EQuiP

European Association for Quality and Safety in General Practice/Family Medicine

June 2022

Newsletter

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SIMULATION IN PRIMARY HEALTH CARE:
DEVELOPING SAFE PRACTICE

Uroš Zafošnik **Davorin Marković**

Work in healthcare demands a high theoretical knowledge backed up with practical expertise. This is especially important when we are talking about vitally endangered patients that put us in high degree of stress because we do not encounter those kinds of patients every day.

The number of vitally endangered patients in primary healthcare is too low for medical teams to have enough experience with them. This is why it is very important to continually educate medical teams so they can achieve a high degree of theoretical and practical knowledge and with that also become more trustful in their own abilities and reduce stress levels.

We can reduce the number of medical mistakes with proper staff education that consists of use of simulations in healthcare. In SIM Centre CHC Ljubljana (in primary health care) we offer training to nurses, doctors, health care teams, medical students, nursing students and clinical mentors. Our goal is safety and contentment of the patient.

The goal is to reduce the risk in life threatening situations in primary health care and to implement the knowledge we have to offer. SIM Centre's main objective is to improve the safety of the patients and to improve clinical results with the use of simulation in the training and learning process. SIM Centre's vision is to enable competent medical professionals who are practically and theoretically qualified. Our main activities are therefore education and research. We define work processes, evaluate them through scientific research and standardize the process on a national level. This process then provides clinical excellence to users of our services.

Simulation is an excellent way for health care workers to train their skills in a safe environment. It is an effective, ethical and safe way to practice theoretical knowledge. Trainees acquire experience in simulation in life threatening situation, how to approach acute situation and situations where decisions have consequences. This way we approach the clinical environment as close as we can. But sadly, learning with simulations in healthcare is usually not available to professionals.

Contributing factors to this problem are the lack of knowledge and poor equipment combined with high education costs and time shortage in medical teams. We have developed a mobile simulation unit (SIM mobile) that will enable all medical teams in primary healthcare access to modern simulation equipment.

We have used SIM mobile to conduct simulations in over 186 different locations in Slovenia, 31.716 km. (Community health centers, prehospital units). Participants were doctors of family medicine, nurses and EMT workers. There was at least 1 participant in every training. At the end of training the participants filled out a question form about their previous experiences with use of simulations in healthcare, their need for this kind of education and availability of this kind of education.

At the beginning and in the end we have measured the intake and outtake theoretical knowledge of every individual. There were 1488 participants included in this program from different parts of Slovenia.

They were all at least 50 km from CHC Ljubljana. SIM mobile was available for 1488 hours in 186 days. Total training time was 1488 hours. The simulation that was carried out was the management of vitally endangered patient – anaphylactic shock.

The participants were prepared for the simulation with theoretical education, education of hand skills and with help of augmented reality. All of the participants have said that the physical environment of SIM mobile was very comfortable and appropriate for learning and training. 10% of the participants have said that they have the access to simulation based learning in their workplace, but the equipment is too old and not realistic enough.

All of the participants have agreed that the SIM mobile is a great program for renewal of knowledge for experienced doctor and nurses. It is also a great learning tool for a beginner doctor and nurse to prepare themselves for work with real patients. Participants have also said that they would not attend this kind of education if it was not at their doorstep because of lack of time and resources.

Pre- and post-evaluation experiment of qualification indicates that the level of knowledge in simulation is higher for 60 %.

Prepared treatment protocols were excellent valued. Latent security risks, that have been identified, were: problems with equipment, high stress of some participants, uncoordinated team, not to lead the process of supply vitally threatened by the doctor, too long response time, and inadequate resuscitation algorithm. SIM mobile is a mobile education unit which brings state of the art, hands–on training, using high fidelity human patient simulators, to medical professionals.

The »SIM mobile« is a 16 meters long trailer with two simulation spaces: a simulation room and debriefing room. SIM mobile will provide standardized, high quality training to ensure consistent outcomes to rural team in primary care.

SIM mobile provides opportunities for outstanding educational experiences that translate into better patient care and improved provider safety. A mobile simulation experience that can be brought to healthcare professionals in rural and frontier communities, thus reducing the need for providers to travel for training.

A variety of courses that can be customized to meet local needs. A source of continuing education to supplement existing local training resources. This kind of education type brings a lot of benefits as: Provides effective training related to key community health needs such as heart attack, stroke, and maternal and pediatric emergencies. Reduces the time staff is pulled away from the bedside by cutting travel time, which in turn reduces training costs.

SIM mobile was tested in different weather conditions from 10°C to over 30°C. At every condition the participants evaluated it as a very comfortable environment.

A few participants have stated that they occasionally have simulation equipment available for them to learn on but it is not used for its bad state because of lack of resources to buy new one. The main advantage of SIM mobile is that it can make simulation equipment available to a broad specter of medical teams in primary healthcare and is not limited by geographical position.

There are a couple of factors that contribute to medical teams not attending this kind of education and it is usually with work stress. That means long working hours, tired employees and limited free time. If we make this kind of education available to them at their doorstep they are more likely to attend it because it does not take additional time from them to come to us. SIM mobile program also has an option to reduce its costs that are linked to simulations. Building and maintaining big SIM centers is expensive and is logical only for big CHC or hospitals.

It is certainly not cost efficient for smaller hospitals or rural locations. The use of SIM mobile program to give simulation based education in primary healthcare has proven to be a successful program and our participants have confirmed this. SIM mobile can bring simulations to a wide group of health professionals all around Slovenia and beyond.

