

# Some tips and ideas for Educational Supervisors

Updated July 2022

# 1. Getting Started- QI expertise is not important

How do I oversee a trainee myself

I know some QI

1. How important is the topic ?
2. How much do we know already ? Mini audit needed
3. Who do we need to involve?

I don't know any QI

1. How important is the topic ?
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3. Who do we need to involve?

## 2. Focus on what matters- keep to a clear time scale- don't make it overly complicated-

### **Supervisor**

- You are the clinical content expert- what is best practice and why
- You know the people who can support/ join in/ unlock barriers
- You are responsible for the quality of patient care
- Having a department plan of what we would like to fix is a great idea
- Understanding how this might breakdown into steps over time would be a valuable consultant conversation to have

### **Trainee**

- You probably know more about QI methods than the supervisor
- You need to check out the tool box and get the current situation well understood
- You will need to make sure the team is multi-professional and that weekly get togethers keep pace up
- How will you know a change is an improvement?

### 3. Using QI methodology is a discipline that is needed in complex systems if change is to be safe and effective

#### **Supervisor**

- Know who in the trust can support QI methods
- Know about the basics- current situation review, the need to really understand what happens now (process map, walk through, analysis of what goes well and what does not, workarounds etc)
- Understand time ordered measurement principles ( BP chart analogy)

#### **Trainee**

- Which QI methods suits things best- suggest Model for Improvement the most likely but Lean/ Microsystems/ Co production may
- Seek ideas on what changes might be needed from the team
- Lay them out before deciding which to try first
- How will you know its an improvement ?

# 4. Whole teams build a better project and deliver improvement faster and in a way most likely to be sustained over time

