STONEY HEALTH SERVICES POLICY AND PROCEDURES

INTEGRATED QUALITY & SAFETY MANAGEMENT POLICY

Effective: May 15, 2014	**Policy Code:** PP + TITLE	**Applies To:**	✓ Leadership & Operations ✓ Programs & Services ☐ Client, Family & Community
Review: October 17,2018	**Sheet:** 1 of 25		
Revision: October 17,2021	**Approval:** ED		

Related Policies and Procedures: SHS Ethical Decision-Making Policy; SHS Safety Incidents Policy - Reporting, Analysis, Resolution and Disclosure of Harm; Safety Officer Policy; OHS Committee Terms of Reference

A. STANDARD: SHS delivers services and makes decisions based on its Integrated Quality Management Framework. All SHS personnel are responsible for and authorized to participate in realizing our Quality Improvement Plan.

B. RATIONALE: For quality improvement to be successful, all employees and clients/families must understand that each one holds some responsibility for the quality and safety of care and services in the organization as a whole. We 'walk that QI talk' using the Quality Improvement Pathway according to model developed by the National First Nations Home and Community Care Program. (*See Appendix B: The Quality Improvement Pathway*). The Quality and Safety Improvement Plan (QSIP) represents the operationalization of our 'just culture' of continuous quality improvement under the overarching objective of obtaining and maintaining Accreditation status. In our QSIP, Client Safety and overall Risk Management are not separate issues, but integral parts of our Integrated Quality Management approach. Clients and families play an important role in preventing adverse events. Stoney Health Services clients'/families' questions and comments are a good source of information regarding potential errors and safety issues. Our clients and families are able to fulfill this role when they are included and actively involved in the processes of designing, planning and evaluating care.

C. POLICY: All SHS personnel shall understand and support the SHS Integrated Quality and Safety Management Framework and comply with the following procedures.

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1. **ACCOUNTABILITY FOR QUALITY AND SAFETY IMPROVEMENT:** All SHS physicians and personnel are all responsible for the success of the Quality and Safety Improvement Plan; more specifically

1.1. **The Stoney Tribal Authority delegates and supports the responsibility for Quality and Safety Improvement to the ED and Leadership Team who subsequently:**

1.1.1. Actively champion the no-blame, 'just' culture of quality, both internally and externally;
1.1.2. Act as quality and safety ambassadors;
1.1.3. Establish a quality framework for the organization;
1.1.4. Promote the idea that quality and safety is everyone's job;
1.1.5. Identify and support QI champions among SHS physicians and personnel;
1.1.6. Implement and measure compliance with Accreditation Canada's Qmentum standards;
1.1.7. Ensure that quality and safety are at the core of the organization's vision and are embedded in the organization's strategic plan;
1.1.8. Include quality and safety issues prominently on the Management and Staff Meeting agendas;
1.1.9. Implement daily huddles and additional safety briefings (as required);
1.1.10. Focus hiring practices to reflect client safety as a priority;
1.1.11. Establish Client Safety and organizational Risk Management as strategic priorities;
1.1.12. Ensure that all programs carry out an annual risk assessment using the Format in Appendix K to focus on reducing preventable risks through organization-wide participation in their identification, assessment, and management. Note : Targeted high-risks shall be prioritized in the QSIP;
1.1.13. Revise job descriptions, as needed, to ensure that all personnel understand their roles with respect to quality and safety improvement. Conduct Job Safety Analyses on all positions;
1.1.14. Support the Safety Officer in the exercise of his/her functions;
1.1.15. Create and sustain an Occupational Health and Safety committee to ensure that SHS personnel work in conditions of optimal safety and mitigated risk;
1.1.16. Create and sustain a client feedback process to drive quality and safety improvements;
1.1.17. Include quality and safety improvement in staff orientation processes;
1.1.18. Uphold quality-based decisions at client service-delivery levels;
1.1.19. Support staff and clients impacted by errors and adverse events;
1.1.20. Share QSI information across teams and with other organizations to increase the learning;
1.1.21. Ensure that sensitive QI-related interviews, reports, statements, other data, proceedings and records of the SHS management team relating to quality improvement are deemed confidential. (Note: All policies regarding the handling of confidential information apply to the above.);
1.1.22. Set key organisation-wide quality and safety priorities are set annually. These are addressed in the Quality and Safety Improvement Plan (QSIP) which is developed in collaboration with internal and external partners and :

1.1.22.1. Is aligned organizational objectives;
1.1.22.2. Is influenced by evidence-informed practices; and major national initiatives (e.g. Safer healthcare now, CPSI etc.;);
1.1.22.3. Has active senior leadership sponsorship;
1.1.22.4. Is developed and carried out in a collaborative manner by engaging key stakeholders to bring forth proposed quality and safety initiatives;
1.1.22.5. Coordinates quality and safety improvement activities across and between departments;
1.1.22.6. Identifies and addresses redesigning of processes and systems to reduce variation , improve workflow standardization and enhance teamwork;
1.1.22.7. Has appropriate resources allocated to ensure the desired results
1.1.22.8. Has measurable quality and safety *SMART goals ; (*Specific, Measureable, Attainable Relevant and Time-bound).
1.1.22.9. Is monitored for on (at least) an annual basis for progress and performance;
1.1.22.10. Celebrates Quality and safety improvements with key internal and external stakeholders.

1.2 All SHS personnel, physicians and other * contracted service providers are accountable for:

1.2.1 Appreciating and respecting clients' individual and cultural identities
1.2.2 Adopting evidence-informed quality and safety practices
1.2.3 Providing high quality, safe care and services
1.2.4 Generating discussions about quality and safety issues with their colleagues
1.2.5 Participating in ongoing quality and safety improvement efforts
1.2.6 Promptly reporting safety issues and incidents; and, participating in their resolution
1.2.7 Attending quality and safety training sessions
1.2.8 Inviting and encouraging clients/families to be responsible for important aspects of their own care; as well as providing clients with the appropriate self-care tools and support and monitoring self-care outcomes
1.2.9 Ensuring that clients participate actively in their care ; and, understand care and self-care instructions (health literacy)
1.2.10 Note: *All contracted service providers shall attest in writing to the quality of their services in line with this Quality & Safety Improvement Policy. Executive and Managerial personnel shall monitor the progress of contracted services. Defaulting on quality may be grounds for termination of contracted services.

