CAHO-ISQua Webinar 13: Continuous Quality Improvement through Clinical Indicators

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ISQua International Society for Quality in Health Care

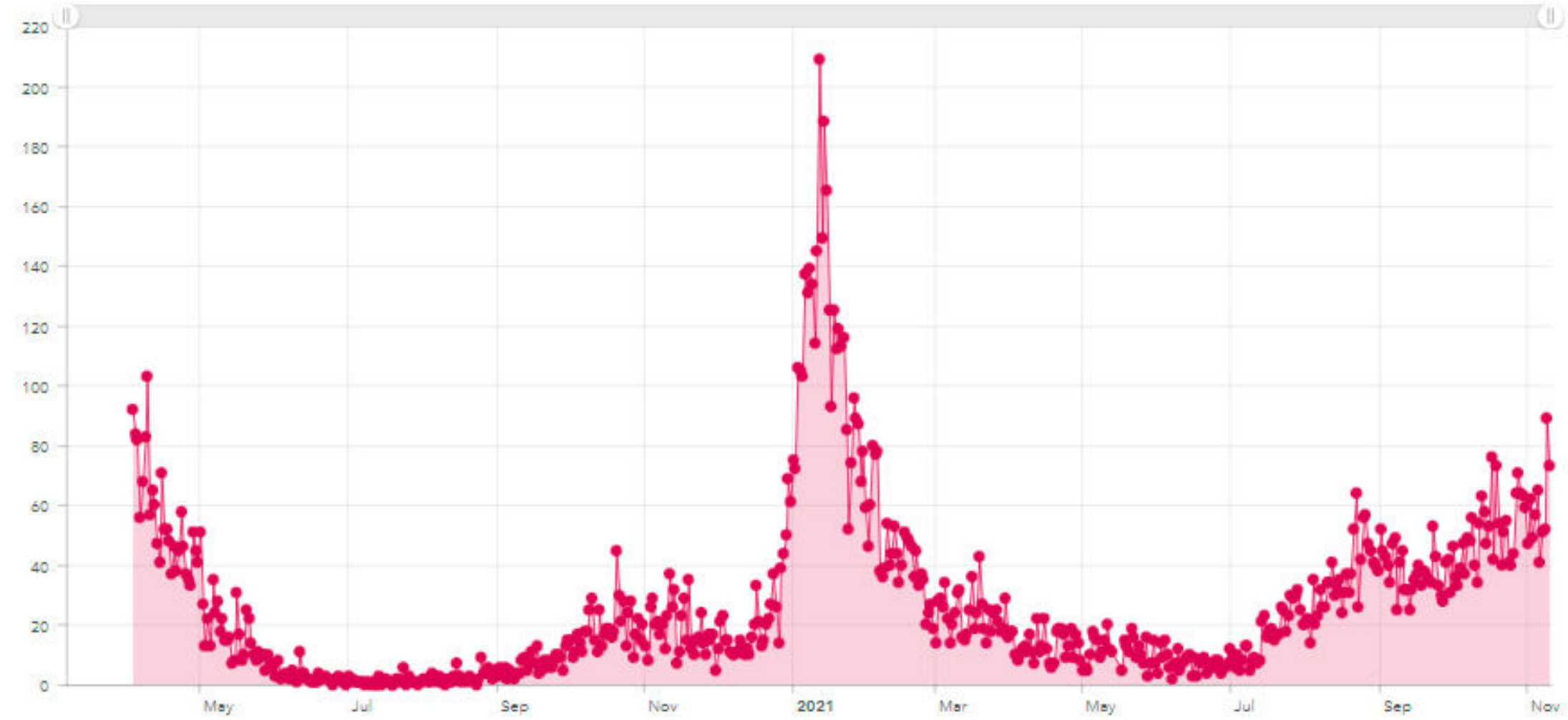
CAHO Committed to Safer Patient Care

Health Service Executive

An Roinn Sláinte
DEPARTMENT OF HEALTH

Challenges in our health services

COVID-19 IN IRELAND - CASES PER DAY FROM APRIL 2020 PANDEMIC UP TO 10 NOVEMBER 2021



Data last updated: Wednesday, 10 November 2021

WHY measure?

Different measures for different purposes

"All improvement will require change, but not all change will result in improvement"

G.Langley et al., The Improvement Guide, 1996

Measurement is not improvement but it is **necessary to answer if our change efforts have resulted in improvement AND to ensure that improvement is sustained or continues**

You can have a great idea but if it has never been tried before you DO NOT know that it will work – so test and measure

Question for Quality, Measure to answer, Seek to Improve

PERSON CENTRED

- Do we ask what matters to me?
- Individual needs

SAFE

- Do we harm people?

EFFECTIVE

- Do we give right treatment every time
- All the time?

Question for Quality, Measure to answer, Seek to Improve

EQUITABLE

- Are services equally accessible to all?

TIMELY

- Is there timely access?
- Waits/delays

EFFICIENT

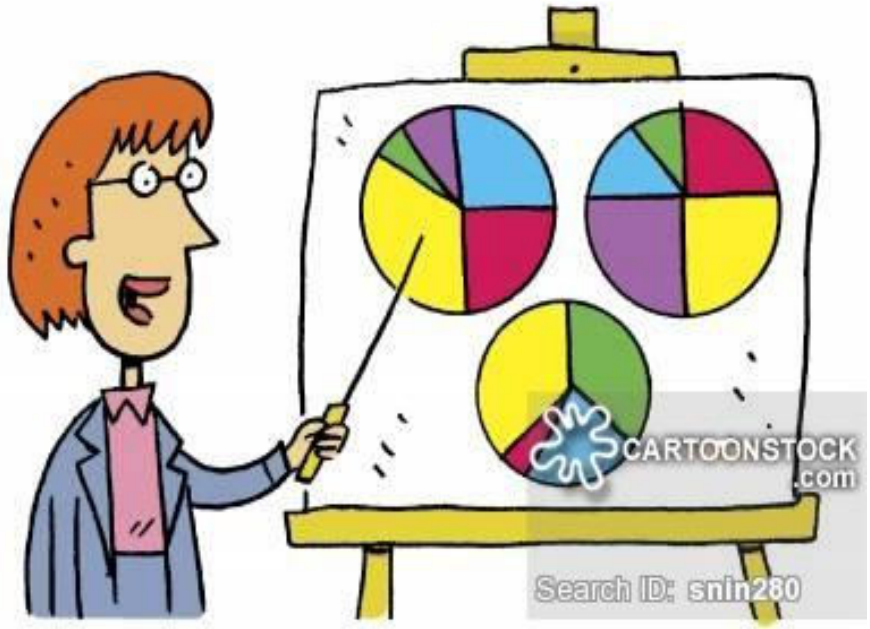
- Do we get value?
- Avoid waste

International Definition of Quality (Institute of Medicine, 2001)

