Diploma in Leadership and Quality in Healthcare

• Established by the Health Service Executive (HSE) and the Royal College of Physicians of Ireland (RCPI) in 2012

• Began due to the needs of a partnership between an educational body and the HSE with the aim to build leadership skills and expertise in quality improvement and to develop a common language between management and clinicians in helping them achieve their common goal of improving Irish healthcare.

• A unique partnership
Doctors Trained

• 160 Doctors trained in our QI education programmes
  • Including 35 Clinical Directors

• Over 1000 healthcare professionals in total trained in our QI education programmes
<table>
<thead>
<tr>
<th>Improvement Science</th>
<th>Measurement</th>
<th>Healthcare Improvement</th>
<th>Leadership/Governance</th>
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</thead>
<tbody>
<tr>
<td>• Model for Improvement</td>
<td>• QI tools (methods)</td>
<td>• The patient at the centre of care</td>
<td>• Influencing skills</td>
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<td>• Lean thinking</td>
<td>• Measuring variation</td>
<td>• Developing person centred care framework</td>
<td>• Frontline ownership</td>
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<tr>
<td>• Profound Knowledge theory and its impact on QI</td>
<td>• Measurement and management of error</td>
<td>• Understanding self-management</td>
<td>• Theories of leadership</td>
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<td>• Microsystems theory</td>
<td>• Developing and measuring a culture of safety</td>
<td>• Management of long term conditions</td>
<td>• Human Factors</td>
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<td>• Understanding flow</td>
<td>• Responding to error</td>
<td>• Shared decision-making</td>
<td>• Conflict</td>
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<td>• Systems theory</td>
<td>• Identify and reporting errors</td>
<td>• Models of chronic disease management</td>
<td>• Self-development</td>
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<td>• Front Line Ownership theory</td>
<td>• Error versus harm</td>
<td>• Care of the caregiver; creating joy at work, meaning and safer healthcare</td>
<td>• Theories of human psychology</td>
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<td>• QI tools (methods)</td>
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<td>• Dealing with healthcare providers in crisis</td>
<td>• Coaching</td>
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<td></td>
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<td>• Second victim and third victim</td>
<td>• Putting quality into governance</td>
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<td>• Building a safe system – human factors, reliability theory, resilience (safety 1 and safety 2)</td>
<td>Understanding safety cultures and high reliability organisations</td>
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<td>• Looking after the customer</td>
<td>• Risk management and open disclosure</td>
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<td>• Patient Safety</td>
<td>• Building and leading an improvement team</td>
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Profound Knowledge

Appreciation for a System
- Interdependence, dynamism
- World is not deterministic
- Optimisation, interactions
- Containing systems, subsystems

Understanding Variation
- Variation is to be expected
- Common or special causes
- Ranking, tampering
- System capability

Psychology
- Interaction between people
- Motivation
- Beliefs, assumptions, inferences

Theory of Knowledge
- Prediction
- Learning from theory, experience
- Operational definitions
- PDSA for learning and improvement

Profound Knowledge
Model for Improvement

The PDSA Cycle

Act
- What changes are to be made?
- Next cycle?

Plan
- Objective
- Questions and predictions (why)
- Plan to carry out the cycle (who, what, where, when)
- Plan for data collection

Study
- Complete the analysis of the data
- Compare data to predictions
- Summarize what was learned

Do
- Carry out the plan
- Document problems and unexpected observations
- Begin analysis of the data

What change can we make that will result in an improvement?
# Project Checklist

<table>
<thead>
<tr>
<th>No.</th>
<th>Task Description</th>
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<tbody>
<tr>
<td>1</td>
<td>Select area for improvement &amp; Draft project charter</td>
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<tr>
<td>2</td>
<td>Scope high level pathway/process</td>
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<td>3</td>
<td>Create (SMART) Aim Statement = Y</td>
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<td>4</td>
<td>Identify Project lead and team</td>
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<td>5</td>
<td>Complete Driver diagram</td>
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<td>6</td>
<td>Identify key metrics</td>
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<td>7</td>
<td>Map stakeholders</td>
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<td>8</td>
<td>Develop communications plan</td>
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<td>9</td>
<td>Capture the voice of the patient</td>
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<td>10</td>
<td>Walk / Observe the process/pathway</td>
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<tr>
<td>11</td>
<td>Maintain Log key issues /opportunities</td>
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<tr>
<td>12</td>
<td>Map the pathway/process</td>
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<tr>
<td>13</td>
<td>Illustrate variation in Y - run chart</td>
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<td>14</td>
<td>Hold issue/opportunity validation meeting</td>
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<tr>
<td>15</td>
<td>Implement quick wins/ PDSAs</td>
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<tr>
<td>16</td>
<td>Updated Project Charter to reflect learning to date</td>
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<tr>
<td>17</td>
<td>Complete Measurement plan (incl agreeing key &quot;Reason for Variation&quot; codes)</td>
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<tr>
<td>18</td>
<td>Capture frequency of causes of variation = X - Pareto</td>
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<td>19</td>
<td>Identify and validate root causes for variation</td>
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<td>20</td>
<td>Implement PDSAs designed to reduce variation</td>
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<tr>
<td>21</td>
<td>Develop &quot;to be&quot; process map</td>
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<td>22</td>
<td>Identify actions to sustain change</td>
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<tr>
<td>23</td>
<td>Agree governance for monitoring pathway</td>
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<tr>
<td>24</td>
<td>Document &amp; present project learning</td>
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Engagement