2. CLIENT AND WORKPLACE SAFETY:

2.1. Client and workplace safety are not a separate item from the broader QSIP. They are part of a core element of Quality and Safety Improvement that deals with reducing risk, preventing harm, and minimizing injury from harm. Client and workplace safety do not rest with any individual or department ; they are part of a larger, collective responsibility for all – clients, families, visitors, volunteers, students, staff and physicians. SHS has adopted the Accreditation Canada Required Organizational Practices (ROPs) as key drivers for client and workplace safety. (See *Appendix C: Overview of the Quality Improvement Plan 2017-2019).* Appropriate policies, processes, practices and/or systems have been developed and implemented to meet these requirements.

2.2. Also, SHS personnel shall inform and educate client and families in writing and verbally about the client and families role in promoting safety

3. MEASURING AND MONITORING QUALITY AND SAFETY IMPROVEMENT: The SHS QSIP will be the object of monthly monitoring and reporting by the Leadership Team. This includes:

3.1. Developing and tracking a balanced set of Key Performances Indicators that collectively reflect governance, leadership, service and client-level quality issues.

3.2. Sustaining incident reporting and monitoring mechanisms using the results to address quality and safety issues in a timely manner.

3.3. Monthly monitoring and reporting of quality and safety initiatives on a monthly basis as per the SHS Incident Reporting, Analysis, Resolution and Disclosure Policy

4. QUALITY AND SAFETY IMPROVEMENT TECHNIQUES: SHS has adopted the following quality and Safety improvement techniques:

4.1. Benchmarking and External Comparison: SHS will be consult outside sources/comparative data (i.e. professional practice standards and guidelines, Alberta Health and Wellness data, etc.) to compare its outcomes and processes to others, identifying areas of focus for quality improvement efforts.

4.2. Failure Mode Events Analysis (FMEA): An FMEA is used to evaluate processes for possible failures and to prevent them by correcting the processes proactively rather than reacting to adverse events after failures have occurred.

4.3. Inter /Intradepartmental Quality Improvement Teams: Quality Improvement Teams will look at quality issues to identify opportunities and use PDSA methodology to improve processes and outcomes.

4.4. The Plan-Do-Study-Act (PDSA) Method: The PDSA Method is used to plan, carry out and evaluate successive, small-scale QI changes in the workplace (See *Appendix H: Plan-Do-Study-Act (PDSA) Cycles*).

4.5. Program Evaluations: Program Evaluations using formal evaluation criteria (i.e. service process and outcome indicators; and client outcome indicators or clinical outcomes) will be carried out regularly to assess if programs or services are meeting intended objectives.

4.6. Quality and Risk Assessment Activities : Quality and risk assessment activities such as individual client interviews or focus groups of clients, client and staff satisfaction surveys, infection control audits, resource utilization and medical record reviews, etc. to help assure that standards are met and maintained, and to identify areas for QI work by quality improvement teams.

4.7. Quality and Safety Measures : Quality measures shall include capacity, process, and outcome measures.

4.8. Quality Walkabouts \ Safety Briefings or 'Huddles' **:** Quality walkabouts and safety briefings or 'huddles' shall be lead by senior SHS personnel.

5. **QUALITY AND SAFETY IMPROVEMENT PLAN:** The purpose of the SHS Quality and Safety Improvement Plan (QSIP) is to bring about change and improvement; and, to demonstrate our commitment to systematically improving the quality of care we deliver. In line with the SHS strategic planning process, the QSIP focuses on direct client care delivery processes as well as on administrative and support processes that promote optimal client outcomes, healthy workplaces and effective business practices. Core dimensions of the SHS QSIP are: 1) a Culture of quality and accountability lead by the SHS Leadership Team, 2) Targeted QSI Objectives with particular attention to Proactive Risk Management and Client Safety, 3) Measurement and Improvement activities; 4) QI Training and 5) ongoing QI Communication. The SHS QISP is reviewed and updated annually in line with Stoney Health Services strategic objectives.

6. **RESOURCE UTILIZATION REVIEW:** SHS provides information on resources utilisation to the Stoney Tribal Administration and various funding agencies on a regular basis, as required (i.e. monthly, quarterly, and annually.

7. **SAFETY INCIDENTS**: See Safety Incidents-Reporting, Analysis, Resolution and Disclosure of Harm Policy.

E. INDICATORS: SHS regularly audits (monthly or quarterly, as the case may be) and reports on key service trends, accidents/incidents and high risk practices (i.e. medication management, fall prevention, infection prevention and control). Results are shared with key internal and external stakeholders; and, are used to inform service development.

F. DEFINITIONS:

- **Accountability**: Accountability is 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. To be held accountable, an individual must have: 1) the skills and experience necessary to be successful; 2) the authority necessary to execute the assigned responsibilities; 3) access to the necessary resources; and 4) visible, tangible leadership support (i.e. adjusted workloads to be able to accomplish the expected tasks or achieve the objective).

- **Accessibility**: Clients receive equitable services in a timely manner (i.e. at the right time and in the right place).

- **Adverse Event:** "...results in unintended harm to the patient [client] and is related to the care and/or services provided to the patient [client] rather than to the patient's [client's] underlying medical condition." *(Accreditation Canada, 2006; Canadian Patient Safety Dictionary, 2003*).

- **Appropriateness:** Services that meet the client's assessed needs based on a structured client assessment that includes all aspects physical, psychosocial and environmental aspects of the clients' situation and as documented in a comprehensive, multidisciplinary care plan. Services being provided must be relevant to the group of people being served.

- **Benchmark:** A "benchmark" is a point of reference from which measurements may be made as a basis for evaluation or comparison. It is a standard that we use to measure how well we deliver 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: 1) by using use the results that other similar health care organizations have achieved and recorded about their experience in delivering care and services to similar client groups or populations, and/or 2) by using our own experiences in serving clients over regularly time(e.g. every six months).

- **Best Practices**: Ways to provide care and services that have a good track record in producing better than average results for clients, based on experiences in other similar programs. Best practices are considered to be "exemplary", "good" or "successfully demonstrated", based on formal measurements. (Adapted from the Canadian Council on Health Services Accreditation, *Achieving Improved Measurement,* 2002, Ottawa).

