

Hvordan involverer vi vores kolleger i forbedringsarbejdet?



Plan for de næste 70 minutter

1. Hvorfor er emnet involvering af kolleger vigtig? 15
2. Hvorfor kan involvering være svært? 15
3. Hvordan inviterer man kolleger med?
4. Hvordan forholder vi os til kompleksitet?
5. Invitation til videre overvejelse

Mål 1 Halvering af antallet af patienter, der henvises og visiteres til specialiseret palliation, men ikke modtages

Mål 2 Andelen af patienter der oplever forbedring af livskvaliteten som følge af behandling skal øges med 10 procentpoint

Mål 3 Forbedring på 10 procentpoint af andelen af pårørende, der vurderer symptomlindring som "fremragende" eller "god"

Mål 4 Forbedring på 10 procentpoint af andelen af pårørende, der vurderer støtten som "fremragende" eller "god" i forhold til patientens ønsker til pleje/behandling og patientens ønske til den sidst tid

Mål 5 Forbedring på 10 procentpoint af andelen af pårørende, der vurderer støtte til pårørende som "fremragende" eller "god"

Mobilisering – Gennemføring - Forankring

Forberedelse til oplæg "Hvordan involverer vi vores kolleger i forbedringsarbejdet?"

- Tænk på en konkret oplevelse, fx et forandrings- eller udviklingsprojekt på dit arbejde, som du har haft lyst til at engagere dig i!
 - Hvad gjorde, at du var motiveret til at bidrage?
 - Hvordan blev du opfordret til at deltage?
- Tænk på et konkret projekt, hvor du ikke følte dig motiveret til at bidrage!
 - Hvad gjorde, at du ikke ville bidrage til projektet?
 - Hvordan har du givet udtryk for, at du ikke ville bidrage?
- Tænk på en konkret situation, hvor du lykkedes med at motivere en kollega til at bidrage til en opgave!
 - Hvordan har du formuleret invitationen?
 - Hvilken relation havde du til denne kollega?

Christian, hvorfor tager du røntgen før blodprøverne, mens det er svaret på blodprøverne vi venter på?

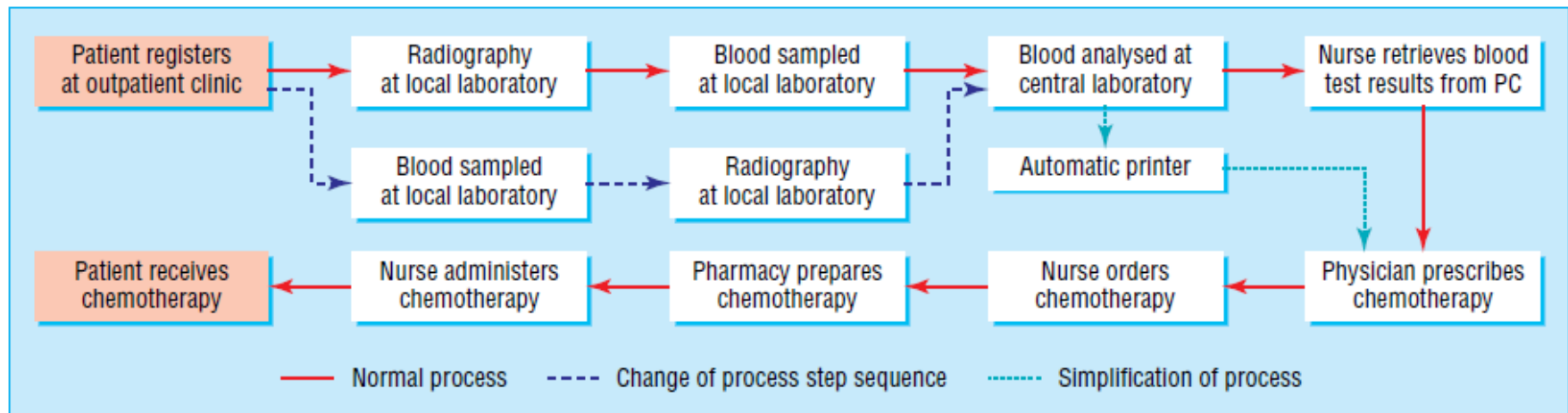
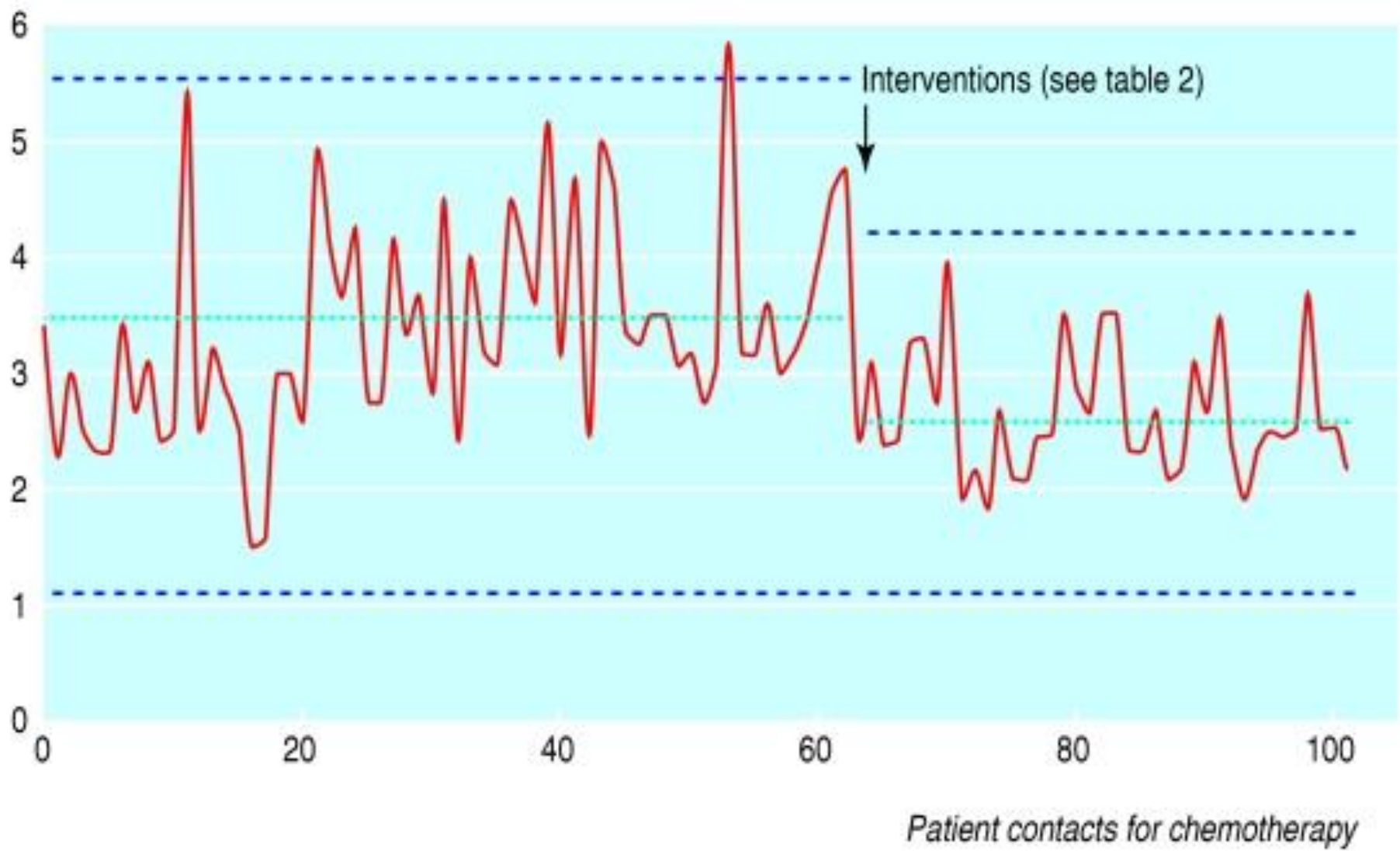


Fig 1 Movement through outpatient clinic for patient with lung cancer

BMJ VOLUME 330 4 JUNE 2005 bmj.com

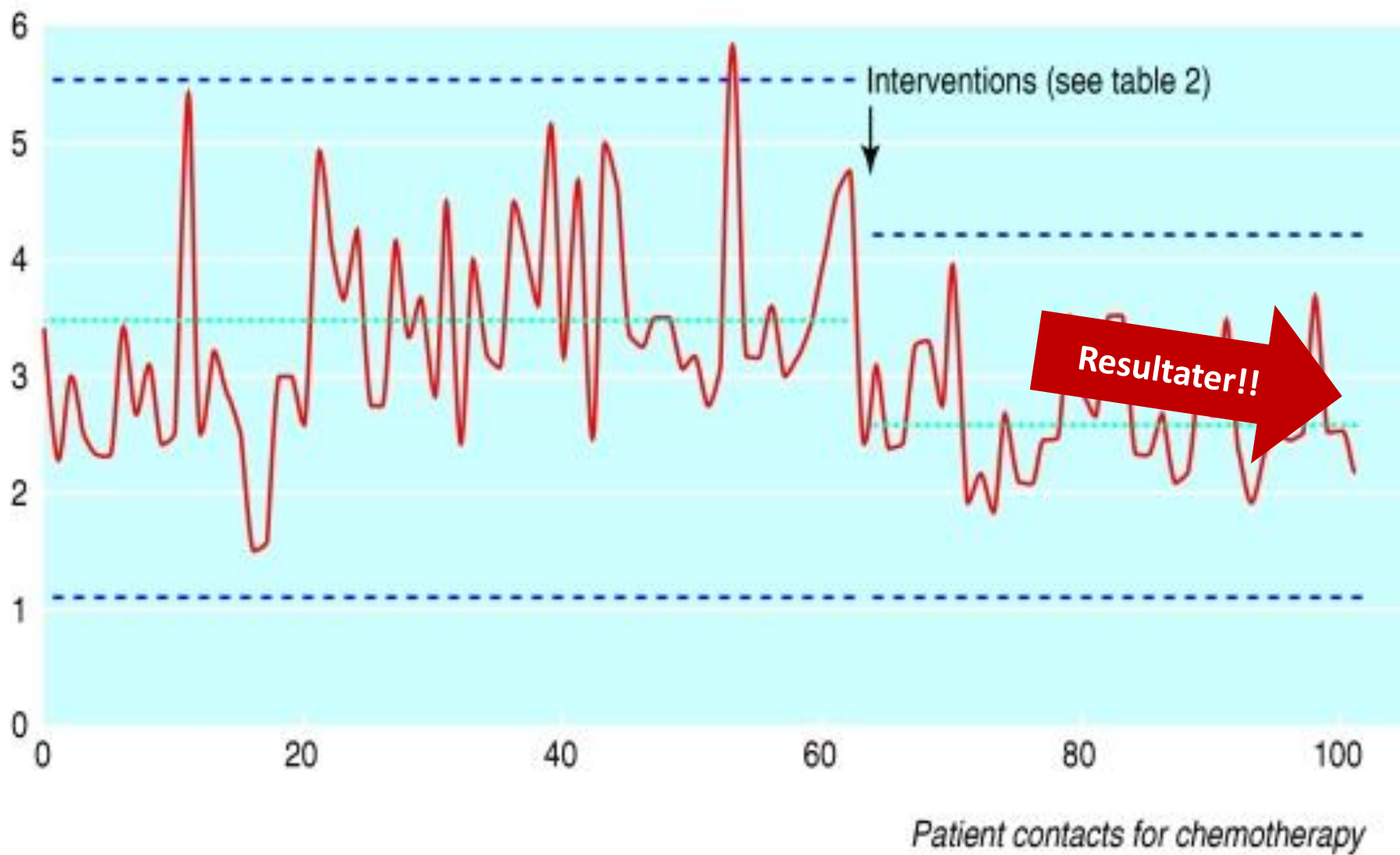
Hours





Dr. Stangeland, torakskirurg

Hours



Kære Christian

Til orientering,

Jeg har afprøvet nogle gange i 0651 at udfylde seddel og pakker løbende - det har fungeret fint og givet mere luft til tavlemødet. Oplevet som logisk af sygeplejerskerne. Jeg har selv sat hakkerne på pt-sikkert hospital mens sgpl. har rettet dag-til-dag seddel til. Det har naturligvis været en speciel uge med få pt. men jeg tror alligevel det er en god vej frem.

Hilsen og god weekend

----- Overlæge, Ph.d.

-----afdeling

Hillerød Hospital



24/7 NHS

The weekend effect

Jacqui Wise looks at recent research and asks leading experts to point

Jacqui Wise *freelance journalist, L*

The health secretary, Jeremy Hunt, has cited to support the government's push to improve on Saturdays and Sundays and to justify imposition on junior doctors.¹⁻⁶ But as the junior doctors

Pålidelige resultater:

- Døgn
- Uge
- År
- ...

