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The Quality Imperative: The Theory

Learning Objectives

- Identify quality improvement theorists and discuss their contributions
- Describe the development and application of quality improvement theory
- Understand the importance of quality in health services delivery
- Define and discuss Hoshin strategic quality planning
- Discuss how HSOs organize for quality
- Conceptualize how improving quality must have a community focus

Discussion Questions

1. *What important changes occurred in health services delivery in the 1980s and 1990s that stimulated HSOs/HSs to adopt the philosophy of CQI?*

HSOs/HSs use continuous quality improvement (CQI) to improve quality. The focus is to improve processes to meet or exceed customer expectations, decrease costs by reducing poor quality (waste, rework, errors, delays), and improve productivity (use resources better). The result is shown by the Deming Chain Reaction in Figure 7.4.

The changes in the 1980s that stimulated emphasis on quality improvement in healthcare were increased competition, higher costs, greater government regulation, and increased customer assertiveness and higher expectations. During the 1990s, managed care organizations (MCOs) were a driving force for CQI. MCOs had the market power to demand lower prices from providers. To provide services at lower cost, providers had to improve quality and productivity. Another driving force was the increasing concern about medical errors and patient safety.

Most changes students are likely to identify were caused by environmental forces and/or stakeholders. It is useful to structure discussion of this question by having students refer to the management model (Figure 5.7) and to list changes related to categories in the general (macro) environment [9] and in the healthcare environment [8]. In addition, the instructor can refer students to Figure 14.6, which shows a stakeholder map for a large hospital. Ask students to identify stakeholders that exhibit increased influence and demands for better quality/service in the 1990s. Changes in the general and healthcare environments include the types discussed next.

General (Macro) Environment

Ethical/Legal. With respect to litigiousness of society and malpractice suits, satisfied customers are less likely to sue, and CQI is one way to prevent poor quality and lawsuits. Chapter 4 asserts that ethical obligations go beyond legal duties and that HSOs/HSs, but more specifically managers, must protect patients and do no harm. CQI assists in meeting this ethical obligation.

Political. Expanded government entitlements and demands for fiscal responsibility caused pressure to reduce costs. HSOs/HSs responded by working to improve quality and decrease the cost of poor quality (more efficient use of inputs), as well as by productivity improvement.

Cultural/Sociological. Changing demographics resulted in a larger population (baby boomers) of persons needing healthcare. Special interest groups and community groups are two types of stakeholders that have sought more involvement and representation in the affairs of HSOs/HSs, including the quality of care.

The Public and Its Expectations. Consumers are more demanding and have higher expectations for products and services. They base purchase decisions on value (the combination of price and quality) and a growing perception that healthcare is a right. This has led to demands for better quality and better service, which have been an inducement for CQI in HSOs/HSs.

Economic. Good economic times, especially in the late 1980s and mid- to late 1990s, resulted in high employment (and more people with employer-provided health insurance), increased and conspicuous consumption, and large numbers of financially secure families (two income earners), all of which stimulated demand for high-quality goods and services.

Healthcare Environment

Public Policy. Deregulation in healthcare delivery resulted in increased competition. Government initiatives to expand healthcare programs and beneficiaries increased demand for healthcare coverage. Important stimuli for HSOs/HSs were The Joint Commission's "Agenda for Change" in the mid-1980s, incorporation of quality/productivity improvement (Q/PI) into accreditation standards, and the American Hospital Association embracing the philosophy of CQI.

Competition. Alternate forms of delivery such as MCOs (health maintenance organizations [HMOs] and preferred provider organizations [PPOs]), freestanding ambulatory HSOs, an increase in the number of physicians (some now with evening and Saturday hours and making house calls), and excess hospital capacity have put HSOs/HSs at marketplace and financial risk. Market differentiation must be made to a greater extent on quality and service. It has become more of a buyers' market, and organizations must entice customers to them. With its customer focus, CQI is one way to do this.

Healthcare Financing. Diagnosis-related groups (DRGs) changed the financial and competitive mix. Government and third-party payers (primarily businesses) with rising healthcare costs demanded more accountability, more value, and better control of volume and quality (second opinions, precertification). Increasing deductibles and copayments caused consumers to demand better healthcare quality and service. The downward pressure of reduced payments to providers has forced greater efficiency. The rise of MCOs had the same effect.

Technology. Magnetic resonance imaging (MRI) and cardiac angioplasty were among the new high-tech procedures introduced. Patients expect and demand the best and most technologically advanced healthcare available.

2. Define CQI. Why is it an organizational philosophy? What are its attributes? How can CQI lead to an enhanced HSO/HS competitive position?

The text defines CQI as an ongoing, organizationwide framework in which HSOs/HSs and all those associated with them (managers and GB members and clinical and nonclinical staff, including licensed independent practitioners [LIPs]), are committed to and directly or indirectly involved in monitoring and evaluating all aspects of the HSO's/HS's activities (inputs and processes) and outputs so as to continuously improve them. The essential elements of this definition are that CQI is organizationwide and process focused; it uses output and outcome measures and is customer driven.

