Performance Improvement and Patient Safety (PIPS) Models

ABC’s of a Trauma PI Plan - Session 2

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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

1. **Plan**
   - Establish objectives & processes necessary to deliver results that meet customers’ requirements & organization’s policies

2. **Do**
   - Implement processes. Put words into action

3. **Check**
   - Monitor & measure processes / products against objectives, requirements & policies. Report results

4. **Act**
   - Take actions to continuously improve process performance
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