# Data Driven Surgical Quality Improvement: Beyond M&M

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MTQIP
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# What is Surgical QI?

- Quality/Safety/Regulatory
  - Sentinel Events
    - When a sentinel event occurs, the accredited organization is expected to conduct a timely, thorough and credible root cause analysis; develop an action plan designed to implement improvements to reduce risk; implement the improvements; and monitor the effectiveness of those improvements.
  - RCA
    - Root Cause Analysis: A structured process for identifying the causal or contributing factors underlying adverse events, adverse outcomes, or other critical events
  - Creating/Amending Policies & Procedure
    - Match current practice- Joint Commission and CMS hold hospital's accountable for their own policy/procedure
    - New policies/procedures are not always a cure for process improvement it may be as simple as a need for re-education

# What is Surgical QI?

- Departmental
  - Surgical M&M
    - Educational sessions
    - More focused on personal rather then system improvement
  - Grand Rounds
    - More education
    - May occasionally be dedicated to Quality Improvement and outcomes data
  - NSQIP

# What is Trauma QI?

- Trauma Registry
  - Data, Data analysis?
- Trauma Program Manager
  - Project Management, Planning
- Multi-specialty Peer Review Committee
  - Error Analysis: Deaths, Audit Filters
- Institutional Trauma Committee
  - Change Agent? Communication Mechanism?
- NTDB
  - Benchmarks

# Basic Elements of QI

- Data Collection
- Data Analysis
- Error Analysis
- Process Improvement

# Basic Elements of QI

| | Registries | Peer Review | Quality Improvement |
|---|---|---|---|
| **Data Collection** | + | - | + |
| **Data Analysis** | +/- | - | + |
| **Error Analysis** | - | + | + |
| **Process Improvement** | - | +/- | + |

# Basic Elements of QI

| | Registries | Peer Review | Quality Improvement |
|---|---|---|---|
| Data Collection | + | - | + |
| Data Analysis | +/- | - | TQIP + |
| Error Analysis | - | + | + |
| Process Improvement | - | +/- | PIPS + |

# Basic Elements of QI

| | Registries | Peer Review | Quality Improvement |
|---|---|---|---|
| Data Collection | + | Who | + |
| Data Analysis | +/- | - | + |
| Error Analysis | - | + | + |
| Process Improvement | - | +/- | + |

# Basic Elements of QI

| | Registries | Peer Review | Quality Improvement |
|---|---|---|---|
| Data Collection | + | - | + |
| Data Analysis | +/- | What | + |
| Error Analysis | - | + | + |
| Process Improvement | - | +/- | + |

# Basic Elements of QI

| | Registries | Peer Review | Quality Improvement |
|---|---|---|---|
| Data Collection | + | - | + |
| Data Analysis | +/- | - | + |
| Error Analysis | - | Why | + |
| Process Improvement | - | +/- | + |

# Basic Elements of QI

| | Registries | Peer Review | Quality Improvement |
|---|---|---|---|
| **Data Collection** | + | - | + |
| **Data Analysis** | +/- | - | + |
| **Error Analysis** | - | + | + |
| **Process Improvement** | - | How | + |

# QI: Data Collection

- Who are the patients?
  - Registries
    - Chart Abstraction
    - Specific Elements
  - Self Reporting
    - M&M
  - Administrative Data
    - Delayed, Poor Quality

# Identification of Surgical Complications and Deaths: An Assessment of the Traditional Surgical Morbidity and Mortality Conference Compared with the American College of Surgeons-National Surgical Quality Improvement Program

Matthew M Hutter, MD, MPH, Katherine S Rowell, MS, MHA, Lynn A Devaney, RN, Suzanne M Sokal, MSPH, Andrew L Warshaw, MD, FACS, William M Abbott, MD, FACS, Richard A Hodin, MD, FACS

**Table 1.** Postoperative Morbidity and Mortality Rates from the General Surgical Services at the Massachusetts General Hospital (July 1, 2002, to June 30, 2003)

| | M&M conference | | NSQIP | | |
|---|---|---|---|---|---|
| | n | % | n | % | p Value |
| Total major cases | 5,905 | | 1,439 | 24 | |
| Morbidity (% with morbidity) | 380 | 6.4 | 416 | 28.9 | < 0.0001 |
| Mortality (% with mortality) | 53 | 0.9 | 28 | 1.9 | 0.001 |

Rates are presented as determined either in traditional morbidity and mortality (M&M) conference, or by a National Surgical Quality Improvement Program (NSQIP) nurse-reviewer.

