

THE COMPONENTS OF A QUALITY ASSURANCE PROGRAM
FOR SMALLER HOSPITALS

by

Carol J. Finnie

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Department of Health Care + Epidemiology

The University of British Columbia
1956 Main Mall
Vancouver, Canada
V6T 1Y3

Date 85/10/15

ABSTRACT

The components of a quality assurance program for smaller hospitals in British Columbia have been defined. These components have been defined by a comparison of the normative standards as determined in the literature and by a survey of administrators. Sixteen administrators of predominantly acute-care, accredited, 20-50-bed hospitals in B.C. were surveyed. Twelve of these administrators were surveyed twice.

A new requirement for accreditation was introduced by the Canadian Council on Hospital Accreditation (C.C.H.A.) called the Quality Assurance Standard (1985). This Standard required that quality assurance (QA) programs be established in every department or service in the hospital. The Standard does not give a clear description of the QA functions for each individual department in a smaller hospital. An important and relevant list of specific functions for a QA program were identified at various C.C.H.A. seminars held across Canada in late 1983 and early 1984.

The literature review indicated that there were a number of controversial issues affecting the implementation of the QA Standard. In spite of many methodological problems associated with quality measurement and assurance, most hospitals will adopt a quality assurance model.

The first survey asked the administrators to define the purpose, goals and objectives of a QA program. They were also asked to determine the QA functions for four areas: hospital board, dietary, nursing and pharmacy. Administrators were asked to identify who in the hospital is primarily responsible for the overall QA program and for the QA program in four areas; the problems and benefits encountered when trying to implement a QA program; and their opinion of the new QA requirements for accreditation.

The second survey asked the administrators to assign a priority to those functions identified in Round I. The empirical findings were then compared with the normative standards.

With some exceptions, the empirical data were consistent with the normative standards. The empirical findings shows that there are problems related to implementing a QA program but at the same time there are a number of benefits related to the program.

The priority ratings of the functions indicated areas of high or low importance to the administrator. It is likely that these priority ratings are useful for planning when alternatives must be considered during this time of fiscal restraint.

Government policies along with the strong voluntary support of accreditation programs make it vitally important that suitable models for implementing QA are developed. The Doll model is suggested as a basis for implementing QA. Further areas for research are presented.

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CHAPTER I

Introduction

Quality assurance is a popular issue at present. The assessment of the quality of health care has evolved from the development of regulatory requirements to voluntary accreditation programs. Accreditation Standards have moved from minimal requirements to optimal requirements of quality of care. The most recent Standard is that hospitals have a quality assurance program.

Quality Assurance was introduced as an "Essential Element" in the Standards for Accreditation of Canadian Health Care Facilities, 1983. There is now a requirement for accreditation that a quality assurance program be in place by 1986. This program requires a written plan describing the organization and implementation of an institution-wide quality assurance program. Quality assurance programs are now required in every department directly involved in providing patient care or indirectly through the provision of support services.

However, a detailed model or description of quality assurance programs for each individual department is not presented in the Standards. This fact has caused much concern for the administrator of a smaller facility. This

administrator often has limited human and financial resources to launch a new program such as a quality assurance program. The administrator needs to know not only what the Standards for accreditation are but how to integrate a quality assurance program into already existing hospital activities.

The Study

Given the significance of the Quality Assurance Standard and the impact of this requirement for smaller hospitals, the following study questions were formulated:

Primary Question - What are the components of a quality assurance program for the smaller hospital?

Subquestions -

1. What does the literature determine as the quality assurance components for smaller hospitals? (i.e. normative standards).

2. What are the purpose, goals and objectives of the smaller hospitals' quality assurance program? (i.e. empirical findings).

3. What are the quality assurance components for the smaller hospital as determined by the administrator and/or delegate? (i.e., empirical findings).

4. What is the compatibility between theory and practice? (i.e. How do the normative standards and empirical findings compare?)

Definitions

Administrator - a person who is responsible for the management of a smaller hospital.

Component - a constituent part: ingredient, serving or helping to constitute (Webster, 1971, p. 580).

Empirical findings - are those based on factual information and capable of being confirmed, verified or disproved by observation or experiment (Webster, 1971, p. 743).

Program - a program typically consists of an organized group of people, time, equipment, buildings and money to perform activities for the benefit of clients or patients. Program evaluation is concerned with determining the value or worth of a particular program (Baker, 1983, p. 153).

Quality - the degree of conformity with generally accepted principles and practices and the degree of attainment of achievable outcomes consonant with appropriate allocation of resources (Slee, 1982, p. 1).

Quality Assurance - includes quality-of-care measurements and when it seems necessary, efforts to improve health care

quality (Baker, 1983, p. 153).

Smaller Hospitals - those predominantly acute-care hospitals offering all or some other levels of care, currently accredited, with 20-50 beds, in British Columbia.

Standard - an authoritative or recognized example of correctness, perfection or some definite degree or any quality of something set up as a rule for measuring, or a model to be followed (Webster, 1971, p. 2223).

Objectives of the Study

The major goal of the study is: to determine the components of a quality assurance program for smaller hospitals. The objectives of the study are:

1. To determine from a review and analysis of the literature the normative standards for quality assurance.
2. To determine the purpose, goals and objectives of the smaller hospitals' quality assurance program as based on empirical findings.
3. To determine the components of a quality assurance program for the smaller hospital based on empirical findings. Four areas will be investigated: hospital board, dietary services, nursing services and pharmacy services.
4. To compare the normative standards with the empirical findings.

5. To make recommendations and conclusions as based on analysis of the data.

Methodology

A review of the literature is presented. This review presents the history and background information about the accreditation Standards. An analysis of the current Quality Assurance Standard is presented. Concepts related to quality measurement and assurance are analyzed. Finally, background and demographic information about the development of standards of care for smaller hospitals in B. C. are presented.

The results of a survey of the administrators (or their representatives) is presented. To obtain this empirical data, an initial survey was conducted with a pre-test, the format of the questionnaire was edited and more questions added to it for a second survey with a preceding pre-test.

Many of the smaller hospitals are in the formative stages of developing a quality assurance program. The administrators are unsure as to what extent they need to develop their quality assurance program in order to meet accreditation requirements. In addition, the administrators are at various stages in developing the components of a quality assurance program.

A major assumption made is that, these hospitals are

already engaged in quality assurance activities. However, these activities may not be integrated in an institution-wide quality assurance program.

The empirical data is compared with the normative standards. Conclusions and recommendations are presented as based on this comparison.

Thesis Format

The thesis is organized to address the objectives set out above. Chapter II presents the literature review. Chapter III presents the methodology. Chapter IV presents the empirical data and compares the data with the normative standards. Chapter V presents the conclusions and recommendations.

CHAPTER II

Literature Review

This chapter will address the first objective of the study: To determine from a review and analysis of the literature the normative standards for quality assurance.

The evolution of the formalized standards for quality of care are traced. The current Canadian Council on Hospital Accreditation "Quality Assurance Standard" is analyzed in depth. Also, concepts related to quality measurement and assurance are analyzed. Following this, a description of the development of quality of care standards in smaller hospitals is presented.

The Evolution of Standards for Quality of Care in Hospitals

1900 to 1917

The ideas underlying the development of the first formal Standard for quality of care reflect a general movement that can be identified as commencing in the 20th century. Three studies during the early 20th century received wide attention and exerted various influences on the standards of medical care and medical education (McLachlan, 1976, p. 223).

The first study was conducted by Groves in 1908. He

surveyed 50 hospitals in Great Britain. From this survey, he concluded that, there was a need for an acceptable standard classification of diseases and operations and a follow-up system for particular categories of diseases.

In 1910, Codmern, a surgeon in the U.S., attempted to institute a follow-up system of surgical patients to determine whether the operations were warranted and if the operations had improved the patients' symptoms.

The third study was called the Flexner Report (1910). This Report raised the whole question of medical practice standards and their relation to empirical research (Berliner, 1975). This Report eventually became a series of reports that set the basis for scientific medicine. The Flexner Reports prompted major improvements in the structure and content of medical education in the U.S. and Canada.

Hospitals also required improvements. Clinical laboratories for conducting adequate studies of surgical patients were a scarcity; medical records were unsatisfactory; and the medical staff were poorly supervised and unorganized. In response to these conditions, a resolution was passed at the Third Clinical Congress of Surgeons of North America, 1912. This resolution stated that "some system of standardization of hospital equipment and hospital work should be developed..." (Shanahan, 1983, p. 21).

The Minimum Standard

1917

In response to the deficiencies found in the hospitals and amongst the practitioners, the American College of Surgeons (ACS) developed the Minimum Standard in 1917. The Minimum Standard contained the first formal requirements for the review and evaluation of the quality of health care. The Standard addressed the quality of the medical record, the requirements of the medical staff and the quality of the physicians' clinical performance. The Standard required the medical staff to assess and analyze, at various intervals, its experience in clinical departments and to base the assessment on the patients' clinical records (Shanahan, 1983, p. 22).

The Hospital Standardization Program

1918 to 1951

A year following the introduction of the Minimum Standard, the Hospital Standardization Program was inaugurated by the ACS. The ACS recruited Dr. MacEachern, the administrator of the Vancouver General Hospital to provide leadership in developing the Hospital Standardization Program and in obtaining the acceptance of the Program by hospitals

and individual practitioners (Agnew, 1974).

Many problems were encountered in trying to gain acceptance of the Program. It was not difficult to interest the hospital trustees to become involved but it was difficult to interest the individual doctors. Doctors were busy and had competing interests for their time. The requirement of writing up reports was seen as a ridiculous waste of their time. Nor did the physicians welcome any kind of supervisory committee. However, these problems diminished when the Program was adopted by the Catholic Hospitals Association and when the doctors saw the accreditation reports as a way to increase their support in asking for more equipment or more facilities (Agnew, 1974).

The Standards were constantly being updated to reflect the increasing complexity and sophistication of hospital and medical practice. The War years (WW II) in particular brought great advances in medical practice. Following World War II, studies on health care provision emphasized more structural or process elements rather than that of outcomes of care as advocated earlier by Codman and Groves. Studies evaluated structural variables such as the innate characteristics of physicians (e.g., their age or length of training) and of facilities (e.g., staffing patterns or structural soundness of buildings) and process variables such as the adequacy of diagnostic and therapeutic intervention.

The Joint Commission of Accreditation of Hospitals (JCAH)

1951

Due to the growing cost of operating the Hospital Standardization Program, the ACS sought out the support of other national organizations. Thus the Joint Commission of Accreditation of Hospitals (JCAH) was created in 1951 with representation by the American College of Surgeons, the American Medical Association, the Canadian Medical Association, the American Hospital Association, and the American College of Physicians (Shanahan, 1983, p. 22).

The Standards and membership of the JCAH have undergone dramatic changes since 1951. The newly revised edition of the Standards for Accreditation in 1953 included brief standards on bylaws, governing bodies, buildings, nursing services, food services and drug control. In addition, there were requirements of the medical staff to use the executive committee (i.e., the Medical Advisory Committee) to coordinate the clinical areas, to conduct tissue reviews, to review medical staff credentials and to review medical records.

The Canadian Council on Hospital Accreditation

1953-to-1983

The Canadian Medical Association withdrew from the JCAH in 1958 and formed a distinct Canadian program under the auspices of the Canadian Council on Hospital Accreditation (CCHA). The CCHA was formed in 1952 as a voluntary commission under the Companies Act. The CCHA is the only body officially authorized to conduct an accreditation program for Canadian hospitals.

The Board membership consisted of 12 members in 1953. These members were from various associations: The Canadian Hospital Association -- 5, the Canadian Medical Association -- 4, the Royal College of Physicians and Surgeons -- 2, and L'Association des Medecins de Langue Francaise du Canada -- 1. The members carry out their responsibilities as individuals rather than as representatives of their parent organizations.

In 1971, the CCHA reviewed and rewrote the Standards so that the Standards were based on an "optimal" rather than "minimal" concept. The requirements were raised from the level of minimum essential to the level of optimum achievable. In 1972, the Guide to Hospital Accreditation presented standards that required the responsibility of the hospitals' governing body to be stated, the role of the chief executive

officer to be recognized, the role of the medical staff to be stated and that conflicting lines of authority and communication be avoided. In addition, these Standards introduced the requirement of medical staff to undertake "an appropriate peer group method by which required basic functions of clinical audit are thoroughly performed at least monthly."

By 1977, the CCHA acquired one more member to its board; one representative of the Canadian Nursing Association. The revised 1977 Standards reflected popular policies then supported by the federal government. The Standards increased emphasis on health maintenance, prevention of ill health and out-patient care.

The Quality Assurance Standard

In time, the CCHA health professionals recognized that the medical audit requirements were self-limiting in terms of evaluating the quality of care provided in hospitals. The next major development occurred in 1983 when Quality Assurance was introduced as an essential element in the Standards for Accreditation of Canadian Health Care Facilities. The quality assurance activity would not be used in the determination of awards until 1986. In 1986, a quality assurance program will be an essential requirement to obtain a three year

accreditation award.