Organizational philosophy embraces the HSO's/HS's explicit or implicit view of itself and its work and values. An organization's philosophy (values) has many dimensions, including delivery of services, quality of care and CQI, and employee and other stakeholder relationships. The philosophy is linked to and rooted in the organization's belief and values (i.e., culture). HSOs/HSs are primarily social enterprises with economic dimensions. Their overriding commitment is maintaining or improving the health of patients. In contrast, businesses are primarily economic enterprises with social dimensions, and they usually have an organizational philosophy focused on shareholder returns and profitability. As with HSOs/HSs, however, those that are successful have a commitment to customers' needs/expectations and the use of CQI to meet them. Generally, in the early 1980s, businesses did not have this commitment. This has changed and is changing, however, as the importance of meeting customers' needs and expectations using CQI has been recognized.

- CQI is a philosophy—how the HSO/HS views itself—that becomes its culture. CQI is pervasive and customer driven.

- CQI requires total commitment and involvement by all HSO/HS managers (especially those at the senior levels) and staff. It is not a program to be undertaken by a few.
- CQI is prospective and ongoing. It aims to prevent poor quality before it happens and to seek opportunities to improve processes.
- CQI requires certain things from management: leadership, commitment of resources, and facilitating worker involvement and organizational change.
- CQI leads to enhanced competitive position through improved quality of outputs, decreased costs, and productivity improvement.

Refer students to the logic flow in the CQI model in Figure 7.3 and the Deming Chain Reaction in Figure 7.4.

3. Throughout history, a number of reformers have sought to improve the quality of medical care. What common thread connects them? Why did some fail?

The common thread most likely to be identified by students is that the reformers' views ran counter to existing practice or prevailing "knowledge." Existing practice is based on traditions and customs that, in the case of medicine, are passed from one generation of physicians to the next. Existing practice is so ingrained that it becomes its own truth, even though there is no science to support it. For example, even though Ignaz Semmelweis had empirical data to show that hand washing with carbolic acid reduced cross-infections of puerperal fever to almost nil, his medical colleagues were unconvinced and ostracized him. Innovation is disruptive, threatens the established order, and calls into question the competence of previous practice and those who used it. Thus it is feared.

Reformers may fail to appreciate how threatening their innovation or change is to colleagues and peers. Oftentimes, political allies are needed to provide support and give weight and credibility to the change(s)/innovation(s) being sought. An educative and supportive approach by the reformer will be more effective than condescension or haughtiness, both of which are likely to anger those who are being asked to change. But, as history has shown, even evidence and education may not persuade.

4. Think about the nursing service in a hospital. Who or what are its customers? If the nursing service is the customer, who or what provides inputs (is the supplier)?

This question reinforces Figure 7.1 and students' thinking about customers and suppliers in a broader sense. Customers are not only patients. Customers may be internal or external and may be individuals, groups, or units. Customers are any downstream users of output, and suppliers are any upstream providers of goods or services (inputs). This concept is integral to understanding CQI. A typical sequence is that a customer is provided goods or services by a supplier, and that customer adds value to the goods or services and, in turn, becomes a supplier to the user of those goods or services. This is what Joseph Juran titles the triple role of the worker, who is a customer, adds value, and becomes a supplier to the next step in the process.

Suppliers for nursing service in a hospital include admitting, supply chain, diagnostic testing, dietary services, physicians, and the human resources department. Customers include patients and their families, visitors, social services, pharmacy, and physicians. The instructor can ask the same question for virtually any area/department of any HSO/HS. It is important to emphasize that the customer–supplier roles are common for the same worker in a process and that they alternate as the worker is first a customer, adds value, and then becomes a supplier.

5. Identify the similarities and differences in the approaches to quality taken by Deming, Juran, and Crosby.

Table 7.3 shows the differences and similarities among the quality theorists Deming, Juran, and Crosby.

6. Discuss the elements of the PDSA cycle. Apply it in a health services setting using a hypothetical example.

PDSA—Plan, Do, Study, Act—is a methodology for improving processes. It focuses on the use of small-scale, data-driven process interventions that are planned (Plan), implemented (Do), studied/analyzed (Study) to understand their effect(s), and changed, as appropriate, to hold the gain in quality (Act).

Dr. Walter Shewhart developed the PDSA cycle while working at the Hawthorne Works of Western Electric near Chicago. Shewhart and W. Edwards Deming were contemporaries at Hawthorne, and Shewhart mentored Deming. PDSA was derived from the use of statistical process control (SPC) to improve quality in the telephones being manufactured. The slogan at Hawthorne was “Alike as two telephones,” meaning that the variation among them was so slight that they were indistinguishable. The focus of both SPC and PDSA is to 1) understand variation in processes, and 2) reduce that variation as much as possible. Reducing variation improves quality. In the late 1940s, Deming introduced the Shewhart cycle of PDSA to industrial leaders in Japan. His introduction caused the PDSA cycle to be called the Deming Cycle in Japan. Because of a translation error, the PDSA cycle is known as the Plan, Do, Check, Act (PDCA) cycle in Japan.