What can my department do to embed improvement in the day job

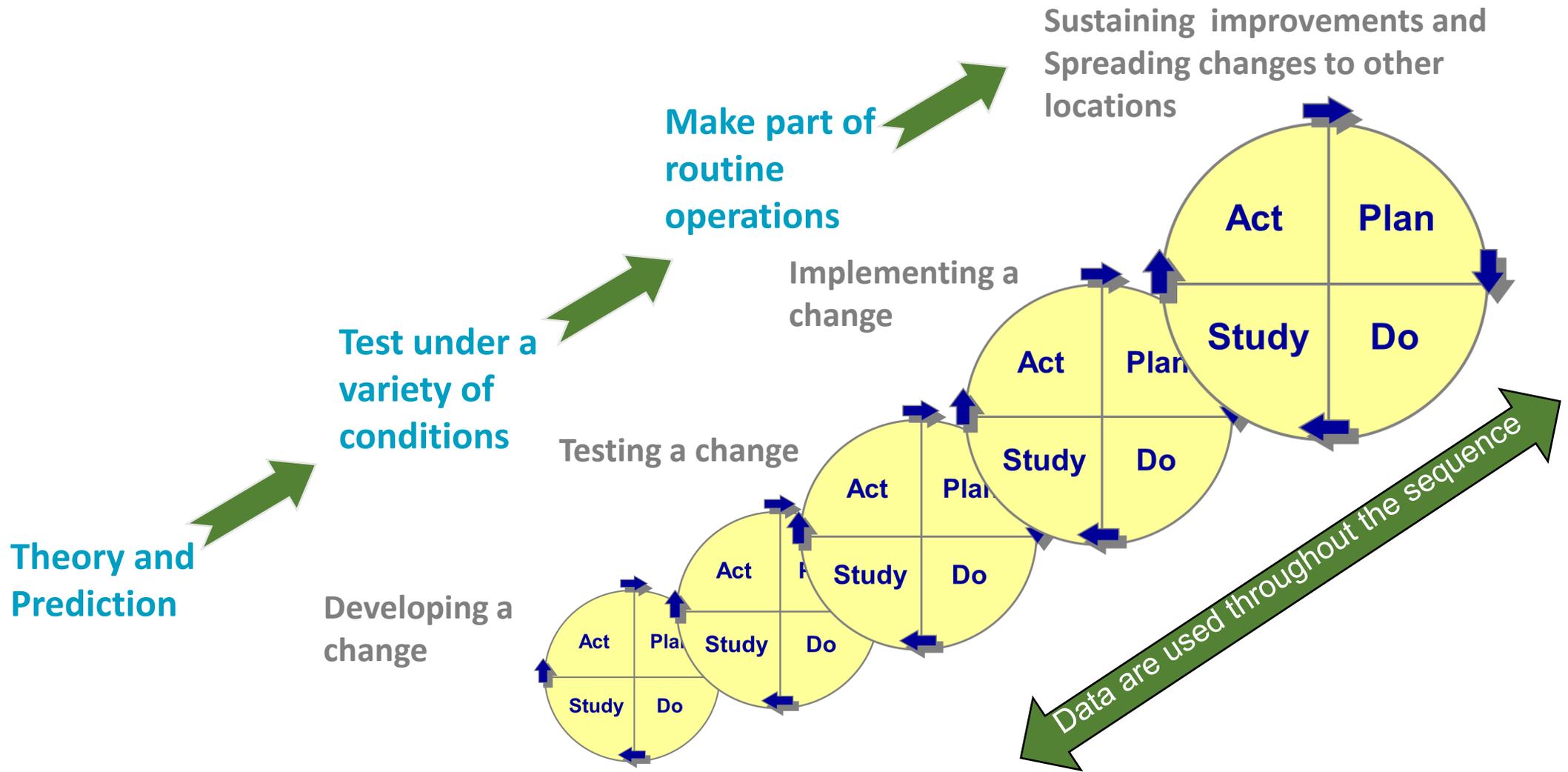
## • I champion QI

- Use national audits or other quality reviews to target key areas
- Have a department plan
- Work to ensure the new trainee can take over from the current one
- Support and champion sharing at local/ regional meetings
- Join a collaborative if there is one
- Keep your consultant colleagues on board
- Promote QI in all appraisals

## • I am a bit of a sceptic

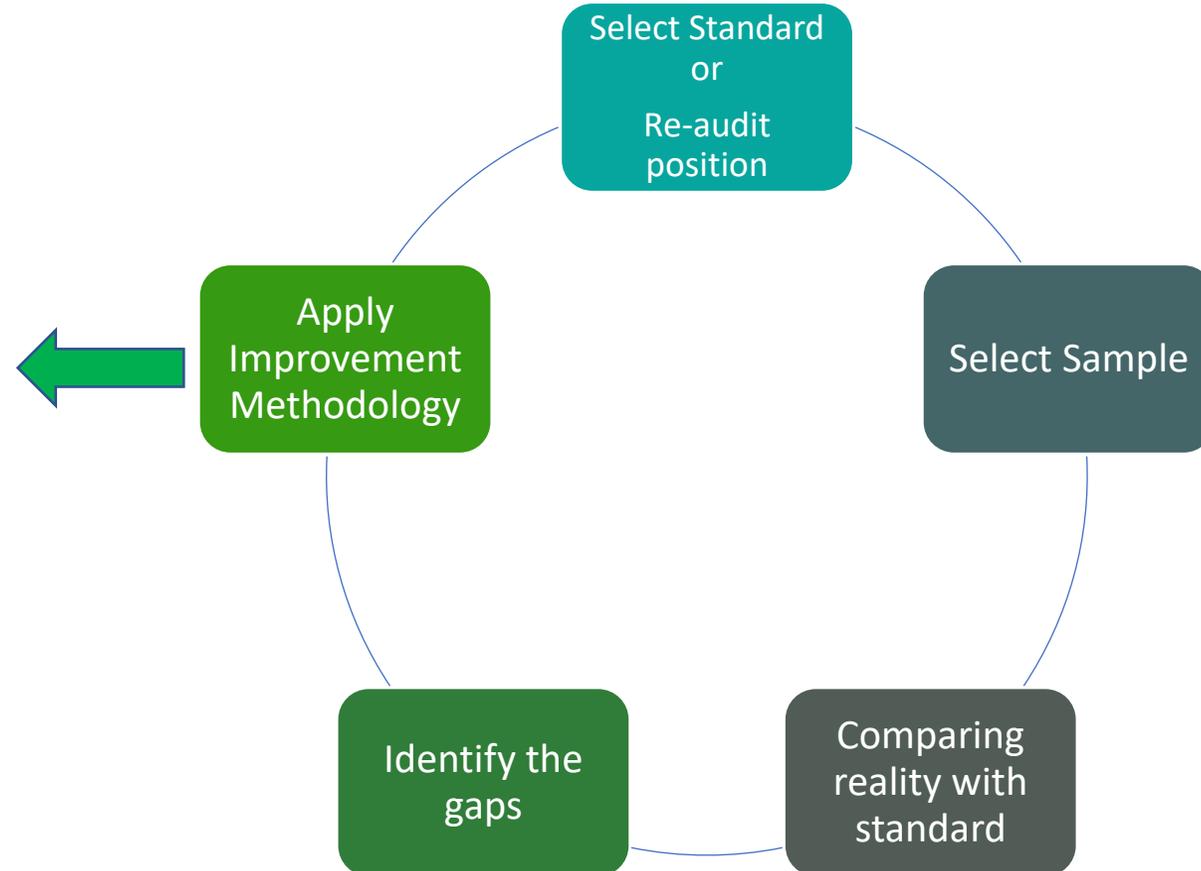
- Take anything less than optimal outcomes/ audit/ other review seriously even if you don't know how to fix it or have tried before
- Remain neutral on ideas but think of how you all might know they actually are an improvement and share this.
- Read about Appreciative Enquiry and how it should be used to build a better team and reduce group think errors
- Be a champion for the patient- ask them what is not working and feed this back