Visual Display of Data

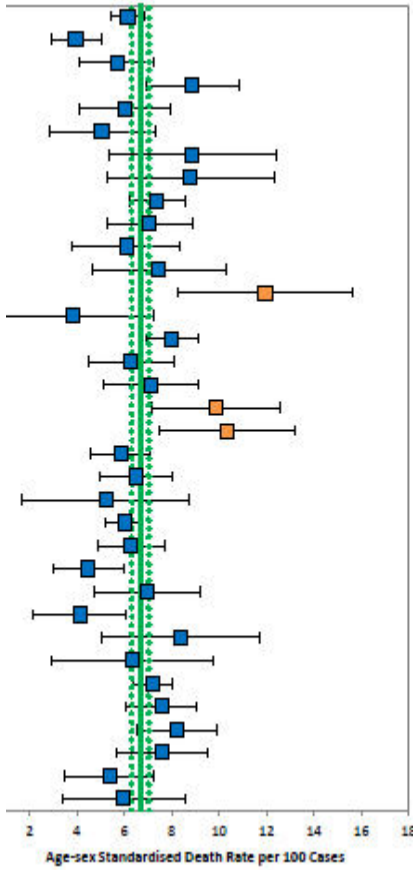
"The only thing worse than a Pie Chart is several of them…"

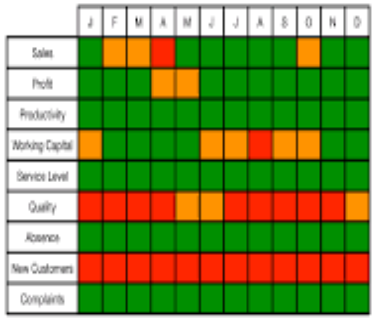
Edward Tufte

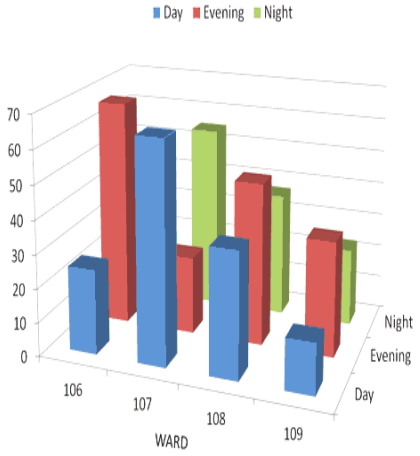


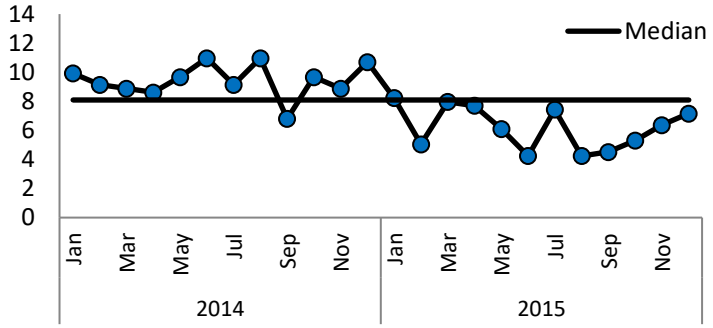
"As you can see from these full-color charts, we're spending a lot of money on toner."

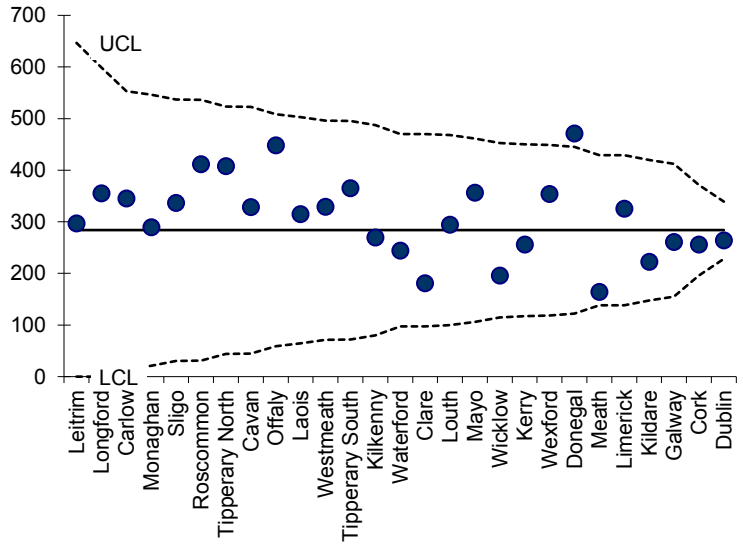
Visual Display of Data







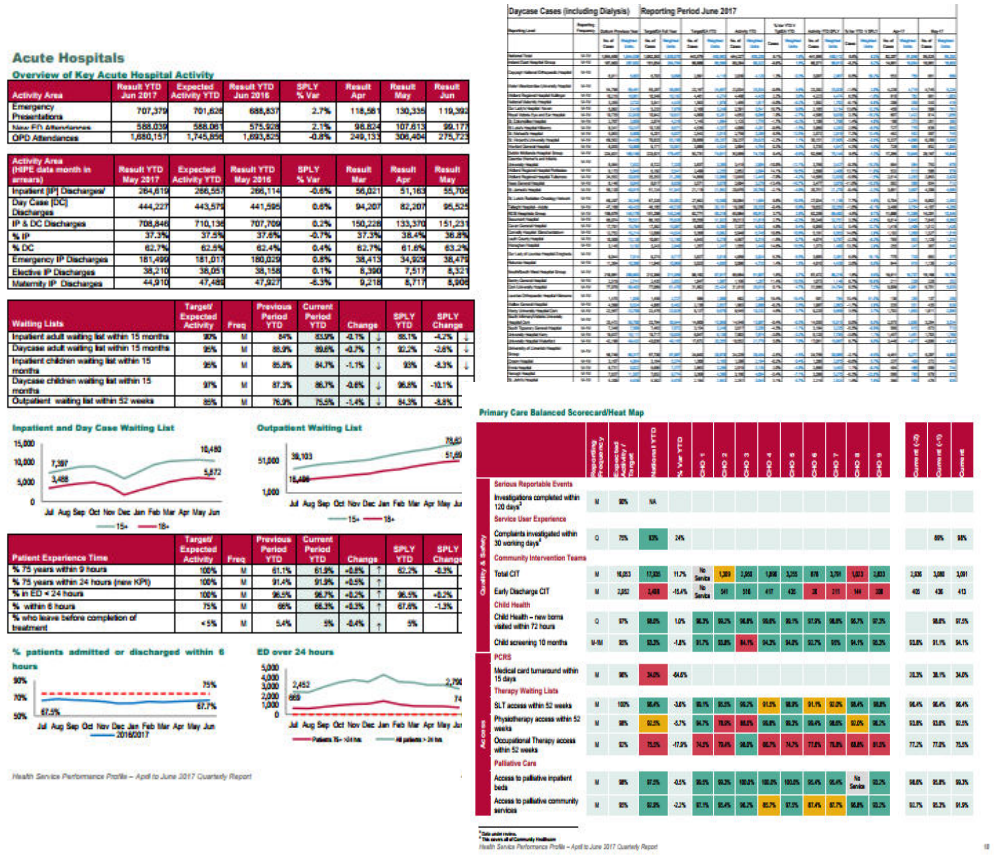




Measurement for Quality?

Currently in the HSE...