The Quality Assurance (QA) Standard was updated in 1985. Briefly, the Standard requires that there must be institution-wide goals established, means to attain these goals, evaluation procedures to determine if the goals are attained and if not, alternative plans made. The Standard requires that there must be a written plan describing the organization and implementation of an institution-wide quality assurance program.

This Standard requires that quality assurance programs are in place in every department directly involved in providing patient care or indirectly through the provision of support services. The program may use multiple approaches to carry out the plan (see Appendix I for complete description).

An Interpretation of the Standards for Small Hospitals

In response to the consistent complaints about the accreditation program by small hospitals, the CCHA introduced an "Interpretation" of the Standards. The intent of this Interpretation, published in October 1984, was to assist the small health care facilities 'to identify those elements of the accreditation program which were not applicable to them and to understand how the Standards could be "adapted" to

apply to a "small facility." This Interpretation was written primarily for the non-departmentalized acute health care facility of less than 50 beds (see Appendix II for complete details).

Specific Quality Assurance Functions and Activities

Although the JCAH and CCHA have identified the need for quality assurance programs and have described "components" for these programs, they have not specified other components which are more specific to the functioning of the program. Articles in the literature do specify some of the functions and activities for various hospital departments. An important and relevant list of specific activities for a QA program were identified at various CCHA quality assurance seminars held across Canada in late 1983 and early 1984. These activities are listed in a booklet entitled: Proceedings of the Seminars on Quality Assurance, October 1983 to May 1984, CCHA.

Summary - the Normative Standards for Quality Assurance

The literature review revealed that the Standards written by the CCHA have received national recognition. However, there are no explicit "Gold Standards" (i.e., commonly agreed upon standards) for specific functions of the quality assurance program. Given these facts, it is proposed here

that three documents be used to represent the normative standards for a quality assurance program. These documents are:

1. Standards for Accreditation of Canadian Health Care Facilities, 1985 CCHA.

2. An Interpretation with Special Reference to the Needs of Small Acute Health Care Facilities (small General Hospitals), 1984, CCHA.

3. Proceedings of the Seminars on Quality Assurance, October 1983 to May 1984, CCHA.

As noted, the intent of this study is to compare the normative standards with the empirical findings and make an analysis based on this comparison. Before the empirical data are presented, the following discussion reveals some of the controversial issues of quality assurance.

Justification for the New Quality Standard

A review of the literature indicates that the introduction of the Quality Assurance Standard was based on a number of beliefs--first, that public accountability demands assurance for quality of care; second, that the mechanism to achieve quality of care is to meet a recognized standard; third, that the establishment of an institution-wide quality assurance program would enable hospitals to achieve the

highest level of care with the appropriate and effective use of resources.

In comparison to other efforts to improve the quality of care, the Quality Assurance Standard is more comprehensive. For example, former quality control activities only involved auditing. Alternatively, a quality assurance program coordinates individual quality control procedures and other quality assurance activities of an overall planned approach.

A Brief Debate About the Advantages and Disadvantages of the Quality Assurance Standard

Little has been done to study the relationship between quality and cost or the problems of structuring quality control in the hospital. The successful implementation of a quality assurance program requires a reconciliation of individual professional demands for autonomy with the need for institutional accountability. Ideally, there must be an expansion of professional accountability to include a concern for quality, cost and the development of explicit mechanisms of control, both on a local and federal basis.

The new Standard calls for an increase in bureaucratic structure in order to deliver service and this comes only with increased administrative cost. The new Standard requires the creation of new roles, new rules and new regulations that

serve to threaten the existing power structure. However, the CCHA argues that, in time, a quality assurance program should eventually become a normal part of the management function of a hospital and that, the time spent on the program will be time well spent because of the improved level of patient care (Proceedings, 1984, p. 27).

The creation of new roles could create conflicts between the bureaucratic structure and professionals claiming clinical freedom. Previously, the Medical Audit Standard relied heavily on the medical staff to evaluate and improve the quality of care. Now the new Quality Assurance Standard shifts power in the direction of those in hospital and patient service positions and away from the primacy of medical service oriented managers.

Justification for the QA standard is based on the belief that formalization of the quality assurance activities will favorably affect quality of care according to the extent that the organization is structured to foster professional autonomy through meaningful involvement in the program. However, a review of the literature shows varying about the impact of formalization on the quality of care (Heatherington, 1982, p. 194).

Assumptions Affecting the Implementation of the Quality Assurance Standard

There are a number of assumptions underlying the acceptance of the Standard. One is that people function well in groups and teamwork is facilitated by the group process even though there are obvious status differentials between the members. Another assumption is that professionals want to be involved in quality assurance activities. For example, it is assumed that in instances where there is professional misconduct, the professional groups will objectively assess the actions of members of their own professional group and take necessary action. A third assumption, and this one is very critical, is that the government will support the goals of improving the quality of care and the CCHA quality assurance standard, even though the economic cost may be very high initially.

In general, individuals tend to develop regularities in their behavior and will often oppose change either overtly or covertly. Labour contracts maintain roles that are not amenable to change. Statutes, regulations and internal policies offer other sources of constraint. In addition, there are resource limitations imposed by government agencies and a number of sunk costs that do not allow for the creation and refocussing of budgetary resources to develop new programs.

Quality Measurement and Assurance

Rationale for Using Quality Assurance Models

A review of the state-of-the-art quality of care studies revealed a number of major issues affecting the validity of quality measurement and assurance. First, there is little agreement as to the definition of quality. The literature is abundant with contrasting definitions of quality, quality assessment, quality assurance, program evaluation, effectiveness and efficiency.

Second, variations in definition lead to problems in topic selection, measurement and implementation. For example, should studies be on episodes of care or on a single event? Measurement issues include: the appropriate choice of data, criteria and target behaviour to evaluate quality of care programs. A major issue when implementing quality assurance programs is defining the purpose. Is the program meant to improve the general level of quality or to identify and eliminate episodes of poor care or both?

In spite of all these methodological problems associated with quality measurement and assurance, most hospitals will adopt a quality assurance model. Quality assurance models provide frameworks for guiding the overall plan for measuring and assuring quality of care.

A review of the literature indicated that there are a number of quality assurance models. It is not the intent of this review to list and describe all these models; they are well documented elsewhere (Donabedian, 1982, Vol.1)

This literature review concluded that the most relevant model for the smaller hospitals is the Doll model. The following paragraphs present a summary analysis made about the application of the Doll model and the popular Donabedian model to smaller hospitals.

Two Popular Quality Assurance Models

The most popular model used in studies found in the literature is the Donabedian model. In overview, the Donabedian model emphasizes the structure, process and outcomes of care. The term structure refers to characteristics of practitioners and facilities, and the manner in which they are organized. Process variables refer to what health professionals do for the patient. Outcome refers to the end results of health care in terms of health and satisfaction.

This model does not provide rules of thumb for what to do and what not to do. The framework is a guide for the administrator to evaluate the methods now at hand and to adopt them to his purposes and to participate in the further

evaluation and development of new methods. The Donabedian model has been commonly used to evaluate medical care and has adapted readily to the 1977 CCHA requirement of a medical audit. The model was constructed in the context of a fee-for-service system.

Alternatively, the Doll model was constructed in a capitation and salaried system (Doll, 1974). It can be argued that the Doll model appears more appropriate for the current CCHA requirements and that the Doll model is more suited towards smaller hospitals than the Donabedian model. Table 1 compares the Doll, Donabedian and CCHA models. As shown, the Doll model is a logical extension of the CCHA models.

There are three elements of the Doll model: medical efficacy, social acceptance and economic efficiency. Doll sees each element of his model as being monitored in terms of the outcome achieved or the process by which the outcome is reached. This monitoring method is analogous to the problem solving approach. As compared with Donabedian, Doll does not deal with the concept of structure because he sees structure as part of the process by which the outcome is reached. Instead, Doll stresses the importance of medical care indices (medical efficacy) as the object of monitoring and has referred to process principally in relation to social acceptability and economic efficiency.

Methods Used for the Identification of High Priority Topics for Quality Review

There are three major activities of a quality assurance program: monitoring care, assessing problems and improving care. Methods used to identify high priority topics for quality review include: survey techniques, criterion-based screening, variations from norms, multifactorial quality indices and small group methods. The most commonly used methods in smaller hospitals are the criterion-based screening, the small group methods, and variations from norms. For the purposes of this study, the survey method is used. The rationale for this choice of methodology is presented in Chapter III.

Summary and Conclusions About the Quality Assurance Standard and Methods for Evaluating Quality of Care

Accreditation provides overall direction towards a specific standard of care in hospitals by requiring adherence to provincial health acts, hospital bylaws and regulation, medical and departmental audits, continuing educational programs, and the like. The most recent effort has been the introduction of the Quality Assurance Standard.

The preceding discussion revealed the controversial issues affecting the implementation of the Quality Assurance Standard. This discussion raised numerous questions about the

TABLE 1 - QUALITY ASSURANCE MODELS

<u>DONABEDIAN</u>	<u>CCHA (1977)</u>	<u>CCHA (1985)</u>	<u>DOLL</u>
STRUCTURE ----- the characteristics and organization of practitioners and facilities.	use of patient charts -----	institution-wide program in-house morbidity and and mortality surveys.-----	structure part of process <u>MEDICAL EFFICACY</u> (outcome) the mounting of regional morbidity and mortality surveys to determine need. mortality data distinguished by age group, locality, provider category, hospital and disease specific. hospital data linked to individual cases. controlled trials in limited settings. impact of lifestyle factors.
<u>PROCESS</u>	<u>MEDICAL AUDIT STANDARD</u>	<u>QUALITY ASSURANCE STANDARD</u>	
what professionals do for the patient -----	criteria based ----- medical care audit.	problem-solving approach, setting of organizational ---- and departmental goals, assessing whether these goals are met and if not making plans to meet deficiencies in care. in-house consumer and patient surveys. -----	monitoring care in terms of the outcome achieved or the process <u>SOCIAL ACCEPTABILITY</u> (process) public opinion polls.
<u>OUTCOME</u>			
end results of care in terms of health and satisfaction. -----	the results of chart audit about the medical care provided.		<u>ECONOMIC EFFICIENCY</u> (process) regional comparisons of utilization. cost-benefit analysis. utility of health states and their monetary equivalents.

significance of the Standard for the smaller hospitals. For example, what are the administrators' opinions about the Standard and what do the administrators' perceive as the advantages and disadvantages of the Standard?

Both of the above questions are asked during the collection of the empirical data. These questions were asked concurrent with the primary research question in order that the significance of the Standard could be better understood.

The review presented a rationale for using quality assurance models. More importantly, this review represents a summary of an analysis of the various quality assurance models and recommends the use of the Doll model over other models for the smaller hospital.

The Doll and Donabedian model will be used in the analysis of the compatibility between theory and practice. This analysis will apply conjointly the models as a means for assessing and monitoring some of the empirical functions for smaller hospitals.

Smaller Hospitals

Political, economic, professional and social factors provide the context in which quality of care standards developed in smaller hospitals. The development of the professional associations and health policies by government

has set the background for the Quality Assurance Standard.

The Beginning of Standard Setting

18-19th Century

Health care in the early 18th Century in North America reveals not one type of practice but many competing forms that were often unorganized. Throughout the colonial days and until the end of the 19th Century, hospitals in Canada were mainly devoted to the care of people whose needs were largely social rather than medical. These institutions were mainly refugee centers for the aged poor, orphans, and the sick poor and the infirm without resources.

The development of these hospitals mark the beginning steps towards providing universal health care by bringing in from the cold, destitute people. The availability and universality of health care are still today, two of the national standards for providing quality health care in Canada.

Most of the earliest hospitals were organized by religious orders or by citizens' groups, sometimes working with municipal authorities. Many of the duties of running the hospital were done by volunteers who had a genuine concern for the well-being of the residents.

These voluntary hospitals were largely free from

government control and determined their own standards of care. Most of the standards were based on the availability of expertise and resources. Doctors acted as consultants to the early charitable institutions. Physicians often managed health matters such as quality of care policies within their local communities. However, it was only following the development of scientific medicine and the Nightingale system of nursing that the hospital came to be generally accepted as a superior institution for medical care (Agnew, 1974).

Towards the end of the 19th Century, hospitals were seen to be workshops for doctors treating sick people. People were admitted to hospital on the grounds of illness not on the grounds of poverty. This change of objectives was important because the goals changed to those of providing quality of care rather than providing refuges. It was only at this point that standard setting for quality care in hospitals could begin.

Legislated Standards

18th-20th Century

In the pre-confederation period, the government was concerned primarily with public hygiene and established local boards of health. These boards were intended to control

epidemics and were often disbanded when the immediate threat of disease subsided. Standards were set for reporting infectious diseases, for establishing quarantines and other public health measures. Programs and legislation were limited, specific and quite localized. It was not until the second half of the 19th Century that legislated standards were generalized and spelled out.

