

BC
Patient Care Quality Review
Boards

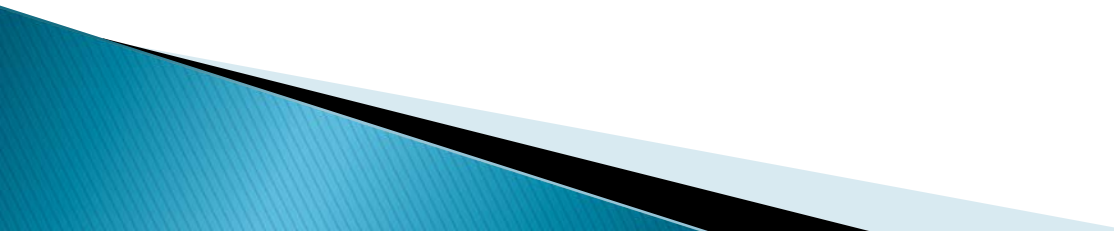
For the Health Quality Network

Jack Chritchley

09 - 09 - 09



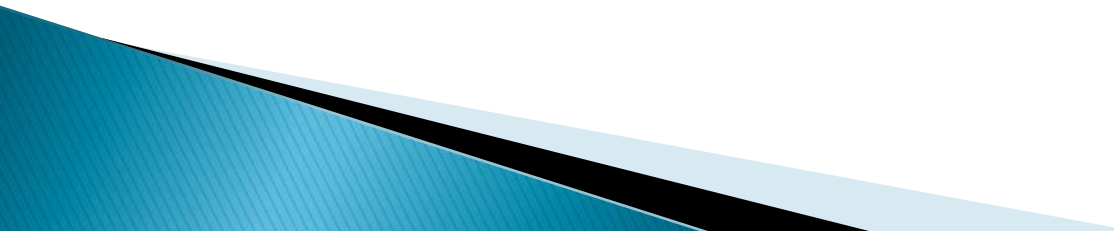
What is the PCQRB?

- ▶ 2008 October 15 Act of legislature
 - ▶ Standardized approach to the management of complaints by the Health Authority.
 - ▶ Independent reviews of patient complaints.
 - ▶ Review matters directed by the Minister of Health Services.
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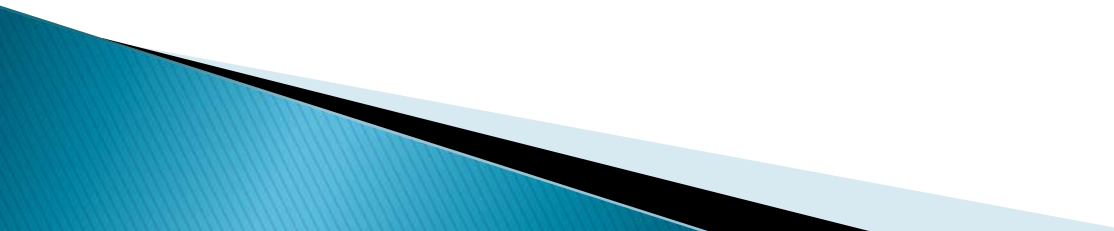
Ministry of Health Services

Expectation

The Review Boards will deliver a

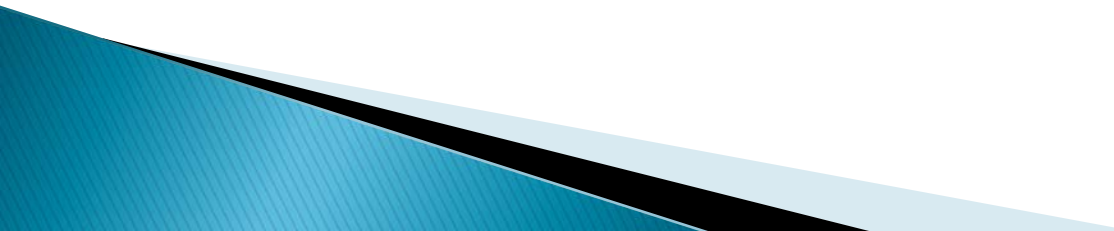
1. Clear, consistent, timely, transparent, review of any care quality complaints that have been unresolved.
 2. Make recommendations to the Minister and the Health Authorities on improving the quality of health care.
 3. Provide the Minister with aggregate information about care quality complaints.
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Expectations – continued

