West Moreton Hospital and Health Service

Quality improvement strategy
2015–20

Providing a clinical governance framework for
West Moreton Hospital and Health Service
# Contents

A joint message from Dr Mary Corbett and Ms Sue McKee ................................................................. 2
A message from Dr Mary Seddon ........................................................................................................... 3

## Introduction ............................................................................................................................................. 4
- What is a quality improvement strategy? .......................................................................................... 4
- Why do we need a quality improvement strategy? ........................................................................ 4
- How does this strategy fit in with Research and Clinical Education strategies? .............. 4
- What is healthcare quality? ............................................................................................................. 5
- What is quality improvement? ......................................................................................................... 5
- How will we implement the quality improvement strategy? ......................................................... 5
- Governance ...................................................................................................................................... 5

## Principles .................................................................................................................................................. 6

## Context ...................................................................................................................................................... 7
- Our vision ........................................................................................................................................ 7
- Our values ..................................................................................................................................... 7
- Wider strategic context .................................................................................................................... 8
- National Standards .......................................................................................................................... 8
- Highly reliable care ............................................................................................................................ 9

## Our quality improvement priorities ..................................................................................................... 10
- Safe care ......................................................................................................................................... 10
- Timely care .................................................................................................................................... 10
- Effective care ................................................................................................................................ 11
- Equitable care ................................................................................................................................ 11
- Efficient care ................................................................................................................................... 12
- Patient and family centred care ........................................................................................................ 12

## What quality improvement methods should we use? ......................................................................... 15

## Measurement for quality improvement ............................................................................................ 16
- An integrated measurement methodology for performance excellence ................................... 17

## Conclusion ............................................................................................................................................... 18

## Appendices .............................................................................................................................................. 19
- Appendix A ........................................................................................................................................ 19
<table>
<thead>
<tr>
<th>‘Triple aim’ mission</th>
<th>Healthcare quality</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>S</strong> Safe</td>
<td>Safe</td>
</tr>
<tr>
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</tr>
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<td><strong>T</strong> Timely</td>
<td>Timely</td>
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<td>‘Best in class” in 5 conditions measured by the Health Roundtable</td>
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<td><strong>E</strong> Equitable</td>
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<td><strong>E</strong> Efficient</td>
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<tr>
<td>Reduced waste by 5% year-on-year, through efficient processes</td>
<td></td>
</tr>
<tr>
<td><strong>P</strong> Patient Centred</td>
<td>Patient Centred</td>
</tr>
<tr>
<td>Excellent scores in patient experience surveys</td>
<td></td>
</tr>
</tbody>
</table>
Welcome to our Quality Improvement Strategy 2015–20, a high level road map that sets out our vision and goals for safety and quality improvements over the next five years. This strategy will guide us as we ensure new knowledge gleaned through continuous learning is embedded in our everyday practice for the benefit of our patients.

Our definition of ‘quality healthcare’ goes beyond the provision of safe and effective care. We know that patients care about lots of other things – the way they are greeted at reception, the cleanliness of the ward, the quality of the information they receive and the empathy shown by clinical staff.

With this in mind, we align our quality improvement priorities with the more holistic, ‘STEEEP’ framework. This is a well-accepted model used globally by healthcare organisations to assess healthcare quality according to a broader range of indicators. According to STEEEP, quality healthcare is:

- **Safe** – avoiding harm to patients from care that is intended to help them
- **Timely** – reducing delays that have an impact on the smooth flow of care to the patient
- **Effective** – providing clinically effective healthcare based on scientific knowledge to all who could benefit and refraining from providing services to those who are not likely to benefit
- **Equitable** – providing care, including access to care, that does not vary in quality according to personal characteristics such as gender, income, ethnicity or location
- **Efficient** – using resources to achieve best value by reducing waste and reducing production and administrative costs
- **Patient centred** – providing care that is respectful and/or responsive to individual patient preferences, needs and values.

Quality improvement involves looking at the things we do in a critical light, asking whether we can improve the way we do things and constantly working to make the processes better. It requires the vigilance and cooperation of the whole healthcare workforce, where every member of staff sees themselves as playing a key role in the patient experience and is passionate about providing the highest quality care and improving patient outcomes.