HSOs are services delivery organizations. PDSA applies equally to delivery of a service as to production of a product. This conceptualization bears reinforcement; some students will think of quality only in terms of products. The PDSA cycle allows HSOs to identify a process that data show is producing results that are less than the desired quality. Examples of processes in HSOs include patient admissions, patient billing, surgical scheduling, pharmacy prescription filling, and patient discharge. More complex, interdepartmental processes should be broken into components or subprocesses, to which the PDSA cycle can be applied. PDSA is data driven, and application of Plan, Do, Study, Act must be based on data that the process being analyzed is producing.

7. Discuss the application(s) of the Deming Chain Reaction in health services delivery.

The Deming Chain Reaction shown in Figure 7.4 depicts the relationship between quality and costs. It is common for organizations, including HSOs, to reduce costs first—often by across-the-board budget cuts. Deming dismissed this approach as wrongheaded. He asserted that improving quality must be the first step. Better quality decreases costs, which improves productivity. In turn, this leads to decreased prices and increased market share; thus the organization stays in business, provides jobs, and yields greater returns—even in not-for-profit HSOs. Consequently, competitive position is enhanced. Deming argued that improved quality results in better resource use (lower costs) because improved processes mean less rework (re-admission of patients), fewer mistakes (repeat of tests), and fewer delays (waiting for a service such as patients being discharged). These results occur because the prospective and continuous assessment of and changes made to work processes and inputs yield both improved quality and improved productivity. Again, service and product should be considered interchangeable concepts in quality and performance improvement.

8. Figure 7.8 identifies visible and hidden costs of poor quality. Add several types to each category.

This question should challenge students’ thinking and insightfulness. Examples include the following:

Visible Costs: 1) Negative publicity; 2) reduced reimbursement (e.g., CMS deductions for in-patient readmissions); 3) reduced volume of elective admissions; 4) difficulty recruiting clinical staff; 5) higher malpractice insurance premiums

Hidden Costs: 1) poor employee morale; 2) high employee turnover; 3) rework in processes; 4) delay(s) in patient care; 5) difficulty recruiting first-tier GB members and senior management

9. Discuss the role and activities of quality improvement teams (QITs). Identify the attributes of their members.

The role of QITs is to take primary responsibility for recommending ways to improve a process. After a process that will benefit from improvement activities has been identified, the team uses previously collected data and/or collects new data to begin to understand the process and points at which variation is occurring. Control charts are especially important to understand variation and determine that a process is in control—only processes that are in control (absence of special cause variation) can be improved. It is common that a flow diagram or process map will be developed using the knowledge of team members or others invited to contribute process knowledge. The flow diagram should show the details of the process and all its complexities. The data collected are analyzed using Pareto charts, scatter plots, and bar charts, among others.

QITs may be intradepartmental or cross functional. The former are established by a department head or service line manager who uses QITs to improve processes that are unique/specific to that unit. These QITs do not require approval from a coordinating body such as a quality improvement council (QIC). Recommendations from an intradepartmental team can be implemented without review, unless there are significant budget or other cost implications, or there are implications outside the department.

Cross-functional teams work to improve processes that involve more than one unit (department/service line). It is common that they are established only with approval (sanctioning) of a QIC, or similar review body. Recommendations from cross-functional QITs are reviewed by the QIC and require approval from managers whose units are affected. Usually, someone more senior in administration will be involved in review and approval as well.

The most important attribute that members of QITs bring to the team is a commitment to diligence in process improvement. In addition, members of QITs should be selected because they have process knowledge at a level that allows them to provide information about the complexities of a process. Effective improvement can occur only by understanding, collecting, and analyzing data about the complexities of a process. Knowledge about QP/I theory is helpful but is a secondary consideration and can be learned “on the job.” Typically, HSOs have a quality department or unit whose members are trained in quality improvement methodologies and techniques. Such persons provide resources to QITs, including trained facilitators who attend QIT meetings. It is desirable that team members have some basic understanding about data arrays and displays and have the ability to think logically and critically. At its core, quality improvement is straightforward and should be within the intellectual grasp of anyone employable by an HSO.

10. Identify the ways HSOs interact with their communities. Discuss the importance of CQI in those interactions.

HSOs are vital community resources in their service area. In many communities, hospitals are the major employer, and the CEO is considered a community leader. This prominence means that almost everything the HSO does that becomes public has an effect on the relationship with its community. HSOs are a resource to the community at many levels. They provide health services such as custodial care in facilities and the home (long-term care and home health), emergency and acute care services (hospitals), health promotion and disease prevention (education, screening, vaccinations, etc.), education of clinical personnel (nursing assistants, physicians, nurses), and administrative and clinical research. Communities take pride in their HSOs, especially their hospitals, and look to them as sources of care and cure.

Engaging in CQI shows the community that the HSOs are aware of CQI's importance and that they are continuously seeking to improve the services they offer and how they are delivered. This commitment to quality in all that they do causes the HSO and community

to have a unique bond and special connection. HSOs, especially the acute care hospital (regardless of for-profit or not-for-profit status), are a social enterprise with an economic dimension.

