



Improving quality on the pediatric surgery service: Missed opportunities and making it happen



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ABSTRACT

In surgery, quality improvement efforts have evolved from the traditional case-by-case review typical for morbidity and mortality conferences to more accurate and comprehensive data collection accomplished through participation in national registries such as the National Surgical Quality Improvement Program. Gaining administrative support to participate in these kinds of initiatives and commitment of the faculty and staff to make change in a data-driven manner rather than as a reaction to individual events can be a challenge. This article guides the reader through the process of interacting with administrative leadership to gain support for evidence-based quality improvement endeavors. General principles that are discussed include stakeholder engagement, taking advantage of preexisting resources, and the sharing of data in order to shape QI efforts and demonstrate their effectiveness.

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Introduction

The Institute of Medicine (IOM) defines quality in health care as “The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.”¹ Quality and safety efforts became a national priority when the IOM published its report “To Err is Human,” in 1999, revealing that there were close to 100,000 preventable hospital deaths per year in the United States. The initial reaction to this report was to assign blame to individuals and organizations and hold them accountable for errors, but the IOM committee’s approach was to emphasize that improvements in patient safety and quality of care should be mediated through the health care delivery system. The intent of this article is to help surgeons identify methods and strategies to focus on system improvements rather than individual blame. After reviewing historical efforts at quality assurance, several concepts will be presented that will help readers engage both surgeons and hospital leaders in improving surgical outcomes and quality.

Evolving beyond traditional surgical quality assurance

In surgery, morbidity and mortality (M&M) conference has historically served as the classic forum for discussing adverse events. It was presumed that these retrospective event reviews

would incentivize individuals to prevent future complications or similar occurrences. In M&M, cases tend to be presented one at a time and focus on individual actions that led to the event, rather than systems issues that are likely to be at fault. The M&M discussions often deteriorate into placement of blame on an individual provider or team of providers who were involved in the case. This strategy fails to identify systems-based problems, has no impact on the likelihood of the same event happening in the future, and fails to measure similar incidents over time to increase institutional learning.

In order to improve outcomes, one must be able to accurately measure them. Several reports have demonstrated the failure of M&M as an outcome-reporting mechanism^{2–4} when compared with externally recorded data registries such as the American College of Surgeons National Quality Improvement Program (ACS-NSQIP). The culture in surgery has changed over the last decade, with increasing appreciation of the importance of evaluating outcomes in a forum that goes beyond traditional M&M. Regular objective measurement of surgical outcomes is critical so that patterns can be identified and trends tracked over time. This type of data gathering can be achieved via in-hospital initiatives (for example, hospital infection control projects) or by participation in national data registries. Hospitals participating in NSQIP have experienced reliable decreases in complication rates.^{5–7} The rapid increase in the number of hospitals participating in both adult and pediatric NSQIP is a demonstration of an increasing commitment to improving patient safety and delivering the highest quality care. Importantly, improved outcomes are also likely to translate into cost savings and this justifies the commitment of resources that is necessary to participate in clinical registries.⁸

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Engaging the C-suite

Just as there are numerous regulatory agencies to which the hospital must regularly deliver quality and compliance data, there are also a number of different clinical registries available to the institution. Whether the decision to join a registry is driven by a physician or the hospital administration, the key first step is for both the surgical and administrative leadership to agree with supporting the process. If both of these parties are not behind any program to make change, it will fail. Hospital leaders, if not already well-versed in the value of participation in these registries, need to understand that participation has been shown to result in superior outcomes and significant cost savings.⁸

Certain preconceived notions on the part of clinicians and hospital leaders may exist and should be addressed and dispelled early on:

