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First Nations and Inuit
Home and Community Care

QUALITY RESOURCE KIT

Canada

"Greetings!"

Congratulations! The FNIHCC Program Quality Network (formerly the Quality Working Group), would sincerely like to thank you for your commitment to quality improvement and for your role in helping your colleagues become quality champions in their own right!

The Quality Network is pleased to provide a Quality Resource Kit for the First Nations and Inuit Home and Community Care Program.

The purpose of the Quality Resource Kit is to support efforts in communities to strengthen and enhance quality in the home care health delivery system. It is a practical and relevant guide that can be used by your health team to improve the delivery of health services to clients.

The Quality Resource Kit includes five handbooks that contain quality improvement and risk management tools and resources as well as links to relevant websites. These handbooks can be used to support capacity building, educate your team, and spread and sustain quality improvements.

The *Plan-Do-Study-Act* model for improvement is used throughout the Quality Resource Kit as it is well known, simple and easy to apply. Making change in an episodic way can often be time consuming; however, using the PDSA cycle allows for small changes to be carried out one at a time that can result in big improvements. It is highly effective and applicable to all levels of the home and community care program.

The intent of the Quality Resource Kit is to enhance quality by doing the right thing (getting needed services); at the right time (when services are needed); by the right health care provider in the right way (using the best approach) to achieve best possible results.

The Quality Network will continue to provide support as quality improvement initiatives are implemented in your region and in your community.

As your quality journey begins, the Quality Network hopes that you can work together to improve health outcomes for all clients.

"Quality care is safe and effective home and community care delivered in a respectful client-centered and culturally sensitive manner"

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QUALITY RESOURCE KIT

Introduction to Quality

Handbook 1

Strengthening and Improving Home and Community Care

Canada

Health Canada is the federal department responsible for helping the people of Canada maintain and improve their health. We assess the safety of drugs and many consumer products, help improve the safety of food, and provide information to Canadians to help them make healthy decisions. We provide health services to First Nations people and to Inuit communities. We work with the provinces to ensure our health care system serves the needs of Canadians.

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First Nations and Inuit Home and Community Care (FNIHCC) Quality Resource Kit is available on Internet at the following address: http://www.hc-sc.gc.ca/fniah-spnia/pubs/services/_home-domicile/prog_crit/index-eng.php

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Acronyms

AANDC	Aboriginal Affairs and Northern Development Canada
AFN	Assembly of First Nations
AMT	Aggression Management Training
CHN	Community Health Nurse
e-HRTT	Electronic Human Resource Tracking Tool
e-SDRT	Electronic Service Delivery Reporting Template
FNIH	First Nations and Inuit Health
FNIHCCP	First Nations and Inuit Home and Community Care Program
FMEA	Failure Mode and Effect Analysis
HCA	Health Care Aid/Home Care Attendant
HCC	Home and Community Care
HCCP	Home and Community Care Program
HCN	Home Care Nurse
HR	Human Resources
HSW	Home Support Worker
HV	Home Visits

ITK	Inuit Tapariit Kanatami
LOS	Length of Stay
MOU	Memorandum of Understanding
NIHB	Non-Insured Health Benefits
NP	Not in Place
OHS	Occupational Health and Safety
PCA	Personal Care Assistant
PDSA	Plan-Do-Study-Act
PSW	Personal Support Worker
QA	Quality Assurance
QI	Quality Improvement
QWG	Quality Working Group
RCA	Root Cause Analysis
RHA	Regional Health Authority
RM	Risk Management
RN	Registered Nurse
RMAT	Risk Management Appraisal Tool
VON	Victorian Order of Nurses

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A. About the Quality Resource Kit

Developing the Quality Resource Kit

Established in 1999, the First Nations and Inuit Home and Community Care Program (FNIHCCP) was designed to assist First Nations and Inuit communities to meet the increasing home care demands of community members living with chronic and acute illnesses. In recent years, communities / local Home and Community Care Programs (HCCPs) identified the need for system changes to strengthen and enhance the program, and for guidance and direction in implementing these changes.

In response, a Quality Working Group (QWG) was established in 2006 to develop a process to improve and enhance quality in HCCPs across the country. This group of stakeholders, comprised of First Nation and Inuit community members, regional coordinators, Assembly of First Nations (AFN) and Inuit Tapariit Kanatami (ITK) and representatives from the FNIHCCP National Office, developed a "Roadmap for Quality" that identified three strategic areas of Quality Improvement (QI) within HCCPs:

1. Building Capacity;
2. Communication and Education;
3. Spreading and Sustaining Quality.

That same year, FNIHCCP initiated development of the Quality Resource Kit, in partnership with the QWG (see Appendix A).

The Quality Resource Kit is designed to be a practical, relevant and useful resource for all community-based health care workers. The aim is to support program changes that will improve the quality of care, allow for quicker access to care and enhance its continuity, thereby sustaining and improving client outcomes.

The QI process encourages a collaborative approach and facilitates the exchange of ideas and solutions between community members and health team members. The fundamental belief is that HCCPs will achieve safer and better client health outcomes if the right care is provided by the right provider at the right time, and if clients and care providers are supported in identifying how best to achieve this goal.

Communities are encouraged to use QI activities that are community-based and community-paced. It is anticipated that communities and health team members will share proactively in developing quality improvement strategies and the related successes and challenges that are expected to emerge from this process. Ultimately, a proactive approach in assessing needs and addressing system gaps will positively impact client care and community well-being.

Ongoing learning and sharing of leading practices with other local, regional and national communities is also encouraged. Benchmarking with similar communities is important to collect, learn and assess information. Instead of reinventing the wheel, the HCCP can share tools or applications that could be used to support QI activities. The Quality Resource Kit is therefore intended to help communities meet that objective.

Purpose of the Quality Resource Kit

The *First Nations and Inuit Home and Community Care Quality Resource Kit* (referred to, going forward, as the "Quality Resource Kit") provides details about QI and RM activities that communities can use to strengthen and improve the quality of their HCC program.

The Quality Resource Kit is a tool to be used by the community, groups of communities, tribal councils, Regional and National First Nations organizations and First Nations and Inuit Health (FNIH) zone and regional and national health authorities. (*NB: Due to the wide range of stakeholders who will use the Quality Resource Kit, future reference to the various groups will appear as community/organization. This is an inclusive term referring to all users of the handbooks*).

The Quality Resource Kit addresses the following topics:

- Comprehensive QI and RM theory and concepts;
- A consistent approach to QI and RM;
- Use of QI and RM processes and tools;
- Shared information on QI and RM activities;
- Building a set of common home and community care indicators;
- Linking quality and risk indicators with regional health indicators;
- Collaboration and support for capacity-building;
- Respect for cultural and traditional ways of healing;
- Increasing community ownership of quality improvement;
- Showcasing existing HCCP QI and RM initiatives.

To ensure that the Quality Resource Kit serves as a useful and practical tool for communities/organizations, relevant, real life examples specific to the HCCP are applied throughout. The following case scenarios represent the types of system and program issues encountered in the home care program. This case study is meant to demonstrate the real life issues that require the development of QI and RM processes and activities.

The Quality Resource Kit as a Guide:

- The Quality Resource Kit outlines the steps to assist communities and/or organizations in setting up their QI and RM processes;
- HCCP coordinators, staff, community health nurses and other individuals involved in QI and RM, will find this kit useful. It can be adapted for use in all HCCPs. For example, in larger programs/communities, the leadership may decide to establish a quality team to oversee QI and RM activities. This is an excellent way to ensure that all levels of the program/organization work together to achieve the same goals. In smaller programs/communities, there may only be one individual carrying out QI and RM activities. In this case, it is important that this person can count on support from local community leaders and/or other HCCPs to better achieve Quality Improvement outcomes for individual clients and the community in general.

Case scenario*

The HCCP provides services to a large majority of clients who are elderly and/or disabled. These clients require case management services, nursing and personal care and other supportive services.

After an episodic illness, many of these HCCP clients are discharged from acute care regional health facilities without any formal discharge plan in place.

Clients usually arrive home in the community requiring immediate care and close follow-up. Often there is limited or no information available about the client and their immediate care needs.

*(*This case scenario is an example of a HCCP program and/or system-type situation that the program might encounter. It was written especially for this handbook. It is not about a particular community and/or HCCP).*

Structure and Use of the Quality Resource Kit

The Quality Resource Kit is divided into five handbooks:

- Handbook #1 *Introduction to Quality* provides a general introduction to Quality Improvement, with special attention to the way QI can enhance quality care in the HCCP. The handbook also introduces the Quality Resource Kit's use;
- Handbook #2 *Quality and Quality Improvement: Theory and Tools* focuses on the theory and processes involved in carrying out Quality Improvement. The handbook provides the theory and supporting rationale for QI and its related activities;
- Handbook #3 *Risk and Risk Management: Theory and Tools* focuses on the concepts and practices of Risk Management;
- Handbook #4 *Electronic Resources and References* contains the references and templates used throughout the Quality Resource Kit. The handbook is accompanied by a CD-Rom that contains electronic versions of all the tools and resources useful for Quality Improvement and Risk Management;
- Handbook #5 *Glossary* explains the terms used throughout the Quality Resource Kit.

QI is present to some degree in all programs. This Quality Resource Kit is intended to support communities in formalizing their QI and RM activities. It focuses on using a simple approach to making changes that will improve the delivery of care and services in your community. As such, the Quality Resource Kit will benefit communities that do not have existing QI and RM processes and those that do.

For communities/organizations that do not have QI processes in place, the Quality Resource Kit provides information on how to develop and implement Quality Improvements within HCCPs. For communities/organizations that already have QI processes in place, the Quality Resource Kit is meant to offer additional suggestions and tools to enhance existing QI processes. *Table 1 – Benefits of the Quality Resource Kit* shows how all communities can make use of this tool.

Table 1: Benefits of the Quality Resource Kit

Type of Community	Examples of Benefits of the Quality Resource Kit
Communities that do not have QI and RM processes	• Identify issues of concern and set up a plan to address, monitor and evaluate problem areas; • Learn how to use the PDSA cycle to resolve issues or concerns in their program; • Learn how to use RM tools and processes.
Communities that have existing QI and RM processes	• Enhance QI and RM processes already in place; • Link community specific QI and RM indicators to regional health indicators; • Move the community towards accreditation; • Maintain accreditation.

B. Building a Case for Quality

Quality Improvement (QI) is an ongoing learning process that supports the enhancement of quality in your HCCP. In all cases, Quality Improvement begins with identifying a need for change. Often, improvement occurs as a reaction to a change in the demand for services. In other cases, HCCPs may decide to make improvements to current services. For example, many HCCPs are already involved in revising care procedures to ensure they align with current practice standards or improve staff training.

As HCCPs grow and expand, new opportunities arise to improve service delivery. The model for improvement provided in the Quality Resource Kit enables you to organize, plan, implement and evaluate improvements to your HCCP. While the First Nations and Inuit Home and Community Care Program (FNIHCCP) remains a good foundation for delivering home and community care, the needs of communities, clients and health providers have changed since the program first began.

Today, home and community care is influenced by both internal and external factors, all of which provide opportunities for improvement to HCCPs. The main factors are:

- Increasing complexity of health needs and related care and service requirements;
- Higher rates of chronic illness;
- Aging populations and diminishing informal caregiver support;
- Increasing demand for home and community care/support;
- Increasing difficulty with recruitment and retention;
- Increased emphasis on individual responsibility for self-managed care;
- Earlier discharge from hospital to home;
- Rapid expansion of healthcare and related information management technologies.

What's in it For You, Your Clients and Your Communities?

Improving the quality of HCCP services is advantageous for everyone concerned. For example:

- Clients and families benefit from improved quality of care and services. Strengthening the quality and the continuity of HCCP care can reduce the likelihood of client re-admission to hospitals. Improving how HCCPs deliver chronic care also ensures that clients attain better health outcomes and increase families' abilities to cope.

- HCCP goals and objectives are more likely attained with well-developed quality improvement processes in place. When HCCP and community leaders, staff and other care providers, including clients/families get involved collectively in QI, there's more 'bang for your buck'. Creative juices start to flow as people begin to fix things that have bothered them for some time. Competency and capacity increase. New quality improvement initiatives spring up, and gradually, small and incremental quality changes lead to major improvements and increased efficiency in the way services are provided.

- Within local HCCPs, QI changes are likely to last and spread to other parts of the organization and community. Program staff will be more involved and satisfied with better client outcomes. Absenteeism or turnover rates will likely decline when staff feels more respected and valued as team members.

- Community leaders will be proud that clients, families and community partners recognize that the quality of HCC care has been enhanced under their governance. Furthermore, when external health care providers, such as the local or regional hospital, home care agencies or supportive services see that the HCCP is involved with QI initiatives, the program's credibility will increase.

C. The Quality Framework

A Quality Framework for HCCPs

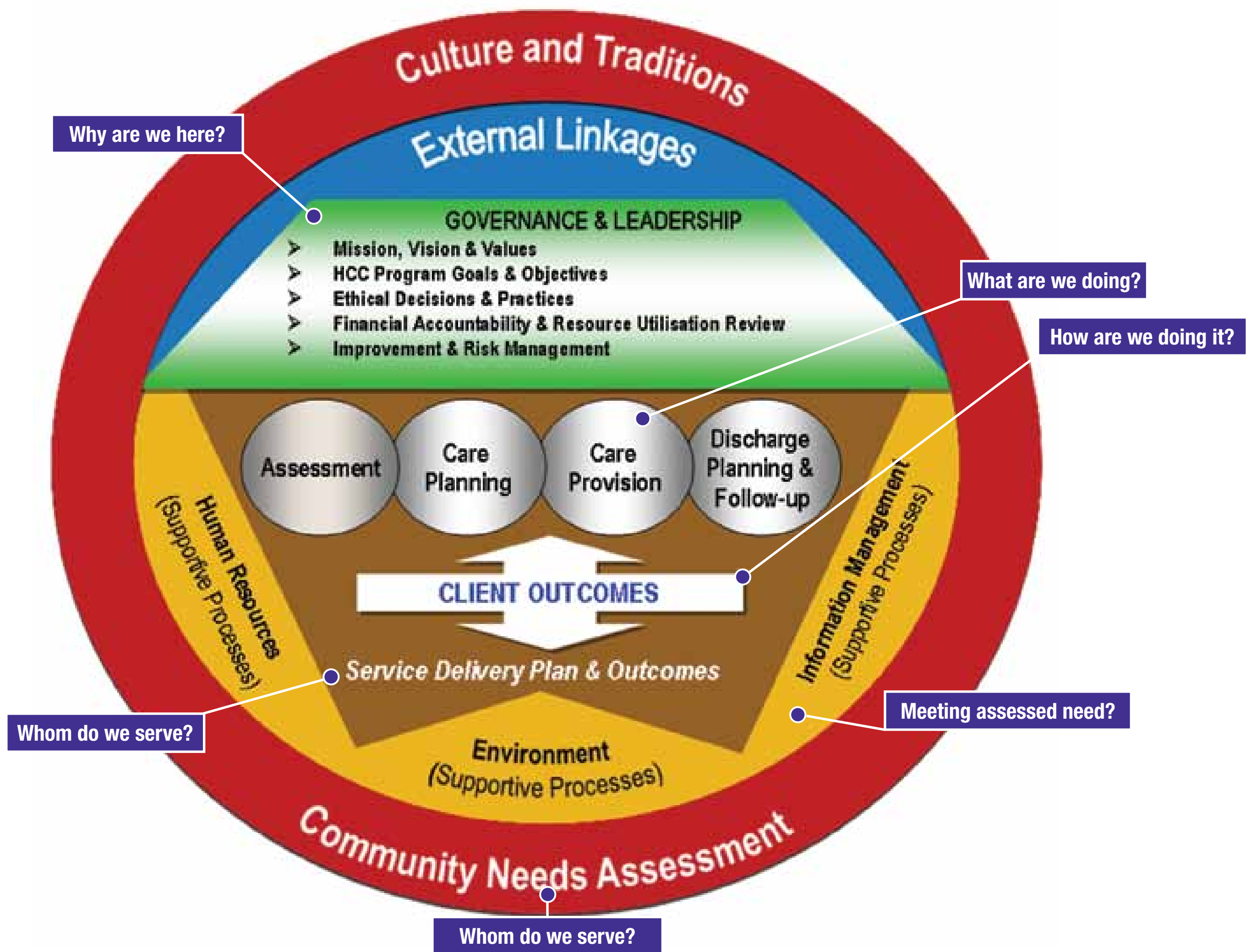
The following Quality Framework (Figure 1) helps to connect HCCP processes, such as leadership, service delivery and support services to essential QI and RM dimensions for better client and service outcomes. It helps you link critical program performance questions (see blue inserts in Figure 2) to program planning efficiently, safely and effectively.

Figure 1: Quality Framework

Key HCCP performance questions:

- Why are we here?
- Whom do we serve?
- What are we doing?
- How are we doing it?
- Are we meeting the assessed needs of those we serve?

Figure 2: Quality Framework and HCCP Performance Questions



A framework provides an essential supporting structure or template to a system, program or activity. The framework represents the template much like the walls and foundation of a building, structure or program. It contains key elements that link (or align) "why are we here?" and "whom do we serve?" with "what are we doing?" and "how are we doing?" to "are we meeting the assessed needs of those we serve?"

Communities are encouraged to adapt the Quality Framework to their setting. The key objective for the Quality Framework is to have a comprehensive and systematic approach that enables HCCPs to:

- Plan services conforming to standards of excellence;
- Effectively deliver care safely, prevent risk and manage incidents;
- Monitor quality indicators to objectively evaluate client and program outcomes;
- Identify opportunities for improvement;
- Link with and benefit from other local, provincial and national Quality and Risk Initiatives.

A quality framework is an integration of the key elements used to plan, deliver, evaluate, improve upon and report HCCP services to better meet the clients' and program outcomes.

Appendix A — Quality Working Group Membership

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QUALITY RESOURCE KIT

Quality and Quality Improvement: Theory and Tools

Handbook 2

Strengthening and Improving Home and Community Care

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A. Defining Quality and Quality Improvement

Quality is the degree of excellence and the extent to which an organization meets the clients' assessed need. Quality is composed of seven interactive dimensions, which will be discussed in greater detail in Section B (below). The following quality vision statement was developed by the Quality Working Group in 2009 for the First Nations and Inuit Home and Community Care Program (FNIHCCP).

Vision Statement

Quality care is safe and effective home and community care delivered in a respectful client-centered and culturally sensitive manner.

Quality Improvement (QI) is a continuous learning process using formal steps to make improvements. Accreditation Canada defines QI as *"...an organizational philosophy that seeks to meet clients' needs and exceed their expectations by using a structured process that selectively identifies and improves all aspects of care and service."*

Some examples of QI activities include: implementing risk-evaluations, training staff on new procedures and standardizing Human Resources (HR) policies. QI will be discussed in more detail in Section D of this handbook.

B. Quality Care for HCCPs

Quality has many different dimensions and each one of us would describe or explain it in different terms. Imagine having eaten at your favourite restaurant, you leave feeling satisfied with the quality of the experience. Thinking about the quality of service, you may consider the friendliness of service as important, while others would consider the taste and the freshness of the food, the timeliness, appeal of the plate, the cleanliness of the restaurant, the décor, or the company whom you shared a meal with as a quality experience. In most cases, it is an appropriately balanced combination of these descriptions that help you define "quality".

In home and community care programs, Quality Care means that care and services are client-centered and that they focus on meeting the *assessed* needs of clients in a way that is consistent with the HCCP's goals and objectives. Quality also means that the family may be an integral part of the client's care plan. That is, program staff do their best to serve the interests of the clients and families, while at the same time taking into account the resources available to do so.

Quality Characteristics for HCCPs

A "quality" HCCP demonstrates seven key characteristics (or "dimensions") in a continuous and well-balanced manner, as represented in the green outer ring of the Quality Circle in Figure 1, below. Each one of these dimensions is part of an ***overall and integrated commitment to quality*** by the **program leaders/coordinators** in collaboration with the **program personnel** with the help of **program supports and processes** for the benefit of the **community** as a whole as well as for those who become home care **clients**.

Figure 1: Quality Circle

Roles and Responsibilities Within the Quality Circle:

Each quadrant within the Quality Circle plays an important role. For example, the role of the **Program Leader** is to encourage, facilitate and guide quality improvement within the HCCP.

Make quality part of everyday activities!

Through the HCCP structure, it is important and necessary for community leadership and the Health Director to clearly demonstrate to all who work or link with the HCCP that the program is committed to delivering safe, quality care.

Creating and supporting a QI team sends a powerful message that the HCCP leadership values the experience and knowledge of its staff; that it intends to provide staff with the flexibility to come up with QI ideas; and to support staff in putting these ideas into practice!

It is inspiring to see Program Leaders actively sending the message that client-centered quality improvement is a priority for their organization. There are many ways for leaders to send this message. Specifically:

- Inviting discussions about quality improvement in a non-blaming manner;
- Including quality and safety in the program's mission statement;
- Including quality and safety follow-ups in regular management meetings;
- Doing quality walkabouts to "catch staff doing things right";
- Encouraging staff and managers to become quality champions;
- Leading a quality and safety study group to prioritize areas for improvement and to minimize risks;
- Rewarding quality initiatives;
- Providing quality improvement and risk management training for staff;
- Encouraging staff, clients and community members to suggest quality improvements.

Example: Building Program Leaders' Support for Quality

HCCP staff identifies that some staff members are being subjected to verbal abuse in the home from family members of a specific client. The HCCP develops a QI plan to address this issue. The plan calls for a meeting between family members, the affected staff and the HCCP Manager to discuss the problem and agree on a solution.

The Chief and Council/Community/Organizational leadership is informed of the issue (not the specifics regarding the client) and the solution proposed to address the issue. A process is set up with the leadership to keep them informed of this and other similar issues. The organization adopts a No-Tolerance of Violence policy and makes it known to all clients and community partners.

Within the Quality Circle, program staff also forms a QI team to identify and manage quality issues. When staff is actively involved in this process, they can often identify the issues and recognize and find solutions to fix unsafe practices. A QI team approach should include anyone involved in the key aspects of care or service being addressed. For example: managers, program coordinators, supervisors, nurses-in-charge and other staff with day-to-day responsibility for service delivery, as well as external care partners, volunteers and staff from support services.

Example: Building a Team Approach to Quality Improvement

A staff member approaches the supervisor with a problem that she has identified. The supervisor suggests that she bring it up at the regular staff meeting. The staff member describes the problem and/or issue to other staff members at the meeting. Together, the staff members discuss possible solutions for the issue and come up with a plan to try one of the solutions and identify ways to measure if improvement occurs.

Service delivery supports and processes help to ensure integration of the four quadrants of the Quality Circle. They include the many functions required by the HCCP to meet client needs; to ensure the effective delivery of care and services; and to achieve the goals of the HCCP. These functions include clerical activities, environmental and structural management of HCCP installations, management of equipment and supplies, human resources planning and management and information management. Some suggestions to consider as quality enhancements to the supports and processes for your HCCP, may include making "Quality" part of everyday activities by:

- Talking with staff about quality and risk from an organization perspective;
- Making quality a standard item on staff meeting agendas;
- Including QI in orientation of new staff and in ongoing training and professional development activities;
- Building in time for regular discussions about ways to improve the quality of services and to better manage risk; and customizing reporting forms to include measurements of the changes implemented (QI indicators);
- Creating Quality Bulletins and sharing in lessons learned.

Community members and home care **clients** are not only partners in care; they are also partners in quality. Involving community members and organizations with whom the HCCP has developed service partnerships, brings added perspective to QI in your HCCP. Through their eyes they help you to see from the outside in. Their collaboration in QI will help you to focus on clients as part of a larger community.

Delivering client-centered care may also mean having clients and their families as partners. When you identify and carry out improvements that affect direct care, it is important to understand all of your clients' assessed needs and whether you can meet them. It is also important to involve clients and families when you are testing and implementing changes.

In conclusion, remember that all the components in the Quality Circle interact with one another to ensure the delivery of safe, effective client-centered care. Overall we see that a quality HCCP provides care and services that are appropriate and ***accessible*** at the right time and in the right place, provided by the right health care provider to meet the clients' assessed needs. When you start a QI activity, it is essential to have a good idea of the needs of the clients. These same services are also ***client-centered*** in that they respect the clients' needs and wishes while at the same time being ***effective*** in obtaining the best possible results through ***efficient*** use of available resources. And finally, care and services are provided in a ***safe*** and ***timely*** manner. Table 1 shows the dimensions of quality with applicable examples of how quality is reflected in a Home and Community Care Program.

Table 1: Quality Characteristics

Dimensions of Quality	Examples of Quality
1. ***Accessibility:*** Clients receive services in a timely and appropriate setting.	• The HCCP develops appropriate links and partnerships to ensure the provision of timely services. Clients are referred to the HCCP with sufficient information to ensure an appropriate care plan. The Case Manager sets up a formal linkage with the regional hospital to facilitate an effective discharge planning process.
2. ***Appropriateness:*** Services meet the assessed needs of clients. Care givers provide care to meet the needs in the care plan.	• Due to an amputation, a client has reduced mobility: The home care program has a process in place for care providers to order and arrange for support bars or raised toilet seats to be installed for clients who require them.
3. ***Client-Centeredness:*** Care that respects the client's needs and wishes.	• The HCCP best practice standard stipulates that Client Care Plans be developed in consultation with the client and family. All HCCP clients play an active role in their own care and are satisfied with the care and service.
4. ***Effectiveness:*** Using available resources to achieve the best possible results.	• The program constantly reviews the use of available resources and related outcomes of care. An assessment review 4-6 weeks after service begins ensures that the homecare services being delivered are appropriate and still meet the client's needs.
5. ***Efficiency:*** Making the best use of resources to achieve positive health outcomes.	• The HCCP establishes a care plan and efficiently uses resources by ensuring that the right care is provided by the most appropriate provider. RNs are assigned to provide case management and nursing care for clients and Personal Support Workers (PSWs) provide personal one-to-one care for the client (see Table 2).

Dimensions of Quality	Examples of Quality
6. ***Safety:*** Safe provision of care and service minimizes risk and achieves the intended results for clients and the HCCP.	• As a result of an amputation, a disabled and/or elderly client is at an increased risk for falls. The program implements a falls assessment form to assess risk of falls for clients on admission to the program.
7. ***Timeliness:*** Providing services in a timely manner.	• HCCP Clients receive services in a timely manner. The program standard is for all new referrals to receive an initial nursing assessment within 48 hours. The length of time from the referral date to the RN's first contact and assessment is tracked.

The Six Rights of Quality Care for HCCPs

Another way to think of quality in HCCPs in terms of the six rights. These are:

Right care — Care provided is based upon assessed need and upon current standards of excellence; client safety goals are identified and met;

Right Care Provider — The care provider is competent and proficient;

Right Client — The client may be the individual, the family and/or the community;

Right Time and Place — Services are delivered in the most appropriate and safe time and place;

Right Outcomes — Intended outcomes, based upon clients' optimal health status and assessed need are achieved; unintended outcomes are minimized; clients/families are satisfied with care;

Right Staffing and Support — Staffing adequately to meet the assessed need of clients; HCCP personnel are well supported by the application of current standards of excellence in human resource and workplace health and safety; staff is satisfied.

Table 2 (next page) illustrates the Six Rights in various aspects of HCCP care and service delivery.

