QUALITY MANAGEMENT IN A PRIVATE SPEECH-LANGUAGE THERAPY PRACTICE

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ABSTRACT

This study investigated the principles of quality management and their application to a private speech-language therapy practice. The history of quality management and the development of quality management in industry and health care services were reviewed. Quality was defined in terms of the context of the author's private speech-language therapy practice and a working definition of quality was developed. The principles in the development of a quality management programme were described. These principles were used to develop and implement a quality management programme in the author's private speech-language therapy practice. Financial management and client satisfaction were selected as strategic quality factors in the initial stages of the quality management programme. Practice policies were revised to establish success criteria and to measure the practice's conformance to these criteria. The quality management programme enabled the author to improve the quality and effectiveness of her practice's financial management system and to demonstrate the client-centered orientation of the practice by implementing client satisfaction as a quality indicator.

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CHAPTER 1

QUALITY MANAGEMENT

1.1 INTRODUCTION

Quality is not easy to define. Its presence is appreciated, recognized and desired by everyone and its absence leads to intense dissatisfaction and displeasure. Every client expects high quality when buying a product or using a service; every manufacturer and service provider ostensibly strives towards providing good quality. While everyone is familiar with the concept, few people are able to describe or define quality. The Oxford Dictionary defines quality as a "degree of excellence", while Pirsig (1992) claims that quality needs no definition because it is a direct experience, independent of intellectual abstractions, and that everyone therefore understands it.

The author was introduced to the concept of quality management in 1994 in a course on Ethics and Quality Assurance as part of postgraduate studies at the University of Cape Town. Her interest in quality started with a personal desire to measure and continually improve the quality of the services provided in her private speech-language therapy practice. While she explored health care literature, it became clear that a concern with quality has become a driving force in health care all over the world in the past decade. Concern with quality was also evident in the speech-language therapy and audiology literature in the United States of America and Britain (Frattali, 1990; Heaton, 1992; Boston, 1994). In South Africa, however, references to quality were confined to the medical and dental health care literature. Only one reference pertaining to quality in speech-language services was found (Tuomi, 1993).

Concern about the quality of health care services has become a prominent issue in the past decade. Health care services all over the world are confronted with changes that are mainly driven and determined by economic considerations. There is always a limit to available resources, even in the wealthiest first-world countries (Coyte, 1992; Koch & Fairly, 1993; Tuomi, 1993; Harrison & Frattali, 1994). Clients, medical aid schemes and governments demand that these resources be used to the optimum benefit, not only of the individual client, but of society at large. Health care services all over the world experience political and social pressure to improve the quality of care. There is a growing demand for quality management that embodies concepts like accountability, cost-efficiency, treatment efficacy, focus on outcomes and client satisfaction (Maxwell, 1984; Ellis, 1989; Frattali, 1990; Shekim, 1994, Miles & Lugon,1996).

In South Africa, rapid social, political and economic transformations in the past four years are causing major upheavals in the health care system. Speech-language therapists, like medical practitioners, are under pressure to demonstrate that their service rendering is in keeping with the democratic values of the "new" South Africa and in keeping with the changing trends in health care delivery in South Africa. Tuomi (1993) states that in order for speech-language therapists to have a future in South Africa, they will have to prove the value and the relevance of their services to the people and the government. Our survival as a profession depends on our ability to evaluate our services and to demonstrate that the majority of the population benefit from our services. Without an unequivocal commitment to the management and continual improvement in the quality of our services, we will find it very hard to convince either the people or the health care authorities of our indispensability.

Questioning health care's effectiveness or outcome is a relatively new phenomenon. People have always assumed that medical care is effective, but two perspectives cast doubt on the effectiveness of modern medical intervention. Firstly, vast increases in health care expenditure in the past three decades have produced only modest gains in life expectancy, and secondly, even the best designed research studies fail to ascribe positive outcomes directly to the intervention that took place (Wilson & Goldschmidt, 1995). Most interventions are introduced into clinical practice without scientific assessment of their effectiveness. Empirically based outcome criteria are scarce and there is a pressing need for research data that link interventions with positive outcome (Wilson & Goldschmidt, 1995). In speech-language therapy the same situation prevails. Therapists have always assumed that their services are appropriate and effective, despite a lack of empirical evidence (Frattali, 1990; Heaton, 1992; Boston, 1994).

In becoming familiar with the principles of quality management in the service and manufacturing industries, health care services and speech-language therapy, the author realized that continual quality improvement required more than good intentions and occasional reflection on the efficacy of clinical services. Furthermore, recent developments in the health care system in South Africa and the advent of managed health care convinced the author of the need to be able to *prove* that services are effective and cost-effective and that clients are satisfied with the outcome of therapy. Although it was always a goal to provide good quality services in her practice, the author became aware of the inadequacy of self-evaluation without well-defined quality goals. The need for a systematic way to measure and implement quality, in other words the need for a quality management system, became apparent.

Private speech-language therapists in South Africa have to rely on self-evaluation when trying to demonstrate or determine the quality of their services. There is no voluntary or formal accreditation, audit or peer review system pertaining to private speech-language practice in South Africa. Competencies at entry level into the profession are well defined and regulated by the universities and the Professional Board. After qualification, however, it is left to every therapist to define quality, to establish quality indicators and to determine his or her conformance to these subjective measures through self-evaluation. In the author's case this was done in a random fashion and without a clear statement of intent regarding quality and outcome.

Before the introduction of quality management principles, the focus of the author's practice was on clinical intervention procedures, because it was perceived as the "most important" function of the practice. Practice protocols were policy statements in the form of tree diagrams specifying procedures to be followed in treating various disorders. These protocols were developed over eighteen years in clinical practice and continually updated to accommodate new knowledge gained through experience, reading and attending workshops and lectures. Adherence to these "best practice" guidelines was regarded sufficient to assure quality. The current emphasis on quality, treatment efficacy, cost-effectiveness and outcome made the practitioner aware of a need for a more comprehensive approach to quality in the practice.

As the author became familiar with the notion of quality management and its potential application to a private speech-language therapy practice, different perspectives emerged. *Firstly*, the concept of **total quality management** became a cornerstone of the quality management programme. Like many practitioners,

clinical intervention was perceived to be the primary and "most important" function of the practice. One of the fundamental principles of quality management, however, states that quality is all pervasive and must extend to every aspect and function in an organization (Crosby, 1979).

Secondly, although the author has always been committed to client-centered practise, **client satisfaction** was never considered a fundamental therapy goal. When confronted with the notion of client satisfaction as a quality indicator, the author realized that services in the practice were still largely practitioner-centered. While concerned with the well-being of clients, their actual satisfaction with the practice's services was never measured. Client satisfaction is regarded as one of the mainstays of quality management and a primary quality indicator. In the words of Deming (1986), quality has only meaning in terms of the client.

Thirdly, the concept of quality management as a **production level** instrument changed the way in which the author viewed services provided in her practice. Production level quality is concerned with production outcomes. It relates to organizations managed by a manager who is responsible and accountable for the outcome of productions (Wilson & Goldschmidt, 1995). Production level quality in a speech-language practice refers to the *improvement* in the client's communication ability, the *cost-effectiveness* of the intervention and the *satisfaction* of the client. Furthermore, the practitioner as the quality manager is accountable for the outcomes produced by the practice.

All quality experts emphatically agree that unless quality is quantified and qualified, it remains an obscure and elusive concept that does not readily translate into meaningful change or progress. Crosby (1994) states that quality is *not* the same as

goodness, and more pertinently, that quality never happens without a deliberate and concerted effort. It was realized that a quality management programme has the potential to provide the practitioner with a systematic approach to enhance problem solving, accountability, efficiency, cost-effectiveness, outcome and client satisfaction in the practice (Frattali, 1994).

Traditionally associated with manufacturing and industry, quality management principles have only recently been implemented in health care services, including speech-language therapy services. This dissertation endeavors to describe the basic principles of quality management gleaned from an extensive search of the literature pertaining to this subject. The history, development and evolution of quality management will be briefly described. The various aspects that have to be considered in the development and implementation of a quality management system will be demonstrated. These aspects include the definition of quality as determined by the different role-players and contexts of service delivery. The application of quality management principles to health care, and particularly speech-language therapy services in South Africa, will be described.

Finally, the development of a quality management programme for the author's private speech-language therapy practice and the initial stages of the implementation of the programme in the practice were documented and evaluated.

1.2 HISTORY OF QUALITY MANAGEMENT

Many of the principles of what is known today as quality management have been around for centuries. What is new, is the integration of these principles into a coherent system and the application of the system to improve an organization's performance with the purpose of satisfying clients' needs. The following is a short description of the evolution of quality management over the past 500 years and its recent introduction in health care and speech-language therapy.

1.2.1 Quality in industry and manufacturing

According to Widtfield and Widtfield (1992), the roots of total quality management can be traced back to the beginning of the Industrial Revolution. Before that, durable goods were provided by craftsmen who were part of the community. Their reputation and livelihood depended on the product being effective and cost-efficient in terms of durability and suitability.

The Industrial Revolution brought, amongst other things, mass production. The assembly line was created and work was reduced to a system of simple procedures. Quality assurance was introduced in the form of rigorous checking to ensure a product of reasonable quality.

The outbreak of World War II required relatively unskilled workers to supply the war effort with mass produced tanks, airplanes, bombs and bullets. It was during this era that the concept of quality control was introduced for the first time. It was based on the ideas of Shewart, a physicist. Through a system of measuring machine output, charting the variability of that output and then adjusting the machines accordingly, *process control* was initiated. Acceptable levels of variation were set and every exception was targeted for further analysis. Workers were trained to do their own

monitoring and to make adjustments where necessary. At this stage, quality control was a combination of process control and rigorous inspection to ensure that either the process was effective or that adjustments could be made to improve effectiveness (Widtfield & Widtfield, 1992; Williams, 1994). After the war, however, pent-up consumer demand was so great that manufacturers could sell anything they made. Quality improvement and client satisfaction became less important because every product was sold and few alternatives or competitors existed (Williams, 1994).

The first systematic quality control measures in industry started in Japan in the 1950s and 1960's (Widtfield & Widtfield, 1992; Harrison & Frattali, 1994). These systems were introduced by two Americans, Deming and Juran. Deming, an industrial engineer, is generally regarded as the father of production quality and quality control. Although Deming was an outspoken exponent of quality improvement, his theories were largely ignored in America. He was then invited to Japan by Japanese industrial leaders who were eager to rebuild Japan's economy and improve its standing as a trading partner. They realized that for Japan to prosper, its early reputation for producing poor quality goods had to change, and that a new culture based on quality production needed to be introduced.

Deming's methods were grounded in the assumption that the system is the source of 85% of all production problems and not the workers. He developed a philosophy of management consisting of his famous Fourteen Points, calling it an operational theory of management. These fourteen points are still considered to be the cornerstone of quality management. Deming claimed that quality does not cost extra and should be built in from the beginning of the process. In addition, he advocated a clear tactical approach to total quality management - the so-called

Deming cycle based on Plan-Do-Check-Act. The Deming cycle results in the Deming chain reaction, whereby improved processes lead to improved quality, resulting in improved productivity. Improved productivity, in turn, results in increased market share and greater job creation (Deming, 1986; Widtfield & Widtfield, 1992; Macdonald, 1993; Morgan, 1994; Williams, 1994).

Juran, a contemporary of Deming's also contributed significantly to the quality improvement movement. Like Deming he believed that the majority of quality problems are related to systems. He postulated the managerial breakthrough theory, stating that management problems cause 85% of all systems failures. He argued that management should therefore take responsibility as well as the initiative for improving quality, instead of focusing on control and crisis prevention. Juran's greatest contribution to quality improvement was his introduction of a customer-focused orientation. He believed that the needs of the customer should be the ultimate motivation for quality improvement (Deming, 1986; Widtfield & Widtfield, 1992; Morgan, 1994; Williams, 1994).

The results of Deming's and Juran's efforts in Japan are well-documented. A paradigm shift occurred in Japanese industry and resulted in Japan surpassing the United States in many products and services. Japanese manufacturing came to stand for consistency in quality (Deming, 1986; Widtfield, 1992; Macdonald, 1993; Morgan, 1994; Williams, 1994)

A third advocate of total quality management who contributed greatly to our current understanding of the concept, was Philip Crosby. He proposed the Four Absolutes of quality management that form the cornerstones of continual quality improvement. The Four Absolutes are: *Conformity to requirements; prevention; error-free standard*

of performance and *the cost of quality.* Crosby introduced the "cost of quality" concept based on two aspects, namely the cost of conformance and the cost of nonconformance. The cost of conformance is described as costs incurred in training and planning and are seen as investments in the quality process. Nonconformance costs, on the other hand, are all due to mistakes, for example rework, crisis management, error detection and waste. In other words, nonconformance costs are the cost of "not doing it right, the first time" (Crosby, 1979).

Although these three authorities, Deming, Juran and Crosby, all developed different theories and strategies in their quest for quality, five universal principles became evident. These are *customer focus, management commitment, training, process capability and control,* and *measurement using quality improvement tools* (Widtfield & Widtfield, 1992).

The results of the introduction of total quality management in manufacturing and industry speak for themselves. In the past decade quality management has also spilled over to health care services. In their quest for increased cost-effectiveness and improved quality of care, health care services are turning to the tools of industry and manufacturing in an attempt to comply with the demand of society and governments to provide affordable, appropriate and effective care to all citizens.

1.2.2 Quality in health care

As stated before, health care services all over the world are experiencing political and social pressures to improve the quality of care. There is a growing demand for continual quality improvement and to include concepts such as accountability, cost-efficiency, treatment efficacy, focus on outcomes and client satisfaction

(Maxwell, 1984; Ellis, 1989; Frattali, 1990; Coyte, 1992; Koch & Fairly, 1993; Tuomi, 1993; Harrison & Frattali, 1994; Bowling, 1997).

It could be argued that quality considerations have always been a part of health care. Hippocrates (460-377 BC) implored his pupils to "do no harm" and Parè (1517-1590) cited the tasks of medicine as "to cure sometimes, to relieve often, to comfort always". The concept of the well-being of the patient as the foremost concern in health care and as a reflection of the quality of care, is not new. Already in 1947 the World Health Organization defined health, not merely as the absence of disease, but as a state of complete physical, psychological and social well-being (Vuori, 1987; Bowling, 1997)

The medical profession has an uncontested history of noble concern for patients. The problem is that good intentions are not enough to assure quality. In fact, modern quality theory emphatically states that quality is *not* the same as goodness (Crosby, 1994). Doctors and therapists are faced with the challenge to implement quality management in a systematic, deliberate and measurable way without compromising the affective and interpersonal aspects of care.

It is not an easy task to apply quality management principles and procedures that work so well in manufacturing to health care services. Even the terminology of industrial quality, for example defects, customers, suppliers, processes, variance control, et cetera, sounds foreign in the health care environment. Health care management has succeeded to some extent in transferring traditional quality management methods to the business and administration side of health care services, for instance to referral procedures, patient admission and discharge procedures. It is, however, much more complicated to apply conventional quality

management methods and principles to clinical services and the interpersonal processes in health care (Frattali, 1994; Wilson & Goldschmidt, 1995; O'Neill, 1996).

Avedis Donabedian is regarded as the pioneer of modern quality management in health care services (Frattali, 1990; Luthert & Robinson, 1993; Morgan, 1994). Donabedian advocated a holistic approach to quality, based on sound technical training and skills within a culture that understands and responds to clients' needs. He defined three main components of quality in health care, namely technical care, interpersonal relationships and amenities. *Technical care* refers to the application of the science and technology of medicine to the management of a health care problem. *Interpersonal relationships* are the social and psychological interaction between the client and the practitioner. The third component, *amenities,* refers to the decor, equipment and physical environment in which the service is rendered.

Donabedian regarded quality management as much more than the competency and clinical skills of the health care practitioner. The industrial quality experts, Deming and Juran, observed over four decades ago that management and systems, and not workers, are responsible for 85% of quality problems. This point is also noted by Wilson & Goldschmidt (1995), who state that it is a fallacy to assume that all health care quality problems are caused by doctors, and conversely, that improving the technical skills of doctors will lead to improved medical care.

Despite Donabedian's definition of quality in terms of the three quality components in health care, the focus today is still predominantly on the competency and skills of the health care practitioner, in other words, *technical care*. The essence of improvement in health care *and* speech-language therapy is still seen by many to lie

in the training of clinicians, accreditation programmes and continuing education to ensure continual quality improvement in the services rendered. There seems to be a reluctance to investigate management and systems as the primary source of quality problems.

Donabedian realized that the *measurement* or *evaluation* of quality posed the greatest challenge to quality improvement in health services. Bowling (1997) describes evaluation as the scientific and systematic collection of research data to assess the effectiveness of organizations, processes and programmes in achieving predetermined goals and objectives. Donabedian identified three approaches to the measurement of quality, namely *structure, process* and *outcome* (Donabedian, 1992). The three approaches are an attempt to organize all the components of the clinician-patient interaction in a structured framework that can be used to define, measure and evaluate the quality of care.

Structure, process and outcome will be briefly discussed in general terms in the following section. The application of the three approaches to speech-language therapy in a private practice will be discussed in chapter 2, in the section pertaining to the formulation of a business plan.

i) Structure

Structure refers to variables pertaining to human, material and organizational resources and inputs into the care process, in other words, the resources needed to achieve the defined goal of the intervention (Donabedian, 1992; Luthert & Robinson, 1993; Wilson & Goldschmidt, 1995; Bowling, 1997). Structure comprises characteristics of people, equipment and environment in a specific organization. Factors such as the qualifications and training of practitioners,

adequacy of facilities and financial resources are also regarded as structure. Assessment data on structure and input are usually obtained through questionnaires and descriptive surveys, comparing structure in relation to outcome (Bowling, 1997).

Quality assessment at this level measures the extent to which the structures increase or decrease the probability of good care being given, in other words, the relationship between structure and outcome.

ii) Process

Process describes how the service is organized, delivered and used, in other words, the methods and procedures employed, and the technical skill and expertise required to perform them. It is described by some authorities as *professional practice* and includes the assessment, planning, implementation and evaluation of care (Øvretveit, 1992a; Luthert & Robinson, 1993). Process describes all the practitioner's activities designed to manage the client's identified need or problem. Process is not only confined to the technical activities, but also includes factors such as appropriateness of care and interpersonal relationships, (Donabedian, 1992a; Øvretveit, 1992a; St. Leger, Schnieden & Walsworth-Bell, 1992; Luthert & Robinson, 1993; Wilson & Goldschmidt, 1995).

Quality assessment at this level measures conformance to the defined level of professional competence as stated in practice guidelines and criteria, practice policy, quality pathways, et cetera. The purpose of quality assessment at this level is to gauge the deviation from the predefined standards of care and to evaluate whether scarce resources are used efficiently and appropriately. Data

collection is usually in the form of the documentation and analysis of events and interactions (Bowling, 1997).

iii) Outcome

Outcome refers to the consequences of efficient and effective use of resources and the following of good professional practice. *Effectiveness* is a statistical concept describing the results of interventions (St. Leger *et al*, 1992). It refers to the difference between a disorder's natural history and the difference made by an intervention. True effectiveness refers to this difference determined in such a way that it can be attributed confidently to the intervention. A medical intervention can only be regarded as effective if it produces a measurable outcome or effect, namely improvement in the patient's health status (Luthert & Robinson, 1993; Wilson & Goldschmidt, 1995). Speech-language therapy can only be regarded as effective if it produces a measurable outcome or effect, namely improvement in the client's communication status. Effectiveness thus describes the *measurable* improvement as the direct result of an intervention.

Assumed or observed effectiveness refers to what is observed in practice and usually overestimates true effectiveness. Only well-designed, well-conducted scientific studies can validly measure an intervention's effectiveness and differentiate specific effects from general effects. (Barkham, 1993; Schalock, 1995; Wilson & Goldschmidt, 1995).

The problem is that empirically based outcome criteria and research data that link interventions with positive outcomes are scarce. Most medical interventions are introduced into clinical practice without scientific assessment of their effectiveness (Wilson & Goldschmidt; 1995; Haines, Freemantle, Watt & Lugon,

1996). In speech-language therapy the same situation prevails. Therapists have always *assumed* that their services are appropriate and effective despite a lack of empirical evidence (Frattali, 1990; Heaton, 1992; Boston, 1994). There is a need for outcome-based analyses of intervention programmes that include effectiveness, impact and cost-effectiveness criteria. These analyses can be used to determine whether a programme is meeting predetermined goals, whether it makes a significant difference in the client's well-being, and whether it represents a reasonable return on the client's or funding agency's investments (Schalock, 1995).

Boston (1994) states several reasons for the scarcity of outcome data in speech-language therapy. These include the absence of appropriate information technology, lack of a common language for reporting outcome data, absence of standardized formats and descriptions of outcomes, absence of networks and central data banks for data sharing and incompatible software programmes for registering and collection of data.

Some reasons for the lack of outcome data can be found in the failure of the speech-language profession to comply with the principles of evidence-based practice. Boston (1994) states that speech-language practitioners lack experience and training in collecting data and tend to confuse cause and effect in clients with multiple problems. The speech-language profession also has a history of focusing on process rather than outcome.

On the other hand, it should be realized that over-reliance on scientific trials may not always be possible or in the best interests of patients. Rigge (1996) states that rigid insistence on evidence-based protocols overlooks the fact that it is not

possible to diagnose some patients and that others, despite an accurate diagnosis, cannot be treated. While there is a great need for scientific outcome data, this must be viewed against the background of scientific uncertainty and the uniqueness of every interaction between clinician and patient.

