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THE QUALITY MANAGEMENT SERIES

PRINCIPLES OF QUALITY MANAGEMENT
ESTABLISHING A CULTURE OF PERFORMANCE EXCELLENCE
LESSONS LEARNED IN PREVENTION PRACTICES
HAVE YOU BEEN QA'D?

PROGRAMS UNDER DEVELOPMENT

HAVE FUN STORMING THE CASTLE
THE BASICS OF STATISTICAL ANALYSIS & TESTING
DATA ANALYSIS TECHNIQUES USING MS EXCEL™
STATISTICAL PROCESS CONTROL (SPC)
PROCESS MAPPING
LISTENING TO THE VOICE OF THE CUSTOMER
LEAN
THE BALANCED SCORECARD IN EMS
USING CENSUS DATA FOR SYSTEM DESIGN

PRINCIPLES OF QUALITY MANAGEMENT

An Introduction to the Theories and Principles of Quality Management

This program is designed for EMS students, educators, and managers as an introduction to the history, theories, and principles of quality management and their application in Emergency Medical Systems. Participants will be introduced to the many theories of performance management that have emerged over the years. A workable definition of quality in emergency medical services will be introduced. Emphasis will be placed on developing error free systems and approaching performance deficits as system issues instead of provider issues.

Recommended Audience

EMS Students, Educators, Managers, providers interested in the principles and theories of quality management.

Category of Education

Ambulance Operations/EMD Operations/Operations Management/Quality Improvement/Performance Excellence

Program Duration

75 - 90 minutes

AV Resources Required:

- XGA projector
- Laptop (supplied by speaker)
- One easel pad and easel

Participant Resources

- Presentation Outline (supplied by conference/seminar sponsor)
- Unlimited Secure Access to Performance Management Resources at www.iioe.net

Learning Objectives/Discussion Topics

- A. What is Quality?
- B. Traditions in Healthcare Quality Management
- C. The History and Theories of Quality Management
- D. Total Quality (TQM)
 1. Reputation Quality
 2. Image Quality
 3. Service Quality
 4. Technical (Clinical) Quality
 5. Operational Quality
- E. Defining Quality – A New Perspective
 1. Customer Focus
 2. Systems Improvement Orientation – Eliminating a Culture of Blame
 3. Recommendations of the Institute for Healthcare Improvement
- F. How Do We Get Started In Quality Management

ESTABLISHING A CULTURE OF PERFORMANCE EXCELLENCE

Using the Baldrige Criteria as a Model for System Development

The focus of this program is to review the current standards used by the Baldrige National Quality Program as they apply to Healthcare Organizations. After review and discussion of each area of the Baldrige criteria, the participants should be able to identify how these standards can be used to improve the overall organizational performance of agencies that elect to use the Baldrige Model in defining, measuring, analyzing, improving, and control its own organizational and operational systems.

Recommended Audience

Educators and Managers

Category of Education

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Program Duration

75 - 90 minutes

AV Resources Required:

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Learning Objectives/Discussion Topics

- A. The History and Background of the Baldrige National Quality Program
- B. Healthcare Criteria for Performance Excellence Framework: A Systems Approach
 1. Organizational Profile
 2. Leadership
 3. Strategic Planning
 4. Focus on Patients, Other Customers, and Markets
 5. Measurement, Analysis, and Knowledge Management
 6. Workforce Focus
 7. Process Management
 8. Results
- C. Taking Steps Toward Developing Mature Processes
- D. Tools for Organizational Assessment

LESSONS LEARNED IN PREVENTION PRACTICES

Using Failure Mode & Effects Analysis to Design Error Proof Systems

Prevention of errors before they occur is one of the hallmarks of an effective Process Management System and is one of the main principles of Continuous Quality Management. The focus of this presentation is to review the principles of Product and Process Failure Modes and Effects Analysis. The goal of this program is to provide the participants with the knowledge and resources required to build systems and identify operational tools, through analysis and preplanning, which operate with minimal errors.

Recommended Audience

Educators and Managers

Category of Education

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Program Duration

75 - 90 minutes

AV Resources Required:

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Learning Objectives/Discussion Topics

- A. Defining Failure Mode and Effects Analysis (FMEA)
 1. Design Failure Mode and Effects Analysis (DFMEA)
 2. Process Failure Mode and Effects Analysis (PFMEA)
 3. Healthcare Failure Mode and Effects Analysis (HFMEA)
- B. Purpose and Uses of FMEA
- C. FMEA Elements and Procedures
 1. Severity
 2. Probability of Occurrence
 3. Probability of Detection
- D. Examples of Success and Failure in FMEA
- E. Redefining FMEA Elements and Procedures
 1. Severity as a Measure of the Cost of Poor Quality
 2. Preventability v. Delectability
- F. Assignment of Responsibility, Follow-Up, and Review

HAVE YOU BEEN QA'D?

Identifying Solutions Through Root Cause Analysis and Eliminating the Culture of Blame

Many EMS providers doubt the value of quality improvement activities and are suspicious of those involved in the quality improvement process...this is a learned response. All too often, when things go wrong, people look for someone to blame. This is one of the traditions of healthcare that is only now beginning to change through the efforts of several innovative thinkers in the healthcare arena. This program explores the principles of Root Cause Analysis as a retrospective tool for evaluating the performance of systems, not people. The discussion centers on the teachings of the National Center for Patient Safety and provides knowledge and tools to identify solutions in system performance deficits.

