

The Role of the Manager

Imagine yourself on the first day of your new job. Where do you start? Regardless of whether you manage a unit such as Oncology, a process such as infection control, or a service such as Pharmacy or Nutrition, more than likely you have a staff, a budget, and your own manager to whom you report. You are responsible for the smooth operation of a specific environment, one with a defined scope of care. You may have a set of expectations and responsibilities that are not very clearly delineated, those that your manager or supervisor expects of you, and those that you expect of yourself and of your staff.

Before you can get your coat off and pick up a pencil, a problem erupts. This is health care, and crises are a daily and anticipated event. What approach do you take to handling the problem? Your reaction and the procedures you use are important, as your staff will take their cue from you for how to behave in a crisis. Rest assured that problem solving, quick decision making, and crisis management will be among your primary tasks as a manager.

SERVING THE ORGANIZATION

Perhaps it was once possible to confine your work solely to your own unit, but today most health care managers and supervisors are required to interact with many people and departments outside their unit, all of whom have their individual agendas, philosophies, techniques, and expectations. Managers have to develop a host of working relationships and achieve some sort of balance between their own expectations and responsibilities and those of the rest of the organization. For instance, hospital administrators are concerned about financial issues and reimbursement and will demand that you work within a budget to provide efficient and effective services. Managers from various departments—Legal, Planning, Materials, Environment, Risk Management, or Human Resources—may ask you for information or may invite you or members of your staff to collaborate on projects. And your own manager or supervisor may request reports about your decisions and monitor how you deliver care.

Physicians also require that you manage your responsibilities as effectively as possible so that their patients' needs and expectations are well met. Without an amiable working relationship with the physicians who admit patients and have the primary responsibility for their medical care, your job becomes much more difficult.

And there's more. The manager has to be familiar with and work in a manner that is congruent with the organization's articulated mission and vision. A good health system will actually demand that its guiding principles be incorporated into the daily work of the staff and reflected in the services delivered to the patients. Also, most health facilities prepare a strategic plan that outlines their goals for the future and that dictates how resources will be allocated. The managers must all know their own roles in the strategic plan, and not solely in terms of what the plan entails. Managers actually help shape the plan because goals need to be identified and objectives delineated. The strategic plan articulates a sense of direction for the managers, one that can be used to effectively encourage staff to meet expectations. Figure 1.1 illustrates the many internal and external forces that you must respond to as a manager, while managing the staff, budget, environment, and clinical services of your own department.

Serving the Patient

The manager, then, has to handle crises, juggle competing agendas, administer and provide efficient and effective services, manage staff

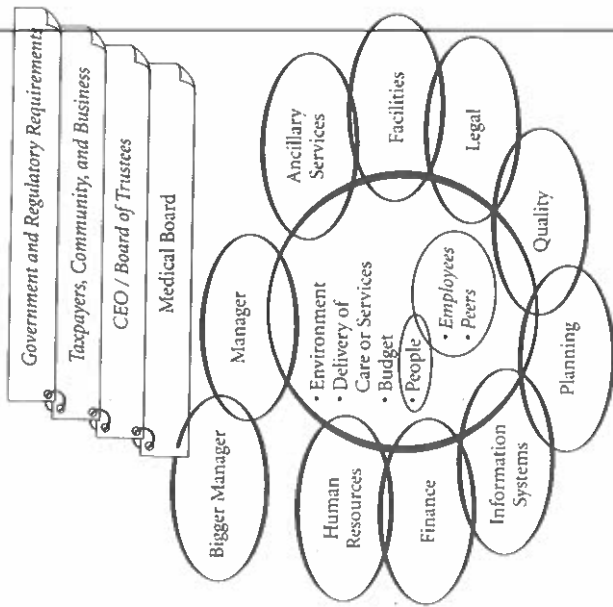


Figure 1.1. The Complex Role of the Manager.

schedules, competency, and workloads, and do so within a restricted budget in addition to being accountable to the organization's administrative and medical hierarchy—all the while maintaining the all-important role of being the patients' advocate. It is the manager who mediates between direct care to people who are vulnerable, unhappy, and often out of control of their lives and the rest of the complex health care organization.

To manage bedside care and direct staff effectively, the manager must be organized and gather the information required to set daily priorities to ensure the proper flow of activities that will enhance patient care. Morning rounds as shifts change, for example, are a good opportunity to acquire knowledge about the patients and their needs in order to set the activities of the day in motion. Staff input, together with predefined expectations and goals, influence priorities for providing services to the patients.

Patients today, unlike the patients of decades past, feel entitled to the highest quality of care—and they are educated about the relationship between medical interventions and changes in clinical status. They expect interventions that will improve the way they feel, and if they are not feeling better, they want to know why. Also, as patients are accountable for their bills, they scrutinize the tests they receive and evaluate the interventions and the physician contact in terms of effectiveness. This appraisal of the exchange of goods and services for improved outcomes transforms the traditional relationship between patient and caregiver from one of physical and emotional dependency to a more rational and equal role paralleling that of a consumer and a provider.

As a result, today's managers must understand that the patient is an active consumer of health care services rather than a passive and compliant responder, and they are responsible for training their staff accordingly. Patient satisfaction can influence the organization's budget and thus indirectly the manager's own position. Simply stated, without patients, you have no one to work for. Not only must there be adequate patient census for the manager's services to be evaluated positively, the services must be of excellent quality as well. If many patients complain that the staffing on the manager's service was inadequate, or that care was poorly delivered, or that errors occurred, or that the equipment or environment was not excellent or functioning properly, the manager hears about it. This is as it should be. Health care should serve the patient.

Patients expect that their care should be respectful, courteous, polite, considerate, and compassionate; managers are accountable for providing patients with appropriate education—about their care, their hospital stay, their disease process, and expectations for posthospital care. Patients need to understand informed consent forms, discharge plans, and medication regimens; they may also need orientation to hospital services, pain management, patient and consumer rights, and medical procedures.

Patients demand and expect efficient and effective care, care that eliminates or reduces their problem without incurring undue expense from the inappropriate use of resources. Understandably, patients have no desire to pay for unnecessary services or for a prolonged hospital stay that their insurance carrier won't cover. As paying customers, they introduce a new voice into the chorus of health care services, one that forces the manager to balance all their requirements, their needs as

patients and also as intelligent consumers. Therefore, the manager needs to coordinate staff for appropriate patient services while attending to the patients' physical environment as well as their emotional needs and social expectations. It is never good business to have unsatisfied customers.

In a service business whose consumers are emotionally and physically compromised, care is often rendered not because of direct payment expectations but simply because it is the right thing to do. Many hospitals have as part of their mission that they provide care to everyone, regardless of ability to pay. This decency puts a burden on the managers to manage especially wisely, so as to balance good patient care with the financial responsibilities of the organization. If a patient receives a letter stating that henceforth all hospital expenses will no longer be paid by the insurance carrier but by the patient, the manager and the care provider have to determine how best to continue to manage that patient's care. There may be choices that would satisfy the monetary constraints of the patient without compromising good care. For example, the manager or caregiver could provide extensive education to the patient regarding discharge expectations or provide follow-up care in a less acute facility.

Serving the Public

People realize that one day they or someone they love might become a patient in a health care facility; therefore, it is unsurprising that the public demands that health care facilities deliver outstanding care. Health care is expected to be responsive to the needs of the community, with community representatives, who form the Board of Trustees, charged with ensuring that care is appropriate and safe, and that it meets the expectations of the local population. The manager of a unit or service answers to the Board, directly or indirectly, about the delivery of care.

Various monitoring agencies including the state and federal health departments and regulatory agencies such as the Joint Commission for the Accreditation of Healthcare Organizations (JCAHO), also representing the concerns of the public, have a big impact on how services are delivered. Today's manager is expected to be compliant with regulations.

