



Conversations with Quality Improvement Stakeholders Phase I Final Report

Goal:

1. *Demonstrate the value of partnership-based relationships*
2. *Effective and efficient physician engagement with current quality processes.*

Overview:

The purpose of Phase 1 was to delineate the processes a family physician at KBRH can take to address a patient safety or quality of care issue.

Objectives:

1. Strengthen relationships with stakeholders through face-to-face conversations
2. Identify and map KBRH patient safety and quality improvement processes

Methodology (see Appendix A for detailed information)

- Relationship-centred approach
- Iterative dialogue process – initial informal interviews with follow-up interviews for clarity and confirmation
- Exploratory process

Limitations:

- Study limited to family physicians at KBRH, limited participants in Phase 1
- Study limited to available processes at KBRH
- Non-physician stakeholders not included in Phase I
- No base line information

Key Findings:

- Participants were engaged and interested in the project
- Information flow through KBRH patient safety and quality processes appears to have significant opportunities for improvement. Further research is needed to delineate factors responsible and to explore and implement potential solutions.

Outcomes

<i>Objective 1: Improved relationships with stakeholders</i>	<i>Objective 2: Information Flow Diagrams</i>
<p>No baseline relationship data was established due to project scope limitations, however, a subjective relationship assessment provided a general sense of improved relationship.</p> <p>This was demonstrated through participant's expressed interest in and engagement during the project work, encouragement to continue the work, and to share the findings of the project with others.</p> <p>The willingness of the participants to meet multiple times and to contribute to the information collection process with positive energy and attention contributed to my (EP) evaluation of improved relationships.</p>	<p>After the initial interviews, three diagrams were developed that identified three distinct processes available at KBRH, and the flow of information within each, that can be used by physicians to report/manage an issue of patient safety and/or quality of care.</p> <p>Follow-up interviews served two purposes: (a) to verify that the information mapped was correct and (b) that information flow issues were accurately identified and recorded.</p> <p>It is important to note that this project did not address the factors responsible for issues with information flow.</p>

3 Processes

The diagrams represent three processes and *are limited to the processes occurring within KBRH.*

- 1) An individual, informal process – simple situation
- 2) Medical administrator process - complicated or complex situation
- 3) PSLS report process – potentially systemic situation requiring systemic solutions

See Appendix B for full size diagrams.

1) Individual, Informal Process

Purpose

Best suited for issues that can be resolved through a conversation between two people.

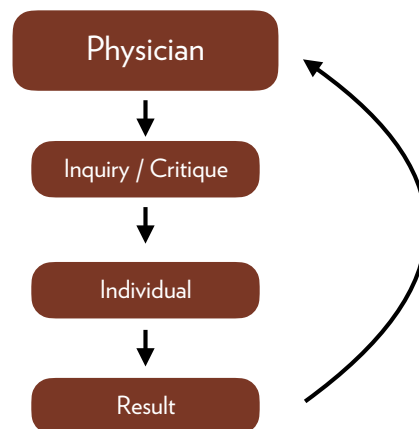
Findings

Anecdotal information found that physicians are underutilizing this process, particularly for interpersonal communication issues. Compounding this is a lack of clarity surrounding roles and responsibilities related to clinical versus procedural concerns that may result in a complex inquiry.

Recommendations

- Further exploration of information flow within this pathway to identify factors that contribute to or detract from its use and how information flows with identification of factors that enhance or inhibit flow.
- Once the above has been researched, initiate solution-finding processes with Plan Do Study Act (PDSA; see Appendix C) testing of proposed solutions.

Individual, Informal Process



2) Medical Administrator

Purpose

The Medical Administrator process can be used for:

- Assistance in resolution of an issue if the individual, informal process is not successful
- The issue is more complicated in that it involves more than one other individual and/or resolution of the issue requires the involvement of a number of people with differing roles and responsibilities

Findings:

