From Bedside to Boardroom
Assuring the Board of Quality of Clinical Care and Patient Safety

Temple Street in collaboration with HSE QI Division

Presented by Mona Baker, CEO & Aveen Murray, Non Executive Board Member, National Patient Safety Conference, Dublin Castle.
Thursday 26th October 2017
Our rich history

From the Children’s Hospital Temple Street established in 1872

To Temple Street Children’s University Hospital in 2017
Good governance supports strong relationships between frontline staff, service users, executives and board members creating a culture of trust by working together with respectful and robust challenge in achieving high quality care in a sustainable way.

HSE 2017
Good Governance with respect to patient safety
Temple Street perspective

PATIENT SAFETY
Focus on continuous quality improvement to ensure high quality, effective and safe patient care
Delivering Quality Clinical Care

Clinical care that is person centred, effective, safe and results in better health and wellbeing

HIQA Guide to National Standards for Safer Better Healthcare
Driving better outcomes

Board Quality Dashboard
Moving from Speedometer to SPC Charts

% Complaints Dealt With 30 Working Days Last Quarter

Patient Centred Care
Complaints Received - C-Chart

- UCL = 35.63
- LCL = 7.70
Good Governance with respect to patient safety
Temple Street Board Perspective

Board on Board with Quality of Clinical Care Project

Aim
By May 2017, the Board of Directors, individually and collectively: Get a comprehensive picture of the Quality of clinical care in Temple Street; Have an understanding of same; Hold the Hospital to account on the Quality of Clinical Care delivered

Planned outcomes
Quality of Clinical care indicators have priority, are discussed, assessed, and where appropriate recommendations made, actions taken and reported back to Board

Embed a culture of Quality Improvement and Safety
Board leads by example
Board on Board Short life Quality Improvement Project 2016

DRIVER DIAGRAM

**AIM**

The Board will discuss, make assessments and recommendations on clinical care Indicator Information by February 2017

- Enhanced understanding of Quality of Clinical Care Indicators/outcomes (Board of Directors)
  - Identify Board members needs and understanding of QCC Indicators
  - Review all current data collected and identify those that are reflective of Quality or Clinical Care
  - Align each QCC identified to domains of Quality

- Provide 6 appropriate reliable and timely QCC measurements to Board of Directors monthly
  - Identify communication pathway for production and ratification of Quality of Clinical Care dashboard by Quality & Patient Safety Executive (Clinical Governance)
  - Agree communication pathway for QCC Dashboard following Board assessment & recommendations

- Strengthen two way communication process between 800 and Executive on QCC outcomes and indicators
  - Identify and agree appropriate QCC indicators to prioritise for Balanced Scorecard

- Enhance scorecard to include fit for Board purpose quality of clinical care Indicators (QCCI) using structured communication tool (adapted ISBAR)
  - Redesign Scorecard to include monthly QCC report to BOD
  - Indicators presented in a format that is easy to understand, and facilitates discussion using structured communication tool (adapted ISBAR) and that results in Board recommendations if appropriate

- No. of BOD recommendations for actions if appropriate, as recorded in minutes
  - Board member self-assessed confidence in understanding QCC indicators increased by one point on 10pt likert scale
  - % of time spent on discussion of QCC

TSCUH Quality Department
July 8th 2016 draft 4(a)
AIM

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Primary Drivers

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- % of time spent on discussion of QCC outcomes at Board meeting

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July 8th 2016 draft 4(a)
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**Measures**
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July 8th 2016 draft 4(a)
Asking the right questions

‘The goal is to turn data into information, and information into insight’  
Carly Fiorina
DELIVERING QUALITY CLINICAL CARE

Creating the Vision
- Board Identify Patient Safety/Person Centred Care as a Priority

Building the Will
- Establishment of Board Project Team

Building Capacity Improvement Capability
- Monthly Surveys for Board Feedback and Recommendations

Making it Happen
- Phased Implementation of QCCIs using PDSA Model

Sustainability
- Presentation of Project at National Quality and Patient Safety Conference
DELIVERING QUALITY CLINICAL CARE

PERSON CENTRED
- Number of complaints received

EFFECTIVE
- Number of children who code outside PICU
- Percentage emergency readmissions (surgical and medical within 30 days of discharge)

SAFE CARE
- Number of medication incidents reported
- Number of 'good catches' reported
- Number of days between 'clinically significant blood stream infections'

BETTER HEALTH & WELLBEING
**Effective Care and Support**

**Number of Children who Code Outside Of ICU-C-Chart**

**Indicator Description:**
This SPC chart shows the total number of children who coded outside of the Paediatric Intensive Care Unit with Bag Valve Ventilation or chest compressions or both and is reported quarterly from January 2012 to June 2017. A code is a life-threatening situation, in which emergency clinical interventions are required to prevent further patient deterioration and sustain life. The desired direction for this indicator is downward.

