Institute *for* Healthcare Improvement

III ENCUENTRO NACIONAL DE CALIDAD EN SALUD
Santiago de Chile

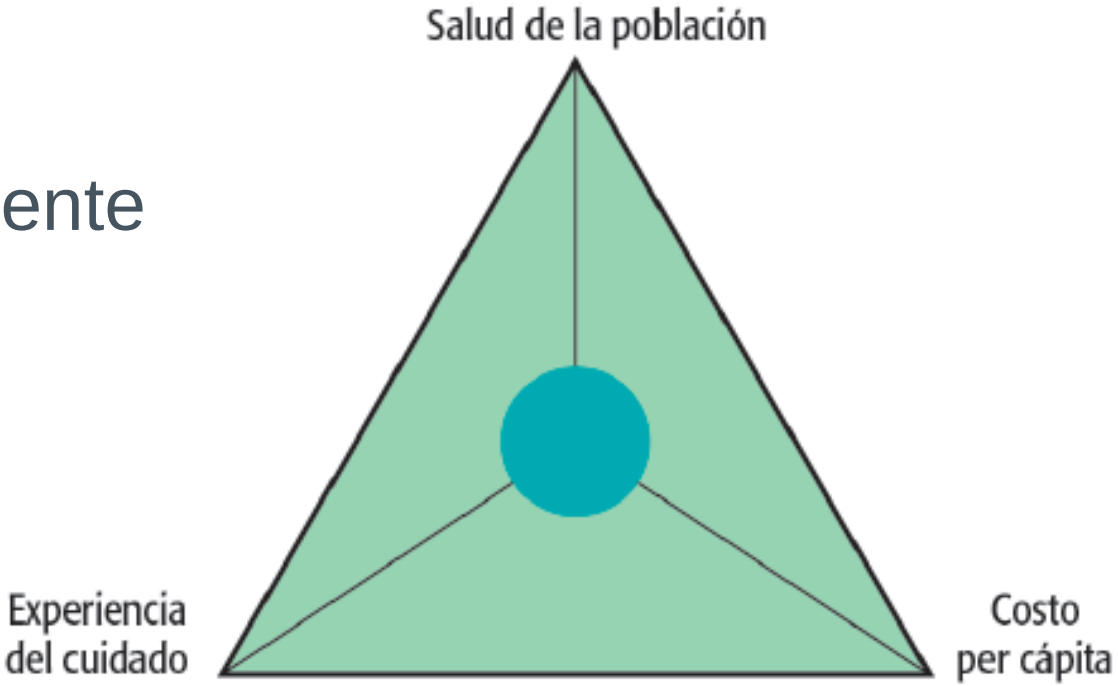
2 de Julio, 2013

Estrategias innovadoras para mejorar la seguridad de la atención al paciente

Pedro Delgado
Executive Director
@pedroIHI

I. Triple Meta del IHI

- **Segura**
- Centrada en el paciente
- Oportuna
- Eficiente
- Eficaz
- Equitativa



I. Marcos y soluciones

Madurez, brechas

La Trilogía de Juran

‘Quality Planning’
(Planificación)

Políticas, recursos, coordinación, contabilidad/gobernabilidad, ejecución

‘QA’

Estándares/ Guías/ protocolos

Acreditación de centros y profesionales

Seguimiento de desempeño

MEJORES RESULTADOS

‘CQI’

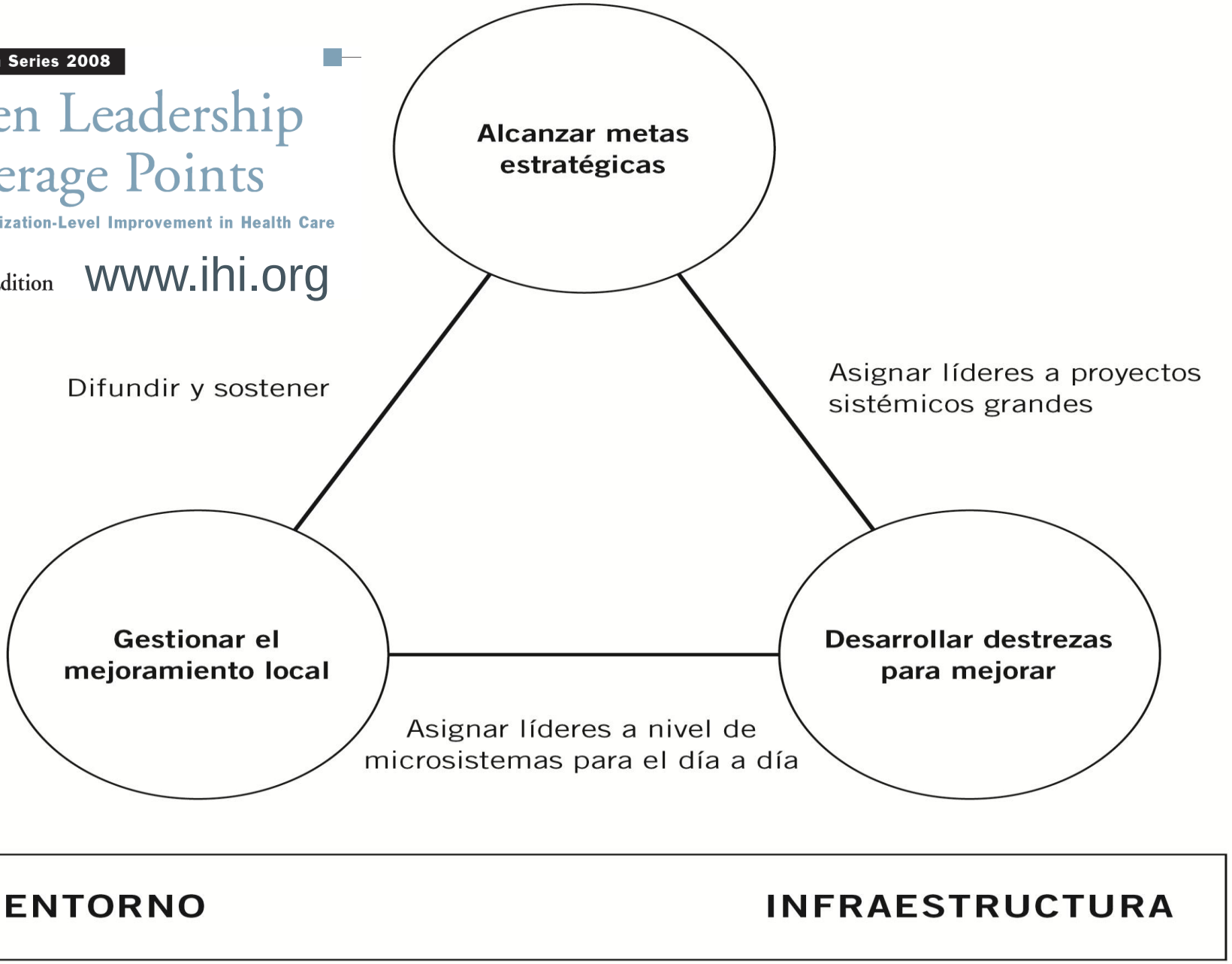
1. **Metas:** cuales son las brechas en desempeño y resultados?
2. **Medidas:** herramientas para medir y retroalimentación de procesos y resultados
3. **Cambios**: cambios a todo nivel como consecuencia del aprendizaje rápido y dinámico, para cerrar la brecha

Innovation Series 2008

Seven Leadership Leverage Points

For Organization-Level Improvement in Health Care

Second Edition www.ihi.org



Annals of Internal Medicine | SUPPLEMENT

The Top Patient Safety Strategies That Can Be Encouraged for Adoption Now

Ann Intern Med. 2013;158:365-368.

10

12

Strongly encouraged

- Preoperative checklists and anesthesia checklists to prevent operative and postoperative events
- Bundles that include checklists to prevent central line–associated bloodstream infections
- Interventions to reduce urinary catheter use, including catheter reminders, stop orders, or nurse-initiated removal protocols
- Bundles that include head-of-bed elevation, sedation vacations, oral care with chlorhexidine, and subglottic suctioning endotracheal tubes to prevent ventilator-associated pneumonia
- Hand hygiene
- The do-not-use list for hazardous abbreviations
- Multicomponent interventions to reduce pressure ulcers
- Barrier precautions to prevent health care–associated infections
- Use of real-time ultrasonography for central line placement
- Interventions to improve prophylaxis for venous thromboembolisms

Encouraged

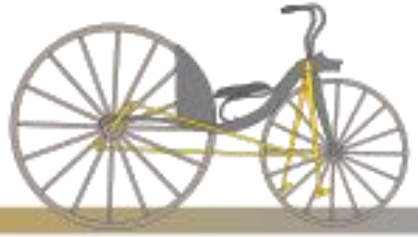
- Multicomponent interventions to reduce falls
- Use of clinical pharmacists to reduce adverse drug events
- Documentation of patient preferences for life-sustaining treatment
- Obtaining informed consent to improve patients' understanding of the potential risks of procedures
- Team training
- Medication reconciliation
- Practices to reduce radiation exposure from fluoroscopy and CT
- The use of surgical outcome measurements and report cards, such as those from ACS NSQIP
- Rapid-response systems
- Use of complementary methods for detecting adverse events or medical errors to monitor for patient safety problems
- Computerized provider order entry
- Use of simulation exercises in patient safety efforts

