



Implementing A Quality Plan:

- **Framework**
- **Process**
- **Project Teams**
- **Consumer Feedback**

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Introduction

The Health Care Corporation of St. John's has developed a process for Quality planning to ensure the ongoing evaluation and continuous improvement of the quality of care and services we provide.

Programs, Departments, Professional Practice Groups, and Committees of the Corporation which cover major functions (i.e., Medical Advisory, Occupational Health and Safety, Infection Control, Utilization Management, Emergency Preparedness Planning, etc.) are expected to have established mechanisms for monitoring and ensuring quality.

The foundation of the Quality Plan includes:

- An organizational culture which, through its Vision, Mission and Values, demonstrates the commitment to provide quality care and service.
- A leadership style that facilitates teamwork.
- The evaluation and improvement of processes so that intended outcomes are achieved.
- A commitment to understand and strive to meet the needs and expectations of consumers.

Quality improvement is a structured process that selectively identifies and improves aspects of care and service on an ongoing basis. It seeks to meet or exceed consumers' needs and expectations, within available resources and achievable goals, with a minimum of effort, rework and waste. The goal is to achieve improvements in our services and programs while continuing to monitor and maintain past gains.

This booklet will serve as a guide to assist managers and team members by providing direction for establishing objectives, identifying and measuring performance, and making ongoing improvements in the quality of care and service delivery. It will help staff and physicians in developing and operationalizing a Quality Plan.

Section I

Overview & Direction

Section I

Overview & Direction

Board of Trustees - Statement

The Health Care Corporation of St. John's embodies the principles of continuous quality improvement in the provision of care and service. The Mission and Vision Statements of the Health Care Corporation articulate the commitment to quality in the fulfillment of our mandate. Our Values further articulate the integration of quality into our belief systems.

The fundamental principles of quality improvement encompass an accountability to consumer responsiveness, organizational commitment, staff involvement, and pursuit of evidence-based care and service.

The quality framework for the Health Care Corporation of St. John's encompasses these principles and provides a multi-dimensional approach to care and service that is consumer focused. It serves as the basis for the organizational quality plan.

Responsibility for the quality of care and service rests with the Board of Trustees. The Board has delegated the authority and responsibility to effectively implement and manage the quality improvement plan to the Chief Executive Officer and the Medical Advisory Committee. The leadership team, together with the staff of the organization, will continuously evaluate and improve its activities.

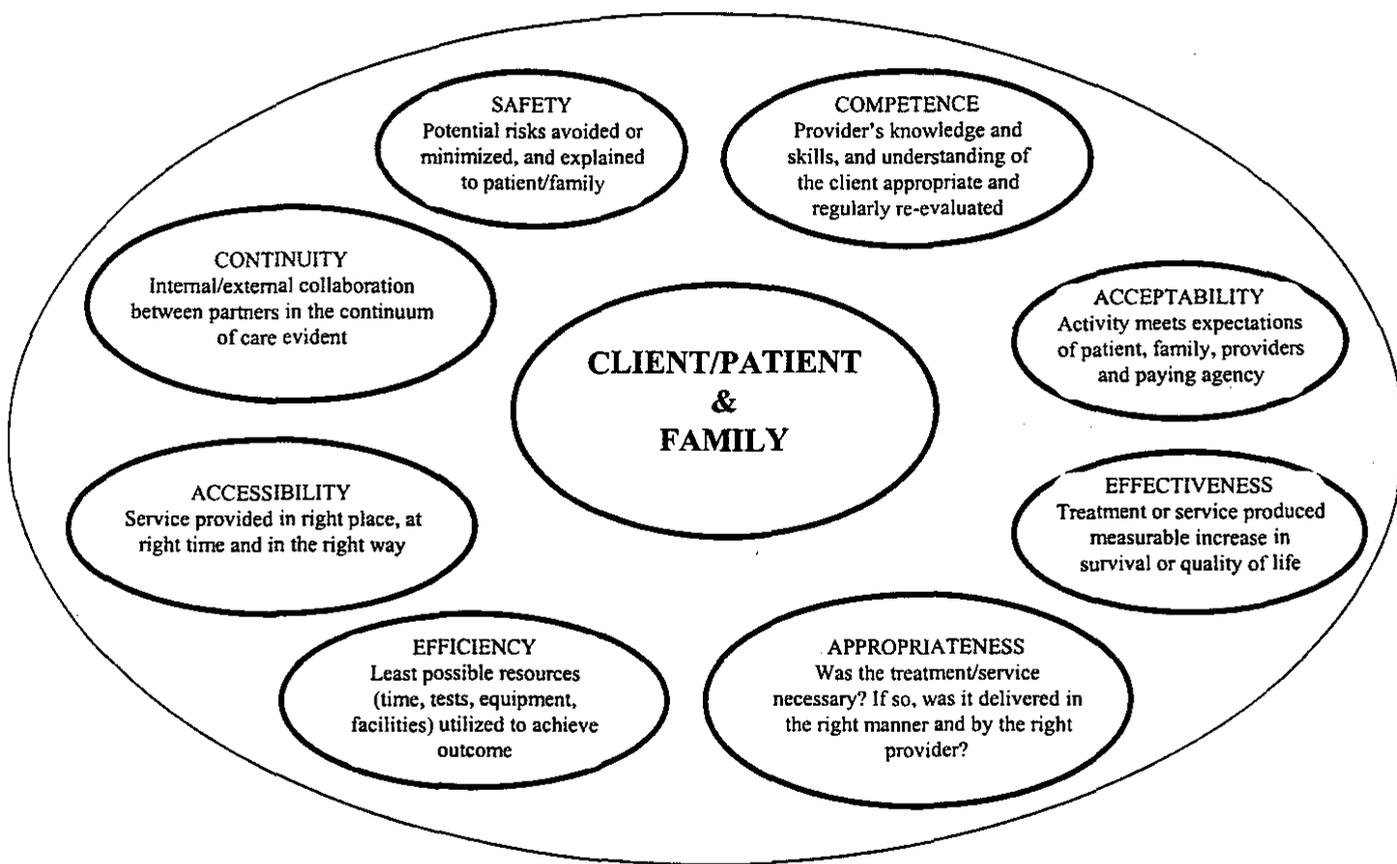
Quality is achieved through the collaborative efforts of staff, physicians, volunteers, consumers (patients/clients), and leadership teams. Public consultation and partnership with stakeholders further strengthens our organization.

The Board entrusts the organization's staff to do the **right things right and make continuous improvement**. In so doing, there is a systematic process through the Corporate Quality Initiatives Committee, and Quality Initiatives Committee of the Board by which ongoing monitoring and evaluation take place.

(Approved: Board of Trustees, March 26, 1998)

Definition of Quality & Evaluation Framework

Quality means doing the right things right and making continuous improvements. Individuals differ in how they define quality. The Health Care Corporation of St. John’s has adopted an eight dimensional framework by which we can consistently evaluate and improve the quality of care and service and communicate the results.



(Reference: CCHSA 1997)

The dimensions may be grouped as:

- doing the right thing -** acceptability, effectiveness, appropriateness, and accessibility
- doing things well -** safety, competence, efficiency, and continuity

Dimensions of Quality

The eight dimensions of quality prompt thinking about aspects of care and service in a systematic approach:

Safety:

The potential risks of an intervention or the environment are avoided or minimized.

Competence:

An individual's knowledge and skills are appropriate to the care/service being provided.

Acceptability:

All care/service provided meets the expectations of the client, community, providers, and paying organization, recognizing that there may be conflicting, competing interests between stakeholders, and that the needs of the consumer/ patient are paramount.

Effectiveness:

The care/service, interventions or actions achieve the desired results.

Appropriateness:

The care/services are relevant to the consumers'/patients' needs and based on established standards.

Efficiency:

The desired results are achieved with the most cost-effective use of resources.

Accessibility:

The consumer/patient is able to obtain care/service at the right place and at the right time, based on respective needs.

Continuity:

Uninterrupted, coordinated care/service is provided across programs, practitioners, organizations, and levels of care/service, over time.

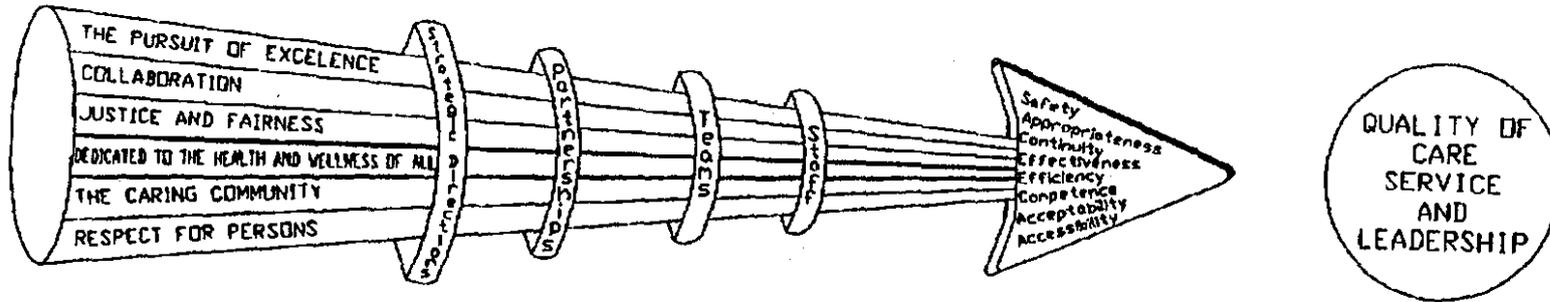
Quality Model

The Model demonstrates the interrelationship between the Health Care Corporation's Mission, Vision and Values in the pursuit of quality care, service and leadership.

The Corporate Strategic Directions guide the staff, teams and partners towards quality outcomes. The eight dimensions of quality provide an evaluation framework through which we can measure success in reaching the goal (Quality Target).

The pursuit of quality is exemplified through such processes as recruitment, performance evaluation, strategic planning, allocation of resources and a commitment to ensure meaningful public consultation.

QUALITY MODEL



Accountability

Within Programs/Departments

Accountability for quality of care and service rests with the Program/Department Leadership and staff. A formal structure will exist to ensure that:

- a comprehensive quality plan is in place,
- evaluation is ongoing,
- evidence based practice is pursued,
- results of evaluations are analysed,
- improvements are undertaken to address priority areas identified.

Formal structures include Internal Advisory Committees, peer review activities, External Advisory Committees, indicator monitoring and quality improvement activities. Accountability is to the applicable Vice President. Quality reports will be reviewed in detail within the Department/Program before being presented to Corporate Team.

Inter-Program/Department Issues

Accountability for quality of care and service is shared between related departments/ programs. External Advisory Committees, project teams, or liaison committees can act as formal structures to ensure improvements are acted upon and results or outcomes monitored. Accountability is to the appropriate member(s) of Corporate Team.

Organizational Issues - Corporate Committees

Corporate committees are accountable to:

- monitor key issues,
- make recommendations to their respective Vice-President(s) (for reporting to Corporate Team and/or Medical Advisory Committee), and
- oversee the implementation of the approved recommendations.

Corporate committees include, but are not limited to, Infection Control, Pharmacy and Therapeutics, Utilization Management, Occupational Health and Safety, waste Management, Internal Communications Advisory Committee, Information Management, Product Evaluation and Internal Documentation.

Ad hoc committees may be struck from time to time to deal with specific issues. Recommendations arising from such committees will be made to the appropriate leadership group who has authorization to act upon the recommendations.

Professional Practice Issues

Accountability for professional practice is a responsibility of the individual practitioner in collaboration with the Professional Practice Coordinator for the discipline.

Discipline-specific councils/committees are in place to provide a forum for the identification, discussion, and resolution of professional practice issues.

Corporate Quality Initiatives Committee

This committee is comprised of the Corporate Team and Director of Quality Initiatives. All programs/departments/professional practice groups and some committees will be required to report annually (personally or through written report) on their quality indicators, their annual planning priorities and achievements. The Committee will provide feedback and recommendations following the review. (Reference policies on Internal Reporting - Appendix A)

Board of Trustees

The Board of Trustees is accountable to government and to the public it serves for the quality of care and service provided by the organization. The Board, through its Quality Initiatives Committee structures, expects the organization's staff to do the **right things right and make continuous improvement**. All programs and departments will provide summary reports of their Quality initiatives annually. Corporate indicator reports will be submitted on a regular basis.

Reporting Requirements

The Health Care Corporation of St. John's, as a publicly funded Corporation, is responsible to report on a regular basis to the government in a number of areas such as budgetary status, MIS guidelines, vital statistics, and others.

Within the Corporation, Programs and Departments are accountable to report to Corporate Team and the Board.

Quality Initiatives Reporting Format

Content

Quality reports will include a brief overview of achievements, current planning, reviews and evaluations, identification of significant quality issues and the program/department indicator set. This data will be itemized in alignment with the eight dimensions of quality, including trends, benchmarking, and action plans to deal with results. A sample format that will assist in preparing the report is attached (Appendix B).

Level of Information

The level of information required at the divisional level, program/department level, corporate team level, and board level will differ. Programs/Departments, in consultation with their Vice President, will need to determine the level of detail required to facilitate decision making.

Departments that hold or generate information (information holders) will prepare and distribute reports in a format that offers meaningful summary trends and benchmarks. Corporate-wide indicators will be summarized according to Vice President portfolio and/or the Corporation as a whole. Quality Initiatives staff will assist in the preparation if required.

Time Frame for Reporting

Programs/Departments/Professional Practice Groups are required to report at least annually to the Corporate Quality Initiatives Committee in accordance with the established schedule. This report should summarize the previous four quarters (12 months) of activities. Reports should be discussed at the Program/Departments Internal Advisory Committee and reviewed by the accountable Vice President prior to being presented to the Committee.

Annual Report (Fiscal Year End) to Executive

Programs/Departments and Professional Practice Coordinators are required to submit a fiscal year end, Annual Report to the Chief Executive Officer. This Report will normally be submitted to the respective Vice President by May 30th of each year. The reporting format used for the Quality report will be used for the Programs'/Departments' annual reports. The Professional Practice reporting format shall evolve based on the Professional Practice Model. Any different information required by individual Vice Presidents can be added as mutually determined between the Director and the Vice President.

Reporting to the Senior Advisory Council

Corporate-wide indicators (aggregate) will be presented to the Senior Advisory Council on a quarterly basis. Details of operational issues will not be addressed at this forum.

