COPE® Handbook: A Process for Improving Quality in Health Services

EngenderHealth's Quality Improvement Series

ENGENDERHEALTH

COPE® Handbook:
A Process for Improving Quality in Health Services

Revised Edition

ENGENDERHEALTH
Improving Women's Health Worldwide
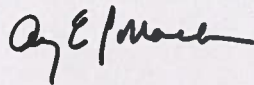
Dedicated to Grace Wambwa

In honor of her innovation and commitment to improving the quality of reproductive health services, we dedicate this handbook to our dear friend and colleague, Grace Wambwa, upon her retirement from EngenderHealth. Together with key colleagues, Grace was one of the early leaders in developing the COPE® process, and particularly in shepherding it through its introduction throughout Sub-Saharan Africa. Grace served as a mentor to countless COPE facilitators over the past 15 years. Her strong belief that all health care workers want to do their best, combined with her tireless energy and inspirational success stories of hospitals and clinics using COPE, have helped COPE grow from its origins in Kenya to worldwide recognition as a best practice in quality improvement.

Amy E. Pollack, M.D., M.P.H.
President, EngenderHealth

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Preface

One of the first, and most important, questions that facilitators ask during the first COPE® exercise is: "What is quality? If your sister, mother, brother, or uncle came to this facility for services, how would you like him or her to be treated?" The answers to this question are the building blocks of a definition of quality that incorporates clients' rights to quality care and staff needs for the support (supervision, training, supplies, and equipment) that will ensure their clients receive that level of care. The answers also incorporate something else: a collective vision of quality woven from the individual voices of different levels of staff, all sitting together discussing the services at their facility and how they can improve them. The spirit of COPE is embodied by the idea that changes in quality will be most successful and lasting when they are initiated by staff working together within the facility, using their expertise to identify problems and develop recommendations for solving these problems.

Reproductive health care staff working in hospitals and clinics are often seriously impeded from giving their clients high-quality care, especially in resource-poor settings where staffing, resources, and supportive supervision may be lacking. Yet despite these obstacles, providers continue to work and try to do the best they can with what they have. COPE was developed to provide a means for staff to assess their own work, so as to identify problems in their facility and local solutions to those problems. COPE also helps staff become more aware of the needs of clients and, through the international standards of care embedded in the COPE tools, become more aware of what it will take to provide the highest possible level of care (and thereby meet those needs).

COPE is not a cure-all: Many problems require the infusion of outside resources or (for administrative or political reasons) are too great to be solved from within the facility. COPE also is meant not to be used in isolation, but to be integrated with other quality improvement (QI) approaches and tools that a facility might find useful, including more formal methods of evaluation that involve external assessment.

Studies on COPE over the past decade have looked at both process and outcome data, with extremely positive results. A study in four African countries examining the proportion of problems solved versus the proportion of those identified showed that 109 problems were identified through COPE action plans over the course of 15 months (Lynam, Rabinovitz, & Shobowale, 1993). Of the 88 deemed potentially solvable (meaning that staff could act on them without outside intervention or funds), 73% were solved within the 15-month period. The same study examined outcomes of the use of Client-Flow Analysis (an integral part of the COPE process) at five clinics that had identified client waiting time as a problem. At those five facilities, waiting time declined by from 17% to 56%, with an overall average of 42%. As an example, in one clinic where the previous average waiting time was 130 minutes, the waiting time dropped to less than 60 minutes. These are significant changes in a problem often identified as a chief source of client dissatisfaction.

An evaluation of COPE for Child Health conducted in Kenya and Guinea examined changes in quality over a 15-month period at eight intervention sites where COPE was introduced and compared these with events at eight control sites where it was not (Bradley et al., 2002). Results—whether reported by providers, observed by evaluation staff, or reported by clients—showed that on almost every quality indicator, the intervention sites performed

significantly better than the control sites, with most problems solved without outside assistance. Client-provider observations revealed greatly improved provider performance in such areas as respect shown toward clients, information given to clients, privacy, personal communication skills, diagnostic skills, home care instructions, prescribing practices, and immunization practices. (For sample data on this and the above study, see Appendix B.)

Clients at the intervention sites in Kenya and Guinea found staff to be very knowledgeable, friendly, and respectful, explaining things well and giving them privacy and plenty of time. Clients at the intervention sites were also much more likely than those at the control sites to report understanding everything they were told, getting all of the information they needed, and being "very satisfied" overall with the visit. As to whether clients had observed any changes in service delivery over the past year, 80% of clients at the intervention sites said that services were better than before, compared with 27% of clients at the control sites.

Perhaps most important, the COPE process affected staff's sense of empowerment and accountability:

"Before, most problems were someone else's responsibility. But we now see that we ourselves can solve most problems." (Kenya)

"COPE has raised our consciousness, and due to this we have become more responsible." (Guinea)

What is interesting about the changes in each of the studies cited above is that although the COPE guides suggest what standards of care might be, there is no specific intervention or training associated with them—e.g., no one tells staff that they need to treat clients better, give out more information, or ensure that no one interrupts their consultations. Thus, simply by providing a structure and a forum for staff to meet together on an equal, nonjudgmental basis and ask the questions that need to be asked about the services they provide, COPE can reap profound changes in the quality of care, in staff performance, and in client satisfaction.

This handbook reflects the lessons that EngenderHealth and its counterparts in more than 45 countries have learned over the past decades in developing, applying, evaluating, and adapting COPE. As you adapt and apply COPE, we invite you to share your lessons and improvements with us, as well as with your colleagues and with the clients you serve.

Acknowledgments

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* Before 2001, EngenderHealth was known as AVSC International.

The New Edition of COPE

COPE® was pilot-tested in Kenya and Nigeria in 1988 and was then introduced in other countries in Africa and Asia from 1989 through 1994. In 1995, EngenderHealth* published *COPE: Client-Oriented, Provider-Efficient Services: A Process and Tools for Quality Improvement in Family Planning and Other Reproductive Health Services.* This handbook was designed to help clinic and hospital staff improve the quality of their family planning services through more efficient use of resources and improved overall performance. Now used in more than 45 countries worldwide, COPE has been translated into at least 15 languages (Arabic, Bahasa, Bangla, French, Khmer, Malagasy, Mongolian, Nepali, Portuguese, Russian, Spanish, Tagalog, Turkish, Urdu, and Vietnamese). Over the years, service providers have asked that the tools be expanded to include other aspects of health services, such as maternal care, child health, and adolescent reproductive health services.

During this same period, EngenderHealth and its partners have learned more lessons about how to introduce the COPE process to ensure that it becomes a sustainable and continuous quality improvement (QI) process. The desire to share these lessons, and the fact that providers began to utilize the COPE process for different areas of reproductive health services in addition to family planning, created the need for us to revise the original COPE handbook, which focused specifically on family planning. Likewise, EngenderHealth had begun to widen its mission to focus on more comprehensive reproductive health services and developed additional content-specific toolbooks (see page 2). With a review of the COPE handbook came a decision to revise the content, making it more generic and more focused on the "how-to" aspects, and to redesign the handbook so it can accompany the content-specific toolbooks. In addition, this revision strengthens the information provided on orienting key managers (Chapter 2) and, more generally, on helping facilitators prepare for the COPE process. In response to requests from the field, we have also enhanced the section on facilitation skills (Appendix D). We hope that these changes make it easier both for those newly initiated to the process to conduct COPE and for "older hands" to pick and choose the information they need. Our general goal is to help make the COPE process more sustainable in the long run, by easing the transfer of skills in COPE facilitation through the step-by-step process outlined here.

Consequently, this new edition provides a more comprehensive explanation of how to introduce and sustain the COPE process. This process is applicable to any set of services that the facility wants to explore, with adaptations to the tools as needed. This handbook is intended for use together with different toolbooks, each containing Self-Assessment Guides, a Client-Interview Guide, Client-Flow Analysis forms, and other assessment tools for a particular type of health services.

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The COPE Toolbooks

Since COPE's inception as a tool to improve the quality of family planning services, it has been evident that clients around the world expect and deserve quality of care in all types of health services, and that family planning services do not exist in isolation from other kinds of health care. Over time, as providers have expressed the need for such tools for other health services, the COPE process and tools have been adapted. Below is a listing of EngenderHealth's current set of COPE toolbooks:

- *COPE® for Reproductive Health Services: A Toolbook to Accompany the COPE Handbook* (2003)
- *COPE: Client-Oriented, Provider-Efficient Services: A Process and Tools for Quality Improvement in Family Planning and Other Reproductive Health Services* (1995)
- *COPE® for Maternal Health Services: A Process and Tools for Improving the Quality of Maternal Health Services* (2001)
- *COPE for Child Health: A Process and Tools for Improving the Quality of Child Health Services* (draft, 1999)
- *Community COPE: Building Partnerships with the Community to Improve Health Services* (2002) (This is a variation on the COPE process.)

Many of the above toolbooks are currently being revised for use in conjunction with this handbook. In addition, new toolbooks on such topics as adolescent reproductive health care and services related to HIV and STIs are being developed (see Appendix F).

How to Use This Handbook

This handbook's format has been updated to be more user-friendly for facilitators as they orient managers, train site facilitators, guide facility staff in using the COPE tools, and adapt the COPE process and tools to best fit the facility's needs.

The chapters are organized to take the reader from an introduction to the concepts of COPE and QI to the basics of how to prepare and lead the first COPE exercises, facilitate an Action Plan Meeting, conduct subsequent exercises, perform a Client-Flow Analysis, and follow up between exercises. Additional chapters focus on orienting key managers so as to obtain critical support and on measuring progress over time.

In addition, samples of COPE forms and background materials that had been included in the text in previous editions of this handbook have now been placed in the appendixes to this book, for easy reference:

- **Appendix A—Sample COPE Forms** contains samples of the various tools discussed in the handbook: the self-assessment guides, record reviews, client interviews, Client-Flow Analysis, and action plan.
- **Appendix B—COPE Successes** contains examples of positive changes made around the world through the COPE process.
- **Appendix C—Orienting Key Managers: Talking Points** features bulleted presentations of topic areas to cover when introducing the concepts of COPE and QI to managers and stakeholders.

- **Appendix D—Facilitation Skills** consists of suggestions on how to begin and end meetings, some general facilitation tips, and some recommendations for dealing with difficult participants.

- **Appendix E—Flipcharts** offers visual aids that capture the main ideas to communicate. These can be presented as flipcharts, as overhead slides, as handouts, or in some other fashion. They can be used to show key messages for orienting managers or for instructing staff during the COPE exercises. Facilitators may adapt these messages and may choose not to present *all* of the key messages as flipcharts or slides, but should be sure that the information is covered in the discussions. The flipcharts are referenced as appropriate throughout the handbook.

- **Appendix F—Contents and Applications of the COPE® Toolbooks** provides a summary of the COPE toolbooks mentioned above.

- **Appendix G—Alternative Quality Improvement Approaches** describes how complementary QI approaches such as performance improvement and appreciative inquiry compare with the approach presented here.

Throughout the text you will find the following icons or symbols:

This symbol marks the appearance of a **Troubleshooting Tip**, an explanation of how to address a potential pitfall or overcome a barrier that might occur in the COPE process.
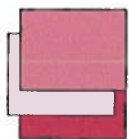
This symbol stands for **adaptations** or **variations**, and appears in the text wherever there is a description of how the COPE process (or steps within the process) can be modified to best suit local needs.

Adapting COPE

COPE is meant to be adapted to the specific context and needs of each hospital, health center, or clinic that adopts the COPE process. COPE is conducted *by* staff and *for* staff; because staff needs at each health care facility are different, COPE will be different at every facility. When adapting the COPE tools or when introducing additional tools to a specific facility, facilitators and site managers should be creative, keeping COPE's key principles in mind: reliance on self-assessment, participation, and the use of local efforts and local resources to identify and solve problems and build on strengths.

Facilitators should:
- Treat the information in this handbook as suggestions, not instructions
- Not feel obliged to use every part of this handbook at every exercise
- Not feel that the process must be limited to the material in this handbook

Sharing COPE Experiences

EngenderHealth welcomes feedback from users. Please forward any problems, suggestions, and comments from your experiences with COPE to:

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e-mail: info@engenderhealth.org

The COPE Process and Tools

This chapter explains the COPE process, describing the various tools that constitute COPE and the staff members who conduct or participate in each COPE exercise. It also outlines the principles of clients' rights and staff needs upon which COPE is grounded, and describes COPE's relationship to a range of quality improvement (QI) approaches.

Objectives

After reading this chapter, you should be familiar with:
- What COPE is
- What clients' rights and staff needs are
- How the COPE process operates
- The principles upon which COPE is based
- Some examples of COPE successes
- How COPE fits into EngenderHealth's QI package of approaches and tools

What Is COPE?

COPE, which stands for "client-oriented, provider-efficient" services, is a process that helps health care staff continuously improve the quality and efficiency of services provided at their facility and make services more responsive to clients' needs. COPE provides staff with practical, easy-to-use tools to identify problems and develop solutions using local resources, and it encourages all levels of staff and supervisors to work together as a team and to involve clients in assessing services. Through COPE, staff develop a customer focus, learning to define quality in concrete terms by putting themselves in their clients' shoes. The process also enables staff to explore the strengths of their work site.

COPE emphasizes staff involvement, ownership of services, self-assessment, and teamwork. It recognizes staff members' understanding of local conditions and resources and provides a forum for discussion among staff. The process also helps staff identify concrete and immediate opportunities for action and is responsive to local needs, thus building commitment to QI.

Clients' Rights and Staff Needs

The COPE process is based on two key assumptions:

1. Recipients of health care services are not passive patients waiting to be seen by experts. Instead, they are autonomous health care consumers, or clients.* Clients are responsible for making decisions about their own health care and deserve—indeed, have a right to—high-quality health care.

2. Health care staff desire to perform their duties well. However, if they lack administrative support and critical resources, they will not be able to deliver the high-quality services to which clients are entitled.

As is the case with EngenderHealth's other QI tools and approaches, COPE was developed around a framework of seven clients' rights and three staff needs (see Figure 1-1). These rights and needs underlie the two assumptions given above. The rationale is that the more these rights are honored and these needs are met, the higher the quality of care will be.

Clients who use health care services experience a wide variation in service quality from facility to facility and over time. Depending on their individual experiences, clients may feel satisfied with and eager to use certain services again, unhappy with and determined never to use the services again, or even desperate, if they are dissatisfied with their care but have no other services available or accessible.

Unfortunately, staff rarely learn what their clients' experiences have been. This is because staff usually do not ask clients their opinions about services, and clients often are reluctant to express their feelings to the staff who serve them. Regardless, clients form opinions about the services they receive, and poor-quality services may, among other things, lead clients to stop using services they really need.

Similarly, health care staff experience a wide range in the quality of their work environment, in the information and training they receive, and in the equipment and supplies available to them—all elements that staff need if they are to provide quality services. When staff do not have a forum in which to identify and voice their needs, the necessary changes often are not made.

The framework of clients' rights and staff needs can guide a facility's managers, supervisors, and staff in their efforts to improve quality. Acknowledging that clients have a right to expect certain things when they come for services is a powerful concept, one that has implications for staff behavior and performance. Moreover, recognizing that service providers and other staff have needs that must be met if they are to provide quality services is a motivating force among staff and supervisors. Staff are often frustrated at being unable to provide the kind of services that they both would like to provide and know are needed. This book describes the tools that staff can use to overcome problems and provide better care for their clients.

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* In most health care settings, the persons receiving care are referred to as *patients*, a word that often connotes passivity and ill health. This book uses the word *clients* to reinforce the concept of a customer focus, which is essential in QI, and to suggest a more active role on the part of the person seeking services.

Figure 1-1. The Rights of Clients and the Needs of Staff

The Rights of Clients

Information: Clients have a right to accurate, appropriate, understandable, and unambiguous information related to reproductive health and sexuality, and to health overall. Information and materials for clients need to be available in all parts of the health care facility.

Access to services: Clients have a right to services that are affordable, are available at convenient times and places, are fully accessible with no physical barriers, and have no inappropriate eligibility requirements or social barriers, including discrimination based on sex, age, marital status, fertility, nationality or ethnicity, social class, religion, or sexual orientation.

Informed choice: Clients have a right to make a voluntary, well-considered decision that is based on options, information, and understanding. The informed choice process is a continuum that begins in the community, where people get information even before they come to a facility for services. It is the service provider's responsibility either to confirm that a client has made an informed choice or to help the client reach an informed choice.

Safe services: Clients have a right to safe services, which require skilled providers, attention to infection prevention, and appropriate and effective medical practices. Safe services also mean proper use of service-delivery guidelines, quality assurance mechanisms within the facility, counseling and instructions for clients, and recognition and management of complications related to medical and surgical procedures.

Privacy and confidentiality: Clients have a right to privacy and confidentiality during the delivery of services. This includes privacy and confidentiality during counseling, physical examinations, and clinical procedures, as well as in the staff's handling of clients' medical records and other personal information.

Dignity, comfort, and expression of opinion: All clients have the right to be treated with respect and consideration. Service providers need to ensure that clients are as comfortable as possible during procedures. Clients should be encouraged to express their views freely, even when their views differ from those of service providers.

Continuity of care: All clients have a right to continuity of services, supplies, referrals, and follow-up necessary to maintaining their health.

The Needs of Health Care Staff

Facilitative supervision and management: Health care staff function best in a supportive work environment in which supervisors and managers encourage quality improvement and value staff. Such supervision enables staff to perform their tasks well and thus better meet the needs of their clients.

Information, training, and development: Health care staff need knowledge, skills, and ongoing training and professional development opportunities to remain up-to-date in their field and to continuously improve the quality of services they deliver.

Supplies, equipment, and infrastructure: Health care staff need reliable, sufficient inventories of supplies, instruments, and working equipment, as well as the infrastructure necessary to ensure the uninterrupted delivery of high-quality services.

Adapted from: Huezo & Diaz, 1993; IPPF, 1993.

An Overview of the COPE Process

The COPE Tools and How They Work

The COPE process consists of a set of tools designed to be used together:

- The **Self-Assessment Guides** are sets of questions that help staff think about the way in which services are provided and whether adequate supervision, training, and equipment are available at their facility. There are 10 guides, organized around a framework of clients' rights and staff needs. COPE participants form teams, each of which is responsible for reviewing one or more of the guides. The team members discuss the questions and decide which of them reveal a problem that they have observed or experienced at their own facility. After going through the self-assessment questions, the team members discuss the problems they have identified, determine the root causes of those problems, and recommend solutions, including who will implement them and when. They record their findings in a Team Action Plan for later discussion at the full group's Action Plan Meeting (see page 49). An example of a Self-Assessment Guide appears in Appendix A.

  One component of the self-assessment concerns the client's right to safety. Part of safety involves ensuring that clients' health records are up to date and accurate. For this reason, the Self-Assessment Guide to safety includes the Record-Review Checklist, which staff use to determine whether key information is being recorded accurately and completely in clients' records and whether clients are receiving care according to standards. One or two team members review 10 client records at random to identify record keeping strengths and weaknesses. A sample form appears in Appendix A.

- The **Client-Interview Guide** consists of questions that staff ask clients to learn clients' views of and opinions about the services provided at their facility. Following the guide, individual staff conduct informal interviews with clients who have completed their clinic visit. (Generally, staff conduct a total of 15 interviews, though these numbers may vary, depending on the size of the facility and the volume of clients.) The interviewers encourage each client to discuss the quality of his or her visit, what was good and bad about the visit, and how the quality of services could be improved. A sample completed Client-Interview Guide appears in Appendix A.

- **Client-Flow Analysis (CFA)** is a method of tracking clients through the facility, from the time they enter until the time they leave. Staff track the flow of each client who enters the facility during a specified time period—for example, from 8 a.m. to noon, or from 8 a.m. to 4 p.m. The Client Register Form is used to track clients from the time they enter the facility until the time they leave, by recording their contacts with a provider and the duration of each contact. One or two team members complete the Client-Flow Chart and the Client-Flow Chart Summary. They then chart, graph, and analyze the data, discuss the findings, and record them as a Team Action Plan for presentation at the Action Plan Meeting. EngenderHealth recommends that facilities not perform CFA during the first COPE exercise. Sample completed CFA forms appear in Appendix A.

- The **Action Plan** is a written plan that staff develop to help resolve the problems they identify during a COPE exercise. When COPE participants have completed the self-assessments, client interviews, record reviews, and CFA (if performed), they convene at the Action Plan Meeting to discuss, consolidate, and prioritize the problems and recommendations in the Team Action Plans. Through this process, the group develops an Action Plan for the facility that lists:
  - Each of the problems identified
  - The root causes of each problem

▲ The actions recommended to solve each problem

▲ The staff members responsible for implementing the recommended actions

▲ The completion date for each action

Sample completed Action Plans are presented in Appendix A.

Because COPE is ongoing and flexible, additional tools may be adapted for use in later exercises.

Who Participates in COPE?

Improving quality is the responsibility of all staff at a facility. Therefore, as many staff as possible should participate in COPE exercises. It is important to ensure that each department and each cadre of staff is represented. This includes the facility's manager(s), supervisors, service providers, nurses, medical or surgical assistants, counselors, health educators, administrative staff, receptionists, guards, cleaning staff, other support staff, and affiliated community health workers who work in clinics, wards, the laboratory, the X-ray department, or surgical units.

Who Conducts the Exercises?

COPE exercises are led by two types of facilitators, each of whom fills a different role in the COPE process:

- The *external facilitator* introduces COPE to the facility, guides the staff through the COPE process during the first COPE exercise, and trains one or more staff members to be site facilitators. He or she generally comes from outside the facility and is often someone from higher levels in the facility's organization or from a technical assistance organization with experience in conducting COPE exercises. He or she may provide assistance to the site facilitators for the first few exercises.

- The *site facilitator* organizes and facilitates subsequent COPE exercises, to establish a continuous QI process at the facility. Having a trained site facilitator is essential for staff to continue to do COPE on their own. Alternatively, a staff member may receive training in COPE facilitation off-site and then return to the facility to introduce COPE.

More information about the roles and qualifications of external facilitators and site facilitators will be provided in later chapters.

What Happens before the COPE Exercises?

The external facilitator's first priority is to orient facility managers about COPE and assess the facility's level of support for QI exercises. This orientation will focus on three main content areas—COPE and the QI process in general, the manager's role in the COPE process, and what will be required of the manager in following up and continuing the process. The external facilitator also will need to discuss with the facility manager which health services or areas the first COPE exercise should focus on.

Another important preliminary step is selecting and orienting a site facilitator. While the external facilitator conducts the facility's first COPE exercise and helps with subsequent exercises, the site needs its own trained facilitator if COPE is to become a continuous process. The external facilitator should invite the facility manager to choose someone or to ask for a volunteer from the staff; this person will be coached by the external facilitator on

Figure 1-2. COPE at a Glance

Self-Assessment Guides
Self-assessment teams:

- Schedule meeting and pick a team member to present Team Action Plan
- Meet to review self-assessment questions
- Conduct self-assessment and record review
- Prepare Team Action Plan: identify problems and root causes, recommend actions, assign responsibility for actions, and establish completion dates

Introductory Meeting
Facilitator:

- Describes quality in real terms
- Explains COPE components

Facilitator and all participants:

- Form teams
- Assess progress on previous action plans (if a follow-up exercise)

Client Interviews
Interview team:

- Meets with facilitator to review interview instructions and obtain interview guide
- Conducts interviews
- Prepares Team Action Plan: identifies problems and root causes, recommends actions, assigns responsibility for actions, and establishes completion dates
- Picks a team member to present Team Action Plan

Action Plan Meeting
Facilitator and all participants:

- Discuss strengths
- Discuss Team Action Plans: problems, root causes, and recommendations
- Consolidate and prioritize problems
- Develop facility Action Plan with problems, root causes, recommended actions, staff responsible for actions, and completion dates
- Form COPE Committee
- Schedule follow-up

Site Preparation
Facilitator:

- Orients key managers
- Selects and orients site facilitator
- Prepares materials and room
- Selects participants

Client-Flow Analysis (CFA) (for follow-up exercises)
All participants:

- Meet with facilitator to review CFA instructions
- Establish entry points
- Assign team members to: distribute Client Register Forms at entrances, collect Client Register Forms before clients leave, and present findings at the Action Plan Meeting
- Number Client Register Forms
- Track client flow
- Prepare summary sheets, charts, and graphs
- Analyze client flow and staff utilization
- Meet to prepare Team Action Plan: identify problems and root causes, recommend actions, assign responsibility for actions, and establish completion dates

Follow-up

how to conduct COPE exercises and will be expected to take on increasing responsibility over time for facilitating the exercises.

Finally, before the COPE exercises can begin, the external facilitator needs to work out (with the facility manager) a schedule that minimizes service interruptions and their impact on clients, a plan for which staff members should participate in the exercise (both how many and from which units or departments), and how much space will be needed for meetings and group work.

What Happens during COPE Exercises?

During a facility's first COPE exercise, the external facilitator orients participants to the idea of continuous QI and to the concepts of clients' rights and staff needs and explains how to do self-assessment using the Self-Assessment Guides and Client-Interview Guide. Groups of staff work together to discuss and answer the questions posed in the Self-Assessment Guide, while other staff interview clients. Based on the responses, staff members identify areas in need of improvement and develop an Action Plan for presentation and discussion with the larger group. In addition, during this exercise, the external facilitator works with the site facilitator to explain the continuous COPE process and facilitation skills, as well as to give the site facilitator some responsibilities in facilitating the exercise. (See Figure 1-2 for a graphic representation of how the COPE process works.)

Figure 1-3 provides an overview of all of the stages in the COPE process, as well as estimates of the minimum amount of time that will be needed for each activity and of how frequently the activity should be conducted.

Figure 1-3. Timetable for the COPE Process

Stage	Minimum time period needed/ how often
Site preparation • Orient key managers and staff	1 to 2 hours or more, depending on time availability
• Select and orient site facilitator	Variable
• Prepare materials and room	3 to 4 hours
• Select participants	Variable
Introductory Meeting	2 to 3 hours
Application of COPE tools	A few hours of time, usually spread over the course of 1 to 3 days
Action Plan Meeting	3 to 4 hours
Follow-up on the Action Plan	Within 1 month after the first COPE exercise, and then ongoing
Second and subsequent COPE exercises	2 to 3 days once every 3 to 4 months
Measurement of the facility's progress over time	Quarterly; annually

Note: This process is flexible. The following chapters provide some suggestions for adapting the process to meet an individual facility's needs.

Both facilitators share responsibility for facilitating the second COPE exercise; by the third COPE exercise, the site facilitator leads the exercise alone or with only minor assistance from the external facilitator. Thereafter, the site facilitator conducts COPE follow-up exercises on his or her own, with support from the facility's supervisors, higher-level supervisors, and headquarters administrators.

Establishing the COPE Committee

At the end of the facility's first COPE exercise, the external facilitator helps the staff establish a COPE Committee. This committee—composed of staff members, supervisors, and site managers—plays a critical role in making QI an ongoing responsibility and the focus of the daily work of staff at all levels. The committee's main role is to monitor progress in carrying out the facility's ongoing COPE Action Plan. If there is already a QI committee, the facilitators ensure that monitoring progress of the Action Plan is added to its agenda.

Principles Underlying COPE

Quality Improvement Principles

Quality in health care is often defined as providing client-centered services and meeting clients' needs (Berwick et al., 1990). The QI process is an effort to continuously do things better until they are done right the first time every time. There are several reasons to improve the quality of the health care services provided at a facility. Improving quality safeguards the health of both clients and staff, adds features to attract clients, maintains the organization's strengths, and leads to savings (less repeat work and waste).

The COPE process and tools draw on management theories and principles widely used in a range of fields, including health care. The most important QI principles on which COPE is based are:

- Taking on the mindset of the customer (client)—meeting the needs and expectations of clients
- Having staff become involved in and feel ownership of quality and of the process for improving quality
- Focusing on processes and systems, and recognizing that poor quality is often a function of weak systems, weak processes, or implementation problems, rather than the fault of individuals
- Promoting efficiency and cost-consciousness by eliminating the costs of poor quality (e.g., repeat work and waste)
- Encouraging continuous staff learning, development, and capacity-building, since staff need skills to carry out the QI process and provide quality services, and supervisors and team leaders need to be able to facilitate the work of staff and the development of those skills
- Implementing continuous QI work, as there will always be opportunities to improve what staff do and to have a sustained positive impact on services

COPE enables staff to apply these principles at service facilities.

COPE and the QI Process

COPE fits within a *continuous process* of QI. This process consists of the following four steps, which repeat:

- **Step 1—Information-gathering and analysis:** Using self-assessments, client interviews, record review, and CFA to identify problems
- **Step 2—Action Plan development and prioritization:** Refining a problem, prioritizing, recommending solutions, and deciding by whom and by when the problem will be addressed
- **Step 3—Implementation of the Action Plan**
- **Step 4—Follow-up and evaluation:** Including discussion of the progress made on the Action Plan, evaluation of successes and failures, further information gathering, and development of a new Action Plan, with new problems and solutions identified, and completing the process by beginning again with Step 1

Why Use COPE to Improve Quality?

- **Self-assessment promotes a sense of ownership among staff.** When staff assess their own services, rather than having the services assessed by outsiders, they feel that the problems they identify are theirs, and they feel responsible for addressing the problems. This creates a sense of *ownership* and *commitment* to the solutions developed.
- **COPE relies on the wisdom of the experts.** The experts on the services at a facility are the *staff* who provide them and the *clients* who use them. COPE gives both staff and clients a chance to apply their expertise and insights toward improving services.
- **The tools are practical and relatively simple to understand and use.** An important reason why COPE works well is that the tools are practical and easy to use. The process is not full of theories or complicated diagrams that staff must learn. Rather, the tools are directly related to what staff do in their daily work.
- **COPE promotes teamwork and cooperation among all levels of staff.** By using the tools together, supervisors and staff become accustomed to working as a team.
- **COPE boosts staff morale and provides a forum for staff and supervisors to exchange ideas.** Staff members who have used COPE have said, "I knew that we could improve services by doing that, but I never had the opportunity to talk to [the doctor-in-charge] before." By providing an opportunity to become involved in problem solving and decision making, COPE leads to increased staff morale.
- **COPE helps communicate service standards to staff and, thereby, improves performance.** The COPE Self-Assessment Guides are based on international service standards. (These guides are described in more detail in Chapter 2.) Using the guides raises staff awareness of the importance of quality, what quality services are, and what is important to clients.
- **COPE is cost-effective.** COPE is inexpensive to do. All that is needed are a few hours of a facilitator's time, a small amount of time for staff to participate during regular work hours, flipchart paper, and photocopies of the forms needed for the exercises.
- **COPE is transferable and adaptable from one setting to another.** COPE has been used in a range of health care facilities, from national referral hospitals to small clinics, in private- and public-sector institutions, and in both very-low-resource and very-high-resource settings. COPE also has been applied to many different health services, from family planning to maternal and child health services to infection prevention practices for all staff at a health care facility.

- **COPE helps site managers work more effectively.** Although site managers may initially find introducing COPE and QI to be time-consuming, once staff become involved in solving day-to-day problems on their own, managers generally find that they have more time to focus on major problems. In addition, COPE helps site managers solve problems, thus relieving them of some of the burden.

- **Poor quality is costly.** If something is not done correctly the first time, it must be fixed, often repeatedly. Moreover, the consequences may be serious, in terms of both cost and the health of individuals and the community. COPE helps reduce the cost of poor quality by helping staff identify and solve problems, focusing on processes and systems to prevent problems from occurring in the future. The examples below (Figure 1-4) show how poor quality is wasteful and how improving quality increases efficiency and saves money. In each of the examples, the solution comes from changes that the service providers and other staff themselves can make to substantially improve the quality of services.

Figure 1-4. Savings from Improved Quality

Area	Costs of poor quality	Savings and benefits from improved quality
Sterilization/processing of equipment	Incorrect processing increases the incidence of infections among clients (for example, during IUD insertion or delivery). This requires treatment of complications using additional staff time, medications, and other supplies. The reputation of the clinic suffers and clients may stay away from the services. Some clients may suffer permanently as a result of the infections they contract.	Correct processing reduces the incidence of postprocedure infection and complications, avoiding unnecessary additional expenses and supplies. Clients are satisfied with the services and recommend them to family and friends. The number of clients served at the facility may increase.
Performance of tests (such as Pap smears)	Unsatisfactory tests require repeat testing, thereby wasting resources (supplies and money) and staff and clients' time. Unsatisfactory tests give false or no results.	Clients and staff save resources and time. Clients' health is improved, and illnesses are diagnosed in a timely manner.

Note: The *Facilitative Supervision Handbook* (EngenderHealth, 2001) provides more examples of how improved quality leads to savings.

COPE Successes

There are countless stories of successes using COPE, gathered from the experiences of health care staff from around the world. The examples below illustrate how changes can take place using COPE. Additional examples appear throughout this handbook and in Appendix B.

Asking the Right Person

One facility did not have running water for a very long time. Managers attributed the problem to low water pressure and hired tanker trucks to deliver water, which staff then carried in buckets to each ward. After a while, staff proposed replacing the hospital's entire water system, but the cost was too great. Their only option was to ask donors to pay for building a new water system. They waited for a while, but this did not happen. Then COPE was introduced at the facility. After listening to the discussion about the water problem, the hospital's groundskeeper, who was included in the exercise, said, "But don't you know that the reason you do not have water is that the pipe that leads into the hospital is broken? All you have to do is repair the pipe." Managers asked the groundskeeper why he had not said anything earlier, and he replied that no one had asked his opinion before. The pipe was repaired, and the problem was solved at a much lower cost than had been expected.

