HEALTH CARE QUALITY

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Objectives

- To obtain knowledge about the standard of quality in health care services.
- To identify the cause of error in health care delivery.
- To consider strategies for improving quality & safety & reducing error in health care delivery.

How do you decide whether your doctor is competent?

- The practitioner's performance as a student
- Qualifications
- Reputation
- Location
- Cost
- Waiting times
- The practitioner's outcomes
- The practitioner's mistake recorded

Dimensions of quality

- Access to health care
- The efficiency with care is delivered
- Safety issues
- The effectiveness of the care
- The appropriateness of the care
- The acceptability of the care to the patient

Definitions

- The degree of excellence.
- Consistently meeting or exceeding informed customers (WE Deming).
- The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge (IOM).

Other framework for examining quality 2.Donabedian's framework

- Structure : the physical setting & the organisational setting in which care take place
- Process: the method of delivering care
- Outcome: the results of care

Other framework for examining quality
3. Accountability framework

- Accountability
- Individuals who are responsible for a set of activities & for explaining or answering their actions.
- Taking responsibility for one's own actions and defending them to anyone who asks (e.g. to stakeholders, the general public, colleagues, partner agencies and policy makers).
- A condition in which individuals who exercise power are constrained by external means and internal norms.

Components of Accountability

- Who –
- Doctors, Nurses, MLTs, Directors, Patients, Professional bodies
- What – Domains of accountability
- An activity, practice or issue for which a party can legitimately held responsible & called on justify or change its action.
  - Professional competence, ethical conduct, adequacy of access, public health promotion, & community benefit.
- How – the procedure of accountability
  - Evaluation
  - Dissemination

Quality Assurance

is a dynamic, systematic process that assures the delivery of high-quality care to clients

What is Quality Improvement (QI)?

Healthcare Quality Improvement is the body of knowledge, attitudes, and skills necessary to *efficiently influence and continuously improve the multiple elements of care delivery* within a medical practice.

Sporadic (ad hoc) activities to improve care are not enough, systematic and continuous approaches to evaluate and improve the quality are needed.

WHO

- Health
  - Health outcomes/improvement
  - Technical quality/proficiency/competence
  - Appropriateness
  - Effectiveness
  - Safety
  - Timeliness
  - Prevention / early detection
  - Access / availability /continuity
- Responsiveness
  - Consumer participation / choice
  - Patient experience
  - Acceptability
  - Respect & caring
  - Availability of information
  - Timeliness

Country	Rank
Japan	1
Switzerland	2
Norway	3
Sweden	4
France	5
Canada	7
UK	9
Australia	12
Sri Lanka	80
India	121
Bhutan	144

Patient safety

- Freedom from accidental injury due to medical care, or medical errors.
- Medical errors
- The failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim.
- Deficiencies in design, organisation, maintenance, training, & management that create conditions in which persons are more likely to make mistakes.

Adverse events

- ' an unintended injury that was caused by medical management & resulted in measurable disability'
- Diagnostic – a delay in diagnosis or wrong diagnosis
- Treatment related – error in the dose or method of using a drug
- Preventive – failure to monitor or follow up treatment
- Other – failure of communication or equipment

Examples

- Doses omitted
- Wrong dose
- Unprescribed drug given
- Wrong dosage form given
- Wrong route of administration
- Wrong rate of administration
- Wrong time of administration
  - time of day
  - in relation to food

  etc....
- Using unstable/expired drug
- Wrong administration technique
- Incorrect reconstitution
- Extra dose given

Adverse events

- Things that go wrong that should not.
- Australia –
- 16.6% of hospital admissions be associated with an adverse event.
- 51% of adverse events be preventable
- Human error was found to be a prominent cause of hospital adverse events.
- USA –
- 3.7% of hospital admissions due to adverse events.
- Deaths due to medical error are almost the top 10 causes of death

Why do people make mistakes?

- Deficient leadership and management
- Poor communication
- Poor infrastructure
- Intolerance to criticisms
- Deficient skill bases
- Poor term work

Why do people make mistakes?...

- Unmotivated staff
- Diffusion of responsibility with multiple individuals and departments involved in the care of the patient
- Inadequate systematized and formalized procedures and protocols
- Preoccupation with targets and goals other than quality

Forces driving the health care quality improvement

- Large number of preventable adverse events
- Unexplained variation in clinical practice
- Changes in society, including an increased access to information & a demand for accountability
- The escalating costs of health care & increasingly scarce health care resources that have led to cost-containment strategies

Quality improvement methods

- Audits
  - Review of medical records, looking for errors or inappropriate management of patients
  - Review of patient who die
  - Review of adverse drug reactions to see if inappropriate medication was prescribed
  - Review of clinical diagnosis against laboratory confirmed diagnosis.
- Monitoring for statistical variation
  - **Rate of hospital mortality**
  - **Rate of wound infection**
- Patient satisfaction surveys

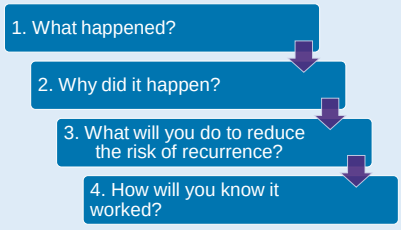
Quality improvement methods

- Utilisation reviews
- Credentialling
  - **A practice that reviews the experience of doctors & whether they should be allowed to practice in a specified area. Eg- only to allow surgeons to perform endoscopies**
- Recertification
  - **Updating of qualifications**
- Accreditation
  - **Inspection from an outside independent body of experts to ensure that certain specified standards are being met**.

Quality improvement methods

- Use of practice guidelines
- Sentinel events
- An unexpected occurrence involving death or serious physical or psychological injury or the risk thereof.
  - Typically rare events that have such grave consequences.
  - Be investigated in detail
  - Conducting a timely, thorough & credible root cause analysis
  - Developing an action plan designed to reduce risk
  - Implementing & monitoring the effectiveness.

Learning From Defects: Four Questions



If a surgeon amputates the wrong leg

- Correct leg not marked clearly in patient's medical history
- Wrong leg stated on consent form – not picked up by patient, and consenting doctor
- Wrong leg marked or leg not marked by staff preparing patient
- Wrong leg prepared in theatre

Causes of poor quality

- Two general approaches
- 1. as a result of the failure of an individual.
- 2. a system failure.
  - **Many clinical conditions are hazardous, many treatments & interventions are hazardous & many patients are vulnerable biophysical state.**
  - **People being fallible, make mistakes frequently.**
  - **Many defenses built into the patient care process & the organisations providing care to prevent or mitigate these errors.**
  - **When these defenses fail, harm can result to the patient.**
- To protect against errors, systems establish processes, rules, procedures, regulations & organisational culture.

Factors that influence the delivery of quality care

- Environmental factors (funding, training)
- Organisational factors (culture, management, supervision)
- Team factors (communication, leadership, conflict resolution)
- Individual staff factors (experience, fatigue, training, recertification)
- Task factors (clinical guidelines)
- Patient factors (age, chronicity, co-morbidity, severity)

Summary

- Quality
- "It is doing the Right thing for the Right patient at the Right time with the Right results"
- Approaches – Epidemiological / Systems
- Audits
- Sentinel events investigation
- Monitoring of statistical variation
- Accreditation
- Use of clinical guidelines
- Patient satisfaction