5. The Most Important concept to grasp is that Plan DO Study Act is a sequence of small steps- it is fundamental to ALL QI methods



# 6. Adding a QI method into the current audit loop accelerates change and measures sustained progress- but it includes far more than just an action plan!

1. Understand variation
2. Understand system
3. Create stakeholder involvement
4. Come up with ideas
5. Get right people on the team
6. Work across several components
7. Know ideas are making improvements
8. Keep people enthusiastic
9. Embed improvement so cannot revert to old way of working
10. Evidence the value of the work to others less keen for change



## 7. Devising an Exercise in understanding complexity

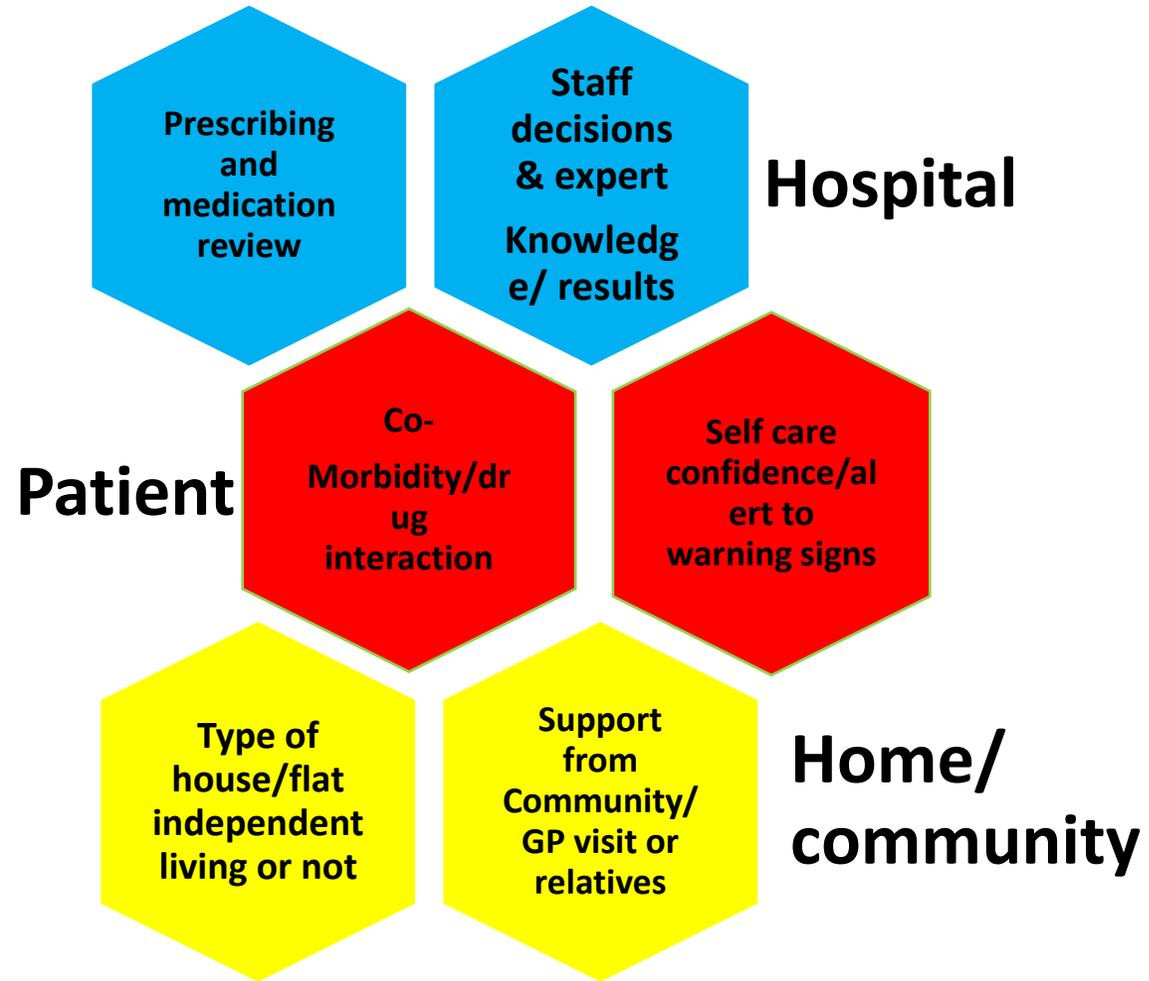
Ask your colleagues their  
ideas on this scenario.