Zalika Klemenc-Ketiš

Introduction of peer support as part of scaling-up integrated care in patients with concomitant diabetes and arterial hypertension at the primary health care level in Slovenia

Tina Virtič, Majda Mori Lukančič, Nataša Stojnić, Zalika Klemenc-Ketiš, Antonija Poplas Susič
Community Health Centre Ljubljana, Slovenia

Chronic non-communicable diseases pose a serious global public health problem (1,2), the most common of which are arterial hypertension (AH) and type 2 diabetes (T2D) (3–6). The management and control of T2D and AH calls for a comprehensive patient-centred care which should be accessible, connecting, continuous, and lifelong. The desire is for efficient, safe and quality care that actively involves the patient in the decision-making and is based on the appropriate organisation of care and monitoring of its quality (7,8).

In our SCUBY research project (SCale-Up diaBetes and hYpertension care; project is funded by European Union's Horizon 2020 programme under grant agreement No. 825432) we seek to upgrade the integrated care of vulnerable patients with the DB and AH by increasing the scope of the integrated care package. In this way, we want to involve the patient and their caregivers to a greater extent and empower them for successful self-management and self-care of the disease, which would lead to a better quality of life (9,10).

One of the possible solutions on how to upgrade the existing model of integrated care for chronic patients with the DB and AH in Slovenia is the introduction and appropriate organisation of peer support and functioning of specially trained individuals, so-called peer supporters.

The partners outside the health care system can make a significant contribution to the integrated care of a patient with a chronic illness, due to the fact that we know that maintaining a patient's continued capacity for self-help and self-care is a task beyond the capabilities of the health care system and healthcare professionals (7,8). The persons who provide peer support have their own experience of the disease and are a great source of energy for continuous and lifelong support to another patient with the same chronic disease and there are no linguistic nor cultural barriers between them (8,11–13).

This allows the patient to better adopt a healthy lifestyle and related behaviour due to the increased knowledge of the disease and a sense of social cohesion (12–16).

Peer supporters understands that they are not a healthcare professional in this role (8). Peer support can be grouped into four main functions: i) assistance and counselling in every-day life decisions, ii) emotional and social support, iii) assistance and liaison with healthcare professionals, iv) continuous and lifelong support (13).

Our pilot study within the SCUBY project started in May 2021 with recruitment of 36 patients with T2D and/or AH. 32 participants have successfully finished educational programme in a total of 15 hours of group and individual training by educator (nurse with special skills) and have become trained peer supporters. Such persons are responsible to themselves and the tasks undertaken, are empowered to take good care of their illness, with a developed sense of trust and with the ability to listen, understand and communicate with people.

They decided to work with people voluntarily and are aware of the importance of regular cooperation with a mentor / educator from the healthcare organisation.

They represent a link between the patient, the healthcare system and the local community, and at the same time enable intergenerational connections. For the purpose of our pilot study each peer supporter is now voluntarily sharing his knowledge and own experiences among a small group of 10 patients with T2D and/or AH in the local community in a relaxed atmosphere through monthly meetings for 3 months.

Outcomes will be evaluated with questionnaires including sociodemographic and clinical data, knowledge about T2D and AH, Appraisal of Diabetes Scale, Diabetes Empowerment Scale, Theoretical Framework of Acceptability and interviews to provide quantitative and qualitative data. Data collection process will last until June 2022.

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Big news from Estonia

Elle-Mall Sadrak

In 2009 first quality guidelines for Estonian family practices were made. 9 years later, 2018 we renewed the guidelines and in 2022 we finished with the implementation manual of quality guidelines and also translated them to English and Russian to sheer them internationally, especially to our EQUIP colleagues. Both of these documents are available online.

Guidelines

Implementation manual

You might find some chapters odd or too basic, but trust me, simple things also need to be put clearly on paper.

After the first edition was published,in 2009, Estonian association of family doctors implemented voluntary based practice accreditation system, where some (20) indicators from the guidelines were chosen to be audited with the family practices. We started auditing 20-30 practices and now we are at 150 audits this year. (In total we have 430 family practices in Estonia).

What does audit mean?

Every year family doctors have to fill in a questionnaire, where they have to answer Yes/No to the chosen questions for the year. Each question gives points- maximum is 20 points. By receiving 19 and more points practice is rewarded with a A-level practice mark. If practice receives 16-18 points a B-level practice mark is given and so on. A and B level practices receive a extra bonus funding as well from Health Insurance Fund.

At the moment questionnaire consists of 16 questions:
First 4 questions are prefilled by Health Insurance Fund.
1. Does family doctors practice sends all health records to the digital network(1)
2. Are all family doctors, who have their own practice list, resertified(2,5)
3. Did 2/3 of practice lists receive a result in QBS
4. Is there nurses work coded, mandatory at least 800 per year, per patient list
5. Can you register to a family doctors appointment in a way it doesn't disturb family doctor/nurses appointments
6. Is there a written reason why patient is coming to an appointment
7. Are all health records digital
8. Do family doctors practice have regular personnel meetings, where patient clinical questions/patient safety cases are discussed
9. Does a family practice have website with adequate information for patients
10. Does a family practice collects regular feedback from patients
11. Does each family nurse have a workplace with a computer
12. Can you make an appointment for family nurse, using digital registry
13. Does each family nurse have their own appointments for 20h per week
14. Are all family nurses recertified
15. Does a family practice do something to propagate the specialty (teaching, articles, etc)

And then we have 8 questions which we follow and hint where are we planning to move towards the following years. For example – there is no pharmaceutical commercials in the waiting area.

After finishing with the questionnaire all practices who score more than 16 points first time ever are chosen for the audit and we randomly pick around 50 practices who received less than 16 points. Last few years we have focused on those practices who do very bad.

If a practice is chosen for the audit they will be contacted and a team will visit them during the summer.

It means that 2 family doctors or 1 family doctor+ 1 family nurse + 1 guest from either Social Ministry, health Insurance Fund, Health board will visit the family doctors practice and give feedback using pair-to-pair method – teaching and learning at the same time – they will give feedback and advice if needed.

And by the end of august we have all chosen practices visited and during our annual family doctors conference we will congratulate those who did well.

