Continuous Quality Improvement: A shared governance model that maximizes agent-specific knowledge

Vanessa Bartkowski, Jennifer Yoon
London Health Sciences Centre, Ontario, Canada

Context:

To engage staff and influence change that would support quality improvement, an innovative shared-governance model was implemented at London Health Sciences Centre (LHSC), through the establishment of interprofessional cross-functional continuous quality improvement (CQI) councils. The model leverages the knowledge and expertise at the point of care and provides a mechanism for change that fosters ongoing enhancements to the quality and safety of care delivery.

Aim Statement:

To engage staff in the identification, formulation, execution, evaluation and dissemination of quality improvement initiatives, using agent-specific knowledge.

Strategy for Change:

To engage staff and influence change for improved quality and safe patient care, concepts from the STAR model were used to develop an approach to shared governance that enabled agent-specific knowledge to be used to make improvements.

CQI councils were structured across the organization to support partnership, accountability and ownership of the process to improve quality and safety. A steering committee was formed to facilitate, monitor and sustain the model. Point of care staff, management, and clinical education leaders were trained to ensure sufficient knowledge and resources were available to foster implementation.

Empowering frontline staff, management and clinical education leaders with the appropriate tools, education and resources has been key to recognizing, rewarding and motivating all levels of staff.

Figure 1. Change culture

CQI councils, comprised of multi-disciplinary and cross-functional point-of-care staff were formed and supported through:

1. Standardized/interprofessional and cross-functional CQI Council terms of references outlining a common purpose and set of accountabilities on which all CQI councils align – this created a common foundation on which frameworks for communication and collaboration could be established across the CQI network.
2. Centralized calendar of CQI Council meetings and events
3. Standardized/systems and LEAN curriculum designed and implemented to enable autonomous problem-solving, process analysis, planning, implementation and evaluation of improvements by frontline staff.
4. CQI council leaders to act as an a repository of quality improvement activity and leveraged as a collaborative resource of improvement experience.
5. Corporate CQI Steering Committee was developed to give representation from each area council to discuss challenges, share experiences and gain through understanding lessons learned by other areas.

Summary of Results:

61 CQI councils were established with 59 quality and safety initiatives in various stages of implementation. Improvements range from evidenced-based to a grassroots approach. Through process improvements, there was active engagement of approximately 1000 point of care staff.

A registry was established to provide a reporting mechanism with approximate 99 quality and safety. A steering committee was formed to facilitate, monitor and sustain the model. Point of care staff, management, and clinical education leaders were trained to ensure sufficient knowledge and resources were available to foster implementation.

Aims Statement:

To engage staff and influence change for improved quality and safe patient care, concepts from the STAR model were used to develop an approach to shared governance that enabled agent-specific knowledge to be used to make improvements.

Strategy for Change:

To engage staff and influence change for improved quality and safe patient care, concepts from the STAR model were used to develop an approach to shared governance that enabled agent-specific knowledge to be used to make improvements.

CQI councils were structured across the organization to support partnership, accountability and ownership of the process to improve quality and safety. A steering committee was formed to facilitate, monitor and sustain the model. Point of care staff, management, and clinical education leaders were trained to ensure sufficient knowledge and resources were available to foster implementation.

Empowering frontline staff, management and clinical education leaders with the appropriate tools, education and resources has been key to recognizing, rewarding and motivating all levels of staff.

Figure 1. Change culture

CQI councils, comprised of multi-disciplinary and cross-functional point-of-care staff were formed and supported through:

1. Standardized/interprofessional and cross-functional CQI Council terms of references outlining a common purpose and set of accountabilities on which all CQI councils align – this created a common foundation on which frameworks for communication and collaboration could be established across the CQI network.
2. Centralized calendar of CQI Council meetings and events
3. Standardized/systems and LEAN curriculum designed and implemented to enable autonomous problem-solving, process analysis, planning, implementation and evaluation of improvements by frontline staff.
4. CQI council leaders to act as an a repository of quality improvement activity and leveraged as a collaborative resource of improvement experience.
5. Corporate CQI Steering Committee was developed to give representation from each area council to discuss challenges, share experiences and gain through understanding lessons learned by other areas.