By the early years of the 20th Century, government began to authorize by statute, municipalities to group together into unions to set up hospitals for a district. These hospitals were governed by Boards which were composed of members that were elected at the annual general meeting of the voluntary hospital association. These hospitals were governed by Boards which were composed of members that were elected at the annual general meeting of the voluntary hospital association. The Board was responsible for monitoring the standards of care in the hospital.

The B.C. Hospital Act (1961) delegated ultimate responsibility for operating the institutions and providing quality patient care to the hospital governing boards. The Boards in turn, delegated the management operations to the administrator and the surveillance of quality of care to the medical staff.

Professional Standards

18th-20th Century

This study is concerned with the quality assurance functions of four areas: board, dietary, nursing and pharmacy. The history of pharmacy presents a vague and confused story up until the 19th Century. Nursing and dietary services are only clear and specific in the 20th Century. The beginning quality assurance functions for the Hospital Board was discussed in the previous paragraphs.

This review concentrates on the development of professional associations and legislation related to the professions. These mechanisms are generally necessary to establish an identity for the profession. Without a clear identification of the profession in terms of registration, educational and skill requirements, the profession is unable to clearly define it's role in providing quality of care.

Medicine as the dominant profession attempted at first, to control other professional groups. Early legislation governing the practice of these professions were contained in medical legislation. The struggles of obtaining the legitimacy of these professions have proceeded along similar courses. The steps taken in legitimizing the medical profession are discussed below as an example of these

struggles.

The Royal College of Physicians developed with the idea that it should be a self-regulating body with sharp punitive powers, accountable to no public authority. There was little definite control of the medical profession until Acts were passed governing conditions of practice of medical boards.

°Generally there was little control over a large number of unlicensed practitioners until the middle of the 19th Century. Some of the practitioners had diplomas from recognized European universities; some had no credentials at all. Medical Entrepreneurs moved freely across the American and Canadian borders. This lack of educational and professional standards led to some "fly-by-night" practices.

In 1843, the College of Physicians and Surgeons was formed for the purposes of improving the standards of practice. The first Medical Act was passed in 1865 and formed the Royal College of Physicians and Surgeons. Medical Acts provided a rationale basis to registration and the movement towards a system of self-government of the medical profession.

Pharmacists had organized and formed the Canadian Pharmacist Association by Confederation. However, the standards for practice in pharmacy and medicine remained dubious for a long time. The respective associations did not, at first, have the effect of ensuring adequate education standards among practitioners.

The first twenty years of this century were characterized by advances in preventive medicine and in health education. New techniques such as blood transfusions and debridement of wound became possible from first World War activities. Smaller hospitals along with larger teaching hospitals developed their own laboratories and installed X-ray equipment. Technological discoveries necessitated specialization in the services provided.

The people who provided these new services were often trained on the job. More progressive hospitals recognized the wastefulness of this method and hired instructors and students were given a probationary period. However, there were no set standards for admission to training schools or standards for the education that was taught in these schools. There was no standard regarding the length of the practical experience or the course to produce a professional.

In time, various registration acts were passed and various professionals were distinguished from others. There was a considerable struggle for nurses to obtain the Registration Act. Nurses had been hampered by groups of men, doctors and legislators who objected to women having control over their own group. Nurses in B.C. obtained a weak registration Act in 1918.

In the following decade, educational standards remained

the foremost pre-occupation of the nurses. The Weir Report in 1930 confirmed that nursing was a profession. Dr. Weir advised in this report that the nurses Act be revised in order to raise the standards in B.C. and the educational requirements.

The first record of employment of dietitians in B.C. wasn't until 1911. The B.C. Dietetic Association was founded in 1928. The Canadian Dietetic Association was incorporated under the Societies Act in 1957. The B.C. Dietetic Association has petitioned the provincial government to become incorporated with no success.

The maintenance of professional standards is delegated to professional associations. There exists an implicit assumption that this method will provide capable workers who give quality of care.

Licensing and educational standards are set by professional groups. Internal professional standards control the educational and socialization process of the members. Labour unions are voluntary mechanisms that define standards of work conditions, clear role definitions and add constraints to the system. Restrictions are set that do not allow tasks to be shifted or personnel redeployed to enhance the effectiveness and efficiency of care delivery.

The Impact of Government Policies on Quality of Care

20th Century

Canadian governments in the 20th Century are drawn more and more into redistribution and regulation policies. Governments have reacted to the increasing costs of health care by introducing policies concerned with improving the quantity and quality of care.

In the early part of this Century, some provinces began per diem grants and enacted laws requiring municipalities to bear hospitalization costs of the indigent resident. Governments were interested in safeguarding government expenditures and began to introduce a number of Regulations such as Building Codes, Plumbing Codes, Occupational Health & Safety etc.

The provincial governments have worked closely with voluntary health agencies in providing services and promoting education for the professionals and lay persons. The provincial subsidies in remote and poverty-stricken areas has helped alleviate regional disparities in the quality and availability of health services.

By 1940, provinces showed marked differences in quality and extent of services; and within provinces there were substantial differences between one community and another.

The delivery systems were obviously incomplete and needed a great deal of planning to comply with modern standards.

Recognition of this need is reflected in actions by the federal government. The federal government attempted to evolve a planned approach to program development and long-range policy based on careful definition of national needs.

National Health grants were made available to the provinces in 1948. Mandatory health insurance programs were introduced in response to political pressures to achieve greater equity in health services. The national health standards for health insurance programs are: universality, reasonable access, comprehensiveness, portability and non-profit administration.

However, when the health insurance programs were introduced, the patterns of health care delivery were left untouched. The subsequent rise in health care expenditures generated a whole new series of regulatory controls, among which are deliberate strategies to restructure the financing of health care resources and the patterns of health care delivery.

At the beginning of the 1970's, it was thought that health services in Canada were of high quality and that controlling costs would not jeopardize the general health of the nation. Authorities were faced with the issue of striking

a balance among cost control, quality of care and the internally generated demand of the system (Van Loon, 1978, p. 454).

There has been a changing focus in the debate about what is necessary and sufficient to assure quality services. These debates have led to the development of more cost-efficient services. For example, it is now popular to provide less intensive services in Long Term Care because the clientele are viewed to be "residents" not "patients."

It is not clear if the increase in the number of utilization of physicians and high technology provides quality of care. In fact, a popular argument is that health care could be improved, if it was less sophisticated and if it was directed towards holistic and preventive principles. For these reasons and because of the rise in health expenditures, the B.C. government has taken steps to curtail the issuing of doctor's billing numbers and providing funds for new hospital equipment and it's maintenance.

In B.C., the Role Study was one attempt made by the planners of the Ministry of Health to provide a rationale for distributing money to hospitals according to their defined roles. The Role Study was to be negotiated between government and the British Columbia Health Association (B.C.H.A.). It was thought that this process would lead to a better quality service.

However, by 1980, efforts to control overall health costs were offset because of the effectiveness of professional bargaining units in negotiating expensive wage settlements. As a consequence, cost became an overriding concern of the Ministry of Health and the Role Study was abandoned for more radical plans.

With the deepening recession of the 1980s, there was a move by the provincial government towards the corporate model of management and increased power of the Treasury Board. The government gave more authority to the Ministry of Finance than to the service oriented ministries such as Health. These actions mark the change of objectives from program development to that of cost control.

The B.C. government brought down a budget in July 1983 which eliminated or curtailed a wide range of social services. Some services affected were family support workers, child abuse teams, transition houses for battered women and special services for severely disabled children. Strong opposition to this budget came from many community and professional groups claiming that the quality of care would diminish. The impact of these changes meant that some of the curtailed services would have to be met by existing services, i.e. the family doctor, local community health centers and hospitals.

The change of objectives of the B.C. government to that

of cost control raises questions about the impact on the quality of care provided in community. Has the quality diminished or are services more efficient?

It was against this political-economic backdrop that the Quality Assurance Standard was introduced by the CCHA, a national self-regulating body which is not responsible to any governmental authority. However, the CCHA is a voluntary agency that is widely accepted and has developed standards based on peer judgement.

Demographic Characteristics

Chapter 1 holds the definition of "smaller" hospitals used in this study. Some demographics are presented so that some characteristics of these hospitals are understood.

The hospitals selected for the sample are scattered throughout the province of B.C. The population of the province is estimated at 2,910,000 in 1985 as based on projections from 1981 census data. Most of the hospitals are found in rural areas. These areas have a population that varies between 2,000 to 10,000.

Some of the hospitals are isolated from larger secondary centers by many miles and hours of travel. Some of the hospitals are relatively close to larger secondary centers. Those hospitals that are closer to other health care

with other facilities for shared services.

There are 105 predominantly acute-care hospitals in B.C. There are 80 (76%) of these hospitals accredited. There are 17 facilities in the province which meet the criteria for smaller hospitals as defined in Chapter 1.

The standards of care provided in the hospitals depend upon the conditions treated at the hospital and the attitude of the professionals. Many of the administrators are concerned about being able to work within the budget and many are in a deficit budget. There is a general concern that they may not be able to meet the necessary minimal standards yet alone the optimal quality assurance standard if the budgets are reduced any further.

CHAPTER III

Methodology

This chapter describes how the empirical data were collected in order to meet the second and third objective:

- to determine the purpose, goals and objectives of the smaller hospitals' quality assurance program as based on empirical findings.

- to determine the components of a quality assurance program for the smaller hospital as based on empirical findings. Four areas will be investigated: board, dietary, nursing and pharmacy.

The Sample

The study is concerned with determining selected quality assurance components for hospitals. The subjects chosen were those administrators of currently accredited, 20-50 bed public general hospitals in B.C. (see full definition in Chapter 1).

Rationale for Selection of this Sample

This particular group of hospitals (administrators) were chosen for study for a number of reasons. First, preliminary

interviews with these administrators indicated that many smaller hospitals are hindered in developing the components of a quality assurance plan due to the lack of available resources.

Second, because of the limited resources, the smaller hospital must use alternative methods in meeting the CCHA standards. This fact is acknowledged by the CCHA and addressed in the supplement to the Standards called "An Interpretation With Special Reference to the Needs of Small Acute Health Care Facilities...".

Third, the administrators and/or their delegates were selected as subjects because they are the managers who are operationally responsible to implement a quality assurance program in the hospital.

Fourth, only hospitals that are currently accredited were chosen. Those hospitals that have not received the results of an accreditation survey indicating that they have met minimal requirements of quality service were ruled out because they were perceived as having difficulty meeting the minimal Standards. This study is concerned with an optimal Standard.

Fifth, only hospitals in B.C. were selected. Smaller hospitals in other provinces were not included because of the problems and costs related to coordinating larger groups which are widely dispersed.

The four areas chosen for study are: the hospital board, nursing, pharmacy and food services. These areas were chosen because they represented a cross-section of the main functional areas: i.e. administration and management, patient care services, and hospital services. Areas such as laboratory and maintenance were ruled out because many quality control regulations are already in place.

Having presented the rationale for the selection of this particular sample, it is appropriate at this time to discuss the assumptions of this study.

Assumptions

1. The single most confounding factor associated with the selection of the sample is determining who is an expert. There is a tremendous difference between a panel of 15 to 20 administrators and a panel of 100 quality assurance "coordinators" and/or quality of care researchers. The administrators were considered experts for the study on the basis that they are educated in and experienced with smaller hospital management.
2. The hospitals are already engaged in quality assurance activities and the administrators can determine the priority of the quality assurance functions.

Project Methodology

The original concept of this study was to determine the components of a quality assurance program in a smaller hospital for four areas: board, dietary, nursing and pharmacy. The intent was to conduct a regional (B.C.) survey to determine optimal and minimal quality assurance components for these areas, and then conduct more intensive research in these areas. The methodology was to use multiple iterations of a questionnaire.

A submission was made to the University of British Columbia Behavioral Sciences Screening Committee for Research and other studies involving human subjects. The experimental procedures proposed for this study were found to be ethically acceptable by this committee and a certificate of approval was issued (see Appendix 111).

Round 1

A pilot test was initiated the first week of March, 1985. Six subjects were contacted by letter first and then by telephone call on March 14 to explain the intent of the questionnaire. A letter of support by Mr. Francis Brunelle (Vice-president, Advisory Services, British Columbia Health Association) was sent out with the questionnaire.

In summary, the questionnaire requested subjects:

1. to identify the purpose, goals and objectives of the hospitals' quality assurance program.
2. to identify minimal and optimal quality assurance functions for each subject area and determine the priority of these functions. The four subject areas were: board, dietary, nursing and pharmacy.

One administrator refused to participate with the study at the onset and left this message with her secretary. Two administrators returned completed questionnaires by the third week of March. The two remaining administrators reported that they had trouble finding the time to complete the questionnaire but agreed to a personal interview.