Table 2: The Six Rights of a Quality HCCP

Program Services, Activities and Processes	Most Appropriate Provider(s)
Initial assessment and development of nursing care plan within 48 hours of referral. **(Right Care)**	• Case Manager/Home Care Nurse • Client and immediate family members **(Right Client)**
Providing the necessary nursing care and/ or personal care, such as regular dressing changes, medication administering/ monitoring of the client, assistance with activities of daily living. **(Right Care)**	• Home Care Nurse **(Right Care Provider***)* • Personal Care Worker • Primary Care Nurse (after hours and on-weekends) **(Right time and place)**
Ongoing management and care with periodic RN re-assessment at regularly scheduled time periods. Providing the right types of supportive care and inter-program referrals**.** (**Right Care***)*	• Home Care Nurse • Community Elder/Traditional Healer • Mental Health/Addictions Worker • Community Physician (**Right staffing and support**)
Providing the required in home support services, such as assisting with homemaking and meal preparation. *(***Right Care**)	• Home Support Worker • Family • Community Volunteers *(***Right Care Provider**)
Program is successful in helping clients cope with the impact of their illness on daily living activities. **(Right outcomes)**	• Home Care Nurse • Mental Health Worker *(***Right Care Provider**)

The following case scenario can be used to understand the application of the quality dimensions and the Six Rights to an actual client situation. Table 3 provides examples of how each of the dimensions can be applied to a specific client, staff and program to ensure quality care is delivered in the HCCP.

Case Scenario

While providing care to her client, Mr. John, the Home Care Worker (HCC) notices that he has several bruises on his arm. Upon talking with Mr John, he tells her that he has fallen twice while getting out of the tub. The HCC worker relates the information to her nursing supervisor and charts what she has learned in his file. Together they discuss the next steps, which include a home visit to Mr. John and subsequent changes in the care plan.

Table 3: Application of the Quality Dimensions to Mr. John's case

Quality Dimensions	Definition	Examples of Areas to Improve/Enhance
Safety	Safe provision of care and service minimizes risk and supports the intended results to clients, care provider and the HCC program.	**Client:** • Changes to Mr. John's bathroom reduce the risk of falls; rugs are removed; a lift is provided to help the family with his care; hallway and stairwell lighting is improved and Mr. John is provided with skid-free socks and a tripod cane. **HCC Care Provider:** • A home safety assessment and falls prevention checklist are completed for Mr. John. • Mr. John's care plan is altered to reflect the results of his fall risk assessment and to minimize his risk for falls. **Program:** • A policy is developed to ensure that all HCC clients have a risk-for-falls assessment upon admission to the program and whenever an important change in health status is noted. Pertinent HCC program personnel are trained to carry out risk assessments and a process is put in place to track outcomes at the program level. • Home safety assessments, including falls prevention checklists are completed upon admission to the home care program and reassessed in 4-6 months.

Quality Dimensions	Definition	Examples of Areas to Improve/Enhance
Appropriateness	Services meet the assessed needs of clients. Care givers provide care to meet the needs in the care plan.	**Client:** • Mr. John's care plan is adjusted to reflect assessed changes in his status. **HCC Care Provider:** • The schedule of Mr. John's care provider is adapted to allow more time with Mr. John and his family to help them understand the risk for falls and to put in place various preventive mechanisms. **Program:** • The HCC program Nursing Supervisor conducts an overall assessment of other vulnerable clients in the program.
Efficiency	Making the best use of resources to achieve positive health outcomes.	**Client:** • Mr. John is advised not to buy new rugs to replace those that are worn out. **HCC Care Provider:** • The training session on bathing for care providers is expanded to include training on risk assessment, thus minimizing staff replacement and travel costs for a separate training session on falls prevention. **Program:** • The Nursing Supervisor develops a train-the-trainer session for on-site trainers for falls assessment for smaller programs, thus reducing travel expenses for a single trainer.

Quality Dimensions	Definition	Examples of Areas to Improve/Enhance
Effectiveness	Using available resources to achieve the best possible results.	**Client:** • Mr. John and his family are aware of the risks in the home; they agree to have support bars installed in key areas (the bathroom, and near the front steps) and to remove scatter rugs. **HCC Care Provider:** • The HCC provider demonstrates skill in risk assessment; uses equipment for Mr. John to better support him and his family; and provides the necessary care in a safe manner. **Program:** • A process is developed to ensure that equipment is available as needed; an equipment maintenance schedule is also implemented.
Accessibility	Clients receive services in a timely and appropriate setting.	**Client:** • Services are provided in Mr. John's home; a simple pamphlet is provided to Mr. John and his family as a reminder about falls prevention. **HCC Care Provider:** • Care plan is altered to reflect change in care. **Program:** • Equipment is provided through Non-Insured Health Benefits.

Quality Dimensions	Definition	Examples of Areas to Improve/Enhance
Timeliness	Providing services in a timely manner.	**Client:** • Mr. John's home visits are re-scheduled for early afternoon to allow his family to assist in a demonstration by the care provider on how to use the lift for bathing. **HCC Care Provider:** • Changes in Mr. John's health status lead to changes in his care plan within 48 hrs. **Program:** • Policy for Home Safety Assessment.
Client-Centeredness; Cultural Holism	Care that is respectful of client's and family's choices, values and traditional practices.	**Client:** • Mr. John and his family are involved in the decision regarding changes to care plan. **HCC Care Provider:** • The Care provider respects Mr. John's right to refuse to wear the skid-free socks after clearly explaining the possible consequences to him and his family. **Program:** • HCC Program develops and implements a *Client Rights and Responsibility Policy.*

C. The Quality Improvement approach Using the PDSA Cycle

This section of the Quality Resource Kit specifically addresses the Quality Improvement approach. Here, you will learn how to choose a QI team and how to make a QI Plan. Specific quality improvement tools are also discussed. Before we begin, the PDSA Cycle is briefly defined.

All changes do not lead to improvement, but all improvement requires change.

(Langley, G. et al, 2009)

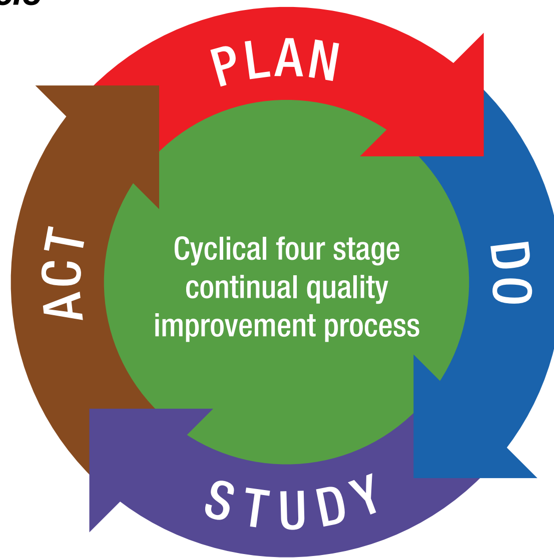
What is a PDSA Cycle?

The Plan-Do-Study-Act Cycle, also known as PDSA Cycle or Deming Cycle, as shown in Figures 2 and 3 (next page) is a simple problem-solving approach that anyone can use to improve quality. One person can use the model to lead a QI process or groups can use it to work together to make improvements.

PDSA cycles promote action-oriented learning. The PDSA Cycle is a trial and learning model for quality improvement in the form of a cyclical four-stage process. It allows changes to be tested and implemented in real work settings.

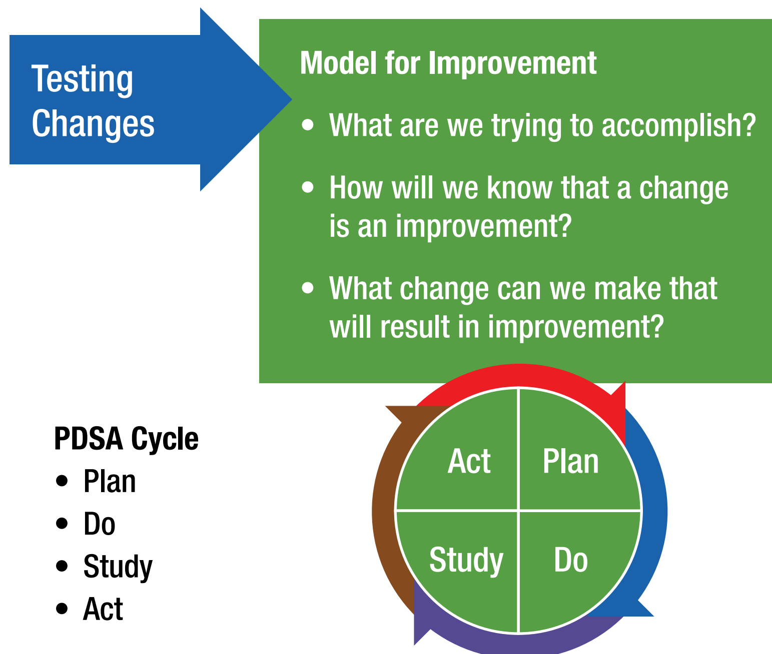
If Quality Improvement is considered as a continuous, collaborative learning process using formal “steps to make improvements”, then the PDSA Cycle can be considered as the actual steps. A PDSA cycle is a way to identify areas for improvement, to plan for and test a change destined to be an improvement and then to evaluate the outcome of the test before doing the change on a larger scale. In this way, small-scale changes can be developed, tested and implemented over time to generate continuous improvement through successive PDSA cycles.

Figure 2: PDSA Cycle



Not all change requires months to happen. It begins by making a small change over a few days and/or weeks and uses the PDSA cycle to make the change. A good starting point might be to use the PDSA cycle to change a process for a few clients and then apply the successful changes to larger groups of clients. The idea is to make small changes first to test your plan.

Figure 3: Testing Changes with PDSA



Quality Improvement: The Approach and the Steps

The Approach

A HCCP that wants to make changes to improve services to clients needs two things: a model to guide the QI process and an individual and/or team to implement the model. The basis for the QI approach in the *Quality Resource Kit* is the Model of Improvement, introduced by Nolan and Langley (1996). The Model presents a process (set of steps) for implementing quality improvement changes.

Some of you may recognize the four (4) steps to Quality Improvement (below) as the nursing process because they are built upon the same premise of assessing, planning, implementing the plan and evaluating the plan's results. The difference is that while the Nursing care plan addresses the care needs of a single client, the Quality Improvement Plan addresses the quality improvement needs of the care and service delivery systems in the HCCP for the benefit of all clients.

Using such a **standardized QI approach** has three advantages. Firstly, a standard QI approach makes it possible for all key stakeholders to participate in and follow the process. Secondly, it allows you to identify, plan and carry out successive improvements. And thirdly, a standard QI approach helps you to measure client and program outcomes, thus allowing your HCCP services to be compared objectively with similar ones in other communities.

The Four Steps to Quality Improvement: How to Do It!

The four steps to QI are:

- Build a commitment to quality across the HCCP;
- Create a QI team by involving the appropriate people;
- Develop a QI plan using the ***PDSA Cycle*** to implement changes;
- Share the results of the QI activities.

See also Table 4: The Quality Improvement Approach: An Overview.

1. **Build a Commitment to Quality Across the HCCP.**

Quality is everyone's responsibility; it takes a team effort. Involving all HCCP staff in QI processes will help build the commitment needed to make the necessary changes. Everyone involved in the HCCP, whether in a front-line or leadership role, must clearly understand how and why QI benefits clients, staff and the program, in general.

If we keep doing what we have been doing, we will keep getting what we have been getting. To get something better, we have to start doing something different!

Everyone does not have to be on the actual QI Team and not everyone has to be involved in the same way. However, everyone needs to understand what QI is about and what the QI Team plans to do to improve quality. Be sure to include team members that are able to overcome barriers in your HCCP system and those who have technical expertise with the QI problems you wish to address. Include others who can be day-to-day quality champions to help keep the momentum going.

The commitment of **front-line staff** is essential if QI is to be successful. Front-line staff is directly involved in the delivery of client services and is therefore best placed to see what the quality of those services looks like in real life. They know if their clients are getting better or getting worse; they worry about clients at risk and about families trying to cope. Most have good ideas about how to make services better.

Through the HCCP governance structure, it is important that community leadership and the Health Director demonstrate to all who work or link with the HCCP that it is committed to delivering safe, quality care. The support of HCC **program leaders** is also essential to successful QI implementation. Community and program leaders should set the tone and be actively involved in the process to encourage and support front-line staff. Furthermore, since QI is important at the community, regional and national levels of the HCCP, leaders also need to promote sharing between communities and encourage communities that are uncertain about participating to become interested and involved in enhancing their HCCP. It is also important to involve community partners and other care providers in the QI processes.

2. **Create a QI Team by Involving the Appropriate People**

The QI Team's **purpose** is to develop, carry out and sustain QI initiatives in the HCCP. In the same way that a team approach is beneficial for clients, a team approach to quality improvement ensures that all those concerned with quality issues around care and services are included in the improvement process to different degrees. As they share their perspectives in QI issues, QI team members work together to generate new ideas and plans, to learn new approaches and to gradually make positive changes for the greater benefit of the whole HCC program.

The **composition** of the QI Team is important. Having the right people on the team is the key to QI success!

First, the Team should have a **leader** (or a pair of leaders) familiar with QI well-organized to lead others on the QI journey, and respected by other team members as a credible resource. The Team leader(s) sets the vision, the pace and the structure of the QI work, always acting as a visible champion of the process.

Team **members** may come from all areas of the HCCP. Anyone involved with giving the best care possible is a potential QI Team member, including current and former clients, family, front-line staff, management staff, volunteers, community leaders, etc. Team members also need to be familiar with QI concepts and tools before beginning actual QI work, where each team member is assigned specific responsibilities. Some larger HCC programs have full QI teams, while smaller programs may only have one or two people assuming the QI Lead. (For smaller programs, you may wish to have certain team members who assist participate via teleconference).

Think about what kinds of know-how the team needs. For example, if you are working with clients with amputations, you may need a physiotherapist, occupational therapist or someone who specializes in mobility management on your QI team. As communities may not have all these types of personnel on site, members may join the team by teleconference when needed.

Either way, put together the QI Team that best suits your program and community needs by referring to the following elements:

- Who in your HCCP and community is knowledgeable about QI issues?;
- The optimal QI Team size for your HCCP and the community you serve;
- The ability of team members to work together effectively;
- The issues and challenges faced by your community;
- The scope (number of people affected) and complexity of the issues;
- The information available or not available for the issues.

A list of possible QI team members suitable for the case study can be found in the *Additional Resources* section of this booklet (see Appendix A).

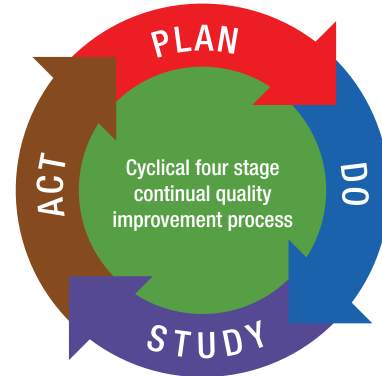
Each QI Team lays out its own ground rules (i.e., dates, times, places and rules for meetings). One excellent way to help the QI Team come together in a common understanding of its role is to develop a *Terms of Reference* document, which sets out:

- The purpose and structure of the QI Team;
- How the scope of the QI work will be defined, developed and validated;
- A formal process for making future decisions;
- A road map for doing the QI work, including what needs to be achieved by whom and when (e.g., a team lead is the person who arranges the meetings, updates and is responsible for data collection); and assigning specific roles (e.g., chair, timekeeper and note taker);
- The ground rules for the team's work (e.g., everyone has an equal voice; meetings start and end on time).

A template for preparing a *Terms of Reference* can be found in the *Additional Resources* section of this handbook (see Appendix B).

3. **Develop a QI Plan Using the PDSA Cycles**

Note: This third step can be broken down into the PDSA Cycle as follows:
(See also Main Actions).



Plan: Decide on what QI priorities to address and what changes to make;

Do: Test the changes on a smaller scale to see if they work;

Study: Analyze the results of the test to see if the change improved quality;

Act: Implement the change on a larger scale and monitor the results.

Main Actions in Each Phase of the PDSA Cycle	
Plan • Assemble the team; • Develop plan (4 w's: who, what, where, when and how); • Collect the data to predict which change will improve the process; • Decide on a small step to start with.	**Do** • Carry out the plan by testing on a smaller scale; • Collect data to evaluate the results, including expected and unexpected observations; identify the trends.
Study • Data Analysis; • Compare results to predictions; • Summarize outcomes.	**Act** • Adopt the change as is; • Adapt — make modifications to the change you tested; • Abandon the change if it did not produce the desired results — not working; • Determine next strategy or next cycle.

a) Deciding on what priorities to address (Plan)

> *Avoid doing too much "fire-fighting", especially at the beginning.*

How do we identify what our QI issues are? It may be tempting for your team to jump right into choosing fixes for the most obvious problems affecting your clients. However, this jump-start could lock you into working on issues that aren't the real priorities, or that may not have the best chance of success. Take your time when deciding on what QI activities to address; look before you leap!

When choosing a quality improvement issue, consider how fixing it will improve the quality of services delivered to your clients. You will generally find your program's priority QI opportunities by looking closely at the processes used to deliver care and services. A good way to begin is to invite your work group to brainstorm what works well in the program (i.e., clients are satisfied with the timeliness of personal care services) and what doesn't work; for example, your program has frequent equipment breakdowns. You can also do some research (e.g., study patterns of service delivery that create problems for clients and families) to help you decide which issue(s) to tackle first. You may also want to collect some data (just a bit) to check your hunches. To do this, collect current information and past history to compare trends over time.

Look more closely at your HCCP delivery system. You need to be familiar with and understand every part of it — what happens and why? Here are some sample broad questions for you and your team to ask:

- What does our HCCP do well (for clients, for the community, for staff)?
- What challenges affect our ability to achieve program goals?
- How well do we manage these challenges?
- What process do we use to solve unavoidable issues (e.g., care giver absence) and unsafe situations (i.e. identification of aggressive clients)?
- Who else is helping us to solve the daily challenges that we and our clients face?

Example

Service Delivery/Medication Usage — Best medication administration practices require that medication be reconciled on admission to the program. This involves checking the medications (right medication, right dosage, right times and right administration route) that the client brings into the program, with those prescribed on discharge from the hospital. This will ensure consistency according to the client's condition.

In completing a quality and safety review of your HCCP, you determine that this process is Not in Place (NP). If this is the case, then the probability is high that a client with newly-diagnosed diabetes who requires insulin and who is not experienced in managing his disease will be at risk. Should that risk materialize, the severity of harm will also be high, perhaps even resulting in coma or death (a sentinel event). This also puts the HCCP at significant risk for ensuring safe care to other types of clients.

A good tool to get you started in assessing your HCCP delivery system is the *FNIHCC Program Quality and Safety Scan* found in Handbook # 4. Many of you are already familiar with the Risk Management Appraisal Tool (RMAT) organized around the following nine essential elements of the HCCP:

- Client assessment;
- Case management;
- Home care nursing services;
- Home support services: personal care and home management;
- In-home respite care;
- Access to medical supplies and equipment;
- Information and data collection;
- Management and supervision;
- Linkages with other services.

The *FNIHCC Program Quality and Safety Scan* in the Electronic Resources and References Handbook # 4 is a quality improvement and risk management tool, organized according to the Quality Framework introduced in Handbook # 1. The Scan combines the nine core elements and activities from the RMAT with key elements of quality improvement integrated from the Accreditation Canada Qmentum program to help you do a more thorough scan.

Like the RMAT, which is also referenced in Handbook # 4, the *FHIHCC Quality and Safety Scan* is a checklist tool that supports a systematic risk assessment of your current HCCP processes, using the key program components as outlined in the Quality Framework. Each of these key components is further broken down into the core activities required within that component.

Activities are assessed according to the legend below to help you identify if a service/activity is being delivered completely and safely. Any activities that are not rated as **PE** require a risk assessment. This can be done by assigning a weighting to its probability to cause risk if the activity is not put in place, and determining the severity of potential program risk if it is not done.

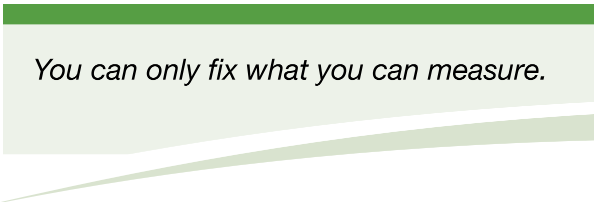
- **PE** Process established and working effectively.
- **PX** Process in place but needs enhancement.
- **PD** Process in development, but not in place.
- **NP** Process not in place.

Which QI issue is the most important for us to start with? Once you and your QI team have identified several priorities using the Quality and Safety Scan, pick one priority to begin with**.** It is suggested that the QI Team look at each one individually and try to identify specifically:

- *Set short term goals*
- *Look for "easy wins"*
- *"Where can we get good results fast?"*
- *"What can we do by next Tuesday?"*
- *Keep it simple. Get it started.*

- What is the problem?
  - How do we know that it is a problem?
  - How often is it happening (frequency)?
  - How long has it been going on?
  - Is it a high or low urgency problem?
  - Who identifies it as a problem?
- What effect is this problem having on our clients, our staff, our program and/or our community?
  - Does it put clients/staff at high or low risk?
  - Does it generate high or low cost to fix?
- Is there potential area for improvement?
  - Consistent with providing care and essential services elements, goals/objectives, core functions and strategic directions of your HCCP;
  - An opportunity that relates to your community's health needs;
  - A recommendation from other reports and operational reviews.

- *Does our client and program data, including any research and best practices we may use give us information about QI opportunities or back us up in terms of QI opportunities we've spotted?* Various sources of data may include:
  - Accident and incident reports;
  - Feedback from clients and families, community members and/or other care providers, and HCCP staff;
  - Program and client assessment data:
    - ESDRT EHRTT data;
    - Chart reviews;
    - Client assessments;
    - Epidemiological data about the population your HCCP serves (e.g., types of chronic diseases, total persons living with diabetes on reserve, etc.).



b) Deciding what changes to make and how to make them (Plan)

How do we decide which change to test? Once your QI Team has decided what QI priority to work on first, you need to decide what changes will actually fix the problem. Be inspired by demonstrated best practices when choosing the change**.** Study data collected under different conditions and study different effects on the system to see how the intended change may impact on your particular HCCP. (See also *Addendum 1: Analyzing Data and Interpreting Results* for help at this stage).

Choose an issue that is within your control, at least to begin with. For example, you may not be able to change the amount of funding your program receives, but you can change the information your clients get, or improve on the way resources are allocated within your limited budget.

Also, try to pick an issue that is in line with the priorities for your program. Issues that reduce error or waste, that save time, or the way work is done (work flow), are usually easily identified by program staff. (Think about the number of times you may have said: "*I hate when that happens*!")

Remember that some issues need to be taken care of right away, but others are not so urgent. Try to pick the issue that combines the most gain for your program with the greatest degree of comfort for the QI Team when starting out.

Start with issues that you know well, that are within your control (e.g., record keeping) and where staff are ready to make improvements.

***How do we plan to make the change*?** Once you have chosen the desired change, make your plan. Make sure that your change goal is specific and that your plan is clear.

Be specific about the time frame, the (measurable) improvements you want to achieve; the client population or process targeted, what personnel to involve, what approaches to use and how to evaluate the outcomes.

Set goals that are meaningful (e.g., reducing falls among all frail elderly adult clients in their home).

For example, your QI team reads that faster follow-up by home care personnel increases longer-term client compliance with diet and medication regimes in newly-diagnosed diabetics recently discharged from hospital. Based on this and previous problems identified with client compliance, the QI Team decides to reduce the delay time from referral to the HCCP to the first contact by the HCCP nurse, to 8 hours (instead of the current 2-day delay). This will happen over the next 6 months for all new clients with diabetes.

All RNs will be involved in this process, which will include telephone contact with the client before discharge from the local hospital, a teaching package and linking the client to a network of diabetics in his community for peer support. A client-family interview will be done at 3 months to evaluate satisfaction with the process, and program data on client compliance will be tracked over time to see if the changes have the desired effect. Partnering with other QI initiatives and/or local health authorities who have well established QI programs will provide additional resources to support your HCCP.

c) Testing the changes on a smaller scale to see if they work (Do)

Testing the changes on a smaller scale is a powerful learning tool to help you see what works and what doesn't. Obviously, testing is also less disruptive for clients and program staff than full-scale change, while allowing the QI Team to better predict the results *and to avoid an embarrassing "Oops"!* In this way, testing helps to build support, minimize resistance and adapt the change to local conditions in your HCCP.

Testing is easier if you involve committed team members**.** Also**,** try to get advice from those with experience beforehand. Test the change on a small scale first with one team, one provider, one small group of clients, etc. Do this over a short period of time, preferably side-by-side with the existing system to illustrate improvements. Developing a plan to simulate the change is also a good idea, if possible.

Finally, let everyone know you are ready to reassess the plan. Remember, it is meant to be questioned; that is exactly how change starts!

For example**,** the QI Team decides to test the implementation of standardized risk evaluations for all (100%) new clients.

The QI plan states that the evaluations will be carried out by two designated RNs for a 3-month period using a revised Risk Evaluation Tool. To save time and to ensure continual monitoring of this tool after the test period, the Team wisely integrates indicators into the tool itself as part of a continuous quality improvement strategy (i.e., degree of risk and time required to carry out the evaluation). The plan also includes immediate flagging of high-risk cases to the on-call RN and compiling of the two indicators by the receptionist for follow-up at weekly team meetings. Additionally, monthly follow-ups by the program manager will compare the test results with incidence of aggression-related incidents reported by staff.

d) From here: analyzing the results of the test (Study)

> *Pay attention to test results! What works … and what doesn't.*

Analyzing the results of the test will determine if the QI process effectively meets the goals of enhancing quality within the HCC program. There are several ways to evaluate the results of the test, such as: surveys, telephone, or one-to-one interviews with the people involved and review of various QI charts and data tables, as previously discussed. See also the *Addendum on Interpreting and Presenting QI Data* for help in this area.

Remember that any QI process takes time to reach its full potential. Do an evaluation when you and your staff have been carrying out the QI process consistently for a pre-determined period of time. When you do evaluate your QI process, it's important to look at the effectiveness of:

- The action you took to improve quality (Did it work?);
- Staff understanding/knowledge of the QI process;
- The QI team functioning;
- Time management;
- Data collection and analysis; Sharing the information between team members and other key stakeholders.

The QI team (where a team is in place), or the person who is responsible in your HCCP for leading the QI process, should do the evaluation. They are in the best position to readily measure how well the QI process has functioned. The evaluation will help the Team decide if the QI change should be adopted, adapted or abandoned and replaced by another.

In all these cases, the QI team will have learned something important about how to improve the quality of processes in the HCCP. They may also find that there is a need for more education, better communication and/or more systematic support to encourage all health care providers to be involved in QI activities.

For example, to continue with the Risk Assessment case after the first month preliminary data indicate that the time required to complete risk assessments with new clients during the test is acceptable (10 minutes). Another advantage is that staff appreciates having rapid and clear information about high-risk clients, however it is determined that the HCCP leadership group is receiving complaints from the community about this process. Consequently, the group questions the validity of pursuing this practice and asks for a better understanding of the potential impacts of keeping it as a permanent QI tool.