- **Client and Family-Centered Care**: Care that recognizes, respects and prioritizes the perspective, needs, wishes, experiences and cultural preference of clients and their families.

- **Client Safety**: Client safety involves all activities to prevent or mitigate harm to clients while providing services. The reduction and mitigation of unsafe acts through the use of best practices leads to minimized risk and harm prevention as well as to optimal client outcomes. A client safety assessment is a way to identify client safety

issues within the organization. Using this information to develop a client safety plan can identify steps that have been taken and that will be taken to address client safety issues. Client safety may be improved by coaching and mentoring staff and service providers, leading client safety leadership walkabouts, implementing organization-wide client safety initiatives to promote widespread learning, accessing evidence and best practice, encouraging staff and service provider innovation, providing feedback to staff and service providers on client safety issues and safety improvement suggestions, recognizing staff and service providers for their suggestions to improve client safety, and acting on staff and service provider recommendations

- **Client Safety Incident**: A safety incident that could have resulted, or did result, in unnecessary harm to a client

- **Continuity Of Care**: Services that are coordinated and seamless with smooth transitions.

- **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.

- **Failure Mode Events Analysis:** Failure Modes and Effects Analysis (FMEA) is a systematic, proactive method to evaluate processes for possible failures and to prevent them by correcting the processes proactively rather than reacting to adverse events after failures have occurred in order to identify the parts of the process that are most in need of change. The emphasis is on prevention and reducing risk of harm to both clients and staff. FMEA is particularly useful in evaluating a new process prior to implementation and in assessing the impact of a proposed change to an existing process. FMEA includes review of the following: 1) Steps in the process; 2) Failure modes (What could go wrong?); 3) Failure causes (Why would the failure happen?) and 4) Failure effects (What would be the consequences of each failure?) (*IHI Website, 2014*).

- **Focus Group**: Gathering information from individuals through conversations with small groups of eight (8) to ten (10) people ; the Stoney Health Services Client Advisory Circle, is one such example. 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 us to learn more about the views, opinions and feelings that clients, staff and community members have about a specific issue or topic. We can then use the information to make decisions about care and services.

- **Harm:** An unexpected, unintended outcome event occurring in the context of care or services provided by SHS personnel that negatively affects the health or quality of life any member of SHS personnel, medical staff, consultants, clients and-or their family members.

- **Hazard:** A circumstance or set of circumstances that, if left unchanged, could cause harm to contribute to harm.

- **Incident Analysis**: A structured process that aims to identify what happened, how and why it happened, what can be done to reduce the risk of recurrence and make care safer, and what was learned. The analysis always ends with recommendations for preventing further similar incidents.

- **"Just Culture"**: A key element of the broader QI culture. It supports and empowers healthcare providers by encouraging and rewarding their participation in creating a safety culture, by focusing on the improvement of processes and systems while actively discouraging individual blame (*except for those rare situations where responsibility for an adverse event is lies clearly with individual*). "Just Culture" implies a transparent organizational safety culture that means being honest, forthright and accountable to clients, colleagues and partners-in-care.

- **Measuring For Improvement:** It is critical to the SHS *quality culture* that metrics identified in the QSIP allow the measurement of progress. Effective measurement comes about when quality and safety measures migrate away from being 'tasks' and become embedded in the psyche and routine of every staff member and physician. Effective monitoring of the QSIP is necessary to:
  - keep us focused on the desired activities and outcomes;
  - inform internal and external stakeholders about the effectiveness of the QI initiatives underway;
  - direct attention to areas where adjustments in activities or targets may be required;
  - permit early identification of possible problems or gaps;
  - remind stakeholders of the quality priorities of the Board and the senior executive team;
  - inspire and motivate staff by showcasing the results of their efforts;
  - demonstrate value for money

- **Near Miss (Good Catch Or Close Call)**: A safety incident that could have but did not impact negatively on the client, visitor and/or any member of SHS personnel, medical staff or consulting personnel. Replaces "close call", an event or circumstance which has the <u>potential</u> to cause serious physical or psychological injury, unexpected death, or significant property damage, <u>but did not happen</u> due to chance, corrective action, and/or timely intervention; <u>NB</u>: Estimated to be three times more prevalent than adverse events.

- **Operational Planning:** According to Accreditation Canada, an operational plan is a detailed action plan that summarizes the activities to be undertaken each year toward meeting the strategic goals. The operational plan is <u>not</u> combined with the strategic plan, since it has a very different purpose. Rather, the operational plan stems from the strategic plan, breaking down the broad strategic goals into, more manageable pieces, each with their own operational objectives identifies the necessary processes, actions, activities, resources, responsibilities and time frames.

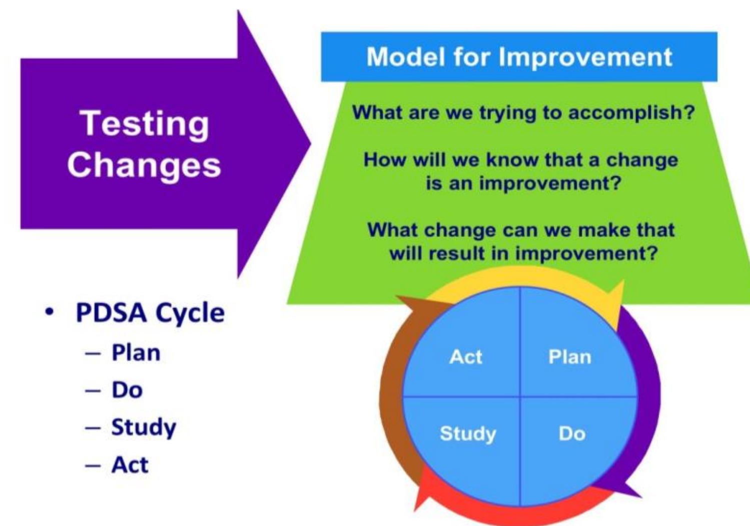
- **Organizational Performance:** Organizational is defined by the Health Council of Canada (2012) as: What an organization does (what processes) or achieves (what outcomes) to influence client outcomes. It can also be thought of as the extent to which health care activities/ services achieve specific standards, benchmarks or targets as per the Accreditation Canada (1996) definition.