Compliance, however, is merely the beginning of effective management. Regulations should be considered as a kind of compass designed

to supply direction for advancing patient care and improving the workings of the unit or service. For example, the requirement to provide patients with a safe environment details how to do it, when to do it, why, and how often. Although creating a safe environment might involve expenses that should be budgeted, in terms of personnel, equipment, and efficient processes, ignoring the requirement or merely giving compliance minimal lip service could lead to problems, unsatisfied customers, unhappy administrators, and a displeased Board of Trustees. The purpose of the regulation is to encourage health care facilities to do the right thing for their patients, regardless of expense.

The general public has a big impact on health care services also. The public perception of care, especially of poor care, influences the financial success of health care facilities. Information regarding quality and safety in health care, and about specific hospitals, physicians, and medical services, is becoming readily available through the Internet and the media. No one wants inadequate or inappropriate care; no one wants to enter a hospital with a reputation for endangering patients. No hospital wants the care it delivers to be labeled as substandard. It is part of the manager's job to ensure that the hospital has a good reputation and is highly regarded in the public eye.

Media attention has focused on the mistakes, errors, problems, and flaws in today's health care environment. The widely discussed 1999 Institute of Medicine report, *To Err Is Human*, condemns health care delivery in this country as inadequate, inefficient, fragmented, unscientific, and in need of fundamental change. Private organizations including the Leapfrog Group and the Midwest Business Group have taken it upon themselves to dictate standards for quality care, insisting on accountability from hospitals.

These groups have a great deal of buying power and they want to be assured that their money is well spent. The *Wall Street Journal* reported that "poor quality care costs companies around \$1,700 to \$2,000 per covered employee a year" (Landers, 2002). Indeed, these groups require proof of good management and good quality—the two go hand in hand—and are outcome-oriented. Patients can exercise the privilege of going where they think the best care is offered, and large businesses can negotiate contracts for their employees where they think they will get the best results. Poor health care quality costs money.

Public expectations pressure health care institutions to provide—and to be able to document—safe quality care. Managers are there-

fore concerned not to make mistakes, to monitor safe practices whatever the scope of their charge, and to be able to rationalize and defend the processes and decisions they make as being beneficial to the patient and the health care institution.

Managers, then, have to provide excellent clinical service while keeping their eye on the financial aspects of the delivery of care as well. A busy unit does not necessarily reflect a cost-effective unit that is providing good clinical care to its patients. A busy unit may simply be a poorly managed unit, one that serves neither the patients nor the institution well. For example, inefficiencies in bed turnover can keep the beds full but actually mask the fact that new patients are not coming into the unit and therefore revenue is lost, and worst of all, that patients are inappropriately cared for. To equalize the pressures between financial success and excellent clinical outcomes requires that the manager work with the managers of other departments (such as Housekeeping, Discharge Planning, and Social Work) to efficiently move each patient through the continuum of care.

GETTING HELP FROM ALL THE RIGHT PLACES

How can a manager begin to juggle all these responsibilities, and to acquire the skills necessary to manage all that needs to be managed? Enter the government.

Health care today is a highly regulated industry. The regulations are designed to assist health care leaders and managers as well as to protect the patient and monitor the delivery of care. This is as it should be, because a health care institution is, in many ways, unique. What other kind of organization deals with the *business of life and death*, pain and suffering, illness and well-being? Or with social issues such as undocumented residents who are afraid of the bureaucracy of the admissions process and use Emergency Departments as primary care physicians for their children, and who often can't pay for services, or the elderly, who have no place to go upon discharge and who also often can't pay for services. Social issues. Financial issues. And, of course, complicated medical issues. Health care is a business that needs very careful management.

If you drive along a small, untraveled country lane, you would represent a series of traffic lights that attempted to control the nonexistent congestion. However, when you drive on chaotic, overcrowded roads

that converge at busy intersections, you are grateful for the control imposed by traffic lights. In addition to being useful and appropriate, the lights are effective because laws dictate that drivers react appropriately to them, and drivers honor the rules out of a mixture of agreement with their purpose and fear of the consequences of breaking them.

Regulatory Agencies Help Define Good Care

The numerous, lengthy, and complex government regulations for health care institutions became necessary because care was chaotic, and the public had the accompanying fear of accidents. Hospitals were not being managed well, nor were they managing their responsibilities adequately. Patients were not receiving standardized care; hospitals were increasingly unsuccessful as financial organizations, incurring massive debts with profoundly unsatisfied customers. Performance requirements had little standardization, and the institutions had few formal operating principles to follow.

Confusion reigned even about what kind of service a hospital should be in the business of providing. It was not universally apparent what it meant to provide good care. Should care be based on principles related to financial reimbursement? If so, then delivering good care and managing services effectively involved understanding severity indices, the acuity of illness, and appropriate diagnoses—the bases of reimbursement. Or perhaps good care should be based on competition for public regard (as income is better than yours), in which case quality indicators such as mortality and morbidity rates would be the central focus.

In an attempt to stem the confusion, to ensure parity for services, and to protect patients from harm, today the management of health care services is carefully regulated—how it is delivered, when it is delivered, in what environment it is delivered, to whom it is delivered, and with what outcome. The JCAHO, the Department of Health (DOH) in each state, and many other regulatory agencies require health care organizations to define the structure, the processes, and the staff necessary to manage the delivery of quality care.

Overall, these regulatory and oversight agencies force organizations to examine the competency of their staff and to evaluate the quality of the care they deliver in order to assess whether or not they are doing a good job. Good care is now equated with quality care—care that is measurably safe, of the highest standard, evidence-based, uniformly delivered, with the appropriate utilization of resources and services.

The JCAHO expects processes to be developed, implemented, monitored, and assessed on an ongoing basis, and it is the managers' responsibility to comply with these expectations.

During the accreditation survey process, surveyors interact with unit managers, inquiring about the process and provision of care and about performance improvement efforts that each manager has introduced and supervised. Surveyors also interview staff and patients on the unit to verify that the staff has been properly educated and is competent (another managerial responsibility) and that the patients express satisfaction with their care. And the JCAHO is only one agency to which the manager is accountable.

State health departments can take a different focus. In New York State, the DOH evaluates outcomes of care in addition to evaluating the processes used to deliver that care. It monitors mortality for high-risk procedures (such as cardiac surgery), incidents and errors, and patient complaints—and reports its findings out publicly. Good care is defined as having successful results for the patients.

Regulatory Agencies Help Define the Manager's Role

These regulatory agencies also provide additional definition about the manager's role in the organization, regardless of department, and set expectations about management responsibilities. Before the regulatory agencies began setting standards, managers had very few, if any, guidelines for what was expected of them in their role. Hospital administrators and human resource professionals had no principled basis on which to hire professional staff because they had no established criteria for good management.

Before the oversight of regulatory agencies, administrators would rely on the managers themselves to define their own roles within the organization and to develop their personal set of responsibilities. Administrators had little experience with the kinds of professional expertise their managers had (nursing, pharmacy, respiratory therapy, social work, and so on), and therefore they were at a disadvantage in attempting to direct their delivery of quality services or evaluating their performance.

Now, based on JCAHO criteria, Human Resource departments have a prescribed methodology for staffing that can actually identify for administrators the appropriate qualifications and requirements for a manager. For example, the JCAHO standards for leadership specifically

a huge task! Without a deliberate process for handling the responsibilities of the job, managers can easily find themselves overwhelmed. How would you, as a manager, go about assessing and improving your department's performance? Would you know where to start? The JCAHO requires that you improve performance using data, and that you identify, gather, and analyze data, both internally and in collaboration with other departments. Most managers have no background or education that would enable them to easily respond to this mandate.

Data collection is required for budgetary reasons and to help Human Resources allocate appropriate staff for the delivery of required services. Data are necessary for quality control in Pharmacy, in the laboratories, in radiology, and for the blood bank, to name a few examples. Even more than using data to meet regulatory expectations, data can be used to measure care in order to evaluate and improve services. How do you know what kinds of data to collect, or how to collect information so that it is reliable or how to analyze data for performance improvement?