- Publication of a large volume of data
- Limited analysis of trends over time
- Comparisons of current values with targets or previous values
- Can result in overreaction to noise or failure to react to signals

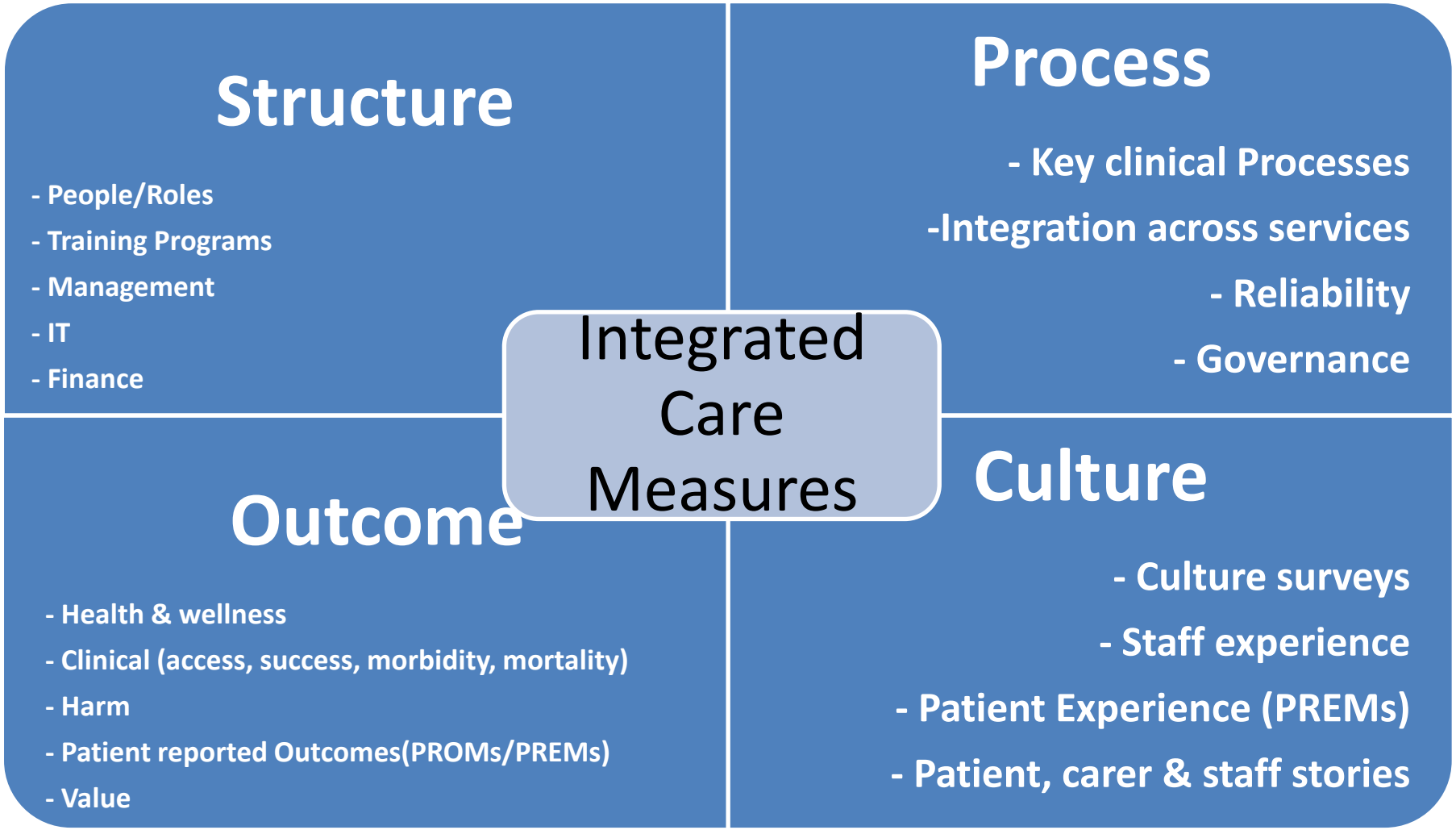


When to measure

Juran

Trilogy

WHAT to measure?

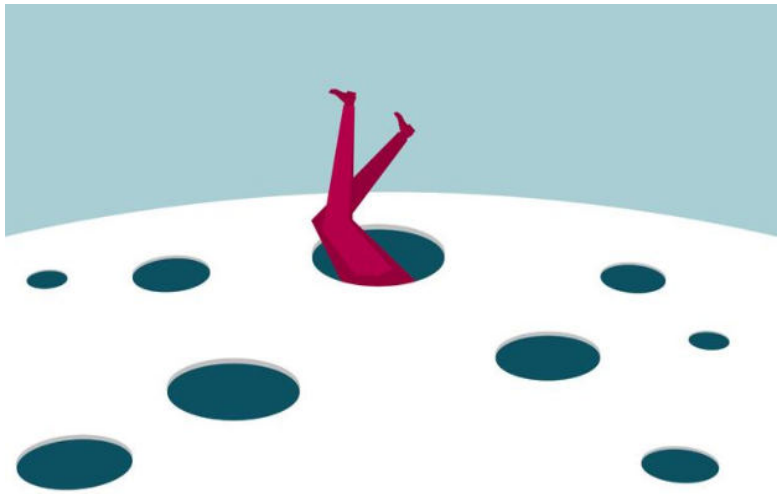


Framework for Improving Quality in our Health Service

Measurement for Quality Driver: Key Components

- ✓ Measure only what matters
- ✓ Transparency in measuring, sharing & reporting
- ✓ Measure variation & trends over time
- ✓ Build capability to measure & analyse data to support improvement

2 Common Pitfalls



Trying to improve something that doesn't need to be improved or which you have no control over improving

Not involving Subject Matter Experts (both data and clinical) from the start and throughout any improvement project

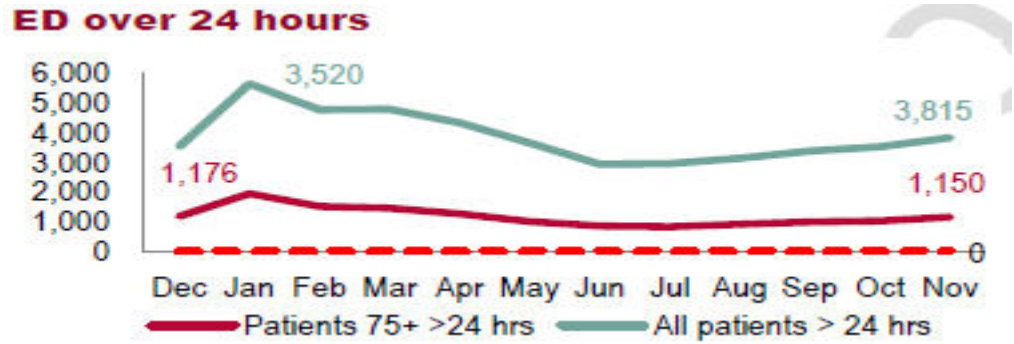
What are indicators used for

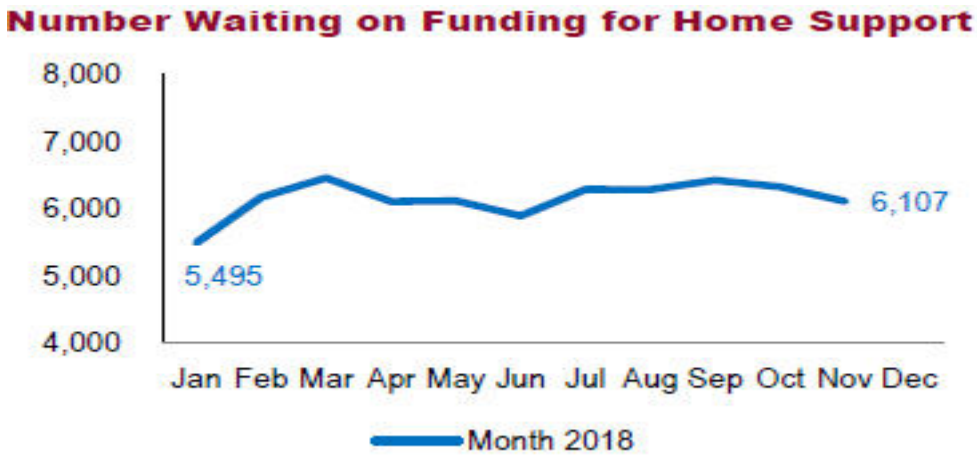
- Document the quality of care
- Benchmarking and making comparisons over time
- Performance monitoring
- Accountability, judgement, regulation and accreditation
- Based on standards of care
- Directed to learning and improvement