The QI Team then prepares a brief, factual presentation to this effect and succeeds in convincing the leadership to support Risk Assessments as a permanent practice. In the process, the QI Team learns a valuable lesson about the importance of testing to evaluate all potential impacts of changes from a systems perspective and about the absolute necessity of leadership support for QI.

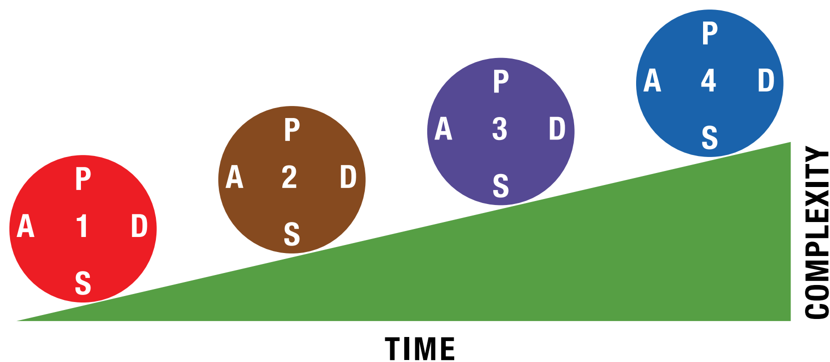
e) Implement the desired changes on a larger scale and continue to monitor results (Act)

Implement only when you know the change works!! Once you have decided that the change you tested improved quality in the way you thought it would, it is time to extend the change across your HCCP. The QI Team will need to prepare others for the change by outlining the plan (in the same way as they did for the test). Perhaps training will be necessary where staff need to learn new skills. Some roles may need to change to cut out wasted steps. Or, perhaps some new tools need to be built to help staff implement the change in a consistent manner across various sites of your HCCP. Last but not least, the QI Team should ensure that results continue to be monitored. QI only works if you keep at it!

Linking small tests of change helps to overcome resistance to change. Small changes can be successively combined over a period of time. Figure 4 shows that the completion of one turn of the PDSA cycle flows into the beginning of the next. At each successive change cycle, the process is reanalyzed and a new test of change begins.

How do you eat an elephant?
One bite at a time!

Figure 4: Linking PDSA Cycles



* *Langley et al, 1996*

Monitoring the results of the changes is always an essential step in QI even when the change is permanent. The process is similar to the one used for the test analysis. See also the *Addendum on Analyzing Data and Interpreting Results* for further information.

4. **Share the Results**

Share the results of the QI activities with everyone in the program, including clients, staff, volunteers, community and other key stakeholders, such as community partners, other care providers, etc. Sharing ensures that commitment to quality and QI learning continues to develop across your HCCP.

Table 4 (below) provides a snapshot view of the QI Approach, including the application of the PDSA cycle.

Table 4: The Quality Improvement Approach: An Overview

Steps to Quality Improvement	Actions
1. Build a commitment to Quality across the HCCP.	• Advertise the new QI Team to all internal and external partners; • Revise the strategic plan to include quality and safety targets; • Plan monthly walk-about/or open meetings with clients/staff to discuss QI initiatives.
2. Create a QI team by involving the appropriate people.	• Determine membership from all levels of the HCC Program; • Recruit HCCP staff, clients, volunteers, community partners and other care providers; • Train team members in QI; • Develop Terms of Reference for QI Team; • Determine meeting dates and role of team members.

Steps to Quality Improvement	Actions	
3. Develop a QI plan using the PDSA Cycle.	a. Decide on what priorities to address. (Plan)	• Brainstorm with QI team to identify QI concerns; • Review accident/incident reports for past year; • Review client/family complaints for past year; • Review new care guidelines for key areas; • Ask Program staff for QI suggestions.
	b. Decide what changes to make and how to make them. (Plan)	• Brainstorm to determine if the intended change is aligned with HCCP objectives, something within your control, supported by best practices, a high risk or problem-prone area, etc.; • Plan the specific change in the QI Team: determine numerical goal, time frame, personnel involved, approaches and indicators to be used.
	c. Test the changes on a smaller scale to see if they work. (Do)	• Determine the time frame for the test and who will do it; • Determine to what situation or group of clients the test will apply; • Decide what indicators* to monitor to see if the intended changes improve quality.

Steps to Quality Improvement	Actions	
	d. Analyze the results of the test. (Study)	• Monitor the test and document both expected and unexpected outcomes; Develop surveys or QI interview with test subjects to gather qualitative feedback; • Track indicator data QI charts; • Compare your results with those of other HCCPs and with current Best Practices; Adopt (as is) or adapt (modify) and extend the change across the HCCP ***or*** abort the change and replace with more appropriate change.
	e. Implement the desired changes on larger scale. (Act)	• Plan the change (same as the small PDSA cycle); • Do training, tool revision, etc, if necessary.
	f. Monitor the changes using indicators.* (Act-Plan)	• Same as PDSA.
4. Share the results of the QI activities with everyone in the program.	Discuss at staff meetings; Develop a QI newsletter and send to clients, staff, volunteers, community partners, other care providers, etc.).	

(*signs or signals that indicate whether or not the changes have been successful)

The following excerpts are examples that illustrate the application of the PDSA cycle in the HCCP.

Example of using the PDSA cycle to address the issue of client falls in the home:

- HCCP staff noted an increase in the number of falls in the home among elderly people;
- The program implemented a QI plan. They reviewed the data to determine the cause of the falls and noticed that several resulted from clients tripping over scatter rugs and other obstacles in the home;
- Staff implemented a home safety checklist, including a falls risk section. They worked with the clients and their families to remove scatter rugs and other obstacles from the homes. Then they tracked the number of falls among their elderly clients over a three-month period;

The result? There were fewer falls. This was a successful QI plan and process. Following this success, the program implemented a second QI plan — they created a Home Safety Checklist. Staff uses the checklist to assess all elderly clients on admission to the program.

Example of Using the PDSA cycle to achieve improved client outcomes (decrease in amputations)

The home care nurses noticed an increase in clients who required amputations secondary to diabetes. They reviewed all the clients who had received amputations over the past year and found that these clients had not been educated on self-care of the feet, nor did they receive any foot care from health care providers. As a result of their review, the home care nurse(s) took a certified program on foot care. They then implemented regular clinics where they provide foot care and education on care of the feet. The home care program tracked amputations for the next 24 months and found that there was a reduction of 65% in amputations.

A second solution was suggested to see if there could be a further improvement in client outcomes. The staff found that very few of their clients had been referred to chiropody for a full foot exam and possible orthotics or adjustments to foot wear. As a second initiative, they created a new process and developed a new form to request chiropody referrals for their clients. They measured the number of client referrals to chiropody for the next 6 months and noted an increase of 50%.

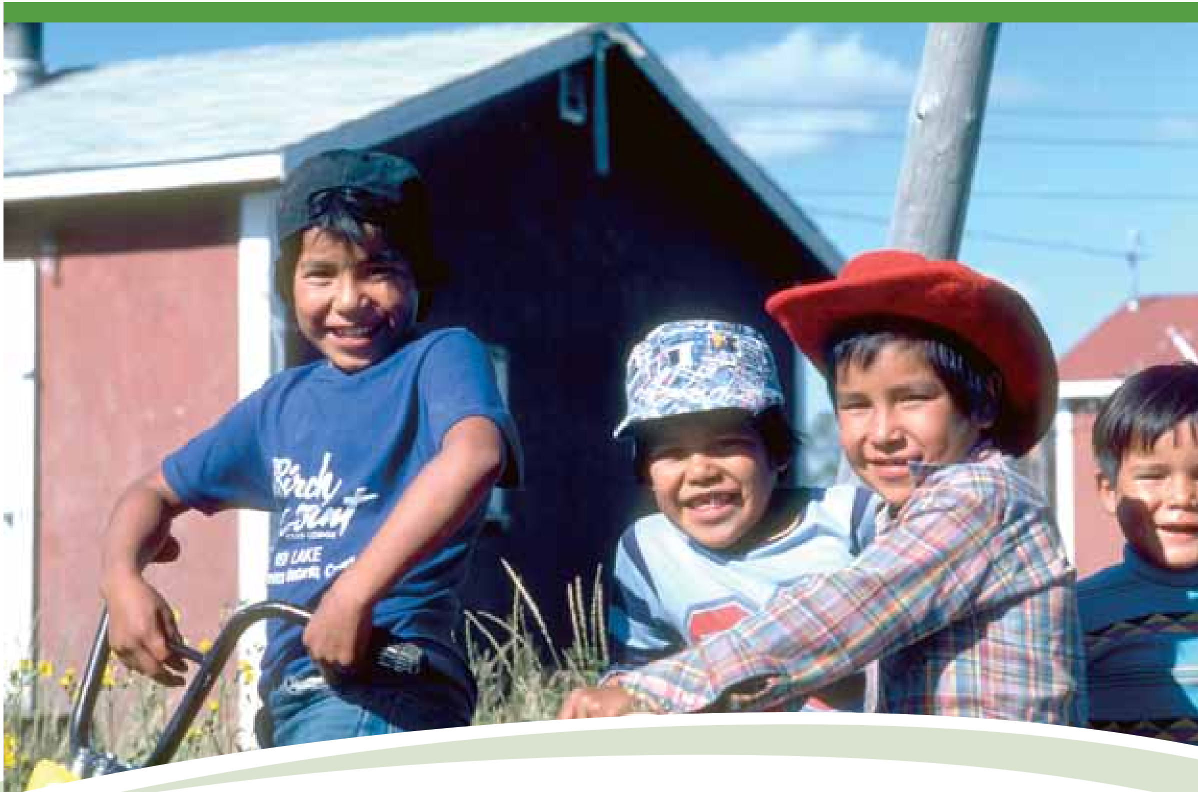
Over the next two-year period the HCC program continued to track amputations and noted a further decline of 75% from before the program started.

Testing the PDSA Cycle and the Model for Improvement

A selection of communities from across the country was chosen to pilot test the PDSA cycle and the Model for Improvement. Participants were provided with a QI Action Plan Template to assist them in completing their PDSA cycle (*Please see Handbook #4 and the CD-Rom for the actual QI Action Plan Template tool).*

Participants from each pilot site were brought together for a one-day intensive training session on completing PDSA cycles. The training session was followed up with periodic teleconference calls to provide support to the pilot projects as they completed their PDSA cycles. A selection of the completed PDSA cycles is provided in this Handbook (See Appendix D) as examples of QI activities that can promote change and quality improvement at the community level.

Additional examples of completed PDSA cycles on client satisfaction, discharge referrals, foot care services, initial RN assessment and nursing bag infection control, are provided in Handbook #4 and on the CD-Rom.



Addendum 1: Analyzing Data and Interpreting Results

Applying the PDSA Cycle to Quality Improvement An Example Using Data to Analyze and Interpret Results

To start your QI journey, use the following steps to identify an area for improvement, your potential sources for data specific to the area you are interested in improving and the PDSA cycle you will use to implement the improvement. A case scenario is provided in the boxes to help you better understand the process. (This tool can be found on the Electronic Resources and References CD-Rom.)

1. **Build commitment across your HCCP*:*** *Remember that Quality is everyone's responsibility*. To build commitment, all HCCP staff needs to clearly understand QI and know why and how it will benefit clients, staff and the program. It is also important to involve all staff in QI processes, either as active partners on the QI team or as supportive champions of the process.

2. **Select your QI team:** *Remember to choose representatives from key areas of your program*, especially those who are familiar with the process you will evaluate. Be sure to include people who understand the day-to-day aspects of your HCCP, and those who can understand and remove barriers to change if need be.

Begin the actual PDSA cycle

3. **Plan:** *Select one area for improvement that the team will examine further*. Remember to focus on key areas of care or service. High risk, high volume and/or problem-prone areas are usually good places to start.

Example

The QI team has received complaints lately from families and clients that clients referred to the program are waiting more than 48 hours before receiving an initial contact by an RN. The program parameter for this first contact is a maximum of 48 hours. Such delays may put clients at risk for injury, interruptions in continuity of care and/or unnecessary emergency room visits.

4. **Develop an aim (or goal) statement** *that is clear about what you will change to correct the problem*.

   a. What are we trying to accomplish?

   b. How will we know that a change is an improvement?

   c. What change can we make that will result in an improvement?

State what you want to accomplish in a SMART objective format; meaning the objective contains specific, measurable, achievable, relevant and timely terms (see example in following text box). Be as precise as possible about the desired outcome to evaluate if the change you carried out improves the quality of services. Benchmarking with other programs is also a good idea at this time.

Aim: In 6 months, 85 per cent of clients who are referred to the program receive an initial contact by an RN within 48 hours.

Improvement Indicator for the intended change :

$$\frac{\text{\# of clients who receive an initial contact by an RN within 48 hrs}}{\text{Total \# of clients who were referred to HCC (1 month).}}$$

In this example, the program measures the change on a month-by-month basis. Therefore, over the course of six months, the community/organization would monitor/track the numbers to see if there is a decrease in the number of clients waiting more than 48 hours for initial contact. A change like this would indicate an effective solution and the change was an improvement.

5. **Select data source/s** *to help you better understand the actual process*. Begin to collect the preliminary data and record it in a readable form so that you can see trends. Remember to select data that helps you separate what you *think* is happening from what is *really* happening and to establish a baseline to measure improvement. Look at past and current data for the same problem area to get an idea of the trends over time. This will help you avoid putting solutions in place that do not solve the problem.

Example

The team has decided to collect data about referral dates and dates of initial contact over a month-long period to establish a baseline. See the Data Table (below) and Figure 5. You will note from the preliminary data collected the team was able to identify that in the period of the data collection, 60% of patients were not assessed within 48 hours. The team was thus able to be precise about their goal of having 85% of patients assessed within 48 hours of referral.

Table 5: Delays from referral to first contact

Client	Referral Date	Initial Contact	Difference	>48 hrs	Comments	Goal
A	3-Mar	7-Mar	96 hrs	Yes		48 hrs
B	5-Mar	7-Mar	48 hrs			48 hrs
C	7-Mar	11-Mar	72 hrs	Yes	weekend	48 hrs
D	11-Mar	14-Mar	72 hrs	Yes		48 hrs
E	17-Mar	24-Mar	140 hrs	Yes		48 hrs
F	18-Mar	19-Mar	24 hrs			48 hrs
G	20-Mar	24-Mar	36 hrs		weekend	48 hrs
H	20-Mar	21-Mar	24 hrs			48 hrs
I	25-Mar	28-Mar	72 hrs	Yes		48 hrs
J	31-Mar	3-Apr	72 hrs	Yes		48 hrs

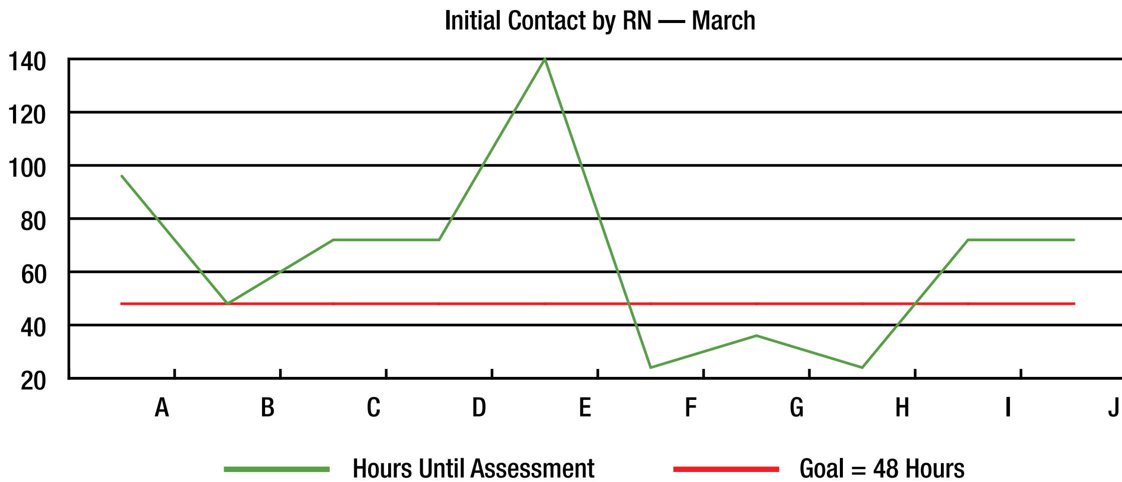
6 patients were not assessed within 48 hours: 6/10 x 100 = 60%

4 patients were assessed within 48 hours: 4/10 x 100 = 40%

Goal: 85% of patients assessed within 48 hours

Figure 5 (below) is a run chart that also shows the trend that approximately 40% of clients had an initial RN contact within 48 hours of their referral to the HCCP.

Figure 5: RN Assessment Wait Times



6. **Determine what changes** *would result in an improvement*. Decide on what change you actually want to carry out using best practices as a guideline.

Example

The QI team created and carried out a plan of action to ensure that a nurse was available to do initial contact with clients (with referral) returning to the community. To achieve this, the HCCP would:

- Hire a part-time RN to do initial contact or;
- Partner with the Community Health Nurse (CHN) to do initial contact or;
- Develop a Memorandum of Understanding (MOU) with the Regional Health Authority (RHA) to complete the initial contact.

7. **Do:** *Test the changes on a small scale.* Testing the changes on a smaller scale allows you to see if the change will work or not. Changes that do not work can then be discarded and other plans created.

Example

The HCCP decided to hire a part-time nurse for a period of 3 months to see if this would help reduce the wait time for an RN assessment.

8. **Study:** *Analyze the results of the tested changes***.** This will help you to determine if, in fact, the change is effective in meeting your goal as outlined in the aim statement. Remember you can learn about your processes from studying both the expected and the unexpected results from your test.

Example

The part-time nurse was hired for a period of 3 months and during that time period 95% of clients received their initial assessment within 48 hours of referral. The change was successful.

9. **Act:** *To change the entire referral process*. Once the change has been tested and proven to work, it can be implemented.

Example

The part-time nurse was hired in a permanent part-time position.

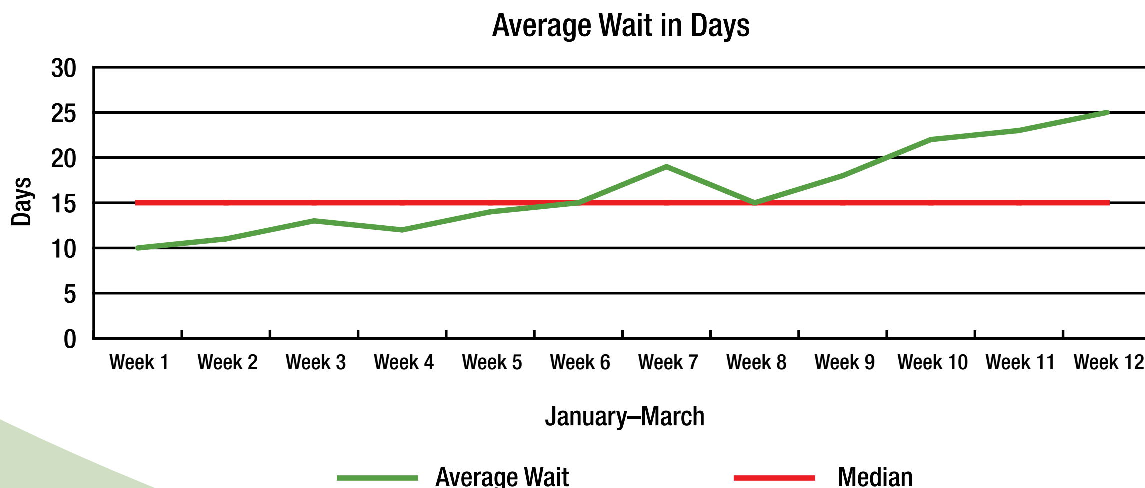
Addendum 2: Interpreting and Presenting QI Data

Interpreting the data you collect around QI testing is a very important part of the process. Tools for interpreting and presenting data include run charts, pie charts, data tables and histograms (or bar charts). Use the tools to get the most out of your data and involve team members in the QI process.

Run Chart

A run chart helps track trends over a specified period of time. With a run chart, look for meaningful trends and patterns. For example, in the run chart below, average wait times for physiotherapy have increased almost steadily from ten (10) days in week one (early January) to twenty-five (25) days in week 12 (late March). However, keep in mind that every variation in data is likely not significant. For example, in week 8 (below) there was a drop in the increase in wait times. While this may or may not be significant, understanding the reason for the decreased wait time at that point might be helpful from a problem-solving perspective. This data provides some information for developing and carrying out a QI action plan to identify what can be done to decrease wait times for physiotherapy.

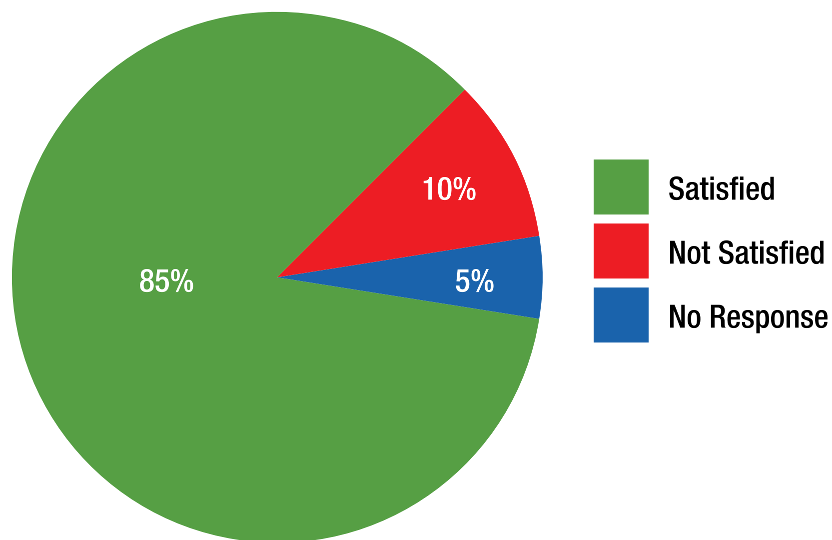
Figure 6: Run Chart: Average Wait for Physiotherapy



Pie Chart

A pie chart is a circular graph that shows data as wedges or slices of a circle (or a pie). Each sector is proportional in area to the quantities of the data sets represented. Pie charts are good for presenting survey findings and financial information.

Figure 7: Pie Chart: Client Satisfaction With Timeliness of Physiotherapy Services



In this example, approximately 85% of clients were satisfied with the physiotherapy services, while 10% said they were not satisfied with the services and 5% did not respond.

Data Table

A data table is another way to display information for a small data set where you might want to examine trends on an individual case basis. For example, in the data table below, 10 specific cases were examined to determine the actual wait times in number of days for physiotherapy services. Some clients were seen within 1 day while others waited up to 10 days to receive services. The table shows that wait times increase when the available staff complement decreases. Understanding that changes in the staffing level will affect wait times is helpful. The organization can use this data to support the hiring of replacement staff during absences.

Table 6: Sample Waits for Physiotherapy

Client #	Referral Date	Initial Contact	Difference	>3 Days	Comments	Goal
1	3-Jan	13-Jan	10 Days	Yes	Staff Vacation	3 Days
2	5-Jan	13-Jan	8 Days	Yes	Staff Vacation	3 Days
3	10-Jan	14-Jan	4 Days	Yes	Staff Vacation	3 Days
4	12-Jan	14-Jan	2 Days	No		3 Days
5	13-Jan	17-Jan	4 Days	Yes	Weekend	3 Days
6	14-Jan	17-Jan	3 Days	No		3 Days
7	17- Jan	19-Jan	2 days	No		3 Days
8	19-Jan	25-Jan	5 Days	Yes	Staff Sick Leave	3 Days
9	24-Jan	26-Jan	2 Days	No		3 Days
10	25-Jan	26-Jan	1 Day	No		3 Days

5 patients waited longer than 3 days for services: 5/10 x 100 = 50%

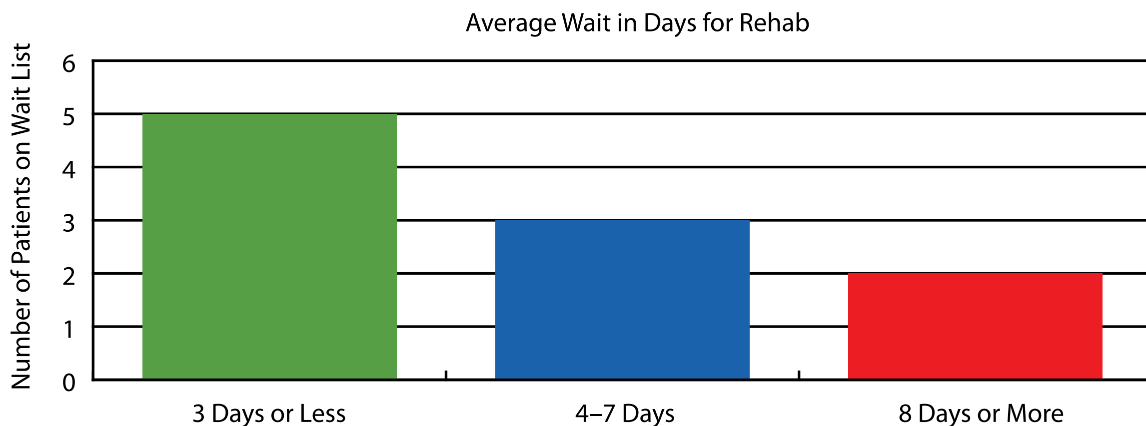
5 patients waited less that 3 days for services: 5/10 x 100 = 50%

Histogram

The histogram is a popular graphing tool. It is used to summarize discrete or continuous data measured on an interval scale. Often used to illustrate the major features of data distribution in a convenient form, a histogram divides the range of possible values in a data set into classes or groups. For each group, a rectangle is constructed with a base length equal to the range of values in that specific group, and an area proportional to the number of observations falling into that group. This means that the rectangles are of non-uniform height. A histogram has an appearance similar to a vertical bar graph, but when the variables are continuous, there are no gaps between the bars. When the variables are discrete, however, gaps should be left between the bars.

Figure 8 (below) shows a total of 6 patients on a wait list for physiotherapy services; 5 waited 3 days or less, while 3 waited between 4 and 7 days, and 2 waited 8 or more days.

Figure 8: Histogram — Patient Wait Days for Physiotherapy Services



The following website link demonstrates how to create pie charts. Additional resources are listed in Handbook #4.

http://spreadsheets.about.com/b/2008/12/15/excel-2007-pie-chart-tutorial-4.htm

Addendum 3: Frequently Asked Questions about QI

1. Does the QI process require more staff or supplies?

QI is meant to be integrated into your daily program work so you may or may not need more resources. The process of QI itself does not always require new materials and/or resources. It is important, however, to allot additional time at the beginning of the process so key QI team members can develop the QI plan and plan the various change initiatives. The actions that occur to achieve the new outcomes may need additional resources. This will depend on the issues you identify and whether solving them will take extra time or materials.

2. What is the role of leadership in Quality Improvement?
(See also "Building Commitment")

It is critical for the HCCP to demonstrate to all who work or link with the HCCP that it is committed to delivering safe, quality care. Community and program leaders should set the tone for quality improvement and be actively involved in the process to encourage and support front-line staff.

3. How can I introduce QI to our HCCP staff, clients and program?

- Explain why QI is important and how clients, staff and the program will benefit from the process;
- Show them the Handbook and review the tools with them to ensure they are comfortable using them;
- Have a discussion about improvement opportunities.