Recommended Audience

Educators and Managers

Category of Education

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Program Duration

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Participant Resources

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Learning Objectives/Discussion Topics

- A. Introduction to Quality in EMS: Definitions, Traditions, and Barriers
- B. **What** is Root Cause Analysis
- C. **Why** is Root Cause Analysis Used?
 1. Establishing a Culture of Improvement
 2. Eliminating a Culture of Blame
- D. When is Root Cause Analysis Conducted?
 1. Sentinel Events (Defined)
 2. Serious Events or Near Misses (Defined)
- E. **Who** is Included in the Process of Root Cause Analysis?
- F. **How** is the Process of Root Cause Analysis Conducted?
 1. Process Analysis and Management Tools
 2. Ensuring Process Credibility
- G. Tools and Techniques in Root Cause Analysis
- H. The Root Cause Analysis System of the US Veterans Administration Center for Patient Safety

HAVE FUN STORMING THE CASTLE

Examples of Performance and System Design and Analysis (max 20 participants)

Through team exercises and post exercise review, the participants will define a process to achieve a common goal, use a Statapult or Trebuche to measure system performance, and identify causes for success, failure, and variation. Once corrective measures for their process have been established, the team will re-evaluate any process changes they may have implemented to determine if there is further system changes required to achieve the desired goal.

Recommended Audience

Educators and Managers

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Program Duration

75 - 90 minutes

AV Resources Required:

- XGA projector
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- One easel pad and easel

Workshop Resources Required (supplied by speaker)

- Statapult or Trebuche (one for each participant team)
- Design of experiment materials

Participant Resources

- Presentation Outline (supplied by conference/seminar sponsor)
- Unlimited Secure Access to Performance Management Resources at www.iioe.net

Learning Objectives/Discussion Topics/Participation & Demonstration

A. **Define** - Introduction and Discussion on the Principles of Process Design

1. Determining Objectives and Outcomes
2. System Planning - Mapping Processes
3. Establishing Process Controls (i.e. Operational Policies)

B. **Measure** - Workshop Exercise

1. Process Instruction and Goal Setting
2. Group Activity (Teams of 4-5 participants)
3. Process Measurement (Introduction to the Statistical Process Control Chart)

C. **Analyze** - Data Analysis and Discussion

D. **Improve** – Changing the Process

1. Revision of Group Processes
2. Testing of the Process Improvements

E. **Control** - Retrospective Analysis/Discussion of Lessons Learned

SPEAKER BIOGRAPHY



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Bill Dunwoody is the Principal Consultant/Educator for the International Institute for Organizational Excellence. He began his career in emergency medical services in 1978 with the Lyndon State College Rescue Squad in Lyndonville, Vermont.

Throughout his career, Bill has worked for several volunteer, non-profit, for-profit, and hospital based ambulance services in Massachusetts and Maine. He has been an active contributor to local and statewide system development in the State of Maine. He has been active leader with several local agencies including the executive committee of the **Kennebec Valley EMS Regional Council** where he held the positions of Education Chairperson, Finance Chairperson, Council Vice-President and Council President. He was appointed by the Governor of the State of Maine to three terms on the **Maine Board of EMS**. He was the Charter Chairperson of the **Maine EMS Quality Improvement Committee**, and served as the Treasurer of the **Maine Ambulance Association** from 1997 to 2005.

In addition to conducting regular research and developing systems to improve the delivery of emergency medical services to the organizations served by his company, Bill is actively involved in supporting the development of systems nation-wide as a charter member of the **National EMS Management Association** where he serves on the Board of Directors. He is an active member of the **American Society for Quality (ASQ) Healthcare Division** where he serves as the Regional Counselor for Region 1 covering the States of Connecticut, Maine, New Hampshire, Massachusetts, Rhode Island, and Vermont. He has also holds the position of Secretary of the ASQ Healthcare Division. Bill is active in the **ASQ Pine Tree Section (Maine)** and holds two certifications, Certified Manager of Quality/Organizational Excellence and Certified Quality Improvement Associate, from the American Society for Quality. He was a contributor to the **National Association of EMS Physicians** book, "Improving Quality in EMS, Second Edition." His contribution included a chapter on Traditional Benchmarking. He is also a member of the **ASQ Healthcare Division Speakers Bureau** and is a frequent national speaker at workshops and conferences on topics related to the basics of performance excellence and process management, the Baldrige method of performance excellence, preventative process management through failure mode and effects analysis, identifying the reasons for performance variation through root cause analysis and techniques in the design of experiments for process improvement.

Bill holds a Bachelor of Science in Professional Studies and a Master of Business Administration, both conferred by Thomas College in Waterville, Maine. He is currently enrolled in a Doctoral program in Operations Research through Walden University. He lives in Madison, Maine with his wife, Virginia, and son, John. In his spare time, he dabbles in gardening, photography, learning to play the bagpipes, visiting family and friends throughout the world, and researching his family history.