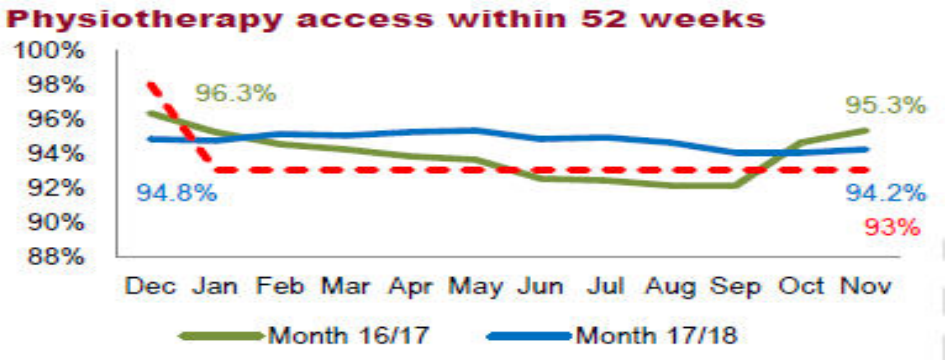
A Clinical (*quality*) indicator should

- Give an indication of the quality of the patient care delivered
- Measure in a valid reliable manner so that they are suitable for comparisons between professionals, practices, and institutions
- Be relevant to important aspects (effectiveness, safety and efficiency) and dimensions (professional, organisational and patient oriented) of quality of care
- Be feasible - not too hard to gather and able to improve
- Involve patients in defining outcomes to ensure the development of meaningful measures

Have we normed this performance?







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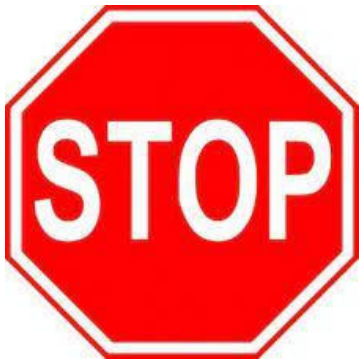
Misuse of clinical (*quality*) Indicators



- focus on achieving clinical indicators and performance diverts attention from patient care
- outcomes measured against clinical indicators to dictate or impose levels of safety or quality or for pay for performance purposes
- performance data used for the purpose of promotion or disparagement
- quality/ Clinical indicators that are not supported by evidence, or important for safety and quality, risk are driving unproven and inappropriate clinical activity
- gaming and tunnel vision

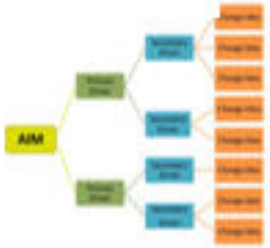
Different Levels of Measurement for Improvement

1

- PDSA cycle Level

2

- Quality Improvement Project Level



3

- System or Organisation Level

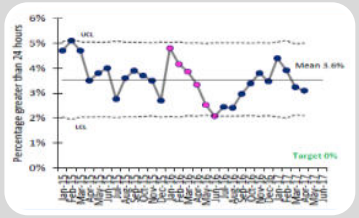
The National Quality Profile

Aim

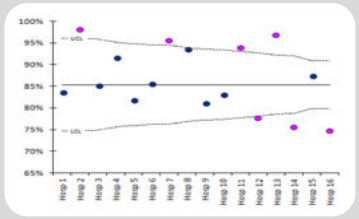
Present and analyse information on the quality of care in a format that allows for the evaluation and promotion of improvements in quality of care

- **Uses existing data collected as part of monthly reporting cycle**
- **Presents data over time in Statistical Process Control Charts**
- **Analyses variation within the health system using funnel plots**
- **Identifies common and special cause variation**

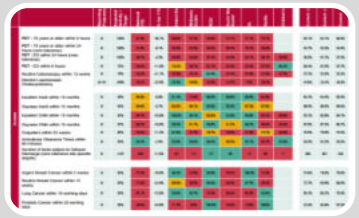
The National Quality Profile: Results



SPC charts show evidence of improvements in quality of care that were missed by only comparing the current month to a previous value



Funnel plots show occurrences of special cause variation, both better and worse than expected, that were also missed



Measures with common cause variation only can be categorised as red, amber or green in a heat map which may lead to overreaction.

The National Quality Profile: Key Benefits

Provision of information that describes changes in quality of care and can be used to promote improvements

SPC charts can reliably distinguish potential signals from random variation

- ✓ **Facilitates appropriate reaction to signals when present**
- ✓ **Prevents overreaction to normal variation**

Health care leaders are better informed by having access to this information

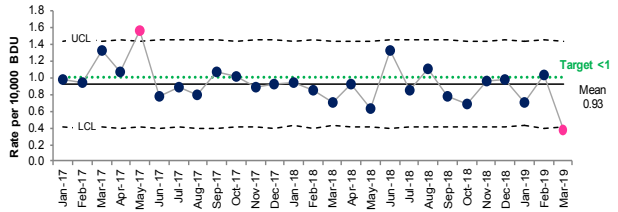
The National Quality Profile: Results

Safe

Hospital acquired new cases of *S. aureus* bloodstream

Desired Direction ↓

National Rate



Average national performance is on target and shows a signal of improvement in March 2019.

NEW DATA

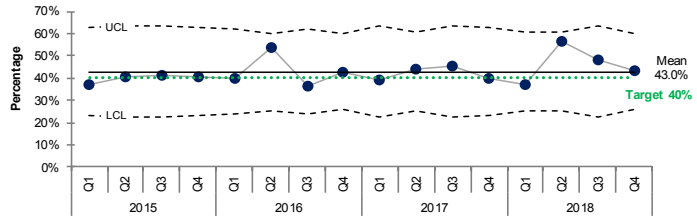
The rates for 3 hospitals are above the upper control limit.