The initial pre-test indicated that there was a potential for fatigue in order to complete the questionnaire. Yet, those administrators interviewed in person not only completed the questionnaire but gave additional information about the hospital's quality assurance program. For example, data was given about the protocol sheets used for conducting nursing audit procedures, annual reports about medical audit procedures, and minutes of quality assurance meetings.

Discussions with the first five administrators led to voluntary disclosures by them about their opinions of the

Quality Assurance Standard. In fact, many of the administrators seemed more comfortable discussing the issues concerned with implementing the Standard than with answering the questionnaire. All of the subjects reported that they were developing their quality assurance programs but had not completed an overall plan. They assured me that their hospitals were providing quality services.

The questionnaire was edited on the basis of the feedback of the first respondents. The request to distinguish between optimal and minimal quality assurance functions was removed and the following questions were added to the questionnaire:

1. Does your hospital have an overall quality assurance plan?
2. Who is primarily responsible for the quality assurance program and who is operationally responsible for the quality assurance program in the four areas?
3. What are the problems and benefits derived when trying to implement a quality assurance program?
4. What is the administrators' opinion of the new quality assurance requirements for accreditation? (see Appendix IV).

The remaining ten administrators were contacted by letter and by telephone. Attempts were made to have as much personal contact with the administrators as possible. All the

administrators were surveyed over the phone about their perceptions of the Quality Assurance Standard. The researcher met with nine administrators personally, four at their respective hospitals and five in Vancouver. Upon receiving twelve responses (one administrator is the administrator for two of the hospitals), the Round II questionnaire was designed and pre-tested at the beginning of June, 1985.

Following this, another completed Round I questionnaire was received. In addition, this administrator submitted the newly approved hospital's Quality Assurance Plan.

Round II

The responses from the Round I indicated a wide range of functions for each subject area. On average, each administrator indicated five or six major quality assurance functions per area. Collectively these responses made up 16 to 19 functions per area. A second questionnaire was designed that listed all these functions and requested the subjects to assign the priority of these functions (see Appendix V). The intent of this questionnaire was to obtain further validation about the functions and to obtain a consensus about the priority of these functions.

Given the competing demands for the administrators' time, the thesis members recommended a re-surveying of only some of

the administrators. Those three administrators who had not participated in Round I were re-surveyed as were ten other administrators. The other ten administrators were selected according to a stratified sample based on regional representation. All of the administrators returned a completed questionnaire by the end of July, 1985.

Limitations

As with all survey techniques there are questions related to reliability and validity. Two important questions considered during the designing of the questionnaire were: does the instrument actually measure what is planned to be measured and do these data really represent reality? The following list identifies those major reliability and validity concerns for this study.

1) The administrators were expected to complete the questionnaire in consultation with the Chairman of the Board, the dietitian, the Director of Nursing, and the pharmacist. I do not know to what extent these persons were consulted either formally or informally.

2) The subjects were surveyed during the time of many other hospital management activities such as year end budget appraisals, audit programs, annual society meetings, and

preparation for accreditation. In addition, many of the administrators were surveyed during vacation and education leaves. Subsequently, there were long periods of waiting for returns of the questionnaires.

3) These administrators were surveyed by other investigators at the same time; at least two other surveys were being conducted (these surveys were not about quality assurance). Ongoing surveying of these administrators only serves to fatigue and anger them.

4) Only one person did the editing and content analysis of the raw data. The data from Round I were edited so that statements of similar meaning were condensed to one statement. The analysis could have been improved if there were more investigators involved in the process. Considerable time was spent re-assessing the editing and analysis.

5) The reliability of the instrument has not been established. It is not certain if the respondent would mark the questionnaire in the same way if given the same questionnaire for a second time.

6) This type of study does not provide answers to the consequences of undertaking the "quality" assurance functions as described by the respondents.

7) It will not be confirming whether or not these quality assurance functions are really done in the hospitals.

8) The viewpoints of the patients will not be solicited.

CHAPTER IV

Results

This chapter presents the empirical findings from the surveys of the subjects. These data are presented in relatively raw form so that the remarks made by the administrators are clear to the reader. These data are organized under three major headings. An analysis and summary follows each major heading. This analysis attempts to meet the objective of comparing the normative standards with the empirical findings.

Purpose, Goals, and Objectives of the Smaller Hospitals' Quality Assurance Program

The hospitals have Mission Statements which delineate the goals of the hospital. The Mission Statement identifies the hospital board as having the responsibility to provide quality care. In addition to the Mission Statement, three hospitals have a written quality assurance plan that describes the quality assurance program. Six hospitals described the purpose, goals and objectives of their quality assurance program using the questionnaire provided.

Most of the hospitals are in the formative stages of their quality assurance plans. The hospitals are at different

stages of specifying their quality assurance components. Vague, specific and mediocre statements of purpose, goals and objectives for the hospitals' quality assurance program. Two parameters of these statements are summarized below.

1. Vague statements:

Purpose: To achieve and maintain optimum patient care.

Goals: To develop and implement a study, review and adjustment mechanism that will be directed towards the above purpose.

Objectives: To monitor patient care from medical practice through nursing, therapeutic treatments, nutrition and cleanliness of environment, comfortable and safe accommodation through a well maintained facility, courteous, sympathetic and helpful attention to all patient needs.

2. Specific statements:

Purpose: To meet the real and perceived needs of the community by providing optimum care consistent with the geographical location, special requirements both industrial and demographic through the efficient and effective use of the resources available.

Goals: To establish and maintain appropriate methods to review and evaluate care/services provided by the hospital so that problems may be identified and resolved.

Objectives: 1) To maintain adequate administrative/ documenting systems; medical and other records; nursing care; policies, procedures, protocols. 2) To maintain recruitment, orientation, documentation of all personnel including medical staff. 3) To maintain accreditation both general and specific (Lab, CCHA) and conform to all requirements of appropriate regulations and legislation (Workers' Compensation Act; Pressure Vessels Act; Pollution Control; Electrical, Fire Safety Codes). 4) To maintain documented reviews of clinical work of physicians, nurses, patient services. 5) To maintain a communication and feedback system.

In addition to the above statements, I also received statements categorized by one administrator as "practical" and "theoretical." These statements enunciate some of the frustration and controversy related to the CCHA Standard. These statements are informally supported by at least half of the subjects. These statements are summarized below.

1. Purpose statements -

Theoretical: To ensure that the care being provided is of the highest quality possible within our hospital's fiscal framework.

Practical: To retain our accreditation status.

2. Goal statements -

Theoretical: Establish a reporting system (with action

and feedback mechanism) that will document the various quality control measures already occurring and put these together in an organized manner to detail for the board how quality is being ensured.

Practical: To try to get already overworked personnel involved and motivated to tolerate more meetings and analyze further documentation that is currently provided and won't likely change our methods appreciably.

3. Objectives -

To meet the above goals while trying to cope with a deficit, total lack of secretarial staff and one of the most productive smaller hospitals in the province, while hoping CCHA will one day awaken to the real world.

Summary

An analysis of the data indicated a wide range of purpose, goals and objectives for the smaller hospitals' quality assurance programs. Interviews with the administrators indicated that many of them were unsure as to how specific they needed to write these statements and some discussed frustration in trying to write meaningful statements. Some administrators thought that it would be difficult to implement a quality assurance program given the

current provincial policy of fiscal restraint.

The CCHA QA Standard does not provide a written plan for quality assurance that delineates the purpose, goals and objectives of the program. The detailed descriptions of quality assurance programs are expected to be developed in the field and will not be imposed by CCHA.

However, in 1984, CCHA decided to include the Mission Statement as one of the Standards under "Governing Body and Management" (see Appendix VI). This Standard identifies that an "overall plan" is needed to address the achievement of goals and objectives and that this plan is to be subject to regular review and revision.

The booklet of the Proceedings of the Quality Assurance Seminars October 1983 - May 1984, CCHA suggests that quality assurance has to start with a definitive Mission Statement. This booklet gave an example of a Mission Statement that included the following components:

- the population that the hospital serves.
- the level of care that the institution intends to deliver (i.e. primary, secondary or tertiary).
- the major services to be provided in support of the level of care such as general medicine, pediatrics, obstetrics, general surgery, pathology and radiology.
- a definition of the institutions' secondary role in

relation to other local health services.

- a statement of what the hospital is not going to provide
- statements that determine the people who are going to monitor the carrying out of the services.

- a statement on the medical staff's privileges and credentials.

All of the hospitals' Mission Statements have most of these statements, although varying in degree of specificity. One hospital had all these statements and added a few more to the above list, these were:

- the auspices under which the hospital is operated and funded, i.e. a hospital society and through an annual grant from the Ministry of Health, payments of co-insurance, fees from Worker's Compensation Board claimants, and fees from patients not covered by the Medical Services Plan of British Columbia.

- the scope of the services, for example the provision of maternity and birthing care for women experiencing a low risk pregnancy; the provision of 24 hour emergency services.

- the Standards of Care, i.e., CCHA Standards.

- the Community Role, e.g. programs for the education and training of health workers and the role it provides as an economic contributor to the community.

A recent article added to this growing list. This article clearly makes the point that the goals and objectives for the development of a hospital-wide QA program be part of the Mission Statement (Cockerill, 1985, p. 27). This point is not clear from reading the Mission Statement, Goals, Objectives and Planning Standard (CCHA, 1985).

Quality Assurance Functions for the Board, Dietary, Nursing and Pharmacy Areas in Smaller Hospitals

Appendix VI holds all the tabulated results of Round II. The QA functions in Round II were prioritized on a scale of one to five; one representing first priority. For the purposes of compiling scores (13) into cumulative scores, the priority ratings were reversed so that higher priority functions would be represented by higher scores.

The highest possible score would be 65. The range of scores for the board functions is 40 to 60; dietary is 43 to 54; nursing is 31 to 61; and pharmacy is 41 to 59. The three highest and three lowest scores for the functions in each area are displayed in the following tables.

TABLE II

The Three Highest Scores for the Quality Assurance Functions
in Four Areas: Hospital Board, Dietary, Nursing and Pharmacy.
Chosen by 13 Administrators of Predominantly Acute-Care,
Accredited 20-50 Bed Hospitals in British Columbia
June - July 1985.

Area	Function	Score
Board	Development of Mission Statement	60
	CCHA survey recommendations	59
	Appointment/review of medical staff	56
	Appointment/review of senior administrative staff	56
Dietary	Financial controls (budget, records)	54
	Cleaning schedules	54
	Job descriptions	53
	Care and maintenance of equipment	53
	Performance appraisal of staff	53
	System for handling physician diet orders to ensure accuracy	53
	Review and update of goals, objectives, policies and procedures	51
	Staff orientation and continuing education	51
	Application of diet manual	51
	Tray audit	51
Nursing	Review of policies and procedures	61
	Establishment of goals and objectives	58
	Unusual incident/medication error reporting and follow-up	58
	Safety Committee	58
	Nursing Audit	56
Pharmacy	Written procedures for storage, preparation, administration and precautions	58
	Report of medication errors	58
	Development of hospital formulary with regular review	57
	Narcotic control and inspection	56

TABLE III

The Three Lowest Scores for the Quality Assurance Functions in
 Four Areas: Hospital Board, Dietary, Nursing and Pharmacy.
 Chosen by 13 Administrators of Predominantly Acute-Care,
 Accredited, 200-50 Bed Hospitals in British Columbia
 June - July 1985

Area	Function	Score
Board	Joint Conference Committee	47
	Patient satisfaction poll	47
	Utilization review	45
	Risk management	40
Dietary	Patient survey	44
	Staff survey	44
	Provide Meals on Wheels to the Community (Not applicable for four hospitals)	
Nursing	Nursing practice committee	40
	Regional committee	33
	Patient classification systems	31
Pharmacy	Patient discharge counselling program	45
	Patient self-administered drug program	41
	Drug documentation audit (HMRI)	39

Summary

This study illuminated components of a quality assurance program for a smaller hospital which are more specific than those found in the CCHA Standards. The study identified specific quality assurance functions for four areas of a smaller hospital. Further, these functions were prioritized and cumulative scores computed. The highest and lowest scores have been presented. Conclusions can be drawn about which functions are necessary or essential or which functions are least important.

The CCHA QA Standard does not provide a detailed list of QA functions. The booklet about the Proceedings of the Seminars on Quality Assurance holds lists of quality assurance activities presently in effect or planned as identified in various workshops. These activities are not prioritized. For the most part these activities are similar to those functions identified by the subjects with some exceptions. The following Table shows those functions that were not identified in both lists.

TABLE IV

Quality Assurance Functions Unique to Administrators of
Predominantly Acute-care, Accredited 20-50 Bed Hospitals in B.C, June - July 1985
or to the Proceedings of the Seminars on Quality Assurance, CCHA, 1984

Administrators

Board

Monitor all QA committee activities
by reviewing the target for all
department.
Review adequacy of facility and
equipment.