Outcome represents the total, interactive effects of structure and process and is concerned with the impact of the service on clients and their communities. *Quality assessment* at outcome level measures evidence of changes in the health status of patients and evidence of satisfaction of the patient *and* the practitioner with the results of professional practice (Donabedian, 1992; Barkham, 1993; Luthert & Robinson, 1993; Schalock, 1995; Wilson & Goldschmidt, 1995). Outcome measurement is the ultimate indicator of both the quality of care and the benefit derived from the services. The benefit derived from contact with the service can also be seen as the benefits received from each of the component procedures of the service. The effects of diagnostic procedures, treatment and home programmes may be examined separately to determine their function in the eventual outcome of the intervention (Coyte, 1992; St. Leger *et al*, 1992).

The modern trend is to consider outcome in terms of quality of life. Treatment and care are increasingly viewed in terms of the impact the outcomes of these processes have on the patient's quality of life (Coyte, 1992; Schalock, 1995; Bowling, 1997). The *well-being* of the patient becomes paramount instead of measuring outcome in terms of survival rate or decreased levels of toxicity. Health-related quality of life as an outcome measure broadens the concept of outcome considerably. It forces the clinician to evaluate the impact of the condition and its treatment on the person's emotional, social and physical

functioning. Quality assessment must therefore include the patient's perspective on outcome.

Donabedian (1992) warns that structure, process and outcome in themselves are not properties of quality. They are *sources of information* that can lead to inferences about the degree of goodness in one or more attributes of quality. It is, for example, often necessary to measure structure and process in order to interpret outcome. The collection of qualitative and quantitative descriptive data about process and structure will tell the clinician if and how outcome was caused by the activity itself and/or variations in structure, or in the way it was delivered. The data can then be used to readjust the processes and circumstances in the delivery of health care.

The three approaches represent subdivisions in a chain of events where each event is the consequence of the preceding event and in turn causes another event to follow. They reflect the dynamic nature of quality management and aim to inform, generate and monitor changes in health care service provision. The boundaries between these events are not clearly defined and it is often difficult to determine where, for instance process ends and outcome starts (Donabedian, 1992). Health care practitioners must also recognize that the lack of empirically based research data linking interventions with positive outcomes implies that outcomes can be anticipated but not guaranteed. The relationship between process and outcome is therefore probabilistic rather than deterministic (Miles, Lugon & Polychronis, 1996)

Donabedian's contribution to quality in health care was his introduction in the 1960s of a systematic and systemic approach to the definition and measurement of quality. The concepts structure, process and outcome have been used in various health care quality management programmes to delineate both clinical and

administrative procedures. One example of a quality management programme based on Donabedian's three tenets is the framework developed by the Royal Marsden Hospital in England (Luthert & Robinson, 1993). Structure, process and outcome were redefined as *resources, professional practice* and *outcome*. A summary of this framework can be seen in the following table.

Table 1.1 The Royal Marsden Hospital framework for quality management

RESOURCES	PROFESSIONAL PRACTISE	OUTCOME
- people - equipment - environment	- assessment, planning, intervention and evaluation - documentation of every step - information-giving	- client satisfaction - professional satisfaction - evidence in documentation

This framework was used at the Royal Marsden Hospital to define standards of care for all divisions in the hospital, ranging from chaplains to speech therapists. This framework formed the basis of the quality management programme developed by the author in her private speech-language therapy practice. This will be discussed in chapter 3.

Since Donabedian's early definitions, quality management in health care has evolved from quality assurance, i.e. conforming to standards, to structured quality review, i.e. case-by-case quality assessments to reveal patterns of care (Wilson & Goldschmidt, 1995). The latest development in the quality evolution is the emphasis on evidence-based medicine. Evidence-based medicine (EBM) is the critical appraisal of evidence for its validity and usefulness, application of the appraisal to

clinical practice and evaluation of the outcome of interventions based on evidence-based practice protocols. The practice of EBM is described as a process of lifelong, problem-based learning. It is aimed at improving the quality of health care by improving and demonstrating the effectiveness of health care (Sackett & Haynes, 1997).

1.2.3 Quality in speech-language therapy

The development of quality management in speech-language therapy in the United States of America followed the same trends as quality development in other sectors of health care. According to Abrams and Siferd (1994) quality assurance, that is the development of standards and criteria and measuring conformance to the prescribed standards and criteria, was initially at the center of quality programmes. There was, however, no attempt to delineate quality indicators or procedures for the measurement of the quality of services. A nationwide interest and concern with quality in the speech-language therapy and audiology professions in the USA, led in the 1990s to the development of a data-based computer programme specific to speech-language therapy and audiology. This programme, known as the Quality Assurance System Annual Review (QUASAR) can be installed in any medical center's computer system (Abrams & Siferd,1994). It identifies variables which equate to quality and cost, produces monthly workload reports for clinic management and provides trend information for quality management.

In the 1990s the American Speech-Language-Hearing Association (ASHA) produced clinical standards and position statements pertaining to most aspects of speech-language therapy and audiology services. In 1992, a national workshop was held with the purpose of developing nationwide quality indicators for evaluating speech-language therapy and audiology services. The great number of articles and

books published since 1992 in the USA attests to a growing concern for and commitment to quality in speech-language therapy services (Abrams & Siferd,1994).

In South Africa the focus of quality has mainly been on the improved training of therapists and the development of professional standards and guidelines. The South African Speech-Language and Hearing Association (SASLHA) is in the process of writing standards and guidelines for various aspects of professional practice, for instance screening procedures in schools, early intervention, et cetera. No form of nationwide data collection or systematic quality measurement is taking place. In the private sector no form of accreditation, in-sevice training or licensing exists. Speech-language practitioners do not have to comply, after graduation, with any form of audit and are not required to produce any evidence to demonstrate the outcome or effectiveness of their services.

Very few, if any, speech-language therapists will admit to *not* striving to provide the highest quality of service to their clients. Very few speech-language therapists however, are able to define what they mean by the quality of their services beyond a vague statement about the "best possible care". In the next section the author will describe the factors that need to be considered when creating a working definition of quality and quality management.

1.3 QUALITY: IN SEARCH OF A DEFINITION

All quality experts agree that unless quality is quantified and qualified, it remains an obscure and elusive concept that does not result in meaningful change or progress (Donabedian, 1992; Frattali, 1994; Pinkney-Atkinson, 1995). According to Øvretveit (1992a) and Miles *et al*, (1996), it is impossible to achieve high quality without

defining what it means. Wilson & Goldschmidt (1995) summarize these statements in declaring that quality has to be measured to be improved, and defined to be measured. A definition of quality is therefore a prerequisite in the clinician's pursuit of quality.

The following section aims to examine the concept of quality, to explore all the aspects that are relevant to the development of a definition of quality in a private speech-language practice and, finally, to recommend a working definition for quality in a private speech-language practice.

A first step in defining quality is to clarify some of the terminology surrounding the term *quality.* Frattali (1994) cites the complicated terminology surrounding it as one of the reasons why quality management often fails and why people see it as just another fad. The terms *quality assurance, total quality management (TQM), continual quality improvement (CQI), quality management* and *quality maturity* will be briefly discussed.

1.3.1 Quality Terminology

i) Quality assurance

Originally, *quality assurance* was at the center of quality programmes. The term quality assurance suggests assurance of a product's quality. In health care and speech-language therapy that means assurance that clinical care conforms to predetermined criteria or standards. Quality assurance entails the setting of standards, monitoring and evaluation, and corrective action where indicated. The central notion of this definition is that quality should be carefully defined and

steps taken to ensure that this defined level is maintained (Ellis, 1989; Frattali, 1990; Olswang, 1990; Bassett, 1993; Whittaker, 1993; Abrams & Siferd, 1994).

Quality assurance therefore demands explicit standards and expectations regarding quality, measurement against these standards and feasible steps that can be taken to correct any demonstrated deficiencies. Utilization review, one of the tools of managed health care, measures quality by comparing actual performance against defined standards and criteria (Veliotes, Magennis & Brown, 1993).

Quality assurance in health care consequently focuses mainly on the clinical aspects of care and the practitioner's performance. Utilization review, as part of the managed health care system, focuses on measurement against a set of standards or criteria. One of the criticisms leveled at managed health care is this emphasis on *retrospective* review or audit instead of prevention and proactive management (Wilson & Goldschmidt, 1995).

According to Crosby (1994), quality assurance or quality control is based on statistical actions and techniques to contain the nonconformance of processes by applying a series of screens and sieves. This method of quality assurance can be described as the "detection approach" and is reactive rather than proactive in nature (Crosby, 1984; Abrams & Siferd, 1994; Harrison & Frattali, 1994). Quality assurance has grown with time into a new paradigm of total quality management (TQM) and continual quality improvement (CQI). The emphasis shifted from *quality assurance* as a system of meeting standards, to *quality management* as a process designed to prevent problems as well as continually improving the quality of the product or services (Frattali, 1990;

Whittaker, 1993; Abrams & Siferd, 1994; Heaton, Beliveau & Blois, 1995). Quality assurance is therefore seen as only part of the much more extensive quality management process.

ii) Total quality management and continual quality improvement

The terms total quality management (TQM) and continual quality improvement (CQI) originated in industrial management and manufacturing. These concepts were responsible for a quality revolution in manufacturing and compelled health care to take a new look at quality as a production function. TQM refers to an organization's management philosophy to attain customer satisfaction through a comprehensive programme of techniques, tools and training (Williams, 1994). The emphasis on *total* quality implies the application of quality management principles to *every* aspect of the organization.

Continual quality improvement is the process of continually improving the quality of care, usually by improved conformance to practice policies or standards (Wilson & Goldschmidt, 1995). It is sometimes referred to as *kaizen*, a Japanese term meaning constant improvement (Peters, 1994).

The present study will use the term *quality managemen*t instead of total quality management (TQM) or continual quality improvement (CQI). According to Wilson & Goldschmidt (1995), *quality management* encompasses more than traditional total quality management while continual quality improvement is only one of its aspects. The term quality management embraces all quality improvement activities.

iii) Quality management

Quality management is "client centred, product focused, measurement orientated, improvement driven and all pervasive" (Wilson & Goldschmidt, 1995: xlii). Quality management is committed to prevention, so that there is nothing to sieve out. It is a systematic way of guaranteeing that all activities within an organization happen the way they have been planned. It is generated and driven by efforts to meet the defined needs and expectations of clients (Crosby, 1984). Quality management entails involvement of *all* individuals participating in the rendering of care. Furthermore, the aim of quality management is to save time and to reduce costs by eliminating inefficiency, rework and waste (Harrison & Frattali, 1994). It is, in the words of Crosby (1979) about "doing things right, the first time, every time".

iv) Quality maturity

The product or outcome of quality management is continual quality improvement. The goal of quality management is *quality maturity.* The latter term is used by Wilson & Goldschmidt (1995) to describe an organization where quality has evolved and grown over a period of time to include all forms and functions in that organization. A quality mature organization strives continuously toward greater excellence and continuously improves its quality of care and services as well as the mechanisms that produce such improvement. A quality mature hospital increases patients' health status maximally, at the least cost, with the greatest patient satisfaction, and refines tradeoffs between these objectives if they cannot all be met simultaneously (Wilson & Goldschmidt, 1995). Applying this description to a quality mature speech-language therapy

practice, the defined goal would be improved client communication status, at the least cost, with the greatest client satisfaction.

It is evident that there are major conceptual differences between quality assurance, and quality management and quality maturity. Quality assurance implies conformance to standards and is based on retrospective review. Quality management, on the other hand, is a systematic way to plan for and implement quality in an organization to enable it to attain quality maturity.

Most current definitions of quality in health care acknowledge and reflect the complex and multifaceted nature of the concept. It is defined by some as a philosophy (Jaeger, O'donnell & Judge, 1994); as a systematic process (Sale, 1990; Donabedian, 1992; Luthert & Robinson, 1993; Armstrong, 1994; Frattali, 1994; Harrison & Frattali, 1994); a scientific and technological approach (Ellis, 1989) or in terms of client satisfaction (Sunol, 1987; Vuori, 1987; Ellis, 1989; Cunningham, 1991; Harrison & Frattali, 1994; Heaton, 1992; Øvretveit, 1992a; Wilkin, Hallam & Doggett 1992; Lacap, 1994). According to Øvretveit (1992a) quality is no single unified theory, but a number of approaches, all based on a systematic and scientific approach to improvement.

Pinkney-Atkinson (1995) states that for a definition of quality to have any value, it must be translated into the different components relevant to the context. Quality is dynamic and complex and the importance or relevance of each dimension can change from one context to another, or even within the same context at different times. In other words, the definition of quality is not static and cannot be separated from the health care context in which it is provided.

Before attempting to recommend a working definition for quality in a private speech-language practice, it is necessary to explore the *contexts* that are relevant to the development of a definition of quality in a private speech-language practice. Each context consists of different *stakeholders* or *role-players* whose perspectives on quality need to be considered.

1.4 QUALITY MANAGEMENT DEFINED BY CONTEXT

In order to develop a quality management programme the private speech-language practitioner needs to understand, firstly, the difference between quality at system level and quality at production level and, secondly, that quality management is a production function.

1.4.1 Quality at system level

System level quality, according to Wilson & Goldschmidt (1995), refers to the quality of the health care system of a specific country in its totality. A noted authority on quality in health care, Robert Maxwell (1984), defines six quality dimensions at this level, namely, *appropriateness, equity, accessibility, effectiveness, acceptability* and *efficiency*. At system level the key quality factors are accessibility and the improvement in the health status of the population in general as a result of the health care services provided. A system that gives good care to 20% of the population, but which is not accessible to 80% of the people, will be judged inferior to a system that gives less good care to the average person, but to which everyone has access. However, if the latter system results in inappropriately high costs and patient dissatisfaction, quality is again compromised.

Quality at system level is a complex issue that can be, and should be viewed from the different perspectives of all the role-players. Value tradeoffs, in other words

tradeoffs between quality of care, cost-effectiveness and patient satisfaction, need also to be taken into consideration (Wilson & Goldschmidt, 1995).

In South Africa the quality of speech-language therapy at system level leaves much to be desired. The majority of the population has no or limited access to speech-language therapy services. Speech-language services are largely confined to the urban areas and vast rural areas are not provided for. In terms of the criteria specified by Maxwell (1984), namely *appropriateness, equity, accessibility, effectiveness, acceptability* and *efficiency*, speech-language therapy services in South Africa do not fulfill the needs of the majority of our population. The advent of democracy in 1994 did not improve the situation because the restructuring of the post-apartheid health care and educational services resulted in the loss of many speech-language therapy posts at hospitals, university clinics and schools.

1.4.2 Quality at production level

This dissertation focus on quality management in a private speech-language therapy practice, in other words, quality at production level. Quality management is a production level tool which applies to organizations like hospitals, university clinics or private practices. Organizations are concrete systems whose managers are accountable, or should be, for the quality of their products. The term quality management does not apply to the health care system, because the latter is a conceptual system and not managed by a manager in an organizational sense (Wilson & Goldschmidt, 1995).

Accessibility as a quality indicator is irrelevant at this level; what is important is the quality of the service provided for existing clients. Production level quality is concerned with production outcomes. Health care production performance therefore

refers to the extent to which providers, like hospitals and private practices, improve patients' health status, at what cost and with what patient satisfaction (Wilson & Goldschmidt, 1995). Production level quality in a speech-language practice refers to the *improvement* in the client's communication ability, the *cost-effectiveness* of the intervention and the *satisfaction* of the client. The outcome of the treatment is therefore the ultimate indicator of quality at production level.

A private speech-language practice is a concrete system whose manager, the speech-language practitioner, is responsible and accountable for the outcome of the services rendered by the practice. The aim and purpose of the practice is not only to provide speech-language services, but to produce positive outcomes, i.e. maximal improvement in the clients' communication status. Quality management demands that positive outcomes are produced in a cost-effective way and to the client's satisfaction. Furthermore, quality management principles require the practitioner to produce data to *prove* that the practice produces positive outcomes and that clients are satisfied.

The definition of quality cannot be separated from the health care context in which it is provided. The perspectives, expectations and interests of the stakeholders are important aspects of the context. The private speech-language therapy practitioner, in order to manage quality in his or her practice, must know how quality is defined by the role-players involved in the practice. The following section will explore and discuss quality in terms of the stakeholders involved in the context of a private speech-language therapy practice.

1.5 QUALITY IN TERMS OF STAKEHOLDERS

Heaton (1992) states that quality in health care is always viewed from different perspectives, those of society, the profession, the client and family, the employer, the government, the referral source and the practitioner. The perspectives of all the major interest groups and stakeholders need to be understood when an attempt is made to define the quality of a service. Donabedian (1992) emphasizes that the definition of quality must be accepted as legitimate by those expected to act upon it as well as those directly or indirectly affected by it.

The role-players considered to be major stakeholders in the context of private speech-language services are *society, funding agencies, referral sources, the speech-language profession, the speech-language therapy client* and *the speech-language therapist.* No working definition of quality in the practice can be developed without considering and including the perspectives and requirements of all these stakeholders. The next section endeavors to explore quality in terms of the stakeholders in a private speech-language practice.

1.5.1 Society

There is always a limit to available resources, even in the wealthiest first-world countries. Society demands that these resources be used to the optimum benefit, not only of the individual client, but of society at large. In the past decade a growing concern about the quality of health care services has resulted in a demand for accountability, cost-efficiency, treatment efficacy, focus on outcomes and client satisfaction (Maxwell, 1984; Ellis, 1989; Frattali, 1990; Coyte, 1992; Koch & Fairly, 1993; Tuomi, 1993; Harrison & Frattali, 1994; Shekim, 1994).

No private speech-language practice exists and functions in a social vacuum. Although part of the private sector all developments and changes in the government and public health sector, directly affect the private practice. Every practice forms part of society at large and cannot detach itself from the political, sociological and economical climate of the community or country, in other words, the macro environment of the practice. Chapters 2 and 3 will describe ways to investigate the macro environment of the practice to enable the practitioner to respond to the demands of society.

Society has distinct expectations concerning the parameters of quality care. These include accessibility regardless of geographical location, competence of clinicians and effective outcome of treatment. Society expects every client's needs to be accurately assessed and that these needs be dealt with in a timely, efficient and effective way. Society also presumes that every qualified speech-language therapist has the knowledge and competence to assess and treat a wide range of communication disorders in an appropriate and effective manner (Heaton,1992).

These expectations and demands are certainly within reason. If the speech-language therapy profession fails to meet these basic demands, the purpose and right of existence of the profession should be questioned. Although private speech-language practitioners deal with society at a smaller and different scale they still have responsibilities towards society at large. It can be argued that society contributed financially through taxation towards every practitioner's training and that society is therefore entitled to some form of return on its investment.

Speech-language services in South Africa are confronted with several problems that have a negative impact on their relevance to society. Accessibility and

language are two of these concerns. In South Africa accessibility is a major problem because therapists are usually concentrated in urban areas, training hospitals and university clinics, leaving vast rural areas without speech-language therapy services (Tuomi, 1994). Society expects clients to be treated in their home languages. In South Africa, where there are eleven official languages and where the majority of therapists speak only Afrikaans and/or English, this expectation is seldom fulfilled.

Rapid social, political and economic transformations in the past five years are causing major upheavals in the health care system. All health care practitioners, including speech-language therapists, are under pressure to demonstrate that their service provision is in keeping with the democratic values of the "new" South Africa. Society rates the quality of speech-language services against its expectations for affordable and accessible service rendering. Unless these expectations are met, the quality of speech-language services as perceived by society at large, will remain in doubt.

1.5.2 Community

The scope of this dissertation is quality in a private practice. Society in this context refers not to society at large, but to society pertaining to a specific private practice, in other words, the community served by the practice.

Private speech-language practitioners depend on their communities for their livelihood. It is crucial that they know and understand the expectations of their clients. A scan of the macro and micro environments of the practice is one way to ascertain how clients define quality and how they expect to benefit from the

services offered by the practice. Environment scans will be discussed in chapters 2 and 3.

The community pertaining to a private speech-language practice is not only the clientele of the practice, but everyone affected by the communication status of every individual client: parents, friends, neighbours, teachers, employers and family members. The client is seen not only in terms of the symptoms of his disorder, but also in terms of the effect this disorder has on his or her communication status and interaction with the community. Improvement in the communication status of every client as the result of therapeutic intervention by the practitioner, therefore serves and benefits the community. This perspective is in keeping with the modern trend of viewing the outcome of a service in terms of the improvement in the psychological, physical and social quality of the life and well-being of clients.

1.5.3 Referral sources

The livelihood of any practice depends on the referral of clients from the community by doctors, psychologists, teachers and other paramedical professions. The most important referral sources, however, are satisfied former clients and their families (Øvretveit, 1992a; Peters, 1994). Word-of-mouth referrals are the most valuable marketing tool available to the private practitioner (Lacap, 1994).

It is crucial that the private practitioner knows how referral sources define quality and what their expectations are. It is the author's impression that clients are mainly referred to the speech-language therapist nearest to the client. In some cases, however, a referral agent will refer the client to a specific therapist on the grounds of his or her expertise in a certain field. Two factors therefore, location and

effectiveness, or in quality management terminology, accessibility and outcome, seem to be important quality indicators to referral agents.

