The first step in creating success is having a plan on how to get there.

The second step in creating a successful future is making the plan happen.

Success has a price tag on it, and it reads COURAGE, DETERMINATION, DISCIPLINE, RISK TAKING, PERSEVERENCE, and CONSISTENCY - doing the RIGHT THING for the RIGHT REASONS and not just when we feel like it.

What we each need to understand is that our future is built from a series of continuous choices. Our life and the lives of the people who count on us remain choices up and until tomorrow arrives. At that moment in time, they become our reality and the best we can hope for are the choices we have made.

Creating a Culture for Quality

Pacing our Way to Healthcare Quality

Setting the PACE, Managing the PACE, and Maintaining the PACE

of our Organization's Future

Working with Your Quality Calendar

A great patient experience exists when a patient feels well cared for and deeply cared about.

Working to Plan, Act, Check and Enhance

The **PACE** Cycle is a structured model for quality and performance improvement. It focuses on methodically working through a series of steps to create or improve a process until the desired outcome is achieved. It is at the heart of an organization's change engine - the quality improvement program. Important to the PACE cycle is an understanding that the improvement process involves the identification of a plan to create the desired improvement, taking action to carry out the plan, checking for the resulting outcomes, and enhancement of the plan, if necessary, to achieve the best possible results.

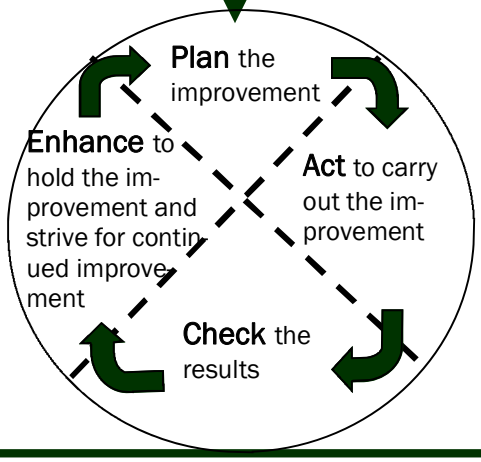
P - Plan to create improvement
A - Act to carry out the plan
C - Check to see if we are achieving the desired results
E - Enhance the plan and approach to hold the improvement and strive for continuous improvement

When one is engaged in quality and performance improvement activities, it is important to recognize that the first plan for improvement may not turn out to be the best plan. All initial quality improvement plans should be viewed as a draft that will be completed as it is tested and refined. Once a plan is in motion, it will generally go through a series of revisions to make it the best plan possible. In some situations, it may need to be totally retooled because it is not the best approach for the healthcare provider's current situation. The success of the initial plan is largely dependent on how comprehensive and effective the activities are that led up to the plan and how well critical ingredients come together to turn the plan into a reality. Some important considerations that influence the success of the initial plan are:

1. Does the initial plan address the root cause of the issue or is it designed to simply treat and control a symptom?
2. Is the plan developed using a multidisciplinary approach and not the result of functional silo thinking (which is very important in health care)?
3. Does the topic and plan address something that supports the department or organization's mission and/or vision and avoid topics that have superficial value to strengthening patient care or operations?
4. Does the plan include all the right people and support necessary to make the plan happen?

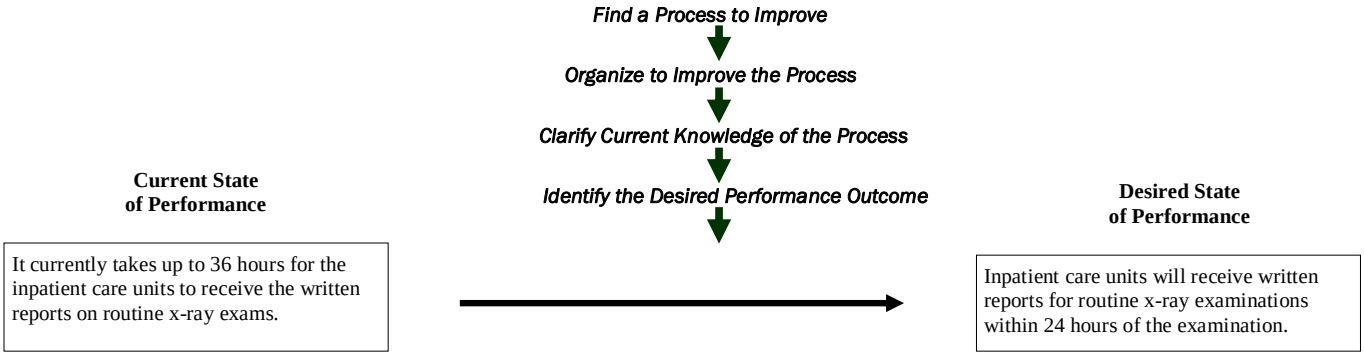
The **PACE** Cycle involves the following steps:

Find a Process to Improve
↓
Organize to Improve the Process
↓
Clarify Current Knowledge of the Process
↓
Identify the Desired Performance Outcome
↓
Identify the Performance Gap between Current and Desired Outcomes
↓
Select the Process Improvement Activity Most Likely to Produce Needed Outcomes
↓



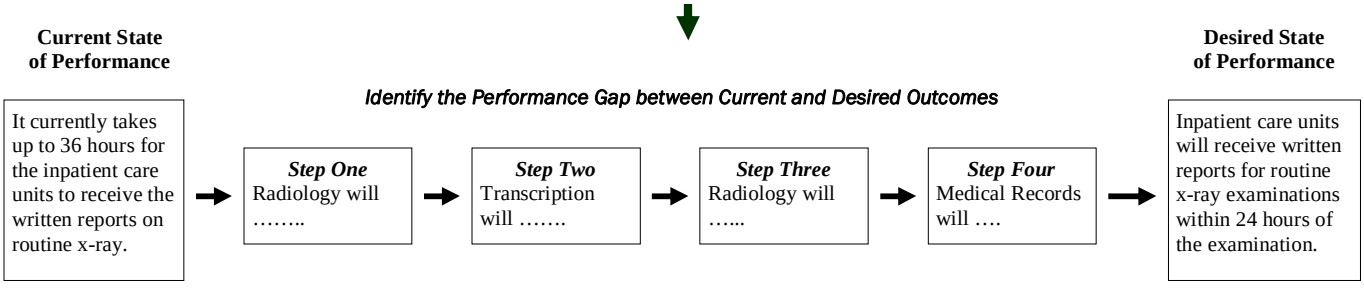
Working to Plan, Act, Check and Enhance

As a group works through the **PACE** cycle to improve a process, there are several important points to keep in mind about each step. These are:

1. When *Finding a Process to Improve*, it is important to get to the root cause of the issue. Too often, quality improvement activities focus on treating symptoms of the issue. The resulting corrective action plan simply becomes an activity to control for the symptom rather than an activity to improve the process. When symptom control becomes the focus, the corrective plan frequently adds complexity to the process and requires a higher level of resources over time to sustain the outcome.
2. In *Organizing to Improve the Process, Clarifying Current Knowledge of the Process and Identifying the Desired Performance Outcome*, the steps of effective process improvement activities are important to understand. The goals are to have a clear understanding of where the activity is at the current moment in time and the performance that will yield the desired outcomes. The goal is not to cosmetically dress a process up to make it look the best it can. The goal is to drive a meaningful level of actual improvement into the process to create meaningful and sustainable improvement.
3. 

3. When *Identifying the Performance Gap between Current and Desired Outcomes*, it is important to utilize a multidisciplinary approach. This step identifies the outcomes that each contributing party must achieve if the larger goal is to happen. As this step lays the groundwork for success, it is important to include every department and entity who can impact the process. It is important to recognize that a system is frequently made up of several smaller systems and processes that all come together to make the larger system happen. Successful process improvement recognizes the importance of each subsystem or process and looks to identify the contribution that each one needs to make to the improvement effort.

4. When *Selecting a Process Improvement Activity Most Likely to Produce Needed Outcomes*, the goal is to identify the best series of activities that, if brought together, will yield the greatest results. This step recognizes that there are usually multiple potential courses of action. Because of the structure and nature of health care, most opportunities for improvement do not have "yes-or-no" answers. The goal becomes to select the best possible course of action for the present environment taking into account the variables most likely to change in the immediate future. This course of action should strive to meet the following criteria:
    A. To create knock-your-socks-off experiences for patients and visitors.
    B. To achieve greatness in the delivery of care or supporting operations.
    C. To drive simplicity into the process.
    D. To promote efficiency and effectiveness.
    E. To drive implementation activities to the lowest possible level of the organizational structure.
    F. To empower front line workers to create success.

