LEARNING FROM EXPERIENCE—A REVISED APPROACH TO QUALITY ASSURANCE

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This article introduces a model for directing quality assurance activity in hospitals outside of the US. We believe that this model will be more expedient than the systems presently in use. The rationale for this new approach is based on the American experience but proposes an improved organizational and scientific method that has evolved to replace the previously existing ad hoc committees and punitive, post-factum approach. The suggested model includes the establishment of an inter-related network of institutional and departmental committees coupled with the active participation of the hospital director and a specialized unit for quality assurance activities. This approach has the potential for affording major improvements in the implementation of quality assurance in hospitals, outside of the US, which have not been part of the evolutionary process which has taken place in America.

Key words: Quality assurance, health care, trends.

INTRODUCTION

The subject of quality assurance in medical care in general, and in hospital care in particular, has received dramatic impetus in the last decade, firstly, in the US and then in other countries in the Western world. During this time, the field has undergone changes, both in philosophy and practice, in an attempt to improve the quality assurance process. Until recently, in the US and elsewhere, this subject was addressed mainly by hospital committees whose responsibility was to review various clinical areas and investigate cases which deviated from accepted norms of diagnosis or treatment. Once the procedure was determined to be deviant, the committee

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would recommend steps to be taken against the physician held responsible and, at times, would propose measures to prevent such situations from recurring [1]. However, this alone did not prove to be an effective method of changing and correcting questionable practices. As a result, American leaders in general, and the leaders of the medical profession in particular, insisted that existing quality control systems be improved, and initiated a movement in the US, whose purpose was to develop, in an orderly fashion, an improved process for monitoring the quality of medical services. This movement received the support of national and local American political authorities, who provided the legislative backing for this course of action [2,3].

Major features which were introduced and which contributed to the success of this effort included putting greater emphasis on the systematic gathering of data; making a commitment to invest the necessary resources, in time and money, to properly analyse the data collected; allocating increased resources to support the operation of the newly developed quality assurance monitoring models; and intensifying disciplinary measures against medical staff, paramedical professionals and hospital departments which deviated from the medical institution's agreed upon norms [4,5].

A prerequisite for attaining the goals set forth was the development of assessment criteria acceptable to the medical profession. The debate on this issue focused on four main approaches, each with its own group of loyal followers. They were (a) those who gave credence to the input element, namely the level of diagnosis, as the key element in assuring the high quality of medical care services; (b) those who saw the process, namely the treatment, as the key factor in maintaining high quality of medical care; (c) those who saw in the output, namely the outcome of the diagnosis and treatment, the basis for judging the quality of the services provided; and (d) those who argued that a combination of two or all three of the above was the way to evaluate and assure better quality of medical care services [6].

Although the above issue had not yet been fully resolved, due, in no small measure, to the substantial difficulty in obtaining a true measure of any of the above-mentioned components, the approach to quality assurance or, as it is also called, quality control was changing. This change manifested itself in a number of different ways. (a) The scientific community began to launch an increasing number of research projects which focused on the various aspects of quality assessment criteria and the methods by which these criteria could be effectively implemented [7]. (b) The managerial sector advocated greater integration and cooperation among the chief participants in the provision of medical care (i.e. the administrators, physicians, nurses and other relevant staff members), without which no meaningful change would be effected [8]. (c) The organizational theoreticians pointed out the need to create new methods for monitoring and solving problems that arose as a result of the new quality assurance policies and activities [9]. As a result, an atmosphere developed in the US where no self-respecting medical institution could afford to function without a special network which would gather data, monitor and advise on subjects and activities associated with improving the quality of medical services [10].

This network was expected to perform the following functions [11]:

1. Identify quality-related questions associated with a wide range of medical conditions according to agreed upon criteria.
2. Study the problems identified and ascertain the best way for monitoring them.
3. Analyse findings, draw conclusions and make corrective recommendations.
(4) Propose methods for implementing the recommendations.
(5) Develop a system for recording the steps to be taken.
(6) Develop built-in evaluation and follow-up mechanisms designed to monitor the measures taken and to ascertain whether they had rectified the problems discovered and prevented them from recurring or, at least, had reduced them to a minimum.
(7) Develop a network to disseminate relevant information to all institutional levels.

