GETTING READY TO WORK ON QUALITY IMPROVEMENT (QI) AND SAFETY TEAMS

A Primer for Advisors

You have been asked to participate in a quality improvement or safety team in your organization. Many organizations have successfully involved advisors in ongoing committees or teams. There are constant opportunities for changes to be made that will improve health care processes, programs, and services. The delivery of health care can be complex and fragmented. These conditions present safety risks to the patient (or resident living in a long-term care community), and staff. Inviting patient, resident, and family advisors to participate in quality improvement projects ensures that improvements maintain or improve safety and respond to the priorities and needs of those most affected by the changes. You bring important insights to these conversations.

Benefits of Partnering with Advisors

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- Health care professionals make fewer assumptions about what patients, residents, and families "want" and engage in more dialogue about what solutions are possible when advisors are members of quality improvement and patient or resident safety committees and teams.
- Advisors "see things differently," and will ask, "Why do you do it this way?" Health care professionals often realize there is no evidence-base or valid answer. This helps organizations let go of processes that don't work for patients, residents, families, clinicians, and staff and find better solutions that benefit all.
- Advisors challenge what's possible. Often, staff say, "we can't do it that way" or "our accreditors and vendors won't support this change." Having the voices and support of patients, residents, and families makes change within and outside the organization more likely than one might imagine.

Role of an Advisor on Quality Improvement and Safety Teams:

Your role is to participate fully on the committee and bring the perspective of your lived experience or your family member's experience with the health care system. As a patient, resident, or family advisor, you have an interest in helping improve health care experiences by making them more efficient, effective, useful and helpful to all patients. Sharing the value you place on quality and safety is important. It is easy to forget that behind each number or chart are many people who had a care experience that could have been better or safer. You are an expert on your own experience. While other team members may bring their clinical or operational experience, only you can share what its like to experience care.
Each member of the team has values and by working together improvements can be made that will improve the experience for all.

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Suggestions from Advisors Who Have Served on Quality and Safety Committees:

- Be a full member of the team. Your views and experience are important—share them.
- Let other members of the committee know if they are using language or acronyms that you don't know. Each organization has abbreviations that can be confusing. Often, staff and clinicians don't realize they are using "shorthand."
- Ask questions and encourage staff and clinicians to think about the situation from the perspectives of patients, residents, and families.
- If you are confused or the meeting is moving too quickly, let the committee know. In these meetings, all members are expected to actively participate which includes asking for an explanation when things aren't clear.
- Use your own health care experience as a reality check as new ways of doing work are discussed.
- Think broadly about others in the community and their different perspectives. How might the committee's conversation/decisions impact other patients, residents, and families?
- Share with the committee leaders and/or your mentor what support or resources you need to be an effective member of the team.
- Review materials before the meeting, if provided. Show up a little early and call if you are unable to attend.

Strategies to Prepare for Serving on a Quality or Safety Team:

The organization where you serve as an advisor should provide you with some specific orientation to working with an existing quality and/or safety committee. This may include formalized training on quality and safety methods. It may also include information on the following:

- Name of committee, its members and their roles/titles, time of meeting and location.
- The purpose of the group – is there a document that outlines its charter or by-laws?
- Previous minutes or documents generated by the group.
- Summary of data that is reviewed regularly in the meeting and its purpose.
- Special words or terminology used in the committee.
- Length of service required.

You can ask for additional information that will be helpful to you that the organization may not have provided. Some ideas or requests that other advisors have made include:

- May I meet with the committee chair prior to my first meeting?
- Would it be helpful if I provide to the committee, before my first meeting, a short written bio, a recent picture of me and a statement of why I would like to be involved in the committee Are there any special skills or background I will need to work on this group?
- Are there other advisors who serve on the committee? If so, may I meet them before my first meeting?
- What kinds of recommendations or work does this group produce?
- How have advisors been involved with this group in the past?

At the completion of an orientation to quality improvement, patient safety, and the particular project or team assignment, you should be able to answer the following questions:

- What is quality improvement and what tools or methods are used to improve services in the organization?

