Creating a Favorable Environment/Culture to Sustain Quality

SLMTA Symposium ~ ASLM 2018
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2009

sus·tain·a·bil·i·ty

2018

sus·tain·a·bil·i·ty

/səˌstānəˈbilədē/
noun
the ability to be maintained at a certain rate or level

?

What are the key elements required to sustain quality?


?
?
?
Secret
Sauce

Creating a Favorable Environment/Culture to Sustain Quality

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What are the key elements required to sustain quality?

News Flash: Highlighting Components of Sustainable Quality Improvement

National Comprehensive Strategy for Sustainable Quality: Vietnam

Leadership for Sustainable Quality: Kenya

Hospital Continuous Quality Improvement (CQI): Malawi

Building Sustainable Quality Across the Laboratory–Clinic Interface: LARC

VIETNAM


National Laboratory System
Policies
Training
Biological Safety
Quality Management
Laboratory Management
Laboratory Infrastructure
Organizational Structure
National Standards

STRUCTURE

PROCESS

P + S = O

KENYA - Paradigm Shift

SLMTA = Fulcrum

LARC – Process Improvement → Empowered People

Overarching Concepts

Quality Improvement

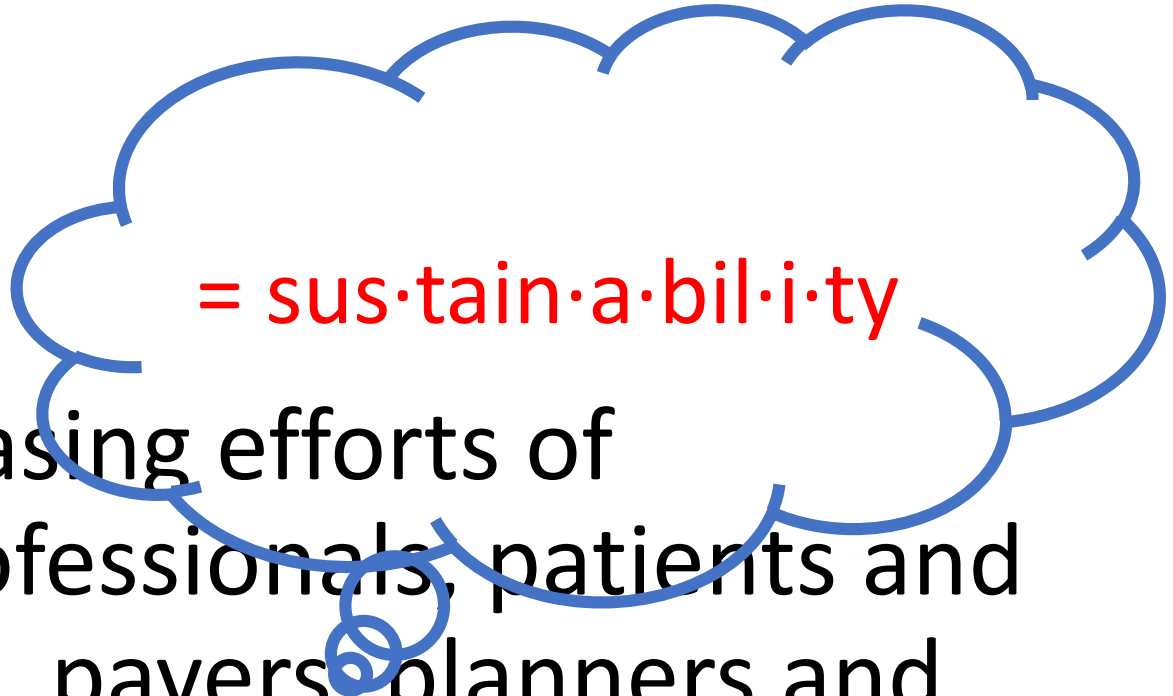
High Reliability

Quality Improvement

Quality = Consistent Excellence

Quality Improvement

Defined as:



"The combined and unceasing efforts of everyone—healthcare professionals, patients and their families, researchers, payers, planners and educators—to make the changes that will lead to **better patient outcomes (health), better system performance (care) and better professional development.**"

Paul B. Batalden and Frank Davidoff

Qual Saf Health Care. 2007 Feb; 16(1): 2–3.

What is "quality improvement" and how can it **transform** healthcare?