Our collective contribution, effort and enthusiasm for continuous improvement is evidenced by the improvements we have made in service delivery and by the many patient-centred processes and initiatives we have embedded across the organisation in recent years. This strategy will help to ensure we continue to build on these achievements and deliver on our mission to provide excellent health, excellent care and excellent value to our community.

Dr Mary Corbett  
Chair  
West Moreton Hospital and Health Board

Ms Sue McKee  
Chief Executive  
West Moreton Hospital and Health Service
“Face reality, seek new designs and involve everyone” – this quote from Don Berwick encapsulates what this strategy is all about. We all know the reality: increasingly aged population and health workers, increased patient demand, an explosion of chronic care, constrained funding and increased expectations. To meet this new reality we need to be nimble and innovative, using the science of quality improvement to introduce and assess new ways of doing things.

This Quality Improvement strategy aims to provide a framework to allow staff and patients to drive the improvements, new models of care and the new designs necessary. Frontline staff and patients can easily identify when things don’t work as well as they should, and they can often identify the solutions to the problems.

The strategy introduces the Model for Improvement, which asks three questions central to any improvement work:

1. What are we trying to accomplish?
2. How will we know that a change is an improvement?
3. What change can we make that will result in an improvement?

This strategy is intimately linked to the Research and Innovation Strategy (establishing new knowledge) and the Clinical Education and Learning Strategy (ensuring that staff have the necessary skills).

West Moreton HHS has the opportunity to build on the solid foundations that already exist, and develop a culture of patient safety and high quality care.
Introduction

What is a quality improvement strategy?
The West Moreton Hospital and Health Service Quality Improvement Strategy is a high level road map that sets out:

- our vision and goals for safety and quality improvement by 2020
- the initiatives we will implement to achieve our goals
- what we will measure to know how we are progressing to achieving our goals.

Why do we need a quality improvement strategy?
Despite our best efforts, the safety and quality of care received by West Moreton patients is not yet as good as it could be. This is not unique to West Moreton, with several studies over the years showing that an unacceptable number of patients are harmed by the healthcare they receive.

In order to achieve our vision of healthcare excellence West Moreton needs to focus on continuously improving the quality of care we deliver.

How does this strategy fit in with Research and Clinical Education strategies?

- Research and Innovation Strategy
  Establishes new knowledge

- Clinical Education and Learning Strategy
  Supports continuous learning

- Quality Improvement Strategy
  Embeds new knowledge into practice
What is healthcare quality?

We define healthcare quality according to the internationally well-accepted framework first developed by the Institute of Medicine and since reframed as a memorable acronym ‘STEEP’ care, that is:

- **Safe** – avoiding harm to patients from care that is intended to help them
- **Timely** – reducing delays that have an impact on the smooth flow of care to the patient
- **Effective** – providing clinical effective healthcare based on scientific knowledge to all who could benefit and refraining from providing services to those who are not likely to benefit (avoiding overuse and underuse)
- **Equitable** – providing care, including access to care, that does not vary in quality according to personal characteristics such as gender, income, ethnicity or location
- **Efficient** – using resources to achieve best value by reducing waste and reducing production and administrative costs
- **Patient centred** – providing care that is respectful and/or responsive to individual patient preferences, needs and values.

What is quality improvement?

There is no single definition of quality improvement, but this definition from Dr. John Ovretveit highlights some of the important elements:

“*better patient experience and outcomes achieved through changing provider behaviour and organisation through using a systematic change method and strategies.*”

The key elements in this definition are the combination of a ‘change’ (improvement) and a ‘method’ (an approach with tools), while paying attention to the context in order to achieve better outcomes.

The purpose of a quality improvement programme is to provide solutions to problems, and in particular to provide solutions to quality problems where in many cases, neither the root cause of the problem, nor even the precise nature of the problem itself is well understood. In most cases, a quality improvement programme does not have an end (because we are always striving to improve from where we are) nor a known implementation path (because when we start, we usually do not know the precise problem or root cause). Accordingly, quality improvement methodology is fundamentally different to traditional project management.

Quality improvement means looking at the things we do in a critical light, asking whether we can improve the way we do things, and constantly working to make the processes better.

How will we implement the quality improvement strategy?

Accompanying this Quality Improvement Strategy is a Quality Improvement Action Plan setting out the actions we will take to make measurable improvements in the care we deliver.