What is new for 2022 – we are doing county based audits – it means that all practices from that region are audited and given feedback individually and county based as well.

Please feel free to give any feedback you have – write ellemall.sadrak@gmail.com

Zzz... is for Zero:
A Coproduced Approach to Reducing Sedative Medication Prescribing in Ballyhale Health Centre

John Brennan

Bio

Dr. John Brennan is an International Society for Quality in Healthcare (ISQua) Fellow and Board Member, past ISQua/ Royal College of Physicians of Ireland (RCPI) Scholar in Residence and a practicing General Practitioner in Ireland. In addition to providing clinical care, he also currently works with the RCPI in designing and delivering quality improvement and patient safety education across a variety of platforms, including in collaboration with the Health Service Executive in Ireland to deliver health service improvement.

John has served as lead QI faculty for the National COPD Improvement Collaborative in Ireland and RCPI Diploma in Leadership and Quality in Community Care. He is a past chair of the Irish College of General Practice National GP Trainee Committee, and a previous member of the national Postgraduate GP Training Committee responsible for the governance and accreditation of GP training in Ireland.

He is a member of the Q Community and the European Society for Quality and Safety in Family Medicine (EQUIP). John has published extensively in peer reviewed scientific journals and has received several awards for quality improvement work presented globally. He is a co-author of the RCPI Improvers Guide, multiple book chapters on QI, patient safety and person centred care, and recently co-edited the Oxford Handbook of Patient Safety.

Background

Prescribing rates for sedative medications (benzodiazepines and 'z-drugs') in Ireland are high compared to other OECD nations. The vast majority of ongoing prescriptions for these medications are generated in General Practice. These medications carry a high potential side effect and safety risk for patients, including an increase in the relative risk of developing dementia by 30-60% and an increased risk of falls and injury in older patients by up to 200%. In Ballyhale Health Centre, a rural general practice serving approximately 3000 people, a Health Service Executive Primary Care Reimbursement Service (HSE PCRS) audit in early 2019 indicated that prescribing rates for these medications were amongst the highest 50% of general practices nationally.

The aim of this quality improvement project has been to reduce the total amount of sedative medications prescribed by 66%, in all patients attending Ballyhale Health Centre by 1st July 2020. This outcome measure represents a reduction in the total number of milligrams of the 6 most commonly prescribed sedative medications (diazepam, alprazolam, temazepam, lormetazepam, zopiclone and zolpidem). Despite the deadline of 1st July 2020 having passed, this initiative continues to reduce sedative prescribing.

QI Approach

All staff (doctors, nurses and administrative staff) at Ballyhale Health Centre, with the input and expertise of patients, have been using quality improvement methodology to understand and improve prescribing in this area of care. Systems understanding tools utilised include process mapping for prescribing in the practice, root cause analysis, in-depth patient chart reviews and patient stories/feedback. Nominal group technique and brainstorming were then employed to generate change ideas. The project theory linking these change ideas to drivers for improvement is represented in the attached Driver Diagram (Fig. 1).

Using the Model for Improvement, change ideas tested to date include a medication safety notice (co-designed with patients), a standardised opportunistic verbal medication safety message, an agreed clinical practice guideline on sedative medication prescribing, and a standardised approach to sleep hygiene education including a co-designed rapid reference leaflet and a more detailed resource kit.

Clinical and non-clinical improvement team members have been engaging with patients, community pharmacists and other members of the multidisciplinary community healthcare team in a bid to socialise this change across the community. A key enabler for this project has been the adoption of co-design and coproduction approaches, involving shared decision making and patients as co-owners of this improvement work.

