Creating a Favorable Environment/Culture to Sustain Quality

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sus·tain·a·bil·i·ty

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

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What are the key elements required to sustain quality?

Creating a Favorable Environment/Culture to Sustain Quality

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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

Policies
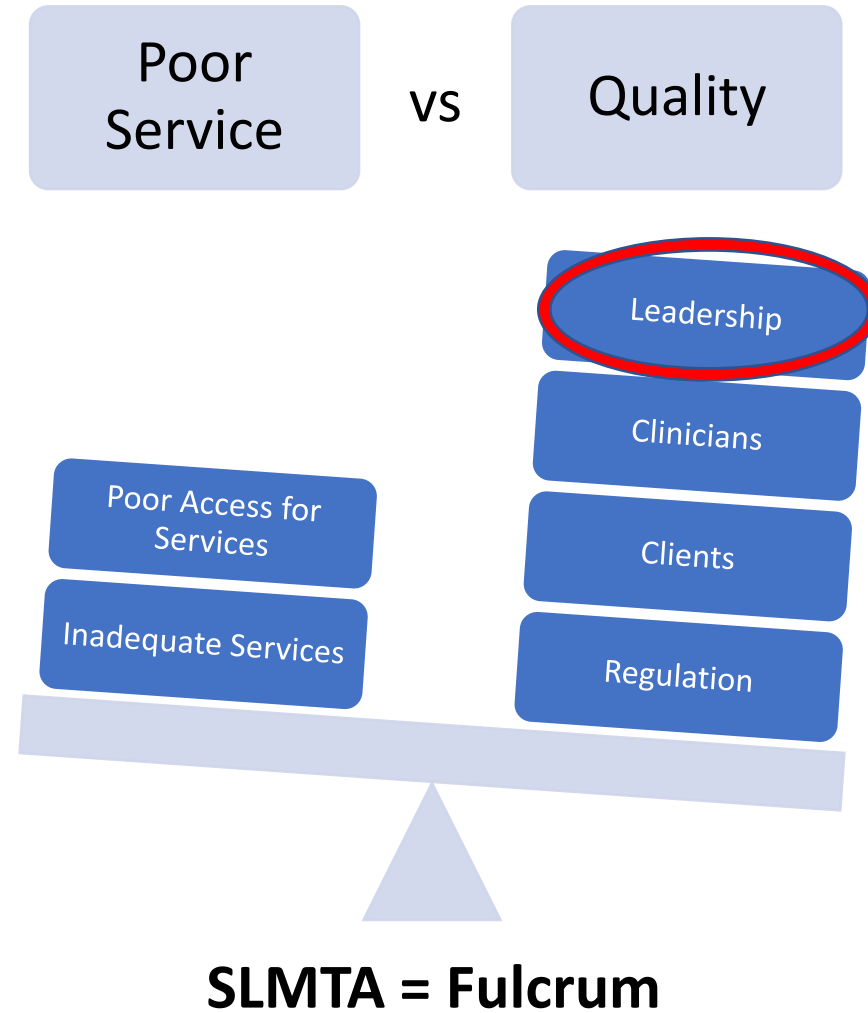
Training

Biological Safety

Quality Management

Laboratory Management

Laboratory Infrastructure

Organizational Structure

National Standards

National Laboratory System

KENYA - Paradigm Shift

LARC – Process Improvement → Empowered People

Overarching Concepts

Quality Improvement

High Reliability

Quality Improvement

Quality = Consistent Excellence

= sus·tain·a·bil·i·ty

Quality Improvement
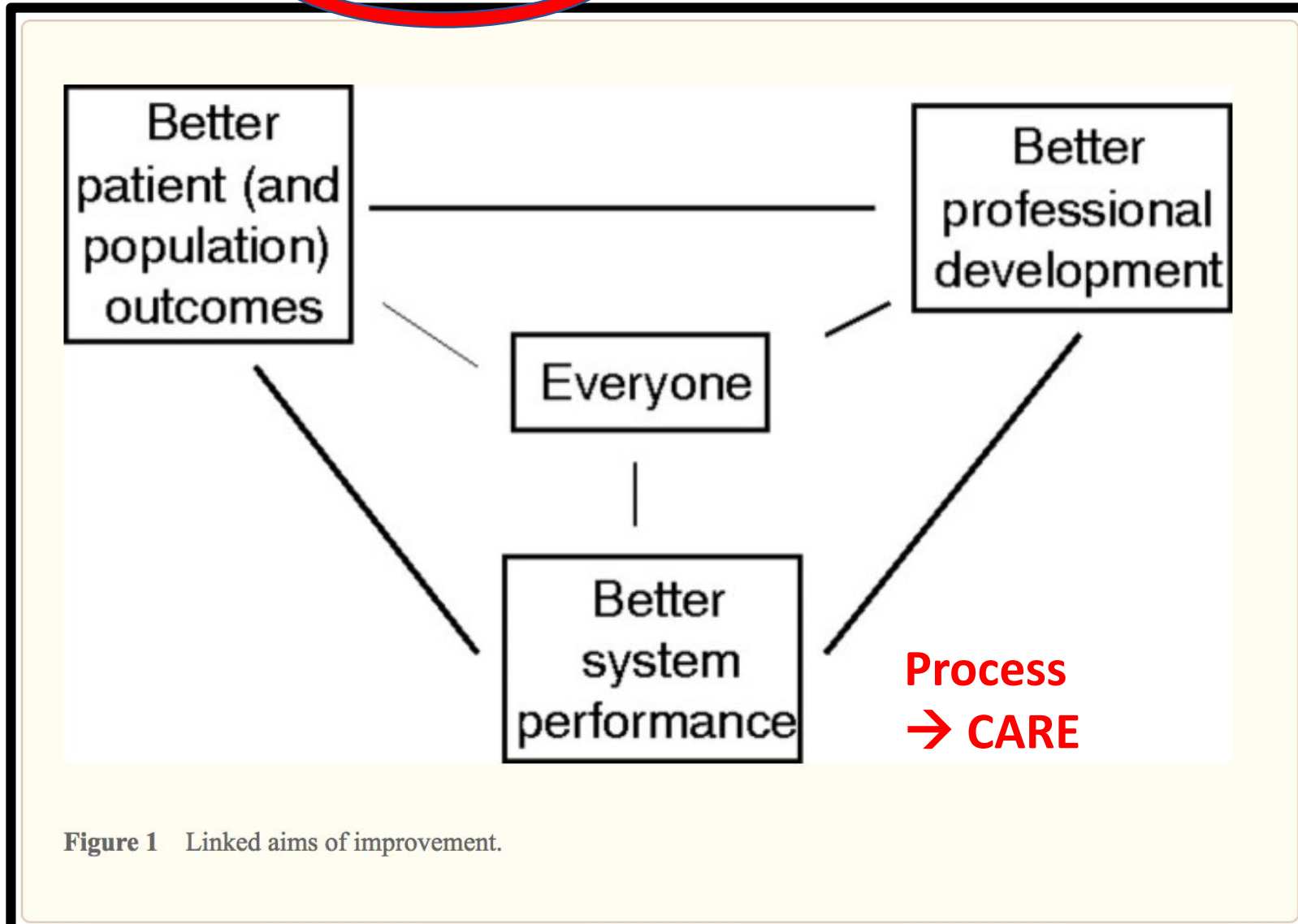
Defined as:

= sus·tain·a·bil·i·ty

"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

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

Outcome → HEALTH

HEALTH CARE PROFESSIONALS → EMPOWERMENT

Process → CARE

Better patient (and population) outcomes

Better professional development

Everyone

Better system performance

Figure 1 Linked aims of improvement.

Quality Improvement

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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

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@
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president of the Joint
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Strengthening Laboratory Management Toward Accreditation

Module 6:
Quality Assurance

2009

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

My lab... Assures accurate and reliable testing processes

Key Message ...

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Desired Outcome

Consistently accurate and reliable test process
- **Pre-analytical**
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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"

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"

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Safety Culture

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+ Robust Process Improvement
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