Increasing Child Immunization Using Available Resources

During a COPE exercise, staff at an East African health center identified a problem: Too many young children did not receive the full course of immunization injections, and there was no follow-up approach for these cases. One of the root causes was that inconsistent record keeping made it difficult to know which clients needed follow-up. The clinic often ran out of the official Ministry of Health "Road to Health" child health cards, so the information either was not recorded at all or was documented unsystematically (for example, mothers would buy school exercise books in which to keep their children's health records). To address this issue, the health center figured out a system for procuring child health cards more consistently and developed a standard way of documenting immunization information on alternative documents (such as exercise books). With these systems in place, clinic staff are now better able to identify infants who are in need of immunization follow-up, and the rates of follow-up immunization have increased.

Adapted from: AVSC International, 2000a.

COPE Is Part of a QI Package

COPE is not a cure-all for improving services. Rather, it is one approach among several components of EngenderHealth's QI package, all of which are most successful when continuously used together. (For more information about how the tools function together as a package, see Dohlie et al., 1999.)

In addition to COPE, the main components of EngenderHealth's QI package are:

- **Facilitative supervision.** This approach emphasizes mentoring, joint problem-solving, and two-way communication between a supervisor and those being supervised. To facilitate change and improvement and to encourage staff to solve problems, supervisors must have the solid technical knowledge and skills needed to perform tasks, know how to access additional support as needed, and have time to meet with the staff they supervise.

- **Medical monitoring.** This is a medical QI intervention that includes the objective and ongoing assessment of the readiness of and processes involved in service delivery. It is conducted to identify gaps between best practices and actual practices, and is meant to lead to recommendations for improvement.

- **Whole-site training.** This approach is aimed at meeting the learning needs of a facility. Whole-site training links supervision and training, emphasizes teamwork and sustainability, and includes a range of training strategies. Whole-site training includes *inreach* (staff orientations, referrals, linkages between departments, and adequate signs) to ensure that clients do not miss opportunities to access information and services for all of their reproductive health needs when they come to the facility.

- **Quality Measuring Tool.** This tool is used annually to measure QI over time. Based on the self-assessment tool used in COPE, facility staff and supervisors use the Quality Measuring Tool together to determine whether clients' rights are being upheld and whether staff needs are being met. Any new problems identified are then incorporated into the facility's ongoing Action Plan.

- **Cost-Analysis Tool.** Health care staff use this tool to measure the direct costs of providing specific health services. It measures the cost of staff time spent directly providing a service or clinical procedure and the costs of the commodities, expendable supplies, and medications used to provide that particular service or procedure. The information can be used to improve the efficiency of staffing and the use of staff time and supplies at a facility, as well as to set user fees that reflect the actual direct costs of different services.

- **Community COPE.** This participatory process and tool, an extension of COPE, is for health care staff to build partnerships with community members, to improve local health services by making services more responsive to local needs. It can also have the result of increasing community "ownership" of health facilities and services and of increasing advocacy for resources for health. It is particularly useful to facilities in areas undergoing health care reform, as a means of engaging the community in defining and supporting the quality of services they want. The range of activities for learning about local needs and suggestions for improvement include individual interviews, group discussions, community meetings, facility walk-throughs, and participatory mapping. Like COPE, the process includes identifying and analyzing problems, developing an Action Plan, and prioritizing solutions. Community members select representatives to join the health facility's QI committee and facilitate ongoing communication between the community and the facility's staff.

chapter 2

Orienting Key Managers to the COPE Process

> This chapter is aimed at external facilitators.

This chapter provides an overview of the concepts facilitators need to communicate to key managers to obtain their support in introducing COPE. In addition, the section beginning "Once You Have Received Key Managers' Support" contains information to give to facility managers about what aspects of COPE's implementation they will need to coordinate and administer.

Objectives

After reading this chapter, you should be:
- Familiar with the core components of orienting facility managers to the COPE process
- Able to identify other critical stakeholders and orient them to the COPE process

After obtaining facility managers' support, you should be able to assist them to:
- Schedule the first COPE exercise and alternatives to fit the facility's needs
- Decide which health services or areas to focus on during the first COPE exercise
- Select a site facilitator
- Discuss who should participate, and inform and invite them
- Form a facility COPE Committee

Getting to Know COPE

Before introducing COPE to a facility, become thoroughly familiar with this handbook and with the COPE process. It is important to be well prepared before orienting important stakeholders to the process and before conducting the first COPE exercise.

It is highly recommended that you have observed *at least* one COPE exercise and have good facilitation skills before conducting a COPE exercise. (Facilitation skills are discussed in detail in Appendix D.) In addition, to increase your skills in conducting a COPE exercise, you might practice conducting one with your colleagues, or you might ask a colleague or other professional who has conducted a COPE exercise to train you or discuss the process with you.

Generating Critical Support

To introduce COPE at a facility successfully and to ensure ongoing follow-up of the process, it is essential to have the support of certain stakeholders within both the facility and the institution.

Key stakeholders are those staff who have some decision-making authority or supervisory responsibilities. At the facility level, they could include, for example, the medical officer in charge, the head nurse, the hospital administrator, and the supplies manager. At the institutional level, key stakeholders could include senior-level people among the medical, clinical, supervisory, training, and supplies staff. Positions and titles may vary across different facilities and organizations or others may also be key stakeholders. You will need to consider whom the key stakeholders are for each individual facility or institution, to ensure that you orient the key people to the COPE process.

Facility-Level Support

Key stakeholders

There are three different sets of stakeholders who can have a substantial impact on the success of COPE:

- **The facility manager.** * The facility manager is the first key person whose support is needed for COPE. This individual should always be oriented about COPE and consulted about logistical matters before the process is introduced at the facility.
- **Managers or supervisors with day-to-day responsibility for service delivery.** These are people who interact with the staff on a daily basis. All of these managers should attend the orientation, if possible, since their support will be crucial in enabling staff to become involved in self-assessment and problem-solving activities.
- **Facility staff.** COPE's success at a facility depends on the enthusiasm of the staff. If you show enthusiasm for the process while conducting COPE exercises, staff are more likely to become enthusiastic as well.

Facility-level commitment

Because QI is an ongoing process, one COPE exercise alone will not lead to continuous improvement. A sustainable process requires long-term commitment at the facility level.

Prior to the first COPE exercise, you may not be able to accurately assess facility managers' and staff's support for the COPE process. Therefore, during the orientation with facility managers, it is important to raise questions about the facility's level of support, so you have a sense of it before the exercise begins. While there is no guaranteed formula for success, working with facility managers can help nurture facility-level commitment throughout the process.

Enabling Conditions at the Facility Level

To foster facility-level commitment to the COPE process, it is helpful if facility managers approach the COPE process with:

- A vision of high-quality services, clear expectations for staff, and the motivation to communicate their vision and expectations to staff

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* The person who holds primary managerial responsibility for a site may be known by various titles in settings around the world. Here, the term *facility manager* refers to the head doctor or physician, chief of hospital, clinic director, clinic manager, or any other person serving in this role.

- The understanding that engaging staff in routine problem solving will enable managers to focus their attention on larger management issues and on furthering the overall facility goals
- An awareness that staff generally want to perform well, are experts about their work environment, and have the capacity to help improve quality
- An understanding that work processes and systems frequently hinder people from performing at optimum levels
- An interest in improving quality and supporting the initial COPE exercise
- A commitment to ongoing follow-up and a receptivity to change
- A willingness to provide the resources necessary for the process (The main resource is time; many interventions do not cost a lot of money.)

Staff, in turn, need to be willing to follow the organization's leadership to improve quality when given the necessary resources. Most often, there are potential leaders among staff who can help guide their colleagues to become more involved in the COPE process. These leaders are not necessarily senior staff; rather, they can be anyone whom the other staff respect and listen to. If these leaders are identified by facility managers and notified early in the process, the facility's initial commitment level to COPE may be strengthened.

Institution-Level Support

Key stakeholders

At the institutional level, the key stakeholders are senior managers who are responsible for overseeing service delivery, including those who manage service standards, supplies, training, and supervision. The support of senior managers is important because COPE exercises may identify some facility-level needs that require support from higher levels in the institution, such as those involving training, supplies, and supervision. (See the case study "Getting Support from Headquarters" in Appendix C [page 122] for an illustration of this.) Without such external support, facility staff may become frustrated by problems that they are unable to solve at the facility level and the QI process may lose momentum.

Institution-level commitment

Commitment at the institutional level is equally crucial for the QI process to become sustainable at the facility level. The process of introducing COPE may help build supportive conditions within an institution by strengthening two-way communication between facilities and higher levels and by promoting a problem-solving approach.

Enabling Conditions at the Institution Level

To foster institution-level commitment to the COPE process, it is helpful if senior managers:

- Are aware of what continuous QI involves and what COPE can contribute
- Are willing, in the long run, to change institutional practices, standards, or personal behaviors so as to help facilities improve services
- Understand that COPE will create demands on support and resources and remain willing to provide the support needed (such as institutional support in supervision, training, or supplies)

When COPE is introduced at the facility level, it often creates demand for resources and support from the institutional level. To help institutions build an enabling environment and

meet the demands for improved supervision, refer to the *Facilitative Supervision Handbook* (AVSC International, 1999).

Orienting Key Managers

There is no single preferred method for orienting key managers. However, orientation should be held in person and should fit the circumstances and the schedules of the people involved. Although it is possible to orient facility and institutional managers and stakeholders together, generally their orientations are conducted separately because these managers usually work in different locations.

Orientation can take place in a variety of settings. It may consist of a single meeting with key managers, a series of shorter meetings, or a workshop with representatives from several facilities or institutions. In planning an orientation, the keys are knowing the main points you wish to convey and being flexible: Your planned two-hour presentation could turn into a 10-minute discussion if circumstances change and the manager is called away.

Managers will need to be oriented on three main content areas:
- COPE and the QI process in general
- Their immediate role in the COPE process
- The commitment required of them in following up and continuing the process

Appendix E contains flipcharts that can be used during formal presentations to key managers.

Orienting Managers to QI and COPE

In introducing managers to the concepts of QI and COPE, four main topic areas should be emphasized:
- **Site strengths.** Drawing out from managers what they see as the strengths of their facility or institution allows you to learn what their work is like and also serves as a vehicle for building a positive connection with them. COPE builds on the strengths of their facility or institution.
- **Quality.** It is important to emphasize the philosophy behind this QI process. The discussion could include the following elements:
  - What is quality? Quality can be defined in terms of clients' rights and staff needs. Staff are the experts in the quality of care at the facility.
  - Why improve quality? What are the costs of poor quality?
  - What are the principles of QI?
- **COPE overview.** This involves explaining what COPE is, what the tools are and how they work, and how COPE fits into QI overall. It includes answering the question "Why use COPE?" and giving examples of its success elsewhere, as well as describing EngenderHealth's QI package.
- **Stages and steps of the COPE process.** Here you can explain the "nuts and bolts" of how the process works: what is involved in preparing for a COPE exercise, orienting staff to the process, using the COPE tools, conducting the Action Plan Meeting, planning for follow-up, and maintaining an ongoing COPE process.

Appendix C provides a series of orientation topics that expand on the four main concepts detailed above. You can discuss these topics separately or as a whole, choosing which are most important and appropriate given the time available. These same topics are also covered in large part in Chapter 1.

Orienting Facility Managers to Their Role in COPE

Enabling staff to improve quality

Emphasize that facility managers and supervisors are catalysts for QI and have four important roles:

- To set goals for staff
- To lead and motivate staff to improve quality
- To build trust and create an environment conducive to QI
- To meet staff needs for:
  - Facilitative supervision and management
  - Information, training, and development
  - Supplies, equipment, and infrastructure

Site managers need to have a clear perspective on their role as liaison between staff needs and the institutional resources available to meet those needs. As staff experience the power of the participatory process of COPE, they will inevitably have demands and expectations for resolving problems as they identify them; it is the facility manager's role to support and facilitate this process.

Explaining shared decision making and shared responsibility for solutions

Because COPE provides a forum for supervisors and staff to assess and improve the quality of their services as a team, some decisions will be made at lower levels than before. For example, staff such as nurses, counselors, receptionists, and cleaners all participate in identifying problems, proposing solutions, and implementing solutions related to their work.

Acknowledging that people may feel threatened

Supervisors and facility managers may feel threatened by the delegation of decision-making authority inherent in COPE. However, because supervisors also participate in the COPE process, they have a chance to explain their concerns about a particular problem or about a solution proposed by other staff. Many supervisors and managers find that delegating some problem solving and decision making frees them to attend to problems that cannot be solved at lower levels. Under the best of circumstances, this change leads to better work performance and higher motivation and job satisfaction at all levels. Supervisors have little to lose and much to gain in involving staff in problem solving to improve quality.

Discussing the time commitment to COPE

The facility manager must allow the staff time to participate in COPE. Time commitments include:

- About two to three hours on the first day for the Introductory Meeting
- A few hours for group work (which can be done while staff carry out their regular duties)
- About three to four hours on the second day for the Action Plan Meeting

The facility manager should plan to be present and to participate actively in the introductory and action plan meetings.

Discussing with facility managers their role in the first COPE exercise

Site managers can demonstrate their commitment to quality and the COPE process by actively participating in the Introductory Meeting. Therefore, discuss with facility managers whether they could introduce or facilitate any part of the Introductory Meeting (such as the icebreaker). It is important for staff to see the manager as "just another participant," to lessen any feelings of intimidation. At the same time, to set a tone of leadership and support of the COPE process, it is better to have facility managers introduce or facilitate some (small) part of the exercise than to have the facilitation be done entirely by outsiders.

Committing Managers to Follow-Up

Explain that if COPE is introduced without adequate follow-up, it will have few lasting effects; COPE must become an ongoing process. If you have not already assessed the level of commitment of managers at the facility and institutional levels, ask them:

- Are you ready to make a long-term commitment to QI? While the COPE tools are not difficult to use, the process requires long-term commitment beyond the introductory activities, and the process can be challenging and difficult.
- Is internal support (and external support, if needed) available to sustain the QI process?

Follow-up at the facility includes:

- Conducting subsequent COPE exercises every three to four months. This allows staff sufficient time to resolve some of the problems identified without losing the momentum for making changes.
- Choosing and mentoring an on-site staff person to take over as facilitator from the external facilitator over a period of two to three COPE exercises. Training and mentoring a site facilitator is a key component of a sustainable COPE process.
- Establishing a COPE Committee, or integrating its activities into an existing QI committee.

Once You Have Received Key Managers' Support

After you have presented the overview of COPE and QI, the managers you have oriented might need some time to decide whether to pursue this QI process. This section covers the logistical and administrative areas that facility managers need to know about once you obtain their support. It orients them to their responsibilities in coordinating and setting up the first COPE exercise (specifically related to logistics and scheduling), in selecting the health service or area to focus on, in selecting the site facilitator, in inviting COPE participants, and in forming the COPE Committee.

Logistics and Scheduling

Flexibility and adjustability of the COPE schedule

The schedule for a COPE exercise is flexible and can be adapted to accommodate a facility's workload, client load, and staffing shifts, for example. Communicate to key managers that:

- It is crucial that staff's participation in the exercise disrupt service delivery as little as possible. Scheduling the meetings to take place during a less busy time of day or day of the week is an important element in planning.
- Use of the Self-Assessment Guides and Client-Interview Guide can be spread over a series of days if staff time is very limited (although it is recommended that the complete exercise not take longer than one week, as staff may lose focus and momentum and may therefore see fewer immediate improvements).

Review the sample schedules below and on page 24 with the facility manager, decide together on a meeting space for the Introductory Meeting and Action Plan Meeting, and set a time for the introduction to begin.

Figure 2-1. Sample Schedules for the First COPE Exercise

Sample A: A facility with a steady client load all day

Day 1
Morning—Introducing COPE
- Tour the facility and meet management and the participants in COPE
- Conduct the Introductory Meeting with staff (approximately 2 to 3 hours)

Afternoon—Conducting the Client Interviews and Self-Assessment
- Conduct the client interviews ⎫ Carried out during routine work hours,
- Conduct the self-assessment ⎭ at the staff's convenience

Day 2
Morning—Preparing Action Plans
- Prepare the Client-Interview Action Plan ⎫ Carried out during routine work hours,
- Prepare the Self-Assessment Action Plan ⎭ at the staff's convenience

Afternoon—Presenting the Action Plan
- Hold the Action Plan Meeting with the same staff who participated in the Introductory Meeting (approximately 3 to 4 hours)
- Select the COPE Committee members
- Schedule dates for the Follow-Up Meeting and for the next COPE exercise

Figure 2-1. Sample Schedules for the First COPE Exercise
Sample B: A facility with its heaviest client load in the morning

Day 1
Afternoon—Introducing COPE
- Tour the facility and meet management and the participants in COPE
- Conduct the Introductory Meeting with staff (approximately 2 to 3 hours)

Day 2
Morning—Conducting the Client Interviews
- Conduct client interviews } Carried out during routine work hours, at the staff's convenience

Afternoon—Conducting Self-Assessment and Preparing Action Plans
- Prepare the Client-Interview Action Plan
- Conduct the self-assessment
- Prepare the Self-Assessment Action Plan

} Carried out during routine work hours, at the staff's convenience

Day 3
Afternoon—Presenting the Action Plan
- Hold the Action Plan Meeting with the same staff who participated in the Introductory Meeting (approximately 3 to 4 hours)
- Select the COPE Committee members
- Schedule dates for the Follow-Up Meeting and for the next COPE exercise

Explain how the schedule can be adapted, depending on the size of the facility, the number of staff and shifts, and the client load, among others. For example:

- **For a large facility.** One large regional hospital conducted the first COPE exercise with representative staff from several departments together. Participants used the Self-Assessment Guides, the Client-Interview Guides, and the Record-Review Checklist to develop an Action Plan for the facility. Since then, monthly COPE follow-up exercises have taken place at the ward and department levels. Staff review the progress made in the ongoing Action Plan and identify and solve new problems.

- **For a small facility.** A small family planning clinic introduced COPE by having staff review two Self-Assessment Guides, conduct client interviews on the next day, conduct record reviews on the next day, and then hold the Action Plan Meeting. The facility followed the same schedule for subsequent COPE exercises, thus spreading each exercise over four days. Within five COPE exercises, all 10 Self-Assessment Guides were used.

- **For multiple shifts.** A large maternity hospital conducted COPE introductory exercises for staff in three separate shifts (in the morning, afternoon, and night), involving a total of 186 participants. Representatives of all shifts were involved in the afternoon and night exercises, and participants reviewed the Action Plan developed by the morning shift. Then staff used the Self-Assessment Guides, conducted client interviews and record reviews, and added new problems to the facility's Action Plan. For subsequent COPE exercises, each shift worked with selected Self-Assessment Guides, so that over the course of the year they had a chance to use all of the guides.

Selecting Health Services or Areas on Which to Focus

Discuss with the facility manager which health services or areas to focus on in the first COPE exercise. Depending on which health services the facility provides, the first COPE exercise may focus on solving problems related to reproductive health, family planning, child health, or other areas. *COPE® for Reproductive Health Services: A Toolbook to Accompany the COPE® Handbook* is the most general of the COPE toolbooks, and therefore usually is used first. Many questions, such as those about infection prevention, client privacy, staff training, and supervision, apply to all health services and are contained in each COPE toolbook.

If a facility or some wards at that facility provide other kinds of services, staff may still use many of the guides that are common for all services and combine them with questions relating to the facility's standards or to national standards. Remind the managers that even if the facility is assessing a single set of services in depth, it is important to include a range of staff from different departments, to build and maintain teamwork and linkages between departments.

Selecting the Site Facilitator

The external facilitator conducts the facility's first COPE exercise and helps conduct subsequent COPE exercises. However, for COPE to become a continuous process, it is important for the site to have its own trained facilitator. This is someone, selected by the manager, who is coached by the external facilitator on how to conduct COPE exercises and is encouraged to take on increasing responsibility over time for facilitating the exercises.

Generally, site facilitators are staff members at the facility or within the unit where the COPE exercise will take place, representing any unit and any level within the facility. There may be occasions in which the facilitator is a staff person within a local network of facilities who may be familiar with the facility but who does not work on-site.

Ask the facility manager if he or she prefers to choose someone or to ask someone to volunteer. Either way, site facilitators should meet two essential criteria:

- Other staff should consider them credible and should trust and be open with them during COPE discussions.
- They should have demonstrated facilitation skills or the potential to develop them.

It is helpful if the site facilitator has a general knowledge of health services. If this person does not have technical experience in the health services(s) to be assessed through COPE, then he or she should be prepared to ask clinical staff for clarification on specific standards and guidelines. Other helpful qualities include skills in organizing or leading teams and group activities and the ability to serve on the COPE Committee.

If the facilitator comes from outside the work site, consider how staff might perceive the facilitator. For example, does the facilitator have an ongoing relationship with the work site? If this person does not have an existing relationship with the facility, the COPE introduction and the training of the site facilitator will require establishing an ongoing relationship based on trust and communication.

Informing and Inviting Participants

It is essential that all staff understand the concept of quality and the importance of each person's contribution to the QI process. Explain the following to key managers:

- At *medium-size* or *small* facilities (those with 20 or fewer staff members), it is ideal to encourage all staff to participate in the COPE exercise.
- At *larger* facilities, all staff need to be informed about the COPE exercise and process. However, all staff do not need to participate at first; only representatives of all *units* and all *levels* of staff need to participate. At these facilities, each group that completes one or more Self-Assessment Guides should include different levels of staff (see the instructions at the top of each Self-Assessment Guide). When discussing each of the guides, groups should seek input from other staff to help involve those who do not participate directly in the exercise.

For ease in facilitating the exercise and the discussions, facilities generally limit the introductory and action plan meetings to about 30 participants. However, some large facilities have conducted exercises with more than 150 participants. If the facility is large and has many staff, the exercise may be repeated among different groups of staff over time. However, each group should include a mix of levels of staff. Managers should inform staff about the exercise ahead of time and should encourage staff to participate. This helps staff organize their work duties appropriately and arrive promptly for the meetings.

Remember to arrange for space for meetings and group work that is large enough to accommodate the participants.

Discussing the Formation of the Facility COPE Committee

The COPE Committee (or Quality Improvement Committee, or some other name chosen by the facility) plays a critical role in making QI an ongoing responsibility and the focus of the daily work of staff at all levels. Its main role is to monitor progress in implementing the COPE Action Plan. The committee, which is formed at the end of the introductory COPE exercise, should represent different levels of personnel at the facility, including managers, supervisors, and staff members. The group can be newly formed or can be an existing committee at the facility, possibly with a few adjustments.

Ask the manager whether the facility has a QI Committee or whether a new committee should be formed.

Generally, the COPE Committee consists of about five to eight staff members, as follows:

- In facilities with eight or fewer staff members, the entire staff serves on the COPE Committee.
- Larger facilities may have one large, overall coordinating committee and several smaller committees at the ward or department level. Alternatively, larger facilities may create functional teams that focus on improving specific issues, such as infection prevention.
- If the facility already has a committee representing the various units and staff levels, that committee may incorporate follow-up of the COPE Action Plan into its ongoing work. If a facility's existing committee does not represent the various units or levels of staff, its membership should be expanded.

Identifying the Facility Manager's Responsibilities

If COPE is to proceed smoothly, the manager of the facility needs to assume a number of logistical responsibilities, ranging from setting schedules that do not interfere with the provision of clinical services to arranging appropriate space for meetings and for group work. Figure 2.2 outlines the most important logistical issues for which the facility manager will need to take responsibility.

Figure 2-2. Logistics Checklist for the Facility Manager

✔ Schedule the first COPE exercise for a time that will minimize interruption of services and any impact on clients. (Do not disturb normal services at the facility.)

✔ Choose the health service or area that the facility will assess during the first COPE exercise.

✔ Select a site facilitator.

✔ Select the participants (how many and from which units or departments).

✔ Distribute information or invitations to the participants ahead of time.

✔ Arrange for space for meetings and group work.

✔ Discuss with the manager formation of the facility's COPE Committee.

Troubleshooting Tips

IF: *The key facility manager does not seem supportive of the idea of introducing COPE as a whole...*

■ **Do not introduce COPE without his or her support.** Ask the manager what his or her concerns are. Some facility managers are concerned that by encouraging staff to share in decision making, managers will lose their authority and may be seen as handing over their responsibilities to staff who are less experienced in making such decisions. Explain that COPE does not take away the authority of supervisors at a facility, but builds staff ownership of solutions and responsibility for implementing them.

IF: *The key facility manager is not willing or able to commit to following up the process after the COPE introduction...*

■ **Do not introduce COPE.** Facility managers have an important role to play in communicating to staff their expectations about the high quality of services the facility should be providing and in demonstrating their support for staff to be able to provide such high-quality services. Facility managers must be willing to help ensure that the process is continuous by incorporating follow-up into ongoing systems, such as by asking the COPE Committee to report on progress with the Action Plan during weekly meetings or by forming a COPE Committee, if one does not already exist at the facility.

IF: *Senior managers in the institution do not understand what COPE is or what it can contribute...*

■ **Ask if they have concerns or questions about the process.**

■ **Explain that COPE is a process for solving more problems at the facility level, building teamwork, and improving service quality.** When staff are given the tools to identify and solve many problems on their own, they are likely to take more responsibility for improving services and, in time, even begin to prevent problems from occurring. This may happen in part by improving communication between different levels

(continued)

Troubleshooting Tips (continued)

of staff. This process does not diminish the authority of senior managers, but should reduce the number of small problems that they are asked to solve, allowing them to use their time more effectively by focusing on bigger problems.

IF: *Senior managers in the institution do not understand that COPE will generate demands on resources and are not willing to provide these resources to facilities implementing COPE...*

- **Explain that to conduct a COPE exercise, the main resource needed is staff time (though most activities can take place while staff carry out their daily work).** The process and schedule are flexible and can be adapted to fit the facility's needs. In addition, as a result of each COPE exercise, senior managers must be prepared to face demands on resources, since staff may identify needs related to training, supplies, and supervision. Senior managers should understand that COPE is a way of documenting the needs of the facility and can be used to advocate for efficiently channeling resources to it.

IF: *Senior managers in the institution are not willing to change institutional practices or standards to help facilities improve services...*

- **Explain that many of the changes that come about through the use of COPE are small improvements at the facility level, but that as the COPE process continues, some systemic problems may be identified.** In time, if these systemic problems are not addressed, the level of QI will stagnate or even decline. However, institutions that address these problems generally are able to sustain the QI process, and a sustainable QI process may mean survival for facilities facing increased competition among different service providers. (Remember that the willingness to change may be difficult to assess at this stage and may shift over time.)

Conducting the First COPE Exercise

This chapter is aimed at the facilitators who will be conducting the first COPE exercises.

The first COPE exercise has three components: holding the Introductory Meeting, using the tools, and developing an Action Plan. This chapter addresses the first two components. (The Action Plan Meeting is discussed in the next chapter.)

Objectives

After reading this chapter, the external facilitator should be able to:

- Prepare for the exercise (collect materials, set up the room, and adapt tools as needed)
- Understand the elements of the first COPE exercise
- Conduct the Introductory Meeting
- Provide guidance to participants in using the COPE tools to gather information on service quality at their facility

Preparing for the Introductory Meeting

Facilitators' Roles and Responsibilities

The external facilitator has two primary roles:

- To be involved in introducing the first COPE exercise
- To pass along to the site facilitator skills in COPE facilitation, so the site facilitator can assume all such responsibilities in future COPE exercises

Before the first COPE exercise, the external facilitator explains the continuous COPE process and works with the site facilitator on his or her facilitation skills. The external facilitator and the site facilitator conduct the first exercise together, with the external facilitator taking the lead role. Both facilitators then follow up with the site's COPE Committee.

By the second exercise, both facilitators share in conducting the meeting. By the third exercise, the site facilitator should be able to lead the exercise alone or with only minimal assistance from the external facilitator. Thereafter, the site facilitator should conduct all COPE follow-up exercises, with support from facility supervisors, higher-level supervisors, and headquarters administrators.

Orienting the Site Facilitator

Before the first COPE exercise begins, the external facilitator and the site facilitator should meet, and the external facilitator should:

1. **Orient the site facilitator to the COPE process and tools** (if this has not already occurred), by reviewing the topics that were covered in the orientation for key managers (Chapter 2).

2. **Review the site facilitator's role in the first COPE exercise.** The site facilitator's role is to:
   - Help prepare for the first exercise
   - Work with the external facilitator in conducting the first exercise
   - Possibly become a member of the facility's COPE Committee

3. **Review the site facilitator's role in future COPE exercises.** In the future, the site facilitator must be able to:
   - Co-facilitate the second exercise
   - Conduct COPE on his or her own by the third or fourth exercise
   - Take primary responsibility for follow-up with the facility's COPE Committee (with additional support, as needed, from the external facilitator)
   - Train other site facilitators, as needed

4. **Review the facilitation skills that are needed.** Explain that the purpose of facilitation is to involve everyone, keep the group on track toward the objectives, manage conflict, deal with difficult people, and achieve consensus. The external facilitator should review these skills with the site facilitator before the first COPE exercise. (See Appendix D for a full discussion of facilitation skills, including tips for managing difficult participants.)

   Apart from the general facilitation skills discussed in Appendix D, the following *key skills* should be kept in mind, particularly for the Introductory Meeting:

   - Ideally, the site facilitator should share in or lead as much of the facilitation of the meeting as possible.
   - Facility managers should be encouraged to participate in the Introductory Meeting as much as possible. This is a great opportunity for them to show leadership and support for QI efforts at the facility and to welcome a wide range of staff to participate in them.
   - The COPE tools and action plan format should be explained clearly and completely. The better the facilitators explain how to get to a problem's root cause and how to be specific about recommended solutions, the clearer the action plan will be.
   - Remember that trust often builds gradually over time. Create an environment right from the beginning that is conducive to trust and open discussion, but be prepared for each person to respond at his or her own pace.

5. **Review the stages of the COPE process and the schedule for the first exercise.** The Introductory Meeting orients staff to the COPE approaches and starts them off in using the information-gathering tools (see Figures 1-2 and 2-1).

Preparing Meeting Materials

Always bring to the facility the materials needed for the Introductory Meeting and Action Plan Meeting (see Figure 3-1). Do not assume that the facility will have them.

Figure 3-1. Materials Needed for the First COPE Exercise

Handbooks
- 3 COPE handbooks for the facility to use in follow-up exercises

COPE Tools (contained in the COPE companion toolbooks)
- 3 to 5 copies of each of the 10 Self-Assessment Guides*
- 15 copies of the Client-Interview Guide*
- 1 copy of the Record-Review Checklist*

Other supplies
- Paper for the attendance list
- Large sheets of paper (flipcharts or newsprint) for the Introductory Meeting, for recording information from the COPE tools, and for the Action Plan Meeting (One complete flipchart pad should be sufficient.)
- Colored markers for recording the Action Plan (enough to share with the participants)
- Tape for displaying the large sheets of paper
- Handouts, or paper for participants to take notes on (optional)

*Provided in the COPE toolbooks.

In addition, you may adapt and reproduce the key messages that supplement the text of Chapter 4. (These key messages are provided in Appendix E as sample flipcharts.)

Using local technology to develop materials

Some facilities have developed appropriate local materials to convey information about COPE to the staff. At some facilities, it may be appropriate to use transparencies or PowerPoint slides to present information about COPE to managers and staff. Remember, though, that your goal is to introduce a process that is sustainable, so do not use these technologies if they are not readily available.
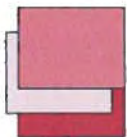
- Instead of using flipcharts or newsprint to present information about COPE, one program printed the key messages in the local language on large pieces of cloth. This material can be easily stored and reused during COPE exercises at different facilities.
- A facilitator developed visual aids to illustrate the clients' rights and staff needs. Using colored paper, markers, scissors, and masking tape, she cut out one set of shapes to form the body of a client and another set of shapes to form a health care facility. Each shape was labeled with a client's right or a staff need and was taped to a board or wall. Together, the shapes built the equation "Clients' rights + staff needs = Quality." This helped staff visualize and remember the elements of quality services. (See Figure 3-2, on page 32.)

Figure 3-2. Clients' Rights + Staff Needs = Quality
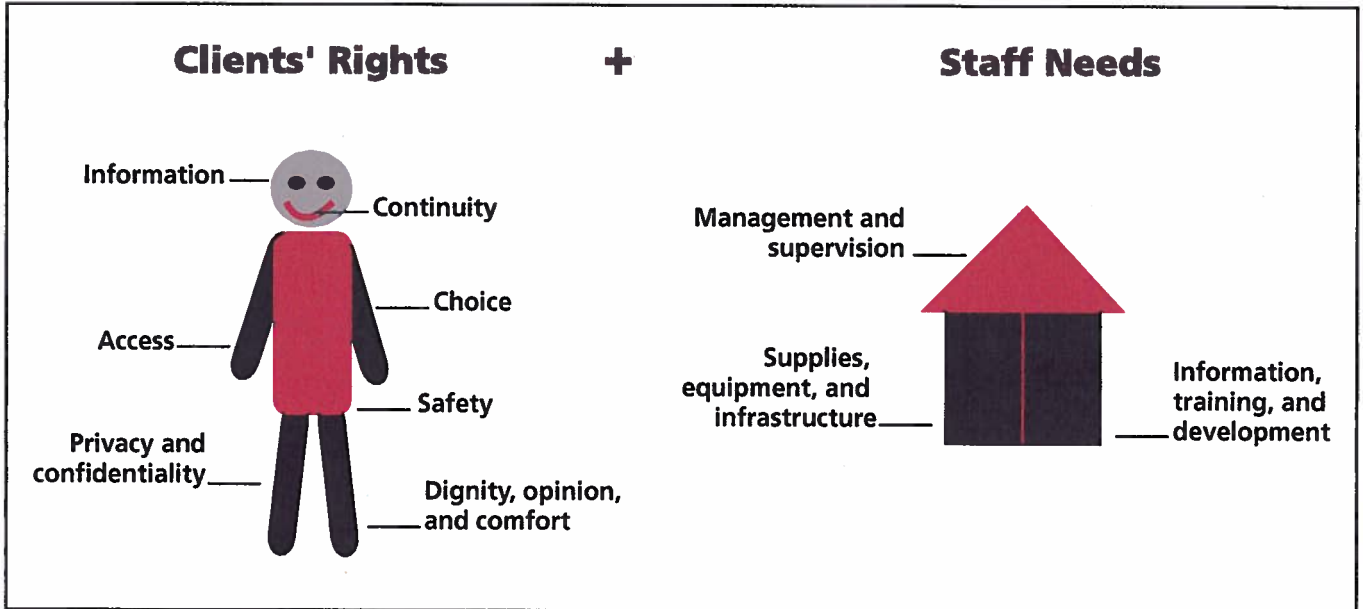
Adapting the COPE tools to facilities' needs

Every service-delivery program has a different set of goals and objectives. Therefore, you may need to adapt the COPE tools before conducting a COPE exercise at a facility. Adapt the COPE tools as described below:
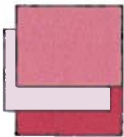
- **Self-Assessment Guides.** Determine whether any questions from each guide do not apply to the facility or institution and should be eliminated or changed, and determine whether questions need to be added. Discuss with the site facilitator which services are available, so that during the Introductory Meeting you can suggest to staff that they ignore questions about services not provided and add those they believe are important. For example, if a facility is using the Reproductive Health Self-Assessment Guides and does not provide infertility services, it may skip questions about infertility services (except those pertaining to staff members' ability to inform and refer clients to other facilities). Likewise, if an important service is not reflected in the Self-Assessment Guides, appropriate questions can be added beforehand. Often, however, issues concerning the addition, elimination, or amendment of questions will arise during the self-assessment exercise itself, so facilitators do not need to anticipate all of these changes prior to the exercise. (A sample of the Self-Assessment Guide on privacy and confidentiality is provided in Appendix A.)