Dietary

Organized system for consultation
with a qualified dietitian.
System for handling doctors' orders
to ensure accuracy, e.g., use of
a kardex.
Menu review and planning.
Staff survey
Providing Meals-on-Wheels to the
community.
Financial controls, e.g., budget,
records.

Nursing

Staffing guidelines.
Regional committee

Pharmacy

Review and update of the goals,
objectives, policies and
procedures.
Written procedures for storage
preparation, administration and
precautions.
Availability of up-to-date CPS
and other references.
Medical staff regulations re
orders, etc.
Staff education and supervision.

CCHA

Board

Trustee orientation.
Periodic review of Mission
Statement (yearly).
Policies concerning job
descriptions and performance.
Monthly departmental budget
reports for trends.
Productivity standards.

Dietary

Therapeutics Committee.
Nutritional support.
committee -- TPN etc.
Dietary internship.
Number of therapeutic diets
compared with regular diets.
Cost per patient per day.
Utilization statistics.
Purchasing from approved
sources.
Tendering.

Nursing

CPR and annual review of
competency
Professional Responsibility
Committee

Pharmacy

Professional standards
Pharmacy and Therapeutic
Committee
Additive program
Security through "night
cupboard" -- assess number
of times necessary to call
pharmacist or ask supervisor
to enter pharmacy

Summary

The survey of the administrators about the functions of a quality assurance program yielded 18 to 22 functions whereas the Proceedings . . . identified 18 to 25 functions. The area of highest agreement for functions is nursing services.

It is not clear as to why there are differences in the kind of quality assurance functions identified by the administrators or at the CCHA Seminars. A reason could be that the functions are relevant to both groups but people failed to mention them when surveyed. Also, the data were collected at two different points in time.

Alternatively, maybe there are real differences between the groups. It could be that the CCHA seminars are dominated by people from very different institutions, i.e., large teaching hospitals that have different priorities than smaller hospitals.

It is not clear as to why nursing services have the highest rate of agreement between the two groups. It could be that nursing has established more commonly known and understood standards for quality assurance.

Additional Empirical Findings

What is the Stage of Development of the Hospital's Quality Assurance Program?

As stated before, most the hospitals are in the formative stages of their quality assurance plan. The following data show some of the verbatim responses of the administrators when asked the preceding question:

"We don't have specific goals and objectives; there are goals and objectives found in the constitution of the hospital."

"The board is not very involved." (This response was common to five hospitals)

"We are at the point of developing a purpose and goal statement for a quality assurance program although we haven't met yet."

"There hasn't been any formal reporting through the quality assurance committee to the Board."

"We are not presently far into quality assurance, but expect that in the next couple of years we will probably do more."

"Our QA program was approved at the end of April. Given the restraint program, the hospital couldn't afford extra staff; so we needed a plan that was simple and practical."

"We have made several attempts to bring this program together. Lack of staff and time prevents us from putting it all together."

"Segments of QA are already in place."

"Only the medical staff have a developed quality assurance program Other departments are working on quality assurance."

Who is Operationally Responsible for the Quality Assurance Program?

The board is ultimately responsible for the quality assurance program. This statement is supported by the normative standards and the empirical findings. In the hospitals, the responsibility for monitoring the program has been delegated to the administrator and/or the Director of Nursing and/or to committees. The QA functions may be assigned to already existing or newly created committees such as the Patient Care Committee and the Joint Conference Committee.

Membership of the Joint Conference Committee typically consists of an equal number of board members, members of the medical staff as well as representatives from senior administration. Membership of the Patient Care Committee usually consists of the administrator, Director of Nursing,

Chief of Medical staff and various department heads. The amount of involvement of individual board members on these committees varies from nil to chairing the QA committee.

The responsibility for the day to day quality assurance program in the dietary department is the food supervisor or head cook. The majority of the hospitals maintain consultation with a dietitian who routinely phones, visits or sends information by mail. The dietitian establishes therapeutic diets and methods of evaluating the providing high quality food for patients and staff.

The Director of Nursing (D.O.N.) or Director of Patient Care Services (as found in one hospital) is responsible for the quality assurance program in the nursing department. In two hospitals, the D.O.N. position is currently vacant, so the head nurses and administrators are assuming the responsibility for the ongoing functioning of the quality assurance program in the nursing department. In eight hospitals, the D.O.N. is often responsible for other service areas such as pharmacy.

Four hospitals do not have a pharmacist. The other hospitals have a part-time or consultant pharmacist. The consultant pharmacist may be a hospital or community pharmacist. The administrators usually prefer a hospital pharmacist.

Undoubtedly, the administrator is the person primarily

responsible for the ongoing commitment to the quality assurance program. This responsibility often includes the sending out of notices of the meetings, preparing the agenda, chairing the meetings and writing up the minutes. Many of the administrators do not have secretarial staff to assist them in this process.

What problems did the administrators encounter when trying to implement a Quality Assurance program?

The following is a list of verbatim responses from the administrators:

"We really have no one on staff with sufficient time and support services to adequately handle the task "

"There has been lack of direction and lack of knowledge; with no lead from CCHA."

"Funding is insufficient for basics let alone QA."

"It is difficult when there are the same people involved in so many committees."

"There has been problems in generating enthusiasm; describing and convincing department heads of need and benefits of QA."

"Getting started is a problem."

"There is a general lack of understanding; we need to cut through the mysteries of the QA lingo."

One administrator described the process of setting up a quality assurance program as thus: "Nobody had any idea what QA meant, or how a QA program should work. We all (administrator and department heads) had to review the literature to arrive at a common understanding of QA." They had to build up their knowledge base. The determining of specific QA functions and standards in each department was a difficult process. The staff were unsure as to what criteria should be set for the study standards. The process of setting up the quality assurance program was very time consuming.

There were unique problems associated with setting up a quality assurance program in the dietary and pharmacy departments. These problems related to the lack of full-time qualified pharmacists and dietitians. The administrators managed with the problems as realistically as possible. Many of the administrators delegated the responsibility for quality assurance in the pharmacy department to the nursing department. Many of the administrators utilized surveys to determine the palatability of the food for staff and patients. In the nursing department, as in some of the other departments, it is difficult to organize meetings because of the assignment of personnel to shift work.

Most small hospitals require longitudinal studies in order to obtain adequate numbers of cases for their results to

be significant. Some hospitals may never get enough data on rare disorders or the therapeutic treatment may change before efficacy is demonstrated. The time required to carry out these studies represents more of a time commitment than other study designs such as cross-sectional which can be used in larger centres. Nor may the staff have the training or the inclination to do the necessary research.

A common complaint by administrators is that there are no funds available for attendance not only at inhouse quality assurance meetings but also for any job related conferences or quality assurance seminars which, because of demand, are usually located in large population centers. Thus, part of the reason for this lack of attendance is because of the long distances that staff have to travel on their own time. In short, the development of a quality assurance program represents an increased expense for the smaller hospital administrator. This provides little incentive for the voluntary commitment to accreditation.

However, many of the problems related to monitoring the quality of care delivered in smaller hospitals are overcome by a number of specific management techniques. Daily contact with all staff in all areas is possible in a smaller hospital. Senior management is able to observe directly and subjectively the state of cleanliness, the appearance of food and the need

for repair of the physical plant. The complaints of time constraints by department heads in order to meet accreditation requirements are countered by a combination of practical assistance and assertion of authority.

In any smaller hospital, no complaint rarely goes unreported because of the close work environment. Because of the close community ties, complaints are investigated immediately with a quick response to the complainant.

What Benefits Have Been Gained From Implementing a Quality Assurance Program?

In spite of all these problems listed above, there are benefits associated with implementing a QA program. The following is a list of verbatim responses from administrators:

"There is not a well understood and able to be acted upon medical audit."

"Good way to get work out of the board member who chairs the QA committee."

"Great improvement of hospital manuals."

"Audit results prove excellence of service previously only 'felt'."

"Brought into the open interdepartmental conflicts."

"None yet."

"We have all become more aware of what we should be doing and how well it should be done versus our actual performance."

"People have been forced to think about their jobs and their performance and are taking more pride in themselves."

What Are the Administrators' Reactions to the New Quality Assurance Requirements for Accreditation?

The following lists the administrators responses:

"The requirements are good. They clearly outline what is required but leave the 'how to' for each hospital to figure out. This follows appropriate rules of delegation."

"Terrible! The requirements give no consideration to the cost, the difficulty of implementation, the fact that government does not support the program or that CCHA do not themselves know what they want from QA."

"Good. It assures the provider and consumer that care is being assessed and graded."

"Object somewhat to its being mandatory but am pleased to see the introspection it forces upon the hospital."

"Both good and bad. Good -- they make the process dynamic and require systems to maintain adherence to the Standards. Bad -- created a new language system that seems to require a new profession to unravel the mysteries to the unknowing."

Summary

The data show that there are problems related to implementing a QA program but at the same time there are a number of benefits related to the program. The variety of responses of the administrators to the QA requirements could represent the stage of acceptance or non-acceptance commonly experienced during a significant change.

The Application of the Doll and Donabedian Models

The last area for analysis is to compare the two most popular quality assurance models with the empirical findings. The Donabedian model was constructed as a framework to evaluate the methods for assuring quality of care, i.e., structure, process and outcome. The Doll model presents three elements of a model that define quality. These elements are medical efficacy, social acceptability and economic efficiency.

In Chapter II, it was argued that the Doll model was more appropriate for the current CCHA requirements than the Donabedian model. the Doll model includes more elements that are relevant to the current policies of fiscal restraint by government and the requirements of a quality assurance program by the CCHA. The policy of fiscal restraint could be

represented in the element of economic efficiency and the requirements of quality assurance could be represented in the elements of social acceptability and economic efficiency. Take as an example, some of the empirical quality assurance functions identified in the dietary department. These functions could fit into the doll model as follows:

1. Medical efficacy would include:

cleaning schedules, care and maintenance of equipment, temperature audits, public health and sanitation tests, application of diet manuals, organized system for consultation with a qualified dietitian, etc.

2. Social acceptability would include:

patient and staff surveys, tray audits.

3. Economic efficiency would include:

stocking and inventory, financial controls, performance review of staff, etc.

It is not difficult to convince the reader that the Doll model is a suitable model for categorizing various quality assurance functions. The challenge is to determine if the model can also be used as a method to assess and monitor quality assurance components. Doll sees each element as being monitored in terms of the outcome achieved or by the process in which the outcome is reached. Since Doll uses the terms

common to Donabedian, it seems appropriate to combine the two models. The Donabedian model is used as a broad framework to assess and monitor the elements that define quality as suggested by Doll. A similar suggestion was made earlier by Donabedian (1982). The conjoint application of these two models is displayed in Table V. The empirical quality assurance functions for the dietary department are used in this example.

Table V

A Method for Assessing and Monitoring Quality Assurance
Components in the Dietary Department

Quality Assurance Elements	Approaches to Assessment and Monitoring	
	Process	Outcome
Medical Efficacy	<ol style="list-style-type: none"> 1. Application of diet manual. 2. Recording of dietary progress of patients. 3. Cleaning schedules. 	<ol style="list-style-type: none"> 1. Health-effects of eating the diet: as indicated by weight, etc. 2. Public health and sanitation tests indicate adequacy of schedules.
Social Acceptability	<ol style="list-style-type: none"> 1. Patient survey. 2. Staff survey. 3. Tray audit. 	<ol style="list-style-type: none"> 1. Public satisfaction or dissatisfaction.
Economic Efficiency	<ol style="list-style-type: none"> 1. Financial controls. 2. Stocking and Inventory 	<ol style="list-style-type: none"> 1. Indicators: within budget or over the budget. 2. Criteria for determining if stock is well utilized.

Final Summary and Conclusions

This chapter presented the empirical findings from the surveys of the subjects. The data were collected in order to determine what are the purposes, goals and objectives of the smaller hospitals' quality assurance program. This data were analyzed and compared with the normative standards. It is not clear from the CCHA standards as to what these statements should include. However, the booklet of the "Proceedings of the Quality Assurance Seminars" . . . suggests that quality assurance should start with a definitive "Mission Statement." This chapter has described components for a "Mission Statement" based on normative standards and empirical findings.

The review of the literature showed that there were no explicit "Gold Standards" (i.e., commonly agreed upon standards) for specific functions of the quality assurance programs for smaller hospitals. The survey data indicate the most common and most strongly or weakly agreed upon functions for four areas: board, dietary, nursing and pharmacy. These functions were compared with those functions identified in the CCHA Seminars and differences were found. It is uncertain as to why these differences exist.

The literature review also indicated that there were a

number of controversial issues affecting the implementation of the Quality Assurance Standard and raised questions about the significance of the Standard for the smaller hospitals. A number of questions were asked to determine if there were issues affecting the implementation of the quality assurance program and an evaluative question to determine the stage of development of the quality assurance program. The empirical data indicated some ambivalence and obstacles to implementing a quality assurance program. Yet, hospitals were proceeding with developing a quality assurance program. As pointed out in the literature, these obstacles may be due to a response to change.