Reporting to the Board of Trustees

Reports that have been reviewed by the Corporate Quality Initiatives Committee will be presented to the Quality Initiatives Committee of the Board. Department/Program representatives may be invited to attend to address highlights of the report. The Quality Initiatives Committee of the Board provides regular reports to the Board of Trustees.

Closing the Loop

The Board and Corporate Quality Initiatives Committee shall provide timely feedback to Programs and Departments. Directors are expected to share the feedback received with their Advisory Committees and staff, thereby reinforcing everyone's involvement in the Quality process. Communication is critical to ensure staff involvement and knowledge. Multiple strategies should be used to communicate depending on type of information being shared and the target audience. Use of e-mail, memorandums, communication books, bulletin boards, poster displays, staff meetings, and others are encouraged.

Section II

Quality Process: Developing a Quality Plan

Section II

Quality Process: Developing a Quality Plan

Preamble

Quality of health care is not a new concept. What is new is the approach taken to assure that quality is evident and demonstrated in all activities of patient care and service delivery. Systems must be in place to continually assess our work and improve at every opportunity.

Quality is Achieved Through People

Quality will only be achieved through the collaborative efforts of all persons involved: staff, physicians, consumers/patients, families, volunteers, and leadership teams. It is through consultation, collaboration and commitment among the key stakeholders that best results are achieved.

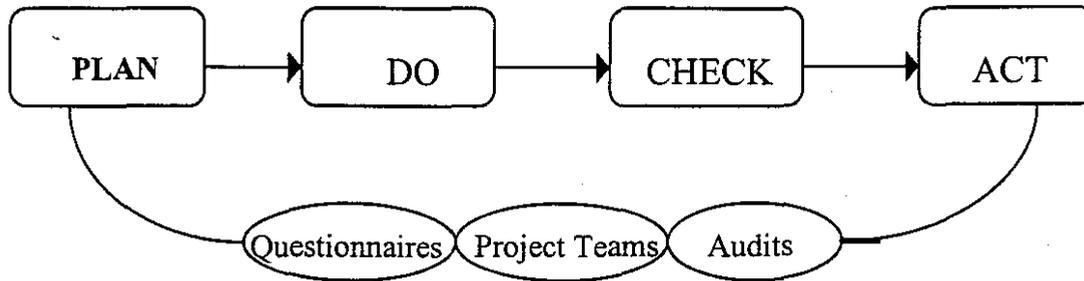
Information is Key

In the pursuit of quality, information management is critical. A comprehensive information management system is necessary to support:

- accountability to government,
- public accountability,
- complex data collection,
- timely, accurate and reliable information retrieval,
- informed decision making, and
- monitoring and follow up of improvements and impacts of change.

Putting the Quality Plan Into Action

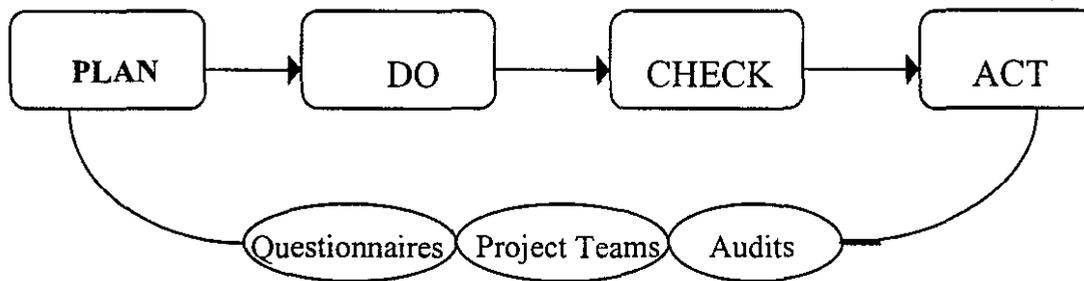
The Plan-Do-Check-Act Cycle (The Deming Management Method, 1986) is widely used as a way of visualizing the process of striving toward the goal of quality improvement. In the following sections, this cycle and the steps within it will be described in operational terms - i.e., what you need to do to get started, keep going, and continuously strive towards improvement.



Introduction - Plan-Do-Check-Act Cycle

The Plan-Do-Check-Act Cycle (P-D-C-A) is a consistent process that will assist in achieving improvements by guiding the work/project/process logically from one stage to the next.

As the diagram outlines, this P-D-C-A Cycle can be used in both the initial planning stages and during process improvement or evaluation stages. In continuing the quality cycle, many tools may be used including surveys, audits, questionnaires and project teams.



Each component of the P-D-C-A Cycle is described in more detail in the following sections.

Getting Started

Overview

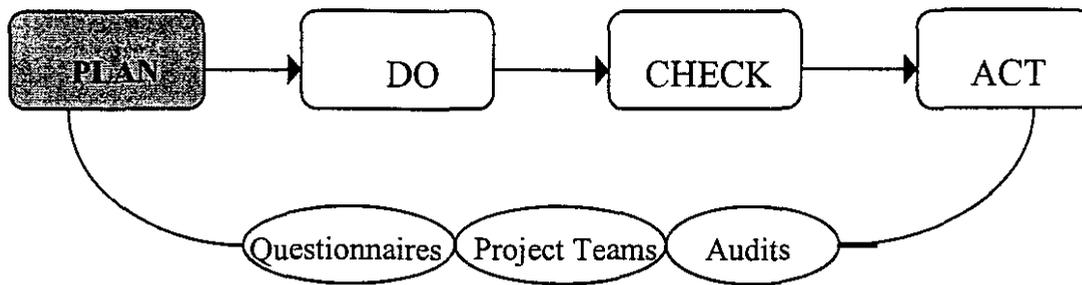
The work required in **first** establishing your Quality Plan differs from the **ongoing** review of performance. However, the key steps used to initially build a plan remain part of the review process. In establishing the initial Quality Plan for your Program/Department/Group/Committee, the first efforts will be focused on:

- continuing to provide services to your patients/clients/consumers with a view to determining priorities, required standards, and an equitable allocation of resources;
- reviewing the Strategic Plan of the organization with a view to adopting appropriate priorities into your plan;
- identifying your consumers/clients/patients/stakeholders (including staff) and developing a process for ensuring responsiveness;
- developing and articulating the key directions and objectives of your Program/Department in alignment with the Mission, Vision, Values, Guiding Principles, and Strategic Plan of the Corporation, and in consultation with consumers and stakeholders;
- identifying the indicators and information needs to measure and evaluate your performance in meeting the key directions and objectives you set to meet the needs of your consumers/clients/patients - using the eight dimensions of quality framework and the Quality Model of the Corporation;
- identifying appropriate benchmarks of performance that can be used for comparison;
- determining and applying the measures of performance to the ongoing care and service that will ensure quality processes and outcomes;
- effectively identifying and using teams in continuous improvement processes.

Cycle - 4 Stages

Each of the major stages in the Cycle is important at the outset. The stages are outlined in more detail. For each stage, the part of the P-D-C-A Cycle involved is highlighted and explanation given for the application.

1. Plan Stage



Reviewing the Strategic Plan for the Organization

In considering what is quality for your Program/Department/Committee, a critical first step is a review of the strategic direction for the organization. The Mission Statement, Vision, Guiding Principles, Values, and Strategic Plan all provide important direction for the stakeholders in the Corporation. This review will be of primary importance when determining the strategic directions for your Program/Department/Committee.

Who Are Your Consumers/Clients/Patients/Stakeholders?

In order to determine whether you are providing a quality result, you first need to determine who are your consumers and what are their needs. The analysis of identifying whom you serve is an essential building block in quality initiatives. The key questions in this analysis are:

- Who are the direct users of your services within the organization?
- Who are the people that provide service (including staff, physicians and volunteers)?
- Who requires inputs from your Department/Program within the organization?
- Who are the direct users of your services outside the organization?
- What are the needs and expectations of those you serve (determined through utilization, consumer feedback, health status, regulatory requirements, etc.)?

Typically, clinical services are directed externally; however, through accountability and/or committee structures, there may be many internal “customers” who depend on the clinical service information in order to do their work (Materials Management, Housekeeping, Food Services, Finance, Information Systems). For example, the documentation on the clinical record relating to an episode of care is important for the health care provider and the patient. Other users of that data include Health Records staff who code, file, and secure the documentation, Finance and Budgeting who maintain funding and statistical information, Food Service who provide the meals, etc.

Aligning Strategic Directions With Organization Direction

When consumers have been clearly defined, the Department/Program/Committee develops strategic directions that are consistent with and support the Corporate directions as well as the prioritized needs and expectations identified by the consumers. Strategic directions are described in broad statements; key directions are more specific and define the concrete steps needed to achieve the strategic directions. (Appendix C provides sample forms you can use to present strategic directions).

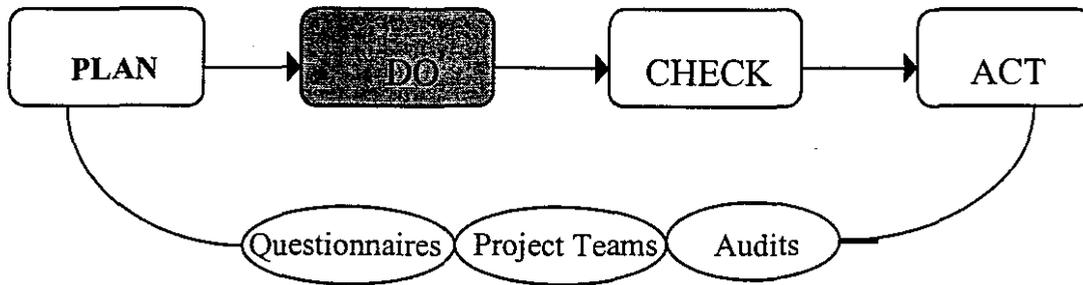
The statement of strategic directions for your Program/Department/Committee is a guiding document that is achieved with input from all staff, consumers, and stakeholders and is reaffirmed by your respective Vice President. The strategic directions are reviewed periodically throughout the year to ensure they continue to guide your activities.

Because key directions are specific actionable steps that the Program/Department plans to complete, it is important to prioritize and set realistic target dates. Some key directions may be completed within a short time frame, whereas others may take more than one year to complete. When assessing your objectives, consider the following RUMBA questions:

- **R** - Is the objective Realistic?
- **U** - Is the objective Understandable?
- **M** - Is the objective Measurable?
- **B** - Is the objective Behavioral requiring those involved taking action?
- **A** - Is the objective Achievable?

The planning process should be thoroughly reviewed and updated at least annually, as well as when any significant change affects the care and service delivered.

2. Do Stage



Service Delivery

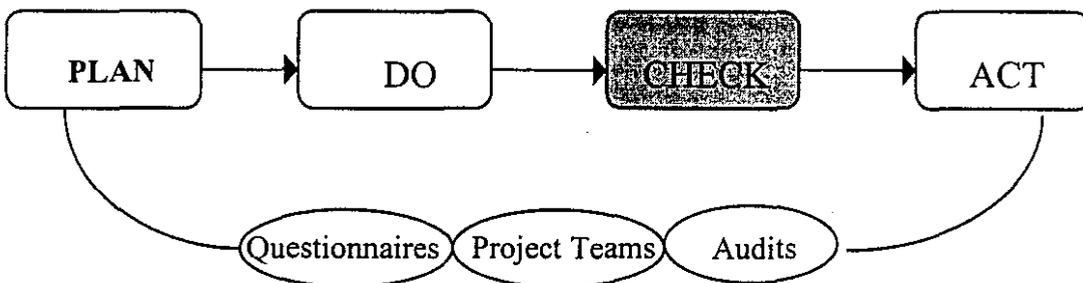
Throughout the planning process, your Program/Department continues to provide care and service - work goes on. All aspects of this care/service come under review when establishing your quality plan.

Implementing Objectives/Making Changes

It is important to ensure that a systematic approach is taken when implementing planned changes in order to minimize any disruption in the care and service delivery. Delays and inconveniences do occur despite good planning. Therefore, ongoing communication with all major stakeholders (e.g., consumers/patients/staff/physicians) is critical. The impact on consumers must be continually assessed and plans modified if that impact is not appropriate.

Prior to implementing a change, it is essential to establish the monitoring mechanism to be used in evaluating the effectiveness of the change. More discussion of that issue follows in the 'Check Stage'.

3. Check Stage



Defining Indicators, Measures of Performance

It is at this stage in the process that you will assess how well you have achieved your key directions. The use of indicators or performance measures is an objective method of assessment.

When defining your strategic directions, you also identify the **measures of performance (indicators)** you will use to determine that your key directions (and ultimately the strategic directions) have been attained or the degree to which they have been achieved. There are also ongoing evaluation mechanisms or tools that provide feedback to the Program/Department on performance. Audits, satisfaction surveys, recalls, and follow-up research are all examples of ways a Program/Department can obtain evaluation data about care and service which may not otherwise show up in an evaluation of strategic directions only, unless there are significant problems.

The volume of information involved in health care management makes it impractical to review all the relevant details all the time. The use of **indicators** helps to focus the assessment of key areas of importance.

One of the best analogies for indicators is the automobile dashboard. Considerable amounts of information are communicated to drivers by a limited number of dials and warning lights. If a warning light flashes or stays on or a gauge is low, the driver is alerted to take corrective action - buy gas, check the oil, etc. In a health care context, indicators can be length of stay, turn around time, waiting times, survival rates, infection rates, accident rates, sick leave rates, occurrences, etc. Indicators need not only be quantitative; qualitative measures are often extremely helpful - e.g., patient satisfaction information, quality of life, staff satisfaction.

Corporate-wide indicators will exist that may deal with some of the measures; however, Department/Program-specific indicators and evaluation strategies are also necessary. Within the Corporation, the eight dimensions of quality are used as the framework for indicator development. (For more detail about indicator development see Appendix D).

Identifying Benchmarks for Comparison

Benchmarks are reference points of best performance. To the degree possible, each Program/Department should seek benchmarks for each of their indicators. The goal of benchmarks is to compare your performance with the best and to strive to continually improve.

