

## Outline

# New challenges for Quality and Patient-Safety officers

## QPSO

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1. A brief history of QPSO
2. Adaptation required
  1. The need for revisiting patient safety
  2. Removing ambiguities between Medical Effectiveness, Quality and Safety, and Resilience
3. Adapting QPSO to significant changes coming in Healthcare
3. Conclusions

## I. A BRIEF HISTORY OF QUALITY AND PATIENT SAFETY OFFICERS (QPSO)

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### A glance on recent history

#### 1. The naïve enthusiasm of pioneers, 1995-2003

- Q&S interventions situated within the tradition of Epidemiology and Continuous Quality Improvement (CQI)
- Prevalent idea simple enough
  - Gather information on medical risk, complications rate, errors, and Adverse Events (Na<sup>t</sup>IAES, reporting systems, vigilances, etc.)
  - Reduce the number of AE/complications developing technical recommendations, and best practices;
  - CERTIFICATION/ACCREDITATION, addressing both medical processes (infections, blood, material, drugs...) and system organization (blame free reporting systems, Quality monitoring tools, etc.)
  - Monitor, and make adjustments
- Deceptive results : little or no reduction of AEs after 5 years
- Diagnosis
  - lack of specific professionalism in Quality and Safety, lack of basic tools including IT's

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### A glance on recent history

#### 2. The advent of professionalism, 2002-2005

- Recruitment of Quality and Patient Safety Officers (QPSO)
- Prevalent idea
  - Risk management (imported from Industry) is at the core of the success
  - Address causes instead of symptoms
    - Risk analysis methods and In-depth analysis (M&Ms, ALARM, RCA) inspired from Industry become standards as well as concerns with Human and Organizational factors of Safety (working time directive, medication labeling, hand washing and infection controls, etc.)
- Still quite deceptive results
- Diagnosis :
  - efforts capsulated to happy few specialists.
  - hierarchical positioning of QPSO proved being much too low
  - significant advances done to map risks, design barriers, develop safety protocols good for paper and pencil exercises fitting the certification requirements, but not enough to convince professionals, and especially doctors, to fully adhere to concepts.

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### A Glance on recent history

#### 3. Changing Safety culture as a solution for unfreezing progresses, 2005-2011

- Improving safety culture as a Gospel
- Prevalent idea
  - Risk management (imported from Industry) is at the core of the success
  - Address causes instead of symptoms
    - Risk analysis methods and In-depth analysis (M&Ms, ALARM, RCA) inspired from Industry become standards as well as concerns with Human and Organizational factors of Safety (working time directive, medication labeling, hand washing and infection controls, etc.)
- Need time to see results : Generation shift??
- Diagnosis
  - Still some aspects of safety were not properly addressed.
    - ESPECIALLY the link between Quality and Patient Safety and Working Conditions (occupational accident, absenteeism, satisfaction at work, careers, salaries)

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4. New challenges coming, 2010-continue

System changes

- Technical innovations (day surgery is only one example) all leading to a drastic and rapid reduction of the average length of stay.
- Sociological changes (population aging, acute diseases becoming chronic, patients becoming experts, news medical professions-interventionists-, increase female participation in medicine)
- More public transparency
- More supervision by authorities via administrative and medical databases
- A financial crisis, especially in Europe.

Leading to new challenges

- Imposing a rapid shift
  - From an ALWAYS MORE IN-HOSPITAL Strategy
  - to an ALWAYS MORE OUT-CLINIC / HOME CARE Strategy
  - Painful transition time
- Shift from safer medical acts to safer patient's journey

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II. THE NEED FOR REVISITING PATIENT SAFETY GOALS

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Patient safety perimeter : two family of AEs

- Medical complications as listed and known by scientific Colleges

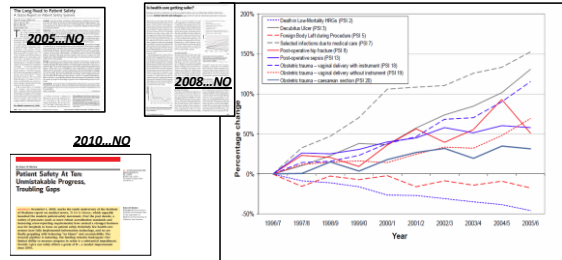
- Unthinkable problems (by Colleges)
  - Wrong patient, wrong side, wrong doctor, fall in the operating room, dying in a falling lift, etc.



