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La qualità in medicina d'Urgenza: chi valuta cosa?

Indicatori e standard

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Framework for Quality and Safety in the Emergency Department 2012

http://www.ifem.cc

History of Emergency Medicine and IFEM

… in countries where EM is well-established, attention is now being paid to defining and assuring quality in emergency care. Many IFEM members have done extensive work within their own healthcare systems to identify quality in EDs, applying various measures and promoting these measurements as important to the public and funding bodies. In some countries, there has been national implementation of mandatory quality standards, and external review by governmental and other bodies.

History of Emergency Medicine and IFEM

At the same time in countries where EM is developing there may be immense pressures on the emergency care system, combined with limited resources to support that system. Under such circumstances measures of quality may yet need to be implemented, but there are important lessons to be learned from better resourced countries and there is potential for universal standards to be developed and applied.

History of Emergency Medicine and IFEM

For these reasons we came together to start the work of defining an IFEM framework for quality and safety within the ED that would be applicable across the globe. This will support the development of EM internationally, and also assist in ensuring that our patients receive the best possible care within the finite resources available. We agreed that because quality is a multi-faceted concept a single indicator, such as a universal time-based standard, is undesirable and potentially dangerous because it ignores other aspects of quality …

History of Emergency Medicine and IFEM

… such as clinical effectiveness and the service experience. The result can be a distortion of ED activity to achieve this single measure at the expense of other aspects of quality. A further challenge is that although EM is defined in terms of the emergency management of illness and injury, the definition of a medical emergency is often perception-driven, and EDs are usually expected to provide safe, high-quality healthcare to all those who seek it, regardless of the actual degree of acuity or urgency.

What patients should expect from an ED

The IFEM terminology Delphi project defines an ED as: "*The area of a medical facility devoted to provision of an organized system of emergency medical care that is staffed by Emergency Medicine Specialist Physicians and/or Emergency Physicians and has the basic resources to resuscitate, diagnose and treat patients with medical emergencies*" …

How the ED differs from other healthcare settings – decision making

A particular feature of the ED is a high density of clinical decision-making. Not only does each clinician have to identify a set of diagnostic and therapeutic priorities for each patient in limited time and with limited information, but there is an added pressure around disposition because the period of observation that can occur on a ward or in primary care may often prove difficult to implement in the ED …

How the ED differs from other healthcare settings - crowding

Unlike most other healthcare settings the ED can readily fall victim to crowding because inflow is rarely regulated, and outflow to inpatient beds is often outside of the control of the ED. This is not desirable in an intensive decision-making environment.

Crowding has a direct effect on quality of care, morbidity and mortality. Multiple studies have demonstrated its harmful effects …

A theoretical framework for the domains of quality and safety

During the conference we identified the Institute of Medicine framework as an excellent starting point, in that it encompasses our aspiration of “right patient to the right clinician at the right time in the right setting”. The domains of quality from this framework are described in the table below:

A theoretical framework for the domains of quality and safety

Domain	Description
Safe	Avoiding harm to patients
Effective	Providing services based on scientific knowledge to all who could benefit, and refraining from providing services/care to those not likely to benefit
Patient-centred	Providing care that is respectful of and responsive to individual patient preferences, needs, and values
Timely	Reducing waits and sometimes harmful delays
Efficient	Avoiding waste (personnel, resources, finance)
Equitable	Providing care that does not vary in quality because of personal characteristics

Enablers/barriers to quality care in the ED

A) Staff: trained, qualified and motivated to deliver efficient, effective and timely patient-centred care, compliant with local or national guidelines for ED staffing numbers skill/grade mix, including allied health professionals and support staff.

Barriers: staff burn-out, low morale, poor remuneration, inadequate career development opportunities, high turnover, adverse incidents, lack of co-ordinated teamwork, culture of apathy and weak leadership. …

Suggested indicators

A series of quality questions and their associated measures are shown in the following table. The questions posed cover a range of issues that are fundamental to the delivery of high quality care in any ED, but the exact measures used will depend on local factors, the availability of data, and over-arching elements of the healthcare system in any particular setting.

Suggested indicators

Quality question	Structure measure	Process measure	Outcome measure
Facilities adequate?			
Numbers and skill mix of staff adequate?			
Is there a culture of quality?			
Data support adequate?			
Key process measures in place?			
Access block present?			
Evidence based practice resulting in appropriate care and optimal results?			
Patient experience measured and acted upon?			
ED staff experience measured and acted upon?			

Facilities adequate?