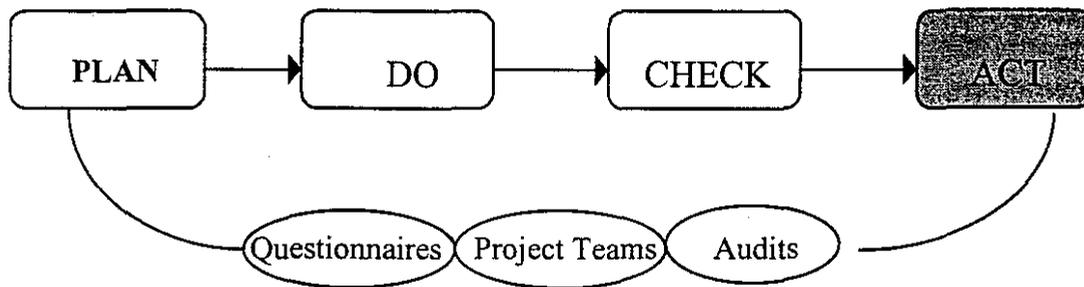
There are three types of benchmarks: internal, competitive, and functional.

1. **Internal Benchmarks** involve benchmarking using performance within your own organization. For example, in the absence of a good external benchmark, a Program/Department can use its own previous performance as a reference with an objective to improve on the results from last year/quarter by an agreed amount.

2. **Competitive Benchmarks** involve results from within a sector or industry - e.g., matched case length of stay, inventory turnover.
3. **Functional Benchmarks** are derived from best practices in a particular activity regardless of industry or sector - e.g., many hospitals have studied highly successful hotels in assessing best practices in areas such as inventory control, human resource management, housekeeping, and food service standards of practice.

Do use caution in choosing and using benchmarks. Benchmarks, like all human endeavors, are never static. The benchmarks chosen must be regularly reviewed to ensure they reflect best practice. The best organizations are always striving to be better; that is what got them there in the first place. Standardized definitions and comparability remain challenges in the health system. Benchmarks should facilitate the review of comparative performance; it is critical that the comparisons be valid.

4. Act Stage



Applying the Measures of Performance

The next step involves applying your measures of performance to determine if your key directions have been achieved through the current and past service provided. If there are gaps or shortcomings in performance, action plans to improve these gaps are necessary. There are many evaluation tools and methods that will provide each Department/Program with information about the delivery of care and service - e.g., audits, consumer surveys, outcome studies, utilization, and risk information. Some you have used in the past, and other data will be new to you. The critical step is, of course, to **ACT** on the information that indicates that a significant problem or improvement opportunity exists.

Implementing change can be straightforward or complex, depending on the issue and the change. If it can be done simply, then do it. If the change is more complex and/or involves multiple stakeholders, then take an approach that includes the individuals who will be affected. Remember - **quality is a product of people; their input is critical.**

When selecting an issue or process for improvement, priority should be given to those that are:

- high risk (processes that have potential to harm patients, staff or property/assets)
- high volume (processes that occur frequently)
- high cost (processes that contribute significant costs)
- problem prone (processes that frequently run into problems)

A description of performance measurement and improvement tools is provided in Appendix E - A Brief Review of Quality Improvement Tools.

You Have A Plan

Your Program/Department now has a quality plan and continuous improvement can be achieved with the Plan-Do-Check-Act (P-D-C-A) Cycle.

- You have established your strategic directions, key directions, performance measures, and benchmarks and your Program/Department continues to provide service (DO).
- Through the use of the new performance measures and benchmarks, you will regularly evaluate whether your key directions have been met (CHECK).
- If you find that you are not meeting the objectives and that significant gaps exist, you will seek to address the problem (ACT).
- The steps you take require that you revisit the strategic directions, key directions, and performance measures you require (PLAN).
- Continue through the P-D-C-A Cycle.

Follow this process regularly to assist the Program/Department to constantly progress in a mode of continuous improvement.

Section III
Improvement & Project Teams

Section III

Improvement and Project Teams

Teams and Group Dynamics

Typically, improvement initiatives involve teams of the people impacted by the change. The word *team* is often misused. A team is made up of a diverse group of people who share a goal and need each other to reach that goal.

A group of people working in the same area is not necessarily a team. A group of people does not become a team simply by working together on the same project. It takes a conscious effort, over an extended period of time, to create the synergy of a true team. Synergy means that the whole is greater than the sum of its parts. The people who make up the team, in other words, are more effective when they work together in harmony than individuals can be when working alone.

This organization, like the rest of the health care sector, already has many types of teams, including project teams and care/service delivery teams that oversee the functioning of units, Programs and Departments. Project teams generally are time limited, designed for a specific task while care teams are usually constant over time.

Project Teams

Much of the care and service delivered within the health care system is a product of the efforts of many skilled people who are members of various ongoing interdisciplinary teams.

A *project team* (or as it is often called, *process improvement team*) is comprised of various skilled people who come together to address an issue(s) and disband when the improvement has stabilized. The team has the mandate to lead initiatives that help to improve outcomes of work activities. Project teams are an investment of resources from care and service delivery. As such, they should only be used as necessary and disband once the work is completed.

Good reasons to form a process improvement or project team:

- to solve problems by drawing on the talents of a variety of individuals;
- to foster togetherness in the workplace while tackling projects;
- to reduce or eliminate a lack of communication among staff members on projects;
- to heighten productivity by encouraging an atmosphere of cooperation;
- to effectively facilitate a change process.

Building a Process Improvement Team

In planning a quality initiative and assembling a team, the following steps can be used as a general guide:

- develop a statement of purpose for the initiative - a “team mission statement”;
- select the appropriate team (include all disciplines involved) recognizing the relationships with other Programs/Departments;
- agree on the teams “Mandate” and “Terms of Reference” including timelines for completion;
- gather the available data for the issue;
- identify the current and desired levels of performance, including consumer/patient requirements;
- chart the process(es);
- identify possible causes for problems.

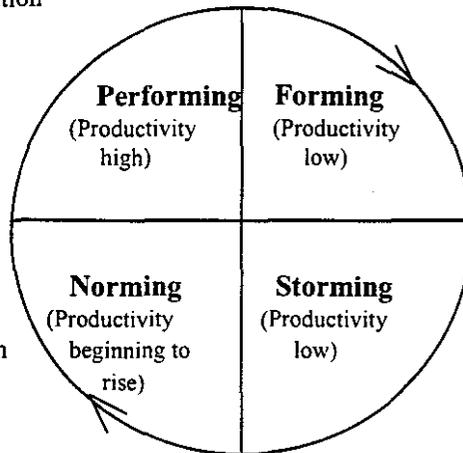
As you work with teams, you should be conscious that teams go through various stages of growth; at times the task is difficult, even when the appropriate people are on the team.

The four stages of team growth include:

- Forming
- Storming
- Norming, and
- Performing.

Morale is on the rise
 Team members working together
 Using team members' strength
 Group trusts each other
 Problem diagnosis and resolution

Enthusiastic about being chosen
 Eager to work on problem
 Getting to know each other
 Don't realize the need for trust
 Defining the problem



Team spirit beginning to form
 Resolving issues of conflict
 Group norms forming
 Trust beginning
 Project is moving forward

Enthusiasm wanes, reality sets in
 Become more task-oriented
 Lack of trust
 User personal expertise and resist working as a team

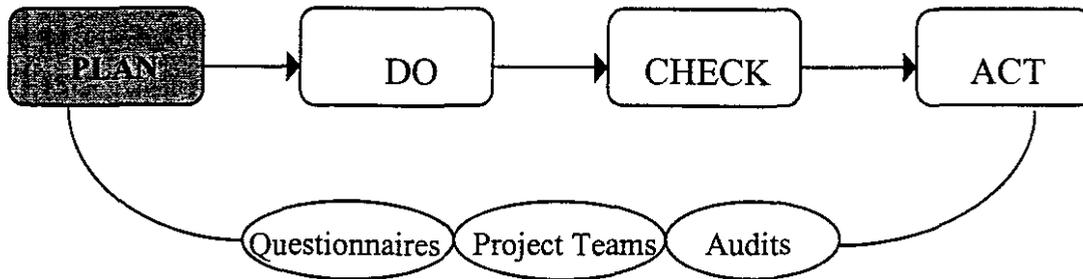
Quality Cycle in a Project Team

The Plan-Do-Check-Act Cycle can be applied to an improvement process.

In considering a quality initiative, the Program/Department should review:

- any changes in the strategic direction of the organization and the implications, if any, to the Program/Department and/or their consumers/patients;
- the strategic directions of the Program/Department to ensure they remain consistent with the strategic direction of the organization;
- the improvements that the Program/Department has achieved.

1. Plan Stage



At this stage in the P-D-C-A cycle the project team is looking to improve some aspect of its care or service.

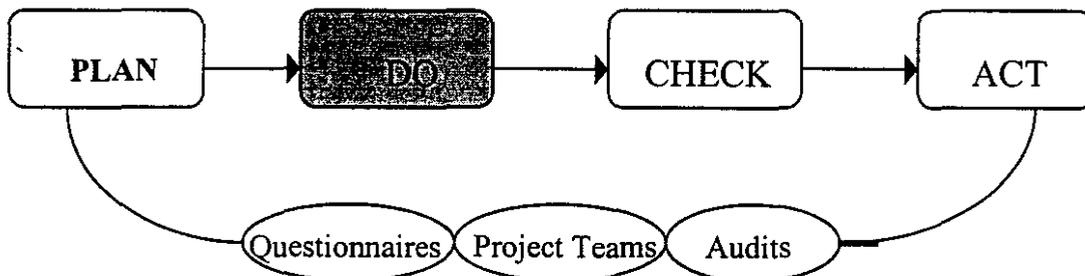
Key questions that should be answered at this time include:

- what have you learned so far?
- what new initiatives will be required to improve performance?
- will new expertise be required for the next steps?
- how will this new expertise be obtained?

Often it is not within the authority or scope of the Program/Department or project team alone to implement the change as activities in one area significantly influence other Programs/ Departments. Significant issues that involve multi-Programs/Departments should be brought to the attention of the respective Vice President(s). If need be, a multi-Program/Department project team can be formed. There are several existing mechanisms, through the various Corporate Committees that can assist with improvement opportunities.

Once an opportunity for improvement has been identified, the project team continues the PDCA cycle by moving on to the “Do” step.

2. Do Stage



This is the actionable phase of the process where information is analyzed and solutions are selected for testing. This analysis would involve a complete evaluation of all data collected, indicator trends, as well as, a comparison with available benchmarks.

Example:

If your **objective is to improve the turn-around time for reports**, then, data will need to be collected on:

- the current turn-around time,
- jobs that are affected by this expectation,
- the process of generating reports,
- what indicators measure turn-around time, and
- are these indicators comparable to any benchmarks etc.

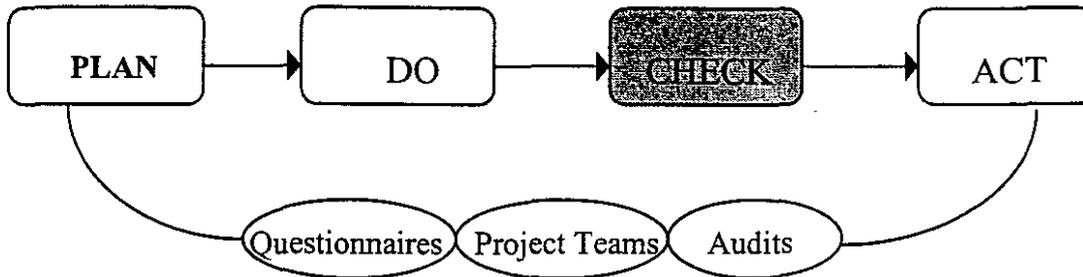
From this information common trends and opportunities for improvement are identified. Prior to implementing sweeping changes throughout the Program/Department, a small-scale study or pilot project may be warranted. The pilot project should identify:

- Who is responsible for the process?
- Who needs to be aware of the proposed change?
- What specific change is going to be tried?
- How do we know this is the right change to try?
- What steps should be taken to try out the change?
- Who will be involved in the pilot phase?
- What procedures will be followed?
- What training is required/who needs training?
- How will we check the effectiveness of the change?
- Do we need any checklists or reporting forms for the pilot?
- Do we need any assistance in completing the analysis of the project?

During the pilot project, it is important to follow the outlined plan without deviation and to monitor results, indicators and outcomes.

For example, the team has identified the current turn-around time to be six weeks. One opportunity to reduce turn-around time to four weeks is to modify staff job duties to have designated staff responsible for all data input on a daily basis. The pilot project is to implement this change in one area of the department and to monitor the outcome of this change. If the pilot project is not followed exactly, then it will be difficult for the team to assess whether the outcomes of the trial were due to the change or to other measures.

3. Check Stage



The next step is to review and evaluate the result of the change. This step is outlined below on a Flow Chart. Was the pilot project carried out as planned? If no, then it will be important to conduct the pilot phase again prior to implementing full changes.

The team should also confirm or establish the means of monitoring the solution. Are these measures valid, reliable and comparable?

MEASUREMENT INTEGRITY

Validity - how well does the indicator measure what it is supposed to measure?

Reliability - how “repeatable” is the measure?