The last area of analysis was to determine the compatibility between the popular quality assurance models and the empirical findings. The conclusions are that the two models can be used conjointly to determine and assess the functions of a quality assurance program. However, it is suggested that more research be done in applying the two models as a method to assess and monitor quality assurance components. The Doll model is appropriate for implementing a QA program, i.e., identifying the elements that define quality.

CHAPTER V

Conclusions and Recommendations

The components of a quality assurance program identified in this study has produced many items which might be considered obvious. However, the technique of pooling together the functions identified in Round I and re-surveying of subjects in Round II illuminated more quality assurance functions. There were approximately two times more functions acknowledged by the administrators in Round II.

With some exceptions, the empirical data are consistent with the normative standards. The intent of the study was not to establish an institutional-wide QA program as specified in the Standards but to identify components specific to a QA program in smaller hospitals. The CCHA Standards do not identify the specific functions of the QA program for smaller hospitals; this study does.

The functions identified in this study are specific and are generated by the administrators who have the responsibility for the ongoing operation of the QA program. It is likely that the priority ratings of these functions are useful for forward planning when alternatives must be considered during this time of fiscal restraint.

The administrators' reaction to the QA Standard could be

summarized in one statement: "Quality is good but at what cost?" Although the QA Standard was developed in response to shifting political and professional pressures, it may not fully take into account formal and informal restrictions to innovative programs. These formal restrictions are resource limitations imposed by government and the informal resistance to change by professionals.

The CCHA Standards appear to be overwhelming to smaller hospital administrators. This study has demonstrated that the hospitals can identify many components of a QA program but may not be able to integrate them into an overall QA program.

Reliability and Validity of the Study

Many of the reliability and validity issues have been discussed in Chapter III; some of these issues deserve further discussion now that the study is completed.

The method of enquiry used in a study will inevitably affect the results. This kind of study is based on human opinion and judgement. It does not provide scientific truths. It only took into account those components identified by the administrators who participated in the study.

Those who were chosen and agreed to participated in this study will be different from those who did not participate. The validity (accuracy) or the study could be confirmed by

repeating the study with a different group, different observer, or by a different method. One method would be to use a committee as the participant group. It is unsure if a committee would have the patience or time to generate such a comprehensive list of functions and vote on these functions.

The literature indicates that the reliability (reproducibility) of the information is increased by having more Rounds. The impression is that the reliability of the information would decrease with subsequent rounds because of the potential for fatigue of the participants. A larger number of participants would have meant altering the sample criteria or selecting participants from out of the province.

The reliability and validity of the study was improved by the high rate of returns of the questionnaires and by the use of random sampling with the pre-test and stratified sampling with Round II.

Recommendations

On the basis of an analysis of the literature and the empirical data, the following recommendations are suggested.

- 1) It is recommended that the hospital establish a Quality Assurance Plan that includes the following elements: purpose, philosophy, organizational structure and roles, goals

and objectives.

The purpose outlines the intent of the plan. The philosophy identifies the guiding principles and beliefs for the conduct of the QA program. The organizational structure and roles identifies the lines of authority and responsibility of the people involved in the QA program. The roles of the board, medical staff, senior administrative staff and hospital staff need to be defined.

The goal statements guide the development of the objectives. The goals are statements of relatively broad scope and need to be specified in measurable terms. Objectives are narrower than goals and more specific in scope. Objectives are measurable, achievable, time-related, understandable and specific. The difference between goals and objectives is illustrated in the following example. The hospital's goal is to provide high quality care; one of its objectives is to comply with CCHA Standards.

2) Administrators who are developing their QA program should be aware of this study.

The QA components developed in this study would be of interest to larger and smaller, accredited and non-accredited hospitals. The QA functions identified in this study are similar to those identified in the CCHA seminars, with some exceptions. These exceptions help distinguish those quality assurance functions which are unique to smaller hospitals.

3) Administrators should be aware of functions identified as high and low priority.

This information would be of interest in planning a QA program and for determining priorities for the QA program.

4) Recommend that suitable models for implementing QA are developed and utilized.

Government policies, along with the strong voluntary support of accreditation programs, make it vitally important that suitable models for implementing QA are developed. As argued in this study, the Doll model is suggested as a basis for implementing QA. Given the competition for health services resources, health planners and hospital administrators can ill afford to ignore a model which might provide greater benefits through the inclusion of more elements.

5) Recommend that where geography permits, groups of hospitals pool together their resources and conduct QA studies jointly.

One component of the doll model is the mounting of regional morbidity and mortality surveys to determine need. Another component is to conduct controlled trials in limited settings. Following a review of these components and the empirical data, the preceding recommendation was formulated. This recommendation seems appropriate, particularly for

smaller hospitals where there are limited resources both material and human.

6) Recommend that a clear methodology for assessing the quality of care be developed.

This study discussed the numerous methodological problems associated with assessing quality of care. In addition, the administrators verbalized that there is a general lack of direction and lack of knowledge about how to carry out a QA program. Also, this study suggested the use of the Doll model and the Donabedian as a methodology for assessing the quality of care. This methodology needs to be further tested in order to determine its usefulness.

It is important that a methodology be developed that is relatively practical, timely, inexpensive and not disruptive to the current system. The methodology should be widely acceptable to the people who work in the hospital and the community at large. The methodology should be consistent and objective so that it can be applied repeatedly using the same ground rules. Finally, the methodology should be directly or indirectly related to outcome.

7) Recommend that smaller hospitals use more qualitative methods rather than quantitative methods to evaluate the quality of care.

There was some concern expressed by administrators that there is lack of adequate numbers for the smaller hospital to

conduct meaningful studies. One way to deal with this problem is to focus on broader, generic topics that cut across a variety of situations. These topics could include the staff and patients' opinions about the quality of the food, the effectiveness of discharge planning and the effectiveness of out-patient care.

8) Recommend that administrators eliminate redundant committees and consolidate activities that can be carried out by small structured groups.

Some administrators were concerned about the redundancy of meetings and the same people having to spend time attending numerous meetings. Alternatively, other administrators expressed a concern that there was often just one or two people who are carrying the responsibility of the QA program. The documentation process demands a lot of time. Decreasing the frequency of meetings and eliminating redundant meetings could lead to more meaningful staff involvement in the institution-wide QA program.

Conclusion

This study was concerned with a primary objective: to determine the components of a Quality Assurance program. Along with this objective, other objectives and questions were generated. A major assumption made at the beginning of the

study was that hospitals are already engaged in QA activities. This assumption was supported by the empirical data. a The objectives were met and the questions researched.

In comparison to other efforts to improve the quality of care, the QA standard is more comprehensive. However, many smaller hospital administrators expressed their concern about being able to fully meet the requirements of the QA standard.

The information derived from this study could be used as a basis for forming a QA program in a hospital.

Areas for Further Research and Development

Many of the issues discussed in the study are not new. Research into the methodology used in quality measurement and assurance needs to be continued. Research needs to be continued about methods of retraining and re-orientating people who are involved in QA at the service level.

There is a need to investigate the effects of environment and organizational structure on the quality of care. The operational and conceptual sides of organizational behavior need to be investigated.

Having identified specific components for QA, it would be interesting to examine specific hospitals to see whether these QA functions are being carried out, what priority these QA functions have and to what extent the QA program is carried

out. The hospitals examined could be large or small, rural or urban, acute care or extended care. Other hospital departments and the medical service could be investigated too.

There is a need to investigate the effects of environment and organizational structure on the quality of care. The operational and conceptual sides of organizational behavior need to be researched and developed in order to further our understanding about quality assurance. This study and the CCHA standard leaves us somewhat unclear about the organizational dimensions of QA programs.

An important research question is: how much are we willing to spend on health care and for what amount of quality. Another question involves the relative cost and benefits of individual QA functions. With limited amount of resources, how much are hospitals willing to spend on assessing the quality of health service versus the actual provision of QA?

Another more global policy issue is: should health service resources go towards assessing the delivery of care or should money go towards changing people's lifestyles? The Lalonde Report was one federal report that challenged the policy of focussing resources on health care organizations. Almost all of the federal health service expenditures go towards health care organizations, whereas the largest

should money go towards changing people's lifestyles? The Lalonde Report was one federal report that challenged the policy of focussing resources on health care organizations. Almost all of the federal health service expenditures go towards health care organizations, whereas the largest percentage of current morbidity and mortality can be related to lifestyle.

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APPENDIX I
QUALITY ASSURANCE

93

PRINCIPLE

THE HEALTH CARE FACILITY SHALL DEMONSTRATE A CONSISTENT ENDEAVOUR TO DELIVER OPTIMAL PATIENT CARE. A MAJOR COMPONENT IN THE APPLICATION OF THIS PRINCIPLE IS THE OPERATION OF A QUALITY ASSURANCE PROGRAM.

QUALITY ASSURANCE IS THE ESTABLISHMENT OF HOSPITAL-WIDE GOALS, THE ASSESSMENT OF THE PROCEDURES IN PLACE TO SEE IF THEY ACHIEVE THESE GOALS AND, IF NOT, THE PROPOSAL OF SOLUTIONS IN ORDER TO ATTAIN THESE GOALS. THE QUALITY ASSURANCE PROGRAM SHOULD BE INTERNAL, INTERNALLY-ADMINISTERED, ONGOING, SPECIFIC TO THE INSTITUTION, STRUCTURED AND COORDINATED WITHIN THE FACILITY.

STANDARD I ESSENTIAL COMPONENTS

A QUALITY ASSURANCE PROGRAM MAY USE MULTIPLE APPROACHES AND METHODOLOGIES TO DETECT AND ASSESS PROBLEMS, PLAN MEASURES TO REDUCE OR ELIMINATE SUCH PROBLEMS, AND EVALUATE AND MONITOR THE EFFECTIVENESS OF IMPLEMENTED CHANGES.

Interpretation

The overall program should include:

Periodic revision of the mission of the health care facility.

Coordination of departmental goals with those of the health care facility.

Evaluation of human and physical resources.

Problem detection through: monitoring of statistics and indicators
 auditing
 external reviews and consultations.

Objective assessment and investigation of identified problems.

Recommendations for resolution of these problems.

Implementation of actions and measures to overcome problems.

Monitoring activities designed to assure that the desired result has been achieved and sustained.

Documentation that substantiates the effectiveness of the overall program to enhance patient care and to assure sound clinical performance.

STANDARD II ORGANIZATION AND ADMINISTRATION

THERE SHALL BE A CURRENT WRITTEN PLAN DESCRIBING THE ORGANIZATION AND IMPLEMENTATION OF A QUALITY ASSURANCE PROGRAM DESIGNED TO ENHANCE PATIENT CARE.

Interpretation

The board, having the overall responsibility for the conduct of the health care facility, shall initiate and support the development of a facility-wide quality assurance program to assure the attainment of the goals of the health care facility in support of the board approved mission statement.

The development and coordination of the quality assurance program may be accomplished through a committee, group or individual. The organizational structure shall be determined by the board on the advice of the administration and the professional and other staffs of the health care facility.

The written plan for quality assurance shall describe the mechanisms used to:

Delegate responsibility for the various activities that contribute to the program.

Assure completeness and integration of all components of the program.

Define reporting channels for professional and other departmental quality assurance activities.

Existing professional quality assurance activities detailed in other sections of these standards, such as medical staff credentialling and delineation of privileges, death and complication review, infection control, tissue review and structured audit programs, and nursing staff incident reviews, patient classification programs and nursing audit programs, and facility-wide utilization reviews must be encouraged and integrated in the overall health care facility quality assurance program.

Other departments and services shall develop appropriate mechanisms to evaluate their degree of attainment of their unit goals.

Terminology used to describe studies conducted or methods employed shall be defined in writing and be available to all.

STANDARD III DIRECTION AND STAFFING

IT IS EXPECTED THAT THE QUALITY ASSURANCE PROGRAM BE SUPPORTED BY DESIGNATION OF APPROPRIATE PERSONNEL ON EITHER A FULL-TIME OR PART-TIME BASIS TO THE ROLE OF QUALITY ASSURANCE COORDINATOR OR BY ASSIGNING RESPONSIBILITY FOR QUALITY ASSURANCE DIRECTION WITHIN THE EXISTING ORGANIZATIONAL STRUCTURE.

Interpretation

The quality assurance program may be coordinated by a full-time or part-time quality assurance coordinator, or by assigning quality assurance responsibilities to existing department and service heads or committees. Whatever the structure used for coordination, all duties and responsibilities shall be clearly described in writing and agreed upon by all concerned.

If a full-time coordinator is assigned, their role may be that of a resource person, stimulator or activator or it may be that of a data collector and correspondence secretary depending on the role assigned to department or service heads within the organizational structure.

If the quality assurance program is entirely assigned to existing staff within the existing organizational framework, there may be no additional staff assigned to this function.