92 year old was discharged  
home from ward 5 following  
4 day admission for  
pneumonia

What could possibly go  
wrong?

The answer is from experience (recent or past) that there are a lot of things that might not go according to plan; be overlooked, be forgotten in the rush to manage the practicalities of discharge, be lost in the hospital notes or the process of having investigations and getting results back.

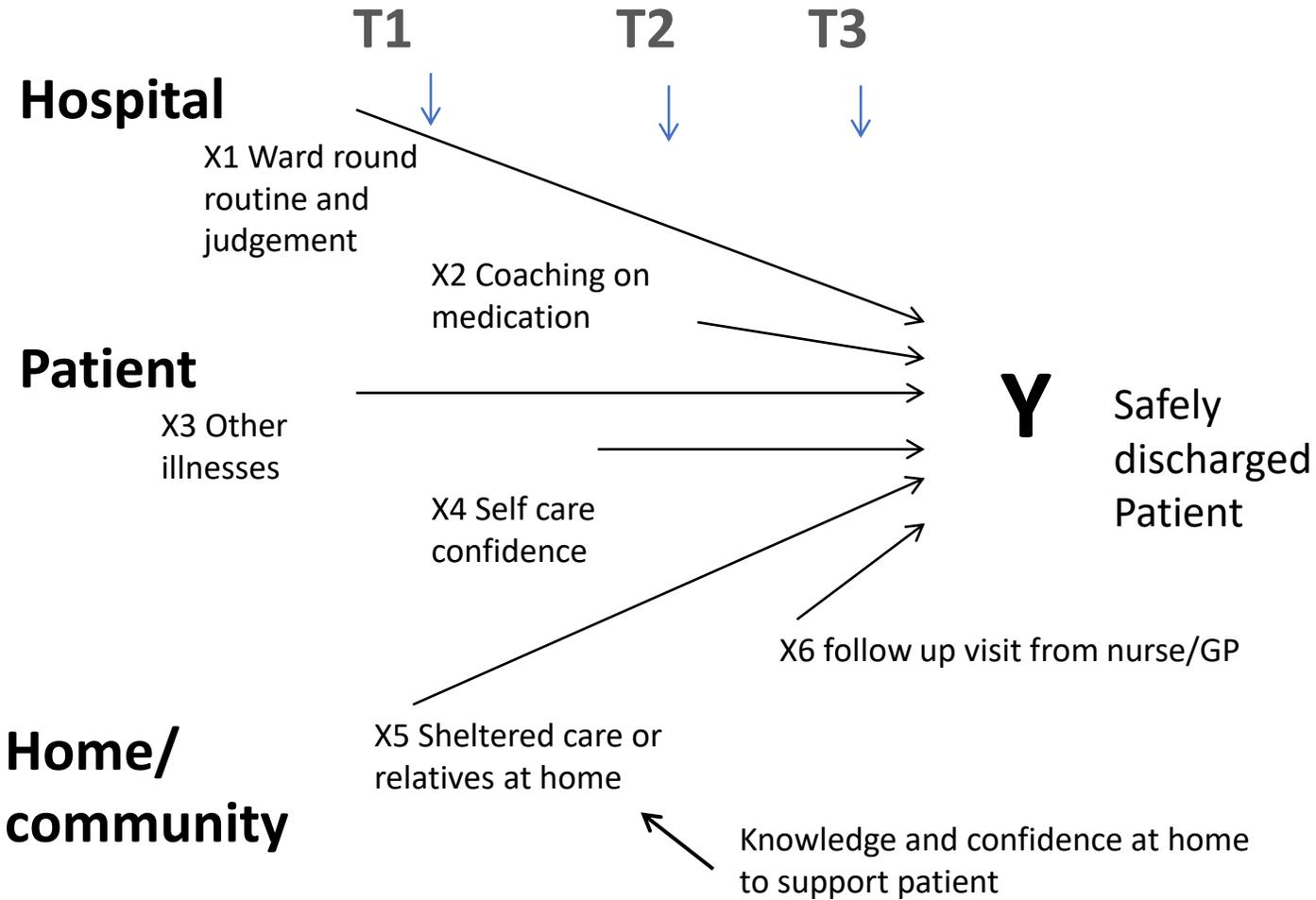
The list can be organized in several ways but a good way is to group the reasons in a way that makes sense to everyone- here a group of hospital doctors and nurses organize according to these three groupings – hospital , with patient and home/community