4. **How do I best explain the benefits of Quality Improvement to staff?**

- Find a real example of something that you want to improve by doing it differently;
- Draw staff attention to the benefits to their clients as services improve;
- Draw staff attention to the benefits for them in reviewing established work processes and finding more efficient ways to provide care and services;
- Explain the value of monitoring trends on an ongoing basis to address issues before they become bigger problems.

5. **How can I keep their enthusiasm?**

- Provide QI training to staff;
- Involve staff in QI activities and designate time for QI, if possible;
- Ensure that staff knows about the successes;
- Share quality improvements and demonstrate how they helped clients and staff;
- Recognize and reward individual quality improvement efforts of staff;
- Ensure QI is an agenda item at all appropriate meetings.

6. **What ongoing support will I receive?**

This Handbook is intended to be a mechanism for supporting programs in developing and carrying out their QI program. Other supports may come from consulting with other communities that have already implemented successful QI programs. As different communities implement their QI process, they are encouraged to share their successes and challenges. As QI is an ongoing learning process, strategies, tools and leading practices should be shared as widely as possible.

Participating in the accreditation process and getting support from your National, Regional and/or tribal representatives as well as Regional Health Authorities and other local agencies are all valuable means of ongoing support.

7. I am the only health care provider in my community. How can I best use the Quality Resource Kit?

As a single provider of care, there are a number of ways to implement QI initiatives in your community:

- Use the Handbook to become familiar with the QI process;
- Pick an issue that is in within your control;
- Collect information to set a baseline for the selected issue; try to connect with other programs in your area for support and/or comparison;
- Apply the Model for Improvement to test the solution (we need to present PDSA before we refer to it);
- Use a short time period to decide on the effectiveness of the test;
- Analyze the outcome and begin to plan for either broader application or re-test using another solution;
- Where and when possible, share the successes you achieve or the challenges that you face;
- Connect with local QI initiatives, Regional Health Authority and/or other regional and local QI initiatives.

8. Do we have to implement the whole process?

One of the advantages of this Handbook is that you can pick and choose which parts of QI you want to put into practice in your community. You may decide to start with one small piece and try it out before moving on to another piece. Or, you may choose to implement a change using the PSDA cycle. It is up to you to decide.

D. Additional Resources

Appendix A: List of Possible Quality Improvement Team Members

- Home Care Nurse
- Primary Care Nurse
- Community Health Nurse
- Personal Care Worker
- Home Support Worker
- Physiotherapist/Occupational Therapist
- Patient Navigator
- Discharge Planner
- Community Physician
- Mental Health/Addictions Worker
- Community Elder/Traditional Healer
- Family Member
- Current/Former Client
- Community Volunteers
- Community Leadership
- Management Staff
- Other Front-Line Staff / Partners-in-care (not listed above), such as hospital liaison staff, local physicians and local and regional community agencies.

Appendix B: Sample Terms of Reference for QI Team

SUMMARY:

The team oversees quality improvement matters pertaining to the HCCP in the community.

AUTHORITY:

The team is under the authority of the community leadership.

MANDATE

1.0 Team Functions

The QI team functions are to:

1.1. Initiate and participate in discussions and focus groups to find solutions to problems and concerns that affect the HCCP;

1.2. Receive, provide and make recommendations from/to people in the community about quality improvement for the program;

1.3. Indentify opportunities for improvement within the HCC Program;

1.4. Make recommendations for change to HCCP supervisors about the quality of HCCP services;

1.5. Plan, test and evaluate changes to improve quality;

1.6. Monitor adopted changes that the HCCP carries out to ensure quality improvement remains continuous;

1.7. Develop a communication plan to help build and sustain commitment across the HCCP.

QI STRUCTURE

2.0 Members

1. Membership may consist of one or more of the following:
   - Leadership
   - Registered nursing staff
   - Personal Support Worker
   - Volunteers
   - Client or family member (volunteer position)
   - Other members as appropriate
2. The Senior Administrative Officer is an ex-officio member.
3. An administrative assistant will attend meetings to record minutes, if required.

2.1 Conditions of Membership

1. Alternates should be established to replace members as required;
2. All members shall participate fully in discussions and recommendations;
3. All members must be committed to information-sharing, building, cooperative decision-making and ensuring the effective functioning of the QI team process;
4. All members must maintain confidentiality at all times.

2.2 Role of the Chair

1. The program leaders or leader designate will be the Chairperson;
2. The Chair ensures a recorder is present, either a team member or an addition to the team;
3. The Chair ensures that minutes are taken, completed and distributed to the QI team and forwarded to the other community health leaders as needed;
4. The Chair ensures that the duties of the QI Team, as listed in the terms of reference, are carried out;
5. The Chair shall conduct QI Team meetings according to the terms of reference.

2.3 Meetings

1. The minutes of the meeting will be recorded in writing and shall include the date, time, attendance, regrets or absences, topic, discussion/debate and recommendations of the QI Team;
2. At least two-thirds of the permanent membership of the team shall be present for the meeting to proceed;
3. If the official Chair of the meeting is absent, the pre-determined Co-Leader may preside, or the team may select an alternate Chair for that meeting;
4. Meetings will be held regularly; the frequency to be determined by the team. Ad hoc meetings may be called if necessary;
5. If a member is unable to attend a meeting, they are required to notify the Chair at least one day prior to the meeting. If a meeting is cancelled, the Chair or the team Administrative Assistant is responsible for notifying the members as soon as possible.

2.4 Decision-Making

1. Decisions will be made by consensus vote and based on evidence as much as possible. If the team is unable to reach a consensus vote, decisions will be made by majority rule;

2. The Chair shall only vote to break a tie.

2.5 Communications

1. The Chair is responsible for ensuring that all actions, decisions and recommendations of the QI Team are forwarded to the Senior Administrative Officer;

2. The Chair shall refer issues to the appropriate Manager or Director, if required.

Notes:

The team is only responsible for quality improvement. Other issues such as individual complaints should be redirected as appropriate.

These terms of reference are an example only. They may not be suitable for all programs and communities/organizations, depending on the size and the available resources.

It is suggested that programs and communities/organizations use all or part of the terms of reference to suit individual community needs.

Appendix C: Process Evaluation

HOME AND COMMUNITY CARE PROGRAM
SAMPLE QUALITY IMPROVEMENT PROCESS EVALUATION

Circle the appropriate response

1. Poor 2. Fair 3. Good 4. Very Good 5. Excellent

Efficiency	
The QI Team meets regularly.	1 2 3 4 5
The meeting starts and finishes on time.	1 2 3 4 5
The discussions are useful.	1 2 3 4 5
My opinions are respected.	1 2 3 4 5
Decisions are made by consensus.	1 2 3 4 5
Opportunities for improvement are readily identified by reviewing:	
• Reports (both internal and external)	1 2 3 4 5
• Indicators	1 2 3 4 5
• Satisfaction surveys	1 2 3 4 5
• Quality Improvement instruments that were presented.	1 2 3 4 5
Quality Improvement issues are assigned appropriately to:	
• Individuals	1 2 3 4 5
• Special committees (e.g., Health and Safety)	1 2 3 4 5
• Focus Groups	1 2 3 4 5
Regular progress reports are received by the committee on QI projects.	1 2 3 4 5
I receive minutes of QI meetings.	1 2 3 4 5
Effectiveness	
The committee receives regular progress reports on QI projects.	1 2 3 4 5
Issues related to QI activities are addressed effectively.	1 2 3 4 5
Changes are made as a result of recommendations.	1 2 3 4 5

Comments: ____

QI Action Plan Template (Alberta)

Issue to be addressed:	Ensure all Home Care clients who require foot care have services every eight weeks
AIM Statement:	Within 6 months, 90% of Home Care clients will have regular foot care
QI Lead or QI Team Members:	Home Care Nurse, Health Care Aides (3)
Date for Completion:	December 2009

ACTION PLAN					
Item #	Change (What)	Plan (Who, Where, When, How)	Do (Date started)	Study (Gather data to see if change was an improvement)	Act (Adopt the change; Amend the change or Abandon and try something else)
1	• Clients who need foot care from the contracted RN need to be tracked to ensure they are booked to attend an appointment. If they are unable to attend, the Home Care Nurse will contact them to do foot care.	• Short questionnaire for clients to determine who requires foot care by an RN, administered by HCA's; • Appointments will be made the week prior to the scheduled clinic; • HCA's will make up appointment reminder cards and deliver; • After clinic list will be reviewed and those who missed will be contacted; • RN will be notified to do foot care for those missed.	Oct 26-30, 2009 November 2-6, 2009 November 12,13, 2009 Contracted Foot Care Clinic Week of November 16 — Reviewed client list	15 Home Care clients were seen at the Foot Care Clinic. 24 Home Care clients requiring foot care by an RN. • Of the 9 clients not seen at the clinic: – 4 were booked and did not show; – 3 stated they did not require foot care; – 2 clients were not contacted; – 75% of home care clients had foot care; – 25% to be contacted by RN; – 67% of clients had foot care after last clinic in Sept.	• Continue with booking appointments one-week prior; • Appointment cards will be made out for each client who requires foot care; • Reviewing list made the RN aware of who still needed foot care; • Aim for 90% of clients after January 2010 Foot Care Clinic.

Notes:

QI Action Plan Template (Saskatchewan)

Issue to be addressed:	Continuity of Mental Health Services
AIM Statement:	100% of clients with chronic mental health conditions will have a completed homecare program assessment
QI Lead or QI Team Members:	Homecare Director, Nurse Supervisor, Homecare, Nurse Assessor and Wellness Nurse (RPN)
Date for Completion:	To commence Oct 1st, 2009 and to be completed by November 15th

ACTION PLAN					
Item #	Change (What)	Plan (Who, Where, When, How)	Do (Date started)	Study (Gather data to see if change was an improvement)	Act (Adopt the change; Amend the change or Abandon and try something else)
1	• Improve continuity of care	• 100% of clients receiving mental health services will have a completed Homecare Assessment.	• Client lists will be completed from current workload documents (ESDRT) and staff, effective October 5th 2009.	• Collect data on timeliness of assessment and referral process.	• Process will be reviewed to see if current assessment process meets the needs of the mental health program.

Notes:

QI Action Plan Template (Manitoba)

Issue to be addressed:	Employee late arrival to morning client is currently at 50% (half of the Health Care Aides (HCAs) arrive late to work in the morning)
AIM Statement:	Goal: In 1 month, arrival time to morning client from the HCAs will improve to 80% (12/15 HCAs will improve arrival times)
QI Lead or QI Team Members:	Homecare Director, Nurse Supervisor, Homecare, Nurse Assessor and Wellness Nurse (RPN)
Date for Completion:	To commence Oct 1st, 2009 and to be completed by November 15th

ACTION PLAN					
Item #	Change (What)	Plan (Who, Where, When, How)	Do (Date started)	Study (Gather data to see if change was an improvement)	Act (Adopt the change; Amend the change or Abandon and try something else)
1	• HCAs will improve on their arrival time to their morning clients; • Decrease the risk that client's needs are not being met during their scheduled visit;	• Meet with the staff and inform them on the issue and concerns of late arrivals in the morning. i.e., safety to client; costs of tardiness, complaints by clients; • Stress the importance of arriving daily on time to client to complete care in the time allotted to provide the necessary care; • Have workers arrive a few minutes before the shift starts, not after start;	(Oct 16 2009)	Baseline: $\frac{\text{\# of timely Home Visits by HCAs}}{\text{Total \# of timely HVs by HCAs}}$ 7/15 = 50% beginning of project • Oct 19-23 2009–10/15 = 67% • Oct 26-30 2009–11/15 = 73% • Nov 2-6 2009–11/15 = 73% • Nov 9-13 2009 did not use this week; short work week • Nov 16-20 2009–12/15 = 80% • Clients report that workers are arriving on time and are satisfied with services;	• Based upon the data the team decides to continue to monitor the HCAs arrival time and continue with the program as is; • Continue with phone calls with those who arrive late repeatedly; • Continue with schedules in clients homes; • Continue with client satisfaction phone calls but moved to biweekly monitoring or monthly.

Continued on the next page

QI Action Plan Template (Manitoba) (continued)

ACTION PLAN					
Item #	Change (What)	Plan (Who, Where, When, How)	Do (Date started)	Study (Gather data to see if change was an improvement)	Act (Adopt the change; Amend the change or Abandon and try something else)
	• Ensure safety issues such as enough time to complete the personal care scheduled and not be rushed; • Save costs to program with regards to total time not at work due to tardiness.	• Collaborate with Admin Assistant and Home Care Attendant (HCA) attendance data collector who will monitor the call in/out answering machine daily. – Do this every morning at 9:00 am; • Random phone calls to clients to follow up on care they received that morning by Program Manager, Admin Assistant or HCA attendance data collector; • Schedules will be given to each client on hours of service to expect. These schedules will be weekly, given at the end of every week to show the schedule for the upcoming week for a period of 4 weeks in 2009; • Program Manager will complete client satisfaction phone calls or Home Visits (HVs) at the end of each week with a 3-part question:	(Oct 19 2009) (Oct 19 2009) (Oct 19-Nov 13 2009) (Oct 23, 30, Nov 6 & 13 2009) (Oct 23, 30, Nov 6 & 13 2009)	• Clients expressed satisfaction in having schedules in home as sometimes workers say they are not scheduled to be there on a particular day. Clients know when to expect a Home Care Attendant; • Client satisfaction increased re: time and services provided to them for care; • Client enjoys having nurse involved in care. $\frac{\text{\# of timely Home Visits by HCAs}}{\text{Total \# of timely HVs by HCAs}}$ • Improved to 80% by 4 week end period.	• Week of Oct 23 2009 improved to 63% • Week of Oct 30 2009 improved to 73% • Week of Nov 6 2009 improved to 73% • Week of Nov 20 2009 improved to 80% of employees arrived on time for their morning clients.

Continued on the next page

QI Action Plan Template (Manitoba) (continued)

ACTION PLAN					
Item #	Change (What)	Plan (Who, Where, When, How)	Do (Date started)	Study (Gather data to see if change was an improvement)	Act (Adopt the change; Amend the change or Abandon and try something else)
		– How are things in general? – How do you feel about the services you received this week? – Do you feel your worker had enough time to complete the care? • Program Manager will monitor any changes and collect data on changes weekly, with a total at the end of the 4 week period.			

Notes:

- 15 HCAs half arriving late to clients in the morning
- 7 out of 15 HCAs arrived late at beginning of study
- 12 HCAs did arrive on time by end of study
- Goal was reached by using the PDSA Action Plan

QI Action Plan Template (Nunavut)

Issue to be addressed:	User-friendliness of HCC Intake/Referral Form
AIM Statement:	To improve user-friendliness, accuracy, and comprehensiveness of the HCC Intake/Referral Form to reduce the number of follow-ups that have to be done and forms that have to be sent back for clarification, so that within one month only 20% of Intake/Referral forms will require follow-up.
QI Lead or QI Team Members:	Home Care Nurses (2), Home Care Coordinator, Home Care Representative, Occupational Therapist, Territorial Home Care Coordinator
Date for Completion:	Monday, November 13th, 2009

ACTION PLAN					
Item #	Change (What)	Plan (Who, Where, When, How)	Do (Date started)	Study (Gather data to see if change was an improvement)	Act (Adopt the change; Amend the change or Abandon and try something else)
1	• Home & Community Care Intake/ Referral Form	• HCC team will replace the current forms with revised forms for the hospital and public health clinic.	To be implemented Friday, October 16, 2009	• To be reviewed November 10th to determine if any forms had to be sent back and if it improved the referral process time. • Upon reviewing the data at the end of the 3 weeks, it was found that the new Intake/Referral Form was 100% successful and no forms had to be returned or followed up. All forms received after the new Intake/Referral Form was implemented were comprehensively completed. Positive feedback was also received from the doctors at the hospital.	• Given the success of the piloting of the new Intake/ Referral Form, a decision has been made to adopt the new form; • At the next territorial home care meeting, the new Intake/Referral Form is provided so that the other regions can pilot the form to see if it will be successful throughout the territory to provide consistency.

Notes:

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QUALITY RESOURCE KIT

Risk and Risk Management: Theory and Tools

Handbook 3

Strengthening and Improving Home and Community Care

Canada

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First Nations and Inuit Home and Community Care (FNIHCC) Quality Resource Kit is available on Internet at the following address: http://www.hc-sc.gc.ca/fniah-spnia/pubs/services/_home-domicile/prog_crit/index-eng.php

Également disponible en français sous le titre:
Soins à domicile et en milieu communautaire des Premières nations et des Inuits (SDMCPNI) Trousse de ressource pour l'amélioration de la qualité

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A. Defining Risk, Related Events and Risk Management

All healthcare organizations need to systematically manage risk. The purpose of risk management is to help the Home and Community Care Program (HCCP) meet its goals and uphold its integrity by providing the safest care possible for all those involved. This includes clients and families, program staff and/or volunteers.

To understand risk management, we must first understand risk, good catches, adverse events, sentinel events, liability, accountability and disclosure.

What is Risk?

Risk is defined by Accreditation Canada as **actual or potential danger, harm or loss**. In HCCPs, risk means the possibility that clients, care providers, volunteers and the public may experience danger, injury or loss in the course of receiving and/or providing services.

Undetected risk in HCCPs can result in loss of health or life for clients, damage to property or equipment used by home care providers and financial instability of the program, if resources are poorly used.

Examples of Risk

Current / Actual Risk — A client has just been discharged from the hospital to his home community without a thorough referral to home care. He is now required to take insulin twice daily and is not able to administer his own insulin at this time. This client is at risk of going into a diabetic coma if he does not receive his insulin in a timely manner.

Potential Risk — The client is a new amputee. His mother is a frail elderly woman. The client is at risk from wound infection and both he and his mother are at risk-for-falls in the home.

Not all risks are identifiable and not all harm is preventable, even if risks are identified. Fortunately, not all risks cause harm.

What Kinds of Risk Can Occur in HCCPs?

There are many types of potential risk including, but not limited to, the following:

- Risk related to service provision includes potential risks such as, improper application of compression bandages, medication error, and/or missed services;
- Physical risk to the client, such as a urinary infection, physical and/or other types of abuse, and/or poor circulation;
- Environmental risk, such as equipment failure, inadequate handicapped access, and/or smoking;
- Emotional risk, which can result from intimidation, social isolation, and/or depression;
- Informational risk, resulting from a breach of confidentiality and/or lack of informed consent;
- Financial risk, which can occur as a result of misuse of supplies and/or inadequate funding;

- Personal injury that is accident-related, such as a person slipping and breaking a bone;
- Risk to property, which may occur, for example, when personal belongings are broken;
- Legal risk resulting from the failure to disclose, and/or the inadequate credentialing of care providers;
- Other risks such as building shutdown, natural disasters, etc.

Can Risk Be Avoided?

Not all risks are identifiable and not all harm is preventable, even if risks are identified. Fortunately, not all risks cause harm.

The HCCP must consistently take reasonable measures to detect and reduce risk and to quickly intervene when dangerous situations happen. If the HCCP does not take these reasonable measures, it could result in loss of credibility as the program may not be seen by the community and by partners-in-care as providing the safest possible care and services.

What is Risk Management?

Risk Management is a key component in improving the quality of services. It is a systematic process used to identify, prevent and manage risk to ensure that client and service objectives are more likely to be attained; that beneficial things are more likely to occur; and that damaging things are less likely to happen. The Risk Management process looks carefully at HCCP decisions, the activities related to these decisions and the client and service outcomes to:

- Enhance the safety of clients, care providers and volunteers;
- Enhance the quality of services by minimizing risks that negatively affect the quality of services and make the most of safety improvement opportunities;
- Ensure the overall viability of your HCCP by promoting accountability, instilling confidence in clients and partners and avoiding liability situations.

There are four steps in the risk management process, which can be considered as a PDSA cycle designed to reduce a risk issue. They are:

1. **Identification of potential & actual risks** (See *What Kind of Risks Can Occur in HCCPs)*: Sources of actual risk areas include: high volume, high risk, high cost, or problem-prone issues. Another source that can help to identify potential risk is the *First Nations & Inuit Home and Community Care (FNIHCC) Quality and Safety Scan*.

2. **Prioritizing risks:** Risks should be prioritized according to the probability and the severity of a potential or actual adverse event.

    - *Probability* refers to the frequency and the circumstances under which an adverse event is likely to happen.

        – For example, if the front steps to clients' homes are not well shovelled after a winter ice storm, the probability that the nurse and/or the client will slip and fall is high.

    - *Severity* refers to the degree of harm or consequences caused; consequences are usually rated as severe, moderate or low.

        – In the previous example, if the client is elderly and has osteoporosis, the consequences could be severe, such as breaking a hip!

3. **Developing a Risk Management (RM) plan** to address the risks using the Plan-Do-Study-Act (PDSA) model.

4. **Monitoring indicators** to analyze the outcomes of the RM Plan.

Good catches, adverse events and sentinel events are all ways to categorize the degree of harm caused when a risk becomes real (See Figure 1).

Good Catches (Near Misses)

Good catches are events or circumstances which have the potential to cause serious physical or psychological injury, unexpected death, or significant property damage, but do not happen due to chance, corrective action, and/or timely intervention (Accreditation Canada, 2006; *Canadian Patient Safety Dictionary*, 2003). Also called "near misses," good catches are lessons in error prevention!

A "near miss" lesson in error prevention.

An example of a good catch: The Personal Care Assistant (PCA) notices that the client's daughter has bought two scatter rugs for her mother's home. The PCA discusses the risk of slipping with both the client and her daughter and both decide to put the rugs on the wall instead.

Adverse and Sentinel Events

Adverse events are negative or unfavourable incidents that are unintended, unexpected or unplanned and that usually have a low to moderate severity of negative consequences. (Accreditation Canada, 2006).

An example of an adverse event: An elderly woman living alone at home mistakenly takes a double dose of an antibiotic prescribed for her because she does not understand the instructions on the bottle. She has a bit of diarrhoea and loss of appetite, but is otherwise fine within a few hours.

A sentinel event is also an unexpected incident, related to system or process deficiencies, which leads to death or *major and enduring loss of function* for a recipient of health care services (Accreditation Canada, 2006). A major, enduring loss of function is considered a sensory, motor, physiological, or psychological impairment not present at the time services began, lasting for a minimum period of two weeks and not related to an underlying condition.

An example of a sentinel event: An elderly woman living at home alone mistakenly takes a double dose of an anti-hypertensive prescribed for her because it was inappropriately labelled. Later, when she stands up too quickly, the elderly woman becomes dizzy and falls down her front steps, fracturing her hip.

Figure 1: Good Catches, Adverse Events & Sentinel Events

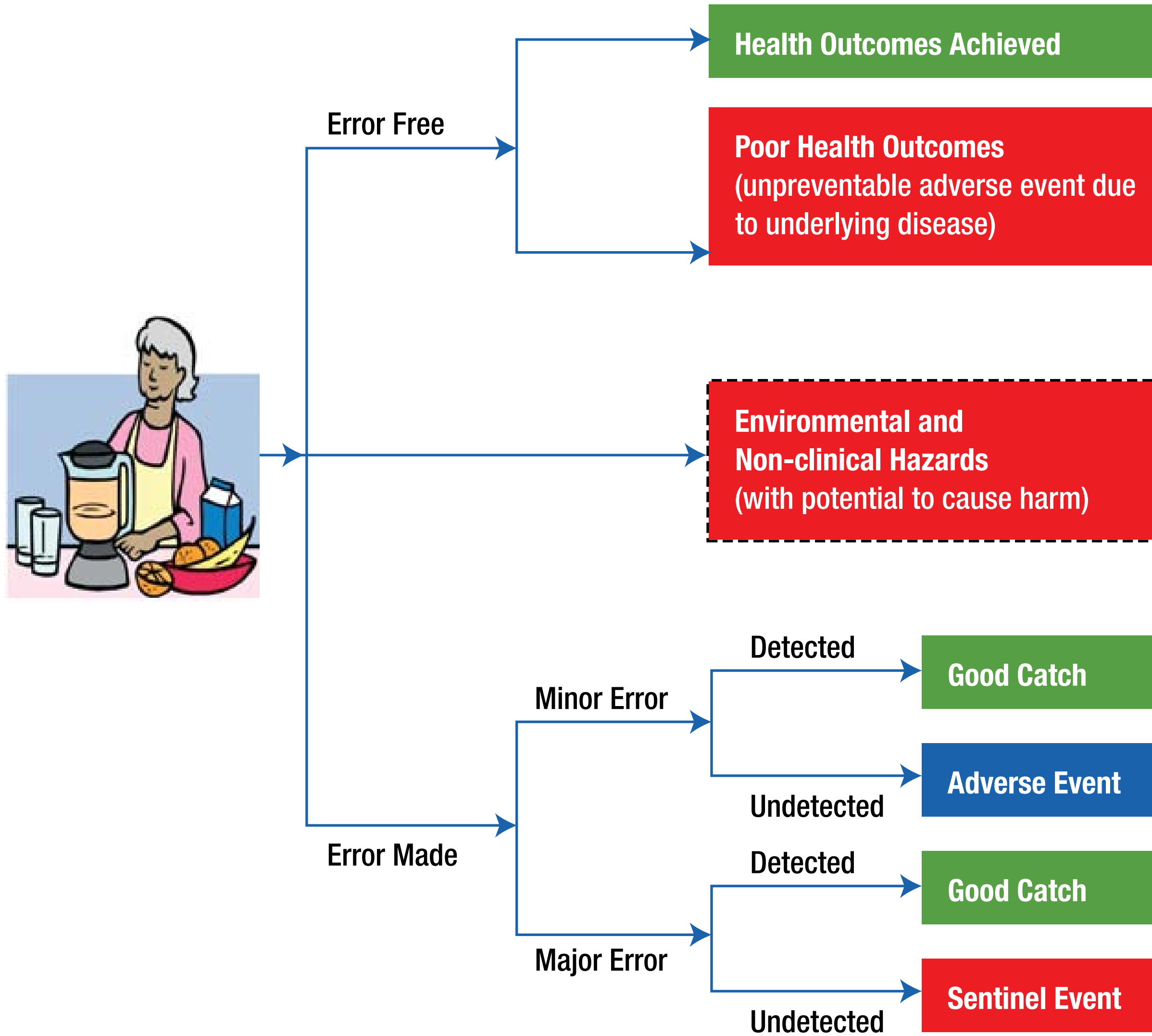


Figure 1: Adapted from Accreditation Canada

Liability, Accountability and Disclosure

- **Liability** is the legal risk for which a person or body (such as a HCCP) may be held accountable if another person or body suffers an injury or loss. Liability related to injury or loss can arise from an act, a failure to act, or from breaching a term of a contract or duty. The HCCP is also liable if someone is injured on the program's property. All HCCPs must obtain the necessary insurance coverage, inclusive of malpractice and liability for staff, general liability and property.
  - *Example*: If your HCCP fails to repair faulty equipment lent to clients, the program could be held liable by a client who is injured using this equipment.
- **Accountability** (Emanuel & Emanuel, 1996) means assuming responsibility for actions taken. Individuals need to be accountable for their actions. The HCCP must also be legally accountable for any harm or damage resulting from its own activities and those of its employees.
  - *Example*: A newly-hired Registered Nurse (RN) without the appropriate training is requested to apply lower leg compression, does it anyway, and as a result the client loses a limb. The nurse is accountable for her actions; she should have advised her manager that she had not been trained. The HCCP could also be held accountable for not making this training available to all new staff in a timely fashion.
- **Disclosure** is information given by health care workers to clients or their significant others (families), about any healthcare event affecting or liable to affect the client's interests. Disclosure means telling clients when we, as healthcare providers, make a mistake.

