Quality Improvement Plan Guide

Contents

Introduction to Quality Improvement Plans

What is a Quality Improvement Plan?

A set of goals and actions that a team makes to improve specific outcomes, practices, processes, and/or quality issues. It **is not** an all-encompassing list of everything your team is working on towards your team's and/or the organization's priorities.

Why do we need to complete a Quality Improvement Plan?

Quality improvement plans are essential for setting clear goals, measuring progress, which will ensure that we provide safe, accessible, and sustainable people-centred health aligned with our strategic priorities (link to strategic plan on the website). Ultimately, these plans are meant to empower teams towards continuous improvement.

Who needs to complete a Quality Improvement Plan?

All programs and sites. It is expected that all staff are comfortable to speak to their team's Quality Improvement Plan, priorities, the steps taken, and the results and outcomes from the work.

What is the timeline for the Quality Improvement Plan?

Quality Improvement Plans are meant to be ongoing, live working documents that your team reviews and updates on a regular basis to monitor the progress you are making and to hold everyone accountable for their commitments towards priorities.

Programs and sites will be asked to submit their Quality Improvement Plans once a year to the Quality and Accreditation Coordinator by May 1st. The plans will be uploaded on the staff website and kept as a locked document. Quarterly reminders will be sent to the teams to keep the plans updated regularly.

When submitting your Quality Improvement Plan, there is no expectation that priorities are completed. Your team decides what are reasonable timelines for the priorities and/or objectives.

Where can I find Quality Improvement Plan resources?

On the Health Provider Site under Programs & Services – Quality Improvement Plans (link here). Or scan QR code to access (log in to Health Provider Site required):

Completing a Quality Improvement Plan

In preparation

1. **Identify the appropriate team members who can contribute to the plan.**
   These people should be able to provide relevant input and influence the areas that will be involved in the quality improvement initiatives.

   ☐ Leaders: Click or tap here to enter text.
   ☐ Front line staff: Click or tap here to enter text.
   ☐ Clients and families: Click or tap here to enter text.

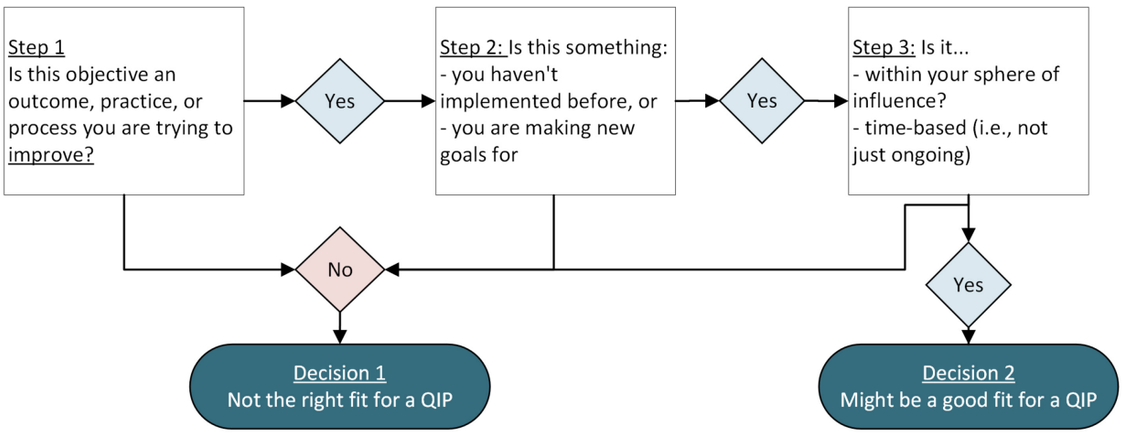
2. **Consider all relevant sources of data to make an informed decision on your team's priorities.**
   Remember that Southern Health-Santé Sud's Strategic Plan (available on the staff website) should guide all decisions. There is a place in the Quality Improvement Plan template to identify how the priority was identified.

