Plastic Surgery Tool-Kit To Build A Culture of Patient Safety, Quality, and Service

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Background: Despite the increasing importance of quality assessment and improvement initiatives in health care, national quality measures and patient safety practice guidelines remain difficult to define in plastic surgery. As a quality of life specialty, plastic surgery may require heavier reliance upon unique patient-reported outcomes and different clinical indicators of quality. Comprehensive departmental frameworks for patient safety, quality, and service have yet to be described in the plastic surgery literature. These conditions present us with opportunities to standardize and improve the quality of care. We describe a dynamic model for quality improvement used successfully for the past three years in the Department of Plastic Surgery at Johns Hopkins and provide a tool-kit for implementation across various practice environments and hospital infrastructures.

Methods: Drawing from three years of experience using a Comprehensive Unit-Based Safety Program, formal quality improvement committee structure, literature review, and work from The Johns Hopkins Armstrong Institute for Patient Safety and Quality, we devised a framework specific to and exportable for the field of plastic surgery.

Results: Our departmental structure provides channels to facilitate the input and output of naturally trending and recorded data. Monthly Patient Safety, Quality, and Service Committee meetings are a transparent way to address important topics and expeditiously make appropriate changes. Meetings are attended by departmental administration, physicians, physician extenders, clinical support staff, clerical support staff, and trainees, and are structured in a bottom-up fashion to encourage participation from all levels. Four key domains are addressed: (1) safety, (2) external measures, (3) patient experience, and (4) value.[1] Examples of indicators we use from these domains include hand washing, pain management, rate of postoperative hematoma, readmission rates, the Breast-Q Reconstruction Survey, and auto-scheduling (pre-scheduling) of postoperative clinic appointments. The core team identifies opportunities and needs; develops, implements, and tracks improvement plans; and celebrates and advertises accomplishments to colleagues, the institution, and the public.

Conclusion: We anticipate that formal departmental quality improvement structure will promote excellence and national leadership on externally reported measures of patient safety, quality, and service. We provide other plastic surgery departments and divisions with a potential framework that can be adapted to different settings. This work becomes increasingly relevant as value-based reimbursement and pay-for-performance initiatives are implemented with the expectation to drive improvements in healthcare.

References:

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