Effective

Return of spontaneous circulation (ROSC) at

Desired Direction ↑

National Rate



Average national performance is on target & stable

NEW DATA

Latest data available: Quarter 4 2018

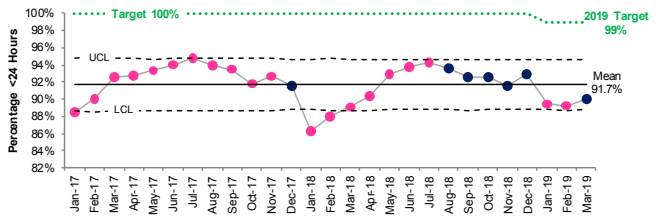
Page 9

Person-centred

Percentage of all attendees aged 75 years and over at ED who are discharged or admitted within 24 hours

Desired Direction ↑

National Rate



Average national performance is worse than the target & unstable

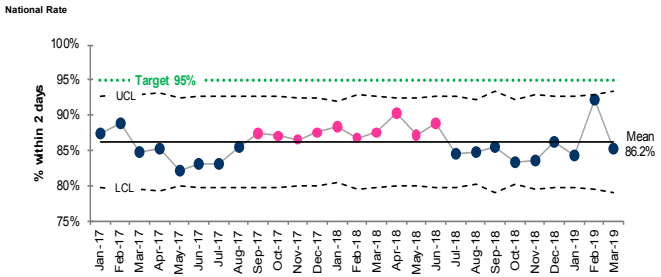
NEW DATA

The National Quality Profile: Results

Timely

Hip fracture surgery within 48 hours

Desired Direction ↑



Average national performance is worse than the target.

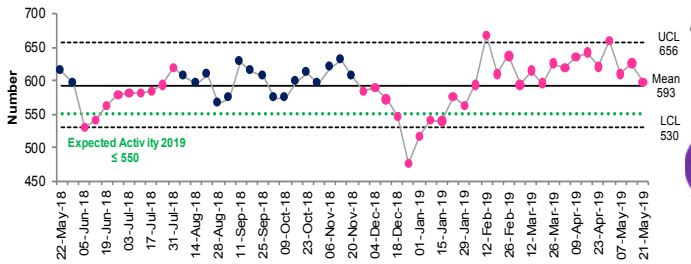
The rates for 2 hospitals are above the UCL.
The rates for 2 hospitals are below the LCL.

NEW DATA

Efficient

Weekly number of delayed discharges

Desired Direction ↓



Average national performance is above the expected level of activity and shows a signal of disimprovement

NEW DATA

Latest data available: 21 May 2019

Board Strategic Scorecard

Purpose of the Strategic Scorecard

- The Board Strategic Scorecard provides the HSE Executive Management Team (EMT) and HSE Board with a monthly report on progress against key Programmes/Priorities.
- The Scorecard provides a point in time view of progress every month in relation to expected outputs/deliverables and targets for the year.
- The Scorecard allows the EMT and Board to understand the current status of each Programmes/Priority and the forecast of year-end achievement.

Current list of 2021 Scorecards	
1. COVID-19 National Test and Trace	11. Operational Services Report (OSR)
2. COVID-19 Vaccination Programme	12. Quality and Patient Safety
3. Primary Care and Community Reform	13. Patient and Service User Partnership
4. Home Support and Residential Reform	14. People and Recruitment
5. Scheduled Care Reform	15. Finance and Financial Management
6. Mental Health Reform	16. Integrated Information Services (IIS)
7. Disability Services Reform	17. Technology and eHealth
8. Population Health and Prevention	18. Infrastructure and Equipment
9. Enhancing Bed Capacity	19. Risk Management
10. Implementation of National Strategies	20. Strategic Communications
	21. New Drugs

Board Strategic Scorecard (Put in Vaccination BSS)

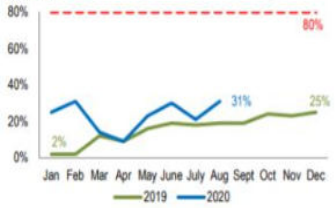
Performance Assurance Report

Quality and Patient Safety

Performance area	Reporting Level	Target/ Expected Activity	Freq		Current Period YTD	Current (-2)	Current (-1)	Current
Serious Incidents – Number of incidents reported as occurring	**National**				**1109**	**100**	**76**	**46**
	Acute Hospitals (incl NAS, NSS & NCCP)				604	61	48	29
	Community Healthcare				505	39	28	17
Serious Incidents – Incidents notified within 24 hours of occurrence	**National**	80%	M	●	**48%**	**48%**	**39%**	**39%**
	Acute Hospitals (incl NAS, NSS & NCCP)	80%	M	●	52%	61%	48%	38%
	Community Healthcare	80%	M	●	43%	28%	25%	41%
Serious Incidents – Review completed within 125 calendar days*	**National**	80%	M	●	**20%**	**30%**	**21%**	**31%**
	Acute Hospitals (incl NAS, NSS & NCCP)	80%	M	●	24%	34%	23%	36%
	Community Healthcare	80%	M	●	13%	20%	15%	24%

% of serious incidents being notified within 24 hours of occurrence to the senior accountable officer

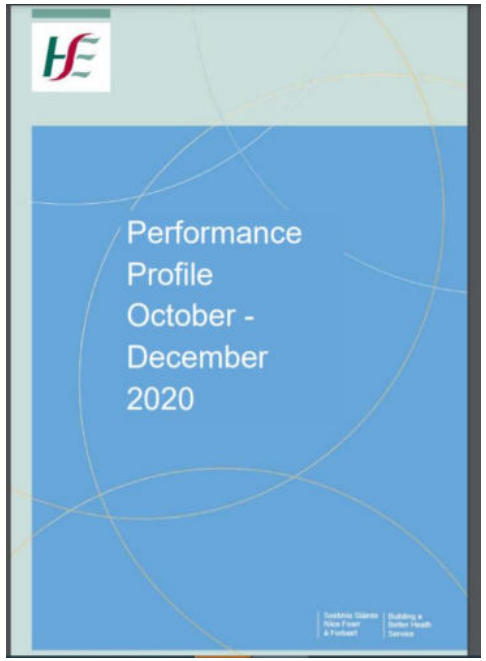
% of serious incidents requiring review completed within 125 calendar days of occurrence of the incident



Health Services Performance Profile October to December 2020 13

- Monthly analysis of key performance data from Divisions, such as Acute, Mental Health, Social Care, Primary Care, Health and Wellbeing, Finance and HR.

- Activity data reported is based on Performance Activity and KPIs outlined in the current National Service Plan



Patient Reported Outcome Measures

- Patient-reported outcome measures (PROMs) capture a person's perception of their own health through questionnaires. They enable patients to report on their quality of life, daily functioning, symptoms, and other aspects of their health and well-being .

- Responses to PROMs questions help hospitals and healthcare services provide the care that patients need and want. These measures aim to fill a vital gap in our knowledge about outcomes that matter to patients.

- (Australian Commission on Safety and Quality in Healthcare)

Making a start:
Integrated Care Measures –Older Persons

Eq5d outcome measure
This PROM measures a patient's health across five different domains: mobility, self-care, usual activities, pain/discomfort, and anxiety/depression.

The EQ-5D provides a simple yet descriptive profile and single index value for health status that can be used in the clinical and economic evaluation of healthcare.