   ☐ Accreditation results (unmet requirements such as Required Organizational Practices, High Priority criteria, red or yellow flags in self-assessment results, etc.). Accreditation report available on the staff website.
   ☐ Identified risks (e.g., SH-SS corporate risks available on the staff website or results of HIROC's Risk Assessment Checklist results or risk reference sheets at www.hiroc.com/resources)
   ☐ Personal care home standard(s)
   ☐ Dashboard information or key performance indicators
   ☐ Disrupting Racism (Shared Health website) and Indigenous Reconciliation (e.g., Truth and Reconciliation Calls to Action)
   ☐ Patient safety (e.g., Patient Safety Learning Advisories available on the staff website, Critical Incident recommendations)
   ☐ Ethical issues
   ☐ Staff feedback or staff survey (i.e., WSWQS results available on the staff website)
   ☐ Client experience surveys (reports available on the staff website) or client/family feedback
   ☐ Others

3. **Tips on involving clients/families**
   Consider ways in which the experience of patient, clients, or residents and/or caregivers can inform quality improvement initiatives, such as through:
   - surveys
   - feedback through compliments and concerns
   - involvement in developing priorities and actions using existing relationships (i.e. resident councils, clients currently receiving care, clients that provided feedback, etc.)
   - sharing the quality improvement plan and progress made while also taking their feedback into consideration

The content

1. **How to determine if the objective is a good fit for a Quality Improvement Plan**
   While the action, objective or effort you have in mind may be contributing towards your overall priority, a QIP is a documented set of commitments to drive improvements. The decision-making tree below may help you in deciding what is a good fit. For more ideas on what to include and not to include, please see Appendix A.



2. **Has your team applied SMART goals when developing objectives?**
   - ☐ **Specific**: What needs to be accomplished? When does it need to be accomplished? Who will be involved? Why do we want to accomplish this? Where will this work take place?
   - ☐ **Measurable:** How will the team know if they are successful?
   - ☐ **Achievable:** Are the objectives/priorities attainable with the resources available?
   - ☐ **Relevant:** Is the objective/priority worthwhile? Is it more important to achieve than others?
   - ☐ **Timely:** Is there a deadline to reach the objective/priority? Is there a date for when actions will be taken?

3. **How do I know what measures to include?**
   If you developed a SMART objective, your measure of success could be very straightforward. For example, if your objective is to "Reduce the proportion of residents who had at least one fall in the last 30 days on 4A to 14% over the next six months" then your measure may be as simple as whether you reached your 14% target by the date indicated (yes/no). With each action step, you may also have process indicators or measures of success.

   Remember that these measures, like the objectives, have to be in your sphere of influence and timely (for e.g., if you only conduct client experience surveys every 2 years it wouldn't be a good measure of success for a target in the next 6 months). For more ideas on measures or indicators of success, please see Appendix B.

4. **Our team is working on so many objectives and priorities, how do we know what to prioritize?**
   Knowing what or how to prioritize will be unique to every team, it's important to find something that works for you. You can ask clients/families and/or staff what matters to them, you can seek guidance from your lead (e.g., senior leader or director), and/or you may choose to use one of the prioritization tools included in Appendix C.

The Formatting

1. **Why is the formatting in Word rather than Excel?**
   While Excel has multiple features that would have been beneficial for the Quality Improvement Plan (e.g., tabs to navigate), one of the main drivers of the Word template is that it's easier to comply with the Accessible Information and Communication Standard under the Accessibility for Manitobans Act (see January 2024 Admin Update on the staff website). There are also other advantages of the Word template, including consistent header rows that move to the next page, it's easy to print, you have the option of using track changes if multiple people update the document, and it has clickable checkboxes. The template should be far less glitchy than the original but if you are having issues, please let us know.

2. **How do I ensure my Quality Improvement Plan meets accessibility standards?**
   There are many accessibility guidelines available in the Southern Health-Santé Sud Graphic Standards Manual (available on the staff website) as well as the January 2024 Admin Update on the staff website. The current Quality Improvement Plan Template has been designed to meet accessibility standards, a few quick tips on how to maintain that:
   - Do not change font sizes smaller than 11 points just to fit the content on fewer pages
   - Avoid merging (e.g., across columns or rows) or splitting cells
   - Instead of pressing the "Enter" key twice to leave a blank line between two lines of text, add spacing by going to Paragraph – Spacing and add or remove spacing points before or after your selected line of text. Depending on your desired effect, you may need to check or uncheck the box for "Don't add space between paragraphs of the same style"
   - Run an accessibility check in word (File – Check for Issues – Check accessibility) and address any errors that come up

3. **Printing the Quality Improvement Plan**
   The Quality Improvement Plan template is prepared on a legal size document (8.5" x 14").