Once the above structure became established in American institutions, hospitals in other western countries began to take notice of these developments. They observed the American experience which indicated that, in order to perform successfully the aforementioned functions in a hospital setting, the overall execution of the institution’s quality assurance activities must be the direct responsibility of the hospital’s Director. They realized that in order to introduce the approach just described, the hospital’s Director should oversee the establishment of the institution’s new quality assurance organs, including the Hospital Quality Assurance Committee, which he should chair, and the Hospital Quality Assurance Unit/Department. This structure was markedly different from the loosely organized quality assurance apparatus that existed previously in hospitals in and outside of the US. Hitherto, elements of quality control in medical institutions were developed as a result of sporadic individual initiatives by hospital directors or zealous department heads and not as part of a systematic and purposeful establishment of an institutional infrastructure backed by clear-cut upper-level management policy. This restructuring of quality assurance operations was meant to give new substance and credibility to the previously existing network of quality related committees. Once the Quality Assurance Unit was established as an operational instrument of the institution’s top level, it was expected to monitor the individual committees’ structures and operations, thereby increasing their strength and effectiveness [12]. Institutions in, or outside, the US desiring to improve their quality assurance function, will have to go through a period of transition during which time they develop a comprehensive quality assurance framework on the institutional as well as the departmental level. The hospital Director plays the vital role of the main protagonist in the process. The model proposed next is based on the knowledge and experience gained during the last decade in many American hospitals, which has begun to spread to hospitals outside the US as well. This simple model is structured around two organizational levels—institutional and departmental.

THE INSTITUTIONAL LEVEL

The institutional level should be responsible for the development of the organization’s general policy and the establishment of a network to engage in the ongoing examination of quality assurance issues. This network will consist of a number of committees established by the hospital Director [13]. The committees will receive professional assistance and direction from the Hospital Quality Assurance Unit, which will be an integral part of this framework. The Hospital Quality Assurance Unit will report its findings and be directly responsible to the hospital’s Director. The committees should include the following.
1. The Hospital Committee on Quality Control

This body will be the hospital's executive quality assurance committee and should consist of the Hospital's Medical Director and the major department heads. The committee will conduct regular reviews of quality assurance activity in the hospital and will assume responsibility for the implementation of recommendations. Its overall objectives should be:

— to assure the provision of optimal treatment for the patients in the hospital through continuous and systematic assessment of the different aspects of diagnosis and treatment;
— to receive reports on all subjects pertaining to quality control, in the hospital, to analyse them, to develop policy and to recommend steps for the implementation of the conclusions;
— to identify and reduce the various risk factors found in the hospital;
— to monitor the selection of the quality control measures adopted by the hospital departments;
— to monitor the activity of the quality assurance committees and unit.

2. The Medical Records Review Committee

This committee should consist of senior physicians representing various departments such as Internal Medicine, Surgery, Neurology and Medical Records. Its objectives should be:

— to evaluate the composition of the hospital medical record;
— to evaluate the quality of medical records, with special attention to accurate and complete recording of medical information and post-discharge follow-up directives;
— to monitor the recording of diagnoses according to the ICD-9;
— to evaluate the quality of reports on surgery and other invasive procedures;
— to evaluate the medical record and discharge forms in use in the Emergency Room.

3. The Blood Utilization Review Committee

This committee should consist of the Director of the Blood Bank, a senior hematologist and two senior physicians, preferably with surgical backgrounds. This committee's objectives should be:

— to evaluate the policy for the use of blood and blood by-products in the hospital;
— to examine adverse reactions to transfusions of blood or blood by-products;
— to monitor orders for blood by the hospital departments;
— to examine the possibilities of reducing blood usage in the hospital.

4. The Mortality Monitoring Committee

This committee should consist of the Director of the hospital and the heads of the Departments of Internal Medicine, General Surgery, Pathology and Social Medicine. The committee's objectives should be:
— to analyse the causes of death in the hospital, in general, and in unusual circumstances in particular;
— to examine the causes of post operative mortality;
— to examine mortality rates from specific diseases;
— to compare interdepartmental and inter-hospital mortality rates.

