Reflections on Hospital Quality Assurance Programs

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INTRODUCTION

This paper reviews the concept of quality assurance (QA) as it applies to hospital programs. It does not pretend to be a thorough or scientific bibliographic review of the subject. Rather, the practical observations and reflections presented here are intended to demystify QA, show that it is not complicated, and demonstrate that it is achievable in any hospital. The basics of QA are described in simple, nontechnical language so that hospital managers may gain a better understanding of the subject and increased confidence in implementing QA programs.

Quality assurance is a powerful administrative instrument, not merely a fashionable trend in organizational theory. In fact, QA is an old concept that resurfaced as industries tried to duplicate the productivity and efficiency achieved by Japanese companies (1). Thus, quality assurance, under the rubric of "quality management," is an organizational theory revisited.

Quality has been a concern since the earliest days of hospital care, for obvious reasons: the outcome of actions performed upon someone's body is a cause for concern. During the Crimean War, Florence Nightingale did quality assurance for the British military hospital based in Turkey. She organized the activities of the wards by type of wound, made sure the environment and the patients were kept clean, and did other things that are now taken for granted in the daily routine of hospitals. In 1916, E.A. Codman proposed what he called the "end results" method to judge the clinical practice, organization, administration, and economic soundness of a hospital (2).

It is important to emphasize the positive aspects of quality assurance. It does not exist to blame or punish people, but rather to prevent (or minimize) mistakes. The idea is to do things right the first time and thus avoid the need to redo them.

It is frequently thought that implementing a quality assurance program implies an increase in costs; this is not necessarily so. Quality assurance can actually help reduce costs. During the implementation phase, the hospital may see costs increase slightly, but this investment will be paid back amply when the program gives results (3). A QA program should not require more resources than those already being used by any hospital in its normal operation. The quality of care is not necessarily higher in institutions that spend more (4).

Two conflicting tendencies in resource use are frequently observed in hospitals. On the one hand, the professionals in charge of technical aspects of the hospital (doctors, nurses, etc.) were trained to perform according to the medical model, which obligates them to do everything possible to save a patient's life, regardless of costs. On the other hand, the administrative staff operate under the paradigm of trying to do the most with the least. Although these two tendencies are conflicting, they have to work together. "Quality management" might serve as the catalyst that integrates them.

Hospitals should strive for patients to receive the appropriate treatment at the right moment, with the most efficient use

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of the resources available. Ideally, the sequence of services is arranged in such a way that patients get the most out of their treatment in a very efficient manner. Use of a less efficient strategy produces services of lesser quality. This concept has been called "clinical efficiency," in contrast to "efficiency of production," which is related to the use of resources in the nonclinical aspects of treatment. For example, if the hospital is only partially occupied or the laboratory results are not ready on time, the care given in that institution is of low quality, since efficiency is one component of good quality of care (5).

It is also important to highlight the ethical dimension of quality assurance. In this case, ethics refers to the bioethical concepts that regulate the relationship between health professionals and their patients, and not deontological or legal-scientific ethics. There is nothing more ethical than delivering good quality care at the lowest cost. Donabedian refers to this as "our peculiar, even our sacred, mission" (6).

ELEMENTS OF QA

A QA program can be understood as the combination of an information system and the decision-making processes based on the information generated by it. Obviously, it is not sufficient to collect and analyze data. It is necessary to take action to correct errors and avoid committing mistakes. The purpose of a QA program is to measure, assure, and improve quality on a continuous basis.

Most conceptual models proposed for QA programs are based on three elements for which indicators of quality are selected and organized: structure, process, and results. This model, proposed by Donabedian, uses elements from systems theory and covers all sectors of a hospital (7). Structure indicators are objective and quantifiable variables. They measure components that are necessary for good quality but not

sufficient in and of themselves to guarantee it — facilities, all sorts of supplies, human and financial resources, and the organizational structure. Process indicators are related to what is done for patients in terms of diagnosis, treatment, rehabilitation, prevention, etc. Indicators of process are the most difficult to assess, but they are key elements in the assurance of quality. More research is needed in this area. Results (output, outcome, and impact) can be defined as the consequence of the structure and process put to work for patient care. Classical indicators of results are morbidity, mortality, and disability. However, it is important to emphasize that these results are not exclusively related to the interventions of health care professionals.

DEFINITIONS AND PRINCIPLES

Quality of care is one of those concepts that is easy to understand but difficult to define. Everyone seems to know what quality of care means, but it does not have the same meaning for everyone. The professional who is responsible for care will judge quality differently than another professional who is not directly involved in the case. Patients understand quality in a different way than their doctors do. The hospital management team has another view of quality of care, and so do third-party payers.