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Are we getting safer? YES AND NO...



Strongly contrasting with other data

- Continuous improvement of healthcare
- Longer life, longer healthy life
- Less complications, survival rate significantly extended in majors diseases (cancer, MI, AIDs, etc)

2010...NO  
Patient Safety At Test: Unacceptable Progress, Troubling Gaps

2010...NO  
Temporal Trends in Rates of Patient Harm Resulting from Medical Care

Why the number of AEs associated with Poor Quality should continue to grow

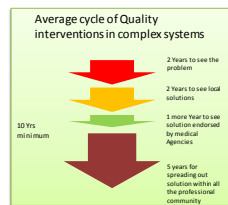
- The innovation rate much higher in healthcare compared to the rest of industry
  - We continuously change definition of EBM, and recommended strategies. Little value of historical comparisons.

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The 'power of innovation'

How Quickly Do Systematic Reviews Go Out of Date? A Systematic Analysis



Half-life Nuclear Knowledge 17Yrs  
Half-life Civil Aviation Knowledge 13Yrs  
Half-life Medical Knowledge 5,5Yrs  
Half-life Software Industry Knowledge 2,4Yrs

06/11/2012

MBA

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### Why the number of AEs associated with Poor Quality should continue to grow (Continue)

- The innovation rate much higher in healthcare compared to the rest of industry
  - We continuously change definition of EBM, and recommended strategies. Little value of historical comparisons.
- At least 4 times more process driven Q&S protocols within a period of 10 years.
  - The more we generate process driven protocols, the more we mechanically increase noncompliance and deviance and increase the number of (so called) errors
- The global count of AEs depends on our thermometer
  - We mechanically count more AEs when the sensitivity of our thermometer increases (Trigger tools is a good example... near misses also)
- A vast majority of case mixes generating multiple ambiguities
  - The decision on avoidability is a polemist matter, augmented by insurance driven approach
- The paradox of the last victim
  - The better the safety, the more the complains

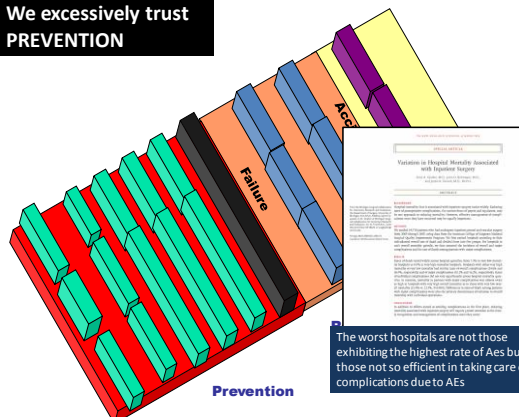
### Why the number of AEs associated with out-of-thinking Incredible situations should (also) continue to grow

- Listless events : Infinity of unbelievable very low frequency events that may unfortunately occur in the journey of patients
  - Large number strategies/ randomised trials do no apply
  - Greater risks at transition care
  - No capacity rationalizing all possible Never events of the category: *Need generic coping strategies (culture oriented?) instead of dedicated plans for dedicated problems*
- Largely induced by the growing inclusion of patients at risks and the growing complication of the medical chain
  - multiplication of transitions of care, and poor culture of safety, especially for middle and top management
- Even more AE of this category expected due to the hard transition times coming for healthcare: hospital downsizing, etc.
  - destabilisation of organisations, new complexity of organizations,

### Consequences for QPSO (1)

- No matter the frequency of AEs, what counts is the severity of AE; Pareto's strategy cannot correctly apply to Medicine
- Counting AEs is probably a dead end for Quality and Safety improvement
  - Must turn to in-depth analysis of causes for improving prevention
  - And even more developing and improving recovery and mitigation strategies ; turn Patient safety from Ideal care to Acceptable care

