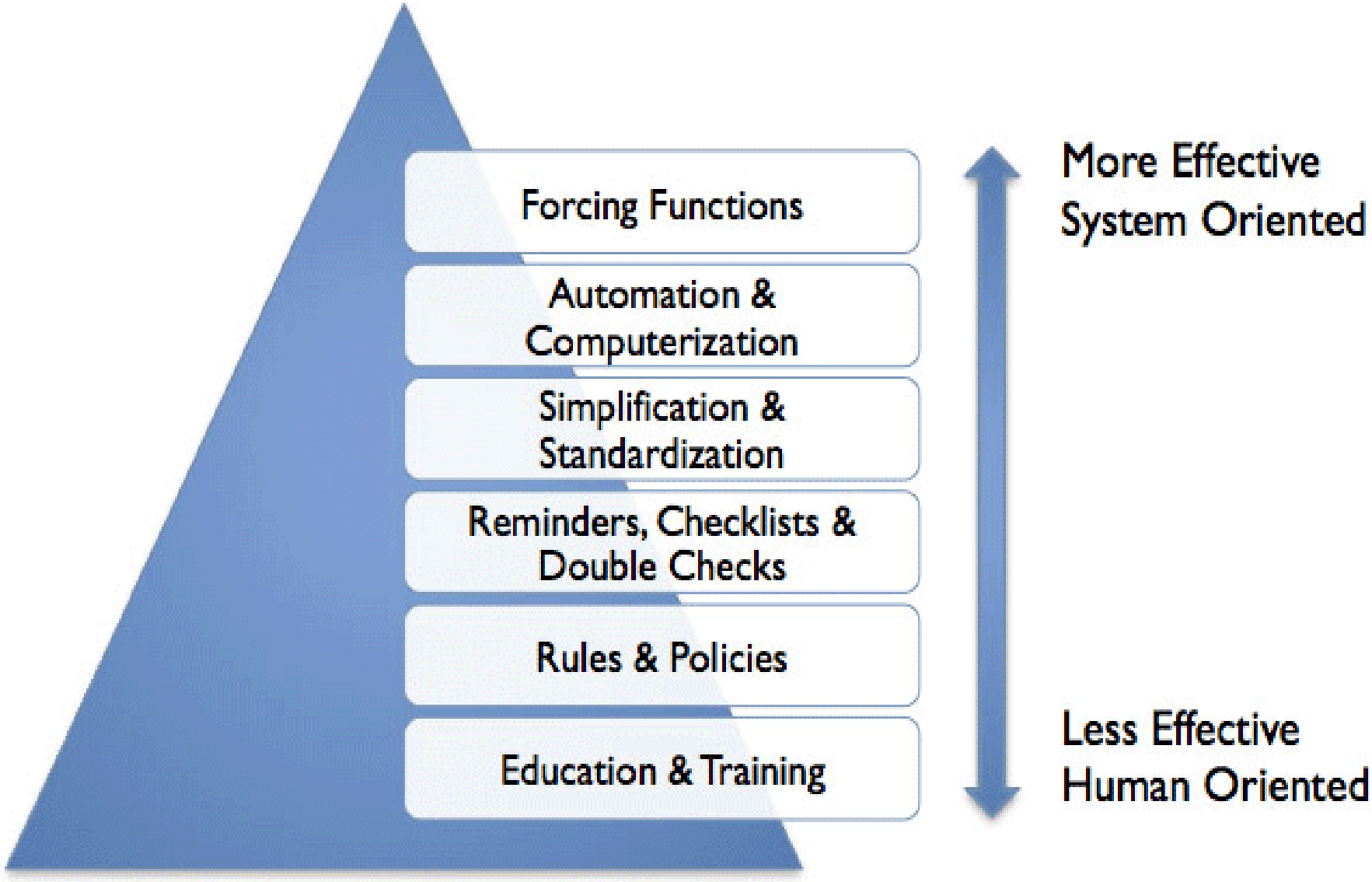


The goal is to embed excellence into everyday work and operations. Moving to being proactive instead of reactive.

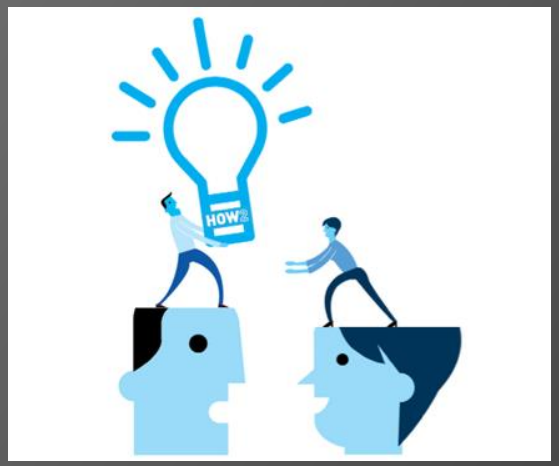
Who leads Improvement Planning in response to a PSE?