Summary of Results:

61 CQI councils were established with 59 quality and safety initiatives in various stages of implementation. Improvements range from evidenced-based to a grassroots approach. Through process improvements, there was active engagement of approximately 1000 point of care staff.

A registry was established to provide a reporting mechanism with approximate 99 quality and safety. A steering committee was formed to facilitate, monitor and sustain the model. Point of care staff, management, and clinical education leaders were trained to ensure sufficient knowledge and resources were available to foster implementation.

Aims Statement:

To engage staff and influence change for improved quality and safe patient care, concepts from the STAR model were used to develop an approach to shared governance that enabled agent-specific knowledge to be used to make improvements.

Strategy for Change:

To engage staff and influence change for improved quality and safe patient care, concepts from the STAR model were used to develop an approach to shared governance that enabled agent-specific knowledge to be used to make improvements.

CQI councils were structured across the organization to support partnership, accountability and ownership of the process to improve quality and safety. A steering committee was formed to facilitate, monitor and sustain the model. Point of care staff, management, and clinical education leaders were trained to ensure sufficient knowledge and resources were available to foster implementation.

Empowering frontline staff, management and clinical education leaders with the appropriate tools, education and resources has been key to recognizing, rewarding and motivating all levels of staff.

Figure 1. Change culture

CQI councils, comprised of multi-disciplinary and cross-functional point-of-care staff were formed and supported through:

1. Standardized/interprofessional and cross-functional CQI Council terms of references outlining a common purpose and set of accountabilities on which all CQI councils align – this created a common foundation on which frameworks for communication and collaboration could be established across the CQI network.
2. Centralized calendar of CQI Council meetings and events
3. Standardized/systems and LEAN curriculum designed and implemented to enable autonomous problem-solving, process analysis, planning, implementation and evaluation of improvements by frontline staff.
4. CQI council leaders to act as an a repository of quality improvement activity and leveraged as a collaborative resource of improvement experience.
5. Corporate CQI Steering Committee was developed to give representation from each area council to discuss challenges, share experiences and gain through understanding lessons learned by other areas.

Summary of Results:

61 CQI councils were established with 59 quality and safety initiatives in various stages of implementation. Improvements range from evidenced-based to a grassroots approach. Through process improvements, there was active engagement of approximately 1000 point of care staff.

A registry was established to provide a reporting mechanism with approximate 99 quality and safety. A steering committee was formed to facilitate, monitor and sustain the model. Point of care staff, management, and clinical education leaders were trained to ensure sufficient knowledge and resources were available to foster implementation.

Aims Statement:

To engage staff and influence change for improved quality and safe patient care, concepts from the STAR model were used to develop an approach to shared governance that enabled agent-specific knowledge to be used to make improvements.

Strategy for Change:

To engage staff and influence change for improved quality and safe patient care, concepts from the STAR model were used to develop an approach to shared governance that enabled agent-specific knowledge to be used to make improvements.

CQI councils were structured across the organization to support partnership, accountability and ownership of the process to improve quality and safety. A steering committee was formed to facilitate, monitor and sustain the model. Point of care staff, management, and clinical education leaders were trained to ensure sufficient knowledge and resources were available to foster implementation.

Empowering frontline staff, management and clinical education leaders with the appropriate tools, education and resources has been key to recognizing, rewarding and motivating all levels of staff.

Figure 1. Change culture

CQI councils, comprised of multi-disciplinary and cross-functional point-of-care staff were formed and supported through:

1. Standardized/interprofessional and cross-functional CQI Council terms of references outlining a common purpose and set of accountabilities on which all CQI councils align – this created a common foundation on which frameworks for communication and collaboration could be established across the CQI network.
2. Centralized calendar of CQI Council meetings and events
3. Standardized/systems and LEAN curriculum designed and implemented to enable autonomous problem-solving, process analysis, planning, implementation and evaluation of improvements by frontline staff.
4. CQI council leaders to act as an a repository of quality improvement activity and leveraged as a collaborative resource of improvement experience.
5. Corporate CQI Steering Committee was developed to give representation from each area council to discuss challenges, share experiences and gain through understanding lessons learned by other areas.