Monday 2nd October 2017

08:00 – 08:45	**Welcome Coffee with Poster Display**

Monday Morning Opening and Plenary 08:45 – 10:00

Opening Ceremoney and Plenary
Chair: Jennifer Dixon; UK

Official Conference Opening (20 minutes)
Cliff Hughes; President, ISQua
Jennifer Dixon; CEO,The Health Foundation

Making the Most of the Conference:
Peter Lachman; CEO, ISQua

Morning Plenary- Title TBC
Pip Hardy; Founding director, Patient Voices Programme
Speaker: Ethan Basch; US

Morning Break: 10:00 - 10:30

Monday Concurrent Sessions
A1 – A10
10:30 – 12:00

A1 – Masterclass: Lessons Learned in Leading for Quality– 90 minutes

The global **Healthcare Quality Improvement and Patient Safety Community** is replete with **wonderful and inspiring leaders**. These leaders strive relentlessly for improvement to enhance the healthcare environment for patients and providers alike. Lived experiences from such leadership can provide **essential lessons and remarkable insights**, upon which future improvements may be built.

ISQua recognises that a **key enabler** for the future spread and sustainability of Healthcare Quality Improvement is that these lessons may be **shared and celebrated as significant points of direction** on the healthcare improvement map.

This session provides a fantastic opportunity to **explore and engage healthcare improvement leaders in shared reflection** of their improvement journey to date, the **essential learning** that they have gained along the way and an opportunity to impart some aspects of the human narrative in leading improvement. It is hoped that these reflections may help to **inspire the next generation of improvement leaders** as they embark on their own improvement adventure.

This session will be lead by:
Dr John Brennan, 4th Year Registrar in General Practice, RCPI/ISQua Quality Improvement Scholar in Residence &
Dr Rory Conn, Child and Adolescent Psychiatist ST6, Whittington Health NHS Trust.

The confirmed healthcare improvement leaders include:
Gail Nielsen - Fellow & Faculty, Institute for Healthcare Improvement & RCPI Faculty & Coach
David Bates - Chief of General Internal Medicine at Brigham and Women's Hospital & Professor of Medicine, Harvard Medical School
Cliff Hughes - ISQua President
Kevin Stewart - Director of the Clinical Effectiveness and Evaluation Unit at the Royal College of Physicians of London
Christina Krause - Executive Director, BC Patient Safety & Quality Council, Canada
Pat O'Connor - Faculty member of the Institute of Healthcare Improvement
Sibylle Erdmann; Chair of the London Neonatal Parent Advisory Board

A2 – Understanding Systems for Safety – 90 minutes

Chair: Charles Vincent; UK

Patient Safety, System Safety and Organisational Resilience

Speakers: Rebecca Lawton; UK, Christian von Plessen; DK, Jeffrey Braithwaite; AU

A chaired panel discussion between experts, enabling a 'deep dive' into the resilience and other approaches which stress a more proactive and positive approach to patient safety. We aim in particular to explore the practical implications of such ideas for leadership, culture, interventions to improve safety and regulation for safety. The session will allow the experts on the panel to explore these in detail and discuss theory, methods and practice, together with the opportunity for questions and discussion with the audience. The session will aim to provoke robust debate - so come and join the conversation!

A3 – Data to Drive Decision Making/Health Policy – 45 minutes each

Session 1: Understanding Professional Misconduct: A Novel Method to Analyse Datasets to Understand the Individual, Social and Organisational Factors Where Professional Misconduct Occurs

Speakers: Rosalind Searle, Douglas Bilton; UK

This session explores the results of a pilot study using cluster analysis and case analysis to understand the relationships between individual, social and organisational factors in misconduct cases involving health and social care professionals. The study utilises data from the Professional Standards Authority (which holds data on the outcomes of fitness to practise cases against regulated health professionals), CQC reports, and NHS staff surveys. This pilot study was commissioned by the Professional Standards Authority for Health and Care, which oversees professional regulators. It was carried out by Professor Rosalind Searle, Centre for Trust, Peace and Social Relations, Coventry University, Professor Jeremy Dawson, Professor of Health Management, Sheffield University and Dr Charis Rice, an expert in qualitative coding. The project is introduced by staff of the Professional Standards Authority who explain the Authority's interest in protecting the public through better understanding of how, when and why professionals do not follow their regulator's code of conduct, and how regulators might use this insight to reduce prevalence in future. The session will include presentations from the Authority, the research team and conclude with an interactive discussion with the audience.

Objectives:

- Learning to identify the factors that may combine to make an unsafe system for patients.
- Introduction to a model for analysing individual, social and organisational factors in wrongdoing.

Session 2: New Frontiers in Professional Regulation: Building Risk Based Approaches to Prevention of Patient Harm

Speaker: Martin Fletcher; AU, Anna van der Gaag; UK

Safe health care systems require both well designed systems of care and competent, well trained and safety aware clinical frontline staff. This workshop provides a unique opportunity to consider how risk based approaches to regulation of health professions create new opportunities to strengthen the contribution of regulation to system wide efforts to improve patient safety and reduce patient harm. This interface is vital if we are to improve our collective effort to ensure safer health care systems. Drawing on examples from research and experience in Australia and the UK, this workshop will explore the concept of 'risk based regulation' which is bringing a shift in focus from a predominantly reactive model to one based on harm reduction as the core business of practitioner regulation. It will illustrate examples of how regulators are learning from regulatory data to identify 'hot spots' which may cause harm. It will show how such learning is being used to build evidence and to apply different regulatory tools. It will also show how regulators are working much more closely with others to strengthen clinical governance systems and help to prevent harms arising in the first place.

Objectives:

- Understand the concept of 'risk based' regulation and how it is being applied.
- Learn from examples of how risk based approaches to data analysis are helping to identify patterns of risk and choice of regulatory interventions and tools.
- Consider a future agenda to further strengthen the contribution of professional regulation to patient safety and move from a predominantly reactive to a more proactive regulatory stance.

A4 – Quality in the Community – 45 minutes each

Session 1: Implementing Integrated Care: Key Lessons for Improving Quality and Outcomes for People And Communities

Speaker: Nick Goodwin; UK

This seminar examines the evidence related to the successful implementation of integrated care programmes in policy and practice around the world. It seeks to showcase how people-centred and integrated health services delivery can significantly promote value in health and care provision. Specifically, it examines the core design components when integrating care and sets out key strategies in how transformational change may be managed

Session 2: Developing and Improving a Systems Approach to Diagnostic Safety in Primary Care

Speakers: Sudeh Cheraghi-Sohi, Hardeep Singh, Ian Litchfield; UK

Both the US Institute of Medicine and World Health Organisation have recently highlighted the problem of diagnostic error and the imperative to improve the diagnostic process. The session will cover recent advances in understanding diagnostic errors, their measurement and how electronic health records (EHRs) and their abundant data can be leveraged for diagnostic safety improvement. We will 1) discuss definition(s), causes and measurement science around diagnostic errors; 2) use a case study to illustrate process breakdowns in test result communication and follow-up that lead to diagnostic errors and 3) discuss potential challenges and opportunities offered by EHRs in diagnostic error measurement and improvement. Session will include practical takeaways, conceptual frameworks and potential areas for solutions for mitigating diagnostic safety risks.

Objectives:

- Measurement of diagnostic errors: Understanding their causes and how they are measured.
- Understanding key contributory factors to diagnostic error: a focus on diagnostic test-results communication and follow-up.
- Understanding how Electronic Health Records and their data can be leveraged for diagnostic safety improvement and the challenges that need to be addressed to make this possible.

A5 – Disruptive Improvement and Adaptive Change – 45 minutes each

Session 1: Using Data Analysis to Guide Quality Improvement in Primary Care

Speakers: Sarah Deeny, Isaac Barker, Rebecca Rosen, Rebecca Fisher; UK

This session will give examples of innovative uses of data analytics in primary care to aid quality improvement, the profile of which has rose appreciably in recent years. In common with other countries, primary care in the UK is under significant pressure. Those attending primary care increasingly require treatment for multiple, chronic conditions, increasing the complexity of the patient need. Health systems are also trying to move the treatment of patients from secondary to primary care. With resources (both funding and workforce) remaining constrained, the pressures in the primary care system are clear.
We will present recent research on how data analysis in general practice can be used to guide quality improvement methods in a number of ways. These include identifying segments of the population who need alternative approaches to care, formatively evaluating local quality improvement initiatives, and by analysing data beyond single practice level to identify suitable targets for improvement, and monitor outcomes post intervention.

Objectives:

- Knowledge of examples of using data analysis to guide quality improvement in primary care.
- Knowledge of the challenges and benefits of using applied data analytics in primary care
- Discussion around on how innovative applied data analytics could be used more widely in a range of settings

Session 2: Improving Patient Safety, Using a Variety of Tools

Speakers: Louis P. Ter Meer; NL/CL, Ezequiel García-Elorrio; AR; Veronica Young, John Burnam; US

Most of the times patients are ill prepared when undergoing treatment. Besides a wide range of general facts, such as a list of personal preferences and medical facts, which should be known to caregiver, patients and their families are mostly forgotten in the healthcare process and as a result, even the most basic documentation like medication lists, allergies, or ethical questions are seldom completed without error.
The Batz Patient Safety Foundation is working to disrupt this current paradigm by producing patient safety guides and health literacy resources in multiple languages in both printed and electronic versions. By offering learning materials, asking questions, and providing space for prompted conversation, the Batz Foundation aims to equip patients and their families with the tools they need to help contribute to optimal care while facilitating a more secure, less stressful environment for all involved.
During the session, the Batz Foundation team, their researchers, and app developers will provide insights on their model, use an application of their material, discuss future plans for including artificial intelligence, and demonstrate how hospitals, community partners and patients are utilizing these resources.
Session attendees will each leave with copies of the paediatric and adult Batz guides and models for how their healthcare setting can take advantage of these free resources.

Objectives:

- By attending this session, delegates will learn how to better include their patients in their own treatment, how to help patients best advocate for themselves, and how to help increase health literacy among patient populations.

A6 – Generalisability of Improvement Outcomes – 45 minutes each

Session 1: Enabling Clinician-Led Quality Improvement: Mixed-Methods Findings from the Epoch Trial

Speakers: Carol Peden; US, Tim Stephens, Graham Martin; UK

The Enhanced Peri-Operative Care for High-risk Patients (EPOCH) trial is one of the largest quality improvement studies undertaken globally, involving 27,000 patients in 90 hospitals in the United Kingdom. The trial operated at 2 levels; a high level data analysis of an intervention implemented as a stepped-wedged cluster randomised trial, and 90 separate hospital-level improvement projects . The overarching research question was, "Can a quality improvement programme enable the implementation of a care pathway to reduce mortality after emergency abdominal surgery?". This session will address both aspects of the study, combining the main quantitative trial results with ethnographic and process evaluation data to describe and analyse how the local clinician-led quality improvement developed iteratively across the 90 hospitals.

Objectives:

- Delegates will hear practical wisdom generated from the experiences of clinicians delivering local improvement within EPOCH, including the key barriers and enablers to local improvement efforts and clinical pathway implementation, and consider how this could be applied in their own settings
- Delegates will learn the answer to the question, "Can a quality improvement programme to enable the implementation of a care pathway reduce mortality after emergency abdominal surgery?" and the robust research methods leading to this answer
- Delegates will have the opportunity to consider and discuss how research methods can and should be applied to manage the tension, present in real world improvement research, between robust trial methodology and on-the-ground implementation

Session 1: Designing Improvement Evaluations to Maximize Learning: Salzburg Global Seminar – Session 565 Insights in Practice

Speakers: Rashad Massoud, Gareth Parry, Emily Evans, Liana Rosencrantz Woskie; US

This session will present on the outcomes of applying lessons learned from the Salzburg Global Seminar – Session 565 "Better Health Care: How do we learn about improvement?" to the evaluation designs of three improvement activities: hospital acquired infections in Palestine, improving maternal and child health outcomes related to Zika in Latin America, and improving HIV care in Lesotho. Presenters will explain how evaluation was integrated into the design of each improvement effort in order to maximize attribution and generalizability as well as lessons learned from this change in evaluation and improvement design.

Objectives:

- Learn from how the outcomes of the Salzburg Global Seminar was applied to 3 improvement initiatives to better understand what worked, how it worked, what was generalizable able what was context specific in each initiative.
- Learn which evaluation and research designs can be used to maximize learning, including mixed methods.

