

ISQua's 35th International
Conference, Kuala Lumpur 2018

HEAD, HEART & MINDS – QUALITY AND SAFETY IMPROVEMENT IN HEALTHCARE



**THIS REPORT WAS COMPILED FOLLOWING THE ISQUA 2018
CONFERENCE IN KUALA LUMPUR**



EXECUTIVE SUMMARY

Change is at the heart of quality improvement in healthcare. As the needs of populations continually fluctuate, healthcare must evolve to reflect and serve those needs. **The overarching theme of the 2018 ISQua conference, hosted in Kuala Lumpur, was ‘Heads, hearts and hands weaving the fabric of quality and safety’, which led many speakers to examine change in quality and safety improvement through the lens of these three central elements.** Collectively, the conference presentations formed a picture of the global landscape of quality and safety in healthcare and offered many valuable examples of innovation that can facilitate sustainable change.

Identifying areas for transformation and implementing change can be relatively straightforward, but lasting change is much more challenging to realise. This topic was widely discussed, with many speakers sharing their experiences and learning on embedding lasting change through organisational culture. It is evident that investing time and resources to engage those on the frontline of healthcare delivery can have a huge impact on quality improvement.

Inviting patients to be active participants in their care was also a prevalent subject at ISQua 2018 and has been high on the healthcare agenda for many years.

Delivering truly person-centred care involves a reimagining of the patient-clinician relationship, and organisations that have strived to do this – from small initiatives right through to whole models of working – articulated their journeys at the conference. Tied to delivering patient-centred care is the ability to measure patient experience and satisfaction, and several ideas on how to engage with this challenge were put forward over the course of the event.

This report aims to shine a spotlight on key presentations and seminars at ISQua 2018, offering insights that healthcare professionals and leaders can take back to their institutions and use to inform their strategies of quality improvement.

This year also marks **40 years since the adoption of the Alma-Ata Declaration**, when the world came together to pledge a commitment to protecting and promoting the health of all people through primary health care. The commitment to this declaration was renewed in October at the Global Conference on Primary Health Care, held this time in Astana, Kazakhstan. The anniversary was the subject of the Monday afternoon plenary at ISQua 2018, where **Dr Shams Syed, Coordinator Quality Systems and Resilience at the World Health Organization, looked at the current state of primary health care and what has changed since the original declaration of 1978.**

The last decade, Dr Syed noted, has seen a real focus on co-production, patient records, defining population catchment areas where services are provided, and primary health care becoming a core coordinator. Syed detailed the three strands of primary health care – multisectoral policy and action, empowered people and communities, and integrated health services prioritising public health functions and primary care.

Dr Syed explained why primary health care is so important: *“Primary health care is uniquely well-positioned to respond to a complex and rapidly changing world [...] it is proven to be a highly effective and efficient way to address the main causes and risks of poor health.”* The two domains of quality care and high-performing primary health care are complimentary, he said. *“When we’re talking about quality, if we don’t take [primary health care] into consideration, we are not going to make the impact on populations that we all want to see.”*



HEADS

'Heads' refers to the mentality and values of individuals that together decide the culture of an organisation and influences how it operates. The importance of culture as a tool in instilling positive change, particularly when it comes to patient safety, is increasingly recognised. Improving culture can in turn facilitate improvements in patient safety by embedding this as an approach to delivering care rather than a series of objectives.

In Head, Heart and Hands – Managing change in clinical quality improvement, speakers on the panel pointed out that, often, inadequate attention is given to engaging clinicians in change, which makes that change hard to maintain. In order for change to go deeper, behaviours must be transformed. For real quality improvement, a philosophy of care must be developed alongside commitment and passion, and skills and methodology.

Resistance to change is natural, and leaders must accept and plan for this. It is important to acknowledge and show sensitivity towards resisters, and leaders must seek to understand the root of objections – are they based on logic or fear of losing control? Resisters can in fact aid the cause by identifying blind spots or problems and helping you strengthen and clarify the message. Speakers explained that the consequences of not changing must be clearly communicated and making early wins visible can garner support and reassure resisters.