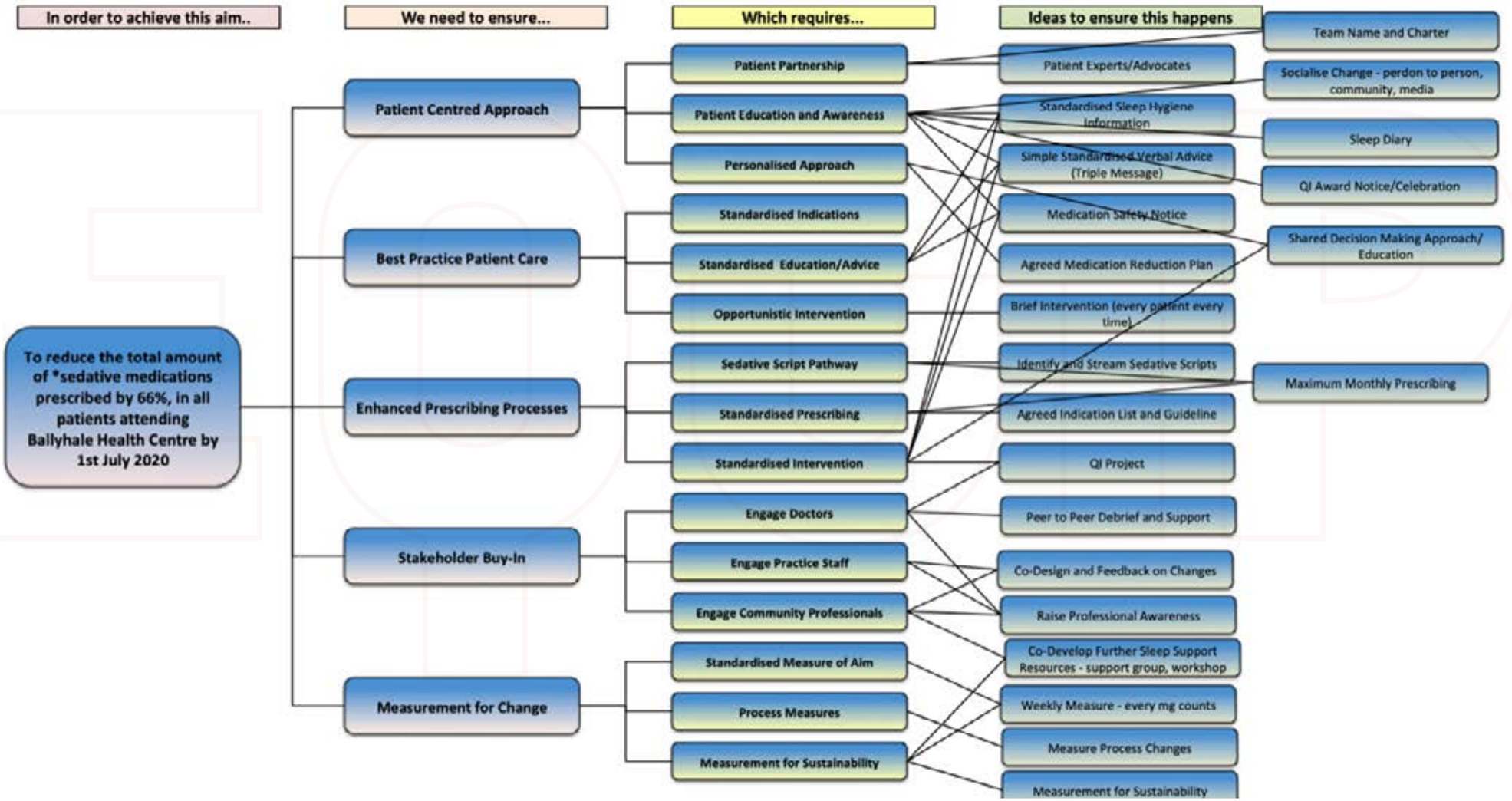


Figure 1 Driver Diagram

Progress and Improvement

Since May 2019, we have reduced the total weekly amount of sedative medication prescribed in Ballyhale Health Centre by 52.5%. Prescribing rates for sedative medications are falling (Fig. 2) and the project has continued throughout the Covid-19 pandemic. In addition, our clinical team has improved care of insomnia more generally through the development and co-design (with patients) of standardised sleep hygiene resources (paper and online), a sleep diary and a broader focus on working with patients to improve underlying determinants of sleep (e.g. pain, mental health and lower urinary tract symptoms amongst others). Our improvement team has reflected very positively on working together to coproduce improvement in this area of medication safety. These team based relationships continue to develop and underpin other quality improvement endeavours in the practice and wider community. We also continue to spread practical approaches learned during this initiative to as many other general practices as possible for the benefit of all patients.

Coproduction

To begin, the practice clinical team were invited to review the international, national and practice level (PCRS Audit report) data on sedative prescribing in the practice. A conversation developed around what mattered most to the clinicians culminating in a shared view that the prescribing rates in the practice for these medications represented a significant avoidable harm for patients. A literature review completed by the team confirmed the evidence base for this shared concern. The clinical team reflected on the complexity of the problem and agreed to adopt a formal QI approach.

The clinical team immediately recognised the need to involve patients with lived experience of this issue to co-design effective, workable and person-centred change ideas for improvement. Five patients of the practice were approached and invited to meet the clinical team to explore the problem. The clinical team shared their concerns around the performance of the practice in this area and prescribing rates. Three patients agreed to volunteer their time to assist the practice team directly with the project, while 2 others offered further availability for consultation on specific aspects.

The full improvement team then applied QI tools to develop a comprehensive and shared understanding of the problem before generating, prioritising and testing change ideas together. The team met on a weekly basis for 30 minutes initially, and then every 2 weeks (in-person pre-Covid 19, then via Zoom). Prescribing rates for sedative medications were measured on weekly basis up-to-date data displayed at team meetings to continue to drive change.

