How to fit patient safety into Quality Improvement Mechanisms: Consensus Statements from the 3rd Quality Improvement Forum, Heidelberg

Abstract

Objective: evaplan GmbH at the University of Heidelberg, together with the International Society for Quality in Healthcare (ISQua), AQUA Institute, and Institute of Public Health at the University of Heidelberg recently organized the 3rd Quality Improvement (QI) Forum for Health in Heidelberg to discuss how to fit patient safety into quality improvement mechanisms in low and middle income countries. The QI Forum for Health shared and critically appraised strategies, best practices, and evidence-based tools to understand and tackle common patient safety challenges as elements of systematic and data-guided mechanisms, referred to as Quality Improvement. Vibrant discussions took place around four key areas: (i) context and generalisibility; (ii) hidden safety issues; (iii) whether current quality improvement interventions reflect safety; and (iv) role of standards to meet safety needs. The two-day programme demonstrated the breadth and depth of discussion ranging from what is quality improvement to defining what it takes to be safe.

Participants: The participants of the QI Forum included quality improvement and health systems strengthening experts, various government agencies, non-governmental organisations, universities and health consultancies. The forum brought together experts to have discussions, which allowed the QI Forum participants to discuss and work through the question of where patient safety sits in the quality improvement mechanism.

Workshops: On the first day of the forum participants were asked to join a group around four key areas: (i) Rigor, attribution, and generalizability of quality and safety data for health system strengthening; (ii) What are hidden patient safety issues related to culture, gender, ethnicity and marginalization?; (iii) Do current quality improvement mechanisms reflect patient safety?; and (iv) How can health care standards be (re-)formulated to reflect patient safety needs in different health systems? The groups then rotated on the second day of the forum. Thus, every QI Forum attendee participated in two different groups by the end of the second day. Each group had a designated moderator and subject matter experts. In each group, subject matter experts gave a 5 to 10 minute presentation, which was then followed by brainstorming and / or rich open discussions facilitated by the group moderator. After each group session, the principal statements

and findings were collated / documented; and specific recommendations for each key area were crafted by the group moderator(s). Key statements / messages that were produced on day one were further discussed, adapted and refined on day two of the forum.

Consensus Process: Following multiple group work sessions, each group moderator presented three draft statements / messages in relation to the different levels of the health system on the second day of the QI Forum for Health. The statements will be revised following subsequent rounds of review and comment, and the proceedings from the forum will be discussed at a lunchtime meeting at the ISQua conference in London in October 2017.

Conclusions: There is a need for a systems approach and local solutions to improve patient safety, where QI Forum for Health participants felt that quality improvement mechanisms do not reflect patient safety. Nearly all group moderators stated that there should be a stronger focus on awareness and context, including addressing the social determinants of health. There is demand in formulating and reformulating certain standards to reflect patient safety issues, and exploring hidden patient safety issues related to culture, gender, ethnicity and marginalization in low and middle-income countries.

The 3rd Quality Improvement Forum generated a lot of momentum between the key experts, moderators and the audience. There is a need for a systems approach and local solutions to improve patient safety – this was reflected in Group C's group discussion where participants felt that quality improvement mechanisms do not reflect patient safety. Nearly all the groups stated that there should be a stronger focus on awareness and context, including addressing the social determinants of health.

The following key messages / statements were presented on day 2 of the forum:

Key Messages / Statements

Group A – "*Rigor, attribution and generalizability of quality and safety data for health systems strengthening*"

Moderator: Irmgard Marx[1]

1. Harmonise and link sources of data related to quality improvement and patient safety and use for evidence-based decision making.
2. Policy makers define priorities, set standards and take action based on analysis and evaluation considering all stakeholders' perspectives.
3. Context factors should be considered in all steps of quality improvement planning and implementation of activities.

Group B – "*What are the hidden patient safety issues related to culture, gender, ethnicity and marginalization*"

Moderator: Dr Sylvia Sax

Each message that Group B composed and agreed on are targeted at international and national level policy efforts.

1. Transparent plan of care and payment based on shared information and decisions between patient(s) and provider(s).
2. Provide opportunities to prevent the sources of hidden patient safety issues. The opportunities should go beyond the focus on traditional curative, disease based care and treatment.
3. Start education in childhood on health, wellbeing, positive diversity and each person's right to health and wellbeing.

Group C – "*Do Quality Improvement mechanisms reflect patient safety?*"

Moderator: Leighann Kimble[2]

1. There must be awareness of the importance of Patient Safety in Quality Improvement at the patient-level, provider-level, and policy-level.
2. The context must always be considered in quality improvement to ensure that safe care is being provided to patients within their own context (beliefs, culture, traditions, personal preference, family considerations etc.).
    a. Basic inputs (water, soap, human resources, supplies) are available to provide safe patient care.
    b. Providers are held accountable to providing care (leadership, policy, etc.).
3. Patient Safety must be explicit as part of Quality Improvement; it cannot be assumed.
    a. Patient Safety must be prioritized and enforced at all levels (policy, providers, patients).
    b. Both Providers and Patients must be aware of and take responsibility for Patient Safety:

[1] The topic was 'bulky' so only a few participants took part. The input from subject matter experts was very different and ranged from European to low- to middle income country perspectives. The moderator found it hard to pull the
[2] Participants did not have a clear understanding of what a quality improvement mechanism is. Many of them talked about quality improvement as a whole in relation to patient safety.

i. **Providers:** Providing quality clinical care to patients' that is safe, in consideration of the patient context.
ii. **Patients (and their families):** Aware that they have a right as a patient to safe care and holding providers, policy makers, etc. accountable to providing them with safe, quality care that is safe within the patient view of care.

Group D – "*How can health care standards be (re)formulated to reflect patient safety needs in different health systems?*"

Moderator: Svetla Loukanova

1. The patients have to take responsibility and ownership on the standards through their involvement in the process of consent to the standards in order to make the system "*accountable*" to the society.
   Issue: Adaptation/patients and communities ownership of the standards.
2. To make priorities on the patient safety issues into the standards from the beginning in terms of: cost (financial aspects); volume; risk and value added to change.
   Issue: Prioritisation
3. The existing and unified standards have to be "*deliverable*" to the different levels of the system and consider the multi-disciplinary and multi-sectoral approach to patient safety.
   Issue: System Approach