Improvement Charter

A written plan, sometimes called an Improvement Charter, is a documented plan to guide the work of your team. Charters are useful for projects because they:

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- Clarify purpose
- Limit the tendency to get off track
- Outline roles of various team members
- Show where to start
- Determine when the project is finished

Improvement Charter Example

Organization, facility or site:

Executive sponsor:

A QI team must have leadership support in order to make system wide, lasting change. Make sure that you have leadership engagement from the start to make it easier!

Team lead(s):

It is often good to have co-leads on the work so it can continue if there are any staffing challenges.

Team members:

A QI team should generally have 5-8 people (at least three) to support diverse opinions and experiences, as well as share the work, making it a team effort.

What are we trying to accomplish?

Aim statement – What will improve? By when? By how much? Example: We will reduce the number of falls with injuries in the Smith LTC Centre by 50%, from 12 per month to 6 per month by December 2021.

How will we know that a change is an improvement?

Measures – what can we track to show us how we are doing?

Outcome measures:

- *# of falls per month*
- *# of falls with injury per month*

Process Measures:

- *Percentage of Residents with Completed Falls Risk Assessment on Admission*
- *Percentage of Residents with Completed Falls Risk Assessment Following a Fall or Change in Medical Status*
- *Percentage of "At Risk" Residents with a Documented Falls Prevention/Injury Reduction Plan*
- *Percentage of Residents Designated "At Risk" and Risk Status Communicated*
- *Percent of residents With Completed Fall Risk Assessment Following a Fall*
- *Percentage of incident reports following a fall*

Balancing Measure:

- *Use of physical restraints*

What changes can we make that will result in improvement?

Change ideas – what changes can we test to improve care?

Example: Our change ideas include:

1. *Conduct risk assessment for falls for all residents at admission/re-admission, a change in status.*
2. *Develop an updated Plan of Care, based on risk assessment and use visual cues to easily identify residents at high risk for falls with injuries.*
3. *When a resident is identified at risk for falls, ensure that staff implements one intervention at a time, to evaluate effectiveness.*
4. *Develop and conduct an inter-disciplinary post-fall assessment to identify contributing factors to the fall with injury (e.g., vision, gait, continence, medications, environment, behaviour/cognitive status, footwear, change in health status, the time of day the fall occurred).*

Context and/or information unique to your home that will help tell your home's quality improvement story:

- *High number of residents with impaired mobility*
- *High number of cognitively impaired residents*
- *High number of incontinent residents*
- *High number of residents with more than 10 medications*

How will we manage the improvement project?

How will our team work together? Who will do what? What are key dates?

Your team should work to come up with a plan that works for you and your timeline. Please note that you should be meeting to review the data at least once a month to determine if you should adapt, adopt or abandon the changes that you are testing, and see if you are making progress toward your aim (without negatively impacting other parts of the system).