Governance

The implementation of this Quality Improvement Strategy will be overseen by the West Moreton HHS Peak Safety and Quality Committee. This Committee will regularly evaluate progress against the strategy and will provide regular reports to the HHS Executive and the Board.

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1. Baylor Healthcare
Principles

There are a number of important principles that underpin this Quality Improvement Strategy and that will guide the implementation of the strategy through the Quality Improvement Action Plan.

1. West Moreton is committed to providing Highly Reliable Care. That is, every patient will receive consistently safe, high quality care.

2. Healthcare quality at West Moreton is STEEEP care, that is: Safe, Timely, Effective, Equitable, Efficient and Patient-centred.

3. West Moreton is committed to a ‘systems approach’ to quality improvement. Don Berwick’s first law of improvement: “every system is perfectly designed to achieve exactly the results that it gets” makes the point that errors and waste in healthcare are system properties, and that to improve these, we must improve the system - not ask our people to ‘do better’ or blame individuals when the system goes wrong.

4. West Moreton is committed to a ‘just culture’.

5. The system of care will be improved by front-line staff, empowered by senior leaders, with support, direction and technical assistance by those trained in quality improvement.

6. Measurement and setting clear aims are central to quality improvement. Measurement is for improvement not for judgement or punishment.

7. There is transparency for the staff, Board and community with respect to quality indices at West Moreton.

8. Quality improvement will drive us to exceed national standards for accreditation.

3. President of the U.S. based Institute for Healthcare Improvement (www.ihi.org)
Context

Our vision

West Moreton Hospital and Health Service (HHS) has a clear vision for the future: *Proud to deliver healthcare excellence.*

We have a ‘Triple Aim’ mission – *Excellent health. Excellent care. Excellent value.* This ‘Triple Aim’ is adapted from the concept first developed in 2007 by the US Institute for Healthcare Improvement in response to healthcare organisations focusing primarily on the financial bottom line to the detriment of the actual delivery of care. Interestingly the danger of singularly pursuing a financial bottom line was also one of the conclusions to come out of the Mid-Staffordshire review into failings of care in the NHS in 2013:

“This failure was in part the consequence of allowing a focus on reaching national access targets, achieving financial balance and seeking foundation trust status to be at the cost of delivering acceptable standards of care.”

At West Moreton we are committed to focussing simultaneously on three bottom lines:

1. **Excellent health** – our focus is on improving the health of our population and reducing inequalities of care between subsets of the population. This incorporates health promotion and disease prevention strategies alongside quality clinical care.

2. **Excellent care** – our focus is on improving care as experienced by individual patients, their families and carers. This includes the quality and safety of care provided to individual patients, as well as the coordination of care across boundaries. It incorporates patient and family centred care and customer focus.

3. **Excellent value** – our focus is on improving the quality of care to reduce the cost per case of care. Increasing the quality of care reduces wasted resources, allowing us to provide more and better care for the same amount of money.

Our values

West Moreton has a strong set of values developed by our staff. These values will be reflected in everything we do and are central to our delivery of this Quality Improvement Strategy.

**Really care** – every day we are proud of how we care for our patients, how we work together, and how we deliver our work.

**You matter** – we are part of the community we service. What is important to our community is important to us. We respond to your feedback about our work, our attitude, the services we provide and the way we provide them.

**We deliver** – our patients, their families, our colleagues, our staff, our partners and our community can be confident in our people and our services. We honour our commitments.

**Be the best** – we are here to make our patients’ healthcare experience the very best it can be. We aspire to realise our vision and be *Proud to Deliver Healthcare Excellence.*
Wider strategic context

This Quality Improvement Strategy sits within the WMHHSs Strategic Plan – Path to Excellence: 2015–19. The plan has six interrelated Strategic Directions that make up our continued focus on the delivery of healthcare excellence:

- Excellence in patient and family centred care
- Excellence in service delivered through innovation, research and lifelong learning
- Provide an agile, resilient health service that anticipates and responds to need
- Enable staff to be their best and give their best
- Remain financially astute
- Integrated systems that transform the delivery of healthcare excellence now and in the future.

This Quality Improvement Strategy aligns with the WMHHS Research and Innovation Strategy: 2015–20 “Turning research into excellent care” with its key mission to create a visible and viable research programme that supports high quality clinical research and quality improvement with the aim of improving patient care.