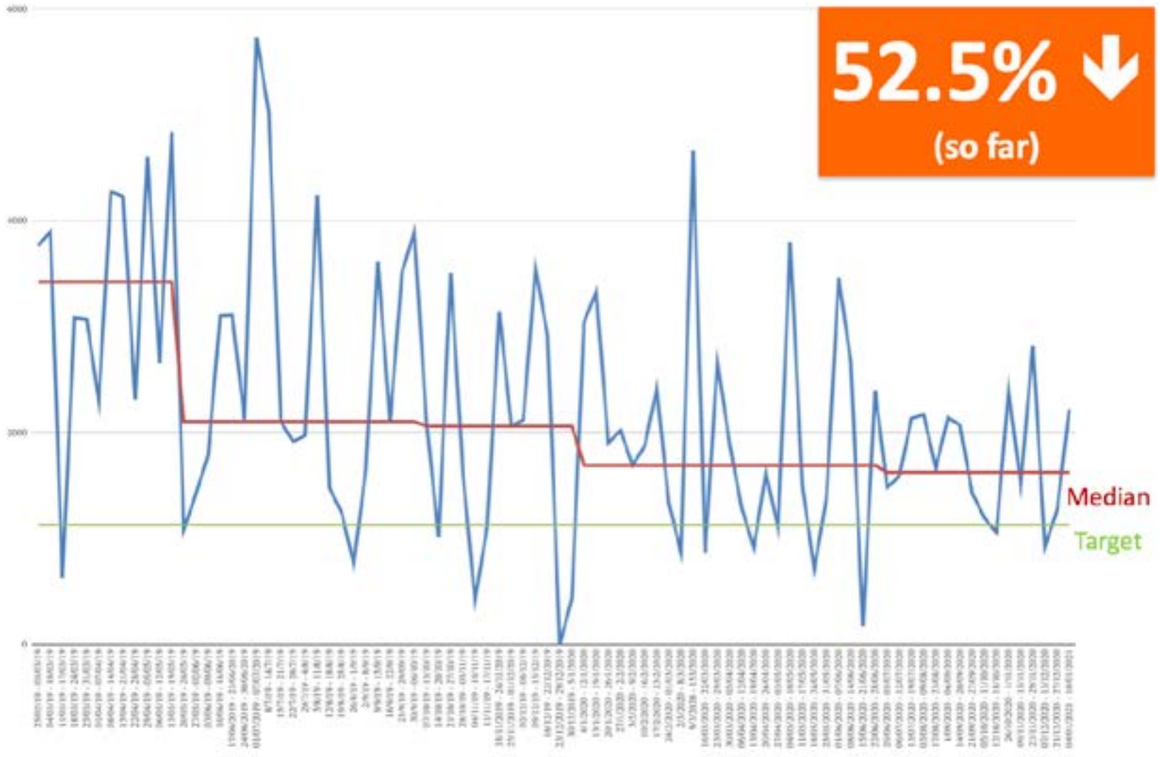


Figure 2 Run Chart

Outside of formal team meetings, both clinical and patient team members had further informal conversations about the project and other aspects of the co-production process. Clinical and patient team members also engaged other members of the local Primary Care Team, community pharmacists and wider public by highlighting the project, it's aims and how others could support it. Posters were also designed and placed in the waiting room to generate engagement with other patients.

Sustaining Improvement

Over the course of this project, we have sustained and continue to improve prescribing in this area through the following means:

- All clinicians adopting a standardised approach to the management of insomnia
- Continuously learning from and adapting our change ideas as exceptional situations and cases arise
- Co-designing and iteratively adjusting change ideas such that they are easy for clinicians to apply in every day practice and are acceptable in the real world for patients (including the adoption of a shared decision model to allow for ongoing conversations around care and priorities)
- Ensuring this project and approach are part of induction for all new clinical staff
- Regular and ongoing measurement to drive improvement
- Continuing coproduction of improvement and accountability to patient team members
- Celebrating success and improvement together
- Continuing to commit to safe and effective care for poor sleep
- Taking every opportunity to spread change ideas from this project to as many other settings as possible both nationally and internationally

Adrian Rohrbasser

Understanding how and why quality circles improve standards of practice, enhance professional development and increase psychological well-being of general practitioners: a realist synthesis

Method

We collected data in four stages to develop and refine the programme theory of QCs: (1) co-inquiry with Swiss and European expert stakeholders to develop a preliminary programme theory; (2) realist review with systematic searches in MEDLINE, Embase, PsycINFO and CINHAL (1980–2020) to inform the preliminary programme theory; (3) programme refinement through interviews with participants, facilitators, tutors and managers of QCs and (4) consolidation of theory through interviews with QC experts across Europe and examining existing theories.

Sources of data

The co-inquiry comprised 4 interviews and 3 focus groups with 50 European experts. From the literature search, we included 108 papers to develop the literature-based programme theory. In stage 3, we used data from 40 participants gathered in 6 interviews and 2 focus groups to refine the programme theory. In stage 4, five interviewees from different healthcare systems consolidated our programme theory.

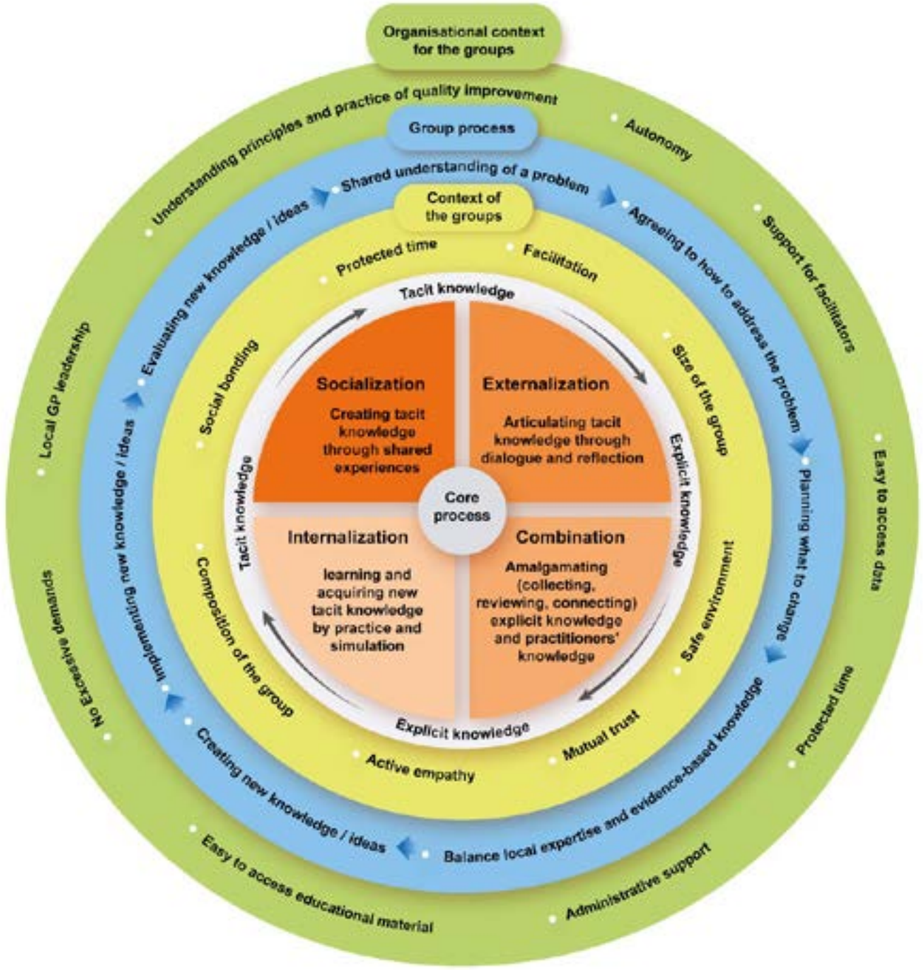
Result

Requirements for successful QCs are governmental trust in GPs' abilities to deliver quality improvement, training, access to educational material and performance data, protected time and financial resources. Group dynamics strongly influence success; facilitators should ensure participants exchange knowledge and generate new concepts in a safe environment. Peer interaction promotes professional development and psychological well-being. With repetition, participants gain confidence to put their new concepts into practice.

