Topic:	BOR 170 - **Quality Assurance and Service Evaluation**
Responsible:	Director of Intensive Services
Approved By:	Executive Director
Effective Date:	January1, 2016
Supersedes:	2-8-10, Sept 2007
Last Review Date:	Dec 2015
Frequency of Renewal:	Every four years
Regulatory Body:	Governing Body: CCA Section/Reference: ORG-OPP-4;ORG-OPP-5
Authorizing Signature:	

POLICY:

Skylark recognizes the need to maintain high quality standards of service delivery in all aspects of the agency's operation. Quality assurance and high quality services are guided by the following:

- the Board of Directors procedures ensure that the Agency complies with its own policies, procedures and relevant laws and regulations; it sets overall expectations for the quality of services and safety of the organization's clients, personnel and operations; it ensures a process that monitors and improves the quality of services and operations throughout the Agency, including analysis of trends, issues and risk management; and, ensures that action is taken when problems are identified.

- There is a management information system that collects clinical and outcome data at the client level.

- client service needs and expectations; clients are involved in service planning, delivery, and evaluation

- staff understand the agency's philosophy, service model, interdisciplinary Team approaches, and use the resource supports that are available to them; they are actively involved in service planning, service delivery and evaluation, and know and adhere to the related policies and procedures;

- regular clinical supervision assesses the adequacy and effectiveness of services to individual clients [individual client needs, anticipated treatment goals, and actual outcomes which are reflected in individualized action plans] and discharge reports or termination plans

- aggregate data summarizes related to trends in service provision, service effectiveness, staffing resource levels and expertise requirements, flexibility and collaboration with community partners, and degrees to which the agency has met service objectives as outlined in the Annual Service Plan or Strategic Plan

- results are provided to staff, directors, stakeholders and partners.

PROCEDURES*:*

Quality Assurance and Service Evaluation results, whether aggregate or program level, are aimed at ensuring Continuous Quality Improvement. They are submitted to: funders and stakeholders, the Agency's annual Service Plan planning process, the Board of Directors and the website.

Quality Assurance

Quality assurance, while everyone's concern, will be monitored by the Manager of Research and Evaluation and the Research and Evaluation Committee comprised of staff and managers. The Executive Director is ultimately responsible for Quality Assurance within the Agency and reports to the Executive Committee of the Board of Directors on these matters.

The Research and Evaluation Team meets on a regular basis to review data, monitor outcomes and provide oversight to the agency's program evaluations and continuous quality improvement projects.

Several formal approaches to quality assurance are routinely used:

1. **End of Service Satisfaction and Outcome Ratings:** Each client will be asked to complete an End of Service Form when their involvement with the agency terminates. This will happen in all mental health programs offered by Skylark. The form is completed either online or in paper form and entered into Survey Monkey. Results are tabulated by the Manger of Research and Evaluation for each program as part of the End of Year Program reporting. Results are given to the program manager and team, management team and to the board.

2. **Program specific measures** (some of which are standardized) are utilized to inform program development and monitor effectiveness such as:
   Within Skylark's Mental Health programs the BCFPI is used at intake and at the end of service to profile the areas of problematic functioning and positive outcomes.

3. **Community Feedback:** Community feedback is sought on a regular basis and shall occur at least once between each accreditation site review**.** The completed questionnaires are reviewed by the Research and Evaluation Committee, the management team and the results are shared with the Board of Directors.

4. **Clinical records** are audited by all programs to ensure that they are accurate, up to date and of a high quality. Each program will determine the number of cases to be audited, the frequency and if necessary the sample size and method of sampling. Documentation errors will be corrected by the worker responsible for the error within the established program timelines. Supervisors will review audit forms and take any actions necessary with staff to bring documentation into compliance with agency standards. This may include education, review of requirements and if warranted disciplinary action. An audit summary will be reviewed by the program manager/director.

In addition, each staff member will take personal responsibility for Continuous Quality Improvement in their own program. This may take various forms including:

1. Ensuring that Action Plans and strategies and interventions are specific and tailored to each youth in the program.

2. Ensuring that all documentation is up to date and of a high quality

3. Ensuring that the program specific measures for their program are done in a timely fashion and that the information is utilized in treatment planning.

4. Playing an active role in evaluating program processes and effectiveness and offering suggestions for improvement.

The purpose of all evaluation activities is to improve the quality of services delivered. Learnings from the above processes are utilized to make changes on an individual staff/client level as well as on a program/agency level. Information is discussed, analyzed and improvement plans are put into place.

Serious Occurrence Reports (SOR) and Incidence Reports are reviewed by the manager and director involved with the program and SOR's are also reviewed by the ED to identify any trends or patterns in service delivery and to develop strategies to address those. The Executive Director will ensure that any concerns requiring Board attention will be shared at the next Board meeting. Similarly, the Executive Director will inform staff at the next general staff meeting of any recommendations and/or changes resulting from these reviews. Concerns specific to an individual staff member will be shared by that employee's immediate Supervisor. The annual Summary and Analysis of Serious Occurrences will be reviewed by the Continuous Quality Improvement Committee whenever, but not limited to, a significant injury or death of a client or staff occurs.

Service Evaluation

Service evaluation assesses service impact (i.e. logic models, client outcomes, progress towards treatment goals) and the manner of service provision (i.e. process, efficiency and effectiveness including financial performance). Evaluation of *client outcomes* assesses changes in symptoms/behaviour/knowledge/skills over time using a variety or measures including valid and reliable pre- and post-treatment measures (i.e., standardized for use with the agency's population). Evaluation of *service effectiveness* involves client, family, staff, community, and partner feedback, which is collected on a voluntary basis. Refusal to participate in evaluation does not affect client access to service or service provision. All evaluation data is kept secure against loss or unauthorized access, and individual responses remain confidential.

Service evaluation will use industry standard tools of evaluation which may include: client and staff feedback, process evaluation of the program, information from community partners, client file audits, standardized measurement tools; changes in client awareness, knowledge, skills, behaviour and health status; and, operational outcomes (e.g. HR, financial performance) There is a documented plan to periodically evaluate the implementation of evidence-informed practices.

The Board of Directors, in conjunction with Agency staff and anyone else they may, from time to time, appoint will undertake periodic reviews of all aspects of service delivery and evaluation of programs offered by the Agency. The review may be internal, e.g. random review of client files, or external, e.g. questionnaires completed by clients, referral sources, etc., or some combination of internal and external evaluation. All new programs will be evaluated within two (2) years of commencement of operation. All programs will be evaluated on a regular basis, at least once between each CCA accreditation site review.

All client files are to be kept current in accordance with Clinical Records policy (**FPR-GEN 310**).

On an as needed basis, each Supervisor will review closed files to ensure the file is compliant with Agency requirements.

Program results are reported to stakeholders through our annual report and updates to our website including copies of formal evaluation reports.