# Identification of Surgical Complications and Deaths: An Assessment of the Traditional Surgical Morbidity and Mortality Conference Compared with the American College of Surgeons-National Surgical Quality Improvement Program

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**Table 2.** Postoperative Occurrence Rates Stratified by Different Groupings of Complications

| Occurrences, complication group | M&M conference (n = 5,905) | | NSQIP (n = 1,439) | | p Value |
|---|---|---|---|---|---|
| | n | % | n | % | |
| Wound | 71 | 1.2 | 104 | 7.2 | < 0.0001 |
| Respiratory | 58 | 1.0 | 120 | 8.3 | < 0.0001 |
| Urinary | 34 | 0.6 | 70 | 4.9 | < 0.0001 |
| Central nervous system | 4 | 0.1 | 11 | 0.8 | < 0.0001 |
| Cardiac | 32 | 0.5 | 24 | 1.7 | < 0.0001 |
| Other | 181 | 3.1 | 87 | 6.0 | < 0.0001 |
| Total | 380 | 6.4 | 416 | 28.9 | < 0.0001 |

Rates are presented as determined either in traditional Morbidity and Mortality (M&M) conference, or by a National Surgical Quality Improvement Program (NSQIP) nurse-reviewer.

# QI: Data Analysis

- What is the problem?
  - Standard Reports
  - Ad Hoc Reports
  - Data Tracking (Run Charts)
  - Risk Adjustment
  - Benchmarking

ORIGINAL ARTICLE

# Health Care Reform at Trauma Centers—Mortality, Complications, and Length of Stay

*Shahid Shafi, MD, MPH, Sunni Barnes, PhD, David Nicewander, PhD, David Ballard, MD, PhD, MSPH, Avery B. Nathens, MD, PhD, Angela M. Ingraham, MD, Mark Hemmila, MD, Sandra Goble, MS, Melanie Neal, MS, Michael Pasquale, MD, John J. Fildes, MD, and Larry M. Gentilello, MD*

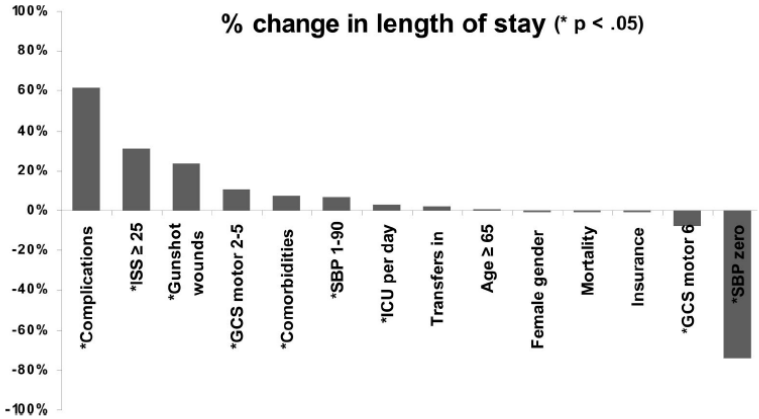


Figure 3. Predictors of length of stay. SBP, systolic blood pressure; ISS, Injury Severity Score; GCS, Glasgow Coma Scale intensive care unit.

