BC PATIENT SAFETY & QUALITY COUNCIL

SQAN
SURGICAL QUALITY ACTION **NETWORK**

Crowdsourcing Surgical Improvement

3RD ANNUAL SQAN MEETING

What does it take to provide top surgical care in BC?

Top 3 Topics

Where did we start?

- Training
- Quality Training
- Research, projects

Where are we now?

-

How did we get here?

- PRIORITIES - goals
- Oversight Quality committees
- Learning institutions

Who led this effort?

- Institutions - hospitals, universities
- Organization leaders
- Patients

Be as specific as possible

How to train next generation

Postcard

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Future

2015

Teamwork & Communication

Allison Muniak

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Where did we start?

Identifying that teamwork & communication games can be used to start the discussions.

Where are we now?

Embedded games with coaching tools Teams / individuals who use improved strategies for communicating.

How did we get here?

- Developing opportunities for coaching
- Work with individuals, teams, health authorities.

Who led this effort?

Front-line staff, admin, Quality & Safety Teams Council (BCPSQC), surgical teams.

Be as specific as possible

Where did we start?
- patients having poor quality of life outcomes after surgery

Where are we now?
- resources available to help patients make informed medical decisions
- extensive patient counselling

How did we get here?
- slow down → this is life + death
- multicultural, patient specific approach
  ↳ building relationships
- appropriate risk assessment
  ↳ cognative risk score etc,..

Who led this effort?
* medical ombudsman
* provincial collaborative
* PATH clinic training
* public involvement

Be as specific as possible

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Appropriateness of Surgery

(26)

Additional Topics

Where did we start?

- lack of standardization + consitancy + data
- sites showing they can + want to improve

Where are we now?

- enhanced recovery across specialties throughout the province
- Improved patient outcomes.

How did we get here?

- shift from open to lap surgeries
- finding out if we are really doing what we think we are doing
- teamwork + collaboration + multi-disciplinary involvement - shared care responsability

Who led this effort?

*need champions from all areas to lead effort => nursing, medicine, patients, nutrition etc

Be as specific as possible

*provincial working group

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ERACS @ 1345

Deborah

Sustainability

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Where did we start? We started with the attitude, "We've always done it this way." silos, ↓ communications, physician on a pedestal

Where are we now?

We provide excellent quality of care, safety is part of our care, no complications, successful interdepartmental teams, leadership involvement, role modeling, patient advertising, ↓ hospital stays, ↓ readmissions

How did we get here?

Interprofessional education, make quality part of nursing & MD curriculum, social media, advertising - mobilize people

Who led this effort?

Everyone - patients, nurses, physicians, teachers, families, all citizens - social movement

Be as specific as possible

Where did we start?

- Is everything we do evidence-based ^(still?)

Where are we now?

- focus on Patient
- appropriate spaces for everything-facility design.
- we have consensus.
- everyone is aware of expectations of them - framework of accountability
- the evidence has/has not changed.

How did we get here?

- we created the opportunity to gather evidence
- resources → facility design
- viable discipline processes
- focus on the patient

Who led this effort?

- joint management of OR
- multi-disciplinary collaboration

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Create Safest space

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Future

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CANADIAN COLLABORATIVE BEYOND NSQIP

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Where did we start?

NSQIP sites across the ~~future~~ country without focus

Where are we now?

Disjointed - no focus but interest

How did we get here?

- Canadian Addendum outlines requirement to share
- Create a way to share data (good + bad), interventions AND contacts

Who led this effort?

Members who are currently interested in Can Coll. ± help from BC SQAN

Be as specific as possible

- Go broad - beyond NSQIP!
- Together with ERAS

Laura Hopkins
Peter Doris

Why is the word administrator a profanity in healthcare

Where did we start?

- Different language
- Different accountability
- funding is vague can't follow the dollar
- tough decisions to be made and someone must make them

Where are we now?

- Trying to be proactive
- Creating a co-leadership model Have team identify savings!!
- HA: senior executive board members applied
-

How did we get here?

- open communication for plan, must be transparent
- need 3-5 year plan Vision that does not change with administrator

administrators + physician collaborating together.

Who led this effort?

Must be collective

~~Custom~~ patient involvement

Be as specific as possible

Postcard from the Future 2015

Andy Hamilton

Where did we start?

Patches of success and good learning.

Where are we now? (2015)

BC Surgery Improvement academy that supports learning + sharing info. of teams in all HA in this province

How did we get here?

A lot of hard work. Supporting implementation c support of Senior Leadership team c $

Who led this effort?

Initial successful front line teams supported by HA's BCMA, MoH + BCPSQC & PSAC ..

Be as specific as possible

Yeh Yeah :)

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WHAT Individuals Can do to ↑ positive Change in HC TEAM

Where did we start?

- Nursing is already a collaborative process
- We are all learners coming w different life experiences & skills, qualities
- Communication between team members is lacking

Where are we now?

- Inspiring new grads ; instilling w confidence
- Common willingness to improve
- Mentorship is available & re-framed in a way that makes it appealing & beneficial for both people
- Student nurses & new grads feel comfortable & confident

How did we get here?

openness

- Stress-management offered to students
- Both sides open to learning from each other
- $ invested in mentorship program
- Research/data to support mentorship program
- Culture to focus on positives & opportunities for learning
- Hearing "conflicting opinions" & stepping back to allow & emotion

Who led this effort?

- Everyone
- Individuals take to National Level
  - Lisa will help lead this
- We all need to commit to being open

Be as specific as possible

nobody can do this on their own

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Empowering Patients

Where did we start?