  Seen from this perspective, Performance Measurement is a coordinated approach to using tools and methods to quantify processes and outcomes. It is a multidimensional, ongoing feedback process to improve performance by collecting and reporting information about the performance of a group (service) or an organization (not an individual) in order to decide if actual outcomes (financial and non-financial) are what was intended. *(Accreditation Canada (1996), Health Council of Canada (2012), Institute of Medicine Website (2012), Shane, B. (2004) and S. Kaplan. et al (1996))*.

- **PDSA Cycles**: The Plan-Do-Study-Act (PDSA) cycle is also known as PDSA Cycle or Deming Cycle which is a simple problem-solving approach that anyone can use to improve quality. PDSA cycles promote action-oriented learning. The PDSA Cycle is a trial and learning Model for Improvement (see below) in the form of a cyclical four-stage process. It allows changes to be tested and implemented in real work settings. It 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. (See Appendix H - PDSA Cycles). *Reprinted with permission from the FNIHCC Quality Resource K*

Figure 1:
Model for Improvement & PDSA Cycle

Langley, G.L. et al (1996), The Improvement Guide : A Practical approach to Enhancing Organisational Performance ; Jossey-Bass.



- **Processes:** A series of inter-related activities and communications necessary to deliver services to clients (e.g., client assessment).

- **Program 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) to assess if the program or service is meeting the objectives for which it was created and before starting a new or reorganized program, service or procedure.

- **Population-Focused Care**: Population-Focused Care is an approach to health that aims to improve the health of the entire population and to reduce health inequities among population groups by addressing a broad range of factors and conditions that have a strong influence on the health of populations (from the Public Health Agency of Canada). It focuses, therefore, on the interrelated conditions and factors that influence the health of populations over the life course, identifies systematic variations in their patterns of occurrence, and applies the resulting knowledge to develop and implement policies and actions to improve the health and well-being of those populations. (Federal/Provincial/Territorial Advisory Committee on Population Health). Accreditation Canada (2014) defines Population-Focused Care as working with communities to anticipate and meet needs.

- **Quality:** The degree of excellence and the extent to which an organization meets the client's assessed need. It describes the various features, characteristics and aspects of quality. Quality is a multi-dimensional construct that covers the Accessibility, Appropriateness, Client-Centeredness, Continuity, Effectiveness, Efficiency, Population-Focused, Safety (for clients and care providers) and Timeliness of care and services.

- **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 Framework: A quality framework is an integration of the key elements used to identify the quality improvement issues to be improved upon in order to plan, deliver, evaluate, and report upon care and services to better meet the clients' and program outcomes.

  - Quality Improvement: An organizational philosophy and formal approach that guides us in improving the performance of our services to achieve optimal better client outcomes. A variety of quality improvement methods and techniques can be used to collect and analyze information in order to identify trends and make improvements 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.

  - Quality Measures or Indicators: Measurement tools, screens or flags used to guide, monitor, evaluate and improve the quality of client care services and organizational functions that affect client and service outcomes. A set of rate-based (numerator and denominator), balanced quantitative and qualitative measures should be developed to monitor all key areas of care and delivery, such as clinical

services (urgent test turn-around times, wound care infection rates etc.), financial (travel time, kilometres per visit, productivity), and human resources (staff satisfaction and turnover rates) over a specific period of time. Balanced measures include quantitative and qualitative indicators that measure capacity (or structure), processes and outcomes.

- Qualitative Measures: 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 (i.e. *the most important quality is integrity*) and what staff members think about the effectiveness of internal communication (i.e. *55% of staff feel that internal communication about aggression risk management should be improved*).

- Quantitative Measures: Objective measures using hard data to identify trends (i.e. 25% increase in number of clinic no-shows in past year; the percentage of clients over age 70 now as compared to last year at the same time etc.). The information can be collected manually or electronically over time (e.g. intake forms) and/or at specific points in time (e.g. a survey).

- Capacity (Structural) Measure: Measurement of the kind and amount of resources that is used to deliver programs and services (e.g. money, beds, supplies, facilities and buildings). Seventy-five percent (75%) of nursing staff will be able to do a risk assessment by June 31, 2014.
- Process Measure: Wait lists for OT evaluation will average no longer than five (5) days by October 1, 2014.

- Outcome Measures: Measure the success of outputs on clients. For example, the percentage of falls by elderly clients in their homes decreases by 50% in six (6) months; or: All clients identified as high suicide risk have a written emergency plan by September 1, 2014.

- **Quality and Safety Improvement Plan (QSIP)**: A Quality Improvement Plan helps us to plan for and operationalize the ongoing QI Program. It is aligned with the Vision, Mission and Strategic Plan of the organization, Best Practices, governing legislation, regional or provincial initiatives, Accreditation recommendations and recognized Quality initiatives (e.g. accreditation, Safer Healthcare Now!) and Emerging trends. The steps in the Quality Plan are not sequential, but are considered in tandem so that the final Plan is realistic. The Quality Improvement Committee develops the Plan with key clinical and non-clinical SHS personnel. This broad-based and consultative 'bottom-up-top-down' process is important:

  - so that front-line staff can provide input into areas of risk, priorities, target-setting , implementation approaches and system re-design;
  - to better engage SHS personnel as QI champions and change agents who understand their role in achieving targets;

- so that all staff become educated about quality objectives and accountabilities;
- to match resource requirements with resource availability;
- to balance 'quick win' changes with longer, more complicated QI projects (projects over a year requiring interim targets) for a more manageable pace of change;
- to prepare for adequate follow-up assistance after a change has been implemented.

The QSIP is displayed in a format that is clear and easily understood in order to help us differentiate between two types of questions: 1) How do we compare to others like us; 2) are we getting better; and 3) are we on track to achieve our aims?

Most organizations prepare a Quality Plan which has a one-year life span. However, since Quality Initiatives often require resources and an organizational culture change that cannot be reasonably achieved in a single year, it is important that Quality Plans take a longer term perspective with respect to quality improvement targets. To accomplish this, health organizations should consider a multi-year timeframe which is used by a number of organizations.