- What are key safety concerns, terms, tools, and methods for improvement?
- What is the team trying to accomplish?
- What is my role on the team?
- How will we know that change is an improvement?
- Who is my main contact for ongoing support and assistance?

If you cannot answer these questions, please provide feedback to your staff liaison or contact. You may need more assistance or information provided to you.

The following background information may be helpful to you as you embark on this new experience. If you have any questions, let your staff liaison or contact know what they are. Enjoy this new experience and know that your participation can make a positive difference for the people who receive services from the health care organization and its staff.

Common Quality Terms and Their Definitions:

Quality. The concept of quality has two dimensions in health care: clinical or technical quality and the patient or resident and family care experience. Clinical or technical quality is defined by agreed upon evidence-based standards, which define the best health outcomes possible. A patient's, resident's, or family member's perception of the care experience defines quality. It is strongly influenced by their values, culture, and whether they felt they were treated with dignity and respect, provided useful information, and that caregivers involved them in decisions related to their care choices.

Quality Improvement in Health Care. The combined and unceasing efforts of everyone to make changes that will lead to better patient outcomes, better system performance and better learning. Improvement efforts generally involve the following three components: Use of data to identify quality gaps, understanding a process, and involving a diverse or interdisciplinary team to work toward solutions to eliminate the problem or improve quality (Batalden, P., & Davidoff, F. (2007). *Quality and Safety in Health Care, 16*, 2-3).

PDSA. This is an acronym used to explain the steps used to test a change basic to any quality improvement effort.

Plan is the first step where the opportunities for improvement are identified through analysis of data, observations and team knowledge. During this time a test of change is planned.

Do is implementation of a small test of change.

Study is the collection of data and observation of learning from the consequences of the test to see if it resulted in an improvement.

Act is the step that integrates what was learned during the test of change into another cycle of change or refinement.

The PDSA cycle is continually repeated until the change has improved the selected outcomes and is ready for widespread implementation.

LEAN. This is an approach to increasing value to the customer by reducing waste in processes. It was originally used in manufacturing. In health care, LEAN uses the concept of waste to redesign work. The first change is to eliminate any work that does not provide value to the

customer—defined as the patient. Waste falls into seven categories: defects, waiting, transporting, inventory, motion, extra processing, overproduction (redundant work) and people (the waste of a person).

Rapid Process Improvement Workshops (RPI). Using a variety of tools from LEAN, Six Sigma, and continuous improvement, these workshops are one to five day events where a team comes together to make rapid, immediate changes to a process or work environment. The group spends significant time in the workplace observing and identifying waste. A sponsor meets with the team at the end of each day to be advised on what changes or recommendations have been implemented and to mobilize resources to eliminate any barriers that would prevent the team from meeting the specific financial, operational, or clinical quality goals established prior to the RPI.

Six Sigma. This is another approach to improving quality through the disciplined use of statistical analysis to show what the process is capable of producing. A clear focus on achieving measurable and quantifiable financial returns from any Six Sigma project puts it apart from other approaches. The goal is a process that has zero defects. A healthcare example is the goal to have zero instances where a patient was given a wrong medication that resulted in permanent harm or death. Six Sigma and LEAN approaches are often used in combination.

Pareto Principle/Chart. This principle says that when identifying opportunities for improvement, it is important to understand the "vital few" that account for the largest problem (60% or more). Pareto created a way to display data that helps a group "see" which causes or issues are the "vital few." Many have come to refer to this as the 80-20 rule. An example of this is looking at medication administration errors that have occurred. By organizing the number of errors by the medication names, it is easy to see which medications are involved in the greatest percent of errors. Through a focused analysis of those few, solutions can be targeted to provide the greatest benefit.

Run Charts and Control Charts. Taking data and plotting it on a graph over time is a visual way to determine whether the changes made have resulted in an improvement. A run chart shows the individual data points in relationship to the average or median of all data collected (shown as a horizontal line on the graph). Because all processes have variation, a run chart helps display whether there is a positive trend in the outcomes or goals set for the improvement team. A control chart is a more rigorous statistical method of displaying data in a graph and can provide more precise information about the nature of the variation. Examples of data to display in these charts are number of falls, length of stay, and time from arrival to treatment in the emergency department.