Enter quality management.

Quality Management to the Rescue

It is the hospital's or health system's Quality Management Department that has the responsibility for interpreting the regulatory standards for hospital accreditation and for helping managers design programs tailored to the specific requirements of their particular service. By explaining the expectations of the regulatory agencies in terms of developing appropriate measurements for evaluating care, quality management methods actually help managers determine what type of data they should collect, how it should be collected, and how to analyze it to improve the processes for which they are accountable.

One of the basic tenets of quality management is that objective information, in the form of data, can be used to assess and improve performance, providing managers with the building blocks they need to construct a well-run department or service. With the proper data, a manager can evaluate the delivery of service and set goals and expectations for improvement. (There is always room for improvement.) Not only can quality management data be used to help managers meet their evaluative and assessment goals, and to motivate staff behavior, the data can also identify problems for proactive improvement efforts. Managers need to know what the problems are before they can begin correcting them.

include department heads, managers, and supervisors, and outline for managers their scope of responsibilities: to plan, direct, coordinate, integrate, provide, and improve health care services that are cost-effective, responsive to member and community needs, congruent with the mission and vision of the organization, and designed to improve health outcomes. Piece of cake, right? And these are just a few of many such managerial responsibilities. Managers, in other words, are expected to do the right thing for the right reason and do it well. Furthermore, managers are expected to measure the care they deliver and present that information to the governing board of the institution.

Regulatory Agencies Help Define the Manager's Responsibilities

JCAHO standards also outline the structures and processes for how this is supposed to happen. Department leaders, to be effective, are expected to integrate and coordinate departmental services with the hospital's primary functions and with other departments; to develop and implement appropriate policies and procedures; to make recommendations about staffing needs and qualifications; to continually assess and improve departmental performance; to maintain appropriate quality control programs; to provide for orientation, in-service training, and continuing education of everyone on their staff; and to recommend space and other resources needed by the department. These responsibilities have to be met or the organization will not be fully accredited.

Moreover, managers are also required to document that these responsibilities have been met. And not only to document appropriately but to communicate effectively. The JCAHO defines different layers of communication within the health care hierarchy. Managers are expected to communicate with their own staff and employees, and also to their managers, the administrators, and the medical boards. The JCAHO even sets expectations about what kinds of information the managers should require of their staff and service providers.

GETTING THE NECESSARY TOOLS FOR THE JOB

All these regulations and recommendations make the managers' job easier, their role clearer, and their expectations better articulated. But what

No Need to Reinvent the Wheel

Using a consistent quality management methodology allows managers to develop processes that can be generalized across multiple issues. This is very productive—you don't want to respond on an ad hoc basis to every problem that arises, hoping to reinvent the wheel under the pressure of a crisis. Moreover, having a defined methodology helps you inform and educate your staff about your expectations—things are to be done in a certain deliberate and sensible way and not another.

The methodology that we use in our Health System, Plan-Do-Check-Act (PDCA), developed by the quality thinkers W. A. Shewhart and W. Edwards Deming in the 1920s, prescribes asking questions, collecting relevant data, planning an action or intervention, then implementing the action and finally assessing the effectiveness of the action. This quality management methodology enables a focused and informed response to the evaluation and improvement of processes, so that managers are well prepared to handle the unexpected, which they can expect to crop up daily.

Ask and Ye Shall Receive

Depending on what kind of manager you are, and what you manage, whether it be a service (Social Work) or a unit (Nursing) or a process (Risk Management, Infection Control), you need to ask appropriate questions about the daily functioning of your department in order to understand your delivery of care. You may want information about staffing levels and competency, about the environment of care and the clinical issues facing your patients. You may need to coordinate with other disciplines to provide your patients with effective services.

For example, as a nurse manager, you might begin with asking this series of questions: What kind of unit is this? Who are the patients? What are their clinical and social issues? What would be the ideal way to run such a unit? What expertise is necessary for staff? What are anticipatable problems? To answer these kinds of questions, a nurse manager needs to collect data regarding the number of patients on the unit (that is, take a simple census), the type of diagnoses they have, and the services required for patients with those diagnoses to receive good care. With the resulting data, the manager can determine what kind of resources are required for effective management of the unit—appropriate staffing, competency requirements of the staff, anticipatable

bed use, length of stay predictions for the delivery of effective care, anticipated turnaround time, and what could be identified as appropriate and successful outcomes. The data that these questions elicit can make the manager's job more coherent and the unit and staff easier to manage.

Another example: If your unit is responsible for elderly patients with pneumonia, collecting comparative data, which quality management supplies to managers, would alert you that such patients are at greater risk for falls and pressure injuries than other patients, and that their nutritional requirements might be critical to maintain health. An awareness of these risks will give you the ammunition, in the form of hard data, to ask for the resources to develop a fall-prevention program or to acquire specialty beds to avoid skin ulcers. You might also develop an educational program for staff regarding fall safety, and for the assessment and treatment of pressure injuries. A patient fall can result in a great expenditure of resources; prevention is always the better way. Avoiding risks and adverse events is key to successful management.

The Blueprint for Success

But complying with regulations, collecting data, and using a consistent methodology for the evaluation and improvement of processes and performance are only the starting points for a good manager. Managers also need a philosophy if they are to function effectively and provide direction for their employees. If the employees know that their manager is operating within a specified framework—in the language of the JCAHO, doing something right for the right reason—they can more productively do their own jobs because their managers are providing them with guidance and a rationale for what they do. Within a specific framework, every incident, problem, or process is handled with a structure, rather than on a case-by-case or crisis-by-crisis basis. Furthermore, if you use data as the basis of decisions, then everyone on your staff knows that decisions are based on objective criteria rather than subjective impressions or capricious or random impulses. Grounding decisions in data offers staff a useful reference point for how to behave.

Quality management provides the health care manager with a working philosophy, one that focuses on the processes of delivering services the right way for the right reasons at the right time. Quality management specialists have developed the tools, techniques, and expertise to

measure the processes and to plan for improvement, and quality management methodology can help managers develop reasonable expectations about clinical outcomes. In other words, working within a quality management framework, managers have a deliberate approach to care so that their staff will understand where they are coming from—and, more important, going to. Figure 1.2 illustrates how the quality management program provides the foundation for the manager and staff to develop consistently defined measurements for assessing and improving care.

Based on the information revealed through quality management measures, improvement initiatives can be planned and developed that are consistent with the strategic plan, the vision, and the mission of the health care institution. Our experience in the eighteen-hospital North Shore-Long Island Jewish Health System (NS-LIJHS) has taught us how integrating quality management into every facet of the organization can implement positive change and improved performance. We do much more than ensure compliance with regulations; that is merely a jumping-off point for monitoring care. Our health system is as successful as it is—in the year 2002 alone, the system received a JCAHO score of 99, one of our hospitals was rated the “best hospital in the country” by an independent survey, two of our hospitals were

awarded the prestigious Magnet nursing award, among many other honors and tributes, and in 1999 the system received the prestigious Codman Award for innovations in outcomes measurements—because quality is embedded into the processes and structures that cross the organization and the entire continuum of care.

Our leadership, including the managers of departments, is committed to weaving a culture of quality into every piece of the organization. Principles of quality management are presented to new employees during orientation. Managers from every discipline attend a two-day course on quality management methodologies and performance improvement strategies to increase their skills on their units and to ensure that they have the necessary tools to do their jobs well while balancing quality, safety, budget, and competency issues. There is no need to wait for administrators or other supervisors to inform managers that patient safety and excellent care is their own responsibility. Working within a quality management framework, managers can establish accountability and better communication with staff while delivering better outcomes for patients.

SUMMARY

The health care manager is expected to take care of all of these responsibilities:

- Provide efficient and effective services in the delivery of care.
- Balance competing agendas of other departments and services within the organization.
- Manage staff schedules.
- Work within a budget.
- Educate patients about their care and hospitalization.
- Respond to the mission and vision of the organization.
- Understand and comply with government regulations.
- Maintain appropriate quality control programs.
- Supervise training and education of the staff.
- Use data to improve performance.
- Work within a quality management framework.
- Define a philosophy for the delivery of care.