Pakker - sengeafsnit

August-2			Gyn 0121	Obs 0131	Obs 0142	Neur 0671	Neur 0871	Orto 1551	Orto 0152	Orto 0661	ITA	IMA	LIA 0651	LIA 0655	LIA B5B6	LIA B7B8	Kard 0842	Kard 0641	Kard B1B2	Kard A5A6	ØNH 0631	Børn				Kir 0151	Kir 0161	Kir 0141	Ak base 2	AK FS	Onk 0861	Onk A8								
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Kirurgipakke		Se dashboard kirurgi				Se dashboard kirurgi												Se dashboard kirurgi																						
AMI	Element	Mortalitet																																						
For-klaringer			95-100 % af procesmålet / resultat nået				70-94 % af procesmålet / resultat nået				1-69 % af procesmålet / resultat nået				Ikke relevant/ ikke besluttet				Indikator på vej				Ingen nye data per 26. august (0 %)																	

Pålidelige resultater:

- Enheder
- Geografi

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DECEMBER 28, 2006

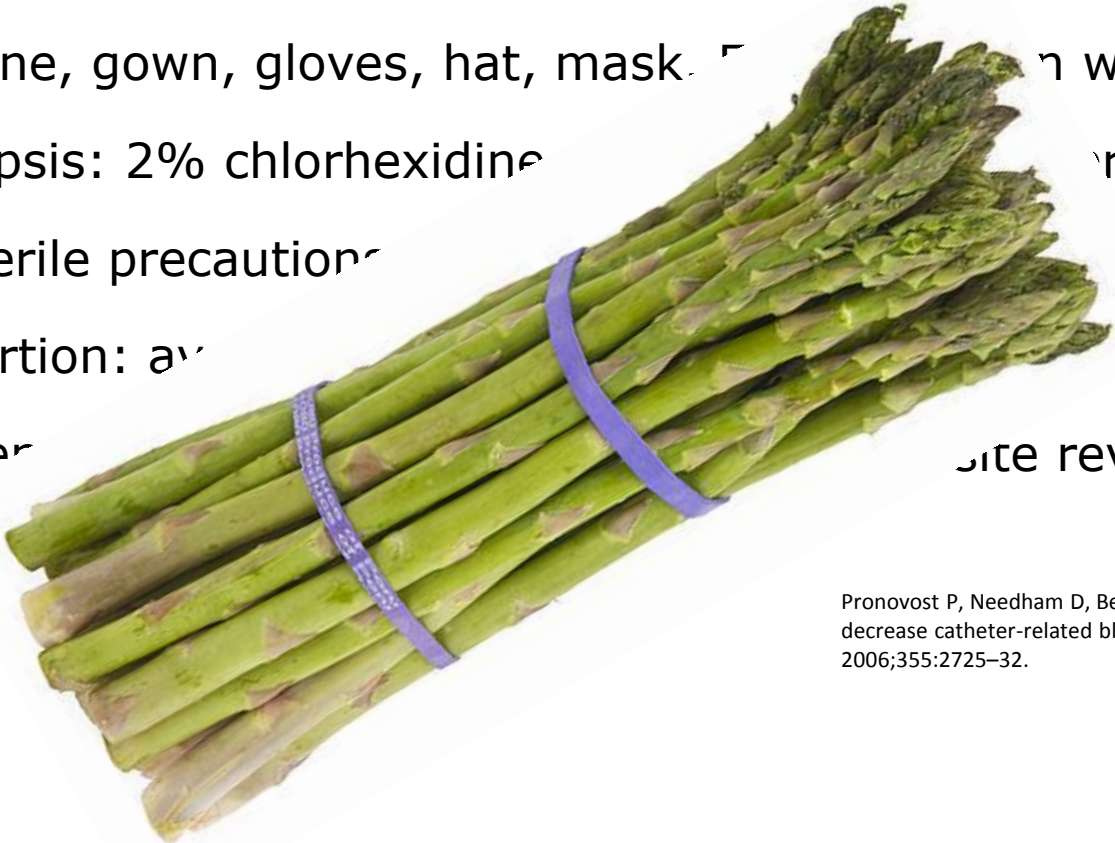
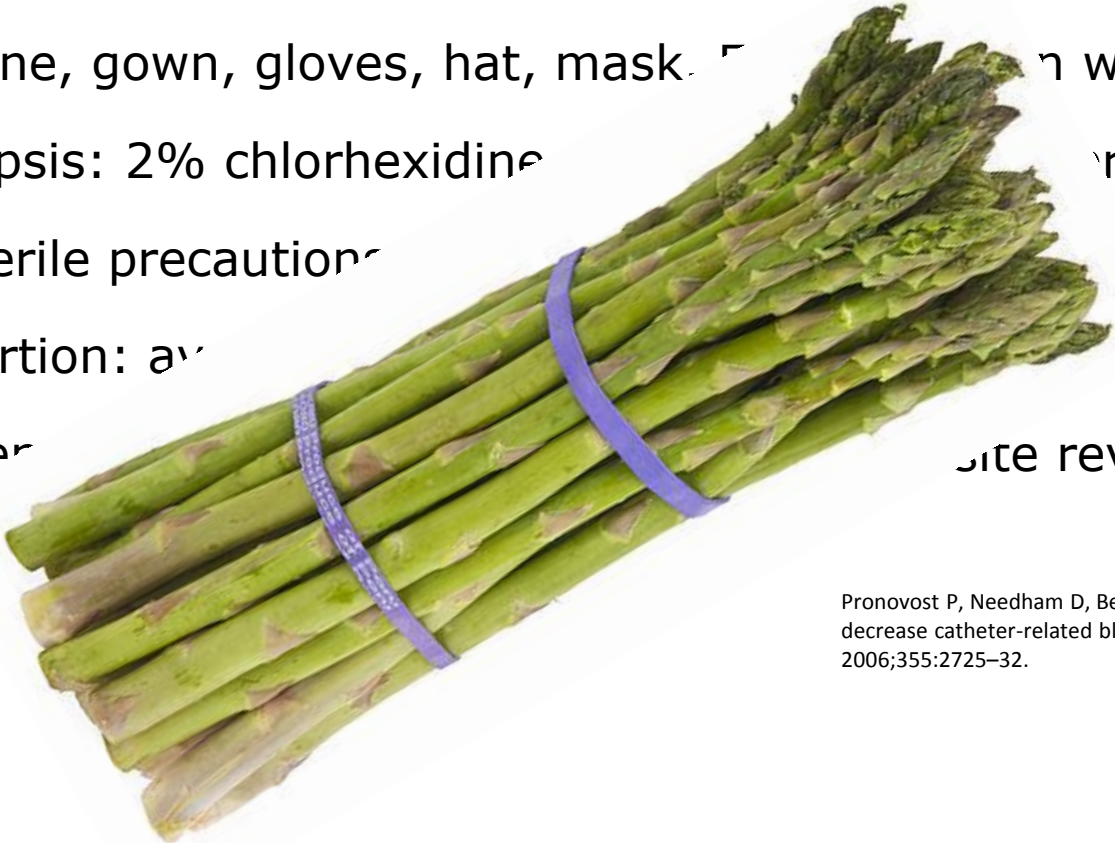
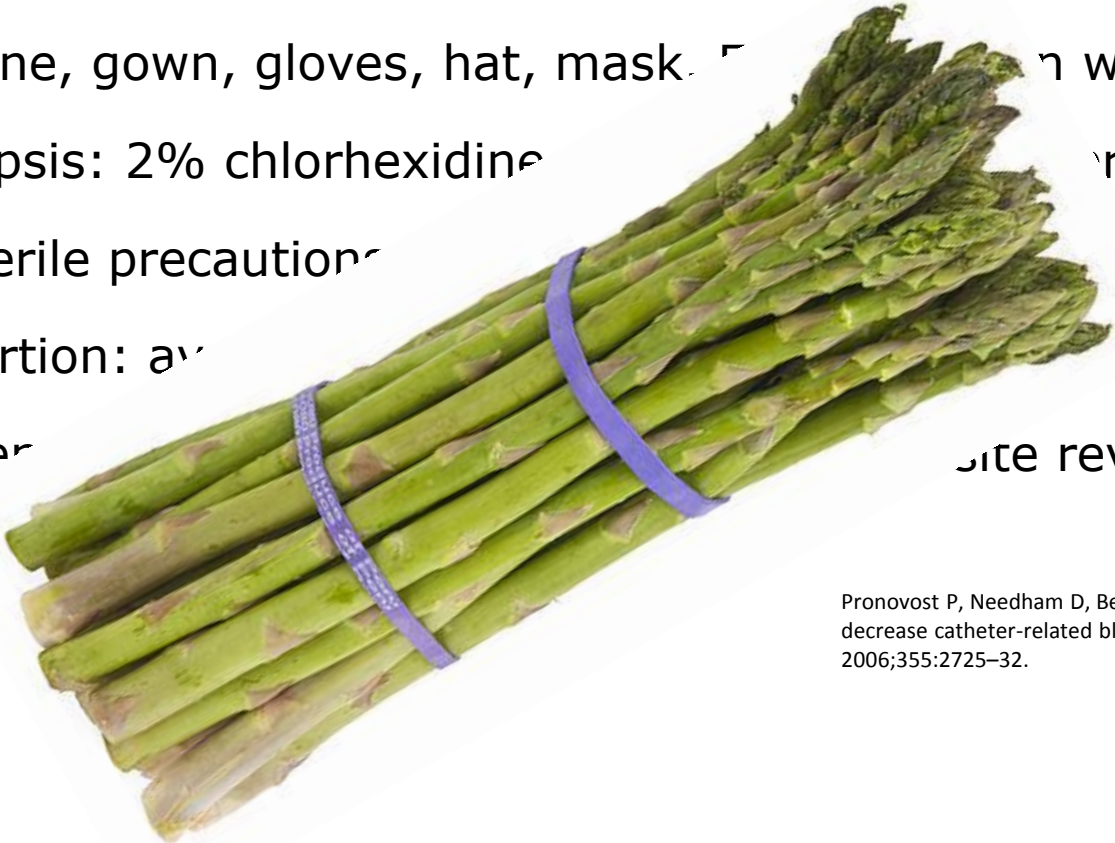
VOL. 355 NO. 26

An Intervention to Decrease Catheter-Related Bloodstream Infections in the ICU

Peter Pronovost, M.D., Ph.D., Dale Needham, M.D., Ph.D., Sean Berenholtz, M.D., David Sinopoli, M.P.H., M.B.A., Haitao Chu, M.D., Ph.D., Sara Cosgrove, M.D., Bryan Sexton, Ph.D., Robert Hyzy, M.D., Robert Welsh, M.D., Gary Roth, M.D., Joseph Bander, M.D., John Kepros, M.D., and Christine Goeschel, R.N., M.P.A.

ABSTRACT

Technical interventions to reduce central venous catheters (CVC)-blood stream infections

- Hand hygiene, gown, gloves, hat, mask.  when indicated
- Skin antisepsis: 2% chlorhexidine  propyl alcohol
- Maximal sterile precautions
- Site of insertion: avoid
- CVC maintenance  site review, and
remove CVC

Pronovost P, Needham D, Berenholtz S, et al. An intervention to decrease catheter-related bloodstream infections in the ICU. NEJM 2006;355:2725–32.

Non-technical and other interventions

- Daily goal sheet
- Intervention to reduce ventilator associated pneumonia
- Comprehensive unit based safety program
- Designate one physician and nurse team leader
- Conferences calls
- Coaching by research staff
- State wide meetings every year



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Pronovost P, Needham D, Berenholtz S, et al. An intervention to decrease catheter-related bloodstream infections in the ICU. *NEJM* 2006;355:2725–32.