Referral agents expect referred clients' needs to be accurately assessed and dealt with in a timely, efficient and effective way. They expect formal feedback from the practitioner and professional cooperation where appropriate. Different referral agents have different needs and expectations; the busy family physician probably expects only a short note stating the outcome of the speech-language assessment and the speech-language practitioner's recommendations. The counselling psychologist on the other hand, will expect a detailed report with test results in order to verify his or her own findings. In order to fulfill the needs of referral sources, speech-language practitioners must know about their expectations and how they define quality.

1.5.4 Funding agencies

In South Africa private speech-language services are financed either directly by the client or by a medical scheme of which the client is a member. Funding agencies as well as clients want to maximize outcomes and minimize costs. In order to do this they need to know the relationship between a treatment and its outcome, and more specifically, the relationship between the cost of the treatment and its outcome. Policy makers and purchasers demand proof of practises that maximize cost-efficiency. They demand practical measurement of the outcome of speech-language services and evidence of treatment efficacy. The funding agency therefore defines quality as value, in terms of positive outcome, for their money.

Health care in South Africa is currently undergoing major restructuring and transformation, with an increased focus on the provision of certain minimum

services to the whole population. An important development in both private and public health care is the advent of managed health care. At the time of writing, very little is known about the consequences of the proposed changes in the health care system for speech-language therapy and audiology services.

A managed care system usually implies strict control and monitoring of costs, emphasis on quality of services, service delivery in a large integrated system and the linking of reimbursement to positive outcome (Veliotes *et al*, 1993; Harrison & Frattali, 1994; Curl, 1994; Corlin, 1996). The advocates of managed health care in South Africa see it as a way to bring an end to the national inflationary trend in the private health care sector and to create a more cost-effective health care delivery system (De Villiers, 1997).

One of the aspects of managed health care that will directly influence private speech-language practitioners is the introduction of the general medical practitioner as "gatekeeper". This entitles the funding agency to demand a referral from the client's family physician as a prerequisite for speech-language therapy. Another aspect usually associated with managed health care is some form of pre-authorization by the funding agency (Veliotes *et al*, 1993). Both the gatekeeper and the persons responsible for preauthorization must therefore be convinced of the efficacy and cost-effectiveness of speech-language therapy or no authorization will take place.

Since the purpose of pre-authorization is to contain costs and curb unnecessary procedures, speech-language practitioners may soon find themselves in a position where they are asked to produce hard data to demonstrate the efficacy of their treatment protocols. Boston (1994) states that the destiny of speech-language

services lies in data. Without hard data regarding outcome and cost-effectiveness, administrators and policy-makers remain skeptical and find it easy to disregard the funding of speech-language services in favour of "more pressing" health care needs.

Past experience has shown that speech-language services are not considered essential services by policy-makers in the South African health care context. An example of this is their exclusion from the previous Medical Schemes Act of 1984. This may be due to their small numbers, lack of awareness among decisionmakers about the profession or as a result of their own neglect and lethargy in marketing themselves as a profession.

It is obvious that quality is defined by funding agencies in terms of value for money, or cost-effectiveness. It can be argued that only a quality management system that includes the measurement and documentation of outcome can provide private speech-language practitioners with the data to prove their efficiency and the cost-effectiveness of their services.

1.5.5 Speech-language therapy profession

The survival of speech-language therapy as a profession in South Africa depends on demonstrating, in concrete ways, that the majority of the population benefits from its services. Policy-makers favour service providers who can guarantee positive outcomes. Boston (1994:37) states that speech-language practitioners can no longer "afford the luxury of presumption of value; they must move from presumption to persuasion". It is in the interests of the profession to strive towards and promote excellence and to demonstrate continual quality improvement.

The arrival of managed health care in South Africa will change the face of health care delivery for ever. Service providers will be required to develop a managed health care system suited for and adapted to the unique health care needs in South Africa. It is of the utmost importance that speech-language practitioners play an active role in the decision-making process to ensure that they are directly involved in drawing up the criteria against which they will inevitably be measured. In that way their professional autonomy could be safeguarded rather than threatened. As Boston (1994) aptly stated, health care policy makers will have no qualms about making their decisions for them.

One way in which a profession can promote the quality of its services, is through the setting of standards. Standards come in many forms: standards of practice, critical pathways, quality indicators, practice parameters, practice policies and practice guidelines. The intent of standards is to reduce unacceptable variation in practice patterns and enhance cost-efficiency of care. Standards are usually based on research findings and state-of-the-art practice and are developed through a peer review process. (Abrams & Siferd, 1994; Curl, 1994; Harrison & Frattali, 1994; Shekim, 1994; Wilson & Goldschmidt, 1995).

An example of comprehensive standards pertaining to speech-language therapy and audiology, is the Standards for Professional Service Programmes in Audiology and Speech-Language Pathology, compiled by the American Speech-Language-Hearing Association (ASHA). These standards were developed for use in the voluntary accreditation of clinical services programmes by the Professional Services Board of ASHA. They are designed to provide a basic foundation not only for assessing and recognizing specific programmes, but also for

stimulating and guiding the continued development and improvement of clinical services. Standards and implementation statements are specified for the following aspects of clinical care; mission, goals and objectives; nature and quality of services; quality improvement and programme evaluation; administration; financial resources and management; human resources; physical facilities and programme environment; and equipment and materials (ASHA, 1992).

In South Africa few formal standards for speech-language therapy and audiology exists although the Standards and Ethics Committee of The South African Speech-Language-Hearing Association is in the process of developing guidelines for each practice group. It can be argued that the formulation of formal standards should be a priority for the speech-language and audiology professions in South Africa. Luthert and Robinson (1993) state that formal standards lead to an increased sense of professional confidence and self-worth. They enhance professional responsibility and create an environment of accountability and rationalization.

A variety of additional purposes can also be served by standard setting for the speech-language and hearing profession in South Africa. The standards can be used to inform other professions, accrediting agencies, funding sources and regulatory bodies of the essential elements, indicators and goals of quality of our services. As explained before, the advent of managed health care in South Africa will require proof of these aspects. Standards can also help to guide the development of new programmes and to provide a framework for self-evaluation, programme modification and future planning in existing programmes (ASHA, 1992).

Another way in which a profession can strive towards continual improvement is through some form of accreditation. Accreditation can be defined as the professional and/or national recognition reserved for practitioners or facilities that meet certain predetermined qualifications or standards. It implies that the individual or health care facility has voluntarily sought to be measured against high professional standards and that it complies with these standards (Flower, 1983; Whittaker, 1993).

In South Africa no system of accreditation or licensing after graduation exists. After obtaining a four-year professional bachelor's degree, a speech-language therapist may register with the South African Health Professions Council. Although this is frowned upon by the South African Speech Language and Hearing Association, there is no law preventing a newly graduated therapist from commencing in private practice.

After graduation, therapists may practise for the rest of their professional careers without having to comply with any form of audit, re-certification or accreditation. They need not even belong to the South African Speech-Language and Hearing Association. In fact, less than a third of all the speech therapists registered in South Africa are members of the only professional association exclusively for speech-language therapists and audiologists.

In other words, once qualified, it is up to every private practitioner to assure the continual quality improvement of his or her own services. According to all the definitions of quality management, this entails instituting a quality management system in his or her practice to continually measure and improve the quality of his or her services in a structured and systematic way.

It is questionable whether South African private speech-language practitioners use quality management systems in their practices. A needs assessment compiled in 1994 by the author as part of the requirements for a masters degree indicated the opposite. None of the five private speech-language practitioners questioned by the author implemented any form of systematic quality management. The practitioners in the study all relied on self-evaluation to ensure quality. None supported a national accreditation system and all deemed their undergraduate training sufficient to ensure clinical competence. Not one of the practitioners measured outcome or client satisfaction as quality indicators.

On the other hand, it could be argued that the setting of standards and an accreditation system will still be no guarantee of continued quality improvement of clinical services. According to Wilson & Goldschmidt (1995) it is a major misconception to assume that a set of professional standards and the practitioner's conformance to it, will *assure* improved quality of services. Øvretveit (1992a) states that accreditation in itself does not assure high quality of care. It is at best only as good as the standards against which providers are measured. Accreditation is also a measure of past performance and no guarantee of future quality performance or continual quality improvement. According to Øvretveit most accreditation systems are not based upon modern quality theories, where the emphasis is on evaluating the effectiveness of the quality management system employed by the service provider. Modern quality systems have also discarded quality assurance in favour of quality management (Wilson & Goldschmidt, 1995).

Quality management focuses on strategies to prevent quality problems, rather than to measure quality after problems have occurred. It is more appropriate to develop

and establish, in the context of a specific provider, a quality system that conforms to the requirements of quality management. The efficacy of the service in complying with its quality system can be assessed and measured through clinical audit. Information obtained from the clinical audit is then used to adapt or improve the quality system where necessary, thereby ensuring continual quality improvement.

Another important issue that needs to be explored is the value of external standards and goals as incentive and motivation for continual quality improvement. It can be argued that intrinsic standards set by the practitioners in keeping with their own principles and personal mission statements will have more bearing on the quality of their services than complying with an external set of standards for the sake of accreditation or certification. Speech-language practitioners who view continual improvement in the quality of their services as part of their own continual self-growth and development, add a dimension to their services that would not be achieved by any external standard setting. The ideal paradigm for continual quality improvement is a commitment to quality at both a personal and a professional level. In this way synergy between personal and professional goals and a culture of continual quality improvement is created.

Most speech-language practitioners are committed to providing the highest quality of care to every client they serve. They are bound by professional and ethical considerations to maintain, as well as continuously improve, the quality of their services. Some speech-language practitioners might argue that the current emphasis on quality reflects a change from the practitioner as a caring scientist to the practitioner as an entrepreneur only concerned with profit and statistics. Some of the resentment voiced at managed health care stems from an impression that

clinical decisions are made by anonymous bureaucrats and that traditional care giving is sacrificed for the sake of cost.

The problem is that good intentions alone are not enough to assure quality. Quality never happens without a deliberate and concerted effort. The practitioner may claim to provide client-centered services with the best interests and satisfaction of his or her clients as the ultimate goal. Without a deliberate system of implementing client-centered services and actually measuring client satisfaction, the practitioner will find it hard to demonstrate the attainment of these goals. The assumption that clients are satisfied with the services rendered by the practice without measuring client satisfaction indicates practitioner-centredness in the highest degree.

Client satisfaction is one of the fundamental principles of quality management. Quality has meaning only in terms of the customer (Deming, 1986). The next section will explore quality as defined by the client, the nature of client satisfaction and ways to measure it.

1.5.6 Quality as defined by clients

Authorities on quality improvement in health services agree that client satisfaction is a legitimate goal in health care. It has been shown that patient dissatisfaction is closely associated with noncompliance with treatment instructions, delay in seeking further care and poor understanding and retention of medical information (Sunol, 1987; Vuori, 1987; Ellis, 1989; Cunningham, 1991). It has also been shown that patients' reported levels of satisfaction reflect doctors' technical competence as judged by independent professional assessors (Wilkin *et al*, 1992). Patient dissatisfaction can therefore be seen as an intermediate outcome which may reflect a failure to comply with patients' needs, meet their expectations, or provide an

acceptable standard of service (Heaton, 1992; Øvretveit, 1992a; Harrison & Frattali, 1994; Lacap, 1994; Heginbotham, 1996).

The reasons for speech-language practitioners to strive for client satisfaction are evident. Concern for the needs and views of clients is a reflection of democratic values, in other words, the notion that those influenced by a process should have a voice in the decision making and planning of that process. Health care clients are becoming increasingly aware of their rights as consumers (Heginbotham, 1996). In the words of Cooper (1994: iv) "patients are no longer patient". Since health care is being marketed as a service industry, providers and practitioners are well advised to heed the needs and wishes of clients if they want to continue providing these services in an increasingly competitive market. Not only the direct recipients of services, but also family members, employers, referral agents and funding agencies should be regarded as clients.

It is sound business practice to satisfy clients' needs to promote practices and attract more clients. Some clients and patients have limited choices and are forced to accept certain services even though they are dissatisfied with those services. In the private sector, however, satisfied clients are needed to ensure a stable income in competitive markets. Seen from this perspective, the dissatisfaction of clients should be considered in terms of the *cost* of poor quality. Øvretveit (1992a) claims that 65 - 90% of dissatisfied health care clients do not use a service again and that every dissatisfied client tells 12 - 15 people of the negative experience. A dissatisfied client not only tells friends and family, but also potential referral sources like teachers, doctors, and other professionals. A satisfied client, on the other hand, provides invaluable word-of-mouth endorsement of the therapist and the practice.

Lacap (1994) justly describes a satisfied client as the most valuable marketing tool available.

The practitioner has to ascertain two aspects of client quality management, namely the attributes of satisfied clients and how to determine or measure their satisfaction. The following sections will explore and describe these two issues.

i) Client satisfaction

Crosby (1994) states that a satisfied client is a successful client. The key to making him or her successful is to determine what he or she wants and to arrange the process in such a way that he or she gets it. A definition, it could be argued, much more suited to describing a manufactured product than speech-language therapy. Most writers agree that the main problem in defining client satisfaction is the subjective and elusive nature of the concept (Vuori, 1987; Ellis, 1989; Øvretveit, 1992a; Frattali, 1994; Wilkin *et al,* 1992; Luthert & Robinson, 1993; Cooper, 1994; Miles *et al*,1996).

Satisfaction represents a complex mixture of perceived needs, expectations and experiences. Not only is there a great variation between the expectations of different clients, but expectations might be different at different times of the intervention process. In other words, expectations prior to intervention may be different from expectations at a later stage of the process. The severe stutterer might, prior to therapy, expect to be completely fluent after a short period of therapy and gradually alter these expectations as therapy progresses. Clients might even be relatively unaware of their expectations unless these are not met. To complicate matters further, what the client *wants*, may be different from what he realistically *expect*s to get, and what he thinks he *need*s may be different from

what he *wants* (Øvretveit, 1992a). An adult stutterer, for example, might *want* to be a normal speaker, although he may realistically *expect* and indeed be satisfied with a moderate improvement in fluency.

Critics of the notion that quality of health services could be assessed by measuring client satisfaction, often state the lack of objectivity as an obstacle. It is argued that clients lack the technical and scientific knowledge to assess the quality of care and that the complexity of the intervention process would make it impossible for them to have a comprehensive, let alone an objective view. Some clients may not be in a mental or physical condition to assess the quality of care. A client's wishes may be inappropriate or detrimental to his own well-being (Vuori, 1987; Øvretveit, 1992a; Harrison & Frattali, 1994; Lacap, 1994).

While these objections raise valid points, it should also be recognized that some of the issues stem from professional self-interest and arrogance (Harrison & Frattali, 1994). Traditionally, the medical model is practitioner-centered and not client-centered, which means that the clinician claims control over the clinical process. Practitioners are reluctant to ask or listen to the patient's opinion and quality is defined according to the practitioner's own standards. (Vuori, 1987; Lacap, 1994).

The argument that the client is not competent to judge the technical quality of therapy should not detract from the fact that his expectations, assumptions and perceptions are still an important part of the process. Patients evaluate their well-being mostly on the basis of subjective feelings rather than objective external data. The adult stutterer who perceives his disfluency as a severe handicap, is usually reluctant to accept the therapist's diagnosis of mild stuttering

based on an objective severity rating scale. Research has shown that subjective feelings have a direct bearing on the outcome of treatment (Vuori, 1987; Øvretveit, 1992a; Wilkin et al, 1992). Even unsophisticated clients can judge whether their perceived needs were met to their satisfaction.

The notion that the client is competent to judge if his needs are met or not is a reflection of a patient-centered approach to health care and therapy. The modern view of patient-centered care is largely based on Carl Rogers' concept of client-centered therapy developed in the context of psychotherapy (Rogers, 1961). Client-centered therapy is based on a philosophy of deep respect for and acceptance of the client as a person competent to direct himself. It requires the clinician to relate to the client not as an object to study or in terms of a diagnosis, but as a person to a person. In recent years the concepts empowerment and autonomy of clients have received much attention. Empowerment is defined as the process of giving a person the power to exercise control over his own behaviour, thereby freeing him to take responsibility for his actions (Armstrong, 1994).

Client-centered therapy requires the clinician to assume the client's internal frame of reference, to perceive the world as the client sees it, to perceive the client as he is seen by himself and to communicate this emphatic understanding to the client (Rogers, 1961). It is about "first seeking to understand and then to be understood" (Covey, 1994: 213). In an article discussing patient-centered care in nursing, Bradshaw (1996, in Fulford, 1996) states that the quality of nursing care arises not from the artificial application of techniques, but from genuine, altruistic service. She states that the initial grounding of patient-centered care

was love for one's neighbor inspired by and fundamentally rooted in the covenant love of God for humanity.

Critics of Rogers' approach claim that it is flawed because this client-centered and non-directive approach depends on a mutual and equal relationship between therapist and client. The therapist-client relationship, however, is *not* based on equality. It is argued that because the client has needs that the therapist does not have, he is vulnerable and open to manipulation, however unintentional (Bradshaw, in Fulford, 1996).

Many health care practitioners resent the implication that the quality of their services is diminished by a so-called practitioner-centered approach. They argue that the patient's primary concern is usually diagnosis and treatment of disease, hence the traditional focus of medicine on diagnosis and treatment of disease. Hope (1996) counters that although the traditional medical approach usually has the patient's best interest at heart, it cannot be regarded as patient-centered because it addresses what is good for the patient from the practitioner's perspective. Patient-centredness, on the other hand, addresses the viewpoint of the patient.

Client-centered care requires more effort from the practitioner. To attend to the distinctive concerns of every individual client and to go beyond his primary concerns, substantially add to the workload of the practitioner. It might adversely influence the cost-effectiveness and efficiency of the practice. In a busy, understaffed hospital context, more time spent with an individual may mean fewer patients treated. Patient-centered care in such a setting may be a highly

coveted ideal, but not a realistic goal. In the private sector, however, clients expect and demand more personalized care.

Clients value three aspects of care: The *instrumental* aspect, the *expressive* aspect, and the *communicative* aspect (Vuori, 1987). Of these, the instrumental aspect refers to the practitioner's clinical skills and technical knowledge, i.e. the *science of therapy*. A client may not be able to judge the clinician's instrumental competence, but in the expressive and communicative aspects of therapy, i.e. the *art of the care,* the client is the ultimate authority (Vuori, 1987; Ellis, 1989; Heaton, 1992; Øvretveit, 1992a; Harrison & Frattali, 1994; Peters, 1994).

Clients are indeed competent to judge the non-technical aspects of clinical care and to decide whether their needs were met to their satisfaction. Factors such as whether clients are treated with respect and dignity, whether their comfort is considered and whether the practitioner really understood the problem, can only be judged by the client. Peters (1994) states that technical quality is never enough. He claims that an affective relationship between the client and the clinician is crucial to client satisfaction and that an emotional link must develop between the product or service and the client.

Peters describes two studies to illustrate this point of view. In one study malpractice suits in the USA were analyzed to determine reasons why patients sued their doctors. It was found that patients seldom sued doctors who treated them with kindness and that patients "who were angry enough to call their lawyers" did so because of small interpersonal aspects of the treatment (Peters, 1994: 260). A recent statement by the medical ombudsman in South Africa, Professor Oliver Ransome, revealed similar sentiments. South African patients

lodged formal complaints when they felt that they were treated with less respect than they felt they deserved. In most cases an honest acknowledgment of the grievance followed with a simple apology would have satisfied clients and prevented a formal complaint (Van der Linde, 1996a).

The value of these small interpersonal aspects becomes apparent in another study quoted by Peters (1994). An Australian physician divided 48 patients randomly in two groups and sent follow-up letters after treatment to one group. Thirteen of the 24 patients in the group who received letters declared themselves "completely satisfied" - the highest rating. Only four out of the 24 patients who did not receive a letter made the same assessment. In other words, a letter increased the number of fully satisfied patients by a factor of more than four. Peters concluded that a consultation *with* a letter is an entirely different service or product, from a consultation *without* a letter.

It is obvious that speech-language practitioners cannot afford to ignore the affective component of their services. Quality management demands a client-centered approach to therapy. Client satisfaction is the cornerstone of the client-centered approach as well as an important quality indicator. Client satisfaction can never be assumed, it must be measured to be improved. The challenge, however, is to measure client satisfaction in such a way that the results can be analyzed and used in a meaningful way in the quality management process.

ii) The measurement of client satisfaction

When devising methods to measure client satisfaction the practitioner must realize that this is only one step in the quality management process and that a

survey in itself would not necessarily enhance the quality of the services. It might also raise expectations among clients and make them aware of needs not expressed before. The practitioner must be committed to act upon the findings of surveys. It would otherwise be a waste of time and money and could compromise the practitioner's credibility (Sunol, 1987; Øvretveit, 1992a).

According to Øvretveit (1992a), a good starting point would be to measure *dissatisfaction,* in other words, to note and analyze all complaints. A practitioner who is serious about client satisfaction and committed to quality management will create an environment of openness and understanding where clients feel free to raise concerns and voice their opinions. Continually seeking out clients' opinions is part of the process of negotiation and empowerment. The earlier complaints are detected and conflict resolved, the less harm is caused by dissatisfied clients. The practitioner also demonstrates in a tangible way that he or she considers the well-being and satisfaction of clients important enough to attend to their concerns. According to Mulcahay (1996) there is a strong correlation between client satisfaction and the belief that their complaints will be acted on so that other clients would not encounter the same problems.