Case Study 1

Fed Up in Dallas¹

Ann Landers responded:

Dear Dallas: It is no secret that the quality of service is not what it used to be. The way to make it better is to punish the slob by refusing to put up with it. But before you leave, be sure to tell them why they lost you.

1. Obviously, Fed Up in Dallas is not a satisfied customer. In general, why do you think some organizations and their staffs are indifferent to customers who buy their products and services?

Indifference to the needs/satisfaction of customers is caused by many variables. (Students should be referred to Discussion Question 1.) These include the following:

- *Lack of competition.* HSOs/HSs that have quasi-monopolies, as in the case of a community with only one hospital, have fewer incentives to offer high-quality service. Even with competition, if there is bound capacity (too much demand), businesses and HSOs/HSs can consciously or unconsciously limit demand by not providing high-quality customer service. An example with special economic considerations is Additional Case Study 2 in Chapter 1, “Demarketing to Avoid Bankruptcy.”
- *Societal Values and Economic Status.* Since the 1960s, society has become more selfish, individualistic, self-centered, and focused on “taking care of number 1.” There is an entitlement mentality. Such attitudes do not support a customer service orientation. High incomes and economic comfort, as well as a desire for leisure, cause people not to work as hard and to acquire “I don’t care if I have your business” attitudes.
- *Transferring costs.* Organizations seek to transfer some of the costs of doing business to the consumer. An example is failing to check a transaction and filling an order incorrectly. The consumer must return for the correct item. Thus the cost of a process step (checking) has been transferred to the customer. This may decrease organizations’ costs in the short term but they will likely lose the customer in the long term.
- *Employee motivation.* People with an “I want/have everything now!” attitude seem to have little incentive to work hard and, thus, do not care about customers. Many employees view having their jobs as a right, not a privilege.
- *Employee skills.* Lack of skills may induce defensive behavior that is anticustomer. One example makes the point. A cashier at a fast-food restaurant rang up a \$5.15 order; the electronic cash register indicated change of \$4.85 based on a \$10.00 bill tendered by the customer. Then the customer added a quarter to the tendered amount in order to receive a \$5.00 bill and a dime. This was done to avoid receiving four \$1.00 bills and several coins. The cashier could not calculate the correct change (because of poor math skills) and was rude to the customer.

Above all, poor service is a sign of a management deficiency. It is management that must recognize and correct the situation. As Ann Landers advises, customers must tell managers when and why they are dissatisfied. Correspondingly, they should tell managers when they are pleased, especially if they are delighted with a product or service. Management often hears the bad; seldom are they told when things are done right.

2. *Describe an instance in which you or an acquaintance encountered a negative customer orientation by an HSO. What was your (or your acquaintance's) reaction?*

Answers to this question will be personal. Students should not name the HSOs/HSs; above all, the discussion should not be a gripe session. The point is to raise the students' consciousness about being customer oriented. Students will likely answer that they simply left when they had a bad experience. Ann Landers said that they should tell management why they went away. Organizations with a positive, customer orientation will do something about the specific situation and will use that information to improve the process. Ask students to describe a situation of poor service in which the organization responded positively after a complaint was made. This is known as service recovery. It is used by organizations that have a customer orientation and want to improve their performance.

3. *Fed Up in Dallas describes negative experiences with four different businesses. Could she be the problem? What should organizations do when confronted with difficult customers?*

There are difficult customers; Fed Up in Dallas may be one of them. The time frame for all of the events described is unclear. The exchange at the gas station seems to have prompted the letter to Ann Landers and led Fed Up to recount other events in which the customer was treated badly. If the events occurred over several years, it is unlikely that Fed Up is a difficult customer.

HSOs/HSs must make customer satisfaction the priority and the focus of Q/PI. Within that context, all reasonable efforts should be made to meet or exceed the customers' expectations. Special efforts at service recovery should be made to respond to customers whose expectations were not met or who had special problems. However, the service recovery efforts must be within reason, lest addressing them becomes excessively costly in time and dollars. Patients who have been injured through malpractice or other misadventure should be put into a special risk management process that mitigates harm, apologizes for the problem, and writes off the charges of the injured person. The Risk Management section of Chapter 11 addresses this concept in more detail.

Case Study 2

Clinics

This case suggests the importance of extending Deming's theory of a system beyond the walls of the organization—the larger the system, the greater the gain. The primary care clinics are now part of the system of care that Newland Hospital offers. The concepts of suboptimization and optimization of a system are highlighted.

1. *Describe the system that Newland Hospital created by purchasing the primary care practices. How do the concepts of optimization and suboptimization of a system apply?*

Newland Hospital took the first step in developing a vertically integrated system. In theory, the primary care practices will be a source of inpatients, either directly or through referrals to specialty physicians, who are also on Newland's medical staff. To make the referral patterns of maximum benefit, Newland's planning staff must understand to which specialists and for what medical conditions referrals are made. A referral spreadsheet will be of great assistance in this regard.