- not pt centered → we are disease and process centered!
- huge differential between pt & doctors

Where are we now?

- have more than 6 minutes with a health-care provider
- options given to families about information practices available
- [redacted] optimization upstream
- less restrictive policies

How did we get here?

- hierachies broken down (@ student level)
- education to all team members
- role modeling from leadership!
- culture shift on dealing w/ families
- provide more info to families (education)
- health care workers listen to families

Who led this effort?

- patients become empowered by the healthcare team
- patient voices network providing feedback

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Surgical Site Infections
-learning from Best Practices

Where did we start?

- We have tools but are not using them as well as we could.
- We need to search for innovative ways to improve
- We can gather/share data with others
- There is more access to information

We have forgotten the "basics"

OR has a culture of tolerance to individual but does not tolerate

- people limited to job descriptions

Where are we now?

We are a pt-centered perioperative journey that allows for & respects individuality of the team while following best practices & eliminating SSIs.

(encouraging and allowing people to speak up)

How did we get here?

- Reducing variability of applying the basics
- Created a mechanism for personal accountability
- Created a culture when accountability is Really taken seriously.
- We got away from task-based work philosophy & moved toward meaningful work.
- Celebrate accomplishments to promote good work & ownership of the success.

Who led this effort?

- all stakeholders
- Nurses
- Administrators
- Surgeons

Be as specific as possible
allow people to volunteer

- Cleaning staff
- Educators

Who ever the champions are - at any level of the organization
→ Need members from every level of the organization on the QI team

Betty Allan

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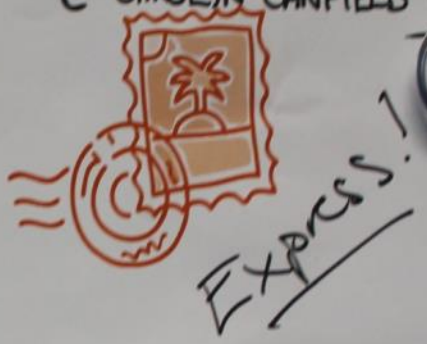
FEEDBACK: making a difference

[CAROLYN CANFIELD]



Where did we start?

Current feedback reflects negative conditions of care.
Balance missing for positive accomplishment, care = burnout.
Much feedback missing, negative happens more rapidly.

Where are we now?

Feedback validates the quality of care we provide.
Feedback acts as a force for change
Feedback is meaningful, relevant, timely.
Feedback supports clinicians, patients, managers.

How did we get here?

spread { Patients View (PSLS) at BC Childrens: better connection after the fact.
Providence HC top down commitment for pt + family centred care.
Simplified communication at all levels, all actors.
Information (feedback) flows UP in the organization to raise priority and resources, understand experience at the point of care.

Who led this effort? "every one"

a system that has power: PSLS re-cast
lots of different mechanisms
centre is passionate leadership to know + act
teaching by abstracting difficult interactions between patient, clinician and manager to teach active listening and problem resolution.

Be as specific as possible

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Keeping Surgeries Public

Where did we start?

- Some surgeries are being contracted out
- worry about decrease quality of care + safety
- we have a growing population + aging population
- requirement to be more resourceful

Where are we now?

- ORs would be staffed effectively + the culture would entice [redacted] them to stay
- funding models [redacted] would change
- have greater capacity

How did we get here?

- looking @ the staff mix
- re-evaluating funding - at the acute care level + at the government level
- review who gets surgery
- find efficiencies within acute care to find more money (e.g. Lean, ERAS)

Who led this effort?

- government
- hospital administrators working w/ health care teams

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Where did we start?

Unable to narrow down improvement projects

Where are we now?

Track all meetings of QI initiatives

Narrowed focus of PDSA Cycles

How did we get here?

Started i small success o build on to be able to spread

Who led this effort?

Multi disciplinary teams who are engaged

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QI Teams
⇒ where to start

How to provide better care for bariatric patients coming for surgery?

Where did we start?

Currently, we face a lack of proper equipment to accomodate safely and respectfully the needs of morbidly obese patients coming for surgical procedures.

Where are we now?

All health authorities are equipped with appropriate bariatric supplies. There's a proper network among different health authorities to share their experience. We have best practice guidelines for BC to care for bariatric patients.

How did we get here?

Creating awareness of the situation.
Statistics and case studies providing data about these patients.
Empowering the patients to advocate for themselves.
Connecting with advocacy groups.
Creating a working group with people from different health authorities and WCB.

Who led this effort?

A provincial task force, with nurse leaders, physician champions.

Be as specific as possible

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SURGICAL WAIT TIMES

Laura + Mary Beth.

Where did we start?

- System is punative → no incentive!
- Stressed environment where meeting targets that MOH set out does not evaluated our work from a patient-centred focus

Where are we now?

A data system with definitions & guidelines on what "wait" is and "cancellations".
Back to the money follows the patient

How did we get here?

- Money
- Good Data (NSQIP)
- Authority to implement changes

Who led this effort?

- Group across health authorities - provincial
- Interdisciplinary stakeholders.
- Executive CEO's group.

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* Model the behaviour & excellence.
Remove non-pay for non performance (penalty)

Mitra Maharaj

Where did we start?

How to quantify cost of pt complication / No agreed or standardized cost

Where are we now?

Use NSQIP Data

Data sharing for those who have done this

How did we get here?

Pick 3 of the complications & have them relate to P4P initiatives

Who led this effort?

VGH

Langley

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How to determine actual cost savings of complications

Mitra Maharaj