The current SHS QI Plan for 2014-2017 outlines the ten (10) QI priorities, as well as related QI strategies and QI projects of varying scope to be carried out in the short to medium-term (1-3 years). Each QI Project has measurable goals and indicators, defined actions, target dates and designated persons to lead and/or participate in the QI initiatives. (See Appendix X for the full SHS Quality Improvement Plan)**.**

- **Leadership Quality Walkabouts and Safety Huddles**: Unit-based opportunities lead by leadership personnel to discuss client and staff safety concerns in a supportive environment, non-blaming and semi-structured manner. They help identify issues early, before problems become bigger and cause harm and to visibly demonstrate a commitment to quality. Walkabouts and huddles support the QI culture while providing opportunities for leadership and service delivery to learn together about quality and safety patient safety and to identify opportunities for improvement. They help establish and consolidate lines of communication about quality and safety among employees and managers, as well as leading to PDSA cycles plan for the rapid testing of quality improvements. Quality and Safety Leadership Walkabouts and Safety Huddles are semi-structured in that they:
    - are introduced as confidential, non-blaming discussions about processes and activities, not about individual performance;
    - are guided by general questions to stimulate collective thinking around quality and safety such as: Are there any ways we can improve this process or this work area? Have there been any near misses or incidents this week? And, how can we address them, etc.);
    - end with a statement about leadership follow-ups that will occur and a request for personnel to tell two (2) other people about the discussion.
- **Risk**: Risk is defined by Accreditation Canada as actual or potential danger, harm or loss to clients, the community, staff or the organization. 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 can and does result in loss of health or life for clients, damage to property or equipment as well as damage to organizational credibility and even financial stability, if resources are poorly used. The potential harm or risk is most often measured as low, medium or high.

- **Risk Management (RM):** Risk Management is process to systematically identify, monitor and minimize risks in order to ensure that objectives are more likely to be achieved, that damaging things do not happen/happen less and that beneficial things happen more often. The success of a risk management program depends on creating and maintaining safe systems of care, designed to reduce adverse events and improve human performance. It requires a structure/system of policies, procedures and practices to analyze, evaluate, prevent/control and monitor risk. Risk Management also requires a commitment to safe outcomes to move beyond blame to build a culture of safety. The basic premises of Risk Management are as follows:
  - Human beings make errors in the ‘right’ circumstances (Human Factors);
  - People do not come to work to do a bad job;
  - Many errors are preventable;
  - Factors in the system contribute to errors;
  - A non-blaming culture that supports measurement, system tools and change strategies can mitigate risk;
  - The most helpful response to adverse events is to seek to understand and address the circumstances in the structure (i.e. equipment failure) and processes (preventive maintenance processes for HC equipment) and to avoid focusing on the outcome (patient injury).

  There are five (5) steps to Risk Management as follows:

  - Gather team members from the program and brainstorm to identify actual or potential hazards;
  - Decide who could be harmed and how;
  - Evaluate the probability (how often) and the severity (how bad) of possible harm;
  - Identify corrective actions;
  - Use PDSA cycles to reduce the harmful process and evaluate the results.

- **Enterprise Risk Management** includes organizational or administrative risk management to address financial, infrastructure, reputational and marketplace risks such as: insurance protection, budget and capital planning processes; human resources; corporate governance; compliance risks associated with standards, policies, and legislation; information systems and technology; property and physical infrastructure; emergency or disaster preparedness; contract management; and risks related to reputation, credentialing, and liability.

- **Required Organizational Practices (ROPs):** According to Accreditation Canada (2104), ROPs are evidence-informed practices addressing high-priority areas that are central to quality and safety. They are essential practices that organizations must have in place to enhance client safety and minimize risk. ROPs are classified into six (6) categories, as follows:
  - Safety Culture: Create a culture of safety within the organization.
  - Communication: Improve the effectiveness and coordination of communication among care and service providers and with the recipients of care and service across the continuum.
  - Medication Use: Ensure the safe use of high-risk medication.
  - Worklife/Workforce: Create a work life and physical environment that supports the safe delivery of care and service.
  - Infection Control: Reduce the risk of health care-associated infections and their impact across the continuum of care/service.
  - Risk Assessment: Identify safety risks inherent in the client population.

- **Root Cause Analysis (RCA):** A systematic, retrospective process of analyzing critical incidents and near-miss events and incident or adverse outcome to determine what happened. The analysis focuses on 1) identifying what happened; 2) why it happened 3) how to prevent it from happening again and 4) what can be learned from the incident about underlying system or process deficiencies. RCA does not assign blame. It is outcome-directed with emphasis on specific actions that take into account human factors, engineering principles and the need to design systems with integrated safeguards. (*ISMP (2012) Canadian Root Cause Analysis Framework).*

- **Safety Culture**: SHS defines a Safety Culture as: What all SHS leadership and service-delivery personnel do when their commitment to safety is not being seen by others. All members of SHS Health Board and personnel work together to develop an active safety culture within their organization, so that safety becomes an integral part of the 'the way we do things around here'. We follow the Safety Culture model of Dr. James Reason in that our safety culture consists of five (5) interacting dimensions, that is: an informed culture, a reporting culture, a learning culture, a just culture and a flexible culture as shown below.

  Leadership is central to our safety culture. All the elements of our safety culture are actively encouraged and demonstrated by SHS Board Members and Leadership personnel on a regular basis. We expect the highest standards of behaviour and practice from themselves first and foremost by words and deeds; and, expect in return the highest standards from all SHS personnel and contractors. All SHS personnel are trained to do their work in a safe manner while proactively looking for hazards and involving client and families in their own safer care. See Figure 2: SHS Safety Culture - Five Dimensions on the next page.

SHS SAFETY CULTURE – 5 DIMENSIONS

SAFETY CULTURE

INFORMED CULTURE : SHS Board Members & Leaders collect and analyse relevant data, &actively disseminate safety information. They continue to seek to understand current & emerging human, technical, organisational & environmental factors that determine the safety of services & care provided to individuals & to the community .

FLEXIBLE CULTURE : SHS is able to reconfigure its' services as needed while responding rapidly & effectively to changing demands.

REPORTING CULTURE : The SHS organisational climate encourages the reporting of near-misses & errors in a no-blame atmosphere where all personnel , clients & families are confident that they can report safety concerns without fear of blame while knowing that confidentiality will be maintained & that the information they submit will be acted upon.

LEARNING CULTURE : SHS monitors &analyses key safety information and implements all necessary local and organisation-wide safety measures in a timley manner. SHS learn from its mistakes & ensures that all personnel &Board Members understand safety at a personal level.

