

4 Essentials to a Great Quality Management System

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Even the best quality management systems (QMS) can be improved. Have you ever found yourself surprised by somebody's actions? Perhaps they performed a task in an unexpected way, or skipped basic quality assurance measures? Instead of condemning the person, the first question should be, 'is the expectation in writing, are the requirements clear?' Often, the answer is no; it's believed that everyone understands the expectation without formally spelling it out. In the world of quality, stating expectations in a detailed and clear format is the expectation so that tasks are performed effectively, efficiently and consistently.

#1 WRITTEN EXPECTATIONS

Formally stating goals and expectations is the first step to ensuring consistency and quality. This includes the mission, a training manual, the standard method to complete tasks, security and safety precautions, and the forms to be used. Having specific desires in writing helps others adhere to expectations. Even when expectations are in writing, updates are continually necessary as existing documents are found to be vague or interpreted differently by different people. Keeping documents up to date, and doing so in a timely manner, is often harder than writing the initial version but it is essential to having a robust QMS!

Tracking changes and maintaining historical versions of documents is a requirement, while sending notifications of changes to relevant parties is an additional, yet important, element of document control.

#2 AUDITS

Checking to ensure expectations are being followed is the second step to having a strong QMS. Audits do not need to be time-consuming, but they do need to be done to ensure the main expectations are being met. If issues are never found, then it is likely that important tasks are not being reviewed, or not being reviewed as diligently as they should be. Suppose a person is asked to review a large document and they find no issues. You have to wonder if their review was thorough. Instead of asking if a work product is good enough, the task of reviewers should be to find something that can be improved.

Audits should be performed frequently. Annual audits allow problems to continue for too long before they are recognized and addressed.

Tracking of audits and findings is vital so that patterns of irregularity can be identified.

#3 ROOT CAUSE ANALYSIS (RCA) / CORRECTIVE ACTION (CA)

The third essential item for a strong QMS is the ability to problem solve to find the root cause of an issue. If the cause of an issue can be identified and addressed, then it diminishes the chances of the problem reoccurring. Blaming the person who performed the task may be an initial instinct, however, attributing the cause to a person does not prevent the issue from occurring with others in the future. Looking for a *systems issue*, and implementing CA that addresses *the system*, has longer term benefits than addressing the more superficial issue. Human error, oversight or pressure to rush are not system related; they are signs that a QMS is lacking knowledge regarding *system* RCA/CA. Human error can be minimized when it is acknowledged that the system lacks controls to prevent human error.

#4 LOOK FOR IMPROVEMENTS

Once expectations are in writing, audits are being performed, and RCA/CA are in place, then additional improvements can be considered. Streamlining processes will save time, money, and effort. There is nothing more worthless than spending time doing something that did not need to be done to begin with. Resources should be used where they are needed, not wasted performing meaningless tasks.

One valuable tool for implementing improvements is to ask yourself, when was the last time I asked for suggestions, and when was the last time I implemented a suggestion offered. Input from others can help identify issues that may have been overlooked.

Having these 4 elements in a QMS not only builds consistency and quality but also is essential for secession planning. A strong QMS is one where another person can easily step in and take over because the mission, expectations and quality assurance measures are in place.

Examples

- A) **PROBLEM:** *A person does not finish projects or respond in a timely manner*
Was a deadline set? If not, the root cause is not the person, it is the lack of stating expectations. The CA should be to articulate the expectation within documents, not in an email, so that all current and future staff are aware of the expectation.
- B) **PROBLEM:** *An error is made*
Which standard operating procedure (SOP) stated how to avoid the error? If none can be found, then the CA is to improve the SOP, or perhaps the training program.

Taking a practitioner off casework and reviewing past cases is looking at the extent of the problem, not looking for the cause of the problem. This is a common misapplication of RCA.

C) **PROBLEM:** *SOPs are not specific enough to prevent errors*

Many may claim that everything cannot be in writing. This is a common rationalization by those unfamiliar with quality assurance tools.

If a staff member forgot to lock their desk (secure evidence), it may have been an oversight, but an oversight is not a cause that can be rectified with a system improvement (i.e., CA). “Try harder” or “be more diligent” are not CAs to the system. Recommending that the staff member keep the key in the lock is a CA that may remind all staff to lock the desk before leaving. It may even be possible to install automatic locks, so staff do not have to rely on their memory for security.

D) **PROBLEM:** *Not enough staff*

It is typical for agencies to feel understaffed. This can be rectified by looking at the mission, the amount of work requested, and the time expected for each work product. By analyzing these factors, an appropriate staffing model can be developed. Developing a staffing model is a simple math problem,

$$\# \text{ of staff} = \text{work per year} / \text{amount of work expected from each person}$$

The math problem becomes a bit more complex when deciding how to establish the amount of work (in cases or number of tasks to be performed) and the amount of work expected from each staff member. The amounts will be different for each agency/unit since tasks vary considerably.

E) **PROBLEM:** *A practitioner whose notes lacked critical information*

Which SOP was violated? If a specific SOP cannot be listed then the cause of the problem is not the practitioner, but rather the lack of defined expectations. Again, the CA should be to improve the SOPs.

If the expectation is clear, perhaps the practitioner was unaware of the expectation. Was staff notified of the SOP change? If not, the CA would be to improve the notification process.

If no deficiencies can be found within the system (training, expectations, notifications, etc.), the issue may be the person. However, this cause should be the last resort.

F) **PROBLEM:** *The SOPs are so lengthy they create conflicting information*

The root cause of this problem may be the misconception that *more is better*. The layout of documents needs to be established up front, so the main tasks are identified individually. Having one SOP on topics like safety or forms to use, ensures that updates only have to be changed in one place, which minimizes conflicting

information. Putting information in multiple places creates a system that is very difficult to keep up in the long run.

G) **PROBLEM:** *Nobody noticed a problem*

Just because an issue has not been addressed does not mean it has not been noticed. When comments are disregarded, people quickly stop offering suggestions for improvement. If the goal is improvement, valuing suggestions from other should be the objective.