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978-1-107-50386-1 - Quality Management in Intensive Care: A Practical Guide
Edited by Bertrand Guidet, Andreas Valentin and Hans Flaatten
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Quality Management in Intensive Care

A Practical Guide

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University Printing House, Cambridge CB2 8BS, United Kingdom

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www.cambridge.org
Information on this title: www.cambridge.org/9781107503861

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First published 2016

Printed in the United Kingdom by Clays, St Ives plc

A catalogue record for this publication is available from the British Library

Library of Congress Cataloging-in-Publication data
Quality management in intensive care / edited by Bertrand Guidet, Andreas Valentin, Hans Flaatten.
p. ; cm.
Includes bibliographical references and index.
ISBN 978-1-107-50386-1 (paperback)
I. Guidet, B. (Bertrand), editor. II. Valentin, Andreas, MD, editor. III. Flaatten, Hans, editor.
[DNLM: 1. Intensive Care—methods. 2. Quality Control. 3. Intensive Care Units—organization & administration. 4. Quality Assurance, Health Care—methods. WX 218]
RC86.7
616.02'8—dc23
2015032932

ISBN 978-1-107-50386-1 Paperback

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Introduction

Hans Flaatten, Bertrand Guidet, and Andreas Valentin

The world is rapidly changing, with demographic, ecologic, and financial constraints. Societal expectations are also rapidly changing with easy access to information (websites, smart phones, etc.): reduced delays, requests for rapid decisions, a need for understanding, being part of the decision (shared-decision model). These changes have translated into the hospital, including our critical care services.

The population expects high-quality care given in a timely fashion. They expect this to be without adverse events and side-effects from the treatment in the short and long term. Since very few (if any) of our intensive care units (ICUs) are in this position, most of us have to improve performance on various levels. This means we must improve the quality of care, and as a consequence, we must work together on quality management.

This book addresses several aspects of quality and safety in critical care. Although the main focus is the ICU, several concepts can be generalized to many other settings within the hospital, or even in other institutions.

Today the ICU plays a fundamental role in all modern hospitals worldwide. The ICU provides coverage 24/7, all year round, and is expected to perform equally well, at the same capacity, in the middle of the night and during weekends as within ordinary daytime working hours. Increasingly the ICU team is solicited for patients that are not admitted to the ICU ("ICU without walls"). This may be prior to admission through medical emergency teams (MET) or to address the goal/level of care after an ICU discharge.

During the ICU admission, several interactions with colleagues with different specialties occur. Hence, in term of management we cannot focus only on the ICU, but we must consider the ICU in its environment. As a consequence, frequently ICU physicians are involved in local committees, regional or national professional groups.

We have been educated as medical students using the diagnosis and treatment approach. It means that for the diagnosis we need tools to assess management skills – indicators of quality. Regarding treatment, we need to implement individualized medicine and not simply apply guidelines regardless of patients' specificities. We need also to build a team with common goals.

We need to work as a team, to share the same goals and values, to work on a safety climate, and to build a common culture. We need leaders to inspire such an approach but still maintain a flat hierarchy. We need an atmosphere to enhance information exchange, allowing for different points of view to be expressed. We need to think together in order to implement corrective actions and to adjust behavior according to expectations and results. A good example is the way serious adverse events are handled in the ICU: declaration, mitigation, analysis, proposals for improvement, and follow-up. If people are not confident, or fear being stigmatized or punished, adverse events are not declared and there is no room for improvement.

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The paradox of modern medicine is that we should endorse individualized treatment adapted to a number of personal factors at the same time as we promote the use of bundles and guidelines in order to reduce the heterogeneity of practice. This means we need initial and continuous training aiming at reaching high competency, but also to diffuse and use protocols locally. This new approach requires active participation of all actors: both new and experienced doctors, in addition to nurses and allied health personnel. Protocols cannot be applied passively; they need to be adapted, tailored according to each unit's culture, case-mix, and environment.

A great step forwards will be to work on communication skills. Important information may be lost on the way from hospital admission to discharge; interpersonal conflicts might arise if people belonging to the same team do not share information. This is true between physicians and between nurses, but also between physicians and nurses. This implies that handover procedures must be formalized and all documentation must be available and shared by the team (medical files and nurses' reports). The electronic ICU management system contributes to easing this sharing approach.

How to improve quality and safety? Several chapters of this book open new horizons and can hopefully be of value to the individual ICUs and ICU clusters at regional and national levels. The number of quality improvement tools we can use has increased substantially in the last decades, and many of these are covered in this book. We do not expect you to use all of them, but hope you will find one or more of the chapters interesting enough to decide to test it out in your ICU.

The development of new ways and methods to improve quality will certainly continue, and with time our "toolbox" will grow. It is hence the hope that some of you will be inspired to find your own way to improve quality and safety of care toward critically ill patients. If you do, share your results and let us all know. In that way we can continue building even better intensive care in the future.

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