1847

166

2013

1818
velocipedo
Karl von Drais
Alemania



1830
velocipedo
Thomas McCall
Escocia

1860
bicicleta con pedales
Pierre Michaux
Francia

1870
bicicleta de rueda alta
James Starley
Francia

1885
máquina segura
John Kemp Starley
Inglaterra

Década de 1960
bicicleta de pista

EEUU

A mediados de 1970
bicicleta de montaña

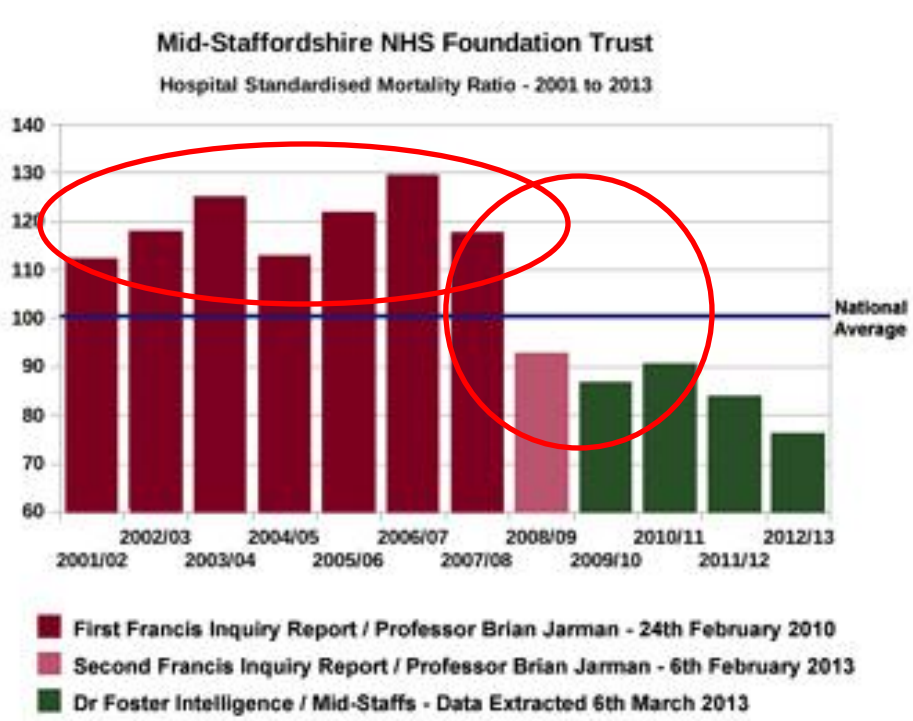
EEUU

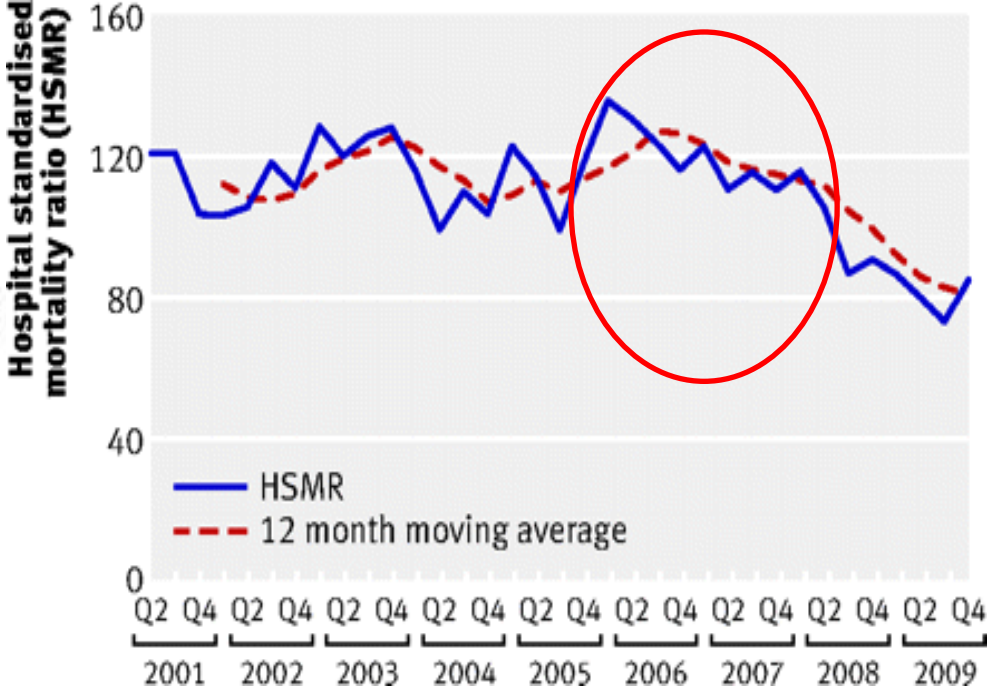
90% de las unidades

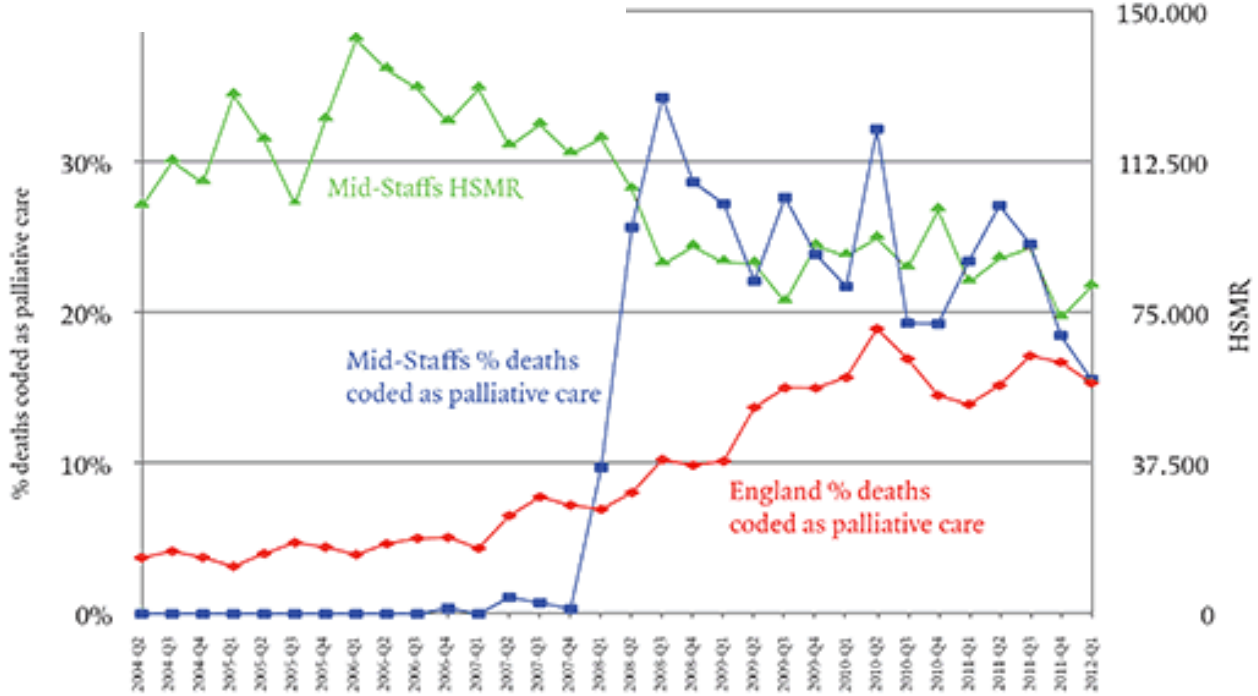
II. El foco equivocado

Riesgos latentes

La tragedia de Mid Staffordshire


Mid-Staffordshire NHS Foundation Trust
Hospital Standardised Mortality Ratio - 2001 to 2013
140
130
120
110
100
90
80
70
60
National Average
2001/02
2002/03
2003/04
2004/05
2005/06
2006/07
2007/08
2008/09
2009/10
2010/11
2011/12
2012/13
First Francis Inquiry Report / Professor Brian Jarman - 24th February 2010
Second Francis Inquiry Report / Professor Brian Jarman - 6th February 2013
Dr Foster Intelligence / Mid-Staffs - Data Extracted 6th March 2013


Hospital standardised mortality ratio (HSMR)
160
120
80
40
0
HSMR
12 month moving average
Q2 Q4 Q2 Q4 Q2 Q4 Q2 Q4 Q2 Q4 Q2 Q4 Q2 Q4 Q2 Q4 Q2 Q4
2001
2002
2003
2004
2005
2006
2007
2008
2009


% deaths coded as palliative care
30%
20%
10%
0%
Mid-Staffs HSMR
Mid-Staffs % deaths coded as palliative care
England % deaths coded as palliative care
150.000
112.500
75.000
37.500
0
HSMR

Los pacientes ignorados…

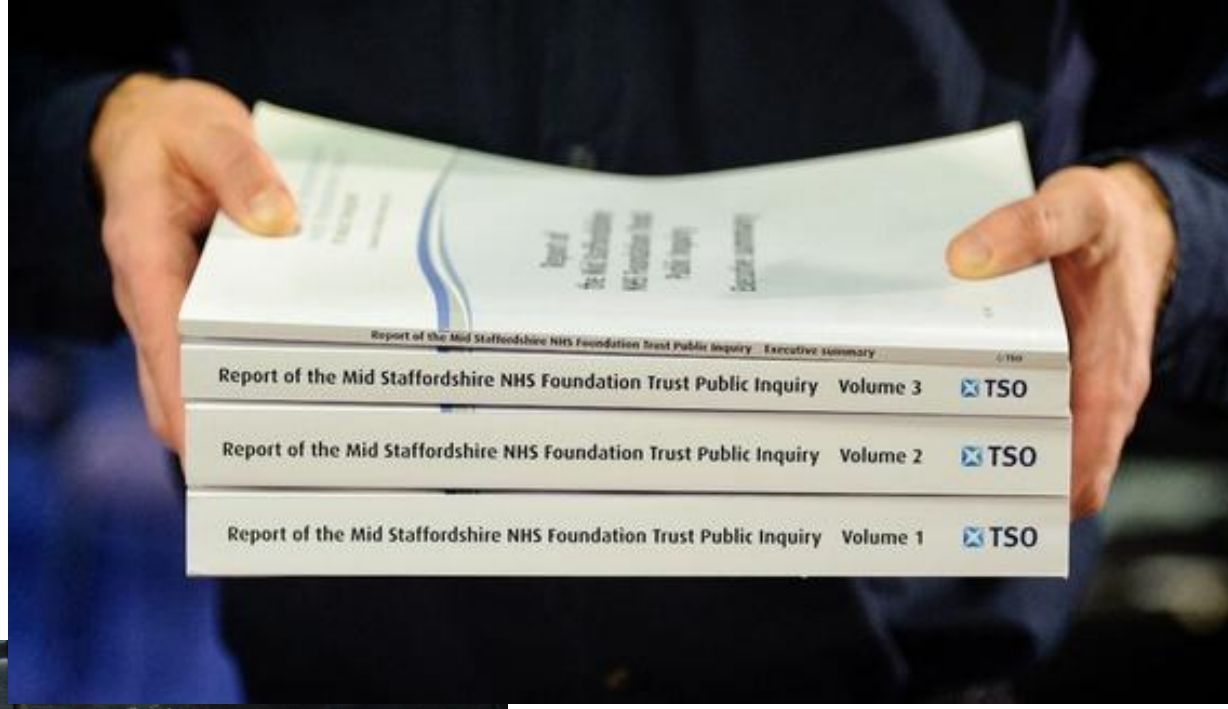
“ For many patients the most basic elements of care were neglected .. some patients needing pain relief either got it late or not at all. Others were left unwashed for up to a month. Food and drinks were left out of the reach of patients and many were forced to rely on family members for help with feeding. Too many patients were sent home before they were ready to go, and ended up back in hospital soon afterwards.