A7 – Education Through Learning and Sharing - 15 minutes each

Effectiveness of an Education of Point-Of-Care Ultrasound Guideline in an Emergency Department (Abstract no. 1734)
Myung Ah Lee, H. Kwon; KR

Medical Student Perception of Academic Stress and Satisfaction with the Revised Curriculum Quality at IAU Saudi Arabia (Abstract no. 2709)
Somanath Mohapatra, A.M. Sebiany, C.C. Jones Nazar; SA

A Conceptual Map for Patient-Centred Care Requirements: Enhancing the Approach of Systems to Achieving Patient-Centred Care (Abstract no. 2215)
Jenny Barr, K. Ogden, D. Greenfield; AU

Training Healthcare Workers to Improve the Quality of Maternal, Newborn & Child Healthcare Services in Marginalized Settings (Abstract no. 2981)
Kamran Baig, F. Shahid; PK

A8 – Sustainable Quality Improvement for LMIC – 15 minutes each

Strengthening Quality Improvement Work in Hospitals by Using WhatsApp: Exploratory Qualitative Study from Indian Hospital (Abstract no. 2417)
Parika Pahwa; IN, S. Smith; US, N. Livesley; IN

Qualitative Evaluation of Low-Dose-High-Frequency Learning Experiences to Improve Newborn Outcomes and Quality of Care, Ghana (Abstract no. 2824)
Amos Asiedu; GH, A. Nelson; LR, P. Gomez; US, F. Effah; GH

Remote Facilitation of Quality Improvement Plans Using Whatsapp Mobile Application in Kwara State, Nigeria (Abstract no. 3268)
Ibironke Dada, O. Adebola, A. Shittu-Muideen; NG

Telemedicine in the Himalayas - Reaching the Unreached (Abstract no. 2624)
Anupam Sibal, **K. Ganapathy**, V. Thaploo, S. Premanand; IN

Improving Efficiency in Hematology Laboratory (Abstract no. 3166)
Mashhooda Rasool Hashmi, B. Moiz, S.A. Baloch, I.A. Ansari; PK

A9 – The Patient's Voice – 15 minutes each

Patient Advisors at the Bed Side for Hand Replantation Patients: What Added Value for Quality of Care? (Abstract no. 1828)
Marie-Pascale Pomey, O. Fortin, J. Arsenault, V. Lahaie, M-A. Danino; CA

Improving Pulmonary Rehabilitation: The Role of Patient Volunteers (Abstract no. 1369)
Sharon Williams, H. Beadle, A. Turner; UK

Patient and Public Involvement in Japanese Clinical Practice Guideline Development (Abstract no. 3274)
Akiko Okumura, T. Nakayama, H. Sugawara, N. Yamaguchi; JP

Co-Designing Patient-Centred Care Using Participatory Action Research [PAR] - the Epilepsy Partnership in

Care [EPIC] Project (Abstract no. 2402)
Jarlath Varley, R. Power, J. Saris, M. Fitzsimons; IE

Consumer Involvement in the Quality Of HIV Care, The Namibian Experience (Abstract no. 1843)
Julie Taleni Neidel, A. Basenero, N. Hamunime, P. Luphahla; NA

A10 – A Mile in my Shoes – 90 minutes
Limited to 30 people

An interactive shoe shop, A Mile in My Shoes, invites you to (literally) step into someone else's shoes and embark on a mile-long physical, emotional and imaginative journey to see the world through their eyes.

The Empathy Museum has teamed up with the Health Foundation to develop a collection of stories from people working within health and social care. The result is a giant shoebox, a display of shoes, and a series of unique audio stories.

Through sharing the experiences of different people, A Mile in My Shoes hopes to show the remarkable contribution and challenges faced by those working in, and using, our health and social care system.

Lunchtime 12:00 – 13:45

12:30 – 13:30	**Patient Safety And Cinema: A Training Opportunity for Developing Empathy in Healthcare Professionals**

Chair: Sara Albolino
Speakers: Riccardo Tartaglia, Stavros Prineas, Jeffrey Braithwaite,

The Workshop will be aimed at promoting the use of movies in the training of healthcare professionals in order to diffuse a patient safety culture and the empathic approach towards patients and families. The workshop will investigate, through the projection and discussion of videoclips, the role of movies and TV series in building a cultural stereotype of healthcare quality and safety issues in both public opinion and clinicians. Moreover, the discussion with participants will focus on understanding how movies not only reflect 'reality' but also how they manipulate it, and how this also reflects in medical error. What we think we see is often different to what's really there. The workshop will include an interview with the Director of the movie *Starfish* in order to explore ways healthcare and patient safety are represented in the cinema.

Objectives:
- Learn how to use movies as a strategic tool for training in patient safety
- Learn how cinema can affect patient safety culture and empathy

12:45 – 13:30	**"We want to work out what works, what doesn't, and why"** **New improvement research institute - 'We need to improve improvement'** **Speaker Mary Dixon- Woods; UK** The Health Foundation is investing around £40 million in the establishment of an improvement research institute. Based at the University of Cambridge, the institute

	will work closely with a wide range of partners including the health service, university and charity sectors and from other sectors across the UK. Led by Mary Dixon-Woods, RAND Professor of Health Services Research and Wellcome Trust Investigator at the University of Cambridge, the institute will produce practical, high quality learning about how to improve patient care and will grow capacity in research skills in the NHS, academia and beyond. The vision is bold and ambitious: the institute will create the enabling infrastructure for the NHS to become the producer of systematic learning about how to improve health care for patients. To do this, the institute will use innovative approaches ranging from citizen science through to large-scale research capacity building, and will be working directly with patients themselves as partners. The basic principle behind the institute is a simple but important one: the need to get better at getting better at delivering healthcare, and one way to make that happen is by creating a better evidence-base for improvement. The institute will be formally launched in early 2018 and the aims, goals and challenges-to-date will be discussed

12:45 – 13:30	**Meeting to Patients and Patient Reps**

E-Poster Presentations
AP1 – AP5
12:40 – 13:30

AP1 – Generalisability of Improvement Outcomes – 10 minutes each

BBCN in Healthy China 2030: Innovative Development of Capacity of Quality Improvement with the Practice of PHS Win-Win (Abstract no. 2114)
QianLi Jiang, WenYuan Li, Yong Zhang, TingFang Liu; CN

Monitor the Quality Indicators to Reduce Rate of Unplanned Return to the Operating Room of Inpatients (Abstract no. 2243)
Wen-Hsin Chang, Feng-Chen Kao; TW

Evaluating the Ten Year Impact of the Productive Ward in Clinical Microsystems in English Acute Hospitals: A National Study (Abstract no. 2425)
Glenn Robert, Sophie Sarre, Rosemary Chable, Jill Maben; UK

Enablers of and Barriers to Change in Primary Care: A Process Evaluation of an Adaptable Guideline Implementation Strategy (Abstract no. 1479)
Cheryl Hunter, Vicky Ward, Tom Willis, Liz Glidewell; UK

Implementation of Recommendation to Avoid Low Value Clinical Practices in Catalonia. Essencial Project (Abstract no. 3257)
Cari Almazán, Johanna Caro, Montse Moharra, Toni Paada; ES

AP2 – Sustainable Quality Improvement for LMIC – 10 minutes each

Improving Quality of Care in Primary Healthcare Facilities in Rural Nigeria Using the Safecare Standards and Methodology (Abstract no. 1053)
Nicole Spieker, U. Okoli, **Njide Oludipe;** NG

Onsite Mentoring to Improve the Quality of Emergency Maternal and Neonatal Care in Nepal (Abstract no. 1789)
Valerie Broch Alvarez, Tulasa Bharati, Pushkar Silwal, Binamra Rajbhandari; NP

Promoting Gender-Based Violence Services in Mozambique: Experience Using a Quality Improvement Approach (Abstract no. 2075)
Edgar Necochea, Ana Baptista, Humberto Muquingue, Alicia Jaramillo; MZ

A Model to Measure Healthcare Quality in Ethiopia (Absstract no. 3235)
Berhanu Endeshaw Mohamed, Tigist Debebe; ET

AP3 – Understanding Systems for Safety – 10 minutes each

Nurses' Experiences and Perceptions of Escalating Deterioration to Treating Teams Using Pre-Met Urgent Review Criteria (Abstract no. 1214)
Gordon Bingham, Mariann Fossum, Lee Hughes, Tracey Bucknall; AU

Safety Attitude of Operating Room Teams Associated with Accurate Completion of Surgical Checklist (Abstract no. 2484)
Florence Sens, Antoine Duclos, Eléonore Herquelot, Cyrille Colin; FR

Missed Nursing Care: The Role of Personal and Ward Accountability in Improving Patients Safety and Quality of Care (Abstract no. 2382)
Einav Srulovici, Anat Drach-Zahavy; IL

Improving Patient Safety by Reduction of Dispensing Near Miss Rate in the Inpatient Pharmacy of a Medical Center in Taiwan (Abstract no. 3129)
Jui-Hu Shih, Wan-Ting Shao, Chih-Wei Huang, Cheng-Chih Hsieh; TW came

From Diagnosing Problems to Idenitfying Solutions: What Can Healthcare Learn from High-Risk Industries? (Abstract no. 1316)
Elisa G Liberati, Mohammad F. Peerally, Mary Dixon-Woods; UK

Code H and its Impact on Reducing Catastrophic Adverse Events due to Bleeding Management Failure (Abstract no. 3261)
Camila Oliveira, Michele Jaures, Roseny Reis, Joao Carlos Guerra; BR

AP4 – The Patient's Voice – 10 minutes each

Communicating Risk in Active Surveillance of Prostate Cancer – Hearing the Patients' Voice (Abstract no. 2954)
Anne Hogden, Kate Churruca, Patti Shih, Frances Rapport; AU

Patients, Students and Professionals Learn Together in an Educational Program to Improve Patient-Centeredness of Health Care (Abstract no. 2378)
Thomas W. Vijn, Hub Wollersheim, Jan A. M. Kremer, Cornelia R. M. G. Fluit; NL

Patients' Self-Management of Breast Cancer Risk: Gaining Control in Clinical and Non-Clinical Contexts (Abstract no. 2245)
Patti Shih, Anne Hogden, Mia Bierbaum, Frances Rapport; AU

Pharmacist-Led Bedside Discharge Medication Counselling Service – A Patient-Centered Approach (Abstract no. 1955)
Hiu Wing Theola Lau, Pak Kin Yick; HK

Conceptual Framework of Patient and Care-Partner's Experience of Dignity and Respect (Abstract no. 2731)
Priscilla K Gazarian, Constance R.C. Morrison, David W. Bates, Ronen Rozenblum; US

AP5 – Data to Drive Decision Making/Policy – 10 minutes each

Embedding Quality Measurement in Health Services Accreditation: Stroke Distinction Program (Abstract no. 3283)
Louise Clémence, Danielle Dorschner, Andrea Gregus; CA

Creating a System of Safety Through Governance & Data Driven Decision Making (Abstract no. 3110)
Pearl Cruz, **Elizabeth Joseph**, Jerry Varghese; IN

Implementation of a Standard Operating Procedure to Improve Viral Load Documentation Practices in Northern Namibia (Abstract no. 2450)
Pearl Kalimugogo, Shirley Geza, Ndapewa Hamunime, Abeje Zegeye; NA

Big Data Exploration for Drugs and Cancer Risk: Online Tool for Massive Observational Studies with Controls (Abstract no. 3255)
Usman Iqbal, Hafsah Arshed Ali Khan, Wen Shan Jian, Yu-Chuan (Jack) Li; TW

Monday Afternoon Concurrent Sessions
A11 – A20
Time: 13:45 – 15:15

A11 – Masterclass: Lessons Learned in Leading for Quality - 90 minutes (Follow on from morning session)

Outline as per A1

A12 – The Patient's Voice – 45 minutes each

Session1: Lessons Learned About Primary Care from Listening to Children's Voices – MOCHA project

Speakers: Michael Rigby; UK, Vinita Mahtani; ES, Alexander Palant; DE, Manna Alma; UK

There are over 70 million children under 18 living in the EU with considerable variation between and within countries in how well they are being served by current primary care health systems. MOCHA (Models of Child Health Appraised) is a Horizon 2020 EU Commission funded project which is appraising the systems in 30 countries. In order to listen to children's voices, the qualitative DIPEx research methodology about patient experiences is used. This workshop will highlight the importance of listening to children's voices, how this has been done within the MOCHA project and what lessons has been learned from listening to children's voices.