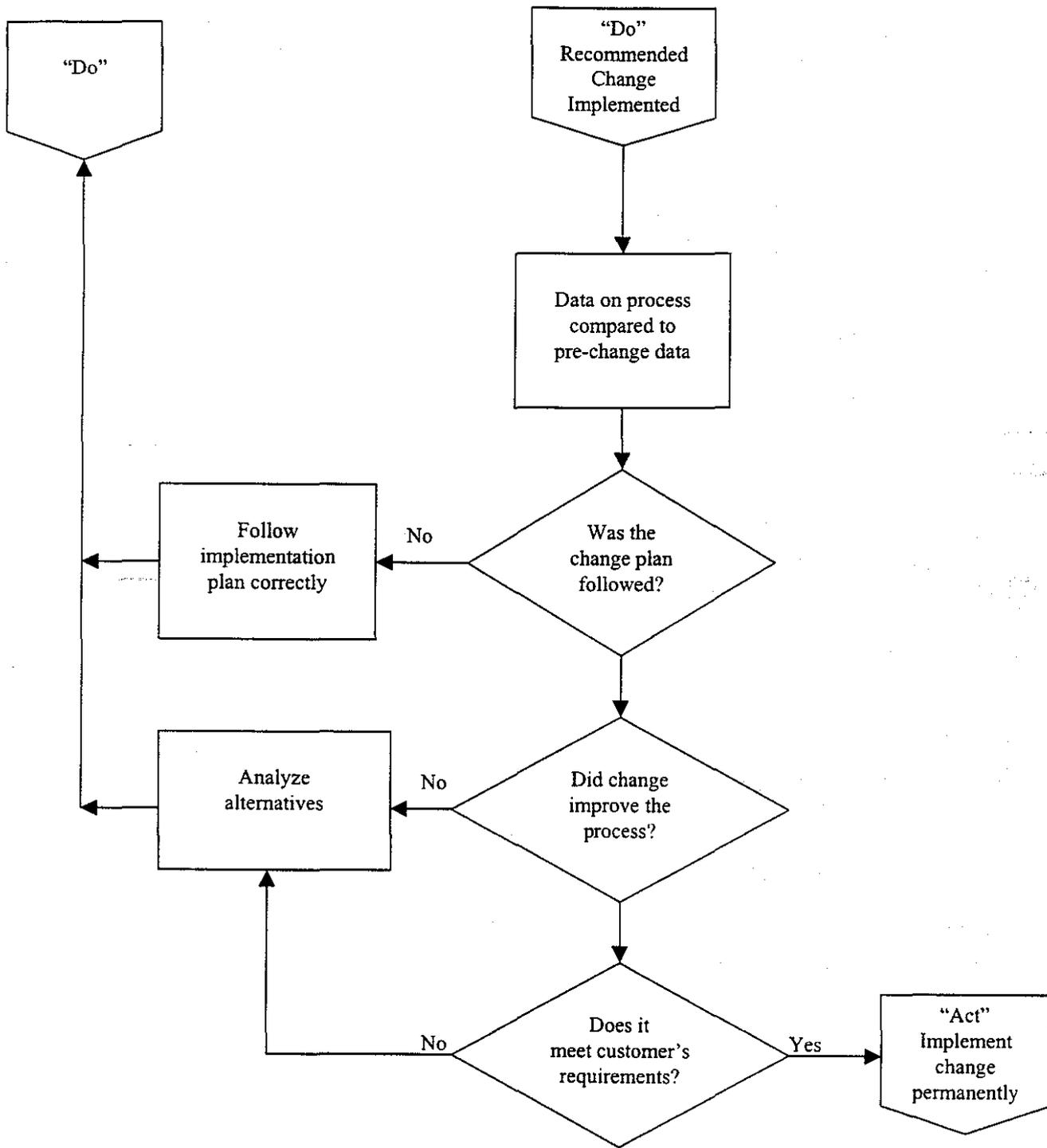
Comparability - how well does the indicator compare over time and/or across agencies?

As part of the pilot assessment, is the solution having the intended effect?

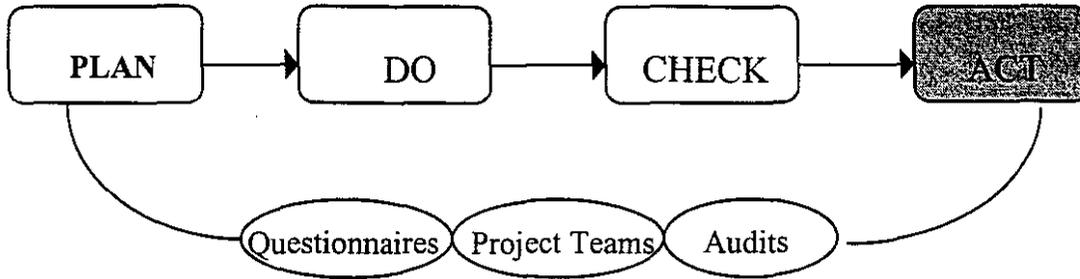
- Did the turn-around time decrease from six weeks?
- Were there any unintended positive or negative consequences of the proposed solution (i.e., turn-around time decreased with a consistent increase in time for other job duties; turn-around time decreased and action could be taken on the reports earlier)?

Another component of the Check Step is to assess the degree to which consumers’ expectations or requirements are met. If the process has been changed but is not meeting the consumer’s expectations, then re-evaluate why the change was implemented and how effective this change will be.

Check Flow Chart



4. Act Stage



This step in the quality improvement process reflects on the results of the pilot project.

- What did the information you collected tell you about the effectiveness of the change?
- What can be done to error-proof the process?
- How can the change that was piloted be refined?

From here, the team should continue the planned change or procedure in other areas of the Department/Program. It is recommended that the procedure be standardized through all areas. The benefits of standardization include:

- smoother implementation;
- easier evaluation of common indicators;
- easier implementation of refinements to the process; and
- minimizing risk - if a particular process is the standard in one area of the organization then unless there is substantive reason to do otherwise, it should be the same throughout the organization (example, policy, standards of care)

Effectively communicating the change is an important aspect of the **Act Step**. The team must be clear in their objectives and action plans. The pilot project must be clearly defined so that it can be adhered to. Evaluation tools must be specific and collection of data should be easily understood. Changes should be communicated to all persons involved in a clear, concise and timely manner. It is important to choose appropriate and sometimes multiple formats for communication. Consider e-mail, memorandums, poster boards, staff meetings as well as other creative methods. Always consider the target audience when planning communication strategies.

Celebrate Success

The quality improvement process has now been completed. Take the time at this stage to celebrate the success of the team and to recognize the contribution the team has made to the Program/Department.

Celebrations of success, commendation, and recognition of the team’s efforts can happen in a variety of creative ways and do not have to cost money. Some suggestions include:

- a “thank you” letter;
- sharing the team’s improvement process with others in a newsletter article;
- having team members speak at conferences.

Continuous Improvement

Continuous improvement presents the ongoing challenge of having to anticipate future improvement opportunities. Once identified through the Quality Planning Process, follow the same cycle of Plan-Do-Check-Act. This cycle can, and should, continue indefinitely, thereby ensuring that past improvements will be preserved and opportunities for future development will be identified.

Section IV

Consumer Feedback

Section IV

Consumer Feedback

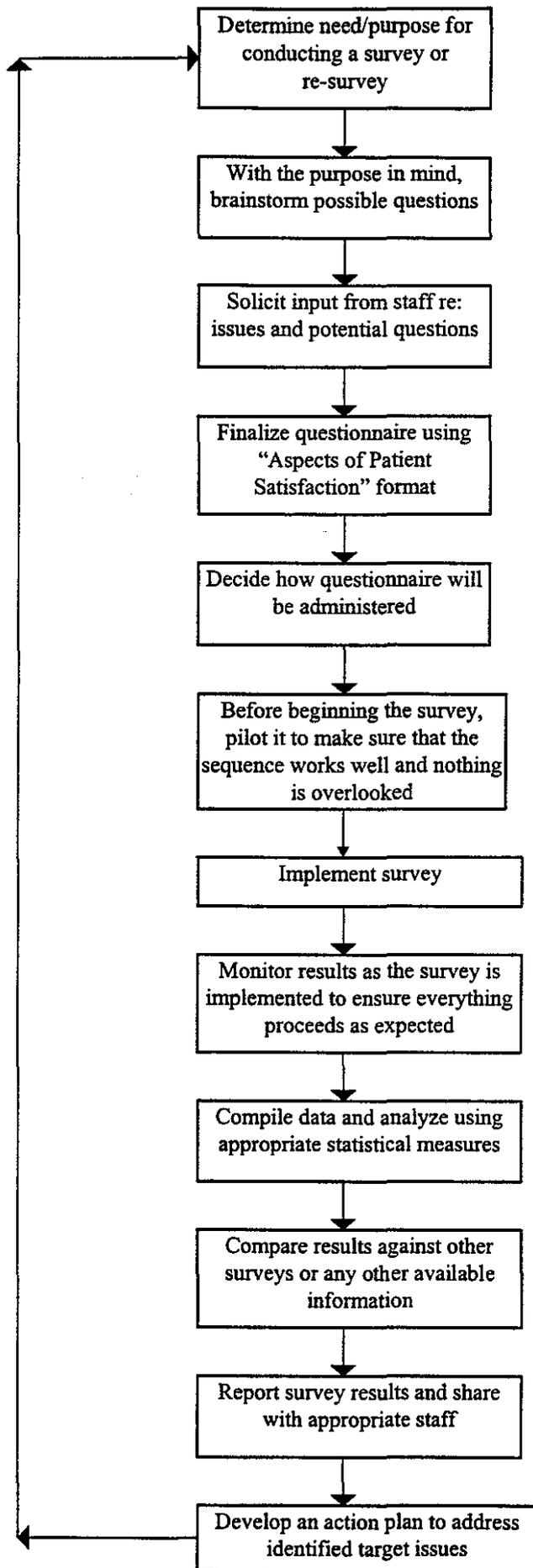
Introduction

The Health Care Corporation of St. John's believes that consumer feedback to health care personnel, programs, departments, professional practice groups, and services is very important. We encourage our consumers to share their compliments, concerns, and complaints with us, whether informally or formally. All staff should encourage consumers to provide feedback on their perceptions of the quality of service they are receiving. This feedback process helps ensure that the Health Care Corporation assists individuals and families in achieving the highest level of health possible.

In consultation with Program staff, a variety of mechanisms and initiatives will be developed to encourage consumers to provide feedback. The consumer satisfaction survey is one mechanism that has been used throughout Health Care Corporation sites. This may include mail out questionnaires, telephone surveys or in-person interviews.

This document provides guidelines for developing and administering a consumer satisfaction questionnaire, as well as guidelines on analyzing and acting on survey results.

The Survey Process



Guidelines for Conducting a Consumer Satisfaction Survey

The following sections discuss seven steps that should be considered when conducting a consumer satisfaction survey. These include:

1. Why do a consumer satisfaction survey?
2. Limitations of paper surveys.
3. How do we develop/write the questionnaire?
4. Should we pilot the questionnaire and/or method?
5. How do we conduct the survey (methodology)?
6. Considerations when analyzing results.
7. Communication and follow-up of survey results?

Why Do A Consumer Satisfaction Survey?

- To periodically evaluate how well your care/service meets consumers' needs.
- To periodically evaluate consumers' perceptions of the care/service they receive.
- To focus on a particular aspect of your care/service such as patient teaching, cafeteria service, etc: Does it meet the consumer's needs? How satisfied is the patient with this teaching?
- To provide every consumer with the opportunity to voluntarily give feedback.
- To determine success/effectiveness of planned change by re-surveying using the same tool.
- To form a database which you can use to improve care/service from the patient's/ consumer's perspective.

Your purpose for conducting the survey should determine your questionnaire content. Continue to evaluate the purpose until it is as specific as possible.

Limitations of Paper Surveys

- Often paper surveys have poor response rates, ranging from 25 to 60 percent. This means that there are a large number of non-respondents, which statistically creates real problems because those who do not respond tend to be skewed either for or against key elements in the questionnaire. One alternative to this would be to conduct in-person interviews or telephone surveys.

- Participants tend not to explain why they scored a particular question high or low. This results in minimal insight into how to improve the service.
- Paper surveys tend to be impersonal making it easy for respondents not to reply.

How Do We Develop/Write Questionnaires?

- First determine the general headings or key areas of focus for your survey.
- Key areas should be driven by your purpose for conducting the survey - i.e., what do you want to find out? (How satisfied are consumers with your care/service? or What is the demand for a specific service?)
- It should reflect your program's or department's principal function (i.e., measure satisfaction with counseling, teaching, admission, discharge, etc., as appropriate to the area involved).
- Review literature and other centers of excellence that may be willing to share their ideas with you.
- Front-line staff and consumers should be involved in developing the questionnaire. Staff and consumers who work closely with a process know best where problems are likely to occur and they may have insights about which questions to ask.
- Questionnaire should include questions about areas that are within your control to do something about.
- A preface or cover letter should accompany the questionnaire that thanks the patient for completing the questionnaire and encourages them to comment freely.
- Research has yet to confirm that shorter questionnaires lead to higher response rates. Generally, it is appropriate to ask more questions in a face to face survey compared to a telephone interview or a paper survey.
- Clear, visually appealing questionnaires (i.e. non-cluttered) are known to increase response rates.
- Vocabulary should be very simple and professional jargon should be avoided.
- A general readability level of grade 8 is desirable.

- Aspects of patient service that are known predictors of patient satisfaction have been established by research in the field. Health care institutions need to focus on the following aspects of care that are rate most critical patients.

Access - (i.e. waiting time to obtain an appointment, efficiency of the admitting procedure, preparation for admission).

Respect - (i.e. consideration of patient/family needs, involvement of patients in decision making around their own care, concern and care, respect for patient decisions, privacy, helpfulness).

Information/Communication/Education - (i.e. ease of getting information, instructions, timely discussions).

Physical Comfort - (i.e. restfulness, condition of room and hospital building, ease of finding location, signage, visitor arrangements).

Transition/Continuity - (i.e. discharge procedures, co-ordination of post-discharge care, liaison with community services).

Emotional Support - (i.e. sensitivity to problems, attention to patient's condition, availability).

Involvement Of Family & Friends - (i.e. attention to concern of family/friends, availability).

Coordination - (i.e., coordination of care and services though the continuum of care).

- When writing the questions, we recommend using “signpost”/“descriptor” formats (Nelson et al., 1991). The “Signpost” identifies the aspect of care/service you are asking the person to rate. The “Descriptor” then asks specific questions related to that aspect of care/service. For example:

Signpost - Access

Descriptor - How satisfied were you with the flow (efficiency) of the admitting process?

- In addition to the signpost/descriptor method of wording your questionnaire, you will need to consider other factors when writing your questions.

- The questions developed for a survey should be scaled. Questions which are scaled are statistically more powerful and offer a tremendous advantage for detecting shifts in opinion. We recommend that you use the following 5-point scale because we are able to interpret the results based on research that has been conducted.

Excellent, Very Good, Good, Fair, Poor, Don't Know/Doesn't Apply

For some items, other scales may be more appropriate:

- * **strongly agree, somewhat agree, somewhat disagree, strongly disagree**
- * **definitely would, probably would, probably would not, definitely would not, does not apply**

- Questions should be as specific as possible and support the purpose of conducting the survey. Some examples follow.

Respect - How satisfied were you with the politeness and approachability of staff for requests or questions?

Discharge: How satisfied were you with the instructions you received on discharge? Did the discharge instructions help you care for yourself at home?

- As well, open-ended questions can be used. Opportunities for patients to comment freely are one of the best reasons to use this type of question; we suggest that these be placed at the end of the questionnaire or at the end of a section. Some examples of this type of question follow

Needed Improvements - Please tell us what we can do to improve the quality of care and services that you received and do a better job of meeting your needs.

Good or Bad Surprises - Did anything good or bad happen during your stay that surprised you? If so, please tell us what it was.