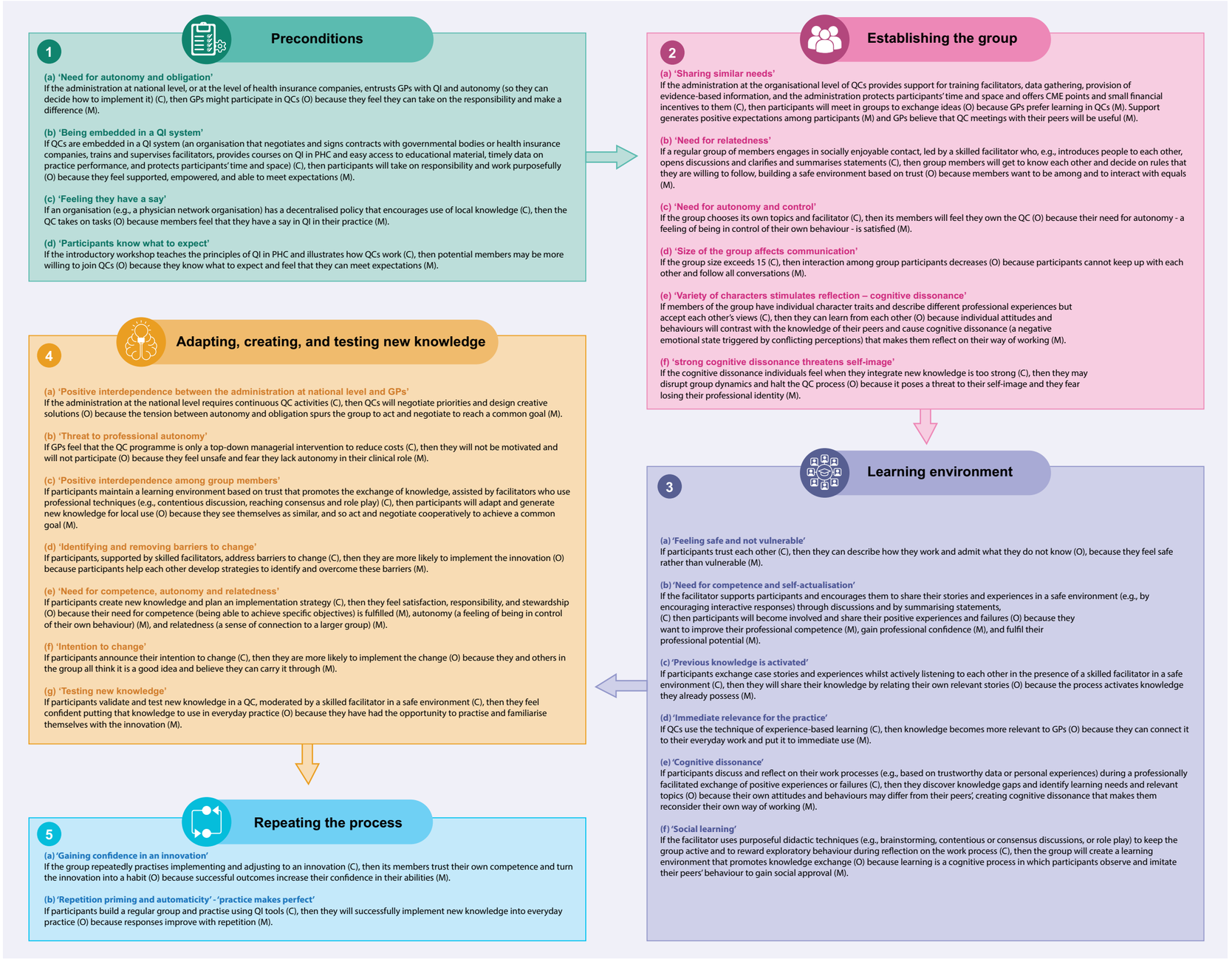
Conclusion

With expert facilitation, clinical review and practice opportunities, QCs can improve the quality of standard practice, enhance professional development and increase psychological well-being in the context of adequate professional and administrative support.

Supplemental material 11 Summary of the QC process and its implications



Legend:
The rings represent the levels of context and their associated processes. The core process is in the centre, illustrating the exchange of knowledge and the creation of innovations in QCs. The process is a spiral rather than a circle, because participants add experience and new knowledge at each turn of the cycle. The size and composition of the group, the social bonds between participants and their mutually benevolent attitude all foster mutual trust and create a safe environment in which participants can have frank discussions. Protected time and skilful facilitation lay the groundwork for a successful core process. At the next level, participants begin with a shared understanding of an issue and agree how to address it and what needs to be changed, ensuring the success of the group process. When QCs solve problems and innovate, they should balance local expertise (soft knowledge) with evidence-based information (hard knowledge); then they can generate new ideas to be tested and implemented in everyday practice. The QC process requires considerable professional and administrative support at the organisational level, so professional associations or university departments must teach QC members the principles and practices of QI and their use, and train and support facilitators. Organisations should also provide easy access to performance data and evidence-based material. Administrative organisations, whether health insurance companies or governmental organisations, should allow QCs to have professional and administrative autonomy and let them take the lead in QI, without placing excessive demands on the group or its members. The level of legislation required to entrust GPs with QI will vary depending on a country's health-care system, and could be enacted at national or local government level.


