Australian and New Zealand College of Anaesthetists (ANZCA)

Guidelines on Quality Assurance and Quality Improvement in Anaesthesia

Background Paper

1. INTRODUCTION

This document, previously *TE09*, was reprinted in 2012 as *PS58*; however, it was not reviewed at that time. With rising community expectations as well as the emphasis of continuing professional development (CPD) on practice evaluation the accompanying guidelines were reviewed to ensure that these demands are met.

Fellows place significant importance on evidence-based practice and there are two separate goals that need to be achieved. The first is quality assurance, which refers to minimum standards, and the second is quality improvement, which promotes continuing advancement of individual performance[1]. Many of the ANZCA professional documents inform quality assurance through the provision of guidelines and expected standards, while the ANZCA CPD Program facilitates the achievement of quality improvement.
The regulatory authorities including the Medical Board of Australia and the Medical Council of New Zealand mandate that all registered specialist anaesthetists and specialist pain medicine physicians practising in Australia and New Zealand, as well as vocationally registered anaesthetists practising in New Zealand must comply with the ANZCA CPD Standard. This serves as evidence that practitioners are actively participating in quality assurance and committed to quality improvement.
The elements of quality healthcare are encapsulated in the acronym STEEEP (Safety, Timeliness, Efficiency, Efficacy, Equitability, Patient-centredness).

2. PURPOSE

The pursuit of quality assurance and improvement is desirable and strongly encouraged. It is an integral part of ANZCA's Mission. Given the differing environments and clinical practices of fellows the intention of the accompanying guidelines is to inform fellows and to facilitate them achieving the highest level of quality care in anaesthesia, perioperative medicine, and pain medicine.

3. SCOPE

Quality assurance and quality improvement are a constant feature of professional practice. It begins during training and continues throughout the practitioner's career. It therefore, applies to all trainees, and all perioperative physicians/anaesthetists.

It is acknowledged that quality outcomes are a function of teams[2] and systems that are involved in performing and supporting surgery and anaesthesia. As a result, quality assurance and improvement activities should preferably be coordinated between anaesthetists, surgeons, nurses, hospital administrators, and other relevant disciplines.

4. DISCUSSION

4.1 Measurement of QA and QI

Comparisons against either accepted standards or against previous outcomes are an essential component of QA and QI. Objective quantitative comparisons based on absolute numbers, percentages, or rates, are preferable, however, there are situations where qualitative comparisons are valid.

Measurement may focus on structure, process, or outcome. Examples of these are included in the accompanying document. Quality improvement programmes focussed on outcomes should include all relevant disciplines involved in the team rather than any one group of practitioners as outcomes are determined more so by the team than any individual practitioner.

4.2 Process of QA and QI

The steps in any program include the need to plan the project; implement data collection and analysis; review the outcome of changes: and setting new improved standards[3,4].

4.3 QA and QI Programs

Service structure and performance considering the overall performance and resources should be compared against accepted criteria as well as those of other equivalent services in the region. Examples have been included in the accompanying document.

In addition, programs should include criteria based audits; review of compliance with clinical guidelines or protocols; voluntary reporting of critical incidents[5]: risk management strategies; peer review; patient surveys; root cause analyses; reporting to external national and state/territory programs; and audit of QA programs.

4.4 QA and QI Resources

The ability to undertake and implement meaningful QA and QI programs and activities requires the allocation of resources including people, time, and support[6,7].

In formally constituted departments of anaesthesia a QA and QI coordinator should be appointed with responsibility for implementation and supervision of QA programs. The coordinator should also ensure that the accompanying guidelines are implemented within the limits of the size of the department.

Anaesthetists who are not exposed to formally constituted anaesthesia departments, such as solo practitioners practising solely in private practice, should ensure that they participate in a relevant QA program.

5. SUMMARY

This revision acknowledges the importance of quality improvement in addition to quality assurance and the need for both to be part of an ongoing process. The accompanying guidelines are designed to inform fellows, promote a greater understanding of QA and QI, and to guide practitioners and organisations undertaking activities within QA and QI programs.

6. PROCESS OF REVIEW

The initial draft was developed by the document development group (DDG), which comprised:

- Professor Alan Merry, FANZCA, Councillor Co-Chair,
- Dr Rodney Mitchell, FANZCA, Councillor,
- Professor Paul Myles, FANZCA and
- Dr Peter Roessler, FANZCA, Director of Professional Affairs (Professional Documents), Co-Chair

The proposed draft was then submitted to the Safety and Quality Committee (SQC) for consideration. Upon approval the documents were then circulated to stakeholders for comment.

The following stakeholders were invited to provide feedback for consideration by the DDG. A final draft was then submitted for approval to be released on the website for a twelve month pilot phase.

- Safety and Quality Committee
- ANZCA regional and national committees
- Australian Society of Anaesthetists
- Faculty of Pain Medicine Board and regional committees
- ANZCA Trainee Committee
- Relevant Special Interest Groups (SIGs)

7. RELATED ANZCA DOCUMENTS

A01 Policy for the Development and Review of Professional Documents

8. REFERENCES

1. Merry AF. An overview of quality and safety in health care. Can J Anesth. 2013; 60:101-110.

2. Weller J, Boyd M. Making a difference through improving teamwork in the operating room: a systematic review of the evidence on what works. Curr Anesthesiol Rep. 2014; 4(2): 77-83.

3. Bessissow A, Duceppe E, Devereaux PJ. Addressing Perioperative Myocardial Ischemia. Curr Anesthesiol Rep. 2014; 4(2):107-112.

4. Wahr JA, Abernathy JH. Improving patient safety in the cardiac operating room: doing the right thing the right way, every time. . Curr Anesthesiol Rep. 2014; 4(2):113-123.

5. Dutton RP. Improving safety through incident reporting. Curr Anesthesiol Rep. 2014; 4(2):84-89.

6. Pronovost PJ. Evaluating safety initiatives in healthcare. Curr Anesthesiol Rep. 2014; 4(2):100-106.

7. Walker IA, Bashford T, Fitzgerald JE, Wilson IH. Improving anesthesia safety in low-income regions of the world. Curr Anesthesiol Rep. 2014; 4(2):90-99.

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**This professional document is being piloted and will be reviewed in November 2017.*

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