THE
MILBANK QUARTERLY

A MULTIDISCIPLINARY JOURNAL OF POPULATION HEALTH AND HEALTH POLICY

Explaining Michigan: Developing an Ex Post Theory of a Quality Improvement Program

MARY DIXON-WOODS, CHARLES L. BOSK, EMMA LOUISE AVELING, CHRISTINE A. GOESCHEL, and PETER J. PRONOVOST

University of Leicester; University of Pennsylvania; Johns Hopkins University

The Michigan project achieved its effects by

1. Generating **isomorphic pressures for ICUs to join** the program and conform to its requirements;
2. Creating a **densely** normative pressure that exerted
3. **Reframing CVC-BS** professional movement combinin am structure
4. Using several interve **commitment to doi** ire of
5. Harnessing **data on i** rates as a disciplinary force
6. Using **“hard edges.”**



Plan for de næste 70 minutter

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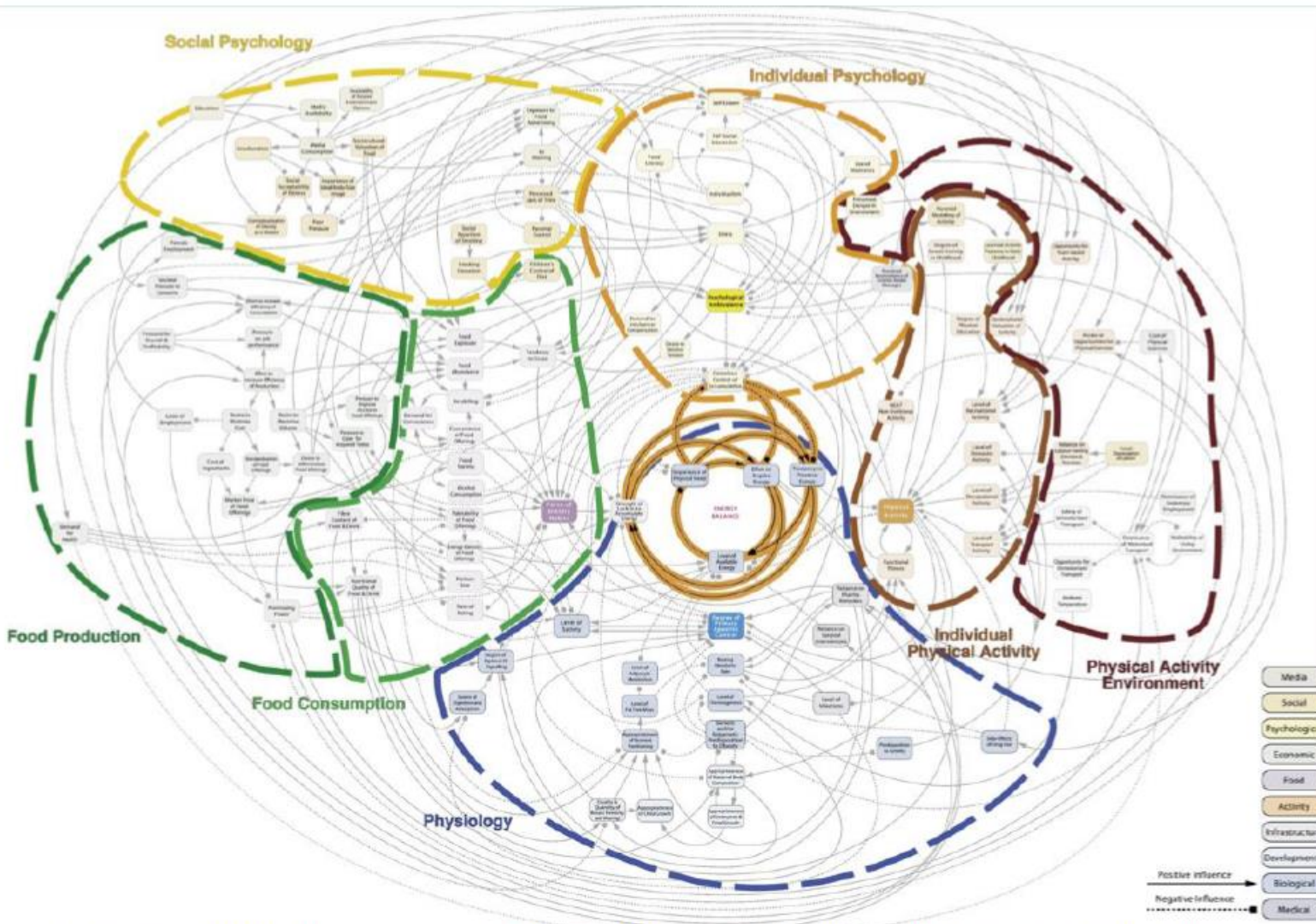


Figure 13 – This system map highlights the enormous range of different and interconnected individual, social and economic systems that influence obesity. Source: Butland, B., Jebb, S., Kopelman, P., McPherson, K., Thomas, S., Mardell, J. and Parry, V. (2007). Tackling Obesities: Future Choices – Project Report. Retrieved from London, UK: <https://pdfs.semanticscholar.org/b910/e21b81d6caa1d15040b2b69d621554716692.pdf>



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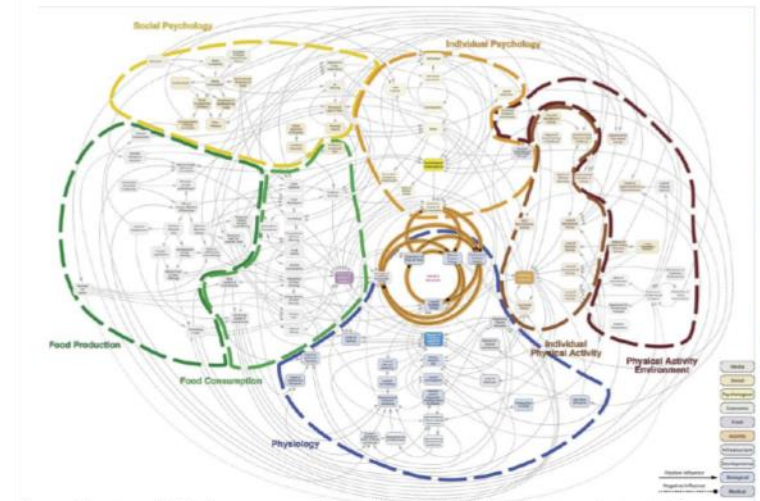
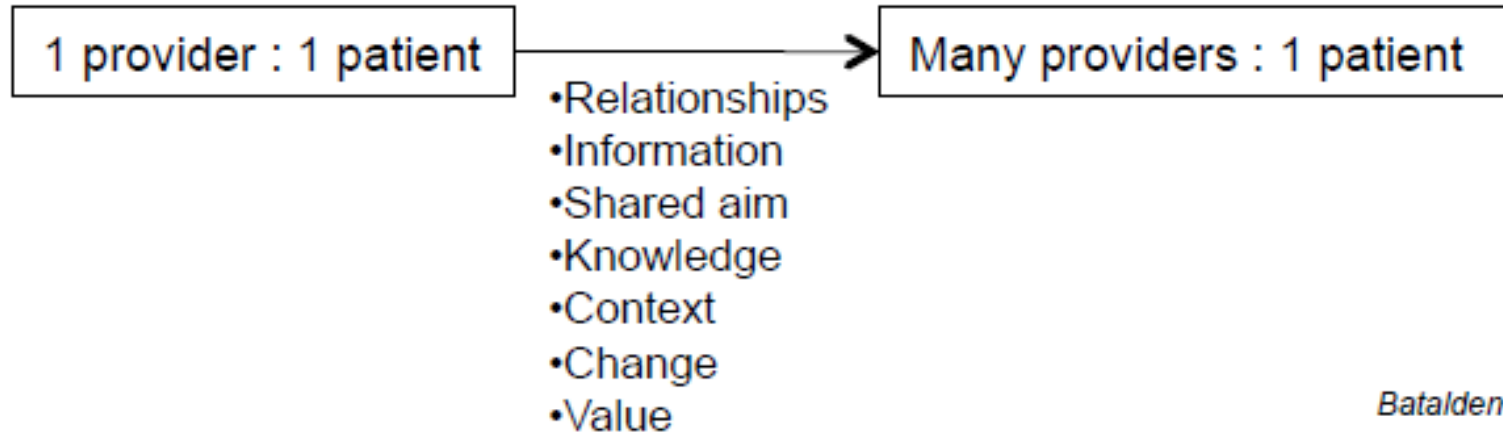


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1:mange

Cherished myth example:



*Batalden P, Ogrinc G Batalden M.
"From one to many"*

J. Interprof Care (2006) 20(5):549-551

*Nelson E, Batalden P, Godfrey M. (2007)
Quality by Design*

San Francisco: Jossey-Bass

Table 1. Distinctive features of aviation and healthcare.

Domain	AVIATION	HEALTHCARE
History	<ul style="list-style-type: none"> Hundred years 	<ul style="list-style-type: none"> Hundreds of thousands of years
Key Raw Material	<ul style="list-style-type: none"> Aircraft, usually less than 30 years old, serviced every few months 	<ul style="list-style-type: none"> Human bodies, can live to around 100 years, check-up every 1-2 years or less frequently
Activities	<ul style="list-style-type: none"> Pilots operate one or two types of aircraft Episode usually lasts 1-10 hours, with same crew on board 	<ul style="list-style-type: none"> Health care professionals have to deal with a wide variety of equipment, diseases and presentations Duration of inpatient stay may be days or even years, with numerous changeovers of staff
Equipment	<ul style="list-style-type: none"> There is a degree of standardisation of displays across aircraft Most procedures are automated, with multiple back-up systems in place Information such as weather conditions is automatically available 	<ul style="list-style-type: none"> There is relatively little standardisation of design across medical equipment Automation of procedures, and back-up systems, are somewhat variable, with much of healthcare being 'hands-on'
Service Users	<ul style="list-style-type: none"> Passengers are healthy Passengers usually have little knowledge of the crew or aircraft or airline Crew rarely know names of individual passengers, and the captain will seldom console a passenger personally if things go wrong 	<ul style="list-style-type: none"> Patients are sick, vulnerable and injured Patients will often come equipped with well-researched information about their condition, their doctors and their hospital Staff will know each patient well and may also become familiar with their families. A consultant will generally console a patient if things go wrong.
Service Delivery	<ul style="list-style-type: none"> More homogenous The same crew usually on board a flight Pilots do not become acquainted with passengers, or have to console them if anything goes wrong Comfort and luxuries rather than safety can be correlated with ability to pay There are few subspecialties of pilots and crew 	<ul style="list-style-type: none"> More heterogeneous with a number of subspecialties involved Health professionals get to know their patients and build up a rapport with them Care is personal and patients are often involved in treatment decisions Quality of care can be related to the ability to pay, especially in developing countries There are many subspecialties in healthcare
Safeguards	<ul style="list-style-type: none"> Many safeguards are in place with a high degree of automatization and computerised support There are strictly enforceable rules to exclude adverse effects of fatigue or alcohol on pilot's performance 	<ul style="list-style-type: none"> Limited safeguards, hands-on work, and a relative lack of automatization and computerised support Lack of strictly enforceable rules to exclude adverse effects of fatigue. Rules about alcohol are seldom made explicit or strictly enforced.
Safety	<ul style="list-style-type: none"> Equal for everyone on plane Fatalities can be over 100 at a time, and usually include the crew of the plane The setting of targets is relatively infrequent, and rarely conflicts with passenger safety 	<ul style="list-style-type: none"> Can correlate with ability to pay, especially in developing countries Fatalities generally involve one person. Staff fatalities directly associated with patient care are very rare. Targets may often be present, and may on occasions conflict with patient safety
Adverse Events	<ul style="list-style-type: none"> Major adverse events are always investigated by a national body Major adverse events are often featured in the media Pilot immunity is often part of the reporting culture Adverse event investigation reports are always published 	<ul style="list-style-type: none"> Major adverse events are usually only investigated locally, though may occasionally be subject to wider investigation Major adverse events only in media Immunity is not necessarily a culture, and disciplinary procedures are not always published Adverse event investigation reports are not always published

Clinical Review



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Aviation and healthcare: a comparative review with implications for patient safety

Narinder Kapur¹, Anam Parand², Tayana Soukup³, Tom Reader³ and Nick Sevdalis⁴

¹University College London, UK

²London School of Economics, UK

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Corresponding author: Narinder Kapur. Email: n.kapur@ucl.ac.uk

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	<ul style="list-style-type: none"> • Degree of standardisation of processes are automated, with check-up systems in place such as weather conditions is readily available • Passengers are healthy • Passengers usually have little knowledge of aircraft or airline • Passengers know names of individual pilots and the captain will seldom address a passenger personally if things go wrong • Passengers are heterogeneous • Passengers usually on board a flight do not become acquainted with each other or have to console them if things go wrong • Passengers seek luxuries rather than safety • Passengers are related with ability to pay • Passengers have few subspecialties of pilots and attendants • Passengers are guarded are in place with a high degree of automation and computerised support 	<ul style="list-style-type: none"> • There is relatively little standardisation of medical equipment • Automation of procedures, and the need for 'hands-on' care • Patients are sick, vulnerable and often come equipped with researched information about their conditions and their hospital • Staff will know each patient well and be familiar with their families. A doctor can console a patient if things go wrong • More heterogeneous with a number of people involved • Health professionals get to know their patients and build up a rapport with them • Care is personal and patients are involved in treatment decisions • Quality of care can be related to the ability to pay, especially in developing countries • There are many subspecialties in medicine • Limited safeguards, hands-on work, and less automation and computerisation • Lack of strictly enforceable rules about the effects of fatigue. Rules about alcohol are made explicit or strictly enforced
Safety	<ul style="list-style-type: none"> • There are strictly enforceable rules to exclude adverse effects of fatigue or alcohol on pilot's performance • Equal for everyone on plane • Fatalities can be over 100 at a time, and usually include the crew of the plane • The setting of targets is relatively infrequent, and rarely conflicts with passenger safety 	<ul style="list-style-type: none"> • Can correlate with ability to pay, especially in developing countries • Fatalities generally involve one person. Staff fatalities directly associated with patient care are very rare. • Targets may often be present, and may on occasions conflict with patient safety
Adverse Events	<ul style="list-style-type: none"> • Major adverse events are always investigated by a national body • Major adverse events are often featured in the media • Pilot immunity is often part of the reporting culture • Adverse event investigation reports are always published 	<ul style="list-style-type: none"> • Major adverse events are usually only investigated locally, though may occasionally be subject to wider investigation • Major adverse events only occasionally featured in media • Immunity is not necessarily a culture, and disciplinary procedures are published • Adverse event investigation reports are not always published