- If you want to collect information about demographics or length of stay or referral source, etc., we recommend that choice boxes be outlined as this facilitates automated trending. For example: How long were you in hospital?

—	1 - 3 days
—	4 - 6 days
—	7 - 10 days

- Consideration should be given to the usefulness of any categories that you choose as well as the parameters (i.e., how will you use the information that a patient was hospitalized for three days to either interpret results or to change aspects of your service delivery?). ***Any question that will not add to either analysis or promoting improvement should not be asked.***

- You may leave a space for the responder to voluntarily include a name, address, and/or phone number. This allows for:
 - * follow-up in the event that a patient has a serious quality concern and you wish to collect more information about the issue;
 - * determining what can be done to improve satisfaction;
 - * letting the patient know that the criticism has been heard/acted upon.

Piloting the Questionnaire

- Pilot testing your tool is recommended.
- A trial or sample questionnaire can assist you with the following:
 - * How reasonable/feasible was your method?
 - * Were there any question(s) that respondents had difficulty interpreting?
 - * From the comments, are there any questions that you would like to consider adding/ deleting from your questionnaire?
 - * Do questions need to be modified to support the purpose of the survey?
 - * What length of time is needed to complete the survey?
 - * Determine if the method works: how manageable is the process, are you biasing the sample in any way, etc.
- Recommended sample size will depend on the sample size that you intend to survey, but generally 25 responses is sufficient to determine the effectiveness of your tools and to pick up any difficulties with the questions.

Conducting the Survey

Time and consideration must be given to many aspects beyond the actual questions themselves before the survey is conducted. These considerations may include:

- How much money is available to dedicate to the survey?
- Will you mail out survey, hand deliver, or telephone? What biases influence each type of data collection? What human resources will be needed to complete the survey?
- Will you follow up with a phone call or mail out to increase response rates?

Communication and Follow-Up Of Survey Results

- Follow-up is vital and must be led and supported by those responsible for conducting the survey.
- Check with immediate staff in the area being surveyed to see if the results make sense prior to communicating at large. This is especially important if there are major issues identified.
- If this is a repeat survey results should be compared to previous surveys to assess if efforts to improve service were successful.
- Complete a full report on the survey results prior to communicating specifics about one aspect. The report format may include:

Introduction - background information, previous surveys, purpose.

Methodology - how the survey was conducted, any problems encountered.

Method of Analysis - state statistical tests, what was considered a significant result, how was qualitative analysis of comments completed?

Characteristics of the Sample - record of demographic analysis.

Results - outline interpretation of data analysis, how comments/questions were grouped, list of significant results and themes, summary of each group of questions

Executive Summary - brief overview of survey listing areas of significant achievement, areas needing improvement, areas of most concern, recommendations for action plan.

- Share survey report with appropriate individuals within the area (i.e. staff, physicians, team leaders, volunteers).
- Arrive at consensus re: follow up action plan. Involve all key individuals who can contribute to this improvement process.
- Re-survey at a later time to assess changes/improvements in targeted areas.

Focus Group Guidelines

Preamble

A focus group is a data collection method, used to obtain the views and experiences of a group of people, who have come together under the guidance of a facilitator.

The intent is to produce qualitative data that provide insights into the attitudes, perceptions, and opinions of participants. The group is not intended to develop a consensus, but can generate a collective consciousness.

Qualitative research provides a tremendous depth of information as it is concerned with the thoughts and experiences of individuals. It is not a substitute for the more quantitative research, but is used to complement other quantitative and qualitative data collection methods.

Four Phases of a Focus Group Study

1. Conceptualize the study:
 - determine the purpose,
 - who will use the information,
 - what information is needed,
 - why is the information needed,
 - who will participate.
2. Prepare for the interview:
 - develop the questions,
 - learn interviewer skills,
 - select group participants,
 - select location and time,
 - determine equipment needed.
3. Conduct the interview:
 - keep the conversation flowing,
 - be informal,
 - encourage interaction,
 - make the experience pleasant.
4. Analyze data results:
 - target report to audience,
 - follow up report with action plan.

Advantages of Focus Groups

- Validation of information.
- Insight into attitudes and beliefs.
- Safe environment to share thoughts and beliefs.
- Cost-effectiveness (time and money).
- Clarification of questions and probing for deeper levels of information.
- Participant interaction uncovers information difficult to obtain in an individual interview.

Limitation of Focus Groups

- Groups are often difficult to assemble.
- Hypothesis cannot be tested.
- Number of questions answered is limited.
- Bias may be a problem (providing evidence to support pre-conceived ideas and/or misunderstanding of a statement, etc.).
- Group findings cannot be general as sample size of population is usually too small.
- Data transcription is often time consuming and difficult to analyze.

Composition of the Focus Group

The decision of whom to involve must be related to the purpose of the study:

- Six to twelve (6-12) participants are thought to be ideal for a focus group.
- Homogenous characteristics are sought in terms of occupation, social class, educational level, etc.
- A guiding principle of homogeneity is the degree to which characteristic factors will influence sharing within the group discussion.
- It may therefore be necessary to conduct more group sessions with a smaller number of homogenous participants in each.
- In confirmatory studies, it is important to draw conclusions, thus a larger group is preferable.
- One to one and half-hour (1-1½) group sessions are recommended.

Identification of Participants

The participants must give informed consent and they must be aware before the session that an audio tape recording will be made. Their individual contributions must remain confidential and anonymous.

The most commonly used procedures in the identification of participants include using existing lists of clients, members, or those who regularly use the services of the organization.

- **systematic sample** - e.g., if ten names are needed from a list of one hundred persons, each tenth person is selected from the list
- **random sample** - e.g., draw names or numbers, or use a random number table to select from a list of one hundred names.

How to Develop Questions

Quality questions require reflection and feedback from others. Remember the purpose of the focus group:

- Identify potential questions (areas of concern).
- Brainstorm with information users, colleagues, etc.
- Include all questions of interest but focus on the important issues.
- Highlight critical questions to ask in a focus group.
- Six to ten (6-10) questions can be asked in a session, but often fewer are realized.

Attendance at Focus Groups

- Establish a meeting time.
- Non-threatening environment.
- Contact potential participants via phone 14-21 days before the meeting.
- Send an invitation one-week before the session.
- Phone each person one to two (1-2) days before the meeting.

Focus Group Facilitator

- Develop range of potential open-ended questions.
- Knowledge of small group dynamics.
- Provide ground rules and set the tone for discussion.
- Guide the discussion through the scheduled meeting.
- Create thoughtful, permissive discussion atmosphere.
- Don't be defensive about opinions generated.
- Encourage participation of all group members.
- Ensure persuasive participants do not dominate.
- Write only brief comments by participants.

Data Analysis

- Remember the purpose of the study.
- Attend specifically to group interaction and uncover meaning at the group level (responses that are specific and are based on experiences).
- Arrange ideas and phrases into categories and themes.
- Consider the energy level or enthusiasm of the group.
- Degree of spontaneity and extent of participation involvement.
- Systematic - prescribed and sequential process.
- Verifiable - a process that would allow another person to arrive at similar conclusions.
- Deliberate process of examining, categorizing, and tabulating evidence.

Follow Up

- Provide a written report outlining:
 - * background and objectives,
 - * methodology,
 - * summary and considerations,
 - * highlights of findings.
- Share report with appropriate stakeholders and participants.
- Develop action plan of “where to from here?”

What The Consumer Feedback Committee Can Do To Help

- We are available to support, assist and/or advise at any stage of your survey or focus group process.
- We can provide samples of questionnaire “tools” which may be helpful in developing or formatting your survey for clear and visually appealing styles.
- We can give advice on securing stamped, self-addressed envelopes which patients can use to return their questionnaires.
- We can assist you to trend/analyze the results and prepare your results for presentation.
- We will keep a central log of all surveys conducted at Corporation sites.

Section V

Frequently Asked Questions

Glossary

Section V

Frequently Asked Question

What does the Quality Initiatives Department do?

The Department of Quality Initiatives exists to provide leadership and support to all Programs and Departments of the Corporation in their efforts to continually improve the quality of care and service delivered. The main areas of focus are Risk Management, Utilization Management, Consumer Feedback, Performance Measurement, and Outcome Evaluation. As well, the Department provides an assortment of educational sessions to support these activities.

Whom do I call in Quality Initiatives if I have a question or have an idea?

Each of the managerial staff in the Quality Initiatives Department is linked with specific Programs/Departments. A listing of current linkages and the telephone numbers is appended to this document (Appendix F). All staff has voice mail and e-mail access. Facilitators carry beepers.

Why is there such an emphasis on quality in the organisation?

In the present climate of change and restructuring, quality and resource management are primary focuses. We are increasingly accountable for the public funds we use. We are entrusted with the responsibility to do the best we can within the allocated resources. We must demonstrate that the choices we make in terms of the standards of care and/or the services provided are the best ones for the health of those we serve given our fiscal realities. Providing quality care and service is critical if we are to become an organisation that is truly responsive to the needs of the patients and other consumers we serve.

How is Quality Improvement different from Quality Assurance?

Often these terms are used interchangeably in health care. Traditionally, Quality Assurance was the term used in the mid 1980's to describe a very structured method of evaluation. The Quality Assurance approach was designed to evaluate designated structures or processes within a department or division. Evaluation was generally limited to a range of pre-set questionnaires that repeatedly addressed an identified area of performance or compliance to a standard. It had as its basis the notion that if the policies and processes were in place, then the end result (outcome) had to be of a high quality. Audits were often organizationally focused rather than consumer focused.

Quality Improvement (sometimes referred to as Total Quality Management or Continuous Quality Improvement) is an approach to quality that moves from a focus on the structures or processes in the organization to include the outcomes to the patient or person served. It is a philosophy and system that involves all staff and health care professionals in the continuous improvement of work processes to achieve better outcomes of patient/client/resident care. It involves applying statistical methods and group process tools to reduce waste, duplication and unnecessary complexity in work. The goal is to consistently meet or exceed the needs of patients, families, staff, other health professionals, and the community. The focus of Quality Improvement is on high volume, high risk, problem prone, and high cost components of our work and uses the eight dimensions of quality as a framework for evaluation.

Do we still need to do audits any more?

Various methods are used to gather data to support the quality review processes. Many of the tools that were used in the past, such as audits, are still very useful and will continue. Audits are regular checks and balances that are good methods to retrospectively ensure that standards and policies are being followed. Audits are particularly important to assure stakeholders that there is compliance with established procedures such as charting standards, safety checks, or inventory systems.

What is the relation between Accreditation and Quality Improvement?

The Health Care Corporation of St. John's, as an organization, is accredited through the Canadian Council of Health Services Accreditation (CCHSA). Most of the benefit gained through the Accreditation process is actually not when the surveyors come to our organization but rather the detailed self-assessment conducted during the months leading up to the survey and the re-evaluation following the survey itself. During this process we identify our strengths and opportunities for improvement and put the wheels in motion to address the improvement areas.

CCHSA standards support the concepts of patient/client focused care in a process of continuous quality improvement.

Other accreditation processes take place throughout the organization which are specific to a particular department or discipline.

What is "evidence or research based practice"?

Evidence based practice is not a new concept. Defined simply, it means planning and delivering the most appropriate and effective care to the patient based on the best research and practices known. Without question, patients want the best possible care, and caregivers want to provide it.

Evidence or research-based practice is not limited to clinical care and patient activity. Services, products, technologies, and processes that are offered within the Corporation must also be evidence based. Activities must be continually evaluated to ensure they are both appropriate and effective. Those that are high risk, high volume, patient centered or problem prone should receive priority.

Research is growing in many traditional and non-traditional areas of health care delivery. New findings continue to challenge our thinking, forcing us to reflect on the job we do and how we do it. The difficult shift usually comes when we question long-standing practices as the change process is often uncomfortable and stressful. There are many questions: Is the research really right? Will it work here? Why change something if it is working? Realize though that uncertainty is healthy as it will ensure close evaluation accompanies any shift in practice.

How can we involve staff?

Quality will only occur if all people involved (patient, staff, families) work together. On a daily basis all staff must continue to ask themselves:

- Is this task necessary?
- Am I doing the right things right?
- Am I adhering to the standards of my profession and those of the organization?
- Am I treating this person the way I would want myself or someone I care about to be treated?
- Is there a better way to do this task/job?

Staff must be involved in evaluation studies, audits, consumer feedback surveys, policy revisions, literature review, and research of best practices. They should be invited to participate on Program/Departmental/unit committees and be encouraged to voice their ideas and observations on opportunities to improve, participate on the quality improvement teams, become a staff representative on the Internal Advisory Committee or the forum within the Program/Department to address the quality issues. All Programs/Departments should have some committee forum that serves as its Quality Committee. Summary reports reflecting the Program and Department progress should be available to all staff. A consistent format for reporting is encouraged.

Glossary

Sentinel Indicator

Measures serious events that require investigation each time they occur (example: reportable deaths, information system crashes, criminal activity).

Rate Based Indicator

Used to trend information of similarly related activities. They are referenced to a population or in some other way and require a numerator and a denominator (example: cost per fte, patient falls per 1000 patient days).

Threshold

The acceptable range within which results are deemed acceptable.

Structural Indicators

Measures the type and amount of resources used to deliver programs and services (example: Accreditation rating, staffing level, beds, supplies).

Process Indicator

Measures performance activity (example: waiting list).

Outcome Indicator

Measures results or consequences of care or service (example: complications, quality of life, pain control, satisfaction, survival rates). In a non-clinical context, it measures the desired end result of the process (example: turn around time, staff satisfaction). Turn around time is also used clinically in areas such as diagnostic areas and operating rooms.

Proximal & Ultimate Outcome Indicator

Proximal - end results in phases of care (example: correct CBC lab results reported within acceptable time frame).

Ultimate - appropriate subsequent care based on knowledge of the CBC result.

Service Indicators

"Hotel" ratings such as comfort, satisfaction, waiting time, speed of discharge.

Appropriateness Indicators

Measures "too much", "too little", C-section rates, CABG rates, trends in diagnostic testing.

Effectiveness Indicators

Mortality, morbidity, readmission rates, return to OR, return to Emergency, complication rates, infection rates, pain control, coping, stress and adaptation to illness, return to work, activities of daily living, quality of life.

Access Indicators

Waiting lists - time and volume.

Efficiency Indicators

Cost per weighted case, average length of stay (LOS), % Day Surgery Rates, (resource use and cost), % alternate level of care days, may not require hospitalization (MNRH) cases.