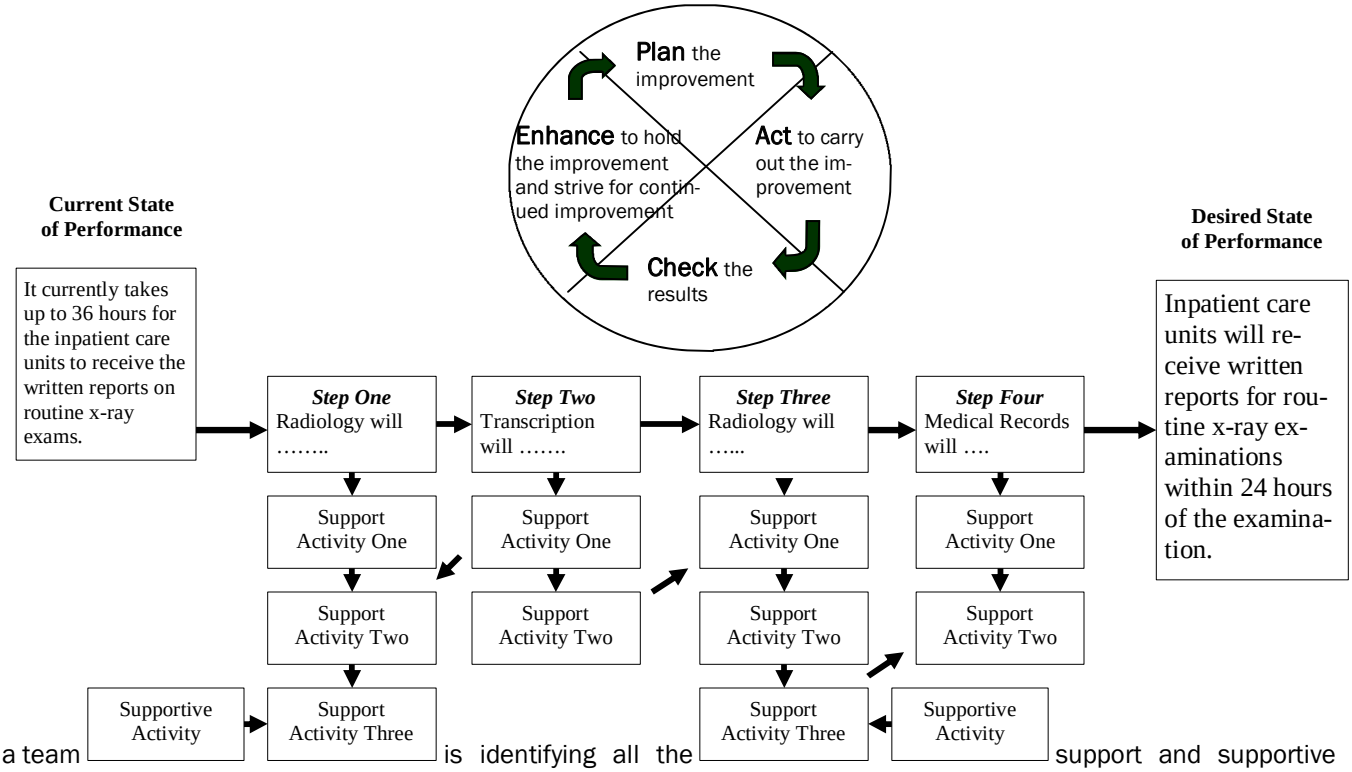


Working to Plan, Act, Check and Enhance

Continued from page 3

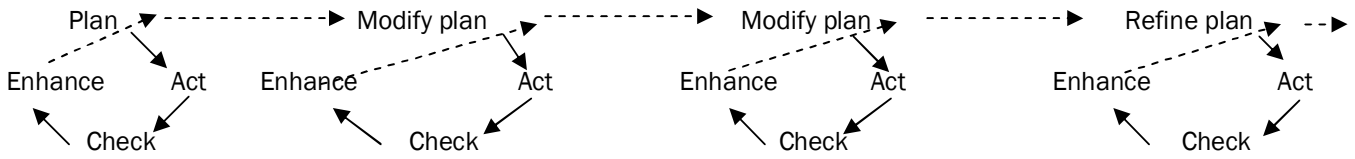
5. Once the seemingly best plan has been identified based on current knowledge, the **PACE** cycle is initiated. In this step, the implementation plan is developed with all details outlined, responsibilities assigned, and target dates for key activities designated. Once the best plan is outlined (planning for the improvement) and implemented (acting to carry it out), it is followed by a structured, well-defined activity for checking on outcomes and acting to maintain or enhance the improvement. This is the step where quality assurance activities that are designed to work with staff to convert new desired behaviors into habits become important.

Select the Process Improvement Activity Most Likely to Produce Needed Outcomes



As a team is identifying all the support and supportive activities that must occur to achieve the desired outcome, it is important to identify the cross-departmental and cross-functional relationships between the involved departments and services. Because health care is a team activity, the success of one department can be seriously impacted by another. Tearing down functional silos and territorial walls is a critical aspect of successful process improvement.

Once the plan is implemented, it is important to check for results and, if necessary, rethink or refine the plan. It is not a sign of failure to have to change or modify an approach, but it is a sign of failure to make a conscious decision to continue down a path that is obviously not going to get to the desired results. Great leaders in quality are people who can easily put the needs of the patient in front of his or her ego, need for control and fear of having to admit he or she is wrong. A good PACE Cycle could look like this:



This repetitive cycling to identify opportunities to improve the quality of the outcome is know as “continuous quality improvement”. It’s goal is to move a quality improvement activity from good or adequate to great. It works to improve the final outcome, drive efficiency into the process and make it more customer-friendly (for the patient or the workforce who live inside it).

Managing Your Quality Activities

Working with Your Quality Calendar

There are three basic types of quality activities in the quality continuum. Quality assurance activities focus on making sure that our healthcare organizations are what they need to be for today. These activities look to make sure that care and services meet today's standards and that our care is the best it can be given the resources available. Quality improvement works to identify and implement opportunities to take what exists today and make it even better for the immediate future. It looks to make sure that our services and approaches are keeping pace with the changing healthcare environment and whenever possible, exceeding the expectations of the customers. Performance improvement involves those activities that will keep our healthcare organizations strong into the long range future. It involves taking all those quality improvement activities aligned with the strategic goals of the organization and making sure they happen.

When quality assurance, quality improvement and performance improvement are each healthy and come together to support one another, a healthcare organization can have a much healthier outlook for today, tomorrow and the long range. The greatest challenge most organizations face involves managing their quality activities so that they are strong enough to achieve and hold the desired performance. There are very few providers that have quality programs that are strong enough to meet the needs of today's market. This is largely because most programs are a by-product of past mistakes of the 1980s when programs were being built.

Quality is not an accident. Quality is something that is deliberately created. That means that it is something that must be managed with the goal of greatness. The quality calendar system is a easy system for creating the structure and management mechanisms for making sure that an organization stays on top of its quality-related activities. The quality assurance side of the calendar identifies and manages all those activities that are important to the organization's success today. It includes all those standards and compliance related activities that an organization must stay on top of in order to know that it is what it needs to be for today. The quality improvement side of the calendar identifies and manages all those quality and performance improvement activities that are important to the organizations' immediate and long range future success. It organizes those activities that will help the organization to keep PACE with the constantly changing healthcare environment.

Quality Assurance Calendar Maintenance

QA Topic	Monitoring Requirement	Responsible Party	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec
Generator Fire-up	Every Friday 6:00 a.m.	Mark	MN OK	MN OK	MN OK	MN OK	MN OK	MN OK	CS OK	MN OK	MN OK	MN OK	MN OK	MN OK
Generator Load Test	Every Friday 6-10 a.m.	Mark	MN OK	MN OK	MN OK	MN OK	MN OK	MN OK	CS OK	MN OK	MN OK	MN OK	MN OK	MN OK
Fire Extinguisher Monthly	Fourth Week of Every Month	Charlie	CS OK	CS OK	CS OK	CS OK	MN OK	CS OK	CS OK	CS QI	CS OK			
Fire Extinguisher Annual	First Week of September	Charlie/Johnson Fire Controls	X	X	X	X	X	X	X	X	CS OK			
Water Temperature Weekly	Thursday Morning	Mark	MN OK	MN OK	MN OK	MN OK	MN OK	MN OK	MN OK	MN OK	MN QI			
OR Humidity	Thursday Morning	Charlie	CS OK	CS OK	CS OK	CS OK	CS OK	CS OK	CS QI	CS QI	CS QI			
Annual Boiler Test	First Week of December	Mark/ Wilson Water Controls	X	X	X	X	X	X	X	X	X			
OR Filter Changes	Fourth Saturday of Every Month	Charlie	CS OK	CS OK	CS OK	CS OK	CS OK	CS OK	CS OK	CS OK	CS OK			
General Filters	First Week of Every Quarter January, April, July, October	Charlie	CS OK	X	X	CS OK	X	X	MN OK	X	X			
Pest Control in Kitchen	First Week of Every Other Month	Charlie/ Pest Free Pest Control	CS OK	X	CS OK	X	CS OK	X	CS OK	X	CS OK			
Pest Control in Hospital General	Second Week of Every Quarter	Charlie/ Pest Free Pest Control	CS OK	X	CS OK	X	CS OK	X	CS OK	X	CS OK			
Parking Lot Lighting	6:00 a.m. every Friday	Charlie			CS OK	CS OK	CS OK	CS OK	CS OK	CS OK	CS OK			

Quality Improvement Calendar Maintenance

QI Topic	Responsible Party	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec
New Handrails on North Hallway for Rehab Patients	Mark			P	A	C,E	C	C	C	C			
Form Dispensers for Hand Cleaning	Mark			P	A-Pilot	C,E	A	C	C,E	C	C		
Fire Extinguisher Monthly	Charlie								P,A	C	C	C	C
Water Temperature Weekly	Mark									P,A,C	QA		
OR Humidity	Charlie							P,A	C,E,	C			
Handicap Ramp at North Entrance	Mark							P	A	C,E	C	C	C
Energy Efficient Lighting	Mark						P	P	P	A	C	C	C

Working with Your Quality Calendar

The identification of all those activities that should be organized on the quality assurance calendar is the first step to building an effective quality management system. This step needs to be the first step because it serves as the foundation of an effective quality program. It identifies those activities that are necessary to making an organization and its departments strong for today. If an organization is struggling to be strong for today, it is increasingly difficult, if not impossible, to be strong for the future as today's activities serve as the foundation on which tomorrow is built.

Those activities that are documented on the quality assurance calendar are those that need to be as strong as possible to make sure that the organization is living up to what it should be for today. These activities are commonly those compliance activities that are imposed through state and federal regulations and/or represent current standards of practice. For example, it is a federal and state regulation that a current history and physical be on the medical record before a surgical procedure is started. In another example, it is a current standard of practice that the incision for an emergency c-section is made within 30 minutes of the decision that the c-section is necessary. Because these are both recognized standards of practice that have been determined to be important to the safety of surgical patients, moms and babies, a healthcare organization has an obligation to live up to them. In both situations, through regulations or standard of practices established by nationally recognized organizations, the minimal expectations for quality care and services are defined and an organization has an obligation to assure their existence in day-to-day operations.

Each department in an organization would have a quality assurance calendar that would list those standards of practice that it is responsible for. The calendar below depicts some of the quality assurance standards that the maintenance department in a typical hospital is responsible for. Organizing these responsibilities in this manner helps to achieve four important outcomes:

1. It helps to make sure that all compliance and minimal standard responsibilities are identified and that they are less likely to get overlooked in an environment as hectic and crisis-driven as healthcare. It also prevent the tendency for activities to lose ground once the desired outcome has been achieved. Many of the systems in our traditional quality programs were built for sprinting rather than endurance performance. They were designed to help organizations get through the next crisis or next survey process rather than the creation of sustainable outcomes. The creation of a strong quality continuum goes a long way in helping to achieve endurance and overcome the mistakes of the past. It can help to bring together the systems and structures that take the loose, people dependent behaviors of the past and move them into approaches and activities that create a more concrete program that yields stronger results. The quality assurance calendar can be a very important tool in helping to achieve this systems approach.

2. The calendar helps to put all the compliance and minimal standard responsibilities into perspective in relationship to one another and the other responsibilities of a department. Once the department can achieve this level of perspective, it is easier to organize the activities and delegate responsibility to make things happen in the most efficient and effective way. As you can see from the sample at the bottom of this page, the quality assurance activities for this maintenance department are divided up between Mark and Charlie (the only employees in that department).