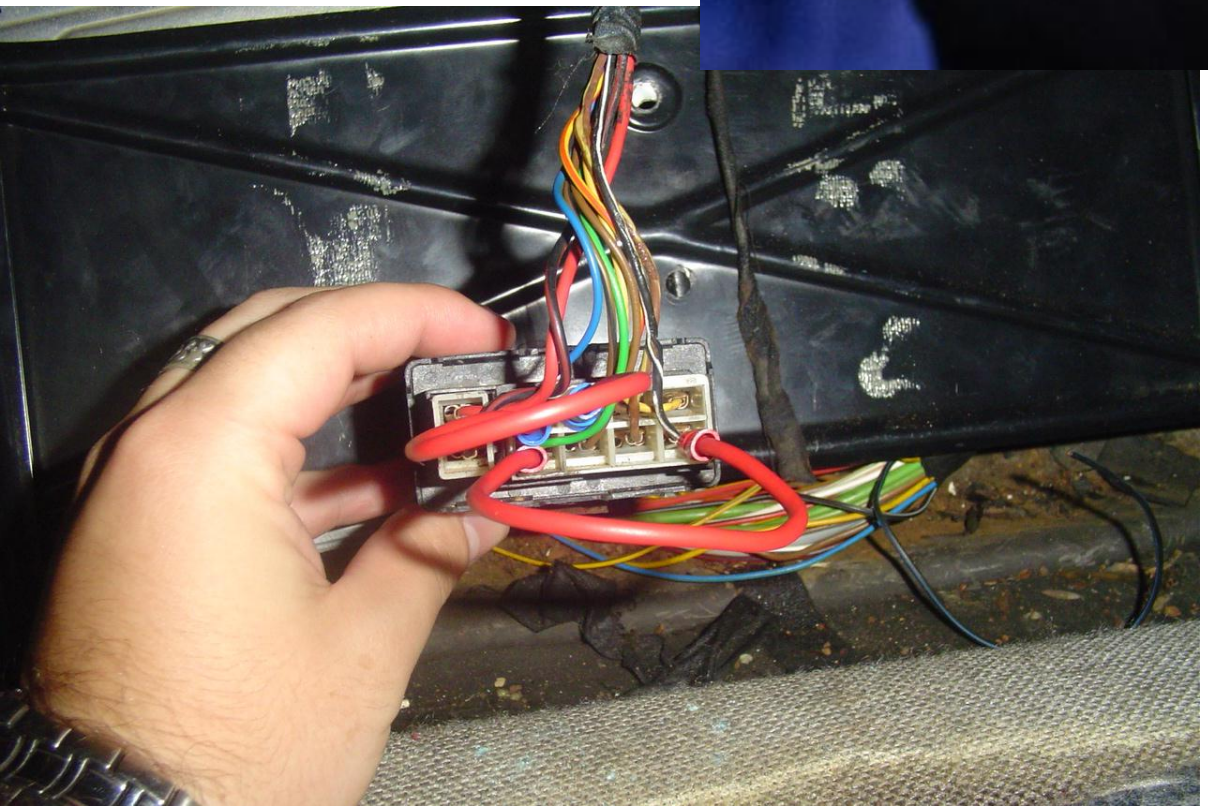
The standards of hygiene were at times awful, with families forced to remove used bandages and dressings from public areas and clean toilets themselves for fear of catching infections.

Patients' calls for help to use the toilet were ignored, with the result that they were left in soiled sheeting or sitting on commodes for hours often feeling ashamed and afraid.

Misdiagnosis was common.”

Sir Robert Francis QC


Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry Executive Summary
Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry Volume 3
TSO
Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry Volume 2
TSO
Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry Volume 1
TSO



Duty of candour =

deber de franqueza

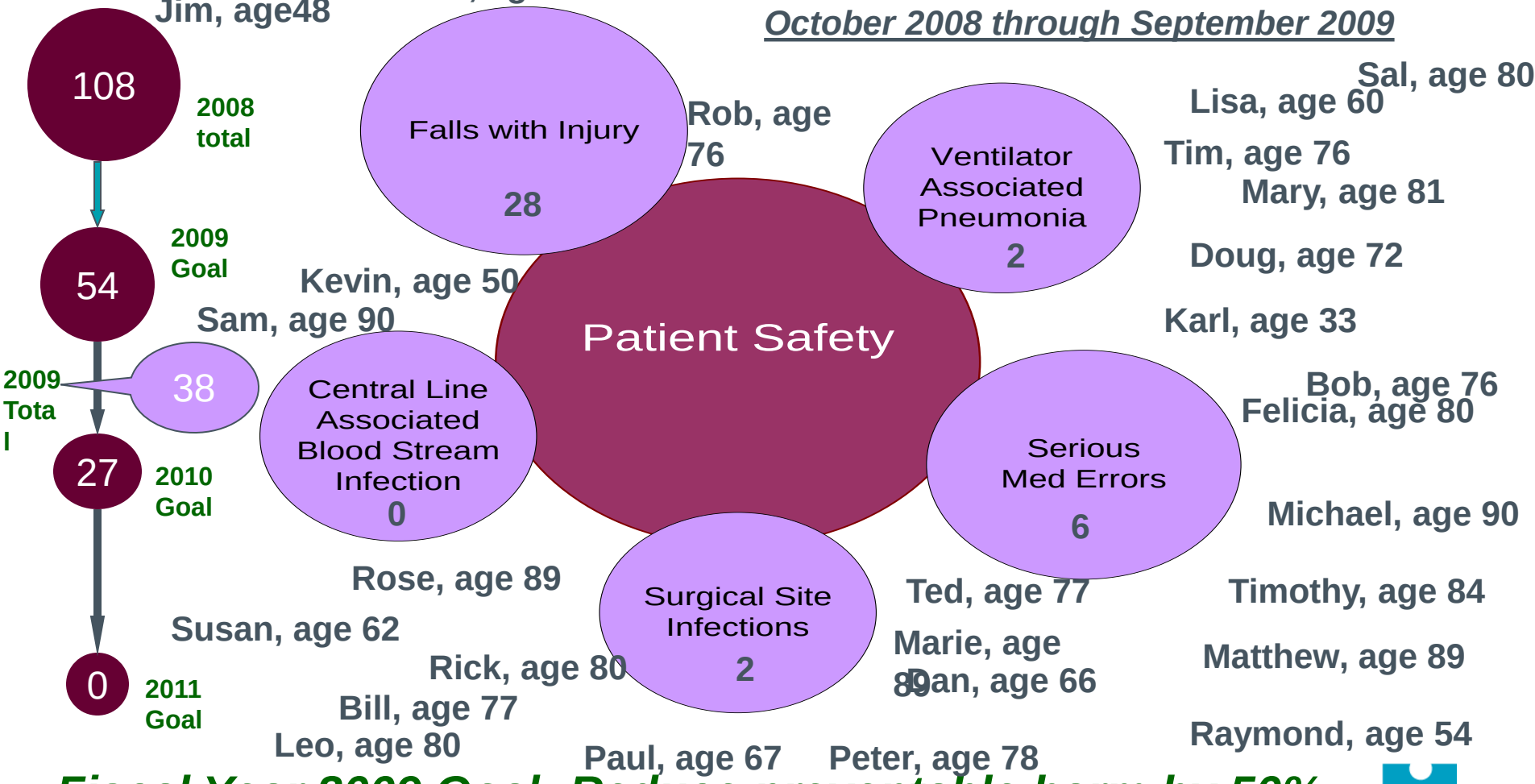
(saber es poder…29%, 72%...

y definir compromisos)