- **Record-Review Checklist.** Review facility standards and records to determine whether any changes need to be made. For example, if the facility provides labor and delivery services and is using the Reproductive Health Toolbook, adapt the Record-Review Checklist to ensure that facility records related to labor and delivery are complete and accurate. (A sample completed Record-Review Checklist is shown in Appendix A.)

- **Client-Interview Guide.** Adapt and translate the client interviews (and other tools) as needed. (A sample Client-Interview Guide is shown in Appendix A.) Check with the facility manager or site facilitator to determine whether:
  - ▲ The questions are appropriate for the services provided at the facility
  - ▲ The questions are phrased in a way that clients are likely to understand
  - ▲ The forms require translation ahead of time
  - ▲ Any questions need to be added or deleted (Sites should try not to add too many questions. Rather, they should select only the most important questions, because a client may become frustrated if an interview takes longer than 10 minutes.)

Troubleshooting Tip

IF: *The facility's service standards conflict with those presented in the Self-Assessment Guides...*

- **Discuss the issue with management and decide together what to do.** The Self-Assessment Guides were developed based on internationally accepted service standards, as well as on frameworks of quality of care, that reflect issues important to clients. However, facilities have different service standards, and service protocols vary depending on such things as the level of the facility and the availability of trained providers and specialized equipment for certain procedures. In addition, service standards at some institutions may not be up-to-date.

Setting Up the Room

For best results during the first COPE exercise, the external facilitator should:

- Bring all of the materials and supplies that are needed (see Figure 3-1)
- Arrange the room in an informal, comfortable style (for example, placing chairs in a circle, so that staff and facilitators can see and hear each other during the discussions)
- Set up training aids (such as a flipchart or a blackboard) so they are visible to all participants
- Prepare a flipchart of clients' rights and staff needs (but keep it covered until the concept is introduced)
- Plan for breaks and refreshments, as needed

Elements of the First COPE Exercise

The first COPE exercise consists of:

- The Introductory Meeting
- Information-gathering using the COPE tools: the Self-Assessment Guides, the Client-Interview Guides, and the Action Plans
- An Action Plan Meeting (including establishing the COPE Committee)

The information provided here relates to the activities of the first two bullets above. (The Action Plan Meeting is discussed in the next chapter.)

For many of the topics discussed below, a corresponding flipchart (referred to by number) outlines the main ideas. These flipcharts can be found in Appendix E.

Conducting the Introductory Meeting: Detailed Steps

❖ ——————— Summary of Introductory Meeting Topics ———————

Topic	Minimum Time Required
Introduction: Welcome, icebreaker, schedule review, and norm-setting	15 minutes
Topic 1: What is quality and why improve it?	30 minutes
Topic 2: What is COPE and why use it?	30 minutes
Topic 3: How COPE works	1 hour
▪ The COPE tools	
▪ Identifying problems, solving problems, and developing an Action Plan	
▪ Follow-up and the COPE Committee	
Topic 4: Organizing the participants for group work	
▪ Grouping participants	5 minutes
▪ Instructing record-review and client-interview groups on using the tools	10 minutes
Total minimum time required	2 hours, 30 minutes

Introduction

1. Present the objectives for the exercise *(Flipchart 1)*. At the end of this COPE exercise, the participants should be able to:

   ▪ Understand the importance of improving quality
   ▪ Understand what COPE is
   ▪ Use the Self-Assessment Guides, the Record-Review Checklist, and the Client-Interview Guide
   ▪ Develop an Action Plan
   ▪ Form a COPE Committee at the facility

   Then ask the participants if they have any questions about these objectives.

2. Explain the elements of this first COPE exercise. These are:

   ▪ An Introductory Meeting, which will include self-assessment or use of the Self-Assessment Guides, the Client-Interview Guides, and an Action Plan—all of which will be addressed during the exercise
   ▪ An Action Plan Meeting, including establishment of the COPE Committee—which will be discussed today and will take place in a few days

Topic 1: What Is Quality and Why Improve It?
Clients' Rights and Staff Needs *(Flipchart 2)*

1. Ask: "How would you want to be treated if you came to this facility for health care? What would you or your mother, father, sister, brother, spouse, or child expect from a high-quality health service?" Write all responses on a flipchart.
2. When the participants have no more responses, ask: "What do you, as health care workers, need to be able to provide such quality services?" Write all responses on a flipchart.
3. Uncover Flipchart 2, which presents clients' rights and staff needs, and compare it with the participants' responses, pointing out the similarities. (If you want, you can refer to Chapter 1, Figure 1-1, for the complete definitions of each client right and staff need.)
4. Explain that the list of rights and needs is based on internationally accepted standards of quality care.
5. Explain that the term *client* is used instead of *patient* to reflect the fact that people make choices in seeking health care services, particularly preventive health services.
6. Explain that *quality services* are defined as those that uphold and maintain clients' rights and that attend to staff needs.

Alternatively, organize the participants into smaller groups (no more than three), and ask each group to answer the first two questions under Topic 1. Visit the groups while they work to encourage all group members to participate. Then ask each group to present its answers to the rest of the participants. Compare and summarize the key points, again referring to Flipchart 2.

Internal and External Customers *(Flipchart 3)*

1. Ask: "What is a *customer*?" Explain that a customer is anyone who depends on a provider's health products and services.
2. Ask: "Who are our customers? Who are our internal customers? Who are our external customers?" Draw a circle for each response given (as on Flipchart 3), and discuss the responses.
3. Explain that customers may be internal or external. *Internal* customers are within the facility or institution and include staff, service providers, supervisors, managers, supplies staff, and maintenance staff. *External* customers are outside the facility or institution and include clients, community members, outside suppliers, and others. Some customers, such as ministries of health and donors, may be both internal and external.

Expertise on Services

1. Ask: "Who are the experts on your services?" Let the participants acknowledge that *they* and their *clients* are the experts.
2. Explain that this is why you are going to ask *them* and their *clients* how to improve services.

Why Improve Quality? *(Flipcharts 4 and 5)*

1. Ask the staff to call out reasons why it is important to improve the quality of health care services. List their responses on a flipchart. Add any points listed in Flipchart 4 that were not mentioned.
2. Ask the staff to give examples for each of the reasons they have listed. (Flipchart 5 gives examples of the costs of poor quality.)

Topic 2: What Is COPE and Why Use It? *(Flipcharts 6 and 7)*
What Is COPE?

1. Explain the following points:
   - COPE stands for "client-oriented, provider-efficient" services.
   - It is a process that helps health care staff continuously improve the quality and efficiency of services provided at their facility and make services more responsive to clients' needs. COPE provides staff with practical, easy-to-use tools to identify problems and develop solutions using local resources, and it encourages all levels of staff and supervisors to work together as a team and to involve clients in assessing the services.
   - Through COPE, staff develop a customer focus, learning to define quality in concrete terms by "putting themselves in their clients' shoes."
   - The COPE process emphasizes *self-assessment*. COPE is not an assessment—or judgment—by outsiders. Rather, facility staff and supervisors assess themselves and the services they offer, identify problems and strengths, analyze shortcomings and bottlenecks, and, finally, decide for themselves what they need to do to overcome problems and maintain their strengths.
   - The COPE process also helps staff explore the facility's strengths.
2. Emphasize the following points:
   - Self-assessment is at the heart of COPE.
   - Staff are the experts on their own facility and their own services. COPE does not depend on outsiders telling staff what to do.
   - COPE is focused on improving systems and work processes, not on blaming individuals.
   - COPE is done *by* staff, *for* staff, to encourage staff and supervisors to recognize what they are doing well and to identify and solve the problems they face.
   - The information generated in the exercise is confidential and will not be used outside the facility.
3. Relate these aspects of COPE to the principles of QI *(see Flipchart 6)*.
4. Mention that COPE uses several tools: Self-Assessment Guides (developed around the framework of clients' rights and staff needs); a Record-Review Checklist; a Client-Interview Guide; a Client-Flow Analysis; and an Action Plan *(Flipchart 7)*. Describe these briefly and explain that they will be discussed in detail later in this meeting.

Why Use COPE?

Discuss how COPE:
- Develops a customer focus among staff
- Empowers staff at all levels and builds teamwork

- Emphasizes the use of local resources in problem solving
- Helps communicate standards and improve performance
- Offers concrete and immediate opportunities for action
- Responds to local needs in decentralized health systems

COPE Successes: Examples

To emphasize the value of the COPE process, give relevant examples to illustrate how COPE has led to improvement at other facilities (without revealing the names of individuals or institutions). Some examples are provided below, or you may use any of those in Chapter 1 or in Appendix B. (In time, you may add your own examples of success stories to these examples.)

Improving Client Confidentiality

At one health center in West Africa, staff discussed the issue of client confidentiality and discovered that it was not well respected in either the reception area or the consultation rooms. Staff would call clients in the reception area and proceed to ask them to describe their reason for coming to the clinic and to provide other sensitive information. During client interviews, it emerged that this practice made clients extremely uncomfortable and that they sometimes did not tell the provider what was really wrong, ultimately not getting the service they wanted. In addition, multiple clients often were seen at the same time in consultation rooms or the door was kept open, compromising confidentiality and inhibiting clients from speaking openly. To remedy these issues, the reception clerk was trained to collect only general information from clients in the reception area, and the health center reorganized the client flow so that only one client at a time would be in the consultation rooms. Providers began closing the door during consultations. These relatively simple solutions dramatically increased the level of client confidentiality and the comfort of clients. Because the ideas came from all staff and not just management, the new protocols have been adhered to successfully. (*Adapted from:* AVSC International, 2000a)

Cleaner Water, No Mosquitoes

A rural health center in Southeast Asia had no clean water available for staff or clients to wash their hands. The dirty water that they were using could lead to a higher risk of infections for clients and staff, and much of it was drawn from an open cistern, which provided a breeding ground for malaria-transmitting mosquitoes. Through a COPE exercise, staff identified the root causes of the problem: The water pump was broken, the well produced muddy water, and the rainwater storage tank had no cover, allowing dust and mosquitoes to contaminate the water. The staff then developed practical solutions and put the cleaner in charge of following up on them. Within one week, local community members made a wooden cover for the water storage tank. The long-term plan is to dig a new well to provide access to cleaner water. Now the facility has clean water, and staff are glad that the cover on their water tank prevents mosquitoes from breeding. It also serves to reinforce the health education message the staff tell their clients about malaria prevention.

Troubleshooting Tip

IF: *The participants seem uninterested, hostile, or defensive during this discussion...*

- **Be aware that they may feel frustrated with their current working conditions and may doubt that the COPE process will change their situation.** The participants may have seen other QI efforts fail and may be skeptical that this one will be any different. In addition, realize that most groups of staff will contain both a few cynics and a few staff who are eager to adopt new ideas or new processes. This is normal. If necessary, revisit the norms established at the start of the meeting (see Appendix D, page 126) and ask the participants to add any that would help them feel "safe" to discuss facility issues. Do not force anyone to participate.

COPE and the QI Process *(Flipchart 8)*

1. Show the diagram of COPE and the QI Process *(Flipchart 8)* and explain that COPE fits within a *continuous process of quality improvement* that includes four steps:

   - **Step 1: Information-gathering and analysis.** During the first COPE exercise, staff use the COPE tools to gather information about services and analyze their findings to identify problems and determine root causes.
   - **Step 2: Action Plan development and prioritization.** Staff agree on solutions to problems identified, establish time frames within which to implement the solutions, and identify person(s) responsible for doing so.
   - **Step 3: Implementation of the Action Plan.** Staff carry out the solutions agreed upon in the Action Plan.
   - **Step 4: Follow-up and evaluation.** Staff meet again to:
     - ▲ Discuss progress on the Action Plan
     - ▲ Evaluate what worked and what did not
     - ▲ Conduct additional information-gathering activities
     - ▲ Develop a new Action Plan

2. In this way, the QI process is repeated, new problems are identified as old problems are solved, and new solutions are implemented.

Topic 3: How COPE Works

The COPE Tools

1. Reintroduce the tools that constitute COPE and describe them in detail *(Flipchart 7)*. (See Chapter 1 for a full description.)
2. Point out that these tools are used in Step 1 of the QI process to gather and analyze information.

Self-Assessment Guides *(Flipchart 9)*

1. Explain key points about the Self-Assessment Guides *(Flipchart 9)*:

   - There are 10 guides, one for each client right and staff need. Each guide contains discussion questions that relate to common issues at most service-delivery facilities. The questions help staff think about the way services are provided and whether the necessary training, supervision, and equipment are available at their facility.
   - The questions in the guides are based on international service standards.

- The guides are not a test. They are intended for groups of staff to ask themselves and then discuss, to help staff identify and solve problems at the facility.

- The COPE toolbooks focus on different content areas. Depending on the health services provided, facilities may focus on reproductive health, family planning, maternal health, or child health. Many focus on reproductive health first because it covers the widest range of topics. Tell the participants which service or area they will focus on during this COPE exercise, based on the decision made by the facility manager.

2. Give some examples of discussion questions (below), or ask a volunteer to read a few questions aloud from the companion COPE toolbook.

- "Are signs showing information about reproductive health services (place, days, times, and costs) prominently displayed throughout your facility?"

- "Are disposable needles and syringes used whenever possible and discarded after a single use? Are reusable needles and syringes properly processed for reuse?"

- "Do staff feel that their on-site supervisor(s) help them do their work better?"

3. Explain the process for using the Self-Assessment Guides:

- Participants will be divided into groups, and each group will receive one or more Self-Assessment Guides to discuss. The guides contain yes-no questions, which the group members will ask themselves.

- Answering "no" to a question means that there may be a problem at the facility. When this happens, the participants should find the root causes of the problem (see page 41).

- Staff should skip any questions that are not relevant to their facility. Staff should add any relevant problems or issues that are not included among the questions.

- Staff should record any strengths that they can identify about the facility, to mention during the Action Plan Meeting.

4. Mention that the group working on the safety guide will also use a Record-Review Checklist to determine whether key information is being recorded accurately and completely in client records and whether clients are receiving care according to standards.

5. Explain that the Record-Review Checklist will be described in detail to the participants who will be working on it.

Client-Interview Guide *(Flipchart 10)*

1. Explain that after clients receive services at the facility, staff will interview them, to learn clients' views on and opinions of the services they received and to find out if clients have any recommendations for improving services *(Flipchart 10)*. Staff will use this information to identify problems and strengths at the facility.

2. Explain that two to five staff typically interview a total of 10 to 15 clients. The interviewers should not be the persons who just served the clients, and should (preferably) not be senior staff. (Counselors may be the best candidates.) This is to help ensure that clients feel most at ease.

3. Give some examples of questions that the participants might ask in a client interview:

- "What type of services did you come for today?"

- "Did you get the services that you came for?"

- "Did the service provider spend enough time with you for you to discuss your needs?"

- "What do people in your community say about the quality of the services at this clinic/hospital?"
- "What do you like most about this clinic/hospital?"
- "Is there anything you think could be done to improve services here?"

Client-Flow Analysis (CFA)

1. Briefly mention that CFA is a process for measuring the time that each client spends at the facility, both the amount of time spent waiting for services and the time spent in direct contact with a staff member. It is used to identify bottlenecks in services.

2. Explain that while CFA and other tools may be used in future COPE exercises, they are not used in the first COPE exercise.

Action Plan *(Flipcharts 11, 12, and 13)*

1. Explain that the staff should use the tools to discuss each problem identified (that is, any self-assessment question to which staff responded "no," or anything that a client described as a problem when interviewed). The staff should record each problem in the Action Plan (see Appendix A, and Flipchart 11 in Appendix E, for a completed sample Action Plan).

2. Explain that staff must state the problem clearly, note the root cause(s) of the problem, and write recommendation(s) that address the problem's root causes, not just its symptoms.

3. Point out that each recommendation must include the name of a *specific person* (not a job title) to follow up on the recommendation ("by whom") and a specific date by which it should be carried out ("by when"). This person is not necessarily the one who will carry out the recommendation; it is the person who will make sure that it is carried out. Writing the person's name rather than his or her job title helps to personalize the Action Plan.

4. Be sure to make the following key points:
   - Working in small groups, each group will develop its *own* draft action plan, which will then be consolidated into one plan for the facility at the subsequent Action Plan meeting.
   - Do not make the same person responsible for too many recommendations. Solutions may be identified more quickly when responsibility for different problems is shared among many different staff members. Rather than assign many recommendations to one person, find other staff members who can help carry out recommendations.
   - Do not make senior staff or members of external organizations responsible for most of the recommendations. All staff have something to contribute. Think first about which recommendations lower-level staff can carry out. Even if external support is needed, consider which staff member can be responsible for seeking external support.
   - For each recommendation, list only one name in the "by whom" column. When more than one person is listed, individual responsibility for ensuring that a problem gets solved is lost. Some solutions may need to be broken into smaller steps, with different individuals named for each step.
   - Set realistic deadlines for carrying out recommendations. It is better to set a later date by which the facility can surely carry out the recommendations than to set an earlier date that cannot be met. In addition, the participants should choose specific dates that can be met, not vague deadlines such as "ongoing," "as soon as possible," or "tomorrow."

5. Give an example for one problem. (Either ask the staff for an example from the facility, or refer to Flipchart 11.)

Developing a Clear Problem Statement *(Flipchart 12)*

Explain the points in Flipchart 12:

- Ask the participants what the difference is between a symptom and a root cause. (You can use a medical example such as observing fever versus diagnosing malaria.) Explain that until the root cause is identified, the problem cannot be solved; only the symptoms can be treated.
- A problem is the difference between the current situation and the desired one.
- Focus on processes and systems. Do not blame individuals for mistakes.
- Staff must agree that something is a problem:
  - ▲ Verify that there is a problem or collect data as needed.
  - ▲ Encourage all levels of staff to give input.

Finding the Root Cause of the Problem *(Flipchart 13)*

1. Explain that for each problem identified through any of the assessment tools, staff should use the "multiple whys" technique to get to the root cause. By asking "Why?" at least three times and then asking "Are there any other causes?" staff will identify the underlying causes of the problem. Display Flipchart 13 (also shown below as Figure 3-3) to provide an example of this technique.

Figure 3-3. Using the "Multiple Whys" Technique

Problem: Clients do not complete their treatment for sexually transmitted infections and are not cured.

Why? Clients do not understand the need to complete treatment after their symptoms disappear.

Why? Service providers do not explain to clients why they should keep taking their medication after the symptoms disappear.

Why? Service providers were not trained in counseling clients about treatment.

Are there any other causes? Service providers are not aware that clients do not receive this information.

2. Explain that generally, facility staff find the multiple whys technique easy to use, and that it is the technique that the participants will use today.
3. Ask the participants to state a problem, work together to develop a clear problem statement, and identify root causes by asking multiple whys.

Examples of Unclear and Clear Problem Statements *(Flipcharts 14A and 14B)*

1. Show the examples of an unclear problem statement and a clear one (also shown in Figure 3-4), and discuss why one works better than the other, by getting to the root cause and thus to a more accurate recommended solution.

Figure 3-4. Examples of Unclear and Clear Problem Statements

(a) Unclear Problem Statement

Problem	Cause(s)	Recommendation	By Whom	By When
HIV-positive pregnant women are lost to follow-up.	Clients are not interested in services.	Make clients more interested in services.	All staff	Immediately

(b) Clear Problem Statement

Problem	Cause(s)	Recommendation	By Whom	By When
Pregnant clients testing positive for HIV do not return for follow-up services.	(1) Staff are not trained to discuss the range of services available.	(1) Conduct whole-site orientation on clinical, counseling, and support services available to prevent mother-to-child transmission of HIV and to support HIV-positive clients.	L. Karisa (clinic nurse)	July 1, 2004
	(2) Clients feel unwelcome and stigmatized by staff.	(2) Conduct HIV and stigma awareness/sensitivity training for all staff.	J. Samanda (nurse supervisor)	July 30, 2004
	(3) HIV-positive clients are afraid that others will find out their status and harm them.	(3a) Review/revise protocols on client confidentiality and orient all staff.	Dr. Ware (clinic director)	August 30, 2004
		(3b) Provide counseling training for providers on how to assist clients in making decisions about disclosure.	R. Minja (HIV counselor)	September 5, 2004

Commitment to Follow-Up and Establishment of the COPE Committee

1. Emphasize that QI must be an ongoing process, and that a single COPE exercise without adequate follow-up will have few lasting effects.

2. Refer back to Flipchart 8 to explain the four steps of the COPE process:
   - Gathering and analyzing information
   - Developing an action plan
   - Implementing solutions
   - Assessing and following up

3. Point out that they are embarking on Steps 1 and 2 of a continuous QI process.

4. Explain that staff will need to follow up on the Action Plan continuously. To help with follow-up, by the end of the Action Plan Meeting, the facility will establish a COPE Committee. (This will be explained in detail during the Action Plan Meeting.) Briefly explain the tasks of the COPE Committee *(Flipchart 15)*.

Topic 4: Organizing the Participants for Group Work
Split the Participants into Groups to Use the Tools

1. The number of groups and how many participants are in each will depend on the facility and on the number of participants in the Introductory Meeting. Generally, facilitators split the participants into four or five groups, with no more than six to eight people in any group. Try to limit the number of groups, since the more groups there are, the longer it will take to present and discuss all of the Action Plans during the Action Plan Meeting.

2. Try to get a mix of staff in each group, so that each staff member's level or position and department is represented and so that appropriate staff are included in each group. For each of the Self-Assessment Guides, the instructions list the categories of staff needed to review the questions for that guide. (For example, the group working on the guide for safe services should include clinical staff such as a clinician, surgeon, nurse, or technical or medical assistant, as well as a housekeeper or cleaner and an administrator or manager. The group reviewing supplies, equipment, and infrastructure should include medical staff and the staff responsible for supplies.)

3. Observe that the strategies followed to set up the groups will vary by the size of the facility, as follows:
   - At **large** facilities, the facilitator and site managers may determine groups before the exercise, since organizing groups may take up a lot of time during the meeting.
   - At **smaller** facilities, you may use the attendance list to form mixed groups and to ensure that appropriate staff are included in each group.
   - Depending on the size of the facility and the number of Self-Assessment Guides being used, some groups may need to work on more than one guide, and some staff may be assigned to more than one group. Generally, facilities use all 10 guides in the first exercise, although some facilities choose to divide the guides and use a few at a time over several exercises. (Refer to the schedule agreed upon with managers.) If a staff member is assigned to more than one group, the group will need to schedule its work to allow the person to work with both groups.
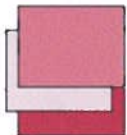
Note: The guide that addresses safety is the longest and has the most direct bearing on the health of clients. One group should work solely on this guide, which includes the Record-Review Checklist. Other groups can work on one or more of the other nine guides and on the client interviews.

Explain the Process

1. Remind all of the groups to be honest and specific about the problems they identify and to keep their discussion focused on their group's topic.

2. Tell each group to go through its particular tools and develop an Action Plan (using the format presented, on a flipchart) based on the problems identified. Through either discussion or their tools, each group should also identify three to five strengths of, or strong points about, the facility. These positive elements of service delivery at the facility should be recognized and maintained. Each group is to present its Action Plan and its list of facility strengths during the Action Plan Meeting.

3. Explain that you will be available to answer any questions that arise during the group work. Throughout the period during which participants are working in groups, both facilitators should circulate to observe, give feedback, and ensure that the participants understand their tools and analyze the root causes of problems before proposing recommendations.

Announce the Time and Place of the Action Plan Meeting

Find out where each group will be meeting, so you can meet with the group to give specific instructions about the tools they will be using, observe how the participants proceed, and guide them if they need assistance.

Instruct the Groups on How to Use the Tools

1. Provide each group with copies of the tool(s) it will be using, and ask the group to review the instructions at the beginning of its tool(s).

2. Emphasize that the Self-Assessment Guides are merely *guides* and that this is not a test. They are not expected to answer every question, and they should feel free to add questions that they think are important.

3. Instruct those who are conducting the self-assessments first to read all of the questions in the self-assessment guides and identify the issues that concern them the most, and then to analyze each problem they identified.

4. Remind the staff that COPE is a continuous process, and that over time all important issues will be addressed.

5. Allow the groups using the Self-Assessment Guides to leave the session and begin their group work. (Ask them to inform the facilitators about where and when they will meet.)

6. Explain the use of the record review and client interviews to the groups using these tools (see pages 45 and 46 for details).

7. Be aware that groups may choose to operate in very different ways. For example:
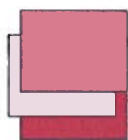
   ■ Some will choose to do their group work *immediately* after the Introductory Meeting, and so will be able to meet without disrupting their normal duties.

   ■ Others may decide to work *individually*, then *reconvene* during breaks or before or after work to discuss their findings and develop their Action Plan. Keep in mind that both facilitators need to be available when a group meets, in case questions arise during their discussion.

- Some groups may choose to *divide the questions* and assign each group member a portion of the questions. (However, as in all groups, staff should be sure to get input from others in answering the questions.)

Using the Record-Review Checklist

1. Distribute copies of the Record-Review Checklist for the staff to review while you explain how to complete it (see Appendix A for a sample completed Record-Review Checklist). Bear in mind that some of the toolbooks have more than one Record-Review Checklist. (For example, the reproductive health toolbook contains a Client Record Review and a Surgical Record Review.)

2. Explain that they will select 10 client records at random that show information for reproductive health clients. Each selected record is to be randomly assigned a number from 1 to 10. Then, they should check each client record against the Record-Review Checklist to see whether the information has been recorded or completed, as follows:

   - For each client record, look for the information specified in the "Checklist item" column. If the information has been written in the record, put an "X" or a check mark (✓) in the corresponding space on the checklist. For example, on the sample checklist shown in Appendix A, the client identification information was recorded (Item 1) on Client Record 4, but not on Client Record 5.

   - When each item on the checklist has been reviewed against each of the 10 records, note the number of check marks for each item in the "Total" column of the checklist.

3. Explain that after they complete the checklist, they should identify incomplete records, consider reasons why the records may be incomplete, and discuss recommendations for solving record keeping problems with other group members or with the external facilitator. Based on this number, group members may also make generalized assumptions about the facility's record keeping for reproductive health clients. For example, in the sample form shown in Appendix A, information for Item 4 was noted in only four of the 10 records. This may mean that six of the 10 clients were not asked for a medical history, or it may mean that a medical history was taken but this information was not recorded. Exploring which, and deciding how to be consistent in record keeping, can be part of the group's Action Plan recommendations.

4. Observe that if a high proportion of the 10 records have incomplete information in one or more areas, the facility may decide to look at a larger selection of records to see whether there is a general record keeping problem.

5. Explain that they should then write the findings in the Action Plan (see Appendix A for a sample completed Action Plan) and present them for discussion at the Action Plan Meeting.

Conducting Client Interviews

1. Explain that:
   - Many staff (and clients) feel shy or uncomfortable during client interviews. This is natural.
   - The goal for each interview is for the client to be relaxed, to speak more than the interviewer, and to provide suggestions for improvement.
   - The interviews should be as informal as possible and should be conducted in private.
   - The interview form is merely a guide. Staff should adapt it to fit their services.
   - No client should be required to be interviewed. All clients must be told that the interview is optional, that their names will not be recorded, and that they will not be treated differently or receive bad service if they do not agree to participate.

- The interviewers should not be the same staff members who just served the clients.

2. Present the following tips for interviewers:

- **Tell clients why you are interviewing them.** Explain that staff are trying to improve services at the facility and want to know what clients think and if clients have any suggestions for making services better. Some facilities inform clients about the interviews while they are waiting for services, so clients will be prepared to answer a few questions after they have received services.

- **Use body language to put the client at ease.** Body language is achieved through posture; the position of arms, legs, and eyes; gestures; space; seating; and tone of voice. Positive body language shows respect, interest, and empathy. Appropriate body language to put clients at ease may depend on factors such as the interviewer's and the client's culture, gender, and age. However, if possible, sit next to the client rather than on the opposite side of a desk or table, because furniture or distance between the interviewer and the client can be a physical barrier or can be perceived as confrontational.

- **Be aware of "courtesy bias."** Some clients may say only positive things about the service they just received for fear of offending the interviewer or other staff. Explain that the facility sincerely wants to improve services and that the client's answers will not affect the services he or she receives at the facility. This may make the client more likely to speak honestly.

- **Ask open-ended questions.** Ask the questions on the forms and then probe the answers by asking open-ended, rather than yes-no, questions. Open-ended questions include: What? Why? How? Where? How long? Ask for specifics, where possible, and be prepared to discuss further any issues of concern. You may need to probe or ask follow-up questions with shy clients.

- **Listen to the client.** Listen calmly and attentively to what the client says, without interrupting or becoming defensive. Acknowledge concerns and welcome suggestions, accepting any criticism that is given. Do not, however, make promises to clients that cannot be met. Remember that it is important for clients to be open about their views and needs, and the facility will learn more from criticism than from compliments. You may clarify the feedback, but avoid presenting your own opinions or overexplaining.

- **Remember to thank the client.** End the interview by thanking the client for his or her help and ideas.

3. Instruct the interviewers to be sure to do the following:

- During each interview, mark the client's responses on the interview form.

- When all interviews are completed, meet with the other interviewers to review all findings and prepare an Action Plan. During the Action Plan Meeting, interviewers should report both the positive and negative things that clients said.

4. Organize the participants into pairs to role-play the interview. This will help them become familiar with the questions, probing techniques, and the translation of the questions (as needed) before talking with clients.

5. Observe a few interviews (if the client gives permission for you to do so), and give the interviewers feedback when the interview is over. Do not interrupt the interview to give your feedback.
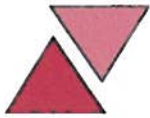
Troubleshooting Tips

IF: *A client gives only positive responses...*
Wait until the interview is over, and then advise the interviewer to repeat that clients are being asked their opinions about the facility so that services can be improved. Some clients may be more likely to share comments about the facility that they have heard in the community than to share their own opinions of services. It may be necessary to ask different questions or to conduct additional interviews to learn more about how to improve services.

IF: *A client does not respond, gives vague answers, or only responds with yes-no answers...*
Advise the interviewer to ask more probing questions, such as "Can you tell me more about...?" "What do you think about...?" or "How do you suggest we improve...?"

Checking In with the Self-Assessment Groups

1. In providing assistance to groups using the Self-Assessment Guides, go through the questions with them after they have reviewed the instructions.

   - For any questions that do not apply to the facility, staff should ask themselves, "Can we do anything to improve, even if we do not offer this particular service?"
   - Caution: Do not eliminate an entire Self-Assessment Guide. It is very important to use all of the guides; if the facility eliminates an entire guide, staff may tend to overlook elements that together define quality of care.

2. Have staff determine if questions need to be added to the guides. If important service standards or other important issues that affect staff's ability to provide quality services are not reflected in the guides, add appropriate questions—space is provided at the end of each guide to do so.

Troubleshooting Tips for the Self-Assessments

IF: *A group doing self-assessment gets stuck...*
Find out why. Ask: Do you understand the questions? Can you describe why you are stuck? Remind the group members that some questions may not apply to their facility, and any important issues that are not listed should be added. Also remind group members to focus on systems and processes, not on blaming any individuals.

IF: *Some group members are shy or dominant...*
Use techniques to encourage participation by all (see Appendix D).

IF: *The group cannot finish in the time allotted or group members are feeling overwhelmed...*
Tell group members to focus on the problems that are most important (life-threatening) and easiest to solve. Future COPE exercises can address more problems in the future.
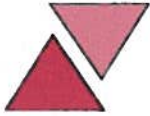
Troubleshooting Tips for Action-Plan Development

IF: *Problem statements are vague or the causes of problems are not clearly identified...*
Recognize that problem analysis is a skill that takes practice. Do not expect the Action Plans to be "perfect" from the first try. Ask the participants to explain how they identified the root causes of the problems, and, if needed, review the multiple whys technique. Ask: Is this really a problem? How is it a problem? Does something else lie behind it? What factors do staff believe could be the sources of the problem? Is the problem a barrier to clients' getting good services? Will the solutions that are listed improve the services?

IF: *Staff have not looked at all possible resolutions for the problem...*
Ask: Is this the best recommendation for the solution, or is there a more effective or easier way to deal with the problem? Is there more than one possible solution?