  All members of the health care team have a responsibility to disclose information, ranging from the direct in-home care provider to the case manager and physician. This is such an important part of developing a culture of safety in healthcare today that the Canadian Patient Safety Institute published guidelines for disclosing adverse events to clients and families.

Proper disclosure ensures that a well-informed client, family and/or caregiver can help correct any harm already done and prevent any further harm. In disclosing adverse or sentinel events to clients and their families, we must acknowledge the event and express our regret for what happened. Clients and their families must be given a thorough explanation of what happened. They also need to know what is being done to mitigate the effects of the injury and what corrective action is being taken to prevent this from happening again to them or another client.

– *Example*: The HCC team takes responsibility by explaining the situation to the client and family. The Home and community care team apologizes to the client and family for the injury that has occurred and shares with them the new plan that has been adopted to ensure that this situation does not occur in the future.

All members of the health care team have a responsibility to disclose information, ranging from the direct in-home care provider to the case manager and physician.

Proper disclosure ensures that a well-informed client, family and/or caregiver can help correct any harm already done and prevent any further harm.

B. A Systems Approach to Risk Management in HCCPs

The best way to manage risk is from a systems perspective. This means looking at all potential and actual physical, environmental, informational and financial risks across all levels of the HCCP and at all stages of the continuum of care. It means setting priorities based on the **degree** of risk associated with each event (how likely is it that the event will occur), and the **severity of the consequences** of that event should it occur (death, grave injury, *versus* minor side effects), then putting in place appropriate measures to reduce these risks and prevent potential harm. Finally, it means responding to adverse events when they occur in a timely and appropriate fashion to minimize the actual harm done.

Risk management is based on a series of assumptions and premises. It is assumed that human beings make errors and that these errors are largely preventable. RM is also based on the belief that people do not come to work to do a bad job or make an error, but that given the right set of circumstances, anyone can make a mistake. RM proposes that the structures and processes in place in the care system contribute in varying degrees to the likelihood of these errors occurring; and it supports the creation of an environment that allows the HCCP to build a culture of safety and move beyond a culture of blame.

Healthcare systems like those in HCCPs are comprised of structures and processes, each designed to achieve certain (intended) outcomes and both potentially leading to risk.

- **Structures** are things we can see and touch, like management structures, committees, training programs, equipment, etc.
- **Processes** are steps or actions taken to achieve intended outcomes. Common HCCP processes include care planning, nursing procedures and human resources processes for hiring and training new staff, etc.
- **Outcomes** are the end results of the processes carried out.

Outcomes may be intended or unintended. Examples of intended outcomes are nursing procedures that lead to better health outcomes for clients and human resource procedures that result in satisfied, well-trained program personnel. In HCCPs, an intended outcome is a client who is restored to his/her pre-admission state and discharged from the program; an unintended outcome may be a complication in the client's health state that could lead to hospitalization rather than to discharge from the program. Unclear policies, poor communications, faulty equipment, inadequate training, distractions in the workplace, uninformed clients, heavy workloads and lack of leadership support, etc., all contribute to unintended outcomes.

Basically, systematic risk management seeks to understand and address the circumstances in the structure and the processes of HCCPs to identify and reduce potential risk *and* respond rapidly and appropriately to adverse outcomes that result when unintended risk cannot be avoided.

While doing RM it is important to remember that most systems are vulnerable to some degree and that our HCCP systems are no exception. Hence, the ability to recognize to what degree our system is vulnerable is essential to improving client safety. According to Reason (2001,*Vulnerable System Syndrome*), elements found in vulnerable systems include: the blaming of front line workers, the denial of existing systemic errors which provoke systemic weaknesses, and being overly focused on productive and financial indicators. These elements should be the objective of an honest evaluation by those responsible for quality improvement and risk management.

C. Culture of Safety for HCCPs

At the heart of a systems approach to RM is the culture of safety. HCCPs are continuously working to improve client safety and the 'attitude' of the HCCP is often an indication of whether or not it has developed a real culture of safety.

A culture of safety encourages identifying and reporting unsafe acts within an organization. Therefore, a culture of safety in a HCCP is one where individuals are not blamed for errors and adverse events; rather, systems are examined to see how to help individuals to do their work more effectively and more safely. When an organization has a culture of safety, it not only identifies safe care as a priority, it promotes the **reporting of any potential system gaps and/or inadequacies** as a way to improve the overall system functioning. A culture of safety takes the blame off the individual and looks to the organizational structures and processes for solutions to improve care.

Successful client safety improvement efforts always need to have one foot on the way things are and the other foot on the way you want them to be. Making client safety a priority is important. Introducing changes that support the culture of safety can help bring about significant client safety improvements. Such changes to enhance the culture of safety include:

- Addressing key issues at an organizational level, not an individual level (organizational accountability) and demonstrating an organizational commitment to quality improvement;
- Encouraging and supporting individuals to demonstrate a commitment to quality improvement (individual accountability);
- Creating an environment that is open to learning and not focused on blaming, with fair and open feedback to staff;
- Creating a culture of reporting and encouraging open discussions of adverse events (i.e. staff and clients have a duty to report);
- Implementing safety related policies, like incident reporting, disclosure, processes for ethical decision-making and critical care issues, etc.;

- Carrying out bias-free investigations of adverse events that focus on system issues and that are not blaming in nature (i.e., incident and accident investigations);
- Putting the necessary supports in place for client safety;
- Putting in place a process for ethical decision-making.

Example: *Home health care workers face risk from needle stick injuries. In response, the employer needs to create standards, policies and procedures to reduce the risk of system error. Placing emphasis on this issue during orientation and ensuring that each home is equipped with the necessary sharps disposal units will lessen the risk for employees and create a culture of safety within the organization.*

Occurrence Reporting of Needle Stick Injuries — The home care coordinator notices a number of adverse events related to needle stick injuries. She determines that it could be because of the lack of a clear policy and set of guidelines and the lack of appropriate disposal systems for sharps within the homes. She goes to the Health Director with this observation and they decide to create a working group to develop guidelines and policies and arrange to install appropriate disposal units in all the homes.

This created an opportunity to problem-solve how to prevent these types of adverse events from continuing. This example is consistent with a system approach that is focused on identifying and preventing adverse events resulting from inadequate systems. If and when other adverse events occur, the same process can be used to systematically examine the system to identify the gaps and breakdowns that might have led to the adverse outcome.

Questions to Consider — Do you have a reporting process in place? Are staff made to feel blame if they report a needle stick injury? How do you handle incident/ occurrence reports?

D. Risk Management Tools and Tips

Risk Management Strategies must recognize that the system contributes to the likelihood of mistakes. They must focus on fixing the system problem and not on blaming individuals. To do this, there must be active participation from the leadership team, the clients and their families and all partners in care within the community.

The overall objective of RM is to raise the level of awareness about preventable risk and make it clear that improving safety should be everyone's priority. Sharing stories of both problems and successes helps everyone learn from past mistakes. It also educates staff on how to recognize and avoid risk.

A good starting point for RM is an overall evaluation of the quality and the risk elements of your HCCP. Refer to the discussion about the HCC Program Quality and Safety Scan in Handbook #4.

Risk Management Tools

There are essentially two types of tools and methods used in the RM process: prospective methods, which are used to prevent errors and adverse events from happening and retrospective tools which are used to analyze why error and adverse events happened. A solid RM strategy in your HCCP will contain both types of RM. Tools of both types are discussed below. (Additional tools can be found in the *Memory Jogger ll — A Pocket Guide of Tools for Continuous Improvement and Effective Planning,* available in English and French. See Handbook #4 for the Memory Jogger web site address).

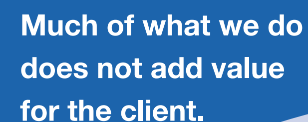
Prospective RM Methods

Prospective Risk Management is used to assess and mitigate the potential occurrence of a loss by analyzing a situation or process that carries with it some inherent risk (Carroll 2006). This means looking at systems to identify potential risk before errors and adverse events happen. Prospective RM methods are future oriented and proactive; they aim to prevent risks from becoming adverse or sentinel events.

Some examples of prospective risk management tools, aside from the HCCP Quality and Safety Scan mentioned earlier in this Handbook, are Process Mapping, Failure Modes & Effects Analysis, Simulation, etc. A few of these methods are reviewed below.

- **Process Mapping**

  Process Maps (or Flow Diagrams — see Figures 2 & 3) are visual representations of a process. They often use symbols, arrows, circles, boxes and other diagram components to show inputs, outputs, tasks performed, task sequence and decision points. The process map that follows in Figure 2 outlines an existing process for receiving and responding to new referrals in the home care program upon discharge from the local hospital.



  When the home care staff mapped out the process they found that there were seven distinct steps in the process. Each step takes time to complete and allows for an opportunity for an error to occur. Figure 2 demonstrates the process the home care program was following when it received new referrals from the local hospital.

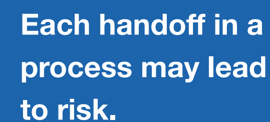
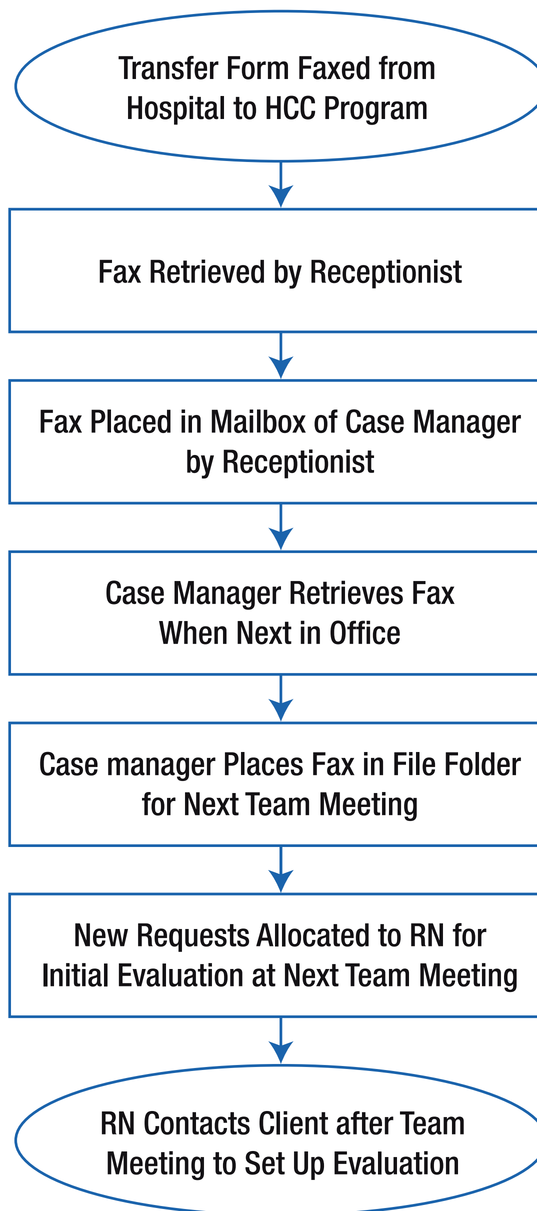


Figure 2: Process Map



Process mapping is usually done in groups with the group clearly laying out the process with the intention of improving and streamlining it. The group will map out the steps in the process in the order they occur so as to clearly identify where there may be inefficiencies, duplications and potential sources of error.

Starting a process mapping activity requires the **gathering together of all the key stakeholders**, inclusive of clients and providers. The materials required for the exercise are items such as, post-it notes, index cards and a white board or bristle board to display the process map as it is developed.

Creating the actual process map requires the group to **focus on what happens to most of the clients most of the time**. Each step is diagrammed, using the white board and post-it notes or other applicable materials. Within each step there may be multiple tasks which need to be identified, including who is responsible for completing that task. (See Figure 2)

Once the process map is complete it needs to be analyzed to make improvements in the process and eliminate steps that have the potential to introduce error into the process.

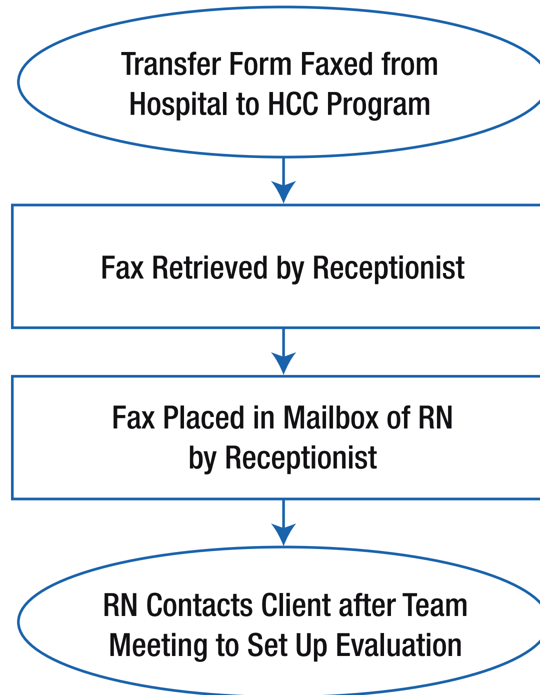
Ask the following questions of the stakeholder group:

- Can we do this in another way?;
- Can we eliminate this step?;
- Is there a more appropriate person to do this task?;
- Is there a different method of doing this?;
- Should we complete the steps/tasks in a different order?;
- Should some tasks occur at the same time?;
- Should we do this in a different location? (See Figure 3)

If there are changes you want to make, **use the PDSA cycle to make one small change at a time**. If this is successful you can build on it with more changes, using multiple small PDSA cycles.

The home care program, upon reviewing their existing process, decided that they could streamline the process thereby eliminating some areas where inefficiencies, potential errors or duplication could occur. The more streamlined process map is demonstrated in Figure 3 below.

Figure 3: Streamlined Process Map



- **Failure Modes & Effects Analysis (FMEA)**

FMEA is an orderly team-based approach to identifying and preventing problems before they happen. It is not necessary for a HCCP to have had a near miss or an adverse event to use FMEA.

Brainstorm all failures and prioritize most likely and most severe.

Instead, the HCCP can use FMEA to make its care and service delivery system stronger by identifying areas where there are weaknesses, or where there is a bigger risk that a problem could happen, and then redesigning that area.

In this example, areas where potential problems can happen are:

- During the discharge process from hospital to home care;
- When transferring the responsibility for care from one institution to another;
- When two health services do not share client information form one service provider to another.

FMEA requires the team to come together and create a process map that identifies the steps in the process being reviewed. Once the steps have been outlined in a diagram or flowchart format, the team answers the following questions for each step in the process:

- What could go wrong? (Failure modes);
- Why would it go wrong? (Failure causes);
- What would be the potential consequences? (Failure effects).

The answers to these questions are then used to develop strategies to prevent the failure from occurring. It is important to note that the strategies need to be tested using a PDSA cycle before being implemented.

Example For Using The FMEA Worksheet To Mitigate Risk:

In the previous case study scenario, the client was discharged from hospital to community without a formal referral process in place. This resulted in the client arriving back in the community with only a minimal medical history available to the home care nurse. According to the Program Quality & Risk Scan carried out by the QI Team of the HCCP, this situation happens all too frequently and is considered to be a high-risk situation for both the client and the program.

Risk Issues (Possible Failures) — There is a risk to the program in that they do not have all the necessary information to establish a quality plan of care for the client. There is a risk to the client that she/he will receive inappropriate care due to the lack of important information about his/her medical condition.

Causes of Failures — Lack of communication between the HCCP and the discharging hospital. HCN works part-time and is not available when the client is discharged home.

Risk Management Strategies (Prevention of Failures) — The HCN initiates contact with the local hospital discharge planner and establishes a process for notifying the HCCP about upcoming discharges. The HCCP develops a client education program that focuses on self-care as it relates to taking responsibility for personal information. The HCCP has a process established with the primary health care team to assess clients upon their return to the community if the HCN is unavailable.

Dealing With Actual Failures — The HCN responds immediately upon notification and visits the client at home to complete an assessment and provide the appropriate care. The client calls the local primary health care provider and initiates the care process themselves.

***See Handbook # 4 and the CD-Rom for the FMEA worksheet tool.*

FMEA would also be useful, for example, if the HCCP considered implementing Aggression Management Training (AMT) for program staff (See Figure 4).

Figure 4

FMEA: Implementation of Aggression Management Training (AMT)				
Steps in Process	**What could go wrong? (Failure Modes)**	**Why would it go wrong? (Failure Causes)**	**What are potential consequences? (Failure Effects)**	**Strategies to Prevent Failure**
Assure Support of Senior Management	• Inadequate budget allotted for training • Lack of support if clients and/or families complain	• Misunderstanding of potential danger to staff, client and public	• Continued high incident rate • Continued staff retention problems	• No violence policy • Business case to address financial, OHS and community relations issues
Develop Education Content	• Poor results	• Inadequate use of best practices	• Poor uptake	• Research best practices • Validate small group
Target High Risk Personnel/ Clients	• High risk presonnel and clients still at risk	• Ineffective prioritization	• Poor uptake	• Develop at-risk evaluation grid
Train an In-House Trainer	• Withdrawal of senior management support	• High Costs	• AMT failure	
Plan Training Schedule	• Conflicts with peak service volumes			
Pilot Test on Small Group				
Evaluate Outcomes				
Modify Training and Deploy				

There are some limitations with the FMEA process. It is resource heavy and time intensive and generally deals with failures one at a time. It is suggested that FMEAs be used for serious potential risk areas, or when the HCCP is starting up a new service/practice and the QI team wants to do a thorough proactive look at all the potential risks.

- **Simulation**

  Simulation is a technique used to replicate or amplify real life experiences with guided experiences in a safe environment. It helps us to learn to recognize actual problems and understand the effects of our responses to these problems.

  Simulation allows for the exploration of "what-if" scenarios. Exploring the what-ifs enables people to prepare themselves for error-prone, high risk or unusual situations by practising beforehand with colleagues.

  The methodology of simulation is comparable to the clinical learning process that medical and nursing students undertake in an academic lab setting. In a risk management simulation exercise, the team members simulate a possible adverse event to help one another respond more appropriately. If possible, a senior team member or other expert can be called in to act as a coach. It is also suggested that one person draw a flow diagram to map the process for further discussion. Some examples where simulation works well include verbal de-escalation and/or wound care techniques, fire and/or emergency evacuation drills, etc.

Retrospective RM Methods

Retrospective Risk Management is past-oriented: it is used to address risk and correct problems after errors and/or adverse events have occurred. In RM, we define an actual problem, identify the cause(s) of the problem, and develop strategies to address the problem to ensure it doesn't happen again.

Some examples of retrospective Risk Management tools are: Brainstorming & the 5 Whys, the Ishikawa Diagram, Root Cause Analysis, etc. A few of these methods are reviewed here. (Additional tools can be found in *The Memory Jogger ll — A Pocket Guide of Tools for Continuous Improvement and Effective Planning).*

- **Brainstorming & The 5 Whys**

  This is a simple questioning technique used to define the actual problem. It is most often done in a team environment as multiple perspectives are often required to get at the 'Why" of the problem. The team leader, or the team member who first identified the problem, describes the problem to the rest of the team.

  Define a problem before attempting to fix it!

  The team asks "Why" and each answer to the "Why" question is followed by another "Why". Each answer is used to further refine the next questions by asking "Why" after each answer. It usually takes "5 Whys" to get to the clearly defined problem and/or issue.

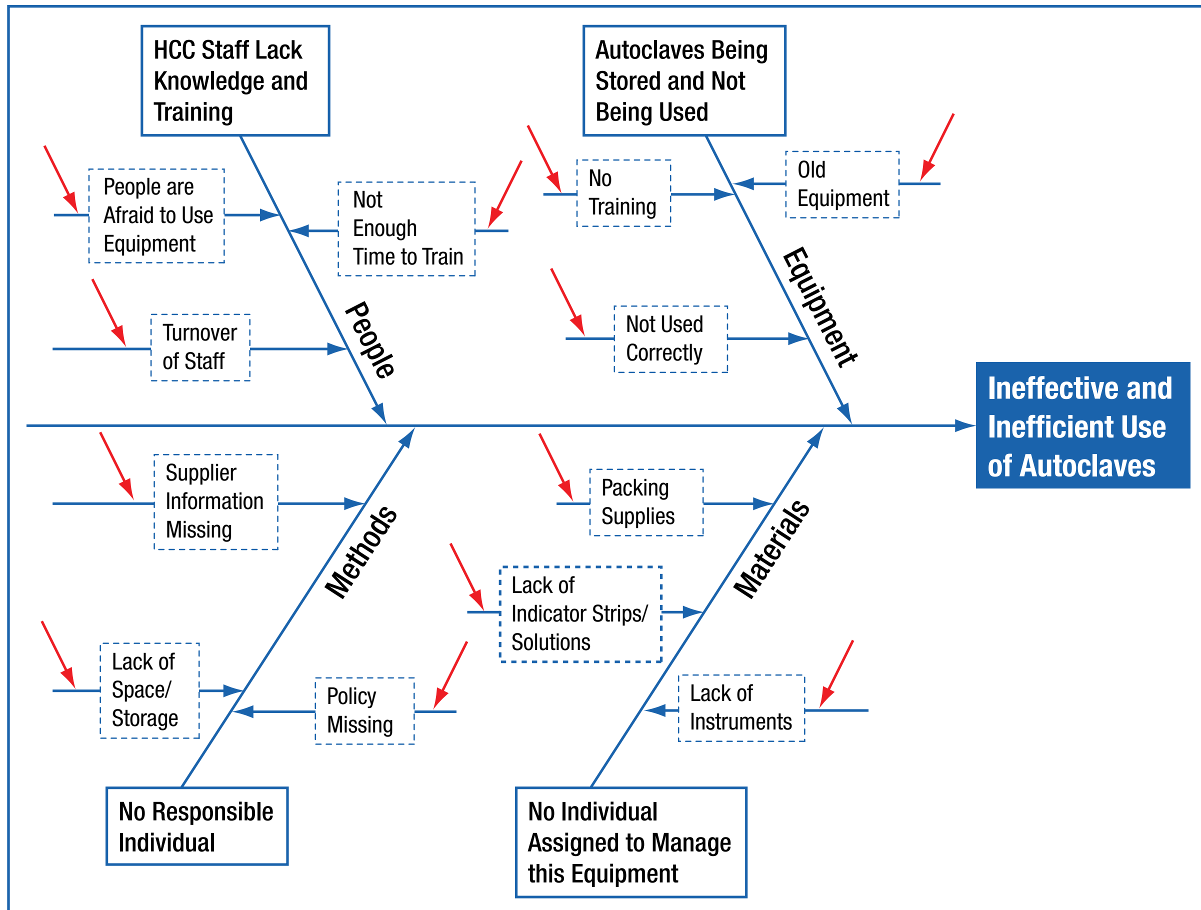
- **Ishikawa Diagram**

  The Ishikawa Diagram is another retrospective risk management tool used to help organize thoughts around various causative factors that can be associated with the main problem identified. It is also known as the "Fishbone" or the "Cause & Effect diagram."

  Creating an Ishikawa Diagram is a simple process requiring only that you draw a spine across a page and give that spine 4 ribs representing people, equipment, materials and methods. These four categories represent the main areas where the causes of problems occur within the HCCP. For each rib, draw diagonal "fish bones"to indicate the influences that help explain each cause.

An example of how an Ishikawa Diagram can be used to address the issue of the ineffective and inefficient use of autoclaves is provided below in Figure 5.

Figure 5: Ishikawa Diagram



***See Handbook # 4 and the CD-Rom for the Ishikawa worksheet tool.*

- **Root Cause Analysis (RCA)**

RCA is an analytical tool that helps healthcare providers perform a comprehensive, system-based review of significant incidents to identify the cause of the incident and help to develop prevention strategies. It includes identifying the root and causal factors, determining the risk reduction strategies and developing action plans along with measurement strategies to evaluate the effectiveness of the plans. In this way, RCA forces the HCCP to look past the easy answer — it was someone's fault — to answer the tougher question: why did the mistake happen? There is hardly ever just one reason.

To complete an RCA requires a significant amount of information gathering, including, but not limited to: chart reviews, site visits, staff and client interviews, policy and procedure reviews, etc. The purpose is to gather sufficient information to develop an understanding of the problem by answering what, when, where, who, how, the sequence of events, etc. This information is usually compiled into a simple flowchart.

The preliminary information is reviewed and the question is asked — Do we need more information? This is where the additional data gathering activities may occur. In the RCA there is a requirement for identifying best practices related to the specific event and its corresponding solution(s). This usually involves a review of the literature and current standards of practice.

Only after all this is there a final understanding and a visual timeline of the event. This is the starting position from which one can detect failure points and determine contributing factors and root causes. Here, additional tools such as the Ishikawa Diagram are needed.

The final stage in the process is formulating (root) causal statements to show how cause and effect are linked. The identification of these linkages supports the development of corrective actions.

The RCA approach has both benefits and weaknesses. The benefits include the use of a highly structured process to look at events. It overcomes the 'rush to judgement' tendency by including a broad range of issues and questions. It provides detailed sources of error, while avoiding blame by helping uncover system and organizational issues. It can be used for sentinel events, clustered events, common occurrences, etc.

The major drawbacks to using RCA are its resource and time intensity requirements. Often it is not clear if the cases that are analyzed are the organization's key problems as it is influenced by bias, based on past experiences and current issues that the organization is facing (i.e., focusing on staffing issues and information systems instead of device failures). It cannot be used on its own and requires other tools to identify and study the incident.

Example For Using The RCA Worksheet To Mitigate Risk:

Using the same case study scenario as in the FMEA example, you can also apply the RCA tool.

What Happened? — The client was discharged from hospital without a proper home care referral in place. This put him at risk and he did not receive the care he needed in a timely manner. The client returned to the Emergency Room in 48 hours.

Why Did It Happen? — There was no communication between the HCCP and the discharging hospital. The Home Care Nurse (HCN) works part-time and was not working when the client arrived home in the community. The client did not inform anyone that he required insulin and was unable to give it to himself.

How To Prevent It? — The HCN initiates contact with the local hospital discharge planner and establishes a process for notifying the HCCP about upcoming discharges. The HCCP develops a client education program that focuses on self-care as it relates to taking responsibility for personal information. The HCCP has a process established with the primary health care team to assess clients upon their return to the community, if the HCN is unavailable.

Action Plan/Risk Reduction Strategies — The HCCP Quality Improvement (QI) team meets and develops an action plan to address this issue.

Evaluate Effectiveness — The HCCP QI team develops indicators to measure their effectiveness in addressing this issue.

AIM Statement: In six months 95% of clients who are discharged from hospital to home will have a notification of discharge sent to the HCCP.

Indicator:

$$\frac{\text{number of clients discharged from hospital to home without notification to HCCP}}{\text{total number of clients discharged from hospital to home (1 month)}}$$

***See Handbook # 4 and the CD-Rom for the RCA worksheet tool.*

Health Canada Santé Canada

Your health and safety… our priority. *Votre santé et votre sécurité… notre priorité.*

QUALITY RESOURCE KIT

Electronic Resources and References

Handbook 4

Strengthening and Improving Home and Community Care

Canada

Health Canada is the federal department responsible for helping the people of Canada maintain and improve their health. We assess the safety of drugs and many consumer products, help improve the safety of food, and provide information to Canadians to help them make healthy decisions. We provide health services to First Nations people and to Inuit communities. We work with the provinces to ensure our health care system serves the needs of Canadians.