In his presentation, **Dr Peter Lachman, ISQua CEO, discussed the value of international networks in improving patient safety, using them as a way to promote and sustain values.** This tied in with points made in *The Art (And Science) of Herding Cats – How to Succeed in Changing Clinician Behaviour*, during which **Adjunct Professor John Wakefield explored individual and group drivers of behaviour**, which are often responsible for the resistance of clinicians in adopting changes in practice. The science of group behaviour is rarely used to inform improvement projects. Core beliefs are powerful drivers, he explained, and are often irrational, deeply held and rarely spoken about. Peer influence can also be powerful in informing behaviours, as humans are tribal in nature and bound with peers by common values and beliefs.

Leaders and managers must take these drivers into account when designing change, seeking to identify target groups and understand their beliefs, assumptions and norms – building a model to explain current behaviours, so that they may be better equipped to change them.

Leaders should play a dominant role in ensuring patient safety is an organisation-wide priority, and this was the subject of **Chris Power and Catherine Gaulton's presentation, representing the Canadian Patient Safety Institute and the Healthcare Insurance Reciprocal of Canada respectively.** They explained that, although culture is complex, it ultimately needs to be the starting point for patient safety rather than an afterthought. Through literature reviews and interviews with thought leaders, they created a **Patient Safety Care Bundle** comprising 13 elements, based on what senior leaders need to know and do, that can be used to inform best practice when applied together.



HEADS

Also imperative to good patient safety is a culture that promotes accountability. In order to make it easier for clinicians to speak up, **Dr Mark O'Brien, medical director of the Cognitive Institute**, said that blame, high workloads, lack of transparency, poor planning and negative attitudes all contribute to a culture where people are afraid to speak up. Again, those at the top have an important part to play in changing this, but board members are commonly unaware of the behavioural issues undermining safety and reliability in their organisation. **Recognising and tackling these issues can provide a greater rate of compliance with safety measures and protocols, as well as lowering staff turnover.**

Dr O'Brien explained the theory, implementation strategy and evaluation metrics of the **'Speaking Up for Safety' programme**, developed by the Cognitive Institute, which has been used in more than 140 hospitals in the Asia-Pacific and UK. The programme uses education and training to build a culture where staff are comfortable checking each other and welcome being checked by others, overcoming entrenched hierarchical behaviours and normalising communication that supports better patient safety.

In their presentation Quality Improvement Through Interactive Simulation, speakers highlighted the importance of being able to learn from mistakes in a safe environment. They said that **in order to learn from mistakes clinicians will need to encounter failure, but emotionally it is hard to fail, and we aren't taught to embrace failure.** So, in order to support people to fail we need to create safe environments for failing.

Representatives from **ISQua and the Institute of Healthcare Improvement (IHI) and Malaysian Society for Quality in Health Care (MSQH) emphasised the significance of finding joy in work** for healthcare providers in their presentation Restoring Joy in Work and Preventing Burnout: An IHI Framework for Joy.

Studies in recent years have suggested that clinician burnout is a problem globally, with knock-on effects including high levels of staff turnover, low levels of staff engagement, low levels of productivity and increased risk of workplace accidents. Low staff engagement is linked to lower-quality patient care and diminished levels of empathy – a crucial component of patient-centred care.

The IHI believes that joy is a huge asset when it comes to reducing burnout and so it is important for organisational leaders to focus attention on restoring joy at work. The IHI suggests leaders can do this in four steps: **ask colleagues at all levels of their organisation what matters to them, identify the barriers to joy at work, commit to making joy at work a shared responsibility, and use improvement science to test approaches.**

The IHI has also identified nine system components necessary for ensuring a joyful, engaged workforce, including daily improvement, camaraderie and teamwork, physical and psychological safety, and meaning and purpose. The IHI has detailed all the components in Framework for Improving Joy at Work, which can be downloaded from the IHI website.