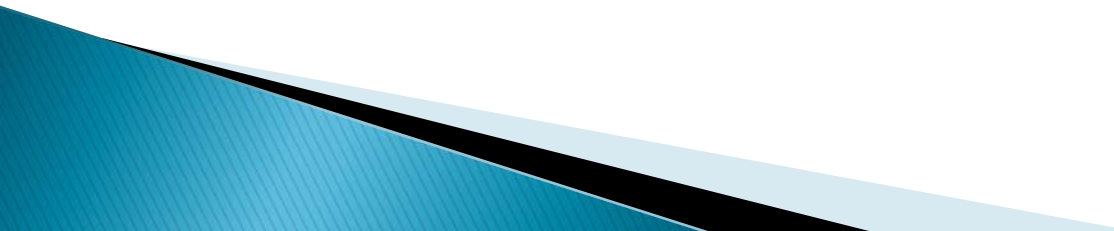
4. Develop an approach to managing patient care quality complaints.
 5. Bring resolution to specific care quality complaints it has reviewed.
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Goals

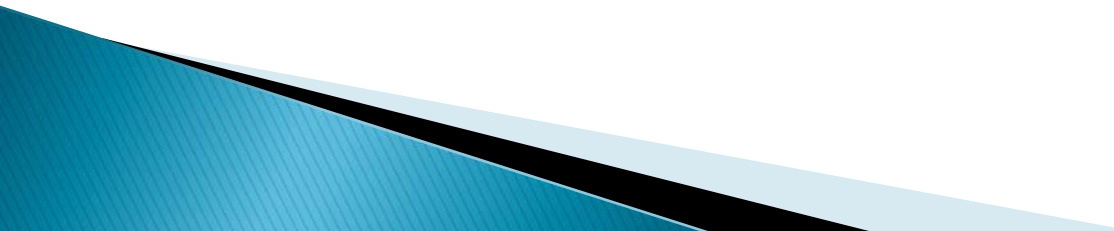
To sustain public confidence in
the health care system
by

- ▶ Improving the process by which quality complaints are made and disposed of.
 - ▶ Reviewing and resolving specific care quality complaints.
 - ▶ Improving patient care quality.
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As part of every quality review we will:

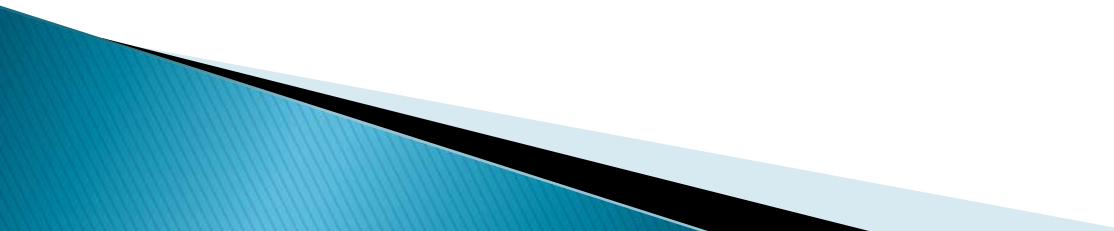
- ▶ Assess the delivery or failure to deliver health care.
 - ▶ Assess the quality of health care delivered.
 - ▶ Assess the delivery or failure to deliver a service related to health care.
 - ▶ Assess the quality of any service related to health care.
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Tools available to the reviewers

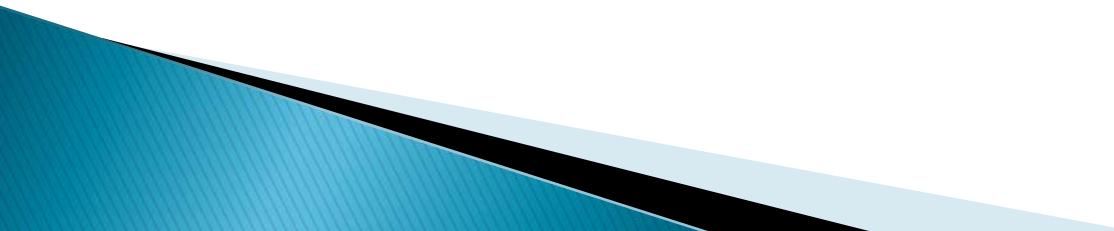
- ▶ We will consider and will have access to any and all information available to a health authority in respect to a care quality complaint.
 - ▶ We will consider all of the circumstances relating to a care quality complaint.
 - ▶ We will determine the policies & procedures that are applicable to the complaint.
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We Report to:

Our analysis of every case and our recommendations are reported in a clear, timely and transparent manner to:

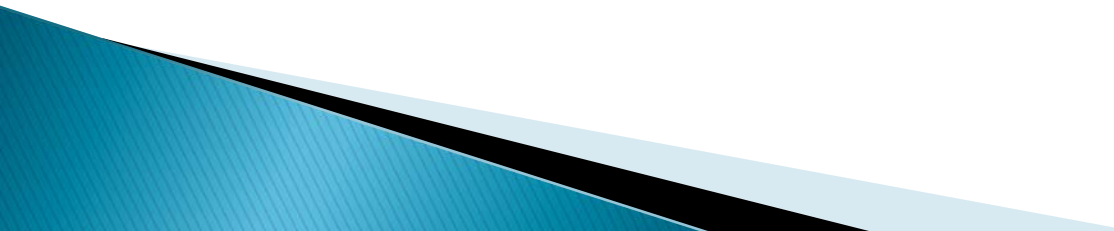
- ▶ The individual who submitted the complaint.
 - ▶ The Minister of Health Services
 - ▶ The involved Regional Health Authority.
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What do we report?

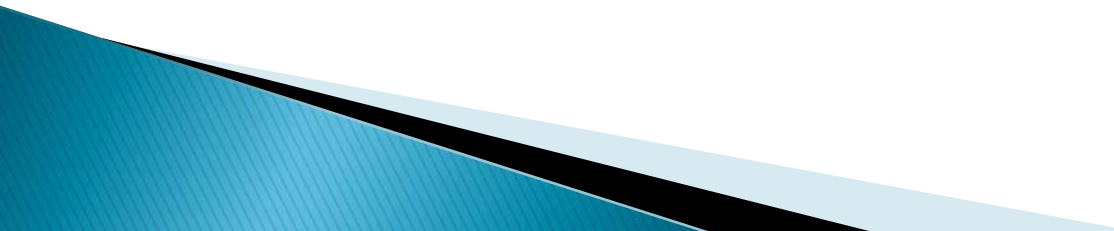
- ▶ The circumstances relevant to the care quality complaint as we understand them.
 - ▶ The applicable policies and procedures involved.
 - ▶ The actions taken in response to the complaints.
 - ▶ Our recommendations for quality improvement for the facility(s) involved, the health region and the whole province!
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The Report

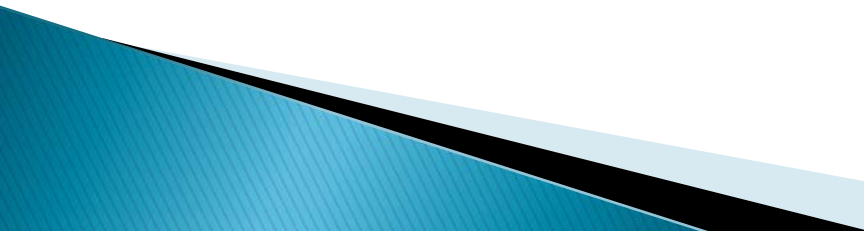
Must

- ▶ Comment upon the care quality complaint process in the Health Authority.
 - ▶ Comment upon the adequacy of the Health Authority's response to the complaint.
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Process

- ❖ What is the nature of the complaint?
 - ❖ Are all the relevant documents to the complaint available for review?
 - ❖ How adequate was the health authority's response to the complaint?
 - ❖ Do we need additional information and/or expert opinion?
 - ❖ What are our recommendations to the Health Authority and to the Minister of Health Services?
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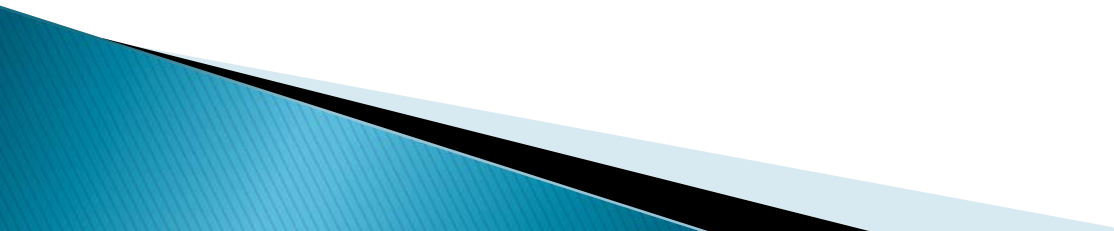
Reviewer's keep in mind that:

- ▶ The existing health care system has much to celebrate! There is much good practice – good care – good outcomes!
 - ▶ Complex systems are not necessarily or inherently safe nor do they necessarily represent good quality.
 - ▶ All systems of health care are huge and complex, there are bound to be examples of poor care but everyone wants to deliver the best possible care to every patient.
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And also the tension ...

