CARLETON PLACE & DISTRICT MEMORIAL HOSPITAL

TITLE:	**Integrated Quality Management Framework**		
Manual/Policy #:	Board of Directors #III-1	**Division:**	CPDMH
Original Issue:	May 2012	**Issued by:**	Board Chair and Board Secretary
Previous Date Reviewed	April 2019	**Approved by:**	Board of Directors
Last Date Reviewed:	January 2022	**Cross References**	

1. POLICY:

The Board of the Carleton Place District & Memorial Hospital (CPDMH) will ensure that the integrated quality management framework is an integral component of the day-to-day work of the organization in providing quality care and service to patients and families, colleagues and others who interact with CPDMH.
Every staff member, physician and volunteer is accountable to provide quality and safe care to patients in the organization.
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2. SCOPE:

This policy applies to all members of the Board, staff, active medical staff and volunteers at CPDMH who play a role in providing the best possible care to patients in the organization.

3. GUIDING PRINCIPLES:

The hospital's mission, vision, values and strategic plan provide the direction to guide the delivery of high quality health services.

An integrated quality improvement plan incorporates risk and utilization management, performance measurement including monitoring strategic goals and objectives, patient safety and quality improvement. It recognizes that these activities are interrelated and therefore need to be coordinated (Accreditation Canada 2019).

The quality improvement initiatives for this plan are based on the ongoing commitment to adopt best practice standards and emerging safety solutions that enhance patient experience and outcomes driven by performance measurement and operational actions.

4. DEFINITIONS:

High Quality Health System: a health system that delivers world-leading safe, effective, patient-centred services, efficiently and in a timely fashion, resulting in optimal health status for all communities (Health Quality Ontario, 2015).

LEAN Methodology: a process focused on understanding the system from the client's experience in it and using that information to increase efficiency, minimize waste and increase quality (Accreditation Canada, 2019).

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5. PROCEDURE:

The Board of Directors is ultimately responsible for the quality of services provided to patients, families, staff, medical staff and all who interact with the organization. The Board ensures that an accountability structure for quality exists as follows:

1A) The Board establishes the strategic direction for quality and provides oversight of quality and risk management. The governance structure includes committees with a mandate to monitor and report on quality and risk management in their areas of governance, and advice the Board, as follows:

- The Board Quality Committee: Monitors and makes recommendations on clinical quality and safety issues, ensures compliance with legislated requirements such as those in the Excellent Care for All Act, and oversees the development and implementation of the annual quality improvement plan .
- The Governance Committee: Monitors and makes recommendations regarding human resources planning.
- The Resource Planning and Utilization Committee: Monitors and makes recommendations regarding financial planning.
- The Medical Advisory Committee: Monitors and makes recommendations regarding quality of care to the Board Quality Committee and makes recommendations to the Board concerning physician, dental or extended class nursing privileges and by-laws respecting the medical staff , dental and extended class nursing staff.

1B) The Board delegates to the Chief Executive Officer and Chief of Staff, responsibility to ensure that an appropriate organizational infrastructure and culture exist to support continuous improvement of clinical and operational quality and risk management.

This infrastructure includes formal committees with responsibility for various aspects of quality and safety: i.e. the Senior Management Team, Patient Care Committee, Infection Control Committee, Occupational Health and Safety Committee, Emergency Preparedness Committee, Joint Ethics Committee and program / service committees. It also includes advisory groups such as the Patient and Family Advisory Council.

As well, the implementation of appropriate policies and procedures is essential to support quality in clinical, operational and patient relations practices.

1C) The Board expects employees, physicians, dentists, volunteers and students to conduct themselves in accordance with the Code of Conduct and through a culture of quality and safety including:

- Practice in a safe manner.
- Practice in accordance with organizational and applicable professional standards.
- Behave in accordance with the organization's values and ethical standards.
- Participate in ongoing learning as required to maintain competence.
- Participate actively in identification and follow-up of quality, safety and risk management issues.

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- Engage in open, fair and blame-free dialogue, in a context of personal and professional accountability.
- Ensure that patients and families are treated with respect and honesty.
- Implement ethical patient relations and disclosure practices.

The Board expects the same of external service providers.

2. Quality Improvement Methodology

The organization's approach to quality improvement is based on the Plan-Do-Study-Act cycle based on LEAN Methodology. Quality improvement opportunities are identified through a variety of formal and informal mechanisms including incident reports, inspection reports, performance indicators and patient and staff satisfaction surveys. Improvement targets are set based on analysis of the data to determine where impactful change can be implemented. Execution of an improvement activity is tracked against pre-determined targets and benchmarks, data and feedback are collected to measure the impact of the change and adjustments are made as necessary to achieve better results.