HEADS

In some parts of the world, improving quality has become a challenge because there isn't a safe and positive environment. In her presentation **Prof Sheila Leatherman, Gillings School of Global Public Health University of North Carolina, USA** pointed out that almost 2 billion people live in countries affected by fragility, conflict and violence. By 2030, an estimated 46 per cent of the world's poor will live in areas characterised as fragile or conflict-affected, the majority living in low- and middle-income countries.

Nana Mensah Abrampah, Technical Officer, Quality Systems and Resilience Service Delivery and Safety at the World Health Organization led a presentation on **the importance of compassion in quality healthcare in low, middle and high-income countries**. Not only is compassion associated with positive perceptions of patient care and building trust, Abrampah said, it is also negatively correlated with physician burnout. **The absence of compassion can cause clinical errors, high rates of absenteeism, poor patient experience, and physician disengagement**. Compassion therefore has a direct impact on quality, leading to improved patient outcomes, and is needed at all levels of the health system and all stages of care. Compassionate care principles, Abrampah said, should be embedded within efforts taken by national authorities to advance quality of care.



HEARTS

Looking at health from a patient perspective formed a major part in this year's ISQua conference. Taking a patient-centred approach to care means considering the patient as an individual with unique preferences and needs. Many speakers throughout the conference expressed the importance of compassion and empathy for any clinician wanting to work in a patient-centric way.

Involving patients in their care is strongly linked to better patient outcomes. Patients that have an active role in their care are imbued with more responsibility over their wellbeing and this may encourage and empower people to look after themselves. **Despite it being something that they want, having a say in their care will not come naturally to most patients, having been passive participants for so long.** Patient mentality, therefore, must be altered. Several presentations focused on how this can be achieved, as well as exploring how patient feedback can be introduced as a method of measuring care quality.

As part of a session titled Using the Patient's Voice to Improve Outcomes: World Class Cases and Pointers, **Karin Jay, senior director of international business development at Planetree, said healthcare needs to be personalised, humanised and demystified.**

Planetree works with healthcare organisations to implement patient-centred care, covering 25 countries across six continents. It also conducts focus groups across these different countries, finding that the issues that continually arise are the same all over the world, namely that patients feel their voice is being dismissed, that they can't ask a question, that they are being rushed and that they are not getting enough information about their conditions.

Jay said that Planetree is "looking to break this down to be a patient-provider partnership, where both sides have responsibilities". For the patient, this involves giving their care team information about what they value, their lifestyle, beliefs and concerns. For the provider this is about giving the patient information about their condition, the benefits and risks of different treatments, and taking into account the human being as a whole – not just in relation to their clinical needs.

In the same session, **Dr Rushika Fernandopulle discussed the ways the patient voice can improve outcomes at all levels of healthcare – for the patients themselves, other patients, the microsystem and the macro system.**

He said he had realised that "we have taken healthcare and turned it from a relationship-based healing endeavour into a series of transactions [...] and what we need to do is start over". Dr Fernandopulle founded Iora Health in the US, building a new model of healthcare with a focus on using patients' voices to improve healthcare and their own outcomes. The company currently has 35 practices across the US founded on this new model and around 27,000 patients.

In order to improve outcomes for patients, Dr Fernandopulle said, **we need to rebuild the system around the patient's needs, not clinician's needs.** Iora Health does this by creating a shared care plan for each patient that considers their wider goals, not just what the clinician wants to see happen. For example, instead of focusing on lowering the patient's blood sugar level, focusing on their goal to make the national football team and working towards that.



HEARTS

When Iora Health physicians see patients, instead of having the patient sit on an exam table in paper gown with the physician standing up, they are both in their own clothes and they sit at the same level. Iora Health also gives patients access to their medical record as, “in order to be an active part of their care, they need to know everything that’s going on”.

A successful patient-led approach to improvement requires a focus on patient feedback. **Lena Cuthbertson, provincial executive director of the British Columbia Office of Patient-Centred Measurement, demonstrated one of the ways to collect patient feedback on a large scale.** In her talk, she explained the execution of a project that aimed to gather feedback from every resident living in a publicly-funded care home for frail seniors in British Columbia Canada, using their experiences and satisfaction to understand the quality of the care they received. The project managed in-person interviews with over 9,000 residents across the region, as well as surveying their most frequent visitors by mail.