Measurement of client satisfaction must be done in a systematic and organized way. The ultimate aim is to *improve* quality and not only to measure it. The practitioner's choice of measurement tools will be influenced by the *cost* of different options, the *usefulness* of the information yielded by that method and the *practicability* of the method. Options may include market research, flow charts, use of existing research in similar environments with similar clients, formal and informal surveys, et cetera.

Less formal and expensive methods can give practitioners important information about the expectations of their clients as well as their satisfaction with the practice. Informal talks with clients about likes and dislikes, a letter sent to a random sample of clients, comment cards, checklists and suggestion boxes are inexpensive ways to measure client satisfaction. An innovative option cited by Øvretveit (1992a), is the so-called "mystery client", where an assessor poses as a client and experiences the service process from a client's perspective. Practice data can also be analyzed for indications of satisfaction and dissatisfaction among clients, such as dropout rate, an increase or decrease in the demand for services, and client-cancelled appointments.

Formal surveys are another way to measure client satisfaction. Lacap (1994) states that the practitioner must first have a clear statement of purpose. A survey to measure client satisfaction differs from a needs assessment. In the needs assessment the client is asked to define his expectations, needs and requirements pertaining to a specific service. A survey with the stated purpose of *measuring* client satisfaction is constructed in such a way that every question focuses on the personal satisfaction of the respondent with the services received. The aim is not only to get feedback, but to get the kind of feedback that is relevant for the stage of quality evolution that the service has reached. The practitioner must be committed to act on the results of the survey and only include questions about aspects that he or she is willing to change. It is futile to ask clients if they are satisfied with the fee structure if the practice is not prepared to change fees. Inability or unwillingness to respond to client feedback will impair the credibility of the practitioner and raise questions about his or her commitment to the needs of clients.

Avoiding client dissatisfaction is not the same as ensuring satisfaction (Øvretveit,1992a). The client who has no complaint is not necessarily highly satisfied with the services. Identifying causes of dissatisfaction should be seen as the first step in the quality management process. To find out what the client really wants from a practice, the practitioner will have to do a needs assessment.

Quality as defined by clients is more than client satisfaction, which in turn is more than the absence of dissatisfaction. As defined by Øvretveit (1992a), quality from the client's perspective is a global and enduring attitude towards a service, built up from repeated satisfaction over time, rather than a judgment in relation to a specific incident.

1.6 QUALITY: A WORKING DEFINITION

The definition of quality cannot be separated from the health care context in which it is provided. The perspectives and interests of all the stakeholders and role-players involved in a private speech-language therapy practice must be considered by the practitioner. Donabedian (1992) states that the definition of quality must be accepted as legitimate by those expected to act upon it as well as by those directly or indirectly affected by it. It is crucial that the quality-conscious practitioner ascertains how quality is defined by the stake holders involved in his or her practice environment. Although awareness of the expectations of the role-players is not enough to guarantee quality, it provides the practitioner with information that forms the basis of the development of a quality management system.

All quality experts agree that unless quality is quantified and qualified, it remains an obscure and elusive concept that does not result in meaningful change or progress. Quality has to be measured to be improved, and defined to be measured. A definition of quality is therefore a prerequisite in the clinician's pursuit of quality.

In the previous sections the author attempted to examine the concept of quality and to explore all the aspects that are relevant to the development of a definition of quality in a private speech-language practice. The following working definition of quality in a private speech-language therapy practice was developed:

> ***Quality in a private speech-language practice is the degree to which all the services of the practice improve the communication status of its clients, at the lowest cost, to the satisfaction of both the practitioner and the clients.***

It is believed that this definition encapsulates the principles of quality management as well as client-centered practise in the following way:

"The degree to which" ...... recognizes the concept of variability and indicates the potential for measurement through quantification and qualitative description of what was quantified (Miles *et al*, 1996).

"All the services of the practice" ...... represents conformance to the principles of total quality management which, by definition, extends to every aspect of the practice.

"Improve the communication status" ...... recognizes the practice's adherence to quality management at production level, in other words, the outcome production function of the practice. It also expresses the practitioner's recognition of the impact of the client's disorder on his or her well-being and quality of life and the effect of the disorder on the client's community.

"At the lowest cost" ...... embodies the practitioner's commitment to cost-effectiveness and responsible use of resources.

"The satisfaction of the practitioner" ...... recognizes the professional expertise and competence of the practitioner to judge the quality of his or her services in accordance with current scientific knowledge and professional standards.

"The satisfaction of the client" ...... reflects the client-centered approach of the practice where the well-being and autonomy of the client are respected and valued.

Once quality was defined, the next step was to develop a quality management policy based on the practice's definition of quality. It was felt that this definition of quality in the author's private speech-language therapy practice represented all the aspects that were necessary to develop a quality management plan for the practice. In chapter 2 the basic principles of the development of a quality management policy will be discussed. In chapter 3 the application and implementation of these principles in the author's private speech-language therapy practice will be described and discussed.

CHAPTER 2

DEVELOPMENT OF A QUALITY MANAGEMENT POLICY

2.1 INTRODUCTION

A quality management policy is a set of activities intended to implement quality management within an organization. The purpose of the policy is to empower the organization to achieve quality maturity (Wilson & Goldschmidt, 1995). The policy extends by definition to all aspects of an organization's functioning, including its relationships with all its clients.

Quality experts warn that quality cannot be "installed" in an organization (Crosby, 1994). Successful implementation of quality policies requires a calculated, coordinated and comprehensive effort from the entire organization. Organization policies must originate in the deliberate planning of processes that stipulate objectives and strategies to achieve them. Quality is designed into all processes and systems, and problems are prevented before they happen (Deming, 1986; Luthert & Robinson, 1993; Armstrong, 1994; Williams, 1994).

The methods to implement quality management are as varied as organizations themselves and depend on the abilities, knowledge and experience of the people involved. There is no standard or perfect process, nor is there only one correct way to achieve quality maturity. In other words, it is impossible to devise a standard quality management policy for implementation by all speech-language private practitioners. Every practice has to develop its own unique policy, in harmony with its own vision, mission, values and principles.

The first step in the implementation of a quality management policy is the formulation of an appropriate business plan for the organization. Many quality programmes fail because of lack of a clear management or business strategy (Øvretveit, 1992a, 1992b; Katz & Gain, 1994; Heginbotham,1996). The quality programme then becomes a substitute for a business plan instead of the driving force behind it. A business plan evaluates the organization in its entirety, identifies areas of strength and weakness, highlights potential problem areas before they arise and can be used to measure achievement (Koehler, Hoffman & Pankowski, 1994; Moskovits, 1994; Rassi & Fino-Szumski, 1994; Brooks, 1995).

In South Africa, practice management and business skills do not form part of the basic training of health care professionals. The number of speech-language therapists entering private practice increases every year, mainly due to lack of posts in the public sector. Most of these therapists are dismally unprepared for the challenges and demands of the private sector. This leads to poor practice management, which may result in financial failure, emotional distress, poor professional satisfaction and ultimately in poor quality service, which harms the image of our profession.

Establishing a private practice involves more than clinical competence. Many speech-language practices fail to reach their full potential because practitioners fail to formulate appropriate business plans. Large medical practices usually employ practice managers, consultants and accountants to coordinate all the activities of the practice. Most speech-language practitioners in South Africa, however, cannot afford to employ other professionals to run the business side of their practices. Speech-language therapists should realize that they can formulate their own business plans. A basic knowledge of management principles, clear thinking and a

willingness to meet challenges are all that is needed. A large body of literature is available to help entrepreneurs to start new businesses.

The following section describes the basic principles in the formulation of a business plan. In chapter 3 the application of these principles to a private speech-language therapy practice is described.

2.2 FORMULATION OF A BUSINESS PLAN

A business plan is a management tool which focuses on the direction and defined purpose of the practice. It is a declaration of intent and defines what the practice wants to become in the long term. At the same time it anticipates the inevitable changes that will confront the practice in the future. The business plan is always firmly rooted within the context of the practice's mission and vision (Armstrong, 1994; Brown, 1996). A business plan can vary from a comprehensive document to a simple plan, depending on the complexity and vision of the practice. It is a living document and should be regularly reviewed and amended according to changes in the practice environment.

2.2.1 Vision, value and mission statements

Vision, mission and *values* are the three components that form the foundation of a business plan as well as a quality management policy. A commitment to quality should already be evident in the vision, mission and value statements (Macdonald, 1993; Armstrong, 1994; Koehler *et al*, 1994; Rassi & Fino-Szumski, 1994; Brooks, 1995).

i) Vision

A vision statement describes the aspirations of an organization and embodies its philosophy. It provides a common objective to everyone in the organization. It is usually a brief summary of the long-term vision of the organization and an expression of its purpose and sense of direction. The vision statement forms the framework for an organization's mission and goals and unites strategy and culture to achieve excellence (Macdonald, 1993; Armstrong, 1994; Koehler *et al*, 1994; Rassi & Fino-Szumski, 1994; Brooks, 1995).

Examples of vision statements, incorporating quality management principles, are as follows:

> "The management and employees of the Alpha Group are committed to providing our customers with what they want, first time, every time. To achieve this we require everyone to strive constantly to improve the quality of the products and services we supply" (Munro-Faure, Munro-Faure & Bones, 1993: 199).

> "The practice aims to offer a quality service as recognized by patients and staff. This will be achieved by providing and developing primary health care effectively and efficiently, using a team approach, thus maximizing the resources to the optimum benefit of patient health" (Brooks, 1995: 65).

The vision statements depicted above represent quality management principles such as client satisfaction, continual improvement and cost-effectiveness. They involve everyone in the respective organizations and reflect their combined vision for the future. A shared vision, however, is only possible if everyone in an organization shares the same values relating to the organization.

ii) Values:

The values of an organization can be described as the qualities, customs and standards regarded as acceptable and desirable by everyone in the organization. Values are usually expressed as beliefs of what is best for the organization. They form an important part of the *culture* that is particular to every organization. The value system aligns an organization's leadership and its people. It determines the actions taken, consistent with the mission, along the path towards achieving the stated vision (Armstrong, 1994; Koehler *et al*, 1994; Rassi & Fino-Szumski, 1994).

According to Covey *et al*, (1994), values should be based on principles. While values focus on shared beliefs, *principles* are based on universal, timeless truths which can be, when correctly understood, applied to every situation and decision. Examples of principles are integrity, openness, honesty, dignity, loyalty and equal opportunity. Values based on principles give a profounder meaning to an organization's vision and mission. A principle-centred organization will be able to respond to any new challenge or change in a way that is in accordance with its vision and mission statements.

An important principle in health care is the principle of the infinite worth of every person. This principle is reflected in the patient-centered approach to health care

and therapy. Hope (1996) argues that although the traditional medical approach usually has the patient's best interest at heart, it cannot be regarded as patient-centered because it addresses what is good for the patient from the practitioner's perspective. Patient-centredness, on the other hand, addresses the viewpoint of the patient. It is obvious that quality management in health care, where the satisfaction of the patient is regarded as an important aim and quality indicator, requires patient-centered care.

iii) Mission

The mission statement is the formal expression of the organization's scope and purpose. According to Drucker (1973, quoted in Armstrong, 1994), an organization is not defined by its name or statutes, but by its mission. Only a clear definition of the mission can lead to realistic goals, objectives and practice policies. An empowering mission statement deals with both vision and principle-based values and becomes the primary factor that influences every moment of choice. It should be explicit about what an organization wants to do, and for whom. A mission statement is compiled by considering certain questions about the organization. These may include the following: "Who are we? What is our purpose? Who are our customers? What are our goals?" (Macdonald, 1993; Rassi & Fino-Szumski, 1994). The answers to these questions will be determined by the organization's vision for its future and its stated values and principles. A quality-conscious speech-language practice will formulate answers in keeping with quality management principles.

The vision, mission and value statements form the foundation of an organization's quality management policy. Since quality is never a fixed goal, the mission and vision statements should periodically and systematically be reviewed

for appropriateness. In this way the practitioner can anticipate and respond to changes in the practice environment.

Vision, mission and value statements express the purpose and intent of an organization. These statements must however, be translated into action to become the driving force for strategic planning and realization of the organization's goals. The setting of goals and objectives is the next step in the development of a quality management programme.

2.2.2 Goals and objectives

Goals and objectives define what organizations, departments, teams or individuals are expected to achieve. Drucker (1973, quoted in Armstrong, 1994) states that goals are not commands but commitments. They serve as guidelines for action and provide a basis for organizational design. Goals are translated into objectives which are descriptive statements of what will have to be done to achieve goals (Øvretveit, 1992a, 1992b; Armstrong, 1994; Rassi & Fino-Szumski, 1994). It should be remembered that quality is not a fixed goal that is achieved, celebrated and then forgotten. It is a moving target and the goal is to constantly improve quality. The essence of quality maturity is continual quality improvement. To achieve quality maturity takes time and long-term commitment. Williams (1994: 86) states that "no goal is forever and no specification is good enough to meet the expectations of tomorrow's customer".

Good work objectives should be consistent with the values of the organization, well-defined, challenging, stimulating, measurable in qualitative and quantitative terms, realistic, obtainable, and time-related or achievable within a specified time

scale (Øvretveit, 1992a; Rassi & Fino-Szumski, 1994; Williams, 1994; Schalock, 1995). In line with the requirements of quality management, work and personal objectives should focus on client satisfaction and outcome.

Once the organization's objectives are clearly stated, the practice environment should be surveyed to determine how the goals and objectives could be best implemented. The practitioner needs accurate information about the practice environment in order to convert goals and objectives into action. Information about the practice environment is obtained from environment scans.

2.2.3 Environment scan

The environment scan is usually done in the form of a so-called SWOT (Strengths, Weaknesses, Opportunities and Threats) analysis. Brooks (1995) states that this is the most useful exercise a practice can undertake to increase the practitioner's knowledge about his or her own practice. The purpose of environment scans and SWOT analyses is to help the practitioner focus on his or her unique circumstances (Armstrong, 1994; White, 1995). It is part of the process of taking ownership and helps the practitioner to translate information into meaningful action.

During the environment scan the practitioner takes note of the realities of the environment with which the practice will be confronted over the next three to five years. In order to be successful in a rapidly changing environment it is necessary to analyze and interpret the practice environment continuously (Maas, 1991; Armstrong, 1994; Brooks, 1995). Quality management requires strategic planning and a calculated, coordinated and comprehensive effort from the entire

organization. A thorough analysis of the environment serves as the grounding for strategic planning.

Environment scans investigate macro and micro practice environments. The *macro environment* consists of the broad health care context in which the practice functions. The *micro environment* includes the task and internal environments of an organization. The following section describes environment scans relevant to the context of a private speech-language therapy practice in South Africa.

i) Macro environment

The macro environment comprises economic, political, socio-demographic and technological categories (Maas, 1991; White, 1995). All health care practitioners in South Africa are acutely aware that these factors have a direct impact on their practices. Health care services all over the world experience changes that are mainly driven and determined by economic considerations. Since the 1994 general election drastic changes have taken place in South Africa. The government's restructuring and transformation of all levels of government have resulted in major changes in health care and education. Aspects of the practice's macro environment such as managed health care programmes and health care legislation have been discussed in chapter 1.

ii) Micro environment

ii a) Task environment

The task environment comprises the suppliers, clients, competitors, referral agents, funding agencies and health care authorities. This is the environment with which the practice directly interacts (Maas, 1991). Every practitioner must

know and understand the community served by the practice. Task environment scanning includes compiling a practice profile to identify and analyze the market from which the practice draws clients. A market analysis will include size, economic trends and the financial status of the practice community (Brown, 1996; Gilligan & Lowe, 1996).

An analysis of the existing client base usually includes aspects like the reasons why clients consult with the practice. It describes the residential and business addresses of clients, funding agencies represented in the client base, and factors like age and sex of clients (Brown, 1994). The practitioner should also identify referral sources and look for ways to expand the referral base.

An important aspect of task environment scanning is an analysis of competitors who may draw clients away from the practice. The practitioner will have to investigate reasons why the competition is able to attract clients. Competing practices may for example offer a better location, extended service networks, lower tariffs and advantageous contracts with funding agencies (Brown, 1996).

A scan of the practice task environment must include a detailed account of all the medical aids and funding agencies the practice is currently dealing with or will be dealing with in future. At the time of writing, there is great uncertainty among speech-language practitioners about the effects that the proposed managed health care system, preferred provider system and the regulation of medical aids will have on our practices. The purpose of the environment task scan is to investigate all these factors and the potential implications for the practice. This enables the practitioner to be proactive and to anticipate changes.

ii b) Internal environment

The internal environment relates to the aspects over which the practitioner has direct control, for example resources (Maas, 1991). One way to define the internal environment is to use the approaches developed by Donabedian. As described in chapter 1, Donabedian realized that the *measurement* of quality posed the greatest challenge to quality improvement in health services. In an attempt to organize all the components of the clinician-patient interaction in a structured framework that can be used to define and measure the quality of care, he identified three approaches to the assessment of quality, namely structure, process and outcome.

The following section describes the analysis of these three concepts in a private speech-language practice environment.

a) Structure

Structure refers to variables pertaining to human, material and organizational resources and inputs into the care process, in other words the resources needed to achieve the defined goals of the practice (Donabedian, 1992). Environment analysis of the structure of a private speech-language therapy practice could examine **people, equipment** and **environment** criteria in the following way:

People

People refers to the training, competence, skills and qualifications of the practitioners and auxiliary staff members, such as receptionists and bookkeepers. The qualifications and competence of speech therapists in South Africa at entry level into the profession are strictly controlled by the various university departments and the South African Health Professions

Council. After graduation, however, no form of licensing or accreditation exists (Tuomi, 1993). It is left to therapists to continually upgrade, develop and expand their knowledge and improve their clinical skills by attending workshops and joining interest groups, and through self-study and postgraduate training. A thorough SWOT analysis will help the practitioner to focus on his or her own strengths and weaknesses as far as clinical skills, knowledge and expertise are concerned. Once weak points have been identified the practitioner can make a concerted effort to amend these. Strengths can be expanded and developed into special interest areas and unique selling points.

The service's clients are also included in the *people* component. The purpose of the environment scan is to provide the practitioner with a profile of the clientele served by the practice. The true client-centered practice will be knowledgeable about the practice's client characteristics and take that into consideration when formulating practice policies. A practice establishes itself in the minds of clients through segmentation and differentiation (Øvretveit, 1992a). Without sound information about the client profile, the practitioner will find it hard to apply these principles to the practice. The concepts *segmentation* and *differentiation* of a service will be discussed in greater detail in the section pertaining to strategic planning.

Equipment

Equipment refers to all the items that are essential in the provision of speech-language services in a private practice. These include all the material needed to assess and treat speech-language clients, such as therapy programmes, language tests, toys, books and audiovisual equipment. The

client-centered practice will ensure that its equipment is appropriate and suited to the needs of its clients. Private practitioners are often targeted by suppliers of educational toys, programmes and equipment, and sometimes find it very tempting to buy the latest educational gadgets or therapy programme. A sound analysis of existing practice equipment and the specific needs of the practice's clients will provide the practitioner with valuable guidelines for upgrading old equipment and sensible acquisition of new material.

Office and computer equipment for record keeping and financial administration are also included in this section. Since these aspects are crucial for quality management, every practitioner must ensure that the practice has the necessary equipment to facilitate efficient and effective administration. Few private speech-language practices in South Africa can afford to delegate all administrative duties to secretaries, bookkeepers and practice managers. Computer software packages for data collection, administration and accounting purposes can help practitioners to develop efficient and cost-effective systems that could save time and money. The new emphasis on data collection in managed health care requires sophisticated information systems. Managed health care systems usually analyze practice data by means of utilization reviews. This requires the creation of databases containing data pertaining to the outcome and cost-effectiveness of services.

Environment

Environment refers to the physical environment required to meet the needs of clients and therapists. Environment requirements from the clients'

perspective include factors such as adequate and safe parking, comfort of the waiting room, reading material in the waiting area, seating arrangement suitable for both adults and children and toilet facilities. The quality conscious and client-centered practice will realize that the practice environment should reflect the practitioner's regard and respect for his or her clients. Crosby (1979) reminds us that everyone is a client. The practitioner should look at the practice environment from a client's perspective and decide if the environment complies with his or her own expectations.

b) Process

According to Deming (1986), poor quality of service is usually the result of badly designed and operated processes, and not lazy or incompetent workers. The quality mature practice focuses on the quality of every aspect in the process with the satisfaction of the client in mind. Quality management process provides practitioners with skills and methods to analyze quality problems and empowers them to make the necessary changes in the process.

Applied to a private speech-language therapy practice, *process* includes all the activities designed to manage the client's identified need or problem. Since process implies purpose, a desired product or outcome is expected to result from the process. The purpose of process in speech therapy would therefore be improved communication status as perceived by *both the practitioner and the client.* In keeping with the *total* management of quality, the practitioner will pay attention to every aspect of the interaction between client and therapist.

The satisfaction of the client with the quality of care is an important goal in health care. The interaction and rapport between the client and the therapist are crucial factors in the ultimate satisfaction of the client and therefore important quality factors. Even if the client's contact with the practice starts in the form of a referral note from the doctor, perceptions and expectations that could directly influence the outcome of therapy are already forming in the client's mind.