III.El Norte

Winchester Hospital **Preventable** Harm Events

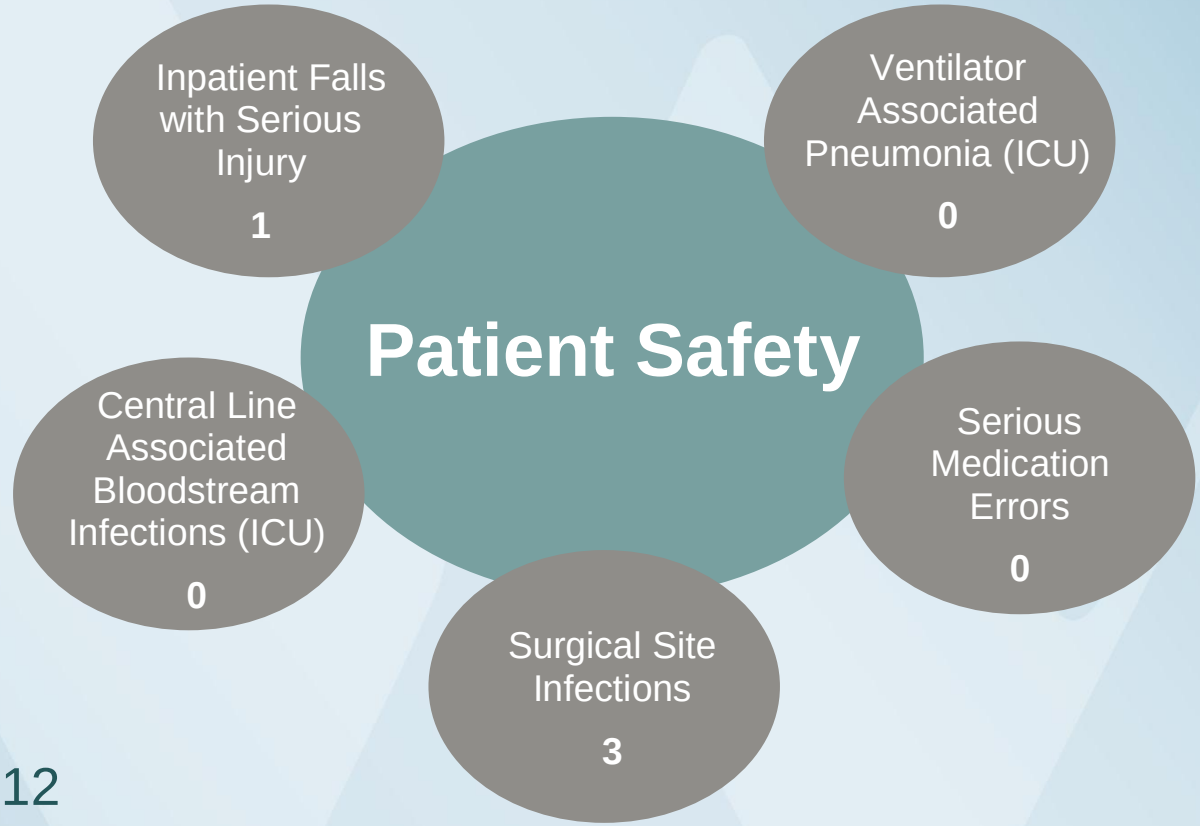
October 2008 through September 2009



Fiscal Year 2009 Goal: Reduce preventable harm by 50%

Selected Preventable Harm Events

FY2010 October 2009 through September 2010
Updated through July 31, 2010



Our Aim: Eliminate Preventable Harm by Dec. 31, 2011

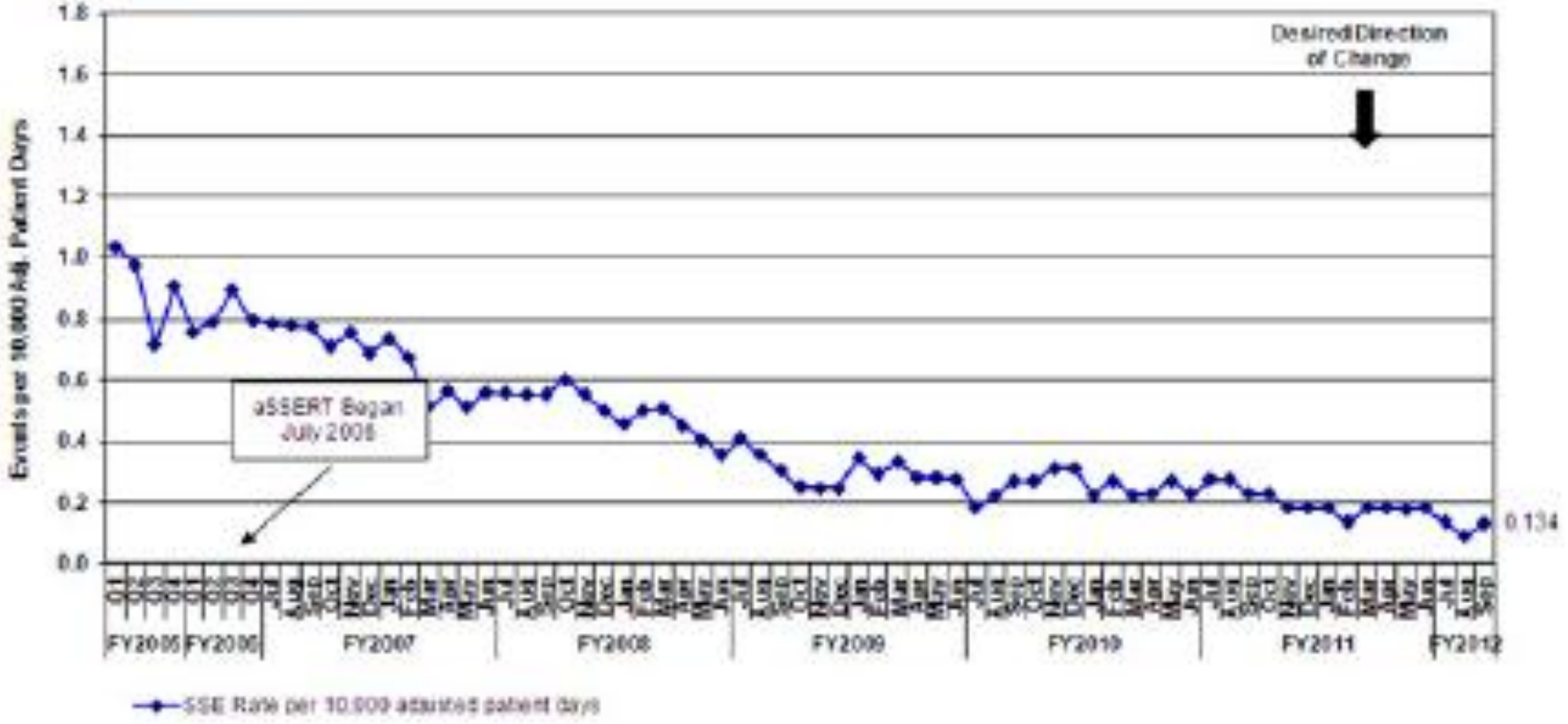
IV. Conocimiento de la situación

Situational Awareness

Basado en principios de alta confiabilidad: Weick K, et al. "Organizing for high reliability: processes of collective mindfulness." Research in Organizational Behavior. 1999.

Cincinnati Children's Hospital Medical Center

Serious Safety Events per 10,000 Adj. Patient Days
Rolling 12-Month Average



Inpatients: todo el hospital a bordo

- 7.30am: ‘huddles’ en cada unidad
  - Prediccion de riesgo (todo el equipo)
- 8.00am: ‘huddles’ en cama
  - Reporte de predicciones (‘charge nurse’)
- 8.30am: ‘safety briefing’ diaria, a nivel de hospital
  - Todas las unidades reportan riesgos esperados
- Durante el dia
  - ‘Defensores’ de los pacientes conversan con el staff de cada unidad acerca de su plan de mitigación
- 4.30pm: ‘huddles’ en la cama
  - Nuevas predicciones basadas en acciones del dia

CS: Area peri-operativa

- **Predecir** – Riesgos especificos a eventos o pacientes
  - ‘Huddles’ en cada turno para identificar riesgos
  - Enfermeras, tecnicos, anestesia, liderazgo, cirujanos
- **Mitigar** – Soluciones basadas en el equipo
  - Revistas con proposito – mitigar, ponerse al dia
  - Brindar recursos
- **Escalar / Comunicar** – Soluciones basadas en el sistema
  - Aumento de recursos y ayuda
  - Conducta esperada, que no es señal de fracaso

Risk Model : EMR Prediction

- Past History / Known Diagnosis
  - Congenital Anomalies
  - NICU experience
  - Co-Morbidities – Cardiopulmonary, DM, Neuro, Obesity,
- Past Experience in Institution
  - Prior Surgery
  - Airway management difficulties
- Prior Risk Incidents
  - SSI, ICU Admission, Anesthesia Experience

Cincinnati Children's

James M. Anderson Center for Health Systems Excellence

Risk Prediction Model

- Previous SSI
- Previous Critical Care Stay
- Anesthesia Pre-Screen/Consult conducted
- Prior return to ED
- At least one Complex Chronic Condition (Neuromuscular, Cardiovascular, Respiratory, etc)
- Morbid Obesity

Patient Name	MRN	Procedure Date	Previous SSI	Previous Critical Care	Previous Anesthesia Consult	Previous Anesthesia Screen	CCC Score	ED Days Prior
		11/25/2011	No	Yes, Last Stay: 11/23/2011	No	No	1	

Surgeon(s):	1)
Procedure(s):	1) MLB W/ BALLOON DILATION
Med Hx:	ANTERIOR GLOTTIC WEB OF LARYNX >>> Previous Discharge Dx: 11/23/2011 - 1) CONGENITAL WEB OF LARYNX; 2) STENOSIS OF LARYNX; 3) ATTENTION TO TRACHEOSTOMY; 4) ESOPHAGEAL REFLUX
Allergies:	OTHER - Dairy products cause constipation., Reaction: Constipation
Anes Comments:	need optical instruments for poss granulation tissue removal
Epic Problem List:	TRACHEOSTOMY STATUS; GERD (GASTROESOPHAGEAL REFLUX DISEASE); CONGENITAL LARYNGEAL WEB; SUBGLOTTIC STENOSIS; VASCULAR RING, AORTA; ADENOTONSILLAR HYPERTROPHY
Previous Patient Experience Issues:	international patient ; Hebrew

Cincinnati Children's

Risk Prediction

James M. Anderson Center for Health Systems Excellence

- **Green** - is all **CLEAR**, patient prepared and verified
- **Yellow** - is **"WATCH ROOM"**, notes elevated risk factors for patient safety identified. Proceed with caution. Communicate possible additional needs to PCF.
- **Orange** - is **"HIGH ALERT"** risk for patient vulnerability during the perioperative process. Requires additional resources and/or support from identified perioperative expert.
- **Red** - is the highest indicator which requires **"HARD STOP"** until the perioperative safety communication system has resolved the identified threat.

Classification of Cases – 30,700 Patients

Green	Yellow	Orange	Red
30,314	329	36	21

Situational Awareness Model

- Prediction of Risk
  - Intrinsic Patient Factors
  - Risk of Procedure
  - Experience of Team
  - Equipment
  - Work Environment
- Risk Report
- Plan for Mitigation
  - OR Staffing Models
  - Anesthesia Staffing
  - OR Team Composition
  - Just in Time Training
  - Environmental Assessment-Case Mix
- Color Coded Risk
- Structured Response Level (1-3)

Mitigation Planning

- Reactive – Depend on individuals to think their way through problems on the scene
- Predictive – Plan in advance for potential risks

- ***A carefully thought out plan developed in advance is nearly always better then a sudden decision made in the midst of an urgent situation.***

Risk Mitigation

- Round with Purpose
  - Structured time based – risk based attention
- Ask Questions . but . Ask the Right Questions
  - Update predictions – concerns, unexpected outcomes or changes
  - What are you worried about, resources met
- Focus on Safety Behaviors we believe will translate into better safer care – (the little stuff)
- Structured Escalation – Doesn't require someone to ask for Help