3. The calendar creates the concrete documentation of what is necessary for compliance. Thus, if a key individual is lost from the organization, temporarily or permanently, the performance of the organization or department can more easily be maintained because the expectations are defined. Too often organizations waste too many resources and too much time running to catch up because they have fall behind every time a key person is lost. Traditional quality programs have been too people dependent. In these people dependent approaches, providers consume way too many resources just to hold status quo because of a yo-yo effect that plays out as experienced people leave and inexperienced people replace them. Every time a person holding key knowledge is lost, ground is often lost and activities needs to start over. Rather that investing to build a strong future, too many providers invest just to survive.

Quality Assurance Calendar
Maintenance

QA Topic	Monitoring Requirement	Responsible Party	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec
Generator Fire-up	Every Friday 6:00 a.m.	Mark	MN OK	MN OK	MN OK	MN OK	MN OK	MN OK	CS OK	MN OK	MN OK	MN OK	MN OK	MN OK
Generator Load Test	Every Friday 6-10 a.m.	Mark	MN OK	MN OK	MN OK	MN OK	MN OK	MN OK	CS OK	MN OK	MN OK	MN OK	MN OK	MN OK
Fire Extinguisher Monthly	Fourth Week of Every Month	Charlie	CS OK	CS OK	CS OK	CS OK	MN OK	CS OK	CS OK	CS QI	CS OK	CS OK	CS OK	CS OK
Fire Extinguisher Annual	First Week of September	Charlie/Johnson Fire Controls	X	X	X	X	X	X	X	X	CS OK	X	X	X
Water Temperature Weekly	Thursday Morning	Mark	MN OK	MN OK	MN OK	MN OK	MN OK	MN OK	MN OK	MN OK	MN QI	MN OK	MN OK	MN OK
OR Humidity	Thursday Morning	Charlie	CS OK	CS OK	CS OK	CS OK	CS OK	CS OK	CS QI	CS QI	CS QI	CS OK	CS OK	CS OK
Annual Boiler Test	First Week of December	Mark/ Wilson Water Controls	X	X	X	X	X	X	X	X	X	X	X	MN OK
OR Filter Changes	Fourth Saturday of Every Month	Charlie	CS OK	CS OK	CS OK	CS OK	CS OK	CS OK	CS OK	CS OK	CS OK	CS OK	CS OK	CS OK
General Filters	First Week of Every Quarter January, April, July, October	Charlie	CS OK	X	X	CS OK	X	X	MN OK	X	X	CS OK	X	X
Pest Control in Kitchen	First Week of Every Other Month	Charlie/ Pest Free Pest Control	CS OK	X	CS OK	X	CS OK	X	CS OK	X	CS OK	X	CS OK	X
Pest Control in Hospital General	Second Week of Every Quarter	Charlie/ Pest Free Pest Control	CS OK	X	CS OK	X	CS OK	X	CS OK	X	CS OK	X	CS OK	X
Parking Lot Lighting	6:00 a.m. every Friday	Charlie			CS OK	CS OK	CS OK	CS OK	CS OK	CS OK	CS OK	CS OK	CS OK	CS OK

Working with Your Quality Calendar

rather than picking up where things left off and moving forward. Organizations need to find ways to break its unhealthy cycle. They need to use their already strained time and resources on planning and building for the future.

4. The calendar system also creates a very simple and efficient way of documenting compliance with current standards. Too many organizations spend too much time documenting and discussing how they are doing in living up to today's expectations and not enough time working to secure their future. Many quality committee meetings spend as much as 80% of the time discussing compliance with today's expectations when 80% of the meeting should be spent discussing quality and performance improvement opportunities for the future. When a provider uses the calendar system to document compliance, the only compliance that needs to happen at the committee meeting involves topics where the organization is currently out of compliance and quality improvement initiatives are underway to bring the areas back into compliance.

Quality Assurance Calendar
Maintenance

QA Topic	Monitoring Requirement	Responsible Party	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec
Generator Fire-up	Every Friday 6:00 a.m.	Mark	MN OK	MN OK	MN OK	MN OK	MN OK	MN OK	CS OK	MN OK	MN OK	MN OK	MN OK	MN OK
Generator Load Test	Every Friday 6-10 a.m.	Mark	MN OK	MN OK	MN OK	MN OK	MN OK	MN OK	CS OK	MN OK	MN OK	MN OK	MN OK	MN OK
Fire Extinguisher Monthly	Fourth Week of Every Month	Charlie	CS OK	CS OK	CS OK	CS OK	MN OK	CS OK	CS OK	CS QI	CS OK	CS OK	CS OK	CS OK
Fire Extinguisher Annual	First Week of September	Charlie/Johnson Fire Controls	X	X	X	X	X	X	X	X	CS OK	X	X	X
Water Temperature Weekly	Thursday Morning	Mark	MN OK	MN OK	MN OK	MN OK	MN OK	MN OK	MN OK	MN OK	MN QI	MN OK	MN OK	MN OK
OR Humidity	Thursday Morning	Charlie	CS OK	CS OK	CS OK	CS OK	CS OK	CS OK	CS QI	CS QI	CS QI	CS OK	CS OK	CS OK
Annual Boiler Test	First Week of December	Mark/ Wilson Water Controls	X	X	X	X	X	X	X	X	X	X	X	MN OK
OR Filter Changes	Fourth Saturday of Every Month	Charlie	CS OK	CS OK	CS OK	CS OK	CS OK	CS OK	CS OK	CS OK	CS OK	CS OK	CS OK	CS OK
General Filters	First Week of Every Quarter January, April, July, October	Charlie	CS OK	X	X	CS OK	X	X	MN OK	X	X	CS OK	X	X
Pest Control in Kitchen	First Week of Every Other Month	Charlie/ Pest Free Pest Control	CS OK	X	CS OK	X	CS OK	X	CS OK	X	CS OK	X	CS OK	X
Pest Control in Hospital General	Second Week of Every Quarter	Charlie/ Pest Free Pest Control	CS OK	X	CS OK	X	CS OK	X	CS OK	X	CS OK	X	CS OK	X
Parking Lot Lighting	6:00 a.m. every Friday	Charlie			CS OK	CS OK	CS OK	CS OK	CS OK	CS OK	CS OK	CS OK	CS OK	CS OK

The steps for the creation of a quality assurance calendar are pretty simple.

1. Each department in the organization would document a list of all the compliance or minimal standards of practice requirements that exist for a department in the first column under "QA Topic". (Remember, every department should have a calendar. One of the most important outcomes for healthcare quality is the creation of great patient experiences. Any department that can impact patient perception needs to be an active player in the quality program. Most patient experiences start with finding the provider and ends with the bill and follow-up care. Every encounter between those two points belongs inside the quality program. See the training module titled "Building the Patient Experience".)
2. The department would then document when that compliance activity is to be routinely done to meet the standards. (Please note that it is easier to make sure that activities that monitor for compliance are done if they have a set time for them to be done. When the expectation is that an activity will be done sometime today or this week, it is much easier for it to get overlooked. Because most quality assurance activities are time sensitive, it is generally impossible to catch up once they don't happen. The organization then has a significant period of time that it is at risk of having that error be problematic. For example, lets say that the maintenance department forgot to run the generator under load for the month. In time-oriented activities such as this, there is no way to go back and make it up once the omission has occurred. For example, it could be problematic for approximately a year on a Medicare survey as most surveyors look at a year's worth of information during survey.

3. Once the department has documented when it currently performs all its compliance activities, it needs to assess the balance of those activities. Please remember that the goal of compliance monitoring and management is to make it as efficient and effective as possible so that the majority of an organization's time and resources can be dedicated to improvement activities that will secure the organization's future. This is also why quality assurance activities should have "zero tolerance rules" and that the penalty for chronic non-compliance should be pretty stiff. Given the fact that most compliance and standard of practice requirements focus on basic issues that can place a patient in harms way if the standard is not maintained, the growing sentiment in the country is that there is very little room for forgiveness for organizations and providers who choose not to take this responsibility seriously. Some general guidelines for making a quality assurance calendar increase a provider's compliance related activities successful through efficiency and effectiveness are:
   a. Only schedule activities that must be done on a Monday for that day. Mondays tend to be bad days in healthcare organizations because of the many issues that spill over from the weekend. As most legal holidays fall

Working with Your Quality Calendar

On Mondays, it is the one day of the week that prompts people to more easily get behind because things from the holiday must be pushed to Tuesday.

b. Similarly, it is best if you minimize the number of flexible activities that need to be done on a Friday because that is generally the day that people are pushing to get things done for the weekend. It is also the most common day that people request off to have a long weekend.

Quality Assurance Calendar
Maintenance

QA Topic	Monitoring Requirement	Responsible Party	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec
Generator Fire-up	Every Friday 6:00 a.m.	Mark	MN OK	MN OK	MN OK	MN OK	MN OK	MN OK	CS OK	MN OK	MN OK	MN OK	MN OK	MN OK
Generator Load Test	Every Friday 6-10 a.m.	Mark	MN OK	MN OK	MN OK	MN OK	MN OK	MN OK	CS OK	MN OK	MN OK	MN OK	MN OK	MN OK
Fire Extinguisher Monthly	Fourth Week of Every Month	Charlie	CS OK	CS OK	CS OK	CS OK	MN OK	CS OK	CS OK	CS QI	CS OK	CS OK	CS OK	CS OK
Fire Extinguisher Annual	First Week of September	Charlie/Johnson Fire Controls	X	X	X	X	X	X	X	X	CS OK	X	X	X
Water Temperature Weekly	Thursday Morning	Mark	MN OK	MN OK	MN OK	MN OK	MN OK	MN OK	MN OK	MN OK	MN QI	MN OK	MN OK	MN OK
OR Humidity	Thursday Morning	Charlie	CS OK	CS OK	CS OK	CS OK	CS OK	CS OK	CS QI	CS QI	CS QI	CS OK	CS OK	CS OK
Annual Boiler Test	First Week of December	Mark/ Wilson Water Controls	X	X	X	X	X	X	X	X	X	X	X	MN OK
OR Filter Changes	Fourth Saturday of Every Month	Charlie	CS OK	CS OK	CS OK	CS OK	CS OK	CS OK	CS OK	CS OK	CS OK	CS OK	CS OK	CS OK
General Filters	First Week of Every Quarter January, April, July, October	Charlie	CS OK	X	X	CS OK	X	X	MN OK	X	X	CS OK	X	X
Pest Control in Kitchen	First Week of Every Other Month	Charlie/ Pest Free Pest Control	CS OK	X	CS OK	X	CS OK	X	CS OK	X	CS OK	X	CS OK	X
Pest Control in Hospital General	Second Week of Every Quarter	Charlie/ Pest Free Pest Control	CS OK	X	CS OK	X	CS OK	X	CS OK	X	CS OK	X	CS OK	X
Parking Lot Lighting	6:00 a.m. every Friday	Charlie			CS OK	CS OK	CS OK	CS OK	CS OK	CS OK	CS OK	CS OK	CS OK	CS OK

c. Try to always set the schedule up so that compliance related activities never consume more than two hours in a given day for any one person. This is one of the reasons that a calendar is so helpful. It allows you to plan and balance things out. Most people can plan to commit up to two hours of the day to designated activities. They can also tend to find time to make those activities happen even on a day when there seems to be one crisis after another.

d. Try to always set the schedule so that the compliance activities are carried out as early in the day or shift as possible. If people get the compliance activities out of the way first, it is easier to make sure that they don't get lost in the chaos of the day.

e. Always set a specific time for an activity to be done. One of the common mistakes that we make in health care is to tell people to get things done before the end of the day. Because these activities tend to be viewed as extras or incidentals by many of our people, they tend to do better in getting them done if the expectation for completion is well defined. For example, if the maintenance director tells a worker to check water temperatures sometime before the end of the shift, the employee is much more likely to forget than if he is told to complete the task right before coffee break or between the hours of 8:00 a.m. and 9:00 a.m.