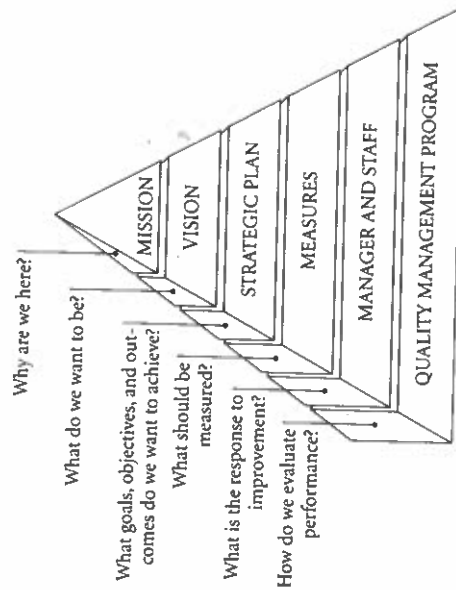


Figure 1.2. Building Blocks for a Quality Organization.

Things to Think About:

- You are given the responsibility to teach and train new managers, regardless of service or unit, to do their job.
- What criteria would you use to evaluate their performance?
- What training do you think would be most valuable?
- What information do they need to best perform their job?
- How would you handle the role of regulatory requirements?
- What would you tell them about data?
- What advice would you give a new manager?

CHAPTER TWO

Managing Quality

As a manager, you want to be successful and assure your patients and administration that you are delivering quality care. But what exactly does the concept of *quality* in health care mean, and why is it important for you to define the concept for yourself and your staff? Regulatory agencies attempt to define quality through mandated standards and the use of comparative measures. Hospital administrators may understand quality in terms of maximum reimbursement and appropriate utilization—getting the biggest bang for the buck. Physicians and nurses may define quality still differently, with physicians focusing on interventions and therapeutic success while nurses focus on the immediate environment, measuring quality in terms of falls, restraint use, skin care, complaints and satisfaction, and psychosocial issues.

DEFINING QUALITY

Struggling to define the idea of quality may seem an unnecessary endeavor to many physicians, who understand quality care as the result of being well trained, educated, competent, and experienced—a kind

of tautology: "I am qualified to give good care; therefore the care I give is good." If the outcomes of care are unsuccessful, as when a patient dies, such a physician might say that the fault lies with the illness; the patient was too sick to be cured. Maybe so, maybe not. In any case, degree of illness is an unsatisfactory way to think about quality because it allows no accountability or room for assessment for improvement.

For doctors who deal with physiological factors (such as tumors or blood levels), quality might be related to how the disease is progressing. But do patients evaluate quality the same way? More likely, patients define quality care in terms of how they feel and how soon, if ever, they can resume their normal lives. Quality, then, must maintain a balance between what doctors do and how patients feel.

Even though the definition of quality in health care has changed over the years, as care has become more complex and a greater number of people and processes become involved in the delivery of care, some fundamentals remain unchanged. Patients are basically helpless and trust their doctors and other professional staff to take good care of them. Since the manager's job is to mediate among the organization, the physician, and the patient, the manager has a tremendous role in determining the quality of care delivered. Our quality philosophy is based on the very simple notion that the patient always comes first—simple as an idea, perhaps, but quite complicated to operationalize.

For the Manager

Although quality is a difficult and slippery concept, it is important to nail it down because managing quality, in a sense, is what all managers have to do. As a manager, you want to have a concrete definition or standard of quality care that can be objectively assessed and communicated to your staff. The definition should be broad enough to span many processes and provide a commonality whether delivering care at the bedside on a unit, day or night, or in the operating room, or providing technical support in the laboratory or the pharmacy, in the Emergency Department, or with services such as Housekeeping, Nutrition, Home Care, or Materials, to suggest just a few areas. In other words, quality care is about a process and a mindset rather than a series of actions or responsibilities. The more dynamic your definition, the more useful it will be to you.

Where does the patient fit into your definition of quality? Patients, as consumers of health care services, are quite different from the kinds

of consumers who visit Disneyland for a good time and evaluate the quality of their experience in terms of the cleanliness of their hotels and the waiting times on line. Consumers of health care services do not come to a hospital for entertainment and pleasure; their satisfaction is related to other criteria. Patients evaluate the quality of their care based on the impact health care interventions have made on their illness, or matched their expectations, or improved the quality of their lives.

For the Patient

It is important to remember that patients are not all alike. Their perceptions of the quality of their care are based on their social and emotional state as well as their physiological response to treatment. They don't constitute a homogeneous group that can be easily and uniformly satisfied. Rather, they are a collection of highly individual and complex traits. If meeting patients' expectations should be incorporated into the manager's definition of quality, which patients are we talking about? Surveys reveal that satisfaction rates differ depending on the reason and the time patients are hospitalized. In the same institution, patients in labor and delivery can be highly satisfied while patients on oncology units or with chronic disease are not. This seems obvious, but nonetheless should be remembered when thinking about patient satisfaction. Your definition of quality should be able to accommodate the needs of all patients, without regard to why they are in the hospital.

You will find some similarities among patient expectations, however. All patients want to be treated with dignity and compassion, and to have their privacy respected and their individuality honored. But even the seemingly simple things, such as responding to call-bells quickly, may involve more than a superficial response.

For the Institution

The call-bells have to work properly (which may involve Engineering) and be positioned so that the patients can reach them (Housekeeping). The patients should understand how to use them and under what circumstances (Patient Education). When a patient uses the call-bell, someone should respond (staffing ratios and nursing education). The manager of a patient care unit needs to supervise all these processes and staff and interact with these other departments to deliver quality care.

If response to the call-bells is slow, the consequences can be serious, leading to adverse events and incidents. A patient who does not get a timely response (according to the patient, not the nurse) may attempt to get out of bed and fall. The fall may result in a fracture or require surgery. The manager then is held responsible and is expected to supply information about what caused the incident, and to make corrections so that it doesn't happen again. It's far better to have processes in place that reduce problems than to wait and respond to problems as they occur. As manager, you must evaluate the processes of care with an eye to establishing processes that prevent adverse occurrences.

If you manage a Pharmacy or a Radiology or Social Services Department, you are responsible for similar seemingly simple processes that generally are not so simple to manage at all. No patient wants to be kept waiting, either in a hallway because an MRI schedule got backed up or for medication because the computers are down in the pharmacy. How do you resolve these problems? How many people and processes are involved? Patients want to go home when they are released, not be forced to wait for lack of transport staff or completed discharge instructions. Your responsibilities might include managing these processes also. The definition of providing quality care should be broad enough to encompass any and all of these circumstances. Again, quality is about providing the best care for the patient, and about developing the processes and measurements that span many aspects of care—including identifying risk points in the process of care that require improvements.

A BRIEF HISTORY OF QUALITY

When the ancient Greek physician Hippocrates declared, "First, do no harm!" in the fifth century B.C.E. (Before the Common Era), he was admonishing his peers not to do any intervention that could hurt patients. This seems an obvious and therefore unnecessary directive. Yet even today, doctors and other professionals can easily cause harm. If they don't know what is causing an illness, if they are not aware of certain physical conditions of their patients, if they are wrong in their diagnoses or their cures, if their information is incomplete, if their interventions are not useful, they do harm. Hippocrates was saying that it was the job of the physician to manage, as we would say today, the quality of care given to the patient. Ancient doctors can be said to be the first quality managers.

Fast-forward to the middle of the nineteenth century, when hospitals were doing a brisk and often bad business in managing the

safety and quality of care their patients were receiving. Florence Nightingale, during her experience as a nurse in the Crimean War and subsequently, was among the first health care providers to put two and two together and have it add up correctly to four. The 1800s, in England, was an age of science and rational thought (the Age of Reason, it was called), and saw the birth of statistics. People began collecting data and analyzing information, asking why things happen in certain ways and not others.