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Equipment	<ul style="list-style-type: none"> There is a degree of standardisation of equipment, with place and conditions is 	<ul style="list-style-type: none"> There is relatively little standardisation of design across medical equipment Automated systems, somewhat 'hands-off'
	<ul style="list-style-type: none"> Knowledge of the system is shared among individual pilots, who will seldom fly if things go wrong 	<ul style="list-style-type: none"> Patients are often researched by multiple doctors Staff will often be familiar with the system, but can seldom fly if things go wrong
	<ul style="list-style-type: none"> More than safety is often a concern, especially to pay pilots and crew 	<ul style="list-style-type: none"> More health care professionals are involved in patient care Health care professionals build up relationships with patients Care is often provided over a long period of time Quality of care is often a concern, especially for patients There are often multiple staff involved in patient care
	<ul style="list-style-type: none"> There is often computerised support There are strictly enforceable rules to exclude adverse effects of fatigue or alcohol on pilot's performance 	<ul style="list-style-type: none"> Lack of strictly enforceable rules to exclude adverse effects of fatigue. Rules about alcohol are seldom made explicit or strictly enforced.
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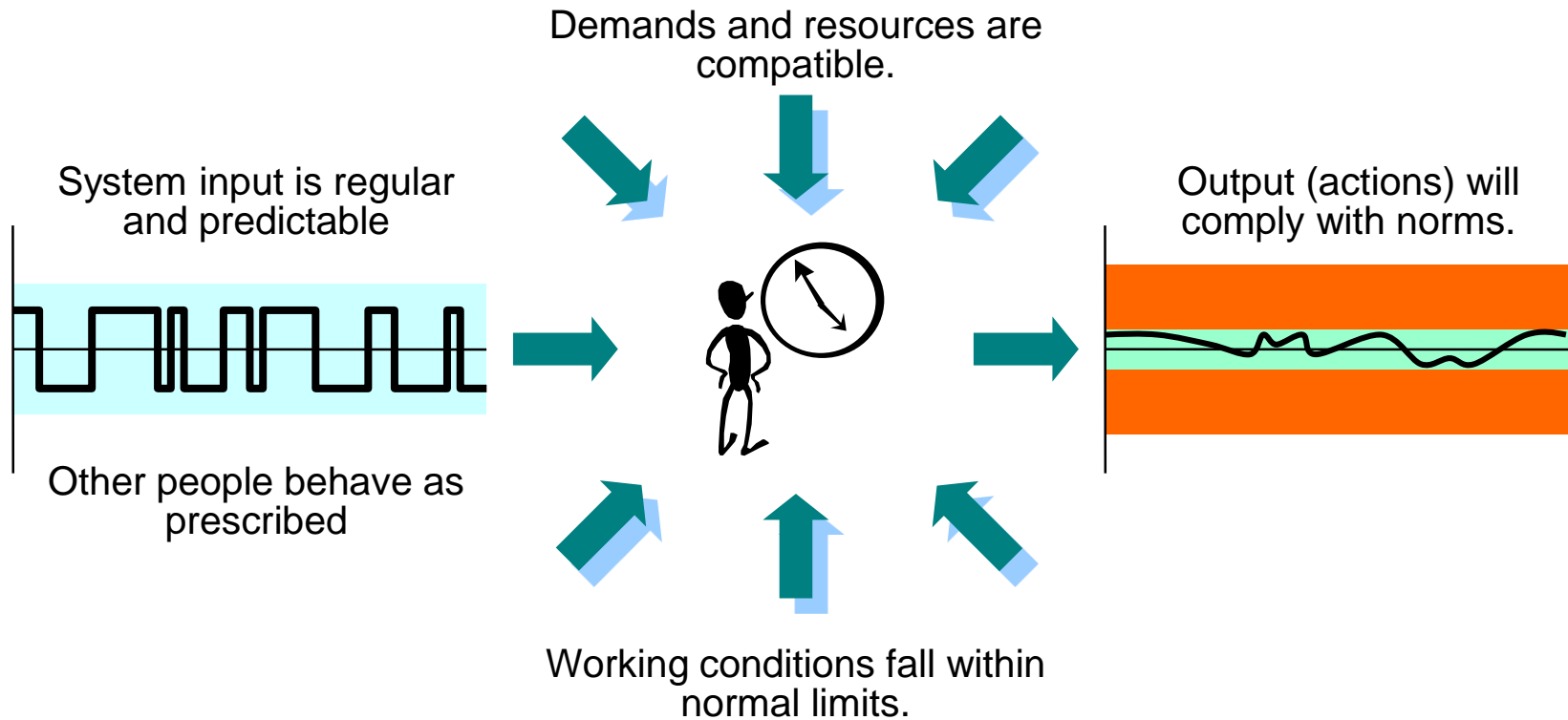
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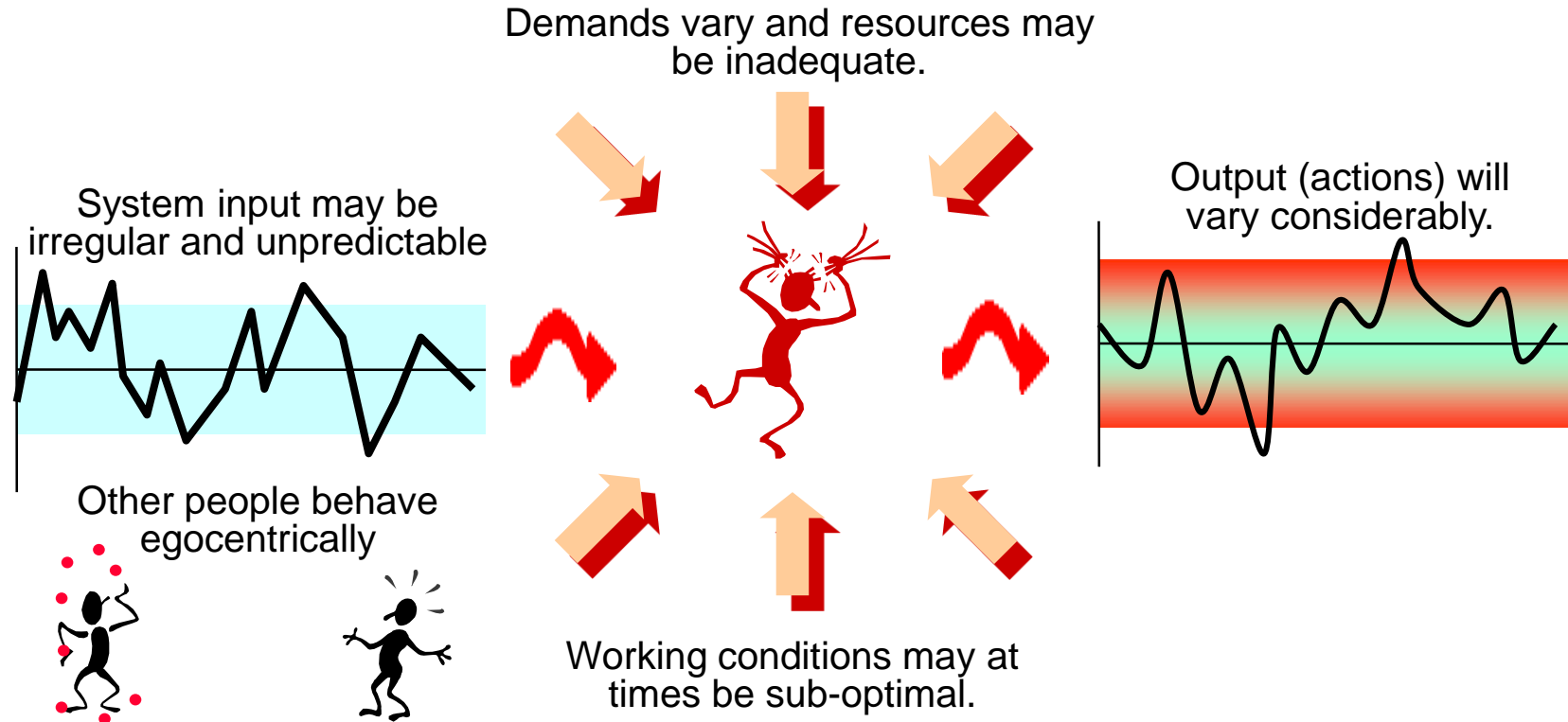
Work as imagined – nominal work



... no need to make adjustments

Hollnagel, E.

Work as done – actual work



... necessary to make local adjustments
Efficiency-Thoroughness Trade-Off (ETTO)

Hollnagel, E.

Plan-Do-Study-Act cirkler [1]

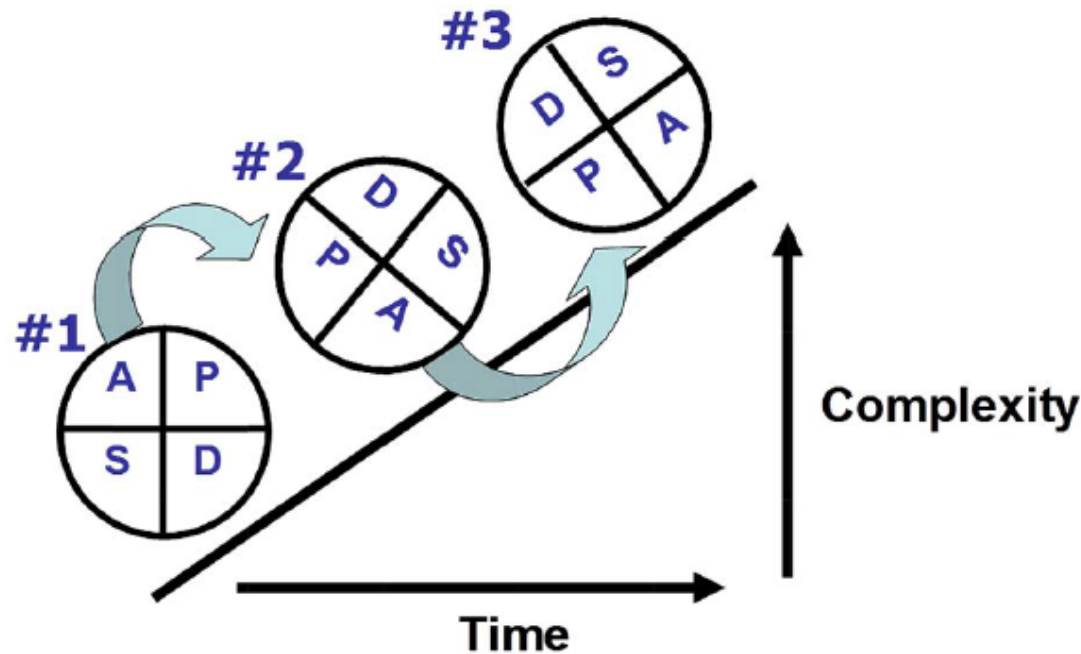


Figure 1 Traditional view of successive plan–do–study–act (PDSA) cycles over time depicted as a linear process. Each preceding PDSA informs the next one. As time goes on, the complexity of each intervention and trial often increases.²

Building knowledge, asking questions

Greg Ogrinc and Kaveh G Shojania

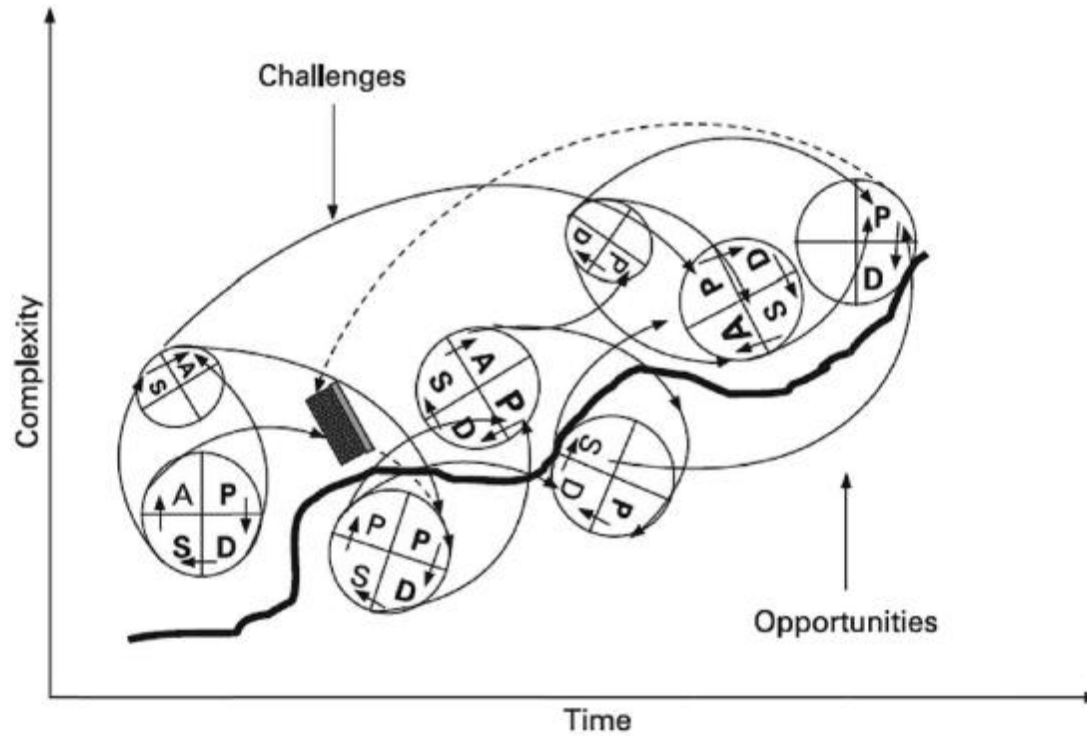
BMJ Qual Saf 2014;23:265–267 originally published online December 23, 2013

Plan-Do-Study-Act cirkler [2]



Building knowledge, asking questions

Greg Ogrinc and Kaveh G Shojania



P = Plan	D = Do	= Barrier	— = Direct flow of impact
S = Study	A = Act	----- = Lingering background impact	Arrowhead = Feedback or feedforward
Different sizes of letters and cycles and bold letters = denotes differences in importance/impact			

Figure 2 Revised conceptual model of plan-do-study-act (PDSA) methodology.⁴

Efficiency-Thoroughness Trade-Off

Thoroughness: Time to think

Recognising situation.
Choosing and planning.