Published by authority of the Minister of Health.

First Nations and Inuit Home and Community Care (FNIHCC) Quality Resource Kit is available on Internet at the following address: http://www.hc-sc.gc.ca/fniah-spnia/pubs/services/_home-domicile/prog_crit/index-eng.php

Également disponible en français sous le titre:
Soins à domicile et en milieu communautaire des Premières nations et des Inuits (SDMCPNI) Trousse de ressource pour l'amélioration de la qualité

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Quality Improvement Tools

FNIHCC Program Quality and Safety Scan: Enhancing Quality in the First Nations and Inuit Home and Community Care Programs

This tool is intended to be used as a preliminary overall scan of the main Home and Community Care Program (HCCP) components. It serves to identify strengths and areas to improve before implementing program-specific Quality Improvement and Risk Management plans.

Weighting — probability (H, M & L) & severity (H, M & L)

Key program components (*see legend for rating)	PE	PX	PD	NP	Probability			Severity			Comments
					H	M	L	H	M	L	
A. Governance, Linkages & Leadership											
1. Mission, Vision & Values											
a. Mission, vision and values clear and accessible to all internal and external stakeholders											
b. Recent Community Needs Assessment completed (last 5 years)											
c. Commitment to client safety adopted as a written strategic goal											
d. Other											

LEGEND

PE – Process established and working effectively
PX – Process in place but needs enhancement
PD – Process in development, but not in place
NP – Process not in place

Key program components (*see legend for rating)	PE	PX	PD	NP	Probability			Severity			Comments
					H	M	L	H	M	L	
2. Program Goals & Objectives											
a. Program goals and objectives clear and measurable											
b. Indicators being tracked and used to improve services											
c. External stakeholders involved in program development											
d. Internal stakeholders involved in program development											
e. Written, up-to-date service delivery plan aligned to objectives of program											
f. Process in place for regular revision of service delivery plan											
g. Other											
3. External Linkages											
a. Service agreements in place with health, social service and community service providers, including coordinated assessment processes, referral protocols and discharge planning protocols											
b. Linkages in place with the Aboriginal Affairs and Northen Development Canada (AANDC) In-Home Care component of the Assisted Living program											

Key program components (*see legend for rating)	PE	PX	PD	NP	Probability			Severity			Comments
					H	M	L	H	M	L	
c. Memorandum of Understanding (MOU)											
d. Regular (annual) community involvement in program development											
e. Other											
4. Financial Accountability											
a. Clearly defined budgeting process in place involving Home and Community Care (HCC) Coordinator											
b. Personnel covered by malpractice and liability insurance											
c. General services covered by liability insurance											
d. Regular (quarterly) revisions of financial plan implemented											
e. Property insurance in place (strongly recommended)											
f. Regular financial reports submitted as required											
g. Annual external audit carried out											
h. Financial accountability indicated in relevant job descriptions											
i. Resource usage processes implemented											
j. Other											

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Key program components (*see legend for rating)	PE	PX	PD	NP	Probability			Severity			Comments
					H	M	L	H	M	L	
5. Ethics											
a. Code of Ethics in place											
b. Access to an Ethics Committee available for personnel											
c. Ethical decision making processes implemented											
d. Charter of Clients' Rights and Responsibilities implemented											
e. Research policy implemented											
f. Ethics training available for staff											
g. Other											
6. Quality Improvement & Risk Management											
a. The organization's leaders to investigate and respond to incidents of workplace violence											
b. The organization's leaders review quarterly reports of incidents of workplace violence and use this information to improve safety and make improvements to the workplace violence policy											
c. The organization provides information and training to staff on the prevention of workplace violence											
d. A comprehensive Quality Improvement Plan is implemented											
e. A no-blame quality improvement culture is implemented											

Key program components (*see legend for rating)	PE	PX	PD	NP	Probability			Severity			Comments
					H	M	L	H	M	L	
f. Policies and procedures are regularly revised (3–5 years) to ensure conformity with current standards of practice											
g. HCC policies and procedures manuals are current and up to date											
h. Annual or PRN Risk Assessments are carried out for the program											
i. Processes exist to report and manage near-misses (good-catches)											
j. Processes exist to report and manage incidents/ occurrences/adverse events and sentinel events											
k. Risk Management Plans are carried out											
l. A Falls Prevention program is implemented											
m. Personnel have access to training for falls prevention											
n. Written and verbal information is provided to clients and families about their role in safety											
o. Medication errors are tracked											
p. Missed services are tracked											
q. Other											

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Key program components (*see legend for rating)	PE	PX	PD	NP	Probability			Severity			Comments
					H	M	L	H	M	L	
B. SUPPORTIVE PROCESSES											
1. Human Resources, Professional Development & Work Life											
a. A Human Resources (HR) planning, recruitment and retention plan is implemented											
b. A staff training plan is implemented											
c. The First Nations & Inuit Home and Community Care Program (FNIHCC) Human Resource Profile is up to date											
d. Recent written job descriptions (3 years) are in place for all positions											
e. Orientation processes are in place for all staff (including a mentoring system for new employees)											
f. Staff have access to training											
g. Exit interviews are conducted and used to improve HR processes											
h. The supervising nurse assesses the competencies of home support workers yearly											
i. A process exists for assessment of the competencies of the Registered Nurse by the appropriate authority											
j. All staff have current certification/licensure/registration											

Key program components (*see legend for rating)	PE	PX	PD	NP	Probability			Severity			Comments
					H	M	L	H	M	L	
k. Training in cardiopulmonary resuscitation (CPR) is available for program personnel according to current standards											
l. Training in First Aid is available for program personnel according to current standards											
m. Professional/clinical support/supervision is available on an ongoing basis to HCC personnel from appropriate health organizations											
n. Registered Nurse supervision and consultation for HCC staff is available at all times during service delivery hours											
o. HCC Personnel on-call have access to supervisory personnel											
p. Staff training in Workplace Hazardous Materials Information System (WHMIS) is available according to current standards											
q. Staff training in management of aggressive behaviour is available according to current standards											

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NP – Process not in place

Key program components (*see legend for rating)	PE	PX	PD	NP	Probability			Severity			Comments
					H	M	L	H	M	L	
r. Annual Performance Appraisals are conducted (including individual learning needs assessments)											
s. A workplace violence prevention program is implemented											
t. Processes exist for service providers to confidentially report incidents of workplace violence											
u. Training for staff in prevention of workplace violence is available according to current standards											
v. A workload policy is implemented											
w. A rewards and recognition program is implemented											
x. Personnel have access to an Employee Assistance Program											
y. Personnel have access to health management education											
z. HR indicators are tracked and results used to improve services											
aa. Other											
2. Communication, Data Collection & Information Management											
a. An information management plan is implemented											
b. Communication strategies are effective											

Key program components (*see legend for rating)	PE	PX	PD	NP	Probability			Severity			Comments
					H	M	L	H	M	L	
c. Staff feedback is regularly solicited and used to improve services											
d. Client feedback is regularly solicited and used to improve services											
e. Family feedback is regularly solicited and used to improve services											
f. Community feedback is regularly solicited and used to improve services											
g. A Privacy policy is implemented											
h. A Disclosure policy is implemented											
i. An Informed Consent policy is implemented											
j. Personnel receive training in Privacy, Disclosure and Informed Consent											
k. Written and verbal information about services is available for clients, families and partners											
l. Client and Service Data is regularly validated for accuracy											
m. Important client information is documented in a comprehensive client health record by health care providers											

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Key program components (*see legend for rating)	PE	PX	PD	NP	Probability			Severity			Comments
					H	M	L	H	M	L	
n. Client health records are stored and handled in a confidential and secure way											
o. Service delivery data is collected and uploaded monthly as per the Electronic Service Delivery Reporting Template (e-SDRT)											
p. Information technologies are adequate for needs of program											
q. Staff are trained in the use of information technologies											
r. Other											
3a. Environment — Emergency Preparedness											
a. A community-based Emergency & Disaster Preparedness Plan is implemented											
b. Regular (annual) community wide emergency drills or Table top exercises for evacuation are carried out											
c. Quarterly fire and evacuation drills are conducted											
d. Home oxygen, fire and burn prevention safety processes are implemented for clients											
e. Personnel receive training in Emergency & Disaster Response											
f. A Pandemic Plan is in place											

Key program components (*see legend for rating)	PE	PX	PD	NP	Probability			Severity			Comments
					H	M	L	H	M	L	
g. Personnel receive training in pandemic response											
h. Other											
3b. Environment — Infection Prevention											
a. Infection rates are tracked											
b. Personnel receive training in infection prevention (i.e. hand washing, infection prevention etc.)											
c. Hand washing facilities and signage are adequate											
d. A vaccination program for pneumococcal infections is implemented for clients and program personnel											
e. Vaccination program for influenza infections is implemented for clients and program personnel											
f. Current health care-associated Methicillin-Resistant Staphyloccus Aureus (MRSA), C Difficile and protocols for other communicable disease (i.e., Sexually Transmitted Infections [STIs], etc.) are followed											
g. Written and verbal information is available for clients, families and partners											

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NP – Process not in place

Key program components (*see legend for rating)	PE	PX	PD	NP	Probability			Severity			Comments
					H	M	L	H	M	L	
h. Home care non-surgical wound infection surveillance protocols are followed											
i. Current equipment sterilization and reuse procedures are implemented appropriately (i.e., autoclaves, cold chain sterilization, etc.)											
j. Responses to infectious processes are documented											
k. Other											
3c. Environment — Occupational Health & Safety											
a. An Occupational Health & Safety (OHS) Plan is implemented											
b. Regular OHS committee meetings are carried out											
c. A No-Violence Policy is enforced											
d. Handicap access to program services is available where applicable											
e. Regular equipment maintenance is carried out											
f. An equipment replacement process is implemented											
g. Procedures for transporting and disposing of hazardous wastes are followed											
h. Personnel receive training in OHS (WHMIS, safe driving and lifting techniques, etc.)											

Key program components (*see legend for rating)	PE	PX	PD	NP	Probability			Severity			Comments
					H	M	L	H	M	L	
i. OHS Indicators tracked and used to improve services											
j. Security processes are in place to prevent risk to care providers in clients' homes											
k. Vehicles are tested for road safety											
l. Other											
C. SERVICE DELIVERY											
1. Assessment											
a. Clients receive an initial contact within 48 hours of referral by a Registered Nurse											
b. A Registered Nurse conducts the assessment											
c. Standardized, current tools are used to conduct the client assessment											
d. The assessment process includes a full risk assessment											
e. There is a complete client reassessment scheduled annually											
f. Additional reassessments are made at any time, as required by the client's condition											
g. Other											

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Key program components (*see legend for rating)	PE	PX	PD	NP	Probability			Severity			Comments
					H	M	L	H	M	L	
2. Care Planning											
a. Case Management processes are implemented											
b. Each client has a comprehensive care plan based upon assessed bio-psychosocial need											
c. Each client signs his/her care plan											
d. Each care plan includes a risk assessment with attention to elements related to the client's medical, functional and social situation as well as pertinent home safety issues											
e. A home safety checklist is completed for each client											
f. Each care plan includes appropriate information, teaching and risk-prevention strategies for the client and/or his/her family											
g. A Registered Nurse develops the care plan in conjunction with the care team and related service providers											
h. The clients, families and/or other care providers are involved in care planning as appropriate											
i. Care plans are updated as required or at least monthly											

Key program components (*see legend for rating)	PE	PX	PD	NP	Probability			Severity			Comments
					H	M	L	H	M	L	
3. Care Provision											
a. The multidisciplinary care team meets regularly *and* as required by the client's condition											
b. Communication processes and tools are in place to make sure important client information is shared across services											
c. Home care nursing services are provided in the home, with exceptions											
d. Home support services are delivered according to the care plan, with exceptions											
e. A Registered Nurse coordinates the care plan with other service providers											
f. A formal backup plan is in place to provide nursing care if the usual HCC Registered Nurse Case Manager is not available											
g. Guidelines regulate the transporting of medications to clients' homes											
h. Standardized medication records are used for tracking administration											

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Key program components (*see legend for rating)	PE	PX	PD	NP	Probability			Severity			Comments
					H	M	L	H	M	L	
i. Pharmaceuticals are provided as indicated by the client's condition											
j. Medication reconciliation is carried out on admission											
k. Medication reconciliation is carried out on transfer/ discharge											
l. Dangerous ("No use") abbreviations are avoided											
m. At least 2 client identifications are used to identify clients											
n. A process exists for efficient, timely management of medical equipment											
o. Medical supplies are provided as indicated by the client's condition											
p. A pain management program is implemented											
q. Respite care (either in home or in another agency) is available as indicated by the client's condition											

Key program components (*see legend for rating)	PE	PX	PD	NP	Probability			Severity			Comments
					H	M	L	H	M	L	
4. Discharge Planning											
a. Discharge planning is done by the Registered Nurse											
b. Standardized transfer and discharge forms are used											
c. Post discharge follows-up are carried out to verify effectiveness											
d. Other											
5. Client & Service Outcomes											
a. Client health outcome goals are attained											
b. Services provided are consistent with client care plan											
c. Program goals are attained											
d. Other											

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QI Action Plan Template

Issue to be addressed:	
AIM Statement:	
QI Lead or QI Team Members:	
Date for Completion:	

ACTION PLAN					
Item #	Change (What)	Plan (Who, Where, When, How)	Do (Date started)	Study (Gather data to see if change was an improvement)	Act (Adopt the change; Amend the change or Abandon and try something else)

Notes:

QI Pathway

PLAN	DO	STUDY	ACT
1. Review the services you provide and identify a priority/ issue or service area you want to improve. 2. Decide on the outcome or target you want to achieve. 3. Develop an action plan to address the problem or area for improvement you have identified. 4. Develop measurement tools to monitor progress (indicators). 5. Assign people to be responsible for collecting and reporting the results of the indicators. 6. Communicate your activities to everyone who is affected by them.	7. Implement the action plan. 8. Monitor the indicators to identify progress. 9. Document the results.	10. Analyze the changes that have occurred since the action plan was implemented. 11. Identify any challenges that have arisen and develop plans to overcome them. 12. Assess whether the target has been reached.	13. Make permanent changes based on what you have learned. 14. Identify the next problem to be addressed.

QI Project Plan

For use by individuals or groups wishing to present quality issues to the Quality Team.

Please identify which of the following best describes your quality issue;

- ☐ Issue that cannot be easily resolved at the service delivery level.
- ☐ Issue that is common across program delivery in the community.
- ☐ Issue that has resisted the usual problem solving approach.

Date: _________________ **Presented By**: _________________________

Part A — *To be completed before presenting to the QI Team*

What is the issue?

Include all details related to the issue, including how long it has been a concern and the risks associated with it.

____

____

What action has been taken to date?

Describe, if appropriate, any steps that have been taken to date to resolve the issue and any progress made.

____

____

What should the resolution be?

Suggestions from the presenter on what should be in place to resolve the issue.

____

____

Part B — ***To be completed during the QI Team meeting and to act as a record of activity***

Action Steps	Responsibility	Progress

Part C — *Project Summary Findings*

To be completed at the project conclusion.

____

____

____

____

Next Steps

Any further steps that need to be taken on this issue.

____

____

____

____

Communicated to:

Names and positions of the people the project results were communicated to.

____

____

____

____

Signed Off:________________________________

Date:________________________________

Steps to QI Form

1. Select one area for improvement to examine further:

____

____

2. Select data source/s:

____

____

3. Collect data:

- Data can help you separate what you think is happening from what is really happening;
- Data will establish a baseline so you can measure improvement;
- Data will help you avoid putting solutions in place that will not solve the problem.

Record findings here:

Case #	Yes	No
1		
2		
3		
4		
5		

4. If the data is not readily available, what sources did you use to collect your data, and what steps did you take to collect this data?

____

____

Risk Management Tools

FMEA Form

Worksheet 1: Failure Mode and Effects Analysis (FMEA)

How to PREVENT FAILURE

- Reminders, checklists, double checks;
- Forcing functions (i.e., people can't avoid doing the right thing);
- Automation/computerization;
- Redundancy;
- Do not rely only on memory, policies and procedures, "perfect" human performance or training/education.

How to PREPARE if FAILURE occurs

- Improve detection or make errors more visible;
- Mitigate any adverse effects.

Process/Service: ____ **Date:** _________________

Team Members:

____

____

____

____

Note: Brainstorm all failures then prioritize *most likely* and *most severe* failures and develop prevention and mitigation strategies for these.

Failure (What could go wrong?)	Cause(s) (N.B. There may be more than one cause for each failure)	How to PREVENT FAILURE (List strategies for *each* cause)	How to PREPARE if FAILURE Occurs (i.e. Prevention strategies fail) (*List ideas for each* cause)

Root Cause Analysis Form

INITIAL REVIEW DATE: ______________________ REFERENCE #:____________

Signatures of review team:

A. What happened?

Briefly *describe* the event in terms of what, when, where, how it happened, etc., in sequence. (Note: a flow diagram may be helpful here.)

B. What is our initial understanding of the problem?

Discuss with all key stakeholders and develop a flow chart, narrative timeline or chronological description of the events involved. Determine if additional information is needed to fill in the gaps.

C. Do we need more information to develop a final understanding of the problem:

- Visit the site of the event:
- Review the clients' file:
- Interview the client/family:
- Interview the staff:

D. What can we learn from the following to help us understand and address this issue?

- Review current clinical guidelines related to this issue:
- Review current practice standards:

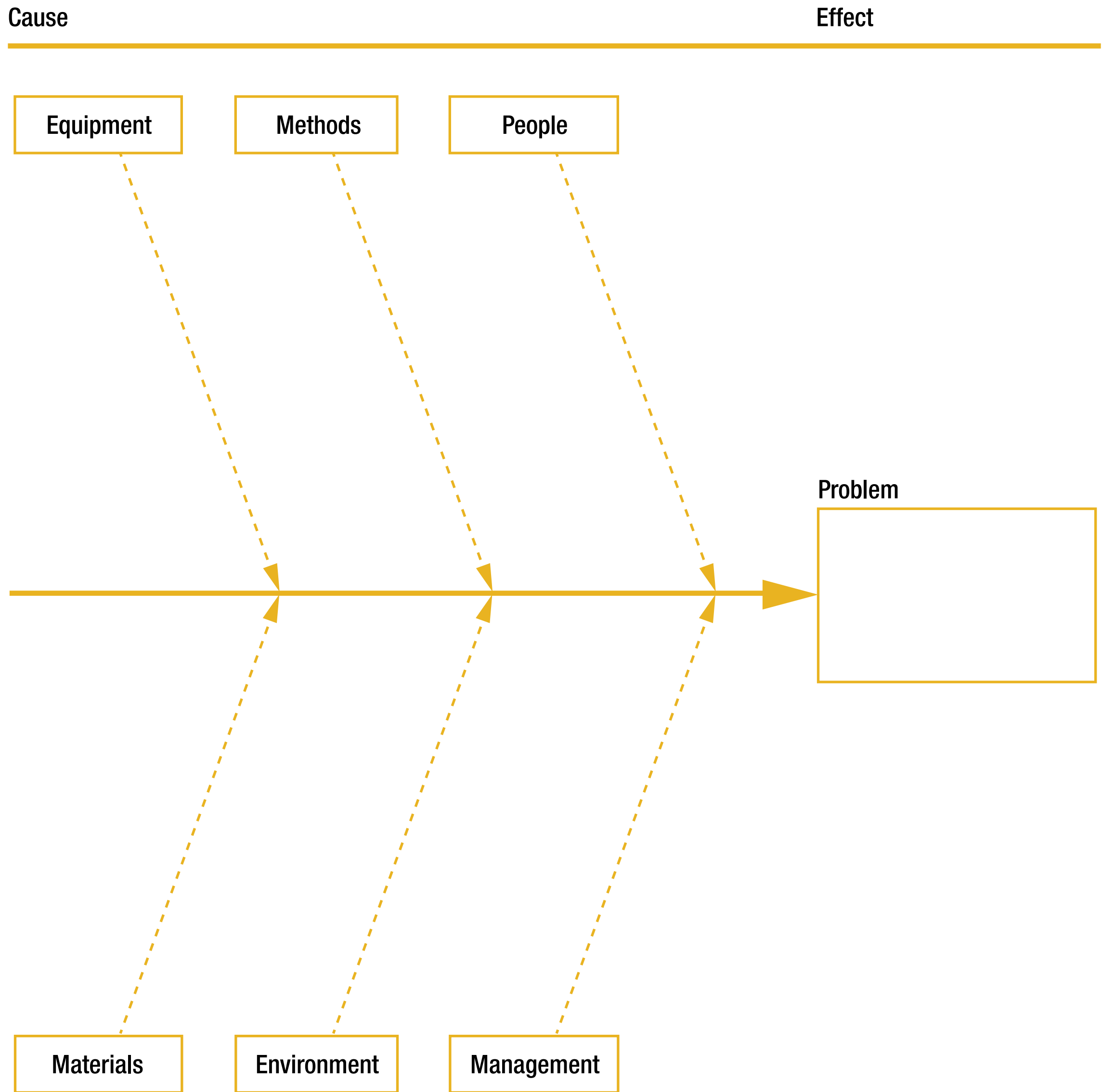
E. What is our final understanding of the problem? Why did it happen?	
a) What are the contributing factors? (factors that would not all have prevented the incident even if corrected)	
Client factors ☐ Client's condition deteriorated rapidly? ☐ Client did not follow instructions? ☐ Others? ____________	
Information Management ☐ Client correctly identified? ☐ Documentation provides a clear picture? ☐ Training issues? Communication issues? ☐ Level of automation appropriate? ☐ Others? ____________	**Equipment** ☐ Display and controls understandable? ☐ Equipment detects and displays problems? ☐ Standardized or several different models? ☐ Maintenance/upgrades up-to-date ☐ Warnings/labels understandable ☐ Others? ____________
Environment ☐ Noise levels interfere with voices? ☐ Lighting adequate for tasks? ☐ Adequate air, water, surface temperature? ☐ Area adequate for people and equipment? ☐ Clutter or inadequate stowage? ☐ Work areas, tools, etc. located correctly? ☐ Security? ☐ Others? ____________	**Policies and Processes** ☐ Audit/quality control for process? ☐ Do people work around official policy? ☐ Standardized process or order set? ☐ Use of checklists or other tools? ☐ Others? ____________

<table>
<tr><td colspan="3">Safety Mechanisms
☐ Did anything stop or decrease harm?
☐ Equipment safety mechanisms functional?
☐ System designed to be fault- tolerant?
☐ Others? ____________________</td><td colspan="3">Human Resource Issues
☐ Staffing levels?
☐ Orientation/training?
☐ Fatigue?
☐ Supervision of staff?
☐ Others? ____________________</td></tr>
<tr><td colspan="6">b) What is the root cause?</td></tr>
<tr><td colspan="6"></td></tr>
<tr><td colspan="6">F. What is our plan to prevent a recurrence of the event?</td></tr>
<tr><td colspan="3">Standardize/simplify
☐ Standardize equipment
☐ Standardize protocol
☐ Remove unneeded step(s)</td><td colspan="3">Automation/computerization
☐ Automatic calculations
☐ Provide reminders
☐ Assist decision-making</td></tr>
<tr><td colspan="3">Improve or new devices
☐ Better controls/displays
☐ Better integration
☐ More fault-tolerant</td><td colspan="3">Improve Environment
☐ Improve flow of personnel
☐ Better lighting, noise, clutter
☐ Better stowage, signage, etc.</td></tr>
<tr><td colspan="6">c) Create an action plan</td></tr>
<tr><td>Risk Reduction Strategies</td><td colspan="2">Actions</td><td>Outcome Measures</td><td>Date</td><td>Responsible</td></tr>
<tr><td></td><td colspan="2"></td><td></td><td></td><td></td></tr>
<tr><td colspan="6">Review Date</td></tr>
<tr><td colspan="6">Sign Off</td></tr>
</table>

Adapted from Veterans Affairs Case Conference Worksheet, May 2005

Cause and Effect Analysis Diagram

Date: ______________________________



Examples of Plan-Do-Study-Act (PDSA) Cycles

Example 1: QI Action Plan — Client Satisfaction

Issue to be addressed:	Client Satisfaction
AIM Statement:	Within 6 months of initiating the QI plan, 90% of clients discharged from the HCCP will report satisfaction with the services they received
QI Lead or QI Team Members:	Case Manager, home care nurse, personal care worker
Date for Completion:	March 31, 2010

ACTION PLAN					
Item #	Change (What)	Plan (Who, Where, When, How)	Do (Date started)	Study (Gather data to see if change was an improvement)	Act (Adopt the change; Amend the change or Abandon and try something else)
1	Clients will report high levels of satisfaction with services delivered.	• Complete initial client satisfaction survey to determine baseline; • Identify issues that cause dissatisfaction; • Develop an action plan to address each issue that causes dissatisfaction; • Complete follow up client satisfaction survey.	October 1, 2009 November 1, 2009 December 1, 2010 March 31, 2010	Baseline measurement: $\frac{\text{\# of clients who were satisfied with services}}{\text{Total \# clients who were surveyed (Time Frame)}}$ Follow-up measurement: $\frac{\text{\# of clients who were satisfied with services}}{\text{Total \# clients who were surveyed (Time Frame)}}$	Based on client satisfaction survey data, decide whether intervention was successful or not.

Example 2: QI Action Plan — Discharge Referrals

Issue to be addressed:	Ensure all clients who require home care services are referred to the HCCP.
AIM Statement:	In 6 months, 85% of clients discharged from hospital/nursing station care and require home care services receive a referral to the HCCP.
QI Lead or QI Team Members:	Case Manager, home care nurse, primary care nurse/physician, referring agency.
Date for Completion:	March 31, 2010

ACTION PLAN					
Item #	Change (What)	Plan (Who, Where, When, How)	Do (Date started)	Study (Gather data to see if change was an improvement)	Act (Adopt the change; Amend the change or Abandon and try something else)
1	Clients are referred to the HCCP when discharged from hospital and/or nursing station care: • Decreases the risk that client needs are not met in a timely manner; • Ensures any urgent needs are identified and acted upon in a timely manner	• Collaborate with the primary care nurses/ physicians/Regional Health Authorities (RHAs) to develop a referral process; • Develop a policy/procedure statement that outlines how the referral process happens, including who is responsible for what activities within the process; • Have all agencies sign and/ or agree to the policy.	October 1, 2009 November 1, 2010 December 1, 2009	# of clients who receive a referral upon discharge ——— Total # clients who require a referral top HCCP (Time Frame)	Based on the data, the team decides to either adopt the policy or revise the process further.

Example 3: QI Action Plan — Foot Care Services

Issue to be addressed:	Ensure all clients can receive basic foot care services from a Registered Nurse (RN).
AIM Statement:	In 6 months, 90% of clients who require basic foot care will receive it from their home care RN.
QI Lead or QI Team Members:	Case Manager, home care nurse.
Date for Completion:	March 31, 2010

ACTION PLAN					
Item #	Change (What)	Plan (Who, Where, When, How)	Do (Date started)	Study (Gather data to see if change was an improvement)	Act (Adopt the change; Amend the change or Abandon and try something else)
1	Clients who require foot care services can receive basic foot care from the home care RN.	• Identify which RNs are interested in providing foot care; • Partner with a training program to provide the necessary foot care training at the basic level.	October 1, 2009 November 1, 2009	# of clients who receive foot care services / Total # clients who require foot care services (Time Frame)	Based on data decision made to continue having the RN provide basic foot care.