Some practitioners focus only on the actual therapeutic interaction, because that is seen as the "most important" part. It is, however, contrary to the principles of quality management to consider certain aspects of the process more important than other parts. Quality management extends to every process in the service. Neglect of the financial and administrative aspects of the practice will have serious implications for the effective and efficient functioning of the practice. Many quality management programmes fail because of lack of a clear management or business strategy. Practitioners must realize that establishing a private practice involves more than clinical competence. Katz & Gain (1995) coined the phrase "practice abusers" to describe medical practitioners who fail to install proper business and management systems. An honest appraisal of business and administrative processes will provide valuable guidelines to enhance the management of total quality in the practice.

c) Outcome

Outcome refers to the benefit derived from contact with the practice. It comprises the benefits received from each of the component procedures of the service. The effects of diagnostic procedures, treatment and home programmes must be examined carefully to determine their relation to the eventual outcome of the

intervention. Outcome measurement is the ultimate indicator of both the quality of care and the benefit derived from the services. Speech-language therapy can only be regarded as effective if it produces a measurable outcome or effect; namely improvement in the client's communication status.

The environment scan must include an analysis of the outcomes produced by the practice as well as the methods used to measure and document outcomes. Policy makers and funding agencies demand outcome data to demonstrate the relationship between a treatment procedure and its outcome. They want proof of outcomes, defined in terms of benefit to the client and cost-effectiveness (Boston, 1994; Wilson & Goldschmidt, 1995). There is a general lack of evidence-based outcome data in speech-language therapy and practitioners find it hard to justify most treatment programmes on the grounds of field-based outcome data (Frattali, 1990; Heaton, 1992; Boston, 1994).

The information gained from the environment scans are used to compile a SWOT analysis. A detailed review of the SWOT analysis will enable the practice to develop new or improved strategies to deal with the demands of the environment.

iii) SWOT analysis

Analyzing strengths, weaknesses, opportunities and threats that are relevant to the practice enables the practitioner to be proactive and to develop contingency plans. It gives perspective and aim to provide answers to questions like "What am I good at?" and "How can I improve?". Compiling a SWOT analysis heightens the practitioner's awareness and facilitates recognition of weak areas. It helps the practitioner to explore every aspect of the macro and micro environment and

to interpret information appropriately. It helps the practitioner to identify unique selling points that distinguish his or her practice in the minds of current and future clients. It provides opportunities for change and empowers the practitioner to take control over every aspect of the service (Maas, 1991; Brooks, 1995; Gilligan & Lowe, 1996). The implementation of environment scans and SWOT analyses and the application to a speech-language private practice will be discussed in detail in chapter 3.

As stated before, there is a lack of outcome data and evidence-based practise in speech-language therapy. These shortcomings are partly due to the lack of appropriate information technology and systematic data collection procedures in most practices. The use of quality tools is one way in which aspeech-language therapy practitioner can address the lack of outcome data in his or her practice.

iv) Quality tools

Statistical tools form an integral part of quality management. The use of measurement, analysis and documentation is a hallmark of quality management. Documentation is usually in the form of analytical charts. The following seven analytical charts have been historically part of the quality management movement: Histograms, Pareto charts, scatter diagrams, flow charts, control charts, run charts and fishbone diagrams (Jaeger *et al*, 1994; Williams, 1994; Wilson & Goldschmidt, 1995). Visual presentations of quality management information can be a valuable tool in the speech-language practice. They depict information in an accessible way and most trained people can comprehend their meaning easily and quickly. Properly constructed and correctly applied, graphs can present the time-pressed practitioner with important information at a glance (Katz, 1994). Most computer word-processing programs can turn practice data

into a variety of graphs and innovative practitioners with a modicum of computer skills can use these facilities. Manually drawn graphs, although more time-consuming, will serve the purpose just as well.

The use of flow charts to evaluate processes is a typical tool of quality management. Flow charts can be used to measure client satisfaction by analyzing the total process from the client's point of view (Jaeger *et al*, 1994; Williams, 1994; Wilson & Goldschmidt, 1995). Patients are taken through all the phases of treatment starting with their initial contact with the practice, and their satisfaction with every phase is recorded. In this way it is possible for the practitioner to determine where the service, from the client's point of view, can improve. This method embodies a client-centered approach as well as the basic principles of quality management.

The phase following the environment scan and SWOT analysis entails an analysis of existing strategies. The information gained from the SWOT analysis enables the practice to analyze whether existing strategies comply with the needs and expectations of the practice environment. This analysis in turn leads to the development of new or improved strategies to deal with the demands of the environment.

2.2.4 Analysis of existing strategies

The practitioner has to determine the relevance of existing practice policies and strategies in the light of the environment scan and SWOT analysis. It is important to build on previous successes and failures and to modify existing strategies rather than create parallel structures (Abrams & Siferd, 1994).

The environment scan should provide enough information about the task and internal environments to enable the practitioner to develop a market-orientated strategy for the practice. It should also provide relevant information about the macro environment to enable the practitioner to anticipate changes and major developments that could affect the practice. An analysis of existing services and strategies usually starts with defining and analyzing all the different sub-services offered by the practice. Øvretveit (1992a) describes the following three concepts that could be used in analyzing current services and devising a market strategy: *Service success equation, segmentation* and *differentiation*. Each aspect will be briefly described and discussed in terms of its application to a speech-language practice.

i) Service success equation

The service success equation can be described as the relationship between the client's needs and the practice's responses, in other words what clients want and the price they are prepared to pay for it, and the practice's capability to respond. Øvretveit (1992a) warns that providers often err in defining a need in terms of their ability to satisfy it. The following example illustrates this point:

> A speech-language therapist starting a new practice identifies her expertise in aphasia therapy as a "strength". Analysis of the practice task environment, however, indicates that there is already an experienced therapist treating all the neuropathology patients in the area. Moreover, this therapist is situated in the only private hospital in the area, and all the neurosurgeons and physicians with consulting rooms in the same building routinely

refer all patients with aphasia to her. Instead of assuming that patients with aphasia will form a significant segment of her practice just because she is able to treat them, the new practitioner will have to do some careful planning to secure a section of the existing market. She may secure referrals from a new physician moving into the area or negotiate with the other therapist for a share of the market. She might even have to reconsider her "strength".

Another common mistake made by practitioners in the private sector, is to identify the needs of potential clients, without considering their ability to pay for it. Øvretveit (1992b: 183) describes expansion into a market with high needs but no purchasing power "commercial suicide". One of the aims of the task environment scan is to familiarize private practitioners with their client's financial status.

ii) Segmentation

A service cannot be all things to all people. Groups or segments of clients must be targeted, their needs determined and a service concept developed that provides a competitive advantage for the provider as perceived by the client (Øvretveit, 1992a, 1992b). Although this idea makes perfect sense from a commercial perspective, it cannot always be applied to speech-language practices. Few speech-language private practitioners can afford to specialize too exclusively in one area of speech-language disorders. Most practitioners tend to be generalists, treating a wide range of disorders, while some combine audiology with speech-language therapy. Some therapists work in remote areas where they are the only providers in a vast area and are forced to be generalists.

iii) Differentiation

A service establishes itself in the minds of clients and referral agents through differentiation (Øvretveit, 1992a, 1992b; White, 1995). Therapists can be generalists and still target and attract a specific segment of the market by developing a special interest area, like stuttering or language-learning disabilities. In that way they market their special interests as unique selling points and gain a competitive edge as perceived by clients and referral agents. Øvretveit (1992a, 1992b) warns that differentiation refers to client perceptions and not what *practitioners* think distinguishes their services from those of competitors. The practitioner must have evidence of how important these aspects are to clients, and the only way to find out is to continually ask clients. Needs assessments and client satisfaction questionnaires are two ways of learning more about the perceptions and expectations of clients.

Ethical regulations in South Africa forbid speech-language therapists to advertise or market themselves as specialists in certain fields. Every private practitioner knows, however, that a major source of referrals is word-of-mouth referrals from satisfied clients. Practitioners soon become established as experts in certain fields in the minds of clients and referral agents without having to resort to direct marketing.

It should be noted that client perceptions are the crucial factor in all three the above-mentioned marketing strategies. Quality is a powerful positioning strategy, but only if it is defined in terms of what is important to the client (Cunningham, 1991). A quality mature practice, where client satisfaction is a decisive component, will differentiate itself through the quality of its services, both in terms of outcome and client satisfaction. Existing strategies for quality management should also be

examined in terms of structure, process and outcome. Key concepts when comparing existing services with the stated objectives of the quality mature practice are efficiency, cost-effectiveness, outcome and client satisfaction. Analyzing existing strategies and measuring these against stated objectives lead to the next phase, which is defining and selecting key strategic issues.

2.2.5 Selection of key strategic issues

A proper analysis of the strategic issues identified in the environment scan and SWOT analysis is crucial in the selection of key features. Øvretveit (1992a) notes that it is a common mistake to select too many key features. It is an indication that the practice's quality priorities are not clearly or accurately defined. This may lead to a haphazard approach to quality improvement and make it difficult to measure progress.

Strategic issues can be defined by identifying the factors that cause the greatest dissatisfaction. The Pareto principle states that 80% of results are caused by 20% of causes (Williams, 1994). Applied to quality management, this would mean that 80% of quality problems are the result of 20% of causes. A practitioner may find that a small part of his or her practice management, for instance client accounts, is responsible for the majority of complaints and a major source of client dissatisfaction. The practitioner can use the Pareto principle to determine which aspects to regard as key quality features. Once defined, new or revised strategies can be developed to eliminate causes of dissatisfaction in a structured and comprehensive way.

Another way to identify priority problems is in terms of cost. Quality management defines the cost of quality as the cost of not doing things right the first time (Crosby, 1979). The practitioner determines which problems cost the practice the most, which problems cost the most to solve and also which problems are least costly to solve (Øvretveit, 1992a). Quality tools that can be used in this process include process flow diagrams, Pareto analyses and fishbone diagrams (Bassett, 1993; Jaeger *et al*, 1994; Williams, 1994).

Key strategic issues can also be selected according to the opportunities and threats identified in the environment scan and SWOT analysis. The practitioner can use information about opportunities to develop unique selling points that distinguish his or her practice in the minds of current and future clients. The selection of strategies that deal with threats to the practice enables the practitioner to respond in good time and to avoid or contain potential harm to the practice.

The identification and definition of key strategic issues provides the practitioner with a starting point in the development of new or revised strategies to improve quality management in his or her practice.

2.2.6 Development of new or revised strategies

Analysis of strategic issues should lead to the development and implementation of new or revised strategies to resolve quality problems and eliminate their root causes (Goodman & Carlisle, 1994; Wilson & Goldschmidt, 1995). Strategic planning is a systematic, analytical approach, which reviews the organization as a whole in relation to its environment. The aim is to create a viable link between objectives, resources and environment opportunities (Armstrong, 1994).

All the information gained from the preceding phases of quality management will be wasted if it is not used to implement constructive change. The central failing of quality measurement according to Luthert & Robinson (1993), is that it is rarely used to change behaviour. Change, is described by Kanter (1984) as "the process of analyzing the past to elicit the present actions required for the future" (quoted in Armstrong, 1994: 47).

To implement change successfully in a practice, it is necessary to involve everyone in the practice, to communicate effectively and to establish clear goals. Changes are more easily accepted by workers if they are perceived to be consistent with the mission and values of the organization. There is often resistance to change because people are easily threatened by change (Goodman & Carlisle, 1994). According to Beer *et al* (1984, quoted in Armstrong, 1994) it is a fallacy to believe that changed attitudes are all that is needed to change behavior. They state that individual behaviour is shaped by the organizational roles that people play. The most effective way to change behaviour is to put people into a new organizational context which imposes new roles, responsibilities and relationships on them. New roles combined with changed attitudes lead to meaningful changes in behavior. A practitioner who accepts that quality management requires him or her to fulfill a completely new role, that of quality manager, will be more likely to implement meaningful changes in his or her practice.

The speech-language practitioner who is serious about quality maturity will be willing to, if required, change every aspect of his or her traditional approach to therapy and clients. The traditional practitioner-centered approach in speech-language therapy is inconsistent with one of the major goals of quality maturity, namely, client satisfaction. Practitioners must understand that quality

programmes mean nothing if they do not lead to behavioral changes that in turn result in a measurable improvement in the quality of services.

The quality mature speech-language practice is a learning practice. A learning organization constantly reframes the world and its own part in it. A learning organization creates an environment in which everyone is actively encouraged to learn, to ask questions, to seek new theories and to test them. Even more importantly, everyone is encouraged to develop his or her "negative capability", i.e. the ability to learn from mistakes (Armstrong, 1994: 77).

Reflection is another hallmark of a learning organization. It can be a powerful tool in the development of professional knowledge and continual quality improvement. Reflection enables the practitioner to examine the components of a situation, identify existing knowledge, challenge assumptions, and imagine and explore alternatives (Kelly, 1995). The reflective practitioner regards every clinical situation as a learning opportunity and continually seeks more effective ways to serve his or her clients.

The implementation of new or revised strategies requires changes. A speech-language practice which is capable of strategic and operational change will guarantee its survival, because it will be able to respond appropriately and proactively to threats *and* opportunities. Following the development of revised or new strategies, the practice must decide on the critical success factors related to the achievement of objectives and the implementation of strategies.

2.2.7 Development of critical success factors

Quality needs to be measured to be improved, and during this phase of the quality management programme the practitioner will decide on criteria to serve as quality indicators. These criteria are usually in the form of practice standards. Quality is then defined and measured in terms of conformance to these standards. Standard setting is an important part of quality management. It articulates professional responsibility, increases professional confidence and helps to create a practice culture of empowerment and accountability (Luthert & Robinson, 1993).

Standards and criteria developed by and for a specific practice should not be confused with professional guidelines or critical pathways developed by professional bodies or academic institutions. The purpose of standards developed by professional bodies is usually to codify current knowledge through peer review into extensive guidelines about "best practices". These standards are usually based on research findings and state-of-the-art practice and are developed through a peer review process (Abrams & Siferd, 1994; Curl, 1994; Harrison & Frattali, 1994; Shekim, 1994; Wilson & Goldschmidt, 1995).

Practice standards are usually based on professional standards, but no set of ready-made, external standards can replace those developed specifically for the practice by the practice. Standards pertaining to quality management in a quality mature practice, are developed by the practice itself as part of a deliberate chain of actions. They apply exclusively to that practice, because they reflect the level of professional evolution in the practice. Practice standards evolve in accordance with the practice's unique vision, mission and stated objectives, against the background of the practice's specific environment. Standards compiled by experienced clinicians

in an established practice will not necessarily be appropriate or relevant in a new practice staffed by recently qualified therapists.

Øvretveit (1992a) states that a good standard should be measurable, understandable, behavioral (describe an action) and achievable. The key quality features selected in the previous phase are the starting point for the development of standards. If properly selected, the key quality features are the factors that would, once changed, result in the biggest quality improvement.

The essence of each key feature must be qualified and quantified, in other words standards should be specific and measurable. Armstrong (1994) warns that measurement should relate to results and not efforts, in other words outcome and not process. General and abstract statements about standards are best replaced with standards that can be measured and observed. The standard should be specified in terms of when it would be regarded as achieved, to enable the practitioner to decide how performance and achievement of the standard will be measured (Øvretveit, 1992a; Brooks, 1994a).

The development and implementation of a practice standard can be illustrated by the following example from the author's practice:

> Long waiting times for direct payments from a certain medical aid were identified as a key problem. This resulted in cash flow problems as well as additional administration in the form of repeated accounts. An analysis of the task environment revealed that the medical scheme issues payments to providers on the fifth of every calendar month. An analysis of existing practice policy

> revealed that practice accounts were sent to the aid "more or less at the end of the month". This resulted in accounts often reaching the medical aid *after* the fifth, thereby extending the waiting time for payment by five to eight weeks. The practitioner then decided to revise the practice policy by developing a new standard to ensure that the medical aid received accounts well before the 5th. To allow for postal delays and processing by the medical aid it was decided to post accounts on the 22nd of each month. A vague and unspecified standard like "accounts must be sent out in time" was replaced with a specific practice standard - "all accounts will be *posted* on the 22nd of each month".

Achievement of this standard can be measured by checking if accounts are indeed posted on the 22nd of each month. If repeated measurement indicates that this standard is not achievable, all the factors should be analyzed again and the strategy revised till the problem is solved. Measurement should also indicate if posting accounts on the 22nd indeed results in earlier payment from the medical aid. If repeated measurement indicates that the key problem, i.e. late payment, is still not resolved, other causes should be examined till the problem is solved to everyone's satisfaction.

Øvretveit (1992a) cites certain mistakes that often occur when practices formulate standards. One common mistake is the formulation of standards that are easy to specify, but are not related to critical strategic issues. Another mistake is to try and formulate standards for everything, too early. Meaningful standards take time to develop and are part of the continual quality evolvement of the practice. Staff

members may resent externally imposed standards and may interpret the over-specification of practice standards as bureaucratic control.

The desire to be self-correcting and self-regulating is a basic element of professionalism. Taking part in quality management can create a stimulating practice environment where clinicians are challenged to resolve quality problems and experience professional growth (Ellis, 1989). The development of standards to direct and measure behaviour is a powerful expression of self-regulation and accountability in any practice.

The next phase in the development of the quality management programme is the development of practice policies. The standards developed by the practice are the foundation of new or revised practice policies.

2.2.8 Development of new or revised practice policies

Practice policies are operational, resource and project plans designed to achieve strategies and meet critical success factor criteria (Øvretveit, 1992a; Wilson & Goldschmidt, 1995). Applied to a speech-language practice, practice policies prescribe the interventions that maximize improvement in the client's communication status consistent with his or her preferences and the practice's resources.

In industry and manufacturing, product specifications are used to define quality. Manufacturers produce products to specifications with as little variance as possible, i.e. the so-called "zero defect". High quality products are those that meet product specifications, satisfy customers' needs and are perceived by customers to represent good value for money (Crosby, 1979; Wilson &. Goldschmidt, 1995). Health care and speech-language therapy, as explained before, are production

functions. Health care facilities produce improved health and speech-language therapy practices produce improved communication. To improve production processes requires specification of products. These specifications are the practice policies.

Practice policies differ from practice standards. Standards are principles that specify action and provide rules for judging whether or not clients were treated appropriately. Standards form the basis of quality assessment. Practice policies, on the other hand, are the basis for practising. They provide direct guidance or instructions to providers about how individual clients should be managed. Practice policies are explicit statements on how to diagnose, treat and otherwise manage clients, and what to expect as a result. Factors such as client preferences, socio-economic constraints and value tradeoffs are taken into account. Practice policies include more than the technical aspects of care; they specify what should be done in specific circumstances and are also influenced by non-technical aspects, for example cost-effectiveness of an intervention (Wilson & Goldschmidt, 1995).

The formulation of practice policies usually starts with the collection of relevant guidelines from professional bodies and academic institutions. These guidelines are then evaluated in the light of the practitioner's experience and the practice environment, and either adopted or adapted to serve the practice requirements. Wilson & Goldschmidt (1995) state that practitioners often object to policies because they are regarded as cookbooks. Practice policies must reflect the complexity of speech-language therapy and leave room for interventions to be tailored to the specific needs of clients.

Policies must however, clearly state the objectives they intend to achieve and the steps to be followed to achieve these objectives. The purpose of speech-language practice policies is to improve client communication status. They should therefore be highly specific and make explicit assumptions between clinical processes and stated outcomes. The following example describing a treatment programme illustrates this point:

> "My average stutterer before treatment stutters on 12% of his syllables; immediately after the intensive phase of his treatment, he will stutter on 0.2%, and one and two years later he will stutter on about 2% of his syllables" (Andrews, 1984, quoted in Onslow, 1996: 36)

The development of practice policies based on quality management principles is an important step in the quality evolution of a practice. Quality management is the result of practice policies that are implemented according to standards set by the practice. The formulation of practice policies, however, must be followed by a proper policy implementation plan to ensure that the policies are actually implemented in the way that was planned.

2.2.9 Formulation of a policy implementation plan

All strategic planning should include an implementation plan. The purpose of the policy implementation plan is to stipulate how the new or revised practice policies are to be implemented in the practice. This is a simple but formal document that describes what is to be done, who is responsible for doing it, according to what timetable, with what resources and the expected results. The implementation plan should also specify the means to measure results and costs (Jaeger *et al*, 1994; Wilson & Goldschmidt, 1995).

Quality management principles require the practitioner to demonstrate the effectiveness of the practice's policies. The policy implementation plan specifies the anticipated results or outcome of the practice policies as well as the date when the outcome of the policies will be measured. The results of the outcome measurement are then formally described and evaluated against the quality criteria stipulated in the preceding phases of the quality management programme.

2.2.10 Policy outcome measurement

The purpose of this step is the validation of practice policies. Outcome measurement is the ultimate indicator of both the quality of care and the benefit derived from the services. Outcome refers to the benefit derived from contact with the practice and the benefits received from each of the component procedures of the service. The effects of diagnostic procedures, treatment procedures and home programmes must be examined to determine their function in the eventual outcome of the intervention.

A practice audit is one form of outcome measurement pertaining to quality management in a practice. An audit is a systematic and scientific approach which compares the results of what was actually done, with the goals and objectives of the practice (Øvretveit, 1992a, 1992b; Bowling, 1996; Miles *et al*, 1996). The purpose of the audit is to operationalize the quality improvement spiral. A data-based management system provides information that can be used for both outcome-based analyses and formative feedback that can be used to increase the effectiveness and efficiency of programmes and procedures (Schalock, 1995). Data obtained from the audit is evaluated against the stated goals and objectives of the practice

and then used to revise or update practice policies if and where deemed necessary.