Connecting the Dots

Florence Nightingale began to make associations. She observed that a soldier had a greater likelihood of dying in a hospital than on the battlefield. Nightingale sought to analyze why this should be, and discovered that sanitary conditions were appalling, ventilation was terrible, cleanliness was disregarded, and so infection spread like wildfire through the buildings. She collected facts, aggregated them, and made causal connections between them. Her analyses were data-driven, based on statistics and evidence.

Doctors who didn't wash their hands as they moved from patient to patient had a greater infection rate and higher rate of mortality than doctors who did. Cause led to effect. Today, all this seems perfectly clear, but the notion of connecting facts, or data elements, with outcomes like mortality was new. With these insights, managing quality became more than the individual physician's responsibility; quality care was shown to be related to the kinds of processes and procedures that permeated the entire health care organization.

Using data to connect the dots between disparate elements (hand washing and mortality, for instance) drove policy and procedures to change, and data were used to assess whether or not the changes made were effective. Nightingale's innovations, not only of care but of analyses of that care, gave rise to the modern notion of quality management. Quality management involves collecting information to assess the quality of care in health care institutions.

Taking Responsibility

The next landmark for quality management occurred in the beginning of the twentieth century, when Dr. Ernest A. Codman suggested that hospitals should be responsible not only for preventing harm but for successful treatment. He said that every patient should be followed

in order to determine if the care received had been successful. If it had not been successful, it was the responsibility of the hospital to discover why not, to determine what had gone wrong so that similar failures could be prevented in the future. Codman held the physician and the institution accountable for their actions.

For Codman and his followers, quality was defined by the results of the care delivered, that is, by outcomes. This definition of quality is forward-looking, both in time and conception, requiring institutions (rather than physicians) to be responsible for quality care, and tracking patients after treatment to assess the totality of their care. In addition to this new theoretical model of quality, Codman (who was detested by his peers) developed a methodology for managing the quality of care by using statistical measurements to analyze outcomes.

Outcomes analyses became the basis for defining quality, expanding the idea of quality care from a discussion of process alone to include that of end results. As another quality theoretician, Avedias Donabedian, summed up: quality is determined by the environment of care, the process by which care is delivered, and the outcomes of the interventions.

But whose definition should be used to define a "good" outcome? The physician, who might be looking for a reduction in tumor size or pleased by a particular lab result; or the patient, who wants to feel better, go home, and return to work? If the tumor is reduced but complications from the treatment prevent the patient from returning to normal life, is that a good outcome? Probably not for the patient. If a physician makes a mistake and injures a patient in the course of treatment, that seems easily defined as a poor outcome. But if the physician communicates the misadventure to the patient openly and honestly, and the patient feels fully informed and sympathetic to the physician, and follow-up care successfully heals the patient (a good outcome), the patient may not take legal action (a good outcome for the institution and the physician) and may feel that the physician is trustworthy (a good outcome). Many variables from many sources, both clinical and patient-centered, must be included in the definition of a good outcome.

Outcome and Income

The recent trend to publish hospital report cards has forced health care institutions to collect data about outcomes and make the results available to the public. Imagine that the hospital you work in is not cleaned adequately; the garbage is not removed, or the floors, walls,

bathrooms are not washed down adequately. Everyone responsible is aware of this problem, but they wring their hands and say there is not enough money in the budget to hire the staff to do it right.

When a prestigious newspaper such as the *New York Times* reports that the infection rate in this hospital is higher than the state average, and that patients are dying from infection, the report of that outcome drives patients away. Fewer patients mean reduced income for the hospital. Suddenly, money can be found in the budget for cleanliness, because the clinical implications, in this case, infection, have been highlighted for administrators. However, once a hospital or health care organization loses its good name, it is very difficult to recoup. It's a buyer's market out there; therefore the relationship between outcome and income should be recognized.

Infection is a poor outcome, one that involves the activities of many departments—Nursing, Infection Control, Environmental Safety, and others. It is imperative to good management to recognize the connection between the services you provide—or don't provide—and the outcomes to patients. Leadership has the responsibility of providing quality care within a budget. The budget can set limits on what the organization can offer to patients, but not on the quality of the care that is offered.

Administrators and managers need to do a kind of ongoing market analysis in order to understand who is in the population being served and why. Why do patients with certain conditions, for example, cancer or high-risk pregnancies, come to certain hospitals and not to others? Or why is one hospital attracting patients who require high-tech services and another is not? If you ask yourself what is attracting patients and what is driving them elsewhere, you can explore the idea of increasing market share. Quality care attracts patients. It is good business. And every manager's success is judged by results. If you manage a unit that is successful, it is because you have understood your market and are committed to the delivery of quality care for your patients.

Quality Control

In the mid-twentieth century, industry began to delve into quality control issues. The idea was that a manager could control the quality of production or services by controlling the number of mistakes or errors. Focusing on mistakes offers a slightly different perspective on quality than focusing solely on successful outcomes. A manager could measure success by measuring errors; fewer errors equaled a higher-quality

product. The goal of the management was to monitor and improve quality (reduce errors) so that costs would be reduced, customers would be satisfied, and products would be standardized and thus manufactured without flaws.

Think about car tires and the way they are manufactured. One factory turns out a high volume of perfect tires, produced without flaws; a second factory has poor management and inadequate processes, and so produces tires that are not up to standard. The outcome might be that the tires manufactured in the second factory have to be recalled because people are getting in accidents and even dying due to faulty tires. Factory one manufactured a quality product; factory two did not.

Even worse would be if the tire company knew that the tires were flawed but because of economics was reluctant to disturb production to investigate the reason for the problem. Disrupting production would certainly have a huge financial impact on the company, but allowing the problem to continue would have a greater one. There would be lawsuits; the government could start monitoring the company, or the company could go bankrupt.

How do you avoid errors in production? It was thought that developing specific standards for high quality and having a methodology to ensure that the standards were met would reduce unwanted variation from the standard. The philosophy was to do it the right way all the time. The focus for quality shifted to standards and variation from standards. Eliminating variation would result in good quality.

It follows that a methodology had to be developed that would measure and monitor the quality of the goods or services produced. In the 1920s, Walter A. Shewhart and W. Edwards Deming developed a model for assessing and improving quality, the Plan-Do-Check-Act (PDCA) model, still used today in health care as a method to develop plans for improvement, implement them, then evaluate them.

Shewhart made use of control charts for determining the success of the improvement efforts. (More about the PDCA and control charts in Chapter Five.) Other scientists (Joseph Juran, Phillip Crosby), working to rebuild Japan's economy after World War II, developed different tools for measuring and monitoring quality. Even today, we use models from the business world, such as Six Sigma, and adapt these models to health care.

MANAGING QUALITY TODAY

But there are important differences between quality in industry and in health care. A patient is not a manufactured widget that can be

forced to conform to uniform expectations like an assembly-line product. Nor is the production of good health the same as flying a plane successfully, although comparisons are often made between health care and aviation. Pilots, like doctors, are responsible for human lives, and their skill, training, processes, and equipment all affect the outcome of the flight.

To avoid tragic accidents, the aviation industry took the concept of quality most seriously and developed policies and procedures for preventive maintenance so that the planes were continually checked for proper upkeep. Built-in redundancy was incorporated into monitoring the equipment, so that more than one person confirmed that the plane was perfectly prepared for each flight. Sleep schedules, off times, and alcoholic intake were all supervised so that pilots would be maximally efficient also.

Of course, equipment maintenance, a safe environment, and competency of professional staff are all important aspects of delivering a quality service. However, a patient is not a flight path. A patient is complicated, with a unique physical history and condition. Treatment needs to be tailored to the specific needs of the specific patient. Moreover, the "product" to be delivered to this unique patient is a good outcome. Health care is unusual in that it is the interaction between the patient and the care provided, the consumer and the service, which results in positive outcomes. In the case of aviation, the pilot and crew interact with the machine and the specialist, like the air traffic controller, rather than with the passengers.