Example 4: QI Action Plan — Initial RN Assessment

Issue to be addressed:	Ensure all clients who require home care services are referred to the HCCP.
AIM Statement:	In 6 months, 85% of clients who are referred to the program receive an initial contact by a RN within 48 hours.
QI Lead or QI Team Members:	Case Manager, home care nurse, primary care nurse/physician, referring agency.
Date for Completion:	March 31, 2010

ACTION PLAN					
Item #	Change (What)	Plan (Who, Where, When, How)	Do (Date started)	Study (Gather data to see if change was an improvement)	Act (Adopt the change; Amend the change or Abandon and try something else)
1	Clients are seen by an RN within 48 hours of arriving back in the community: • Decreases the risk that clients' needs are not met in a timely manner; • Ensures any urgent needs are identified and acted upon in a timely manner.	• Hire a part-time nurse to do the initial contact; • Partner with the primary care nurse to do the initial contact; • Initiate MOU with Regional Health Authority (RHA)/ agency to complete the initial visit.	October 1, 2009 October 1, 2009 January 4, 2010	# of clients who receive an initial contact by an RN within 48 hours / Total # of clients referred to HCC (1 month) # of clients seen by part-time RN / Total # of clients seen by all RNs (Time Frame) # of clients seen by primary care RN / Total # of clients seen by all RNs (Time Frame) # of clients seen by RHA / Total # of clients seen by all RNs (Time Frame)	Based on data, decision made to continue the employment of a part-time RN

Example 5: QI Action Plan — Nursing Bag Infection Control

Issue to be addressed:	Ensure all nursing bags are handled using proper infection control procedures.
AIM Statement:	In 6 months, 100% of staff will employ appropriate infection control procedures in the handling of the nursing bag.
QI Lead or QI Team Members:	Home Care nurses, Personal Support Workers, Interpreters, Home Care Health Aids.
Date for Completion:	March 31, 2010

ACTION PLAN					
Item #	Change (What)	Plan (Who, Where, When, How)	Do (Date started)	Study (Gather data to see if change was an improvement)	Act (Adopt the change; Amend the change or Abandon and try something else)
1	Staff uses proper infection control procedures to handle nursing bags.	• Identify which staff are using/ handling the bags; • Provide education session to all staff handling bags on appropriate infection control procedures for the bag; • Develop bag cleaning log and monitoring process.	October 1, 2009 October 15, 2009 November 1, 2009	Each staff person completes the bag cleaning log; Case manager monitors the log weekly; Results from logs are brought back to the QI team meeting.	Based on data, make a decision: • Continue with the program as is; • Change the education component; • Change the monitoring process.

References

Accreditation Canada (2005), Risk Management Plan

Accreditation Canada (2010), Qmentum Program Update

AIG Healthcare (2007) *Fire & Burn Prevention in Home Health*

AIG Healthcare (2007) *Home Oxygen and Fire Safety*

Barnard, D., et al (2006), *Implementing a Good Catch Program in an Integrated Health System*, Healthcare Quarterly, 9 (Sp), pp. 22–27

Burland, M.J (2008) *An Evaluation of a Fall Management Program in a Personal Care Home Population*, HealthCare Quarterly, Volume 11, Special Issue

Canadian Council on Health Services Accreditation (1996), *A Guide to the Development and Use of Performance Indicators.*

Caldwell, C. et al (2005), *Lean Sigma Six for Healthcare: A Senior Leader Guide to Improving Costs and Throughput*, ASQ Quality Press, Milwaukee, Wisconsin

Canadian Council on Health Services Accreditation (2002), *Achieving Improved Measurement*, Ottawa

Canadian Council on Health Services Accreditation (2005), *Making Sense of Indicators*, Ottawa

Canadian Council on Health Services Accreditation (2010), *Qmemtum Program Update*, Ottawa

Canadian Council on Health Services Accreditation (2005), *Risk Management Plan*, Ottawa

Canadian Patient Safety Institute (2006), *Background Paper for the Development of National Guidelines for the Disclosure of Adverse Events*, November, pp. 1–17

Canadian Patient Safety Institute (2006), *Canadian Root Cause Analysis Framework: A tool for identifying and addressing the root causes of critical incidents in healthcare*

Carroll, R. 2006. *Risk Management Handbook for Health Care Organizations* (5th ed.), San Francisco: Jossey-Bass

Collins, L. et al (2008) *Leading Complex Change in Healthcare: 10 Lessons Learned*, HealthCare Quarterly, Volume 11, No. 4

Deming, W.E. (2009), *Chronic Illness Care, A National Program of the Robert Wood Johnson Foundation*, Seattle, Washington, USA (website, July 2009)

Dingwall, O. et al (2006), *Recommended Readings on Disclosure*, CPSI

Doan, M. et al (2009), *Identification of Safety Outcomes for Canadian Home Care Clients*, Healthcare Quarterly, Volume 12

Emanuel, E. J. & Emanuel, L. L. (1996), *What is accountability in Healthcare?*, Annals of Internal Medicine, pp. 124

Fleming, M. (2005) *Patient Safety Culture Measurement and Improvement: A "How To" Guide*, HealthCare Quarterly, Volume 8, Special Issue, October

Harrigan, M. L. (1999), *Quest for Quality in Canadian Healthcare: Continuous Quality Improvement*

Health Quality Council (2005), *Quality Improvement Tool book: A practical approach to improving the quality of health care — your goal and ours,* Saskatoon SK.

Iedema, R. et al (2008), *Patients' and family members' experiences of open disclosure following adverse events,* International Journal for Quality in Health Care 2008, Volume 20, Number 6

Institute for Health Care Improvement (2004), *Failure Modes and Effects Analysis (FMEA)*

Institute for Health Care Improvement (2007), *Disclosure Toolkit: Establishing a Culture of Respect, Communications and Disclosure*

Institute for Safe Medication Practices Website (2006), *Our Long Journey Towards a Safety-Minded Just Culture Part II: Where We're Going*, September 21 issue

Langley, G. J., Moen, R., Nolan, K. M., Nolan, T. W., Norman, C. L., Provost, L. P. (2009) *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance*, 2nd Ed., Jossey-Bass, California

Ontario Community Support Association (1999), *Managing Risk: Polices and Procedures for Community Agencies*

Ontario Community Support Association (1999), *Standards & Indicators for Community Support Services: The Guide to Quality Care*

Ontario Safety Association for Community & Healthcare (2003), *Health and Safety in the Home Care Environment,* pp. 1–85

Ontario Safety Association for Community & Healthcare (2006), *Occupational Health and Safety Program — Client Self-Assessment Checklist*, March, pp. 1–19

Podsiadlo, D., Richardson, S. (1991), *The timed "Up & Go": A test of basic functional mobility for frail elderly persons*, Journal of American Geriatrics Society, pp. 67:387–389

Reason, J, T. et al (2001), *Diagnosing "vulnerable system syndrome": An essential prerequisite to effective risk management*", Quality Health Care, UK

RNAO (2008), *Preventing and Managing Violence in the Workplace*

Safer Healthcare Now (SHN)! Campaign (2005), *Getting Started Kit, Medication Reconciliation; How-to Guide: Prevention of Adverse Drug Events,*
Updated: November 6, 2005

Sears, N. (2008), *Harm From Home care: A Patient Safety Study Examining Adverse Events in Home Care*

Electronic Reference Sources

www.accreditation.ca

www.cihi.ca

www.healthcanada.gc.ca/accreditation

www.hqc.sk.ca

www.ihi.org

www.npsa.nhs.uk

www.isqua.org

www.ohqc.ca

www.qaproject.org

http://www.qualitycoach.net/memoryjogger.htm

http://www.ihi.org/IHI/Topics/Improvement/ImprovementMethods/HowToImprove

http://spreadsheets.about.com/b/2008/12/15/excel-2007-pie-chart-tutorial-4.htm

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QUALITY RESOURCE KIT

Electronic Resources and References

Handbook 4A

Strengthening and Improving Home and Community Care

Canada

Health Canada is the federal department responsible for helping the people of Canada maintain and improve their health. We assess the safety of drugs and many consumer products, help improve the safety of food, and provide information to Canadians to help them make healthy decisions. We provide health services to First Nations people and to Inuit communities. We work with the provinces to ensure our health care system serves the needs of Canadians.

Published by authority of the Minister of Health.

First Nations and Inuit Home and Community Care (FNIHCC) Quality Resource Kit is available on Internet at the following address: http://www.hc-sc.gc.ca/fniah-spnia/pubs/services/_home-domicile/prog_crit/index-eng.php

Également disponible en français sous le titre:
Soins à domicile et en milieu communautaire des Premières nations et des Inuits (SDMCPNI) Trousse de ressource pour l'amélioration de la qualité

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Quality Improvement Tools

FNIHCC Program Quality and Safety Scan: Enhancing Quality in the First Nations and Inuit Home and Community Care Programs

This tool is intended to be used as a preliminary overall scan of the main Home and Community Care Program (HCCP) components. It serves to identify strengths and areas to improve before implementing program-specific Quality Improvement and Risk Management plans.

Weighting — probability (H, M & L) & severity (H, M & L)

Key program components (*see legend for rating)	PE	PX	PD	NP	Probability			Severity			Comments
					H	M	L	H	M	L	
A. Governance, Linkages & Leadership											
1. Mission, Vision & Values											
a. Mission, vision and values clear and accessible to all internal and external stakeholders											
b. Recent Community Needs Assessment completed (last 5 years)											
c. Commitment to client safety adopted as a written strategic goal											
d. Other											

LEGEND

PE – Process established and working effectively
PX – Process in place but needs enhancement
PD – Process in development, but not in place
NP – Process not in place

Key program components (*see legend for rating)	PE	PX	PD	NP	Probability			Severity			Comments
					H	M	L	H	M	L	
2. Program Goals & Objectives											
a. Program goals and objectives clear and measurable											
b. Indicators being tracked and used to improve services											
c. External stakeholders involved in program development											
d. Internal stakeholders involved in program development											
e. Written, up-to-date service delivery plan aligned to objectives of program											
f. Process in place for regular revision of service delivery plan											
g. Other											
3. External Linkages											
a. Service agreements in place with health, social service and community service providers, including coordinated assessment processes, referral protocols and discharge planning protocols											
b. Linkages in place with the Aboriginal Affairs and Northen Development Canada (AANDC) In-Home Care component of the Assisted Living program											
c. Memorandum of Understanding (MOU)											
d. Regular (annual) community involvement in program development											
e. Other											

Key program components (*see legend for rating)	PE	PX	PD	NP	Probability			Severity			Comments
					H	M	L	H	M	L	
4. Financial Accountability											
a. Clearly defined budgeting process in place involving Home and Community Care (HCC) Coordinator											
b. Personnel covered by malpractice and liability insurance											
c. General services covered by liability insurance											
d. Regular (quarterly) revisions of financial plan implemented											
e. Property insurance in place (strongly recommended)											
f. Regular financial reports submitted as required											
g. Annual external audit carried out											
h. Financial accountability indicated in relevant job descriptions											
i. Resource usage processes implemented											
j. Other											
5. Ethics											
a. Code of Ethics in place											
b. Access to an Ethics Committee available for personnel											
c. Ethical decision making processes implemented											
d. Charter of Clients' Rights and Responsibilities implemented											
e. Research policy implemented											
f. Ethics training available for staff											
g. Other											

LEGEND

PE – Process established and working effectively
PX – Process in place but needs enhancement
PD – Process in development, but not in place
NP – Process not in place

Key program components (*see legend for rating)	PE	PX	PD	NP	Probability			Severity			Comments
					H	M	L	H	M	L	
6. Quality Improvement & Risk Management											
a. The organization's leaders to investigate and respond to incidents of workplace violence											
b. The organization's leaders review quarterly reports of incidents of workplace violence and use this information to improve safety and make improvements to the workplace violence policy											
c. The organization provides information and training to staff on the prevention of workplace violence											
d. A comprehensive Quality Improvement Plan is implemented											
e. A no-blame quality improvement culture is implemented											
f. Policies and procedures are regularly revised (3–5 years) to ensure conformity with current standards of practice											
g. HCC policies and procedures manuals are current and up to date											
h. Annual or PRN Risk Assessments are carried out for the program											
i. Processes exist to report and manage near-misses (good-catches)											
j. Processes exist to report and manage incidents/ occurrences/adverse events and sentinel events											
k. Risk Management Plans are carried out											
l. A Falls Prevention program is implemented											
m. Personnel have access to training for falls prevention											
n. Written and verbal information is provided to clients and families about their role in safety											
o. Medication errors are tracked											

Key program components (*see legend for rating)	PE	PX	PD	NP	Probability			Severity			Comments
					H	M	L	H	M	L	
p. Missed services are tracked											
q. Other											
B. SUPPORTIVE PROCESSES											
1. Human Resources, Professional Development & Work Life											
a. A Human Resources (HR) planning, recruitment and retention plan is implemented											
b. A staff training plan is implemented											
c. The First Nations & Inuit Home and Community Care Program (FNIHCC) Human Resource Profile is up to date											
d. Recent written job descriptions (3 years) are in place for all positions											
e. Orientation processes are in place for all staff (including a mentoring system for new employees)											
f. Staff have access to training											
g. Exit interviews are conducted and used to improve HR processes											
h. The supervising nurse assesses the competencies of home support workers yearly											
i. A process exists for assessment of the competencies of the Registered Nurse by the appropriate authority											
j. All staff have current certification/licensure/ registration											
k. Training in cardiopulmonary resuscitation (CPR) is available for program personnel according to current standards											
l. Training in First Aid is available for program personnel according to current standards											

LEGEND

PE – Process established and working effectively
PX – Process in place but needs enhancement
PD – Process in development, but not in place
NP – Process not in place

Key program components (*see legend for rating)	PE	PX	PD	NP	Probability			Severity			Comments
					H	M	L	H	M	L	
m. Professional/clinical support/supervision is available on an ongoing basis to HCC personnel from appropriate health organizations											
n. Registered Nurse supervision and consultation for HCC staff is available at all times during service delivery hours											
o. HCC Personnel on-call have access to supervisory personnel											
p. Staff training in Workplace Hazardous Materials Information System (WHMIS) is available according to current standards											
q. Staff training in management of aggressive behaviour is available according to current standards											
r. Annual Performance Appraisals are conducted (including individual learning needs assessments)											
s. A workplace violence prevention program is implemented											
t. Processes exist for service providers to confidentially report incidents of workplace violence											
u. Training for staff in prevention of workplace violence is available according to current standards											
v. A workload policy is implemented											
w. A rewards and recognition program is implemented											
x. Personnel have access to an Employee Assistance Program											
y. Personnel have access to health management education											
z. HR indicators are tracked and results used to improve services											

Key program components (*see legend for rating)	PE	PX	PD	NP	Probability			Severity			Comments
					H	M	L	H	M	L	
aa. Other											
2. Communication, Data Collection & Information Management											
a. An information management plan is implemented											
b. Communication strategies are effective											
c. Staff feedback is regularly solicited and used to improve services											
d. Client feedback is regularly solicited and used to improve services											
e. Family feedback is regularly solicited and used to improve services											
f. Community feedback is regularly solicited and used to improve services											
g. A Privacy policy is implemented											
h. A Disclosure policy is implemented											
i. An Informed Consent policy is implemented											
j. Personnel receive training in Privacy, Disclosure and Informed Consent											
k. Written and verbal information about services is available for clients, families and partners											
l. Client and Service Data is regularly validated for accuracy											
m. Important client information is documented in a comprehensive client health record by health care providers											
n. Client health records are stored and handled in a confidential and secure way											

LEGEND

PE – Process established and working effectively
PX – Process in place but needs enhancement
PD – Process in development, but not in place
NP – Process not in place

Key program components (*see legend for rating)	PE	PX	PD	NP	Probability			Severity			Comments
					H	M	L	H	M	L	
o. Service delivery data is collected and uploaded monthly as per the Electronic Service Delivery Reporting Template (e-SDRT)											
p. Information technologies are adequate for needs of program											
q. Staff are trained in the use of information technologies											
r. Other											
3a. Environment — Emergency Preparedness											
a. A community-based Emergency & Disaster Preparedness Plan is implemented											
b. Regular (annual) community wide emergency drills or Table top exercises for evacuation are carried out											
c. Quarterly fire and evacuation drills are conducted											
d. Home oxygen, fire and burn prevention safety processes are implemented for clients											
e. Personnel receive training in Emergency & Disaster Response											
f. A Pandemic Plan is in place											
g. Personnel receive training in pandemic response											
h. Other											
3b. Environment — Infection Prevention											
a. Infection rates are tracked											

Key program components (*see legend for rating)	PE	PX	PD	NP	Probability			Severity			Comments
					H	M	L	H	M	L	
b. Personnel receive training in infection prevention (i.e. hand washing, infection prevention etc.)											
c. Hand washing facilities and signage are adequate											
d. A vaccination program for pneumococcal infections is implemented for clients and program personnel											
e. Vaccination program for influenza infections is implemented for clients and program personnel											
f. Current health care-associated Methicillin-Resistant Staphyloccus Aureus (MRSA), C Difficile and protocols for other communicable disease (i.e., Sexually Transmitted Infections [STIs], etc.) are followed											
g. Written and verbal information is available for clients, families and partners											
h. Home care non-surgical wound infection surveillance protocols are followed											
i. Current equipment sterilization and reuse procedures are implemented appropriately (i.e., autoclaves, cold chain sterilization, etc.)											
j. Responses to infectious processes are documented											
k. Other											
3c. Environment — Occupational Health & Safety											

LEGEND

PE – Process established and working effectively
PX – Process in place but needs enhancement
PD – Process in development, but not in place
NP – Process not in place

Key program components (*see legend for rating)	PE	PX	PD	NP	Probability			Severity			Comments
					H	M	L	H	M	L	
a. An Occupational Health & Safety (OHS) Plan is implemented											
b. Regular OHS committee meetings are carried out											
c. A No-Violence Policy is enforced											
d. Handicap access to program services is available where applicable											
e. Regular equipment maintenance is carried out											
f. An equipment replacement process is implemented											
g. Procedures for transporting and disposing of hazardous wastes are followed											
h. Personnel receive training in OHS (WHMIS, safe driving and lifting techniques, etc.)											
i. OHS Indicators tracked and used to improve services											
j. Security processes are in place to prevent risk to care providers in clients' homes											
k. Vehicles are tested for road safety											
l. Other											
C. SERVICE DELIVERY											

Key program components (*see legend for rating)	PE	PX	PD	NP	Probability			Severity			Comments
					H	M	L	H	M	L	
1. Assessment											
a. Clients receive an initial contact within 48 hours of referral by a Registered Nurse											
b. A Registered Nurse conducts the assessment											
c. Standardized, current tools are used to conduct the client assessment											
d. The assessment process includes a full risk assessment											
e. There is a complete client reassessment scheduled annually											
f. Additional reassessments are made at any time, as required by the client's condition											
g. Other											
2. Care Planning											
a. Case Management processes are implemented											
b. Each client has a comprehensive care plan based upon assessed bio-psychosocial need											
c. Each client signs his/her care plan											
d. Each care plan includes a risk assessment with attention to elements related to the client's medical, functional and social situation as well as pertinent home safety issues											
e. A home safety checklist is completed for each client											
f. Each care plan includes appropriate information, teaching and risk-prevention strategies for the client and/or his/her family											

LEGEND

PE – Process established and working effectively
PX – Process in place but needs enhancement
PD – Process in development, but not in place
NP – Process not in place

Key program components (*see legend for rating)	PE	PX	PD	NP	Probability			Severity			Comments
					H	M	L	H	M	L	
g. A Registered Nurse develops the care plan in conjunction with the care team and related service providers											
h. The clients, families and/or other care providers are involved in care planning as appropriate											
i. Care plans are updated as required or at least monthly											
3. Care Provision											
a. The multidisciplinary care team meets regularly *and* as required by the client's condition											
b. Communication processes and tools are in place to make sure important client information is shared across services											
c. Home care nursing services are provided in the home, with exceptions											
d. Home support services are delivered according to the care plan, with exceptions											
e. A Registered Nurse coordinates the care plan with other service providers											
f. A formal backup plan is in place to provide nursing care if the usual HCC Registered Nurse Case Manager is not available											
g. Guidelines regulate the transporting of medications to clients' homes											
h. Standardized medication records are used for tracking administration											
i. Pharmaceuticals are provided as indicated by the client's condition											
j. Medication reconciliation is carried out on admission											
k. Medication reconciliation is carried out on transfer/discharge											

Key program components (*see legend for rating)	PE	PX	PD	NP	Probability			Severity			Comments
					H	M	L	H	M	L	
l. Dangerous (“No use”) abbreviations are avoided											
m. At least 2 client identifications are used to identify clients											
n. A process exists for efficient, timely management of medical equipment											
o. Medical supplies are provided as indicated by the client’s condition											
p. A pain management program is implemented											
q. Respite care (either in home or in another agency) is available as indicated by the client’s condition											
4. Discharge Planning											
a. Discharge planning is done by the Registered Nurse											
b. Standardized transfer and discharge forms are used											
c. Post discharge follows-up are carried out to verify effectiveness											
d. Other											
5. Client & Service Outcomes											
a. Client health outcome goals are attained											
b. Services provided are consistent with client care plan											
c. Program goals are attained											
d. Other											

LEGEND

PE – Process established and working effectively
PX – Process in place but needs enhancement
PD – Process in development, but not in place
NP – Process not in place

QI Action Plan Template

Issue to be addressed:	
AIM Statement:	
QI Lead or QI Team Members:	
Date for Completion:	

ACTION PLAN					
Item #	Change (What)	Plan (Who, Where, When, How)	Do (Date started)	Study (Gather data to see if change was an improvement)	Act (Adopt the change; Amend the change or Abandon and try something else)

Notes:

QI Pathway

PLAN	DO	STUDY	ACT
1. Review the services you provide and identify a priority/ issue or service area you want to improve. 2. Decide on the outcome or target you want to achieve. 3. Develop an action plan to address the problem or area for improvement you have identified. 4. Develop measurement tools to monitor progress (indicators). 5. Assign people to be responsible for collecting and reporting the results of the indicators. 6. Communicate your activities to everyone who is affected by them.	7. Implement the action plan. 8. Monitor the indicators to identify progress. 9. Document the results.	10. Analyze the changes that have occurred since the action plan was implemented. 11. Identify any challenges that have arisen and develop plans to overcome them. 12. Assess whether the target has been reached.	13. Make permanent changes based on what you have learned. 14. Identify the next problem to be addressed.

QI Project Plan

For use by individuals or groups wishing to present quality issues to the Quality Team.

Please identify which of the following best describes your quality issue;

- ☐ Issue that cannot be easily resolved at the service delivery level.
- ☐ Issue that is common across program delivery in the community.
- ☐ Issue that has resisted the usual problem solving approach.

Date: ________________ **Presented By**: ________________________

Part A — *To be completed before presenting to the QI Team*

What is the issue?

Include all details related to the issue, including how long it has been a concern and the risks associated with it.

____

____

____

____

What action has been taken to date?

Describe, if appropriate, any steps that have been taken to date to resolve the issue and any progress made.

____

____

____

____

What should the resolution be?

Suggestions from the presenter on what should be in place to resolve the issue.

____

____

____

____

Part B — ***To be completed during the QI Team meeting and to act as a record of activity***

Action Steps	Responsibility	Progress

Part C — *Project Summary Findings*

To be completed at the project conclusion.

Next Steps
Any further steps that need to be taken on this issue.

Communicated to:
Names and positions of the people the project results were communicated to.

Signed Off:____________________

Date:____________________

Steps to QI Form

1. Select one area for improvement to examine further:

2. Select data source/s:

3. Collect data:

- Data can help you separate what you think is happening from what is really happening;
- Data will establish a baseline so you can measure improvement;
- Data will help you avoid putting solutions in place that will not solve the problem.

Record findings here:

Case #	Yes	No
1		
2		
3		
4		
5		

4. If the data is not readily available, what sources did you use to collect your data, and what steps did you take to collect this data?

Risk Management Tools

FMEA Form

Worksheet 1: Failure Mode and Effects Analysis (FMEA)

How to PREVENT FAILURE

- Reminders, checklists, double checks;
- Forcing functions (i.e., people can't avoid doing the right thing);
- Automation/computerization;
- Redundancy;
- Do not rely only on memory, policies and procedures, "perfect" human performance or training/education.

How to PREPARE if FAILURE occurs

- Improve detection or make errors more visible;
- Mitigate any adverse effects.

Process/Service: ____ **Date:** _________________

Team Members:

____

____

____

____

____

____

____

____

____

____

Note: Brainstorm all failures then prioritize *most likely* and *most severe* failures and develop prevention and mitigation strategies for these.

Failure (What could go wrong?)	Cause(s) (N.B. There may be more than one cause for each failure)	How to PREVENT FAILURE (List strategies for *each* cause)	How to PREPARE if FAILURE Occurs (i.e. Prevention strategies fail) *(List ideas for each* cause)

Root Cause Analysis Form

INITIAL REVIEW DATE: ______________________ REFERENCE #:____________

Signatures of review team:

A. What happened?

Briefly *describe* the event in terms of what, when, where, how it happened, etc., in sequence. (Note: a flow diagram may be helpful here.)

B. What is our initial understanding of the problem?

Discuss with all key stakeholders and develop a flow chart, narrative timeline or chronological description of the events involved. Determine if additional information is needed to fill in the gaps.