Assessing the primary care practices only as cost/profit centers means that management does not understand the concept of optimization and suboptimization. The practices *must* be viewed in light of their contribution to the entire hospital when viewed as a system. In other words, it may be necessary for the primary care practices to suboptimize—operate at

a deficit—so that the entire system (hospital) can optimize its performance. The primary care practices must be seen as part of a larger system, which includes the hospital.

2. What reasons might explain why the practices are losing money?

The practices might be badly managed, and they may be more costly to operate than they should be. Physician productivity is an important consideration, and data should be readily available to assess how productive the physicians are, especially when compared to their prepurchase productivity. Benchmarks and other comparative data should be used, as well. Since the physicians control their schedules, it is possible that they are seeing fewer patients than they could. It is also possible that there is less demand for primary care services because of greater competition or a change in the service area. The former is more likely than the latter. It is possible that there are low levels of customer satisfaction and that word-of-mouth information advises others not to use the primary care practices. Regardless, the practices must be studied to develop data upon which decisions can be made.

3. Identify the economic value of the clinics to Newland Hospital. Identify the noneconomic value.

The economic value is the optimization of medical services that could accrue from including the primary care practices as part of a larger, more comprehensive system of healthcare delivery. The practices should provide a source of referrals to Newland's inpatient (and specialty) services. The need for some parts of a system to suboptimize so that the entire system can be optimized was discussed earlier but should be reemphasized here.

The noneconomic value has several dimensions. First, acquiring the clinics pushes services into the community and raises the visibility of Newland Hospital. Second, it presents a picture of the hospital as interested in the community and working to meet the community's needs. Third, it should improve the seamlessness of services—from primary care to secondary and tertiary care, as needed. Fourth, availability of linked electronic medical records among levels of care should improve quality of care, increase customer satisfaction, and enhance efficiency.

4. Outline a plan that applies CQI principles and concepts to improve the healthcare delivery system composed of the primary care practices and Newland.

First, the practices and Newland must be seen as an extended system. Second, the connections between the primary care practices and Newland, that is, diagnostic imaging, laboratory testing, and so forth, should be identified, and the cross-functional processes must be flow-diagrammed. Third, these processes—from the first contact of a patient with the primary care practice through any referrals and inpatient care—must be studied, data collected, and improvement efforts using cross-functional QITs undertaken. All persons involved, but especially the physicians, must see themselves as part of the greater whole. Hoshin planning will be a useful means to step back from this new information and work to improve future relationships among the components.

Case Study 3

Where and How to Start?

This case addresses the common and significant problem of HSOs and their need to improve patient satisfaction scores. The importance of patient feedback is heightened by CMS requirements known as HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems). HCAHPS is the first national, standardized, publicly reported survey of patients' perspectives of hospital care.

1. Critique TRH's efforts to this point.

The good news is that TRH is aware of the patient satisfaction issue. More important is that TRH seems determined to do something about it. The bad news is that the sources of information and, thus, data about the issues that cause patients to be dissatisfied have not been used effectively. The staff of TRH has been less than creative in making use of potential data sources. The initiatives attempted have not been focused, organized, or systematic. It isn't clear what effect the scripts for nursing staff, whiteboards, and attention from housekeeping have had on patient satisfaction. Satisfaction scores have not moved in a positive direction, but that does not mean that the efforts have had no effect.

2. Formulate a QI initiative to raise patient satisfaction scores.

This question should cause students to think creatively and innovatively. Areas to be identified and discussed include the following: 1) develop nonduplicative questions that can be asked of patients while they are hospitalized and after discharge; 2) organize focus groups of patients and family; 3) use the PDSA cycle to perform pilot initiatives to increase patient satisfaction in various units and verbally engage patients and family members, such as through use of a short structured questionnaire, to obtain feedback on their effectiveness, or lack thereof; and 4) use "secret shoppers," who are similar to persons hired by retailers to pose as customers and gather information about the customer experience. Secret shoppers can be operationalized by having someone pose as a patient, or by having several reasonably healthy patients keep track of how they are treated. Help in terms of best practices and benchmarks will be available in the literature and in web sites such as those of Press Ganey (<http://www.pressganey.com/researchResources.aspx>) and the American College of Healthcare Executives (<http://www.ache.org/newclub/rbindex.cfm>).

3. Develop a step-by-step plan to implement the initiative.

The answer to this question will depend on how question 2 is answered. The plan should be critiqued using the following criteria: 1) feasibility of implementation, 2) cost, 3) compliance with external constraints, 4) likelihood of producing useful/usable information/data, and 5) thoroughness of data collection.

4. What measures should be considered in addition to those directly affecting patients?

It is generally agreed that staff members will not treat patients better than they are treated. Surveys of staff, especially those with direct patient contact, will provide insights into their satisfaction levels. Efforts to improve employee satisfaction can be based on the information obtained.

Patient satisfaction has many components such as pain control, food service and food quality, and friendliness of staff. A script stated as a rote message to patients is no guarantee of effective interaction or communication with patients. In addition, features of a room or artifacts in the patient care process may affect other aspects. For example, a patient room in need of redecorating may cast a shadow on other aspects of the care experience that contribute to patient satisfaction, including the friendliness and responsiveness of staff, quality and palatability of food, and pain control.