### We excessively trust PREVENTION

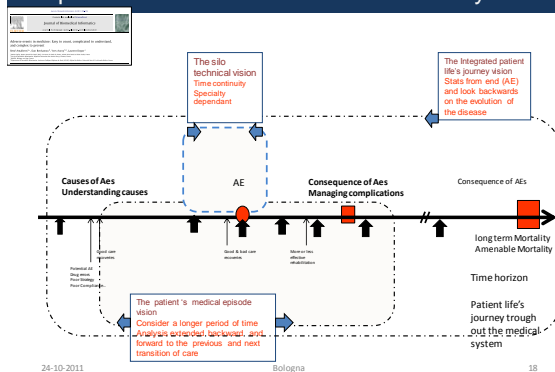


Prevention

### Consequences for QPSO (1)

- No matter the frequency of AEs, what counts is the severity of AE; Pareto's strategy cannot correctly apply to Medicine
- Counting AEs is a dead end for Quality and Safety improvement
  - Must turn to in-depth analysis of causes for improving prevention
  - And even more developing and improving recovery and mitigation strategies
  - applying a 'medical episode' driven approach- and not silo-driven approach and extending the timeframe when analyzing AEs

### Adopt a new vision of Adverse Event analysis

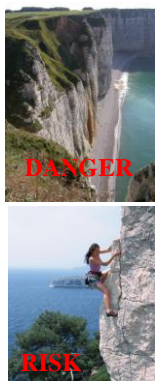


## Consequences for QPSO (12)

- NO matter the frequency of AEs, what count is the severity of AE; Pareto's strategy cannot correctly apply to Medicine
- Counting AEs is a dead end for Quality and Safety improvement
  - Must turn to in-depth analysis of causes for improving prevention
  - And even more developing and improving recovery and mitigation strategies
- Not contradictory with a logic of supervision and Quality indicators
- Justifying actions with the "The try an accident" story of Human factors in Civil aviation

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Danger are cliffs, risk taking is to decide climbing or not

Risk = fonction (Severity & probability)

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## REMOVING AMBIGUITIES

BETWEEN RESILIENCE, PERFORMANCE, AND QUALITY AND SAFETY

Quality, Safety, Performance, and Resilience  
Marriage or divorce?

### The metaphor of climbing cliffs

- Case A: you may have obtained the success easily, everything being like you expected (weather, rock, fatigue)
- Case B: you may have obtained the success in very adverse conditions, overcoming a series of incidents with the surprising unstable nature of rocks, spending an additional night on the rock face, and possibly suffering from frostbite.
- Case C: conversely, you gave up and postponed actions by fear from the foreseen adverse conditions, bad weather, poor personal shape, or any other hindrance. You finally never climbed the cliff.
- Case D: last, but very seldom, you climbed and suffered from a severe incident, possibly accident, consequential for your health with an engagement of vital prognostic, such as a downfall.

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## Applying the metaphor to medicine

### Patient 25 years old with a testicle cancer.

- Case A: you delivered ideal care in the big teaching hospital; the healing was total and perfect within the shorter period of time expected by standard protocols.
- Case B: You delivered effective care and cured the patient although working in difficult conditions (summertime, chronic staff shortage, local hospital) and despite a succession of but true adverse events along the cure: the central catheter infusion installed by a young locum anaesthesiologist came first in pleural cavity, and needed being repositioned in emergency the day after, and later you spent three days after discharge reacting properly to an infection due to a bad coordination with primary care. But finally you cured the cancer.
- Case C: considering the understaffing at that period of the year in your hospital, and the importance of the best expertise for surgery, you have balanced elements and made the cautious decision to postpone the cure for four weeks and get ideal conditions of staffing and expertise to minimize risks of adverse events. A chest metastasis occurred during the 4 weeks .
- Case D: the team made an error with a wrong dose of drug causing a vital threat to the patient spending a month in ICU. Additional to the complication, the cure of the cancer has been postponed and the healing is still not obtained.

What is your opinion on what is safe, effective, or resilient?