IF: *The person assigned to carry out the solution may not be the best choice...*
Ask: Is this the appropriate person to be responsible for implementing this recommendation?

IF: *One or more staff members seem uncomfortable with assignments...*
Ask: Does anyone feel that they have been assigned a recommendation that they cannot perform?

IF: *The same staff person is named for too many tasks...*
Remind the participants that responsibility for following up on the different recommendations should be shared among many staff.
Probe: Do you believe it is feasible for all of these problems to be resolved by one person within the specified time? Can other staff be assigned some of the problems so that recommendations can be implemented more quickly?

IF: *Time frames appear unrealistic...*
Ask the participants how they determined the time frames, and see if these can be adjusted to ensure that staff have adequate time to carry out each recommendation. (This problem may become apparent during the Action Plan Meeting [Chapter 4], when staff see all of the groups' plans together.)

IF: *Some recommendations have been assigned to an outside organization...*
Ask: Can anyone suggest an alternative solution that could be accomplished by the staff? Who will take responsibility for coordinating this recommendation with the other organization?

IF: *The discussion goes off track...*
Gently remind the participants to focus on the task of developing an Action Plan, and remind them of the time frame for their group work.

chapter 4

*The Action
Plan Meeting*

This chapter explains how to facilitate the Action Plan Meeting, in which the different groups of participants present their Action Plans and staff priorities and agree to the overall Action Plan for the facility.

Objective

After reading this chapter, you should be able to facilitate an Action Plan Meeting, providing guidance to participants in arriving at a consensus on an initial Action Plan for their facility.

In preparation, remember to have large sheets of paper or one flipchart pad available, along with tape and colored markers for recording the consolidated Action Plan.

Conducting the Action Plan Meeting: Detailed Steps

❖ ————————Summary of Action Plan Meeting Topics————————

Topic	Minimum Time Required
Welcome and introduction	5 minutes
Topic 1: Group presentations	20 to 30 minutes per group
Topic 2: Consolidating and prioritizing the Action Plans	30 to 40 minutes
Topic 3: Facility strengths	20 to 30 minutes
Topic 4: Establishing the COPE Committee	10 minutes
Topic 5: Closing the meeting	10 minutes
Topic 6: Setting a date for follow-up with the COPE Committee	5 minutes
Total minimum time required	3 to 4 hours, depending on how many groups present their plans

Welcome and Introduction

Introduce the Action Plan Meeting by welcoming everyone back and by asking a general question about how things went. Make an encouraging comment about your observations of their work. Explain that they are now engaged in Step 2 of the QI process—developing the Action Plan.

Topic 1: Group Presentations

Presentation of Action Plans

1. Invite each group to present its Action Plan. (Sample Team Action Plans are shown in Appendix A.) As your time frame permits, facilitate a discussion after each presentation by welcoming all participants to share their opinions, suggestions, or concerns. Both facilitators and participants may ask questions for clarification.

2. As each item is clarified, have the members of the presenting group make the appropriate changes to their Action Plan. (For tips on clarifying Action Plans, review the Troubleshooting Tips for Action-Plan Development on page 48.)

3. To avoid repeating the same problems, advise the participants to call out if they identified the same problem that is being presented by another group. If this happens, the members of both groups should then discuss their perceptions of the root of the problem and their recommendations, and combine or choose among the recommendations.

Remind the Participants of the Importance of Clients' Views

1. Explain that clients are the focus of the services, and that their views of the services are important.

2. Facilitate a discussion on the suggestions made in the client interviews, and ensure that the participants include the suggestions in the facility's Action Plan.

3. Ask the participants if they were surprised by anything that clients said during the interviews, and ask whether the clients and staff said the same thing or different things about services at the facility.

Help the Participants Agree

Often, the participants may disagree among themselves on recommendations for the Action Plans. If this happens, get the best consensus possible and move on. Although some staff may disagree with a specific recommendation, they may be willing to go along with the group's decision.

Invite Others to the Meeting, As Needed

Before finalizing the Action Plan, try to ensure (where possible) that the people listed in the "by whom" column are present and consent to follow up on the recommendations. The facility manager also needs to be present and to agree on the recommendations listed in the Action Plan. If the facility manager or other staff members have concerns about any of the recommendations, they should have an opportunity to raise them at this time.

Improvements Do Not Always Require Additional or External Resources

At some facilities, staff have found that they could reorganize the space to create private areas for use during counseling sessions and examinations. This can be done even at facilities that have difficult physical layouts and inadequate infrastructure. For example, some hospitals have found that they can provide clients with privacy on busy hospital wards simply by repairing old screens and installing them. Often, broken-down equipment can be repaired locally with the help of local government officials or community members and without the help of the central government.

Troubleshooting Tip

IF: *The discussion goes off the topic, or does not reach closure...*
Maintain the pace so the meeting ends on time. Ask: "Is this session dragging or are you feeling rushed? Do we need to take a short break?" Summarize the key points, if necessary, but do not cut off discussion abruptly. Allow the staff a chance to contribute their ideas and opinions. For more Troubleshooting Tips, see page 48.

Topic 2: Consolidating and Prioritizing the Action Plans

If more recommendations have been made than can realistically be achieved by the time of the subsequent Action Plan Meeting, facility staff may choose to prioritize the recommendations and try to carry out no more than 15 to 20.

Choosing Criteria for Prioritizing Recommendations

1. Prioritizing problems listed in the Action Plan can help determine which problems to address first and where to focus staff's energy and resources. Explain that the *first priority* problems include:
   - **Those that are life-threatening or pose a danger to health.** If any life-threatening problems are identified, staff should work to solve these immediately. If the facility does not have the control or support needed to carry out the solutions to some life-threatening or critically important problems, this should be communicated to higher-level managers so the problems can be resolved.
   - **Those that affect many people.** Keep in mind that even if only one or a few clients or staff mentioned a problem, the participants need to consider *all* comments made. Particularly with clients' comments, individuals may be speaking on behalf of other clients or potential clients, such as their relatives, friends, or other members of their community.

2. Explain that additional criteria to consider for prioritizing include:
   - **Problems that can be solved using available resources or at the facility level.** These are generally the easiest, and can make for some "quick wins"—successes that boost morale and give staff energy to tackle harder issues.
   - **Problems slated to be completed soonest** (those with the earliest "by when" dates).

3. Ask if anyone has other criteria for prioritization that the group should consider.

4. Explain that after the criteria for selecting important or priority interventions have been applied, any problems judged to be of lower priority should not be discarded entirely.

Instead, they may either be given later dates for completion (after the priority recommendations) or be given to the COPE Committee for inclusion in a future COPE exercise.

5. After all groups have presented their Action Plans, have the participants revise and add together the annotated Action Plans. (If a clean version is not ready by the end of the Action Plan Meeting, the COPE Committee will be responsible for ensuring that this is completed and then is posted or distributed for all staff to see.)

Topic 3: Facility Strengths

1. Ask each team to present three to five of the most important facility strengths that they identified during the group work.

2. Lead a discussion about these strengths, allowing all of the participants to comment or ask questions.

3. Ask the participants to select any of the strengths they want the facility to improve on even further. (These can be selected by listing all facility strengths on a flipchart and then have the participants vote on those that need further improvement.) Add these to the Action Plan.

Topic 4: Establishing the COPE Committee (*Flipchart 15*)

1. Explain that:

- The COPE Committee plays a critical role in making QI an ongoing responsibility and the focus of the daily work of staff at all levels. Its main role is to monitor progress in carrying out the Action Plan recommendations.

- The committee should represent different levels of personnel at the facility, including managers, supervisors, and staff members. The group could be newly formed or could be an existing committee at the facility, possibly with a few adjustments. Generally, the COPE Committee consists of about five to eight staff members, though at facilities with eight or fewer staff members, the entire staff should serve on the committee. (Refer to the decisions made with the facility manager about the size of the committee and how it will be formed—whether a new group will be formed or an existing committee will be used.)

2. Explain that the COPE Committee can be formed in several ways:

- **To form a new committee,** ask for volunteers from among the participants. If no one volunteers or if the volunteers do not represent a mix of levels of staff, ask each department or unit to choose a representative for the committee. Alternatively, ask each type and level of staff (for example, doctors, nurses, and clerks) to choose a representative for the committee.

- **If the facility has an existing committee** that can take on the responsibility of following up on the Action Plan, ensure that the committee includes representatives of different units and staff levels. If it does not, work with the committee to expand its membership.

- Some facilities choose to assign **formal roles** to committee members, such as chairperson or secretary, while other facilities' committee members have informal roles. In either case, someone must be responsible for scheduling and facilitating committee meetings.

(More information about the role of the COPE Committee is provided in Chapter 5.)

Topic 5: Closing the Meeting

1. Encourage the staff to remember their strengths and continue to build on them.
2. Briefly remind the staff that COPE is a continuous process. If you want, display Flipchart 1 and show them that they are ready to begin the implementation step (Step 3).
3. Ask the staff if they have any questions about next steps. Clarify that as soon as the Action Plan is finalized, the staff should begin to carry out their assigned recommendations. Staff should report the status of the solutions to the COPE Committee.
4. Conduct a plus/delta exercise or some other closing activity. (See Appendix D, page 127, for tips on closing meetings.)

Topic 6: Setting a Date for Follow-Up with the COPE Committee

1. After the exercise is over, meet briefly with the COPE Committee and set a date for follow-up (generally about one month after the first COPE exercise). The second COPE exercise should take place within three to four months after the first COPE exercise.
2. Ask the participants for a copy of the Action Plan for use in following up with the facility over time. Ensure that the results of the exercise are kept confidential, however.
3. Write a letter or contact the facility managers and staff, as appropriate, to thank them for their hard work and enthusiasm.

5

Effective Follow-Up after the First COPE Exercise

> This chapter is aimed at external facilitators and site facilitators.

Improving service quality and facility performance is a continuous process that requires the involvement of all staff. To succeed at improving quality, facilities need to ensure effective and ongoing follow-up of their QI efforts. This chapter contains steps and strategies for supporting implementation of the facility's Action Plan (Step 3 of the QI process).

Objectives

After reading this chapter, you should be able to:
- Effectively follow up after the first COPE exercise
- Monitor progress after the first COPE exercise
- Prepare to conduct the second COPE exercise

Facilitators' Roles

If the consolidated Action Plan is completed by the close of the Action Plan Meeting, the external facilitator will take a copy for use in follow-up. If the Action Plan requires further revisions, the site facilitator should send a copy to the external facilitator when it is completed, or the external facilitator should contact the site within a short time to receive a copy. (In future follow-ups, this step will not be necessary, as the site facilitator will assume complete responsibility.)

If the facility has difficulty in completing the Action Plan, the external facilitator may return to the site to help the COPE Committee and site facilitator complete it.

Timetable for Follow-Up

Within one month after the first COPE exercise, the two facilitators should together review and assess:
- The first COPE exercise, including feedback from the participants and ways to adapt the process for subsequent COPE exercises
- Any need for strengthening the site facilitator's facilitation skills (such as through a role play)
- Whether facility staff are able to carry out the recommendations assigned to them in the Action Plan

- Whether the COPE Committee is functioning as expected
- Whether facility or institutional management supports ongoing QI efforts

Within three to four months after the first COPE exercise, the two facilitators should do the following:

- Meet with the COPE Committee at least once before the second COPE exercise, to assess the facility's progress in establishing continuous QI and effective follow-up. The facilitators should ask the committee members to answer the questions in Figure 5-1. If the committee members answer "no" to any of the questions, the COPE Committee will need to explore ways to address these issues with facility managers.
- Facilitate the second COPE exercise together.

Figure 5-1. Questions for Determining Effective Follow-Up

- Has the COPE Committee finished consolidating the Action Plan?
- Has the COPE Committee distributed a copy of the Action Plan to all staff or put it in a prominent place where all staff can review it?
- Are staff meeting their deadlines for carrying out the recommendations?
- Are staff letting the COPE Committee know when recommendations have been carried out?
- Are staff seeking help from the COPE Committee when they have difficulty carrying out the recommendations?
- Are staff at all levels providing the support needed for carrying out the recommendations?
- Are managers providing the support needed for carrying out the recommendations?

Role of the COPE Committee

The COPE Committee is responsible for following up on the Action Plan on an ongoing basis. This may be achieved in a variety of ways, such as during regular meetings held at the facility between COPE exercises.

To provide effective follow-up, the COPE Committee must:

- **Ensure that all staff have access to a clean or revised copy of the Action Plan** (This copy should include all changes agreed on during the Action Plan Meeting. Staff must receive the Action Plan as soon as possible, so they may begin carrying out the recommendations.)
- **Decide whether to establish formal roles for committee members, such as chairperson and secretary**
- **Agree on procedural issues, such as the tenure for committee members and handling turnover in membership** (While it is useful to have some continuity in committee membership from one COPE exercise to the next, committee membership should change over time, to bring fresh ideas and perspectives to the group.)
- **Set meeting schedules** (This is necessary to regularly review progress in the Action Plan.)
- **Display and communicate Action Plan updates and other information to staff and higher-level management**

- **Help staff carry out the recommendations, as needed**
- **Monitor and celebrate progress** (Ask the COPE Committee how they want to measure the success of the interventions that staff have implemented. [Information about monitoring progress is provided later in this chapter and in Chapter 8.])
- **Monitor deadlines**
- **Keep up-to-date records of all solved and unsolved problems** (This will help the staff track their progress over time.)
- **Modify the Action Plan, as needed,** in consultation with the larger group

Troubleshooting Tip

IF: *The COPE Committee has difficulty meeting to review the Action Plan or is unclear about its role...*

- **Both facilitators should meet with the committee to determine the cause of the difficulty.** Explore why the COPE Committee is having difficulty in carrying out its tasks and then work with it to clarify any confusion and help allay any fears or concerns. Reasons why a COPE Committee might stumble include:
  - Loss of momentum
  - Perception that COPE is not considered important within the facility
  - Loss of will among management
  - Confusion about what to do
  - Difficulty in launching something new
  - Difficulty associated with change
  - Turnover among staff
  - Perception that the problems are too difficult to solve or are poorly defined (e.g., inability to clearly identify root causes, or assignment of an inappropriate person to the responsibility of carrying out the recommendations)

- **Explain** that while change can be difficult, over time their efforts can lead to significant improvement at the facility. It is not unusual for groups beginning a series of changes to undergo the following stages as they begin working in new ways:
  - *Mixed emotions*—Change is exciting but also challenging.
  - *The "valley of despair"*—Changes create some disorientation as staff reorganize.
  - *The "light at the end of the tunnel"*—Staff begin to witness the effects of the changes they have made.
  - *No turning back*—Staff have learned successful new ways to manage their work and to solve problems, and will work to ensure that those changes are here to stay.

- **Remind** the committee of its role in tracking progress. Explain that if the committee notices that a particular recommendation is not accomplished within the specified time frame, the committee should meet with the staff responsible for carrying out the recommendation to either:
  - Set a new time frame for solving the problem, if the initial time frame was unrealistic

(continued)

Troubleshooting Tip (continued)
- Encourage more staff support to complete assigned tasks
- Involve others if the person is unable to follow through on his or her own
- Explore alternative solutions to the problem (For example, ask: Did the recommendations address the root causes? Are alternative solutions more feasible?)

Note: When the committee members meet with the person(s) responsible and other involved staff, it is important that they help identify the barriers to solving the problem *without blaming the person(s) responsible.*

Monitoring Progress

Sites may use the COPE Follow-Up Sheet, or others that they create, to track their progress after the first COPE exercise. This is a relatively simple way for facilities to show their level of progress from one COPE exercise to the next (see Appendix A for a sample completed COPE Follow-Up Sheet).

Communicating Progress to Clients and Staff

Generally, both clients and staff enjoy seeing the progress made to improve services at a facility, particularly when their input helped bring about the changes. Seeing evidence of improvement encourages clients to provide more feedback and more honest suggestions, creating a constructive dialogue between staff and their clients.

Although staff need to know the status of all problems being solved, facilities may not want all clients to see their entire Action Plans. If this is the case, facilities may post a sign listing the clients' suggestions and the corresponding actions taken. To protect confidentiality, the sign should not list the names of the clients who made the suggestions.

To communicate the status of the Action Plan to the staff, the COPE Follow-Up Sheet may be posted in areas of the facility to which only staff have access.

6

Conducting Second and Subsequent COPE Exercises

This chapter is aimed at external facilitators and site facilitators.

In this chapter, the processes of leading both the second and the subsequent COPE exercises are discussed. While there are many similarities between the second COPE exercise and future exercises, they are treated separately here to underline the importance of reinforcing basic concepts and preparing for using different tools. The second COPE exercise is critical to this "imprinting" process. It also provides the site facilitator with an opportunity to take the leading role for the first time, with guidance from the external facilitator.

Objectives

After reading this chapter, you should be able to:
- Understand the elements of the second COPE exercise
- Prepare for the second COPE exercise, including deciding whether to conduct the Client-Flow Analysis (CFA) and making appropriate adjustments to the schedule
- Conduct the second COPE exercise, addressing any problems that may arise during it
- Conduct subsequent COPE exercises
- Follow up between subsequent COPE exercises

Elements of the Second COPE Exercise

The second COPE exercise consists of:
- The follow-up Introductory Meeting, including a review of COPE principles and a review of the previous Action Plan
- The use of the COPE tools, possibly including CFA
- The Action Plan Meeting, including development and presentation of Action Plans

The second COPE exercise incorporates Step 4 of the QI process, follow-up and evaluation. Since it also involves additional information-gathering, the process repeats Step 1, thus continuing the QI process.

Preparing for the Second COPE Exercise

The second COPE exercise is similar to the first, but provides participants with more of a review of the COPE process and tools than an in-depth introduction to COPE.

The time needed to conduct the second COPE exercise depends on:
- How much time has passed since the first COPE exercise
- How many of the participants did *not* participate in the first COPE exercise
- Whether any new tools, such as CFA, are introduced

The Facilitators' Roles

Both facilitators should meet to review any needed changes to the process. This may include changes in the schedule for meetings and group work. The site facilitator will prepare to take a more active role (preferably the lead) in facilitating the second COPE exercise. All participants from the first COPE exercise should be invited to participate in the second COPE exercise.

Discuss with facility managers which tools to use in the second COPE exercise. Rather than move on to new health services or areas, many facilities focus on the same health services (such as reproductive health or family planning) for the first few COPE exercises, so they can see a number of improvements over time and can continue to use the same COPE toolbook. However, depending on the needs identified during the first exercise (e.g., gaps in the quality of care in a particular health service area, or problems with client waiting time or staff utilization), some facilities may wish to use a different toolbook focusing on specific health services (such as child health or maternal care) or use different tools, such as the CFA.

Preparing for the CFA

Information on how to prepare for and conduct the CFA can be found in Chapter 7. However, in planning the second COPE exercise, facility managers and facilitators should keep in mind the following points:
- If the CFA is to be done during the second exercise, it is strongly recommended not to use the Self-Assessment Guides. This is to avoid overwhelming the staff, as doing both can be quite time-intensive. Staff should, however, continue to conduct client interviews.
- If the facility manager decides to use the Self-Assessment Guides, they should be used on a different day from the CFA, because spending staff time on the other tools will cause CFA results to be atypical.
- The staff participating in the CFA will need to be briefed beforehand so they understand how to use the forms.
- As was the case with other COPE tools used earlier, the tools used for the CFA may need to be adapted beforehand to more closely reflect the services offered at the facility.

Scheduling the Second COPE Exercise

The second COPE exercise will last three days if CFA is done, and two days if it is not. CFA requires data collection during one clinic session, shift, or day. The length of the session depends on the circumstances at individual facilities.

Work with the facility manager to:

■ Review the sample schedules (below and in Chapter 7), and determine which one to use, based on the health areas to be explored or the tools to be used during the exercise

■ Decide on a meeting space for the exercise

■ Set a time for the exercise to begin

Below is a sample schedule for the second COPE exercise, without incorporating the CFA. (A schedule for any follow-up COPE exercise that includes the CFA can be found in Chapter 7.)

Figure 6-1. Sample Schedule for the Second COPE Exercise (Without CFA)

Day 1
Morning—Initiating the Exercise
◆ Meet with staff (approximately 2 to 3 hours)
  ◆ Review the Action Plan
  ◆ Review the COPE tools to be used (Self-Assessment Guides, Client-Interview Guide, etc.)

Afternoon—Conducting the Client Interviews and Self-Assessment
◆ Conduct the client interviews ⎫ Carried out during routine work hours,
◆ Conduct the self-assessment   ⎭ at the staff's convenience
◆ Use other tools, as needed

Day 2
Morning—Preparing Action Plans
◆ Prepare the Client-Interview Action Plan ⎫ Carried out during routine work hours,
◆ Prepare the Self-Assessment Action Plan ⎭ at the staff's convenience

Afternoon—Presenting the Action Plan
◆ Hold the Action Plan Meeting with all who participated (approximately 2 to 3 hours)
◆ Review membership in the COPE Committee
◆ Schedule dates for the follow-up meeting and for the next COPE exercise

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Preparing Materials for the Second COPE Exercise

Figure 3-1 (page 31) provides a list of materials needed for self-assessment, client interviews, and the Action Plan Meeting. For a list of additional materials needed for the CFA, refer to Figure 7-2 (page 73). Feel free to make use of appropriate flipcharts as aids in facilitating the second or subsequent COPE exercise (see Appendix E).

Conducting the Follow-Up Meeting: Detailed Steps

❖ ──────Summary of Second or Subsequent Meeting Topics──────

Topic	Minimum Time Required
Welcoming the participants	5 to 10 minutes
Topic 1: Reviewing key concepts	25 to 30 minutes
Topic 2: Reviewing the status of the Action Plan	15 to 20 minutes
Topic 3: Recognizing successes	5 to 10 minutes
Topic 4: Presenting the focus of this COPE exercise	5 minutes
Topic 5: Reviewing the COPE tools to be used during this exercise	30 minutes (plus 30 minutes for the CFA)
Topic 6: Organizing the participants for group work	10 minutes
Total minimum time required	1 hour, 35 minutes, to 2 hours, 25 minutes

Welcoming the Participants

1. Greet the participants and thank them for attending.

2. Take attendance and set norms. When discussing progress on the Action Plan, one key norm for this discussion is to focus on systems and processes rather than on blaming individuals for unsolved problems.

Topic 1: Reviewing Key Concepts

Basics of QI and COPE

1. Review essential QI and COPE concepts (below). (This may be a repetition for some participants, but because some staff may not have participated in the first COPE or may have forgotten some information, such a review of essential concepts is important.)
   - What is quality?
   - Key QI principles
   - Internal and external customers

2. This review may be achieved by using one of the following warm-up exercises:
   - Option 1. Ask staff who participated in the first COPE exercise to raise their hands, and ask them if they have seen any changes or improvements at the facility since the first exercise. Then have all of the participants imagine the facility five years from now (after several improvements in services), by asking:
     - ▲ "What do you see when you walk into the hospital/clinic?"
     - ▲ "How are you treated?"
     - ▲ "What does the facility look like?"
     - ▲ "What is different about the staff?"

- *Option 2.* Ask participants to describe their own experiences:
  - ▲ "Think of a time in your life when you, your brother, your sister, or your child needed medical care. Have you ever experienced service that was so good that you would tell your friends and family to go to that facility? Describe what was good about the service you received."
  - ▲ "Now think about the things the staff must have had in order to be able to provide such good service."
- *For both options:* Compare the staff's responses with Flipchart 2, which lists clients' rights and staff needs, and review the concepts of internal and external customers provided in Chapter 3.

Review: What Is COPE?

Ask a volunteer to explain what COPE is, and let him or her say what gains staff have made as a result of the process. (Refer to Chapter 3 for key concepts.)

Topic 2: Reviewing the Status of the Action Plan

1. Ask a volunteer to present the Action Plan developed during the first COPE exercise. Review each problem, and discuss whether each recommendation has been successfully carried out.

2. This discussion may reveal that some underlying problems were not solved because the groups had not identified all of the problem's root causes. Some recommendations may also have taken more or less time to carry out than the participants had originally expected. Note the results of this discussion on the COPE Follow-Up Sheet (see the sample completed form in Appendix A). Incorporate into the facility's next Action Plan any unresolved problems for which a solution seems possible.

3. Identify potential barriers to solving each of the unresolved problems, and discuss how to overcome the barriers:

   - If the initial time frame was unrealistic, set a new time frame for solving the problem.
   - If the person responsible is unable to follow through on his or her own, involve others in follow-up.
   - Explore alternative solutions to the problem. For example, ask: "Did the recommendations address the root causes?" "Are alternative solutions more feasible?"

Topic 3: Recognizing Successes

Congratulate the participants for resolving some or all of the problems on the Action Plan. This is an opportunity to recognize the participants as part of a group, keep them motivated, and remind them of what they have accomplished.

Topic 4: Presenting the Focus of This COPE Exercise

Describe the health service or area on which the facility manager has decided staff will focus during this follow-up exercise. If this focus has changed since the initial exercise, refer to the introduction to the appropriate COPE toolbook for a description of the major issues related to the health services being assessed. If a CFA is to be done, explain which specific services will be assessed.

Topic 5: Reviewing the COPE Tools to Be Used during This Exercise

1. Explain only the tools that will be used during this exercise. (Refer to Chapter 3 for detailed information about the Self-Assessment Guides, Client-Interview Guides, and Action Plan.)

2. *If CFA is to be done,* skip the Self-Assessment Guides (or use them on a different day), and present instead the key information about CFA provided in Chapter 7.

3. *If CFA is to be done,* introduce the CFA forms to all participants who will have contact with clients. After data collection, organize the participants into groups to share the tasks of completing the charts and graph. (See Chapter 7 for detailed instructions on performing CFA.)

Topic 6: Organizing the Participants for Group Work

1. Follow the instructions provided in Chapter 3. Be sure to mention all of the tools that will be used during this exercise.

2. As described in Chapter 3, provide each group with copies of the tool(s) it will be using, and ask the group to review the instructions at the beginning of the tool(s). If most of the group members participated in the first COPE exercise, information about self-assessment, client interviews, and preparing Action Plans will be a review for them. If necessary, provide the explanations included in Chapter 3, saving detailed discussion of the Self-Assessment Guides for individual group work after the groups have split up.

3. Announce the time and place of the Action Plan Meeting.

4. Circulate among the groups, observing and giving feedback to each group to ensure that the participants understand their tools.

The Action Plan Meeting

This Action Plan Meeting follows the same format as the Action Plan Meeting in the first COPE exercise. (Refer to Chapter 4 for the summary of topics and further descriptions.) At this meeting:

- The participants present and discuss the new Action Plans they developed, based on the different tools used for assessing services.
- Staff prioritize the problems and incorporate their new recommendations into the facility's ongoing Action Plan.
- The participants discuss facility strengths.
- The participants review the members and role of the COPE Committee (to inform those who may not know or to update staff about any changes).
- The participants give feedback in a plus/delta exercise or other closing activity. (See Appendix D, page 127, for tips on closing meetings.)
- The COPE Committee sets a date for follow-up with the site facilitator.

Conducting Subsequent COPE Exercises

COPE exercises should take place regularly, usually every three to four months. Each COPE exercise should be adapted to meet the needs of the facility. Even if a particular COPE exer-

cise worked well for a facility at one time, it may need to be adapted as changes occur at the facility, such as an increase in the number of staff or of services provided.

Facilitators' Roles

By the third COPE exercise, most site facilitators will be ready to conduct the exercises on their own. However, some site facilitators may take more time to become confident about their facilitation skills and may require additional support from external facilitators. Once site facilitators are confident about their skills, they should begin thinking about selecting another staff member at the facility to train as a COPE facilitator.

Elements of Subsequent COPE Exercises

The following elements should be included in every subsequent COPE exercise:

- A review of the process and tools to be used
- A review of the last Action Plan developed for the facility, including tracking progress (Ways to track progress are described in Chapter 8.)
- Client interviews (Sites should conduct client interviews, as described in Chapter 2, during every COPE exercise, to receive regular feedback from clients. In addition, when staff become more comfortable with conducting client interviews, some facilities may make client interviews part of the staff's regular work. Many facilities display suggestion boxes and ask clients to place written comments in them.)
- An update of the facility's Action Plan

In addition, one of the following items should be included in every subsequent COPE exercise:

- *Self-Assessment Guide.* Facilities using COPE generally find it useful to use the Self-Assessment Guides on a regular basis—at the very least, once a year for a particular set of guides—because the questions reinforce international standards and desired behaviors. Repetition is needed, to emphasize the importance of focusing on clients and providing client-centered services. Moreover, staff may not identify all problems in one exercise, nor can they solve all problems at once, and new problems emerge.

  If the facility used the Reproductive Health Self-Assessment Guide during prior COPE exercises, during subsequent exercises it may use Self-Assessment Guides developed for other areas, such as family planning, maternal health services, or child health services, as desired.

- *Tools to involve the community in continuous QI.* Several facilities have complemented their COPE exercises with new tools—such as Community COPE—to seek community members' views about the health services provided at the facility. These tools—which include individual interview and group discussion guides, a facility walk-through guide, and participatory mapping activities—provide a way for staff to learn how individuals and groups in the community feel about the services that a facility provides, to increase the community's understanding of health issues, and to involve community members in the QI process. Creating partnerships between facilities and communities and clarifying clients' expectations are important steps toward building sustainable, responsive health services.

- *CFA combined with cost analysis.* Staff may repeat CFAs as needed, and may combine CFA with an exercise to analyze costs. For example, EngenderHealth has developed an easy-to-use Cost-Analysis Tool (AVSC International, 2000b) to measure the direct costs of providing services. Facilities can use this tool either with or without the help of a computer.

Other organizations have developed more comprehensive cost methodologies, such as CORE: A Tool for Cost and Revenue Analysis (MSH, 1998) and the Mother-Baby Costing Spreadsheet (WHO, 1999). These can be used if the facility needs more comprehensive information and has the capacity to use more complex methodologies.

- *Exploration of facility strengths.* Improving quality and better meeting clients' needs implies improving systems and processes to ensure that mistakes are less likely to happen. This requires being proactive and going beyond solving problems, to preventing problems from developing. To do so, facilities should explore not only problem areas but also strengths that the facility can build on so as to serve clients even better.

Format and Schedule

Subsequent COPE exercises may follow the same general schedule and format as the second COPE exercise. If so, it is important to use the tools in a flexible manner and to add any new tools, such as traditional management tools or performance improvement tools, as needed. (See pages 60 and 61 for schedules and for information on conducting various exercises.) (See Figure 6-2 for a sample timeline.)

Figure 6-2. COPE Process: Sample Timeline
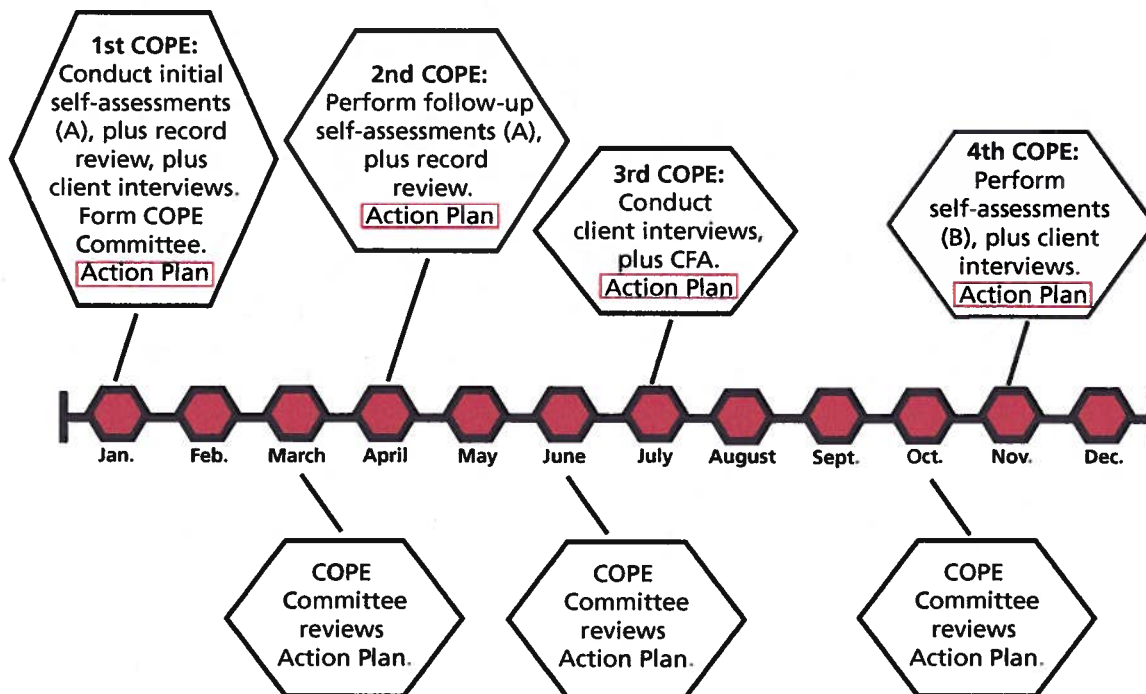
KEY:

A = All 10 Self-Assessment Guides in the Reproductive Health Toolbook
B = All 10 Self-Assessment Guides in the Maternal Health Toolbook
Action Plan = Action Plan Meeting, which follows any information-gathering and analysis step.

Sample Variation on a COPE Exercise: Exploring Facility Strengths

During second and subsequent COPE exercises, sites often choose to focus the participants' attention more on a facility's strengths than on its problems. The variation on a COPE exercise presented below may be conducted during several workdays, over the course of two all-staff meetings, with group work in between. (Refer to Appendix G for information on appreciative inquiry, the QI method upon which this exploration of a facility's strengths is based.)