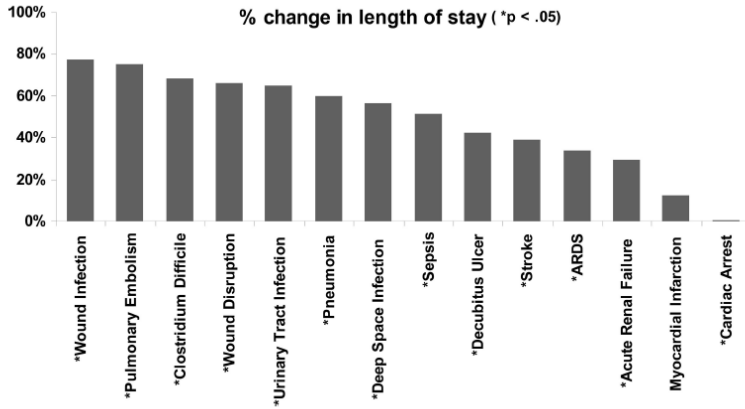


Figure 4. Relative impact of specific complications on LOS. ARDS, acute respiratory distress syndrome.

# Detection of adverse events in surgical patients using the Trigger Tool approach

F A Griffin,[1] D C Classen[2]

**Table 1** Triggers for Surgical Trigger Tool (initial testing)

| | |
|---|---|
| T1 | Unplanned return to surgery |
| T2 | Unexpected change in procedure |
| T3 | Unplanned intensive care unit admission |
| T4 | Body mass index (BMI) >28 |
| T5 | Intubation or reintubation in PACU |
| T6 | Unplanned *x* ray |
| T7 | Transfusion of red blood cells or blood first intraoperative or first 24 h postoperatively |
| T8 | Overnight stay of ambulatory patient |
| T9 | Cardiac/pulmonary arrest |
| T10 | Intraoperative or postoperative death |
| T11 | Mechanical ventilation >24 h |
| T12 | Intraoperative medications |
| T13 | Positive blood culture |
| T14 | Deep vein thrombosis/pulmonary embolism |
| T15 | Increased troponin level |
| T16 | Readmission within 30 days |
| T17 | Change of anaesthesia |
| T18 | Consult in PACU |
| T19 | Complication (any) |
| T20 | Pathology report normal or unrelated to diagnosis |
| T21 | Insertion of central or a-line mid-procedure or in PACU |
| T22 | Intraoperative time >6 h |
| T23 | Unplanned organ removal, injury, repair |
| T24 | Other (for adverse events uncovered that do not "fit" a trigger. Any adverse event can be placed under this "Other" trigger.) |

PACU, postanaesthesia care unit.

# QI: Error Analysis

- Why is there a problem?
  - Need Standardized Taxonomy and Tracking
  - Provides focus for where to start

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# A Report Card System Using Error Profile Analysis and Concurrent Morbidity and Mortality Review: Surgical Outcome Analysis, Part II

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**TABLE 3**

**Delineation of Error, 2005**

| | 2005 | | | 2005 | |
|---|---|---|---|---|---|
| | Study grp | Deaths | | Study grp | Deaths |
| Diagnosis | | | Communication/supervision | | |
| Error Dx | 53.8% | 50.00% | Error communication | 100.0% | 100.0% |
| Delay in Dx | 7.7% | 37.50% | Error signout | 0.0% | 0.0% |
| Inappropriate test | 0.0% | 0.00% | Error consent | 0.0% | 0.0% |
| Failure to act on test | 23.1% | 0.00% | Lack supervision | 0.0% | 0.0% |
| Inadequate preop W/U | 15.4% | 12.50% | Interpersonal conflict | 0.0% | 0.0% |
| Judgment | | | Miscellaneous | | |
| Error judgment | 50.0% | 42.86% | Equipment failure | 25.0% | 50.00% |
| Inappropriate indication | 7.1% | 28.57% | Inadequate supplies | 75.0% | 50.00% |
| Failure prophylaxis | 7.1% | 0.00% | Near miss | 0.0% | 0.00% |
| Failure monitoring | 7.1% | 0.00% | Medication error | 0.0% | 0.00% |
| Failure follow/up | 28.6% | 28.57% | Inadequate credentials | 0.0% | 0.00% |
| Technique | | | | | |
| Error Rx/perfomance | 63.0% | 100.00% | | | |
| Incorrect procedure | 7.4% | 0.00% | | | |
| Inappropriate technique | 11.1% | 0.00% | | | |
| Avoidable delay | 11.1% | 0.00% | | | |
| Omission of care | 7.4% | 0.00% | | | |

ORIGINAL ARTICLE

# Development of an Online Morbidity, Mortality, and Near-Miss Reporting System to Identify Patterns of Adverse Events in Surgical Patients