When patients participate in their care, outcomes are better than when patients are uninformed or uneducated. If they understand the need to get up and move around after surgery, for example, the outcome is better than if they remain bedridden. If they are unable to follow their discharge instructions because they were poorly informed about the importance of complying with their doctor's directions, they may have to be readmitted to the hospital—a poor outcome. Providing quality in health care is not the same as in manufacturing, industry, or aviation.

Setting Standards

In the beginning of the twentieth century, the American College of Surgeons (ACS) began to publish minimum standards for physicians and initiated a voluntary accreditation program for hospitals. This was the start of external regulatory agencies' monitoring competence and

quality of care. In the 1950s the JCAHO (extending the ACS program) published the first standards for hospital accreditation. It is crucial for hospitals to be accredited if they want to receive Medicare reimbursement. Although accreditation is entirely voluntary and optional, few institutions could stay in business without it. Therefore, these standards, which specifically and elaborately define quality, must be met.

The JCAHO standards attempted to normalize the unbalanced relationship between the physician and the hospital. Traditionally, physicians had a free hand in the delivery of care because their economic input into the hospital was vital. If they did not bring in their patients, the hospital would suffer financially. Therefore, physicians were accountable only to themselves and their patients, not to the organization where they practiced medicine. The JCAHO standards forced physicians to be responsible for the quality of care delivered by the hospital with which they were associated. Physicians were expected to participate in hospital activities such as medical staff meetings and to review important areas of practice, such as infection control, medical records, and credentialing, and to participate in mortality and morbidity case conferences.

As JCAHO standards moved beyond monitoring the delivery of quality care to a more problem-oriented approach to care, the agency directed hospitals to collect data to identify *potential* problem areas and to develop corrective actions. The assumption underlying this mandate was that with such a complex organization, problems are inevitable, and anticipating them and providing risk-reduction strategies *in advance* would work to improve outcomes—and thus quality. Today the JCAHO standards encourage organizations to improve the quality of care delivered to patients and improve organizational performance with an emphasis on leadership commitment to quality management data, and with the use of quality measurements and methodologies that can be used to implement improvements and enhance patient safety.

Yet with all the theory and standards regarding the delivery of quality care, it remains somewhat elusive. Health care cannot be said to be exemplary. Just a few years ago, in 1999, the Institute of Medicine published an indictment of the health care industry, suggesting that more than ninety-eight thousand people a year die of medical mistakes in this country. The magnitude of such errors reveals the existence of poor processes that lead inevitably to poor outcomes. Promoting safer practices has provoked private industry and government agencies, such as

the Leapfrog Group and the Centers for Medicare and Medicaid Services (CMS), to monitor the delivery of services for successful outcomes. Figure 2.1 highlights the landmarks in the development of quality management theory through the ages, as it increases in complexity and accountability.

Quality Thinking

For years the health care industry has been making use of quality management models and tools to improve the quality of its services. We have seen many trends and theories (quality improvement, quality assurance, total quality management, continuous quality improvement) about the way to collect data, interpret performance, and plan for improvement. But providing quality care involves more than data measurement and interpretation, and more than monitoring compliance with regulations. Working within a quality management model, health care managers are expected to champion improvement efforts and improve processes, using the PDCA methodology.

How can quality be managed so that the delivery of care is excellent? These past decades prove that knowing the tools and techniques of quality management does not automatically ensure the delivery of quality care. Understanding quality involves thinking about care in an objective way, always keeping in mind that the end product should be good outcomes for all patients. Often, improvement requires changing behaviors, including entrenched behaviors of thought. Managers, along with their staff, need to embrace new ideas, to “think outside the box,” to encourage and empower critical thinking and discourage worn-out, rote responses. The PDCA cycle is so productive because it makes room for new learning about the delivery of care while changing performance.

There is no quick fix for care that needs improvement. Learning is a slow process, occurring over time and involving intellectual activity and new practices. Think of what is involved in learning to ride a bike or make an omelet: principles have to be understood and then practiced; competence comes with repeated, sometimes unsuccessful trials. Managing quality involves a kind of team learning so that change can occur without ignoring the complexity of the services that have to be delivered.

Quality, then, can be thought of as a culture or mindset, one that involves a kind of intellectual openness to problem solving and improving

processes. Working within such a culture, along with the quality tools and techniques and in concert with the regulatory requirements, managers can deliver the care and services they are charged to deliver across a broad range of situations and conditions. Satisfying the physician (clinical performance), the patient (quality of life, outcomes), and the health system leadership (accreditation, efficiency, costs) a quality approach becomes a dynamic and robust methodology that managers can use to empower their staff to think creatively and critically.

Quality Data

The question remains, however, How can you *prove* that you are delivering good care and responding to the different expectations of the physicians you work with, the patients you serve, your own manager, and other departments within the organization? The answer involves the objectivity of data. Data don't play politics or respond to social pressures. If you establish standards rooted in science, collect information regarding services, and compare the standards that you developed through a team approach to others, you then have a framework that can inarguably define the quality of your product. Science, both in establishing guidelines and in statistical analysis, anchors quality care.

It is very difficult to remain unmoved by social and political pressures in a high-stress working environment like health care. It is only natural to try to please your boss and perhaps not rock any boats. If you focus on the quality of care delivered, no doubt someone will be displeased, because quality, especially the framework we are putting forth here, requires new modes of thought, which might lead you to step on some toes. However, quality data are entirely objective because facts tell the truth.

A quality framework creates accountability for performance and sets expectations for staff. The great value of this approach to quality is that it can be used to change behavior and to implement new processes and procedures. It promotes a way of looking at a problem that goes around political and social concerns and interpersonal dynamics. Working with a clear objective—to deliver excellent care and service—you can define success as well as failure.

As a manager, you don't want to accept the status quo as the best you can do; you want to improve—you want to be excellent. Your data, then, are collected not for compliance (for example, lab data) but for change and improvement. You can measure a process because it is broken or inefficient, or you can measure processes because you

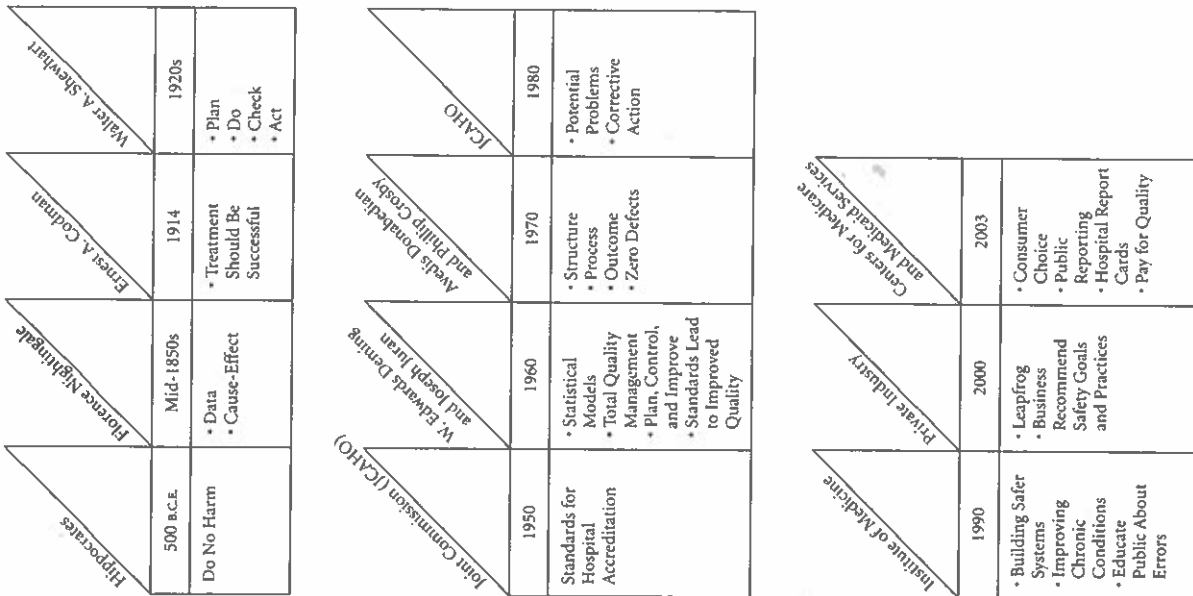


Figure 2.1. Landmarks in Defining Quality Management.

want to improve them. We believe that data and measurements should be collected in a principled way (based on the PDCA model) in order to institute changes.