Near Miss/Good Catch & Occurrence	• Site/Program/Unit Manager or QI Lead
Critical Incident	• Program/Site/Unit/Senior Management or QI Lead(s)

Hierarchy of Effectiveness



How is learning shared on your unit?



PATIENT SAFETY
LEARNING ADVISORY
Lessons from patient safety event reviews

Updating Personal Health Information in ADT/EPR

Safety Event

A recent patient safety event review revealed a risk to patients related to the process for updating personal health information in ADT/EPR.

What occurred?

A patient was brought to an emergency department. The patient did not have a Manitoba Health Card with them at the visit and historic demographic information was generated through the ADT/EPR system. The information was not confirmed with the patient, which resulted in incorrect contact numbers for the patient and family.

Patient health information is an important component of a patient's health record. Incorrect or incomplete demographic information prevents the health care team from contacting a patient or their emergency contacts.

Phone numbers and addresses can change from one visit to another. Each time a patient arrives to the hospital, confirm their personal health, demographic and emergency contact information.

Recommendations

1) Confirm with the patient and/or patient's family current demographic and emergency contact information for each admission to hospital.

References

Section 4.15 WRHA Emergency Program Guideline: WRHA Standardized Roles and Responsibilities of the Emergency Program Triage Team: REGISTERED NURSE

WRHA Collection of Personal Health Information Policy 10.40.070

#159222

To see additional Patient Safety Learning Advisories go to
http://home.wrha.mb.ca/quality/event-learning.php

This alert represents de-identified information from one or several patient safety reviews and is intended for system-wide learning. If you have any questions, please contact the WRHA Patient Safety Team at patientsafety@wrha.mb.ca or contact Client Relations at 204-926-7825.