Professor Madeleine King from the University of Sydney provided an account of her experience with patient-reported outcome (PRO) assessment, reviewing what has been achieved in this field so far and the challenges faced by the next generation in realising the potential of PROs in value-based healthcare.

A PRO is information about the patient’s health condition that comes directly from the patient without interpretation of the patient’s response. Being able to measure PROs is vital as the patient is the best informant of experience, feelings and function, Professor King said. Patient-reported outcome measurement (PROMs) data can inform clinical practice at micro, meso and macro level, but the information needed for each of these differs.

One of the main barriers to having patients’ perspectives as standard data items in healthcare is the abundance of measurement instruments. This has made comparison across institutions difficult. Precision is also an issue, as very precise measurements are needed for the monitoring of individual patients. Computerised Adaptive Testing provides the precision needed for individual level, but is not yet widely implemented in practice.

The Patient-Reported Outcomes Measurement Information System, developed in the US, was created to be relevant across all conditions for the assessment of symptoms and functions. However, its appropriateness needs to be considered when applying it to healthcare systems in other countries with different cultures. Turning patient-reported outcome data into actionable information that aids decision-making and integrating this data into electronic health records present further challenges.

Dr Eyal Zimlichman, deputy director and chief quality officer at Sheba Medical Center in Israel, also discussed PROMs, highlighting that currently in healthcare we are measuring negative outcomes, such as falls, mortality and readmissions, but not intended outcomes. “*Modern medicine, in most cases, is not capable of measuring what we’ve set out to achieve.*” said Dr Zimlichman.

During his talk, he put forward several compelling reasons why PROMs are beneficial. He said: ***“It is value as seen by the patient. We are providing healthcare to the patient, so it makes sense to ask what is valuable to them.”***



HEARTS

PROMs are also capable of measuring continuum of care, and they support accountability, *“because if we measure the value, and the value has not been attained, then somebody is accountable. If the value has been attained, somebody is accountable”*.

Dr Zimlichman discussed how to make PROMs work in busy clinical practices in a session titled Patient Reported Outcome Measures 101 – Principles, Tools and Implementation: A Stepwise Practical Approach, where he spoke alongside **Brant Oliver and Eugene Nelson**. All three speakers were aligned in their view that PROMs would be extremely valuable in producing better outcomes and better healthcare.

Katharina Kovacs Burns is senior manager of Alberta Health Services in Canada. In her presentation Patients Measuring their Experiences with their Healthcare System: Targeting Improvement in Access, Quality, Safety and Patient and Family Centred Care Outcomes, she offered **another method of measuring patient experience in a way that can provide healthcare decision makers with the evidence they need to affect change in practice and policy.** Through the results of surveys and focus groups with more than 2,780 participants in Canada, one study was able to identify indicators for differing parts of the healthcare system and at macro, meso and micro levels, for which patients’ experiences and satisfaction should be measured. These indicators included 12 for healthcare generally, 24 for primary, acute and continuing care, and 36 for drug and other programmes.

While the value of patient engagement in healthcare outcomes is widely acknowledged, there are few effective strategies to optimise these interactions. In her presentation on The Patient’s Voice - A Patient Delivered Handover, **Kim Maddock, a nurse manager for the Nepean Blue Mountains Local Health District in Australia, discussed her organisation’s creative response to the observation that instances of patient engagement were sporadic and clinical incidents and complaints were on the rise.**

Maddock described the implementation of a patient-delivered handover that was introduced at the 2pm shift-to-shift nurse handover at the patients’ bedside. Patient participation is voluntary and, with the patient’s permission, families and carers are also encouraged to participate in the handover. Patients are provided with a template of the topics that the staff would like to be shared, and at the conclusion of the handover staff complete a safety huddle away from the bedside, enabling the communication of sensitive information that cannot be discussed in the patient rooms.