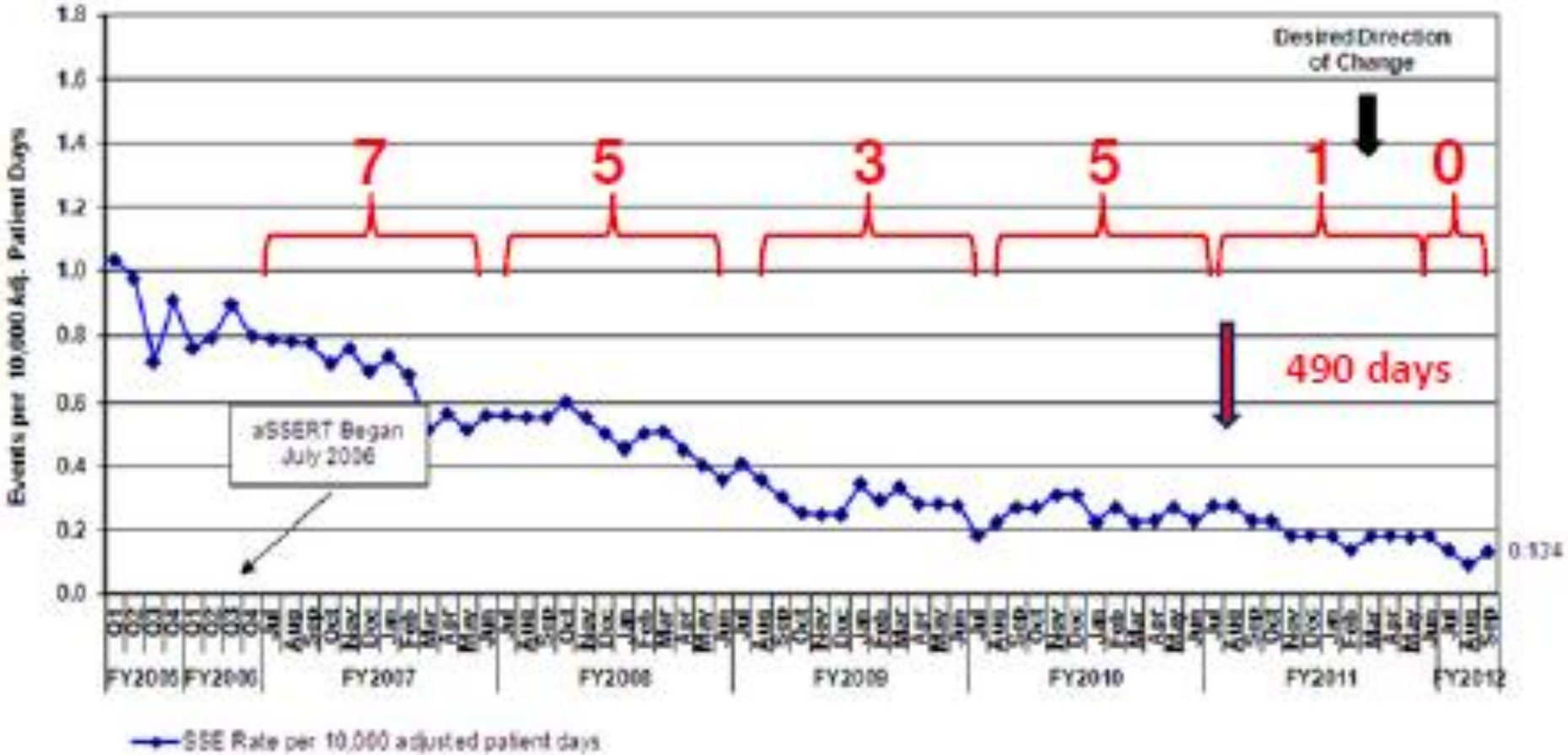
Safety Lessons we have Learned

- We were not clear about "Mission"
  - It is more then "Be a Safe Surgical Team"
- We were not clear about Expected Behaviors
  - Line Item Detail – ALL Providers (Not just RN's)
- We were not clear on Execution
  - Unclear roles, role modeling
- We are still defining Personal Accountability
  - Violation of clear rule vs system problem
  - Blame-free culture vs required responsibility
  - No Exceptions

Peri-Op / Operating Room Events

Cincinnati Children's Hospital Medical Center

Serious Safety Events per 10,000 Adj. Patient Days
Rolling 12-Month Average



V. Colaboración a gran escala hacia la excelencia

Programa Nacional

CONTEXTO

- Escocia 2008
- Daños al 10% de pacientes
- Gobierno - Nacional

CONTENIDO

- Seguridad del paciente (mortalidad, eventos adversos)

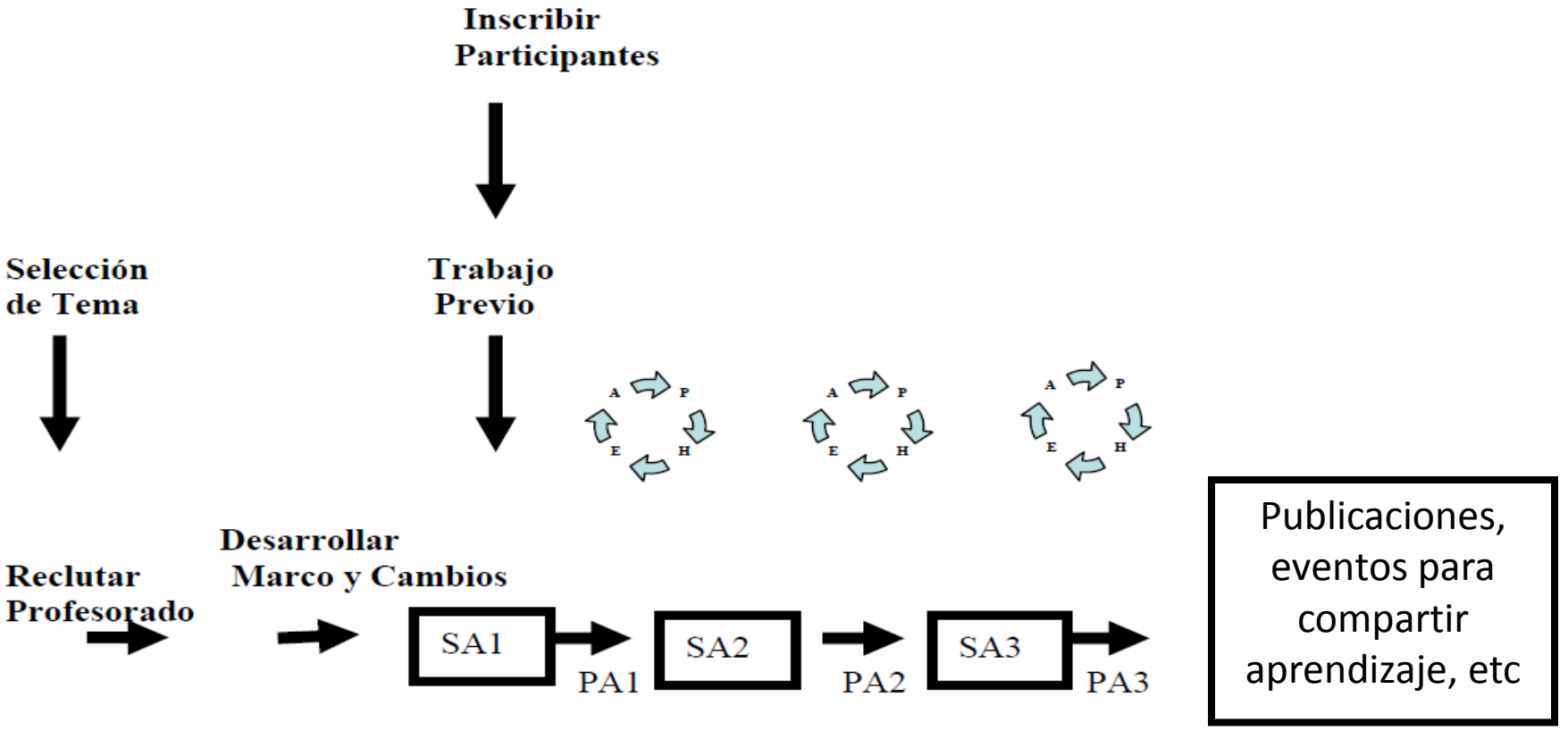
MECANISMO

- Programa a nivel nacional (colaborativa y desarrollo de destrezas de mejora)
- Alineación a todo nivel

Metas Específicas

- **Mortalidad (SMR): reducción del 15%**
- **Eventos adversos: reducción del 30%**
  1. **UCIs**
  2. **Quirófanos**
  3. **Unidades Generales**
  4. **Seguridad en Medicación**
  5. **Liderazgo Ejecutivo**