3. Performance Standards, Monitoring and Reporting

Performance expectations will be set, monitored and reported at the most appropriate level in the organization. The oversight process will include:

- Appropriate communication regarding quality and safety to the Board, employees, physicians, volunteers and students.
- Policies regarding quality improvement, occupational health and safety, patient relations (including full disclosure of adverse events and harm), whistleblower protection, and ethical practices.
- A standardized reporting system for actual and near miss incidents and follow-up.
- Clear processes for employees, physicians, volunteers, students, patients and families to report quality and safety concerns.
- Constructive responses to reports of quality and risk management concerns.
- Provision of education, as required, to employees, physicians, volunteers, students, patients and families, regarding quality, safety and patient relations issues and policies.
- Performance standards set based on best practice and/or industry standard with due regard to legislative and regulatory requirements

1. REFERENCES

AccreditationCanada,2019. Qmentum Program: Leadership. Cited at: https://www3.accreditation.ca/OrgPortal/Node_StdList.aspx

Health Quality Ontario, 2015. Quality Matters. Cited at: https://www.hqontario.ca/Blog/category/quality-improvement/quality-matters-a-playbook-for-health-system-improvement-1

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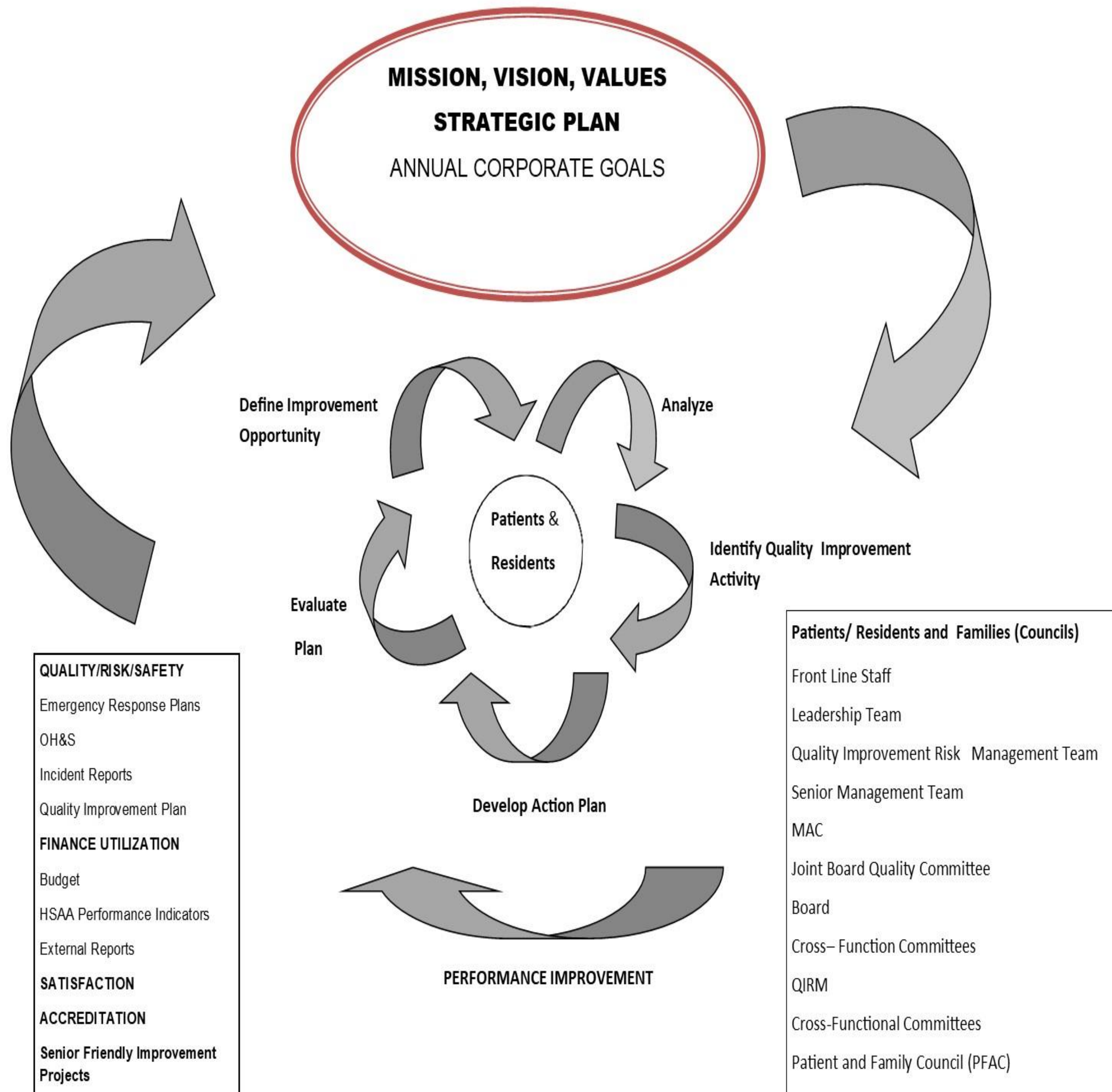
2. APPENDIXES:

Appendix A



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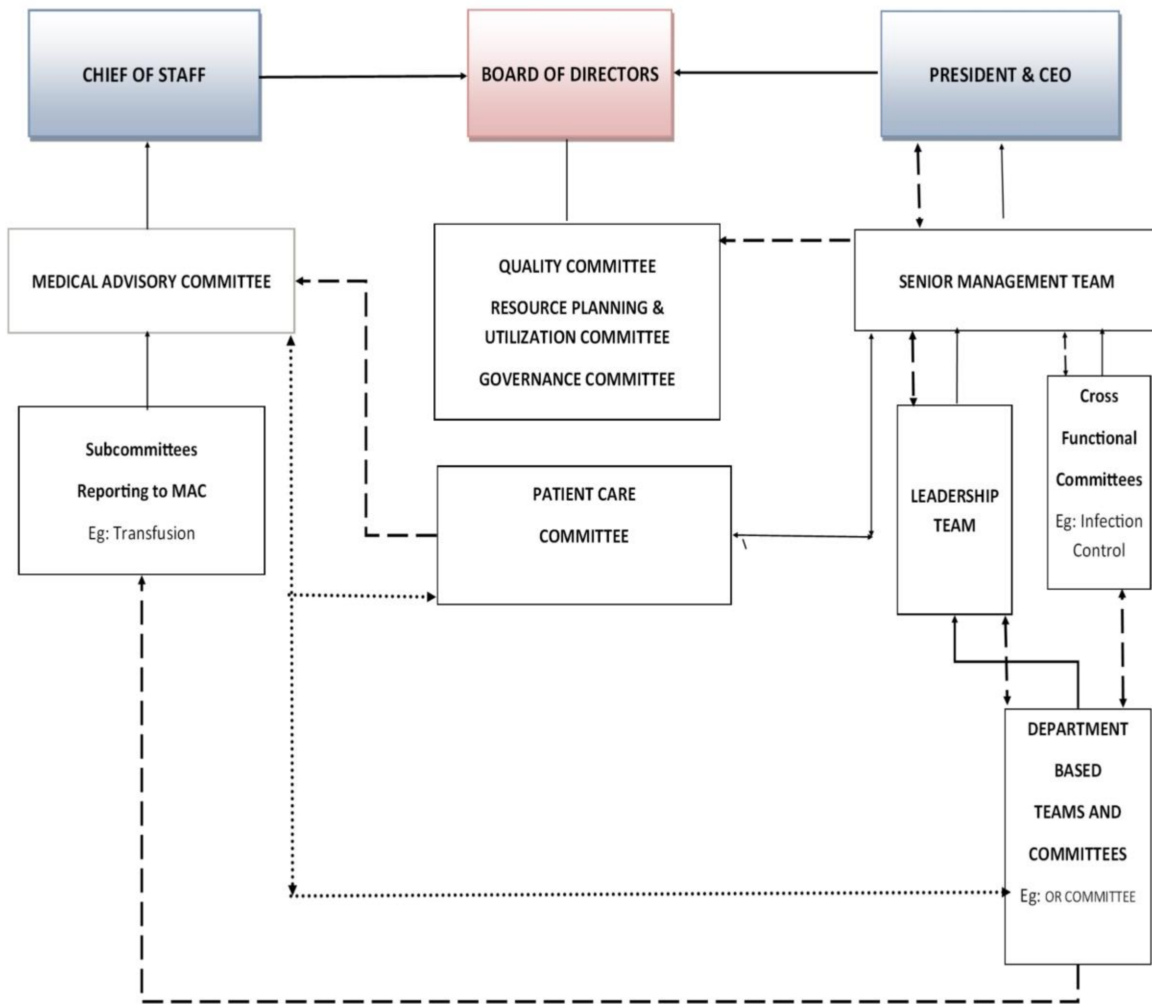
Appendix B



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Evaluation: This policy will be reviewed every two years.

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