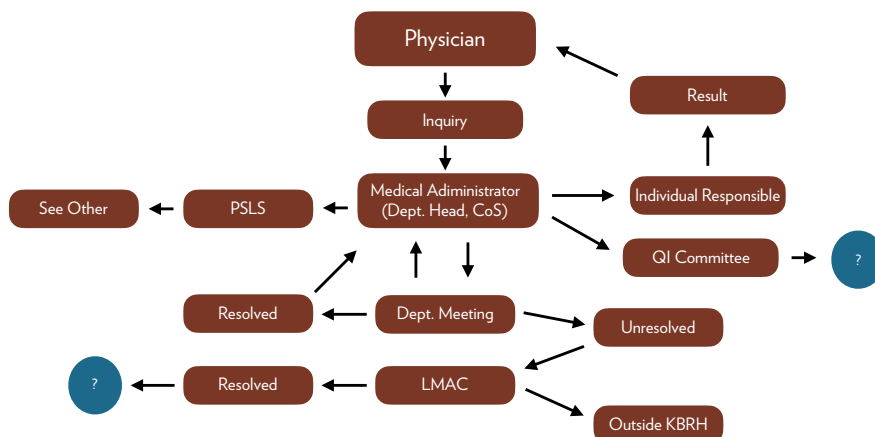
- Feedback to the initiating physician was noted to be absent, or the initiating physician was uncertain if feedback was part of the process and/or when the feedback was to occur.
- At all steps within this process, there appeared to be a general uncertainty as to how information is processed, lack of clarity as to the roles and responsibilities of the various people within the system, and concerns regarding transparency, fairness, timeliness.
- Feedback from higher levels (Dept meeting, LMAC) in this process appeared to be non-existent or limited in quality/quantity
- There appeared to be little clarity regarding the role of the Quality Improvement Committee in this process.

Recommendations:

Further research is required to:

- Clarify the current roles of stakeholders within this process.
- Clarify expectations, outcomes, timelines, process details with stakeholders.
- Identify specific areas where opportunities exist for improvement.
- Implement potential solutions within quality improvement structures such as PDSA cycles.
- Clarify the role and responsibilities of the Quality Improvement Committee (QIC), the current practice of the QIC, and whether opportunities for improvement in process and information flow exist.

Medical Administrator Process



3) PSLS Report

Purpose

The PSLS (Patient Safety Learning System) is a computer-based, province wide system used by healthcare providers to report a concern regarding patient safety. It can be used to address both individual incidents and/or to detect trends within specific areas of concern, such as pressure injury rates and post-op infection rates.

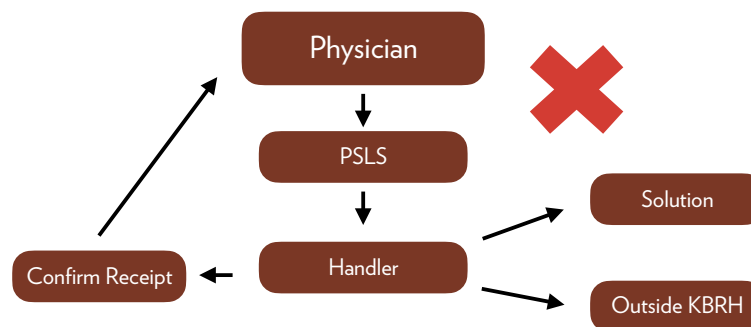
Findings:

1. Anecdotal reluctance of physicians to use this system due to perceived difficulties with the digital/computer reporting system.
2. No consistent mechanisms identified to involve the initiating physician in the resulting process or inform the initiating physician of the outcome of the process.
3. Uncertainty as to who is responsible for receiving the report (the handler).
4. None or limited interaction between initiating physician and the “handler”.
5. Lack of clarity from interviewed physicians regarding the purpose of the PSLS and thus confusion regarding what issues are best dealt with this process.

Recommendations:

- Clarify and define current use of the PSLS system within KBRH.
- Explore the use of the PSLS in other areas of the province.
- Explore and define the “best use” of the PSLS system within KBRH.
- Implement “best use” of PSLS within a comprehensive patient safety and quality improvement program at KBRH.

PSLS Report Process



Appendix A: Methodology

Relationship-Centred approach

This approach is based on the paradigm of relationship-centred care. An article by Beach, and Inui describe the following “All illness, care, and healing occur in relationship – relationships of an individual with self and with others. Relationship-centered care (RCC) is an important framework for conceptualizing health care, recognizing that the nature and quality of relationships are central to health care and the broader health care delivery system. RCC can be defined as care in which all participants appreciate the importance of their relationships with one another.