*Karl Y. Bilimoria, MD, MS; Thomas E. Kmiecik, PhD; Debra A. DaRosa, PhD; Amy Halverson, MD; Mark K. Eskandari, MD; Richard H. Bell Jr, MD; Nathaniel J. Soper, MD; Jeffrey D. Wayne, MD*

**Table 2. Error Grade and Class by Primary Category of Adverse Event**

| | No. (%) | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Anesthesia | Biliary | Cardiac | Endocrine | GI | GU | Hematologic | Infectious | Miscellaneous | Neurologic | Pulmonary | Systems | Vascular |
| Error class | | | | | | | | | | | | | |
| Error in diagnosis | 0 | 0 | 3 (3.9) | 0 | 15 (6.9) | 2 (6.3) | 3 (1.7) | 2 (1.3) | 1 (3.1) | 2 (5.6) | 2 (2.3) | 4 (17.4) | 2 (2.1) |
| Error in judgment | 2 (20.0) | 0 | 9 (11.8) | 0 | 14 (6.5) | 6 (18.8) | 8 (4.6) | 9 (5.6) | 4 (12.5) | 3 (8.3) | 11 (12.5) | 2 (8.7) | 3 (3.2) |
| Error in technique | 4 (40.0) | 8 (88.9) | 1 (1.3) | 2 (50.0) | 90 (41.5) | 7 (21.9) | 96 (54.9) | 48 (30.0) | 16 (50.0) | 12 (33.3) | 23 (26.1) | 1 (4.3) | 52 (54.7) |
| Nature of disease | 3 (30.0) | 1 (11.1) | 61 (80.3) | 2 (50.0) | 98 (45.2) | 16 (50.0) | 68 (38.9) | 100 (62.5) | 9 (28.1) | 19 (52.8) | 50 (56.8) | 12 (52.2) | 36 (37.9) |
| Systems error | 1 (10.0) | 0 | 2 (2.6) | 0 | 0 | 1 (3.1) | 0 | 1 (0.6) | 2 (6.3) | 0 | 2 (2.3) | 4 (17.4) | 2 (2.1) |
| Error grade | | | | | | | | | | | | | |
| I: Non–life-threatening noninvasive treatment | 3 (30.0) | 1 (11.1) | 7 (9.2) | 1 (25.0) | 65 (30.0) | 18 (56.3) | 27 (15.4) | 57 (35.6) | 10 (31.3) | 6 (16.7) | 9 (10.2) | 3 (13.0) | 11 (11.6) |
| II: Potentially life-threatening noninvasive treatment | 1 (10.0) | 0 | 28 (36.8) | 2 (50.0) | 18 (8.3) | 6 (18.8) | 18 (10.3) | 16 (10.0) | 2 (6.3) | 15 (41.7) | 27 (30.7) | 5 (21.7) | 11 (11.6) |
| III: Any complication with invasive treatment | 6 (60.0) | 7 (77.8) | 14 (18.4) | 1 (25.0) | 124 (57.1) | 8 (25.0) | 120 (68.6) | 75 (46.9) | 20 (62.5) | 3 (8.3) | 37 (42.0) | 7 (30.4) | 67 (70.5) |
| IV: Permanent disability | 0 | 0 | 1 (1.3) | 0 | 1 (0.5) | 0 | 0 | 0 | 0 | 6 (16.7) | 0 | 2 (8.7) | 2 (2.1) |
| V: Death | 0 | 1 (11.1) | 26 (34.2) | 0 | 9 (4.1) | 0 | 10 (5.7) | 12 (7.5) | 0 | 6 (16.7) | 15 (17.0) | 6 (26.1) | 4 (4.2) |

Abbreviations: GI, Gastrointestinal; GU, genitourinary.