Sistema de Aprendizaje y Medición, Colaborativo: *todos enseñan, todos aprenden*

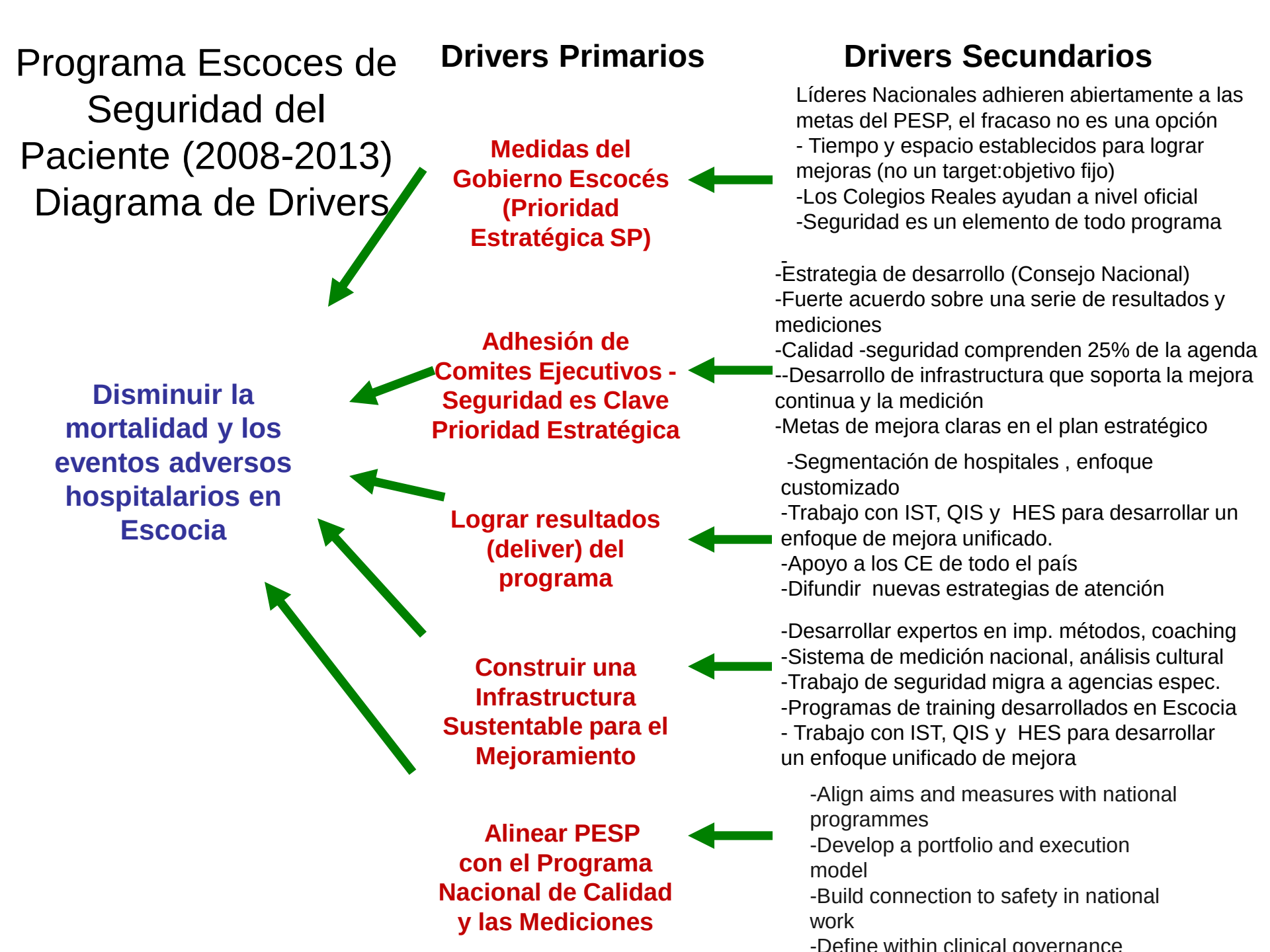


SA : Sesión de Aprendizaje
PA : Period de Acción
PHEA: Planificar/Hacer/Estudiar/Actuar

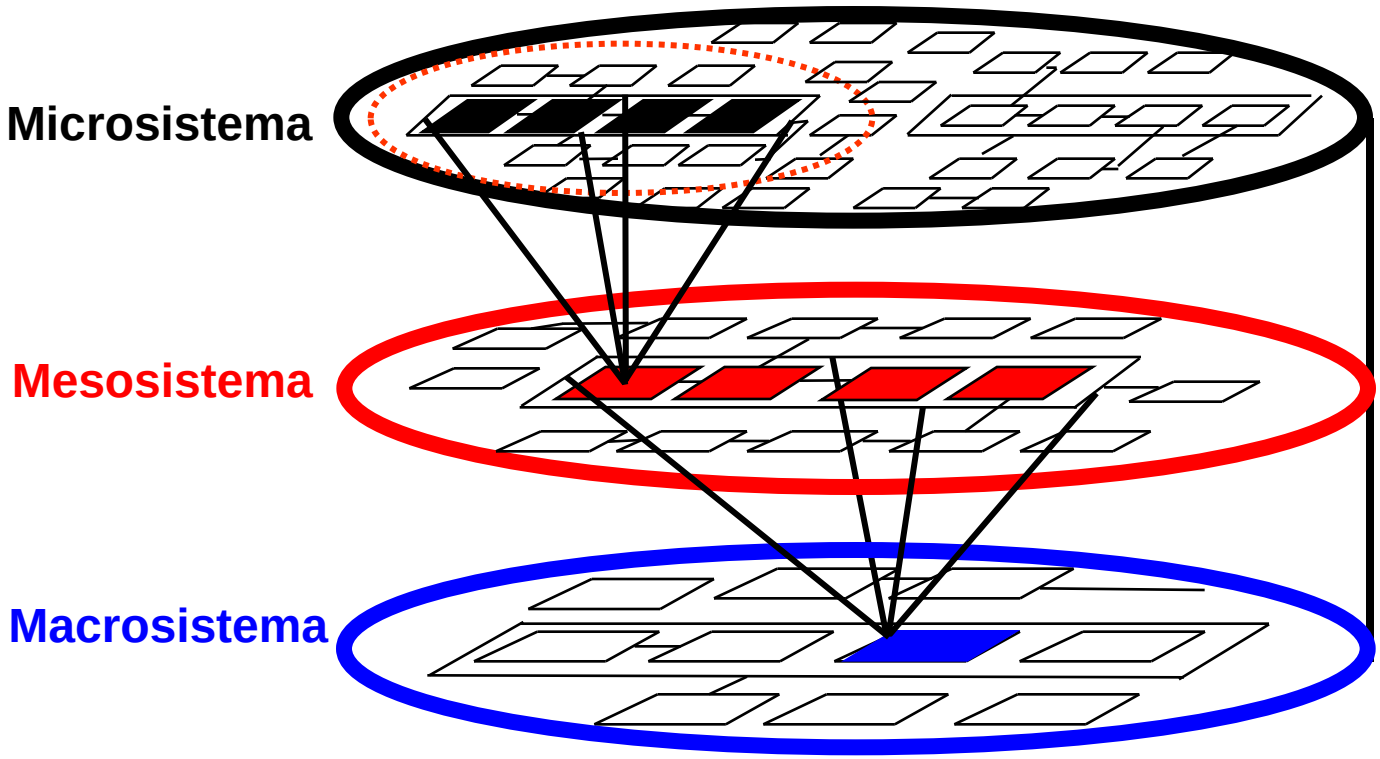
Teoría del cambio

1. Metas claras y una metodología de mejora especifica, con soluciones definidas (‘bundles’, etc)
2. Formación de capacidades en calidad y seguridad
3. Acciones concretas del liderazgo
4. Desarrollo de líderes futuros
5. Medición mensual de procesos y resultados, compartida y transparente
6. Colaboración constante

Programa Escoces de Seguridad del Paciente (2008-2013) Diagrama de Drivers



Todos los niveles alineados



The Scottish Government

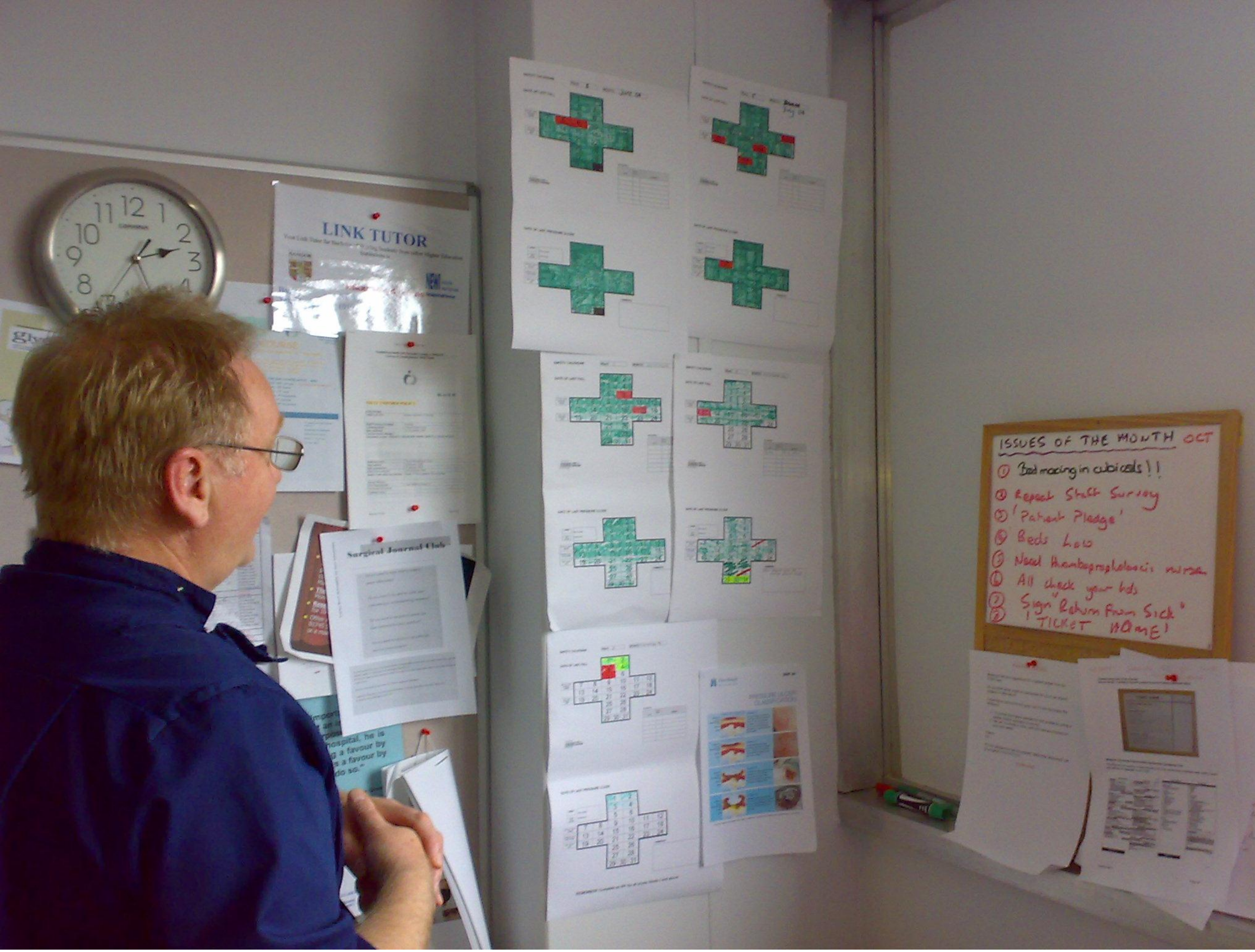
Safety huddles, briefings

http://www.ihi.org/knowledge/Pages/Tools/SafetyBriefings.aspx

- *Riesgos del día (prospectivo)* - 15 minutes

1. Que sucedió que pueda amenazar la seguridad de los pacientes o el staff?
2. Que debió haber sucedido?
3. Donde encontramos la diferencia?
4. Como podemos evitar el mismo resultado la próxima vez?
5. Cual es el plan de seguimiento?