Objectives:

- To get insight in how to listen to children's voices and the value of listening to these voices.
- To get insight in and to understand children's experiences regarding primary care for children.
- To get insight in similarities and differences in children's experiences with primary care across Europe.

Session 2: Removing Barriers and Enhancing Facilitators for Patient-Safety Communication: Improving Care and Safety for Patients with Speech Impairments and their Supporters

Speakers: Bronwyn Hemsley; AU, Susan Hrisos, Richard Thomson; UK

Research shows that patients struggle to make their voices heard in interactions with hospital staff, impacting on their safety [1-4, 11,12]; and that engaging patients in interactions about their safety helps reduce risks for safety incidents [6, 7]. Staff interpersonal skills make an enormous difference to patients and contribute to safer healthcare [5, 8]. ThinkSAFE [9] provides evidence and theory-based support to enable patients and staff to participate collaboratively in discussions about safety. However, patients with communication impairments encounter several barriers to effective communication that warrant additional strategies on the part of hospital staff. We will draw upon patient and carer stories of care [5, 10, 11] and medical record documentation of incidents and patient communication [12], to examine patient-provider interactions for patients with communication difficulties. These incidents will be related to the Generic Model of Patient Safety [16]. Three case-based scenarios will be discussed in relation to strategies to improve interpersonal communication for all patients, including those who have difficulty communicating their patient safety needs.

Objectives:

Through the presentations and by interaction with the other delegates and presenters, delegates will:

- Learn about a range of evidence-based strategies relating to patient-provider communication in hospital for patients, including both patients who are communicatively vulnerable (i.e., the vast majority of patients) and patients with more severe communication disability (i.e., the minority of patients, with little or no speech).
- Hear about patient safety research from the perspectives of patients with little or no speech and their family carers/supporters in hospital.
- Consider how to implement approaches to support collaborative interactions between staff and patients that promote improved quality and safety of healthcare.

- Identify ways to detect common barriers and facilitators to patient-provider communication about safety, apply the generic model of patient safety to guide improvements, and consider directions for undertaking future research in their own settings.

A13 – Regulations Influence on Governance – 45 minutes each

Session1: Safety Standards for Digital Health Services – Learning from a Shared International Perspective

Speakers: Meredith Makeham, Hardeep Singh and Aziz Sheikh,
Workshop Facilitators: Meredith Makeham: Andy Carson-Stevens and David Greenfield; AU

The workshop aims to provide an international perspective on optimising healthcare safety while implementing digital health services and technologies. It will provide an opportunity to share knowledge on digital health safety standards – why they are needed, what is currently in use (noting generally the developmental stage of digital health safety standards), and additional work required to promote future safety standards development. This workshop will support international sharing and collaboration needed to make progress.
The session includes presentations from digital health safety thought leaders providing the evidence base and conceptual foundation to address emerging safety risks related to digital health. Participants will contribute to the key workshop outcome of identifying digital health safety gaps that would benefit from future standards development.

Objectives:
Through the presentations and by interaction with the other delegates and presenters, delegates will:
- An understanding of the current evidence on safety threats associated with the use of digital health technologies and services.
- An understanding of standards to support the safe use of digital health technologies and services (technical and behavioural).
- The opportunity to network with and plan for future collaborations in the field of digital health.

Session2: Developing Metrics for the Complex Care Primary Care Interface for Children

Speakers: Maria Brenner; IE, Mitch Blair; UK

This session will focus on framing person-centric quality for complex care, reporting on the adaptation of standards from the US to explore the integration of care for children with complex care needs across the European Union (EU) and European Economic Area (EEA). This is part of a Horizon 2020 funded project Models of Child Health Appraised (MOCHA), running from 2015 to 2018. The session will present findings from 30 countries using three tracer conditions, in relation to quality and governance at the acute-community interface. Through mapping EU data to the US experience we will present a potential way forward for enhancing quality care for children with complex care needs through our revised standards and proposed model of care

Objectives
- Explore contemporary needs of children with complex care needs in the community
- Critically reflect on the optimum facilitators of integration of care at the acute community interface
- Contribute to discussion on components of a model of care and proposed revised standards for this population.

A14 – Understanding System for Safety – 45 minutes each

Session1: Designing and Implementing Deteriorating Patient Safety Net Systems at Scale – in Australia and Qatar

Speakers: Charles Pain, Cliff Hughes, Malcolm Green, David Vaughan; AU

The background, theory of change, design principles, and lessons learned from implementation of deteriorating patient safety net systems in two different health systems (Australia and Qatar) will be described; and the implications for large scale, sustainable health systems improvement will be derived. Participants will then be guided through the practical design of a deterioration patient safety net system for their own health system by applying the design principles.

Objectives:

- Understand the benefits of deteriorating patient safety net systems.
- Understand the theory of change and design principles of deteriorating patient safety net systems.
- Understand the implications of these principles for the design of other large scale sustainable health systems improvement
- Apply the design principles to the design of their own deteriorating patient safety net system in their home jurisdiction

Session2: The St Vincent's Ethos Program is "Redefining Normal" with a Pragmatic Approach to Addressing Unprofessional Behaviour

Speaker: Victoria Atkinson, Catherine Jones; AU

Entrenched cultures and behaviours in the health sector are putting the safety of staff and patients at risk. Many health services are at a loss as to how to tackle the problem. This session will outline the St Vincent's Ethos program which provides a pragmatic approach to addressing unsafe behaviours including practical skills on how to speak up and how to provide feedback in an informal, respectful, non-punitive way. The St Vincent's Ethos program removes barriers to speaking up; responds quickly and equitably to unsafe behaviours and recognises staff who model positive behaviours. The program includes:

• a validated, tiered accountability pathway* and a peer driven early intervention process;
• a confidential reporting tool;
• capability building and skills training for staff; as well as development of a sector wide web of accountability.

*based on the Vanderbilt Promoting Professional Accountability pyramid.

Objectives:

- Describe how the St. Vincent's Ethos program will improve safety culture.
- Demonstrate skills in how to speak up and how to provide feedback.

A15 – Quality and Safety in Mental Health – 45 minutes each

Session1: The Improvement and Development of Mental Health in Taiwan

Speakers: Sen-Tien Tsai, Shu-ling Lai, Joseph Jror-Serk Cheng; TW

Since 1950, in order to prevent social and living functions from withdrawal, the healthcare model for mental health provided worldwide has been gradually changed from traditional institutions to community- or home-based care, and the treatment for patients has been switched from institution to community. We will share the successful experience in improving and developing mental ill health and the coping measures in response to rapid population ageing, increased patients with chronic mental health and dementia prevalent in the elderly in Taiwan. The contents include: Mental healthcare system, service network and resources in Taiwan; the improvement mechanisms for mental health in Taiwan (including accreditation); and the

diversified community-based healthcare model to implement a patient-centered, community-oriented and rehabilitation-purposed service in order to facilitate the protection of rights and interests of patients with mental illness.

Objectives:

- To continuously improve the quality of mental health.
- To promote diversified community-based care models and solutions (including dementia).

Sesion 2: Safe and Healthy Working Environments: the 'Enabling Environments' Initiative

Speakers: Rex Haigh, Sarah Paget, Sarah Skett, Simon Coope; UK

The Enabling Environments Award is an evidence-based quality improvement project that invites applicants to consider whether they are achieving the ten core standards in their own organisation. Specific criteria give guidance on how to practically achieve them, and how to integrate them into the day-to-day life of the organisation. Achievement of the Award is a mark of quality providing recognition and external validation that the organisation is an "Enabling Environment". It is valid for three years, subject to satisfactory interim reports.
The Francis report argues for changes in the culture of organisations. It supports more openness and transparency and a decrease in defensiveness to improve the organisation's capacity to tolerate and learn from criticism. The Enabling Environment framework supports organisations to develop these qualities.

Objectives:

- Appreciating the impact of psychosocial environment on outcomes.
- Understanding a coproduction methodology to improve psychosocial.

A16 – Data to Drive Decision Making/Policy – 15 minutes each

The Association Between Hospital - Community Continuity of Care Patients with Chronic Disease and Clinical Outcomes (Abstract no. 3302)
Eyal Zimlichman, O. Sharlin, B. Oberman, S. Vinker; IL

Are Mortality Alerts Associated with Other Indicators of Hospital Quality in England? A National Cross-Sectional Study (Abstract no. 1767)
Elizabeth Cecil, A. Bottle, P. Aylin; UK

Comparison of Hospitalisation and Mortality for Patients with Heart Failure in England and Lombardy Region (Northern Italy) (Abstract no. 1421)
Alex Bottle; UK, K. Dharmarajan; US, P. Aylin; UK, A.M. Paganoni; IT

Developing the Digitally-Enabled Learning Health System For Improvement (De-Lhs)
John Ovretveit; SE, Lucy Savitz; US

A17 – Understanding Systems for Safety – 15 minutes each

How to C a Difference: A Multidisciplinary Approach to C. Difficile (Abstract no. 2869)
Vicki LoPachin, B. Koll, G. Patel, R. Anderson; US

The Voice Study: Embedding the Patient Voice of Older Adults in the Exploration of Their Experiences During Care Transitions (Abstract no. 1430)
Chantal Backman, M. Crick; CA

The Incidence, Nature and Trends of Adverse Health Events at a Regional Hospital Between April 2011 to April 2014 (Abstract no. 2942)
Ozayr Haroon Mahomed, D. Kalonji; ZA

Clean Hands Save Lives: Using a Data-Driven Approach to Improve and Sustain Hand Hygiene Compliance (Abstract no. 1836)
Rebecca Anderson, S. Garg, J. Mari, V. LoPachin; US

Prevention of Wrong Medication Through Enhanced Clarification by Pharmacist on Questionable Prescription (Abstract no. 1596)
Shin Ushiro, M. Sakaguchi, H. Sakai, J. Inoue; JP

A18 – Quality and Safety in Crisis – 15 minutes each

WHO Emergency Medical Teams initiative: shaping the future of emergency response – 30 minutes
Speakers: Camila Lajolo; WHO

Disasters and disease outbreaks can occur at any given moment and in any place in the world—often wreaking havoc and seriously disrupting and threatening lives of communities, and imposing an excess burden on health systems. Good intentions are not enough when responding to such events; ensuring appropriate quality of care and coordination is paramount. The WHO Emergency Medical Teams initiative established in 2015 works to help improve the timeliness and quality of care provided by national and international teams that deploy in response to emergencies. This session will present an overview of WHO Emergency Medical Teams initiative and how it is shaping the future of response to emergencies, like natural disasters and outbreaks. Case examples from recent emergencies, like the Nepal earthquake will be used to illustrate the benefits of this initiative

Short 15 minute presentations

Reduce Dengue Fever Effect of Soda Ash on Vector Control (Abstract no. 1080)
Chen Kun Chih, W. Yu-Lung, T. Yu-Hui, W. Guo-Ming; TW

Improving Care in Complex Humanitarian Crises: A Process Evaluation of Médecins Sans Frontières' Approach to Quality (Abstract no. 3337)
Anna Freeman, N. Hurtado, J. Ousley, S. Leatherman; US

Using Clinical Pathway to Manage Dengue Fever (Abstract no. 1024)
Abdul Aziz Abdul Rahman; MY

A19 – Disruptive Improvement and Adaptive Change – 15 minutes each
Implementation of a Standardized Delirium Management Program to Prevent, Detect and Treat Delirium in Surgical Patients (Abstract no. 3024) **Maria Schubert,** E. Lanz, G. Clémençon, D.L. Leuenberger; CH **The Development of a Tariff Model: Pay for Performance (Abstract no. 2294)** **Hansang Kim,** S. Chung, E. Jeong; KR **Collective Leadership and Safety Cultures: Developing an Alternative Model of Leadership for Healthcare Teams (Abstract no. 2839)** **Eilish McAuliffe,** M. Ward, A. DeBrun, U. Cunningham; IE **Health System Transformation in The UK: Making it Happen (Abstract no. 2500)** **David Hunter,** G. Maniatopoulos; UK **Multidisciplinary Embedded Research to Identify Solutions to Emergency Department Overcrowding (Abstract no. 2693)** **Sonya Crowe,** L. Grieco, C. Vindrola-Padros, S. Elkhodair; UK

A20 – A Mile in my Shoes – 90 Minutes Limited to 30 people
An interactive shoe shop, A Mile in My Shoes, invites you to (literally) step into someone else's shoes and embark on a mile-long physical, emotional and imaginative journey to see the world through their eyes. The Empathy Museum has teamed up with the Health Foundation to develop a collection of stories from people working within health and social care. The result is a giant shoebox, a display of shoes, and a series of unique audio stories. Through sharing the experiences of different people, A Mile in My Shoes hopes to show the remarkable contribution and challenges faced by those working in, and using, our health and social care system.