**Background:**
It is important to know which children may be at risk for a code so that the medical team can intervene to make them better or transfer them to an intensive care area if needed.

This chart presents the number of emergency codes outside of Paediatric Intensive Care Unit (TSCUH) with 5 years data presented quarterly.

**Assessment:**
- In 2016, 5 of the emergency codes episodes related to the same patient with complex needs, seizures with associated apneas requiring BVM ventilation. There were 4 emergency codes episodes with a second patient.
- In comparison Q1 2017 we saw an increasing number of codes recorded outside PICU which highlights the number of patients with highly complex needs being cared for at ward level.
- The Resuscitation Committee will facilitate four multidisciplinary Code Blue simulations per year. Additional simulation training for other medical/surgical conditions is facilitated monthly at present.

**Recommendations (for Board consideration):**
The Board welcomes this new indicator and requests that executive report on how children at risk are identified and progression plans in place to support staff at ward level.
Indicator Description:
This SPC chart shows the occurrence of bloodstream infections that are related to invasive medical devices and the number of days between occurrences. Each data point represents an episode of bloodstream infection linked to an invasive medical device (mainly central venous catheters). The desired direction is to increase the number of days between bloodstream infections, i.e. in this chart the line increasing is positive. An initial milestone is set at 100 days (International Benchmark).

Background:
Invasive medical devices are an important source of preventable bloodstream infection (BSI)
- Central venous catheters (CVCs; “central lines”) are the device most frequently associated with BSI.
- Most, and possibly all, CVC-related BSI are preventable, through strict adherence to care bundles during insertion and daily management.
- A large proportion of BSI associated with other invasive devices are also preventable, though this varies according to the device in question.

For this indicator a SPC t-chart is used to identify days since last infection or days between a bloodstream infection (BSI) occurring.

Between February 2015 and August 2017 a case of device related bloodstream infection occurred on average every 47 days in Temple Street.
- There were no device-related BSI cases between December 2015 and February 2017 (408 days).
- Of the five cases occurring in 2017, three were related to central venous catheters, but 2 represent recurrent infection in the same child (with severe underlying risk factors for infection).

Assessment:
- The frequency of device-related BSI at TSCUH is good, compared to most hospitals in Ireland, but international experience suggests we should be aiming for an average of at least 100 days between cases.
- Updated insertion and maintenance care bundles for vascular catheters have been developed, and are being implemented as part of a wider improvement programme around vascular access devices.
- Improved prospective surveillance of device-related infections (not just BSI) is required, that includes measurement of overall device use.

Recommendations (for Board consideration):
The Board request that the Executive develop Business Plan for appropriate surveillance resources to improve the timeliness and applicability of ward and hospital-level data on device-related infection.
Illustrating some project measures

Board of Directors self assessment of the usefulness of measures in understanding how TSCUH is performing on Quality Indicators using 10 pt Likert scale
Illustrating some project measures….

Board members self-assessment of confidence in understanding information provided on Quality Indicators using 10 pt Likert scale.

Median
Non Executive Directors on Project Team

Board representation
Education for Non Executive Directors

Education at initial stages of project

Education at key stages in life of project
Introduction to clinical indicators

Developing knowledge of each indicator
Critical success factors

- An increased understanding, knowledge and robust discussions of the metrics developed by Board and staff
- Recommendations – Call to action & review from Board to Quality and Safety Executive
- The Board is assured that our hospital is safe
Challenges encountered in implementing Board on Board with Quality of Clinical Care Project

- Time
- Expertise
- Accuracy and availability of data
- Allowing time to choose, tweak, the best combination
- Timelines very tight to produce charts and BAR
- Staff changes
Reflections

Research
- Identifying paediatric comparator sites at an earlier stage in the project
- Ensuring that information on international benchmarks were available

Education
- More preparation time with Board & Project Group - Assessment of Need
- Education & training on the use of SPC charts/ISBAR
- Make Project Pack available to each member of the project team
- Timeline too ambitious
"EVER TRIED EVER FAILED NO MATTER TRY AGAIN FAIL AGAIN FAIL BETTER"

Samuel Beckett
Acknowledgements

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• Members of the Temple Street Board on Board with Quality of Clinical Care Project
• Blaithin Gallagher, Project Support

& The Temple Street Board for making the journey
And finally………………

THANK YOU FROM

Mona Baker, CEO, Temple Street

Aveen Murray, Board Member, Temple Street