- *Una persona se encarga de hacer el seguimiento*

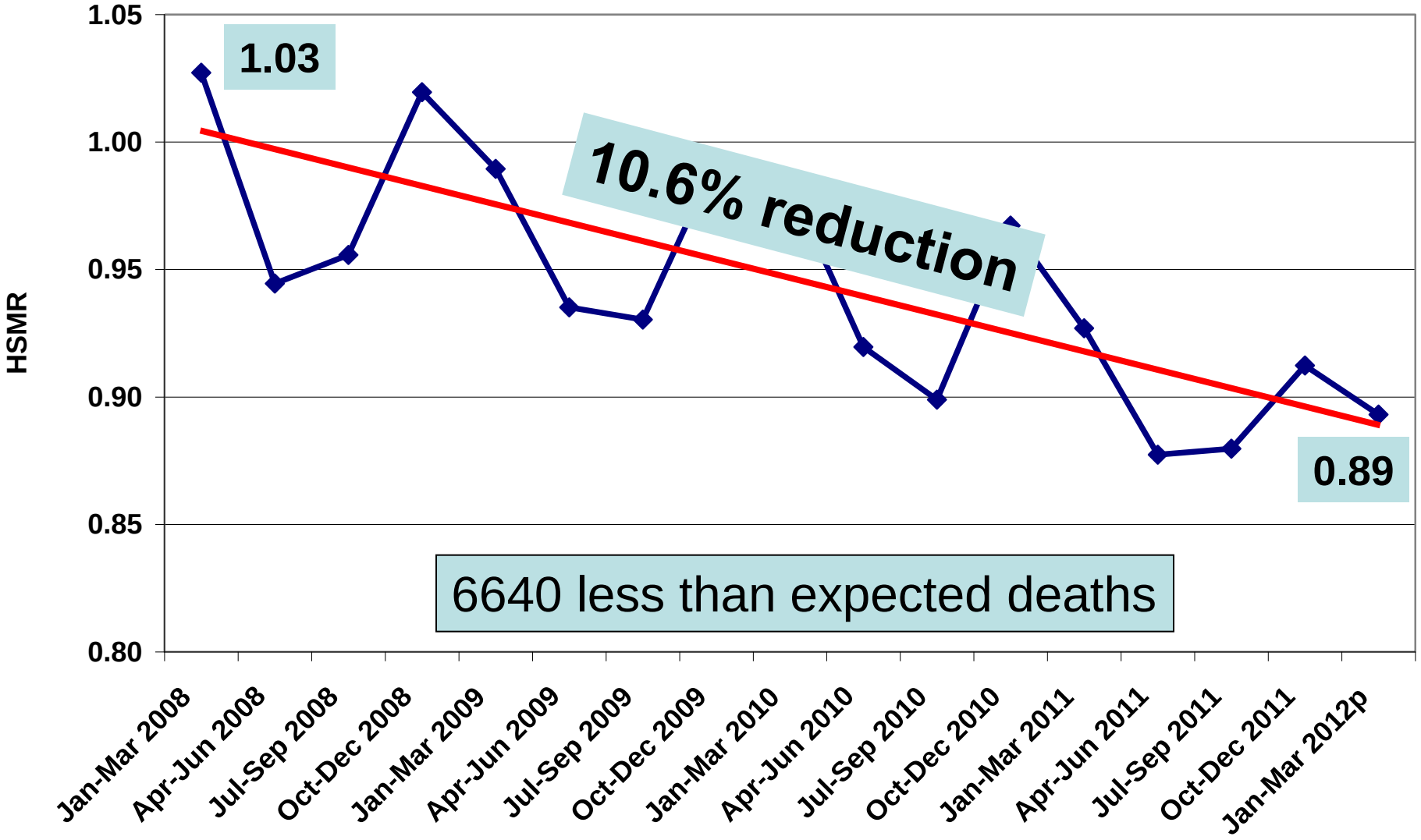

LINK TUTOR
Surgical Journal Club
ISSUES OF THE MONTH OCT
Repeat Staff Survey
'Patient Pledge'
Beds Low
All check your bds
Sign "Return From Sick"
TICKET HOME!

			1	2		
			3	4		
			5	6		
	7	8	9	10	11	12
	13	14	15	16	17	18
	19	20	21	22	23	24
			25	26		
			27	28		
			29	30	31	

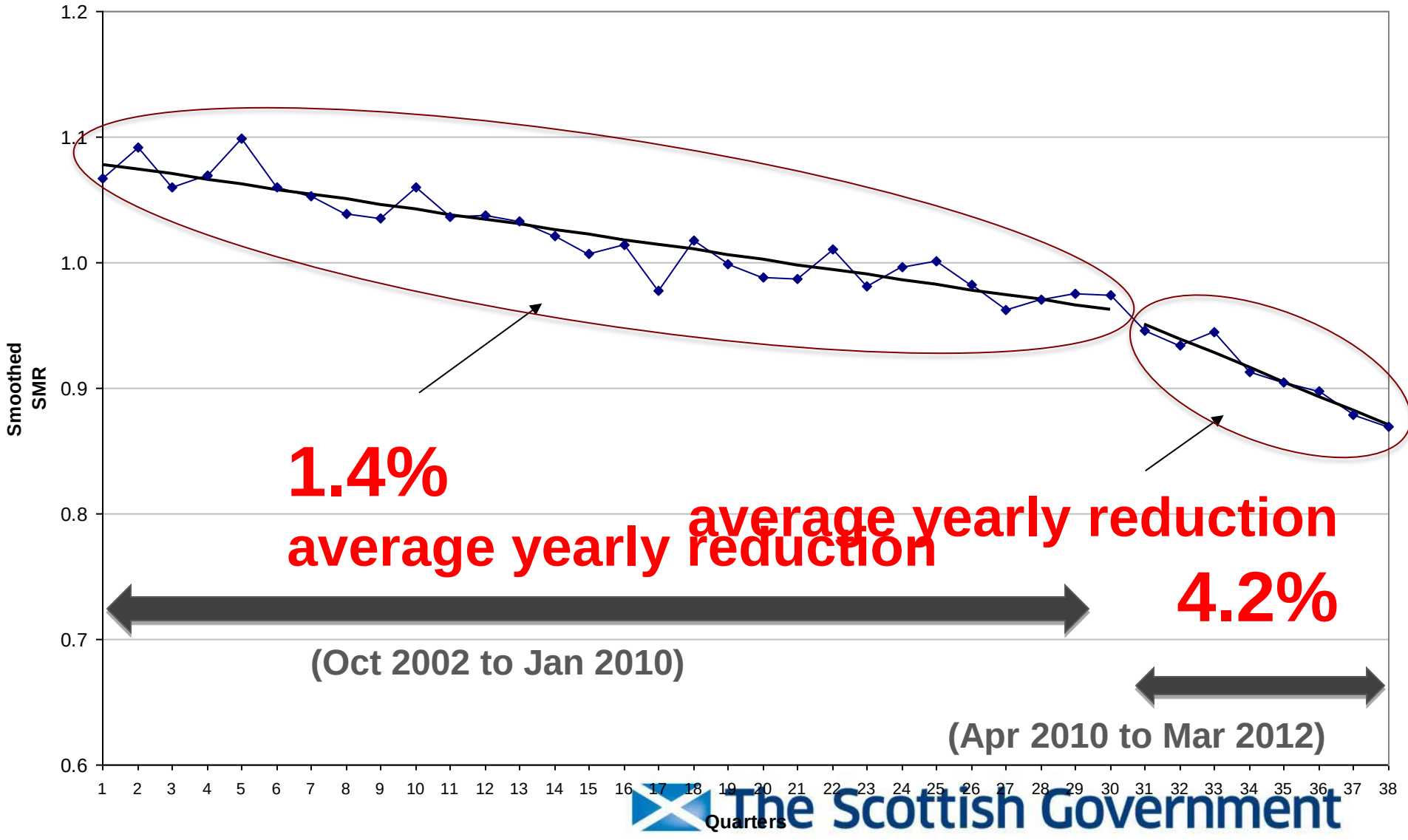
Lectura completada

Lectura no completada

HSMR: Scotland
Jan. ’08 → Mar. ‘12



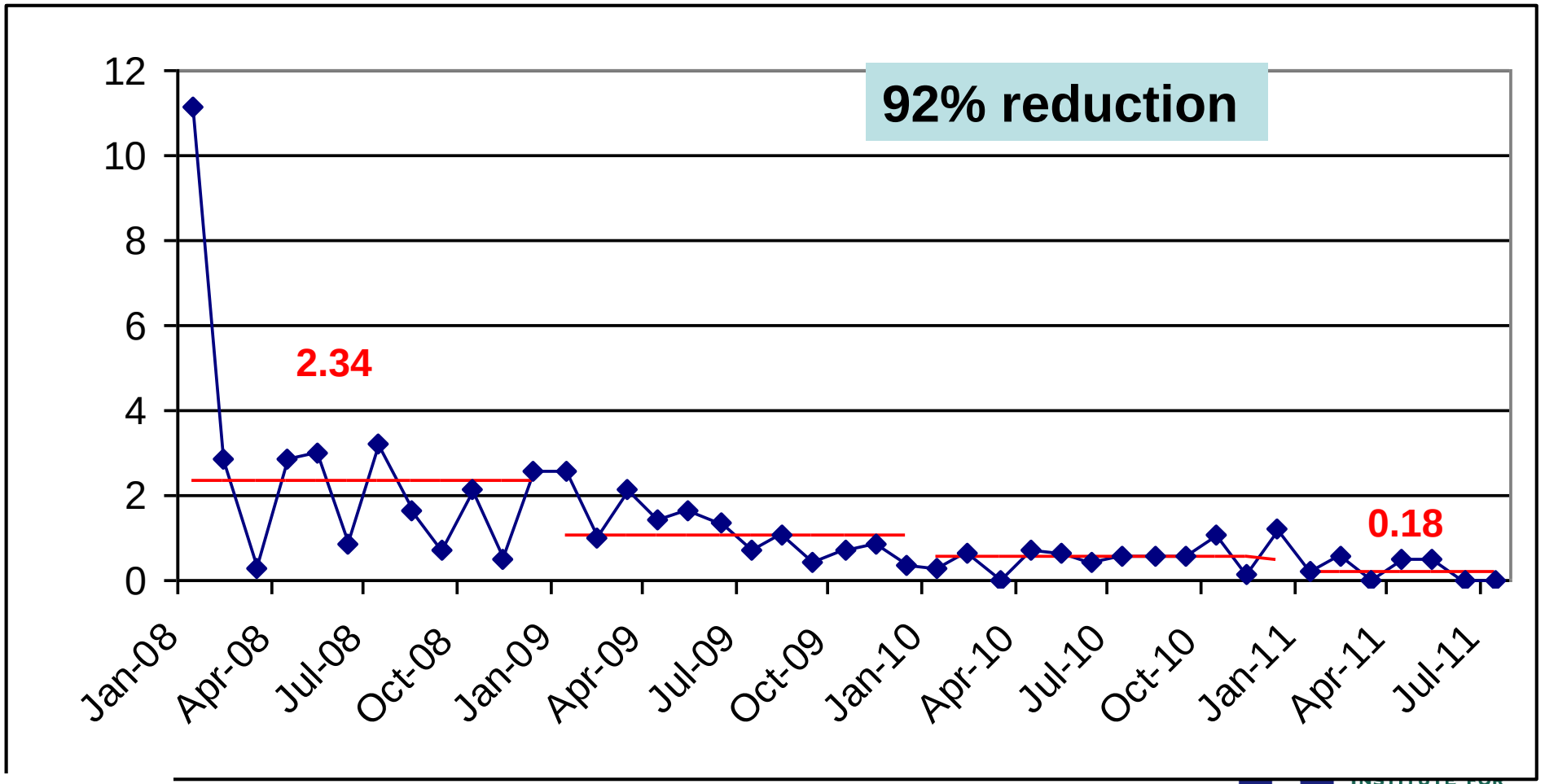
Hospital Standardised Mortality Ratios (Seasonally Adjusted) Scotland: Oct-Dec 2002 to Jan-Mar 2012