This strategy also aligns with the WMHHS Clinical Education and Learning Strategy 2015–20 “Supporting a learning organisation” which aims to maximise the capability of our staff to deliver safe, effective, patient and family centred care.

National Standards

As part of our Service Agreement with the Department of Health we are required to maintain accreditation against the ten National Safety and Quality Health Service (NSQHS) standards – we aim to exceed those standards in the delivery of care to our patients. West Moreton also seeks to exceed the EQuIPNational accreditation standards of the Australian Council on Healthcare Standards (ACHS).

The ten NSQHS Standards and five ACHS EQuIPNational Standards are:

| Standard 1 | Governance for Safety and Quality in Health Service Organisations |
| Standard 2 | Partnering with Consumers |
| Standard 3 | Preventing and Controlling Healthcare Associated Infections |
| Standard 4 | Medication Safety |
| Standard 5 | Patient Identification and Procedure Matching |
| Standard 6 | Clinical Handover |
| Standard 7 | Blood and Blood Products |
| Standard 8 | Preventing and Managing Pressure Injuries |
| Standard 9 | Recognising and Responding to Clinical Deterioration in Acute Health Care |
| Standard 10 | Preventing Falls and Harm from Falls |
| Standard 11 | Service Delivery |
| Standard 12 | Provision of Care |
| Standard 13 | Workforce Planning and Management |
| Standard 14 | Information Management |
| Standard 15 | Corporate Systems and Safety |
There are also National Standards for Mental Health Services (NSMHS) that we aim to exceed in our delivery of mental health services. The ten NSMHS are:

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<th>Standard</th>
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</tr>
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<td>Standard 1</td>
<td>Rights and responsibilities</td>
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<td>Standard 2</td>
<td>Safety</td>
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<tr>
<td>Standard 3</td>
<td>Consumer and carer participation</td>
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<td>Standard 4</td>
<td>Diversity responsiveness</td>
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<td>Standard 5</td>
<td>Promotion and prevention</td>
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<td>Standard 6</td>
<td>Consumers</td>
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<td>Standard 7</td>
<td>Carers</td>
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<tr>
<td>Standard 8</td>
<td>Governance, leadership and management</td>
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<tr>
<td>Standard 9</td>
<td>Integration</td>
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<tr>
<td>Standard 10</td>
<td>Delivery of care</td>
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**Highly reliable care**

West Moreton’s point of difference will be an organisation that delivers Highly Reliable Care. The concept of high reliability builds on the systems thinking principle outlined above and sets out to emulate those high risk industries that never-the-less have excellent safety records.

There are five features of Highly Reliable Organisations:

- **Preoccupation with failure** – a focus on errors and near misses, learning from them and working out how to prevent them happening again
- **Reluctance to simplify** – constantly asking ‘why’ and inviting others with diverse experience to express their opinions (leveraging new thinking)
- **Sensitivity to operations** – an ongoing concern with the unexpected. Situational awareness, paying attention to the frontline and teams that speak up for safety
- **Commitment to resilience** – recognising that things will go wrong and we will make mistakes; but we will quickly identify issues and have structures in place to respond quickly and minimise harm
- **Deference to expertise** – recognising that those closest to the frontline are the experts and empowering them to make decisions when critical issues arise.

The Clinical Services Division introduced the concept called the Fundamentals of Highly Reliable Care. See Appendix A for a list of the ten Fundamentals of Highly Reliable Care and how they align with the National Safety and Quality Health Service Standards.

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4. Weick and Sutcliffe, Managing the unexpected: Assuring high performance in an age of complexity (2001)
Our quality improvement priorities

Safe care

Avoiding injury or harm to patients from care that is intended to help them

Studies all across the world have shown that an unacceptable number of patients are harmed by the healthcare they receive. In studies from the United States, the United Kingdom and here in Australia approximately 10 per cent of hospital admissions are found to be associated with an adverse event, and around 1.5 per cent are associated with permanent disability or death. Common adverse events in healthcare include harm from falls, pressure injuries, medication errors, patient mis-identification and venous thromboembolism (VTE).