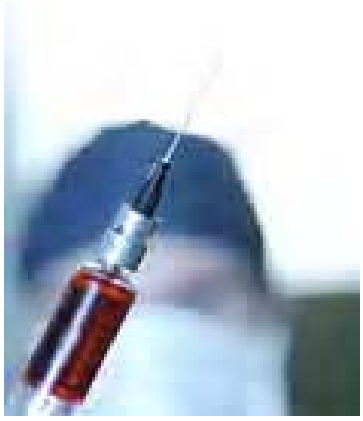
f. Spread the activities across the workforce. The more people involved, the easier it is to reduce the amount of time that the activities will take. Many areas of a healthcare organization suffer from a syndrome called STP— "the same ten people" (or in some places, it can be the same two or three people.) The more responsibilities that are placed on a smaller number of people, the greater the chance that some won't happen. The calendar is designed to assign responsible parties to activities. Involving the staff in these accountabilities increases their awareness of the activity, can serve as an educational activity and increases what a department can accomplish. The biggest problem with "STP" is that when those ten people max out, so does the department or the organization. It is important to break through these self-imposed glass ceiling if people are to make our healthcare organizations everything they can be.

g. For activities that impact more than one department, make sure that they are on the calendar for each entity impacted. This creates a safety-net for the activities because we now have two or more pairs of eyes watching them. For example, humidity levels for the operating room would be on calendars for maintenance and the operating room. While it is generally the maintenance and engineering staff that actually check the humidity levels, it is the operating room's standards of practice that humidity levels be maintained within the recommended range. It is not a sign of weakness to create a system of checks and balances but it is a sign of weakness to let turf wars get in the way of success and patient safety. Another good example would be pest control in the kitchen. This is a shared responsibility for dietary and maintenance. When organizations have two sets of eyes monitoring for the same activity, they reduce the potential for error.

h. Schedule the more flexible activities around the work demands in the department. The demands on most departments in a healthcare organization fluctuate to varying degrees. To be respectful of the workforce and increase the potential for getting the work done, it is important to schedule activities to increase their potential for success. For example, snow removal and yard work may make the

Working with Your Quality Calendar

winter, spring and summers busy times for the maintenance departments in many areas of the country. October and November may represent a narrow window of time where the demands are fewer and be the best time for things like annual policy and procedure review.



i. Require that documentation on the calendar is completed before leaving the building each day and preferably within two hours of completion. Allowing people to catch up documentation of activities increases the likelihood that appropriate documentation won't get done. It also increases the likelihood that the activity will not get done. Having to document in a timely manner means that employees are more likely to remember to do it and do it accurately.

j. The manager should check the calendar every day. It doesn't take long to glance down through it to make sure every box is filled in and it saves the manager from having to play the "Did-Ya" game. The "Did-Ya" game is one where managers waste time and energy running around all day saying "did ya" to make sure things are getting done. This kind of activity wastes time, takes the manager away from more important things (like helping to build the organization's future) and can be pretty damaging to staff relations. Checking the calendar every day also saves the manager from any unpleasant surprises. It also conveys the importance of the activities to the work force. There is nothing more contradictory to a workforce than to have a manager who says something is important but his or her behavior conveys just the opposite. Checking the quality calendar every day is one way a manager can walk the talk.

k. Group activities in ways that promote efficiency and effectiveness. For example, many of the safety monitoring requirements can be achieved as part of well-defined safety rounds. Safety rounds conducted once or twice a month can accomplish a lot in a short period of time. When married to infection control surveillance, such rounds could be highly productive activities.

l. Look for opportunities to increase efficiency through teamwork with other departments. For example, in one hospital, housekeeping staff touched up painted surfaces in patient rooms where the paint had been chipped away during the patient's stay. They did this during terminal cleaning of the room after patient discharges. The maintenance and housekeeping staff found this to be a more efficient use of people's time than the old system where housekeeping would fill out a maintenance request and then maintenance staff would come up and repair a few chipped paint surfaces.

4. After the frequency and definitive time frame for monitoring has been established, the department will determine who will be the responsible party for that activity. This individual will be responsible for the completion of the activity each time it is due. If he or she in unable to complete the activity due to reasons such as a scheduled vacation, he or she is responsible for finding someone to do it and training that person. For example, in the above calendar, Mark was unable to do two of the generator fire-ups in July because he was on vacation. Thus, he made arrangements for Charlie to perform them in his absence.

Once the core elements in the first three columns have been completed, the departments will determine how to facilitate documentation by the responsible parties working inside some general guidelines provided by the quality committee. Each month, the responsible parties will document their initials indicating that they have completed the activity and OK if compliance was maintained. If compliance faltered during the month, the responsible party will document the letters "QI", indicating a quality improvement initiative to bring the activity back into compliance. This quality improvement initiative should be documented and reported to the quality department, along with what steps were taken to correct it within 72 hours. For critical compliance activities that have a high potential for harm or adverse consequences, reporting should take place within 24 hours. The corrective actions taken should then also be included in the department's quality report for the quarter. Please note that documentation for the timely response to non-compliance with standards of practice and regulations is important. Just as it makes people feel more secure to know that the people who care for airplanes are constantly checking, rechecking,

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and aggressively responding to issues that could potentially lead to an airplane crash, patients want to know that healthcare providers take their responsibilities with an equal amount of seriousness. If healthcare providers put the appropriate time and energy into making sure they get it right the first time, the paperwork burden goes away. When providers struggle to get it right the first time, the paperwork becomes an essential piece of the process in demonstrating the efforts to get it right. This is clearly an area where an ounce of prevention is better than the pound of cure. In the quality calendar system, documentation of compliance is as easy as a set of initials and the letters OK. Non-compliance requires more intense monitoring, more involved documentation and more frequent reporting to the quality committee. (We will discuss the reporting and monitoring for non-compliance later in this workbook).

Quality Assurance Calendar Maintenance

QA Topic	Monitoring Requirement	Responsible Party	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec
Generator Fire-up	Every Friday 6:00 a.m.	Mark	MN OK	MN OK	MN OK	MN OK	MN OK	MN OK	CS OK	MN OK	MN OK	MN OK	MN OK	MN OK
Generator Load Test	Every Friday 6-10 a.m.	Mark	MN OK	MN OK	MN OK	MN OK	MN OK	MN OK	CS OK	MN OK	MN OK	MN OK	MN OK	MN OK
Fire Extinguisher Monthly	Fourth Week of Every Month	Charlie	CS OK	CS OK	CS OK	CS OK	MN OK	CS OK	CS OK	CS QI	CS OK	CS OK	CS OK	CS OK
Fire Extinguisher Annual	First Week of September	Charlie/Johnson Fire Controls	X	X	X	X	X	X	X	X	CS OK	X	X	X
Water Temperature Weekly	Thursday Morning	Mark	MN OK	MN OK	MN OK	MN OK	MN OK	MN OK	MN OK	MN OK	MN QI	MN OK	MN OK	MN OK
OR Humidity	Thursday Morning	Charlie	CS OK	CS OK	CS OK	CS OK	CS OK	CS OK	CS QI	CS QI	CS QI	CS OK	CS OK	CS OK
Annual Boiler Test	First Week of December	Mark/ Wilson Water Controls	X	X	X	X	X	X	X	X	X	X	X	MN OK
OR Filter Changes	Fourth Saturday of Every Month	Charlie	CS OK	CS OK	CS OK	CS OK	CS OK	CS OK	CS OK	CS OK	CS OK	CS OK	CS OK	CS OK
General Filters	First Week of Every Quarter January, April, July, October	Charlie	CS OK	X	X	CS OK	X	X	MN OK	X	X	CS OK	X	X
Pest Control in Kitchen	First Week of Every Other Month	Charlie/ Pest Free Pest Control	CS OK	X	CS OK	X	CS OK	X	CS OK	X	CS OK	X	CS OK	X
Pest Control in Hospital General	Second Week of Every Quarter	Charlie/ Pest Free Pest Control	CS OK	X	CS OK	X	CS OK	X	CS OK	X	CS OK	X	CS OK	X
Parking Lot Lighting	6:00 a.m. every Friday	Charlie			CS OK	CS OK	CS OK	CS OK	CS OK	CS OK	CS OK	CS OK	CS OK	CS OK

5. Some important things to remember about working with a quality assurance calendar are:
   a. Some of the items on the calendar may be standards of practice set by the organization or department without any links to outside forces. For example, in the calendar above, the hospital has set an internal standard that all light bulbs in the parking lots will be checked every Friday morning for blown out bulbs because of a number of complaints from visitors about the darkness in the lots because lights don't work. Some organizations run pretty elaborate water treatment systems because of problematic water supplies. Maintenance of these systems frequently creates a number of compliance activities.
   b. Quality assurance calendars tend to be pretty static documents. The items on them do not change from year to year unless a regulation changes, the bar on a recognized standard of practice is raised, a new regulation comes out or the hospital chooses to set a new internal standard. As a result, once items are identified and understood, they should be pretty easy to manage and there is little reason for non-compliance.
   c. Most topics on a quality assurance calendar tend to have some sort of a log that is maintained by the department and create the back-up documentation to provide the details for the activity. The OK on the calendar simply indicates that the monitoring activity took place as it should have and the detailed documentation for that activity can be found somewhere else. For example, logs that document generator checks are generally found hanging near the generator. Logs that demonstrate that crash carts have been properly checked generally hang on the crash cart. It is not necessary to duplicate that documentation as long as it is easily and readily accessible upon request. Remember, additional or repetitive documentation should only occur if it is value adding. Making departments double document compliance is rarely value adding and generally takes valuable resources away from important quality and performance improvement activities.
   d. Some organizations or departments have a number of quality assurance activities that tend to be subsets of a larger quality assurance responsibility. Rather than list out every item in the subset, the large quality assurance responsibility can be listed on the quality calendar as a single item with a detailed list of the component items documented in a supporting log or list. Two of the best examples of this involves all the proficiency and quality control testing that must occur in the lab. The two quality assurance responsibilities of proficiency and quality control testing could easily encompass 20 - 100 individualized quality assurance activities. How these are documented on the quality calendar is largely dependent on the preference of the quality committee and the department's attention to details.
   e. The quality department should provide for some form of auditing of the departmental activities to close an important loop. The auditing provides documentation for the quality committee to validate that the quality assurance activities are being done as outlined and that the back-up documentation supports what is necessary

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necessary for outside reviews. The easiest way to build the auditing function is for the quality department to have its own quality calendar. Reviewing all of the departmental calendars, the quality department would schedule for random audits of key activities with high risk and problem prone areas being priorities. The goal of the review is to validate what is reported by the department and to ensure that appropriate logs and documentation exist and are complete.

