

PREFACE

Several years ago I partnered with a physician, Dr. William Minogue, to respond to an article in a medical journal that bemoaned the lack of successful patient safety improvement initiatives. The article’s authors suggested a new model was needed for conducting patient safety investigations because the current way of doing things was not working. At the time I was facilitating training workshops for the Maryland Patient Safety Center, where Dr. Minogue was the medical director. We both agreed that a new safety investigation model was not the answer. This belief resulted in our coauthoring an article on the subject for WebM&M, an online case-based forum on patient safety sponsored by the Agency for Healthcare Research and Quality.

Our article began by reminding readers of the insights of Louis Pasteur, who, throughout his career, “insisted that germs were the cause of disease, not the body.” Near the end of his life, Pasteur changed his opinion and “declined treatment for potentially curable pneumonia, reportedly saying, ‘It is the soil, not the seed.’ In other words, a germ (the seed) causes disease when our bodies (the soil) provide a hospitable environment” (Spath and Minogue 2008).

This lesson, discovered by Pasteur so many years ago, has application to all quality improvement activities and is reinforced by the topics covered in this book. The systems in health services organizations must be carefully nurtured to create a hospitable environment for the many tools and techniques of improvement to thrive. If the soil is not properly prepared, the seeds of improvement will not take root or be sustainable. Dr. Diane Kelly, author of the first three editions of this book, was insightful in taking a systems approach to quality improvement. Dr. Kelly understood that preparing the “soil” of the organization is just as important as learning how to use the various quality tools. I am honored to have the opportunity to build on Dr. Kelly’s contributions in this fourth edition.

This book is intended for managers—anyone who influences the design of healthcare systems for the purpose of improving quality. It is not necessary to hold the official title of *manager* in an organization to be instrumental in creating and supporting higher-quality services. Many frontline, nonmanagerial clinical and administrative staff members are directly or indirectly involved in

shaping patient care systems and in using improvement techniques to design more efficient, safer processes. Although the word *manager* is used liberally throughout this book, it is not intended to narrow the audience or the purpose. Anyone interested in making improvements in the quality and safety of health services will benefit from the learning in these pages.

Changes from the Third Edition

The emphasis on systems in the third edition is still evident in this edition. What has changed is an expansion of information about quality tools, data analysis techniques, and patient safety. As with all editions of this book, concepts covered in the chapters are supported by real-life examples, illustrations, and thought-provoking end-of-chapter exercises. Some chapters have been added and others reordered. The book is now divided into three major sections instead of two.

Section I provides students with the foundation principles of healthcare quality and how systems affect an organization's ability to accomplish quality goals. The chapter on the role of policy in advancing quality in the third edition was moved to this section so students can better appreciate how external forces affect system behavior and relationships, as well as the quality methods used by health services organizations covered in later chapters. Some of the material relevant to reliability and patient safety covered in this section in the third edition has been moved to a new chapter dedicated solely to the topic of patient safety.

Section II contains three chapters designed to illustrate what health services organizations must do to set the stage for success in quality management efforts. Because teamwork and collaboration are essential for advancing healthcare quality, the teamwork chapter at the end of the third edition has been expanded and moved to this section (chapter 8, "Fostering a Culture of Collaboration and Teamwork"). Much of the information from chapter 10 has been moved to chapter 9 ("Measuring Process and System Performance"), and some topics have been shifted to other related chapters.

The "nuts and bolts" of quality management are found in section III. The chapters in this section are expansions of topics covered in the third edition. Instructors using the third edition in a quality course indicated the need for more detailed explanations of quality models and the tools and techniques of healthcare quality management. In addition, a new chapter has been added (chapter 10, "Using Data Analysis Techniques to Evaluate Performance"). This chapter covers basic concepts of healthcare data analytics, including how to use various statistical and graphical methods for reporting and evaluating performance data. Some of these methods were covered briefly in the third edition, and some of the discussion is new to the fourth edition.

Material on improvement models, project teams, and quality tools are greatly expanded from the third edition and now covered in two separate chapters (chapter 11, “Designing and Implementing Improvements”; and chapter 12 “Using Improvement Teams and Tools”). In the third edition of the book, the various topics related to patient safety were dispersed among several different chapters. Now most of the material concerning patient safety is in a new chapter (chapter 13, “Making Healthcare Safer for Patients”). This chapter is focused entirely on systems issues affecting patient safety and methods for reducing mistakes and preventing patient harm.

Health Administration Press now offers educators the opportunity to build custom textbooks comprised of chapters from several different books. To accommodate this service, the chapters in the fourth edition of this book have been written to stand alone as much as possible. Within each chapter, references to material in other chapters have been minimized, or the concepts summarized and repeated when necessary. Where there are linkages between materials in various chapters, instructors are encouraged to point out these relationships, because the connections are not as clearly stated as in the third edition.

Resources

Listed at the end of each chapter are companion readings and web resources. Instructors can expand students’ learning experience by assigning a companion reading or directing students to explore one or more of the web resources. These readings and web resources are particularly useful in the chapter on data analysis techniques, if instructors want to cover more than just basic concepts. The web resources also provide instructors and students with sources of the most current information on relevant quality management and patient safety topics.

Instructor Resources

This book’s Instructor Resources include explanations of the exercises, a test bank, and PowerPoint slides.

For the most up-to-date information about this book and its Instructor Resources, go to ache.org/HAP and browse for the book’s title or author name.

This book’s Instructor Resources are available to instructors who adopt this book for use their course. For access information, please e-mail hapbooks@ache.org.

Student Resources

For students, end-of-chapter exercise and web resources are available on this book's companion website at ache.org/books/qualitymanagement4.

Reference

Spath, P., and W. Minogue. 2008. "The Soil, Not the Seed: The Real Problem with Root Cause Analysis." *Perspectives on Safety*. Agency for Healthcare Research and Policy. <https://psnet.ahrq.gov/perspectives/perspective/62/the-soil-not-the-seed-the-real-problem-with-root-cause-analysis>.