1
Preconditions
(a) 'Need for autonomy and obligation'
If the administration at national level, or at the level of health insurance companies, entrusts GPs with QI and autonomy (so they can decide how to implement it) (C), then GPs might participate in QCs (O) because they feel they can take on the responsibility and make a difference (M).
(b) 'Being embedded in a QI system'
If QCs are embedded in a QI system (an organisation that negotiates and signs contracts with governmental bodies or health insurance companies, trains and supervises facilitators, provides courses on QI in PHC and easy access to educational material, timely data on practice performance, and protects participants' time and space) (C), then participants will take on responsibility and work purposefully (O) because they feel supported, empowered, and able to meet expectations (M).
(c) 'Feeling they have a say'
If an organisation (e.g., a physician network organisation) has a decentralised policy that encourages use of local knowledge (C), then the QC takes on tasks (O) because members feel that they have a say in QI in their practice (M).
(d) 'Participants know what to expect'
If the introductory workshop teaches the principles of QI in PHC and illustrates how QCs work (C), then potential members may be more willing to join QCs (O) because they know what to expect and feel that they can meet expectations (M).
2
Establishing the group
(a) 'Sharing similar needs'
If the administration at the organisational level of QCs provides support for training facilitators, data gathering, provision of evidence-based information, and the administration protects participants' time and space and offers CME points and small financial incentives to them (C), then participants will meet in groups to exchange ideas (O) because GPs prefer learning in QCs (M). Support generates positive expectations among participants (M) and GPs believe that QC meetings with their peers will be useful (M).
(b) 'Need for relatedness'
If a regular group of members engages in socially enjoyable contact, led by a skilled facilitator who, e.g., introduces people to each other, opens discussions and clarifies and summarises statements (C), then group members will get to know each other and decide on rules that they are willing to follow, building a safe environment based on trust (O) because members want to be among and to interact with equals (M).
(c) 'Need for autonomy and control'
If the group chooses its own topics and facilitator (C), then its members will feel they own the QC (O) because their need for autonomy - a feeling of being in control of their own behaviour - is satisfied (M).
(d) 'Size of the group affects communication'
If the group size exceeds 15 (C), then interaction among group participants decreases (O) because participants cannot keep up with each other and follow all conversations (M).
(e) 'Variety of characters stimulates reflection – cognitive dissonance'
If members of the group have individual character traits and describe different professional experiences but accept each other's views (C), then they can learn from each other (O) because individual attitudes and behaviours will contrast with the knowledge of their peers and cause cognitive dissonance (a negative emotional state triggered by conflicting perceptions) that makes them reflect on their way of working (M).
(f) 'strong cognitive dissonance threatens self-image'
If the cognitive dissonance individuals feel when they integrate new knowledge is too strong (C), then they may disrupt group dynamics and halt the QC process (O) because it poses a threat to their self-image and they fear losing their professional identity (M).
3
Learning environment
(a) 'Feeling safe and not vulnerable'
If participants trust each other (C), then they can describe how they work and admit what they do not know (O), because they feel safe rather than vulnerable (M).
(b) 'Need for competence and self-actualisation'
If the facilitator supports participants and encourages them to share their stories and experiences in a safe environment (e.g., by encouraging interactive responses) through discussions and by summarising statements, (C) then participants will become involved and share their positive experiences and failures (O) because they want to improve their professional competence (M), gain professional confidence (M), and fulfil their professional potential (M).
(c) 'Previous knowledge is activated'
If participants exchange case stories and experiences whilst actively listening to each other in the presence of a skilled facilitator in a safe environment (C), then they will share their knowledge by relating their own relevant stories (O) because the process activates knowledge they already possess (M).
(d) 'Immediate relevance for the practice'
If QCs use the technique of experience-based learning (C), then knowledge becomes more relevant to GPs (O) because they can connect it to their everyday work and put it to immediate use (M).
(e) 'Cognitive dissonance'
If participants discuss and reflect on their work processes (e.g., based on trustworthy data or personal experiences) during a professionally facilitated exchange of positive experiences or failures (C), then they discover knowledge gaps and identify learning needs and relevant topics (O) because their own attitudes and behaviours may differ from their peers', creating cognitive dissonance that makes them reconsider their own way of working (M).
(f) 'Social learning'
If the facilitator uses purposeful didactic techniques (e.g., brainstorming, contentious or consensus discussions, or role play) to keep the group active and to reward exploratory behaviour during reflection on the work process (C), then the group will create a learning environment that promotes knowledge exchange (O) because learning is a cognitive process in which participants observe and imitate their peers' behaviour to gain social approval (M).
4
Adapting, creating, and testing new knowledge
(a) 'Positive interdependence between the administration at national level and GPs'
If the administration at the national level requires continuous QC activities (C), then QCs will negotiate priorities and design creative solutions (O) because the tension between autonomy and obligation spurs the group to act and negotiate to reach a common goal (M).
(b) 'Threat to professional autonomy'
If GPs feel that the QC programme is only a top-down managerial intervention to reduce costs (C), then they will not be motivated and will not participate (O) because they feel unsafe and fear they lack autonomy in their clinical role (M).
(c) 'Positive interdependence among group members'
If participants maintain a learning environment based on trust that promotes the exchange of knowledge, assisted by facilitators who use professional techniques (e.g., contentious discussion, reaching consensus and role play) (C), then participants will adapt and generate new knowledge for local use (O) because they see themselves as similar, and so act and negotiate cooperatively to achieve a common goal (M).
(d) 'Identifying and removing barriers to change'
If participants, supported by skilled facilitators, address barriers to change (C), then they are more likely to implement the innovation (O) because participants help each other develop strategies to identify and overcome these barriers (M).
(e) 'Need for competence, autonomy and relatedness'
If participants create new knowledge and plan an implementation strategy (C), then they feel satisfaction, responsibility, and stewardship (O) because their need for competence (being able to achieve specific objectives) is fulfilled (M), autonomy (a feeling of being in control of their own behaviour) (M), and relatedness (a sense of connection to a larger group) (M).
(f) 'Intention to change'
If participants announce their intention to change (C), then they are more likely to implement the change (O) because they and others in the group all think it is a good idea and believe they can carry it through (M).
(g) 'Testing new knowledge'
If participants validate and test new knowledge in a QC, moderated by a skilled facilitator in a safe environment (C), then they feel confident putting that knowledge to use in everyday practice (O) because they have had the opportunity to practise and familiarise themselves with the innovation (M).
5
Repeating the process
(a) 'Gaining confidence in an innovation'
If the group repeatedly practises implementing and adjusting to an innovation (C), then its members trust their own competence and turn the innovation into a habit (O) because successful outcomes increase their confidence in their abilities (M).
(b) 'Repetition priming and automaticity' - 'practice makes perfect'
If participants build a regular group and practise using QI tools (C), then they will successfully implement new knowledge into everyday practice (O) because responses improve with repetition (M).