There is no wrong way to do this but the right way enables everyone to have a shared understanding of the system

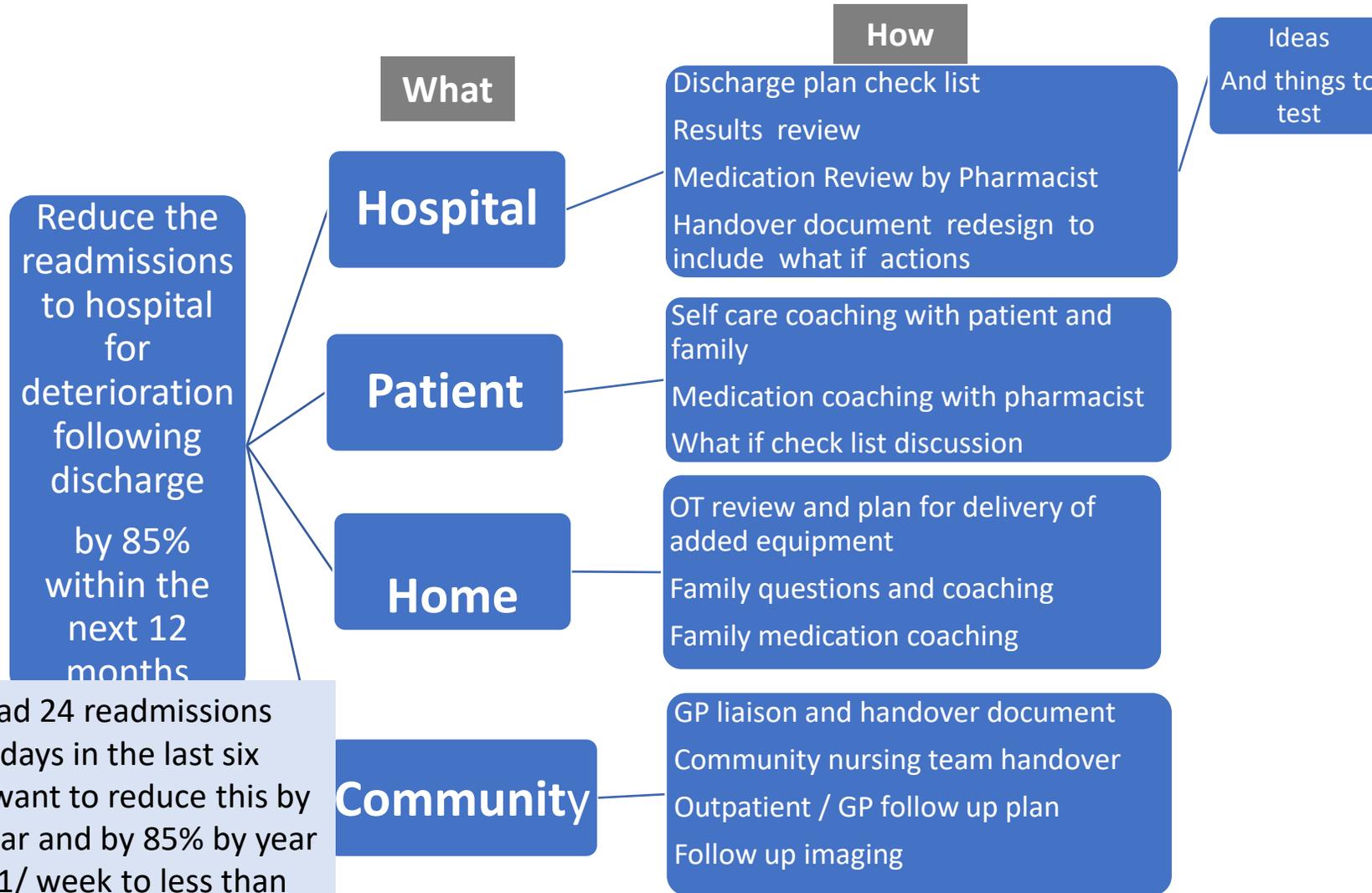
We all know that any one of these problems can lead to an unsafe outcome and often one thing going wrong leads to another and another. Complex systems are by definition joined in many variable ways with knock on consequences that may vary from patient to patient.