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## Consequences for QPSO

- The top priority for healthcare is to propose the largest access to care for all citizens, with the best hope to be cured.
- Quality and Safety programs are one solutions among others, rarely the most contributive to this top priority
- Not contradictory with developing Quality indicators
  - As a reflective tool for healthcare workers ( rate of complications, outcome) +++
  - As a supervisory tool for economic management (poor quality) and public appeasement on the effective control of the system. Publishing on AEs (-) Vs Medical outcomes (++)
- Over-optimization of Q&S constraints for HC management purpose may result in being contro-productive on healthcare top priority (Plan C)
- Good QPSO must develop a double Q&S plan
  - PLAN A for certification
  - PLAN B for degraded conditions

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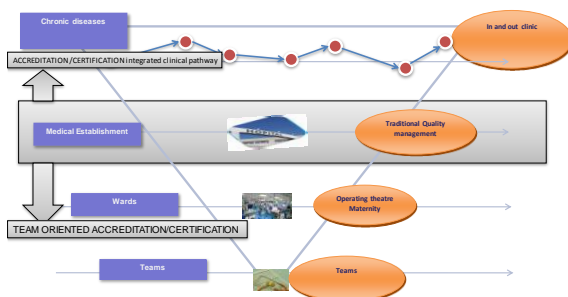
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## IV. ADAPTING QPSO TO THE CHANGES COMING IN HEALTHCARE

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### New targets



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### New challenges coming

#### System changes

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### Change In-hospital Q & S strategies

- Revisit Q&S standards for day surgery, 'day medicine', rapid discharge, develop a schema for global coordination with primary care, rehabilitation care, home care.
- Adapt Q&S indicators et invest priorities in transition care
- Think the next professional capacity as a priority for Q&S at the present
- Downstream Q&S priorities to medical activity, wards and doctors.
  - Make doctors involve
  - Invest on team work improvement
  - Cut silos with management strategies, especially for all aspects related to work climate (absenteeism, occupational accidents, conflicts)
- Include a thorough analysis of the value and cost effectiveness of Q&S approaches

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### Develop Q&S for out-clinic and primary care

- Address the emerging organisations in primary care, clinical pathways, surgery offices in town, medical homes, home care system
- Develop specific Q&S standards for primary care and home care
  - Monitoring quality of patients' pathway, telemedicine, telesurveillance at home, foresee complex embedded medical organizations (including growing delegation to nurses), develop Q&S in home care.
- Add a section on the value and cost effectiveness of Q&S approaches.

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## V. CONCLUSION

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## Three strategic challenges

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- RECONSIDERING MEANS AND GOALS OF Q&S APPROACH,
- SHIFTING QPSO 's POSITION
  - From
  - TECHNICIAN DEMONSTRATING COMPLIANCE FOR CERTIFICATION
  - To
  - MANAGER ARBITRATING Q&S STRATEGIES TO PERMIT THE HOSPITAL DELIVERING ACCEPTABLE CARE IN ALL CONDITIONS
- ANTICIPATING CHANGES
  - Shifting from the ALWAYS MORE IN-HOSPITAL Strategy to an ALWAYS MORE OUT-CLINIC / HOME CARE Strategy
    - Shifting from a local perspective, consultation-driven, hospital-centred vision to a model of Quality & Safety addressing the patient journey through the entire system,
    - Shifting from process-driven results to outcome-driven results, possibly abandoning some of the (numerous) interventions that have not proven efficient.
  - In the mean time, accompanying hard transition times with specific actions including changes in certification processes

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## Conclusion

### Preparing for the future

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- The healthcare system is rapidly moving . We need to adapt quickly.
- We need revisiting in depth the concepts and doctrines of Q&S
- We need developing better inter professionalism and connectivity (IT's supported)
  - New Doctor-Nurses-Socialworkers cooperation schemes
- We need developing new payment scheme
- We need embarking much more the patient and relatives in the control of Quality and Safety in healthcare
- We need managing hard transition times, accompanying changes must become a priority
- We don't necessarily need more money
  - We need to reallocate the money on new priorities
  - We need to simplify requirements, add consistency, and clean Q&S non effective actions
  - We can even use the financial crisis to accelerate the reallocation

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