**Table 3. Error Class According to Error Grade**

| | No. (%) | | | | |
|---|---|---|---|---|---|
| | I: Non–Life-Threatening Noninvasive Treatment | II: Potentially Life-Threatening Noninvasive Treatment | III: Any Complication With Invasive Treatment | IV: Permanent Disability | V: Death |
| Error in diagnosis | 3 (1.4) | 4 (2.7) | 25 (5.1) | 1 (8.3) | 3 (3.4) |
| Error in judgment | 13 (6.0) | 19 (12.8) | 31 (6.3) | 1 (8.3) | 7 (7.9) |
| Error in technique | 60 (27.5) | 39 (26.2) | 252 (51.5) | 1 (8.3) | 8 (9.0) |
| Nature of disease | 138 (63.3) | 86 (57.7) | 175 (35.8) | 8 (66.7) | 68 (76.4) |
| Systems error | 4 (1.8) | 1 (0.7) | 6 (1.2) | 1 (8.3) | 3 (3.4) |

# Transforming the Morbidity and Mortality Conference into an Instrument for Systemwide Improvement

Jamie N. Deis, MD; Keegan M. Smith, MD; Michael D. Warren, MD;
Patricia G. Throop, BSN, CPHQ; Gerald B. Hickson, MD; Barbara J. Joers, MHSA, CHE;
Jayant K Deshpande, MD, MPH

**Table 3. Factors contributing to adverse outcome**

| Factor | % Cases |
|---|---|
| **Communication**: e.g., inadequate handoffs; incomplete clinical information | 64 |
| **Coordination of care:** e.g., involving multiple services and/or care sites | 36 |
| **Volume of activity/workload:** e.g., increased clinical volume and/or perception of workload | 18 |
| **Escalation of care**: e.g., delay or failure to involve more senior physician or nurse | 14 |
| **Recognition of change in clinical status**: e.g., delay or failure to recognize changing clinical signs and/or symptoms | 14 |

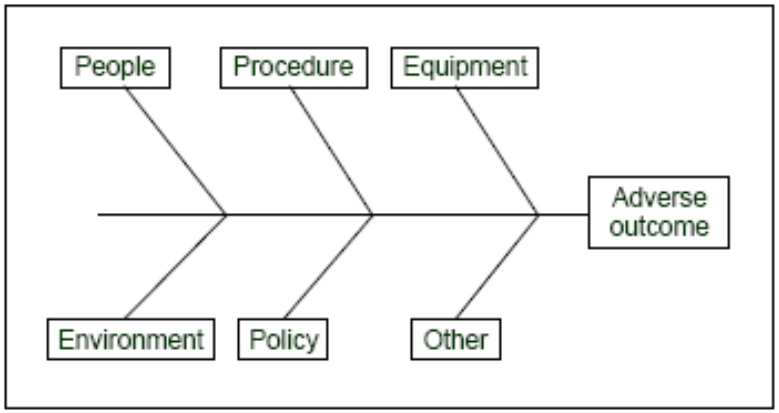



**Figure 1.** Ichikawa ("fishbone") cause-and-effect diagram.

*The Journal of* **TRAUMA**® *Injury, Infection, and Critical Care*

# Patient Safety in Trauma: Maximal Impact Management Errors at a Level I Trauma Center

*Rao R. Ivatury, MD, FACS, Kelly Guilford, BS, RN, Ajai K. Malhotra, MD, FACS, Therese Duane, MD, FACS, Michel Aboutanos, MD, FACS, and Nancy Martin, MS, RN*

**Table 2** Patient Safety Net Event Taxonomy in Trauma With Maximal Impact (Mortality): Type

| Communication | Patient Management | Clinical Performance |
|---|---|---|
| Questionable 3 | Resuscitation Questionable: 35 (airway 11, breathing 1, circulation 23)<br>Questionable OR/ ICU care: 32<br>Missed injuries: 9 | Questionable:<br>Diagnosis: 11<br>Treatment: 31<br>Both: 34 |

**Table 3** Patient Safety Net Event Taxonomy in Trauma With Maximal Impact (Mortality): Domain

| Setting | Phase | Staff |
|---|---|---|
| Outside hospital: 1 | Prehospital: 7 | |
| Prehospital: 6 | Initial assessment and resuscitation: 30 | EMS: 6 |
| Emergency department: 23 | Secondary survey and tests:10 | Physicians: 76 |
| Operating room: 11 | ICU care: 24 | Nursing: 2 |
| PACU: 2 | Post ICU phase: 5 | |
| Intensive care unit: 24 | | |
| Nursing floor: 5 | | |
| Others 4 | | |