If thoroughness dominates,
there may be too little time to
carry out the actions.

Neglect pending actions
Miss new events



Efficiency: Time to do

Implementing plans.
Executing actions.

If efficiency dominates,
actions may be badly
prepared or wrong

Miss pre-conditions
Look for expected results



← Time & resources needed →

→ Time & resources available ←

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SWITCH

HOW TO CHANGE THINGS

WHEN CHANGE IS HARD

CHIP HEATH & DAN HEATH

THE BESTSELLING AUTHORS OF **MADE TO STICK**



Forberedelse til oplæg "Hvordan involverer vi vores kolleger i forbedringsarbejdet?"

- Tænk på en konkret oplevelse, fx et forandrings- eller udviklingsprojekt på dit arbejde, som du har haft lyst til at engagere dig i!
 - Hvad gjorde, at du var motiveret til at bidrage?
 - Hvordan blev du opfordret til at deltage?
- Tænk på et konkret projekt, hvor du ikke følte dig motiveret til at bidrage!
 - Hvad gjorde, at du ikke ville bidrage til projektet?
 - Hvordan har du givet udtryk for, at du ikke ville bidrage?
- Tænk på en konkret situation, hvor du lykkedes med at motivere en kollega til at bidrage til en opgave!
 - Hvordan har du formuleret invitationen?
 - Hvorfor blev invitationen afvist?
 - Hvilken relation havde du til denne kollega?
 - Hvordan kunne du ellers have formuleret invitationen?

Plan for de næste 70 minutter

1. Hvorfor er involvering af kolleger vigtig?
2. Hvorfor kan involvering være svært?
3. Hvordan inviterer man kolleger med?
4. Hvordan forholder vi os til kompleksitet?
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*Hendes Majestæt Dronningen
indbyder*

Sanger Christopher og ægtefælle

til middag og dans på Christiansborg Slot

tirsdag den 15. marts 2016, kl. 19.30

Hofmarskallen

Forside > Nyheder > Christopher er blevet gift

Dronning Margrethe i brev: Christopher er blevet gift



Don Goldman, IHI, Boston

Seven Rules for Engaging Clinicians
in Quality Improvement

Dan Goldman, IHI, Syv måder at engagere klinikere i kvalitetsforbedringer

1. Fokuser på forbedringer ikke kontrol
2. Undgå mystisk sprog
3. Skab sammenhæng mellem forbedringsarbejde og det klinikerer synes er vigtig
4. Tilpas dig klinikerens arbejdsbelastning og arbejdsplan
5. Vær oprigtig om økonomisk agenda
6. Sørg for relevante data
7. Understreg den akademiske case for kvalitetsforbedringer

Farmaceuter





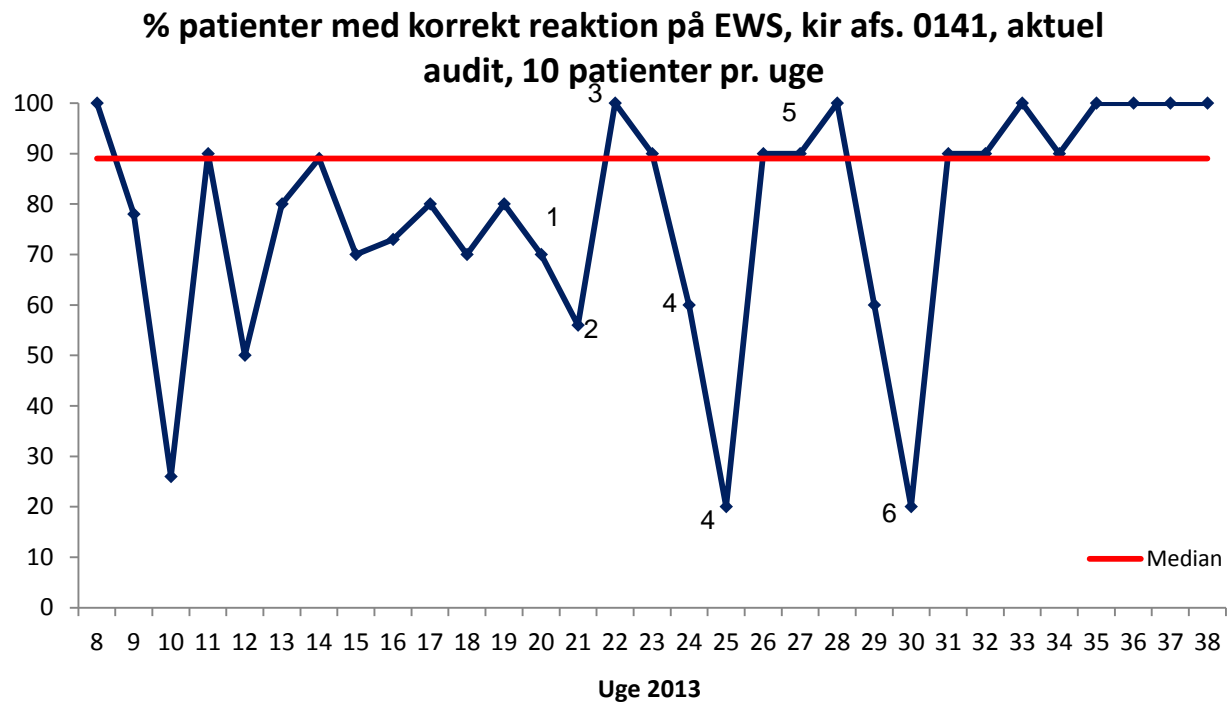


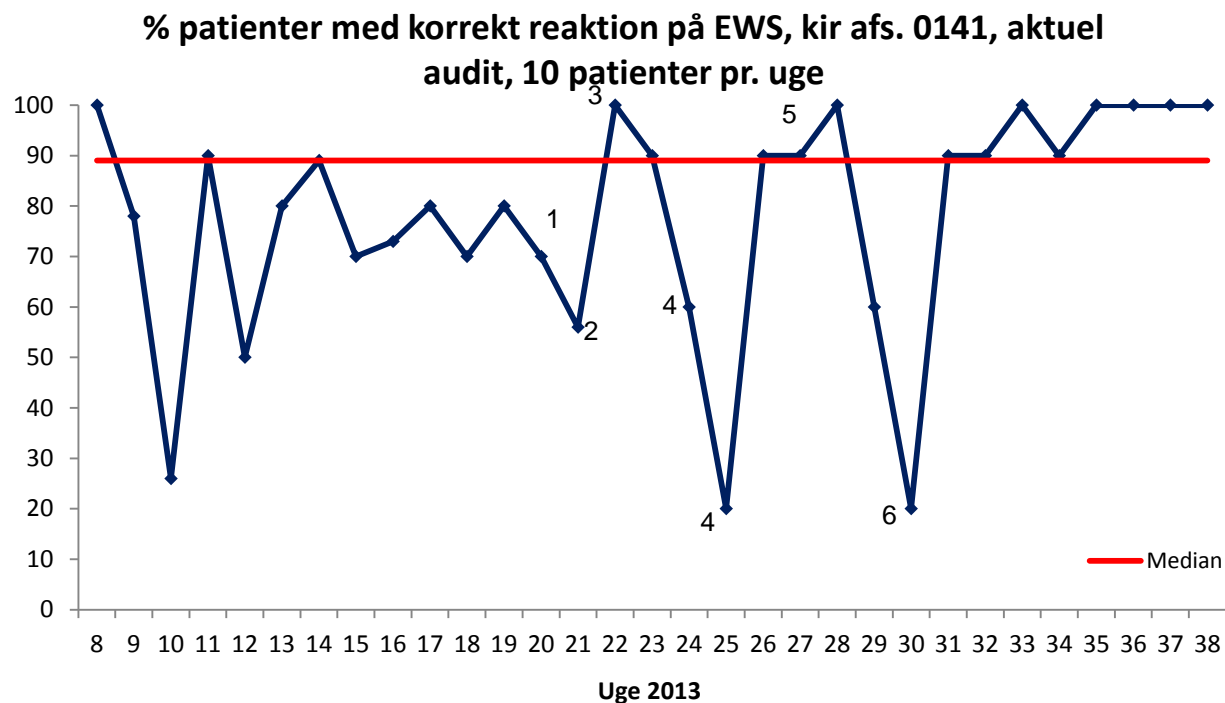
Don Goldman, IHI, Boston

Rule #1: Emphasize improvement, not assurance

Rule #2: Avoid 'mystical' language

Rule #3: Relate improvement work to what matters to clinicians





Indtil uge 18: audit blev gennemført af UKK, afd-sgpl. ikke involveret

1: Personalemøde, principper for EWS gennemgået, EWS skal vises for alle ptt. på tavlen

2: Ugl audit ved UKK og afd-sgpl.. Kriterier for EWS og reaktion på score gennemgås v tavlen bruger pt-case

3: EWS audit gennemføres ved UKK og afd-sgpl. – sammen med personalet på aktuelle ptt.

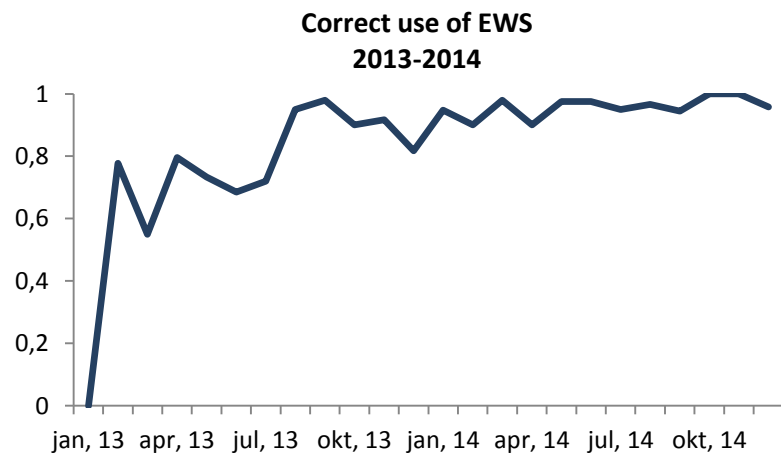
4: Ferie, i uge 25 gentaget formål med EWS, det er et fælles sprog, monofagligt og tværfagligt

5: Kommentarer fra personalet:

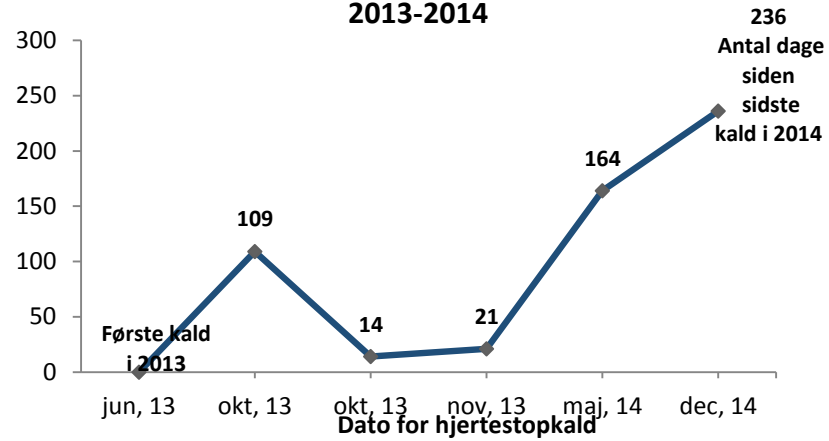
'Nu ser jeg betydningen i brug af EWS som et fælles sprog, tidligere (maj) syntes jeg at vi gjorde dobbeltdokumentation

