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Commentary

Creating a Culture of Continuous Improvement in a Radiation Therapy Planning Department: A Pilot Initiative Using Quality Conversations

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Introduction

Clinical and technical excellence is the foundation of high functioning health care organizations. Organizations now also recognize the importance and alignment of teamwork to high quality care delivery to drive improved patient outcomes [1,2]. There are several approaches used by organizations to improve the quality and safety within the ambulatory care setting including briefings, debriefings, and team huddles [3]. The successful implementations of these tools have been shown to improve patient safety by providing a venue for raising concerns, find opportunities to increase efficiency, and improve teamwork and communication [4–9].

Radiation therapy is linked to practices relating to clinical and technical aspects that provide care to patients. Within the practice of radiation therapy, prevailing views of quality have predominately been focused on planning, treatment delivery, and quality control of equipment [10]. Recently, there has been an addition to these concepts, a shift toward engagement of the team to discuss, implement, and guide conversations related to quality and improvements [11].

In this pilot project, we explore the value of weekly quality conversations (QCs). QCs are defined as short weekly team huddles that provide increased opportunities to identify and act on best practices. QCs are a platform to share ideas and develop solutions to provide more efficient approaches for processes and tasks. In addition, QCs provide an opportunity to acknowledge the accomplishments achieved as a team once the proposed solutions are implemented [11]. The conversation is conducted around a QC board (Figure 1). Designed to align with our corporate strategic priorities of quality (safe, effective, efficient, compassion, partners, and quality culture), these conversations create a forum that integrates best practices, staff concerns and solutions, standardizes quality discussions, develops quality improvement and leadership skills, and acknowledges accomplishments when data or processes improve.

The functions, roles, processes, and flow in a department can be optimized with more frequent opportunities to bring the medical radiation therapists (MRTs) together. We piloted the conversations to determine (1) the influence of introducing QC to staff; (2) the effect on knowledge and awareness regarding quality and patient safety including best practices and existing processes and (3) if the QCs change ideas and solutions are sustainable. Here, we report the outcomes of the QC pilot project and demonstrate the value of enabling open communication and involvement of radiation therapists in the quality improvement process.

Methods

Study Participants

The radiation therapy department at the host institution consists of 120 full-time equivalent MRTs. The pilot project concentrated on the planning department that consists of 40 full-time MRTs who work in computed tomography (CT) scan simulation and dosimetry. For this pilot project, the study group consisted of MRTs ranging from 3 years to 35 years of experience. The pilot project was conducted over a 3-month period (May–July 2017), and all MRTs from the planning department were encouraged to attend the QCs. The goals, purpose, structure, and benefits of engaging in these conversations were reviewed and communicated to all participants.

QC Pilot Program

To introduce the tool and concepts of QCs, training and support were provided to the planning supervisor and the

