Quality and Safety in Women's Health

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Preface

In healthcare today, "variation," "standardization," "quality improvement," and "patient safety" have become buzzwords. The past several years have seen tremendous growth in interest and activity around quality improvement and patient safety. Staff positions and new titles dedicated to patient safety and quality improvement have been created in countless organizations. Committees and councils have been formed, and numerous initiatives have been undertaken. We have entered an era where transparency of performance data and comparison with peers is becoming commonplace, and our competitiveness and financial stability depend upon our responses. Furthermore, the welfare of our patients requires nothing less.

The reality is that "standardization," "quality improvement," and "patient safety" are not just buzzwords. Nor are they necessarily goals to be achieved or short-term initiatives to be undertaken. They are not effective as tactical responses to a focused area of poor performance. Instead, they represent a powerful set of tools and strategies that underlie a culture of quality and safety that we all must embrace. It is not the job of a subcommittee, or of one or a few designated persons. It is not a checklist, or a protocol, or a drill, or a guideline. Instead, it is a deeply embedded culture – the way of doing things every day. It is the job of *everyone* in the organization. It isn't always easy – but it is necessary and most often rewarding.

In this book, we present a highly practical guide for introducing a culture of quality and safety through case presentations of everyday situations that we each face as providers of women's health care, and include in-depth discussion of underlying factors in underperformance and methods for improving them. Though many topics focus on a specific clinical area, the principles are universal and can be applied across many settings. As such, these practices should not be applied in isolation. In doing so, the likelihood for short-term implementation and long-term sustainability is nil. Rather, they should be undertaken as a component of a more comprehensive approach to improving quality and safety, and engaging stakeholders at all levels. Applied in this context, they will serve as important building blocks for the foundation of a culture of quality.

There are a number of methods available for adoption as part of a strategy to improve quality and safety. Among the more prominent quality improvement (QI) methods are Six Sigma, Lean, Kaizen, and the Model for Improvement. For patient safety, common strategies from the Agency for Healthcare Research and Quality (AHRQ) include Team Strategies to Enhance Performance and Patient Safety (Team STEPPS) and Comprehensive Unit-based Safety Progragram (CUSP). Other promising initiatives include the Partnership for Maternal Safety and the Safety Program in Perintal Care, a Team STEPPS based program sponsored by AHRQ. No single methodology has proven itself superior to others. They are perhaps best used in combination, while being adapted to local contexts.

For those looking to build a culture of quality and safety, this book alone will not get you there, but it can serve as a valuable tool with immediate relevance to many clinical and operational challenges we face, and as a building block in the march to build that quality culture.

Several important elements are critical to the success and sustainability of a quality and safety program. Some or all of these may be present at your institution, but many will lack at least some of these. Early efforts must emphasize certain foundational elements, which we will outline below. Certainly, having embedded clinicians and staff formally trained in CQI and safety methods is important, but key aspects of the culture are deeper and more extensive. Ultimately, the formula for quality is simple: *Structure + Process = Outcomes*.

Implementation and sustainability of patient safety initiatives is often difficult and requires a receptive

organizational culture. Leadership, measurement, and engagement are necessary components of this culture.

Leadership that is engaged, present, and involved is perhaps the single most important factor in the successful deployment of any QI or safety program, and in building the culture. Failed efforts to establish QI in any setting can, in the majority of cases, be traced directly to this aspect of culture. Yet it remains overlooked or underemphasized all too commonly. Instead, QI efforts are often relegated to isolated subcommittees or individuals, who often suffer from limited influence and even further limited resources. Leadership at all levels simply must be meaningfully engaged in these endeavors. They cannot be merely complicit.

Measurement is similarly given short shrift in many programs. This may be due to budgetary constraints, limited personnel, or information technology resources. In some cases, it is simply not seen as necessary or important. However, we would very strongly argue that measurement and evaluation are absolutely necessary to the success of any quality program. In the absence of effective measurement, how will teams and stakeholders truly know if they are making a difference, if the investment is worthwhile, or even where, what, and how to improve? Without evidence of impact or cost-effectiveness, efforts and investment will wane, and an opportunity to develop a culture may be lost. Finally, measurement can be a very powerful motivator for staff and teams engaged in QI and safety efforts.

Nearly equally important as the "whys" to collect data is the "what." Data collection can suffer in either direction – collecting too little or incorrect data, or collecting too much data and thus creating clutter, confusion, and consuming unnecessary resources. Measurement should be carefully considered, and should extend beyond those measures required for report to outside agencies. Data collection and analysis should serve the specific and overall goals of your quality program, the pillars of which comprise structural elements, clinical and operational processes, immediate outcomes, and ultimately impact. Use of some simple tools, such as logic models, driver diagrams, or process maps can help with planning measurement and evaluation.

Engagement and empowerment of all staff and relevant stakeholders is critical. The multitude of processes that impact patient safety, clinical excellence, and the patient experience do not take place in a boardroom or administrative office, nor do most of them occur in silos. Rather, they are the culmination of the coordinated efforts of many individuals who comprise a healthcare team. These are happening at the point of care as well as countless interrelated processes taking place behind the scenes.

We hope that you will embrace this book as a valuable set of tools in guiding and developing local efforts in quality and safety, or boosting and tailoring those already functioning. It is targeted to anyone involved in delivering healthcare to women, including leaders, clinicians, and staff in community hospitals, private practices, health departments, and tertiary and academic medical centers. Within the text, you will find many examples of cases representative of our daily practices and challenges. Most chapters have been organized as a relevant case presentation, followed by an in-depth exploration of key factors and suggested responses. Though some may prefer to read the text in its entirety, it is organized in a way that readers may also go directly to a section or even a chapter of specific relevance, and gain the specific perspective of an expert fellow clinician as well as a review of pertinent evidence or experience.

Clinical and system level patient safety topics include obstetrics, gynecology, health policy, office practice, labor and delivery, regulatory issues, quality improvement, and medical education. Within, you will find guidance on surgical safety, obstetrical emergencies, and use of health information technology. There is also a comprehensive chapter on fetal monitoring, given its prominent role in patient safety, and two chapters addressing the incorporation of quality and safety into medical education programs.