Metrics that represent the entirety of the of the older person's pathway

Indicator	Primary Care Reporting	Integrated care reporting		
	Primary Care (Enablers)	Ambulatory/Community Care	Acute Floor	Acute Inpatient
Structural	"Register" of at risk older persons in place	Older persons with complex care needs can access a HUB which acts as a single point of contact for specialist MDT assessement There is an inreach function to the acute setting	A bespoke age atuned pathway is in place for older persons with complex care needs on the acute floor There is an inreach function to inpatients	Number of cohorted specialaist bed days meets the demands of older persons with complex care needs There is an outreach function to primary & community care
Process	Number of older persons recorded on the 'register' by Community Health Network Receipt of MDT transfer of care plan within 24hours of discharge from acute hospital	The number of all patients - Referred - Accepted on to caseload - Discharged from caseload - Remaining on the MDT caseload at close of business on the final day of the reporting period	- The total number of attendances on the acute floor aged >75 years during the reporting period - The total number of acute floor attendances aged >75 years who have received a screening assessment during the reporting period - The number aged >75 who screen positive for frailty following assessment	AVLOS (Medical) - All Patients YTD 75+ - Age 75+ Excluding Those >30 Days YTD - Patients 75+ % Of Total Bed Occupancy YTD - Patients 75+ Median LOS Over 30 Days Percentage change from the same month in the preceding year Indicate if increased or decreased
		The number of patients on the MDT caseload during the reporting Period with: - High - Moderate } Complex Care Needs - Low	Total number of CGAs commenced by the MDT acute floor team during the reporting period	Number of discharges from cohorted ward Number of patients in a cohorted ward discharged with an MDT transfer of care plan
		Source of referral: - GP/Primacy care team - Acute Inpatient - Self/relation/carer - OPD - Acute floor - Other	Total number of older persons >75 years re-attending within 7 days on the acute floor	Number of cohorted beds Bed day demand
		Number of patients seen with a discharge destination of a. Home b. Tertiary care c. Long Term Care	Source of each referral within the reporting period Either - GP/PHN - Self/Home - Nursing Home - Ambulatory care hub - OPD/ Day Case	
		Total number of patients on caseload with a completed CGA	Percentage of: - PET < 6Hr 75+ - PET < 9Hr 75+ - PET < 24Hr 75+ Percentage change from the same month in the preceding year Indicate if increased or decreased	
		- Number of patient questionnaires completed at entry, discharge and 3 months post eg EQ5D (PROMS)	Admission rate (%) for older persons >75 years during the reporting period	
		- Number of Patient Narrative stories reviewed each quarter (PREMS)		
Outcomes	Older persons with complex care needs proactively identified and managed in Community Health Network	- Number of older persons who have received the right level of care, at the right time in the most appropriate location closer to home will increase - Patient experience will improve	- PET times will meet national targets (HSE NSP 2019) - Patient experience will improve	- AVLOS targets will be age attuned in line with national standards (HSE NSP 2019) - Patient experience will improve
Benefits	Early identification of at risk cohort of patients in CHN	Alternative point of access in place that avoids acute hospital attendance	Older persons attending the acute floor are triaged using a frailty screening tool PET times will improve	Older Persons with complex care needs have a care plan and the primary and ambulatory care teams are aware of the discharge and plan
Strategic Objective	Improving Population Health	Delivering Care Closer to Home	Developing Specialist Hospital Care	Developing Specialist Hospital Care

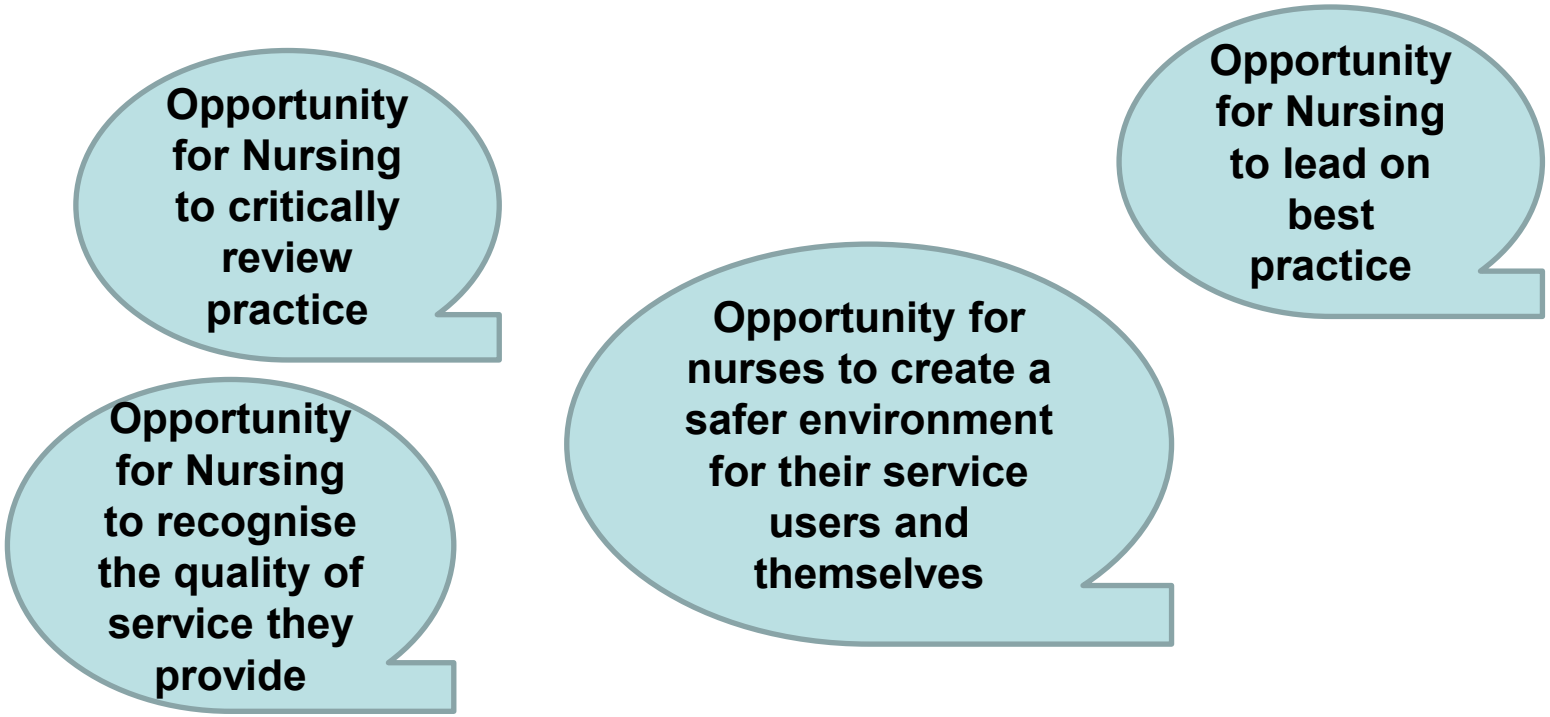
What are Quality Care Metrics (QCM)

- Quality Care Metrics (QCM) are a measure of the quality of nursing and midwifery clinical care processes aligned to evidence-based standards and agreed through national consensus in healthcare settings in Ireland (HSE, 2018)

- QCM data identifies areas of safe practice which is acknowledged and celebrated, and it will also identifies areas where improvement is required