5. The Surgical Tissue Review Committee

This committee should consist of two senior pathologists, a surgeon, an internist, a gynecologist and a representative of the hospital administration. The committee’s objectives should be:
— to obtain information on every surgical excision of an organ or tissue performed in the hospital;
— to examine organs and tissues which have been surgically removed;
— to investigate any surgeon the committee deems necessary, regarding his choice of surgical procedures.

6. The Utilization Review Committee

This committee should consist of the head of the Emergency Room, an epidemiological nurse and a representative of the Social Services department. The committee’s objectives should be:
— to conduct a bi-weekly random sampling of unusually long patient stays in two of the hospital departments;
— to perform regular bi-weekly checks of the reasons for unusually long hospitalizations, in all hospital departments.

7. The Infection Control Committee

This committee should consist of the head of the Clinical Microbiology Department, senior physicians from Microbiology, Social Medicine, the Infection Monitoring Unit and an epidemiological nurse. The committee’s objectives should be:
— to develop systematic data-collection, assessment and reporting on infections in the hospital;
— to give the medical and paramedical staff the necessary tools for identification, treatment and prevention of hospital-acquired infections, especially through the provision of microbiology laboratory support;
— to develop the policy and procedures for prevention of hospital-borne infections and to assume the responsibility for training hospital staff in this area;
— to provide advice on treatment of ad hoc problems, as requested by the hospital administration, department heads, physicians or nurses.

THE DEPARTMENTAL LEVEL

Once the quality assurance apparatus has been established at the institutional level, the departmental quality assurance activity should be developed. The basic idea behind developing this level is to create, in the department’s staff, a sense of
participation in molding their own course of action regarding the quality assurance process and its outcomes. This participatory approach should facilitate the cooperation of the staff to improve this new field of endeavor. Therefore:

(1) Each department will be invited to develop its own quality assurance objectives, and select the methods of operation it feels most comfortable with, in regard to the quality assurance activities which will be incorporated into the department's short- and long-term operational plans. These activities will include:
   (a) on-going monitoring,
   (b) gathering and analysis of data,
   (c) examining deviations from the norm and,
   (d) implementation of corrective action.

(2) The above activities should be directed by the department head, in coordination with the Hospital Committee on Quality Control and the Hospital Quality Assurance Unit.

(3) An integral part of the department's activities will be the periodic selection, by each department head, of two or three quality assurance related subjects which are related to the department's specialty area and are of special interest to the department's medical staff. The selection of topics for study will be followed by the subsequent course of action:
   (a) An intern will be appointed to research these issues in light of the current medical literature on the subject and under the direction of a senior member of the department who is a specialist in the field selected.
   (b) The department head will appoint these two staff members, for a period not to exceed 6 months, during which time they will gather and analyse the necessary data and, finally, present their findings to the department head and departmental staff.
   (c) This ongoing investigation process will be renewed every 6 months, selecting new subjects for investigation and new research teams.
   (d) Conclusions and recommendations will be submitted by the department head to the Hospital Committee on Quality Assurance for their review and approval.
   (e) Each subject investigated will be reassessed after a period of a few years to ascertain the results of the intervention.

CONCLUSION

This article has attempted to bridge the gap between the old approach to monitoring the quality of care in medical institutions, which is still prevalent in many hospitals outside of the US and is in need of change, and the newer approach, based on the system which evolved in American hospitals over a long period of time [14]. To disseminate the lessons learned through the American experience to the international hospital community, we have proposed a course of action for those who have elected to increase their involvement in the sensitive area of quality assurance. The authors are aware that new ideas on the subject of quality assurance are bound to arouse resistance in certain quarters, either because of lack of knowledge or because of fear of reforms and of the unknown. To facilitate this development in medical institutions outside the US, the article intends to initiate a dialogue between the "newcomers", who seek to effect improvement in this area in their institutions, encouraging them to reassess the prevailing "inspection and punishment" model and
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to replace it with active participation in developing a quality assurance system which is suited to their own institutional needs.

REFERENCES