**Table 4** Patient Safety Net Event Taxonomy in Trauma With Maximal Impact (Mortality): Cause

| System | Human |
|---|---|
| 2 | Skill based 6<br>Rule based 65<br>Both 3 |

# QI: Process Improvement

- How are we going to fix the problem?
  - Loop Closure
    - Counseling
    - Policies
    - Guidelines
    - Forms

# QI: Process Improvement

- How are we going to fix the problem?
  - Loop Closure
    - Counseling
    - Policies
    - Guidelines
    - Forms

•Not PI

# Patterns of Errors Contributing to Trauma Mortality

## *Lessons Learned From 2594 Deaths*

*Russell L. Gruen, MD, PhD, Gregory J. Jurkovich, MD, Lisa K. McIntyre, MD, Hugh M. Foy, MD, and Ronald V. Maier, MD*

TABLE 2. Major Patterns of Errors Contributing to Trauma Mortality

| Error Patterns | Cases (n) | % |
|---|---|---|
| Hemorrhage control | | |
| Delayed control of abdominal/pelvic hemorrhage | 10 | 15.6 |
| Delayed control of intrathoracic hemorrhage | 6 | 9.4 |
| Failure to rewarm and/or correct coagulopathy | 2 | 3.1 |
| Airway management | | |
| Unsuccessful intubation and delayed surgical airway | 5 | 7.8 |
| Failure to secure or protect airway | 5 | 7.8 |
| Management of unstable patients | | |
| Unduly long initial operative procedure in unstable patient | 5 | 7.8 |
| Inappropriate interhospital transfer of unstable patient | 2 | 3.1 |
| Unstable patient sent to CT scanner | 2 | 3.1 |
| Procedures | | |
| Complication of intravascular lines | 4 | 6.3 |
| Complication of feeding tubes | 3 | 4.7 |
| Retained intraoperative foreign body | 1 | 1.6 |
| Prophylaxis | | |
| Inadequate DVT/PE prophylaxis | 4 | 6.3 |
| Inadequate GI ulcer prophylaxis | 2 | 3.1 |
| Inadequate physical restraint | 1 | 1.6 |
| Missed or delayed diagnoses | | |
| Intracranial hemorrhage | 2 | 3.1 |
| Intraabdominal injury | 2 | 3.1 |
| Pericardial tamponade | 1 | 1.6 |
| Septicemia | 1 | 1.6 |
| Hyperkalemia | 1 | 1.6 |
| Other | | |
| Overresuscitation with fluids | 3 | 4.7 |
| Other poor management decisions | 2 | 3.1 |

A

| Error group | 1996 | 1997 | 1998 | 1999 | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|---|---|---|---|
| Uncontrolled thoracic hemorrhage | ● | ●●● | ● | | | ● | | | |
| Interhospital transfer of unstable pt | ●● | | | | | | | | |
| Complications of feeding tubes | | ● | ● | | | | | | ● |
| Retained foreign body in OR | | | | ● | | | | | |

B

| Error group | 1996 | 1997 | 1998 | 1999 | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|---|---|---|---|
| Delayed OR/angio control of hemorrhage | | ●● ●● | ● | ● | ●●● | | | ● | |
| Failure to rewarm +/- correct coagulopathy | | | | | ● | ● | | | |
| Airway loss during oro-tracheal intubation | ● | | ● | ● | | | | ● | ● |
| Unprotected airway in vulnerable patient | ●● | | ● | | | ●● | | | |
| Lengthy operation in unstable patient | | ● | | | | | ● | ● | ●● |
| Unstable patient to CT scanner | | | | | ● | | | | ● |
| Complications of procedures | | | ● | | | ● | | ●● | |
| Inadequate VTE prophylaxis | ● | ● | | | ● | | | ● | |
| Inadequate GI prophylaxis | | | | | | ● | | | ● |
| Over-resuscitation with fluid | | | | | | | ●● | | ● |