RCC is founded upon 4 principles: (1) that relationships in health care ought to include the personhood of the participants, (2) that affect and emotion are important components of these relationships, (3) that all health care relationships occur in the context of reciprocal influence, and (4) that the formation and maintenance of genuine relationships in health care is morally valuable. In RCC, relationships between patients and clinicians remain central, although the relationships of clinicians with themselves, with each other and with community are also emphasized.”

Interview Process

The initial informal interviews were conducted to gather baseline information on quality concern processes. Stakeholders involved were: 1 IH administration personnel; 1 Quality Improvement Consultant, Chief of Staff (KBRH); Department of Family Practice Head; and Department of Family Practice physicians (2 plus the project lead physician);

Note: medical and surgical floor managers and PCCs were not interviewed during this project due to unforeseen circumstances. Their involvement is seen as essential for Phase 2 of this project to continue as previously envisioned.

Interview question guidelines were developed:

For physicians:

- What do you know about the current quality processes in KBRH?
- Have you participated in quality processes at KBRH?
- If yes, which one(s)?
- What was your experience with this participation?
- Are you aware of any specific outcomes of the process(es) you participated in?
- What was your experience with the flow of information?
- What is your experience with influencing quality at KBRH?

For Department Head, Chief of Staff, medical and surgical floor managers,

- What are your specific roles and responsibilities in the maintenance and improvement of quality in KBRH?
- What quality processes have you participated in?
- How did you experience the flow of information?

- What is your experience with influencing quality at KBRH?

For QI Consultant and Patient Safety Investigators:

- What are your specific roles and responsibilities in the maintenance and improvement of quality in KBRH?
- What quality processes do you participate in?
- How did you experience the flow of information?
- What is your experience with influencing quality at KBRH?

The follow-up feedback interviews included 1 IH admin personnel and the Chief of Staff.

Scheduling conflicts prevented follow-up with Department of Family Practice Head.

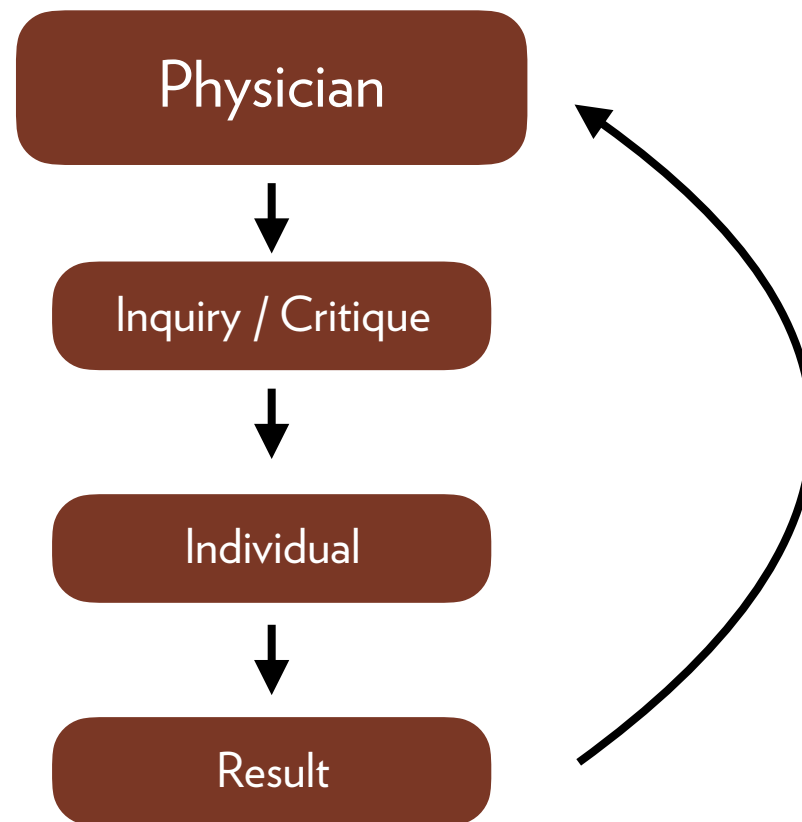
The purpose of this follow-up was to visually present the findings and verify the information.