The outcome measurement system developed by the practice will depend on and reflect the level of quality maturity in the practice. Wilson & Goldschmidt (1995) state that structured quality improvement strategies, if implemented successfully, have greater potential to improve health care's cost-effectiveness in the next twenty years than any other technology. One of these strategies, structured outcome measurement, examines long-term outcomes of interventions and the extent to which conformance to practice policies actually improves the health or communication status of clients. Few private speech-language therapy practices have the resources to do research and data collection at this level. This fact should, however, not detract from the demand for accountability for the results or outcome of their services.

2.2.11 CONCLUSION

A business plan is a management tool which focuses on the direction and defined purpose of the practice. In chapter 2 the author described the basic principles in the development of a business plan for an organization. It was attempted to apply these principles to the context of a speech-language therapy practice. Chapter 3 endeavors to demonstrate and evaluate the initial stages in the development of a business plan for the author's private speech-language therapy practice

CHAPTER 3

DEVELOPMENT AND IMPLEMENTATION OF A QUALITY MANAGEMENT SYSTEM IN A PRIVATE SPEECH-LANGUAGE THERAPY PRACTICE

3.1 INTRODUCTION

A quality management programme was instituted in the author's private speech-language therapy practice in February 1996. The following chapter describes the initial stages of the development of the programme and all the phases of its implementation. It was attempted to apply the principles of quality management to speech-language practise. A business plan that was based on quality management principles, client-centered practise while conforming to the needs and requirements of the specific practice, was developed, instituted and evaluated.

The first step was the formulation of vision, mission and value statements to define the aspirations, purpose and direction of the practice. These statements were formulated in accordance with the author's working definition of quality and the principles of quality management.

3.2 VISION OF THE PRACTICE

The practice aims to become a client-centered, quality mature practice. This will be achieved by assuring that all the activities within the practice are driven by a concern with quality, professional standards and respect for the well-being, needs and expectations of clients.

3.3 MISSION OF THE PRACTICE

The practice is committed to quality management and aims to attain quality maturity. This will be achieved through systematic planning and development of all aspects of the practice to improve the communication status of its clients, at the lowest cost, to the satisfaction of both the practitioner and the clients.

3.4 VALUES

The infinite worth of every client irrespective of age, race or creed is valued. The practice aspires to serve clients with dignity, compassion and love in accordance with the principles of client-centered practise.

3.5 GOALS AND OBJECTIVES

Goal 1

To improve the communication status of every client served by the practice, in a cost-effective way, to the satisfaction of the client and the practitioner.

Objectives

To design, implement and evaluate every aspect of the service in order to increase the client's communication status maximally, at the least cost.

Goal 2

To promote and measure client satisfaction with the services rendered.

Objectives

To design, implement and evaluate every aspect of the service in order to increase the client's satisfaction with the service.

Goal 3

To establish an effective, efficient and cost-effective practice management system.

Objectives

To design, implement and evaluate every aspect of the practice management in order to enhance productivity, eliminate rework and reduce costs

3.6 ENVIRONMENT SCAN

3.6.1 Macro environment

The current economic climate has had a direct impact on the practice. Retrenchments, high interest rates and high inflation rates all contribute to a decline in the disposable income of the practice clientele. This leads to fewer people being members of medical schemes and fewer people being able to afford private speech-language therapy. It was found that people increasingly inquired about speech-language therapy rates and whether medical schemes pay for it. A number of clients stated that they could only afford therapy if the practitioner was willing to wait for payment from medical schemes.

As a result of the weak rand, exchange rates are unfavorable and this makes imported books, tests and practice equipment very expensive. Regular increases in postage fees contribute to escalating practice management costs.

Political changes in South Africa resulted in a shift in the ethics of health care provision. Health care services are currently in a state of flux. New legislation has resulted in changes in all aspects of health services in South Africa. The introduction of managed health care could have far-reaching implications for private

speech-language therapy practices. At the time of writing, practitioners are still waiting to see how these changes will affect their services.

3.6.2 Task environment

i) Clients

A client profile was compiled using data from 197 clients seen in the practice from 1994 - 1996. The information was organized in terms of disorders, age, location, gender and home language preference.

a) Disorders

The practice deals with the following disorders: auditory processing disorders, articulation and phonology, developmental language disorders, learning disorders, fluency disorders, tongue thrust and voice disorders. Figure 3.1 illustrates the distribution of the various disorders treated in the practice.

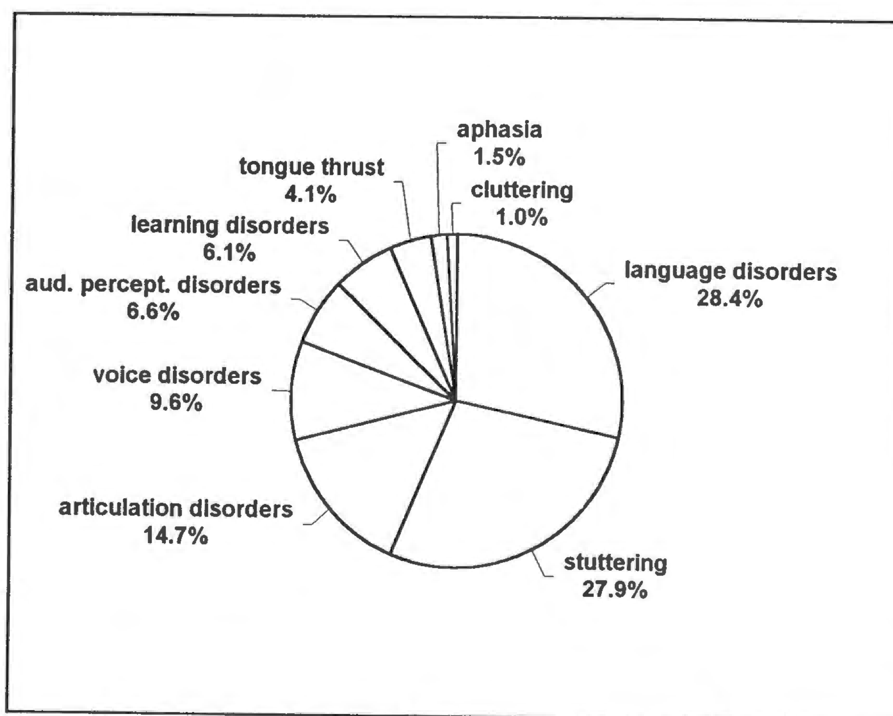

Figure 3.1 Speech-language disorders treated in the practice 1994-1996 (197 cases)

Some clients presented with more than one problem, for instance language *and* phonology problems. The practitioner identified the most prominent problem in clients with multiple disorders, and classified them according to that. Cluttering referred only to clients who were diagnosed as pure clutterers. Stuttering clients with a cluttering component were classified as stutterers. The high percentage of fluency disorders (28, 9%) seen in the practice is a reflection of the therapist's special interest in stuttering and cluttering. The practitioner is also the only therapist treating tongue thrust and infantile swallowing disorders in the area. Two orthodontists in the area refer all clients with these problems to her. Three aphasia clients were treated in 1994, but all subsequent aphasia cases were referred to a colleague. The main reason for not treating clients with aphasia was that the practitioner, being in a solo practice, could not manage home and/or hospital visits.

b) Age

Figure 3.2 illustrates the distribution of clients according to age. It can be seen that preschool children comprise half the practice's clients. Adolescents comprised the smallest group (4,1%). The majority of clients (82%) were under twelve years of age. This fact has important implications for all aspects of the practice, for instance planning of services, buying equipment, tests and designing of the therapy room.

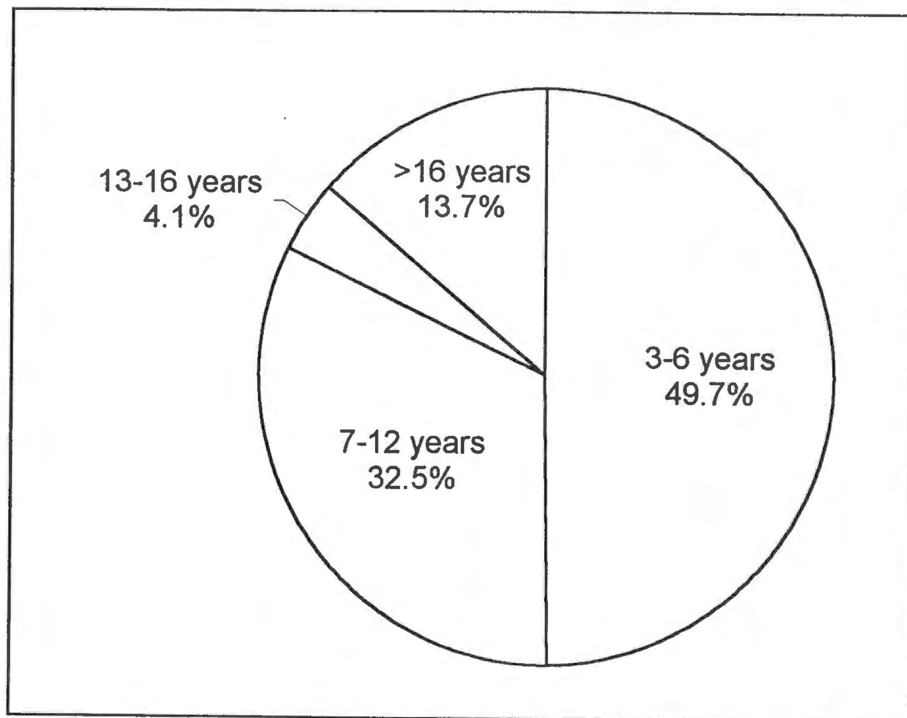

Figure 3.2 Client age groups in the practice 1994-1996 (197 cases)

Another analysis was made to determine the distribution of disorders in the various age groups. The results of this analysis can be seen in table 3.1. It is clear that the majority of the practice's clients are preschool language disordered children (51) and preschool children with articulation disorders (24). A significant number of preschool children presenting with fluency disorders (21) were treated. The practitioner is an active advocate of early intervention in stuttering and uses every possible opportunity to convey the importance for early intervention to parents, teachers and doctors.

Table 3.1: Speech pathology in age groups as seen in the practice 1994-1996

SPEECH DISORDER	AGE (years)				ALL AGES
	< 6	7-12	13-18	>18	
Stuttering	21	20	6	8	55
Cluttering	0	2	0	0	2
Language disorders	51	5	0	0	56
Learning disorders	0	12	0	0	12
Voice disorders	1	3	0	15	19
Articulation disorders	24	4	1	0	29
Tongue thrust	0	6	1	1	8
Auditory processing disorders	1	12	0	0	13
Aphasia	0	0	0	3	3
TOTAL	**98**	**64**	**8**	**27**	**197**
%	**49.7 %**	**32.5 %**	**4.1 %**	**13,7%**	

c) Location of clients

An analysis of the practice profile was made to determine the areas from where clients are drawn. The results are shown in figure 3.3. This figure was compiled by categorizing clients according to post codes. It is clear that nearly half of the clients lived in Durbanville. This means that most clients were drawn from within a radius of 10 km from the practice. It is also the area in which three new speech-language therapy private practices opened in 1997.

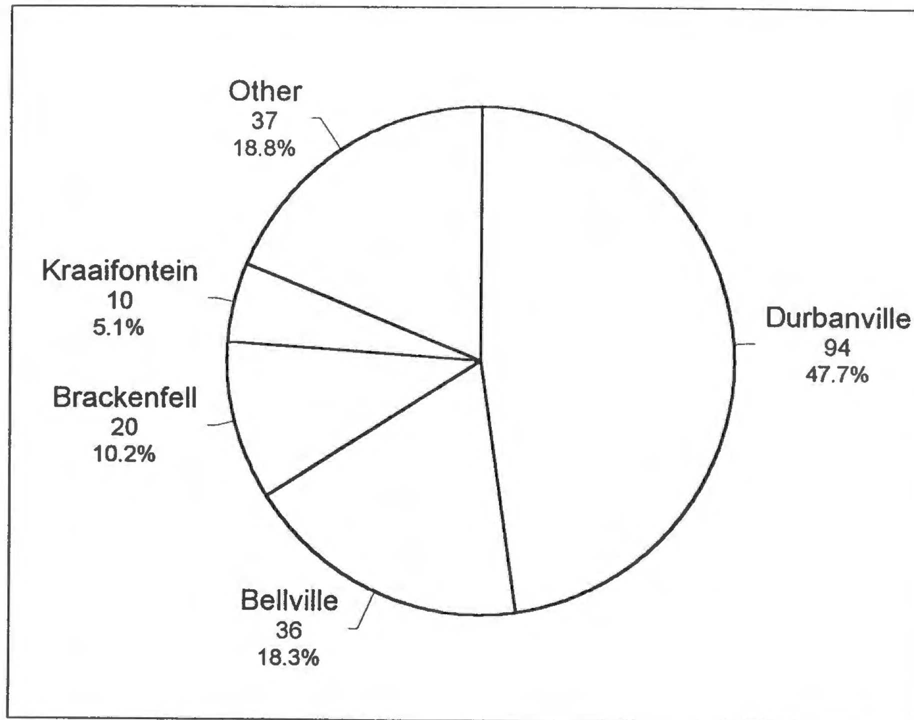

Figure 3.3 Location of the practice's clients (n = 197)

d) Gender

As far as gender is concerned, the client profile indicated that 37% of the clients were female and 63% were male. This finding corresponds with the generally accepted notion that more males than females have communication disorders.

e) Home language

The language distribution among clients indicated that 74% were Afrikaans speaking and 26% English speaking. This is an accurate reflection of the language composition of the community in the area served by the practice. Since the practice was established in 1988, the practitioner has treated only one patient whose first language was not Afrikaans or English. This client was a foreign visitor and spoke English fluently. As far as language, culture

and socio-economic status are concerned, the practice clientele is a homogeneous group.

ii) Referral agents

Clients were referred by medical practitioners, pediatricians, orthodontists, teachers, psychologists, other speech-language therapists, occupational therapists, physiotherapists and former patients. On one occasion a client was referred by the practitioner's veterinarian.

A scan of the practice data indicates that most patients were referred by medical practitioners but this is known to be a misrepresentation. Most medical aids require a written referral by a doctor before accounts may be submitted and clients are therefore routinely advised by the practitioner to obtain a referral note prior to treatment. Clients often arrange the referral telephonically with their doctor without a consultation. It is the practitioner's impression that most referrals from medical practitioners are in fact done by the receptionist at the doctor's request. The receptionist selects names from a list containing all the names of therapists in the area.

Although the practitioner had a strong impression that most clients were referred by former clients, this perception could not be substantiated by the practice data. The lack of data concerning referral sources was identified as a definite weakness.

iii) Funding agencies

The task environment scan indicated that the majority (87%) of the practice's clients belonged to a medical scheme. Initially, when the practice was established in 1988, rates recommended by the South African Speech-Language and Audiology Association (SASLHA) were charged. This policy was changed in 1990 and tariffs according to the scale of benefits recommended by the Representative Association of Medical Societies (RAMS) were susequently charged. These rates are less than half the rates recommended by SASLHA. The main reason for changing to RAMS tariffs was pressure from clients who were members of medical schemes. They felt that they were forced by employers to contribute to medical aids and therefore resisted any additional health care expenditures. Several clients frankly stated that they could not afford speech-language therapy if they had to pay the practitioner directly. The medical aid schemes supported their members in this issue and encouraged practitioners to charge RAMS recommended rates. Incentives included allowing practitioners to submit accounts directly to the schemes and direct reimbursement of the practice by the schemes. These measures saved the practice money and drastically reduced waiting times for payment.

Another reason for charging RAMS rates was the fact that the majority of the practitioners in the Western Cape do the same. In an increasingly competitive private practice environment, the cost of therapy is a decisive factor. Clients phone several practices and inquire about tariffs before deciding which practice to consult. A practice charging more than the rates recommended by RAMS will find itself at a disadvantage.

The 197 clients served by the practice between 1994 - 1996 belonged to 59 different medical schemes. Every scheme has its own policy pertaining to speech-language therapy. This lack of uniformity is a major source of administrative problems. The funding agencies in South Africa are currently in the process of major restructuring. Changes in health care legislation and the introduction of managed health care have resulted in name changes, mergers between schemes and changes in benefits provided to members. To the constant aggravation of practitioners, they are seldom informed of changes in procedures and policies that have a direct bearing on their services.

iv) Competitors

This aspect refers to the competition faced by the practice from other practices and services competing for a segment of the market. From 1992 till 1997 the practice was the only private practice in the Durbanville area. According to the client profile, 48% of the practice's clients came from this area. In 1997 three new therapists started working in the area. It is foreseen that more practices will open in the area because the lack of posts in the public sector compels new graduates to enter the private sector.

Two of the practice's competitors are newly qualified therapists and the third therapist previously worked in a provincial hospital for five years. One therapist works in a group practice with psychologists and remedial teachers and the other two are solo practitioners. At the beginning of 1997 two of the new therapists started screening programmes at the all the schools in the vicinity to identify children in need of speech therapy.

3.6.3 Internal practice environment

The internal environment scan was organized according to the framework developed by the Royal Marsden Hospital to define standards of care (Luthert & Robinson, 1993). This framework is based on the model developed by Donabedian in the 1960s. As discussed before, Donabedian developed a model in which quality is measured in terms of *structure, process* and *outcome* (Donabedian, 1992; Luthert & Robinson, 1993). The Royal Marsden Hospital framework redefined *structure*, process and outcome to *resources, professional practice* and *outcome*.

i) Resources

Resources refer to people, equipment and environment factors that have a direct bearing on the quality of services provided by the practice.

a) People

The people aspect refers to all the factors involving people in the practice. The knowledge, competence, training, continuing education and personality of the practitioner are considered to have a direct bearing on the quality of services provided by the practice.

This practice is a solo practice. Another speech-language therapist shared the premises on a part-time basis between 1992 and 1996, but no formal association was formed. Being the only therapist has distinct advantages for quality management purposes. Since the practitioner is responsible for every aspect of the services rendered by the practice, she can direct and control all processes in accordance with her own vision and quality goals for the practice. In larger organizations, for instance group practices, the successful

implementation of quality management depends on the solidarity between members and their mutual commitment to quality goals. The fundamental principle of quality management requires that quality extends to every person and every process in an organization (Crosby, 1979). Quality management in a group practice requires cohesion, coordination, a shared vision and value system. Quality management in a solo practice, on the other hand, depends largely on the commitment and motivation of one person.

Being a solo practitioner has several disadvantages, including the following: *Firstly,* lack of administrative staff requires the practitioner to perform all the administrative duties herself. Apart from being a clinician, she also fulfills the roles of receptionist, typist, bookkeeper and debt collector. According to the principles of quality management the practice administration requires the same careful planning and continual quality monitoring as the clinical services.

Secondly, being a solo practitioner implies that the practice has no income when the therapist is ill, on holiday or attending courses and conferences. The solo practitioner can literally not afford to ignore the need for continually measuring and monitoring the cost-effectiveness of the practice's services.

Thirdly, being in a solo practice can easily generate feelings of isolation. Working alone often deprives clinicians of opportunities for sharing information, informal benchmarking and emotional and professional support. Isolation can also impede the professional development of the practitioner. These factors contribute to burnout and a lack of professional satisfaction and can have a detrimental effect on the quality of the services provided by

the practice. It is therefore important to have regular contact with other therapists and private practitioners through interest groups, workshops, courses and conferences.

The knowledge, competence and training of the practitioner are important quality factors because these aspects have a direct bearing on the process and outcome of treatment and therefore the satisfaction of clients. The author has 18 years' clinical experience. This includes experience in school clinics, special education schools and private practice. She is bilingual and provides therapy in Afrikaans and English. Her clinical experience is appropriate for and consistent with the range of clients and disorders treated in the practice.

Continuing education and training are regarded as important quality factors by the author. She regularly attends continuing education courses, workshops and conferences and reads widely to keep up with developments in the speech-language therapy field. She enrolled in a postgraduate course work programme at the University of Cape Town to renew and expand her knowledge base. Tutoring students in the clinic for stutterers at the Universities of Stellenbosch and Cape Town has proved an excellent way of expanding clinical experience and theoretical perspectives.

The practitioner has two children. This is a distinct advantage in counselling and advising mothers and families. Due to her age and the fact that she has young children, the practitioner is perceived by the mothers of young clients to be knowledgeable, empathetic and experienced in treating preschool children.

b) Practice environment

The practice is situated in Eversdal, a residential area, and forms part of the practitioner's home. It consists of a waiting room, a large therapy room and a store room. It has a separate entrance and the rooms are used only for practice purposes. Off-street parking for two cars is provided. The practice is accessible to disabled persons.

There are two primary schools, two preprimary schools, a high school, three aftercare centres and various play groups within three kilometers from the practice. The area is relatively safe, with a low crime rate.

c) Equipment

Therapy

The practice inventory was updated in February 1996 and redundant items were removed from the inventory. Equipment was evaluated and needs were identified. A client satisfaction questionnaire included a question relating to satisfaction with the equipment used by the practice.

One of the needs identified was a lack of Afrikaans and English reading material graded according to age and reading ability. It was noted that according to the practice profile (figure 3.2) half the clients were preschool children (49,7 %). Toys and games suitable for this group were acquired. A firm decision was made to select new material on a "need to have" as opposed to a "nice to have" basis.

Furniture

The practitioner deemed the waiting room and therapy room furniture comfortable and suitable for the needs of all the clients. It was decided however, to select a darker fabric for the furniture when the furniture is renovated in future.