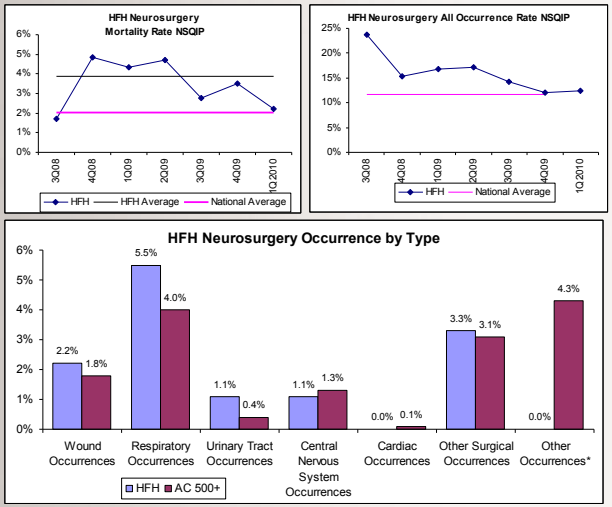
# QI Needs Assessment

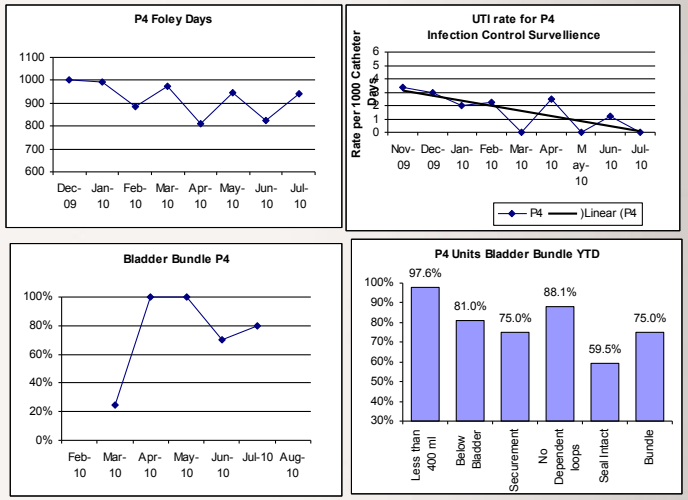
- What we need:
  - Reliable data, Data Analysis (TQIP)
  - Error Analysis, Tracking
  - Data Sharing
  - Strategic Improvement Plan (Change)
  - Multidisciplinary Project Management
  - Communication

# Is this your Data?


# Organizing Your Data Mess

- First Rule of Data to Monitor Processes
  - Track data over time!
  - If it is not a run chart then ask to see it as a run chart!



# Systematic Review of Information

- Outside agency required measures
- Dashboards (regularly updated measures related to key projects and day to day operation)
- Deep dives into topics. Where results are not what are desired take the time to understand process and drivers of the outcomes.
- Listen to Gripes

# Three Nolan Questions

- What are you trying to accomplish?
- What ideas do you have that might lead to an improvement?
- How will you know the change is an improvement?

# Process

- Deep dive into the data
  - Identify opportunities
- Share the data
  - Explain what it means, where it comes from, why its important
    - Surgical Grand Rounds
      - Quarterly session devoted to Quality Improvement
    - Surgical Services/Anesthesia/ED
      - Promote “team”
    - Hospital Administration
- Identified interested stakeholders/champions
  - Bring everyone to the table
  - Collaborative Process Improvement

# Goals of Surgical QI

- Define objectives for a quality plan
- Define stakeholders in surgical quality and their roles
- Apply strategies for engagement, for improvement and for sustaining quality efforts
- Identify best practices

# Team goals

- Establish transparency
  - Data dissemination
    - Successes and “opportunities”
- Develop process improvement plan for opportunities
- Increase communication
  - Safety Checklists
  - Meetings, Newsletters

# Project Leadership

- Process Design
  - Suggest methods for PI (PDSA, Six Sigma, Lean, Homemade)
  - Identify which method will be used
  - Determine measurable goals
    - Let the team come up with the improvement effort based on your data (even though you know what it should be coach toward your pre-determined goal) this will help to create “buy-in”
  - Identify resources to be utilized
    - External: ACS, IHI, IOM, AHA, NPSF, AORN, ANA etc.
    - Internal resources: quality dept, risk management, nursing councils, education depts, pharmacy, anesthesia quality, data analysts etc.