❖ ———— Exploring Facility Strengths: Summary of Meeting Topics ————

Topic	Minimum Time Required
Day 1: Initiating the Exercise	
Topic 1: Identifying past and present staff strengths	30 minutes
Topic 2: Organizing group work	15 minutes
Client interviews	5 minutes
Strengths/stories	10 minutes
Day 2: The Action Plan Meeting	
Topic 1: Presentations of group work	20 to 30 minutes per group
Topic 2: Consolidating and prioritizing the Action Plans	30 to 40 minutes
Topic 3: Closing the meeting	10 minutes
Total minimum time required	1 hour, 45 minutes

Day 1: Initiating the Exercise

Topic 1: Identifying Past and Present Staff Strengths

1. At the point in the follow-up meeting where you would introduce the tools to be used, instead:
   - Explain this new variation on the COPE exercise
   - Hold a discussion on identifying staff strengths

   Rather than look at problems at the facility, during this COPE exercise the participants should try to improve services by looking at the things the facility does well now or has done well in the past. This can help staff build on those strengths so as to serve clients even better.

2. Ask the participants what they feel the facility is doing well now or did well in the past, in terms of providing quality services. Lead a brainstorm about these strengths, allowing all participants to comment, and write the responses on a flipchart. (*Note:* This can be a short brainstorming session; more details will emerge later when staff break into smaller groups.)

3. Identify three to five themes among the participants' responses. (Themes may include providing good family planning information to clients, having high coverage of antenatal clients, using effective infection prevention practices, maintaining respectful and kind interpersonal relations with clients, having a good referral system for emergency obstetric care services, and keeping staff updated on new health information.) Ensure that the participants agree that these themes are, or once were, strong areas for the facility.

Topic 2: Organizing Group Work

When you organize the participants for group work, instruct the group conducting client interviews and the remaining groups on how to focus on strengths.

1. Instruct the group conducting client interviews to ask 10 to 15 clients two questions each:

   - "What, in particular, do you like about the services you receive at this facility?"
   - "If there is one thing that you would like to see changed at this facility, what would it be?" or "What suggestions do you have for improving services here?"

2. In each case, tell the group to ask the clients to give *specific* examples and record their responses.

3. Tell this group to come to the Action Plan Meeting prepared to present three examples of what clients said. Members should pick the examples that are most typical of what clients said or were most frequently mentioned.

4. Instruct the remaining groups to think of specific examples, or brief stories, that support the themes they identified among the facility's strengths. The examples or stories should include how they themselves, as individuals, contributed. If some of the facility's staff are not participating in this COPE exercise, tell the group members to seek their input and incorporate their examples or stories into their presentations.

5. Based on client feedback or on staff's own stories, ask all groups to imagine *what the facility needs,* or what the staff should do, to make an area of the facility even stronger or as strong as it was in the past. For example, if the participants say that their customer relations are good and they have given examples of what clients say, ask what they will do to make customer relations even better. Also ask who will be responsible for follow-up and by when. Record the recommendations and other information in the Action Plan. Tell the groups to come to the Action Plan Meeting prepared to present their stories and action plans to the rest of the participants.

   Note: The Action Plan format can be adapted so that the first column is labeled "strength" rather than "problem." The other columns remain the same.

6. Circulate among the teams to clarify any issues or instructions.

Day 2: The Action Plan Meeting

Topic 1: Conducting the Action Plan Meeting

1. Conduct the Action Plan Meeting for this variation of the COPE exercise in the same manner as other Action Plan meetings, but draw out the information gathered on facility strengths instead.

2. Invite each group that gathered examples or stories to present its examples or stories and their action plans for making the facility stronger. Facilitate a discussion after each presentation by asking the rest of the participants if they agree with the group's assessment and whether any other recommendations are needed. Ask multiple whys, as needed.

3. Invite the group that conducted client interviews to provide its examples. Then ask all of the participants: "Do clients and staff share the same views about what our strengths are? Do we have the same priorities?"

4. Ask the participants if they are surprised by anything the clients have said, and remind the participants that clients' views are important because clients are the focus of services.

Topic 2: Consolidating and Prioritizing the Action Plans

After all of the groups have presented their stories, examples, and action plans, discuss how to prioritize these recommendations, keeping in mind the clients' opinions and suggestions, as well as the activities that the staff can easily do themselves. The staff may adapt the criteria for prioritizing recommendations if desired (see Chapter 4). If the staff or clients identified any elements that are life-threatening to either staff or clients, these need to be categorized as the highest priority for improvement.

Topic 3: Closing the Meeting

1. Thank the staff for their time, effort, and enthusiasm.

2. Ask the staff how they felt about the exercise, and facilitate a discussion about it.

3. Encourage the staff to remember their strengths and to continue to build on them.

Follow-Up between Subsequent COPE Exercises

Follow-up should continue to be done between each COPE exercise.

Some facilities have adapted the way in which they follow up between subsequent COPE exercises, as follows:
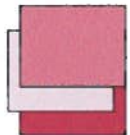
- At one facility, the head nurse keeps a copy of the COPE Action Plan in a logbook. When she makes her rounds to the different wards and departments, she meets with the staff and discusses the status of the Action Plan. Every week, staff on each ward conduct a "mini-COPE" exercise. Every three to six months, a mix of staff from all wards and departments participate in a full COPE exercise.

- Some organizations have taken COPE from the facility level to the headquarters or national level. For example, often one facility's success with COPE spreads to other facilities and, eventually, to upper levels. A headquarters or national-level office may decide to institute COPE at all of its facilities or to use it at their own.

- One facility conducts client interviews once a month, and every six months the staff conduct the self-assessments and record reviews.

Troubleshooting Tips

IF: *Some problems are recurring in subsequent COPE exercises...*
Find out if there are other ways to address the problem. This may mean that the root cause of the problem has not been correctly identified, and that it may be worthwhile to reexamine the problem and identified causes, using the multiple whys technique. Getting at the true root cause may lead to new recommended solutions.

(continued)

Troubleshooting Tips (continued)

Alternatively, reoccurrence could mean that the problem is not one that local staff can address. If so, staff should understand that COPE is not a cure-all to solve all problems. Some problems may require outside support to be resolved, such as from the local community and from higher levels in the institution. (In fact, some problems may be occurring throughout the system and may require intervention at the national level.) If this is the case with a particular problem or set of problems, facility staff need to communicate these ongoing problems to higher levels in the institution.

IF: *Staff turnover is high and many of the participants are new to the COPE process...*
Conduct full COPE exercises—exercises that provide all of the introductory material in a first COPE exercise—on a regular basis to ensure that all staff are oriented to QI principles and to COPE.

chapter 7

Conducting the Client-Flow Analysis

This chapter is aimed at external facilitators and site facilitators.

Client-Flow Analysis (CFA)* is a method for analyzing how clients move through a health care facility while receiving various outpatient services. CFA measures clients' contact time with different service providers, while at the same time measuring staff utilization. This chapter describes how to conduct the CFA, how to analyze and interpret the CFA's results, and how to relate those results to the facility's Action Plan.

Objectives

After reading this chapter, you should be able to:

- Conduct the CFA
- Help staff analyze the findings, interpret the results, and record them on the Action Plan

Preparing for the CFA

CFA is used to analyze client flow in various outpatient services at the facility. For example, a CFA of reproductive health services may include family planning, antenatal care, child welfare, and outpatient obstetric and gynecological services, as well as counseling, testing, and treatment services related to sexually transmitted infections (STIs), HIV, and AIDS.

Sites may choose to simplify or limit the CFA by tracking all clients who enter the facility at a single entry point, rather than at multiple entry points. For example, facilities may track only those clients who enter the maternal and child health (MCH) clinic rather than those entering the outpatient department and the MCH and STI clinics. Still, because these same clients may pass through multiple service areas before leaving the facility, all staff having direct contact with clients in all relevant areas need to be informed in advance and involved in the CFA.

Before conducting the CFA, facilitators should tour the facility to become familiar with the different entry points.

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* COPE's Client-Flow Analysis tool was adapted from a computerized patient-flow analysis developed by the Family Planning Evaluation Division, U.S. Centers for Disease Control and Prevention (Graves et al., 1981). EngenderHealth simplified and redesigned this tool to encourage self-assessment and staff involvement.

Troubleshooting Tip

IF: *A CFA will be done...*

Strongly advise the facility manager to skip the Self-Assessment Guides—while retaining the client interviews—in the exercise. It would be overwhelming for staff to review the prior Action Plan and use all of the tools to identify new problems in one exercise. However, it is important to include client interviews in every COPE exercise, to reinforce the staff's focus on their clients. If the facility manager wishes to use the Self-Assessment Guides, recommend that they be done on a different day from the CFA, to avoid getting atypical data due to staff time being spent working on those tools.

Figure 7-1. Sample Schedule for Follow-Up COPE Exercise with CFA

Day 1
Morning—Initiating the Exercise
- Meet with staff (approximately 2 to 3 hours)
  - Review the Action Plan
  - Explain CFA and make plans to conduct it the next day
  - Review the Client-Interview Guide

Afternoon—Conducting the Client Interviews
- Conduct the client interviews
- Prepare the Client-Interview Action Plan

} Carried out during routine work hours, at the staff's convenience

Day 2
Morning—Collecting CFA Data*
- Collect data for CFA during clinic session

} Carried out during routine work hours, at the staff's convenience

Afternoon—Analyzing CFA Data and Preparing the Action Plan
- Graph and chart the CFA data collected
- Perform preliminary analysis of CFA findings
- Prepare the CFA Action Plan

} Carried out during routine work hours, at the staff's convenience

Day 3
Morning—Finalizing the Action Plans
- Finalize the Client-Interview and CFA Action Plans

} Carried out during routine work hours, at the staff's convenience

Morning or Afternoon—Presenting the Action Plan
- Hold the Action Plan Meeting with all participants (approximately 2 to 3 hours)

*CFA data collection can be done at other times, to assess client flow at different times of day, during different shifts or clinic sessions, or on different days of the week. However, for results to be typical, CFA should take place on a "normal" day of service delivery.

Selecting Participants for the CFA

Staff from all departments being covered should be involved in the CFA. Before the initial CFA meeting, facilitators should meet with the facility manager to identify the staff members who will be responsible for collecting and analyzing information during the CFA, including:

- The first staff member who has contact with clients at the facility—often a doorman, guard, receptionist, or clerk in any of the services to be covered (Sometimes, a staff member is assigned to perform this function specifically for CFA. If so, he or she should not be someone who would otherwise be serving clients in the service being analyzed.)
- The first staff member who discusses a client's reason for the visit
- Any staff member who conducts group education sessions for clients
- Any staff member who has service contact with clients during their visit
- The last staff member who has direct contact with clients before they leave the facility
- Any other staff member who will be responsible for graphing or conducting a preliminary analysis of the information collected

Adapting CFA Tools

The CFA tools may need to be adapted to suit a facility's needs. The examples used here are from the Reproductive Health Toolbook, but they can be adapted to any type of service. CFA tools that were developed for outpatient services may be adapted for inpatient services (such as a ward analysis, to measure the time staff spend with each inpatient on a ward in a given time period). However, multiple shifts of staff will need to know how to use the CFA forms.

Scheduling the CFA

Follow-up COPE exercises will take three days if CFA is done. CFA requires data collection during one clinic session, shift, or day. The length of the session will depend on the circumstances at individual facilities.

Work with the facility manager to review the schedule in Figure 7-1 and set a time for the follow-up exercise, including the CFA.

Preparing the Materials for the CFA

Figure 3-1 in Chapter 3 provides a list of the materials needed for self-assessment, client interviews, and the Action Plan Meeting. Figure 7-2 provides a list of the additional materials needed to conduct the CFA.

Figure 7-2. Supplies Needed for the CFA

- Ruler
- Calculator
- Wristwatches or clocks that are synchronized
- 50 copies of the Client Register Form*
- 3 copies of the Client-Flow Chart*
- 1 copy of the Client-Flow Chart Summary*
- Up to 5 large sheets of graph paper
- Colored pens or pencils for graphing client flow

*Provided in the COPE toolbooks.

Conducting the CFA: Detailed Steps

❖ ————————Conducting the CFA: Summary of Meeting Topics————————

Topic	Minimum Time Required
Topic 1: Describing CFA	20 minutes
Topic 2: Using the Client Register Form	20 minutes
Topic 3: Summarizing and graphing the results	40 minutes
Topic 4: Analyzing and recording findings on the Action Plan	10 minutes
Total minimum time required	1 hour, 30 minutes

Topic 1: Describing CFA

Offering an Overview of CFA *(Flipchart 21)*

1. After reviewing topics 1 to 6 of the second COPE exercise (see Chapter 6), provide an overview of how CFA works (*Flipchart 21,* Appendix E).

2. Explain that CFA is a method of tracking client flow through a facility and measuring the contact time that clients have with all of the different staff whom they see during their visit.

3. Note that for the CFA:
   - Sites collect data during one day or clinic session to identify potential areas for improvement
   - Staff members graph and analyze the data and incorporate their findings into the Action Plan
   - Sites use CFA only if they have identified waiting time or staff utilization as a problem during a previous COPE exercise

4. Explain the benefits of CFA:
   - By visually demonstrating how client and staff time are used, the graphs and charts allow rapid evaluation of client flow.
   - Like other COPE tools, CFA reveals some of the strengths and weaknesses in a facility's operations.
   - CFA is relatively simple to conduct, interpret, and use, and it can be performed as often as needed.
   - If a client-flow problem has been identified at the facility, using CFA can lead to:
     - Reduced staff and client waiting times
     - A more evenly distributed workload for each staff member
     - Reduced personnel costs
     - Increased efficiency, allowing staff to serve more clients

5. Discuss what CFA can and cannot do. To help the participants understand the breadth and limitations of CFA, you may either:
   - Show Figure 7-3
   - Review the points made in Figure 7-3 for your own understanding and explain them to the staff as needed (particularly when the staff are analyzing the data they have gathered)

Figure 7-3. What CFA Can and Cannot Do

CFA Can...	CFA Cannot...
■ Identify bottlenecks	■ Provide the best solution for the bottleneck
■ Identify lapses in client contact time	■ Explain what staff were doing during that time
■ Identify missed contacts	■ Explain why contacts were missed
■ Identify unscheduled client contacts	■ Tell why extra contacts were made
■ Provide personnel cost estimates*	■ Tell whether personnel costs are reasonable*
■ Measure client waiting time	■ Tell whether these waits are reasonable
■ Measure client time spent at each contact	■ Judge the quality of care at each contact
■ Demonstrate the effect of changes in facility operations on client flow	■ Judge whether the effect is a desired one
■ Demonstrate the existence of linkages between services within a facility	■ Judge whether those linkages are sufficient to ensure that clients receive all of the care they may need

* If used together with the Cost-Analysis Tool.

6. Emphasize that while CFA is useful for gathering data, interpreting these data requires the staff's judgment and expertise.

Presenting an Overview of the Steps of CFA

1. Describe the four main steps of CFA:
   - Collecting data, including completing the Client Register Form
   - Summarizing and graphing the results, including completing:
     - ▲ The Client-Flow Chart and Summary (adding up client contact time and waiting time)
     - ▲ The Client-Flow Graph (clients' time)
     - ▲ The Staff-Utilization Graph
   - Interpreting the results
   - Analyzing and recording findings on the Action Plan

2. Explain that you will be observing staff carry out each step of the CFA process, and that you will offer assistance, as needed.

Describing Data Collection

1. Explain that CFA data may be collected at different times of the day, during different shifts or clinic sessions, or on different days of the week. However, data should be collected on a "normal" service-delivery day—not, for example, at a time of year when most staff are on leave.

2. Emphasize that data collection is simple and requires only a few seconds of staff time at the beginning and end of their contact with each client during one or more specified clinic sessions. (Flipchart 21, in Appendix E, summarizes the key instructions for data collection.)

3. Note that the staff should analyze client flow for no more than 50 clients. This is because

the staff will learn a lot from analyzing the flow of 30 to 50 clients, but any more will be too time-consuming to analyze. Once the staff have learned how to do CFA, they can repeat it at a future time to learn more about the facility.

Topic 2: Using the Client Register Form

Presenting the Client Register Form

1. Explain that the Client Register Form is used to collect information about a client's entry and exit times, the amount of time the client spends with each staff member, and the reason for the visit (see Appendix A for a sample completed Client Register Form). Depending on the service being analyzed, additional details, such as contraceptive method, may be tracked for family planning clients.

2. Distribute copies of the sample form for the participants to review while you explain how to complete it.

Preparing the Client Register Form

1. Before data collection begins, explain that the participants should number the Client Register Forms consecutively in the "Client number" space provided on the form and enter the date of the session in the appropriate spaces.

2. Note that if the facility routinely provides any services that are not listed under "Service Type" on the sample form, these should be added to the form.

3. Observe that if there are two or more entry points for clients, the participants should use a different numbering system for the "client number" space on the forms distributed at each entry point (for example, A1, A2, A3, etc., in the outpatient department, and B1, B2, B3, etc., in the family planning clinic).

4. Comment that some facilities may choose to compare client flow for two different sessions (for example, they may choose to follow the first 20 clients during the morning session and then the first 20 clients during the afternoon session). Discuss with the participants what they think is most important to analyze (and what days and times clients have to wait the longest before receiving services).

5. Synchronize all clocks and watches.

Completing the Client Register Form

1. Note that the staff member who sees a client first upon his or her arrival at the facility (for example, a doorman, guard, receptionist, or clerk in any of the services to be covered) should give the form to each client in numerical order as the clients arrive. This staff member should note each client's time of arrival on the form (under "Time client arrived at the facility") and then give the form to the client.

2. Explain that as the staff person hands the form to the client, he or she should say, "Today we are doing an exercise to measure the time that clients spend getting services at our facility. Please carry this form with you during your entire visit today. Present this form to each staff member you have contact with, and leave the form with the last staff member who sees you today."

3. Caution that if the facility will be collecting information about all clients who come to the facility during that session, the staff member distributing the forms should check periodically to see how many numbered forms are left, so that more forms can be prepared, if needed.

4. Explain that each staff member who has contact with clients should:

   ▪ Enter his or her initials (or a previously determined unique identification code, if some staff share the same initials) under "Staff member's initials" on the appropriate line (For example, the first staff member uses the line for "First contact," the next uses the line for "Second contact," and so on.)

   ▪ Log in the exact time when the client contact begins under "Time service started," and log in the exact time when the client contact ends, under "Time service completed" (If contact is less than one minute, a full minute should be entered.)

   ▪ Calculate the amount of time the client spent in contact with a staff member (in minutes) by subtracting "Time service started" from "Time service completed," and enter this figure under "Contact time" (If it is not possible to do this during the session, it may be added later.)

   ▪ Give the form back to the client (unless this is the last contact)

5. Explain that the first staff member with whom a client discusses the *primary reason* for his or her visit should enter this information under "Service type," using the service codes listed. This staff member should also enter whether the client is male or female (under "sex") and whether the visit is a first visit or a follow-up visit *for the primary service* (under "visit timing").

6. Comment that there may be additional reasons why the client has come to see a provider. If so, these should be entered on the form under "Secondary reason for visit," using the same service codes. (This is important information to have when analyzing total time spent during the client visit.)

7. Explain that any other important information about the client's visit (for example, if the client leaves the clinic without completing the visit) should be noted on the form under "Comments."

8. Observe that if clients attend a group education session, the staff member responsible for conducting the session should enter the beginning and ending time of the session on each client's form.

9. Clarify that the last staff member who has contact with clients should collect the form. This staff member should give all completed forms to the staff member responsible for charting client flow. If possible, a staff member should be posted at the exit(s) to ensure that all forms are collected before clients leave the facility.

Reviewing How to Complete the Client Register Form

1. Facilitate a role play to let the participants practice filling out the Client Register Form. Display the form to the participants and say, "I am a client, and I have just come to your hospital. Where do I go first?"

2. When the participants say, "Reception [or wherever]," approach one participant and say, "Now I am coming to see you at the reception desk. What do you do with my paper?" Correct any misunderstandings about how to fill out the form.

3. Then approach another participant and say, "Now I am coming to see you, the nurse. What do you do with my paper?"

4. Summarize the key instructions for data collection with all staff who will have contact with clients during the clinic session. If staff are confused about the CFA or are not aware that it is being done, poor data collection may result.

5. Explain that once the information is entered on the Client Register Form, the participants

will compile this information into the Client-Flow Chart and the Client-Flow Chart Summary form. (These are described in the next section.)

Topic 3: Summarizing and Graphing the Results

Introducing the Client-Flow Chart and Client-Flow Chart Summary

1. Explain the purpose of the Client-Flow Chart and the Client-Flow Chart Summary. These forms are used to collate and chart the information on the Client Register Forms (see Appendix A for a sample completed Client-Flow Chart and Client-Flow Chart Summary). The information can be charted either during or after the session is over and all Client Register Forms have been collected.

2. Distribute copies of the sample forms for the staff to review while you explain how to complete them.

Completing the Client-Flow Chart

Explain that staff should do the following:

1. Enter the date and time of the session being followed and the page number in the appropriate spaces on the form.

2. Enter the client number from each Client Register Form in sequential order, beginning with client number 01, under "Client number." (If you are following more than 20 clients during the session, use additional pages of the Client-Flow Chart and continue to use consecutive register forms.)

3. Enter the "Time client arrived at the facility" from the Client Register Form under "Time in" and the "Time service completed" under "Time out."

4. Calculate the total number of minutes the client spent at the facility by subtracting "Time in" from "Time out," and enter this figure under "Total time at the facility."

Example:

Time in	Time out	Total time at the facility
8:00	8:50	50 min.

5. Enter the "Contact time" from the Client Register Form under "Contact time."

6. On the Client-Flow Chart, subtract "Contact time" from "Total time at the facility," and enter this figure under "Waiting time."

Example:

Total time at the facility	-	Contact time	=	Waiting time
50 min.	-	40 min.	=	10 min.

7. Write the "Service type" codes for primary and secondary services (if applicable) from the Client Register Form in the corresponding spaces on the Client-Flow Chart. Find the code for the "Visit timing" and enter it in the appropriate space.

8. Enter any pertinent information noted on the Client Register Form (such as "Client left clinic before completing visit" or "Client left clinic for two hours and then came back") under "Comments."

9. On the Client-Flow Chart, total the entries in the "Total time at the facility," "Contact time," and "Waiting time" columns, and enter those figures in the spaces provided for "Total."

10. Repeat this process until the information from each Client Register Form has been entered on the Client-Flow Chart.

Using the Client-Flow Chart Summary

Explain that when they have completed the Client-Flow Chart, they should calculate averages for the session by using the Client-Flow Chart Summary. If more than one Client-Flow Chart was used to record information for the session, instruct them to enter the information for each page in the space provided on the Client-Flow Chart Summary (see Appendix A for a sample completed Client-Flow Chart Summary).

Completing the Client-Flow Chart Summary

Explain that to complete the Client-Flow Chart Summary, staff should do the following:

1. Enter the date and time of the session being followed in the appropriate spaces on the form.

2. For each page of the completed Client-Flow Chart, enter in the space provided on the Client-Flow Chart Summary the total number of clients charted. (Each Client-Flow Chart has room for 20 clients.)

3. For each page of the completed Client-Flow Chart, enter the totals for "Total time at the facility" and "Contact time" under "Total time" and "Total contact time" on the summary.

4. For each page of the completed Client-Flow Chart, find the percentage of time that an average client spent in contact with a staff member, by dividing "Total contact time" by "Total time" and multiplying the result by 100. Round this figure to a whole number, and enter it under "Percentage of client time spent in contact with staff."

Example (Page 1):

Total contact time	÷	Total time	x	100 =	% of time in contact
679 min.	÷	2,545 min. x		100 =	27%

---

5. Add the numbers in each column together, and enter the totals at the bottom. However, to calculate the overall percentage of time spent in contact with clients, do not add together the percentages in the last column. Instead, use the same approach as in the example above: Divide the overall "Total contact time" (1,004 minutes in the sample in Appendix A)

by the overall "Total time" (3,845 minutes), multiply by 100, and round the result to a whole number (in this case, 26%).

6. Using the overall totals, divide "Total time" by "Total number of clients," round the result to a whole number, and enter this figure under "Average number of minutes per client."

Example:

Total time	÷	Total number of clients	=	Average number of minutes per client
3,845	÷	30	=	128

7. Divide "Total contact time" by "Total number of clients," round the result to be a whole number, and enter this figure under "Average contact minutes."

Example:

Total contact time	÷	Total number of clients	=	Average contact minutes
1,004	÷	30	=	33

Explaining the Purpose of the Client-Flow Graph

1. Describe how staff can use the information on the Client Register Forms to create a graph of client flow (see Appendix A for a sample Client-Flow Graph). Using this graph, staff can address a number of issues (for example, whether excessive waiting time is associated with a particular type of visit, sex of client, or family planning method). The participants may analyze the flow of all clients during the session, or they may focus on a particular set of clients (such as those who came for antenatal care).

   Note: A blank version of this graph is not provided in the COPE toolbooks. The following items are needed to create the graph:
   - Graph paper
   - The completed Client Register Forms
   - Colored pencils or pens
   - Ruler

2. Distribute copies of the sample graph (see Appendix A) for the staff to review while you explain how to create one.

Creating a Client-Flow Graph

Explain that to create a Client-Flow Graph, staff should do the following:

1. Write the client numbers down the left side of a sheet of graph paper, along the horizontal grid lines. Begin with client number "01," and use as many sheets as needed to graph client flow for all clients followed.

2. Enter "Time" along the top of the graph. Starting at the time the clinic session began, write the time in 5- or 10-minute increments along the vertical grid lines until they reach the time the clinic session ended. Feel free to use as many sheets as needed to graph the entire clinic session.

3. Assign a color to each "Service type," and use a pen or pencil of that color to graph the flow of clients for each type of visit.

4. Using the color that corresponds to the type of services being considered, for each client:

   ▪ Make a symbol (for example, an asterisk or a vertical bar) at the point on the graph that corresponds with the "Time client arrived at the facility" on the Client Register Form.

   ▪ Using the same color, draw a horizontal line beginning at the point on the graph that corresponds with "Time service started" and ending at the point that corresponds with "Time service completed" for each staff member with whom the client had contact. Use a ruler to draw the lines, if desired. The space between the asterisk and the line, or between each line, shows waiting time.

   ▪ For each client, enter the "Service type" code on the right side of the graph.

Example:

On the line for client number 01 on the sample graph, a yellow asterisk is marked at 8:00, indicating that the client arrived at the facility at 8:00. A green horizontal line begins at 8:10, indicating that service for this client started at 8:10, and the green line ends at 8:50, indicating that service for this client was completed at 8:50. Client number 13 had contact with several staff members with breaks in between contact, as shown in the sample graph.

---

5. Repeat the preceding step for each client followed.

Why Examine Staff Utilization?

1. Explain the importance of examining staff utilization:

   ▪ One way to improve service quality is to increase the amount of time that staff members spend in contact with clients.

   ▪ By understanding *staff utilization,* or how staff spend their time there, facilities can gauge how much time staff spend with clients and on other tasks, as well as how much time elapses between the two. For example, at some facilities, staff may prepare rooms, equipment, and supplies for services first thing in the morning, while clients are waiting to be seen. Yet these same staff may have relatively few clients and much free time in the afternoon, which could be used to prepare for the next morning's session and thereby decrease the time that clients spend waiting.

   ▪ In addition, by understanding staff utilization, facilities can look at balances between the workloads of different staff members. For example, at some facilities, one counselor may see many clients, while others may see few. By recording staff members' activities, facilities can determine ways to use the staff's time more efficiently.

2. Explain that two ways to measure staff utilization are by:

   ▪ Calculating the percentage of time that staff spend in contact with clients

   ▪ Graphing staff utilization to show any gaps between the time each staff member spends in contact with clients

3. Explain that to calculate staff time spent in contact with clients, staff should first take a blank sheet of paper and record the total for the "Total contact time" column from the Client-Flow Chart Summary. (In the sample chart, shown in Appendix A, this number is 1,004.)

4. Next, ask staff to go through the Client Register Forms and make a list of the different sets of staff initials. Calculate the total staff minutes available by counting the number of staff who worked during the session and then multiplying that number by the total number of minutes in the session.

<div style="border:1px solid">

Example:

8:00 a.m. to 2:30 p.m. session

Staff members	×	Minutes in the session	=	Staff minutes available
7	×	390	=	2,730

</div>

5. Explain that to find the percentage of available staff time that is spent in contact with clients, the "Total contact time" is divided by "Staff minutes available" and multiplied by 100. This figure is then rounded to a whole number.

<div style="border:1px solid">

Example:

8:00 a.m. to 2:30 p.m. session

Total contact time	÷	Staff minutes available	×	100	=	Percentage of staff time in contact
1,004	÷	2,730	×	100	=	38%

</div>

Developing the Staff-Utilization Graph

1. Explain that the Staff-Utilization Graph has several uses: In addition to understanding what percentage of time all staff spend in contact with clients, it is useful for facilities to understand at which points during the clinic session specific staff members are working with clients and at which points they are performing other tasks or taking breaks or meals. The Staff-Utilization Graph gives a clear, visual presentation of the actual time that each staff member spent in contact with clients during the session.

2. Explain that to create a Staff-Utilization Graph, staff will need the same items used to create the Client-Flow Graph—graph paper, the completed Client Register Forms, colored pencils or pens, and a ruler (see Appendix A for a sample Staff-Utilization Graph).

3. Distribute copies of the sample graph for the staff to review while you explain how to create one.

4. Explain that to create the Staff-Utilization Graph, staff should do the following:

   ▪ Write the initials of all staff members who had contact with clients during the clinic

session (as indicated on the Client Register Forms) down the left side of a sheet of graph paper, along the horizontal grid lines. Assign a different color to each staff member.

■ Enter "Time" along the top of the graph, using the same 5- or 10-minute time increments as were used in the Client-Flow Graph. Use as many sheets as needed to graph the entire clinic session.

■ On each Client Register Form, note the "Time service started" and "Time service completed" for each staff member. Using the appropriately colored pen or pencil for the staff member, draw a horizontal line beginning at the point on the graph that corresponds with "Time service started" and ending at the point that corresponds with "Time service completed." Gaps between contact times represent all other activities, such as paperwork and breaks.

Interpreting the Client Flow and Staff-Utilization Graphs

When the graphs are completed, meet with the staff involved in the exercise to discuss the findings. Ask the following questions to help staff analyze what the graphs represent:

For client service and waiting times:

■ Could waiting times for clients be reduced? If so, at what stage of the client's flow through the facility could this happen?

■ What are some ways in which services could be reorganized to do this?

For staff utilization:

■ Are staff fully utilized at your facility?

■ Are a few staff members doing the major part of service delivery? Why?

■ Could staff time be better used?

■ Could staff time be reorganized so that clients have shorter waiting times?

■ What do the gaps in contact time represent? When staff are not serving clients, what are they doing?

Note: If the graph reveals some large gaps or many smaller gaps between the time spent in contact with clients, staff members may feel that they are being perceived as not working during those times. In such cases, you might point to a gap on the graph and say to the participants: "This gap in client contact does not mean that staff member X was not working, just that [he or she] was not working directly with a client at that time. Our goal is to serve clients as quickly and efficiently as possible, which means limiting the amount of time that clients spend waiting for services. By seeing when the gaps in client contact occur and how long they last, we may be able to determine ways in which you can work more efficiently." This discussion may produce several useful time-management strategies. For example, supervisors can designate certain periods during the session for each staff member to perform activities not related to client contact, rather than having staff members perform such activities all through a session and break up client contact.

Topic 4: Analyzing and Recording Findings on the Action Plan

1. Explain that although using CFA is a good way to measure efficiency, it does not substitute for the judgment and expertise of those who work at the facility. CFA should always be used and interpreted by those who understand the facility operations best: *the staff.*

2. Caution that because CFA only *identifies* potential problems, staff themselves must seek explanations of any unusual occurrences identified in the analysis (see Figure 7-3, page 75). The important part of CFA—addressing problems and improving service delivery based on the findings—is done when staff carefully analyze the root causes of problems (see Figure 7-4) and incorporate findings into the discussions at the Action Plan Meeting.

Figure 7-4. Using the Multiple Whys Technique for Client Flow

Problem: Clients who come to the clinic for a minilaparotomy (female sterilization) procedure must wait several hours before having the procedure.

Why? They must receive counseling about family planning methods before they can have the procedure, and only one counselor is available to see them.

Why? The facility has several counselors, but only one is trained in counseling about long-term or permanent family planning methods.

Why? There has been much staff turnover in the past few months, and none of the new counselors have received training in these methods.

Are there any other causes? There is no system in place to ensure that the new counselors receive this training.

Troubleshooting Tips

IF: *Some clients are not receiving Client Register Forms...*
Find out where they entered the facility, and make sure the staff at that entry point are giving all clients the form (up to a recommended maximum of 50 clients).

IF: *Some Client Register Forms are not being collected before clients leave...*
Remind the staff that the last person to have contact with a client needs to collect the form before the client leaves the facility. Because staff may not always know whether they are the last to see each client, assign a person to stand near the exit(s) to collect any additional forms before clients leave the facility.

IF: *Some Client Register Forms are not completely or correctly filled out...*
Monitor the forms as they are collected, and show relevant staff members how to complete the forms properly.

IF: *Some codes or initials are not used correctly...*
Monitor the forms as they are collected, and show relevant staff members how to complete the forms properly. Staff should use the list of codes provided on the Client Register Form. If this list has been adapted for the facility, ensure that all staff know the appropriate codes and that staff have a written copy of them.

IF: *The calculations on the Client-Flow Chart Summary are incorrect...*
Check the calculations on the form, and show relevant staff members how to complete them properly.

IF: *The Action Plan is unclear...*
Review the troubleshooting tips provided in Chapter 4 for instructions on how to help staff clarify the Action Plan.

Measuring Progress Over Time

This chapter is aimed at site facilitators.

This chapter describes how facility staff can measure progress toward solving the problems identified in the Action Plan. It also discusses the importance of sharing your facility's experiences—in terms of success stories, continuing needs, and lessons learned—with clients, staff, managers, other organizations and facilities, government officials, and donors.