- ▶ Complex systems are usually dynamic tradeoffs between multiple irreconcilable goals i.e. safety vs. efficiency.
 - ▶ Health care professionals and especially hospital based staff, are always under pressure.
 - ▶ Unlike a consumer of a product, a patient is vulnerable, anxious and in distress.
 - ▶ The most fundamental interaction in the health care system is that between the health care staff person and the patient.
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What we don't report?

- ▶ We are not a judicial review board.
 - ▶ The reviewers want to resolve a complaint and improve the system NOT find fault or assign blame.
 - ▶ We want to believe that we are assisting health care professionals in their efforts to deliver the highest possible quality patient health care.
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Canadian Patient Safety Institute CPSI

- ▶ Desired a healthcare environment that did not rely entirely on the personal vigilance of healthcare professionals (as is commonly the case) and instead placed the system as also accountable for each intervention and patient outcome.
- ▶ They adopted the “Root Cause Analysis tool”
2006 www.ismp-canada.org;
www.patientsafetyinstitute.ca;
www.health.gov.sk.ca

Root Cause analysis

The goals of a root cause analysis are to determine:

- ▶ what happened?
- ▶ why it happened?
- ▶ what can be done to reduce the likelihood of a recurrence?

Department of Veterans Affairs, Veterans Health Administration, National Center for Patient Safety, Root Cause Analysis (RCA), <<http://www.va.gov/ncps/rca.html>> (accessed November 28, 2005).

The complainants point of view

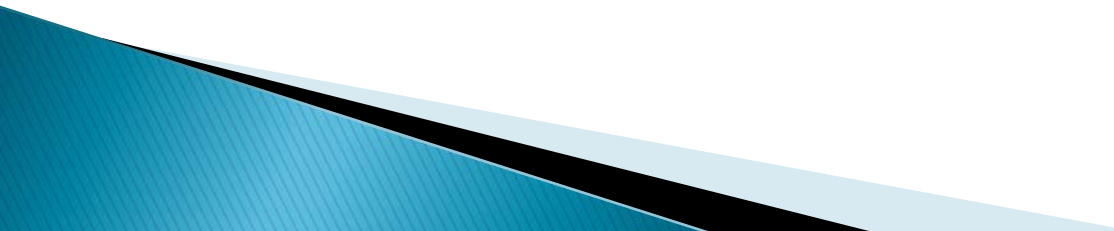
- ▶ ...”from the patient’s point of view, every detail of every interaction and physical environment shapes the unique quality of the experience.”
- ▶ ...”from listening to patients, we learn that the experience of being in (or even in contact with) a hospital, in all its complexity, is produced by the social processes of the health system as a whole.”

Seeing the Person in the Patient–The Point of Care Review; Goodrich & Cornwall; The Kings Fund 2008. publications@kingsfund.org.uk

The Bell Curve of complaints

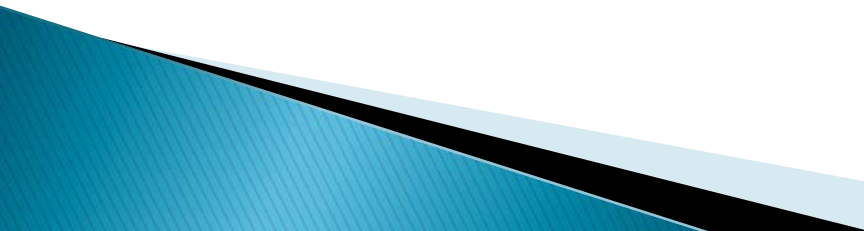
1. Possible exposure of a problem within the health care system that might undermine quality.
2. Real health care quality concern not effectively resolved.
3. Abnormal behaviour – works the system – Can't let go – lots of time – destined to become a spokesperson for a health care issue. Media, MPs, Painful, costly.

Who & Why of Reviewers

- ▶ Who are we?
 - ▶ Why do we do it?
 - ❖ Look beyond the individual complaint to consider the broader issues of the quality of health care and even the public policy underpinning human rights!
 - ❖ Improve the system!
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Silver lining or Dark clouds

Concerns ...