Afternoon Break: 15:15-15:45

Afternoon Plenary and Awards 15:45 – 16:45	
Plenary and Awards **Chair: David Bates; ISQua**	
15:45 – 17:00	**John Ware and Alcin Tarlov Career Achievement (15 minutes)** **Plenary (Topic Quality and Safety in Crisis) Chair:** David Bates; ISQua **Panel:** Jorge Hermida; URC, Sidney Wong; MSF Ashish Jha; Harvard, John Gaffney; Save the Children International

17:00 – 18:00	**ISQua AGM - TBC**
19:00	**Networking Reception** **London Transport Museum**

Tuesday 3rd October 2017

07:45 – 08:30	**ISCOME Meet-the-Expert Panel - "Communication Skills for Safe and High Quality Care"** **Panellists:** Annegret Hannawa, Rick Iedema

07:30 – 08:30	**Meet the ISQua Experts Breakfast Session –** David Bates, Jeffrey Braithwaite & Leslee Thompson **- (Exclusive to ISQua Members, Fellows and Experts)**

07:45 – 08:30	**Connecting the Head with the Heart – Video and Storytelling in Patient Safety** Kelly M. Smith; Medstar

08:00 – 08:45	**Welcome Coffee with Poster Display**

Tuesday Morning Plenary and Awards 08:45 – 10:00

Learning for Improvement: New Paradigms and Practical Inspiration (65 Minutes)

Speakers: Penny Pereira, Dominique Allwood, Helen Bevan; UK

Is the way you, your team and your organisation learn keeping pace with what you want to achieve?
We believe the scale and complexity of improvement needed in health care demands new ways of learning, engaging far more people in a way that's better designed for application. This interactive session will share cutting edge theory on how people learn, with a particular focus on the role of peer networks in enabling change and improvement.

It will provide inspiration and practical lessons from the Q community: an ambitious initiative supporting 1000s of people involved in improvement from all backgrounds to learn and collaborate across the UK. The session will offer fresh perspectives on how to ensure people have the skills, insight and resilience they need to be successful in their improvement work. We'll also introduce an innovative approach to pooling what we know on complex issues: the Q improvement lab.

Objectives
•Reflect on the sorts of learning needed to achieve your improvement goals
•Understand barriers to learning and what's known about how to overcome these barriers
•Navigate the key principles that underpin new modes of learning for improvement

Life Time Achievement Awards (10 Minutes)

Morning Break: 10:00 - 10:30

Tuesday Concurrent Sessions
B1 – B10
10:30 – 12:00

B1 – Health Foundation projects: Quality in community services s – 90 Minutes

Lead: Will Warburton; The Health Foundation

Speakers: Simon Eaton + Lucy Taylor, Colin Gelder, Paul Dodds, Janice Wiseman/ Niro Siriwadena , Rachel Bryers

Projects:

- Ophelia project – Improving health literacy for vulnerable people in the community
- Making Waves, promoting a positive experience for people with COPD
- Making Waves, promoting a positive experience for people with COPD
- PINCER Scaling Up community medication safety
- Co-producing safe transition to adult services

B2 – The Patient's Voice – 45 minutes each

Session1: Enhancing the Use of Patient Experience Data for Improving the Safety and Quality of Care

Speakers: Glenn Robert, Louise Locock, Laura Sheard, Caroline Sanders; UK

There is increasing evidence that more patient-centred organisations have better safety and quality outcomes. But uncertainty remains as to how best to collect and present patient experience data in ways which stimulate action and align national and local needs. There is debate about the level at which to share data and how best to do this. Evidence suggests that while many organisations are capturing a range of patient experience data, less is known about how to use this to improve the safety and quality of services. The results of four projects from a national UK research programme will show how best to make use of patient experience data and how organisations can ensure this leads to improved services and care.

Objectives:

- Discover how patients and healthcare staff working in a range of English hospitals view current methods of collecting patient experience data.
- Consider emerging findings and lessons from a range of projects that are part of a major applied research programme into evaluating and improving the use and usefulness of patient experience data.
- Share practical, proven examples of how improvements can be made to the way in which patient experience data is collected and used to make care and services better.
- 4. Think about how the collection and use of patient experience data can best service different policy purposes (quality improvement, accreditation, performance management)

Session2: Designing and Delivering Safer Care: Incorporating Lay Voices in Every Step (87)

Speakers: John Illingworth, Alex Taylor, Sam Regan de Bere, Jane O'Hara, Bryony Dean-Franklin; UK

This session draws on the significant body of work supported by the Health Foundation, to understand and develop the role of patients in both keeping themselves safe, and helping achieve safer systems of care. We will summarise how this role has developed over the last 10 years, before outlining a range of meaningful ways that lay people can be involved.
From agenda setting, to collecting data for research and real time improvement, - you will hear from professional and lay people who are currently working in synergy to improve safety. The three cases will

also demonstrate several practical ways to create a culture of collaboration leading to greater understanding of how to keep patients safe.

Objectives:

- Explain approaches to understanding and addressing safety issues through involving service users, patients, carers and members of the public.
- Give examples of practical ways to involve lay people in various aspects of research and quality improvement, including how to create a cooperative culture and how to overcome common hurdles.

B3 – Generalisability of Improvement Outcomes – 90 minutes

Chair: Sir Liam Donaldson; UK

Medication Without Harm: WHO's Third Global Patient Safety Challenge

Speakers: David Bates; US, David U; CA, Aziz Sheikh; UK, Regina Kamoga; UG

Unsafe medication practices and medication errors are a leading cause of avoidable harm in health care systems across the world. Medication errors occur when weak medication systems and human factors affect prescribing, dispensing, administration and monitoring practices, which can result in severe harm, disability and even death. Medication errors cost more than US$42 billion each year globally. To address these global problems, WHO has initiated its third Global Patient Safety Challenge: Medication Without Harm. The panellists will discuss the role of patients, health care professionals and leaders, policy makers, and the civil society and industry; and priorities actions required to reduce medication-related harm globally. This will be an interactive panel discussion with following key topics:

• Strategic plan and key components of WHO's Global Patient Safety Challenge: Medication Without Harm
• Issues of global concern and the burden of unsafe practices, medication errors and patient harm in low-, middle- and high-income countries
• The role of patients, health care professionals and leaders, policy makers, NGOs and industry for reducing medication errors and medication-related harm
• Issues related to naming, packaging, labelling and look-alike, sound-alike medications
• Global research priorities for reducing medication-related harm
• WHO's role in implementing the Global Patient Safety Challenge: Medication Without Harm

Objectives:

- Understand the issues of global concern and the burden of unsafe medication practices, medication errors and patient harm.
- Introduce the WHO's third Global Patient Safety Challenge: Medication Without Harm; and encourage participation of institutions and countries in the Challenge.
- Define key interventions and research priorities for reducing medication-related harm.
- 4. Identify key stakeholders and their role in implementing the Challenge

B4 – Quality and Safety in Crisis – 90 minutes

Follow on from Monday Afternoon Plenary & MSF

Panel: Jorge Hermida; URC, Sidney Wong; MSF Ashish Jha; Harvard, John Gaffney; Save the Children International

B5 – Understanding Systems for Safety

Session1: Closing the Gap Between Work-As-Imagined and Work-As-Done: Practical Strategies for Implementing Resilient Health Care - 30 Minutes

Speakers: Robyn Clay-Williams, Jeffrey Braithwaite; AU

The concept of resilient health care is fast gaining traction among researchers, policymakers, managers and health professionals, but there is little practical information on how to give effect to the ideas. Resilient health care argues that the capacity of front line staff to flex and adjust performance in the light of systems complexity is a core characteristic of safe, high quality care. This workshop, presented by two of its leading proponents will introduce participations to practical strategies for understanding and working with a basket of resilience concepts and approaches, using two examples: (1) assessing the workplace for resilience, and (2) designing an intervention.

Objectives:

- Understand how to assess the workplace for resilience and productive safety.
- Know what resilient health care principles to consider when supporting improved care.

Session 2: 15 minute presentations

Beware the rabbit hole of (patient) safety
Speaker: Wendy Nicklin; CA

Clinical risk assessment in a residential care setting: Best practice implementation project
Speaker: Devi Ranasinghe; AU

National incident reporting data analysis for 3 years, Oman
Khaled A. Abouelmagd; OM

B6 – Data to Drive Decision Making/Policy – 15 minutes each

Managing Top Risks In Healthcare Through a Shared Integrated (Enterprise) Risk Management Approach (Abstract no. 2143)
Polly Stevens, J. Noble; CA

Identification of Patients at High Risk for Poor Pain Management Using Clinical Pathways Within EHRS (Abstract no. 2132)
Tina Hernandez-Boussard, K. Desai; US

Approaches to Outpatient Pharmacy Automation: A Systematic Review (Abstract no. 1350)
Yi Feng Lai, O.C. Kheng, S. Yilin; SG

Electronic Health Record of E-MIS Links Routine Service Data to Decision Making for Improved Quality of Care in Bangladesh (Abstract no. 3186)
Jamil Zaman, S. Shafinaz, S. Jahan, J. George; BD

Medication Administration Practices on the Weekend Versus Weekdays?: A Direct Observational Study of 227 Paediatric Nurses (Abstract no. 1976)
Johanna I Westbrook, L. Li, T. Kim, M. Baysari; AU

B7 – Generalisability of Improvement Outcomes - 15 minutes each

Applying the Concept of 'Hard Core' and 'Soft Periphery' of Interventions to Share Learning from Quality Improvement Efforts (Abstract no. 3242)
Julie Elizabeth Reed, N. Stillman, L. Lennox, S. Barber, T. Woodcock; UK

Getting from 22 to 125: Scaling up Interventions to Improve Outcomes of HIV-Positive Mother-Baby Pairs in Northern Uganda (Abstract no. 2076)
Tamara Nyombi; UG, M. Rahimzai; US, J. Aloyo, E. Karamagi; UG

Qualitative Evaluation of the Implementation of a Nationally Used Medication Safety Data Collection Tool in England (Abstract no. 2435)
Paryaneh Rostami, D.M. Ashcroft, M.P. Tully; UK

The Relationship Between Quality Improvement and Resilient Healthcare; Nuances, Complexities and Trade-Offs (Abstract no. 2582)
Jeffrey Braithwaite; AU**, Christian Von Plessen**, A. Nicolaisen; DK, R. Clay-Williams; AU

Quality Improvement Efforts to Reduce Sever Hypoglycemia in a Large Hospital System (Abstract no. 1986)
Mae Centeno, C. Fullerton; US

B8 – Regulations Influence on Governance – 15 Minutes Each

Consecutive Cycles of Accreditation: Persistent Low Compliance Associated with Higher Mortality and Longer Length of Stay (Abstract no. 1573)
Anne Mette Falstie-Jensen, S. Bie Bogh, S. Paaske Johnsen; DK

Regulatory Conceptualisation and Assessment of Healthcare Improvement Capability in the UK (Abstract no. 1226)
Joy Frances Furnival, K. Walshe, R. Boaden; UK

Quality in Long-Term Care: An Expanded View (Abstract no. 1632)
Michelle Crick, C. Backman, D. Angus; CA

Development of Quality Frameworks for Peer Review of Medical Specialists (Abstract no. 3267)
Joppe Tra, M. Ploegmakers, A. Hagemeijer, V. Krones; NL

Improving Care for Older Acute Inpatients: An Economic Evaluation of the Delirium Clinical Care Standard (Abstract no. 1772)
Virginia Mumford, M.A. Kulh, J.I. Westbrook, J. Braithwaite; AU

B9 – Sustainable Quality Improvement for LMIC – 15 Minutes Each

Advancing Patient Centred Care Through Social Audit Mechanisms in Rural Zambia: Evidence on Pediatric Quality of Care (Abstract no. 3007)
Anbrasi Edward, H. Zare; US, S. Malama; ZM, C. Bowles; US

Sepse Protocol Management Impact in Reducing Mortality Rate in Hospital Sao Lucas in Ribeirao Preto, Brazil (Abstract no. 3096)

Taissa Sotto Mayor, T. Monteiro, L. Françolin, L. Freitas; BR

Assessment of Early Mortality in Patients Admitted to the General Medical Ward at a District Hospital in Botswana (Abstract no. 3128)
Colleen Kershaw, **Margaret Williams**, S. Kilaru, T. Barak; US

Redesigning the Namibian HIV Quality Implementation Model To Improve Quality Of Care Systems (Abstract no. 1913)
Apollo Basenero, Julie Neidel, Patience Luphahla, Hamunime Ndapewa; NA

Measuring and Improving the Quality of Private Maternity Care: Lessons Learned from a Private Sector QI Program in India (Abstract no. 3126)
Vikas Yadav, Somesh Kumar, Suranjeen Pallipamula, Parvez Memon; IN

B10 – A Mile in my Shoes – 90 Minutes
An interactive shoe shop, A Mile in My Shoes, invites you to (literally) step into someone else's shoes and embark on a mile-long physical, emotional and imaginative journey to see the world through their eyes. The Empathy Museum has teamed up with the Health Foundation to develop a collection of stories from people working within health and social care. The result is a giant shoebox, a display of shoes, and a series of unique audio stories. Through sharing the experiences of different people, A Mile in My Shoes hopes to show the remarkable contribution and challenges faced by those working in, and using, our health and social care system.