Practice Guideline

Specific, recommended course of action for typical patients under typical circumstances. Practice guidelines are founded on research based best practice.

Appendices

Appendix A
Internal Reporting Policy

Administrative Policy Manual

Section:	Administration	Number:	III - 100
Policy Title:	Internal Reporting - Corporate Committees	Date:	(O) 20-02-1998 (R)
Issuing Authority:	Vice President	Page:	1 of 2

Policy:

All Corporate Committees shall identify (in their Terms of Reference) a line of accountability to a Vice President most responsible for the committee's activities, or a Senior Committee within the Health Care Corporation of St. John's such as Corporate Team or Medical Advisory Committee. The format for developing Terms of Reference shall be adopted from the terms of reference of Board Committees.

Guidelines:

Terms of Reference

All Committees shall have a terms of reference approved by the membership of the Committee which includes purpose, responsibilities, membership, reporting, accountabilities, quorum, voting, meetings, and evaluation format. Key linkages can also be identified.

Standing Committees

1. All Corporate Committees will forward copies of minutes to the Vice President or Senior Committee to whom it reports.
2. Recommendations needing approval should be submitted to the Vice President or Senior Committee to whom it reports. The recommendations must be identified in a letter of attachment indicating rationale, background of issue (if necessary), cost implications, benefits to Health Care Corporation, and anticipated implementation plan.
3. The Vice President or Senior Committee will respond to the recommendations in a timely fashion.

Policy Title:	Internal Reporting - Corporate Committees	Number:	III - 100
		Page:	2 of 2

4. All Corporate Committees shall submit, by May of each year, an annual report to the Vice President or Senior Committee to whom it reports. The report shall highlight their accomplishments, goals and objectives for the following year, and details regarding significant issues the Committee is facing.

Ad-hoc Committees

1. Ad hoc and subcommittees may be struck from time to time by the Corporate Committee with recommendations made to appropriate leadership group.

Administrative Policy Manual

Section:	Administration	Number:	III - 105
Policy Title:	Internal Reporting - Departments, Programs, Professional Practice	Date:	(O) 03-10-1997 (R)
Issuing Authority:	Vice President	Page:	1 of 2

Policy:

All Program, Department and Professional Practice Leadership Teams will submit written reports summarizing their Departments/Programs/Professional Practice activities according to the Guidelines for Internal Reporting.

Guidelines:

Internal Reporting

1. **Quarterly:** All Department Directors, Program Leadership Teams and Professional Practice Co-ordinators will prepare and submit to their respective Vice President a quarterly report summarizing key activities, progress on major initiatives, summary of quarterly indicators, and significant quality or resource/financial issues.

2. **Annual Report - Fiscal Year End:** All Department Directors, Program Leadership Teams and Professional Practice Co-ordinators will prepare and submit to the Chief Executive Officer an annual report by the end of May using a recommended template approved and circulated annually. A copy of the report will also be submitted to the respective Vice President. This report will detail accomplishments made during the year, revised Key Directions for the next fiscal year, summary of quality of care and service issues, annual summary of key indicators/benchmarks and explanation of variances. Professional Practice Co-ordinators' reports may vary from this framework and will reflect on achievements within the Professional Practice Model. A Corporate Annual Report will be prepared by the Chief Executive Officer based on the summary reports of all Programs and Departments.

Policy Title:	Internal Reporting - Departments, Programs, Professional Practice	Number: III - 105
		Page: 2 of 3

A copy of the Annual Report will be made available to the staff in the respective Program/ Department/Professional Practice Group.

3. Annual Report to Corporate Quality Initiatives

Committee: Each Program/Department is required to report at least annually to Corporate Team in its capacity as the Corporate Quality Committee as determined by an established schedule that will be circulated by Corporate Team annually. This report should summarize the previous four quarters (12 months) of activities and use the same format as the quarterly and annual reports. Programs/Departments may be asked to report more frequently at the request of the Chair.

The respective Vice President will follow-up on behalf of the Committee responding in writing to the written submission identifying areas for commendations, recommendations, or seeking clarification or follow-up.

4. Reporting to the Board: Annual reports will be presented to the Board Quality Initiatives Committee following review by the Corporate Quality Initiatives Committee. Representatives of Programs/Departments may be given the opportunity to attend Board meeting to address highlights of the report. Board Quality Initiatives Committee will report at least bimonthly to the Board of Trustees.

The Chairperson of the Board Quality Committee will respond in writing to all written submissions to the Board Quality Committee identifying areas for commendation, recommendations, or seeking clarification or follow-up.

5. Reporting to Senior Advisory Committee: Corporate-wide aggregate indicators will be presented to Senior Advisory Committee quarterly. Details of operational issues will not be addressed at this forum. Specific departmental or program information will not be required, however, Departments that work with organizational information may be asked to prepare such Corporate-wide reports.

Policy Title:	Internal Reporting - Departments, Programs, Professional Practice	Number:	III - 105
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6. All Programs, Departments and Professional Practice Co-ordinators should establish a mechanism to ensure regular reporting within their scope of accountability, e.g. Internal Advisory Committees.

Appendix B
Reporting Format

Quality Initiatives Report/Annual Report

Program or Department

Period - 4 previous quarters summary or annual fiscal report

Overview of Program

A short description of the program, mandate, organizational chart, differences from previous set up, linkages, formation of internal and external advisory committees.

Achievements

An overview of what has been accomplished during the past.

Objectives

An overview of objectives/key directions for this year.

Reviews

An overview of any internal or external reviews, accreditation recommendations, evaluations or audits. A summary on recommendations and action to date.

Consumer Feedback

A summary of any consumer feedback, solicited or unsolicited, complaints, compliments, external advisory.

Quality of Care Issues

A summary of any risk issues, utilization, outcomes, etc.

Education/Research/QI Teams

A summary of any education/research projects or QI teams program staff were involved with.

DRAFT

INDICATORS

8 Dimensions of Quality (Indicators)	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Comparison	Benchmark
Safety						
Appropriateness						
Continuity						
Effectiveness						
Acceptability						
Competency						

8 Dimensions of Quality (Indicators)	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Comparison	Benchmark
Accessibility						
Efficiency						

Discuss significant variances and action plan from above indicators.

Signatures

Director

Clinical Chief



**Department/Program - Strategic Directions
(Sample Template)**

**Period Plan Will Cover _____
(Can also be used by Division/Care Team/Committee)**

Strategic Direction	Key Direction	Strategy/Accountability Time Lines	Evaluation/Progress

Appendix D
Developing Indicators

Quality Indicators

In recent years, leading health care organizations have pioneered the development of indicators and performance measures as a means of reporting the quality of the care and services provided, including efficiency of resource utilization, risk management profile, and clinical outcomes. This approach specifically entails the identification of key indicators for the programs and for the organization as a whole. This brief summary provides an overview of indicator development. It also includes some examples under each of the eight dimensions in the quality framework. Goals and objectives are developed in line with the Strategic Direction of the Organization. Indicators are needed to measure performance in achieving the goals and objectives. A worksheet for indicator development is provided.

Types of Indicators

There are two main types of indicators: (see glossary, page 46)

- Sentinel
- Rate Based

What they Measure

Indicators typically measure the structure, process or outcomes of the Program/Department

- **Structure indicators** measure resource and/or facility inputs (for example, staffing mix, equipment).
- **Process indicators** gauge how the resources are used and the efficiency of the processes in place (for example, the percentage occupancy of nursing units, workload units per full-time-equivalent, response time for a request for service).
- **Outcome measures** have been the least developed of the indicators; however, in an organization with a customer/patient focus, the outcome measures are of paramount importance. Current outcome measures can include: the mortality rate per case-mix-group, health status measures and consumer/patient satisfaction.

Desirable Characteristics of Indicators

Indicator development is a common sense approach to identifying what is important. Ideally, the indicators chosen will be the product of a multi-disciplinary effort that involves staff and physicians at all levels within a Program/Department. More specifically, the indicators should:

- measure the target objective or mandate of Program/Department.
- not duplicate the measurement of another indicator.
- as much as possible, be unaffected by other variables.
- be focused on issues over which you have some control and accountability- i.e. those you can change or correct.
- be available without major cost or effort - information is never free and the cost/utility balance must always be weighed.

Pitfalls

In the process of developing and using indicators, there are a number of common errors made.

- **Focusing on the indicator itself** - It is important to focus on the performance that is being measured, not the measurement itself.
- **Ignoring outside influences** - Indicators that are beyond the control of the Program/ Department or are heavily influenced by external factors may be interesting but are of little value. Clearly, the Program/Department should focus on those areas that it can correct and improve.
- **More than one indicator measuring the same thing** - Many indicators can measure the same objective. Choose the best one(s). Indicators that focus on issues that are high cost, high volumes and/or problem-prone in nature should be preferred.
- **Ulterior motives** - The identification of indicators may reflect agendas other than quality improvement. The pursuit of continuous quality improvement should be central to the process.
- **Too many indicators** - The objective is to limit the first scan of information to a reasonable level. More reliable measurement can be achieved by using more indicators, however, there is always a tradeoff between the cost and effort to get information and the real use of it in the end. A smaller number of indicators that are meaningful and useful are much better than a large list that is seldom reviewed.

Examples of Indicators

To illustrate the process, a number of examples are provided using the eight dimensions of quality used as a framework in the Corporation (Appendix G).

Revision

Indicators are not meant to be “cast in stone”. Each Program/Department should periodically review the indicators used to ensure their value. Similarly, if the goals and objectives of the Program/Department change, the indicator structure must be reviewed and modified.

Appendix E
Quality Improvement Tools

Quality Improvement Tools - A Brief Review

Brainstorming

Primary function - idea-generating technique for groups.

Fundamental Rules

- Offer one thought at a time.
- The more ideas the better.
- Don't criticize ideas.
- Don't discuss ideas.
- Build on each other's ideas.
- Let there be some silence or reflection time before completing.

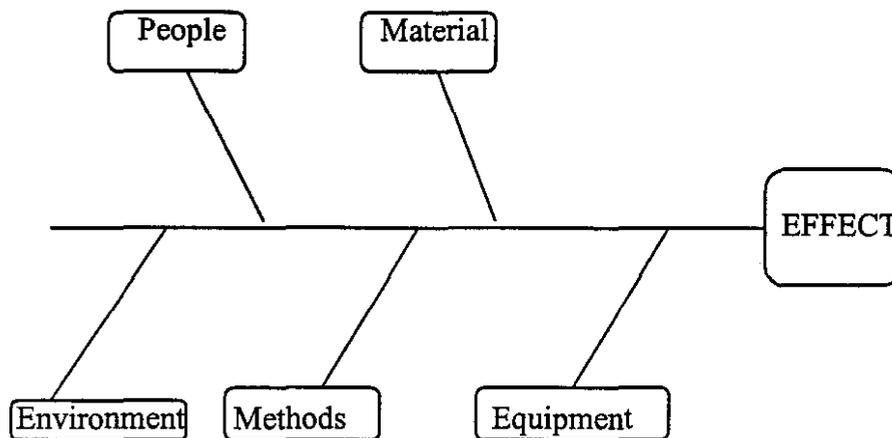
Steps

1. The central brainstorming question is stated, agreed on, and written down for everyone to see.
2. Allow silent time to think.
3. Each team member, in turn, gives an idea. No idea is criticized. Ever!
4. As ideas are generated, write each one in large, visible letters on a flip chart or other writing surface.
5. Ideas are generated in turn until each person passes, indicating that the ideas (or members) are exhausted.
6. Review the written list for clarity and to discard any duplicates.

Cause & Effect

Primary function - to determine contributing factors to a problem

Use this tool to identify, explore, and graphically display, in increasing detail, all of the possible causes related to a problem or condition to discover its root cause(s).



Steps To Develop a Cause & Effect Diagram

1. Write the specific problem in the EFFECT box.
2. Specify the major categories of possible causes (people, material, environment, methods, equipment).
3. Brainstorm the likely causes and list on branching lines.
4. Keep asking “WHY” (at least 5 times) to identify the root cause.
5. Use the checklist listed below to determine if complete.
6. Vote and rank order the most likely causes.

Tips For Success

- There is no right answer.
- Do not argue over potential causes.
- Get as much detail on the categories as possible.
- Get the team to agree on root causes.

Cause & Effect Diagram Checklist

1. Is the effect (problem) correctly stated, including being observable and measurable?
2. Have you listed all the potential causes that the group can think of at this time?
3. Are all the brainstormed causes categorized?

4. Do the causes reflect problems to be investigated versus solutions?
5. Does each cause possibly contribute in some way to the problem?
6. Is the diagram complete and understandable?

Check Sheets

Primary function - to collect data.

Check sheets allow a team to systematically record and compile data from historical sources, or observations as they happen, so that patterns and trends can be clearly detected and shown.

How To Develop a Check Sheet

1. Agree on the definition of the events or conditions being observed. For example, if you are tracking the reason for waiting times, everyone must agree on the list of reasons and what each means.
2. Decide who will collect the data, over what period of time, and from what sources.
3. Design a check sheet form that is clear, complete, and easy to use.
4. Collect the data consistently and accurately.

Example

Reason for Patients Being Ordered a Late Tray

Reason:	March 1	March 2	March 3	Total
Diet changed	IIIIII	IIIIII	IIII	16
Didn't like meal	II	-	I	3
Wrong diet delivered	IIII	II	II	8
Diet order not entered in computer	IIIIIIII	IIIIII	IIIIII	23
Patient in Emergency	IIIIII	IIIIIIIIII	IIIIIIII	27
TOTAL	27	27	23	77

Flow Charts

Primary function - to look at a process

Flow charts are used to allow a team to identify the actual flow or sequence of events in a process that any product or service follows. Flow charts can be applied to anything from the travels of an invoice or the episode of patient care during an admission.

