BLED 2017: workshop quality indicators Report

22 participants from 16 different countries

Germany
Portugal
Australia
Bulgaria
Ukraine
Ireland
Luxembourg
Slovenia
United Kingdom
Estonia
Switzerland
France
Malaysia
The Netherlands
Sweden
Belguim

What did we do?

Sessions	Topics	Learning objectives
Wednesday 15.30 – 18.00	Introduction Scope, content	Get to know each other QM of relevant processes affecting patient safety Formulate research question and aims
Thursday 10.00 – 13.00	Examples for QI development (Sweden) Strategies to develop indicators Stakeholders	Have some idea on QIs and how they are used by different parties – consequences on QI development **General principles for QI development**
Thursday 15.45 – 18.00	Define critical steps in hospital discharge and transfer Define measurable aspects	Practice how to formulate QIs for a guideline / proces **1. version QI set**

Program

Sessions	Topics	Learning objectives
Friday 10.00 – 13.00	Define a measurable and QI set on hospital discharge and transfer	Learn how to compose a QI set (2. version) and define QIs on al relevant aspects
Friday 15.30 – 18.00	Validate three indicators	Validate (3. version)
Saturday 9.00 – 10.30	How to continue Workshop report, PCNE website	Discuss whether we measure our indicators Present our results **Final workshop report**

Results

A General principles on QI development

B QIs on hospital discharge & transfer

A General principles of QI development (1)

What should QIs describe?

- Structures, processes and outcomes
- Purpose: why do we want this?
- Who wants to know:
  Stakeholders,
- To use for what intention:
  internal vs external information

A General principles of QI development (1)

What are crucial properties of QI indicators?

- Specific
- Measurable (easy)
- Reliable
- Relevant to the stakeholders
- Acceptable for the ones who use them and the ones who measure them
- Responsive , be affected by those who are measured

What do we need to develop indicators

- Clear guidelines
- Structures for data transfer clearly defined
- Define whether we want to elucidate
  - Do we have problem?
  - Do we have this problem?
- Experts to develop the indicators
- Tool to collect the data
- Leadership, involve stakeholders
- Application level

B QI development on hospital discharge & transfer

Due to a lack of guidelines on this topic we defined critical process steps for hospital discharge & transfer to primary care.

For these steps we named indicators able to measure structures, processes and outcomes.

Three QIs were worked out and validated.

HOSPITAL

Preparation for discharge

Patient counselling

Referral to pharmacist / GP

Patient records

Medication reconciliation

Is there a clinical pharmacist?

Discharge consultation
Diagnosis, medicines, use, lifestyle, changes + reasons

P, clinical Pharmacist, community pharmacis

Update

New diagnosis

Nurse, social worker, clinical Pharmacist, specialist

Treatment plan

Update

New treatment

Diagnosis, clincial measurements, reasons for changes

Reasons for change

Patient risk assessment: high risk

Information provided:
yes / no
Verbal, written, plain language

Recommendations follow up

Medication review

Information transfer

Number of MRs
N of high risk pat

Number of documented changes
All changes

Number of documented changes / all changes

On the day of discharge Planning?

Electronic record

Structures: cooperation agreements, tasks, responsibilities, specific contact persons

PHARMACY

Intake community pharmacy

Intake counselling

How to identify discharged patient

How to track disch. Pat. (seamless care)

Medication plan available?
Changes documented?
Reasons?
Diagnosis? Lab?

Patient records

Intake concilliation

Actualisation pat records, OTC

Patient records

Patient risk assessment: high risk MR

Training, knowledge e.g. new drugs

Medication plan available?
Follow up plan available?

Dispensing prescribed medication

Logistic problems

Discharge visit

Communication, cooperarion GP

Follow up visit

Information exchange GP, Nurses, caretakers

Number of documented changes
All changes

Structures: cooperation agreements, tasks, responsibilities, specific contact persons

1. Percentage of patients with a discharge summary available and completed

Number of patients with a discharge summary available and completed at the day of discharge
Number of patients admitted to and stazing in the hospital for at least one night

Needed:

- a form developed by all health care professionals involved (hospital specialist, hospital pharmacist, nurse, care provider, GP, practice nurse, community pharmacist, patient,)
- Risk assessment for patients: who should get a discharge form and who not

Validation:
Content validity: completely
Registration reliability: partly (lack of clear, uniform dataform)
Population reliability: partly

2. Percentage of discharge summary information transferred to primary care

Number of patients with discharge information transferred to primary care
Number of patients discharged from hospital

- To also define a more strict indicator, adding „at the day of discharge“ to the numerator
- To define these indicators for specific health care providers in primary care
- To define – use these indicators for specific hospital wards

Needed:

- Elements of „referral“ have to be defined by all health care professionals involved (hospital specialist, hospital pharmacist, nurse, care provider, GP, practice nurse, community pharmacist, patient,) within a guideline
- Risk assessment; who needs monitoring and who does not

Validation:
Content validity: partly (dependent on structures for cooperating health care professionals)
Registration reliability: partly, not at all (depends on the way of registration, electronic, on paper)
Population reliability; partly (not clear where to go)

3. Percentage of patients with a chronic condition and a hospital readmission related to the prior hospital admission

Number of patients with a readmission to hospital)
Number of patients discharged from hospital

Needed:

- Definition of a chronic condition
- Definition , trigger list to identify „causal relationships“ with a prior hospital stay
- Split the indicator in a) do we have a prolbem: count the number of readmissions
  b) what problem do we have: causal relationship of readmissions

Validation:
Content validity: completely (specific indicator depends on the causality criteria, time window)
Registration reliability: partly (uniform way of registration, ICPC coding, way of documentation throughout hospital stay)
Population reliability: partly, not at all

What did we learn?

- It is complicated
- It is a long lasting process
- Great group with different experiences, helped to work us through a complicated process
- Different perspectives
- Learn from each other
- Share personal experiences

Dreams

- Learn more on construct validity
- Develop a QI set for the whole process
  It is possible to develop it with different nations
  It helps to hear from other countries what is feasible for implementation in your own country
- For this to involve other people (experts, hospital pharmacists) from your own countries

Groupsphoto