Working with Your Quality Improvement Calendar

Once a department has established its quality assurance calendar and implemented the management activities to more effectively and efficiently manage compliance activities, it is time to build its quality improvement calendar. This calendar is an extremely dynamic document that constantly changes depending on the quality and performance improvement initiatives that a department or organization has in play throughout the year. It grows and evolves as new initiatives are identified throughout the year. As a department can not possibly know in January what quality improvement opportunities will present themselves in September or November, an effective quality improvement calendar can only be created as time identifies meaningful quality improvement initiatives. A department that has a healthy quality program in place will have an average of 6 - 8 quality/performance improvement initiatives going on at any one time. Some are activities where the department is the lead participant because the activity will have the greatest impact for that department and others are activities where the department plays a support role. Regardless of whether the role is as a primary or supportive participant, the activities will appear as quality improvement initiatives because the contributions of the department are important to success. Departments that only focus on one or two quality improvement initiative(s) at any one time are generally departments that are going no place in a hurry and have little potential for keeping up with the changing healthcare market along with little to no change of ever realizing the kind of greatness that makes people step up and take notice.

Some of the important points to remember about working with quality improvement calendars are:

1. This calendar grows as new opportunities for improvement are identified. In a healthy quality program, this calendar can start out as a blank slate at the beginning of the year and be a multiple page document by the end of the year.
2. Like the quality assurance calendar, this calendar can reduce the amount of paper and documentation that is required to support quality initiatives.
3. Like the quality assurance calendar, responsibility for management and oversight of quality improvement initiatives should be delegated across a number of people. The more people that are involved in these activities, the greater the impact that can be achieved with minimal stress on key people. Many healthcare providers, particularly smaller hospitals and long term care facilities are a great example of why delegation is so important. These providers tend to suffer from a syndrome called STP—the Same Ten People. The Same Ten People are on every committee and involved in every major activity. When these people max out, the organization hits glass ceilings. As an organization's potential is only as great as the people who create it, organizations that suffer from syndromes like STP are generally organizations that finish well below their potential. Delegation and the inclusion of the masses is also important because people who share in the ownership of change tend to embrace it faster and are more outwardly supportive of it. As it is too easy in today's market for a healthcare organization to fall behind, organizations need to take those steps that will allow them to keep PACE. Organizations that have to fight to make change happen generally finish last.
4. Everything that impacts or touches an organization's relationship with its patients is about quality. One of the common mistakes that healthcare has made in the past was to make the focus of its quality activities too narrow. If the activities influence the patients' experience and impacts their perceptions, it is a topic that should be encompassed in the quality program and represent improvement activities to be managed inside a

Quality Improvement Calendar Maintenance

QI Topic	Responsible Party	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec
New Handrails on North Hallway for Rehab Patients	Mark			P	A	C,E	C	C	C	C			
Form Dispensers for Hand Cleaning	Mark			P	A-Pilot	C,E	A	C	C,E	C	C		
Fire Extinguisher Monthly	Charlie								P,A	C	C	C	C
Water Temperature Weekly	Mark									P,A,C	QA		
OR Humidity	Charlie							P,A	C,E,	C			
Handicap Ramp at North Entrance	Mark							P	A	C,E	C	C	C
Energy Efficient Lighting	Mark						P	P	P	A	C	C	C

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structured process. To better understand this, please view the on-line training module titled "Building the Patient Experience".

Quality Improvement Calendar Maintenance

QI Topic	Responsible Party	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec
New Handrails on North Hallway for Rehab Patients	Mark			P	A	C,E	C	C	C	C			
Form Dispensers for Hand Cleaning	Mark			P	A-Pilot	C,E	A	C	C,E	C	C		
Fire Extinguisher Monthly	Charlie								P,A	C	C	C	C
Water Temperature Weekly	Mark									P,A,C	QA		
OR Humidity	Charlie							P,A	C,E,	C			
Handicap Ramp at North Entrance	Mark							P	A	C,E	C	C	C
Energy Efficient Lighting	Mark						P	P	P	A	C	C	C

The quality improvement calendar is an important management tool in that it helps to manage all those initiatives that have been identified as important in strengthening an organization's future and creates a structured system so that these initiatives can not be overlooked or lost. Many healthcare organizations discuss activities that would clearly strengthen their future but these great ideas get lost in the day-to-day hectic pace of the industry. At some point, they generally resurface in conversation just long enough for everyone to comment that they believe the idea was discussed once before and then are lost again in the world of great intentions. If the calendar is used properly, it forces these great ideas to paper and into a system where they can't get lost. The calendar system helps them to remain on the radar screen long enough to increase the likelihood that they will help to move the organization to a better place.

The quality improvement calendar, if used properly can be an extremely valuable management tool in helping to reverse the negativity that has plagued healthcare quality for the past two decades. For too many organizations, the focus of their quality programs is too negative to motivate people to care and to want to be part of it. If the only feedback that people ever hear is what they don't do right and what still needs to be done, it is difficult to feel good about who they are and what they do. The quality improvement calendar can easily become a management tool that can help people to focus on their accomplishments. While it is still important to discuss what needs to be accomplished, people are a lot more amenable to reaching for those goals if they feel good about who they are and the importance of what they do. If, at least twice a year, managers were to sit with their staff and discuss all those contributions their departments make to the success of the organization (the topics on their quality improvement calendar) and the success they have achieved to date, people would be much more apt to work hard to make the remaining opportunities happen. In building and managing your quality programs, it is important to remember that you can't build people up by tearing them down. Too many of our traditional quality structures are built on the premise that if we make people feel bad enough or embarrass them badly enough, they will reach for something better. The problem with this approach is that it is contrary to human nature and there are only three of the nine personalities found in a healthcare organization that respond to this type of stimuli. Many systems only add insult to injury by failing to recognize that even these three types will give up under the pressure of sustained negativity. To better understand building healthier change engines, please review the on-line module titled "Redirecting—Building a Healthier Change Engine".

The steps in building a successful quality improvement calendar are pretty simple:

1. The first step is to identify all existing quality improvement initiatives and to get them on the calendar. These are any activities designed to help the organization achieve a stronger future. That future could be tomorrow, next week, next year or next decade. Remember that the general rule is that if it impacts the patient's relationship with the organization or his or her perception of the organization, it is about quality. For example, physical upgrades to a building that make it more user-friendly are clearly quality improvement initiatives. Activities designed to help two departments work better together are clearly about quality improvement in an industry like health care that is strongly dependent on a team approach to great patient care. Activities designed to increase efficiency are quality improvement activities if they result in more resources that could be committed to other activities that impact patient care.

2. From this point, activities will be added to the calendar as they are identified as new quality improvement opportunities. These could come out of committee meetings, patient complaints, employee suggestions, patient satisfaction surveys, and the multitude of other settings inside a healthcare organization where great ideas that could move an organization to a better place are identified.

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As topics are added to the calendar, the letters ***P***, ***A***, ***C***, and ***E*** are used to indicate the progress the department is making in bringing the opportunity for improvement to life. ***P*** indicates planning for the improvement. ***A*** stands for the act of carrying the plan out. ***C*** indicates that the department is checking up on its progress while ***E*** communicates the enhancements made to the plan to make it stronger and/or improve the outcome. The coding serves three important functions:

Quality Improvement Calendar Maintenance

QI Topic	Responsible Party	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec
New Handrails on North Hallway for Rehab Patients	Mark			P	A	C,E	C	C	C	C			
Form Dispensers for Hand Cleaning	Mark			P	A-Pilot	C,E	A	C	C,E	C	C		
Fire Extinguisher Monthly	Charlie								P,A	C	C	C	C
Water Temperature Weekly	Mark									P,A,C	QA		
OR Humidity	Charlie							P,A	C,E,	C			
Handicap Ramp at North Entrance	Mark							P	A	C,E	C	C	C
Energy Efficient Lighting	Mark						P	P	P	A	C	C	C

a. The coding demonstrates the step that the department is engaged in to bring the improvements to life. If it takes too long at any point in the process, it is easier to identify delays and to promote activities that move the process along with a coding system that makes the steps stand out. For example, a long series of Ps may mean that an activity has moved from planning to procrastination. The procrastination may be the result of change-resistant behavior on the part of one or more departments or parties that need to contribute to the success of the activity. Timely identification of success delays is vital in an environment where living in the change-ready zone is so important and resources are strained. Healthcare providers need to know that they are making every minute and resource matter. If the calendar reflects a chronic string of checks and enhancements (C,E) it may be indicative of a bad plan and the participants are constantly trying to find the band-aid that will make it better.

b. In a well functioning process improvement activity, the plan and action steps should each take 30 days or less. If either of these steps last 90 days, the quality committee should begin to raise some serious questions about delays and what can be done to get the activity on track. The primary exception to this rule exists when formal analyses or evaluation activities delay the implementation. For example, a hospital may decide to bring in an outside firm to do a 90 day study on energy usages before developing their plan for energy reduction. In another example, an organization may decide that it needs to put in a handi-capped acceptable sidewalk entrance but it can not be done while there is snow on the ground. While the quality improvement opportunity (the new ramp) is identified in February, the implementation of the plan is pushed out and scheduled for June.

c. The coding can give the quality committee a sense that a process is in trouble or that an initial plan may not be the best plan because the activity takes too long to bring to closure. If a typical activity takes 30 days or less to develop a plan, 30 days or less to implement the plan and six months to monitor for the successful implementation in a way that makes the change stick, the quality committee should be raising questions for any steps that seem to take too long. For example, lets say that a department has checked and enhanced a plan three times and is still struggling to demonstrate the desired results. Maybe the department is not getting the cooperation that it needs from other departments or perhaps the plan developed is clearly the wrong plan. Delays in progress need to be addressed. When there are unnecessary delays, the organization is at risk of not keeping PACE with the changing healthcare environment at a PACE that will allow it to remain competitive and successful. Delays also tend to consume and waste resources that most organizations do not have to waste. Every time an organization puts money, time and resources into an activity that could happen in a more efficient and effective way, it also reduces its potential for a stronger future.

