

SUBJECT: **CONTINUOUS QUALITY IMPROVEMENT**
APPROVED BY: Chief Executive Officer _____
EFFECTIVE DATE: 2008 07
REVISED/REVIEW DATE:

Purpose:

- To focus on improving work processes and systems, resulting in services that meet or exceed client expectations.
- To guide employees of Labrador-Grenfell Health in the use of the components of Continuous Quality Improvement (CQI).
- To promote a participative, systematic approach to planning, implementing, delivering and evaluating client-focused care and service.

Policy/Standard:

Labrador-Grenfell Health is committed to the ongoing assessment, evaluation, and improvement of services using the principles of Continuous Quality Improvement.

Materials Required:

- Plan-Do-Study-Act (PDSA) Guide and Template (Appendix A)

Related Policies:

- PSQ-5-5 Culture of Safety

Procedure:

A. Individual employees will:

1. Identify processes that require improvement.
2. Direct all improvement ideas within departments to the supervisor / manager.
3. Direct all system-wide improvement suggestions to Quality Council, through the Regional Director of Patient Safety and Quality.
4. Use CQI principles to improve processes on a daily basis and participate on CQI teams when required.
5. Utilize the team concept for system-wide process improvements.
6. Share the results of improvement efforts with others.

B. Team Leaders and Managers will:

1. Promote team participation as a function of all positions.
2. Make every effort to facilitate employee's attendance at team meetings.
3. Participate in the CQI Process as a team leader/member when required and play a key role in the implementation and evaluation of process improvements.
4. Continually monitor processes and provide evidence as an assurance of quality.

C. Patient Safety and Quality Staff will:

1. Act as a resource for all departments on quality initiatives.
2. Identify trends and/or incidents of concern that require process improvements.
3. Consult with appropriate stakeholders in initiating CQI Process Teams as required.
4. Inform Quality Council, through the Regional Director of Patient Safety and Quality, of the initiation of all process teams.
5. Participate as a member of CQI Process teams and help facilitate the implementation and evaluation of improvements.

D. Quality Council will:

1. Provide opportunity for established CQI Teams to regularly report on quality improvements/initiatives in their respective areas.
2. Select system wide projects/processes and team members when identifying quality improvement initiatives.
3. Review information received regarding the establishment of CQI Process Teams and provide further input as necessary.
4. Review all CQI Process Team reports (see Appendix A-3), address recommendations and provide feedback to the process teams and employees.
5. Encourage process teams to communicate their improvement process to co-workers.
6. Ensure that quality improvement initiatives are evaluated.
7. Report on quality initiatives to the Board of Directors through the CEO.

E. Board of Directors will:

1. Promote a culture of safety and continuous quality improvement through evidence based decision making.
2. Review Quality Reports received and provide feedback as necessary.

3. Promote quality initiatives in the health authority's by-laws, strategic plan, position descriptions, and other regulations and guidelines.

References:

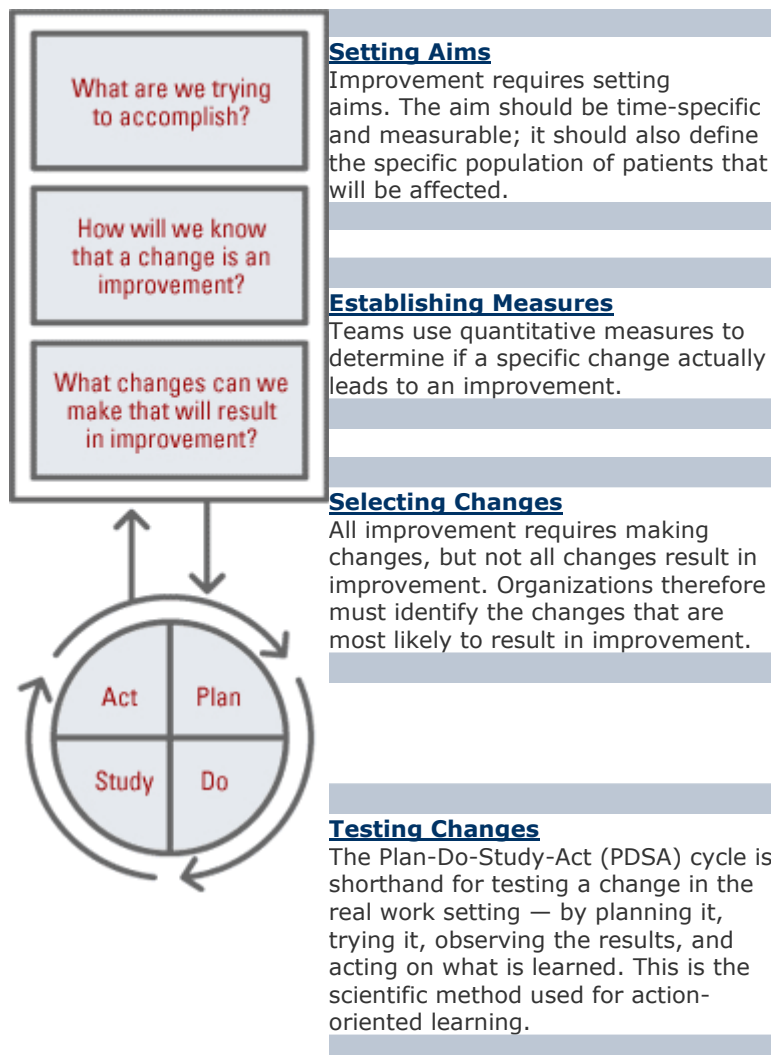
Health Labrador Quality Management Administrative Policy, 2002.
Grenfell Regional Health Services Continuous Quality Improvement
Administrative Policy (#170), April 2001