'Jeg vil gerne at vi gennemgår denne pt., jeg mener at lægeordination med kroniske værdier er farlige for patienten'

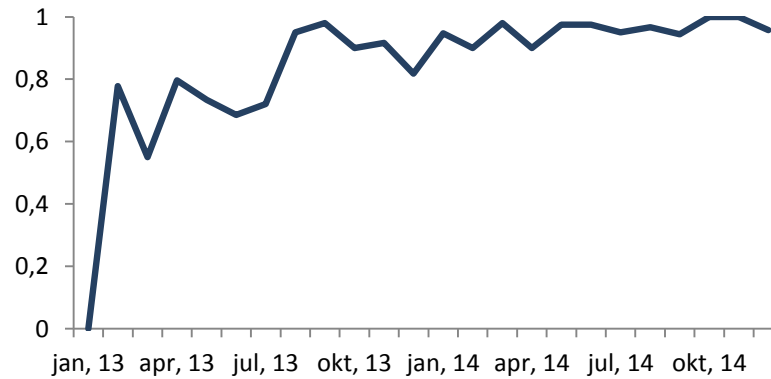
6: Gentaget principper for EWS og algoritmen – de næste punkter taler for sig selv



**Days since last crash call
2013-2014**



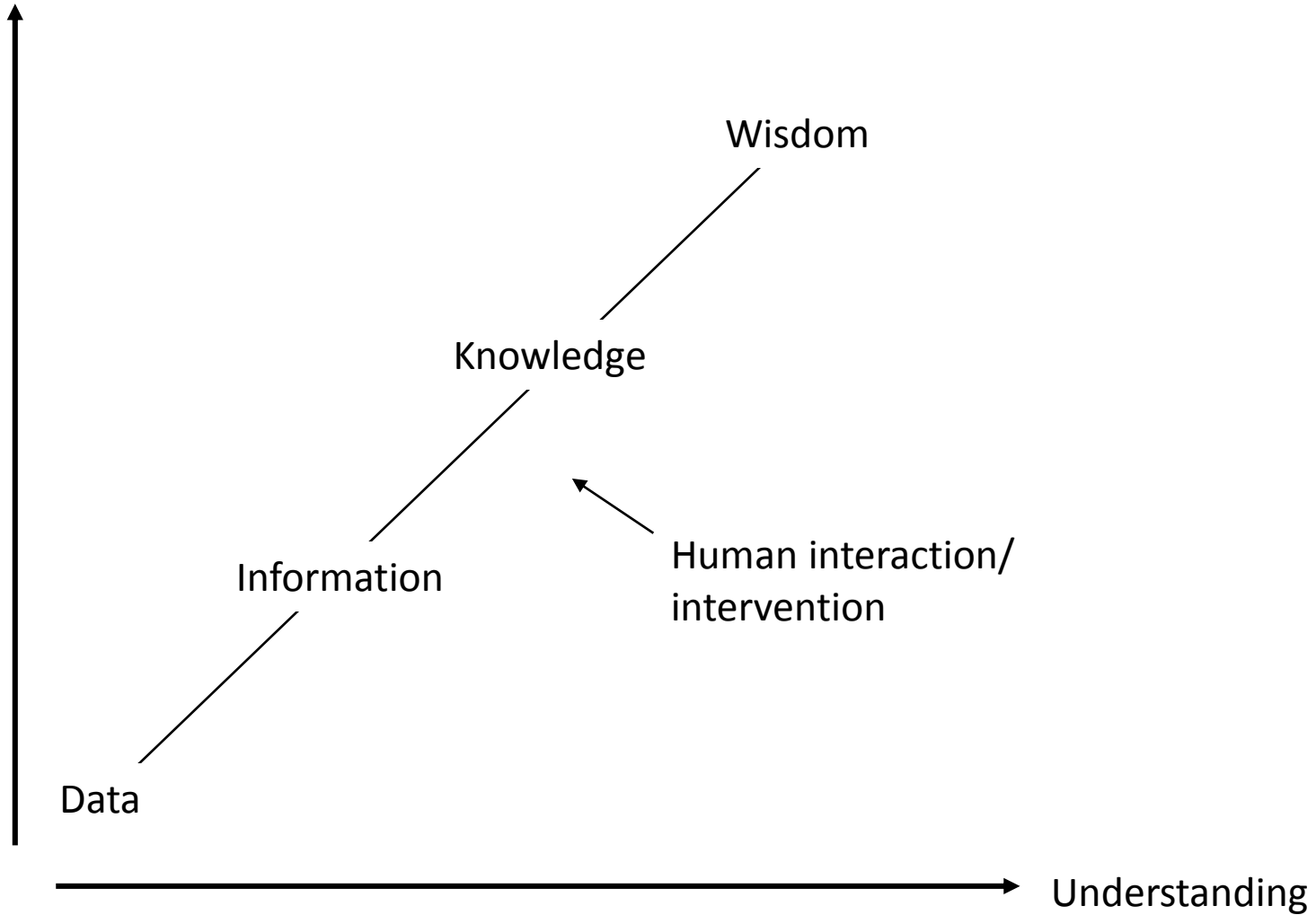
**Correct use of EWS
2013-2014**







Connectedness



Efter: Ackoff

/Hvert problem råber på sit eget sprog./

Thomas Tanströmer: "Om historien"

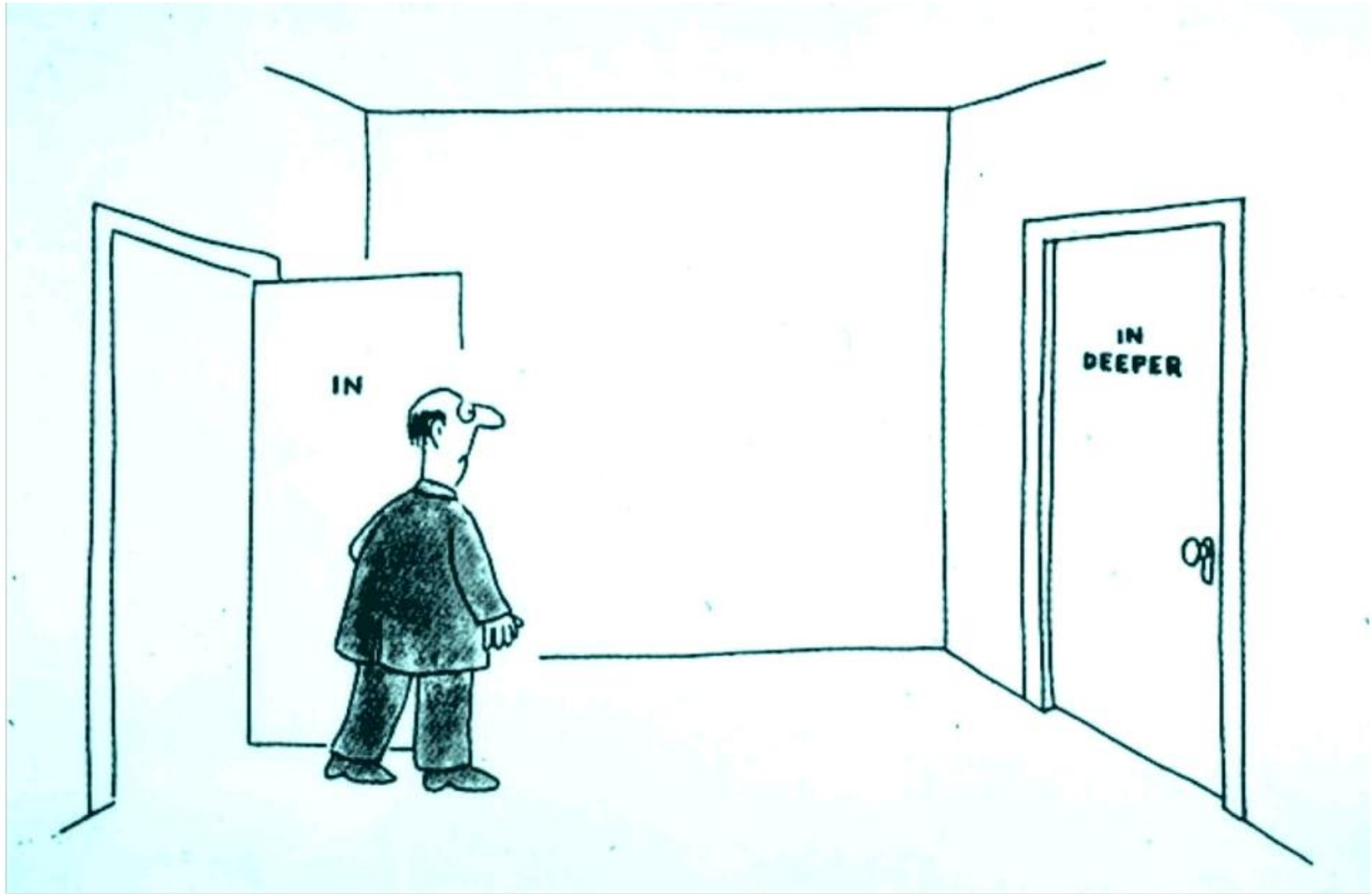
En måde at sige det på...	En anden måde at sige det på...
Jeg har ikke tid	
Jeg skal tage mig af mine patienter	
Det skaber bare bureaukrati	
Det er ikke en sygeplejeropgave	
...	

Dan Goldman, IHI, Syv måder at engagere klinikere i kvalitetsforbedringer

1. Fokuser på forbedringer ikke kontrol
2. Undgå mystisk sprog
3. Skab sammenhæng mellem forbedringsarbejde og det klinikerer synes er vigtig
4. Tilpas dig klinikerens arbejdsbelastning og arbejdsplan
5. Vær oprigtig om økonomisk agenda
6. Sørg for relevante data
7. Understreg den akademiske case for kvalitetsforbedringer

Forberedelse til oplæg "Hvordan involverer vi vores kolleger i forbedringsarbejdet?"

- Tænk på en konkret oplevelse, fx et forandrings- eller udviklingsprojekt på dit arbejde, som du har haft lyst til at engagere dig i!
 - Hvad gjorde, at du var motiveret til at bidrage?
 - Hvordan blev du opfordret til at deltage?
- Tænk på et konkret projekt, hvor du ikke følte dig motiveret til at bidrage!
 - Hvad gjorde, at du ikke ville bidrage til projektet?
 - Hvordan har du givet udtryk for, at du ikke ville bidrage?
- Tænk på en konkret situation, hvor du lykkedes med at motivere en kollega til at bidrage til en opgave!
 - Hvordan har du formuleret invitationen?
 - Hvilken relation havde du til denne kollega?