STANDARD IV REPORTING

FINDINGS OF QUALITY ASSURANCE ACTIVITIES THROUGHOUT THE FACILITY SHALL BE REPORTED BY THE PROFESSIONAL AND OTHER STAFF ORGANIZATIONS TO THE GOVERNING BODY AND MANAGEMENT BY A MECHANISM THAT DOES NOT CONFLICT WITH NORMAL EXECUTIVE REPORTING CHANNELS.

Interpretation

The reporting mechanisms and channels shall accommodate the preexisting quality assurance programs and activities of professional staffs as well as the developing programs in other areas of the health care facility. The reporting mechanisms shall be defined in writing, and shall include reporting schedules, and the format and content of reports at various reporting levels.

Department reports may be part of normal reporting mechanisms.

STANDARD V EVALUATION

THE QUALITY ASSURANCE PROGRAM SHALL BE APPRAISED ANNUALLY THROUGH A DESIGNATED MECHANISM.

Interpretation

The quality assurance program developed by the health care facility should be reviewed on an annual basis for its effectiveness. This reappraisal should identify components of the quality assurance program that need to be altered or deleted.

Evaluation of the quality assurance activities should ensure that the program is ongoing, comprehensive, effective in improving patient care and clinical performance, as well as being conducted with cost and time efficiency.

THE HEALTH CARE FACILITY'S QUALITY ASSURANCE PROGRAM SHALL BE EMPHASIZED IN DETERMINING THE ACCREDITATION OF THE FACILITY.

APPENDIX II
QUALITY ASSURANCE

96

STANDARD I ORGANIZATION AND ADMINISTRATION

Every accredited health care facility must have an organized program of quality assurance which encompasses all the activities performed within the facility. The final responsibility for the creation and maintenance of such a program rests with the Board.

Evaluation
Requirement

The program must be so designed that the Board and, through the Board, the public may be assured that the health care facility is striving to effectively provide the service listed in the mission statement. The Board must be assured that the professional and support services are being continuously evaluated, corrected and improved where necessary.

Program Design

An administrative structure to support the quality assurance program should be planned and implemented. In health care facilities with adequate resources, this may be achieved through the formation of a multidisciplinary quality assurance committee. In small health care facilities the function may be assigned to an existing committee, such as a patient care committee, or to a particular individual such as the chief executive officer, chief of staff or director of nursing. All professional staff should contribute to the program with activities both in the individual services and in multidisciplinary studies.*

Program Structure

An initial step for most health care facilities in setting up a facility-wide quality assurance program is to conduct an inventory of quality assurance activities presently being conducted. In addition to the audits of the medical and nursing staffs and the quality control of the laboratory, most health care facilities will find there are many other activities which may not have been thought of as quality assurance programs. These might include staff performance appraisals, safety inspections, monitoring by the infection control committee, and patient questionnaires. Once these programs have been identified and the activities documented, the responsible group or person should identify the gaps and weaknesses in the overall program and initiate activities to fill these gaps.

Initiating a
Program

* The CCHA Quality Assurance Manual is available from CCHA offices and expands on methodologies for quality assurance programs.

STANDARD II ESSENTIAL COMPONENTS

After a potential problem has been identified by individuals, groups, services, or others, the group or person who has the responsibility for the overall quality assurance program should:

Evaluation
Process

- (a) assess the problem;
- (b) assign it a priority;
- (c) propose methodologies, and suggest and support appropriate studies;
- (d) establish a schedule;
- (e) suggest corrective measures; and,
- (f) assign follow-up studies.

STANDARD III ISSUE/PROBLEM IDENTIFICATION

No further interpretation is required.

STANDARD IV ASSESSMENT

When a problem is specific to a department of service, the methodologies chosen to study this problem must be studied within that department or service. If the subject to be studied is influenced by the activities of a number of professionals, a multidisciplinary approach is suggested.

Responsibilities
of Staff

In either case, each group must be held responsible for carrying out the assessment of its own activities. The creation of a facility-wide quality assurance program does not obviate the department/service responsibility for self-evaluation.

STANDARD V IMPLEMENTATION OF RECOMMENDATIONS

As a result of the studies carried out, suspected problems can be dismissed as non-existent, or the deficiencies can be identified. A summary of these studies and their results should be reported regularly to the responsible authorities including the Board. Recommendations for corrective measures should also be reported. Recommendations should not be viewed as necessarily disciplinary. They may include recommendations for educational programs, additional resources or personnel, etc.

Evaluation
Reporting
Mechanisms

After due consideration, the Board must ensure that these recommendations are implemented. Control studies, following a suitable interval of time, are mandatory to ensure that the original problem has been eliminated.

Follow-up to
Studies

STANDARD VI REPORTING

No further interpretation is required.

STANDARD VII EVALUATION

The purpose of any quality assurance activity is to introduce a process whereby improvements can be made in all the activities of the health care facility. It is therefore necessary that an evaluation of the quality assurance program itself be conducted periodically to assess its effectiveness. A restructuring of the program may be required when deficiencies or weaknesses are identified through this evaluation.

Program
Evaluation

QUESTIONNAIRE

THE COMPONENTS OF A QUALITY ASSURANCE PROGRAM FOR SMALLER
HOSPITALS IN BRITISH COLUMBIA

The purpose of this study is to identify select components of a quality assurance program for smaller hospitals in British Columbia. this study is an essential part of my master's thesis (U.B.C. -- Health Services Planning and Administration). A summary report of the findings will be made available to you upon completion of the study.

I hope that you agree to participate in this study by completing this questionnaire. A refusal to participate or withdraw at any time will in no way reflect adversely on you or your hospital. Names of the participants and the institutions will not be requested, and only I will have access to your completed questionnaire. Please remember that this questionnaire is not a test; I am interested in candid and real responses to the questions.

INSTRUCTIONS:

Your hospital is already involved with quality assurance functions. The manner in which your departments are organized, your everyday problem-solving activities and your performance reviews are all a form of quality assurance. I am requesting you to document here what those quality assurance functions are for: the board, dietary, medicine, nursing and pharmacy. Please follow these steps:

I. First, does your hospital have an overall quality assurance plan? A. No ____ B. Yes ____ C. Partially developed ____

If no, describe in the following space, the stage of development of your hospital's quality assurance, i.e., who is involved, what are the plans, etc. If "yes" or if your plan is "partially developed", please answer the questions as provided.

A.

II. Do you have purpose, goals and objectives for your hospital's quality assurance program? Yes ____ No _____. If "yes", please describe using the space provided on page 4. Alternatively, if the quality assurance goal statements are found in the mission statement, please attach or describe.

III. What is your reaction to the new quality assurance requirements for accreditation?

IV. Please identify for each subject area the quality assurance functions and determine how important these functions are (see Example I, page 5 and Importance Key at the end of page 5 and on page 4). Please use the question sheets provided.

B. If "yes", describe:

1a. Who is primarily responsible for the quality assurance program? _____

1b. Who is operationally responsible for the quality assurance program in the following areas:

- (i) board _____
- (ii) dietary _____
- (iii) medicine _____
- (iv) nursing _____
- (v) pharmacy _____

1c. What problems did you encounter trying to implement a quality assurance program?

1d. What benefits have been gained from implementing a quality assurance program?

QUESTIONNAIRE

STEP II:

What are the purpose, goals and objectives of the hospital's quality assurance program?

Purpose: _____

Goals: _____

Objectives: _____

QUESTIONNAIRE

STEP IV

SUBJECT AREA: MEDICAL RECORDS

II. Please list all the quality assurance functions for this subject area and circle the level of importance:

	IMPORTANCE				
	HIGH			LOW	
	1	2	3	4	5
1. _____					
2. _____					
3. _____					
4. _____					
5. _____					
6. _____					
7. _____					

IMPORTANCE KEY

What is the importance of this function:

1	2	3	4	5
very important	important	somewhat important	unimportant	very unimportant

QUESTIONNAIRE

STEP IV

SUBJECT AREA:

II. Please list all the quality assurance functions for this subject area and circle the level of importance:

	IMPORTANCE				
	HIGH			LOW	
	1	2	3	4	5
1. _____					
2. _____					
3. _____					
4. _____					
5. _____					
6. _____					
7. _____					

IMPORTANCE KEY

What is the importance of this function:

1	2	3	4	5
very important	important	somewhat important	unimportant	very unimportant



THE UNIVERSITY OF BRITISH COLUMBIA
Faculty of Medicine

Department of Health Care and Epidemiology
Mather Building
5804 Fairview Avenue
Vancouver, B.C.
V6T 1W5
(604)228-2772

May 30, 1985.

Dear _____:

Thank you for your participation in my study which is intended to determine the components of a quality assurance program for the currently accredited, predominantly acute-care hospitals of 20-50 beds in B.C. The response rate to the first questionnaire was a very gratifying 75%.

Enclosed you will find summary lists of quality assurance functions for four areas: board, dietary, nursing and pharmacy. These functions were identified as important by the participants of the study. To further clarify areas of agreement and disagreement amongst participants, I am asking the participants to rank the functions. Instructions of the ranking scale is attached.

When completed, please return the questionnaire to me in the stamped addressed envelope by June 14. Once again, I want to emphasize that your replies shall remain confidential. It takes approximately 20 minutes to complete the questionnaire.

The
The time you are taking to participate in this study is greatly appreciated. I will keep you up-to-date with the final results of the study.

Yours sincerely,

Carol J. Finnie, B.S.N.

QUESTIONNAIRE

Round II

THE COMPONENTS OF A QUALITY ASSURANCE PROGRAM FOR SMALLER HOSPITALS IN BRITISH COLUMBIA

The purpose of this study is to identify select components of a quality assurance program for smaller hospitals in British Columbia. this study is an essential part of my master's thesis (U.B.C. -- Health Services Planning and Administration). A summary report of the findings will be made available to you upon completion of the study.

I hope that you agree to participate in this study by completing this questionnaire. A refusal to participate or withdraw at any time will in no way reflect adversely on you or your hospital. Names of the participants and the institutions will not be requested, and only I will have access to your completed questionnaire.

INSTRUCTIONS:

The following list summarizes the views expressed as to the components of a quality assurance program for four areas: board, dietary, nursing and pharmacy.

Please rank each statement by circling the level of importance according to the following scale;

1	2	3	4	5
very important	important	somewhat important	unimportant	very unimportant

EXAMPLE: Medical Records

	HIGH			LOW	
Release of information	1	2	3	4	5
Accuracy of coding and abstracting	1	2	3	4	5
User satisfaction survey	1	2	3	4	5

Master List Board

	HIGH					LOW				
Review of board structure, committees and overall hospital organizations _____	1	2	3	4	5					
Development of mission statement _____	1	2	3	4	5					
Review of bylaws, goals and objectives _	1	2	3	4	5					
Review society membership and public image	1	2	3	4	5					
Review adequacy of facility and equipment	1	2	3	4	5					
Review budget, cash flow, financial record	1	2	3	4	5					
Monitor all quality assurance committee activities by reviewing the targets for all departments _____	1	2	3	4	5					
Appointment/review of medical staff _____	1	2	3	4	5					
Appointment/review of senior administrative staff _____	1	2	3	4	5					
Review administrators (monthly) board report _____	1	2	3	4	5					
Maintain good communication between hospital and community _____	1	2	3	4	5					
Disaster Plan and Fire Plan _____	1	2	3	4	5					

	HIGH				LOW
Patient satisfaction poll _____	1	2	3	4	5
CCHA survey recommendations _____	1	2	3	4	5
Joint Conference Committee _____	1	2	3	4	5
Comparative statistics (with same size facility) _____	1	2	3	4	5
Utilization review _____	1	2	3	4	5
Risk management committee _____	1	2	3	4	5

IMPORTANCE KEY

What is the importance of this function:

1	2	3	4	5
very important	important	somewhat important	unimportant	very unimportant

Any additional comments (please rank if appropriate):

Master List Therapeutic Dietary/Food Services

	HIGH					LOW				
Review and update of goals, objectives, policies and procedures _____	1	2	3	4	5					
Public health and sanitation tests _____	1	2	3	4	5					
Temperature audits _____	1	2	3	4	5					
Cleaning schedules _____	1	2	3	4	5					
Care and maintenance of equipment _____	1	2	3	4	5					
Organized system for consultation with qualified dietitian _____	1	2	3	4	5					
Staffing guidelines _____	1	2	3	4	5					
Job descriptions _____	1	2	3	4	5					
Performance appraisal of staff _____	1	2	3	4	5					
Staff orientation and continuing education _____	1	2	3	4	5					
Stocking and inventory _____	1	2	3	4	5					
Application of diet manual _____	1	2	3	4	5					