It often happens that the personality or behavior of the people delivering care is evaluated rather than their technical capability — the latter being much more difficult to judge. Rather than skillfulness, the amenities of care are frequently used as an indirect measure of quality. Franco et al. define quality as "the degree to which actual performance or achievement corresponds to set standards" (8). De Geyndt, however, suggests that one should sidestep the problem of definitions and focus on what quality of care evaluation is supposed to achieve (9).

Evaluating quality means making value judgments about the results of technical and/or administrative procedures. It is important to understand that such value judgments should not be based on subjective personal preferences, but should be related to standards objectively set in advance. These standards or indicators are basic tools for the evaluation process. On the other hand, the need for indicators should not lead to an obsessive preoccupation with the establishment of minimal standards, above which everything is considered good. If one targets minimal standards, one will never reach excellence.

QA strives to guarantee that results of an administrative or technical action are adequate, considering local characteristics and existing restrictions — in other words, if the results are consistent with the local possibilities and resources. However, one cannot accept inferior performance just because it is compatible with local standards; to do so is to risk keeping quality at low levels. A balance must be maintained between what is adequate and what is appropriate in each case.

Research on applying quality management to health care systems suggests that a good QA program should be guided by the following four basic principles (10):

1. It is adjusted to the needs and expectations of the patients and the community.
2. It is focused on systems and processes.
3. It uses information to analyze quality.
4. It is based on a team approach to problem solving and quality improvement.

Quality assurance must be distinguished from classification and accreditation. Classification ranks institutions by type, size, or other criteria. Accreditation is an instrument to assess the amount and quality of resources available and seeks to evaluate quality of care based on widely accepted, externally generated standards. Some authors believe it should precede any attempt at implementing a QA program (11). QA is an internal process, while the other two are conducted by outside sources.

BASIC CHARACTERISTICS OF QA

Among the characteristics of QA programs, the following should be highlighted: (a) simplicity, (b) continuity, (c) confidentiality, (d) decentralization, and (e) self-evaluation (12).

(a) A QA program can and must be simple. Any institution with a minimal organizational structure should be able to implement a QA program. The first and most important requisite is the will to do so. The tendency to procrastinate is a great obstacle; the right moment never seems to come. Someone in the institution must take the lead and start the process. The leader may not be a senior staff member, but support from the senior management group is indispensable.

(b) Continuity and perseverance are fundamental to the success of the program. QA cannot be a short-term project, started in response to a crisis or to maintain the image of the institution. A QA program that is begun with the wrong motivation will not get off the ground. The main thrust of QA is behavioral change, which does not happen overnight. It takes time to see consistent results. Quality assurance is part of a process of change within the institution, always targeted to higher levels of achievement and, therefore, to continuous improvement.

(c) Confidentiality should be maintained in order to convince everyone of the impartiality of the process, which does not aim to assign blame but rather to stimulate people to improve their performance. The information generated and transmitted within a QA program is only pertinent to those who can do something to correct possible errors and learn from them. This does not abrogate the obligation the hospital has

toward its patients nor the need to keep them informed.

(d) Even if the coordination and control of the QA process is at the central level, it will only be effective if it is performed at the periphery of the system, which means the operational units of the hospital where services are being delivered to the customers.

(e) To the extent possible, QA should stimulate self-assessment and not be an exercise in control and supervision from above. It must be assumed that the organization's personnel are mature adults who are interested in doing their jobs well and that feedback mechanisms are sufficient to let them know at what level of quality they are performing. This feedback must be aggregated and followed up by the higher echelons of the organization that will sanction performance levels.

IMPLEMENTING QA

Implementing QA in a hospital setting is not possible without the firm commitment of the board and senior management officers to the process. It is necessary that the senior level of the institution be aware of the implications of a QA program and be willing to accept the risks of its implementation. After this commitment is established, it is equally important to sensitize all other levels of the hospital hierarchy, mainly the medical staff. QA should be understood as a continuous process that permeates the whole institution and becomes part of its organizational culture. Changing the ingrained habits that constitute an organizational culture is not an easy task. If the right attitude is not present, QA is doomed to fail before it even starts. The right attitude implies a willingness to empower subordinates, delegate authority, maintain transparency of actions, and promote honest communication.

Most hospitals probably carry out some activities that could be called quality assurance. One way to initiate a formal QA program is to put these activities together under the same umbrella and improve the program incrementally by adding other activities or making existing ones more sophisticated. To avoid duplication, it is necessary to understand what is already happening in the organization, especially what is working well (13).