Explanation of the graphic to the right

In this YouTube video you can experience Adrian Rohrbasser chronologically go through all the points listed in the colorful graphic to the right.

Click below to watch the video.

	Recommendation	CMO configurations in the programme theory
For the administration at a national level	Invite participants to take responsibility for their QI but let them decide what they do and how they perform QI.	CMO configuration 1 a-c, 4 b
For professional organisations or university departments	Provide information about the basic principles of QI, like the Plan-Do-Study-Act cycle (PDSA) and explain how to implement those principles in QC practice.	CMO configuration 1 b and 1 d
	Give rewards (such as CME credits) to acknowledge that QI work is further education.	CMO configuration 1 b and 2 a
	Provide facilitator training and additional coaching or supervision.	CMO configuration 1 b
	Provide access to knowledge resources like evidence-based information, clinical practice guidelines, and help with gathering practice performance data including their interpretation. Actively involve health-care professionals in collecting the local data needed to address their local priorities; this will increase their motivation and trust in the findings.	CMO configurations 1 b and 2 a
For administrative organisations	Give access to appropriate venues and help them organise meeting times.	CMO configurations 2 b and 2 a
	Integrate and use the new knowledge developed by QCs, so that GPs can see that their efforts have changed practice. Administrations must also accept local adjustments to national solutions or guidance, because QI is a local process and QCs will adapt or devise new interventions and ways of working.	CMO configuration 1 c and 4 a
	Provide protected time, so groups can work during regular working hours or at mutually agreed times. The process should not be disturbed by phone calls or urgent patient problems since these disrupt discussions.	CMO configuration 2 a, 4 a
	Accept that QCs work at different speeds, because excessive demands for rapid results often undermine QI efforts.	CMO configuration 1 c, d, 4 b
	Group size affects the level of cooperation between members. Between six and twelve members is the optimal size for communication.	CMO configuration 2 d
For facilitators	The social aspect of the group lays the ground for frank discussions. For example, eating together before starting work eases social interaction, making participants feel more comfortable. A friendly, relaxed, and non-hierarchical atmosphere encourages participants to share sensitive information and motivates their continued attendance. Agreement on group norms and removing barriers like computer screens, or arranging tables and chairs in a circle facilitates social interaction.	CMO configurations 1 c, 2 b-c and 3 a
	Create an atmosphere of openness based on trust, so that participants can interact authentically. Facilitators should open discussions, summarise, clarify statements, and raise questions.	CMO configuration 2 b
	Encourage participants to talk about their own clinical cases, because these are the basis of a learning community where participants can reflect on their current practice and compare it with educational or evidence-based material.	CMO configurations 3 a-c
	Aim at a balance between comfort and challenge that allows an appropriate degree of conflict within the group to stimulate learning.	CMO configuration 3 f
	Close meetings on time and plan future meetings by summarising progress and highlighting the goals that have been achieved.	CMO configurations 2 b, 4 c-d
	Support participants in expressing themselves since it can be hard to make implicit knowledge explicit. Participants require 'active empathy' when they struggle to express their thoughts. Active empathy is the ability of QC members to actively listen to and care for each other, even when they question each other's statements.	CMO configuration 3 b
	Promptly identify and resolve conflicts because breaking established habits may feel high-risk and even threaten selfimage. Individuals who feel this way may choose to withdraw or, worse, disrupt the group process.	CMO configuration 2 f
For participants in the group	Gaining agreement on the topic to be discussed is central in QC work. The group must have a shared understanding of the problem when it embarks on the QI process and the topic must be relevant to everyday practice and manageable. The group should agree on the need for change, or at least agree that a problem exists.	CMO configurations 2 c and 3 d
	Come to an agreement on how to address the topic and balance local expertise with wider knowledge. Once a topic is chosen, members should start with personal experiences. Discussing personal cases increases a sense of ownership and helps connect new knowledge to everyday practice.	CMO configurations 3 b d
	Develop new concepts and ideas by reflecting on members' experiences, discuss individual cases, add information from guideline and educational evidence-based material, prescription data, or invite input from a respected local opinion leader. Members should be ready to adjust their ideas about how to change and improve care, or work differently, to fit local circumstances	CMO configurations 3 ef, 4 a and 4 c
	Implementing innovation is a continuous, repetitive process. Discuss the advantages and disadvantages of new ideas or changes to practice and address barriers to change.	CMO configuration 4 d
	Debate proposals for change and agree on action plans. After testing and trying out these plans, the group may then choose to move forward with one or more of them, depending upon how sure it is that the plans will be successful.	CMO configuration 4 f
	Each time the group tests the innovation, the goal should be improving it. Members should devise plans to implement the next version based on their own practice until they feel satisfied.	CMO configurations 4 g and 5 a
	Be patient. QC groups have a learning curve and the group grows more skilled and improves performance after each QI cycle.	CMO configuration 5 b

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