Quality Assessment

Whatever type of service or unit you manage, your role as a manager is to deliver good outcomes, maintain a pleasant environment, provide processes for crisis reduction, ensure the proper utilization of resources, and meet the discharge disposition of your patients in a timely way, while maintaining a high level of quality care. If you manage an oncology service or unit, for example, how can you ascertain if you are doing as well as you should, or if you could do better? First you need to collect information to understand and analyze what the care is like on your unit.

Who are your patients? What are their diagnoses? What are the typical comorbidities common to this patient population? What services are required for care? What problems have arisen? How were they handled? What is the competency level of your staff? Are resources being used appropriately?

Once you collect this information, you still may not be able to evaluate if the care you are delivering is excellent or not. If you know that a certain percentage of your patients has pain management problems, how do you know if that is a reasonable or acceptable outcome? You might want to compare your data to the data regarding care in other similar units. You might want to look at such readily available data as length of stay or patient satisfaction to see if your data compare well to nationally established standards, often called *benchmarks*. The other question you might ask is if you need to get involved in clinical matters. The answer is yes, but not at the individual patient level. You need to address the global issues that can make your patients satisfied with the care your service provides.

Asking Quality Questions

The managers' role is to ask "why" and "why not" in search of ways to improve the services they deliver and to meet the goals established in the organization's strategic plan. If your inquiries reveal that your oncology patients experience terrible fatigue and nausea with chemotherapy treatments, how might you improve their situation? As a manager, you always want to improve.

But before you can make improvements, you need facts, and that means you ask more questions. Is it normal to be fatigued? Is it acceptable? Is fatigue experienced by all chemo patients, or is it as a result of certain treatments and not others? What can be done to relieve it? Are the current processes adequate? Are the staff and environment responsive? Is the fatigue causing any problems on the unit? Is the staff/patient ratio reasonable to handle the consequences of this problem?

You are not expected to know all the answers to all the questions you ask, but as a manager, you are expected to develop resources as needed. You can form a multidisciplinary team of experts to discuss the issues and assign staff to research the literature on fatigue and oncology patients. Once the current practice is delineated and the issues that warrant improvement identified, you can begin to plan for change. Perhaps if nausea is an expected and inevitable result of treatment, then new protocols should be developed to care for patients who are experiencing this problem. If palliative care measures need to be developed so that your patients are more comfortable, what would they consist of?

The information your team has collected enables you to make informed decisions about staffing ratios, bed utilization, ancillary services, education of patients, families, and staff, medication needs, nutritional involvement, or alternative therapies available to manage discomfort. Moreover, you can ask for support and resources in a non-random way. You can provide objective evidence that additional services are needed. You can make the case for change.

Don't congratulate yourself, yet. This is not the end of the story. Once you begin to implement new practices, you need to collect data to evaluate their impact on an ongoing basis. Monitoring the effectiveness of new protocols focuses attention on the improvements in the delivery of care. If successful, your changes—the data—can be communicated to other units within the hospital or system.

Another example. You receive a call at 6 A.M. about an incident in the Emergency Department (ED) where a specimen was not delivered in a timely way to the laboratory. You try and collect the facts. Instead of keeping the specimen in the refrigerator until the next routine pickup, staff wrapped the specimen in a towel and left it on a desk. Why? Upon investigation you discover that a physician was leaning against the refrigerator talking to the patient's family, and the nurse did not want to interrupt or intrude. The towel was to prevent visitors from seeing the specimen. The delay caused the patient to have another (unnecessary) biopsy—the improper storage meant that the specimen could not be used for diagnosis.

You call Quality Management and Risk Management to report the incident. But this is your unit, and so this is your problem. What do you, as the manager, do? You can fire the nurse who forgot to deliver the specimen on time, or you can expose her to the blame and shame response of her colleagues. ("How could you be so stupid and careless?") But no. You are a good manager who works within a quality framework with a team who believes in a quality culture. Therefore you begin to ask pertinent questions. How often does such an error occur? For this particular staff person? Under what circumstances does it occur? A good manager will do a root cause analysis to figure out what had an impact on the problem with the intention of improving the process.

Improvement is intended to change the process or the environment in which a problem, like the misplaced specimen just described, occurred. Removing the individual responsible would not solve the problem or change anything, although such a response might instill fear in your employees that if they make a mistake and admit it, their jobs would be in jeopardy. Real improvement attacks those elements that provided the opportunity for the incident to have occurred. Why did the doctor need to speak with the patient's family near the specimen refrigerator? Should the refrigerator be moved to a less public location? Improvement is difficult and time-consuming and needs to be monitored and measured to see if the changes made are effective.

Getting Quality Responses

Now that your initial questions have been answered, you can begin to get a handle on some of the issues that caused the incident. The next step is to prioritize what to do. If the room was too crowded, a new process flow has to be designed, implemented, and tested for effectiveness. If the nurse was too shy, staff education has to occur, for both physicians and nurses, stressing the importance to the patient of communication and carrying out responsibilities. If the nurse was distracted and asked to do something else and then forgot to return for the specimen, your staff need a procedure for following through assigned tasks, even under fire. Was there not enough staff present to do what needed to be done? Perhaps the rest of the staff relaxed their vigilance because this did not seem like a crisis event. Constant vigilance for details needs to be inculcated into the staff.

Other processes have to be analyzed as well. Is there a way to decrease the number of steps involved in getting a specimen from the

ED to the lab? Is new technology required (or old technology, such as a pneumatic tube)? If so, what data would show time savings and error reduction in the delivery of specimens? Is there a procedure whereby the receiving lab alerts the floor that an expected specimen hasn't arrived? All this information would promote change, creating greater efficiency, utilization, accuracy, and timeliness.

CREATING A CULTURE OF QUALITY

In any working environment informal peer pressure can interfere with management's goals. Quality can mediate between the two. For example, if a member of the staff makes a medication error, there may be informal censure from peers, or even a wall of silence as the staff unites in a cover-up for the manager. If the problem becomes serious enough for an error to reach the patient, a formal structure is mandated, as sentinel events are required to be reported in a particular framework.

A good manager will recognize the difference between formal and informal processes and use quality methods to develop a bridge between the two, perhaps by encouraging a blame-free environment or rewarding staff for identifying small problems before they become serious ones. The attitude of the manager is all-important in eliciting trust and respect from the staff. Shared expectations for excellence and a genuine respect for patient care will help the manager create a culture of quality.

Viewing the Big Picture

With information regarding the environment, technology, equipment, patients, staffing needs, and competency requirements of the staff on the unit, and understanding the expectations of the organization as defined by its mission and vision statements, the manager can develop processes for improving care even in the most difficult situations, such as a busy and crowded Emergency Department. Difficult situations challenge the manager to manage well. The challenge can seem overwhelming, but that is precisely when having deliberate processes in place can be of most value.

Say you have a flow problem. Patients are spending long periods of time in the ED waiting to be seen and treated. Obviously, some process is failing. If you are a clinician, you will find it tempting to step in to help to try and improve the situation. But if a manager does

that, becoming a member of the caretaking team, who is left in charge and supervising? Who is in a position to see the big picture? Lack of supervision can create additional problems in an already problem-ridden environment.