6. Adopt an Engaging Style:
   6.1 Involve physicians from the beginning
   6.2 Work with the real leaders, early adopters
   6.3 Choose messages and messengers carefully
   6.4 Make physician involvement visible
   6.5 Build trust within each quality initiative
   6.6 Communicate candidly, often
   6.7 Value physicians’ time with your time

5. Show Courage:
   5.1 Provide backup all the way to the board

4. Use “Engaging” Improvement Methods:
   4.1 Standardize what is standardizable, no more
   4.2 Generate light, not heat, with data (use data sensibly)
   4.3 Make the right thing easy to try
   4.4 Make the right thing easy to do

Engaging Physicians in Quality and Safety

1. Discover Common Purpose:
   1.1 Improve patient outcomes
   1.2 Reduce hassles and wasted time
   1.3 Understand the organization’s culture
   1.4 Understand the legal opportunities and barriers

2. Reframe Values and Beliefs:
   2.1 Make physicians partners, not customers
   2.2 Promote both system and individual responsibility for quality

3. Segment the Engagement Plan:
   3.1 Use the 20/80 rule
   3.2 Identify and activate champions
   3.3 Educate and inform structural leaders
   3.4 Develop project management skills
   3.5 Identify and work with “laggards”
What is the Project’s (SMART) aim statement?

What are the key success drivers for this project:

What measure(s) will be used to track project benefits?

What are the project deliverables required for sign off?

Who needs to be consulted & get informed about this project?

Which key aim is this project aligned to?:

- Quality
- Safety
- Access
- Flow
- Waste
- Team

Project Plan

<table>
<thead>
<tr>
<th>No</th>
<th>Action</th>
<th>Date</th>
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Identify Waste
Caldwell G. Clinically lean: cutting the crap!

1. Waste of over producing
   Duplication & covering our backs

2. Waste of waiting
   Waiting

3. Waste from transporting
   Wasted journeys & walking

4. Waste of processing time
   Useless IT & too many forms

5. Waste from excess motion
   Wasting time getting common essentials

6. Waste of inventory
   Bed blockers & clutter

7. Waste from Defects = scrap and rework
   Not getting it right 1st time

Dr Gary Kaplan: Virginia Mason Medical Centre, Seattle.
Measure variation

Understanding variation

A measure of variation = Standard Deviation

\[ S = \sqrt{\frac{n}{n-1} \sum_{i=1}^{n} (\bar{x} - x_i)^2} \]

Illustrate Variation – Run Chart

1. Identify your SMART aim = Y
2. Use driver diagram to identify key measures
3. Make sure you have a documented operational definition for each measure
4. Develop a measurement plan
   - Sample size?
   - Period of measurement?
   - Data source?
   - Who? How? When?
   - Collection format/template?
   - Illustration/Graphical format?
5. Focus on the “So what” and “Next Steps”
Every process displays variation:

**Controlled variation**
- stable, consistent pattern of variation
- “chance”, constant causes

**Special cause variation**
- “assignable” pattern changes over time
Common traits of redesigned processes

- Organize around outcomes
- Demand pull workflow
- Preparation reduction
- Quality at the source
- Smaller batch sizes
- Capture info at the source
- Error proofing
- Continuous improvement mindset
- Standardize on best practices
- Parallel processing
- Visual process controls
Sustainability
Clinically led cycle of continuous improvement

1. Shared values (HRO)
   - variation identified
   - JDI or Project?
   - Aligned & effective team meetings

2. Directorate mission, aims & objectives
   - access
   - resource & finance
   - team

3. Standardised pathways
   - [Diagram]

4. Clarity of role & accountability

5. End to end pathway metrics / dashboard
   - demand & capacity model

6. PDSA’s/Projects
Figure 2. Information and information technology are a feeder system to support all four key success themes—leadership, staff, patients, and performance.