A formally structured QA program may call for a QA committee or similar arrangement, depending on the characteristics and needs of the institution. This committee must be multidisciplinary, with the nursing administrator, the manager, and the medical director as participants. The committee may be further organized into several subcommittees that deal with important activities:

1. The nosocomial infection subcommittee is probably the best and oldest example of a quality assurance instrument in use in hospitals. The methodology for surveillance of nosocomial infections is well established and developed. Hospitals can save substantial money by managing nosocomial infections properly, and patients can be spared a lot of needless suffering and time in the hospital (14).

2. The professional credentials subcommittee covers all those activities related to the way professionals are credentialed to perform their duties in the institution. Professional qualifications are reviewed and employees' continuing education and performance are tracked. In smaller institutions this subcommittee may be merged with the following one.

3. The professional audit subcommittee evaluates performance according to the best standards set up by peers and described in the literature. Also called peer review, the main objective is educational, not punitive. Mortality and morbidity review activities fall under this heading.

4. The utilization review subcommittee makes sure that institutional resources are being effectively and efficiently used. It en-

compasses review of the hospital's basic data (admissions, discharges, average length of stay, etc.) as well as more sophisticated analyses, such as those dealing with the appropriateness of admissions or readmissions.

5. The risk management subcommittee covers activities related to the analysis and prevention of risk conditions in the hospital that may threaten the patients, their families, visitors, the staff, and the facility itself. Occupational medicine and prevention of malpractice suits fall within this domain. Some authors consider risk management to be an umbrella concept that encompasses all other QA activities; in this case QA and risk management would be considered synonymous.

6. The patient relations subcommittee is in charge of activities related to consumer satisfaction. This area is often neglected under the false assumption that lay people are not qualified to evaluate the services rendered to them. However, since patients are the recipients of care, they must be at the center of the definition of quality of care. This acknowledgment requires the development of some mechanism to gauge the patients' views, such as interviews or questionnaires. These activities serve as a health education tool for patients since they are asked to analyze the care they receive. In this way, the consumers participate in the life of the institutions. Much research is still needed in this area, but hospitals should not put off implementing proper evaluation of patient satisfaction. Some authors identify satisfaction of "customer" expectations as a way of measuring quality of care. In this case, two types of customers — internal (personnel) and external (patients and their families) — should be considered (15).

7. The bioethics subcommittee oversees ethical concerns in regard to the relationship between patients and health professionals. It deals with life and death decisions as well as the appropriateness of certain treatments (16). Ethics demands delivery of good quality care; in this sense, this subcommittee is part of the quality movement.

8. A subcommittee may oversee quality evaluation of certain medically and economically important special services provided by the hospital. Some of these services traditionally apply the QA concept. However, there are no limits as to what areas can apply QA. It is up to the creative administrator to be aware of the needs of the hospital and to propose new areas of work (17). Among the most common ones are the following:

Patients' charts — The chart is the important document on which diagnostic and therapeutic decisions are recorded. If this document is not of high quality, in terms of what data are collected and how they are recorded, it will not convey the proper information to the professionals who need to analyze it in order to care for the patient. It is in the best interest of both professionals and patients that this document be of the best possible quality.

Laboratory — Along with nosocomial infection control, the laboratory has received the most attention in terms of quality assurance. For many years, laboratories have carried out statistical control of the processing of tests. They often participate in a laboratory network that allows for external evaluation as well as internal control.

Blood bank — This is another service that is usually subject to quality evaluation, especially since the beginning of the AIDS epidemic and the growth of concern over transmission of HIV, as well as other viruses, through blood transfusion. Here, too, external and internal quality evaluation is important.

Pharmacy and therapeutics — A subcommittee in this area oversees the institution's formulary, defines guidelines for the addition of new drugs and the removal of old ones, and analyzes treatment protocols.

CONCLUSION

The QA program should ultimately result in decreased morbidity and disability, fewer iatrogenic problems, and more value for the money spent on patient care. But in addition to these quantifiable results, there should also be other accomplishments, such as satisfaction among patients and families, a committed and fulfilled staff, efficient use of resources, and the determination to "do the right thing right, right away."

As pointed out earlier, the will to start is the fundamental requisite for implementing a QA program in a hospital. It does not matter if the program is only partially implemented at the beginning; it can start small and be expanded over time and made more sophisticated. Although it should be a comprehensive activity, it can grow incrementally until it is established within the whole institution.

The intention of this paper was to convince hospital managers to engage in QA programs. If that has been done, then it may be said that the paper achieved a certain level of quality.

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