Lunchtime 12:00 – 13:45

12:30 – 13:30	**From the Authors Perspective – Sharing Successful Stories** **Speakers:** Yu-Chuan (Jack) Li, Reizenstein Award winner Authors, Reizenstein Runner ups Authors, IJQHC Editor's choice Authors The goal of this research seminar is to help potential authors to share their successfully published high quality research in the field of healthcare quality. This seminar is an opportunity to review the principles and approach to conducting high quality research studies, and the publication of their findings, in high quality journals. It will also highlight new knowledge from a set of recent outstanding papers published in ISQua's official journal IJQHC by authors sharing their experiences. The session is truly interdisciplinary. We welcome audience participation from the disciplines of health services research, health care evaluation, policy, health economics, quality improvement, management, and clinical research focused on the quality and safety of care. By the end of the session, participants will have learned about a range of matters including: • About ISQua's official journal - *International Journal for Quality in Health Care (IJQHC)*

	• Reizenstein Award winner and Runners up • IJQHC Editor's choice We believe that this seminar will help anyone who wants to improve their scientific writing and share author's experience of best papers. It will provide a great feedback to participants in their endeavor to publish in high quality journals such as *IJQHC.*

12:30 – 13:30	**Principles of Managing During Crisis: Lessons Learned from Zika and Ebola** **(Invite only)** **Lead:** M. Rashad Massoud

E-posters Presentatons
BP1 – BP5
12:40 – 13:30

BP1 – Education Through Learning And Sharing – 10 minutes each

A Patient-Centred Approach to Develop a Food Safety Intervention to Reduce Chemotherapy Patients' Risk of Foodborne Illness (Abstract no. 2443)
Ellen W Evans; UK

Facebook as a Relation Management Tool for Hospitals (Abstract no. 2429)
Wang Yu-Ling, Szu-Ching Shen, Chang-Ruay Ay; TW

When Bioethics Becomes a Cultural Asset for Both Health Accessibility and Competitive Advantage: The Meditar's Case (Abstract no. 2854)
Erwin Padinger; AR

Use of Donald Kirkpatrick's Evaluation Model to Assess the Impact of a Family Planning Training Program in Nigeria (Abstract no. 2535)
Emmanuel Otolorin, Bright Orji, Gbenga Ishola, Adetiloye Oniyire; NG

BP2 – Regulations Influence on Governance – 10 minutes each

National Accreditation System in Turkey: Standards and External Evaluation (Abstract no. 1852)
Ibrahim Kayral, Mustafa Berktaş; TR

Introducing Outcome Measurement to a Standards Based Accreditation Programme (Abstract no. 3323)
Moyra Amess, Mark Grainger; UK

Assuring the Quality of Medical Practice in the UK: The Role of Annual Appraisal in Identifying Concerns About Doctors (Abstract no. 1753)
Marie Bryce, Julian Archer; UK

Publicly Available Specification (Pas) 1616: A Generic Specification for Clinical Services (Abstarct no. 2916)
Roland Valori, Robert Turpin, Deborah Johnston; UK

BP3 – The Patient's Voice – 10 minutes each

An Ounce Of Prevention: The Impact of Early Consumer Engagement on the Melbourne Genomics Health Alliance (Abstract no. 1431)
Liat Watson; AU

Patient Engagement's Integration into Quality Management Systems: Towards an Understanding on what Managers Actually Do (Abstract no. 2122)
Nathalie Clavel, Marie-Pascale Pomey; CA

Capturing the Patient Voice in Standard Risk and Assessment Forms and Care Processes (Abstract no. 2600)
Bernice Redley: AU

Patent Measurement of Safety : A Tool to Improve Safety Culture From Patient Perspective (Abstract no. 1541)
Rola Hammoud El Houcheimi, Serena Abu Samra; LB

Patient Experience- Bridging the Cultural Gap (Abstract no. 1940)
Subashnie Devkaran: UAE

BP4 – Disruptive Improvement and Adaptive Change – 10 minutes each

Implementation of a Discharge Assessment Checklist and to Reduce Return to ICU from the Respiratory Care Center in Taiwan (Abstract no. 2473)
Pei-Jung Hsu, **Jih-Shuin Jerng**, Hsiu-O Kao, Jui-Sheng Sun; TW

Utilization of Portable Blood Gas and Electrolyte Analyzer in Intensive Care Unit by Using DMAIC Methodology (Abstract no. 2488) – Hong Kong
Po Ching Mak, Kwan Tse, Rowlina Leung, Kit Hung Anne Leung; HK

International Comparison of Organized Activities to Promote Practice Guideline Implementation
Noriko Sasaki, Akiko Okumura, Naohito Yamaguchi, Yuichi Imanaka; JP **(Abstract no. 1873)**

1 other TBC

BP5 – Data to Drive Decision Making/Health Policy – 10 minutes each

The Impact of the National Antimicrobial Stewardship Programmes on Clinical Outcomes: A Baseline Trend Analysis (Abstract no. 1621)
Violeta Balinskaite, Alison Holmes, Alan Johnson, **Paul Aylin**; UK

Measuring Patient Harm in Canadian Hospitals and Driving Improvement (Abstract no. 1403)
Anne MacLaurin, Sandi Nadine Kossey, Tracy Johnson; CA

Predictors and Consequences of Rural Clients' Satisfaction in the District Public-Private Mixed Health System Of Bangladesh'(Abstract no. 1228)
Ashim Roy; BD, Nanne de Vries, Trudy vander Weijden; NL

Implementation of a Value-Driven Outcomes Program in 11 Hospitals Including Surgical, Orthopedic and Urological Patients (Abstract no. 3081)
Gerhard Halmerbauer, Ramona Haslinger, Nicole Kamptner, Christoph Ausch; AT

French Accreditation Process: An Increasing Role to Federate Quality Improvement Initiatives in an Integrative Way (Abstract no. 2083)
Bruno Lucet Catherine Grenier ; FR

Tuesday Afternoon Concurrent Sessions
B11 – B20
Time: 13:45 – 15:15

B11 – Health Foundation projects: Quality in mental health services – 90 minutes

Lead: Dominique Allwood**;** The Health Foundation

Speakers: Frank Rohricht, Emma Louisey, Owen Bowden- Jones, Dima Abdulrahim, Kim Grosveno; UK

Projects:

- Mobile technology health solutions for patients with severe mental illness
- I-THRIVE – person-centred model of care for young people's mental health
- Novel Psychoactive Treatment: UK Network (NEPTUNE) II: From guidance to good practice: A multi-dimensional approach to spreading improvement
- NEPTUNE II
- Golden Ticket dementia care

B12 – Understanding System for safety – 90 minutes

Taking care of Second & Third Victims after Adverse Events

Speakers: Kris Vanhaecht; BE, Massimiliano Panela; IT, Albert Wu; US

Healthcare professionals can be traumatized after being involved in adverse events. Although patients and their social network are the most important victims of error, one should not underestimate the professional and personal impact for clinicians.
Recent research found a twofold risk of burnout if clinicians were involved in error in the past six months. Personal, situational and organisational factors which influence the impact of the event were found in both qualitative and quantitative studies. These factors will be used to further improve the available peer support systems.
Not only patients and clinicians are victims after adverse events. The impact on the reputation of the involved organizations and managers is described. Research from 2016 even showed the impact on defensive medicine.

Objectives:

- Understand the evidence base on the second victim phenomenon.
- Recognize second victim signs & symptoms care.
- Be up to date on opportunities and pitfalls of peer support systems.
- Understand the impact of adverse events on third victims (managers, organizations and policy).

B13 – Education Through Learning and Sharing – 45 minutes each

Session 1: Online Patient Stories Supporting Staff Learning and Promoting System Change

Speakers: Michael Greco; AU, Irene Barkby, James Munro; UK

Social media and online patient feedback are increasing used in many countries and sectors. In the UK and Australia, non-profit Patient Opinion has taken an open, citizen-centred approach to online feedback which is leading to near real-time staff learning, service improvement, restoration of relationships and increased trust between patients and staff. The stories and responses on Patient Opinion (www.patientopinion.org.uk, www.patientopinion.org.au) allow everyone to see learning and change occurring. This session will include experiences from NHS Lanarkshire where clinical teams are now engaging directly with online feedback to drive learning and QI.
In addition, Patient Opinion is now being used in five UK universities so that future professionals are exposed to real patient experience from the very start of their training.

Objectives:

- Participants will gain an understanding of the range of impacts which can be created by effective use of online patient feedback.
- Participants will be able to identify a range of Session objectives for feedback systems and appreciate how and why systems differ.
- Participants will gain an up-to-date insight into the mission, values and service provided by Patient Opinion.

Session2: Tips: Trainees Improving Patient Safety Through QI. A Peer Lead Imitative in the North West of the UK (Haelo)
Outine to be received

B14 – Regulations Influence on Governance – 45 minutes each

Outlines to be received
Session 1: Kieran Walsh - Regulation in Health Care
Session2: Lena Low and Christine Dennis - Accreditation as a Cultural Long Term Change

B15 – Sustainable Quality Improvement for LMIC – 45 minutes each

Session1: Establishing a National Quality Improvement Programme in Mozambique Through North-South Partnership
Speakers: David Weakliam; IE, Elenia Macamo Amado, MZ, Peter Lachman; ISQua, Jonas Chambule, MZ

This session presents an initiative by the Mozambique Ministry of Health to develop a national quality improvement programme through a partnership agreement with the Irish health service. The session will describe its implementation and the key roles played by ISQua and Irish Aid in the collaboration.
We will describe the capacity building approach, involving a quality improvement collaborative with Mozambique hospitals and the Ministry of Health. Results from the programme will be presented with collated data from the 14 teams and a detailed case study from one of the hospitals.
Following presentations there will be a consultative exercise with participants to gather ideas on the key success factors for developing sustainable capacity for quality improvement in a low resource setting.

Objectives:

- To understand how a national Quality Improvement programme can be developed through a North-South partnership.

- To learn the process and results of the quality improvement collaborative in Mozambique.
- To explore critical success factors for building sustainable capacity for quality improvement in a low resource setting.

Session 2: Drawing on Evidence and Experience to Develop a Coherent National Quality Strategy

Speakers: Tim Gardner, Aoife Molloy; UK

Through the NHS, England has the potential to be a world leader in developing a strategic, coordinated approach for delivering high quality healthcare within available resources but has struggled to do so. So how can national decisions, plans and actions most effectively support the people, teams and organisations at the frontline? How to identify interventions that are most likely to have a meaningful impact, and make prudent use of resources? This session draws on research by the Health Foundation to review evidence on the impact of policy interventions to improve quality, and assess how an array of organisations, initiatives and approaches to quality stack up as an emergent strategy.