Case Study 4

Extent of Obligation

This case considers the problem of inadequate clinical performance by a physician and the obligation management/the employer has to provide a recommendation. Historically, it was common for physicians to be given neutral or even positive recommendations despite the presence of significant problems with their performance in the HSO. There are ethical and

legal issues arising from providing references for staff whose performance was less than it should have been. As the case notes, this has caused employers to simply report dates of employment and provide no other information.

1. Identify the ethical, legal, and quality issues present in the case.

Ethical Issues. 1) general duty of beneficence to HSOs and patients who might be affected by Nieren in future delivery activities, and 2) meeting the virtues of honesty and trustworthiness in communicating with those who might inquire about Nieren's performance.

Legal Issues. 1) some states recognize that previous employers have a legal "duty to warn" if there is information that should be communicated to a future employer on inquiry; 2) writing an honest, thorough reference letter might be used by a potential plaintiff (former patient) who has been injured by Nieren during her year-long tenure with the group practice; 3) an "honest" letter might cause Nieren to sue the group practice for defamation, tortious interference with a contract, and loss of income. Though likely to be unsuccessful, such a suit will be costly to defend.

Quality Issues. 1) it has taken too long (almost a year) for the group practice to act on problems with Nieren's work that were probably evident much earlier, 2) a better process for reviewing/monitoring the quality of physician care—especially new physicians—must be developed and implemented, and 3) a policy regarding hiring and quality review of newly hired physicians should be developed.

2. What should you do regarding the letter that Dr. Nieren is demanding?

1) Ask the physicians who evaluated Nieren's work to confirm that their assessment/review was correct. 2) Speak to legal counsel to determine the legal risks (and benefits) of writing a letter for Nieren and what the letter should contain. 3) Determine if a report to the federal Data Bank (combined National Practitioner Data Bank and the Healthcare Integrity and Protection Data Bank) is required. 4) Discuss the situation with the risk manager; determine if any similar situations occurred previously in the group practice. Acting prudently and with deliberation is wise, but extensive delay will only heighten the risk of legal action by Nieren. It is unlikely that she is employable unless she can obtain a reference from her employer of almost a year.

3. Identify and discuss your obligations to Dr. Nieren's future patients and the sites at which she might seek clinical privileges.

As already noted, the managing director of the group practice has a general duty of beneficence to sites that might consider employing Nieren. The American College of Healthcare Executives Code of Ethics requires that its members "Conduct professional activities with honesty, integrity, respect, fairness and good faith in a manner that will reflect well upon the profession." This admonition is relevant here. In addition, all those in the health professions have a general obligation to assure the integrity of their professions and the competence of those who practice in them. Turning a blind eye to a practitioner whose competence is doubtful diminishes all those who encounter that practitioner and risks the health and well-being of the public.

4. Draft a letter that could be sent in response to inquiries from sites of potential employment or clinical affiliation for Dr. Nieren.

This letter will vary in focus and substance. There is no information as to the potential legal liability, although this is something students might be interested in researching. The letter could be as short as the dates of employment, or longer with platitudes and generalities that have little or no content of value to a future employer. Because they are wide-ranging, it will be difficult to gloss over the problems Nieren had at the group practice. Students are at a disadvantage too, because they do not know the details of Nieren's clinical work at the group practice. A letter that states only the dates of employment will be a red flag to a potential employer, who is likely to require Nieren to provide detail/information, ask the group practice for specifics about performance and other variables, and/or refuse to consider Nieren further.

Case Study 5

Surgical Safety—Retained Foreign Objects

This case describes a “never” event—a retained sponge in a surgical patient. It considers the use of root cause analysis to investigate the reason(s) for the incorrect sponge count. Further, the case suggests a significant weakness in the hospital process used to track sponges and assure that no sponges and other items are missing.

1. *After reading the documentation of the process in place, what resources can you use to compare your program to national best practices?*

Several sources provide information as to national best practices regarding retained surgical items such as sponges:

1. The Joint Commission web site at http://www.jointcommission.org/sentinel_event.aspx
2. Association of Operating Room Nurses (AORN). “Recommended practices for sponge, sharp and instrument counts is up for review.” *Infection Control Today Magazine*, April 1, 2005 (see <http://www.infectioncontrolday.com/news/2005/04/aorn-s-recommended-practices-for-sponge-sharp-and.aspx>).
3. NoThing Left Behind®: A National Surgical Patient-Safety Project to Prevent Retained Surgical Items (see NoThingLeftBehind.org)
4. Sentinel Event Alert Issue 51: Preventing unintended retained foreign objects, The Joint Commission, October 17, 2013 (see http://www.jointcommission.org/assets/1/6/SEA_51_URFOs_10_17_13_FINAL.pdf).
5. Cima, Robert R., Anantha Kollengode, Amy S. Storsveen, Cheryl A. Weisbrod, Claude Deschamps, Mark B. Koch, Debra Moore, & Sarah R. Pool. “A multidisciplinary team approach to retained foreign objects.” *The Joint Commission Journal on Quality and Patient Safety*. 35:3 (March 2009): 123–132.