C. Do we need more information to develop a final understanding of the problem:

- Visit the site of the event:
- Review the clients' file:
- Interview the client/family:
- Interview the staff:

D. What can we learn from the following to help us understand and address this issue?

- Review current clinical guidelines related to this issue:
- Review current practice standards:

<table>
<tr><th colspan="2">E. What is our final understanding of the problem? Why did it happen?</th></tr>
<tr><td colspan="2">a) What are the contributing factors? (factors that would not all have prevented the incident even if corrected)</td></tr>
<tr><td>Client factors
☐ Client's condition deteriorated rapidly?
☐ Client did not follow instructions?
☐ Others? ____________</td><td></td></tr>
<tr><td>Information Management
☐ Client correctly identified?
☐ Documentation provides a clear picture?
☐ Training issues? Communication issues?
☐ Level of automation appropriate?
☐ Others? ____________</td><td>Equipment
☐ Display and controls understandable?
☐ Equipment detects and displays problems?
☐ Standardized or several different models?
☐ Maintenance/upgrades up-to-date
☐ Warnings/labels understandable
☐ Others? ____________</td></tr>
<tr><td>Environment
☐ Noise levels interfere with voices?
☐ Lighting adequate for tasks?
☐ Adequate air, water, surface temperature?
☐ Area adequate for people and equipment?
☐ Clutter or inadequate stowage?
☐ Work areas, tools, etc. located correctly?
☐ Security?
☐ Others? ____________</td><td>Policies and Processes
☐ Audit/quality control for process?
☐ Do people work around official policy?
☐ Standardized process or order set?
☐ Use of checklists or other tools?
☐ Others? ____________</td></tr>
<tr><td>Safety Mechanisms
☐ Did anything stop or decrease harm?
☐ Equipment safety mechanisms functional?
☐ System designed to be fault- tolerant?
☐ Others? ____________</td><td>Human Resource Issues
☐ Staffing levels?
☐ Orientation/training?
☐ Fatigue?
☐ Supervision of staff?
☐ Others? ____________</td></tr>
<tr><td colspan="2">b) What is the root cause?</td></tr>
<tr><td colspan="2"></td></tr>
</table>

F. What is our plan to prevent a recurrence of the event?	
Standardize/simplify	**Automation/computerization**
☐ Standardize equipment	☐ Automatic calculations
☐ Standardize protocol	☐ Provide reminders
☐ Remove unneeded step(s)	☐ Assist decision-making
Improve or new devices	**Improve Environment**
☐ Better controls/displays	☐ Improve flow of personnel
☐ Better integration	☐ Better lighting, noise, clutter
☐ More fault-tolerant	☐ Better stowage, signage, etc.

c) Create an action plan

Risk Reduction Strategies	Actions	Outcome Measures	Date	Responsible

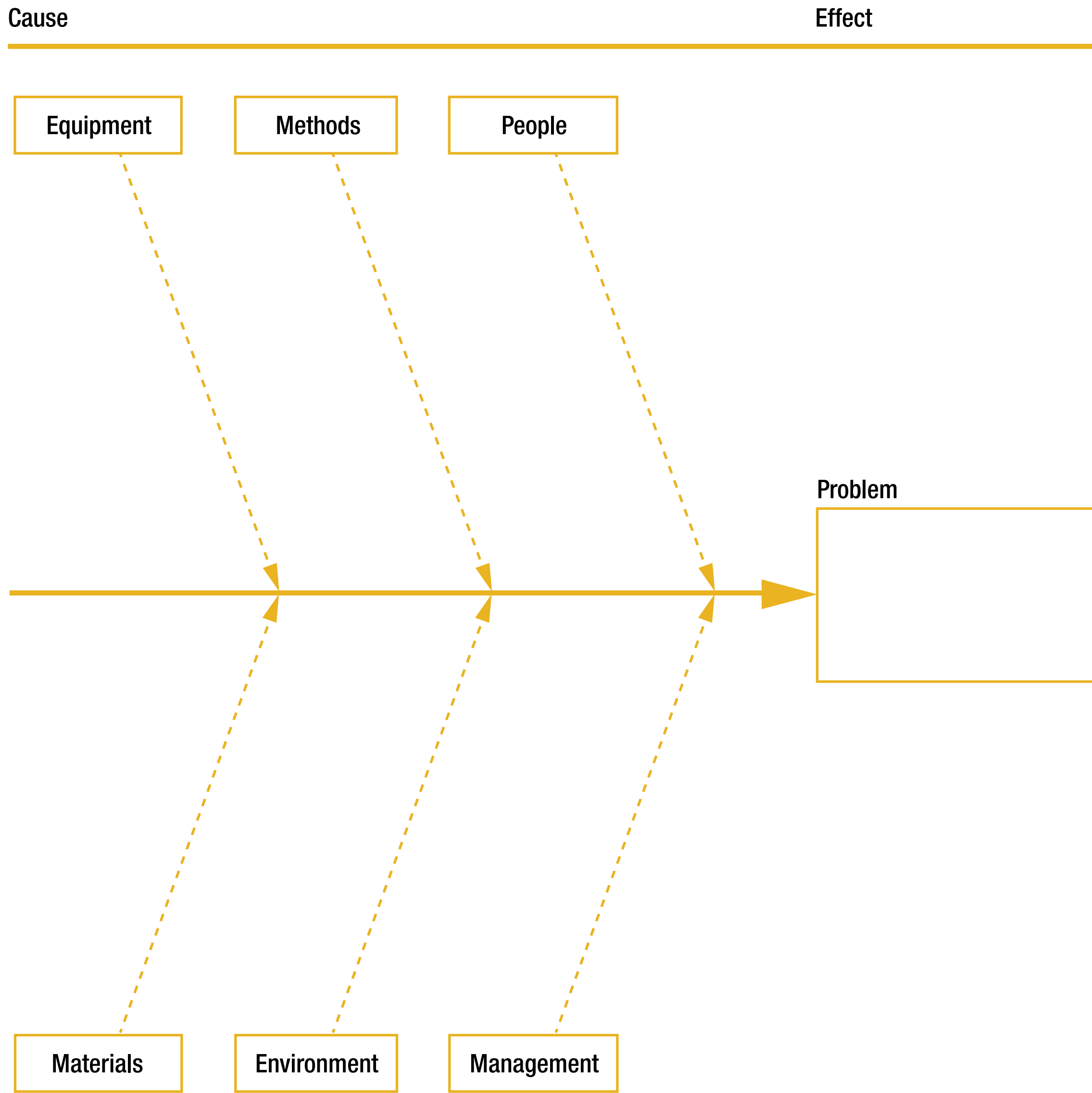
Review Date

Sign Off

Adapted from Veterans Affairs Case Conference Worksheet, May 2005

Cause and Effect Analysis Diagram

Date: ______________________________



Examples of Plan-Do-Study-Act (PDSA) Cycles

Example 1: QI Action Plan — Client Satisfaction

Issue to be addressed:	Client Satisfaction
AIM Statement:	Within 6 months of initiating the QI plan, 90% of clients discharged from the HCCP will report satisfaction with the services they received
QI Lead or QI Team Members:	Case Manager, home care nurse, personal care worker
Date for Completion:	March 31, 2010

ACTION PLAN					
Item #	Change (What)	Plan (Who, Where, When, How)	Do (Date started)	Study (Gather data to see if change was an improvement)	Act (Adopt the change; Amend the change or Abandon and try something else)
1	Clients will report high levels of satisfaction with services delivered.	• Complete initial client satisfaction survey to determine baseline; • Identify issues that cause dissatisfaction; • Develop an action plan to address each issue that causes dissatisfaction; • Complete follow up client satisfaction survey.	October 1, 2009 November 1, 2009 December 1, 2010 March 31, 2010	Baseline measurement: $\frac{\text{\# of clients who were satisfied with services}}{\text{Total \# clients who were surveyed}}$ (Time Frame) Follow-up measurement: $\frac{\text{\# of clients who were satisfied with services}}{\text{Total \# clients who were surveyed}}$ (Time Frame)	Based on client satisfaction survey data, decide whether intervention was successful or not.

Example 2: QI Action Plan — Discharge Referrals

Issue to be addressed:	Ensure all clients who require home care services are referred to the HCCP.
AIM Statement:	In 6 months, 85% of clients discharged from hospital/nursing station care and require home care services receive a referral to the HCCP.
QI Lead or QI Team Members:	Case Manager, home care nurse, primary care nurse/physician, referring agency.
Date for Completion:	March 31, 2010

ACTION PLAN					
Item #	Change (What)	Plan (Who, Where, When, How)	Do (Date started)	Study (Gather data to see if change was an improvement)	Act (Adopt the change; Amend the change or Abandon and try something else)
1	Clients are referred to the HCCP when discharged from hospital and/or nursing station care: • Decreases the risk that client needs are not met in a timely manner; • Ensures any urgent needs are identified and acted upon in a timely manner	• Collaborate with the primary care nurses/ physicians/Regional Health Authorities (RHAs) to develop a referral process; • Develop a policy/procedure statement that outlines how the referral process happens, including who is responsible for what activities within the process; • Have all agencies sign and/or agree to the policy.	October 1, 2009 November 1, 2010 December 1, 2009	# of clients who receive a referral upon discharge ——— Total # clients who require a referral top HCCP (Time Frame)	Based on the data, the team decides to either adopt the policy or revise the process further.

Example 3: QI Action Plan — Foot Care Services

Issue to be addressed:	Ensure all clients can receive basic foot care services from a Registered Nurse (RN).
AIM Statement:	In 6 months, 90% of clients who require basic foot care will receive it from their home care RN.
QI Lead or QI Team Members:	Case Manager, home care nurse.
Date for Completion:	March 31, 2010

ACTION PLAN					
Item #	Change (What)	Plan (Who, Where, When, How)	Do (Date started)	Study (Gather data to see if change was an improvement)	Act (Adopt the change; Amend the change or Abandon and try something else)
1	Clients who require foot care services can receive basic foot care from the home care RN.	• Identify which RNs are interested in providing foot care; • Partner with a training program to provide the necessary foot care training at the basic level.	October 1, 2009 November 1, 2009	# of clients who receive foot care services / Total # clients who require foot care services (Time Frame)	Based on data decision made to continue having the RN provide basic foot care.

Example 4: QI Action Plan — Initial RN Assessment

Issue to be addressed:	Ensure all clients who require home care services are referred to the HCCP.
AIM Statement:	In 6 months, 85% of clients who are referred to the program receive an initial contact by a RN within 48 hours.
QI Lead or QI Team Members:	Case Manager, home care nurse, primary care nurse/physician, referring agency.
Date for Completion:	March 31, 2010

ACTION PLAN					
Item #	Change (What)	Plan (Who, Where, When, How)	Do (Date started)	Study (Gather data to see if change was an improvement)	Act (Adopt the change; Amend the change or Abandon and try something else)
1	Clients are seen by an RN within 48 hours of arriving back in the community: • Decreases the risk that clients' needs are not met in a timely manner; • Ensures any urgent needs are identified and acted upon in a timely manner.	• Hire a part-time nurse to do the initial contact; • Partner with the primary care nurse to do the initial contact; • Initiate MOU with Regional Health Authority (RHA)/ agency to complete the initial visit.	October 1, 2009 October 1, 2009 January 4, 2010	# of clients who receive an initial contact by an RN within 48 hours / Total # of clients referred to HCC (1 month) # of clients seen by part-time RN / Total # of clients seen by all RNs (Time Frame) # of clients seen by primary care RN / Total # of clients seen by all RNs (Time Frame) # of clients seen by RHA / Total # of clients seen by all RNs (Time Frame)	Based on data, decision made to continue the employment of a part-time RN

Example 5: QI Action Plan — Nursing Bag Infection Control

Issue to be addressed:	Ensure all nursing bags are handled using proper infection control procedures.
AIM Statement:	In 6 months, 100% of staff will employ appropriate infection control procedures in the handling of the nursing bag.
QI Lead or QI Team Members:	Home Care nurses, Personal Support Workers, Interpreters, Home Care Health Aids.
Date for Completion:	March 31, 2010

ACTION PLAN					
Item #	Change (What)	Plan (Who, Where, When, How)	Do (Date started)	Study (Gather data to see if change was an improvement)	Act (Adopt the change; Amend the change or Abandon and try something else)
1	Staff uses proper infection control procedures to handle nursing bags.	• Identify which staff are using/ handling the bags; • Provide education session to all staff handling bags on appropriate infection control procedures for the bag; • Develop bag cleaning log and monitoring process.	October 1, 2009 October 15, 2009 November 1, 2009	Each staff person completes the bag cleaning log; Case manager monitors the log weekly; Results from logs are brought back to the QI team meeting.	Based on data, make a decision: • Continue with the program as is; • Change the education component; • Change the monitoring process.

References

Accreditation Canada (2005), Risk Management Plan

Accreditation Canada (2010), Qmentum Program Update

AIG Healthcare (2007) *Fire & Burn Prevention in Home Health*

AIG Healthcare (2007) *Home Oxygen and Fire Safety*

Barnard, D., et al (2006), *Implementing a Good Catch Program in an Integrated Health System*, Healthcare Quarterly, 9 (Sp), pp. 22–27

Burland, M.J (2008) *An Evaluation of a Fall Management Program in a Personal Care Home Population*, HealthCare Quarterly, Volume 11, Special Issue

Canadian Council on Health Services Accreditation (1996), *A Guide to the Development and Use of Performance Indicators.*

Caldwell, C. et al (2005), *Lean Sigma Six for Healthcare: A Senior Leader Guide to Improving Costs and Throughput*, ASQ Quality Press, Milwaukee, Wisconsin

Canadian Council on Health Services Accreditation (2002), *Achieving Improved Measurement*, Ottawa

Canadian Council on Health Services Accreditation (2005), *Making Sense of Indicators*, Ottawa

Canadian Council on Health Services Accreditation (2010), *Qmemtum Program Update*, Ottawa

Canadian Council on Health Services Accreditation (2005), *Risk Management Plan*, Ottawa

Canadian Patient Safety Institute (2006), *Background Paper for the Development of National Guidelines for the Disclosure of Adverse Events*, November, pp. 1–17

Canadian Patient Safety Institute (2006), *Canadian Root Cause Analysis Framework: A tool for identifying and addressing the root causes of critical incidents in healthcare*

Carroll, R. 2006. *Risk Management Handbook for Health Care Organizations* (5th ed.), San Francisco: Jossey-Bass

Collins, L. et al (2008) *Leading Complex Change in Healthcare: 10 Lessons Learned*, HealthCare Quarterly, Volume 11, No. 4

Deming, W.E. (2009), *Chronic Illness Care, A National Program of the Robert Wood Johnson Foundation*, Seattle, Washington, USA (website, July 2009)

Dingwall, O. et al (2006), *Recommended Readings on Disclosure*, CPSI

Doan, M. et al (2009), *Identification of Safety Outcomes for Canadian Home Care Clients*, Healthcare Quarterly, Volume 12

Emanuel, E. J. & Emanuel, L. L. (1996), *What is accountability in Healthcare?*, Annals of Internal Medicine, pp. 124

Fleming, M. (2005) *Patient Safety Culture Measurement and Improvement: A "How To" Guide*, HealthCare Quarterly, Volume 8, Special Issue, October

Harrigan, M. L. (1999), *Quest for Quality in Canadian Healthcare: Continuous Quality Improvement*

Health Quality Council (2005), *Quality Improvement Tool book: A practical approach to improving the quality of health care — your goal and ours,* Saskatoon SK.

Iedema, R. et al (2008), *Patients' and family members' experiences of open disclosure following adverse events,* International Journal for Quality in Health Care 2008, Volume 20, Number 6

Institute for Health Care Improvement (2004), *Failure Modes and Effects Analysis (FMEA)*

Institute for Health Care Improvement (2007), *Disclosure Toolkit: Establishing a Culture of Respect, Communications and Disclosure*

Institute for Safe Medication Practices Website (2006), *Our Long Journey Towards a Safety-Minded Just Culture Part II: Where We're Going*, September 21 issue

Langley, G. J., Moen, R., Nolan, K. M., Nolan, T. W., Norman, C. L., Provost, L. P. (2009) *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance*, 2nd Ed., Jossey-Bass, California

Ontario Community Support Association (1999), *Managing Risk: Polices and Procedures for Community Agencies*

Ontario Community Support Association (1999), *Standards & Indicators for Community Support Services: The Guide to Quality Care*

Ontario Safety Association for Community & Healthcare (2003), *Health and Safety in the Home Care Environment,* pp. 1–85

Ontario Safety Association for Community & Healthcare (2006), *Occupational Health and Safety Program — Client Self-Assessment Checklist*, March, pp. 1–19

Podsiadlo, D., Richardson, S. (1991), *The timed "Up & Go": A test of basic functional mobility for frail elderly persons*, Journal of American Geriatrics Society, pp. 67:387–389

Reason, J, T. et al (2001), *Diagnosing "vulnerable system syndrome": An essential prerequisite to effective risk management*", Quality Health Care, UK

RNAO (2008), *Preventing and Managing Violence in the Workplace*

Safer Healthcare Now (SHN)! Campaign (2005), *Getting Started Kit, Medication Reconciliation; How-to Guide: Prevention of Adverse Drug Events,* Updated: November 6, 2005

Sears, N. (2008), *Harm From Home care: A Patient Safety Study Examining Adverse Events in Home Care*

Electronic Reference Sources

www.accreditation.ca

www.cihi.ca

www.healthcanada.gc.ca/accreditation

www.hqc.sk.ca

www.ihi.org

www.npsa.nhs.uk

www.isqua.org

www.ohqc.ca

www.qaproject.org

http://www.qualitycoach.net/memoryjogger.htm

http://www.ihi.org/IHI/Topics/Improvement/ImprovementMethods/HowToImprove

http://spreadsheets.about.com/b/2008/12/15/excel-2007-pie-chart-tutorial-4.htm

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QUALITY RESOURCE KIT

Glossary

Handbook 5

Strengthening and Improving Home and Community Care

Canada

Health Canada is the federal department responsible for helping the people of Canada maintain and improve their health. We assess the safety of drugs and many consumer products, help improve the safety of food, and provide information to Canadians to help them make healthy decisions. We provide health services to First Nations people and to Inuit communities. We work with the provinces to ensure our health care system serves the needs of Canadians.

Published by authority of the Minister of Health.

First Nations and Inuit Home and Community Care (FNIHCC) Quality Resource Kit is available on Internet at the following address: http://www.hc-sc.gc.ca/fniah-spnia/pubs/services/_home-domicile/prog_crit/index-eng.php

Également disponible en français sous le titre:
Soins à domicile et en milieu communautaire des Premières nations et des Inuits (SDMCPNI) Trousse de ressource pour l'amélioration de la qualité

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Accessible:

- Clients receive services at the right time and in the right place.

Accident:

- An adverse or harmful outcome not caused by chance or fate. Most accidents and their contributing factors are predictable. The probability of their occurrence may be reduced through system improvement.

Accountability:

- The responsibility for achieving a particular outcome and/or delivering a specific service or program. Tasks within a program or service can be delegated, but the responsibility for outcomes cannot.

Active Failure:

- An event/action/process that takes place while providing direct patient care and fails to achieve its expected aims. While active failures may contribute to patient injury, not all do.

Adverse Event:

- This manual covers three kinds of adverse or harmful events:
  - An unexpected or undesirable incident directly linked to the care or services delivered by the Home and Community Care Program (HCCP) to its clients or staff;
  - An incident that happens while the HCCP delivers care and results in the client's injury or death;
  - An adverse outcome for a client, including injury or complication.

Appropriateness:

- Services that meet the client's assessed needs. The HCCP finds out what these needs are by carrying out a client assessment. Based on these needs, the HCCP decides on a care plan and records the care and services that it will provide to the client.

Benchmark:

- According to the online Miriam Webster's dictionary, a "benchmark" is: a) a point of reference from which measurements may be made; b) something that serves as a standard by which others may be measured or compared; c) serves as a basis for evaluation or comparison;

- A standard that the HCCP uses to measure how well it delivers care and services (e.g., the number of days between the time that the HCCP first meets with a client and the client starts to receive services). The benchmark can be set in one of two ways: the HCCP can use the results that other health care organizations have achieved and recorded about their experience in delivering care and services to similar client groups or populations, and/or it can set benchmarks based on experiences in serving clients. The HCCP compares the results it achieves with the benchmark on a regular basis (e.g., every six months).

Best Practices (Best Practice Guidelines):

- Ways to provide care and services that have a good track record in producing better than average results for clients, based on experience in the HCCP or other programs. Best practices are considered to be "exemplary", "good" or "successfully demonstrated", based on formal measurements. The HCCP can adapt best practices to meet its needs and those of its clients. (Adapted from the Canadian Council on Health Services Accreditation, *Achieving Improved Measurement,* 2002, Ottawa).

Brainstorming:

- A group problem-solving technique that involves members of the group contributing spontaneous ideas. The mulling over of ideas by one or more individuals to devise or find a solution to a problem.

Care Plan:

- A formal plan that records the care and services that the HCCP delivers to a client, based on a client assessment. The "road map" that guides everyone who participates in the client's care.

Cause:

- A set of actions, circumstances or conditions that produces an event, effect or a phenomenon. A cause may be proximate (immediately before) or remote (a contributing force) to the event, effect or phenomenon.

Client Assessment:

- A formal process that the HCCP carries out to determine the client's physical, emotional, social and spiritual needs. This assessment helps the HCCP to decide on the amount of care (number of hours per week and kind of services) and the level of care required (e.g., Registered Nurse, Occupational Therapist, Personal Support Worker) and to set goals and outcomes for these services. HCCP then develops a care plan for the client based on the assessment.

Client-Centered Care:

- Care that recognizes and respects the client's wishes.

Client Satisfaction Surveys:

- A process to collect information on what clients think about the services they receive and whether the services have met his/her expectations and needs. Client surveys can be written or verbal, while the client is receiving services, or after discharge.

Complication:

- A disease or injury that arises subsequent to another disease and/or healthcare intervention.

Criteria:

- A checklist of rules and/or standards for the HCCP to use in deciding on the delivery of care and services (e.g., criteria for admission to the program might include demonstrated need, the availability of physician's orders, and a safe home environment).

Cultural Context:

- First Nations and Inuit aspirations, beliefs, values, cultural knowledge, practices and strengths related to home and community care. They affect how the HCCP provides care and services to First Nations and Inuit clients and include ways of perceiving, relating, thinking and doing.

Culturally Appropriate:

- Taking into account the culture and language of the community in developing and delivering care and services. This includes making sure that the HCCP staff have the knowledge they need to deliver safe quality care that meets individual, family and community needs.

Disclosure:

- Information given by healthcare workers to clients or their significant others about a healthcare event that affects, or is liable to affect the client's interests. The obligation to disclose is proportional to the degree of harm to the client or the realistic threat arising from an untoward event.

Effectiveness:

- Using available resources such as people, dollars, equipment, materials and facilities to get the best possible results for clients and client groups.

Efficiency:

- Making the best use of resources such as people, dollars, equipment, materials and facilities to achieve positive health outcomes for clients and client groups.

Evaluation:

- Formally and objectively measuring the success of a program, service or procedure. It is a "best practice" to develop the evaluation criteria (e.g., reducing the length of time from client assessment to start of service) and tools (e.g., data collection and analysis) before starting a new or reorganized program, service or procedure.

Focus Groups:

- Gathering information from individuals through conversations with small groups of 8 to 10 people. Before the focus group meeting, a group leader (moderator) prepares a series of open-ended questions. At the meeting, the group leader asks the people attending to answer the questions in their own words. There are no right or wrong answers. At the end of the focus groups, the group leader summarizes what everyone said in a report, without identifying the contributors. The information from focus groups can help the HCCP to learn more about the views, opinions and feelings that clients, staff and community members have about a specific issue or topic. The HCCP can then use the information to make decisions about care and services.

Good Catch:

- See "Near Miss."

Goals:

- Statements describing what the HCCP wants to accomplish as an organization at the program, service or individual level. Setting goals provides the basis for deciding what specific activities to carry out to achieve positive outcomes.

Hazard:

- A set of circumstances or a situation that could harm a person's interests, such as their health or welfare.

Human Error:

- The failure to complete a planned action as it was intended, or when an incorrect plan is used in an attempt to achieve a given aim.

Incident:

- An event not usually part of delivering care or services that may have a negative impact on the client, staff, community or organization. Incidents should always be measured in terms of the degree of risk.

Indicators:

- A measurement tool, screen or flag used to guide, monitor, evaluate and improve the quality of client care services and organizational functions that affect client outcomes.[1] Indicators can be applied to all areas of the HCCP, such as clinical (wound care), financial (travel time, km per visit, productivity), and human resources (staff turnover rate).

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1 Canadian Council on Health Services Accreditation: *A Guide to the Development and Use of Performance Indicators.*

Medication Error:

- The failure to complete a planned action as it was intended, or when an incorrect plan is used when providing medications to patients.

Near Miss (Good Catch):

- An event or circumstance that could have, but did not, cause an incident or critical incident because one or more people took corrective action and/or made a timely intervention (adapted from Barnard, D., et al, 2006).

Outcome:

- The results or impacts that care and/or service activities or events have on a client. For example, clients receive care and services that are culturally appropriate.

Outcome Measures:

- Measuring the success of outputs on clients. For example, the percentage of falls by elderly clients in their homes decreases.

Patient Safety:

- The reduction and mitigation of unsafe acts within the healthcare system, and through the use of best practices lead to optimal patient outcomes.

Practice Guidelines:

- See “Best Practices.”

Process:

- A series of inter-related activities and communications necessary to deliver a service to a client (e.g., client assessment).

Quality:

- The degree of excellence and the extent to which an organization meets the client's assessed need. An ongoing process of building and sustaining relationships by assessing, anticipating, and fulfilling stated and implied need.

Quality Care:

- The delivery of care and service at the right time, in the right way, by the right person, for the right client, resulting in the best possible outcome.

Quality Assurance:

- A validation process, using evidence that supports care and service delivery. The HCCP uses quality assurance processes regularly to see whether the program is efficiently and effectively achieving quality for clients, the community, staff and the organization.

Quality Dimensions:

- Describes the various features, characteristics and aspects of quality. Quality is often multi-dimensional.

Quality Improvement:

- An organizational philosophy and formal approach that guides the HCCP in improving its performance. A variety of quality improvement models can be used to collect and analyze information. The HCCP uses the findings to identify trends and make changes in processes and procedures. These changes help make programs and services better in meeting client and community needs, reduce risk and improve efficiencies and the work environment.

Qualitative:

- Information that describes what individuals say they think, feel or believe about an issue or topic, based on their experiences. Tools like focus groups and interviews are used to collect qualitative information, such as the characteristics and features they value in a Personal Support Worker and what staff members think about the effectiveness of internal communications.

Quantitative:

- Objectively measuring and confirming information using hard data, such as case loads, increase in number of visits, waiting time and the percentage of clients over age 70. The information can be collected over time (e.g., intake forms) and/or at specific points in time (e.g., a survey).

Resources:

- Includes people, dollars, equipment, materials, facilities and buildings.

Risk:

- The potential harm to clients, the community, staff or the organization. Risk is most often measured as low, medium or high.

Risk Management:

- Identifying risk; evaluating its severity (high, medium, low); estimating its potential impact; and deciding what action to take to avoid, reduce or handle the risk, when necessary.

Root Cause Analysis:

- A systematic process of investigating an incident or adverse outcome to determine what happened. The analysis focuses on identifying what happened, why it happened and how to prevent it from happening again.

Safety:

- Providing care and services to minimize risk and get the intended client and program outcomes.

Sentinel Event:

- An unexpected incident related to shortcomings in a system or process, which results in death or major and enduring loss of function for a client receiving services from the HCC program. (Adapted from the *Reference Guide on Sentinel Events, Achieving Improved Measurement*, *2005*, Canadian Council on Health Services Accreditation, Ottawa).

Stakeholder:

- One who is involved in or affected by a course of action.

Standard:

- A statement used as the basis for measuring the outcome of a care or service activity. The standard describes the desirable and achievable level of performance. For example, all clients are aware of their rights and responsibilities.

Standard of Care:

- Governed by a policy or clinical guideline, or in common practice, a set of steps to follow or an outcome to expect.

Structure:

- A supporting framework or essential parts of it, including all elements of the healthcare system that exist before any actions or activities take place.

Structure Indicators:

- A way to measure the kind and amount of resources that the HCCP uses to deliver programs and services (e.g., money, beds, supplies, facilities and buildings).

Timeliness:

- Providing services at the right time to meet the needs identified in both the client assessment and the client's care plan.

Unsafe Acts:

- The three types of unsafe acts are: error, violation and sabotage. *Error* is defined as the failure to complete a planned action as it was intended, or when an incorrect plan is used to achieve a given aim. *Violation* is defined as representing a deliberate deviation from standards, rules or safe operating procedures. *Sabotage* is defined as an activity in which both the act(s) and the harm or damage are intended.

Validation:

- Confirming that a service or activity achieves what it was intended to do. For example, a specific service is delivered in a culturally appropriate way.