The coding system of PACE allows for easier monitoring of the timeliness, efficiency and effectiveness of quality improvement activities. In organizations that simply rely on narrative reporting, it is too easy to lose track of the history of an activity. Suddenly, the realization that an activity has been going on for two years comes to light and everyone stands around scratching their heads and wondering how that could happen. It happens because most quality activities are not managed. They are left to just happen. A serious problem with traditional quality approaches lies in the fact that, in the grander scheme, surviving the day always takes priority over building for tomorrow. This is the primary reason why so many healthcare organizations stagnate. Future growth and development only happen when they are planned for and managed. A healthy quality program provides the foundation on which to build for the future.

Working with Your Quality Calendar

Another category of quality improvement activities that should be managed on the quality improvement calendar are those that come out of an organization's performance improvement activities. These are those quality improvement activities that are necessary to secure an organization's long term future. The quality improvement opportunities that generally come out of performance improvement are linked to the organization's strategic goals. When one breaks down a strategic goal into implementation actions, one generally will find 6-15 quality improvement activities that need to happen across a number of departments. The key to success is having all those activities come together in just the right way and at the right time to create "break-through" performance. If any one of the needed quality improvement initiatives does not happen, the potential for a stragetically positive impact is lessened. This is a crucial reason for these activities to be managed inside a system. Today's fast paced and highly stressed environment increases the potential for failure unless actions are taken to protect them.

For example, imagine that a hospital felt it had an opportunity to draw a larger number of emergency room patients from the surrounding areas because of its reputation for customer-friendly and timely patient care. The leadership recognized that the emergency room wass considered the face of a hospital to the community because it is the one outpatient service that community members are most likely to use and experience the hospital's approach to patient care. If patients have great emergency room experiences, they are more likely to try out other services. The hospital believes that this has the potential to create strategic advantages for them. The hospital decides that the outcomes needed to achieve the strategic goal of increased emergency room volume are to make the emergency room the most customer-friendly emergency room in the area and to build a reputation for very timely care. In order to achieve the two measurable outcomes that are most likely to turn the strategic goal into a reality, the hospital identifies all the following quality improvement activities that would need to occur across the organization. (The time frames in the ( ) indicate the level of performance when the strategic project started.)

1. The ED will have an atmosphere in the ED where walking wounded patients feel well cared for and deeply cared about.
2. Patients need to have initial nursing contact within 15 minutes. (occurring 60% of the time)
3. Patients need to have initial physician contact within 20 minutes. (occurring 48% of the time)
4. X-ray films will be shot within 20 minutes of the order. (40 minutes)
5. Lab draws will occur within 15 minutes of the order. (25 minutes)
6. CT scan reads will occur with 30 minutes of testing. (2.3 hours)
7. The admission process will be completed within 10 minutes of arrival. (10 minutes)
8. Admissions to the patient care units will occur with 20 minutes of the decision to admit. (30 minutes on days, 45 minutes on evenings, and 1.2 hours on nights)
9. EKGs will be completed within 20 minutes of the order. (13 minutes)
10. 95% of class 1, class 2, and class 3 patients will be discharged in less than two hours. (64% of the time)

Over time many other quality improvement activities were identified from many other departments in order to create the kind of environment that promoted the growth of the ED volume and the development of the organization's reputation as the best in the area. When they all came together, they worked to improve the overall performance of the organization. Each of these activities represent quality improvement initiatives from two perspectives. First, they are activities that help to position the hospital to have a stronger future. The other benefit is that once the organization starts working on the identified activities and working towards the designated goals, patients begin to experience a better level of care or service almost immediately. For example, the minute the hospital begins to implement the activities to create a more customer-friendly environment, patients coming to the emergency room have the potential to feel better about their experiences. Quality improvement activities linked to strategic goals frequently have the benefit of improving an organization's immediate future at the same time they are working to secure the organization's long term future. As a result, these are activities that can be extremely beneficial to an organization.

Documenting and Reporting

When using the quality calendar system, documentation of quality assurance activities that are in compliance is very easy. The calendar reflects the management level monitoring with an entry as simple as a set of initials and the symbol OK. The detailed documentation can then be found on the logs that are kept for the different activities. If a quality assurance activity falls

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out of compliance, a higher level of documentation is necessary and that documentation includes the planning, action steps, checking for outcomes and enhancements that the department engages in to bring the activity back into compliance.

For example, on the quality assurance calendar to the right the OR humidity fell out of compliance during the summer months and the maintenance department had to bring it back into acceptable limits. In September, the mixing valve on the water system failed and needed to be replaced. The failed valve was making water at the patient sinks higher than the acceptable limits. As a result these activities became a quality improvement initiative for the organization. Once the valve was replaced, it was important for the maintenance department to document the activity. The documentation demonstrates the timely identification of the non-compliance, the actions taken to correct it and the follow-up activities to ensure that the actions corrected the issue.

One of the common mistakes that organizations make is to not have any documentation that supports the timely identification and intervention for areas of non-compliance. In the event of surveys, inquiries from outside agencies, complaint investigations and malpractice cases, this documentation can be important. Documentation should be simple, but it should exist and become part of a department's quality report to the committee.

Quality Assurance Calendar
Maintenance

QA Topic	Monitoring Requirement	Responsible Party	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec
Generator Fire-up	Every Friday 6:00 a.m.	Mark	MN OK	MN OK	MN OK	MN OK	MN OK	MN OK	CS OK	MN OK	MN OK	MN OK	MN OK	MN OK
Generator Load Test	Every Friday 6-10 a.m.	Mark	MN OK	MN OK	MN OK	MN OK	MN OK	MN OK	CS OK	MN OK	MN OK	MN OK	MN OK	MN OK
Fire Extinguisher Monthly	Fourth Week of Every Month	Charlie	CS OK	CS OK	CS OK	CS OK	MN OK	CS OK	CS OK	CS OI	CS OK	CS OK	CS OK	CS OK
Fire Extinguisher Annual	First Week of September	Charlie/Johnson Fire Controls	X	X	X	X	X	X	X	X	CS OK	X	X	X
Water Temperature Weekly	Thursday Morning	Mark	MN OK	MN OK	MN OK	MN OK	MN OK	MN OK	MN OK	MN OK	MN OI	MN OK	MN OK	MN OK
OR Humidity	Thursday Morning	Charlie	CS OK	CS OK	CS OK	CS OK	CS OK	CS OK	CS OI	CS OI	CS OI	CS OK	CS OK	CS OK
Annual Boiler Test	First Week of December	Mark/ Wilson Water Controls	X	X	X	X	X	X	X	X	X	X	X	MN OK
OR Filter Changes	Fourth Saturday of Every Month	Charlie	CS OK	CS OK	CS OK	CS OK	CS OK	CS OK	CS OK	CS OK	CS OK	CS OK	CS OK	CS OK
General Filters	First Week of Every Quarter January, April, July, October	Charlie	CS OK	X	X	CS OK	X	X	MN OK	X	X	CS OK	X	X
Pest Control in Kitchen	First Week of Every Other Month	Charlie/ Pest Free Pest Control	CS OK	X	CS OK	X	CS OK	X	CS OK	X	CS OK	X	CS OK	X
Pest Control in Hospital General	Second Week of Every Quarter	Charlie/ Pest Free Pest Control	CS OK	X	CS OK	X	CS OK	X	CS OK	X	CS OK	X	CS OK	X
Parking Lot Lighting	6:00 a.m. every Friday	Charlie			CS OK	CS OK	CS OK	CS OK	CS OK	CS OK	CS OK	CS OK	CS OK	CS OK

Quality Improvement Calendar
Maintenance

QI Topic	Responsible Party	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec
New Handrails on North Hallway for Rehab Patients	Mark			P	A	C,E	C	C	C	C			
Form Dispensers for Hand Cleaning	Mark			P	A-Pilot	C,E	A	C	C,E	C	C		
Fire Extinguisher Monthly	Charlie								P,A	C	C	C	C
Water Temperature Weekly	Mark									P,A,C	QA		
OR Humidity	Charlie							P,A	C,E,	C			
Handicap Ramp at North Entrance	Mark							P	A	C,E	C	C	C
Energy Efficient Lighting	Mark						P	P	P	A	C	C	C

For consistency purposes, the PACE reporting approach should be utilized. As the two samples on this and the next pages demonstrate, the maintenance department can generally report its compliance-oriented correction activities on one piece of paper. The documentation approach creates a paper report of the timely identification of the issue, timely intervention, a short period of intensified monitoring to assure that the fix brought the activity back into compliance and any enhancements that were made to the plan, if needed.

One of the benefits of the calendar system is that there is no need for specialized long term monitoring as with other quality improvement activities because the long term monitoring already exists as part of the routine quality assurance monitoring for ongoing compliance. Thus, as these examples demonstrate, the department simply reverted back to that routine monitoring once it had completed a short period of more intensified monitoring (generally daily) to provide very timely evaluation to make sure the action brought the activity back into compliance.

Most compliance issues can be rectified within 30 days and thus the single report form demonstrated on the prior page is enough. Occasionally quality improvement activities necessary to bring an activity back into compliance requires a more extended period for corrective actions. In the example to the right, an organization may find that it

Date			Department: Maintenance Topic: Maintenance of Water Temperatures at Patient Care Sinks
9/06	P	PLAN	How do you plan to get from the current level of performance to the desired level? Who will be involved, what will their responsibilities be, what are the steps that will be taken, and what are your target dates for accomplishments? Replace mixing value on primary water line.
	A	ACT	Take action! Do it! Make it happen! What did you do? Who did what? New mixing value was ordered on 9/12/06 over night delivery. It was installed on 9/14/06.
	C	CHECK	Check the results! – What did you learn? Or, how is it working? Are the desired results being achieved? The department monitored water temperatures daily for the first week after installation to assure proper temperatures. The department continues to monitor water temperatures on weekly basis there after as part of its ongoing QA.
	E	ENHANCE	Enhance the approach! Do you need to enhance your approach to achieve the desired results? How will you enhance the plan or approach to hold the improvement and strive for more? No enhancements necessary.

