Ontario surgical quality network advancing on many fronts

From cleaning the lint out of your belly button prior to surgery to the potential for province-wide collaborative efforts to improve surgical quality, the second annual meeting of the Ontario Surgical Quality Improvement Network (ONSQIN) spanned a wide range of topics.

“This program never ceases to amaze me,” said Lee Fairclough, vice-president of quality improvement at Health Quality Ontario, in her introductory remarks to the meeting which had more than 300 registrants from 70 hospitals.

Thirty-three Ontario hospitals are participating in the ONSQIN program which allows them to benchmark their surgical outcomes against the American College of Surgeons – National Surgical Quality Improvement database (NSQIP) on a variety of risk-adjusted outcomes.

With the support of Health Quality Ontario, hospitals in the network are working to develop surgical quality improvement plans, implement best practices and contribute to a community of practice for collaborating and sharing ideas to support improvement.

During the conference, those in attendance heard both of overall plans and programs involving ONSQIN as well as case studies and success stories from individual centres striving to improve areas such as surgical site infections (SSIs) and post-operative urinary tract infections.

In his introductory remarks, Dr. Tim Jackson, surgical lead at Health Quality Ontario and a general surgeon at the University Health Network in Toronto noted that in just two years of existence the network is already moving from simply measuring surgical quality parameters but beginning to have an impact on outcomes such as SSIs.

Those in attendance were told of the importance of comparing surgical safety parameters in a single-payer jurisdiction such as Ontario against hospitals in other countries in order to both instill confidence in patients about the high quality of care being provided, and to stress improvements underway in the province.

At a conference driven by data, keynote speaker Judith John provided the vitally important perspective of the patient and the importance of taking into account the patient perspective when considering surgical outcomes. As Fairclough said, her presence reminded delegates of the ‘why’ behind the network.

John, who has had multiple surgical interventions due to a brain tumour and describes herself as “an accidental advocate”, told those in the room to remember the commonality “between the precision of one who cuts and the warmth of someone who asks.”

“The real metric that matters is (to) treat me like a person,” she said, noting that while doctors tend to be “explainaholics” they needed to take the time to actually listen to patients and try and understand their concerns.

In his presentation Jackson noted that many surgical programs have taken the initiative to develop Surgical Quality Improvement Plans to transform NSQIP data into opportunities for improvement. To date, he said, 27 hospitals in the province have submitted such plans.

Jackson said he felt the network was now mature enough that it could move from an onboarding to a collaborative mode to set targets as a group and implement change at the provincial level.

“You’re off to impressive start here,” said Dr. Karl Bilimoria, medical director of surgical quality at Northwestern University, Chicago who presented an overview of the acclaimed Illinois Surgical Quality Improvement Collaborative which involves 55 hospitals in the state.

There were many obvious parallels between the work done in Illinois and the evolution of the Ontario network, not least being the balance between institution- based and collaborative initiatives to improve quality.

Several specific case studies of initiatives by ONSQIN members to improve the quality of surgical care in their institutions were presented.

The reference to belly buttons came from Dr. Duncan Rozario, a general surgeon at Oakville Trafalgar Memorial Hospital who detailed the bundle of changes instituted at that hospital to improve SSI rates. He noted the various pre-operative measures including cleaning out belly buttons as being important elements of this bundle.

Details were also presented of the recently released Canadian Cardiovascular Society guidelines on perioperative cardiac risk assessment for patients not undergoing cardiac surgery – one of the key recommendations being to cease acetylsalicylic acid use (ASA being the active ingredient in Aspirin) in all such patients 72 hours prior to surgery because of the increased bleeding risk.

At the conclusion of the meeting, Jackson and Fairclough stressed the positive nature of the meeting, and Fairclough returned to a theme she had introduced earlier of the importance of collaboration to truly make significant changes.