JUST CULTURE : An atmosphere of trust exists at SHS where all are encouraged & rewarded for providing safety information and safe care. Errors & unsafe acts will not be punished if unintentional. However, those who act recklessly or take deliberate & unjustifiable risks will be subject to disciplinary action.

Adapted from Reason (1997) The Components of Safety Culture: Definitions of Informed, Reporting, Just, Flexible and Learning Cultures

- Client Safety (i.e. involving clients, families and visitors such as falls, etc.);
- Equipment Safety (i.e. involving equipment and vehicles used by SHS personnel such as such as vehicular breakdowns , non-functioning medical equipment etc.):
- Workplace Safety (i.e. involving SHS personnel, physicians and-or contracted workers):
- Environmental Safety (i.e. hazards, such as spills, floods etc. in the physical environment at the Health Centre, at Turning Point and/or in the immediate vicinity as well as in clients' homes and in any location where SHS personnel are called upon to intervene);
- Infection Prevention (i.e. wound infection, poor handwashing, etc.);
- Informational Safety (i.e. breaches of confidentiality, computer system 'downtime');
- Medication Safety (i.e. medication errors).

- **Satisfaction Surveys**: A written or verbal process to collect information on what individuals think about the services they receive and whether the services have met his/her expectations and needs. Staff Satisfaction surveys address work life issues. Client satisfaction issues address issues related to care and services; they can be carried out while the person is receiving services, or after discharge.

- **Sentinel Event:** An unexpected incident, related to system or process deficiencies, which leads to death or major and enduring loss of function (severe harm) for a recipient of health care services (sensory, motor, physiological, or psychological impairment not present at the time services began, lasting for a minimum period of two (2) weeks and not related to an underlying condition).

- **SMART Goals**: SMART goals are Specific, Measurable/Meaningful, Attainable, Relevant/Results-Oriented and Time-Bound.

- **Timeliness**: Providing services at the right time to meet the identified need.

- **Resource Utilization Review:** An analysis of the necessity, appropriateness, efficiency and use of medical and health-related services, procedures, resources (i.e. medical supplies, personnel, etc.), facilities, and practitioners; can be done on concurrent and retrospective basis. A Drug Utilization Review (DUR) is defined as an authorized, structured, ongoing review of prescribing, dispensing and use of medication. DUR encompasses a drug review against predetermined criteria that results in changes to drug therapy when these criteria are not met. It involves a comprehensive review of patients' prescription and medication data before, during and after dispensing to ensure appropriate medication decision-making and positive patient outcomes. As a quality assurance measure, DUR programs provide corrective action, prescriber feedback and further evaluations.

- **Workplace Safety**: The degree of security in the working environment that encompasses all factors which impact the safety, health, and well-being of the staff, clients, visitors, and consultants. A structured approach designed to 1) improve the safety and health for all workers, as evidenced by fewer hazards, reduced exposures, and fewer injuries, illnesses, and fatalities; 2) to change workplace culture to increase employer and worker awareness of, commitment to, and involvement in safety and health; and, 3) to secure public confidence through excellence in the development and delivery of programs and servic

G. REFERENCES:

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- Shane, B. (2004); A Performance Measurement System: Leadership-Driven Methodology; BPC Management Consultants

H. RESPONSIBILITIES:

- **EXECUTIVE DIRECTOR** Responsible for the approval and dissemination of this policy.
- **MANAGERIAL /SUPERVISORY PERSONNEL:** Responsible for review, revision, dissemination, monitoring and compliance with this policy.
- **STONEY HEALTH SERVICES PERSONNEL AND CONTRACTORS :** Responsible for compliance with this policy.

I. DEVELOPED BY:

____________________________ Date _______________

J. APPROVALS:

____________________________ ____________________

A.Khan
Chief Executive Officer
Executive Director

Date

STONEY HEALTH SERVICES POLICY AND PROCEDURES

INTEGRATED QUALITY & SAFETY MANAGEMENT POLICY

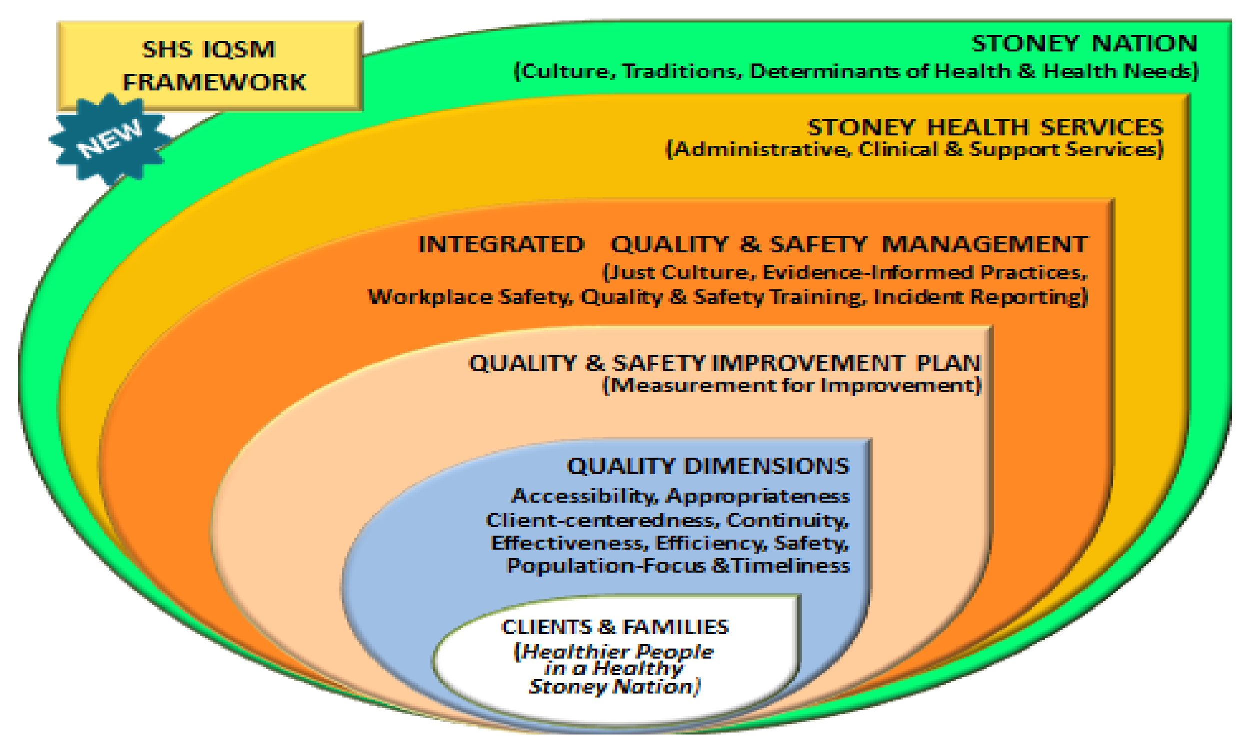
Effective: May 15, 2014	Policy Code: PP + TITLE	Applies To:	✓ Leadership & Operations
Review: October 17,2018	Sheet: 19 of 25		✓ Programs & Services
Revision: October 17,2021	Approval: ED		☐ Client, Family & Community

