From Standards to Reporting to Quality: How to make it Person-Centred

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About ISQua
ISQua

- Not for Profit Membership Organisation
- Mission:

“to inspire and drive improvement in the quality and safety of healthcare worldwide through education and knowledge sharing, external evaluation, supporting health systems, and connecting people through global networks.”
The ISQua Network System

Policy Development

Quality Improvement and Patient Safety

Innovation and Research

Experts

Membership

Education Fellowship

External Evaluation Accreditation

IAP

Accreditation Council
External Evaluation Network

ISQua offers a peer review assessment framework to support the improvement of performance and practice of health and social care standards and external evaluation bodies.

EXTERNAL EVALUATION

We award:

- Standards
- Organisations
- Surveyor Training Programmes

Over 90 International Surveyors

60+ Client Organisations in over 30 Countries

International Best Practice

Continuous Quality Improvement

4-Year Cycle

Peer Review
Ingredients for Improvement

1. Culture

2. Standards

3. Framework for Quality

4. Theory (and method) to Improve

5. A Method to Learn
1. Culture

Pathological
It is ok as long as nothing happens

Reactive
Safety is important - we do a lot when something happens

Calculative
we have systems in place to manage all hazards

Proactive
We work on problems we still find

Generative
Safety is how we do business here

Increasing informedness or mindfulness

Increasing information

Hudson P. Applying the lessons of high risk industries to health care
Qual Saf Health Care 2003
2. Standards and Their Role

- Minimum: what is essential
- Maximum: to which we all aspire

Structure Process and Outcomes
3. Framework for Quality

- Quality planning
- Quality improvement
- Quality management
- Quality control

Based on Juran
4. A Theory to Improve

System where you work

Variation in the system

Theory of knowledge

Psychology - the people
5. Framework to Learn

Reporting
to learn from what does not go well
Understanding why Harm Happens

- **Organisation & Culture**
  - Management decisions & Organisational processes
- **Contributory factors**
  - Environment factors
  - Team factors
  - Staff factors
  - Task factors
  - Patient factors
- **Care delivery problems**
  - Unsafe acts
  - Errors
  - Violations
- **Defences & Barriers**

**Latent failures**

**Human factors**

**Active failures**

Adapted from Charles Vincent and SEIPS System Model Carayon 2006
Reporting to learn from what does go well
From Safety 1 to Safety 2

Figure 6: The basis for safety is understanding the variability of everyday performance

Hollnagel E., Wears R.L. and Braithwaite J. From Safety-I to Safety-II: A White Paper. The Resilient Health Care Net: Published simultaneously by the University of Southern Denmark, University of Florida, USA, and Macquarie University, Australia.
A Holistic Approach

What did we do well?
Learning
Past Harm
Anticipation
Reliability
Sensitivity to operations

Moving to person-centred care
Bring it Together

- **New ways of thinking (Deming)**
  - We need different ways to solve the problems

- **A change in culture**
  - Change language and the way we act, behave, learn and teach

- **Active changes**
  - Actively adopt new ways to solve challenges

*Slide concept based on IHI White Paper*
What really matters for Person-Centred Care

- Personalised care
- Dignity and compassion
- Coordinated, Safe and Effective care
- Enabling care

“Medicine begins with storytelling. Patients tell stories to describe illness; doctors tell stories to understand it.”

Siddhartha Mukherjee
The Emperor of All Maladies: A Biography of Cancer
“For human beings, life is meaningful because it is a story. A story has a sense of a whole, and its arc is determined by the significant moments, the ones where something happens.”

Atul Guwande
Being Mortal
Know your Underlying Values

Does the process lead to a culture of person-centred care and facilitate

“What really matters to me as a care giver”
Improvement

Better outcomes → Better professional development → Better systems

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