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
Belgium
## What did we do?

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<th>Sessions</th>
<th>Topics</th>
<th>Learning objectives</th>
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<td><strong>Wednesday</strong></td>
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<tr>
<td>15.30 – 18.00</td>
<td>Introduction</td>
<td>Get to know each other QM of relevant processes affecting patient safety</td>
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<td></td>
<td>Scope, content</td>
<td>Formulate research question and aims</td>
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<td><strong>Thursday</strong></td>
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<tr>
<td>10.00 – 13.00</td>
<td>Examples for QI development (Sweden)</td>
<td>Have some idea on QIs and how they are used by different parties – consequences on QI</td>
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<td>Strategies to develop indicators</td>
<td>development</td>
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<td>Stakeholders</td>
<td><strong>General principles for QI development</strong></td>
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<td><strong>Thursday</strong></td>
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<tr>
<td>15.45 – 18.00</td>
<td>Define critical steps in hospital discharge</td>
<td>Practice how to formulate QIs for a guideline / proces</td>
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<td>and transfer</td>
<td>1. version QI set</td>
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<td>Define measurable aspects</td>
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<td>Sessions</td>
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<td>Friday 10.00 – 13.00</td>
<td>Define a measurable and QI set on hospital discharge and transfer</td>
<td>Learn how to compose a QI set (2. version) and define QIs on all relevant aspects</td>
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<td>Friday 15.30 – 18.00</td>
<td>Validate three indicators</td>
<td>Validate (3. version)</td>
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<td>Saturday 9.00 – 10.30</td>
<td>How to continue Workshop report, PCNE website</td>
<td>Discuss whether we measure our indicators Present our results</td>
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<td><strong>Final workshop report</strong></td>
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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.
Preparation for discharge

Patient records

Medication reconciliation

Is there a clinical pharmacist?

Update

New diagnosis

New treatment

Patient risk assessment: high risk

Medication review

Number of MRs

N of high risk pat

Number of documented changes

All changes

Patient counselling

Discharge consultation

Diagnosis, medicines, use, lifestyle, changes + reasons

Nurse, social worker, clinical Pharmacist, specialist

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

Number of documented changes / all changes

Referral to pharmacist / GP

P, clinical Pharmacist, community pharmacis

Treatment plan

Diagnosis, clinical measurements, reasons for changes

Recommendations follow up

Information transfer

On the day of discharge

Planning?

Electronic record

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

**Intake community pharmacy**

- **Intake counselling**
- **Intake conciliation**
- **Patient risk assessment:** high risk MR
- **Dispensing prescribed medication**
- **Discharge visit**
- **Follow up visit**
- **Information exchange GP, Nurses, caretakers**

**How to identify discharged patient**

**How to track discharged patient** (seamless care)

**Actualisation patient records, OTC**

**Patient records**

**Training, knowledge** e.g. new drugs

**Communication, cooperation GP**

**Logistic problems**

**Number of documented changes**

**All changes**

**Reasons?**

**Diagnosis? Lab?**

**Medication plan available?**

**Changes documented?**

**Patient records**

**Medication plan available?**

**Follow up plan available?**

**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 staying 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 problem: 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