Reporting Your Quality Activities

suddenly has bacteria in its water source after a minor earthquake and its efforts to address it in a simple way have not worked. As a result, it is determined that the hospital needs to install a specialized water purification system. The time needed for the system to be identified, purchased and installed will be approximately 90 days because the specific unit needed by the hospital is back ordered. As a result, the maintenance department will need to maintain a manual system for temporarily treating the water and bottled water will need to be supplied to high risk areas of the building until the unit can be installed. The maintenance department will need to provide extended documentation of its efforts to protect the hospital and its patients while bringing the system back into compliance. As you can see from the sample pages to the right, the report would encompass 90 days of activities. The initial report supplies the detail necessary to understand the first PACE cycle. The supplemental page provides a brief summary of the activities carried out to manage the situation over time and bring the activity back into compliance.

This level of documentation on compliance-oriented issues that are important to patient safety is critical. Healthcare organizations must be able to document their efforts to protect the patients and others in the event of a sustained non-compliance and their efforts to bring those activities back into compliance. They need to be able to demonstrate that they are closely monitoring the situation and working to address new issues quickly.

As most departments only report to the quality committee on a quarterly basis, quality improvement activities that are designed to bring a required activity into compliance should be reported every month. Because of the importance of these activities to patient safety and relationships with outside agencies, there should be no delays in the identification and management of these activities. Noncompliance should be reported to the quality director within 72 hours (24 hours for high risk and untoward event issues) of becoming aware of the non-compliance and then the reports that summarize the steps to bring the activities back into compliance should be made available for review at the next quality meeting. As the quality committee is charged with the oversight responsibilities for the effectiveness of the quality program and has accountability for the program's effectiveness to the governing body, the quality committee should always be aware of areas of non-compliance with standards of practice and performance and be on top of making sure that the appropriate actions are being taken to bring the activity back into compliance.

Reporting quality improvement activities that are designed to secure the organization's future is a little more involved as the reporting style and format needs to allow an organization to demonstrate its incremental progress in reaching its goals. For example, a hospital's data shows that the documentation of patients' vital signs are complete in the medical record 58% of the time. While the ultimate goal is 100% with a lower level cut-off of 98%, it is highly unlikely that that level of progress will be made in one month or one attempt. More than likely, it will take several months and be a continuous climb to the goal with periodic enhancements to the plan in order to finally achieve that goal. Thus the reporting format needs to allow an organization or department to show that growth and progress.

Date			Department: Maintenance Topic: Water Purity
9/06	P	PLAN	How do you plan to get from the current level of performance to the desired level? Who will be involved, what will their responsibilities be, what are the steps that will be taken, and what are your target dates for accomplishments? A recent earthquake has seemed to impact the ground water tables and the hospitals water is now testing high for bacteria.
	A	ACT	Take action! Do it! Make it happen! What did you do? Who did what? An outside firm was brought in to treat the well that feeds the hospital. During the interim while bacteria counts remain high, high risk areas will be provided bottled water. Drinking water in all areas will be supplied through bottled water. Water testing will be done at least once a week to monitor water purity.
	C	CHECK	Check the results! – What did you learn? Or, how is it working? Are the desired results being achieved? Treatment of the well on three different occasions has not brought water purity back within normal limits.
	E	ENHANCE	Enhance the approach! Do you need to enhance your approach to achieve the desired results? How will you enhance the plan or approach to hold the improvement and strive for more? It has been determined that a specialized ultraviolet water purifying system needs to be installed. The unit has been ordered and a unit large enough to meet the needs of the hospital is back ordered. The consultant recommends that the hospital continue to treat the well weekly in an attempt to improve the condition of the water. They point out that the problem may still correct itself but the purifying system is the best plan at this time. In the meantime, bottled water will continue to be supplied for all drinking, cooking and patient care activities.

	Date	Report of Follow-up Activities (Was your improvement plan successful? How do you know? Was an audit done? What were the findings and observations? How close are you to your goal? Is the improved performance showing sustainability? What impact does the improvement seem to be having?)	Now What? (What are your plans for further efforts regarding this activity and follow-up monitoring. Do you need to modify your plan to achieve the desired outcome? What do you plan to do next? Have you identified additional opportunities to enhance performance? What will you do to assure sustainability? How long do you plan to monitor for sustainability?)	When to evaluate again? (Date)
PACE	10/06	The water management system put together seems to be working well for the hospital. We have had two instants where people drew drinking water from sinks. We have now put signage above all sinks reminding people not the draw drinking water or patient care water from these sites. We are still waiting for the sterilization unit to arrive.	The water management plan will be continued. As the company that will install the unit says they will respond immediately when the unit arrives. They have agreed to install it on the weekend if necessary.	Next Month
PACE	11/06	The water treatment unit arrived on 11/02 and was installed the same day. Daily water testing for the first week after the unit was installed has tested with bacterial counts within normal limits. Testing every three days for the remaining two weeks of the month continued to test out well.	The hospital will return to its normal schedule for testing water.	Return to routine water testing schedule
PACE				

Quality Improvement Reporting
Maintenance Department

Plan

Opportunity for Improvement: Reduce Electric Bills

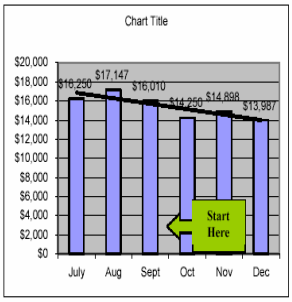
What is the Planned Improvement? The installation of energy efficient lighting in high usage areas of the building can help to reduce the hospital's electric bills. Studies have shown that the bills could be reduced by as much as 15%.

Act

What did you do to improve the process? Energy efficient lighting was installed in all hallways and patient care areas where lighting stays on more than 12 hours per day.

Check

What did you learn? Were improvements realized? The new lighting went into effect the third week of September. Initial data for the first three months after installation indicates that the electric bills have dropped by as much as an average of $2000 per month. It will be important to determine how much of that drop is from the costs associated with air conditioning/heating versus lighting.



Enhance

There are no planned improvements at this time. We plan to monitor through the winter months to determine long term impact of lighting changes.

Reporting Your Quality Activities

The PACE reporting format for quality improvement activities allows an organization or department to document their PACE activities and to depict progress in a simple graphic format. The saying that a picture speaks a thousand words is very true in healthcare quality. A graphic depiction of progress makes it much easier for people to see that their efforts are paying off and to understand the impact of those efforts. The graphic to the top right makes it very easy to see the decline in the hospital's electric bills. The same message could take several sentences and maybe a couple of paragraphs to communicate in narrative form. It is also important to understand that people think in pictures and thus they can process the information in a picture with much greater speed than they can when they read words because they actually have to convert the words into an image. If we give them the image as part of the reporting process, they can generally process the information more quickly and in many cases, they can process more of it more accurately.

Emergency Department

Plan

Opportunity for Improvement: Timeliness of ER Transfers

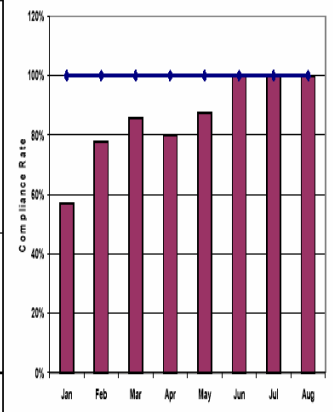
What is the Planned Improvement? As the timeliness of the transfer of some emergency room patients to a higher level of care can have a significant impact on their potential clinical outcomes, it is important that we get patients out of our ED within 2 hours. A study conducted in January 2006 found that only 58% of our patients got transferred out in less than 2 hours. Our goal is that all patients requiring transfer will leave our ED in less than 2 hours stabilized to the best of our ability.

Act

What did you do to improve the process? We have analyzed all steps in the management of critical patients that present to the ED. We have identified ways to improve turn-around for lab, x-ray, and EKG. We have established a system so that ambulances are put on notice earlier so there is not a delay in response.

Check

What did you learn? Were improvements realized? In February and March we saw improvement but we still experienced some delays because of the wait time for personnel to come in to run diagnostics. We established a system where LPNs could do the EKGs and the registered nurses could draw the labwork so the lab personnel only need to run it when they get here. That way if the patient is in x-ray when the lab gets here, there is no delay.



Enhance

What are your next steps to further improve the process. In June, July and August we were able to achieve 100%. Any case where the transfer takes more that 2 hours will be flagged for review to determine what could have been done to prevent the delay. That information will then be used for education and continued monitoring of focused areas that could be problematic.

In completing the PACE report for quality improvement activities, the responsible department would indicate:

1. the opportunity for improvement,
2. a brief description of the planned improvement,
3. a brief description of the actions taken to improve the process,
4. a brief description of what was learned and the actual improvements that were realized, and
5. a description of enhancements to the original plan that were identified to be value adding to the success of the quality improvement activity as the responsible parties worked through the implementation phase. (continuous quality improvement)

Plan

Opportunity for Improvement: Documentation of Vital Signs on Discharge

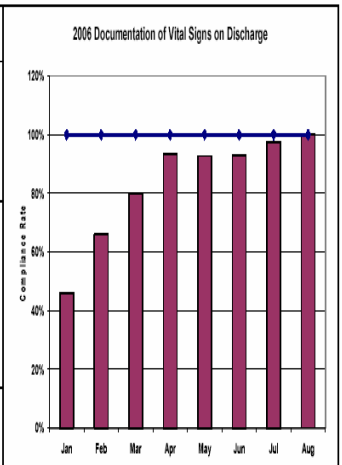
What is the planned improvement? Vital signs are an important component in the final assessment for patients being discharged from the emergency department. A study done in January showed that discharge vital signs are only documented on 50% of our discharges. Our goal is 100%

Act

What did you do to improve the process? We established a policy that the nurse has to do the final discharge from the emergency department. We found that some patients were being discharge by the physicians to help out and several aspects of the final documentation and assessment were not being done. Discharge assessment and documentation guidelines were established.

Check

What did you learn? Were improvements realized? The discharge process in the emergency department has been poorly defined and thus people tended to do what they personally though was right rather than worked for consistency. Discharge assessment and documentation guidelines were established. In April, we reached 92% compliance.



Enhance

What are your next steps to further improve the process? In August we achieved 100% documentation of vital signs on discharge. We will continue to monitor performance through the end of the year to make sure we can hold this success.

Quality improvement activities designed to improve the immediate and long term future of a healthcare organization are generally reported to the quality committee on a quarterly basis. As these are activities where the desired outcomes are achieved over time, there are rarely value adding benefits achieved by looking at the information more frequently. The two times that it is helpful to monitor the data more frequently are:

1. If a department or healthcare entity is struggling to implement a quality improvement activity that has been sanctioned by the quality committee, it is the committee's responsibility to facilitate actions to encourage and/or assist them in taking that responsibility more seriously. The committee may need to assist the department manager with implementation because of a lack of knowledge or it may need to hold the individual or group more accountable because of resistance to change.
2. If the data is not showing the kind of outcomes that would be anticipated or are needed, the quality committee could require more frequent reporting in order to better understand the process and assist in identifying enhancements that would lead to more effective or efficient improvements. It is only appropriate for the committee to allow a department or group to struggle with success or implementation for a very short period of time.