Related Policies and Procedures: SHS Ethical Decision-Making Policy; SHS Safety Incidents Policy - Reporting, Analysis, Resolution and Disclosure of Harm; Safety Officer Policy; OHS Committee Terms of Reference

APPENDIX I : SHS INTEGRATED QUALITY AND SAFETY MANAGEMENT FRAMEWORK

Introduction: The SHS Integrated Quality and Safety Management Framework is a visual representation of how SHS leadership and operations work together around common quality and safety goals; and, and using ethical principles for the ultimate benefit of the Stoney Nations in terms of better health outcomes. The Quality and Safety Improvement Plan (QSIP) focuses on evidence-informed practices, Client and Workplace Safety as well as organizational Risk Management. It is linked to the SHS Vision, Mission and Goals; and is shared, understood and applied all across our organization.

SHS believes that ongoing improvement, innovation and a sense of discovery will lead our organization into the future. Under the careful oversight of our Leadership Team, SHS is committed to a 'just culture' of continuous Quality and Safety Improvement (QSI) for the benefit of its clients, the Stoney community and SHS personnel. Our Integrated Quality and Safety Management Framework combines Quality and Safety Management, Client and Workplace Safety and Measuring for Improvement into one comprehensive strategy. This strategy helps us to assess, develop, demonstrate and evaluate our commitment to quality and safety at all levels by providing common quality and safety goals, a clear understanding of roles and expectations as well as related training, tools and support for our personnel. Improved client and service outcomes then sit at the heart of our IQSM strategy; quality being a multidimensional construct consisting of nine (9) domains encompassing the Accessibility, Appropriateness, Client-Centeredness, Continuity, Effectiveness, Efficiency, Safety and Timeliness of Population-Focus care and services we provide for, to and with the Stoney community.



APPENDIX II: THE QUALITY IMPROVEMENT PATHWAY

The four steps to the QI Pathway are as seen below:

Health Canada Santé Canada *Your health and safety... our priority. Votre santé et votre sécurité... notre priorité.*

Quality Improvement Pathway

Building Commitment to Quality

- Determine QI Awareness
- Initiate Community QI Awareness Activities
- Establish and Engage Leadership Support for QI
- Review/Update Program Mission and Vision for Quality and Safety Statement
- Hold Community Meeting to Communicate Vision for QI
- Prepare Activities for QI Launch
- Promote "Culture of Safety" Amongst Staff – no Blame

Creating a QI Team

- Establish QI Team Membership
- Develop Terms of Reference (TORs) for QI Team
- Recruit and Train QI Team Members
- Brainstorm a List of Possible QI Initiatives and Prioritize

Developing QI Plan using PDSA Cycle

(PLAN)
- Choose a QI Initiative
- Develop an Action Plan
- Decide on What Data to Collect

(DO)
- Test Changes on Small Scale
- Monitor Progress of Test
- Document Results

(STUDY)
- Analyze Results of Test

(ACT)
- Decide Whether to Adopt, Amend or Abandon Changes

Sharing Results of QI Activities

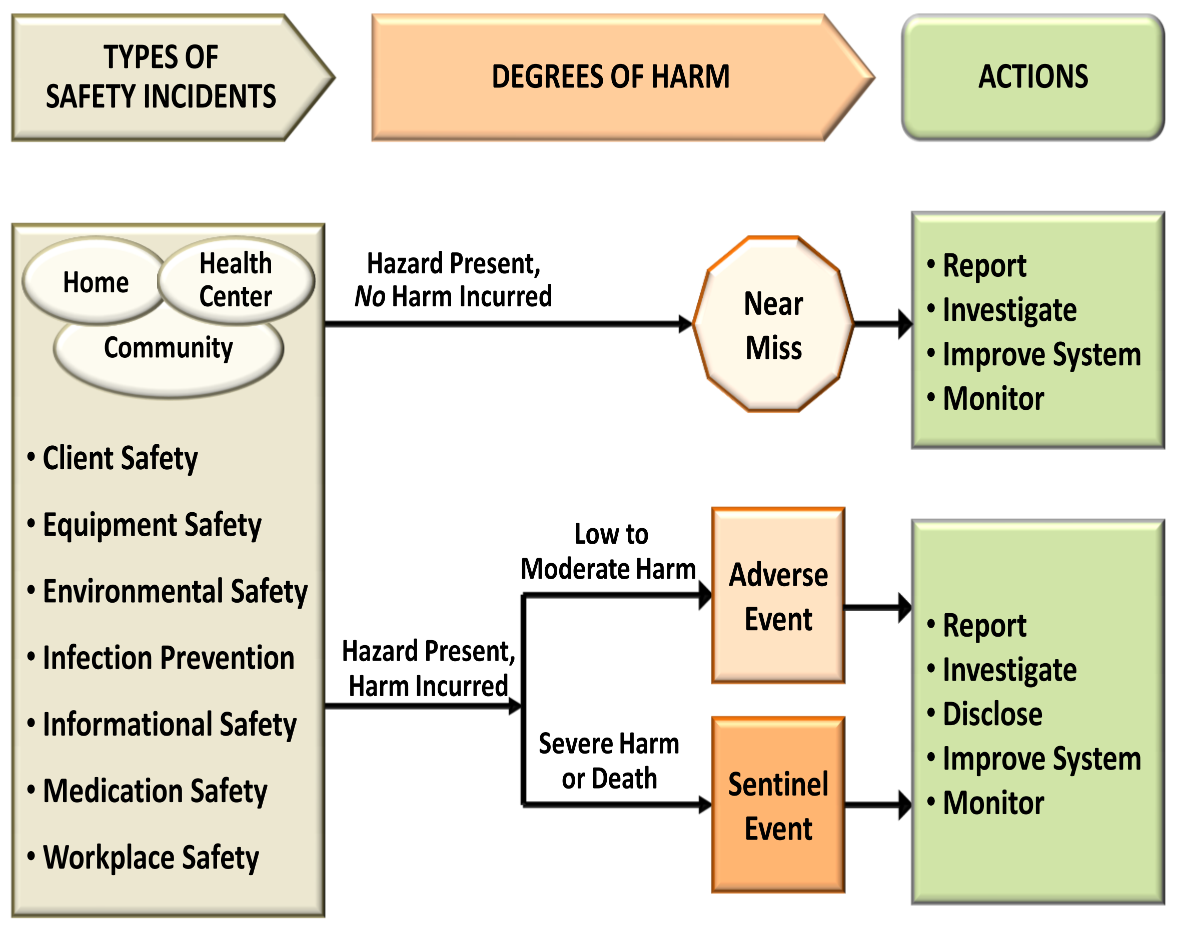
- Identify Key Results
- Prepare Summary from Analyzed Information
- Review Results with Leadership
- Share at Staff Meetings
- Develop QI Newsletter
- Wrap-up Meeting with QI Team and/or Community
- Begin Next QI Cycle