2. *Your patient safety department decided that it should organize a group to perform the root cause analysis that is required by The Joint Commission. Identify by title those who should be included.*

The group should include perioperative personnel involved in patient care in the operating room (OR), including circulating and scrub nurses, surgeons, surgical technicians, and anesthesiologists, as well as quality improvement staff, supply chain staff, and administrative leadership from patient safety.

3. *The root cause analysis found that there is a process to keep track of surgical sponges, but there are other places to put used sponges that blood has colored red. This can conceal the fact that a sponge was misplaced. How could this fact be included in the best practice?*

Although lack of effective communication is one of the most common causes for any patient safety errors,² staff also found that a blood-stained sponge could be accidentally unseen in the red plastic bag used to line the waste receptacles near the OR table. The first “fix” is for staff to use the system to account for sponges as they were trained to do. However, removing the red bags from the waste receptacles would allow staff to easily see if a used sponge had been accidentally discarded into a waste receptacle. (Once the surgery is complete and the surgical item counts are verified, waste can be put into red bags for disposal.) This change in the process will help prevent erroneous counts.

4. *Comment on the possibility that an OR staff member miscounted or deliberately reported a correct count.*

Hospital policy requires that at least two staff members count sponges or equipment as a team. If the policy is followed, it is hard to state that one person miscounted. Much of this depends on the “culture of safety” that is present within the team. Does staff feel safe enough to speak out if there may have been an error? Or is staff so concerned about reprisals that they are unwilling to speak out? Do all levels of staff trust that they will be supported by the surgeon and administration if they made a mistake or call out an error?

Additional Case Study 1: “Trying Hard Memorial Hospital” and “Do It Right Medical Center”³

This case allows students to see the importance of senior leadership in determining how effective an HSO is in implementing and living a quality improvement philosophy. Beyond leadership’s commitment is the focus on quality in all aspects of the HSO’s operation and the commitment of resources to making quality the first and foremost focus. The answer list for each HSO takes facts and commentary directly from the case. This case was written using total quality management (TQM) to communicate a continuous quality improvement (CQI) philosophy. Students should be told that, for the purposes of this case study, *TQM* and *CQI* are synonymous and that *CQI* is the preferred acronym and concept in the field.

“Trying Hard Memorial Hospital”

At “Trying Hard Memorial Hospital,” the chief executive officer (CEO) frequently reminds the staff of her commitment: “Keep up all of your good work on TQM! It’s an important project for this organization and one that should bring impressive results quickly.” The CEO stops by the major TQM training sessions to give the opening remarks and visits quality council meetings when her schedule permits. She also tries periodically to observe [quality] improvement team meetings.

The hospital holds special quarterly meetings to discuss the progress of TQM. When time permits, TQM also is discussed under “other business” at regular management meetings. TQM is ostensibly a major goal in the organization’s strategic plan. However, because of severe financial constraints, the TQM budget includes only a half-time coordinator, four facilitators, and \$10,000 for TQM training.

“Trying Hard Memorial Hospital” made sure that it provided TQM training for most of the vice-presidents and for facilitators in the first year of TQM implementation. The director of human resources designed the curriculum and training workbook. Courses included an awareness session, 4 days of training for facilitators, and a 1-day training session for vice-presidents. The hospital focused its training on TQM analytical tools so that people could see that TQM really differs from quality assurance (QA)—that total quality incorporates, advances, and extends beyond the traditional QA process. The first TQM team started work 2 months after the training session.

A few physicians at the hospital have expressed interest in TQM, and the chief of staff is a standing member of the quality council. Unfortunately, however, most physicians at the hospital do not really understand TQM, and they cannot afford to take time away from their practices to attend the training sessions. Thus, “Trying Hard Memorial Hospital” plans to hold one TQM informational meeting that would be open to all members of the medical staff. The hospital also hopes to generate more physician interest in TQM when the results of the pilot improvement team on turnaround time in the OR are announced.

Because of the financial constraints mentioned previously and because of an upcoming Joint Commission site visit, “Trying Hard Memorial Hospital” had decided to delay until next year the development of new TQM information systems, a new TQM planning and budgeting process, and other new management systems.

“Do It Right Medical Center”

Meanwhile, at “Do It Right Medical Center,” the CEO is continually reminding employees by her actions that she is committed to TQM. The management committee has been designated as the quality council, chaired by the CEO, to guide the organizationwide effort. The CEO has gone through 15 days of TQM training from internal TQM staff, working with an outside consultant, to become a facilitator and team leader. She also teaches one TQM course every month. She is currently serving as team leader of an improvement team that is applying TQM to the cost management process. The CEO has restructured her job to delegate more operational responsibilities so that she can spend at least 50% of her time directly with internal and external customers. “What could be a more important use of my time?” she asks those who question her schedule.

At “Do It Right Medical Center,” quality is the first item on the agenda at all management and board meetings. Every month a quality report is presented. This report monitors agreed-on quality performance measures, much as the financial report monitors financial performance measures.