- (1) “My institution cannot be compared with other institutions since our patients are sicker.” This argument does not apply to data when it is risk-adjusted for patient comorbidities and severity of the acute illness. Registries such as NSQIP have robust risk adjustment capabilities as opposed to administrative data where there is less reliable comorbidity capture.
- (2) “I will be able to use this information to evaluate the outcomes for individual surgeons for the purpose of credentialing and recertifying.” These programs are not comprehensive registries of all cases done at a participating institution but rather a representative sample evaluating the overall care of patients evaluated. Currently, they should not be used to evaluate the ability of a surgeon since only a fraction of the surgeon’s cases are included. It is possible that, in the future, these data could be used for credentialing but at this time the data are not powerful enough for this purpose.
- (3) “Each adverse outcome that is revealed through this effort should be reviewed on a case by case basis in order to understand how we can effect change.” Since hospital leaders are familiar with the concept of peer review and performing root cause analyses, they may mistakenly apply this approach to information revealed by participation in a national registry. It should be made clear that the purpose of this participation is to evaluate the overall management of patients in order to identify patterns and track changes over time rather than focusing on individual events. These data are for “learning and not for judgment.”
- (4) “We should target certain operations for quality improvement efforts.” This is an approach that is common in adult surgical quality improvement (QI). In children’s hospitals nested within an adult hospital, the hospital leadership is likely to be familiar with this approach. An adult hospital may perform 600 colorectal procedures per year, generating enough information to design quality improvement projects specifically for this population. Many of the operations associated with significant complications are performed infrequently in children. Therefore, it is important that the leadership understands that interventions will likely be designed for bundled groups of procedures (for example, all abdominal surgery) rather than those undergoing one specific procedure. However, there may be complication-prone procedures with occurrences that occur frequently enough in some centers that specific process changes can be developed to improve outcomes for those patients. For example, a high-volume orthopedic center may do enough spine surgeries to justify QI projects designed specifically for this patient population.

Closing the improvement loop

An example from our own institution here will be helpful. Surgical leaders and hospital executives must understand that resources will be necessary not only at the outset of participation in order to facilitate data collection but also to support the QI initiatives that will result from data analysis. For support to be ongoing, data should be shared with hospital executives on a regular basis to demonstrate the need for QI and the ongoing commitment of resources. Creating this kind of loop closure garners an appreciation for data-driven improvements in the delivery of patient care. When this feedback loop is completed, it is easier to justify the commitment of hospital resources. For example, when we involved hospital leaders in the development of an SSI prevention bundle, they supported our efforts by assigning a consultant to facilitate stepwise implementation of the bundle. This individual facilitated the process by assigning tasks and timelines and meeting regularly with updates to keep the implementation on track. To ensure that their support was justified, the leadership has made SSI reduction a goal for the entire Department of Surgery.

Teaming up with administrators and surgeons

Leaders will bring resources and remove resistance to process change and should participate in the decision making regarding which areas should be targeted. However, involvement of surgeons will be essential to the process of defining QI goals and setting quality metrics, as they are often the content experts. Defining areas of focus is impossible without input from clinicians and can lead to misguided initiatives. For example, an administrator without the appropriate clinical context may observe that there is a high incidence of unplanned reintubation and decide to focus on this as an operating room (OR) performance metric. A surgeon would recognize that reintubation is related to many factors that go beyond care delivered in the operating room, making “unplanned reintubation” a poor OR quality metric. It is essential to have both surgeons and hospital leaders guiding the decision-making process when it comes to defining quality goals.

Importance of communication

Once resources have been committed to participation in a national clinical registry or internal data collection efforts, it is important that key players understand how data are collected, the limitations of the data, and how it should be interpreted. For example, when a hospital initiates participation in the ACS-NSQIP, the surgeon champion and surgical clinical reviewer (SCR) must begin the process by understanding the program itself. Frequent presentations of data and the associated learning tools provided on the NSQIP website to the various surgical divisions will promote an understanding of the data collection process and how data are analyzed. This knowledge is essential in order to begin discussion of the program in general terms and gain support for this effort by educating other surgeons and leaders.

Enlisting stakeholders

In order to accomplish a quality agenda, one must communicate effectively with all the “stakeholders.” Surgeons, anesthesiologists, consultants, critical care doctors, primary care doctors, extended care providers, nurses, surgical technicians, pharmacists, and hospital administrators should be considered “stakeholders” and engage in the improvement process. All stakeholders need to

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