A complex system is the hardest to understand and to improve.



Direct and a complex system over time – **THEY ALL NEED ATTENTION**

# This is then how you might build your 'Improving Safe Discharge' Project



We have had 24 readmissions within 28 days in the last six months/ we want to reduce this by half by mid year and by 85% by year end – from 1/ week to less than 1/month

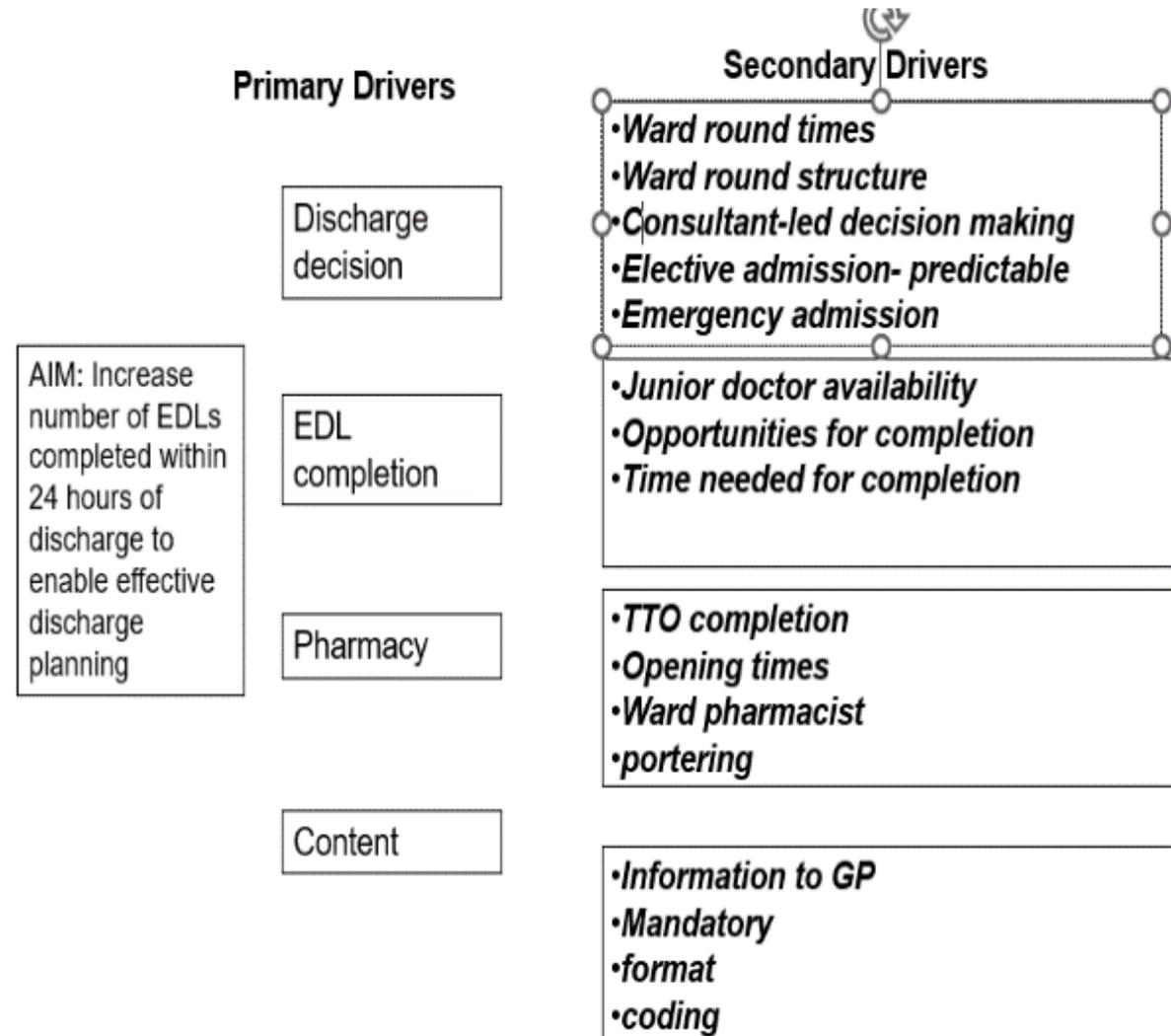
- ### Improvement Journey in a nutshell:
1. Review the whole system in which the problem is happening (suspend decisions on solutions)
  2. Map a process/ create a fishbone analysis/ review patients comments +ve and -ve
  3. Organise the challenges into primary drivers (the 'WHATS' that need to be redesigned/ reorganised)
  4. Brainstorm ideas (? Post it notes) to improve any/all of the systems as described
  5. Have a theory on why the idea will improve things then organise these under the 'WHATS'. This is HOW improvement will happens
  6. Agree which is a good idea to start with, rethink what happens and test out a different way as soon as possible