Submission & Implementation

1. **Prior to submission, it is strongly encouraged that you review your quality improvement plan with:**
   ☐ your program-assigned Decision Support Analyst
   ☐ your Director (for sites) or your Senior Lead (for programs). Senior Leads/Directors may be in touch with their preferred review process.

2. **Where do I submit my Quality Improvement Plan?**
   Please submit to Quality & Accreditation Coordinator – Cailin Gagnon cgagnon@southernhealth.ca and cc' your program-assigned Decision Support Analyst.

3. **How can we keep our teams updated regularly?**
   Each team is different, it's important to find ways that work for you. Here are a few suggestions:
   - Upload your quality improvement plan on your program/team's Microsoft Teams channel or a shared drive.
   - Have it as a standing item on your agenda as part of meetings on a regular basis. You may have the expectation that staff provide their updates in the QIP prior to the meeting or provide updates at the meeting itself.
   - If multiple people are updating the document, you may find it helpful to use Track Changes in Microsoft Word. This allows you to see the date and the author of the revisions. Once the updates have been reviewed or approved by the team you can Accept Changes. There is also a place in the template header to indicate the date the document was last updated.
   - Some sites have large dry erase board with the QIP and updates for all staff on site to view and any public that happen to view while in that area.
   - Print off updated copies on a regular basis for staff to review.

4. **What to do with completed objectives and/or priorities?**
   Each team is different, it's important to find ways that work for you. Here are a few suggestions:

- Keep the completed objectives/priorities in your QIP for the fiscal year. Start with a fresh template each fiscal year and keep the objectives/priorities that are still in progress.
- Have a blank QIP template where you cut and paste objectives under their respective priorities as they are completed. You may choose to have a "Completed QIP" version per fiscal year or on an ongoing basis (the date completed column would help you keep track of when it was completed).

5. **What happens if my priorities/objectives change?**
   These plans are meant to be adaptable. Quality improvement is a continuous activity, not a one-time thing. As changes are implemented, there will usually be issues to address and challenges to manage; things are never perfect. If there are no concerns from the perspective of leadership, service delivery, accountability agreements, etc., there is likely no problem removing them. If objectives or priorities you had set out are too big or unattainable, you may also consider revising into smaller, achievable, realistic goals. This is why it is important to set out SMART goals from the beginning.

Appendix A: Content to Consider Not Including or Reviewing

Consider Not Including As Objectives (Or Priorities)	But think about…	Maybe consider
Posting and filling a position. Why? This is a normal process that would be followed for the organization, not "quality improvement".	Was there feedback from an exit interview about the position in question? Is it difficult to retain staff for this position? Is it difficult to attract people to position?	Conducting % of exit interviews to determine ways to make employees stay – then develop a QIP action based on suggestions to retain new staff OR Revamp a job description to reflect better on duties (include client/families)? OR Consider changing certain requirements for position to increase pool of candidates. If you really want to include an objective around reducing vacancy rates (as a SMART objective), then make sure that the actions you include are not something you have already tried.
Participate in Provincial Initiatives Why? Most priorities are being led and directed by another person and therefore may not truly be in your sphere of influence.	Are there parts of the initiative that are the sole responsibility of your program/site?	Including specific details of the strategy that will be owned and directed by your program/site
Ensure staff have everything they need to start their new role in program Why? This is a normal part of setting up new employees when they start in program	Is the process for orientating new employees into your program/site written down? Are there parts of onboarding new staff that are not always shared?	Develop an orientation checklist for new employees who start with program to ensure they have all necessary equipment, knowledge and tools to start. OR Include this as an action towards bigger objective such as 'streamline process for orientating new staff…'.
Submit additional evidence for Accreditation Canada or PCH Why? Submitting evidence is not quality improvement.	Why is the criteria not met? What are some of the underlying issues? What are you going to do to make improvements?	What needs to happen in order to address the quality issue identified by Accreditation Canada (e.g., through unmet criteria/requirement for evidence submission)? In your plan of action, you can include evidence submission as a step. For example, If PCH needs to submit evidence to meet falls ROP: **Objective:** *reduce falls in PCH by 15% in first quarter (April – June 2024)* **Actions:** • CRN to review falls assessment with team by April 1 2024 • Nursing staff to audit 2 charts each to identify falls assessments by May 1 2024 • CSM to submit audits and information reviewed with team to Accreditation Canada by May 15 2024 • CRN to review % of falls with team to determine if actions have been successful by June 1 2024

Appendix B: Measures or Indicators

Remember that regardless of what measures you choose you have to consider: the availability and timeliness of the data/measures and the amount of resources needed to measure.