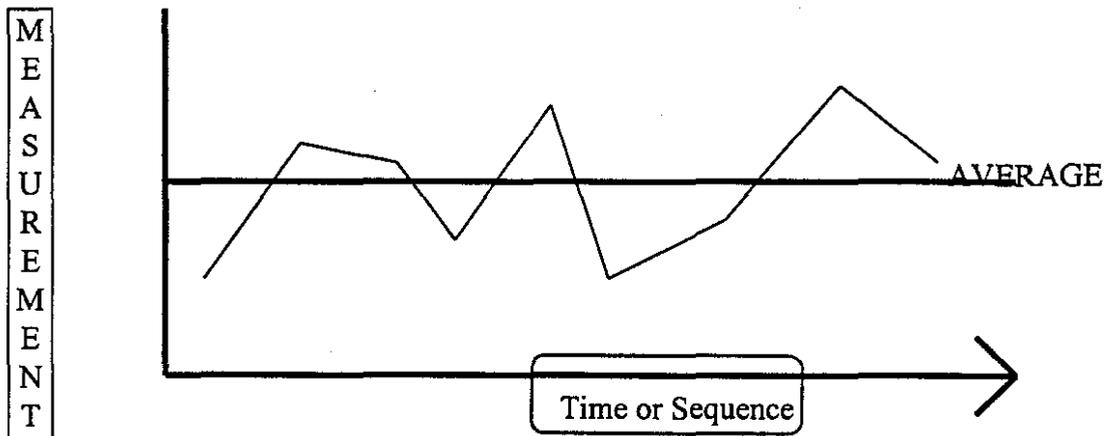
What Flow Charts Can Do

- Shows unexpected complexity, problem areas, redundancy, unnecessary loops, and where simplification and standardization may be possible.
- Compares and contrasts the actual versus the ideal flow of a process to identify improvement opportunities.
- Allows a team to come to agreement on the steps of the process and to examine which activities may impact the process performance.

Run Charts

Primary function - to look at what has happened over time

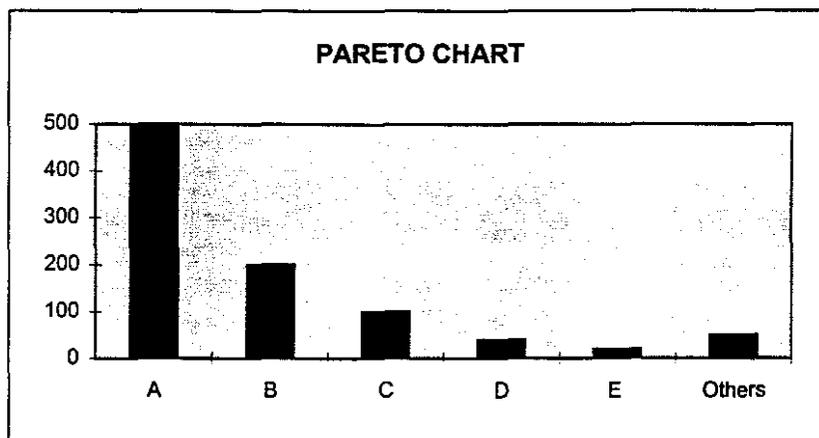
Run charts are used to visually present data and are effective in showing variation from the average over a time span. Some variation should be expected with points above and below the average. From a statistical perspective, if the average is valid, there should be roughly the same number of points above and below the line over time. If you are observing a predominance of data above or below the average or expected value, you are likely seeing a variation that is significant. Further evidence of change or variation can be inferred if six or more points in a row are on one side of the average. Either result on a run chart would cause you to do further investigation.



Pareto Charts

Primary function - to determine the most common problems

Pareto Charts are used when you need to display the relative importance of all the problems, issues or conditions identified. You can often use the results to choose the starting point for problem solving, to select an issue for action or to identify the basic cause for a problem. Pareto's Law generally holds true - i.e. that 80% of the problems, issues, successes, etc. arise from 20% of the underlying causes. In other words, if you can identify and change the important 20% of your work, you can effect change over 80% of the results. Pareto Charts are used to help identify the key 20% percent of activities.

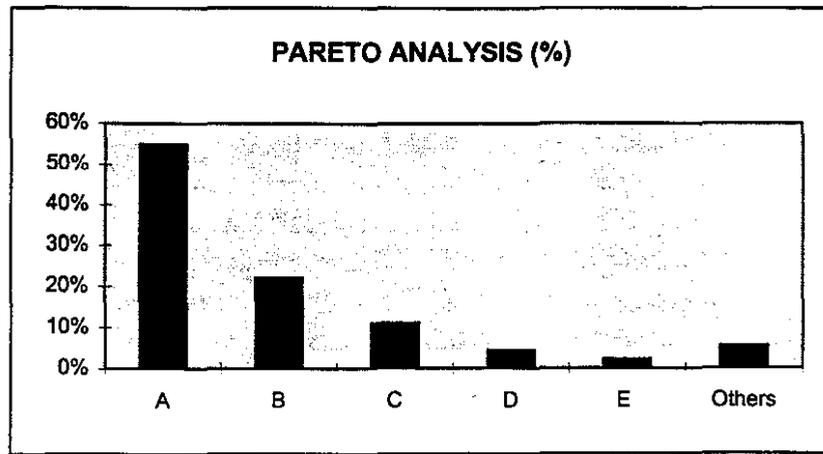


Based on this chart, problem A would be the first to be considered.

Key Steps In Constructing a Pareto Chart

- Selecting the problems to be charted;
- Selecting the measurement - e.g., frequency, cost;
- Gathering the data;
- Graphing the data in decreasing order.

It is not unusual to group the results on a percentage basis. Using the data above, the results would look like the following chart:

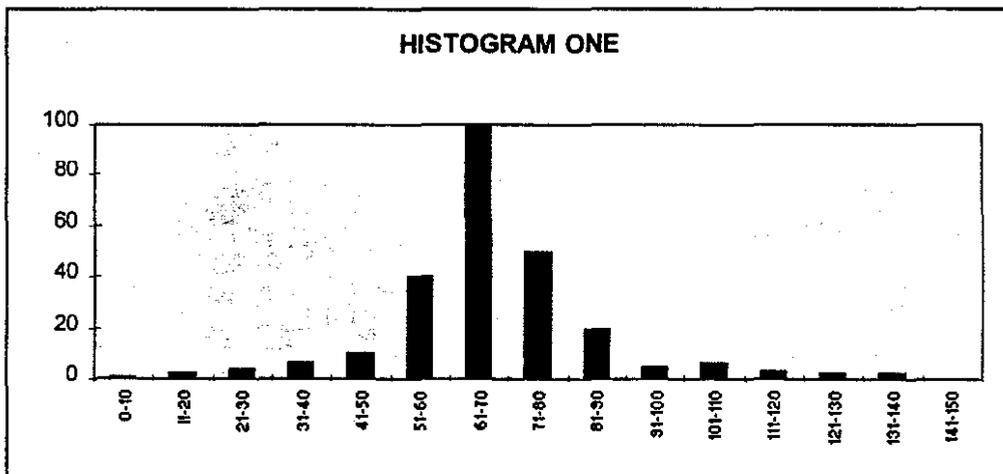


Collectively, problems A and B account for about 80% of the overall concerns.

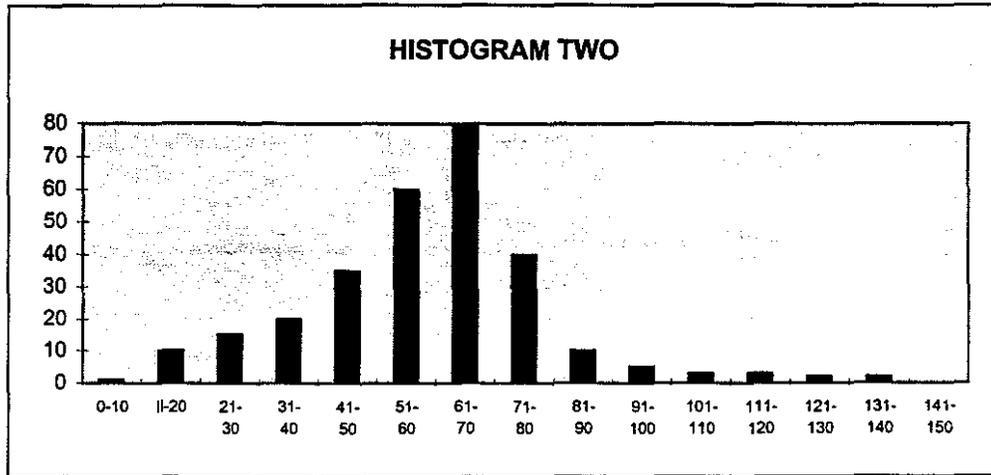
Distribution Graphs

Primary function - to look at the frequency of problems occurring

Two common types of graphs are used to show the distribution of data. Histograms are bar graphs with a linear scale on the horizontal axis. The degree that the data cluster around the average is a measure of the overall variability and the symmetry shows whether the data is skewed.



This distribution shows little variation around the average and is not skewed.

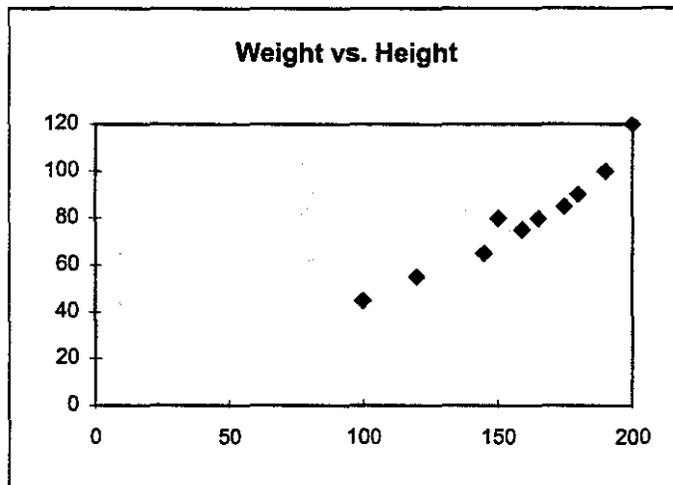


Histogram Two shows that the data are not as tightly clustered around the average and that there is a definite skew to the left. In interpreting the results, you compare the histogram to the kind of pattern you would expect with optimal performance. The expected pattern can be a normal shape such as Histogram One or skewed such as in Histogram Two.

Scatter Diagrams

Primary function - to look at cause and effect relationships

Scatter Diagrams are used to explore cause and effect relationship. For example, you might want to consider that height has a relationship with weight. Plotting one against the other would produce a scatter plot such as:



In a scatter plot, tightness of the cluster of points is a measure of the closeness of the relationship between the variables. This type of graphic can be useful in exploring cause for problems.

Appendix F

Linkages

Quality Initiatives Department Program/Department Linkages

Sharon Smith (Director)	Joan Crawley (QI Facilitator)	Bonnie Donovan (QI Facilitator)	Nancy Parsons (QI Facilitator)	Heather Predham (Risk Manager)	Karen Abbott (Utilization Mgr.)
Emergency School of Nursing HR Pol.&Emp. Rel. HR Dev. & Plan. Infection Control Quality Initiatives Board of Trustees Corporate Team - Internal Auditor Medical Advisory PPC - Nursing	Critical Care Cardiac Care Perioperative Surgery Child Health Pharmacy PPC - Respiratory PPC - Nursing	Ambulatory Care Central Laundry Continuing Care Seniors' Care Rehabilitation Women's Health Admitting/Registral. Audiology Food Services PPC - Clin.Nutrition PPC - Physiotherapy PPC - Speech Ther. PPC - Occup. Ther.	Medicine Palliative Care Laboratory Walter Templeman Communications Pastoral Care Diagnostic PPC - Social Work PPC - Rec. Ther. PPC - Psychology Housekeeping	Facilities Mgmt. Finance Health Records Materiels Mgmt. Mental Health	Budgeting Information Systems Mgmt. Engineering
	Site Linkage: Janeway General	Site Linkage: Grace Miller Centre	Site Linkage: St.Clare's Bell Island	Site Linkages: Waterford	

Revised: September 14, 1998

Appendix G
Examples of Indicators

Discussion Document for Information Management - Draft for Review

Quality Dimension	Information Required	Source	Technology	Availability	Program/Dept. Basis
CONTINUITY INDICATORS					
% Medically Discharged Days	Number of medically discharged days	Health Records, Quality Initiatives Admitting/Registration (possible)	Meditech, manual	Quarterly with delay	NO
% ALC Days	Number of ALC days	Health Records	Meditech, manual	Monthly, Daily Monthly	NO
% Referred to Comm. Health	Number of referrals to Community Health	Community Health, Referral staff Health Records	Meditech, manual	Monthly, Quarterly with delay	NO
Program/Dept. Specific Indicators	To be determined	To be determined	To be determined	To be determined	UNKNOWN
EFFECTIVENESS INDICATORS					
Readmission Rate (same or related diagnosis)	Number of readmissions for same or related diagnosis	Health Records	Meditech, manual	Monthly	NO
Infection Rate	Number of Infections (Class 1, 2, 3)	Infection Control Service	Manual	Monthly	NO
Mortality rate by CMG	Number of deaths by CMG or procedure	Health Records	Meditech, manual	Quarterly with delay	NO
Repeat Procedure Rate	Number of total and repeat procedures	Health Records	Meditech, manual	Monthly	NO
Related Complication Rate	Number of complications	Health Records	Meditech, manual	Monthly	NO
Program/Dept. Specific Indicators	To be determined	To be determined	To be determined	To be determined	UNKNOWN
ACCEPTABILITY INDICATORS					
% Patients Satisfied	Patient satisfaction surveys	Quality Initiatives	PC, manual	Quarterly	YES
Complaints/Compliments	Number of complaints/compliments	Multiple Sources	PC, manual	Quarterly	NO
Program/Dept. Specific Indicators	To be determined	To be determined	To be determined	To be determined	UNKNOWN

Discussion Document for Information Management - Draft for Review

Quality Dimension	Information Required	Source	Technology	Availability	Program/Dept. Basis
SAFETY INDICATORS					
Occurrences (rates)	Number of occurrences	Quality Initiatives	MS Access database	Monthly	YES
Legal claims (rates)	Number of legal claims	Quality Initiatives	MS Access database	Monthly	YES
Staff injuries/incidents (rates)	Number of staff injuries/incidents	HR - Policy & Employee Relations	Manual	Monthly	NO
WCC claims (rates)	Number of WCC claims	HR - Policy & Employee Relations	Manual	Monthly	NO
Complaints (rates)	Number of significant staff complaints	Multiple sources	Manual	Monthly	NO
Staff infection rates	Number of staff infections	Staff Health	Manual	Monthly	NO
Program/Dept. Specific Indicators	To be determined	To be determined	To be determined	To be determined	UNKNOWN
APPROPRIATENESS INDICATORS					
% Potentially ambulatory	Number of procedures potentially ambulatory	Health Records	Manual	Quarterly with delay	NO
% MNRH	Number of admissions not requiring hospital	Health Records	Manual	Quarterly with delay	NO
Skill mix	Number of FTE's of different providers	Payroll system	Meditech multiple	Monthly	NO
Program/Dept. Specific Indicators (e.g.)	To be determined	To be determined	To be determined	To be determined	UNKNOWN
% Using clinical guidelines	Number of patients using clinical guidelines	Multiple sources	Manual	Quarterly	NO
Antibiotic use	Number of appropriate antibiotic scripts	Pharmacy	Meditech & manual	Monthly	NO
% Using screening tools	Number of patients using screening tools	Multiple sources	PC and manual	Quarterly	NO

