

Performance Improvement and Patient Safety (PIPS) Models

ABC's of a Trauma PI Plan- Session 2

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July 18, 2014



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Objectives

- Enhance the understanding of performance improvement models
- Identify features of RCA and PDCA
- Utilize group activity and discussion examples to assist in building Level III and IV trauma center PI programs

Principles of Quality Management

- Quality can and should be measured
- Everyone has a customer
- Processes are the problem (not people)
- Everyone is responsible for quality
- Problems should be prevented, not just fixed

Principles of Quality Management

- Measure quality so it can be controlled
- Improvements must be continuous
- Needs based goals
- All changes do not lead to improvement
- All improvement requires change

PIPS Models: Why?

- Provides structure
- Define your stakeholders
- Define desired and actual performance
- Select/define/implement interventions
- Monitor and evaluate performance
- Ensure sustainability

Sentinel Events

- Unexpected event involving death, serious physical or psychological injury
- Require immediate investigation and response
- Sentinel event is not the same as a medical error
- Reported to The Joint Commission voluntarily or by a complaint process
- If reviewed, hospitals share action plans
- Events and root causes are recorded in a de-identified database

Root Cause Definition

- Fundamental reason(s) why something fails
- Point in the process where intervention can change outcome
- Majority of events have multiple root causes
- It can be resolved
- The resolution will not cause bigger problems
- All alternatives have been considered
- Group activity
 - Jefferson Memorial discussion

Root Cause Analysis (RCA)

- Error analysis tool used in healthcare
- Structured method to solve complex problems
 - What
 - Why
 - Reduce reoccurrence
- An approach is identify the underlying cause(s) of why a process failed
- Look beyond the obvious symptoms of the problem

Root Cause Analysis (RCA)

- Avoid focusing on mistakes made by individuals
- Identify active errors
 - Point of interface people / process
- Identify latent errors
 - Hidden problems that contribute to adverse events

Root Cause Analysis

- Defined process
- Data collection
 - Chart review
 - Staff interviews
- Reconstruction of the event (timeline)
- Multidisciplinary team
- How and Why

Root Cause Analysis: What is an actionable item?

- Identify and select a solution
- Define what is meant to be changed
- How it is meant to be changed
- Unit of measure for the change
- Target for change
- Target date

RCA: Measure of success

- Method of measuring success
- Holding the gains
- Hardwiring the process
- Goal to prevent future harm
- Tie into trauma PI plan

Plan Do Check Act (PDCA): Origins

- Also known as the Shewhart Cycle and the Deming Cycle
- Developed in the 1930's
- Belief that constant evaluation of practices + willingness to adopt/disregard ideas = evolution of success
- Specification/Production/Inspection
- Modified in the 1950's
- Design/Produce/Sell/Redesign through market research
- Evolution to Plan Do Study Act (PDSA)