Benefits of QCM

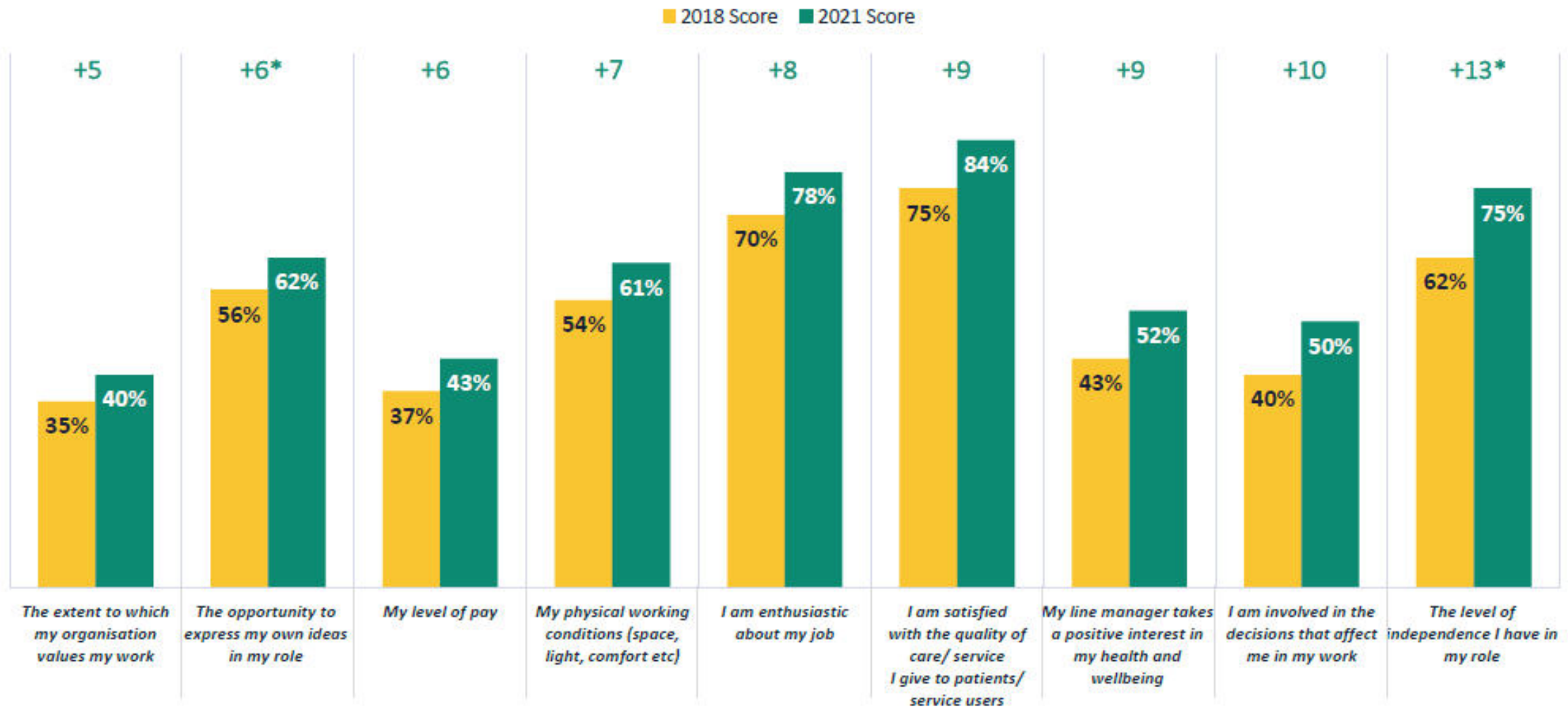
- Quotes from nurses and midwives:



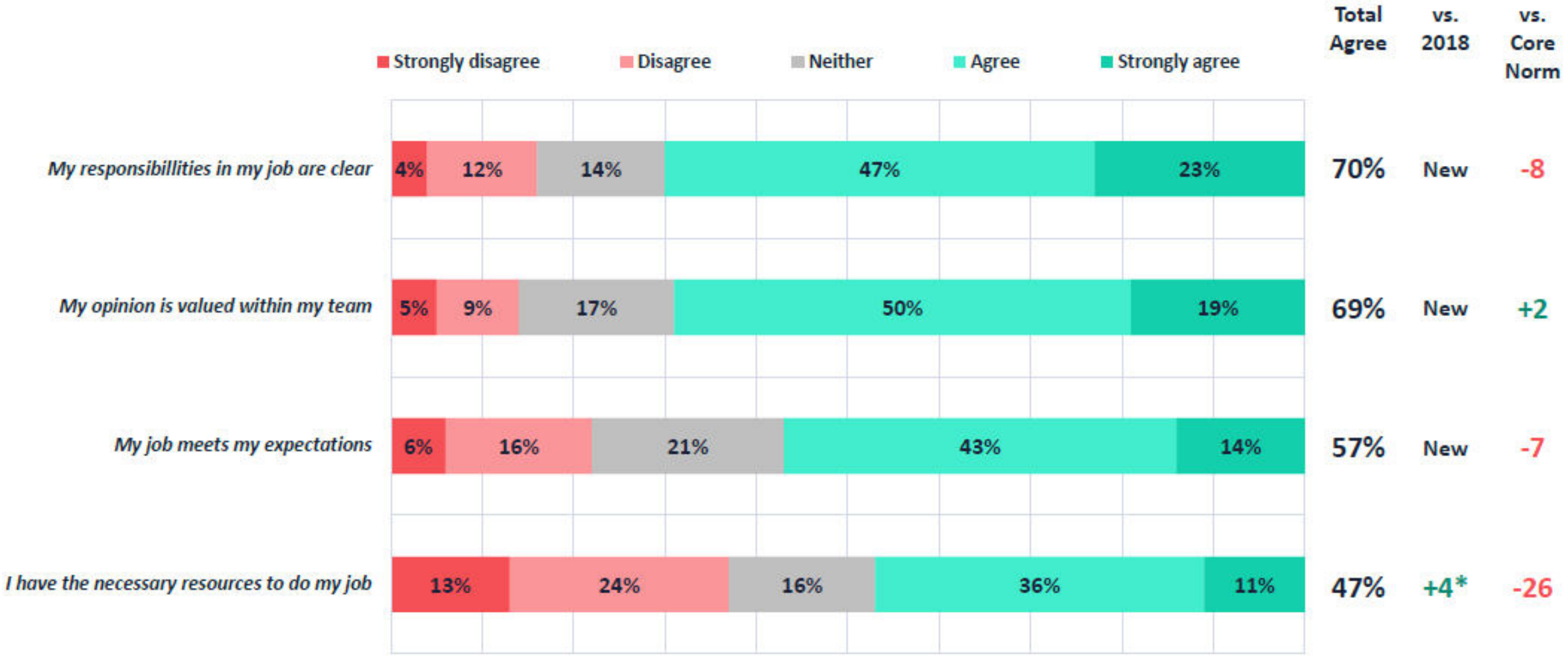
Staff Engagement Forum

Staff Engagement

Staff Survey 2021- Positive Improvements since 2018

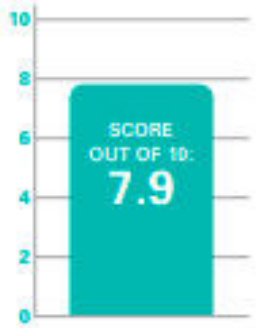


Your Job and Your Role –7 in 10 feel their opinion is valued within their team. Less than half feel they have the resources to do their job.



Patient Experience Survey 2019

Admission to hospital



The average patient rating for the 'admissions' stage of care was 7.9 out of 10.