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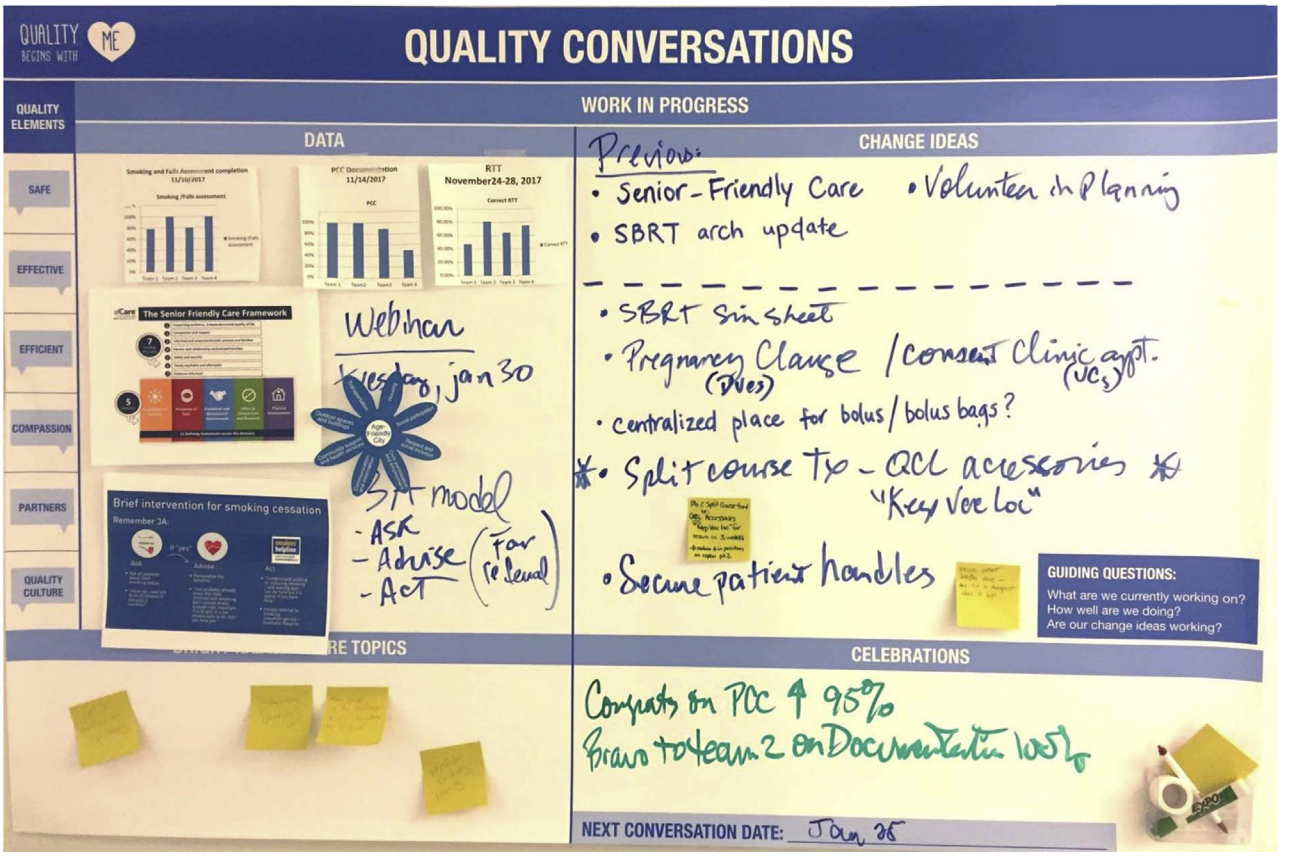

Figure 1. The quality conversation board. The six quality elements are located on the left side of the board. Sections include data, change ideas, bright and future topics, and celebrations. The three guiding questions for the conversation are also located on the right side of the board. Post-its, pens, and the next conversation date are also included.

professional leader by the quality and patient safety department staff at our institution. The support was designed to (1) understand what QCs are, (2) use easily obtained data from our electronic patient system of record to inform improvement priorities (ie, smoking cessation assessment–documented data), (3) engage staff to lead improvement and patient safety initiatives, and finally (4) increase awareness of quality improvement skills to guide team members toward improvement.

The conversations were conducted weekly at the same time and location. The 15-minute conversations were booked into the calendars of all the planning teams. The booking time did not affect the therapists' case load, and patients were not impacted by MRTs attending the QC sessions. The QCs were initially led by the planning supervisor and the professional practice leader. The rapid cycle improvement model (Plan, Do, Study and Act) was used as the basis to guide the change ideas from inception to completion. Each week, the MRTs reviewed data by looking to see if improvements were made and discussed findings of the Plan, Do, Study and Act cycles. This allowed participants to build new quality improvement skills as part of their weekly work. During the 3-month pilot phase, staff were encouraged to look at existing data, post new change ideas on the board using post-it notes, probe for workable solutions, and participate in suggested change initiatives. Participants and change leads returned the following week of QC to report on progress, accomplishments, and to generate more change ideas (Figure 1). After each conversation, a short e-mail summary was sent to all MRTs to inform them of the content of the conversation, the changes to be tested during the week, and future topics to discuss.

The QC format was guided by three leading questions: (1) what are we currently working on? (2) How well are we doing? (3) Are our change ideas working? By keeping the conversations closely aligned to these questions, conversation leads were able to guide the dialog away from complaints and nonsolution seeking behaviors. The first topics discussed at the initial QCs were: smoking cessation, falls risk, and person-centered care (PCC). Smoking cessation is defined as a discussion with the patient to see if he or she smokes. The patient will be advised about the benefits to quit and will be referred to the smoker's helpline if needed. Falls risk will ask the patient if they are at risk of falling or if the patient has fallen in the last 3 months. PCC is defined as focusing care on the needs of the person at the point of interaction and is documented via the completion of a simple question: what is most important to the patient at this time? This also includes the intervention or action taken (if needed) at that time. These topics were selected as they incorporate