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Keynote Speech - Real Healthcare Reform

Mr. Denham began by addressing what was on everyone's mind- why is an American delivering the keynote speech at a European congress!? Moreover, what can we learn from the US- a country with possibly the lowest quality of care and the most expensive of the industrialised nations? Mr. Denham believes that healthcare reform and quality are not only national, but global perspectives.

His objective was to share some of the very harsh business lessons that they are learning through healthcare reform in the US in the hope that Europe does not have to go through the same pain.

Quality Through Leadership

The focus was on the opportunity that leaders have to make a significant impact on healthcare reform. "It is my belief that the next generation of breakthroughs in healthcare quality will not be software; it won't be hardware; it won't be a new pharmaceutical agent; it won't be a new breakthrough in understanding the genome. It will be you. It will be leaders."

Mr. Denham stressed that research in the US suggests one in ten patients has harm from the care that we as healthcare providers deliver and that we have an excellent opportunity to reduce that harm. To illustrate the problems with healthcare in the US, Mr. Denham used the example of a news magazine. The cover story highlighted the best hospitals in America while another article described the problem of over-prescription of medications and another the dangers of medical insurance fraud. Also included was a patient survival guide for going into hospital. Clearly quality of care is a preoccupation of the general public as well as healthcare providers.

Story Power

Stories are a key tool for leadership. There are many stories that can provoke improvements in processes and quality. Dennis Quaid joined Safety Leaders because of his particular story. His ten-day old twins experienced a catastrophic medication error. They were admitted to the hospital for an infection and were given 1000 times the dose of blood thinner herapin, twice. By joining the organisation and sharing his story he is helping to build awareness.

For Mr. Denham, leaders can use stories to bring the heart and the head together. That means bringing together facts and numbers with emotion and love. The greatest leaders are those that can communicate and empower their staff by telling stories.

Failure of Support Systems

Why are there so many quality issues? Denham believes that these problems are due to the failure of support systems: leadership support systems, practice support systems and technology support systems. These three systems can deliver high quality care but this is not happening in practice; information is not managed correctly nor are medications and pathology reports. System failures have a direct impact on quality.

Taking nurses as an example, Denham claims that, "We are asking our staff to do more and more without teaching them how to work smarter with leadership." Nurses go to the nursing station on average 200 times a shift, and to the medication cabinet 100 times meaning they are travelling three to five miles in a typical shift. They RFID tagged the nurses to calculate how they were using their time but the technology failed as the nurses moved too fast to be recorded. This illustrates the pressures put on healthcare staff.

The Four A's

For Mr. Denham, the four A's: Awareness, Accountability, Ability and Action are key to quality in the adoption of technologies and practices. "Awareness of performance gaps, accountability of those who must close the gaps, the ability or know-how of those who are accountable (you can be aware and accountable but not be able to close them), and then the direct actions that need to take place."

To illustrate the importance of the four A's, Mr. Denham looked to the CT scan radiology accident issue, something prevalent in both the US and Europe. He showed a photograph of a patient with a Saturn ring area of alopecia on his head due to radiation. Basically the patient was given too high a dose. In the US 70 million CT scans are performed per year but there is a 30% overutilisation rate and 40% of studies are inappropriate.

Mistakes like these are system failures, the leadership are more often than not unaware, there is a lack of accountability, and no investment in knowing when accidents might occur and the risks and actions. The four A's prevent problems like this from occurring.

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