# The driver diagram displays complex interactions in one place for everyone to see, think about and suggest ideas

- Helps you to **set priorities**
- Identifying the drivers that will have the **biggest impact**
- Help **organize your theories** about what it takes to achieve improvement
- Leads you to the third question in the model for improvement – **What changes can you make** that will result in improvement?
- Helps you then **understand your current level of performance** on these drivers
- Essentially is a set of concepts – to make these concepts operational you will need to **identify measures** that indicate progress towards aim(s)

Emma Vaux RCP 2012

<https://www.rcplondon.ac.uk/guidelines-policy/itmd-quality-improvement>



The purpose of our measurement	Date for Learning	For Performance Management	For Research
<b>Aim</b>	Improving care/ Reliability/ Safety/ Quality	Comparing, choice, ranking, focus attention/blame	New knowledge / efficacy of Rx
<b>Methods</b>			
<b>Testing observable</b>	Yes study each test	No testing	Testing blinded/controlled
<b>Bias</b>	Consistent bias accepted	Measure to reduce bias	Designed to eliminate bias
<b>Sample size</b>	Just enough, sequential samples	100% or relevant data	Large just in case
<b>Hypothesis</b>	Flexible	Non	Constant/fixed/null
<b>Testing strategy</b>	sequential	Non	One large test
<b>Is the change an improvement?</b>	Analytic stats SPC Control/ run charts/time ordered	May rank up or down or % change	Enumerative Stats t- test/ p value /Chi
<b>Is data confidential?</b>	Only used by those improving	Public	Subjects concealed

# Be committed and listen to these short presentations

<https://www.youtube.com/watch?v=WimimYZ5qpl>

## Are you QI convinced

- Have a recharge on why aiming for excellence is our purpose as doctors (self and system)  
<https://www.youtube.com/watch?v=5PNPIYEFwCc>
- Check out the WEAHSN tool box so you know what is in it  
<https://www.weahsn.net/toolkits-and-resources/quality-improvement-tools-2/>
- Read this update of safety design  
<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3835697/>
- Adjust the driver diagram for you and get started

## Are you not yet QI convinced

- Watch this video on the vital importance of Medical leadership from the front line  
<https://www.youtube.com/watch?v=5PNPIYEFwCc>
- Check these short guides from IHI  
<http://www.ih.org/education/ihopenschool/resources/Pages/BobLloydWhiteboard.aspx#1>
- and RCP  
<https://www.rcplondon.ac.uk/guidelines-policy/itmd-quality-improvement>
- Adjust the driver diagram for you and get started

# Useful additional resources

<https://www.ebooks.com/en-us/book/209956117/abc-of-quality-improvement-in-healthcare/tim-swanwick/>