Outcome → HEALTH

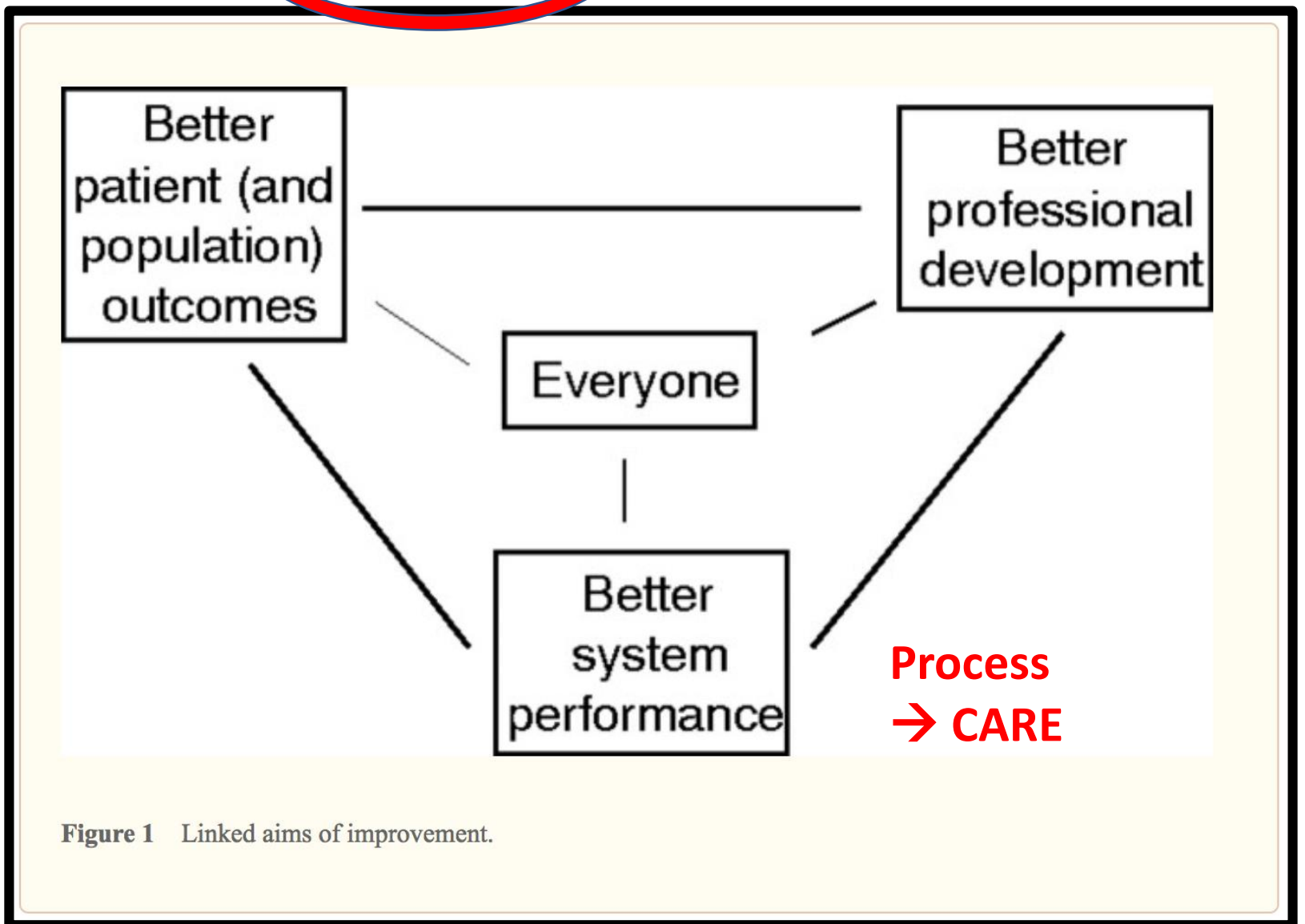


Figure 1 Linked aims of improvement.

Process → CARE

HEALTH CARE PROFESSIONALS → EMPOWERMENT

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Quality Improvement

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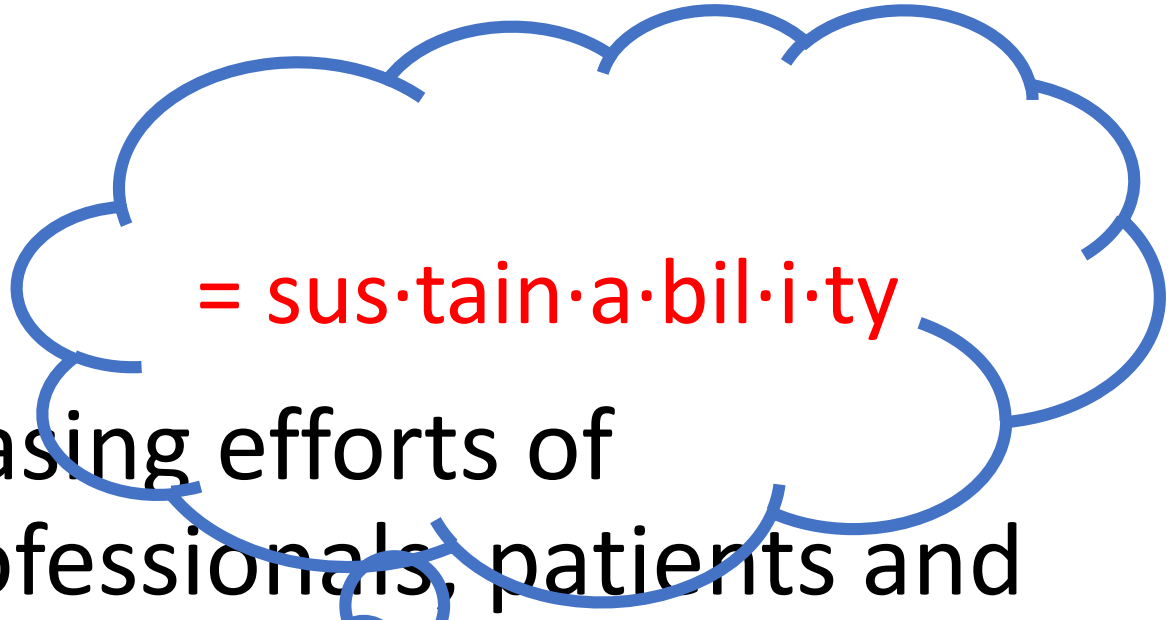