Quality Initiatives Department - January 1997

Discussion Document for Information Management - Draft for Review

Quality Dimension	Information Required	Source	Technology	Availability	Program/Dept. Basis
COMPETENCY INDICATORS					
% Performance Appraisals	Number of staff and performance appraisals completed	Payroll system, program and department records	Meditech, manual	Biweekly and unknown	NO
% Staff Credentialed	Number of staff requiring credentialing and number credentialed	Payroll system, program and department records	Meditech, manual	Biweekly and unknown	NO
% Certification Maintained	Number of staff requiring certification and number certified	Payroll system, program and department records	Meditech, manual	Biweekly and unknown	NO
Program/Dept. Specific Indicators	To be determined	To be determined	To be determined	To be determined	UNKNOWN
ACCESSIBILITY INDICATORS					
Rate of referrals	Number of referrals	Health Records, DOH and Others	PC, Meditech & manual	Quarterly	NO
Waiting list/time	Number of patients on list & time waited	Multiple sources	PC, Meditech & manual	Monthly	NO
Program/Dept. Specific Indicators	To be determined	To be determined	To be determined	To be determined	UNKNOWN

Discussion Document for Information Management - Draft for Review

Quality Dimension	Information Required	Source	Technology	Availability	Program/Dept. Basis
EFFICIENCY INDICATORS					
Cost per FTE	Payroll and benefit costs, Number of FTE's	Payroll System, General Ledger	Meditech	Monthly	NO
Units of service per UP FTE	Workload hours (or other Units)	Lab, Diag Imaging, Many sources	PC, Manual, Meditech	Daily to unknown	NO
% Budget variance	YTD and Monthly Budget/Actual Costs	General Ledger	Meditech	Monthly	INCOMPLETE
% Budget by category	Salary,benefit,M/S Supp,Drugs,Other Supp \$	General Ledger	Meditech	Monthly	INCOMPLETE
Worked/Paid Hour ratio	Worked hours, Paid Hours	Payroll System	Meditech	Biweekly	NO
WCC Days/FTE	Number of WCC Days	Payroll System	Meditech	Biweekly	NO
Sick Leave Days per FTE	Number of Sick Days	Payroll System	Meditech	Biweekly	NO
% Overtime & Callback	Overtime and Callback costs	Payroll System	Meditech	Biweekly	NO
Cost per Discharge	Inpatient Costs, Number of Discharges	General Ledger, Health Records Admitting/Registration	Meditech	Costs monthly Discharges daily	INCOMPLETE
Cost per Census Day	Number of Census Days	Admitting/Registration	Meditech	Daily	INCOMPLETE
Cost per Patient Encounter (Ambulatory)	Ambulatory Costs, Number of Encounters	Admitting/Registration Many sources	PC, Meditech, Manual	Daily to unknown	NO
% Occupancy	Average number of beds staffed/in operation	Admitting/Registration	Meditech	Daily	NO
Cost per Weighted Case	Number of Weighted Cases	Health Records	Meditech, Manual	Quarterly with delay	INCOMPLETE
Average Length of Stay	Number of matched cases	Health Records	Meditech, Manual	Quarterly	YES
Program/Dept. Specific Indicators	To be determined	To be determined	To be determined	To be determined	UNKNOWN

Appendix H
Accreditation Policy

Administrative Policy Manual

Section:	Administration	Number:	III - 25
Policy Title:	Accreditation	Date:	(O) 09-11-1997 (R)
Issuing Authority:	Vice President	Page:	1 of 3

Policy:

Accreditation

The Health Care Corporation of St. John's, in its continuing efforts to provide the highest quality of programming possible, supports accreditation processes. Accreditation is a process of external peer review undertaken with the intent to evaluate and improve the quality of care, service or educational programming. The Accreditation process is considered an intricate part of the Health Care Corporation's Quality Improvement Program.

1. Corporate Team approval is required for application to all Accreditation Programs in which the Corporation is the primary sponsor. (Group I)
2. Accreditation processes organized by other organizations such as affiliated educational institutions, should be communicated to the appropriate Vice President through the liaison Program/ Department/Professional Practice Group. Conditions of participation and level of disclosure should be discussed with the Vice President prior to participation. (Group II)
3. The Canadian Council on Health Services Accreditation is the only Corporate-wide Accreditation Process encompassing Board, Leadership Groups, Supports Teams, and Clinical Care Teams. This Accreditation process shall be overseen by a Corporate Accreditation Steering Committee that will be struck approximately eighteen months prior to the survey. The Committee's main purpose will be to establish a time line to meet requirements, oversee the preparations throughout the organization including education, communication, and support to teams.

Policy Title:	Accreditation	Number:	III - 25
		Page:	2 of 3

Group I

The following Accreditation Programs are recognized by the Health Care Corporation and are coordinated primarily by the Corporate groups. Participation is voluntarily and regular and includes:

- Canadian Council of Health Services Accreditation - Organizational Survey
- Canadian Association of Universities Schools of Nursing: BN Collaborative Program - Centre for Nursing Studies
- Canadian Physiotherapy Association: Physiotherapy Service
- Canadian Association of Occupational Therapists: Occupational Therapy Service
- Canadian Accreditation of Services Programs: Speech-Language Pathology and Audiology Programs
- Intersocietal Commission for the Accreditation of Vascular Laboratories: Vascular Laboratory
- Canadian Board for Certification of Prosthetics and Orthotics: Prosthetics/Orthotics Services
- Canadian Association for Pastoral Practice and Education: Clinical Pastoral Education Program
- Canadian Medical Association: Emergency Medical Attendant Program Level I and II
- Commission on Dental Accreditation of Canada: Child Health Dental Service
- Trauma Association of Canada: Emergency Program
- Dietitians of Canada: Dietetic Internship Program

Policy Title:	Accreditation	Number:	III - 25
		Page:	3 of 3

Group II

The following Accreditation Programs are recognized by the Health Care Corporation but coordinated primarily by external stakeholder groups. Participation is voluntarily and regular and includes:

- Royal College and College of Family Physicians: Medical Specialty Programs. Accreditation is conducted in Partnership with Memorial University of Newfoundland
- Canadian Association of Radiologists: Diagnostic Imaging Component of the Provincial Breast Screening Program for Newfoundland and Labrador Sponsored by the Department of Health
- Association of Canadian Medical Colleges and Liaison Committee Medical Education: Medical School Accreditation
- Canadian Medical Association Conjoint Association Services: Clinical component of the College of the North Atlantic Programs: Medical Laboratory Program, Cytotechnology Program, Diagnostic Ultrasound and Medical Radiography Programs, Respiratory Therapy Program
- Canadian Council for Accreditation of Pharmacy Programs: Clinical Component of Memorial University of Newfoundland's School of Pharmacy Program

Administrative Policy Manual

Section:	Administration	Number:	III - 70
Policy Title:	External Reviews	Date:	(O) 09-11-1997 (R)
Issuing Authority:	Vice President	Page:	1 of 1

Policy:

External Reviews

There are several inspections, audits and reviews of programs and services of the Health Care Corporation of St. John's that occur on a regular basis in addition to Accreditation processes. These external reviews are important components of the Quality Improvement Program of the Health Care Corporation.

These reviews include, but are not limited to:

- Council for Licensed Practical Nurses: Practical Nursing Program - Centre for Nursing Studies
- Association of Registered Nurses of Newfoundland: BN Collaborative Program
- Newfoundland Pharmaceutical Association: Pharmacy Services
- Annual External Financial Audit
- Auditor General
- Revenue Canada
- Department of Health
- Provincial Government Pensions Division
- Atomic Energy Board of Canada
- Department of Labour
- Narcotic Control (Federal Government)

Appendix I
Occurrence Reporting Policy

Administrative Policy Manual

Section:	Quality	Number:	XX - 15
Policy Title:	Occurrence Reporting	Date:	(O) 22-10-1997 (R)
Issuing Authority:	Vice President	Page:	1 of 6

Policy:

Occurrence involving patients, visitors, others and property of the Health Care Corporation of St. John's must be investigated and reported using the Corporate Occurrence Report Form.

The Occurrence Reporting process is a component of the Health Care Corporation's Quality Plan in ensuring the ongoing monitoring, evaluation and improvement of the quality of care and service.

Definitions:

Occurrence

Any event, accident, error or circumstance which is not in keeping with expected process or outcome of care or service. Occurrences may result in an injury to an individual, damage or loss of equipment or property.

Staff related occurrences arising from a work related injury or potential injury will be recorded on the Staff Incident/Occurrence Form. Professional Practice related issues will be noted on the Professional Practice Issues Occurrence form.

Outcome

The result of a particular event.

Clinical Outcome

The assessment and treatment the patient may need arising from an occurrence:

Policy Title:	Occurrence Reporting	Number:	XX - 15
		Page:	2 of 6

- **non apparent** - no problem and no assessment required
- **assessment/no intervention** - patient is assessed by a physician and no testing or treatment is required
- **assessment/minor intervention** - patient is assessed, diagnostic testing is done, minor treatment is administered (bandage) e.g. bruise, skin tear, first degree burn
- **assessment/major intervention** - patient assess, diagnostic testing and major intervention required. e.g. surgery, fracture, major laceration requiring suturing, third degree burn, extended stay, admission to hospital
- **death** - if death follow Reportable Death Policy and The Fatalities Act

Non-clinical Outcome

Refers to the results in a non-patient care related occurrence.
 Example of non-clinical outcome could be:

- police involved (take badge number)
- complaint resolved
- legal action commenced
- property

Loss Control

Refers to the preservation or securing of information, evidence and documentation in order to assist in the investigation of an occurrence. Also it will assist in the event of a medical/legal situation arising from the occurrence.

Procedure:

Responsibilities

Occurrence Report forms are available through Stores at each site.

Policy Title:	Occurrence Reporting	Number:	XX - 15
		Page:	3 of 6

All Staff

Any staff members that observes/discovers the occurrence, after providing immediate attention to the situation, shall:

1. Initiate Occurrence Report Form at the time of the occurrence according to the guidelines. This will include:
 - a) enter applicable demographic information or, if a patient addressograph, on top of form
 - b) enter date, time, location, Department/Program/Division and site
 - c) indicate the event(s) that best describe the occurrence, or fill in the blank after "other" as necessary
 - d) complete all applicable areas on the report, checking more than one box, as necessary
 - e) record only **factual information** about the occurrence in Section 6 - Brief Statements of Fact; **do not** express personal opinion, find fault or lay blame
2. Document facts of patient's condition on health record where applicable. **Do not** place occurrence report or reference occurrence report on health record.
3. Notify in-charge person, manager, attending physician or Clinical Chief as appropriate as soon as possible.
4. Initiate "loss control" if occurrence is a result of equipment, object, medication, etc. This will include securing equipment, device or other pertinent evidence so that it is not repaired or put back in service before the necessary investigation is completed.
5. Participate in follow-up of occurrence with manager.
6. Forward the completed form to the Program/Department Director/Clinical Chief for further action.

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Program/Department Management

1. Review the occurrence; initiate an investigation and follow-up process. Assistance of the staff most involved with the occurrence will be required.
2. Discuss all occurrences resulting in actual or potential patient injury or that have implication for significant complaint with the patient or family. Open communication and ongoing discussion with patient and family is expected.
3. Forward completed occurrence form, within 48 hours, to staff in the Quality Initiatives Department linked with your Program/Department.
4. Report significant occurrences immediately to the applicable Vice President or Vice President On-call and to Risk Manager by next working day.
5. Notify appropriate Program/Department Director if occurrences relate to other Program/Department.
6. Follow-up is required for all significant complaints or occurrences that result in patient injury and when the occurrence involves other Program/Departments. When follow-up is completed prepare "Occurrence Follow-up Form" and forward copy to the appropriate Quality Initiatives Department staff member or if appropriate to your applicable Vice President.

Quality Initiatives Department

1. Monitor, trend and provide summary reports on occurrences to the Program/Department Leadership on a quarterly basis and upon request.
2. Retain all original occurrence reports and copies of related follow-up forms.
3. Assist Program/Departments, upon request, with the investigation and "loss control" activities of significant occurrences.

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4. Assist Program/Departments in identifying, controlling or preventing their risk issues.
5. The Risk Manager liaises with Insurer and/or legal counsel as appropriate.

Loss Control

1. When there is an occurrence or someone is injured the first responsibility is to the injured person or to ensure the area is safe in the case of a property issue.
2. When the immediate issue is handled staff should consider controlling the potential for loss. Loss control is the responsibility of all staff.
3. The person most immediate to the occurrence will commence initial "loss control". The manager, in consultation with the Risk Manager/Quality Facilitator, will follow-up on the initial activities.
4. Loss control activities:
 - a) If the occurrence involves equipment. arrange for the object to be secured in order to prevent it from being repaired or put back in service before the investigation/assessment is completed. Equipment should be assessed and determined to be safe for use before being reinstated for use (consultation with the Facilities Manager/Biomedical Engineer and Risk Manager is recommended).
 - b) If disposable items are being used, retain the item until the investigation is completed.
 - c) Secure and physically lock up any records (including notes, test results, monitoring strips, X-rays or other diagnostic films). This ensure that the records re not lost or altered. Coordinate with Program Leadership, Risk Manager and Health Records.

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- d) Secure applicable policies and procedures.

- e) Needs of the various individuals should be anticipated and may include:
 - emotional support to the patient/family (Pastoral Care, Bereavement support, etc. **Employee and Family Assistance Program** is available to employees and medical staff. "Response to Stress" assistance is arranged through Employee and Family Assistance Program
 - providing opportunity for patient/family to review chart
 - providing a copy of the chart to the physician for Canadian Medical Protective Association

Reference: Peer Review Policy and Reportable Death Policy

Appendix J
Consumer Feedback/Focus Group References

Consumer Feedback/Focus Group References

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