Administration equipment

The computer hardware was upgraded in 1993 to a 486 system to operate new accounting software. Practice software included Lotus AmiPro, a word-processing program and an invoice system that was written specially for the practice. The invoice system often caused problems resulting in mistakes, complaints from clients and rework. A Pentium CD ROM was acquired at the end of 1995 to enable the practice to upgrade to Windows 95 and install new software, including Microsoft Word, Microsoft Excell, Microsoft Power Point and Microsoft Publisher.

ii) Professional practice

a) Practice management:

A flow chart was compiled to illustrate the practice procedures and protocols for admission, treatment, referral, discharge and follow-up (see figure 3.4). Flowcharts are typical quality management tools and often used to help the practitioner to visualize and organize all the processes in the practice. The practice management processes were reviewed and evaluated in terms of the mission and goals of the practice. Weaknesses were identified and documented and the information was used to formulate revised practice policies.

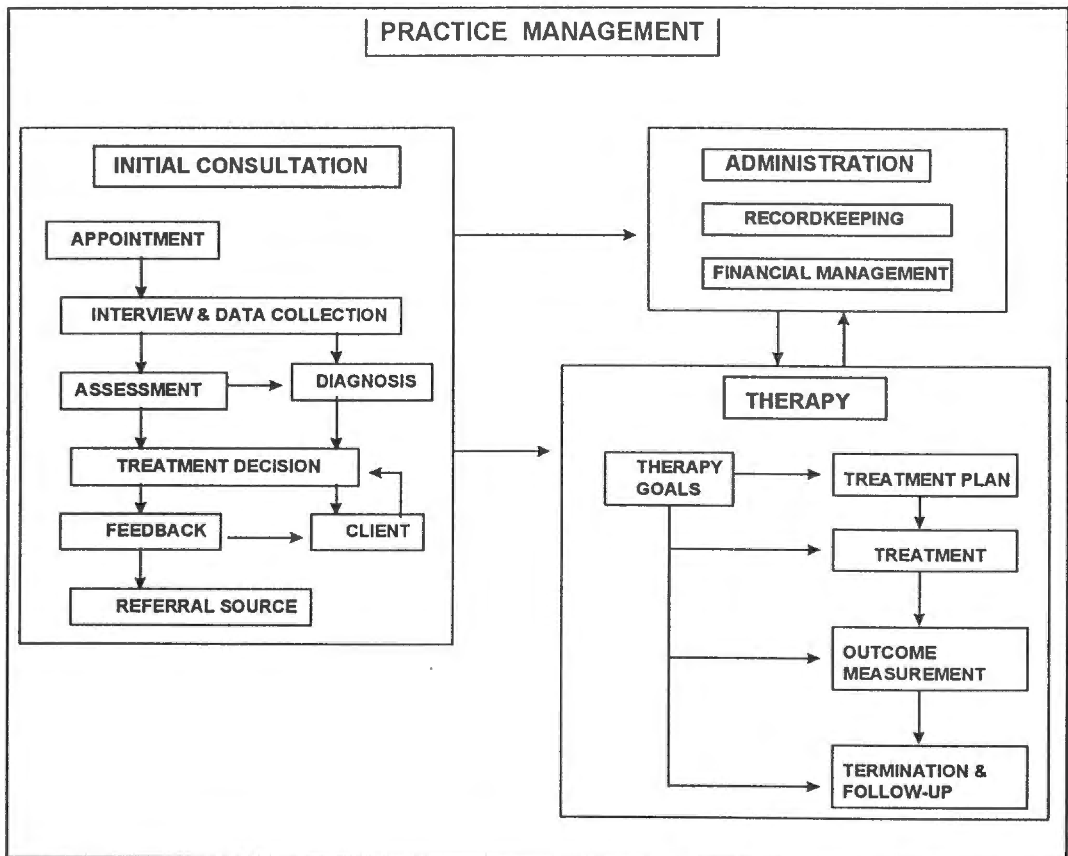

Figure 3.4 Practice management flowchart

Appraisal of the internal practice environment revealed serious deficiencies in the practice management system. The financial administration was not effective and resulted in cash flow problems at certain times of the year. This led to frustration and resentment and had a detrimental effect on professional satisfaction. It was realized that quality management required effective and efficient management of every aspect of the service. The administration system was analyzed by means of a flow chart with the aim to identify and redesign processes to enhance efficiency.

b) Clinical services

The existing evaluation, treatment, referral, dismissal and follow-up procedures were reviewed. Practice protocols consisted of broad statements

stipulating procedures to be followed in treating various disorders. These protocols were reviewed and evaluated in terms of the mission and goals of the practice. The Standards for Professional Service Programmes in Audiology and Speech-Language Pathology (ASHA, 1992) and clinical guidelines pertaining to various disorders were used in the evaluation of practice procedures and protocols (Yoder & Kent, 1988; ASHA, 1995). Reviewing the practice policies against the stated mission and goals of the practice underlined the need for greater focus on client-centered services. Clinical services in the practice conformed to accepted norms and clinical standards but were to a great extent practitioner-centered. It was decided to focus on aspects that would reflect a concern with client satisfaction such as consultation and negotiation with clients and disseminating information.

iii) Outcome

The procedures and protocols implemented by the practice to evaluate outcome were evaluated according to The Standards for Professional Service Programmes in Audiology and Speech-Language Pathology (ASHA, 1992). Outcome measurement consisted of regular evaluation during and after therapy to measure and document progress. Although clients were always consulted about the therapy process and their opinions were valued and respected, it was realized that outcome measurement was based on professional judgment only. Client satisfaction was never seen as a legitimate therapy goal or a quality indicator or an indication of successful outcome.

3.6.4 SWOT analysis

The purpose of the environment scan is to enable the practitioner to compile a analysis of the practice's strengths, weaknesses, threats and opportunities based on the information gained from the scans.

i) Strengths

a) Preschool children comprise half the practice's clients. The practitioner has young children, while none of the three new therapists working in the area have children. This is a distinct advantage because the practitioner is often perceived by mothers of young clients to be more knowledgeable and experienced in dealing with preschool children.

b) The practice is well-established in the minds of the community and referral agents. The practitioner lives in the community served by the practice. She is familiar with the policies and procedures at play groups and schools in the practice area and is known to the teachers. She is involved in the community and is often asked to give talks on speech-language development to parent groups.

c) The practice is located near several schools. It is convenient for school children to attend therapy before or after extramural activities at schools.

d) The practitioner is an experienced clinician, while the other therapists working in the area are relatively inexperienced.

e) Rates according to the tariffs recommended by RAMS are charged. This is seen by clients as a major incentive to use the practice.

f) The practitioner is established in the minds of clients and referral agents as competent in treating fluency disorders. This is regarded as a unique selling point because several private practitioners in the Western Cape do not treat fluency disorders at all.

ii) Weaknesses

a) The financial administration was identified as the main source of quality problems.

b) Being a solo practitioner has several disadvantages, as discussed in 3.6.3.

iii) Threats

a) The influx of new therapists to the practice area.

b) The new health care legislation and managed health care systems may favor group practices. Solo practices may find it difficult to compete with group practices offering multidisciplinary services.

iv) Opportunities

a) To establish the practice in the minds of clients and referral agents through the quality of the services rendered, both in terms of client satisfaction and outcome.

3.7 ANALYSIS OF EXISTING STRATEGIES

During this phase of the quality management programme the. practitioner determined the relevance of existing practice policies and services in the light of

the environment scan and SWOT analysis. The purpose of this step was to provide guidelines for the development of practice policies and to evaluate existing strategies against the mission and goals of the practice.

The following is an analysis of the existing services according to the concepts *service success equation, segmentation* and *differentiation* (Øvretveit, 1992a). The aim of this analysis is to develop market-oriented services and strategies to enable the practice to become more competitive.

3.7.1 Service success equation

This concept describes the relationship between the client's needs and the practice's ability to respond. The practice profile indicated that the needs of the clients who consulted the practice were met by the services offered by the practice. The practice location was appropriate; 48% of the clients lived within 10 km from the practice (see figure 3.3). The disorders treated in the practice were consistent with the practitioner's clinical experience and training and the practice's resources. Based on the professional judgment of the practitioner it was felt that treatment policies and protocols were appropriate and successful in terms of outcomes produced. A low dropout rate and a constant flow of new referrals were interpreted by the practitioner as indications that clients and referral agents were satisfied.

3.7.2 Segmentation

This concept refers to the practice's ability to secure a segment of the market to provide a competitive advantage for the practice. The practice profile shows that the practitioner had succeeded in establishing herself in the minds of clients and referral agents as skilled in treating fluency disorders. The high percentage of fluency disorders (28,9%) treated in the practice was interpreted as a reflection of

successful service segmentation. Two orthodontists in the area referred all their clients with tongue thrust to the practice because they deemed the practitioner competent to treat this disorder.

3.7.3 Differentiation

This concept refers to the unique selling points that differentiate the practice from other practices in the minds of referral agents and clients. The SWOT analysis indicated location, experience of the practitioner and expertise in treating fluency disorders as unique selling points. These factors were perceived by the practitioner to provide a competitive edge on the three other practitioners in the area.

An analysis of the existing strategies highlighted the need for greater harmony between the stated mission and goals of the practice and practice policies. The mission of the practice is to attain quality maturity through the systematic planning and development of all aspects of the practice to provide maximum benefit to clients in terms of outcome and satisfaction. A quality mature practice aims to differentiate itself in the minds of clients and referral agents through the *quality* of its services as perceived by the clients and referral agents. Concepts such as effectiveness, outcome, client satisfaction and cost-efficiency must be included in the development of a quality management programme. In this way, quality becomes the unique selling point of the practice.

At this stage of the quality management programme it was again realized that the practitioner relied primarily on her own perception of her clients' needs and the practice's success in satisfying these needs. It was therefore decided to give priority to measuring the satisfaction of clients and referral agents and to devise strategies to substantiate the practitioner's perception.

3.8 SELECTION OF KEY STRATEGIC ISSUES

The purpose of the environment scan and SWOT analysis was to enable the practitioner to identify acute quality problems. Øvretveit (1992a) states that many quality programmes fail because practitioners try to solve too many problems at once. It is important to select the most significant quality problems first. The Pareto principle states that 80% of quality problems are caused by 20% of the quality factors in a process (Williams, 1994; Wilson & Goldschmidt, 1995). This implies that a major improvement in quality can be accomplished by targeting and changing a few factors. Another way to identify key strategic issues is to define problems in terms of costs (Crosby, 1979; Øvretveit, 1992a). In other words, to identify the problems that cost the practice the most and also problems that would cost the least to solve.

The practitioner realized that the development of a quality management programme takes time. It was not possible or necessary to change every aspect of the service at once. After careful consideration the following two issues were identified and selected as key quality issues, namely the *financial management* of the practice and *client satisfaction.*

3.8.1 The financial management system

The practice's accounting system was identified as an acute quality problem. The existing system was not effective, efficient or cost-effective and resulted in financial losses, complaints from clients, rework and frustration. Although a small part of the total service, it demonstrated the Pareto principle in that it contributed to the majority of the problems. Specific problems were the following:

Invoice software

The computer software program used for the practice accounts was too complicated. Instead of easing the practitioner's administrative tasks, it required a great deal of time and concentration to prepare accounts. Mistakes often occurred, resulting in complaints from clients. The practitioner was also not satisfied with the format of the accounts. The lettering was too small and some medical schemes and clients could not interpret it. This resulted in delays in the processing of accounts.

Another problem area was the lack of a documented procedure for the time management of invoices. Accounts were sometimes sent out too late in the month resulting in delays in payment. It was decided that money could be saved on postage (R 1,00 per account) by handing accounts directly to clients instead of posting them.

3.8.2 Client satisfaction

Client satisfaction was selected as the second key strategic issue. The existing practice policies did not provide for any deliberate and systematic measuring of client satisfaction. In accordance with the mission and goals of the practice, client satisfaction is regarded as a crucial aspect of the quality management programme and a primary quality indicator. Furthermore, it was presumed that incorporating client satisfaction into every process of the service would result in the greatest improvement in the quality of all the practice's services.

The selection of these two strategic issues led to the next phase of the quality management programme, namely the development of new or revised strategies.

3.9 DEVELOPMENT OF NEW OR REVISED STRATEGIES

During this phase of the quality management programme new strategies are devised to resolve quality problems and eliminate the root causes of these problems. It was decided to devise strategies to solve problems in the financial management system and to develop a systematic way to enhance and measure client satisfaction.

3.9.1. Financial management system

It was decided to target the financial management system during the initial stages of the quality management programme for the following reasons:

- It was a major cause of quality problems and client dissatisfaction.
- Problems in this system cost the practice money in terms of time wasted in redoing accounts and in terms of money spent on stamps and stationery.
- Quality problems in the financial management system could be solved with relatively little cost and effort.

The information obtained from the internal and task environments was used to devise the following strategies:

i) Invoice software

The invoice software was replaced with a more efficient and cost-effective system. It was decided that the practice did not need expensive and complicated invoice systems. A new system was created, using existing software. It was inexpensive, relatively uncomplicated, easy to read and easy to operate.

ii) Time management of accounts

A payment for services policy that would reduce delays in payment was developed. It was decided to continue charging RAMS tariffs for services. Clients, however, would in future be expected to pay the practice directly within 14 days after receiving accounts. Accounts would be sent out on the 22nd of every month. Where possible, accounts would be handed to clients directly to save postal fees and to ensure that they actually receive them. The only exceptions would be clients who were members of Sanmed, Bankmed and Medscheme. These funds allow the practitioner to submit accounts directly to them and they refund the practice directly. Accounts would be posted to these funds on the 22nd of every month to ensure processing before the payment date which is usually on the 5th of the next month. The new policy would be clearly stipulated when clients contacted the practice for an appointment.

3.9.2 Client satisfaction

In accordance with the mission, goals and objectives of the practice, it was decided to make client satisfaction the focus of every aspect of the practice's services. Existing practice procedures and policies were reviewed and evaluated to determine if they conformed to the stated goals and mission pertaining to client satisfaction. Every part of the service, as depicted in the flow chart (figure 3.6), was critically analyzed by the practitioner to determine if procedures and policies indeed reflected a client-centered approach. Information gained from these analyses were noted and used to form the basis of new and revised practice policies.

3.10 DEVELOPMENT OF CRITICAL SUCCESS FACTORS

Following the development of revised or new strategies, critical success factors or standards related to the achievement of objectives and implementation of

strategies were developed. Quality needs to be measured to be improved (Wilson & Goldschmidt, 1995). During this phase of the quality management programme, practice standards pertaining to the financial management and client satisfaction were developed. These standards were to serve as quality indicators and to measure actual quality improvement as a result of implementing the revised strategies. The following figure, Figure 3.5, illustrates the critical success factors developed for the practice.

KEY STRATEGIC ISSUE	➔ FINANCIAL MANAGEMENT	➔ CLIENT SATISFACTION
TARGETS FOR IMPROVEMENT	➔ accounts	➔ all aspects of the service
STANDARD	➔ 100% accuracy	➔ 95% of clients satisfied with service
MEASUREMENT	➔ * note accounts redone due to mistakes ➔ * note complaints from clients and medical schemes	➔ * client satisfaction questionnaire ➔ * note client complaints ➔ * note dropout rate
WHEN INTRODUCED	➔ February 1996	➔ February 1996
WHEN MEASURED	➔ November 1996	➔ November 1996

Figure 3.5 Critical success factors for the implementation of revised practice policies.

It was attempted to develop standards that were measurable, attainable, specific in terms of actions required and time-related. The practitioner found it relatively easy to develop standards pertaining to the financial management of the practice. Client

satisfaction, however, is an abstract concept and it was difficult to define objective quality criteria without relying on the subjective judgment of the practitioner.

3.11 DEVELOPMENT OF REVISED PRACTICE POLICIES

Practice policies are operational, resource and project plans designed to achieve strategies and to meet critical success factor criteria (Wilson & Goldschmidt, 1995). Practice policies form the basis of a practice and are explicit statements on how to manage all aspects of the interaction between the client and the practitioner. The practice's policies before the development of the quality management programme focused on clinical intervention only. Previous practice policies were statements in the form of tree diagrams and flow charts defining protocols and procedures for assessment, treatment, dismissal and follow-up.

The purpose of the quality management programme is the continual improvement in the quality of the practice's services. According to the vision statement the aim of the practice was to become a client-centered, quality mature practice. This vision required the revision of all previous practice policies to ensure that all aspects of the service conformed to the stated mission, goals and objectives. The key strategic issues identified earlier in the quality management programme, namely the financial management system and client satisfaction, became the first aspects to be incorporated into the revised practice policies.

3.11.1 Financial management

The revised practice policy pertaining to the financial management was formulated and depicted in a flowchart in the following way:

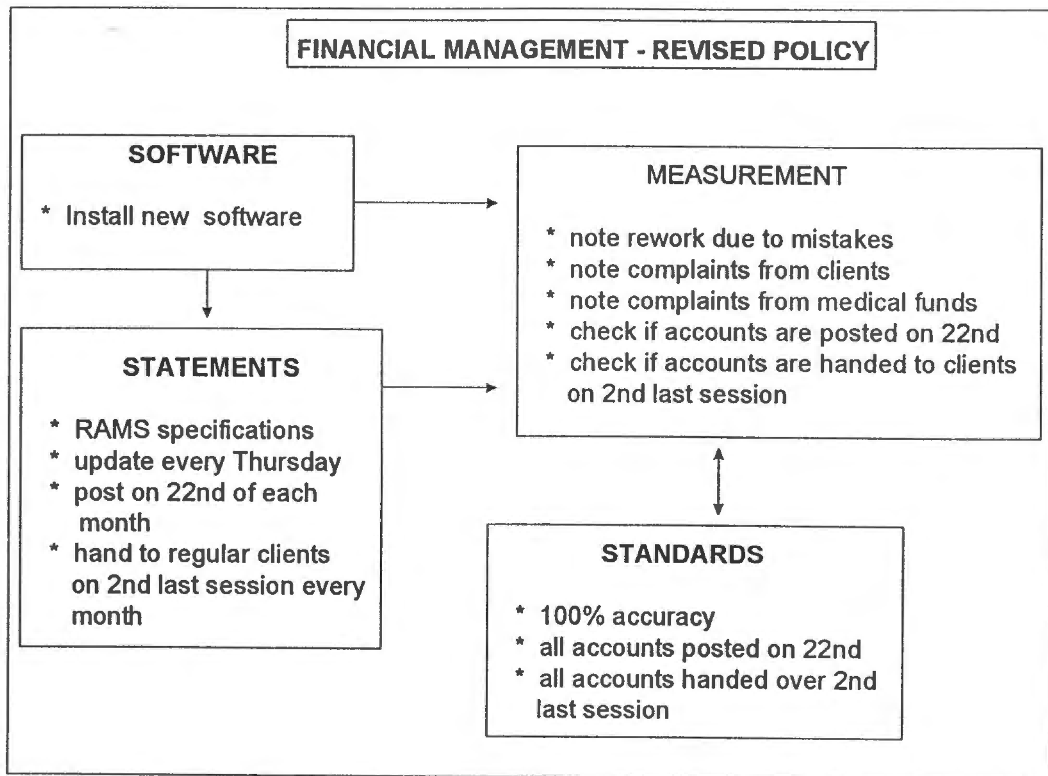

Figure 3.6 Revised financial management practice policy

3.11.2 Client satisfaction

According to the mission and goals of the practice, client satisfaction was regarded as a fundamental requirement of all aspects of the services. All facets of the existing practice policies were viewed from a client-centered and client satisfaction perspective. It was kept in mind that the perceptions and expectations of clients, and not the practitioner, were the focus. The practitioner tried to view the service as objectively as possible from the client's perspective.

The flow chart depicting the practice process were used to review procedures and to specify measures that reflected the practitioner's concern with the client's expectations, needs and satisfaction. The following figure (figure 3.7) describes the

measures included in the practice policies to enhance client satisfaction and to reflect the client-centered orientation of the practice.