Question guidelines were:

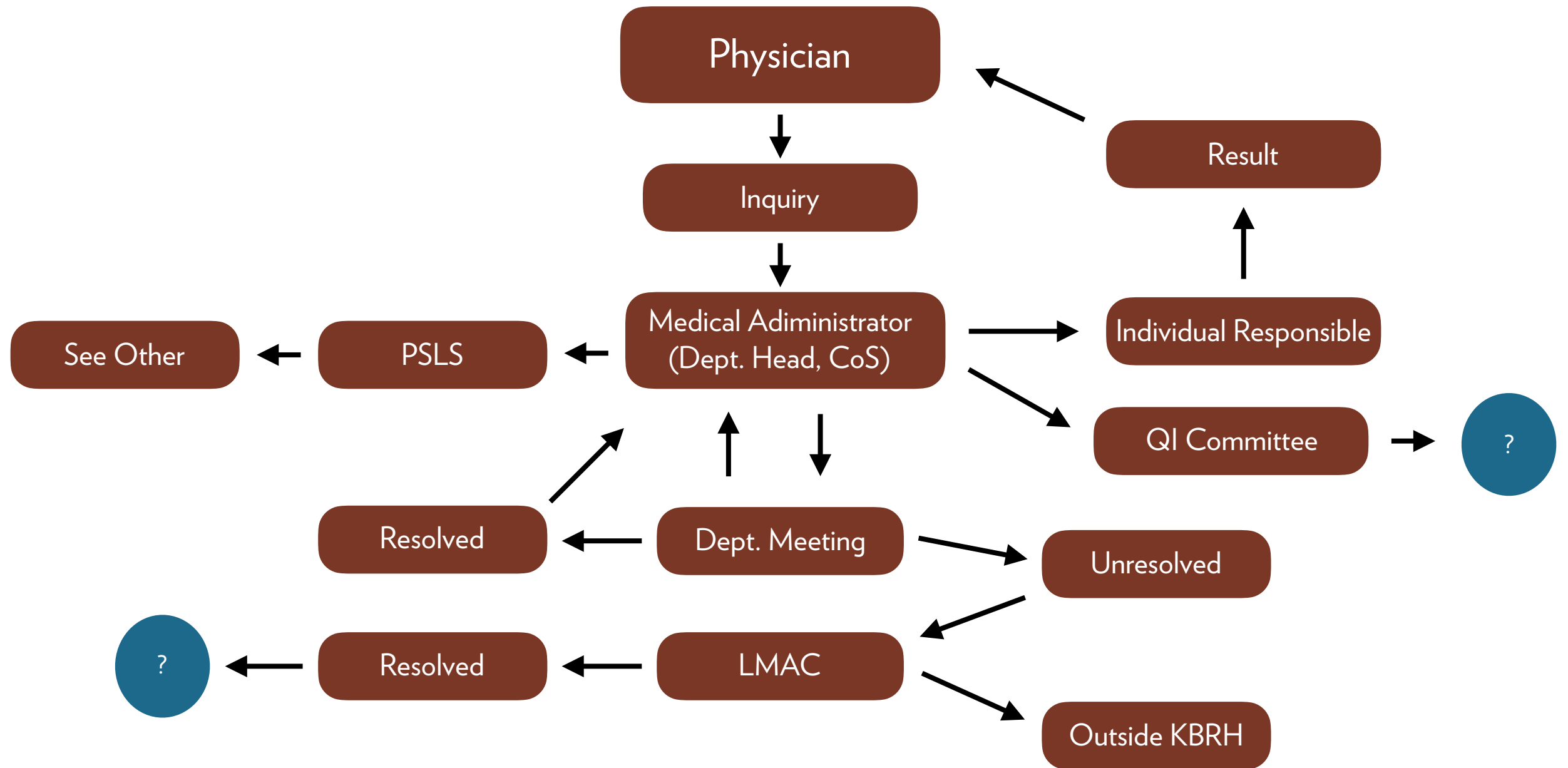
- How does the current quality concern process work?
- Where do you see information flow blockages?