Despite this level of harm being known for nearly 20 years, the improvement in patient safety has been patchy. In part this is because as standards improve and patient safety knowledge grows, more types of harm have come to be regarded as preventable. As the scope of what is considered to be preventable harm expands it becomes more difficult to demonstrate improvement over time.\(^5\)

It is also generally accepted though that healthcare has been slow to learn from other high reliability industries; these industries accept that humans are fallible and prone to making errors. They accept human fallibility, and then design systems that make it hard for people to do the wrong thing, or at least hard for that error to impact on the patient. This is what high reliability organisations (e.g. nuclear power stations) build into their culture.

As James Reason said in response to the repeated error of injecting vincristine into the intrathecal space (where it is neurotoxic and usually fatal):

“When a similar set of conditions repeatedly provokes the same kind of error in different people, it is clear that we are dealing with an error prone situation rather than with error prone, careless, or incompetent individuals.”

Blaming and removing the person who made the error does not make the situation any safer for the next patient. Once we accept this, the focus of the patient safety improvement programme switches from the individual, to the system or process of care, and it is only then that it is likely to have a lasting impact.

Timely care

Reducing delays that have an impact on the smooth flow of care to the patient

“Care should continually reduce waiting times and delays for both patients and those who give care.”

These delays add no value to the patient and are a form of waste. The National Emergency Access Target (NEAT) – ED waiting times – and the National Elective Surgery Target (NEST) – surgical waiting times – are two indicators in this stream. However, there are many other delays in our care system, and most can be avoided with redesign.

Providing timely care is more than just a respectful use of people’s time, it has been shown to reduce mortality in the frail elderly,\(^6\) in patients presenting with acute myocardial infarctions,\(^7\) cancers\(^8\) and many other conditions.

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Effective care

Providing clinically effective care, avoiding overuse and underuse

“Millions of people are receiving drugs that aren’t helping them, operations that aren’t going to make them better, and scans and tests that do nothing beneficial for them, and often cause harm”. Atul Gawande

Although this dimension gets less play than patient safety it is undoubtedly the dimension that can affect the most improvement. Mark Chassin’s triad of overuse (ineffective care), underuse (effective care not delivered) and misuse (errors in care delivery) is a useful way to think about clinical effectiveness.

- Overuse. Interventions that have no clinical benefit. For example, over-prescribing of antibiotics for viral illnesses accounted for $100 million a year (2002 data) in Australia, and in the United States, $17 million spent for common cold alone. As well as the cost of these drugs, there is an estimated annual cost of US $5 billion to treat the consequences of increasingly drug resistant organisms resulting in part from overuse.

- Underuse. Lack of intervention where evidence suggests an advantage. Beth McGlynn’s seminal paper showed that fewer than 50 per cent of patients, across a range of conditions, got all the effective care that they would benefit from.

For more than 20 years the Dartmouth Atlas has documented glaring variations in care provision – from the type of surgeries offered to medical management. These large variations in care are not explained by differences in patient mix. Most of these differences related to local practice, group-think and where practitioners had been trained. Reducing this variation through ‘standardizing that which can be standardized,’ through checklists and clinical pathways is important in improving the overall effectiveness of care.

Many of Australia’s medical colleges and professional societies are now coming together to improve the quality of healthcare through considering tests, treatment and procedures where evidence shows they provide no benefit, or in some cases, lead to harm through the ‘Choosing Wisely Australia’ campaign.

To enable clinicians to know whether they are providing effective care, there needs to be a formal programme to measure that care. It is envisaged that each clinical area will own their clinical indicators with the expectation that these will be used for improvement.

Equitable care

Providing care, including access to care, which does not vary in quality according to personal characteristics such as gender, income, ethnicity or location

“Equity conveys a sense of fairness, but sharpens fairness by adding equality and fellow-feeling.”

“Pursuing equity in health means eliminating health disparities that are associated with underlying social disadvantage or marginalisation. Equity focuses [our] attention on socially disadvantaged, marginalised or disenfranchised groups within and [among] countries, but not limited to the poor.”

Ethnicity, gender and income should not prevent anyone from receiving high-quality care, but there is ample evidence that it does.

West Moreton has a demographically diverse population including metropolitan and rural communities, high deprivation communities and a significant population who are Indigenous Australians or born outside Australia. West Moreton must reduce inequities in access to health care so the benefits can reach everyone in our community equally.