Objectives:
- To examine how action at national, regional, institutional and individual levels of the health system could support and improve healthcare quality through a systematic and evidence-based approach.
- To discuss research findings and a conceptual taxonomy for the NHS in England and discuss how this approach could be adapted and implemented in the context of other health systems.

B16 – Quality in the Community – 15 minutes each

'Clients Tell Us It Works': Using Principles of Trauma Informed Practice to Deliver High Quality Care (Abstract no. 2571)
Renee Lovell, K. Eljiz, A. Sue, D. Greenfield; AU

Trends in the Quality of Structured Diabetes Care in Primary Care (Abstract no. 1820)
Fiona Riordan, S. McHugh, V. Harkins, P. Kearney; IE

Integration of Specialist Diabetes Teams in Primary Care: An Efficient Model of Care With Better Outcomes for the Population (Abstract no. 1321)
Shamasunder Acharya, A. Philcox, M. Parsons, B. Suthers; AU

Where Next for Primary Care Patient Safety? A National UK Prioritisation Setting Partnership (Abstract no. 2610)
Rebecca Lauren Morris, S. Campbell; UK

B17 – Understanding Systems for Safety – 15 minutes each

Horizon Scanning: Internalising the Impact of the Good, Bad and Ugly in Healthcare (Abstract no. 2949)
Sandhya Mujumdarm, D. Santos; SG

Medicines Reconciliation in Primary Care Following Hospitalisation (Abstract no. 3144)
Yogini Jani, C. Shah, J. Hough; UK

Implementing Evidence Based Tools to Reduce Telemetry and Ventilator Alarm Frequency in an ICU Setting (Abstract no. 1570)

Hisam Alahdab, I. Yerlikaya; TR

Developing and Implementing a National Paediatric Early Warning System for Managing Child Clinical Deterioration (Abstract no. 3305)
Rachel MacDonell, V. Lambert, J. Fitzsimons, S. Horkan; IE

Learning to Cross Boundaries: Deconstructing Quality in Care Transitions (QICAT) (Abstract no. 2770)
Karina Aase, L. Schibevaag; NO, J. Waring; UK

B18 – The Patient's Voice – 15 minutes each

Literacy on Patient Health Care Rights (Abstract no. 3306)
Ana Maria Reis, A. Borges; PT

How Many Hospital Websites Provide Information to Attract Patients to Attend Cardiac/Pulmonary Rehabilitation Across England? (Abstract no. 3279)
Faiza S Chowdhury, S. Elkin, D. Bell, A. Bottle; UK

Patients' Experiences of Adverse Events: A Data Linkage Study of Australian Adults Aged 45 and Over (Abstract no. 1150)
Merrilyn Walton, R. Harrison; AU

Caller Experiences and Compliance Since the Introduction of an Information Sharing Cloud for NHS 111 in London, UK (Abstract no. 1680)
Sarah-Ann Burger, A. Tallett, C. Witwicki, I. Maconochie; UK

The Effect of Adverse Events on Patient Experience Among Hospital Inpatients (Abstract no. 1752)
James M Naessens, Richard Caselli, Matt Johnson, Dan Ubl; US

B19 – Disruptive Improvement and Adaptive Change – 15 minutes each

Improving Hand Hygiene in Outpatient Setting with an Automated Notification System (Abstract no. 1406)
Zhi Qian Hen; SG, R. Geilleit; NL, C. Yin Chong, D.F. De Korne; SG

Does a Clinical Pathway on Ischemic Stroke Work? A Pre-Post Analysis in an Italian Teaching Hospital (Abstract no. 2144)
Antoniogiulio Debelvis, G. Giubbini, F. Lohmeyer, M.L. Specchia; IT

Contemporary Technology for Patient-Centred Innovation - A Mixed Method Evaluation in Sexual Health (Abstract no. 2156)
Paula Baraitser, G. Holdsworth, D.S. Joia, C. Free; UK

The OASI Care Bundle - A Quality Improvement Project to Change Provider Behaviour and Reduce Perineal Trauma in Childbirth (Abstract no. 2404)
Posy Bidwell, R. Thakar, A. Hellyer, N. Sevdalis; UK

Effective Internal and External Strategies to Decrease Overcrowding and Access Block in Emergency Department (Abstract no. 1593)
Che-Hung Tsai, C-L. Wu, Y. Yao, C-S. Chang, W.H-H. Sheu; TW

B20 – A Mile in my Shoes – 90 Minutes Limited to 30 people
An interactive shoe shop, A Mile in My Shoes, invites you to (literally) step into someone else's shoes and embark on a mile-long physical, emotional and imaginative journey to see the world through their eyes. The Empathy Museum has teamed up with the Health Foundation to develop a collection of stories from people working within health and social care. The result is a giant shoebox, a display of shoes, and a series of unique audio stories. Through sharing the experiences of different people, A Mile in My Shoes hopes to show the remarkable contribution and challenges faced by those working in, and using, our health and social care system.

Afternoon Break: 15:15-15:45

Afternoon Plenary and Awards 15:45 – 17:00
Chair: Helen Crisp; UK
Multidisciplinary Approach (Panel) Putting the Person Back into the Health System, A Multidisciplinary Approach (60 Minutes) Sibylle Erdmann; UK, Cliff Hughes; AU, Brian Robson, Brendan McCormack; UK **ISQua Fellowship Awards (15 Minutes)**

Wednesday 4th October 2017

07:30 – 08:30	**Meet the Health Foundation Experts**

07:30 – 08:30	**Meet the ISQua Experts Breakfast Session –** Cliff Hughes, Rene Amalberti, Wendy Nicklin

08:00 – 08:45	**Welcome Coffee with Exhibitors**

Wednesday Morning Plenary and Awards 08:45 – 10:00

Welcome to Malaysia 2018 (10 Minutes)

Plenary: Quality in Mental Health (50 Minutes)
Speaker: Geraldine Strathdee and others inc. service users (Start with Power of People video**)**

International Accreditation Awards (15 Minutes)
Steve Clarke; ISQua

Morning Break: 10:00 - 10:30

Wednesday Concurrent Sessions
C1 – C10
10:30 – 12:00

C1 – ISCOME Session – 90 minutes
Discussion leader: Sir Liam Donaldson

"Horizons for Evaluation and Accreditation: How do we Assess 'Safe Communication' as a Core Competency?" – ISCOME
Panellists: Annegret Hannawa, Marcia Childress, Richard Frankel, Albert Wu

C2 – WHO Session – 90 minutes

Triangulating for Quality Service Delivery: Policy, Measurement & Activated Learning

Speakers: Heitham Awadalla; Sudan, Ed Kelley, Shams Syed; WHO

Quality service delivery requires effective health sector reform, in which local improvement and measurement efforts work alongside global learning to inform national policy and strategy. Numerous countries – particularly LMICs – are looking at innovative ways to ensure the sustainability of proven health care interventions. This session focuses on three key entry points to support countries in delivering quality health services. First, shifting the paradigm from a top-down policy development approach to bottom-up implementation-informed development of quality policy & strategy. Second, proactively applying measurement approaches to maximize impact of quality improvement initiatives. Third, cascading lessons from implementation to ensure continuous activated learning at national and global levels to accelerate change at all levels of health service delivery.

Objectives:
By the end of the session, participants will:

- Appreciate different approaches to developing national quality policies and strategies, and the challenges faced in such a process.
- Understand the role of data and measurement in development and monitoring of national quality policies and strategies, health worker performance, and quality improvement.
- Identify currently available resources for quality measurement.
- Recognize the principles of activated learning and secure access to the WHO Global Learning Laboratory for Quality UHC;
- Comprehend the interaction between national quality policies & strategies, measurement and activated learning
- Appreciate the importance of quality service delivery in the context of resilient services

C3 – Understanding System for safety – 90 Minutes

Investigate Post Serious Events (Title TBC)

Speakers: Shaun Lintern, Kevin Stewart and Carl Macrae; UK (90 Minutes)

C4 – The Patient's Voice – 45 minutes each

Transforming Care Towards a Culture of Person-Centeredness: Practical Approaches.

Speakers: Gro Rosvold Berntsen; NO, Ronen Rozenblum; US, Tricia Woodhead; UK

Person-centred care is considered a key dimension of healthcare quality. Yet, despite expanding initiatives to enhance this dimension of care, many healthcare organizations around the world have faced barriers when attempting to transform their organizational culture from 'provider focused' to 'patient focused.' This session will review evidence based key principles of person-centred care. Examples from a variety of countries will be discussed and practical approaches given to transformation at patient, provider and policy level. The session will include a panel discussion and Q & A on the fundamental principles that need to shift,

evidence-based practical initiatives, frameworks, structured programs and patient-facing health information technologies that will develop and enhance person-centred care, the patient experience and both staff and patient engagement.

Objectives:

- Attendees will have greater understanding of the key principles, challenges and opportunities for improvement in 'ensuring what matters to the patient drive discussion and decision making about their care'.
- To share practical examples and success stories of person-centered care at patient, provider and policy levels so as to inspire and enable others to test ideas and make changes in their own organizations.

Session 2: Practical Approaches for Hearing the Patients' Voices

Speakers: Gail A Nielsen; US, John Brennan; IE

In 2002, Dr. Donald Berwick asked, "Are patients and their families… someone to whom we provide care? Or are they active partners in managing and redesigning their care?" This workshop will explore practical approaches to listening to and using the voices of patients and families to transform care. This interactive session will provide you with usable techniques, tools, and lessons learned from a variety of care settings to help you to maximise patient involvement, engagement and partnership in care. Participants in this workshop can look forward to learning how to make person centred care practicable, applicable and possible for all involved in healthcare, in all settings around the world.

Objectives:

- To learn about proven methods used for hearing and incorporating patients' voices in the improvement of care delivery.
- To discover practical techniques and tools that unlock person centred care and are applicable to healthcare settings worldwide.

C5 – Sustainable Quality Improvement for LMIC – 45 minutes each

Session 1: An Interactive Map of HIV Data Sources, Users, Elements, and Decision Points in Malawi

Speakers: Andrea Fletcher; US, Maganizo Monawe; Malawi, Tyler Smith; US

Outline:
The Kuunika Project seeks to improve information available to decision-makers at all levels of the health system. The project focuses on improving the supply of high-quality, routine health information and stimulating demand for and use of empirical data for more informed decisions. The ultimate goal is better use of key information to improve HIV and health outcomes. Many countries lack a comprehensive inventory of available data, primary users, and systems (both paper and electronic). In Malawi, this limited the ability of the Kuunika Project planners to assess gaps, bottlenecks, and hone in on people and processes where health system investments will yield the greatest return. Further, critical decision points for the HIV response and data needed to support these decisions had not been previously, systematically documented. The team established a catalogue and relational database for data elements, systems, users, and decisions made using HIV related data.

Session Objectives:

- Examine the interactive data map data created for HIV data in Malawi, and use the map to highlight critical information gaps and bottlenecks to support strategic planning of digital health systems.
- Identify key data sources, users, and elements in the Malawi healthcare system to be used in interventions through interacting with the map.
- Critique the mapping process and methodology used in creating the map and validating assumptions regarding data flow

- Replicate the methods used in the Malawian context in other countries and systems.

Session2: Proving Quality Improvement In Healthcare Is Worth The Cost – Or Not. (56)

Speaker: Edward Broughton; US

More than twelve economic analyses have been completed on improvement interventions in low- and middle-income countries (LMICs) in the last 5 years by USAID's ASSIST Project. Generally, the evidence shows the improvement work has been cost-effective or cost saving. However, there is danger in assuming all such efforts in these and other settings are acceptably efficient and it is important to conduct economic analyses to provide the best evidence that we are using the optimal methods to achieve health service delivery improvements. We discuss the learning from these studies, both results and methodology, and directions of future research on this topic in LMICs and also how the findings and methods can be used in higher income settings.

Objectives:

- Participants will understand the basic methodology used to conduct cost-effectiveness analysis of improvement activities.
- Participants will understand what the results of CEA of improvement means and what are their practical applications in guiding improvement and in decision-making.
- Participants will appreciate the methodological issues of such studies and how these relate to the applicability of these studies in their own settings.