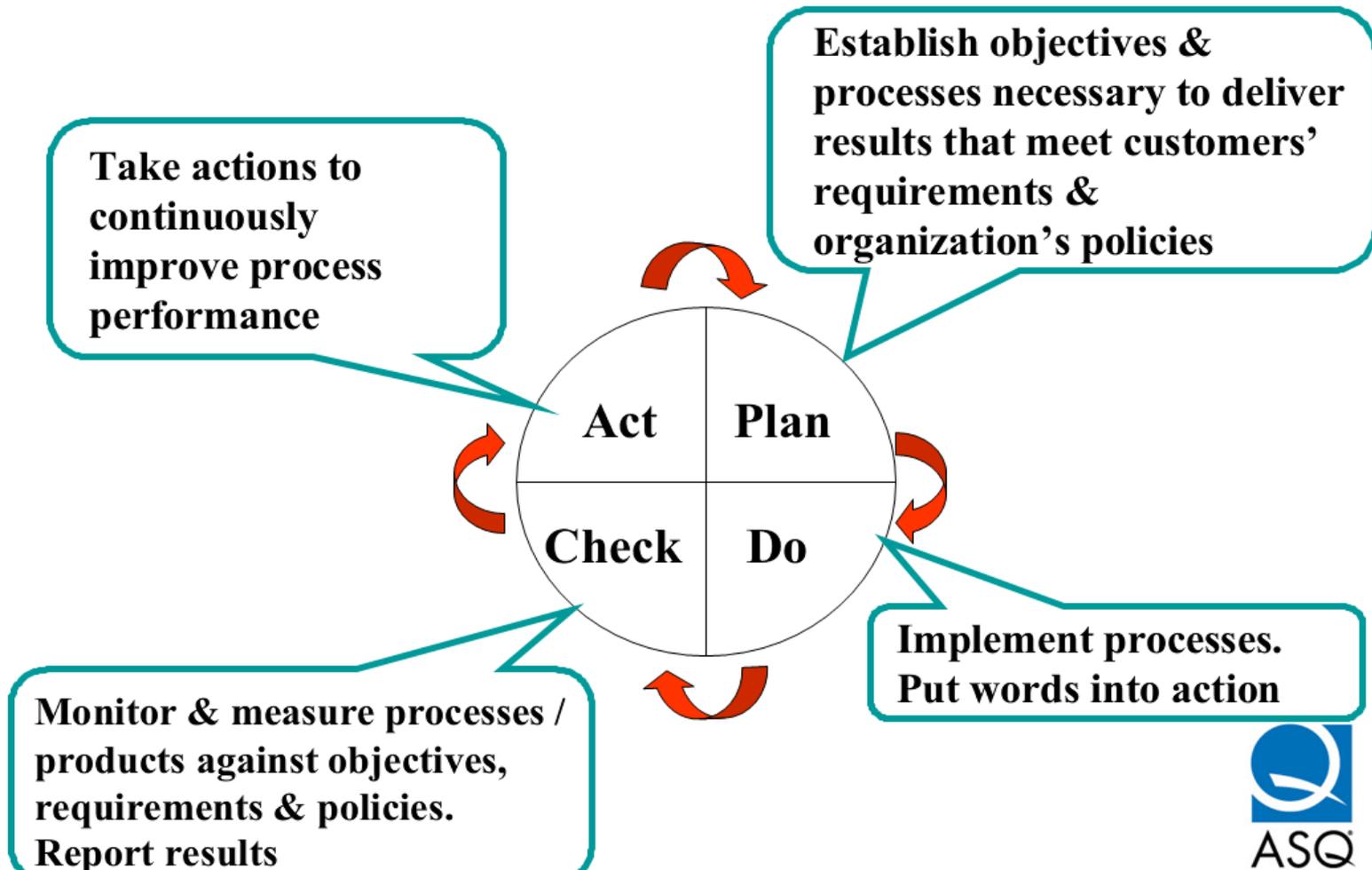
PDCA Cycle

- Popular model for continuous improvement
- Can be used for product, process and service
- Methodical approach to problem solving and solution implementation
- Explore new solutions in a controlled environment
- Avoid wasting resources from a poor solution

Rapid PDSA Cycles

- Testing change(s) on a small scale
- What are we trying to accomplish?
- How will we know that a change is an improvement?
- What changes can we make that will result in improvement?
- Implement change on a broader scale
- Continuous improvement

PDCA Cycle



PDCA: Plan

- Identify the problem
- Define your team
- Baseline or benchmarking data
- Consideration of regulatory requirements
- Barrier identification
- Leadership support

PDCA: Do

- Test on a small scale
- Implement trial run
- Communication and education

PDCA: Check

- Result evaluation
- Was the process followed?
- What was successful?
- What was learned?
- Repeat cycle as needed

PDCA: Act

- Standardize the change
- Ongoing monitoring of improvement
- Identify other areas for improvement
- Report out to stakeholders (operations and peer review committees)
- Incorporate into trauma PI plan

PDCA: Ease of use?

- Encourages involvement of everyone
- Few barriers to participate
- Basic training and education
- Hands on practice

Conclusions

- PI models are data driven
- PI models are a toolbox
- Use a PI model for complex/larger issues
- Use when external entities are needed to develop a solution
- PI moves your program forward
- Live in a world of change
- No one method addresses every problem
- Apply the right method, in the right way, at the right time to get the required results

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Thank You