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

Canada

Reprinted with permission from Health Canada, First Nations and Inuit Home and Community Care Program, 2012

APPENDIX III: SHS SAFETY INCIDENT CONTINUUM



APPENDIX IV:
PLAN-DO-STUDY-ACT (PDSA) CYCLE SUMMARY and 2. PDSA ACTION PLAN TEMPLATE

1. Plan-Do-Study-Act (PDSA) Cycle Summary

PLAN

- Assemble the QI team
- Develop plan: *who, what, where, when and how*
- Collect the data to predict which
- Determine what 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

- Analyze the data
- Compare results to predictions
- Summarize outcomes

ACT

- Adopt the change as is
- Adapt; make modifications to change
- Abandon change if it did not produce desired results
- Determine next cycle

Adapted from: Safer Healthcare Now (2011); Improvement Frameworks, Getting Started Kit. See also: Health Canada (2012); First Nations and Inuit Home and Community Care Quality Resource Kit

2. PDSA: ACTION PLAN TEMPLATE

Stoney Health Services
Box. 8 Morley, Alberta T0L1N0
Phone: (403) 881-2712
Fax: (403) 881-2174

PDSA (Plan-Do-Study-Act)
ACTION PLAN TEMPLATE
(CODE: F + TITLE)

Quality Improvement Project Name:				
Quality Improvement Project Lead & Team Members:				
SMAART Goal:				
Change Being Tested & Outcomes Prediction:				
Start Date:		End Date:		
	What (including required data)	How	When	Who
PLAN				
DO	• *Carry out the plan.* • *Record data, observations (expected and unexpected) and modifications to the plan.* • *Use visual descriptions (i.e. plot pie charts, run charts, etc. and use a storyboard).*			
STUDY	• *Analyze the results.* - *Do the results agree with our predictions? What are our new predictions?* - *What new questions or issues arose?* - *Under what conditions could the results be different?*			
ACT	• *What action are we going to take as a result of this cycle (Adopt, Adapt or Abandon)?* • *Are we ready to implement?* • *What other processes might be affected by what we change?*			
Conclusion & Next PDSA Cycle:				
Submitted BY;		Submitted to:		

SHS General Consent for Invasive Procedure Approved: A. Khan Oct.17,2018

APPENDIX V: EVALUATION GUIDELINES FOR ANNUAL QUALITY & SAFETY IMPROVEMENT PLAN REVIEW

Each year, the SHS Leadership Team will assess the effectiveness of QSIP at two levels, as follows:

1. General Overview: Ask the following questions:

- Did the QI Plan reflect input from key internal and external stakeholders?
- What were the main accomplishments/successes?
- Do we get a good sense of the corporate risk and risk management strategies in place?
- Were there any special circumstances?
- Were there any shortfalls and why? What lessons did we learn from these shortfalls?
- Is our definition of quality and safety and quality framework still meaningful?

2. Detailed Assessment: Ask the following questions:

- Are we making progress in our desired improvements over time?
- If not, why not? What might we do to make a significant improvement in performance?
- Are we measuring the right things? Are we using the right performance indicators? What other measures could we use?
- Are we motivating the right behaviours? Are we impacting the culture in the desired way?
- What are the impacts on client outcomes and safety ; and on the safety of our personnel?

Adapted from:

Hicks, L. and Niniger , J. (2012) A Guide To Developing And Assessing A Quality Plan For Healthcare Organizations: An Initiative Of The BC Collaborative For Excellence In Healthcare Quality Version 1, Feb.

APPENDIX VI: ANNUAL PROGRAM/SERVICE - LEVEL RISK MANAGEMENT FORM

Stoney Health Services
Box. 8 Morley, Alberta T0L1N0
Phone: (403) 881-2712
Fax: (403) 881-2174

PROGRAM/SERVICE LEVEL RISK ASSESSMENT FORM (CODE: F + TITLE)

Instructions:

1. Gather team members from the program and brainstorm to identify actual or potential hazards.
2. Decide who could be harmed and how.
3. Evaluate the probability (how often) and the severity (how bad) of possible harm.
4. Identify corrective action.
5. Use PDSA cycles to reduce the harmful process and evaluate the results.

Legend:

- Probability of Harm : High, Medium or Low; Severity of Harm: High, Medium or Low

Program Title:	**Date of Risk Assessment:**

Actual/Potential Hazards (*one per line*)	**Who Could Be Harmed and How**	**Probability of Harm**			**Severity of Harm**			**Corrective Action Planned**
		H	M	L	H	M	L	
1.								
2.								
3.								
4.								
5.								

Other Comments/Recommendations:

Report Written By:	**Report Submitted To:**

Oct. 18,2018