C6 – Regulations Influence on Governance – 15 minutes each

Service and Professional Regulators - Moving fom Understanding to Structured Interaction for Enhanced Patient Care (Abstract no. 2093)
John Sweeney, G. Hanrahan; IE, D. Williams; CA

Patient-Centred Care and Leadership Standards Compliance: A Latent Class Analysis (Abstract no. 2039)
Ana Rodríguez-Benavente, M. Herrera-Usagre, Á. Palop-Río, Á. Barrera-Vargas; ES

Lots to Learn: Accreditation Lessons from other Industries (Abstract no. 1718)
Michael Daly, E. Willims; AU, K. Brubakk; NO, P. Barach; US

Regulatory Action to Reduce Burnout and Barriers to Treatment-Seeking Among Providers (Abstract no. 3046)
Mark Staz, H. Chaudhry, A. Hengerer; US

How do Hospital Boards Enact Quality Governance? A Mixed Methods Study of 15 Organisations in England (Abstract no. 3314)
Lorelei Jones; UK

C7 – Education Through Learning and Sharing - 15 minutes each

Scaling up Quality Improvement in Nursing Education Through a System Approach: The Indian Experience (Abstract no. 2958)
Swati Mahajan, N. Agrawal, S. Bhargava; IN

Application of Quality Control Circle Method in Improving Sustained Quality Improvement Activities (Abstract no. 2648)
Yanrong Ye, X. Gao, N. Wei, Z. Chen; CN

Providing Family Planning Post Partum Counselling Using Balance Counselling Strategy Approach in 9 Districts in Indonesia (Abstract no. 2125)
Fransisca Maria Lambe, I. Riswan, H. Blanchard; ID

General Practitioner-Led Gynaecology Clinic in a Maternity Hospital: A Service Evaluation (Abstract no. 2747)
Ailis Ni Riain, M. Daly, M. Quinlan; IE

C8 – The Patient's Voice – 15 minutes each

The Value of Arts Based Methods to Empower Pregnant and Postnatal Women to Share Their Safety Concerns About Serious Illness (Abstract no. 1957)
Nicola Mackintosh, J. Harris, C. Collison, J. Sandall; UK

People with Learning Disabilities as Equal Partners in Service Improvement (Abstract no. 1743)
Joanna Goodrich, S. Edwards, E. Munks, J. Parr; UK

Listening to the Patient: Quality Improvement Lessons from Five Years of Patient Complaints in a Large Maternity Service (Abstract no. 2186)
Ben Nowotny, E. Wallace, E. Loh; AU

Listening to Women's Voices in Maternity Care (Abstract no. 1294)
Marie Kehoe-O'Sullivan, L. Weir; IE

What Matters to You: Working with the Patient Voice to Improve the System (Abstract no. 1693)
Deon York, C. Walsh; NZ

C9 – Quality in Mental Health – 15 minutes each

Quality and Safety in Perinatal Mental Healthcare: Detection and Response to Maternal Near Miss Events (Abstract no. 1816)
Abigail Easter, L. Howard, J. Sandall; UK

Quality of Care and Clinical Outcomes of Heart Failure Among Patients with Schizophrenia in a Universal Health Care System (Abstract no. 2138)
Mette Jørgensen, J. Mainz, K. Egstrup, S.P. Johnsen; DK

Simulations Improvements in Patient Safety Culture and Medication Safety at a Psychiatric Centre in the Faroe Islands (Abstract no. 2372)
Solvejg Kristensen, S. Feldbaek Peitersen; DK, E. Lindenskov; FO, J. Mainz; DK

Mental Health Social Inclusion Through Job Placement: Implementing IPS in Spain (Abstract no. 2430)
Rosa Sunol Sala, D. Koatz, P.B. i Dalmau, P.H. Madariaga; SP

No Sector Left Behind: Advancing Mental Health Quality in Ontario, Canada (Abstract no. 1692)
Anna Greenberg, R. Solomon, P. Kurdyak; CA

C10 – A Mile in my Shoes – 90 Minutes
An interactive shoe shop, A Mile in My Shoes, invites you to (literally) step into someone else's shoes and embark on a mile-long physical, emotional and imaginative journey to see the world through their eyes. The Empathy Museum has teamed up with the Health Foundation to develop a collection of stories from people working within health and social care. The result is a giant shoebox, a display of shoes, and a series of unique audio stories. Through sharing the experiences of different people, A Mile in My Shoes hopes to show the remarkable contribution and challenges faced by those working in, and using, our health and social care system.

Lunchtime 12:00 – 13:45

12:45 – 13:30	**Follow on Heidelberg QI Forum ""How to Fit Patient Safety into QI mechanisms?" Partners: Evaplan International Health at the University Hospital Heidelberg, the AQUA Institute, Göttingen, the Institute of Public Health, Heidelberg University, and ISQua**

12:45 – 13:30	**Models and Real-Life Examples of Implementing and Measuring Infection Prevention and Control (IPC) Programmes** **Julie Storr; CH, Benedetta Allegranzi; CH Raheelah Ahmad; UK, Claire Kilpatrick; CH** The global threats caused by antimicrobial resistance and infectious disease spreading through uncontrolled outbreaks and every-day unsafe health care practices, have highlighted the need for stronger IPC programmes. WHO identified standards and core components for effective IPC programmes but their implementation and impact on practices may pose some challenges. Speakers in this session will reflect on quality improvement and implementation models that demonstrated to be instrumental to implement IPC interventions and will describe the WHO approaches based on these models, along with real-life examples of country implementation, with focus on low-resource settings. The session will consist of two presentations and interactive discussion with the audience. The presentations will be on the following topics: • quality improvement and implementation models applied to IPC • WHO approaches and real-life examples to implement and monitor IPC interventions at the country and facility level

12:45 – 13:30	**Quality and Safety in Mental Health** Geraldine Strathdee and others covering user coproduction from teams to communities to QI specific products to inspirational hope, influence and political influence

E-posters Presentations
CP1 – CP5
12:40 – 13:30

CP1 – Quality in Mental Health – 10 minutes each

Scotland's Approach to Improving Access to Psychological Therapies and Child & Adolescent Mental Health Services (Abstract no. 1063)
Dan Harley, Kirsteen Ellis, Gavin MacColl, **Joseph Adams**; UK

The Effect of Psychiatric Nursing Home Accreditation in Taiwan (Abstract no. 2269)
W. J. Chiu, P. Y. Chen, Y. T. Wu, C. I. Huang; TW

Patterns of Care for Terminally-Ill Cancer Children (Abstract no. 1643)
Hsiu Mei Liu; TW

Implementing Guidelines on Physical Health in an Acute Mental Health Setting: A Quality Improvement Approach (Abstract no. 3284)
Stuart Green, Liz Evans, Ed Beveridge, Bill Tiplady; UK

CP2 – Quality and Safety in Crisis – 10 minutes each

Quality Services at the Heart of Public Health Emergency Preparedness: Reflections from Engagement with Six Countries (Abstract no. 3296)
Matthew Neilson, Dirk Horemans, Shams Syed, Sohel Saikat, Edward Kelley; CH

Resilience in Healthcare Providers During On-Scene Medical Response to a Disastrous Earthquake in Taiwan (Abstract no. 1069)
Ya-Ting Ke; TW

Zika Outbreak Challenges Health Systems in Latin America and the Caribbean (Abstrcta no. 1848)
Eric Baranick, **Jorge Hermida**; US

1 other TBC

CP3 – Regulations Influence on Governance – 10 minutes each

A Systematic Method Of Tackling Disruptive Clinician Behavior Through Clinical Governance (Abstract no. 2801)
Sucharita Hota, Anita Lim, Sandhya Mujumdar; SG

The Life Cycle Model of Accreditation - A Nine Year Study (Abstract no. 1932)

Subashnie Devkaran; AE

Observing Nurse Compliance to the Dutch Guideline on Administering Injectable Medication (Abstract no. 1419)
Bernadette Schutijser, Joanna Klopotowska, Cordula Wagner, Martine de Bruijne; NL

Accreditation of Danish Specialist Physician Practices: Findings from Surveys and Outcomes After the Opportunity to Improve (Abstract no. 1736)
Rikke Marthinsen, Jesper Gad Christensen, Carsten Engel; DK

Hospital Accreditation in Indonesia: The Role of Organizational Design Factors and Java-Outside Java Disparities (Abstract no. 3127)
Viera Wardhani, Tjahjono Kuntjoro, Adi Utarini; ID

CP4 – Quality in the Community – 10 minutes each

Screening for Cervical Cancer in Israel: Quality Of Care And Disparities (Abstract no. 2733)
Michal Krieger, Ronit Calderon, Ora Paltiel, Orly Manor; IL

GP Shared Care of Long Term Survivors of Complex Cancer Treatments (Abstract no. 3133)
Josie Samers, Greg Wheeler, Natalie Goroncy; AU

Improving Access to Health Services for Vulnerable Populations Using Quality Improvement Approaches in Rural Malawi (Abstract no. 2285)
Tiwonge Moyo, Linley Hauya; MW

Risk Communication In Gastrointestinal Cancer MDTS: A Study Protocol (Abstract no. 2196)
Mia Bierbaum, Anne Hogden, Patti Shih, **Frances Rapport**; AU

Wednesday Afternoon Concurrent Sessions
C11 – C20
Time: 13:45 – 15:15

C11 – ISCOME Session – 90 minutes
Discussion leader: Cliff Hughes (ISQua) and Annegret Hannawa (ISCOME)

"Research Priorities for Safer, Higher Quality Care" – ISCOME

ISCOME Panellists: Rick Iedema, John Øvretveit, Aziz Sheikh
ISQua Panellists: Chris Cornue, David Greenfield, and Ezequiel García-Elorrio

C12 – Sustainable Quality Improvement for LMIC – 30 minutes each

Session 1: Chinese Hospital QCC in Healthy China 2030 Strategy: From Theory to Practice

Speakers: Tingfang Liu, Qianli Jiang, China

China has the largest central-controlled health care system, with universal health insurance and has recently started the "Healthy China 2030" plan. When Professor Tingfang Liu introduced PDCA+Quality Control Cycle (QCC) in 2005, few Chinese hospitals knew the quality of their care. With theoretical training and the

establishment of the China Federation for Hospital QCC,4 rounds of the National Competition of QCC, and 40,000 cycles have been completed. 400,000 health care staff have participated, 23 training bases and 6 professional committees have been established. With continuous spread of QCC, the hospital culture and medical education in China has changed. QCC has improved the total quality in healthcare of China. The theoretical construct and examples of projects will be presented

Objectives:

- To share China's experience with other countries of Quality Control Circle activities organized by the China Federation for Hospital Quality Control Circle to continuously improve the medical quality in China.
- To share the story of QCC development in China, which will be valuable to the international organization how to "enter China" and how apply the learning to local contexts.

Session2: Sustainability of Quality Improvements In Public And Private Sectors in South Africa

Speakers: Jacqui Stewart, Shivani Ranchod, Gareth Kantor; SA

This session will be based on a large body of ongoing work in the area of quality measurement and improvement in South Africa.
Part of the session will relate to the South African context (including the overarching policy direction), and available evidence on the quality of care in both the public and private sectors. Evidence is drawn from:

- Survey data reflecting patient experiences;
- Accreditation data reflecting the structure and process of care;
- Some outcomes data; and
- Analysis of insurance claims data revealing patterns of waste, defensive medicine and poor care co-ordination in the private sector.

The speakers will also reflect on the regulatory processes in place in South Africa relating to quality measurement, and the shortcomings of the current approach. Evidence will be drawn from:

- the reports of the Office of Health Standards Compliance (OHSC);
- the recent Health Market Inquiry undertaken by the Competition Commission; and
- an analysis of the approach taken by the OHSC.

The challenges associated with sustaining quality improvement will be highlighted via a case study presented by Dr Kantor. He will reflect on the experience of the -successful 'Best Care…Always!' patient safety campaign, which operates across both the public and private sectors.

Objectives:

1. Understanding the different challenges in public and private sectors.
2. Highlight the challenges associated with the sustainability of quality initiatives.
3. Put forward suggestions on how to strengthen sustainability.