Plan for de næste 70 minutter

1. Hvorfor er involvering af kolleger vigtig?
2. Hvorfor kan involvering være svært?
3. Hvordan inviterer man kolleger med?
4. Hvordan forholder vi os til kompleksitet?
5. Invitation til videre overvejelse

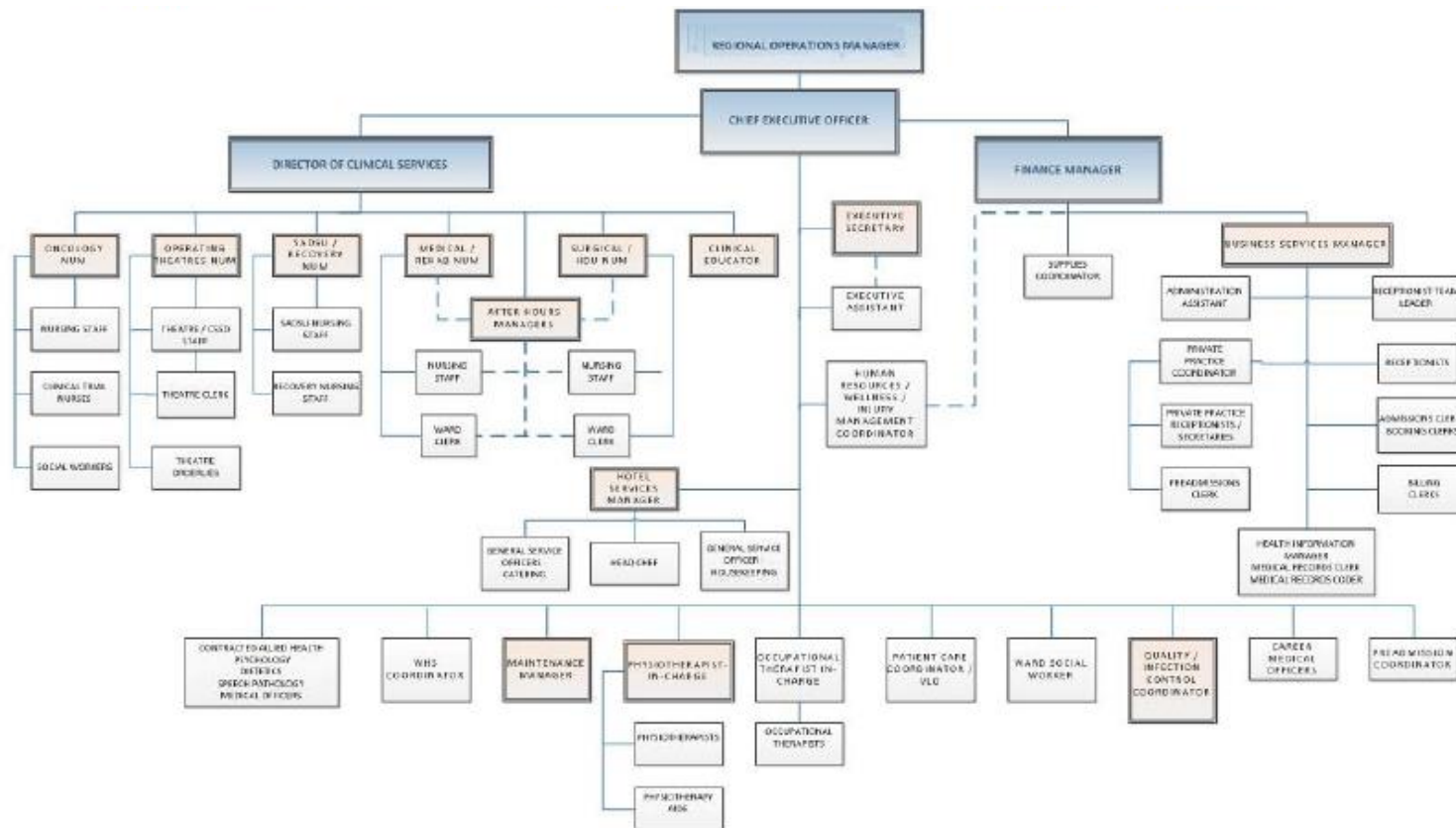


Figure 4 – Linear hospital organisational chart providing a structured view of the reporting and authority relationships. A representation of a complicated system. Source: adapted from Southern Highlands Private Hospital (2017) <http://www.southernhighlandsprivate.com.au/About-Us/Organisational-Chart>

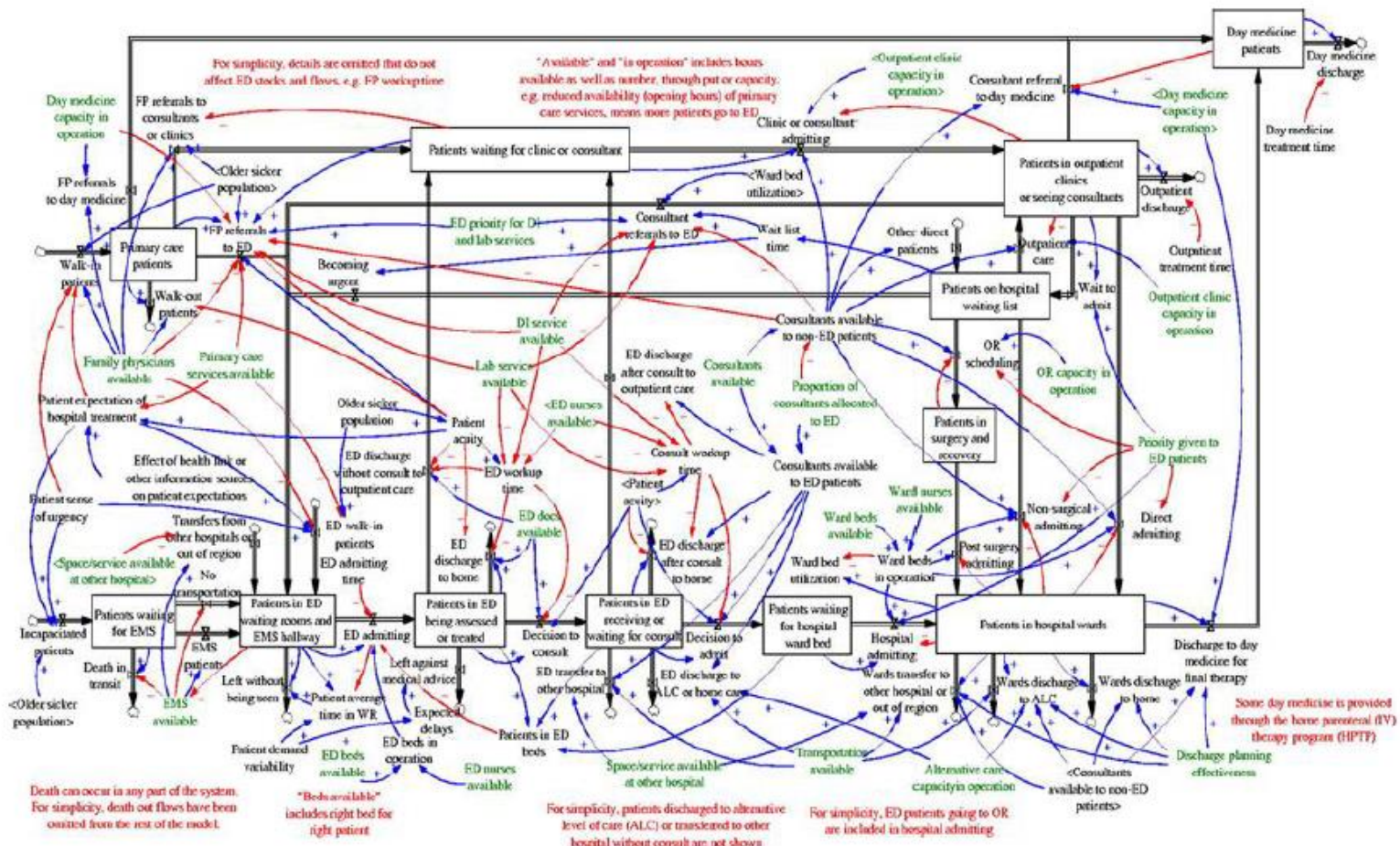
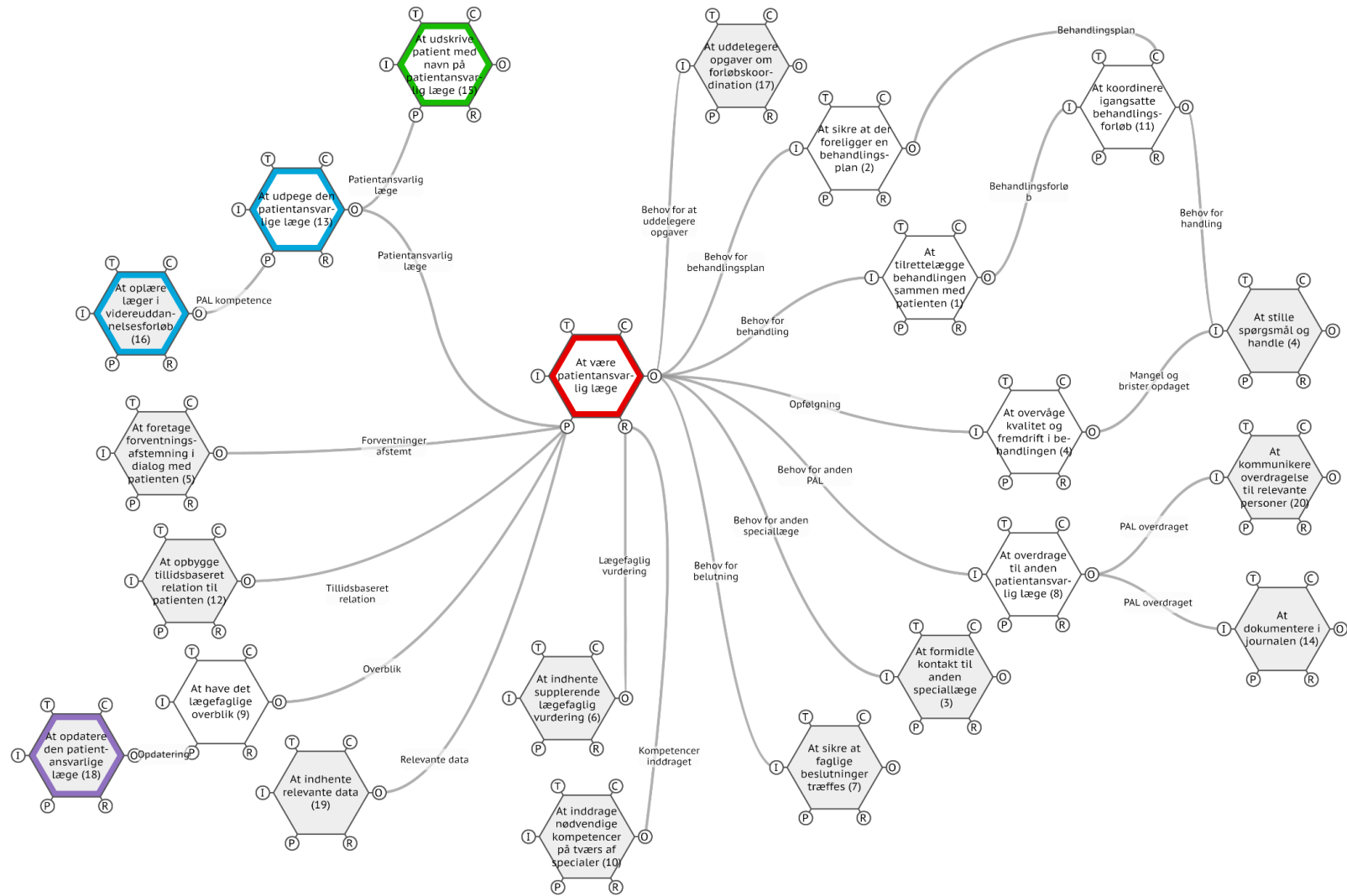
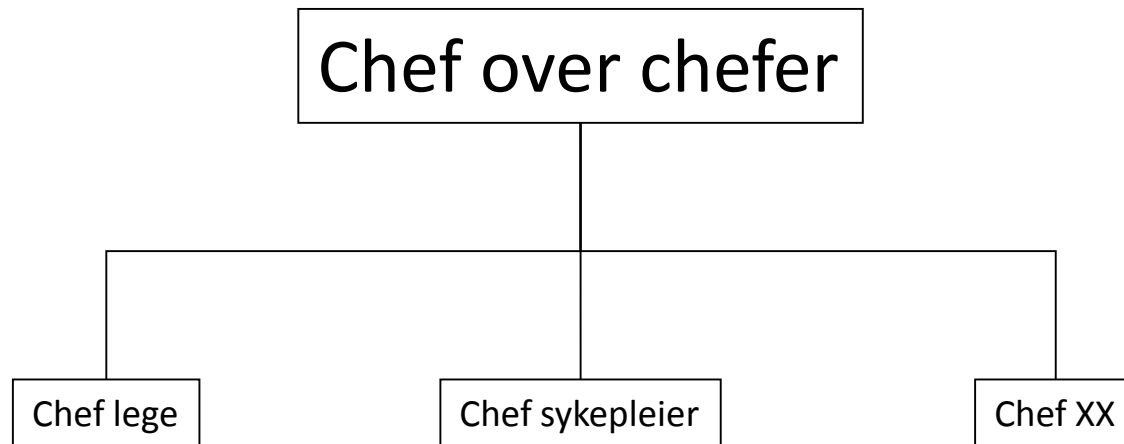


Figure 5 – Hospital as a CAS depicted through a Causal Loop Diagram, representing aspects of the dynamic complexity of the organisational interactions. A representation of a complex system. Source: Braithwaite, J. (2015). Modelling causal pathways in health services: A critique. Retrieved from https://www.slideshare.net/CLAHRC_WM/modelling-causal-pathways-in-health-services-critique-jeffrey-braithwaite







5. Match change designs with situation requirements. Health care faces simple, complicated, and complex situations.

Health care situations:

Simple	Complicated	Complex
<ul style="list-style-type: none"> • Baking a cookie • Elements and their interactions known • Recipes help • Forcing functions help 	<ul style="list-style-type: none"> • Rocket to moon • Elements and interactions are knowable • Algorithms help • If, then... 	<ul style="list-style-type: none"> • Raising a child • Elements and interactions are <u>not</u> knowable • Shared aim, relationships matter
Reliability is reasonable	Reliability is possible	Reliability not possible; Resilience is a better aim

Glouberman S, Zimmerman B. (2002) Complicated and complex systems: what would successful reform of Medicare look like? Discussion paper no. 8. Saskatoon: Commission on the Future of Health Care in Canada.

Liu SK, et al. "Improving the Simple, Complicated and Complex Realities of Community-acquired Pneumonia" QSHC (2009) 18: 93-98.