14. www.choosingwisely.org.au
15. Leeder SR. Achieving equity in the Australian healthcare system. MJA. 2003; 179: 475-478
Efficient care

Using resources to achieve best value by reducing waste and reducing production and administrative

Providing ineffective care is inherently wasteful, and the best way to improve efficiency of service is to ensure that appropriate patient care is provided.

However there is also much waste in the healthcare system that does not directly involve the patient. These sources of waste include administrative waste (over- and under-ordering of supplies, poor organisation), delays (wasted theatre time, long lengths of stay due to inefficient hospital processes, admissions just to access tests) and service deficiencies (broken equipment, lack of extended hours of services, wrong services in the wrong places), and environmental waste. Eastern Health in Victoria have already achieved significant cost savings through their sustainability and environmental waste programme. These non-clinical wastes are often just accepted as part of the problems of large complex organisations. Most jurisdictions consider that waste can be reduced year-on-year without impacting on clinical care. Exposing and reducing this waste is the prime function of lean-thinking quality improvement methods.

Patient and family centred care

Providing care that is respectful of and responsive to individual patient preferences, needs and values

Healthcare workers have prided themselves on being patient focussed; however in recent years it is clear that patient-focussed care (doing what is best for, or to, the patient) is not meeting patient and family expectations. Working with the patient and family is what underpins Patient and Family Centred Care (PFCC).

The Institute for Patient and Family Centred Care have outlined four principles of PFCC:

1. Dignity and respect – health care practitioners listen to and honour patient and family perspectives and choices. Patient and family knowledge, values, beliefs and cultural backgrounds are incorporated into the planning and delivery of care.

2. Information sharing – health care practitioners communicate and share complete and unbiased information with patients and families in ways that are affirming and useful. Patients and families receive timely, complete and accurate information in order to effectively participate in care and decision making.

3. Participation – patients and families are encouraged and supported in participating in care and decision-making at the level they choose.

4. Collaboration – patients, families, health care practitioners and hospital leaders collaborate in policy and program development, implementation, and evaluation; in health care facility design; and in professional education, as well as in the delivery of care.

PFCC is a term that describes a continuum from treating patients with respect, through to full patient and family engagement, and active partnership. There are different levels of engagement that have been outlined in a multidimensional framework by Carman et al (see diagram below):

1. Direct care – this includes sharing of information, shared decision-making, and identifying families as partners in care

2. Organisational design and governance – organisational commitment to PFCC in vision statements, systems for patient experience feedback, and patients and families on key committees

3. Policy making – patient recommendations about service delivery and funding priorities.

Diagram 1. Multidimensional framework

Levels of engagement

Direct care
- Patients receive information about a diagnosis

Organisational design and governance
- Organisation surveys patients about their care experiences
- Hospital involves patients as advisors or advisory council members

Policy making
- Public agency conducts focus groups with patients to ask opinions about a health care issue
- Patients' recommendations about research priorities are used by public agency to make funding decisions

Partnership and shared leadership
- Treatment decisions are made based on patients' preferences, medical evidence and clinical judgement
- Patients co-lead hospital safety and quality improvement committees
- Patients have equal representation on agency committee that makes decisions about how to allocate resources to health programs

Factors influencing engagement:
- Patient (beliefs about patient role, health literacy, education)
- Organisation (policies and practices, culture)
- Society (social norms, regulations, policy)
PFCC requires some adjustment on the part of health professionals and healthcare administrators. At its centre it requires a rethink of the role patients and their families play in their care, from passive recipients to active partners. Families, however they are defined, are essential to patients’ health and well-being and are crucial allies for quality and safety.

From the principles above flow a number of work areas:

1. Face-to-face engagement with patients and families
   
   Supported by the learnings from the Studer Group and the acronym AIDET (Acknowledge, Introduce, Duration, Explanation, Thank you), this work area aims to improve face-to-face communication between healthcare workers, patients and their families. Although simple, many of our patient complaints stem from inadequate attention to face-to-face engagement, particularly staff not introducing themselves or not discussing treatment plans with patients and their families. Engaging with patients and families is a central tenet of the Fundamentals of Highly Reliable Care at West Moreton.