Figure 3.7 Revised practice policies pertaining to client satisfaction

INITIAL CONTACT	*"only one chance to make a first impression"*
❖ telephone	➔ friendly, helpful, courteous, convey respect ➔ listen to client's concerns, willing to give information ➔ willing to discuss options, e.g. therapist closer to client, other services available
❖ answering machine	➔ clear, bilingual message ➔ check messages regularly ➔ return calls the same day
❖ make appointment	➔ meet client's preferences if possible ➔ clear instructions on how to find practice ➔ instructions on information needed, e.g. medical fund details, referral note from doctor, school reports, other reports
❖ first consultation	➔ parking area clean ➔ waiting room neat, suitable magazines, toys for siblings ➔ therapist punctual ➔ friendly, warm welcome, eye contact ➔ therapist introduce herself, use client's name, acknowledge and welcome children ➔ explain procedures ➔ allow time for young children to become familiar with therapist and surroundings
❖ initial interview	➔ put client at ease, create calm, relaxed atmosphere ➔ data collection forms: in client's home language, easy to read, no complicated terminology, not too long ➔ explain need and purpose of background information: *"any information that will help me to understand your problem better"* ➔ convey respect for client's opinion, views and concerns: *"I could never know your child as well as you do"*
❖ measurement	➔ measure client satisfaction with initial contact procedures

ASSESSMENT	→ convey cost-consciousness to client: *"It is my policy never to do unnecessary tests or procedures"* → keep practice goals in mind: assessment in itself does not change communication status → explain reason for assessment: *"We need to know as much as possible about the problem to compile an appropriate treatment plan"*
❖ tests and assessment protocols	→ explain procedures and aims of assessment, e.g.: *"I will analyze this speech sample to understand the nature of your disfluency. We can use this information to decide which therapy techniques would be best suited to your needs."* → conform to accepted clinical guidelines and "best practices" → provide information about broader communication status and functioning, not only presenting symptoms
❖ measurement	→ measure client satisfaction with assessment procedures
FEEDBACK ❖ diagnosis	→ explain results of assessment, provide time for questions: *"Do you have any questions about the procedures or tests?"* → involve client/parent in diagnosis: *"Does this information confirm your impression and views of the problem?"* → explain, if applicable, the need for diagnostic therapy, ongoing assessment or referral for more tests: *"I want to provide you with the best possible service and need more information to be able to do that"*
❖ treatment decision	→ explain reasons and rationale for treatment decisions → involve parents/clients in decision, give options, e.g.: *"According to age norms his articulation is age appropriate. It is still acceptable for a four year old to substitute /th/ for /s/. He will probably learn to say the /s/ without treatment. However, if you or the child feel very strongly about it, we can discuss a home programme"* → explain the therapy process: clarify the roles of therapist and clients/parents. → agree on aims of treatment in terms of short-term and long-term goals
❖ referral source	→ explain need for feedback to referral source; e.g. to coordinate treatment programmes with occupational therapist or psychologist → convey regard for confidentiality to clients → ask permission to give feedback to referral source
❖ measurement	→ measure client satisfaction with feedback procedures

TREATMENT	
❖ goals	➔ establish client satisfaction as a therapy goal ➔ negotiate realistic and appropriate short-term and long-term goals with client in terms understood and accepted by client ➔ explain and establish success criteria in consultation with client ➔ adapt, revise and review goals in consultation with client where necessary
❖ treatment plan	➔ explain rationale and reasons for treatment protocol and procedures ➔ explain facilitating role of therapist, active role of client ➔ encourage input from client, empower client to become own therapist
❖ treatment	➔ equipment and procedures age-appropriate and suited to the needs of the client ➔ "homework" assignments to improve transfer to client's own communication environment ➔ encourage sef-evaluation and self-monitoring; client becomes own therapist ➔ convey respect for client's preferences and opinions
❖ outcome measurement	➔ formal measurement of improvement in communication status and in terms of agreed success criteria ➔ measure improvement in communication status as perceived by clients ➔ measure satisfaction of clients with outcome of intervention
❖ termination & follow-up	➔ terminate therapy in consultation with clients ➔ establish guidelines for follow-up procedures in consultation with clients ➔ "open-door policy"; client/parents encouraged to return or phone practice if concerned about any aspect of communication
❖ measurement	➔ measure client satisfaction with treatment procedures
ADMINISTRATION	
❖ files and records	➔ keeping of client files and records according to established practice management principles ➔ convey regard for efficient, professional and confidential administration principles to clients ➔ provide appropriate and professional reports to clients and referral sources
❖ financial management	➔ explain payment procedures and invoice system to clients ➔ accounts accurate, easy to read and understand
❖ measurement	➔ measure client satisfaction with administration

3.12 POLICY IMPLEMENTATION PLAN

The aim of the implementation plan is to stipulate what is to be done, according to what timetable, with what resources and the expected results. The following figures (figure 3.8 and figure 3.9) describe the policy implementation plan for the two strategic issues selected to be the first targets of the practice's quality management programme.

STRATEGIC ISSUE		**ACCOUNTS**
ACTION	→	* replace invoice software
RESOURCES NEEDED	→	* new software
	→	* stationery
	→	* monthly checklist
STARTING DATE	→	* February 1996
RESULTS EXPECTED	→	* accounts 100% accurate
	→	* reduction in waiting time for payments
MONITOR DATE	→	* November 1996

Figure 3.8 Policy implementation plan - financial management

STRATEGIC ISSUE		**CLIENT SATISFACTION**
ACTION	→	* introduce client satisfaction principles into all aspects of the service
RESOURCES NEEDED	→	* revised policy statement re client satisfaction
STARTING DATE	→	* February 1996
RESULTS EXPECTED	→	* 95% client satisfaction
MONITOR DATE	→	* November 1996

Figure 3.9 Policy implementation plan - client satisfaction

3.13 POLICY OUTCOME MEASUREMENT

The purpose of this step is the validation of practice policies. Ideally, structured outcome measurement should be used to validate practice policies (Wilson & Goldschmidt, 1995). Applied to a speech-language therapy practice, structured outcome measurement examines the long-term improvement in client communication status as a result of conformance to practice policies. At this stage of the practice's quality evolution, structured outcome measurement was still a future goal. Consequently, policy outcome measurement at this stage focused on policies pertaining to the two strategic issues selected, namely financial management and client satisfaction. The outcome of the policy implementation plan was measured against the critical success factors or standards developed during an earlier phase of the quality management programme. The results are described in the following section.

3.13.1 Financial management

i) Invoice software

A new invoice system was installed. It was inexpensive, uncomplicated, easy to read and easy to operate. The format was neat and complied with RAMS specifications for accounts. The practitioner felt that it conformed to the quality goals of the practice.

The new invoice system was introduced in February 1996. Outcome measurement pertaining to the accuracy of accounts was done in November 1996 as stipulated in the policy implementation plan. No complaints pertaining to accuracy, and no inquiries regarding accounts were received from clients or medical schemes in this time. This was interpreted as an indication that the new invoice system complied with the quality management standard of 100%

accuracy. In the patient satisfaction questionnaire, the question pertaining to the financial management and accounts indicated that only one of the respondents (N =19) felt that it "could improve". The rest were "satisfied" and "very satisfied".

ii) Time management of accounts

As stipulated by the revised policy plan, accounts were updated at the end of each working day, posted on the 22nd of every month or handed to clients after the penultimate therapy session every month. Reminders in the practitioner's diary and a monthly checklist assured that the stipulations were followed. The only exception was during July 1996, when no accounts were sent out because the practitioner was on holiday for three weeks and no therapy took place during this time.

Although it was not found that the waiting time for payments was reduced significantly, the practitioner felt that the revised policy pertaining to the time management of accounts enhanced the effectiveness and efficiency of the practice's management. It led to a greater sense of control, saved time and improved the efficient functioning of the practice. Furthermore, the satisfaction of clients and funding agencies was enhanced.

3.13.2 Client satisfaction

i) Client satisfaction questionnaire

As stipulated by the policy implementation plan, a client satisfaction questionnaire was sent to a group of clients. The purpose of the questionnaire was to measure the satisfaction of clients with different aspects of the service. It was decided to include only clients who had been recipients of all aspects of the practice's services during 1996. Only clients who had completed the therapy

process, starting from initial contact with the practice until termination of therapy, were included. Clients who were still receiving treatment, clients who had been evaluated but not treated and clients who had been reassessed or seen for follow-up assessment were not included in this group. Fifty clients who had been seen in the practice between February and November 1996 met these criteria.

Questionnaires and a covering letter explaining the purpose of the questionnaire were sent to the 50 clients (see Appendix I). Self-addressed stamped envelopes were included for the return of the questionnaire. The questionnaires were returned anonymously. The questionnaire contained 14 questions about various aspects of the practice's services. Clients were asked to indicate their satisfaction by using the ratings "poor", "can improve", "satisfied" and "very satisfied". Room for additional comments was included. Parents of children who received therapy were asked to consult with their children when completing the questionnaire.

Postal surveys have a notoriously low return rate (Schnetler, 1989) and only 19 out of the 50 (38%) questionnaires were returned. The responses to the questions are described in table 3.2. Responses were very positive and indicated a 94% satisfaction rate with the practice's services. This is close to the standard of 95% client satisfaction stipulated as a critical success factor during the development of the quality management programme. The majority of the responses depicted client satisfaction, the areas where clients indicated room for improvement were duly noted. It was noted that two clients were dissatisfied with the parking space. The parking area was subsequently paved and enlarged to accommodate three cars. It was also noted that three clients still felt that the explanation of treatment goals could be improved. Four clients felt that the way

in which parents and family members were involved in treatment, could be improved.

Table 3.2 Client satisfaction questionnaire responses (n=19)

QUESTION	RESPONSES				
INDICATE YOUR SATISFACTION WITH:	POOR	CAN IMPROVE	SATISFIED	VERY SATISFIED	NO REPLY
1. Comfort of waiting room and therapy room	0	0	13	6	0
2. Parking	1	1	10	7	0
3. Initial interview and testing	0	1	10	7	1
4. The way in which the diagnosis was explained to you	0	0	9	10	0
5. The way in which the aims of therapy were explained to you	0	3	6	10	0
6. The actual therapy process	0	1	8	10	0
7. The way in which parents and family members were involved in therapy	0	4	10	4	1
8. Communication between therapist and client	0	1	9	8	1
9. Equipment and games used in therapy	0	0	6	8	5
10. Accounts and financial management	0	1	6	12	0
11. Home assignments	0	1	10	3	5
12. Reports, if any	0	1	4	1	13
13. The way in which therapy was terminated	0	0	13	3	3
14. The results of therapy	1	0	11	6	1
Total responses	**2**	**14**	**125**	**95**	**30**
Percentage of responses	**0,8%**	**5.9%**	**53%**	**40.3%**	

ii) Dropout rate

During the period February 1996 - November 1996, only two clients out of a total of 64 dropped out of therapy. One client, an adult voice case, failed to return for a scheduled appointment after the initial consultation. The other client, a preschool child with delayed language, was assessed and referred for

occupational therapy in addition to speech-language therapy. The mother decided to complete the occupational therapy treatment before starting with speech-language therapy and never returned. The low dropout rate was interpreted by the practitioner to be an indication of satisfaction with the practice's services.

iii) Client complaints

No formal complaints regarding any aspect of the practice's services were received. Previously, inquiries and complaints about the invoice system comprised most of the grievances of clients. The lack of complaints during the period February 1996 - November 1996 was seen as an indication of client satisfaction and a direct result of the quality management programme.

The combined results of the client satisfaction questionnaire, the practice dropout rate and an analysis of the complaints received, lead the practitioner to surmise that clients were satisfied with the practice's services.

CHAPTER 4

CONCLUSIONS AND IMPLICATIONS OF THE STUDY

4.1 CONCLUSIONS

The development and implementation of a quality management programme provided the practitioner with a systematic approach to enhance problem solving, accountability, efficiency, cost-effectiveness, outcome and client satisfaction in the practice. Furthermore, the practitioner proved that her concern with quality amounted to more than good intentions.

It was found that reflecting on the vision, mission and values of the practice provided the practitioner with a greater sense of responsibility and direction. It enhanced her awareness of the need for continuity between the vision, goals and the actual services provided. Practice management problems that involved judgement calls became easier to solve because they were viewed against the stated values and mission.

Expressing the practice goals in writing helped the practitioner to focus on the fundamental purpose of the practice, namely improvement of the client's communication status and not just the provision of services. This statement became the focal point of the practice. Clients' disorders were viewed in terms of the effect they had on their communication status and not only in terms of presenting symptoms. This was a reflection of a true client-centered approach where the client's own reality and perception of his/her disorder and the consequences of the disorder became paramount. Apart from planning processes with the aim of enhancing client satisfaction, the practitioner experienced a greater sensitivity towards the spoken and unspoken needs and expectations of clients.

The focus on client satisfaction resulted in greater client spontaneity and openness, and as a result therapist-client communication improved. This in turn resulted in increased professional satisfaction.

The environment scan provided information about all aspects of the practice. This information was interpreted, analysed and evaluated against the stated vision, mission and goals for the practice. Besides providing valuable information, this analysis led to the development of new strategies and practice policies that were in line with the goals and mission of the practice.

The analysis of existing strategies enabled the practitioner to determine the relevance of existing practice policies and services in the light of the environment scan and against the mission and goals of the practice. Information obtained from this process provided guidelines for the development of more relevant practice policies. It was decided to select financial management and client satisfaction as the first targets of the quality management programme.

In accordance with the principle that quality needs to be measured to be improved, critical success factors were developed to measure actual quality improvement in the selected areas, namely management and client satisfaction. Revised practice policies were formulated with the aim of attaining the stated quality goals of the practice.

Implementation of the practice policy pertaining to client satisfaction resulted in assessment and intervention procedures becoming more client-centered. More time was spent negotiating and discussing therapy goals with clients. Empowerment of the client to become his or her own therapist, became an actual therapy goal.

Therapy sessions were structured to provide time for a conference with the client/parent at the beginning of each session to discuss home assignments and therapy goals for the session. Previously, this period consisted of "checking homework" and telling clients what was planned for the session. This changed to explaining goals for therapy in consultation with the client/parent and promoting awareness of long-term goals. Goals were qualified and quantified and success criteria for every session were agreed upon and evaluated at the end of the session. Establishing success criteria helped to clarify goals and helped clients to become more aware of actual progress.

Where the practitioner had previously relied predominantly on professional judgement and clinical evaluation to measure progress, parents and clients were now enlisted to measure progress and achievement of goals by means of self-assessment scales. Opportunity was provided for input from clients and suggestions were valued and encouraged. Feedback on assignments was seen as a problem-solving opportunity where goals and/or activities were adapted or changed in consultation with clients.

Not all clients were responsive to this approach. Some clients/parents continually failed to perform their agreed upon tasks and seemed to view intervention as the sole responsibility of the therapist. Some clients, on the other hand, responded extremely well and constantly surprised the practitioner with their co-operation, enthusiasm and innovation. This resulted in a definite increase in professional satisfaction and convinced the practitioner of the importance of client empowerment and the role of the therapist as facilitator.

The purpose of outcome measurement is the validation of practice policies. The ultimate aim of a quality mature speech-language therapy practice is to *prove* through structured outcome measurement that conformance to practice policies results in improved client communication status. At this stage of the quality management programme in the author's practice, structured outcome measurement is still a future goal. This dissertation endeavored to describe the initial stages of a quality management programme and reflected the first stages of the practice's quest for quality maturity.

In summary, the practice developed and implemented a quality management programme based on modern quality theory. This enabled the practice to improve the quality and effectiveness of its financial management system. It also enabled the practice to demonstrate the client-centered orientation of its services by implementing client satisfaction as the fundamental quality indicator.

4.2 LIMITATIONS OF THE STUDY

It is realised that this study reports and reflects the experiences and views of one private speech-language therapy practitioner and that it is impossible to generalise the findings to other practices and speech-language therapy environments.

Lack of data about client satisfaction levels *before* the introduction of the quality management programme in the practice makes it difficult to verify that client satisfaction actually improved as a result of the programme. The low return rate (38%) of the client satisfaction questionnaire undermines the assumption that client satisfaction had increased and may in itself be an indication of indifference or dissatisfaction among clients. Ways to increase the response rate, for example

follow-up letters to remind clients to return questionnaires, could possibly have resulted in a more convincing statement pertaining to client satisfaction.

The client satisfaction questionnaire was too vague to provide meaningful information regarding specific aspects of the practice's services. As Øvretveit (1992a) aptly stated, the ultimate aim is to improve quality and not to measure it. Questionnaires must therefore provide the kind of information that can be used to improve specific aspects of the service.

Furthermore, it is realised that being a solo practitioner, the author had had distinct advantages in developing and implementing a quality management programme. Every aspect of the quality management programme could be directly controlled and regulated by the author in accordance with her own personal vision and value system. The implementation of a quality management programme in a group practice, a clinic with several speech-language therapists or even a multidisciplinary practice, is bound to be much more complicated. As stated before, each practice or clinic has to formulate its own working definition of quality before commencing on a quality management programme. It is a challenge to create a shared vision of quality management amongst persons with diverse personal and clinical styles and different perceptions regarding quality.

4.3 IMPLICATIONS OF THE STUDY

This study is the first quality management programme implemented in a private speech-language therapy practice in South Africa. The author endeavoured to make quality management principles accessible to speech-language therapists and

to demonstrate the relevance of and need for quality management in the speech-language therapy profession.

It is strongly felt that the survival of the profession depends on the ability of speech-language therapists to demonstrate the efficacy and cost-effectiveness of their services. A quality management programme can provide practices with ways and means not only to continually improve the quality of their services, but also to provide data as proof of positive outcomes. This study provides clinicians with the basic information needed to develop and implement quality management programmes in their own clinical environments.

4.4 SUGGESTIONS FOR FURTHER RESEARCH

The author selected client satisfaction and the practice's financial management system as strategic quality factors in her practice. This study could be expanded by selecting and exploring other aspects as quality factors, for example outcomes produced by the practice. Policy makers and funding agencies demand outcome data to demonstrate the relationship between a treatment procedure and its outcome. A quality management programme can provide outcome data as well as information about the methods used to measure and document outcomes.

A quality management programme can form the basis for benchmarking in the private speech-language therapy sector. Benchmarking is a continuous process of evaluating organisations to determine work and business processes that represent "best practices" and establish rational performance goals (Armstrong, 1994). Quality management data from several private practices could identify mutual quality problems and ways to solve them, identify best therapy practices, provide a means for assessing treatment outcomes and provide guidelines for setting

appropriate performance standards. These steps will enhance the image and performance of the private speech-language therapy sector. Furthermore, field data collected from the private sector could fuel and direct research and the development of appropriate clinical programmes.

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APPENDIX

Daleen Klop

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Spraakterapeut / Speech Therapist

Tel: 96-5365

Somerstraat 17
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7550

Dear

It is my intention to deliver the best quality service to my clients. I aim to continually evaluate the quality of my therapy and practice management to determine where improvements may be achieved.

The *satisfaction* of my clients is the most important aspect of the practice's quality management programme. I will appreciate it if you would complete the accompanying questionnaire to indicate your satisfaction with my services.

Please return the questionnaire anonymously. All information will be regarded as confidential.

Thank you very much

DALEEN KLOP

Daleen Klop

B.A. Log (Pret.)

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Eversdal
7550

Beste

Dit is vir my baie belangrik om die beste moontlike diens aan my kliënte te lewer. My doelwit is om voordurend die kwaliteit van my terapie en praktykbestuur te evalueer om sodoende te bepaal waar verbeteringe aangebring kan word.

Die *tevredenheid* van kliënte met my dienste is die belangrikste aspek van die praktyk se kwaliteitsbestuur. Ek sal dit baie waardeer indien u die meegaande vraelys invul sodat ek 'n aanduiding van u tevredenheid kan kry. As u kind terapie ontvang het, vra asseblief sy/haar mening as u die vraelys invul.

Stuur asseblief die vraelys naamloos terug in die koevert wat voorsien word. Alle inligting sal as vertroulik beskou word.

By voorbaat baie dankie

DALEEN KLOP

VRAELYS : SPRAAKTERAPIE

Dui asseblief deur middel van 'n kruisie u tevredenheid met die volgende aspekte aan:

1 = swak 2 = kan verbeter 3 = tevrede 4 = uitstekend

1. Gerieflikheid van die wagkamer	**1 2 3 4**
2. Parkering	**1 2 3 4**
3. Die eerste evaluasie of toetsing wat gedoen is	**1 2 3 4**
4. Die wyse waarop die diagnose aan u verduidelik en oorgedra is	**1 2 3 4**
5. Die wyse waarop die doelstellings van terapie aan u verduidelik en oorgedra is	**1 2 3 4**
6. Terapie wat plaasgevind het	**1 2 3 4**
7. Die wyse waarop die terapeut ouers en/of die gesin by terapie betrek het	**1 2 3 4**
8. Kommunikasie tussen die terapeut en die kliënt	**1 2 3 4**
9. Apparaat, materiaal, speletjies wat in terapie gebruik is	**1 2 3 4**
10. Rekeninge en finansiële administrasie	**1 2 3 4**
11. Tuisopdragte, indien enige	**1 2 3 4**
12. Verslae, indien enige	**1 2 3 4**
13. Die wyse waarop terapie gestaak is	**1 2 3 4**
14. Tevredenheid met die resultate van terapie	**1 2 3 4**

Dui asseblief met 'n kruisie aan waarvoor u of u kind terapie ontvang het:

Taalprobleem	**Artikulasieprobleem**	**Stemprobleem**
Stamel	**Hakkel**	**Lees- en Spelprobleem**
Beroerte / hoofbesering	**Slukprobleem**	**Ander**

Enige opmerkings of voorstelle:

Baie dankie, u samewerking word baie waardeer.

DALEEN KLOP

QUESTIONNAIRE : SPEECH THERAPY

Please indicate your satisfaction with the following aspects:

1 = poor   2 = can improve   3 = satisfied   4 = excellent

1. Comfort of the waiting room	1 2 3 4
2. Parking	1 2 3 4
3. Initial testing and assessment	1 2 3 4
4. The way in which the diagnosis was explained to you	1 2 3 4
5. The way in which the goals of therapy were explained to you	1 2 3 4
6. Therapy that took place	1 2 3 4
7. The way in which parents and/or family members were involved in the therapy process	1 2 3 4
8. Communication between therapist and client	1 2 3 4
9. Equipment and games used in therapy	1 2 3 4
10. Accounts and financial administration	1 2 3 4
11. Home assignments, if any	1 2 3 4
12. Reports, if any	1 2 3 4
13. The way in which therapy was terminated	1 2 3 4
14. Satisfaction with therapy results	1 2 3 4

Please indicate for which of the following you or your child were treated

Language disorder	Articulation disorder	Voice disorder
Stroke / head injury	Reading / spelling disorder	Stuttering
Cluttering	Swallowing disorder	Other

Any remarks or suggestions?

Thank you very much

DALEEN KLOP