The Scottish Government

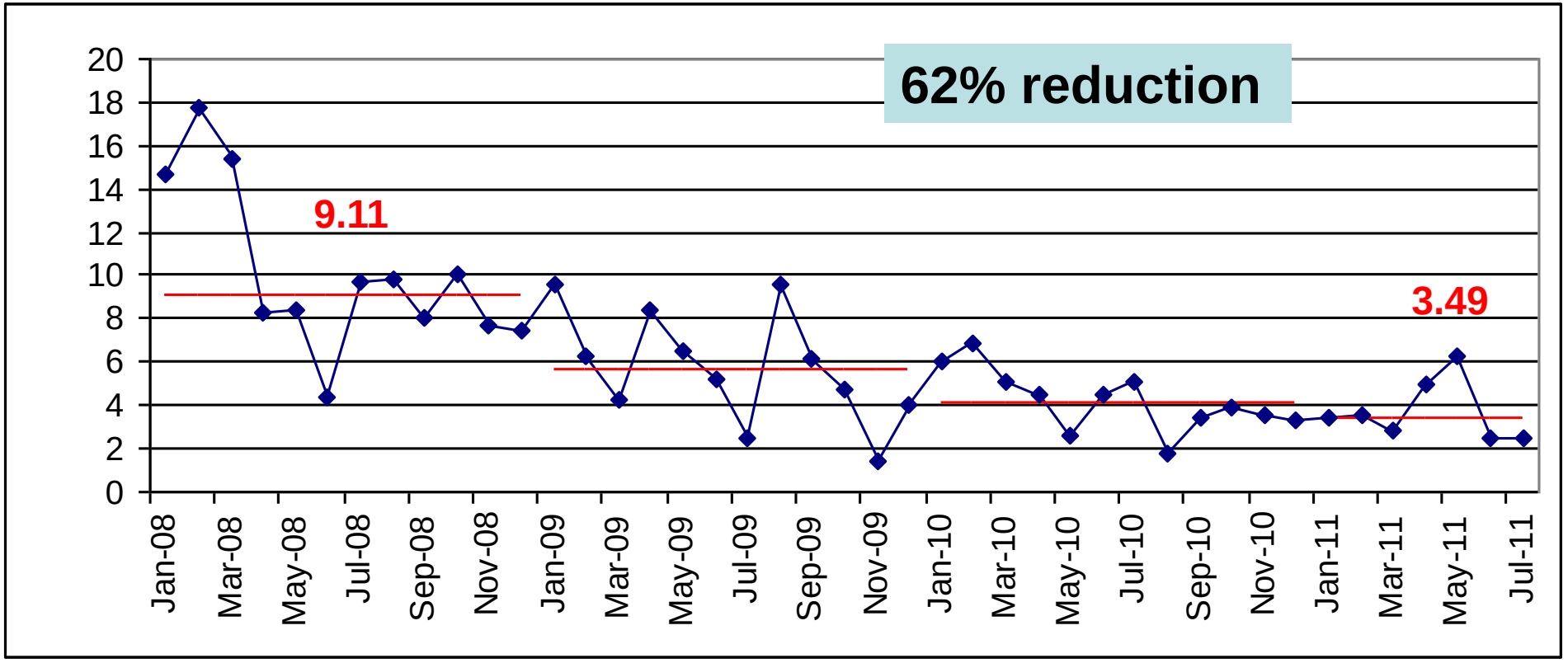
Central line infection rate

(per thousand line days)



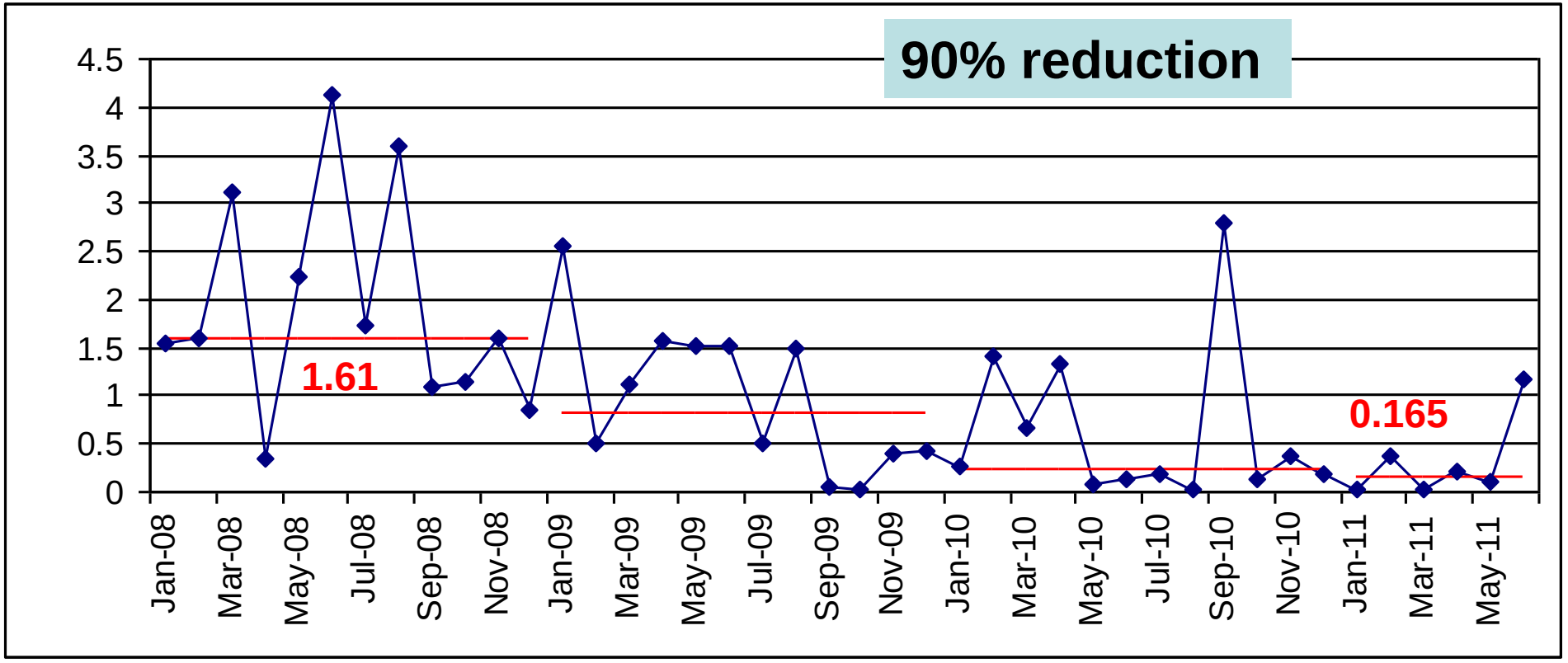
VAP rate

(per thousand ventilator days)



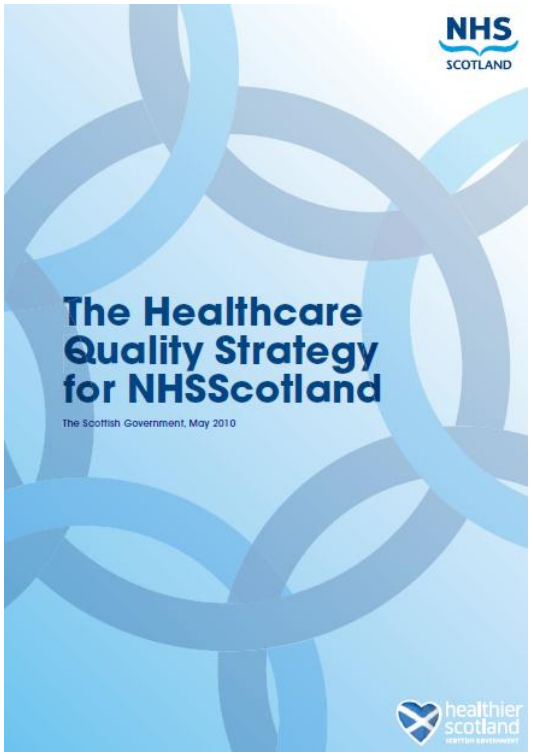
Critical care C-Difficile rate

(per thousand bed days)



La Plataforma

SCOTTISH PATIENT SAFETY PROGRAMME — ACUTE CARE



‘Early Years Collaborative’

SCOTTISH PATIENT SAFETY PROGRAMME — MATERNAL CARE

SCOTTISH PATIENT SAFETY PROGRAMME — PAEDIATRICS

SCOTTISH PATIENT SAFETY PROGRAMME — NEONATES

SCOTTISH PATIENT SAFETY PROGRAMME — MENTAL HEALTH

SCOTTISH PATIENT SAFETY PROGRAMME — PRIMARY CARE

The Scottish Government

Resumen

1. Marcos y soluciones
2. El foco equivocado
3. El Norte
4. Conocimiento de la situación
5. Colaboración hacia la excelencia

Institute *for* Healthcare Improvement

Gracias

www.ihi.org

pdelgado@ihi.org
@pedroIHI