A Clinical Demonstration Program in Quality Assurance

(administration, organization, audit, staff development)

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This paper traces the development of one example of how quality assurance guidelines may be translated into program planning and implementation. An organizational framework is used to provide personnel with the opportunity to develop the skills needed in a quality assurance program. This involves a model that focuses on five key areas of professional practice. A demonstration program is described in relation to the model, and an analysis is made of the way it has facilitated both quality assurance and clinical programs in one occupational therapy department.

When senior management at the University Hospital, London, Ontario, initiated a comprehensive quality assurance program, the internal organization of the Occupational Therapy Services Department was insufficient to facilitate the planning and development of quality assurance or the application of quality assurance guidelines to existing and proposed clinical programs.

Usually, an occupational therapy department has an internal structure designed to deliver services as effectively and efficiently as possible dependent upon the available resources and personnel; with the structure or organization being geared to the program needs of the various medical and surgical specialties referring patients. The program organization of Occupational Therapy Services at the University Hospital is common to that of other general hospitals (Figure 1).

Staff development needed to undertake a number of quality assurance activities was achieved by the addition of a quality assurance organization consisting of a committee structure based on a model outlined by Dr. William Fifer (1) during a series of seminars given at the University Hospital in October 1978. This committee structure has been described in detail elsewhere (2), and is illustrated in Figure 2.

Central to the quality assurance organization is the Senior Committee chaired by the Manager of Occupational Therapy Services Department. The Manager and each of the four program unit Senior Therapists who serve on the Senior Committee also chair one of the five subcommittees in the quality assurance organization.

The task of setting up a Disabled Drivers' Training Program provided an opportunity to demonstrate how quality assurance guidelines could be applied. The committee structure allowed departmental staff to enhance their abilities to:

1. Investigate a topic; 2. State the expected or desired outcomes; 3. Outline in logical order the actions needed to obtain the desired outcomes; 4. Monitor progress, and 5. Compare outcomes to specified standards.

The Demonstration Program

Many disabled people had found learning to drive a problem since none of the local driving schools had access to a vehicle equipped with hand controls, nor driving instructors with any experience in teaching the disabled. Several individuals previously had traveled to another city to receive instruction as well as help in selecting suitable modifications to their cars.

Further inquiries confirmed that there was no program for disabled drivers in southwestern Ontario and that the number of people needing this service justified the efforts to get the service established. After preliminary negotiation, two essentials for such a program were secured, namely, driving instructors and a suitable vehicle. The local Board of Education agreed to accept nonschool-age, disabled drivers into their Driver Education Program. A local Rotary Club donated to the Board of Education a suitable vehicle that was specially modified and equipped with hand controls.

The Senior Committee realized that during the initial stages of the demonstration program much time would have to be spent in gathering information, consulting with the Head of the Driver Education Program, and developing policies, procedures, and standards. This would
Credentialing Subcommittee. This therapist was hired for 2 days a week for a 3-month period to get the program started.

The Senior Committee outlined the nature and scope of the assignment. Priorities were established and the timing of progress reports agreed upon. Meetings with the various subcommittees were planned within a time frame that would be most helpful to the therapist as the program was implemented and developed.

Under the demonstration program, the Senior Committee had scheduled an audit for a specific date. The therapist responsible for establishing the program met with the Audit Subcommittee to decide upon a criterion for auditing the program and the method by which the audit would be carried out. It was important to know in advance what data would be needed a year later in order to evaluate the effectiveness of the program. Otherwise, the necessary documentation or records might not be kept or be available for the audit.

The first program audit used only one criterion. It was decided to monitor how many of the patients referred to the Disabled Drivers' Training Program completed the course of instruction scheduled, and later took the Ministry of Transportation and Communications' examination and received their driver's licenses upon the first examination attempt.

Records were kept of the number of occupational therapy referrals to the program, the number of course graduates attempting the license examination, the number of graduates successful in gaining their driving licenses, and the number of examination attempts made before obtaining these licenses.

Figures obtained from the Minis-
try of Transportation and Communications established that 70 percent of nondisabled drivers gained their licenses at the first attempt. This measure was adopted as the standard for the first year of the program.

The Audit Subcommittee's report, illustrating the results of the audit, is shown in Figure 3.

The audit also revealed that, during the first year of the program, 33 patients contacted the Occupational Therapy Department either by self-referral or as the result of referrals by medical practitioners or other health care professionals. Six of these people completed the assessment and training program and passed the license examination at their first attempt; 3 already had their driver's licenses and requested only information and advice; 5 were considered by their physicians not to be medically fit to drive; 1 was referred to a program in another city because of special problems that program was better equipped to deal with; 12 completed the assessment but deferred training for reasons such as winter driving conditions or the future purchase of a suitable vehicle; 1 person failed the "in-car" assessment; 4 started driving lessons and then withdrew from the program; and I person was unable to arrange the financing for the driving lessons.

Early in the program development phase, the program therapist met with the Clinical Activities Subcommittee to determine what kinds of problems might initiate referral to the program. It was also determined what resources were available to deal with these problems, and what would be considered as acceptable outcomes. Deadlines and actions needed to achieve these outcomes were also discussed as well as the delineation of the respective roles of occupational therapy and of driver education.

These meetings laid the groundwork for later negotiations with the Head of Driver Education, who was employed by the Board of Education.

Input to the demonstration program came from a number of meetings between the program therapist and the Utilization Review Subcommittee, and decisions reached provided the groundwork for further meetings with the personnel of driver education.

For example, it was found that not every patient needed a full course of driving instruction. Several patients had driven before becoming disabled and did not want to spend the time and money to undergo a full driver education course. For these patients the driving instructors were willing to provide consultation and advice regarding hand controls or other modifications, and enough "in-car" instruction to allow them to become confident in using hand controls.

A Standard Care Routine for the program was also developed by the Utilization Review Subcommittee, and this was based on an agreement on standards arrived at previously with the Clinical Activities Subcommittee. The Standard Care Routine spells out the actions needed to deal with common problems that might be revealed by an occupational therapy assessment.

For example, if a patient appears unable to operate the gas and brake pedals because of lower extremity dysfunction, the therapist would:

1. Assess upper extremity function: range of motion, muscle

<table>
<thead>
<tr>
<th>Criterion</th>
<th>Standard</th>
<th>Actual Measure</th>
<th>Monitoring Mechanism (tool-frequency-responsibilities)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients pass driving examination on first attempt</td>
<td>70%</td>
<td>100%</td>
<td>• Referrals and outcomes recorded by secretary (ongoing)</td>
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<td></td>
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<td></td>
<td>• Records audited by Audit Subcommittee (annually)</td>
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<td>• Audit reviewed by Quality Assurance Senior Committee (annually)</td>
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</tbody>
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Action Taken to Improve Actual Measure—none required

Action Taken as Result of Initial Audit

- standard raised to 80%
- Audit Subcommittee requested to develop additional criteria
- re-audit in 12 months
REFERENCES
1. William R. Fifer, M.D., is Clinical Professor of Medicine and Public Health, University of Minnesota, Minneapolis, Minnesota.

RELATED READINGS