	HIGH				LOW
System for handling physician diet orders to ensure accuracy, e.g., use of a Kardex	1	2	3	4	5
Menu review and planning _____	1	2	3	4	5
Recording of dietary progress of patients	1	2	3	4	5
Patient education re: therapeutic diets _	1	2	3	4	5
Tray audit _____	1	2	3	4	5
Patient survey _____	1	2	3	4	5
Staff survey _____	1	2	3	4	5
Provide Meals on Wheels to the community _	1	2	3	4	5
Financial controls, e.g., budget, records	1	2	3	4	5

IMPORTANCE KEY

What is the importance of this function:

1	2	3	4	5
very important	important	somewhat important	unimportant	very unimportant

Any additional comments (please rank):

Nursing Master List

	HIGH					LOW
Establishment of goals and objectives ____	1	2	3	4	5	
Review of policies and procedures _____	1	2	3	4	5	
Performance appraisal of staff _____	1	2	3	4	5	
Staff orientation and continuing education	1	2	3	4	5	
Staffing guidelines _____	1	2	3	4	5	
Develop comprehensive standard care plans	1	2	3	4	5	
Nursing Audit _____	1	2	3	4	5	
Unusual incident/medication error reporting and follow-up _____	1	2	3	4	5	
Interdisciplinary team conferences _____	1	2	3	4	5	
Patient classification systems _____	1	2	3	4	5	
Crash cart audit _____	1	2	3	4	5	
Discharge planning (including referral to community resources) _____	1	2	3	4	5	

	HIGH			LOW	
Patient teaching programs _____	1	2	3	4	5
Transfer of function _____	1	2	3	4	5
Record all medical-surgical supplies ordered _____	1	2	3	4	5
Committees:					
Infection control _____	1	2	3	4	5
Quality Assurance _____	1	2	3	4	5
Nursing Practice _____	1	2	3	4	5
Safety _____	1	2	3	4	5
Regional _____	1	2	3	4	5
Patient conference _____	1	2	3	4	5

If your nursing department does audits, please describe:

IMPORTANCE KEY

What is the importance of this function:

1	2	3	4	5
very important	important	somewhat important	unimportant	very unimportant

Any additional comments (please rank):

Master List Pharmacy

	HIGH					LOW				
Review and update of the goals, objectives, policies and procedures _____	1	2	3	4	5					
Written procedures for storage, preparation, administration and precautions ____	1	2	3	4	5					
Purchasing and inventory records _____	1	2	3	4	5					
Evaluation of: drug utilization _____	1	2	3	4	5					
drug orders _____	1	2	3	4	5					
drug reaction _____	1	2	3	4	5					
cost effectiveness _____	1	2	3	4	5					
Development of a hospital formulary with regular review _____	1	2	3	4	5					
Availability of an up-to-date CPS and other references _____	1	2	3	4	5					
Drug profiles on patients/residents ____	1	2	3	4	5					
Interdisciplinary meetings to evaluate patients _____	1	2	3	4	5					
Medical staff regulations re: orders, etc. _____	1	2	3	4	5					
Review of outdated stock on ward and return of it to pharmacy _____	1	2	3	4	5					

	HIGH				LOW
Consultation with pharmacist _____	1	2	3	4	5
Poison control _____	1	2	3	4	5
Drug documentation audit (HMRI) _____	1	2	3	4	5
Staff education and supervision _____	1	2	3	4	5
Narcotic control and inspection _____	1	2	3	4	5
Report of medication errors _____	1	2	3	4	5
Patient discharge counselling program _____	1	2	3	4	5
Patient self-administered drug program _____	1	2	3	4	5
Drug information service _____	1	2	3	4	5

IMPORTANCE KEY

What is the importance of this function:

1	2	3	4	5
very important	important	somewhat important	unimportant	very unimportant

Please add any additional comments and rank these comments:

THERE SHALL BE A GOVERNING BODY OR EQUIVALENT THAT HAS LEGAL AND MORAL RESPONSIBILITY FOR THE CONDUCT OF THE HEALTH CARE FACILITY IN ALL ITS ASPECTS AND, IN PARTICULAR, FOR MAINTENANCE AND IMPROVEMENTS IN STANDARDS OF PATIENT CARE. IT IS RESPONSIBLE TO THE PATIENT, THE COMMUNITY AND THE SPONSORING ORGANIZATION(S), IF APPLICABLE. ITS OFFICIAL REPRESENTATIVE IS THE CHIEF EXECUTIVE OFFICER. THE FUNDAMENTAL PRINCIPLES OF THE ORGANIZATION INCLUDE THE FOLLOWING:

THERE SHALL BE A WRITTEN STATEMENT DESCRIBING THE MISSION OF THE HEALTH CARE FACILITY WHICH SHALL CLEARLY DEFINE ITS GOALS AND OBJECTIVES. THIS MAY BE TITLED THE MISSION STATEMENT.

THERE SHALL BE DOCUMENTED EVIDENCE OF THE DEVELOPMENT OF A PLANNING PROCESS WHICH SHALL ENSURE REGULAR REVIEW AND REVISION OF GOALS AND OBJECTIVES.

THE CLEARLY DELINEATED GOALS AND OBJECTIVES SHALL BE REFLECTED IN WRITTEN POLICIES, PROCEDURES AND ORGANIZATIONAL PLANS.

THERE SHALL BE AN ADEQUATE AND COMPETENT STAFF AND MEMBERS OF EACH DISCIPLINE SHALL PRACTISE IN ACCORDANCE WITH THE PROFESSIONAL AND ETHICAL STANDARDS OF THEIR PROFESSION.

THERE SHALL BE EFFECTIVE PROGRAMS AND MECHANISMS FOR SYSTEMATIC REGULAR REVIEW OF THE QUALITY AND QUANTITY OF SERVICE PROVIDED. THIS QUALITY ASSURANCE PROGRAM SHALL USE THE METHODOLOGIES OF STRUCTURED PATIENT CARE APPRAISAL AS WELL AS PROGRAM EVALUATION TECHNIQUES.

THE MILIEU PROMOTED SHALL ENHANCE EFFECTIVE COMMUNICATION AMONG STAFF, PATIENTS AND FAMILIES.

SERVICES PROVIDED SHALL BE COORDINATED WITH OTHER APPROPRIATE COMMUNITY RESOURCES, SHALL BE RESPONSIVE TO COMMUNITY NEEDS AND SHALL DEMONSTRATE CONTINUING PROGRESS IN MEETING THE NEEDS OF THEIR PATIENTS.

THE PERSONAL DIGNITY OF THE PATIENT SHALL BE RESPECTED. THE RIGHTS OF THE PATIENTS AND THEIR FAMILIES, INCLUDING THEIR PERSONAL AND INFORMATIONAL PRIVACY, SHALL BE PROTECTED. PATIENTS SHALL BE MADE AWARE OF THEIR RESPONSIBILITIES DUE TO THEIR HOSPITALIZATION.

NO INDIVIDUAL SHALL BE EXCLUDED FROM RECEIVING SERVICES, OR FROM MEMBERSHIP ON THE GOVERNING BODY OR STAFF OF THE HEALTH CARE FACILITY ON THE BASIS OF RACE, CREED, SEX OR NATIONAL ORIGIN.

ATTAINMENT OF ACCREDITATION BY THE CANADIAN COUNCIL ON HOSPITAL ACCREDITATION SHALL BE A GOAL OF THE HEALTH CARE FACILITY AND THERE SHALL BE COMPLIANCE WITH COUNCIL STANDARDS WHICH HAVE BEEN DEVELOPED TO PROMOTE THE ESSENTIAL INTEREST OF QUALITY PATIENT CARE TOGETHER WITH A PROGRAM OF TEACHING AND RESEARCH APPROPRIATE TO THE HEALTH CARE FACILITY.*

*Although its standards are comprehensive and applicable to all health care facilities the methods used to meet standards may vary with the size, location and function of the facility. The Canadian Council on Hospital Accreditation uses practical judgment in evaluating the smaller facility in contrast to the large tertiary care facility.

The chief executive officer and administrative personnel shall be encouraged to attend meetings and seminars relevant to their functions.

STANDARD VII QUALITY ASSURANCE

QUALITY ASSURANCE PROGRAM

An institution-wide quality assurance program is an essential element for accreditation. This program must include review and evaluation of medical, nursing and other direct patient care departments and also evaluation of the delivery of support services as well as performance appraisal of personnel. The governing body shall be responsible for and shall provide the necessary resources to carry this out.

Through individual and/or committee reporting, the chief executive officer ensures that the governing body receives regular reports on and results of all aspects of the quality assurance program. Actions taken as a consequence of the program are also reported to ensure that the governing body fulfills its mandate in ensuring and being accountable for the delivery of optimal quality care.

REVIEW OF GOVERNANCE

The Board shall develop a methodology of evaluating its own function and the governance of the health care facility. Methodologies may include a structured self-evaluation program or the use of outside resources to effect a periodic strategic review of the mission and functions of the health care facility.

UTILIZATION REVIEW: MECHANISMS AND RESULTS

There shall be appropriate review methods and procedures in place to ensure that patient care resources are utilized effectively and efficiently and that potentials for improvement are diligently pursued.

Dependent in large measure upon the institution's management information system(s), formal resource utilization review mechanisms are now viewed as a hallmark characteristic of responsible health care providers. Such reviews are close allies of quality assurance programs generally and medical audit activities in particular. Utilization review is concerned with underutilization as well as overutilization.

Utilization review within clinical departments should be an expected result of the leadership function of the clinical chiefs. Review at senior administrative and Medical Advisory Committee levels should flow from the activities of the hospital's Utilization Review Committee. The composition of the latter should include senior management representatives as well as a broad spectrum representation of clinical and laboratory physicians. In addition to making needed data available there should be evidence of management support of committee initiatives in the form of analytical assistance and assistance with report preparation.

It is essential that the observations, comments and recommendations of the Utilization Review Committee be reported to the institution's governing body. This should be accompanied, of course, with any additional information or recommendations the Medical Advisory Committee, or equivalent, may wish to add.

APPENDIX VII

BOARD	Priority Rating
Development of mission statement	60
CCHA survey recommendations	59
Appointment/review of senior administrative staff	56
Appointment/review of medical staff	56
Review of bylaws, goals and objectives	55
Review adequacy of facility and equipment	55
Maintain good communication between hospital and community	53
Review administrators (monthly) board report	52
Review of board structure, committees and overall hospital structure	51
Review budget, cash flow, financial audit	51
Disaster Plan and Fire Plan	51
Monitor all quality assurance committee activities by reviewing the targets for all departments	48
Review society membership and public image	48
Patient satisfaction poll	47
Joint Conference Committee	47
Utilization review	45
Comparative statistics (with same size facility)	40
Risk management	40

Note: Higher scores indicate higher priority.

THERAPEUTIC DIETARY/FOOD SERVICE

Priority Rating

Cleaning schedules	54
Financial controls	54
Care and maintenance of equipment	53
Job descriptions	53
Temperature audits	53
Performance appraisals of staff	53
System for handling physician diet order to ensure accuracy e.g., use of a Kardex	53
Review and update of goals, objectives, policies and procedures	51
Staff education and orientation	51
Application of diet manual	51
Tray audit	51
Organized system for consultation with qualified dietitian	50
Public health and sanitation tests	50
Stocking and inventory	49
Recording of dietary progress of patients	49
Patient education re: therapeutic diets	46
Staffing guidelines	44
Menu review and planning	44
Patient survey	44
Staff survey	44
Provide Meals on Wheels to the community	not applicable for four hospitals

Note: Higher scores indicate higher priority.

NURSING	Priority Rating
Review of policies and procedures	61
Establishment of goals and objectives	58
Unusual incident/medication error reporting and follow-up	58
Safety committee	58
Nursing audit	56
Performance appraisal of staff	55
Develop comprehensive standard care plans	54
Crash cart audit	53
Staff orientation and continuing education	52
Quality assurance committee	52
Patient teaching programs	51
Transfer of function	51
Record all medical-surgical supplies ordered	51
Patient conference	51
Discharge planning	50
Interdisciplinary team conferences	49
Infection control	47
Nursing practice	40
Regional conference	33
Patient classification systems	31

Note: Higher scores indicate higher priority.

PHARMACY	Priority Rating
Written procedures for storage, preparation, administration and precautions	58
Report of medication errors	58
Development of a hospital formulary with regular review	57
Narcotic control and inspection	56
Review and update of the goals, objectives, policies, and procedures	54
Review of outdated stock on ward and return of it to pharmacy	54
Availability of an up-to-date CPS and other references	53
Evaluation of drug orders	53
Evaluation of drug utilization	52
Drug profiles on patients/residents	51
Evaluation of drug reaction	50
Consultation with pharmacy	50
Cost effectiveness of drugs	47
Staff education and supervision	47
Interdisciplinary meetings to evaluate patients	47
Drug information service	47
Poison control	46
Medical staff regulations re: order, etc.	45

PHARMACY	Priority Rating
Patient discharge counselling program	45
Patient self-administered drug program	41
Drug documentation audit (HMRI)	39

Note: Higher scores indicate higher priority.