CARING FOR HEALTH

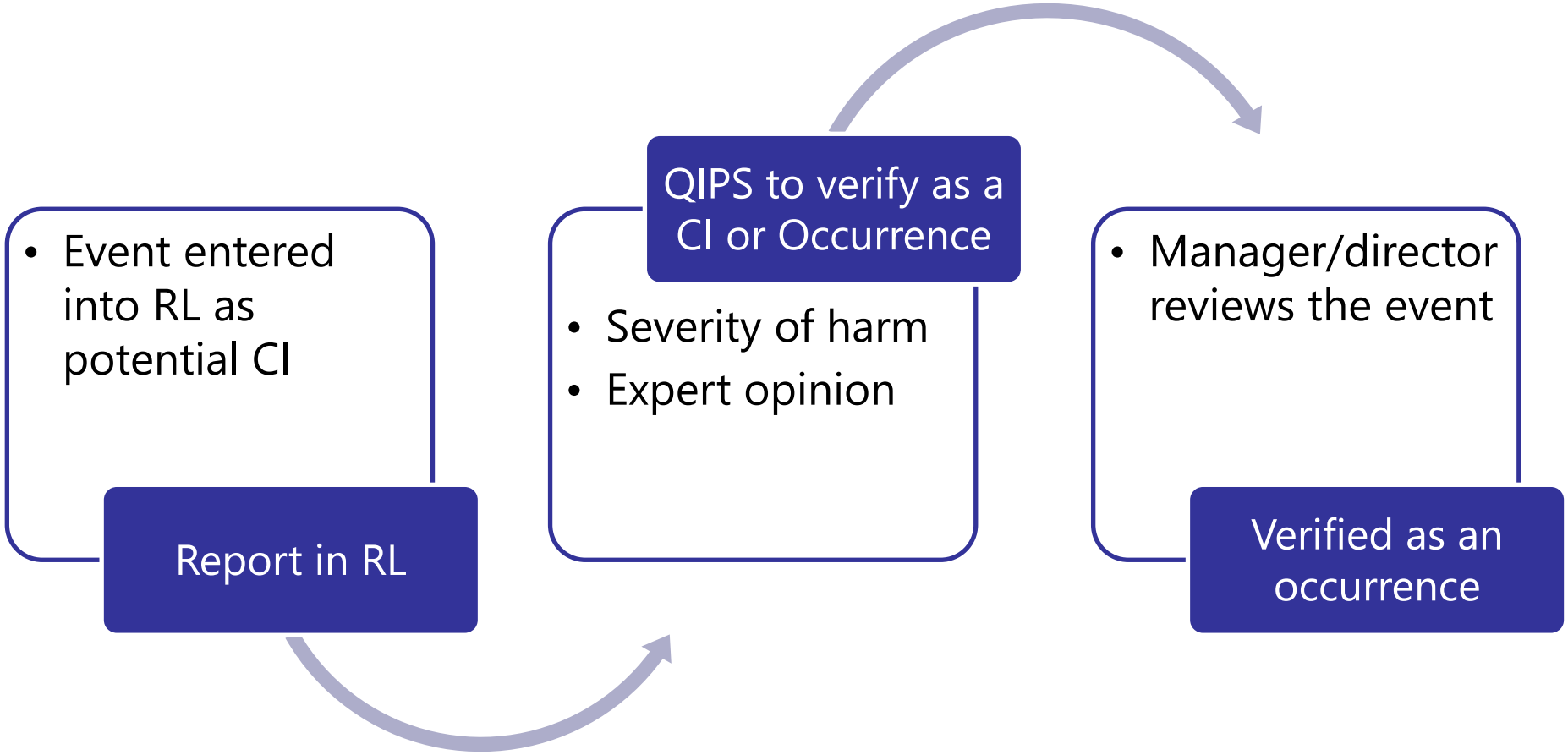
Group Exercise – WRHA Clinic

- A man has been experiencing more difficulty breathing.
- The man has emphysema, Type II diabetes and high blood pressure.
- He quit smoking two years ago after smoking for most of his adult life and has gained weight since he quit smoking.
- He is on inhalers for his emphysema, oral medication for his high blood pressure and insulin for his diabetes.

Group Exercise – WRHA Clinic

- A chest X-ray is ordered and is completed at an outpatient facility.
- Having heard nothing further, he contacts the clinic three weeks later and is informed they have not received the results of the X-ray.
- The clinic contacts the X-ray facility which has difficulty finding the original order or results.
- Two days later, the clinic contacts the patient and informs him that the X-ray indicates a spot on his lung and that additional testing is required.

Type of Patient Safety Event?



Type of Patient Safety Event?

Occurrence

Based on severity of harm:

in this case, he was assessed by a consultant and it was determined:

- Spot is not cancerous
- further monitoring would occur

Critical Incident

Versus a Critical Incident (CI) had the consultant deemed it cancerous and it was too late to provide life saving treatment.

Group Exercise

From the example

- How would you review this occurrence?
  - What approach could you take; what factors would you consider
- Take 10 minutes to discuss in your group
- Jot down some notes

Summary of Case Scenario

- Approach with a view to **understand**
- Areas to explore during the review:
  - the complexity of all the activities and seeks to understand what works and what doesn't, and where there are risks.
    - Work environment factors?
    - Individual factors?
    - Task factors?
    - Team factors?
    - Client factors?
- Recommendations based on the findings?

What is our goal in all this?

To create a safer health system by learning from safety events

Resources

"Need other Quality & Accreditation Education Resources and Tools? These resources can be used to create staff awareness or to inform the content of your staff education. "

1) Accreditation Standards https://home.wrha.mb.ca/quality/Standards2019.php
2) ROP Handbook http://home.wrha.mb.ca/quality/rops.php
3) ROP Resources & Posters https://home.wrha.mb.ca/quality/ROPResources.php
4) Quality Improvement Template and Plans https://home.wrha.mb.ca/quality/ProgramTeams.php
5) Regional Client Experience Survey http://home.wrha.mb.ca/quality/clientexpsurveys.php
6) Canadian Culture of Safety Regional Report and Power Point http://home.wrha.mb.ca/quality/ptsafetysurvey.php
7) Improvement Frameworks Getting Started Kit by CPSI and SaferHealthcare now

- http://www.patientsafetyinstitute.ca/en/toolsResources/ImprovementFramework/Pages/default.aspx

9) Institute for Healthcare Improvement (2017) http://www.ihi.org/Pages/default.aspx http://www.ihi.org/resources/Pages/Tools/default.aspx
10) Plan-Do-Study-Act (PDSA) Cycles

- http://www.ihi.org/resources/Pages/HowtoImprove/ScienceofImprovementTestingChanges.aspx

9) Culture Change Toolbox - BC Patient Safety & Quality Council https://bcpsqc.ca/blog/knowledge/culture-change-toolbox/
10) Medication Reconciliation http://home.wrha.mb.ca/quality/medrec1.php