Maddock explained that the results of this initiative have been significant, reducing falls and complaints, and reducing adverse clinical incidents on the trial unit by 30 per cent. The results of a patient survey pre-implementation indicated that 6 per cent of patients felt their opinion was valued and post-implementation this increased to 86 per cent. In written feedback, 100 per cent of patients said they liked being involved in the handover and would not change it, demonstrating that this could be a low-resource yet high-impact method of increasing patient engagement and input.



HANDS

When planning innovation and creating strategies to improve care, and when making decisions about the delivery of care itself, evidence is an essential foundation.

Clinical practice guidelines promoting the standardisation of care have been available for two decades and yet wide variation in the delivery of healthcare is still prevalent, with patients continuing to receive care that is not in line with the evidence. The extent of this problem is rarely measured, and this was the subject of the presentation **What Proportion of Healthcare is Delivered in Line with the Evidence?** given by **Professor Jeffrey Braithwaite and Peter Hibbert from Macquarie University, Australia.**

They presented the results of **two population-based Australian studies that looked at the proportion of evidenced-based care delivered.** The studies assessed care related to 22 adult conditions against 522 indicators, and 17 paediatric conditions against 479 indicators, using reviews of medical records of 7,743 patients.

They outlined a broad methodology to assess appropriateness of care at population level. Firstly, select conditions that are prevalent and have a high burden of disease, create indicators that reflect appropriate care, recruit patients and healthcare providers, and finally, undertake an explicit manual review of medical records against indicators. They found that, despite the studies possessing limitations, they were largely representative and covered all phases of care.

Through the studies, they were able to identify interventions that are generally effective in reducing patient harm or improving process reliability or patient outcomes. These are: clinical pathways and standardised protocols, audits and feedback, local opinion leaders, local consensus processes, small group interactive continuing medical education, electronic patient management systems, and multiple interventions.

Paul Hunstead and Wendy Stephen, clinical unit nurse managers from the Emergency Department and Children's Intensive Care Unit of Sydney Children's Hospital respectively, used data in their improvement project around the ED to CICU handover, and they presented the results of this at ISQua 2018.

At Sydney Children's Hospital, they had identified communication failures in the clinical handover process that were cause of a significant increase in adverse events such as delay in diagnosis, repeating of tests, and medication errors, as well as increased length of stay. In response to these findings, they aimed to develop a structured approach to the handover process and achieve 90 per cent compliance within two years.

The project team collected data through staff surveys and focus groups and used this to develop a standardised patient transfer process using the ISBAR principles (Identify, Situation, Background, Assessment and Recommendation), including a guideline and a checklist. The process was tested in a simulated environment and refined before being rolled out. The main principles of the new process are that only one person speaks at a time, distractions and interruptions are minimised, the ED is responsible for the patient until the handover is complete, and parents are engaged.

Data showed measurable improvements had been achieved post-implementation, and the results showed further improvement one year on. The guidelines and checklist can be applied to all patient transfers in any critical care environment.



HANDS

In a presentation *Innovation Metrics: The Next Frontier Beyond Quality*, **Leslie Wainwright, of the Research Triangle Institute (RTI) offered a perspective on the importance of measuring innovation.** Innovation is becoming a structured discipline, Wainwright stated, much like productivity and quality.

Progress is hindered, however, by the lingering myths around innovation. Innovation is not just the remit of creative geniuses, Wainwright argued, in reality it is distinct from creativity and as such people that are not intrinsically creative can create high-impact innovation if they follow the right process. It is not reliant on having the best technology, but on business models and finding new ways of delivering value.

Many people believe that innovation is created in the R&D labs, but in reality, innovation can happen anywhere in an organisation. In order to begin thinking about innovation as a measurable activity, leaders need to know what to measure. There are organisations developing indicators to help leaders ascertain whether investments in innovation are having a tangible impact on healthcare transformation. The RTI worked with 20 leading organisations to better understand practices for measuring innovation and developed a set of dashboard metrics that could be universally applied. Wainwright presented these findings.