- ▶ Laplace 1790: “We observe a relatively small number of outcomes from which we infer information and make judgments about the qualities that produced those outcomes”. Are we guilty?
 - ▶ How big is the job?
 - ▶ Are we effective?
 - ▶ Win – win: Bouquets or dish water?
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Categorizing Quality Measures

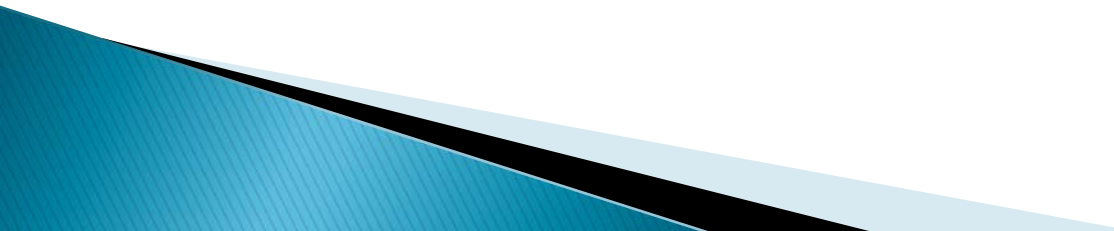
- ▶ Standard, Institute Medicine 2001:
Patient-centered; Safe; Effective;
Timely; Efficient; Equitable.
- ▶ The Seven Dwarfs of Quality:
Appropriate, Acceptable, Accessible,
Effective, Efficient, Competent and Safe.
- ▶ PCQRB – compress to about 250.
- ▶ **PATIENT CENTERED** –Seeing the Person in the Patient–
The Point of Care Review; Goodrich & Cornwall; The Kings
Fund 2008. publications@kingsfund.org.uk

Weekly Reports

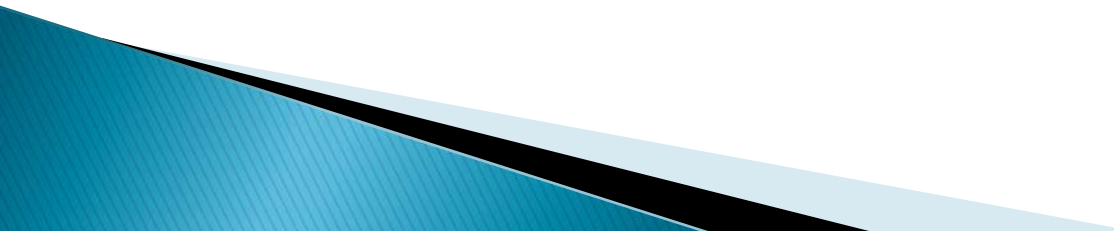
2009 August 01-07

	Fraser	Interior	Coastal	Island	North ern	Provinc ial
For Review	5	5	10	3	0	4
Complete	3	2	1	3	0	2

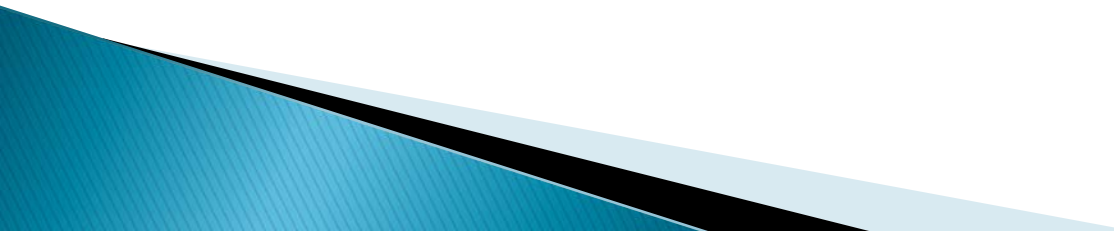
Quarterly Report to the Minister

- ▶ Quarterly data received from health authorities. (Complaint volume, nature of complaints)
 - ▶ Review Board data and Health Authority data combined into single report.
 - ▶ Provided to the Minister of Health Services.
 - ▶ As the depth of data increases so does the value of the report.
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Annual Report to the Minister

- ▶ The Boards are required to report annually to the Minister.
 - ▶ Includes the volume reporting from the quarterly report.
 - ▶ Also will capture an analysis of the work done by the review boards over the previous year.
 - ▶ Still a work in progress (completion Early 2010)
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Thanks to

- ▶ The Ministry of Health Services Secretariat
Thomas Guerrero; Katie MacNeill, Mike Orrey, Christopher Popovich; Brenna Kelln; France de Montigny, Jan Mahoney, Barb Crerar, Deb Crawford.
 - ▶ The Vancouver Island Health Authority Review Board: Richard Swift, Graham Alce, Jennifer English, Michael Patterson, and Linda Thompson.
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Thanks to

- ▶ Interior Health Authority Review Board: Rodger Sharman, Randall Fairey, Thomas Humphries, Gloria Morgan, and Gur Singh.
 - ▶ Northern Health Authority Review Board: William Norton, Lorna Dittmar, Anthony Kenyon, and David Wilbur.
 - ▶ The Lower Mainland Health Authority Review Board: Jack Chritchley, John Gilbert, Robert Holmes, Naznin Virji-Babul, Sandra Wilking and Janis Volker.
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