The Model for Improvement Plan-Do-Study-Act (PDSA)

The Model for Improvement provides a framework for developing, testing and implementing changes that will lead to improvement.

The model consists of two parts that are of equal importance:

1. The first, the ‘thinking part’, consists of three fundamental questions that are essential for guiding improvement work. (Appendix A-1)
2. The second part, the ‘doing part’, is made up of Plan, Do, Study, Act (PDSA) cycles that will help you make rapid change. (Appendix 1-2)



Three fundamental questions for achieving improvement;

Q1. What are we trying to accomplish?

What is the overall aim of what we are doing? What are we hoping to improve?

Q2. How will we know that a change is an improvement?

What will tell us that our changes make things better than they were before? What can we measure that will demonstrate that our changes are actually an improvement? What data (opinions, observation, process data and results) will be useful?

Q3. What changes can we make that will lead to an improvement?

Include all the ways that you can work towards your objective, so that you can develop plans for PDSA cycles. Think about what has worked for other people, what ideas you have yourself and innovative approaches.

The Model for Improvement Plan-Do-Study-Act (PDSA)

PDSA Cycles

PDSA requires the establishment of a CQI Process team. Successful improvement effort is dependent on the involvement of key users of the service requiring change.

Each process team must identify an AIM statement. An Aim statement identifies what the team is trying to accomplish. The aim statement should be time-specific and measurable; it should also define the specific population of patients that will be affected.

The PDSA model identifies four stages that must be explored when improving a process:

Step 1 – Plan a Change

A. Identify the Problem

- Select the problem to be analyzed
- Clearly define the problem and establish a precise problem statement
- Set a performance measure for the problem solving effort

B. Analyze the Problem

- Identify the processes that impact the problem
- Identify the processes that may cause the problem or prevent you from reaching the goal
- Collect and analyze data related to the problem
- Identify root causes of the problem
- Verify or revise the original problem statement (If revised, change work plan)

C. Implement a Change

- Implement the change on a trial or pilot basis

Step 2 – Do- Try the change on a small scale

A. Develop Changes

- Generate potential changes that will address root causes of the problem
- Select a specific change or changes that can be implemented on a small scale and tested quickly to see if it (they) work
- Identify anticipated results from this change

- Plan how you will carry out the change, when and who will do it. This is your first change cycle.

Step 3 – Study – Observe/Evaluate the Results of the Change

- Gather and analyze the data on the change
- Was the change carried out as planned?
- Did you obtain the anticipated results?

Step 4 – Act – Refine and Spread the Change

- List the actions that will be taken as a result of this change and evaluation cycle
- Identify any systemic changes and training needs for full implementation
- Plan ongoing monitoring of the change

References:

Institute for Healthcare Improvement
<http://www.ihl.org/IHI/Topics/Improvement/ImprovementMethods/HowToImprove/>

PDSA Flow Sheet

TEAM MEMBERS:

AIM STATEMENT: (Overall goal you would like to reach)

Every goal will require multiple smaller tests of change
 Describe your first (or next) test of change, including who you are testing the change on.

Person Responsible	When to be done	Where to be done
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PLAN

List the tasks needed to set up this test of change

- 1 -
- 2 -
- 3 -
- 4 -
- 5 -

Person Responsible	When to be done	Where to be done
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Predict what will happen when the test is carried out

- 1 -
- 2 -
- 3 -
- 4 -

Measures to determine if prediction succeeds
1 -
2 -
3 -
4 -

Do Describe what actually happened when you ran the test

Study Describe the measured results and how they compared to the predictions

Act Describe what modifications to the plan will be made for the next cycle from what you learned

CQI Process Team Report

Issue/Concern:

Site/facility affected: (Indicate if issue is a regional one)

Team Leader:

Team Members:

Meeting Dates:

Goal:

Summary of process improvements:

Evaluation Plan (with timelines):

Submitted by:

Date Submitted: