JCAH perspective: Quality assurance in anesthesia services

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This is the first of a series of upcoming articles which will focus on the Joint Commission on Accreditation of Hospitals (JCAH) standards relative to quality assurance in anesthesia services. In this article, the author explains the JCAH standards' impact on anesthesia services. Future articles will utilize case examples of how individual anesthesia departments have improved patient care through the use of JCAH guidelines.

As a chief proponent of quality care, the Joint Commission on Accreditation of Hospitals (JCAH) has always encouraged the hospital staff to provide a high quality of care through compliance with its accreditation standards. Throughout its history, JCAH has responded to the evolving state of the art by revising and improving these standards to keep abreast of the technological, scientific, political, legal and social forces shaping the health care delivery system.

In 1979, JCAH stimulated the evolution of quality assurance by eliminating requirements for medical audit and introducing a quality assurance standard that is aimed at focusing all quality-related functions on problem-solving and on their coordination into an organized comprehensive program. The underlying assumption of this standard is that if review efforts are focused on identifying problems in patient care and solving these problems, the end result will be that care will improve.

To this end, the standard calls for the use of any type of data that would assist health care professionals in identifying problems. Flexibility is encouraged in further evaluations performed to verify or understand a problem. Any type of evaluation, that is, document-based using not only the medical record but also logs, incident or infection control reports; direct observation of procedures performed; or the use of interviews/questionnaires is encouraged. The goal of this process is to demonstrate improvement in care or clinical performance through the resolution of important patient care problems. The standard also calls for the coordination or integration of various quality-related activities in the hospital and medical staff through the establishment of a Quality Assurance (QA) program.

As the focus of the QA standard becomes more widely understood, confusion has grown among professionals within clinical support departments or services. Long before the introduction of the QA standard, JCAH standards for each of these services required the review and evaluation of the quality and appropriateness of care using pre-established criteria and the medical record. In anesthesia services, as well as many other services, the standards specified a quarterly review. In addition, medical staffs were also encouraged to audit the care they provided through a methodology that depended principally on the medical record for data and concentrated on diagnostic topics. As a result, many staffs in support services interpreted their requirements for the review and evaluation of care to mean the conduct of four audits per year, and indeed, JCAH surveyors accepted such studies as evidence of review.
Concurrent with the approval of the QA standard, JCAH removed requirements for medical audit because the use of this methodology did not demonstrate impact on patient care to the extent anticipated. However, the language and frequency requirements describing review and evaluation in support services did not change. As a result, many support services have continued to conduct audits to meet the intent of standards for review and evaluation of care. In fact, the conduct of four audits or studies does not meet the intent of quality assurance requirements for support services. Given the QA standard's focus on problem-solving and the flexibility it provides in evaluation techniques, JCAH has published a clarification of the requirements for review and evaluation of care in support services (Perspectives, September-October, 1980 and May-June, 1982).

The physician director of a given department is responsible for an ongoing monitoring process that consists of the review of multiple indicators of quality care and the evaluation of problems that arise. The process begins when the department head and staff determine what aspects or elements of patient care could serve as "proxies" to characterize the overall quality of care. Collectively, when these "indicators" are monitored and found to be acceptable, they serve as indications that the overall quality of care in the service is good.

**Anesthesia services**

In anesthesia service, for example, broad indicators of quality of care might include:

1. Adequacy of the pre-anesthesia evaluation (JCAH standards require that this be performed by a physician).
2. Adequacy/quality of the delivery of the anesthetic.
3. Quality of the recovery care both in the recovery room and after discharge of the patient.
4. Adequate medical record completion.

Within each broad area, more specific definitions or descriptions should be determined to characterize or proximate each area. For example, the adequacy of the preanesthetic evaluation might be reviewed by examining the appropriateness of the choice of medication relative to the age of the patient or type of procedure being performed. Actual delivery of anesthesia might be monitored by reviewing any adverse occurrences during surgery (broken teeth, reintubation, fluid overloads), the timeliness of delivery of anesthesia or the frequency of line infiltrates. Quality of recovery care might be evaluated by looking at post-surgical complica-

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**Figure I**
Integration of quality assurance activities

- Review and Evaluation
- Inservice
- Systems Policies and Procedures
- Performance

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When problems are identified

When problems are identified as a result of this monitoring process, they may need verification or further study to determine their cause. The cause of other problems may be obvious enough to respond to immediately. Once the cause of a problem is determined action should be recommended to individuals with responsibility for change in the department.

Findings from this monitoring process can be used to adjust departmental policies and procedures, plan inservice programs, modify staffing or systems, or change equipment. Findings should also
be used in the appraisal of each staff member's performance. Within each department or service, integration of quality assurance activities is accomplished when information obtained from a regular monitoring of indicators of anesthesia services is used to modify the day to day management or operation of the department. (Figure I.)

When identified problems cannot be addressed within the individual department, they should be referred through the mechanisms established by the hospital QA plan.

Once problems are addressed, some further attention should be paid to them to make sure they are resolved or reduced. The follow-up or monitoring of a problem can be also considered one of the indicators of care the department monitors routinely until it is satisfied the problem will not recur.

This ongoing process of monitoring and problem-solving is the nucleus of a hospital QA program. If it is done effectively within each clinical support service and if the relevant information is shared and acted on among other hospital-wide or medical staff functions, the outcome of better patient care should be achieved.

The quarterly review question

But, what of the requirement for quarterly review and evaluation in anesthesia? How does this requirement relate to the ongoing monitoring process described in Figure II?

JCAH standards do specify a quarterly cycle to assure that care is reviewed regularly. The requirement, however, refers to the frequency with which QA monitors should be summarized and reported. Thus, a quarterly report (monthly in medical staff departments) could consist of a statement of what indicators or aspects of care are monitored, what was found and what is being done to correct any identified problems. If no problems were found, the report should merely summarize the findings of the monitoring activities of the department. Minutes of department meetings could also be used to summarize findings and actions taken.

It should be noted that review and evaluation of care should not be considered a "problem-hunt." Rather it is an ongoing process of monitoring critical indicators or proxies of care. Just as a good manager monitors the status of the budget or staffing loads routinely to assure a cost efficient department, the quality of care in the department should be monitored with equivalent rigor.

Monitoring activities should reflect the scope of the care or service provided. When the monitors identify problems, they should be analyzed and addressed. But the monitors remain in place until such time as the department head and staff determine to change them.

Overall purpose of a QA program

A QA program cannot be effective unless the individual activities that comprise it are also effective. Review and evaluation of the quality and appropriateness of every clinical support service is a major aspect of the QA program. Medical staff monitors, privileges delineation and the review of care in medical staff departments and facility-wide functions such as infection control, safety, and risk management form the triad that is the foundation of quality assurance.

The purpose of the QA program is to oversee and assure that the individual functions are conducted effectively and to facilitate the exchange of relevant information among departments, the medical staff and administration so that a timely and appropriate resolution of problems affecting patient care may be achieved.

Figure II
Monitoring and problem solving: the nucleus of a hospital QA program

![Diagram](https://example.com/diagram.png)

AUTHOR

Regina M. Walczak, MPH, is Associate Director, Education Programs at the Joint Commission on Accreditation of Hospitals. In 1979, she coauthored JCAH's Quality Assurance Standard and has participated in subsequent field testing, development of QA workshops and publications, and conduct of QA seminars for hospitals and JCAH surveyors. She received a BS degree in Biology from Loyola University, Chicago, Illinois in 1969 and did post-graduate work in pharmacology at Northwestern University School of Medicine, Chicago, Illinois. In 1980, she received a Master of Public Health from the University of Michigan.