Objectives

After reading this chapter, you should be able to:

- Measure progress over time
- Communicate about service improvements with clients, staff, and others

Measuring Progress

During the first meeting of the COPE Committee, the members should determine how they wish to measure the progress of COPE. At a minimum, to track their progress, facilities should keep good records of their COPE Action Plans.

Using Charts and Graphs

In addition to using the COPE Follow-Up Sheet (see Appendix A), facilities may use the table and graph discussed in this chapter (or others that they create) to track their progress after the first COPE exercise and to compare average waiting time between their first and second CFAs.

Table of problems solved through COPE

Staff may use a table to determine what percentage of the problems identified had been solved and the degree to which these problems had been solved. This can help them track their progress and determine bottlenecks to solving problems.

Sites may use a table such as that shown in Figure 8-1 (page 86) during any COPE exercise after the first one. It is recommended that they use it at six-month intervals, to keep up to date on their progress.

Figure 8-1. Problems Solved through COPE

Situation	Number
Problems identified	20
Problems completely solved	12
Problems remaining unsolved*	8
Could be solved without outside assistance	4
Considered unsolvable without outside assistance	4

* Includes problems for which no solution was attempted and problems for which a solution was attempted but the problem remained unsolved.

Determining whether a problem has been completely solved

Some problems may be considered neither solved nor unsolved, but may fall somewhere in between. For example, training all of the staff may have been recommended, but only some staff were trained. Similarly, obtaining five new pieces of equipment may have been recommended, but the facility might have received only one piece. Likewise, a facility's goal may have been to build a wall in two wards, but in reality the wall may have been built in only one of the wards.

These problems would be considered partially solved. Efforts should be made to determine if, when, and how they can be completely solved, or whether it is possible to do more. In each case, however, it is also important to recognize the strides that were made toward success.

Some problems may be considered "impossible" to solve—i.e., beyond the power of facility staff to remedy without outside help or funds. These are needs that facility managers can communicate to higher levels within their institutions or to local community members.

How to analyze the results

Staff at a facility may have set a goal, such as solving a certain percentage of the problems on the Action Plan within a certain time frame (e.g., 75% of problems will be solved within a year) or reducing clients' waiting time to a specific number of minutes. The facility can then use the chart to see if the goal has been met.

If the goal has not been met, facility staff might explore some questions to decide why this occurred. For example:
- Were the root causes of the problems not properly identified?
- Were the people assigned responsibility for carrying out the recommendations an inappropriate choice?
- Were the time frames that were set unrealistic?
- Did facility staff realistically have control over these problems?

In addition, facility staff could check with staff at other facilities to see if they were having the same problems and, if so, how they resolved them.

Tracking Average Waiting Time

Sites can use a chart like Figure 8-2 to compare the average amount of time that clients wait for services after two successive CFAs.

Figure 8-2. Average Waiting Time for Services
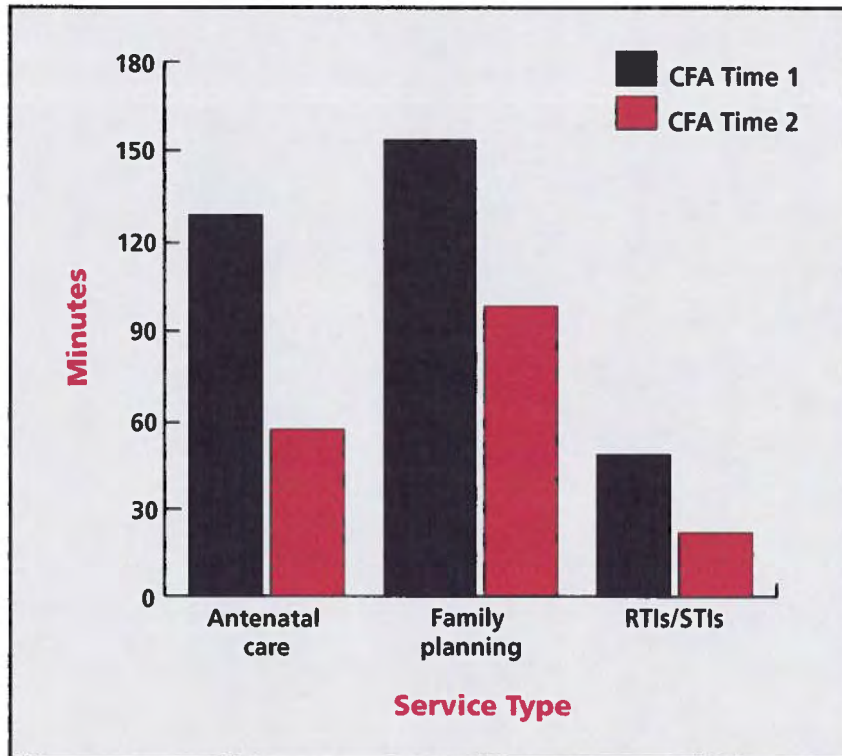
For each service type, staff can compute the average waiting time found in the first CFA and compare it with that found in the second CFA. This visual representation may help staff see whether average waiting time was reduced overall and whether bottlenecks still exist for certain services.

Using the Quality Measuring Tool

The Quality Measuring Tool (QMT) uses the same format as the COPE Self-Assessment Guides to quantitatively assess quality at a facility. Comprising a smaller set of yes-no questions (very similar to those used in the self-assessment) and using the same framework of clients' rights and staff needs, it allows staff to score the level of quality at their facility. This tool strikes a balance between staff self-assessment of quality and external means of assessment and supervision. Ideally, the QMT should be used only when COPE has been established at a facility for a year or more, so that staff do not feel they are being monitored and "tested" early in the process. When performed on an annual basis, this tool can be used to chart progress over time.

Using Other Tools

While COPE is one way to gather information about the quality of services at a facility, it can be complemented by the use of other tools and processes that assess or measure different aspects of quality. These include:

- *Medical monitoring.* This medical QI intervention involves the objective and ongoing assessment of the readiness of and processes for service delivery. It is conducted to identify gaps between best practices and actual practices, and leads to recommendations for improvement.

- *Case reviews or morbidity and mortality review systems.* Case reviews involve presenting individual case outcomes and using guidelines to analyze where something went well or where there was a problem, with the aim of identifying strengths the facility can build on and problems that need to be resolved. Morbidity and mortality reviews use facility records or statistical reviews to assess where there might be problems and identify root causes. This type of review is critical to conduct if there has been a death or severe morbidity.

- *Facilities/equipment/supplies checklists.* These checklists are used to assess gaps in infrastructure, (functional) equipment, or supplies.

- *Local, national, or international service standards and protocols.* Various standards and protocols are used as learning and assessment tools to compare the standards and protocols of a particular facility with other standards.

- *Methodologies to assess costs.* Such methodologies include EngenderHealth's Cost-Analysis Tool (see page 16).

Sites may use these tools as sources of information to identify problems and root causes, to develop problem-solving plans, or to measure success in improving quality. Facilities may use the COPE approach to solve problems identified through these or other tools.

Communicating about QI Achievements

Sharing your facility's success stories, continuing needs, and lessons learned can serve a number of significant purposes with a variety of different audiences:

- *Clients.* Such information can help build and maintain your clients' trust in your desire and ability to provide quality services. Knowing that your services are improving may encourage community members to seek care at your facility. In addition, clients particularly like to know that their own suggestions have made a difference.

- *Staff.* Such information also serves to motivate and encourage staff to continue with the QI process and to feel pride in their accomplishments. Sharing what clients have said about services can also serve to orient new staff or remind current staff to maintain a customer focus.

- *Upper-level managers.* It is important to keep upper-level managers informed about the facility's progress, so they can remain supportive of the process and be aware of the efforts that staff are making. These managers may even be relieved to see what facility staff can accomplish on their own by taking initiative and by thinking creatively. At the same time, upper-level managers need to know when their intervention is truly needed to resolve particular problems.

- *Other facilities and other organizations.* By sharing information about your achievements with other facilities and other organizations, you can exchange creative solutions to common problems, as well as lessons learned about the QI process. This is also an opportunity to propose combining efforts to solve shared problems.

- *Government, donors, or other funding sources.* It is always important to inform government, donors, and other funders and supporters about how their support is being leveraged at the facility level to improve services. Funders are generally less interested in supporting facilities that do not show initiative or make an effort to address problems, and often are more interested in facilities that can show the results of their efforts. In addition, real-life examples of what clients have said about services and what staff have done can be used in promotional or fundraising materials. Sharing information is also an opportunity to explain any areas where further support could help resolve recurring or ongoing problems.

The table below shows examples of essential messages to share with each of the different audiences, as well as means of communicating those messages.

Figure 8-3. Communicating about QI Achievements

Audience	Messages	Ways to Communicate
Clients and community members	▪ "We listen to your suggestions." ▪ Changes/improvements that staff have made ▪ Reasons why certain changes were made (especially related to location or organization of services and any changes in costs of services) ▪ Recognition of the community's input into service improvements	▪ Interpersonal communication ▪ Posters ▪ Bulletin boards ▪ Community meetings
Site staff	▪ The status of the current Action Plan ▪ What was achieved in the last year or since the process began ▪ What clients are saying about services ▪ The importance of teamwork ▪ "There is always room for improvement."	▪ Providing copies of/posting the Action Plan for staff to see ▪ Updates in staff meetings ▪ Interpersonal communication ▪ Newsletter
Upper-level management	▪ What accomplishments have been achieved ▪ What clients say about services ▪ What recurring or systemwide problems may require support from higher levels to be solved	▪ Meetings ▪ Site visits by upper-level managers ▪ Reports
Other facilities and organizations	▪ Examples of creative solutions to common problems ▪ Opportunities for working together to solve problems (with community members, local organizations, etc.)	▪ Meetings ▪ Site visits ▪ Reports
Government, donors, and other funding sources	▪ What accomplishments the facility has made ▪ Examples of what clients say about services at the facility ▪ How their support has helped ▪ Any areas in which further support could help resolve recurring or ongoing problems	▪ Reports ▪ Meetings ▪ Site visits ▪ Newsletter

Appendixes

Appendix A: Sample COPE Forms
Sample Self-Assessment Guide

Clients' Right to Privacy and Confidentiality

Clients have a right to privacy and confidentiality during delivery of services. This includes privacy and confidentiality during counseling, physical examinations, and clinical procedures, as well as in the staff's handling of clients' medical records and other personal information.

> The group working on this guide should include staff who provide reproductive health information or services or who are responsible for record keeping (including receptionists, gatekeepers, and guards).

If any of the following questions reveal a problem at your facility, or if you think any of the questions need to be discussed further, write your comments on a flipchart in the following format:

Problem	Cause(s)	Recommendation	By Whom	By When

If you are aware of a problem at your facility that is not addressed in this guide, please include it.

1. Do providers discuss client care with other staff members only when necessary?

2. Do staff respect clients' wishes about whether to provide information to family members, including spouses and all who accompany them?

3. Are client records kept in a secure space, with access strictly limited to authorized staff? Do staff make sure that clients do not have access to others' records?

4. Does the facility have private space so that counseling sessions, physical examinations, and procedures cannot be observed or overheard by others?

5. Do staff take measures to ensure that counseling sessions and examinations are not interrupted?

6. When a third party is present during a counseling session, an examination, or a procedure, do staff explain the person's presence and ask the client's permission?

7. When discussing a client's care with other staff members, do service providers respect confidentiality by speaking in a private space, so the conversation cannot be overheard?

8. Are all laboratory test results kept confidential?

9. Are all services offered in a manner that is respectful, confidential, and private?

<div align="right">(continued)</div>

Sample Self-Assessment Guide (continued)

Other Issues That You Think Are Important:

10._____

11._____

12._____

Sample Client Record-Review Checklist

Note: This checklist can be used to review the records for clients of any reproductive health services. For surgical procedures, please also use the Surgical Record-Review Checklist.

CLIENT RECORD-REVIEW CHECKLIST

Site: *Sunshine Clinic* Date: *July 1, 2003*

Reviewer: *Linda Karisa*

(Select 10 records at random)

Checklist Item	1	2	3	4	5	6	7	8	9	10	Total
1. Client identification information is recorded.	✗	✗	✗	✗		✗	✗	✗		✗	8
2. Date of visit is recorded.	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗	10
3. Client's reason for visit is recorded.	✗		✗	✗	✗	✗	✗	✗			7
4. Client's medical history is recorded.			✗	✗	✗	✗					4
5. Client's reproductive health history is recorded.	✗	✗		✗	✗		✗	✗		✗	7
6. General physical examination was conducted.		✗	✗		✗	✗			✗		5
7. Client's signs and symptoms are recorded.		✗	✗	✗	✗						4
8. Any prescriptions or treatment are recorded.	✗	✗	✗			✗	✗	✗			6
9. Follow-up plans are recorded.	✗		✗		✗	✗	✗		✗		6
10. Staff signatures are present.				✗							1
11. Entries are legible.	✗	✗		✗		✗	✗				5

Comments on records reviewed:

_____

_____

_____

_____

Sample Client-Interview Guide for Reproductive Health Services

Greet the client and introduce yourself:

My name is _____, and I work here. We are trying to improve services for clients, and we would like your honest opinion of how well we are doing and what we need to improve—both the good things and the bad things. This interview is private and confidential. You are free not to answer any questions you do not want to, and if you do not want to take part in the interview at all, you do not have to. Your name will not be used. This will take about 10 minutes. Your ideas are important to us—may I ask you a few questions?

SITE: <u>Sunshine Clinic</u>   DATE: <u>September 14, 2003</u>

NAME OF INTERVIEWER: <u>Flora Moon</u>

Note to interviewer: Ask the questions printed in boldface type. Check (✓) responses that the client gives. Write additional notes in the spaces provided.

1. Is this your first visit to this facility, or is it a follow-up visit?
   First visit ....☐   Follow-up visit............☑

2. Is the client female or male?
   Female............. ☑   Male..........................☐

3. What type of services did you come for today?
   Check responses given. (Do not read the responses to the client.)
   a. Antenatal care.. ☑
   b. Labor and delivery..☐
   c. Postpartum and newborn care..☐
   d. Family planning...☐
   e. Postabortion care...☐
   f. Reproductive tract infections (RTIs), including
      sexually transmitted infections (STIs)................................☐
   g. HIV...☐
   h. Gynecological services..☐
   i. Men's reproductive health services..................................☐
   j. Infertility..☐
   k. Other: _____

   _____

4. Did you get the services you came for?
   Yes....☑   No....☐

   If no: **Why not? What happened?**

   _____

   _____

(continued)

Sample Client-Interview Guide for Reproductive Health Services (continued)

---

5. How long did you have to wait before you saw a doctor or nurse today?

   _70_ minutes

6. What did you do while you were waiting?

   Read some pamphlets, took care of my 3-year-old.

7. Were you given information today?

   Yes....☑   No....☐

   If yes: **What type of information were you given?** *(Check all that the client mentions.)*

   a. Antenatal care...☑
   b. Labor and delivery...☐
   c. Postpartum and newborn care....................................☐
   d. Family planning...☐
   e. Postabortion care..☐
   f. RTIs, including STIs ....☐
   g. HIV...☐
   h. Gynecological disorders...☐
   i. Disorders of the male reproductive system.................☐
   j. Infertility..☐
   k. Harmful practices..☐
   l. Other: Nutrition

   _____

8. Do you feel that the staff explained information clearly?

   Yes.....☑   No.....☐

9. Were you able to spend enough time with the service provider to discuss your needs?

   Yes.....☐   No.....☑

10. Are there any areas of the clinic that you think need improvement, to make them cleaner, more comfortable, or more private?

   Yes.....☑   No.....☐

   If yes: **Please tell me which ones and why.**

   Waiting room was crowded, no place to sit.

   _____

   (continued)

Sample Client-Interview Guide for Reproductive Health Services (continued)

11. Were the staff respectful?
Yes....☑   No....☐

12. Could the service you received in any of the departments have been improved?
Yes....☑   No....☐

If yes: **What could have been better?**

Make sure there is privacy during examinations.
_____
_____
_____

13. Were you asked to pay for services you received today?
Yes....☑   No....☐

14. Are the services in this clinic affordable to most people in this community?
Yes....☑   No....☐

15. What have you heard from your family or friends or others in your community about the quality of services at this clinic?

In general, people think the services here are good.
_____

*Note to interviewer: If this is the client's first visit to the facility, **skip to question 19.** If he or she has been here before, continue below.*

16. *[For those who have been here before]* **When did you first come to this clinic?**

Last year
_____

17. *[For those who have been here before]* **Since you first started coming here, has the quality of services improved, stayed the same, or gotten worse?**
a. Improved ....☐
b. Stayed the same ....☑
c. Gotten worse ....☐

18. *[For those who have been here before]* **What has changed to make things:**

a. Better? Do not know
_____

b. Worse? Do not know
_____

(continued)

Sample Client-Interview Guide for Reproductive Health Services (continued)

19. **What do you like most about this clinic? Why?**

    The nurses are caring.

20. **What do you like least about this clinic? Why?**

    The crowded waiting room.

21. **Is there anything you think could be done to improve services here?**

    Provide water for the women in the maternity ward.

I would like to answer any questions that you have before you leave. Is there anything that concerns you, or anything that I can help you with?

Thank you for your help and ideas!

Sample Client Register Form

CLIENT REGISTER FORM

Client number: __05__   Date: __Sept. 10, 2004__   Time client arrived at facility: __8:15 a.m.__

Sex: Male ____   Female __X__

Primary reason for visit (see Service Type codes): __A__

Secondary reason for visit (see Service Type codes): __D__

Visit timing: First visit for primary service ____   Follow-up visit for primary service __X__

	Staff member's initials	Time service started	Time service completed	Contact time (in minutes)
First contact	GH	9:23	9:35	12
Second contact	LM	9:45	9:50	5
Third contact				
Fourth contact				
Fifth contact				
Sixth contact				

Comments: _____

_____

_____

_____

_____

Codes: Service Type
A—Antenatal care
B—Postpartum and newborn care
C—Family planning
D—Reproductive tract infections (RTIs), including sexually transmitted infections (STIs)

E—HIV
F—Gynecological services
G—Men's reproductive health services
H—Infertility
 I—Other (if chosen, please describe)

Sample Client-Flow Chart

CLIENT-FLOW CHART
(Use as many pages as necessary)

Page 1 of 2

Site: **Sunshine Clinic**   Date: **September 10, 2004**   Session: **Morning**

Client number	Time In	Time Out	Total time (in minutes)	Contact time (in minutes)	Waiting time (in minutes)	Service type (primary)	Service type (secondary)	Visit timing	Comments
01	8:00	8:50	50	40	10	B	C	2	
02	8:10	9:20	70	11	59	C	-	2	
03	8:15	9:23	68	14	54	C	-	2	
04	8:15	9:25	70	6	64	G	-	2	
05	8:15	9:50	95	17	78	A	D	2	
06	8:15	11:00	165	57	108	F	D	1	
07	8:20	1:30	310	74	236	A	D	2	
08	8:20	11:00	160	17	143	F	-	1	
09	8:20	10:22	122	8	114	C	-	2	
10	8:28	12:55	267	193	74	E	D	2	
11	8:30	9:34	64	8	56	B	-	2	
12	8:30	9:40	70	7	63	B	-	2	
13	8:30	10:08	98	24	74	C	-	2	
14	8:30	10:15	105	6	99	C	-	2	
15	9:00	1:20	260	52	208	B	D	2	
16	9:00	2:10	310	111	199	A	I (ob.emer.)	1	Adm.fem.ward
17	9:00	10:05	65	16	49	B	-	2	
18	9:00	10:05	65	6	59	C	-	2	
19	9:00	10:30	90	6	84	C	-	2	
20	9:30	10:11	41	6	35	C	-	2	
Total			2,545	679	1,866				

Codes: Service Type
A—Antenatal care
B—Postpartum and newborn care
C—Family planning
D—Reproductive tract infections (RTIs),
   including sexually transmitted infections (STIs)
E—HIV
F—Gynecological services

G—Men's reproductive health services
H—Infertility
I—Other (please describe)

Codes: Visit Timing
1—First visit
2—Follow-up visit

Sample Client-Flow Chart Summary

<div style="border:1px solid">

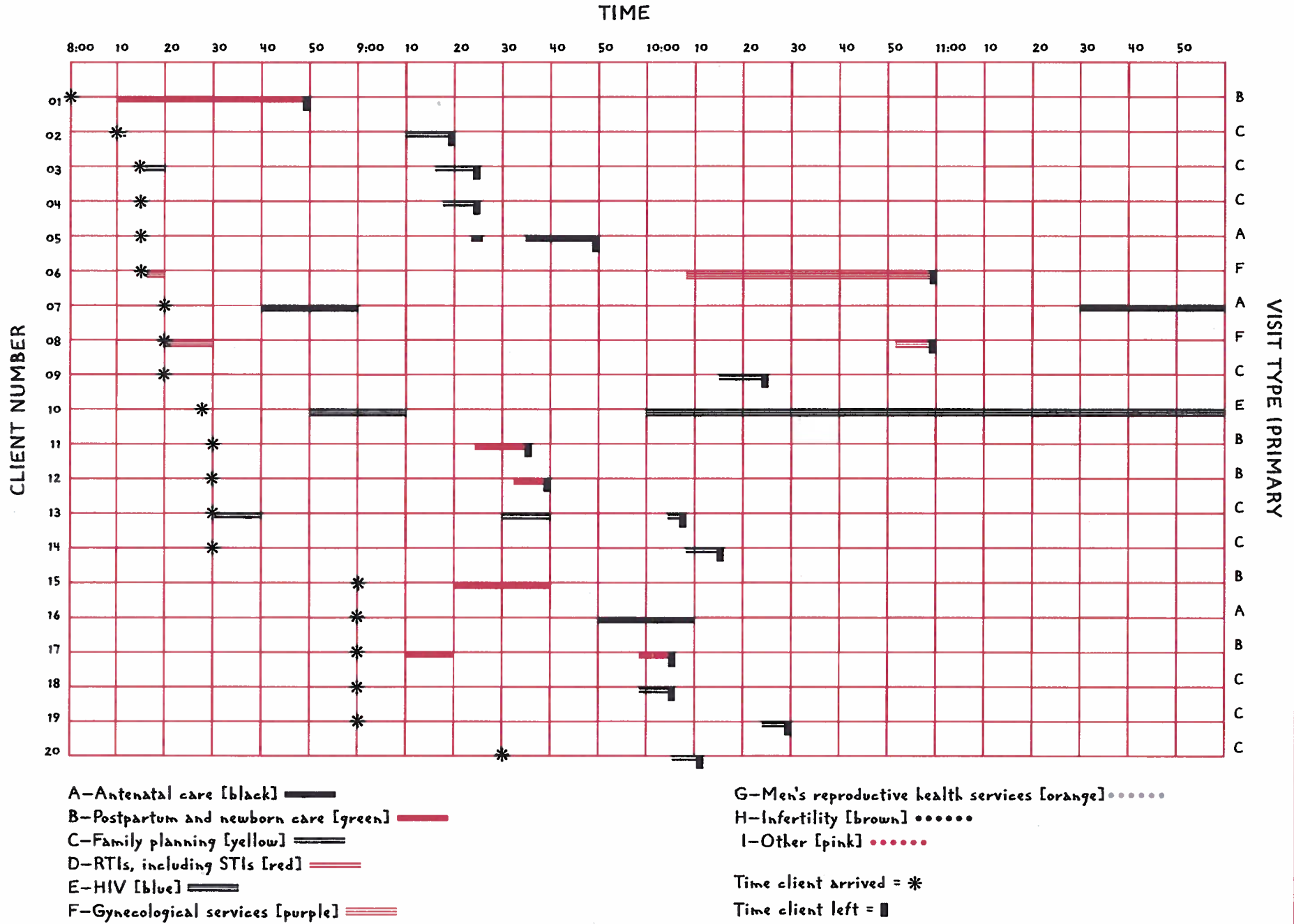### CLIENT-FLOW CHART SUMMARY

Site: <u>Sunshine Clinic</u>   Date: <u>September 10, 2004</u>   Session: <u>8:00 a.m. to 2:30 p.m.</u>

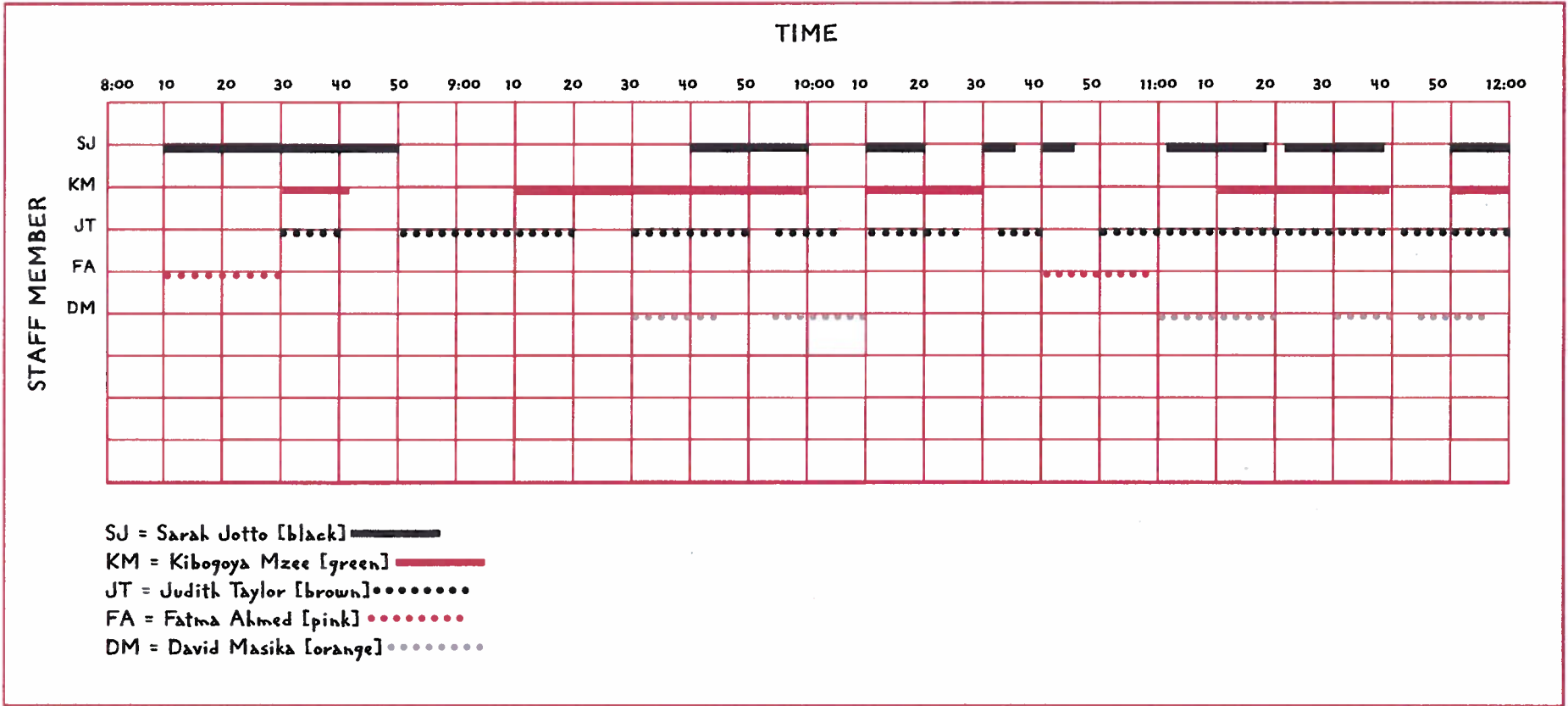| Page	Total number of clients	Total time (in minutes)	Total contact time (in minutes)	Percentage of client time spent in contact with staff
Page 1	20	2,545	679	27%
Page 2	10	1,300	325	25%
Page 3				
Totals	30	3,845	1,004	26%

</div>

Average number of minutes per client (rounded to a whole number): <u>128</u>
(divide "Total time" by "Total number of clients")

Average contact minutes (rounded to a whole number): <u>33</u>
(divide "Total contact time" by "Total number of clients")

Sample Client-Flow Graph

TIME

CLIENT NUMBER

VISIT TYPE (PRIMARY)

A—Antenatal care [black]
B—Postpartum and newborn care [green]
C—Family planning [yellow]
D—RTIs, including STIs [red]
E—HIV [blue]
F—Gynecological services [purple]

G—Men's reproductive health services [orange]
H—Infertility [brown]
I—Other [pink]

Time client arrived = ✳
Time client left = ▮

Sample Staff-Utilization Graph

TIME

| STAFF MEMBER | 8:00 | 10 | 20 | 30 | 40 | 50 | 9:00 | 10 | 20 | 30 | 40 | 50 | 10:00 | 10 | 20 | 30 | 40 | 50 | 11:00 | 10 | 20 | 30 | 40 | 50 | 12:00 |

SJ
KM
JT
FA
DM

SJ = Sarah Jotto [black] ▬▬▬▬

KM = Kibogoya Mzee [green] ▬▬▬▬

JT = Judith Taylor [brown]••••••••

FA = Fatma Ahmed [pink] •••••••

DM = David Masika [orange] ••••••••

Sample Completed Action Plans

Action Plan showing problems identified through use of client interviews

Problem	Cause(s)	Recommendation	By Whom	By When
Long waiting time for antenatal clients	▪ All clients arrive at the same time ▪ No afternoon services	▪ Create appointment system ▪ Extend service hours to 4:30 p.m.	F. Solomon F. Solomon	August 1, 2003 August 30, 2003
Lack of privacy during examination of antenatal clients	▪ No separate room or curtain	▪ Sew and hang three curtains	G. Njeru (cleaner)	July 30, 2003
Not enough seats in waiting area in MCH clinic	▪ Benches are broken ▪ No chairs	▪ Repair benches ▪ Get two chairs from storage closet	C. Greyson (mainte-nance)	July 28, 2003 July 10, 2003
No food for patients in maternity ward	▪ No money to pay for food	▪ Ask local church to contribute food for maternity ward	E. Kamala (ward attendant)	July 20, 2003

(continued)

Sample Completed Action Plans (continued)

Action Plan showing problems identified through use of record review

Problem	Cause(s)	Recommendation	By Whom	By When
Many clients' medical histories are not completed on client record forms.	▪ Staff do not ask their clients for this information. ▪ Staff are not aware of what information they need to ask clients for. ▪ Staff have not been fully trained.	▪ Update all reproductive health clinical and counseling staff on how to take a complete medical history.	S. Diallo	July 21, 2003

(continued)

Sample Completed Action Plans (continued)

Action Plan showing problems identified through use of Self-Assessment Guides

Problem	Cause(s)	Recommendation	By Whom	By When
A chronic shortage of expendable supplies in the maternity ward has led to increased risk of infection for staff and clients.	■ Inadequate budget for hospital supplies. ■ Failure to charge clients any fees for services or supplies.	■ Ask antenatal clients to purchase maternity supplies. ■ Ask the pharmacy to prepackage maternity supplies for clients (bottle of chlorine, pair of gloves, syringes, sanitary pads, etc.). ■ Retain any unused supplies for use by other clients who cannot afford to buy them.	L. Karisa (clinic nurse) Dr. Ware (clinic director) J. Samanda (ward nurse)	July 1, 2003 July 1, 2003 July 1, 2003
Pregnant clients testing positive for HIV do not return for follow-up services.	■ Staff are not trained to discuss the range of services available. ■ Clients feel unwelcome and stigma-tized by staff. ■ HIV-positive clients are afraid that others will find out their status and harm them.	■ Conduct whole-site training on clinical, counseling, and support services available to prevent mother-to-child transmission of HIV and to support HIV-positive clients. ■ Conduct HIV and stigma awareness/sensitivity training for all staff. ■ Review/revise protocols on client confidentiality and orient all staff. ■ Provide counseling training for providers on how to assist clients in making decisions about disclosure.	L. Karisa (clinic nurse) J. Samanda (nurse supervisor) Dr. Ware (clinic director) R. Minja (HIV counselor)	July 1, 2003 July 30, 2003 August 30, 2003 September 5, 2003

Sample COPE Follow-Up Sheet

Problem	Cause(s)	Recommendation	Status	Comments
Child health services are not discussed in any organized way, so supervisors and staff are not updated on these services.	No child health committee exists.	Form a child health services planning committee.	Solved	Meets once a month.
There are no heavy-duty gloves for the cleaning staff, so these staff are not protected against infections.	Gloves were not ordered.	Purchase with petty cash.	Solved	Question now is how to maintain supply.
Some clients are not offered reproductive health services after being treated for abortion complications, resulting in untreated STIs and unintended pregnancies.	Some staff in the gynecology ward are not trained in counseling postabortion clients.	Train all providers in the gynecology ward in reproductive health counseling.	Attempted	Is currently in the planning stage.

Sample COPE Follow-Up Sheet (continued)

Problem	Cause(s)	Recommendation	Status	Comments
Counseling is not always provided to clients tested for HIV.	1) There is no policy on voluntary counseling and training (VCT). 2) Training in counseling skills is inadequate.	1) Develop VCT protocols. 2) Train key staff in counseling clients before and after their HIV test.	In progress	Work group drafted policies and protocols; these are currently under review. Five staff registered for the next district-level VCT training.
The facility does not provide ultrasound services, so clients who need this service have to travel far to another facility.	The facility lacks ultrasound equipment.	Order equipment from headquarters.	Unsolved	There are no funds with which to purchase equipment. A meeting is scheduled to discuss funding alternatives.

Appendix B
Examples of COPE Successes

COPE has been widely successful since EngenderHealth* first introduced it in 1988. It has been used with great success in more than 45 countries around the world.

Many examples of COPE successes exist. The following stories, provided by our colleagues in the field, exemplify the extraordinary role that COPE has played in changing the quality of services provided, the environment, and staff motivation and satisfaction at sites that use it.

Following these examples, on the last page, you will find a guide for adding your own success stories, developed from your personal experiences with COPE.