At “Do It Right Medical Center,” the quality vision statement and the quality goal that is specified in the strategic plan have been integrated into operational plans at every level of the organization. The result is specific, directed action. To accomplish this integration, the quality council first developed performance measures for the vision and goals, in consultation with employees, physicians, patients, and purchasers. Then each department was asked to develop a plan to contribute to the achievement of the organization’s vision and goal. Each departmental plan was then translated into employee work plans and budgets.

The medical center’s education budget has doubled over the past 2 years. An annual training plan directs allocation of these resources. The training plan is developed by the quality council based on input from customers and results from the annual leadership profile completed by all managers. Current courses, which were tailored for the organization, include Managing by TQM, TQM for Team Leaders, TQM for Facilitators, TQM for Teams, Empowerment, Customer Expectations, and TQM Planning. In addition, the first half hour of every improvement team meeting is devoted to just-in-time training, which prepares teams for the specific project at hand, and continuing education about TQM in general. The training curriculum is balanced between analytical techniques, such as statistical process control, and behavioral modules, such as team building.

Physicians are an integral part of TQM at “Do It Right Medical Center.” Led by three physician champions, physicians serve on the quality council, help identify operational and clinical processes that would benefit from improvement teams, serve on quality improvement teams, and discuss the hospital’s quality report at the beginning of their department and executive committee meetings. The medical center is assisting the three largest physician practices to implement TQM in their offices.

TQM seems to be everywhere at the medical center. For example, all budget requests must document how they contribute to TQM. Customer satisfaction ratings are a major factor in performance evaluations. And the CEO always seems to be asking, “What root cause did your team discover for our problem? What data led you to that conclusion?”

1. *Relative to CQI, what is “Trying Hard Memorial Hospital” doing wrong?*

The CEO seems to be the only owner of the process (“her commitment”); there is no indication of senior-level management or governing body commitment to quality. The CEO wants quick results (“should bring impressive results quickly”). There is no long-term perspective.

- There is no indication of a quality vision statement.
- Quality is infrequently discussed, at quarterly meetings—at other meetings, it is last on the agenda under “other business,” if time permits.

- There is minimal resource commitment for quality (a half-time coordinator, only four facilitators, and only \$10,000 for training).
- The curriculum and training workbook were developed internally by the human resources director; there is no indication of expert assistance.
- Senior management received only 1 day of training.
- The first quality team started late—2 months after the initial training session.
- There is no physician involvement; administration has not convinced physicians of the merit of CQI, has not enlisted them as champions, and has not shown how CQI will help them do their jobs better.
- Quality is not organizationwide.
- There is no indication of employee empowerment.
- There is no indication that quality is customer driven.
- There is no indication of output/data collection or process flow focus.
- CQI does not appear to be part of the management philosophy or the organizational culture.
- There is no indication of opportunity seeking and process improvement.

2. *Relative to CQI, what is “Do It Right Medical Center” doing right?*

- The quality initiative is institutionalized; the quality council includes all senior-level managers and three physicians who are committed.
- Quality is organizationwide and part of the culture.
- There has been extensive senior-level management training (15 days).
- An outside expert (consultant) was used as a facilitator and trainer.
- The CEO is a quality leader, devoting 50% of her time to interacting with internal and external customers (“What could be a more important use of my time?”).
- Quality is first on the agenda of all management and board meetings; monthly quality reports are presented, with follow-up to quality performance measures.
- Quality vision and quality goal(s) exist in strategic plans and operational plans at all levels.
- Specific performance measures are employed.
- There is consultation with employees, physicians, patients, and purchasers (i.e., customers) about quality.
- Each department develops a quality plan that is integrated into the budgeting process.
- Resource commitment is evident (doubling the education budget).
- Training has been developed by the quality council with customer input; courses have been tailored for the organization with a balance between analytical techniques for process control and team building.
- Physicians are an integral part of the quality effort; three physician champions serve on the quality council and QITs, and they report at medical department and executive committee meetings. They identify operational and clinical processes that could benefit from QITs.
- The hospital is showing physicians how CQI can help them in their practices.
- CQI is integrated into the budgeting process.
- CQI is data driven (“What data led you to that conclusion?”).

Notes

1. From the *Akron Beacon Journal*, July 12, 1991, C14; Ann Landers and Creators Syndicate, The Chicago Tribune, Chicago, IL. By permission of Esther P. Lederer Trust and Creators Syndicate, Inc.
2. Cima, Robert R., Anantha Kollengode, Amy S. Storsveen, Cheryl A. Weisbrod, Claude Deschamps, Mark B. Koch, Debra Moore, and Sarah R. Pool. "A multidisciplinary team approach to retained foreign objects." *The Joint Commission Journal on Quality and Patient Safety*. 35:3 (March 2009): 123–132.
3. From Melum, Mara Minerva, and Marie Kuchuris Sinioris, eds. *Total Quality Management: The Health Care Pioneers*, 5–6. Chicago: American Hospital Publishing, 1992; reprinted by permission. The term *continuous quality improvement* (CQI) may be substituted for *total quality management* (TQM).