2. Differentiating families from visitors
   
   Families are very important for the recovery of patients and for taking over their care when they are discharged home. Families need to have this special role recognised and they need to be welcomed into our facilities. Failure to do this has led to complaints from families who have felt excluded from conversations with doctors, from being able to support and care for their family member and to plan their post-hospital care. This quote from the US is equally applicable to WMHHS.

   “Current ‘visiting’ policies in many of our nation’s hospitals, even for traditionally defined ‘families,’ are inappropriately restrictive, costly, put patients at risk, and contribute to emotional suffering for both the patient and family, even if administered without a trace of discrimination.”

   We need to help our staff make the transition to including families as partners in care.

3. Useful, timely, feedback from patients
   
   There are several ways in which patients and their families can give feedback to WMHHS. However, this could be strengthened to obtain real-time feedback using the new modalities available. West Moreton HHS has already developed Community Reference Groups and these are important resources for feedback and co-design.

4. Information sharing – “nothing about me without me”
   
   Increasingly patients are becoming engaged in their care (especially those with chronic conditions) and there is a world-wide movement aimed at giving patients access to the information held about them. From providing patients with a copy of their clinic letters to providing an electronic portal that provides access to all the electronic information stored on them.

   This strategy commits to patient and family experience-based co-design as a principle to improve healthcare quality.

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What quality improvement methods should we use?

Many quality improvement methods are available, and there is considerable overlap between them. Most of these share some simple underlying principles, including a focus on:

- understanding the problem, with a particular emphasis on what the data tell you
- understanding the processes and systems within the organisation – particularly the patient pathway – and whether these can be simplified
- analysing the demand, capacity and flow of the service
- understanding human factors and the causes of errors
- choosing tools to bring about change, including leadership and clinical engagement
- evaluating and measuring the impact of change

This strategy adopts the Institute for Healthcare Improvement’s Model for Improvement to frame the issues, but it recognises that there are other methods (e.g. lean thinking) that are better suited for particular types of quality improvement.

The Model for Improvement asks us three critical questions:

1. What are we trying to accomplish?
2. How will we know that a change is an improvement?
3. What changes can we make to result in improvement?

This model encourages precision in defining the aims of any quality improvement and encourages small trials of change to examine promising initiatives (using Plan, Do, Study, Act cycles). It also acknowledges that measurement is essential to determine whether a change has resulted in improvement (“all improvement requires change, but not all change results in improvement”).

Diagram 2. The model for improvement

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22. Institute for Healthcare Improvement. www.ihi.org
Measurement for quality improvement

“Some is not a number, soon is not a time, and hope is not a strategy”
– Don Berwick

Measurement and gathering data are vital elements of any attempt to improve quality and are also needed to assess the impact of any changes made. Measurement for improvement is subtly but importantly different to measurement for research (which tests whether something works) and measuring for judgement (which helps managers gauge performance).

“We are increasingly realizing how critical measurement is to the QI we seek, yet how counterproductive it can sometimes be to mix measurement for accountability or research with measurement for improvement.”

Measurement for improvement is focussed on understanding the process of care, and evaluating changes. It is therefore specific and collects only the data needed to take the next step, compared with the very precise measurement of research or accountability. It can use repeated small sample sizes compared with the large samples needed to control for confounding in research or accountability.

It is also important that measurement captures data over time, to allow assessment of whether a change has produced an improvement. It is proposed that this strategy will use a number of different modalities to effectively display quality improvement data. One powerful tool to determine if there has been improvement over time is to ‘plot the dots’ using Statistical Process Control (SPC) charts.

Diagram 3. SPC chart showing relationship to bell-shaped curve

KQC = Key Quality Characteristic; UCL = Upper Control Limit; LCL = Lower Control Limit; X = mean.

The value of SPC charts in quality improvement is that they show performance over time; can demonstrate improvement in relation to quality improvement initiatives; identify true statistical trends, and are easily understood by clinicians and lay people.

An integrated measurement methodology for performance excellence

An integrated measurement methodology for performance excellence is about measuring and reporting outcomes in an integrated way from the bedside to the board – from the frontline to the top of the organisation.

A robust performance excellence methodology will bring together a set of reporting measures into an organisation-wide balanced scorecard that can be cascaded to every level of the organisation. Central to the methodology will be:

- **Measures that relate to the strategic aims (including the triple aim)**

  At any level of the organisation, the work done must relate to the aims of the organisation. Work that does not contribute in some way to the strategic aims should be elevated to determine why we are doing it.