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High Reliability

Consistent performance at high levels of safety over long periods of time

By Mark R. Chassin and Jerod M. Loeb

The Ongoing Quality Improvement Journey: Next Stop, High Reliability

DOI: 10.1377/hlthaff.2011.0076
HEALTH AFFAIRS 30,
NO. 4 (2011): 559–568

ABSTRACT **Quality improvement in health care has a long history that includes such epic figures as Ignaz Semmelweis, the nineteenth-century obstetrician who introduced hand washing to medical care, and Florence Nightingale, the English nurse who determined that poor living conditions were a leading cause of the deaths of soldiers at army hospitals. Systematic and sustained improvement in clinical quality in particular has a more brief and less heroic trajectory. Over the past fifty years, a variety of approaches have been tried, with only limited success. More recently, some health care organizations began to adopt the lessons of high-reliability science, which studies organizations such as those in the commercial aviation industry, which manage great hazard extremely well. We review the evolution of quality improvement in US health care and propose a framework that hospitals and other organizations can use to move toward high reliability.**

Mark R. Chassin (mchassin@jointcommission.org) is president of the Joint Commission, in Oakbrook Terrace, Illinois.

Jerod M. Loeb is executive vice president for health care quality evaluation at the Joint Commission.

Strengthening Laboratory Management Toward Accreditation

Module 6:
Quality Assurance

2009

World Health Organization Africa | CDC | American Society for Clinical Pathology | Clinton Foundation

Key Message ...

My lab assures accurate and reliable testing processes.

Desired Outcome

Consistently accurate and reliable test process

- Pre-analytical
- Analytical
- Post analytical

Module 6: Quality Assurance 3

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High Reliability Science

EXHIBIT 1

Stages Of Maturity In Health Care Organizations' Path To High Reliability

Organizational characteristic	Stage of maturity		
	Minimal	**Developing**	**Approaching**
Leadership	Quality activities focused on regulatory requirements Strategic importance of quality improvement not recognized Metrics for quality goals not part of strategic plan or incentive compensation Information technology provides little support for quality improvement Physicians not actively engaged in quality improvement	Chief executive officer leads proactive quality agenda Board reviews adverse events Organization sets a few measurable quality aims Information technology supports some quality and safety initiatives Physician leaders champion quality goals in some areas	Organization commits to goal of high reliability for all clinical services Organization aims for near-zero failure rates in vital clinical processes Some services demonstrate near-zero failure rates in some vital clinical processes Reward systems for staff prominently reflect accomplishment of quality goals Information technology integral to sustaining quality improvement Physicians routinely lead quality efforts
Safety culture	No program to assess safety culture No assessment of trust or intimidating behavior Root-cause analyses limited to most serious adverse events; close calls not recognized or evaluated	Establishing safety culture accorded high priority by leaders at all levels First measures of safety culture deployed Beginning initiatives to encourage reporting and analysis of close calls	Safety culture is well established Measurement of safety culture is routine and drives improvement Regular reporting of close calls and unsafe conditions leads to early problem resolution
Robust process improvement	No formal quality management system External requirements are focus of improvement efforts No commitment to sustainable improvement	Organizational commitment to adopt strong quality improvement tools Training of selected staff beginning Improvement tools used to achieve gains in quality and safety in addition to routine business processes	Robust process improvement tools used throughout organization Patients engaged in redesigning care processes Mandatory training of all staff in robust process improvement Proficiency in robust process improvement required for career advancement

Leadership
+ Safety Culture
+ Robust Process Improvement
= High Reliability

Organizational Characteristics in High Reliability

Leadership

"Leadership commitment, the first of these three, because without it, no important initiative for organizational change can succeed"

www.ihi.org

Safety Culture

”An atmosphere of mutual trust in which all staff members can talk freely about safety problems and how to solve them, without fear of blame or punishment."

Robust Process Improvement

“A systematic approach to dissecting complex problems and guiding organizations to deploy highly effective solutions”

content.healthaffairs.org

Safety Culture

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