Flowchart. This is a visual diagram that shows the discrete steps or tasks used to create a product or deliver a service. The word **process** describes any series of steps or tasks that are completed by a combination of people, materials, and machines. Depending on the scope of a project, the process can involve more than one person or department and may even span more than one organization. Examples of processes include admitting a patient to the hospital, seeing a patient at the clinic, and managing a referral to another provider and represent a series of steps and tasks.

Qualitative Data. This data is information that describes something. It can be observational or information gleaned through interviews or surveys. Patient satisfaction surveys are an example of qualitative data. While this data can be reported in numbers and percentiles and compared to others who use the same survey, it is based on what value a person places on their lived experience.

Quantitative Data. This data is information based on the counting of discrete items. For instance, number of patients undergoing a particular surgery or total number of patients who

receive care at a clinic. Many times the raw numbers are then reported in percentages. For example, the percent of people that got an infection from being in the hospital. These numbers can report good outcomes or defects (things that went wrong and are undesirable results of a process).

Common Patient Safety Terms and Their Definitions:

Sentinel Event. Any unanticipated event in a health care setting resulting in death or serious physical or psychological injury to a patient (or patients), not related to the natural course of the patient's illness.

Root Cause Analysis. A systematic investigation that identifies the factors that resulted in a harmful outcome. Its aim is to identify what behaviors, actions, inactions, or conditions need to be changed to prevent recurrence of similar harmful outcomes and to identify the lessons to be learned to promote the achievement of better outcomes. ("Success" is defined as the near-certain prevention of recurrence.)

Rapid Response Team. A group of health care professionals who respond to the identification of a patient in a health care setting whose condition appears to be deteriorating without apparent cause. The goal is to identify the cause and take actions to reverse the patient's decline in health status. In many hospitals, anyone can initiate a rapid response team including patients and family members.

Healthcare-Associated Infections (HAI). These are the most common complications of hospital care. Significant harm can be caused by these infections. These infections result from inadequate safety for key hospital procedures or hygiene practices. The most frequent HAIs are surgical site infections (SSI), catheter-associated urinary tract infections (CAUTI), central venous catheter–related bloodstream infections (CRBSI) and ventilator-associated pneumonia (VAP). These infection types account for 80% of all hospital associated infections.

Medication Reconciliation. A process of comparing the health care organization's documentation of a patient's medication record with the medications the patient is actually taking. Many organizations are working on improving these processes to avoid medication errors or drug-to-drug interactions that can result in significant patient harm.

The definitions above have been adapted from the Patient Safety Network and the Institute for Health Care Improvement. You can contact your quality improvement staff for additional resources. More information on quality improvement and safety terminology or definitions is available at the websites listed below:

- **Institute for Healthcare Improvement** at www.ihi.org. Leadership organization for quality improvement in health care that has many resources and examples of successful QI projects.
- **AHRQ Patient Safety Network** at www.psnet.ahrq.gov/. This patient safety network sponsored by the Agency for Healthcare Research and Quality has patient primers on key safety hazards in health care and an extensive glossary of terms.
- **National Patient Safety Foundation** at www.npsf.org/for-patients-consumers/. The NPSF has many resources for consumers. The Lucian Leape Institute is supported by the NPSF and is a leader in promoting the inclusion of patients and families into patient safety improvement initiatives.
- **Consumers Advancing Patient Safety (CAPS)** at http://www.patientsafety.org/. A consumer-led, nonprofit organization, CAPS is dedicated to improving the safety of health care through partnerships and collaboration. The CAPS website provides both

information about patient safety programs and tools for building consumer capacity for collaboration.

- **Patients for Patient Safety (PFPS)** at http://www.who.int/patientsafety/patients_for_patient/en. A global network of patients and consumers who work with other groups and organizations. The ultimate purpose is to improve health-care safety in all health-care settings throughout the world by involving consumers and patients as partners.

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