Some of the other important guidelines that should be followed to facilitate timely and effective process improvement are:

1. As most healthcare process improvement activities require team efforts, outcomes tend to be most effective when management and reporting activities facilitate team approaches. For example, if a quality improvement activity requires the maintenance, nursing, and housekeeping departments to work together to make the activity happen, the best potential for success exists if the activity is designed to promote a team approach.

Reporting Your Quality Activities

In situations where more than one department or entity needs to be involved in making the improvement happen:

a. the topic should appear on the departmental calendar for each department that will have a role in making the improvement happen, and
b. the involved departments or entities should generate one report. Instead of each department creating its own report, having the departments collectively generate one common report promotes a greater sense of team ownership for the activity. The team generally would appoint a person from one of the involved parties to generate the report for the quality committee but the group would be accountable for its content.

2. From report to report, the information in the planning section will remain relatively unchanged unless the initial plan is determined to be ineffective, in need of major rewrites or enhancements are added. The act, check and enhance portions of the report will change from report to report as the department or group works to drive performance in the desired direction and opportunities to enhance the plan to achieve those outcomes are identified. The graphics portion of the report depicts the progress in achieving the goal while the narrative portion of the report describes the step taken to get there.
3. The quality of the report is not measured in the volume of information generated. It is measured in the impact of the information provided. This is an important skill for health care to work towards. Voluminous reports, policies, procedures and processes were one of the very early mistakes that most organizations made in developing their quality programs. As most organizations did not have a good handle on what a healthy quality program looked like, they started creating lots of stuff in hopes that volumes of information would suffice as quality information. That unhealthy habit has lived inside quality programs for over two decades. These organizations tend to find themselves in trouble these days because their constituents and outside entities have learned enough over time about what they want in the name of quality that they quickly reject these volumes of information if they don't communicate anything value-adding.

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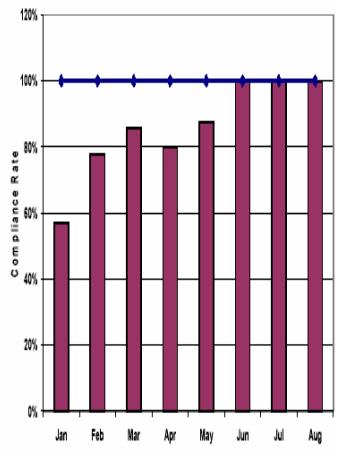

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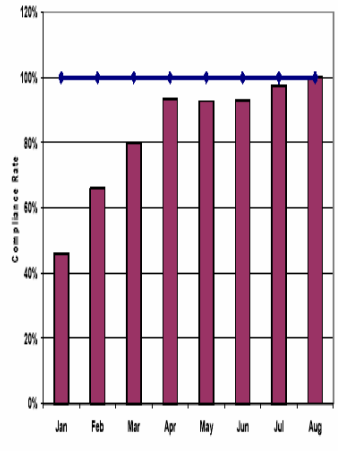

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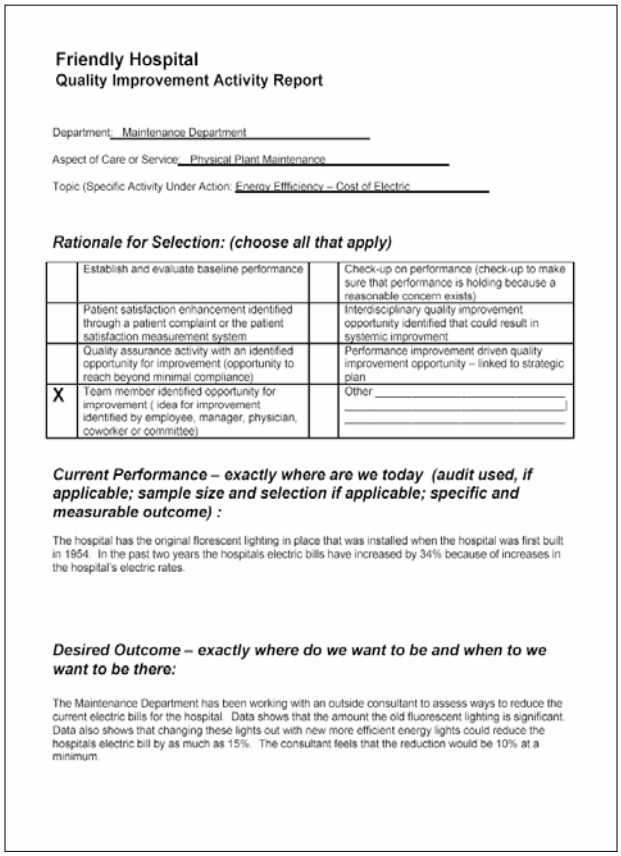
Sanctioning and Sustaining Quality Activities

A healthy quality improvement system has some mechanism where the quality committee is involved in sanctioning the quality improvement activities that a department or group will work on. This step is important in making sure that resources are being used wisely and that people are spending time working on activities that will have meaningful results for the organization. This step is particularly important in organizations where people are working to learn how to effectively manage quality or where there is history of picking quality activities for the purpose of simply saying that people are working on something. In the past, it has been a common practice to pick topics because they were easy, they created the percep-

Reporting Your Quality Activities

tion that something was happening (when nothing meaningful was really happening) or it was thought that the topic would please outside surveyors. Over the past three decades, there have been many quality initiatives that simply created busy work for the staff and had little to no potential to have a meaningful impact. For example, consider the clinic that does a study on the timely reading of EEGs when the clinic does no EEGs or consider the radiology department that studies the presence of an order for all tests completed when the department knows going into the study that its compliance rate is 99.6% (not much room for improvement).



Friendly Hospital
Quality Improvement Activity Report

Department: Maintenance Department

Aspect of Care or Service: Physical Plant Maintenance

Topic (Specific Activity Under Action: Energy Effficiency – Cost of Electric

Rationale for Selection: (choose all that apply)

	Establish and evaluate baseline performance		Check-up on performance (check-up to make sure that performance is holding because a reasonable concern exists)
	Patient satisfaction enhancement identified through a patient complaint or the patient satisfaction measurement system		Interdisciplinary quality improvement opportunity identified that could result in systemic improvment
	Quality assurance activity with an identified opportunity for improvement (opportunity to reach beyond minimal compliance)		Performance improvement driven quality improvement opportunity – linked to strategic plan
X	Team member identified opportunity for improvement (idea for improvement identified by employee, manager, physician, coworker or committee)		Other _____

Current Performance – exactly where are we today (audit used, if applicable; sample size and selection if applicable; specific and measurable outcome) :

The hospital has the original florescent lighting in place that was installed when the hospital was first built in 1954. In the past two years the hospitals electric bills have increased by 34% because of increases in the hospital's electric rates.

Desired Outcome – exactly where do we want to be and when to we want to be there:

The Maintenance Department has been working with an outside consultant to assess ways to reduce the current electric bills for the hospital. Data shows that the amount the old fluorescent lighting is significant. Data also shows that changing these lights out with new more efficient energy lights could reduce the hospitals electric bill by as much as 15%. The consultant feels that the reduction would be 10% at a minimum.

In a healthy quality improvement program, activities are designed to move the organization towards a better future. These activities are about keeping PACE with the constantly changing healthcare environment, reaching beyond adequate or good to great, building and sustaining a stronger reputation for the organization, building healthier relationships with patients and constituents, and positioning the hospital to have a stronger long range future. In a well structured sanctioning activity, the department or group who want to work on a quality improvement activity would report what the activity is, why it is important to the organization, what the current level of performance is, and what the anticipated improvement will be along with its anticipated future impact. The sanctioning activities also become an important mechanism in helping to prioritize activities. For example, if a department has six activities that it is already working on and they all have the potential to have a much greater impact than the newly proposed activity, the committee may recommend that the department or group postpone implementation until one or two of the other activities have been completed. While the quality committee has ultimate sanctioning responsibilities, the committee frequently delegates that responsibility between meetings to the quality director. This prevents the potential for unnecessary or inappropriate delays for important activities. If the quality director is unsure about an activity, he or she generally consults with the committee chairperson or the CEO.

In addition to its responsibility for sanctioning quality improvement activities, the committee also has responsibility for determining when activities can be taken off the active list of current activities. As it takes approximately six months for a person to convert a new behavior into a habit, it is very easy for people to slide back into old comfortable ways if monitoring activities for process improvement do not last long enough to assure that the new behavior will hold. No department can simply stop looking at or working on an activity until the committee is comfortable that reasonable steps have been taken to assure sustainable performance. The length of this monitoring period varies from topic to topic and is impacted by a number of variables such as:

1. How big is the change?
2. How much stress is the workforce under at the time of the change (stress makes it more difficult for the average person to change)?
3. How many people need to adopt the new behavior (the larger the number, the longer the required monitoring period in general)?
4. How many changes are going on at the same time (the more changes going on simultaneously, the more stress on the workforce and the more difficult to sustain the changes)?

The quality calendar and PACE reporting systems are designed to drive efficiency and effectiveness into an organization's quality management systems while making sure that the healthcare team stays focused on the need to protect the organization today, tomorrow and into the future.

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Getting people to work with us is simply the other side of us working with them!

Being Great Isn't That Hard!

A woman went to the local hospital to have a prenatal ultrasound. Just as the technician was finishing up the test, the baby rolled over and the image appeared as though the baby was waving. The technician snapped the image. He then typed a message on it from the baby to the two siblings at home about how she would be joining them soon and happy to be their little sister. The technician gave the ultrasound image to the parents to take home. The parents were so impressed with his gesture that they showed the ultrasound to many people in the community and talked about how wonderful the hospital was. When they arrived at the hospital for the delivery they were well prepared to have a great experience and they did. Greatness is commonly found in the little extras that people do in the course of meeting the minimal expectations. Greatness is found in reaching well beyond good. Great leaders are people who inspire others to reach for those little extras.

Our reputation and the strength of the relationships we have with our customers and communities is a choice. That choice is demonstrated in how we treat them when they are in our world, the commitment we demonstrate to the quality of the care we deliver, the desire we demonstrate to constantly reach for something better than what we have today and our willingness to recognize when we could have done something better and to do something about it.

With our choices, we have a wide range of responsibilities and actions that can result in good and bad consequences. The real measure of who we are and what we are about is not in what we write into our mission statements but it is in the choices that we make which communicate what that mission means to us. If our choices indicate that it has no real meaning to us, why should anyone else place value in it. The strength of our quality programs is one of the measures that says a lot about who we are.