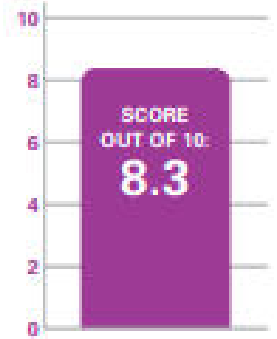
30% of people (2,347) said that they were admitted to a ward within the HSE's target waiting time of six hours, with 331 people (4%) saying that they waited 48 hours or more before being admitted to a ward.

82% of respondents (6,960) said that they were always treated with respect and dignity in the emergency department.

SUGGESTION FOR IMPROVEMENT:

"It would be helpful to have some indicator of waiting time, especially while waiting in A&E."

Care on the ward



The average rating for care on the ward was 8.3 out of 10.

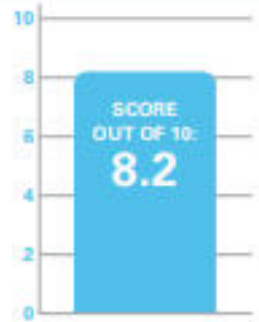
28% of people (3,214) said that the food they received in hospital was poor or fair.

96% of people (11,404) said that the hospital room or ward that they were in was very clean or fairly clean.

SUGGESTION FOR IMPROVEMENT:

"The food could be improved and the tea was cold when it came to the ward."

Examinations, diagnosis and treatment



The average rating for examinations, diagnosis and treatment was 8.2 out of 10.

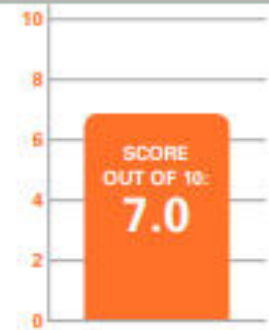
39% of people (4,562) said that they did not always have enough time to discuss their care and treatment with a doctor.

86% of people (10,185) said that they were always given enough privacy when being examined or treated.

SUGGESTION FOR IMPROVEMENT:

"Doctors should spend more time talking and listening to their patients."

Discharge or transfer



The average rating for discharge or transfer was 7.0 out of 10.

55% of people (4,570) said that they were not fully informed about the side effects of medication to watch for when they went home.

71% of people (6,806) said that the purpose of medications they were to take at home was completely explained to them.

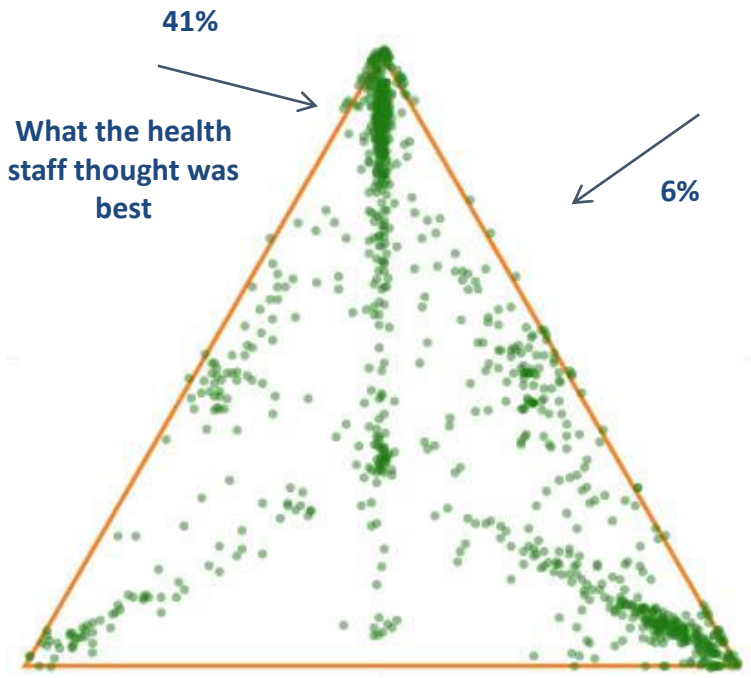
SUGGESTION FOR IMPROVEMENT:

"More information should be given to the patients when leaving the hospital, mainly about precautions, special diet etc."

Patient and Staff Experience: Your Voice Matters

In this experience my treatment was most influenced by:

My GP is very good about treating COPD, very sympathetic. It is the usual treatment, steroids, antibiotics, nebulisers. But if he has a locum in it is sometimes very hard to get the Meds I need. I've really had to argue with him to get steroids. He said he doesn't believe in prescribing steroids. This shouldn't happen to someone who is sick and steroids are vital for recovery.



Combination of all 3

I attended my local GP with my daughter who was suffering from severe anxiety and school refusal. The GP was very empathetic and referred us to CAMHS. She followed this up with a phone call a week later to check on the progress of my daughter. The CAMHS appointment was prompt and we were seen a few minutes after we arrived. The psychologist was thorough seeking information from both myself and my daughter. Time was never an issue. This was always the situation on each occasion we have attended our appointment. It was prompt and we were always given time and listened to. Thank you CAMHS.

My father-in-law was an inpatient this year. Nursing care was excellent. The only concern we had as a family was poor communication from the Medical team in relation to granddad's care. He was at End of life with Alzheimer's and was quite distressed intermittently in the early part of his stay. Once we had frank discussion with the team and correct palliative medication was prescribed he was much more comfortable and had a very peaceful death. We felt ever so grateful to the staff on the ward.

My widowed mother needed a home help package to help her at home after she had a stroke. The public health nurse came and did an assessment and recommended 8 hours a week (5 days) for Mam. However we were then told that there were no resources and Mam was added to a waiting list and would be kept under review. We didn't know how long this wait would be - at first we thought maybe a few weeks but now 2 months on we are so disheartened and upset

No Data without Stories

No Stories without Data

HSE COVID-19 Pulse- Staff Focus Group (October 2021)

Initial Experiences of Covid-19 as Frontline Healthcare workers

"You felt like while you were working really hard and putting a lot of yourself into it, that the results that you're achieving were quite substantial."

"It was really, really hard. For the first few months, I was working eighty-hour weeks, six to seven days a week, like it was very intense, more intense than ever"

"It's been stressful, the uncertainty meant that tensions were running high"

"Everything was happening so fast, and we had to think on our feet. My days were constantly changing and had to adapt, I enjoyed that. Myself and the team were thriving"

Lived experiences of working and living during Covid-19

An Epidemiology of Kindness

Some personal reflections of working, and sometimes flourishing, from people working in the HSE Contact Management Programme during the early months of the pandemic

"united we stand divided we fall"

"there were indeed a lot of long hours worked with blurred lines between work and home life"

It was very much a "can do" attitude.

"TEAM WORK WAS HOW WE ACHEIVED THIS"

"Within the team I felt included, valued, supported and listened to"

Value, develop and engage our people

"How to improve staff engagement: improve quality of leadership, develop effective team working, ensure good working relationships, reduce workload ?

Have an unclouded vision around care quality, put staff in charge of service change, and ensure trust, openness and fairness".

Professor Michael West (2018)

Summary thoughts!

Its not easy!

What

- measure what matters!
- Clinical expertise, evidence base Patient experience
- Outcomes, including patient recorded outcomes and functional status
- Both qualitative and quantitative information

How

- Build capability for measurement – both electronic and staff
- Use patients and clinical experts
- Build data collection into routine work and record keeping
- Use available data
- Measure once use often
- Measure variability, trends over time
- Seek transparency in the measuring, sharing and reporting
- Culture or improvement

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Thank you