- **Measures that are meaningful to that level of the organisation, and part of an integrated framework**

  Often performance frameworks contain measures at many levels of the organisation that have been created in an ad hoc fashion. Some performance measures may not cascade up to the top of the organisation, and often these are not related to the organisation’s aims. Some measures at a high level do not have corresponding measures down through the structure, and these measures will usually fail to be delivered, as those further up in the organisation are not the individuals actually delivering the work being measured. Other measures are simply not appropriate at certain levels of the organisation; the measures need to change as they move up through the structure.

  Presentation of the data is important to facilitate understanding. Although attractively simple, traffic light systems, or excessive uses of averages does not improve understanding.

  The Quality Improvement Action Plan that accompanies this strategy sets out defined outcome measures for action points against each of the quality improvement strategies in this strategy. These measures will form the basis for our balanced scorecard reporting 'from the bedside to the board'.
Conclusion

This Quality Improvement Strategy sets a broad vision to guide work in this area over the next five years. It sets an ambitious goal of reliably delivering safe, timely, effective, equitable, efficient and patient-centred care.

It links in with the organisations values and vision: Proud to Deliver Healthcare Excellence.

The strategy is relevant to all staff, engaging frontline staff to identify the safety and quality issues that they face, and adopting a quality improvement methodology to sustainably bring about change.

This strategy is about making that change happen. It will become central to our philosophy of care, our objectives, our investment and financing decisions, our day-to-day management and to our work.

“Face reality, seek new designs and involve everyone”

– Don Berwick
## Appendices

### Appendix A

Alignment of West Moreton Fundamentals of Highly Reliable Care with national safety and quality standards

<table>
<thead>
<tr>
<th>Fundamentals of Highly Reliable Care</th>
<th>National Safety and Quality Health Service Standards</th>
<th>National Standards for Mental Health Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical handover</td>
<td>Standard 6 – Clinical Handover</td>
<td>Standard 9 – Integration</td>
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<tr>
<td></td>
<td></td>
<td>Standard 10 – Delivery of care</td>
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<tr>
<td>Clinical documentation</td>
<td>Standard 1 – Governance for Safety and Quality in Health Service Organisations</td>
<td>Standard 10 – Delivery of care</td>
</tr>
<tr>
<td>Patient monitoring and management escalation</td>
<td>Standard 9 – Recognising and Responding to Clinical Deterioration in Acute Health Care</td>
<td>Standard 10 – Delivery of care</td>
</tr>
<tr>
<td>Patient and family centred communication</td>
<td>Standard 1 – Governance for Safety and Quality in Health Service Organisations Standard 2 – Partnering with Consumers</td>
<td>Standard 1 – Rights and responsibilities Standard 6 – Consumers Standard 7 – Carers</td>
</tr>
<tr>
<td>Assessment and care planning</td>
<td>Standard 8 – Preventing and Managing Pressure Injuries Standard 10 – Preventing Falls and Harm from Fall</td>
<td>Standard 6 – Consumers</td>
</tr>
<tr>
<td>Ongoing care and discharge / transfer</td>
<td>Standard 6 – Clinical Handover</td>
<td>Standard 6 – Consumers Standard 9 – Integration</td>
</tr>
<tr>
<td>Procedure and test follow-up</td>
<td>Standard 1 – Governance for Safety and Quality in Health Service Organisations</td>
<td>Standard 2 – Safety Standard 6 – Consumers Standard 9 – Integration</td>
</tr>
<tr>
<td>Hand hygiene / aseptic non-touch technique (ANTT)</td>
<td>Standard 3 – Preventing and Controlling Healthcare Associated Infections</td>
<td>Standard 2 – Safety</td>
</tr>
<tr>
<td>Patient and carer on-boarding</td>
<td>Standard 1 – Governance for Safety and Quality in Health Service Organisations Standard 2 – Partnering with Consumers</td>
<td>Standard 1 – Rights and responsibilities</td>
</tr>
<tr>
<td>Highly Reliable Care Leadership Toolkit, Daily Safety Briefings</td>
<td>Standard 1 – Governance for Safety and Quality in Health Service Organisations</td>
<td>Standard 8 – Governance, leadership and management</td>
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