Privacy and Information about HIV and STIs

The family planning staff at a hospital in Asia decided to use COPE to improve the accessibility and quality of their services. During a COPE exercise, the staff identified these and other problems: In the space in which counseling and physical examinations (including pelvic examinations) were conducted—behind a curtain in a corner of the small outpatient department—family planning clients experienced little auditory or visual privacy. In addition, most of the staff were not aware of how to prevent HIV and sexually transmitted infections (STIs).

By the end of the exercise, the staff developed solutions. As a result, the following changes were made:

- The hospital chief and a local health officer converted a room near the outpatient department into a family planning room, allowing clients to receive family planning services in a private area.
- The hospital chief arranged for a local health expert to orient the staff on HIV and STIs, and the site established a system for updating staff about HIV and STIs in monthly staff meetings.
- A sign clearly shows where family planning services are offered.
- The hospital chief and local health officer secured the equipment needed to provide family planning services.

These interventions led to improved services and increased awareness among clients and staff about the services available.

Keeping Clean

A rural health center in Africa had a serious problem with cleanliness and infection prevention. The center's public areas were never swept, the cleaner had no protective clothing or gloves, and waste and needles were scattered on the ground, exposing clients and staff to potential infections. After a COPE exercise, staff at the site implemented solutions to these problems, including supplying the cleaner with gloves, training all staff in proper infection prevention practices, providing receptacles for discarding waste and sharps, and sweeping the center's green spaces, walkways, and waiting areas. Staff believe that their heightened concern for their clients' comfort and safety contributed to an increase in clients seeking services at the center.

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* Before 2001, EngenderHealth was known as AVSC International.

More Motivation

In a hospital in Latin America, staff lacked motivation to perform their jobs efficiently, and the building was deteriorating. One observer said, "What the staff were feeling was demonstrated by the deteriorating condition of the buildings." After a COPE exercise, all staff in every ward and department felt empowered to improve what was within their reach. This motivated the hospital director to seek funding to renovate the building. Together, the staff and supervisors painted walls, posted signs about all services, and purchased basic equipment that had been lacking. The cleaning staff also became more motivated and began keeping the facility more orderly and clean. In the words of one external supervisor, "These days, staff are motivated, and the institution is clean and well-arranged—not luxurious, but very pleasing."

Creative Strategies for Supply Distribution

One site in Eastern Europe had inadequate supplies of contraceptives, but through a COPE exercise, staff identified several root causes and implemented the necessary solutions. First, an emergency order was placed. Next, expired commodities were discarded, and staff were trained in the "first expired, first out" (FEFO) system for storing and dispensing contraceptives. Finally, the site determined a better way to share supplies with other providers: The site had a low demand for certain contraceptives that were close to expiring, while other sites in the area had a low demand for other methods. Staff contacted the other sites and exchanged supplies with them, so that each site had a larger supply of the specific methods most in demand among clients at that facility and fewer supplies that would have to be discarded because they had expired.

Multiple Improvements and More Clients

Through a series of COPE exercises in one nongovernmental organization (NGO) clinic in Latin America, staff made several improvements in their facility. The site revised staff responsibilities to match site needs, trained all cadres of staff in national job performance standards, oriented staff about all of the NGO's programs and services throughout the region, and developed policies for communicating within the region and with other regions. All levels of staff were also trained in infection prevention, in HIV, AIDS, and other STIs, in how to inform clients about family planning services, and in management of client fees for services. As a boost to staff morale and team spirit, sports activities and birthday celebrations were organized. In addition, the site reorganized client flow between services, improved signs showing hours of services, provided a suggestion box for clients, and developed a strategy for promoting services among current clients and in the wider population. Since these improvements were implemented, the site has seen a 75% increase in the number of clients seeking services.

COPE's Impact on Quality of Care and Provider Performance

In an evaluation of COPE's effects on the quality of child health services, COPE was introduced at eight child health centers each in Kenya and Guinea over a 15-month period; results at these eight sites were compared with the status of eight sites in the two countries that were not using COPE. Even over a relatively short period of time, almost every sign of quality services (whether it was reported by staff, observed by evaluators, or reported by clients) was significantly better at the intervention sites than at the control sites. For example:

- Staff at the study sites found the process and tools to be easy to use and were gratified to have a venue in which they could communicate about problems that they already knew existed.

- COPE promoted participation and teamwork, helping to break down barriers between colleagues, between different administrative levels, and between providers and clients.

- Staff at the study sites reported having more positive attitudes toward management and supervisors and their support of the staff's work than did staff at the control sites.

- Staff confidence in their abilities (as measured by their own assessment of their knowledge) was significantly higher at the intervention sites than at the control sites, and this difference was statistically significant in the important areas of immunization, diarrhea management, and infection prevention.

- Providers at the intervention sites reported having reoriented their thinking about clients, helping them to become more reflective and to examine their own behaviors toward the clients they served, and to use suggestions from clients in developing their Action Plans. This reorientation showed itself in statistically significant improvements in adult clients' knowledge and on their perceptions of the quality of services and how they were treated by staff.

- External observations confirmed that staff performance had improved noticeably: They treated clients with more respect, demonstrated improved interpersonal communication skills, and provided clients with more information and privacy than they had before receiving their training.

- Most importantly, staff showed improved diagnostic skills (see Figure B-1), improved ability to give home care instructions (see Figure B-2, page 114), somewhat improved prescribing practices, and improved immunization practices. The consequences of these changes included more informed clients, better immunization coverage for first polio shots and tuberculosis vaccination, and more satisfied clients who acknowledged positive change had occurred over the past year (see Figure B-3, page 114) (Bradley, J., et al., 2002).

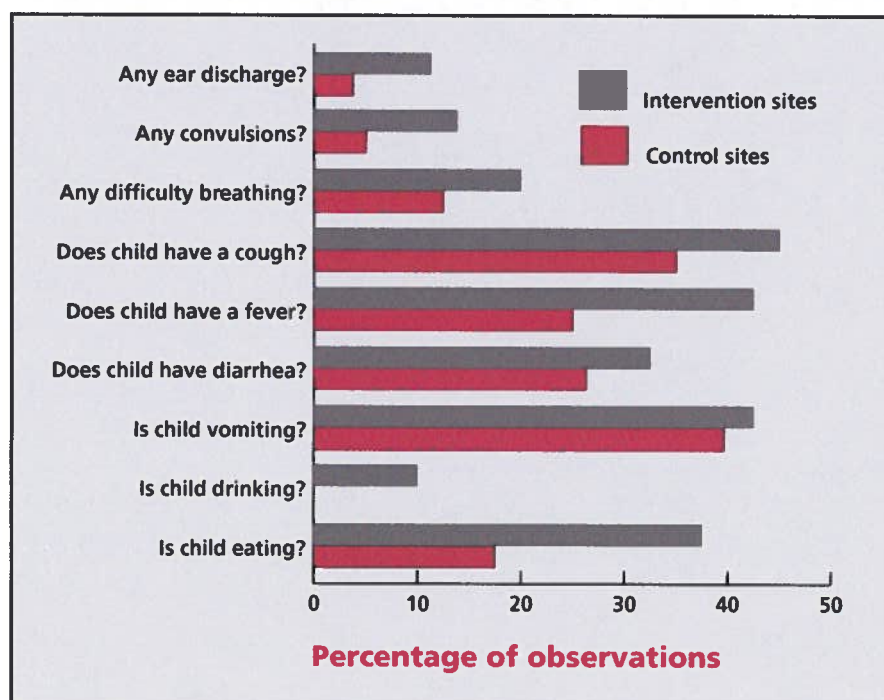## Figure B-1. Sick-Child Diagnostics: Issues or Questions Asked by Providers

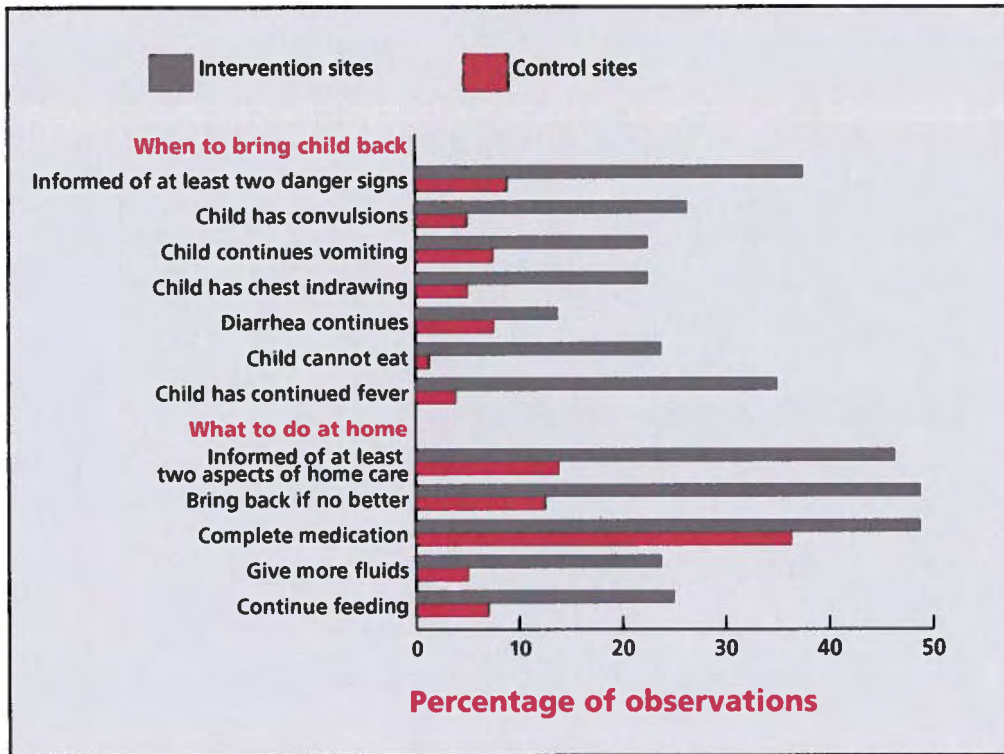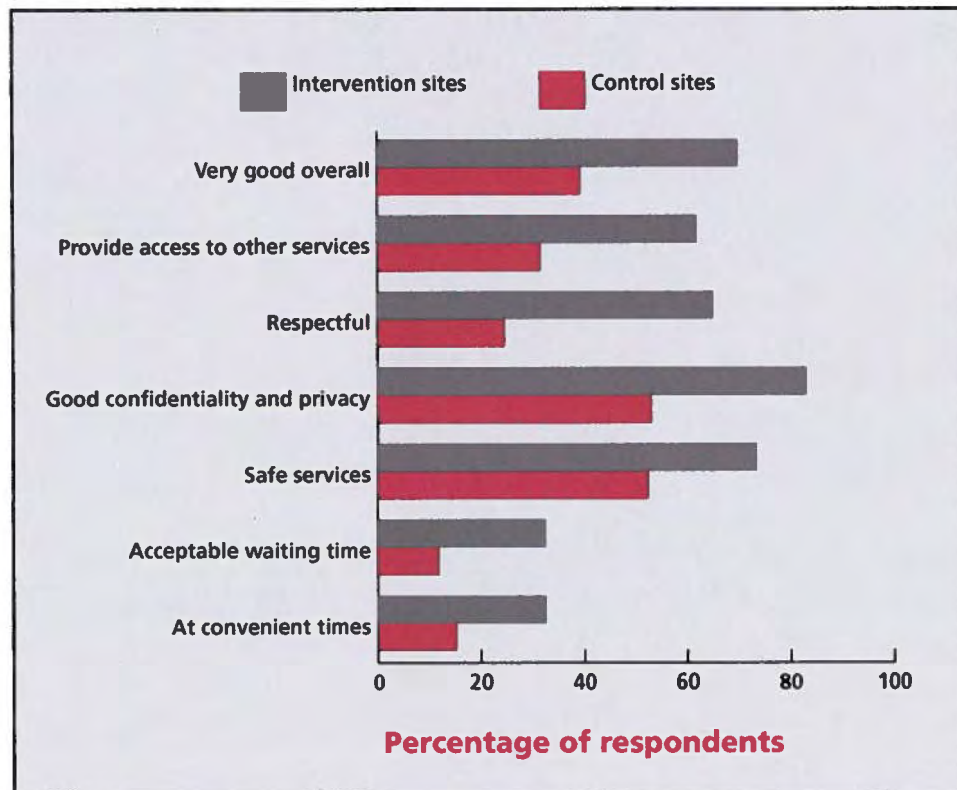## Figure B-2. Sick-Child Home Care: Instructions Given by Providers

Figure B-3. Clients' Perspectives on Services in General: Percentage of Clients Who Agree Strongly with Statements about Services

Using CFA to Shorten Client Waiting Time

A study in four African countries looking at the proportion of problems solved versus the proportion of those identified showed that 109 problems were identified through COPE Action Plans over the course of 15 months (Lynam, Rabinovitz, & Shobowale, 1993). Of the 88 deemed potentially solvable (meaning that staff could act on them without outside intervention or funds), 73% were solved within the 15-month period. The same study examined outcomes of the use of CFA at five clinics that had identified client waiting time as a problem. At those five sites, waiting time declined by between 17% to 56%, with an overall average of 42% (see Figure B-4). As an example, at Site 1, where the average waiting time was 130 minutes before the introduction of COPE, the waiting time afterwards dropped to less than 60 minutes. These are significant changes in a problem often identified as a chief source of client dissatisfaction.

Figure B-4. Average Client Waiting Times: Before and After the Introduction of COPE at Five Family Planning Sites, Africa, 1990 to 1991
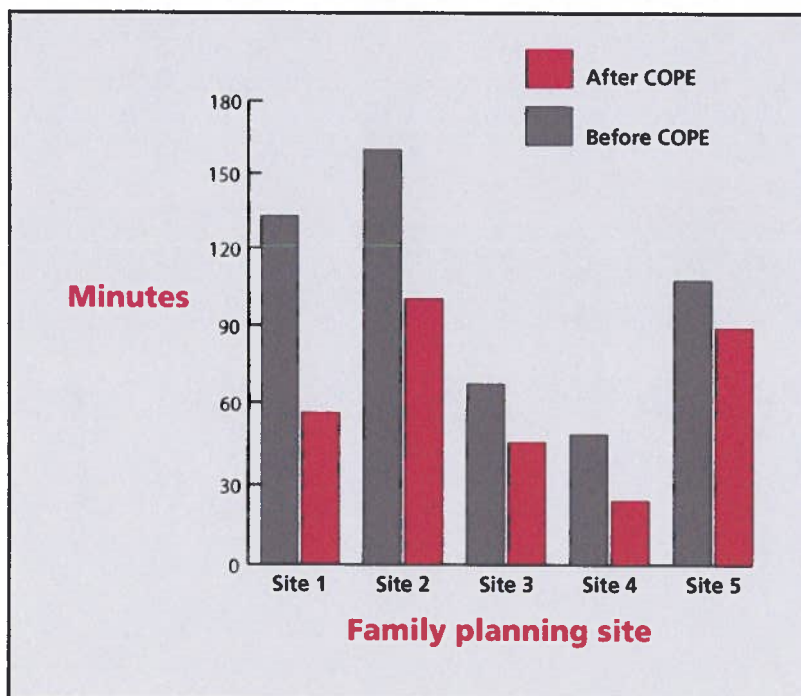
Adding Your Own Success Stories

The following are some questions to think about in describing your success stories:

- What type of site was it? (e.g., Was it a Ministry of Health regional hospital, a private clinic, or a health center?)
- What was the problem identified, and why was it a problem? (i.e., What was the negative impact on staff or clients?)
- What were the causes of the problem?
- What solutions were developed?
- Who was responsible for the solution? (e.g., Was the problem solved by site staff? By what

    level of staff was it solved? Was there involvement from a site supervisor? Was there a need for external assistance? Were community members involved in the solution?)

- What was the time frame? Is the intervention finished or is it still ongoing? If it is finished, when did it begin and end?
- What were the results of the intervention? (i.e., In what ways were things better for clients and staff once the problem was solved?)
- Did the site manage to solve the problem entirely, or is there still a problem?

Appendix C
Talking Points for Orienting Key Managers

When introducing key managers to the COPE process, you may have a few hours to discuss the process comprehensively or you may have time for only a brief orientation. Below are some key "talking points" covering an overview of the quality improvement (QI) process. Each captures the main ideas to communicate within each subject; if you have time, you can expand on them as appropriate.

Topic areas covered include:

- Site strengths
- Quality
  - What is quality? (Clients' rights and staff needs, and staff as experts)
  - Why improve it? What are the costs of poor quality?
  - QI principles
- COPE overview
  - What is COPE?
  - The COPE tools
  - The QI process
  - Why use COPE? Examples of success
  - EngenderHealth's package of QI tools
- Stages and steps of the COPE process

The text boxes on the following pages are small exercises that may help illustrate a point and make the orientation as interactive as possible. This is especially useful if you are orienting a group of managers.

Note: With the exception of the first topic area, on site strengths, each topic in this section is also covered in Chapters 1 and 3. In addition, feel free to make use of the flipcharts in Appendix E (especially flipcharts 16 to 19), as appropriate.

Site Strengths

Facilitate a discussion about site strengths, explaining that you would like to find out what is working well in their site or institution.

Suggested Discussion Questions/Issues

- What has the site or institution done well in the past? What is it doing well now?
- What stories or examples of past and present strengths can you tell, including your own personal experiences in the site or institution?
- What factors made high performance or success possible?
- What strengths that you have identified would you like to build on in the future?

If you have time, one way to answer the questions above is to conduct the following short exercise:

- Ask the participants to imagine what they would like to see for their site or institution in the future. What goals do they envision?
- Ask them to describe one thing their site or institution could do to build on its existing strengths.
- Tell them to focus on what was *positive* in their site or institution's past that they can build on in the future.

Relationship between Site Strengths and the COPE Process

Managers and staff build the site or institution and decide what is needed to improve it (such as customer relations and leadership).

COPE is a process to help managers and staff identify and carry out these improvements.

COPE provides managers and staff with an opportunity to build the future; it involves continuous learning and change, and often leads to changes in management techniques, in training approaches, and in the handling of logistics (see Flipchart 16, Appendix E).

Quality

To discuss quality, elaborate on the concepts of:

- Clients' rights and staff needs
- Clients and staff as the experts on the services provided at a site

Clients' Rights and Staff Needs

Quality services are those that meet the needs of your clients (or customers) and are provided in a manner consistent with accepted standards and guidelines.

The concepts that clients have rights (to information; access; informed choice; safe services; privacy and confidentiality; dignity, comfort, and expression of opinion; and continuity of care) and that staff have needs (for facilitative supervision and management; information, training, and development; and supplies, equipment, and infrastructure) are internationally accepted as the basis for quality health care.

You can prompt an interactive discussion of the clients' rights–staff needs framework through the following exercise:

- Ask: "How would you want to be treated if you came to this facility for health care? What would you or your mother, father, sister, brother, spouse, or child expect from a high-quality health service?"
- When managers have no more responses, ask: "What do health care workers need if they are to be able to provide such quality services?"
- Explain clients' rights and staff needs, and compare them with the participants' responses, pointing out similarities. Explain that the list of rights and needs is based on internationally accepted standards of quality care.

If you do not have time for the exercise above, or if the setting is not appropriate, you can still make your point by describing this exercise to managers as something that is conducted during a COPE orientation for staff. It will give them a more concrete understanding of the meaning of the clients' rights framework.

Staff as Experts on Services

Underlying the COPE approach is the idea that staff experience has value—that staff can contribute their expertise and ideas to efforts to improve services.

- Make the point that the COPE process assumes that managers, staff, and clients are the experts on services provided at a site. Therefore, COPE involves asking *them, their staff,* and *their clients* how to improve services.
- You can make this point by asking: "Who are the experts on your services?" letting the managers acknowledge that *they, their staff,* and *their clients* are the experts.

Why Improve Quality?

Reasons to improve quality could include:

- Safeguarding the health of clients and staff
- Attracting additional customers/clients through the addition of new service features
- Maintaining existing strengths (which all organizations should do)
- Understanding that there is always room for improvement, no matter how good services are
- Saving money through more efficiency, less repeated work, and less waste

You can also discuss the costs of poor quality. For example:

- You can ask: "Can you think of examples from your own experience of the costs of poor quality?" "What would be the savings from QI in those examples?"
- You can give other examples, as needed (for example, misdiagnosis or ineffective treatment of STIs).

Quality Improvement Principles

Explain that the following are some of the principles underlying all QI efforts, and that they are applied in fields ranging from industry to health care. The COPE process helps staff put these principles into practice in service sites:

- A customer mindset
- Staff involvement in and ownership of quality and the process for improving it
- A focus on processes and systems
- Efficiency and cost-consciousness
- Continuous staff learning, development, and capacity-building
- Continuous QI

Refer to Chapter 1 for a more detailed explanation of QI principles.

If the topic arises, you can mention that COPE has some similarities to other QI approaches, such as performance improvement and appreciative inquiry. (See Appendix G for a brief description of these approaches.)

COPE Overview

What Is COPE?

COPE stands for "client-oriented, provider-efficient" services and is a process that helps health care staff continuously improve the quality and efficiency of the services provided at their site and helps them make services more responsive to clients' needs.

COPE provides staff with practical, easy-to-use tools with which to identify problems and develop solutions, using local resources. It encourages all levels of staff and supervisors to work together as a team and to involve clients in assessing services. Through COPE, staff develop a customer focus, learning to define quality in concrete terms by "putting themselves in their clients' shoes." The process also helps staff explore the site's strengths.

The COPE process emphasizes *self-assessment* and confirms that you are not there to judge them or the staff. COPE is not an assessment by outsiders: Site staff and supervisors assess themselves and the services they offer, identify problems and strengths, analyze shortcomings and bottlenecks, and, finally, decide for themselves what they need to do if they are to overcome problems and maintain strengths.

The COPE Tools

If sample COPE tools are available, it is helpful to show them to managers as you describe them.

Self-Assessment Guides

The Self-Assessment Guides are 10 guides, organized around the framework of clients' rights and staff needs. The guides contain discussion questions that help staff think about the way services are provided and whether supervision, training, and equipment and supplies are available at their site.

Participants use the guides in small groups, with each group containing staff having a mixture of levels and functions within the facility. While the guides are intended primarily to help staff analyze how services at their facility are provided, they also serve as educational aids: The questions in the Self-Assessment Guides are based on international standards of care, so these standards are communicated to the staff as they proceed through each guide.

Record-Review Checklist

The Record-Review Checklist is used to determine whether key information is being recorded accurately and completely in client records and whether clients are receiving care according to standards. It is considered a component of the Self-Assessment Guide entitled "Clients' Rights to Safe Services," as ensuring safety also means ensuring that client health information is up-to-date and accurate

Client-Interview Guide

Informal interviews can be conducted (using the client-interview form as a guide) with clients who have completed their clinic visit. (Interviewers should be providers who have *not* had contact with the client during that day.) Questions are designed for staff to learn their clients' views and opinions of the services provided at their site. Interviewers encourage each client to discuss the quality of his or her visit, what was good and bad about it, and how the quality of services could be improved.

Client-Flow Analysis (CFA)

A method of tracking clients through the site to detect any problems with client flow (e.g., "bottlenecks"), the CFA measures staff's contact time with clients and the time that clients spend waiting, and looks at staff utilization

Action Plan

The Action Plan is a written plan that staff develop to help resolve problems identified during a COPE exercise, after they have collected information using the other COPE tools. Staff identify problems and root causes and recommend solutions—all of them recorded in an Action Plan format (see Appendix A for a sample). In addition, staff convene at the Action Plan Meeting to discuss, prioritize, and consolidate the problems and recommendations they have recorded in their group's or team's Action Plans.

COPE and the QI Process

Explain that COPE fits within a four-step process of QI:

- **Step 1—Information-gathering and analysis:** identifying problems from self-assessments, client interviews, record review, and CFA
- **Step 2—Action Plan development and prioritization:** refining a problem, prioritizing, recommending solutions, and deciding by whom and by when the problem will be addressed
- **Step 3—Implementation of the Action Plan**
- **Step 4—Follow-up and evaluation:** gauging progress, including developing a new Action Plan, with new problems and solutions identified

These four steps are repeated, resulting in a continuous QI process.

Why Use COPE?

When discussing the benefits of COPE (see below), feel free to use examples from your own experience—or from among those provided after this section—for a concrete illustration of these benefits.

COPE:

- Develops a customer focus among staff and a sense of ownership
- Relies on the wisdom of the experts—staff and clients
- Empowers staff at all levels to participate in QI
- Builds teamwork and cooperation, providing a forum for staff and supervisors to exchange ideas
- Provides tools for local problem-identification and problem solving that are practical and relatively simple to understand and use
- Communicates standards and suggests good work behavior
- Presents concrete and immediate opportunities for action
- Responds to needs in a decentralized system, by helping site managers work more effectively
- Is cost-effective (and poor quality is costly)
- Can be transferred and adapted from one setting to another

Examples of Success Using COPE

As examples of COPE's successes, present the example below or any of those in Appendix B, or use examples from your own experience with COPE. If using examples from local sites, make sure not to reveal the names of individuals or institutions.

Getting Support from Headquarters

During the first COPE exercise in the clinics of one nongovernmental organization, poor supplies of equipment and commodities were mentioned frequently as a major problem. As a result, headquarters staff decided to conduct a modified COPE exercise in the central stores unit.

The staff at central stores revealed being just as frustrated with the logistics and supplies system as were the other clinic staff. "We were in the middle...," said one staff member. "Clinics were complaining, headquarters was complaining, and we could not see anything positive about our work. But when it was explained to us how important our job was and that we needed to serve our customers (the clinics) or else women would suffer, we set to work."

By listening to the constraints that the supply unit faced and by allowing changes in procedures, headquarters staff empowered the staff in this department. The staff designed new requisition forms and ledgers, agreed on minimum stock levels with the clinics, and provided on-the-job training to clinic staff in how to communicate with their unit. One staff member said, "Clinics had not been planning very well, but now it is better.... We helped them, they helped us, and everyone is much calmer."

Adapted from: Bradley, J., 1998.

EngenderHealth's QI Package

Explain that sites that introduce COPE often find the process to be a springboard for introducing complementary tools and approaches for improving service quality (see Flipchart 17, Appendix E), so they can sustain or increase the level of improvement over time. These other tools and approaches help sustain the QI process by addressing systems for supervision and training, by ensuring medical quality and informed choice, and by measuring QI over time. They include the following tools and approaches:

- **Facilitative supervision** is an approach to supervision emphasizing mentoring, joint problem solving, and two-way communication between a supervisor and those being supervised. To facilitate change and improvement and to encourage staff to solve problems, supervisors must have the solid technical knowledge and skills needed to perform tasks, must know how to access additional support, as needed, and must have time to meet with staff whom they supervise.

- **Medical monitoring** is an approach to medical QI that involves the objective and ongoing assessment of the readiness of and processes involved in service delivery. Readiness includes staffing, facility, equipment, and range of services available; processes include medical techniques, client-provider interaction, and infection prevention. The process of medical monitoring leads to recommendations for improvement.

- **Whole-site training** is aimed at meeting the learning needs of a site. It links facilitative supervision and training, and actively engages supervisors in identifying learning needs, planning and implementing required training (on the job, on-site, or off-site), and facilitating the implementation of newly acquired skills through coaching, mentoring, and teamwork. Types of training could include orientations to new services or concepts, knowledge updates, and skills training. Whole-site training also includes inreach—staff orientations, referrals, and linkages between departments.

- The **Quality Measuring Tool** is used annually to measure QI over time. It is based on the self-assessment tool used in COPE and is used by site staff and supervisors to determine whether clients' rights are being upheld and whether providers' needs are being met.

- The **Cost-Analysis Tool** is used to measure the direct costs of providing specific health services. It measures the cost of staff time spent directly providing a service or clinical procedure, as well as the costs of commodities, expendable supplies, and medications used to provide that particular service or procedure. This information can be used to improve the efficiency of staffing and the use of staff time and supplies at a site, and to set user fees for services that reflect the actual direct costs of these services.

- **Community COPE** is a participatory process and tool and an extension of COPE that can be used to build partnerships with community members so as to improve local health services by making them more responsive to local needs. It can also:
  - Result in increasing community "ownership" of health facilities and services and advocacy for resources for health
  - Be useful to sites in areas undergoing health reform, as a means of engaging the community in defining and supporting the quality of services that they want

Stages and Steps of the COPE Process

Review the "COPE at a Glance" flowchart and time frame (see Chapter 1) with the managers, to give them an overview of the process and a sense of the roles that the two types of facilitators (see Flipcharts 18 and 19, Appendix E) and that they themselves (see Flipchart 20, Appendix E) will play in it.

Appendix D
Facilitation Skills

Objectives

In this section, you will learn:

- How to begin meetings and close meetings
- Some general facilitation tips
- How to work with difficult group members

Although COPE is initially introduced by an external facilitator, the ultimate objective is for someone within the site to become proficient in leading the site staff through the COPE exercises. This requires having or developing a set of skills in working with groups.

To work effectively with groups, the facilitator needs to know how to:

- Foster a nonthreatening environment
- Encourage different levels of staff to work together
- Encourage full and balanced participation
- Encourage the group both to think broadly (e.g., while brainstorming) and to focus their thinking (e.g., when developing concrete next steps or generating solutions)
- Encourage different types of people and personalities to work together
- Manage and resolve conflict

The suggestions in this appendix are meant to help facilitators enhance their skills in these areas and to guide participants through the COPE exercises without dominating the discussions. It begins with some concrete "how-tos" of beginning and closing meetings, important for setting a tone and maintaining the unity of the group. These sections are followed by some general facilitation skills, as well as some tips on how to deal with difficult group members.

Suggestions for Beginning Meetings

The beginning of a meeting is important for setting the right tone. Through words and body language, you can communicate that you welcome people's opinions and will encourage them to participate. It is also the time to let people know what the structure of the meeting will be. (For more on establishing the right tone, see "Establish a Respectful Tone Right from the Beginning," in the "General Facilitation Skills" section.)

Welcome and Orient the Participants

Let the participants know that you are glad they have come. Briefly review the meeting's agenda with them so they will be oriented to the schedule.

Conduct a Warm-Up Exercise (If You Have Time)

In many settings, it is appropriate to begin the Introductory Meeting with a warm-up (ice-breaker) exercise. This type of exercise will set the stage for the staff's active participation in group discussions. (This is especially important in settings in which different levels of participants do not know each other or are not used to participating together in meetings.)

You or the site facilitator may lead one of the following warm-up exercises:
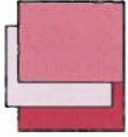
- Ask each participant to write his or her name on the left side of a piece of paper and his or her position on the right side of the paper. Collect the pieces of paper, tear them in half, and either set them aside or throw them out. (Do not throw out the papers if this would be considered offensive in your setting.) Explain that what you have done with the papers symbolizes that the group will set aside any differences in rank or position during the exercise, and emphasize that each person's contribution is important.

- Ask the participants to introduce themselves by name and title and to say one contribution or strength they bring to the site. Give an example: "My name is _____. As a security guard, I am the first person to greet clients when they arrive, and I direct them if they do not know where to go."

Take Attendance

Knowing the numbers and categories of staff is needed before you can form groups or teams to work on self-assessment and client interviews. Be sure to record the participants' names and titles or positions.

Establish Norms

Ask: "Under what conditions will you be able to freely speak your mind?" If you are aware that the group has experienced conflict in the past, ask: "What rules do we need to set today to ensure that we manage conflict at this meeting?" Write their responses on a flipchart. Add the following norms if they were not mentioned:

- Everyone should participate actively
- Participants should respect each other and everyone's opinions
- All ideas are good and will be listened to carefully
- Only one person may talk at a time
- Discussions should stay on track and on time
- The focus should be on processes and systems, not on individuals
- Participants should be supportive rather than judgmental

Ask the staff whether they agree to follow these norms for the duration of the exercise.

Review Meeting Objectives

It is important to be clear about what you intend to accomplish during the time the group will be together, and to check with participants to make sure you are in agreement about the goals of the meeting. You can show the objectives on a flipchart or read them aloud (or both), and ask:

- Are the objectives clear? Does everyone agree to this?
- Are there any objectives you would like to see that are not here?

You may not be able to accommodate everyone's wishes for additions or changes to the objectives. That is perfectly acceptable—just be clear about what you can or cannot do.

Suggestions for Closing Meetings

When closing meetings, your aims are to reinforce what people have learned during the meeting (or next steps) and to acknowledge their teamwork and contributions.

Ask participants to name five things they will remember about the meeting. This will help them retain what they have learned.

Thank the staff for their time, effort, and enthusiasm.

- If desired, conduct a plus/delta (+/Δ) exercise to close the meeting and get feedback from the staff, as follows:
  - ▲ Ask the staff what they think went well during the COPE exercise, and list their responses on a flipchart in the Plus column.
  - ▲ Ask the staff what they suggest be done differently in future meetings, and list these responses on a flipchart in the Delta (or change) column. These suggestions can be applied to future COPE exercises.

Plus (+)	Delta (Δ)
✔ Enjoyed a chance to meet with other staff ✔ Found problems that can be solved within a short time	✔ Schedule the next exercise as part of a regular staff meeting, to minimize time away from other duties

- Alternatively, ask the participants to write their feedback on a handout, by completing the following statements:
  - ▲ The one thing I learned today that I do not want to forget is...
  - ▲ The information or activity that I found most interesting and useful today was...
  - ▲ The one suggestion I have for improving today's session is...

Ask them to write in any additional comments they may have.

General Facilitation Skills

Establish a Respectful Tone Right from the Beginning

It is extremely important to set the right tone from the very beginning of the COPE exercises. Below are some additional tips especially important to consider for the initial meeting, to establish an atmosphere of openness, respect, and comfort. This sends a message that the facilitator will be attentive and responsive to the needs of participants.