When evaluating an idea, leaders should look at impact, including cost savings, length of stay reduction, and 30-day readmission and potentially avoidable admissions. Impact on workflow should be considered, in terms of initial access challenges and, further down the line, transferability. Sustainability is also an important idea metric.

Programme metrics can be evaluated by focusing on different aspects. When focusing on activity, metrics should assess increase in participation, who is engaged, how many offerings have been implemented, and how both time to market and time to impact has improved. When focusing on value, this should be looked at in terms of economic value, organisation value, transformation value, and ecosystem value.

Laura Lennox and Dr Tom Woodcock, from the National Institute for Health Research Collaborations for Leadership in Applied Health Research and Care North West London, believe that, when implementing an improvement initiative, sustainability should be analysed prospectively.

The majority of studies on the sustainability of improvement initiatives investigate sustainability retrospectively, failing to account for the learnings and continuous adjustments that shape the sustainability process. In order to influence sustainability, said Lennox and Dr Woodcock, a prospective approach that combines multiple sources of data throughout implementation is needed.

At ISQua 2018, they presented their findings from the trial of a prospective sustainability tool, exploring the application and impact of the tool on three quality improvement programmes in the UK. The Long-Term Success Tool (LTST) aims to support those implementing improvements, using 12 key factors to identify risks and prompt actions to increase chances of sustainability over time.



HANDS

The study was conducted from January 2015 to July 2017, collecting data and observations from 56 improvement teams across three quality improvement programmes. They found that use of the LTST throughout initiatives aided teams to enhance knowledge of sustainability risks, highlighted diverse perspectives held within teams, and directed attention to areas for improvement. Sustainability is a challenging concept for improvement initiatives to explore but the study demonstrated that sustainability planning can be conducted prospectively to maintain focus and mitigate risks throughout initiatives, which improves the chance of embedding change.

Sustainability was also explored in the symposium *Advancing Frontiers of Improvement in Healthcare: What Effort and Resources are Required for Successful Improvement?* Evidence suggests that there is not a direct correlation between the amount of resource invested and the results achieved, and this session sought to understand why initiatives achieve such varied results and ascertain whether some types of resource are more valuable than others.

In their presentation, **Dr Kate Churruca, Dr Louise Ellis, Dr Janet Long and Professor Jeffrey Braithwaite challenged traditional modes of cause and effect thinking, arguing that complexity science represents the next frontier for improving quality and safety in modern healthcare systems**, which – with their large number of interconnected ‘parts’ (doctors, patients, services, wards) – display characteristics of complex adaptive systems (CAS).

Quality improvement strategies that break problems down into subcomponents and target them individually often lead to little change. While the world and healthcare systems are also becoming more complicated and interconnected, aspirations of continuity of care within this system often fall short. Understanding healthcare systems as CAS, they said, means the system characteristics of sensemaking, emergence and resilience can be harnessed for innovative solutions to improve, and new ways to tackle quality and safety challenges.



CONCLUSION

The ISQua Conference 2018 brought together new ideas and ways to approach quality improvement from across the globe. The presentations covered a wide range of subjects, but all made it clear that sustainable change is possible.

In order for lasting change to become a reality, innovation and sustainability must be viewed as concrete, measurable aspects of change that can be encouraged and worked towards, not conceptual ideas that can only be hoped for.

Cultural change is also central to any changes an organisation hopes to permanently embed – starting at the foundations and building upwards. **Delivering person-centred care requires a shift in the mentality and values of healthcare organisations, providers and patients.**

As they form the two sides of the relationship at the centre of all care delivery, organisations should aim to include patients and providers in the quality improvement process. Their feedback should inform strategies and initiatives, not just at the time of inception but continuously.

By viewing quality improvement as a process and not an end goal, lasting change can be achieved. It is imperative, though, that **the heads, hearts and hands of the system are engaged in this process** – a combination of all three is needed to achieve the healthcare quality both providers and patients envision.

A copy of all presentations given at ISQua's 35th International Conference are available online to ISQua Members and 2018 Conference Delegates - <https://login.isqua.org/resources>