Quality management methods can be brought to bear to improve the situation. First, information is necessary. It may seem counterintuitive in a busy and chaotic situation to stop and brainstorm with your team, because delays and associated problems could be further increased. However, until a rational process is developed, based on information about the process that is in place, improvement is impossible.

The patient flow issues must be analyzed with the goal of understanding the bottlenecks in the process that prevent all patients from being evaluated properly and in a timely fashion. The manager and team have to gather information regarding the environment—is the space adequate to accommodate the stream of people coming in? Is it clean? Is the staffing adequate? Information is also necessary about timeliness of care—is there a holdup in triaging patients? Do the appropriate consultations occur in a timely way? Are tests or technology causing a backup? What is the average time a patient waits before being assessed and treated? How long does a patient stay in the ED?

Once information about these and other appropriate variables is collected and analyzed, the manager has to focus on issues surrounding getting patients to their destination. The manager should meet with the floor managers and unit managers to identify potential obstacles to moving patients quickly onto the units. Is Housekeeping bed turnover a problem? Or is the delay in discharging patients? What is having an impact?

If you try and fix the situation patient by patient and problem by problem, every day will bring new patients with new problems. The solution has to be developed on a higher level, that is, on a process level, involving people from many disciplines, from the ED, Radiology, Ancillary Services, Social Work, Housekeeping, and Nursing, to name just a few. Until the big picture is viewed, the bottlenecks will not be easily identified. Data, over a period of time, will reveal where the problems are and thus where improvements can be targeted to the appropriate issues.

The goal in this example is to improve the flow of patients through the ED. What processes can be measured to see if that goal is met? Say you measure time from entry to discharge, and you find that time for each patient is decreasing. Do you pat yourself on the back and as-

sume the problem has been solved? Not so fast. You have to consider the bigger picture and beware of superficial success.

Perhaps the ED is letting patients go prematurely. How could you determine if that were the case? You can collect data about how many patients left without being seen—those patients may not have been counted in your data about time of entry to discharge (since they were not seen, they were not discharged). Or you could collect information about returns to the ED within seventy-two hours. A good manager never rests on assumed laurels. If you keep drilling down, asking why or why not, and collecting data, you will be in a position to develop improved processes that can make an impact on the way all the patients are treated.

Analyzing Processes of Care

Good processes result in good outcomes, and managers are evaluated by the processes they manage. Regardless of whether the unit is busy, or the shift is changing, or everything is calm, or a crisis strikes, a good manager has processes that enable the unit to run smoothly. A manager can't control people and can't control disease, but can and should control the processes involved in the delivery of care. Without good processes, you can expect poor results or even adverse events.

Data will illustrate whether or not you have good processes. For example, if you manage a unit with patients who have community-acquired pneumonia (CAP), what is your goal, your definition of providing quality care? Perhaps it is to reduce fever, improve breathing, and reduce pain. Government guidelines for CAP recommend that antibiotics be given within a certain time span. Is it important to you to meet that evidence-based recommendation? If you can demonstrate, through data, that the CAP patients on your unit have received antibiotics in a timely way, you have a concrete measure of your unit's performance. You can compare your data to the national benchmark, and if your results are better, you have proof that your care is outstanding. Good outcomes are the result of good processes.

However, if your data reveal opportunities for improvement, you need to drill down and start asking pertinent questions. Figure 2.2 shows that in the months of January and February, on a single unit, the number of patients with CAP increased, and there was also a delay in antibiotic administration. In March and April, on the other hand, the benchmark was met. What caused the difference? It is the manager's job to investigate and understand the delivery of care.

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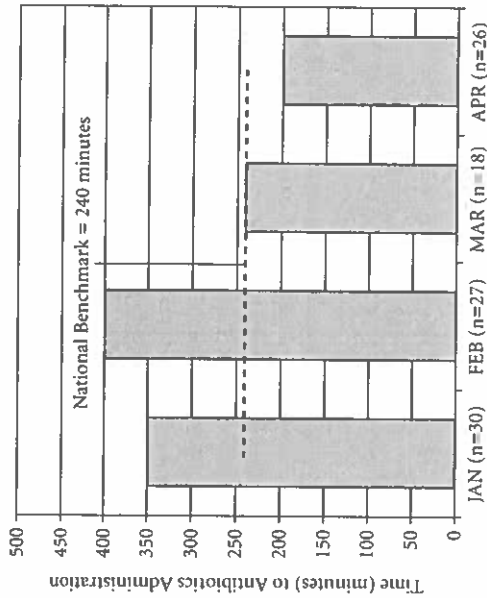


Figure 2.2. Community-Acquired Pneumonia: Antibiotic Timing on a Medical Unit.

Several possibilities should be explored. Were data on each incident accurate and collected uniformly across the four-month period? Did patients receive the antibiotic in the ED rather than on the unit, so the source of the delay was there? Was the pharmacy involved? Did its method of delivery change in any way? On the unit, was there a change in staff? Was the staff large enough to respond to the higher volume during the higher-volume months? Perhaps as a result of data collection, the problem with antibiotic delivery was revealed and the staff responded. Was there an educational effort between February and March? Collecting data provides the manager with information with which to analyze the processes of care.

Set an Example

Within the past decade, the health care industry has evolved to the point where health care institutions are expected to explicitly define their mission and vision, and to articulate their goals and expectations for delivering quality care. Managers are responsible for embedding these goals into the daily processes of patient care, for setting expect-

tations, and for educating their staff appropriately about how to reach the goals.

Having your own definition of what it means to provide quality care in your department or in the service you deliver promotes accountability and is a prescription for success. Success is the delivery of care that results in good outcomes for the patient. Good outcomes for the patient lead to increased revenue for the organization, because physicians, staff, and patients are attracted to a quality organization.

As your staff sees that you value quality and are committed to developing good processes, you will set a direction for their work that will serve you, them, the patients, and the organization well. There will be less chaos because processes will be in place, and there will be fewer errors because the delivery of care will be carefully monitored and assessed, and when necessary improved. Working within a quality framework makes managing manageable.

SUMMARY

Delivering quality in health care includes taking all of the following steps:

- Comply with regulatory standards.
- Use comparative measures to assess performance.
- Balance the expectations of physicians, patients, and the organization.
- Remember that the patient always comes first.
- Develop processes and measurements that span many aspects of care.
- Use objective information to assess the quality of care delivered.
- Analyze processes and outcomes of care.
- Be responsive to the expectations of the community served.
- Measure variation from standards of care.
- Include the patient in the process of care.
- Anticipate problems and develop corrective action.
- Champion improvement efforts.
- Collaborate with other departments on improvement initiatives.

- Assess and improve care through the PDCA methodology.
- Bridge formal and informal processes involved in the delivery of care.
- Develop good processes that lead to good outcomes.

Things to Think About

- You are the manager of an oncology service, and your manager wants proof that you are doing your job well. What proof would you offer?
- A patient commits suicide on the medical unit you manage. How would you handle the investigation?
- You realize that your staff is not forthcoming about their problems or the patient care issues they discover. How would you improve the situation?

CHAPTER THREE

Information and Prioritization



In Chapter Two we suggested the kinds of questions that managers need to ask to do their jobs effectively within a quality management framework. In this chapter, we turn to ways the manager might productively evaluate and use the answers to those questions.

Managers in health care have no scarcity of information. On the contrary, information and data are available from many sources. There are treatment details in the medical record, nursing data in shift reports, errors documented in incident reports, patient satisfaction survey data revealing people's experience with the delivery of care, complaints and compliments from patients and their families, quality indicators collected to satisfy regulatory requirements, as well as diverse information from external databases.

In New York State, the Statewide Planning and Research Cooperative System (SPARCS) database collects data regarding demographics, diagnoses, discharge disposition, length of stay, and case mix index for patients across the state based on billing data. The state Peer Review Organization (PRO) reports information about specific clinical quality indicators, such as time of aspirin administration for patients with myocardial infarction, and establishes benchmarks for comparable