Structure measure	Process measure	Outcome measure
• Capacity indices, such as the number of resuscitation and/or majors cubicles for the patient casemix (in relation to local guidelines) • Specific areas for vulnerable groups (e.g. children, mentally ill, confused elderly) • Presence or absence of functional equipment to ensure patient safety • Adequate security • Disaster/major incident plan	• Maintenance logs for equipment • Regular cleaning records and inspections • Regular stock inventory • Regular testing and rehearsal of disaster plan	• Patient experience • Incidence of hospital-acquired infection • Recorded incidents of assault / injury on staff members

Numbers and skill mix of staff adequate?

Structure measure	Process measure	Outcome measure
• Total number of staff and skill mix (in relation to local guidelines) • Staff turnover and sickness levels • Number of new patients per staff member (with reference to staff seniority) in unit time • Number of patients waiting to be seen (by triage category)	• Times to be seen by decision maker • Times from arrival to discharge from ED • Proportion leaving without being seen	• Complaints and critical incidents

Is there a culture of quality?

Structure measure	Process measure	Outcome measure
• Is the leadership committed to quality and accountability? • Is the leadership "satisfied" or constantly improving? • Does the ED have clinical autonomy and an ability to develop its own evidence-based practice? • Quality or safety committee is seen as part of the essential administrative structure? • Is ED quality seen as a holistic health service issue?	• Hospital leadership visible in clinical areas • Hospital-wide quality initiatives (e.g. care transitions, hand-washing) • ED-led quality initiatives and guidelines • Effective dashboard of quality and safety which is locally available and acted upon • Quality of ED decision-making monitored and acted upon (e.g. through errors and adverse events) • Adequate communication with primary care and other community services	• Patient experience • Patient empower-ment and/or ability to participate in own care • Medication errors

Data support adequate?

Structure measure	Process measure	Outcome measure
• Is there a system in place to facilitate monitoring of the process and outcome measures described in this table?	• System generates reports that support departmental quality management • ICT regularly maintained and developed appropriate to evolving emergency care needs	• Patient experience • Objective measures show continuous quality improvement • Contributions to public health in the local community (child protection, police liaison, etc.)

Key process measures in place?

Structure measure	Process measure	Outcome measure
	• Time from arrival to cubicle • Time to decision maker • Time to analgesia • Audit against other EDs and national guidelines • Left without being seen rate • Bed turnovers	• Patient experience • Survival/functional status for time sensitive conditions (e.g. stroke, MI, sepsis) • Time intervals in journey • Diagnostic errors • Avoidable patient returns to the ED

Access block present?

Structure measure	Process measure	Outcome measure
• Proportion of time that patients are on trolleys in corridor • Frequency with which meal rounds and drug rounds are required in the ED	• Time to offload patients from ambulances • Trolley waits above a locally agreed threshold • Time to admission from decision to admit • Median length of stay for all patients • Left without being seen rate	• Case mix survival measures for high mortality conditions • Length of stay, complication rates for hospitalized patients • Proportion returning to ED within 7 days • Incidence of hospital-acquired infection (depending on length of stay in ED)

Evidence based practice resulting in appropriate care and optimal results?

Structure measure	Process measure	Outcome measure
• Presence of clinical pathways to support best evidence-based practice • Appreciation of cost effectiveness	• Pathway compliance • Times to critical interventions such as reperfusion or antibiotics • Regular audits of use of key investigations and treatments of high risk and high volume conditions	• Patient mortality (general or specified conditions) • Risk adjusted outcomes (e.g. from registry data) • Other clinical outcome data • Proportion returning to ED within 7 days

Patient experience measured and acted upon?

Structure measure	Process measure	Outcome measure
• Use of patient feedback tools • Inclusion of patients on hospital boards	• Changes implemented on the basis of patient feedback	• Progressive improvements in patient feedback • Equitable access for different races/gender and minority groups

ED Staff experience measured and acted upon?

Structure measure	Process measure	Outcome measure
• Feedback at ED staff appraisals • Use of staff feedback tools including other specialities • Training and education programmes for ED staff	• ED staff empowered and supported by management and leadership team • Changes implemented on the basis of staff feedback	• Progressive improvements in staff feedback • Improving trainee and student feedback in training departments

Research questions

… in all cases the aim should be to institute policy and system-based change on the basis of high-quality evidence, rather than opinion or anecdote.

It is also necessary to develop research projects that cross national and international boundaries, so that different systems in different countries can be compared objectively to allow the development and promotion of best practice across the specialty globally …

Conclusions

… the International Federation of Emergency Medicine, with more than 70 member countries, has prepared this document to define a framework for quality and safety in the ED. It sets out reasonable expectations for patients attending any ED globally, and also the additional expectations for EDs functioning in a well-developed healthcare system. Particular attention is drawn to the cognitive and decision-making demands that underpin safe and effective ED practice, and the problems of crowding …