Session 3: Establishing a National Quality Management Directorate in a LMIC

Speaker: Andrew Likaka, Dominic Nkhoma, Jocelyn Masamba, Saulos Mhlanga; Malawi

The Ministry of Health in Malawi has been coordinating several quality improvement approaches supported by different stakeholders since 1990s. Despite developing a National Quality Policy in 2005, implementation of quality improvement initiatives has been fragmented, most of the new approaches taking the mode of a project without any means of sustainability. In 2016, the Ministry decided to establish Quality Management Department to provide strategic leadership and coordination of quality improvement initiatives in the country. This discussion focuses on steps towards establishing a quality department, challenges, opportunities and critical lessons for ensuring implementation of sustainable improvement interventions at all levels of health care delivery. Strong country leadership and ownership is paramount in setting up sustainable quality improvement for LMIC. What is sustainable is what is within the national priorities: involvement, planning together and implementing as a team.

Session Objectives:

- List at least two learning Session objectives delegates should expect to receive.
- Learn how to handle fears to change in establishing Quality Directorate.
- Learn on the role of Partner mapping and resource mapping for coordination.
- Learn on engaging Top management support for establishing Quality Directorate at national level.
- Attributes to successful implementation of a Quality Directorate at National Level.

C13 – Data to Drive Decision Making/Health Policy – 45 minute each

Session1: Measuring Frailty: From Big Data to Patient's Bedside: Exploring Methods for Assessing Frailty Across a Patient Journey

Speakers: Julie Reed, Lotte Dinesen, Tomasz Szymański; UK

For some, population ageing is a challenging period, associated with increased co-morbidity, dependence and resource utilisation: frailty.
The session will be split into 2 parts:

- We explore frailty definitions, and their operationalization, from the literature. This interactive session will explore what frailty means to the delegates and what aspects of frailty matter to them (both professionally and personally), to populations and healthcare systems.
- We offer a unique perspective through the "eyes of the patient": Utilizing an example patient narrative, we explore robust and relevant methodologies to measure aspects of frailty, at each step of the patient journey from the community into acute secondary care: from clinical risk stratification, cost-effectiveness model for medication review and health services mapping.

Objectives:

- Explore definitions of frailty and what they mean to different people.
- Exploring methodologies of robust frailty metrics, from:
  a) The perspective of population metrics to patient's bedside
  b) Mapping health services
  c) Health economic modelling
  d) Clinical decision making

Session 2: Money No One Wants to Have to Receive, or Pay – Exploring Roles of Insurers and Models Of Clinical-Insurer Engagement

Speakers: Tim Draycott, Oliver Quick, Christopher Yau: UK

Across the world, childbirth is not as safe as it could, and should, be. This is not only a tragedy for families for whom the injury was preventable, but the rising litigation costs are an enormous loss of resource to healthcare. These are payments that no one wants to have to receive, or pay. It is money lost to the healthcare service and ultimately, patient care. Improving care and outcomes will reduce litigation, which may release funds that could act as fiscal levers to positively influence patient care. Insurers may be well placed to play a central bridging role in linking healthcare users, healthcare providers and policy, to improve both services and outcomes. We interviewed a number of State insurers around the world (England, Scotland, Wales, Republic of Ireland, Sweden and Australia) to investigate how these national bodies engage with maternity teams and the wider clinical circle to improve care and reduce harm. In this session, we would like to share our findings, explore the roles of insurers and discuss whether they could have a greater part to play in the current policy landscape.

Objective:

- To develop a better understanding of different models of clinician-insurer engagement and the roles of insurers.

C14 – Understanding Systems for Safety – 45 minutes each

Session 1: Safety by Design: How Technology and Behavioural Approaches Can Nudge for Improvement

Speakers: Dirk de Korne; SG, Vineet Chopra; US, Anita Huis; NL, Rajesh Aggarwal; US

Non-compliance to safety standards has often been contributed to knowledge or skills deficits. Therefore, most improvement strategies have a strong educational component intending to cultivate behavioural change. However, studies increasingly show that environmental influence –including design and layout of equipment, work space, social engagement and leadership – play a key role in safety compliance. Instead of accepting a residual safety risk as inherent to being a teaching hospital, for example, current technologies enable simulation of the whole clinical pathway. And while currently 100% hand hygiene compliance is often considered to be unreachable utopia, automation can make it impossible not to perform hand hygiene. This session combines surgical, medical, nursing and health sciences perspectives and experiences in various continents with interactive audience participation.

Objectives:

- To receive an introduction on how environmental influences (e.g. design, layout of equipment, workspace, and social engagement) could improve patient safety by stimulating behavioral change in surgical, inpatient and outpatient settings.
- To receive an outline of the multidisciplinary and multifaceted impact of safety systems on patient outcomes

Session 2: Adapting Critical Incident Management Processes in Times of Patient Safety Crises

Speakers: Bernadette Eather, Carrie Marr, Cate Malone; AU

During times of patient safety crises, health care systems are presented an opportunity to review critical incident management processes to ensure they are responsive to the needs of patients, their families and clinicians involved. This session will detail the factors present to require an adaptive change including a range of critical incidents and how the existing system was unable to adequately respond. Understanding what is important to clinicians, health service managers, and patients and their families, including timeliness, transparency, and feedback is key to ensuring any change in critical incident management processes is effective. An overview of system changes will be outlined including the role of early investigation, open disclosure, a range of investigation methods and the formation of recommendations.

Objectives:

- Understanding the factors which require adaptive change
- Understanding adaptation of critical incident management processes to ensure they are more responsive to patients and their families

C15 – Education Through Learning and Sharing – 45 minutes each

Session 1: A Systems Approach to Improvement and Service Redesign for Health and Care

Speakers: John Clarkson, John Dean; UK

The potential benefits of applying systems engineering to health and care systems has been well promoted. It is heralded as a key ingredient supporting the delivery of integrated, person-centered care.
But systems engineering is challenging for many and successes of its application remain dispersed.
A project currently underway by the by the Royal Academy of Engineering, supported by the Royal College of Physicians Future Hospital Programme, aims to brings together the systems engineering and healthcare

communities. It explores how engineers can add to current understanding and application of systems theory in quality improvement and healthcare redesign.
The session will share, test and challenge the outputs from this project.

Objectives:

- To understand the process of system engineering and how it might be applied within health and care.
- To contribute to the debate on applying a systems approach to improvement and service redesign for health and care and consider any challenges to its implementation.
- To contribute to the development and delivery of the project's output, for widespread use of a systems approach to improvement and service redesign

Session 2: Developing the Habits of an Improver – A New Approach to QI Learning

Speakers: Bill Lucas; UK, Peter Davey; SCOT

A new approach to effectively translate improvement training into healthcare practice through developing people to work in a constant style of 'improvement' – not just adding to professional curricula, or promoting particular QI approaches. Improvers need to develop five essential habits: learning, influencing, resilience, creativity and systems thinking. Educators and QI leads need to understand the teaching and learning methods which best develop these habits. Bill Lucas will present 'The habits of an improver' framework, developed by applying deep understanding of how people learn and apply their knowledge. Peter Davey (Improvement Academy, Tayside, Scotland) will report on using 'The habits of an improver' to frame training for clinical leads, nurses, service managers and patients to learn, embed and spread improvement habits.

Objectives:
After the session participants will:

- Be familiar with the Habits of Improvers framework and the attributes which underpin how improvers think and act and what is needed to foster these to support improvement as a habit in the daily work of healthcare professionals.
- Consider the teaching and learning approaches most likely to successfully translate learning about improvement approaches into improvement of services on the ground.

C16A – The Patient's Voice – 90 minutes

Harnessing Evidence to Change Healthcare Culture: A Framework for Patient /Family Engaged Care

Speakers Susan B. Frampton; US, Morgan Chetty; ZA, Michael Greco; AU, Karin Jay; UK

Patient and family engaged care (PFEC) has been identified as a strategic cornerstone for delivering healthcare that results in better health at lower costs. To promote PFEC, in 2016, the US National Academy of Medicine convened a group of clinical and health service researchers and patient and family leaders to collaborate on the development of a Guiding Framework for Patient and Family Engaged Care. The guiding framework will be presented in this session, along with selected evidence in support integration of the patient voice into quality improvement efforts. The panel will share perspectives on how the tool can be used to accelerate the advancement of PFEC and promote effective partnerships among healthcare professionals and patient, family and community leaders.

Objectives:

- Participants will understand major connections between patient and family involvement in care co-design, and improved health and healthcare outcomes.
- Participants will understand essential organizational practices leading to effective integration of the patient voice in healthcare quality improvement

C17 – Generalisability of Improvement Outcomes – 15 minutes each

There is Need for Improvement of Quality Improvement - A Systematic Review of The PDSA Method in QI Studies (Abstract no. 3217)
Henrik Vitus Bering Laursen, S.V. Knudsen, L.H. Ehlers, J. Mainz; DK

Multidisciplinary Interventions To Reduce Peritonitis Infection In Peritoneal Dialysis Unit, Qatar (Abstract no. 2026)
Vimala Lonappan, F. Al Ali, **M. Amin**, H. Hamdy, S. Ismail; QA

Application of Quality Control Circle to Develop and Apply a New Postoperative Flap Observation Standard (Abstract no. 2743)
Lingli Peng, A. He, J. Tang, Y. Li; CN

Advancing Bed Management Dashboard System to Improve Inpatient Patient Experience in 509 beds Hospital in Indonesia (Abstract no. 2732)
Fathema Djan Rachmat, **Astari Mayang Anggarani**, D.F. Fitriana, S. Aurani; ID

Precision Medicine Plan to Improve the Diagnosis and Care of Kawasaki Disease (Abstract no. 1218)
Ho-Chang Kuo, Y-Y. Lin, C-C. Lin, K-S Hsieh; TW

C18 – Understanding System for Safety – 15 minutes each

Balancing Diagnostic Errors with Conservative Diagnosis: Developing a New Paradigm for More Appropriate Diagnosis (Abstract no. 3085)
Gordon Schiff, S. Myers, L. Volk, S. Martin; US

Global standard barcodes contributing to quality and safety in healthcare
Andrew Raynes; UK

Exploring the Influence of Behavioural Drivers on Procedural Violations in Community Pharmacies (Abstract no. 2923)
Christian E L Thomas, D.L. Phipps, D.M. Ashcroft; UK

Broken Windows Theory and its Application to Healthcare (Abstract no. 1548)
Janet Long, Louise Ellis, K. Churruca, J. Braithwaite; AU

Telemedicine Improves the Health Quality in China
Qingjun LU**, Chen WANG***

C19 – Data to Drive Decision Making/Policy – 15 minutes each

A Clinical Risk Management System (CRMS) Based IP-SDM Care Model In General Hospital (Abstract no. 1379)
Hou-Chaung Chen, Y-N. Hsu; TW

PSI 12 in Orthopaedic Surgery: Results and Perspectives of a National French Programme for Improvement (Abstract no. 1389)
Linda Banaei-Bouchareb, I. Evrard, A. Fouchard, L. May-Michelangeli; FR

The Comprehensive Cost of Illness of Cerebrovascular Disease: Comparison Between Opportunity Cost and Replacement Approach (Abstract no. 1988)
Kunichika Matsumoto, S. Hanaoka, Y. Wu, T. Hasegawa; JP

Is High Quality of Care Associated with Higher Costs? - A Nationwide Cohort Study Among Hip Fracture Patients (Abstract no. 2286)
Pia Kjær Kristensen, R. Søgaard, T.M. Thillemann, S. Paaske Johnsen; DK

Driving Better Decisions Using Statistical Process Control: A National Quality Profile (Abstract no. 2135)
Grainne Cosgrove, P. Crowley, J. Martin; IE

C20 – A Mile in my Shoes – 90 Minutes
Limited to 30 people

An interactive shoe shop, A Mile in My Shoes, invites you to (literally) step into someone else's shoes and embark on a mile-long physical, emotional and imaginative journey to see the world through their eyes.

The Empathy Museum has teamed up with the Health Foundation to develop a collection of stories from people working within health and social care. The result is a giant shoebox, a display of shoes, and a series of unique audio stories.

Through sharing the experiences of different people, A Mile in My Shoes hopes to show the remarkable contribution and challenges faced by those working in, and using, our health and social care system

Afternoon Plenary and Awards 15:15 – 16:20

Plenary and Awards

ISQua Poster and Reizenstein Awards (10 Minutes)

Closing Plenary (50 Minutes)
Jishnu Das (World Bank- work focuses on the delivery of basic services, particularly health and education)

President Closing Remarks (5 Minutes)
Wendy Nicklin; ISQua