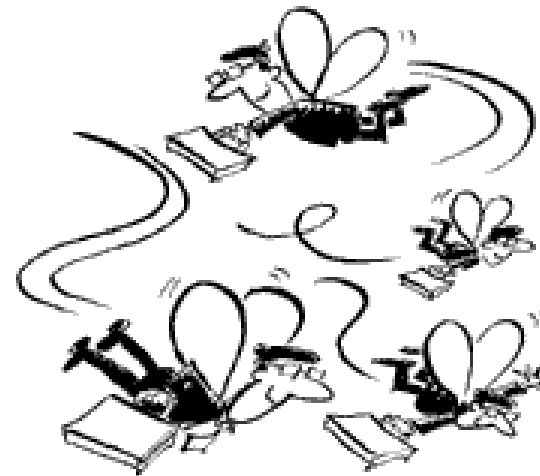
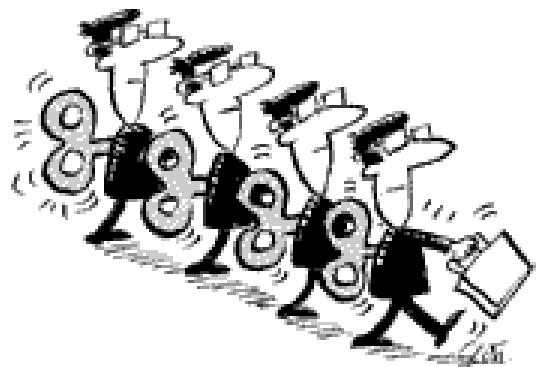
Tavlemøder og kapacitetskonferencer har medført en langt mere systematisk koordinering af patientforløb på tværs af faggrupper og afsnit. Det har dannet grundlag for bedre patientforløb på tværs af akutsygehuset samt etableringen af en 'vi-kultur', hvor patientforløbet i højere grad ses i en helhed og ikke kun fra det enkelte afsnits eller speciales per-

Side 6



Kapacitetskonference på Sygehus Vest med videoforbindelse fra Herning til Holstebro og fælles dataoverblik

Dansk selskab for patientsikkerhet: Sikkert patientflow.
Erfaringer fra et forbedringsprojekt 2015



Clockware	Swarmware
Rational	Creative
Standardized	Experimental
Repeatable	Trying
Controlled	Free
Measured	Autonomous
Knowledge based	At the edge of knowledge/experience

Kilde: Kelly K. Edgeware



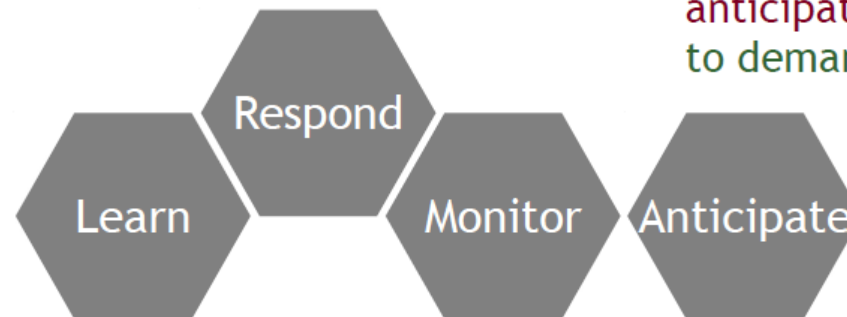
Ledergruppe i et sygehus



The four resilience potentials

Resilient performance requires that the system can **respond** to threats and opportunities alike

Resilient performance requires that the system can **anticipate** long-term changes to demands and resources.



Resilient performance requires that the system can **learn** - both from what goes right and what goes wrong.

Resilient performance requires that the system can **monitor** what happens - externally and internally.

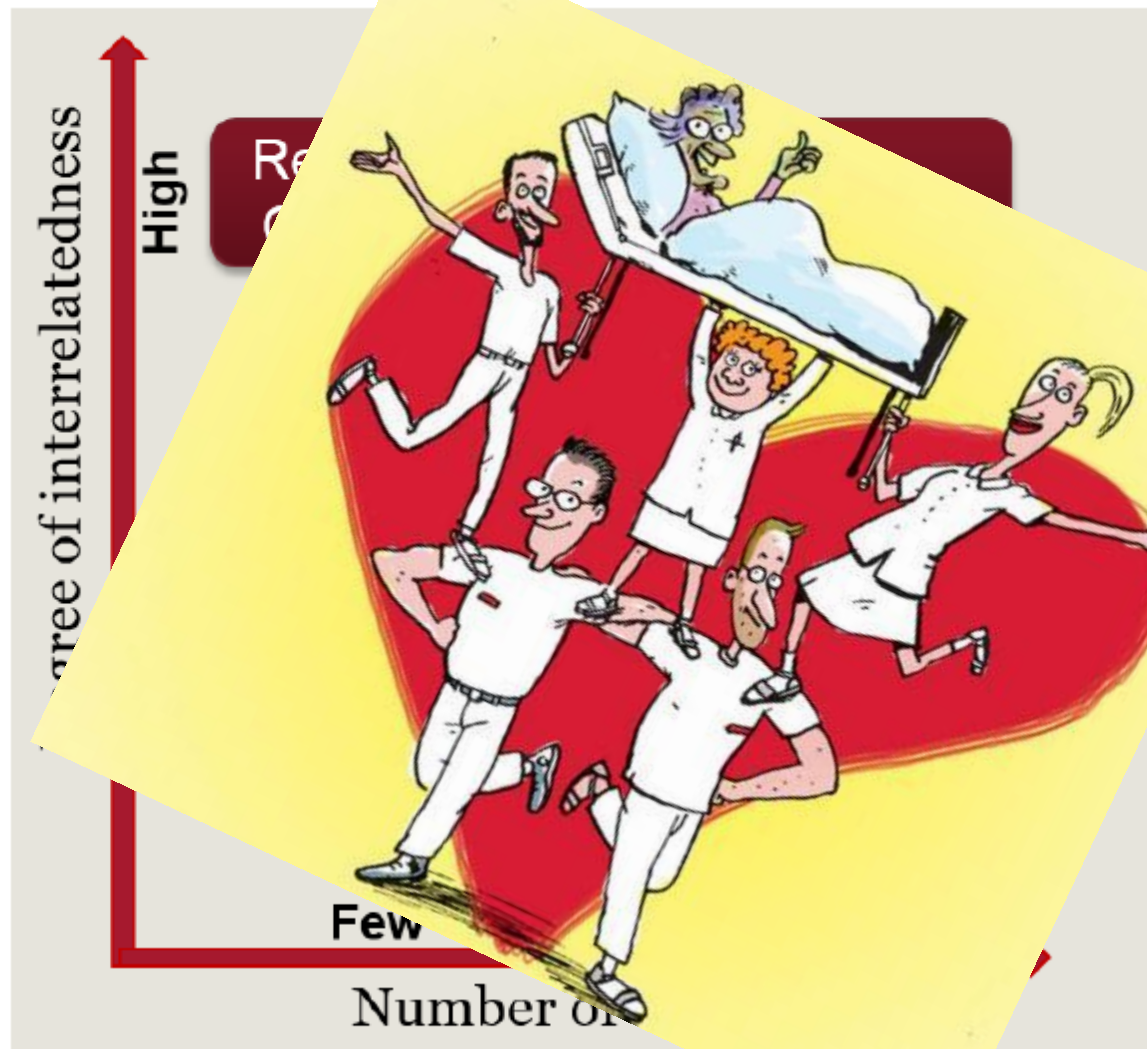


Figure 2 – Illustrative, idealised distinction between simple, complicated and complex systems. Source: adapted from Kannampallil, T. G., Schauer, G. F., Cohen, T. and Patel, V. L. (2011). Considering complexity in healthcare systems. *J Biomed Inform*, 44(6), 943-947.

Plan for de næste 70 minutter

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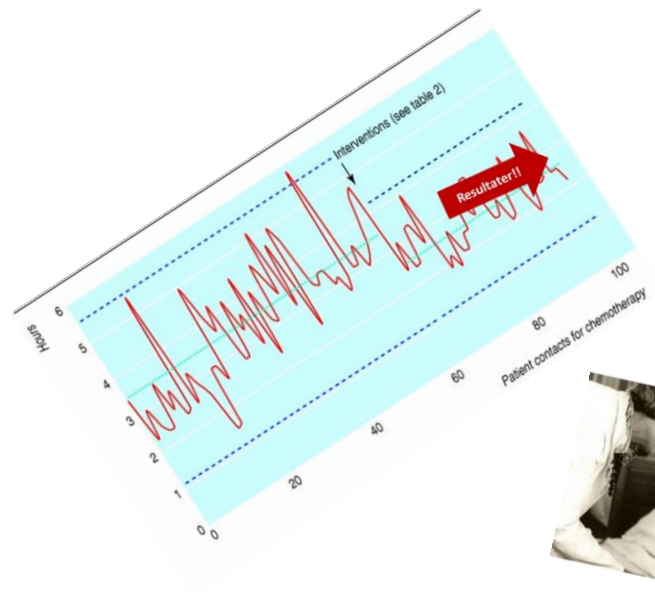
*Hendes Majestæt Dronningen
indbyder*

Deltagerne i læringsseminar palliation

Til at overveje og anvende følgende

Til det næste læringsseminar

Hofmarskallen



1:1

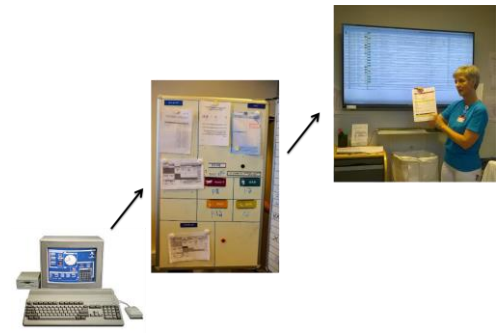


1:mange

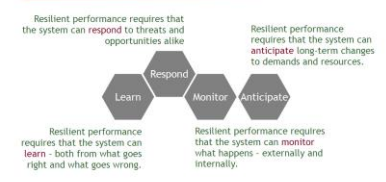


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Det er ikke en lægeopgave	
...	

Efficiency-Thoroughness Trade-Off



The four resilience potentials



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Hvad siger forskere indenfor området? [1]

- Der skal være en helhjertet opbakning fra ledelsen, hvilket *især* betyder, at —
 - Formålet med arbejdet skal være krystalklart
 - Der skal afsættes de nødvendige resurser til forbedringsarbejdet
 - Et givet (nyt) kvalitetsforbedringsarbejde skal tilpasses hvad der i øvrigt findes af igangværende initiativer rundt omkring
 - At man godt må stille krav til medarbejdere om at forpligte sig til at være engageret i kvalitetsforbedringsarbejde
- Der skal være et skarpt fokus på klinisk relevante problemstillinger, hvilket *især* betyder, at —
 - De involverede klinikere ser kvalitetsforbedringsarbejdet som værende relevant i deres hverdag, og især at være til gavn for deres patienter

Hvad siger forskere indenfor området? [2]

- Der skal anvendes et begrebsapparat (et sprog), som ikke er fremmedgørende for folk i de kliniske frontlinjer
 - Folk der arbejder i specifikke kvalitetsudviklingsmiljøer i sundhedsvæsenet skal være tilbageholdende med at pådutte klinisk arbejdende personale det særlige sprogbrug vi har udviklet i vores arbejde
- De problemløsningsforslag (eller -modeller) der bringes på bane i arbejdet skal, så *vidt* muligt være —
 - Baseret på de principper der gælder for evidensbaseret medicin
 - Anbefalet af faglige fyrtårn (*peers*) på området og/eller baseret på konsensus
 - Åbne for evalueringer i forløbet af arbejdet, og til slut

Hvad siger forskere indenfor området? [3]

- Arbejdet med kvalitetsforbedringer skal være overskueligt og gennemskueligt
 - Folk i de kliniske frontlinjer har travlt, så deres engagement i forbedringsarbejde skal gøres let...!
 - God projektstyring: Hvor skal vi hen? Hvor er vi nu? Og hvad gør vi for at komme videre herfra?
 - Effektiv videns- og datadeling i projektforsløbet: Brug af websites, interaktive intranets og/eller 'skyer', hvor al relevant information findes samlet
- Adgang til valide, tidstro data. De er nødvendige for at —
 - Beskrive status (udgangspunktet)
 - Fastlægge mål for indsatsen (*targets*)
 - Monitorere progressionen

Hvad siger forskere indenfor området? [4]

- Husk folk på at kvalitetsforbedringsarbejde kan være meriterende!
 - Lægevidenskabelig forskning baseret på fx laboratoriarbejde og (klinisk) epidemiologiske studier har tidligere være regnet som 'finere' end sundhedstjenesteforskning, men det er ved at ændre sig
 - Der findes efterhånden mange tidsskrifter med høje impact factors indenfor området