To set the right tone for the meeting:

- Start the meeting on time.
- Establish a connection with the group: Communicate the message to participants, either verbally or nonverbally, that you empathize with them and are "on their side."
- Demonstrate respect and sensitivity to the participants: Encourage a quiet person's opinions, for example, but do not push someone to talk who seems truly uncomfortable.
- Demonstrate active listening skills. For example, by allowing people to speak without interrupting them and by showing that you are concentrating on what a speaker is saying, you both model good group skills and establish credibility with the group.
- Relax and be natural. Your being comfortable will help make the participants feel at ease.
- Walk around the room when appropriate; avoid staying at the front during the entire meeting.
- Check to make sure that the participants can see the visual aids and hear the discussion.
- If you do not know the answer to a question, do not be afraid to say so. But tell the questioner that you will try to find the answer and will get back to him or her—and then do so. (This sends two messages—that you are open with the group, and that you will follow through on promises. Both messages build trust.)

Encourage Participation

An essential part of COPE is participation. The facilitator's role is to start things off, but the more that staff participate, the better. Staff are more likely to accept suggestions and to feel ownership and responsibility for making improvements when the suggestions come from themselves rather than from the facilitator.

The facilitator needs to create a comfortable atmosphere and encourage questions and lively discussion, while preventing hostility and managing conflict. One key role of the facilitator is to *be particularly sensitive to gender, cultural, and socioeconomic differences between participants* and to encourage all participants to share equally in the discussions.

The facilitator should set ground rules with the staff:

- *Respect every speaker and all opinions.* A few participants should not dominate the discussions. The facilitator should try to support and encourage people who are shy or not used to participating in meetings where they are asked to express their ideas.
- *Everyone's participation is important in COPE.* No one is to tell any of the participants that they have given a wrong answer or imply that their comments are not worthwhile. There are no wrong answers or opinions.
- *Stay on track.* Encourage participants to keep the discussion focused and to avoid repetition of issues, where possible. The facilitator acts as a guide rather than as a director, but should maintain control.

Show Empathy

The facilitator should show participants that he or she understands how they feel about a situation. This helps participants feel as if the facilitator is part of the group and encourages them to share their feelings and ideas. Empathy statements can start with "I can understand that it must be difficult to…" or "I understand this is a difficult problem for you…." Empathy statements:

- *Help staff express and acknowledge strong emotions*. For example, the facilitator might respond to a strongly expressed opinion by saying: "It sounds as if you feel very strongly about this issue, and that you have had problems dealing with this before." Or when someone is showing anger, the facilitator may begin a reply with: "I can see that you are upset."
- *Encourage the participants to listen*. If the participants feel that the facilitator is genuinely recognizing their emotions, they are more likely to listen to what is being said.
- *Relieve anxiety about discussing a problem publicly*. For example, the facilitator may say: "I can understand why it would be very difficult for you to do effective infection prevention if you do not have the supplies."

Be Flexible

The facilitator should always bear in mind that each site has different needs, strengths, and weaknesses. For example, some of the questions in the Self-Assessment Guides may be appropriate for some sites but not others. COPE tools should be adapted for the circumstances and needs of an individual site; wherever possible, this should be discussed in advance with the site managers. COPE will be a different experience every time it is done.

Talk about Strengths as Well as about Problems

The facilitator should remind staff that improving service quality needs to go beyond identifying problems, to evaluating site strengths as well. The facilitator should ask, "How can we do this even better?" or "How can we further improve attendance?" Many people are too modest to mention their positive qualities themselves, but generally they will do so if asked.

The facilitator should also reinforce the positive and end the COPE exercise on a positive note. For example, he or she may explain, "COPE is done in good sites such as this one, where staff have demonstrated that they are interested in the welfare of their clients." This helps reassure staff members who may believe that the site has been singled out because it needs particular improvement.

Give Examples of Success Stories

It is important to give concrete examples of where COPE has been effective. People love to hear "true-life stories" about other institutions that have faced similar problems and resolved them. If possible, give local examples that are relevant to site staff, but remember not to name names of institutions or individuals. It is very important to maintain confidentiality and reassure participants that *their* problems will not be a subject of discussion at another site's COPE exercise.

Appendix B is a place to record such stories. Facilitators should remind the staff to make sure that this record does not contain specific names or places, only the problems identified and the solutions found.

Ask Open-Ended Questions and Probe for Root Causes

The COPE Self-Assessment Guides consist of yes-no questions. However, to encourage more discussion and to probe for the root cause of problems, facilitators should ask open-ended questions. These questions usually begin with "why," "what," "where," or "how," and will help encourage participation from the staff because participants need to think and respond at some length to answer them.

Open-ended questions can be used to:

- *Start a discussion or get a team member more involved.* For example, such a question might be: "What do you think about infection prevention practices at this hospital?"

- *Bring a conversation back on track.* For example, the facilitator might ask: "What other information do we need to solve this problem?"

- *Find the root causes.* This can be done using the multiple whys technique (discussed in Chapter 3, page 41).

Use Paraphrasing

Paraphrasing helps clarify what was said. It is a way of saying, "This is what I understood you to mean. Am I right?" A restatement of the speaker's message can be introduced by phrases like: "So, in other words...," "It sounds like...," or "Let me make sure I have this right...." Rephrasing can be used to:

- *Clarify what someone is saying.* For example, a statement can be rephrased as follows: "It sounds as if you think we are spending too much time discussing infection prevention."

- *Clarify different opinions and reach agreement.* For example, the facilitator might say: "It sounds as if Dr. Ndete thinks our infection prevention procedures are adequate, while Nurse Obare thinks there is still some room for improvement. What do others think?"

- *Get at deeper issues.* Some things are difficult to talk about. By rephrasing, the facilitator can help participants talk about the root causes of the problems by using statements like: "So in other words, there is more to this problem than meets the eye. Can you think of any other reasons for this problem?"

Working with Difficult Group Members

When groups of people come together, different personalities emerge. Personality differences can have a negative impact on the group if they are not managed well. It is important for the facilitator to recognize personality differences and take them into account so the group can operate at its most productive level.

Emphasizing the importance and value of the group's work to individuals and the site can often resolve any problems with conflicting personalities (Katzenbach & Smith, 1994). The chart on the opposite page shows some additional tips for working with difficult group members.

Figure D-1. Tips for Working with Difficult Group Members

If the participant:	Try this:
Is silent during discussions	▪ Involve the person by directing a question to him or her ▪ Use eye contact or other body language, as appropriate, to acknowledge the person
Is negative or complains	▪ Ask for specifics about the complaint and address them ▪ Refer the complaint to the group
Challenges the facilitator	▪ Ask the participant for his or her solution or idea
Is disruptive or is having a separate, private conversation	▪ Walk toward the person who is being disruptive; he or she may become quiet when attention is directed toward him or her ▪ Address the person by name to involve him or her in the group discussion ▪ Deal with the person individually, separately from the group
Interrupts when others are speaking	▪ Return attention to the person who was speaking and let him or her finish, asking the person interrupting to hold his or her thought for a moment
Dominates the discussion or is too talkative	▪ Interrupt and consider the points one by one ▪ Ask others to react to what the person said

Remember: Good facilitation is a key to the successful introduction of COPE. If the facilitator shows enthusiasm, staff are more likely to become enthusiastic about COPE.

Appendix E
Flipcharts

These flipcharts can be used in a variety of settings, to communicate about COPE and quality improvement (QI). They are intended for use as follows:

- **Flipcharts 1 to 15** accompany Chapter 3 (Preparing for and Conducting the First COPE Exercise) and Chapter 4 (The Action Plan Meeting), and are referenced within the text. Some of these could also be used in a formal presentation for orienting key managers (particularly Flipcharts 2, 4, 5, 6, 7, 8, 11, and 15).
- **Flipcharts 16 to 19** contain additional material that is helpful for orienting key managers, if you have the time to make a more formal presentation.
- **Flipcharts 20 to 21** are helpful for conducting the Client-Flow Analysis (Chapter 7) and are referenced in the text.

Flipcharts for Conducting the First COPE Exercise (Flipcharts 1 to 15)

Flipchart 1

Objectives

At the end of this COPE exercise, you should be able to:

- **Understand the importance of improving quality**
- **Understand what COPE is**
- **Use the Self-Assessment Guides, the Record-Review Checklist, and Client-Interview Guide**
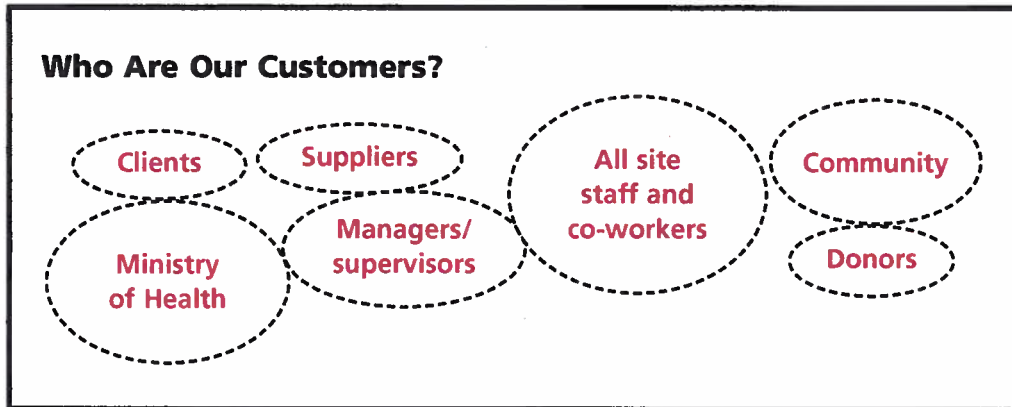- **Develop an Action Plan**
- **Form a COPE Committee at your site**

Flipchart 2

Clients' Rights

- **Information**
- **Access**
- **Informed choice**
- **Safe services**
- **Privacy and confidentiality**
- **Dignity, comfort, and expression of opinion**
- **Continuity of care**

Staff Needs

- **Facilitative supervision and management**
- **Information, training, and development**
- **Supplies, equipment, and infrastructure**

Flipchart 3

Who Are Our Customers?

Clients
Suppliers
All site staff and co-workers
Community
Ministry of Health
Managers/ supervisors
Donors

Flipchart 4

Reasons to Improve Quality

- Quality services protect staff and clients' health.
- Quality leads to savings (less repeat work and waste).
- A site may add features to its services that will attract customers (clients).
- All organizations have strengths to maintain.
- There is always room for improvement.

Flipchart 5

An Example of the Costs of Poor Quality

Area	Cost of poor quality	Savings and benefits from improved quality
Performance of tests (such as Pap smears)	- Unsatisfactory tests require repeat testing, thereby wasting resources (supplies and money) and staff and clients' time. - Unsatisfactory tests give false or no results.	- Clients and staff save resources and time. - Clients' health is improved, and illnesses are diagnosed in a timely manner.

Flipchart 6

Quality Improvement Principles

- Customer focus
- Staff involvement and ownership
- Focus on processes and systems
- Cost-consciousness and efficiency
- Continuous learning, development, and capacity building
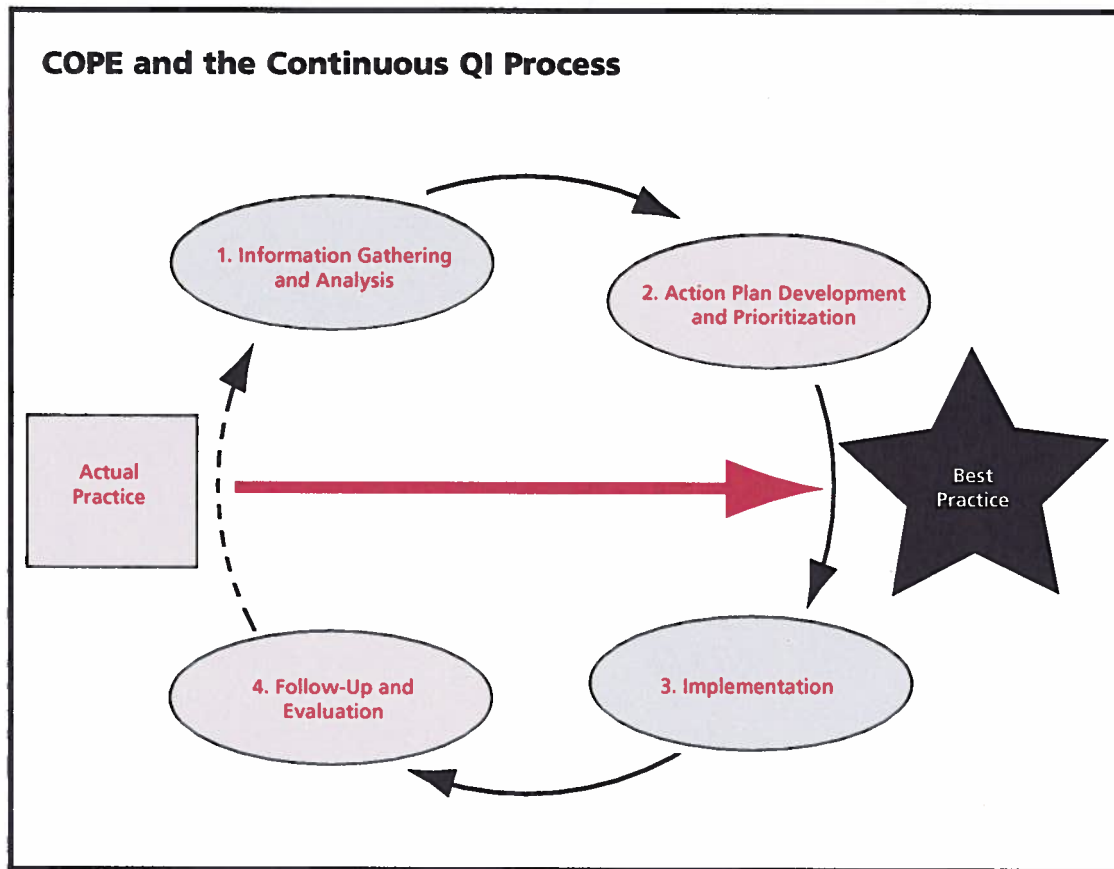- Continuous quality improvement

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Flipchart 7

Client-Oriented, Provider-Efficient: A Continuous QI Process

COPE Tools

- Self-Assessment Guides
- Record-Review Checklist
- Client-Interview Guide
- Client-Flow Analysis (CFA)
- Action Plan

COPE and the Continuous QI Process

Tips for Using the Self-Assessment Guides

1. Skip anything that does not apply to your site.
2. Add anything important to your site that is not listed.
3. "No" means a possible problem. Probe to find out more.
4. Be honest about problems.
5. Get input from co-workers who are not on your team.
6. Be specific and concrete.

Flipchart 10

The Purpose of Client Interviews

- To learn what clients think about the services provided at the site (We do not know how clients feel unless we ask them.)

- To get suggestions from clients about how to improve the services provided at the site

- To show clients that health workers care about their needs

Flipchart 11

Sample Action Plan

Problem	Cause(s)	Recommendation	By Whom	By When
A chronic shortage of expendable supplies in the maternity ward leads to increased risk of infection for staff and clients.	Inadequate budget for hospital supplies	Ask antenatal clients to purchase maternity supplies.	L. Karisa (clinic nurse)	July 1, 2004
	Failure to charge clients any fees for services or supplies	Ask the pharmacy to prepackage maternity supplies for clients (bottle of chlorine, pair of gloves, syringes, sanitary pads, etc.).	Dr. Ware (clinic director)	July 1, 2004
		Retain any unused supplies for use by other clients who cannot afford to buy them.	J. Samanda (ward nurse)	July 1, 2004

Flipchart 12

Developing a Clear Problem Statement

- A *problem* is the difference between the actual, present situation and the desired situation.
- Staff must agree that it is a problem:
  - Verify that there is a problem or collect data as needed.
  - Encourage all levels of staff to give input.
- Measure enough to get a good sense of what the problems are (e.g., five staff need training in the diagnosis and treatment of sexually transmitted infections), but do not try to measure everything.
- Focus on processes and systems. Do not blame individuals for mistakes.
- Identify problems and processes that are manageable.
- List the effects of the problem, if possible.

Flipchart 13

Using the "Multiple Whys" Technique

Problem: Clients do not complete their treatment for sexually transmitted infections and are not cured.

Why? Clients do not understand the need to complete treatment after their symptoms disappear.

Why? Service providers do not explain to clients why they should keep taking their medication after the symptoms disappear.

Why? Service providers were not trained in counseling clients about treatment.

Are there any other causes? Service providers are not aware that clients do not receive this information.

Flipchart 14A

Unclear Problem Statement

Problem	Cause(s)	Recommendation	By Whom	By When
HIV-positive pregnant women are lost to follow-up.	Clients are not interested in services.	Make clients more interested in services.	All staff	Immediately

Flipchart 14B

Clear Problem Statement

Problem	Cause(s)	Recommendation	By Whom	By When
Pregnant clients testing positive for HIV do not return for follow-up services.	(1) Staff are not trained to discuss the range of services available.	(1) Conduct whole-site training on clinical, counseling, and support services available to prevent mother-to-child transmission of HIV and support HIV-positive clients.	L. Karisa (clinic nurse)	July 1, 2004
	(2) Clients feel unwelcome and stigma-tized by staff.	(2) Conduct HIV and stigma awareness/sensitivity training for all staff.	J. Samanda (ward nurse)	July 30, 2004
	(3) HIV-posi-tive clients are afraid that others will find out their status and harm them.	(3a) Review/revise protocols on client confidentiality and orient all staff.	Dr. Ware (clinic director)	August 30, 2004
		(3b) Provide counseling training for providers on how to help clients make decisions about disclosure.	R. Minja (HIV counselor)	September 5, 2004

Flipchart 15

Tasks for the COPE Committee

- Make the Action Plan accessible for all staff to see.
- Follow up on the site's Action Plan.
- Support the staff responsible for implementing solutions.
- Schedule subsequent COPE exercises.
- Help monitor the results.

Additional Flipcharts for Orienting Key Managers (Flipcharts 16 to 20) (if you have time)

Flipchart 16

Site Managers and Supervisors: Catalysts for QI

Site managers and supervisors meet staff's needs for:

- Facilitative supervision and management
- Information, training, and development
- Supplies, equipment, and infrastructure

Flipchart 17

Other Tools and Approaches for Ongoing QI

- Facilitative supervision
- Medical monitoring
- Whole-site training and inreach
- Quality Measuring Tool
- Cost-Analysis Tool
- Community COPE

Flipchart 18

Role of the External COPE Facilitator

- Introduces the COPE process to the site, with assistance from the site facilitator
- Co-facilitates the second COPE exercise with the site facilitator
- Supports the site facilitator in following up with the site's COPE Committee
- Trains one or more staff members to be site facilitators

Flipchart 19

Role of the Site Facilitator

- Works with the external facilitator to introduce the COPE process to the site
- Co-facilitates the second COPE exercise and serves as the lead facilitator by about the third COPE exercise
- Takes main responsibility for follow-up with the site's COPE Committee (with support from the external facilitator)
- Trains other site facilitators, as needed

Flipchart 20

Role of the Manager

- Communicates to site staff his or her support for the COPE process
- Participates in the COPE exercises
- Supports the implementation of recommendations from the Action Plans

Flipcharts for the Client-Flow Analysis (Flipcharts 21 and 22)

Flipchart 21

Client-Flow Analysis (CFA)

- Tracks client flow through a site
- Measures clients' contact time with different staff
- Can help identify bottlenecks or missed contacts
- Measures staff utilization

Flipchart 22

Key Instructions for Data Collection

- Number the forms early, before the first client arrives at the site.
- Synchronize all of the staff's watches and clocks at the site.
- Review and agree on all codes for visit type, etc.
- Agree on staff initials. (To avoid confusion, use a different set for each staff member.)
- Record the information completely, legibly, and accurately.
- Collect all forms at the last contact with the clients and post someone at the exits. Do not let the forms "walk away."

Appendix F
Contents and Applications of the COPE Toolbooks

EngenderHealth is developing a series of revised toolbooks, focused on a variety of topic areas in reproductive health services, to accompany this handbook. Each toolbook will contain Self-Assessment Guides with questions related to the relevant service area, a Client-Interview Guide, a Record-Review Checklist, and forms for use in Client-Flow Analysis. The descriptions in this section summarize the content of each. Where the tools are tailored in some way for a particular guide, the differences are described below.

Note: At the time this revised handbook was published, most of the toolbooks had not yet been updated. Thus, the listings here may describe toolbooks that had not yet been produced at the time this handbook was published. In such cases, the title of the previously published edition of a toolbook is given.

COPE® for Reproductive Health Services: A Toolbook to Accompany the COPE® Handbook

The Reproductive Health Services Toolbook covers a broad range of reproductive health services, and the self-assessment guides reflect key standards of care for each of these. This toolbook serves as a good starting point for facilities that are establishing or strengthening integrated reproductive health services.

Reproductive health topics addressed in the COPE for Reproductive Health self-assessment guides include:

- Antenatal care
- Labor and delivery
- Postpartum and newborn care
- Family planning
- Postabortion care
- Reproductive tract infections (RTIs)
- Sexually transmitted infections (STIs)
- HIV and AIDS
- Gynecological disorders, such as cervical cancer and fistulae
- Disorders of the male reproductive health system, such as diseases of the prostate, and sexuality
- Infertility
- Harmful practices, such as female genital cutting

This toolbook contains two types of record review: a general Client Record-Review Checklist and a Surgical Record-Review Checklist for surgical procedures, with areas for recording dosages of medicine, surgical procedure notes, and notations of complications.

The Client-Flow Analysis (CFA) is for clients of any outpatient reproductive health services.

COPE® for Maternal Health Services: A Toolbook to Accompany the COPE® Handbook

(This toolbook was previously published as *COPE® for Maternal Health Services: A Process and Tools for Improving the Quality of Maternal Health Services* [2001].)

The Maternal Health Services Toolbook is for facilities wanting to focus specifically on improving maternal health care services. The toolbook covers five service categories: general care, antenatal care, routine labor and delivery care, emergency obstetric care (including postabortion care), and postpartum care (immediate and follow-up).

Topics covered include:

- *Antenatal care*—pregnancy testing; screening and recognizing complications; urine tests; tetanus immunization; iron provision; malaria and hookworm treatment; labs; imaging studies; birth plan assistance; antenatal counseling; and referrals
- *Routine labor and delivery care*—initial obstetric evaluation and assessment; recognition of labor, complications, and emergency; normal labor and delivery management; management of prolonged or dysfunctional labor; initial management of routine complications; performance of IV fluid replacement, laceration repair, manual removal of the placenta, bimanual uterine compression, and use of appropriate drugs; immediate newborn evaluation, resuscitation, and routine care, and immediate breastfeeding
- *Emergency obstetric care*—emergency evaluation and assessment; recognition of complications and emergency; initial stabilization of emergency; management of eclampsia, preeclampsia, hemorrhage, obstructed labor, infection, sepsis, ectopic pregnancy, malpresentation, shock, and cardiopulmonary arrest; performance of assisted delivery, blood transfusion, and cesarean section; administration of anesthesia; and management of unexpected surgical complications
- *Postpartum care*—maternal assessment, immediately postdelivery or postabortion and at follow-up visits for complications; infant assessment and management of complications postdelivery and at follow-up visits; counseling about normal care of mother and baby, breastfeeding, family planning, warning signs, and where to come for medical attention; and removal of sutures and incisional care, perineal care, breast care, and breastfeeding support
- *For routine labor and delivery care, emergency obstetric care, and postpartum care*—stabilization and transfer of clients needing emergency obstetric care

The record-review tool is an Obstetric Admission Record Review.

The CFA is targeted to antenatal and postpartum clients.

COPE® for Child Health Services: A Toolbook to Accompany the COPE® Handbook

(This toolbook was previously published as *COPE for Child Health: A Process and Tools for Improving the Quality of Child Health Services* [1999].)

The self-assessment guides include questions specifically related to childhood illnesses, including diarrhea, malaria, measles, pneumonia, HIV and AIDS, and malnutrition. They have also been adapted to be compatible with Integrated Management of Childhood Illness

(IMCI), an approach to child health services developed by the World Health Organization, the United Nations Children's Fund, the U. S. Agency for International Development, and others, in response to the problem of child survival. IMCI focuses on the "whole child," as opposed to an individual condition or disease. The tools that IMCI-trained providers use are the IMCI flowcharts. These charts employ recognition of symptoms and signs to create a pathway to diagnosis and treatment. COPE for Child Health can be used as a support to IMCI.

COPE and the tools for child health can also be used at facilities and in health care systems where IMCI has not been introduced, by the omission of the tool called the IMCI Record Review. Given IMCI's focus on those aged 0 to 5, many questions in the COPE for Child Health Self-Assessment Guides also focus on this age-group.

Sample content areas include:
- Maternal and child nutrition
- Antenatal care
- Postpartum care
- Child immunizations and vaccinations for the mother
- Breastfeeding
- Care for the sick child
- Vitamin supplements for mother and child
- Health education information for the caregiver (including danger signs in childhood illness, childhood diarrhea, acute respiratory infection, vaccination schedules, and prevention of STIs and HIV)
- Family planning counseling

The client interview is directed at the parent or caregiver of the child.

There are two record-review checklists, each designed to complement IMCI criteria for management of children. One is for sick young infants aged 1 week to 2 months; the other is for sick young children aged 2 months to 5 years.

The CFA focuses on clients using a range of services, including well-child care or vaccinations, sick-child care, and antenatal, postpartum, and family planning services.

COPE® for Family Planning Services: A Toolbook to Accompany the COPE® Handbook

(This toolbook was previously published as *COPE®: Client-Oriented, Provider-Efficient Services: A Process and Tools for Quality Improvement in Family Planning and Other Reproductive Health Services* [1995].) (*Note:* This volume is the earlier edition of this handbook. It will remain in print until the revised toolbook for family planning services has been completed.)

Content areas for COPE for Family Planning include:
- All contraceptive methods, both temporary and permanent
- Infection prevention for Norplant implants, the intrauterine device (IUD), injectables, tubal occlusion, and vasectomy

- Counseling or referral for other reproductive health issues, such as breast self-examination, Pap smears, and prevention and treatment of STIs, RTIs, and HIV
- Family planning counseling and referral for postabortion clients

The client interview asks specific questions about satisfaction with family planning counseling services.

The Record-Review Checklist is focused on sterilization services, with categories including intraoperative medications, procedure notes, and records of types of complications.

The CFA is for any family planning client, including those seeking counseling and different types of contraceptive methods, allowing staff to compare client contact and waiting times for different methods.

Community COPE®: Building Partnership with the Community to Improve Health Services

This is an adaptation of the COPE process aimed at learning the needs of a wider population than those who are current clients of a facility. To better meet the needs of individual clients as well as the communities they serve, EngenderHealth and its partners developed a process for health care staff to interact with the community, so they can reach not only people who come to the facility, but also potential clients who have chosen not to come or clients who have stopped using their services.

Using participatory information-gathering and action-plan development, Community COPE is designed to help supervisors and staff at service-delivery facilities:

- Gain support from local leaders
- Learn how community members feel about the services they provide
- Gather community members' recommendations for improving the services or enhancing service strengths and assets
- Determine ways to encourage community members to participate in and take ownership of QI efforts at both the facility and the community levels

Tools include:

- Values-clarification exercises
- Guides for initial discussions with local community leaders
- Individual interview guides for current, former, and potential clients
- Group discussion guides
- Participatory mapping exercises
- Facility walk-through

In general, we recommend that facilities conduct Community COPE participatory activities after staff have already had experience with COPE at the facility level. These activities require strong facilitation skills, because the range of participants and need for building trust and managing conflict may be greater than with COPE exercises conducted at the facility level.

Appendix G
COPE and Other Quality Improvement Approaches

While the emphases of COPE and other quality improvement (QI) approaches differ in several respects, they share many characteristics and underlying philosophies. In particular, COPE has some similarities to two other approaches: performance improvement (PI) and appreciative inquiry (AI). Like PI, COPE focuses on the factors that enable staff to perform well, and along with AI, COPE contains elements that focus on enhancing staff and facility strengths.

COPE and Performance Improvement*

PI is a process for enhancing employee and organizational performance that employs an explicit set of methods and strategies. Results are achieved through a systematic process that:

- Considers the institutional context
- Describes desired performance
- Identifies gaps between desired and actual performance
- Identifies root causes
- Selects, designs, and implements interventions to fix the root causes
- Measures changes in performance

PI is a continuously evolving process that uses the results of monitoring and feedback to determine whether progress has been made and to plan and implement additional, appropriate changes.

The relationship between QI and PI is a subject of ongoing debate. The orientations of QI and PI are somewhat different. QI asks: What steps can we take to make sure we do the right thing in the right way? PI asks: What is needed to improve performance? Ultimately the approaches are complementary, since to provide better client services, we ultimately must grapple with how performers are doing their work.

While the orientations may differ, the QI and PI models have significant similarities:

- Both are cyclical problem-solving processes.
- Both advocate the establishment of standards and the continual quest to meet those standards.
- Both seek to establish the root causes of identified problems.
- Both identify and select the appropriate actions that are intended to address performance problems.
- Both seek the same ends: high-quality products or services.
- Both models draw from the same tool box, although the use of the tools may vary. The approaches are complementary, and the strengths of each should be brought to bear in implementing reproductive health interventions.

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* This information on COPE and performance improvement is excerpted from the Performance Improvement Consultative Group FAQ sheet, at http://www.picg.net/pi_faq.htm, accessed March 30, 2003.

The COPE process draws on many principles of QI and PI. COPE enables supervisors and staff to apply these principles and identify and solve performance problems at the service-site level. COPE stresses the definition of good performance, especially in terms of meeting the needs of providers so they can meet the expectations of their clients.

PI defines *desired performance* through the standards set by stakeholders, while QI defines *quality services* using clients' rights as the overarching standards and assessing them through client interviews, staff self-assessments, and community COPE activities. Additionally, COPE self-assessment guides are based on international standards and guidelines for reproductive health services. PI discusses *performance factors,* while QI discusses *staff needs.* While the terminology and (to some extent) the aims differ, the content is often comparable (see below).

PI Performance Factors	QI Staff Needs
■ Clear job expectations ■ Feedback ■ Motivation ■ Organizational support	■ Facilitative supervision and management (including feedback, motivation, and organizational support)
■ Skills and knowledge	■ Information, training, and development
■ Environment	■ Supplies, equipment, and infrastructure

COPE and Appreciative Inquiry

The COPE process also draws on aspects of AI, which is a capacity-building process that focuses on an organization's strengths (Cooperrider & Whitney, no date). In AI, this process has four stages, known as the discovery, dream, design, and destiny phases (or the 4-D cycle). In the COPE process, AI is reflected in relatively short discussion topics (e.g., during the orientation of managers, in the COPE introduction, and in subsequent COPE exercises). For example, the orientation for managers encourages them to:

■ Focus on what the organization or site has done well in the past, or is doing well now, and explore which factors made high performance or success possible (in AI, the discovery phase)

■ Challenge the current situation by envisioning (or dreaming about) a better future for the organization and by telling stories or giving examples of past and present strengths (including managers' own personal histories in relation to the organization), all of which provides an opportunity to focus on what was positive in the organization's past and lay a foundation for what can be positive in the future (in AI, the dream phase)

■ Build the organization or site by deciding what is important to have (e.g., customer rela-

tions, leadership, etc.) to ensure a positive future for the organization or site (in AI, the design phase)

■ Discuss what the site can do to deliver the dream or provide the level of quality they would like to see (in AI, the destiny/delivery phase)

The last phase provides an opportunity for managers to consider how to work together with site staff to build the future. It involves continuous learning and change, and often leads to a redesign of processes and systems (as does QI). This is the action-planning component of the COPE process.

References

AVSC International. 1995. *COPE: Client-oriented, provider-efficient services: A process and tools for quality improvement in family planning and other reproductive health services.* New York.

AVSC International. 1999. *Facilitative supervision handbook.* New York.

AVSC International. 2000a. *COPE for Child Health project annual report.* New York.

AVSC International. 2000b. *Cost analysis tool: Simplifying cost analysis for managers and staff of health care services.* New York.

Berwick, D. M., Godfrey, A. B., and Roessner, J. 1990. *Curing health care: New strategies for quality improvement.* San Francisco: Jossey-Bass.

Bradley, J. 1998. Using COPE to improve quality of care: The experience of the Family Planning Association of Kenya. *Quality/Calidad/Qualité* No. 9. New York: Population Council.

Bradley, J., et al. 2002. *COPE for Child Health in Kenya and Guinea: An analysis of service quality.* New York: EngenderHealth.

Cooperrider, D. L., and Whitney, D. Undated. A positive revolution in change: Appreciative inquiry. Cleveland: Case Western Reserve University. Retrieved from http://appreciativeinquiry.cwru.edu/Uploads/whatisai.pdf, January 10, 2003.

Dohlie, M. B., et al. 1999. Using practical quality improvement approaches and tools in reproductive health services in East Africa. *Joint Commission Journal on Quality Improvement* 25(11):574–587.

Graves, J. L., et al. 1981. Computerized patient-flow analysis of local family planning clinics. *Family Planning Perspectives* 13(4):164–170.

Huezo, C., and Diaz, S. 1993. Quality of care in family planning: Clients' rights and providers' needs. *Advances in Contraception* 9(2):129–139.

International Planned Parenthood Federation (IPPF). 1993. *The rights of the client.* Poster. London.

Katzenbach, J. R., and Smith, D. K. 1994. *The wisdom of teams: Creating the high-performance organization.* New York: HarperBusiness.

Lynam, P., Rabinovitz, L. M., and Shobowale, M. 1993. Using self-assessment to improve the quality of family planning clinic services. *Studies in Family Planning* 24(4):252–260.

Management Sciences for Health (MSH). 1998. *CORE: A tool for cost and revenue analysis.* Boston.

World Health Organization. 1999. *Mother-baby costing spreadsheet.* Geneva.