<https://www.health.org.uk/sites/default/files/QualityImprovementMadeSimple.pdf>

<https://www.weahsn.net/toolkits-and-resources/quality-improvement-tools-2/>

# 7. What could you do to facilitate QI following an audit ?

- Shorten the audit period ( 25 )
- Train the AUDIT team in QI and supporting QI
- Make sure the form clearly states its QI not just audit
- Set a time to meet and review audit
- Use presentation at M&M/other to crowd develop the driver diagram
- Support and enable an MDT to form around the project
- Keep it simple/ keep it focused
- Work on part of the complexity to start with

- Have a Weekly meeting
- Permit everyone the time to attend/ strict high performing team coaching ( see guide)
- 30 minutes max- record on white board, photo and WHATSAPP
- Agree actions, who, what , when
- Plan, Do swiftly- test and test again
- Coffee/ biscuits/ encouragement
- Timetable feedback to Governance / team
- Collect data
- Display Data
- Ask questions/ involved your leadership
- Find a way to promote/ recognise/ encourage

## 8. What can be changed that will support people to join the improvement journey ?

- How you come together
- The approach to the dialogue
- The DATA you have and how it is displayed and what conversations are had around it
- The size of the steps you take to build confidence the risk is small
- Recalling the journey so far to show the effort is sustainable
- Hearing the heartfelt pride in improving from patients & staff

## 9. Sharing and Publishing –start with the end in mind

- <http://www.squire-statement.org/>

# Where do I find out more?

## COLLEGES

- <https://www.rcseng.ac.uk/standards-and-research/support-for-surgeons-and-services/quality-improvement-in-surgery/>
- <https://www.rcplondon.ac.uk/projects/rcp-quality-improvement-rcpqi>
- [https://www.rcem.ac.uk//docs/QI%20Resources/RCEM%20Quality%20Improvement%20Guide%20\(Nov%202016\).pdf](https://www.rcem.ac.uk//docs/QI%20Resources/RCEM%20Quality%20Improvement%20Guide%20(Nov%202016).pdf)
- <https://www.rcoa.ac.uk/news-and-bulletin/rcoa-news-and-statements/new-qi-e-learning-resource-developed-the-perioperative>
- <https://www.rcpch.ac.uk/work-we-do/quality-improvement-patient-safety>
- [http://aomrc.org.uk/wp-content/uploads/2016/06/Quality\\_improvement\\_key\\_findings\\_140316-2.pdf](http://aomrc.org.uk/wp-content/uploads/2016/06/Quality_improvement_key_findings_140316-2.pdf)

## OTHER

- <http://www.squire-statement.org/>
- [www.health.org.uk](http://www.health.org.uk)
- [www.ihl.org](http://www.ihl.org)
- [www.chfg.org](http://www.chfg.org)
- <http://www.weahsn.net/what-we-do/west-of-england-academy/quality-improvement-tools/quality-improvement-toolkit/>
- <https://www.futurelearn.com/courses/quality-improvement>

## Some useful resources to help build Trainee QI confidence and capacity

- <http://www.aomrc.org.uk/quality-policy-delivery/improving-quality-and-standards/quality-improvement/quality-improvement-resources/>
- <https://www.rcplondon.ac.uk/guidelines-policy/ltmad-beyond-cmt-trainee-pack>
- <https://www.rcplondon.ac.uk/projects/learning-make-difference-ltmd>
- <https://www.futurelearn.com/courses/quality-improvement>
- <http://www.hqip.org.uk/public/cms/253/625/19/624/HQIP%20Guide%20to%20involving%20junior%20doctors%20in%20clinical%20audit%20and%20quality%20improvement.pdf?realName=SK8IRI.pdf&v=0>
- <http://www.aomrc.org.uk/publications/reports-guidance/quality-improvement-training-better-outcomes/>
- <http://www.health.org.uk/publications>
- <http://www.ihl.org>
- <http://qir.bmj.com/>
- <http://www.squire-statement.org/index.cfm?fuseaction=Page.ViewPage&PageID=471>
- <http://link.springer.com/book/10.1007%2F978-3-319-25559-0>
- <http://www.health.org.uk/sites/health/files/BuildingTheFoundationsForImprovement.pdf>
- <https://www.weahsn.net/what-we-do/west-of-england-academy/quality-improvement-tools/quality-improvement-toolkit/>