Outcome Indicators: These measure whether the activities/initiatives are achieving the expected or intended changes, impact, effects on the target population in short, intermediate, and long terms. They answer the question "What are the end results of our quality improvement work?" From a client care perspective, this could include their experience, health outcomes, access, etc.

- E.g., % reporting overall very good experience in client experience survey.
- E.g., Number of days to third next available appointment (for access)
- Adverse drug events per 1,000 doses

Process Indicators: These measure whether the activities/initiatives are being implemented as planned or intended. It measures the changes, outputs (e.g., direct products, deliverables), steps your quality improvement efforts make that ultimately should directly contribute to the desired outcomes.

- E.g., % of clients with a falls risk assessment completed on admission

Balancing measures: These ensure that interventions or services designed to improve one area of the system are not creating problems in other areas. They point to the unintentional negative consequences of quality improvement activities.

- E.g., If the objective is to reduce the average length of stay, we should maybe also monitor the percentage of client readmissions within 30 days.
- E.g., Does this new change improve staff satisfaction but decrease client satisfaction?

Structure Indicators: These inform us about the context of the care setting, the service providers, the systems or processes to provide high quality care. They include human or material resources.

- E.g., ratio of nursing staff to residents or number of influenza vaccines

References

Accreditation Canada (August 2014). A Guide to Measurement for Improvement and Quality Indicators, Ottawa ON.

Centers for Disease Control and Prevention (Reviewed April 9, 2021). Indicators: CDC Approach to Evaluation. Retrieved February 15, 2024 from https://www.cdc.gov/evaluation/indicators/index.htm#:~:text=Outcome%20indicators%20measure%20whether%20the,outcome%20indicators%20as%20impact%20indicators.

Health Quality Ontario (April 2013). Measurement for Quality Improvement. Queen's Printer for Ontario, Toronto ON. Retrieved February 15, 2024 from https://www.hqontario.ca/portals/0/documents/qi/qi-measurement-primer-en.pdf

Appendix C: Prioritization Tools

Whether your team is juggling too many priorities or too many objectives within those priorities, you may choose to use one of the following decision making tools to help prioritize.

Option A: Weighted Decision-Making Criteria and Scoring System:

1) Identify the list of all priorities/objectives you need to choose between
2) Review what criteria you would like to assess them on, we've made suggestions below. You may wish to tailor as appropriate, remove criteria or add others that align with the organization and your team's values (e.g., Promoting equity, people-centred care, etc.)
    - Impact (for public and staff)
    - Urgency (timeliness of certain projects/responsiveness to environment)
    - Resource intensity
    - Short vs. long term (quick wins may be beneficial)
    - SH-SS/Program led vs. provincially led
    - System vs. program/service impact (may not apply to every team)
3) Decide if you will assign scores based on a team consensus or ask each member of the team to assign a score individually. Please see each criteria below for respective scoring.
4) Add up the scoring and prioritize the ones that have the highest scores

Here is an example (blank) table you could fill out with your team:

Action/Priority	**Impact (for public and staff)** 1 = Low 2 = Medium 3 = High	**Urgency (timeliness of certain projects/responsiveness to environment)** 1 = Low urgency 2 = Medium urgency 3 = High urgency	**Resource Intensity** 1 = High resource intensity 2 = Medium resource intensity 3 = Low resource intensity	**Short vs. long term implementation (quick wins may be beneficial)** 1 = Long-term 2 = Medium-term 3 = Short-term	**SH-SS/Program-led vs. Provincially-led** 1 = Provincially-controlled 2 = SH-SS/Program-Led	**System vs. Program/Service Impact Impact** 1 = Program/Service 2 = Across the system
Example action/priority 1						
Example action/priority 2						
Example action/priority 3						

Option B: Impact-Effort Grid Decision Making Matrix

Rate or sort your priorities in terms of their impact (low to high) and effort (low to high) along the matrix below. Prioritize quick wins first and then juggle between major projects and scheduled priorities.