# Project Leadership

- Process Design (Con't)
  - Assign tasks to all team members (homework)
  - Meet often in the beginning of the process to ensure project is progressing
  - Track progress
  - Summarize and provide feedback to the team

# Methods to Improve 1

- Understand Your Current Process
  - Apply tools to understand your current process and identify opportunities
    - Flow diagrams, value stream map, define
    - Gemba walk, observation
    - Process measures
  - Develop possible changes and test.
  - Trial on a small scale if possible

# Methods to Get Started

- Fix the Issues
  - Start small one project at a time “low hanging fruit” - pilot a project
  - Copy best practice
    - Don’t waste time reinventing the wheel
    - Almost always has to be customized for local issues
  - Find out what works - utilize resources
- Give The Team Faith
  - Emphasize success
  - Communicate results

# How to Implement Surgical QI

*Pre-work (preparation phase)*

- Organize your data in a clear concise fashion
  - Display charts/graphs that are understandable to the audience
  - Present “good” and “not so good data”
- Identify the improvement effort ahead of time

# How to Implement Surgical QI

*Pre-work (preparation phase)*

- Perform a total assessment of your hospital's or health systems resources
  - Clinical performance specialists roles
  - Quality improvement specialists
  - Pharmacy
  - Infection Control
  - Nursing
  - Committees that have approval authority
    - Identify what processes have to go where and who has to sign off on them

# How to Implement Surgical QI

*Pre-work (preparation phase)*

- Identify Stakeholders
  - Who needs to be at the table (leadership, MDs, Admin, Nursing etc)
  - Who is accountable
  - Determine the champion of the project
    - May need more than one

# How to Implement Surgical QI

*Work Phase*

- You need a facilitator
  - Invite the stakeholders to a meeting
    - It is important to have the support of administration
  - Run the meeting with the assistance of the champion of the project
    - Set the agenda have a mission and goal for the initial meeting

# How to Implement Surgical QI

*Work Phase*

- Identify a liaison to multiple departments
  - Dept of Surgery and Sub-specialties, Anesthesia, Nursing, Pharmacy, Quality etc.
  - Break down the silos

# Team Building

- Right People
- Right Time
- Responsibility with Authority

# Communicate, Communicate and Communicate Some More

- Identify what are we trying to communicate
  - Message- factual, short, concrete and simple for all audiences to achieve a basic understanding of PI
  - Use a variety of methods to communicate
  - Keep everyone on the same page
  - Do not send mixed messages
  - Know your project

# Staying Focused in a World of Organized Chaos

- Create a vision
  - Review organizational mission, vision and values to ensure consistency
  - Engage others to validate or modify
  - Publish the vision, post the vision, review the vision regularly
  - Ensure leadership team is on board
  - Share with physician leaders

# Staying Focused Continued

- Use the strategic plan to guide your daily work
  - Review regularly to monitor progress
  - Revise - situations change and the strategic plan needs to evolve as the department does
  - Publish and engage frontline staff in accomplishing the goals
  - Document your progress and share the information!
  - Celebrate the accomplishments!

# Strategic Improvement: Change

- The Institute for Healthcare Improvement (IHI) uses a simple mantra to describe the essential elements for strategic improvement: Will, Ideas, and Execution.
- You have to have the *will* to improve, you have to have *ideas* about alternatives to the status quo, and then you have to make it real — *execution*.

# 10 Reasons Execution Fails

- Poor communication
- Impact of change underestimated
- Lack of leadership
- Lack of executive sponsor
- Project management lacking
- Insufficient planning
- Inadequate resources allocated
- Technical knowledge insufficient
- Lack of rationale for need to change
- Consultants not managed closely

# Strategies to Success

- Build the case for change
- Secure executive buy-in and support
- Develop a road map
- Communicate the plan (map)
- Empower others to act
- Start small, deliver early and frequently
- Spread and add value
- Monitor / evaluate progress
- Share the story

“…better is not a number, soon is not a time; trying is having granted yourself permission to fail…”