Appendix B: Full Size Diagrams

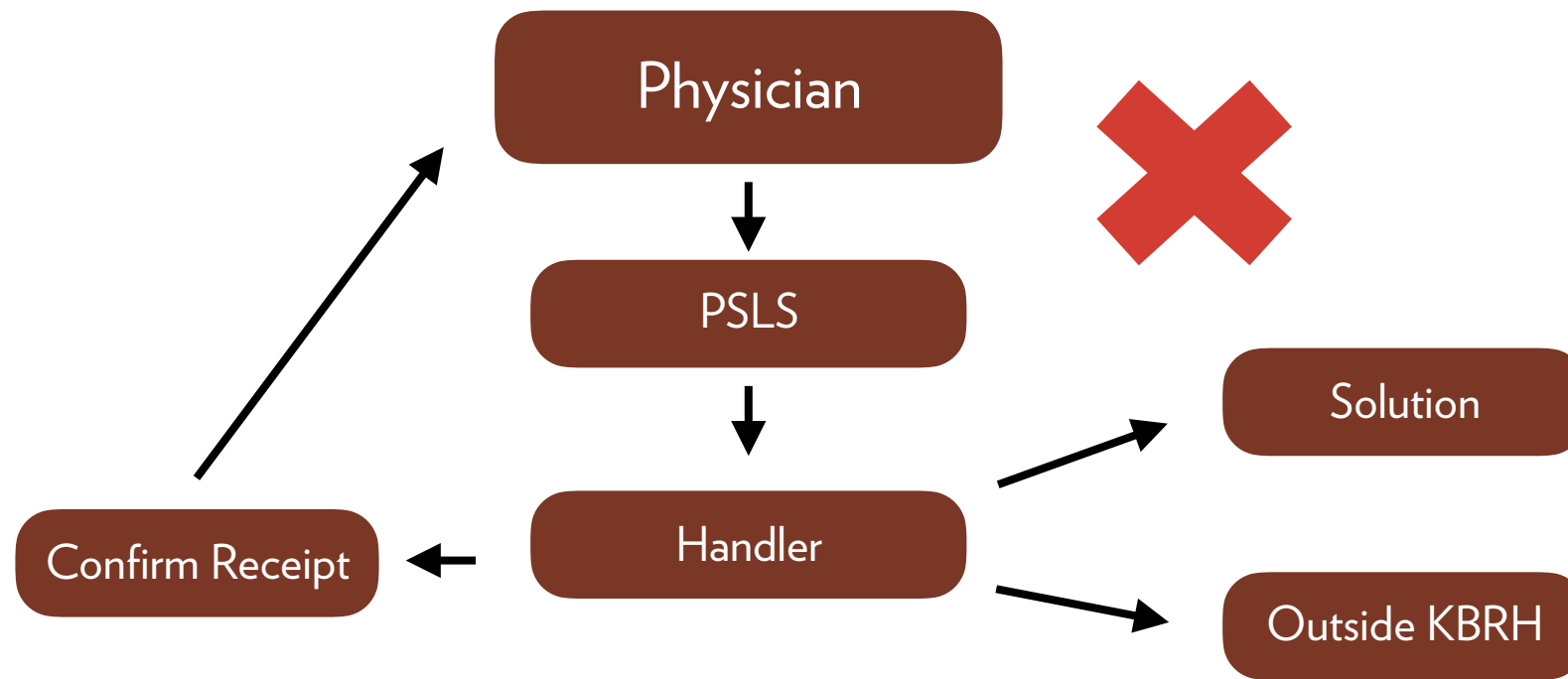
Individual, Informal Process



Medical Administrator Process



PSLS Report Process



Appendix C: About Plan, Do, Study Act Model

The Plan, Do, Study, Act Model is a cycle designed to be a preliminary step before implementing large-scale change. It is intended to be a rapid, small-scale, and dynamic change model that has embedded feedback loops to make adjustments in real-time. Once smaller scale changes have been successful, applying them to a larger group facilitates a smoother transition as fundamental flaws have already been worked out.

This Model for Improvement, developed by the Associates in Process Improvement, starts with three questions before implementing the “Plan, Do, Study, Act” cycle.

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