

**Data for Decision Making Toolkit**

Tools, Resources and Guidance to Develop a Quality Agenda Item for Boards, Committees and Leadership Teams



January 2023

Version 1

**About National Quality and Patient Safety Directorate**

The National Quality and Patient Safety Directorate (NQPSD) was established in mid-2021 as a result of the Health Service Executive (HSE) Central Reform Review. The NQPSD is part of the HSE Office of the Chief Clinical Officer, and is led by Dr Orla Healy, National Clinical Director, Quality and Patient Safety.

**Purpose**

The NQPSD works in partnership with HSE operations, patient representatives and other internal and external partners to improve patient safety and the quality of care by:

* building quality and patient safety capacity and capability in practice
* using data to inform improvements
* developing and monitoring the incident management framework and open disclosure policy and guidance
* providing a platform for sharing and learning; reducing common causes of harm and enabling safe systems of care and sustainable improvements.

**Teams**

In line with the “[Patient Safety Strategy 2019-2024](https://www.hse.ie/eng/about/who/nqpsd/patient-safety-strategy-2019-2024.pdf)”, the NQPSD delivers on its purpose through the following teams:

* [**QPS Improvement**](https://www.hse.ie/eng/about/who/nqpsd/qps-improvement/qps-improvement.html)**:**Use of improvement methodologies to address common causes of harm.
* [**QPS Intelligence**](https://www.hse.ie/eng/about/who/nqpsd/qps-intelligence/qps-intelligence-team.html)**:** Using data to inform improvements in quality and patient safety.
* [**QPS Incident Management**](https://www.hse.ie/eng/about/who/nqpsd/qps-incident-management/qps-incident-management.html)**:** developing and monitoring the Incident Management Framework, Open Disclosure Policy and National Incident Management System.
* [**QPS Education**](https://www.hse.ie/eng/about/who/nqpsd/qps-education/qps-education.html): Enabling QPS capacity and capability in practice.
* [**QPS Connect**](https://www.hse.ie/eng/about/who/nqpsd/qps-connect/qps-connect.html)**:** Communicating, sharing learning, making connections.
* [National Centre for Clinical Audit](https://www.hse.ie/eng/about/who/nqpsd/ncca/ncca.html)**:** Implementing the HSE National Review of Clinical Audit Report recommendations

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**Reader Information**

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| **Acknowledgments:** | We would like to thank the members of the Mater Hospital Board, Children’s Health Ireland at Temple Street Board, the HSE Directorate and the HSE Board Safety and Quality Committee who through co-designing have helped refine our approach and helped identify the key steps to develop a quality agenda item. We would also like to acknowledge our colleagues across NQPSD for the development on a number of tools contained in this toolkit. |
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| **Access:** | National Quality and Patient Safety Directorate website <https://www.hse.ie/eng/about/who/nqpsd/qps-intelligence/qps-intelligence-resources/data-for-decision-making-toolkit.docx> |

**Version Control**

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| 6th January 2023 | 1 | QPS Intelligence Team | Dr Jennifer Martin | Dr Orla Healy |
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**Introduction**

As the National Clinical Director for Quality and Patient Safety, I am delighted to present the***Data for Decision Making Toolkit***. The National Quality and Patient Safety Directorate (NQPSD) have developed this toolkit based on our experience co-designing quality agenda items with the Mater Hospital Board[[1]](#footnote-1), Children’s Health Ireland at Temple Street Board,[[2]](#footnote-2) the HSE Directorate[[3]](#footnote-3) and the HSE Board’s Safety and Quality Committee[[4]](#footnote-4). Quality agenda items are designed to support a board, committee or leadership team to oversee and improve quality and safety. Two quality complementary agenda items were co-designed during these projects providing a quantitative and qualitative picture of quality: a *Quality Profile* that uses Statistical Process Control methods to present indicators across seven domains of quality and ‘*People’s Experience of Quality’* where patient, service-user, family and front-line staff experiences are shared.

**Why would you use this toolkit?**

The tools, resources and guidance in this toolkit are designed to assist committees, boards and leadership teams interested in developing their own quality agenda items. There is an introduction to each tool to assist you in deciding which tools are helpful for you. Links are provided directing you to further resources on our website: <https://www.hse.ie/eng/about/who/nqpsd/>. The toolkit is structured into four parts:

**Part One: Planning and Testing a Quality Agenda Item**

This section contains tools and resources useful when establishing your quality agenda project. The tools facilitate and support a Quality Improvement (QI) approach to your project.

**Part Two: Producing a Quality Profile**

This section contains tools and resources for designing a Quality Profile and for producing and interpreting Statistical Process Control and run charts.

**Part Three: Producing People’s Experiences of Quality**

This section contains guidance on developing patient, service user, family and staff ‘stories’ or experiences to share at committee, board and leadership group meetings.

**Part Four: Evaluation and Feedback**

This section provides useful tools and resources to help you capture feedback from committee, board and leadership members and to evaluate your project.

I would like to thank members of the QPS Intelligence Team who have developed this toolkit in particular Dr. Jennifer Martin, Ms. Gráinne Cosgrove, Dr. Gemma Moore and Mr. Stephen Barrett. I encourage you to use this toolkit to evolve your organisational approach to overseeing and improving quality.

Dr Orla Healy

National Clinical Director, National Quality and Patient Safety Directorate

# Part One: Planning a Quality Agenda Item Tools

### Driver Diagram

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| --- |
| **Introduction** |
| A Driver Diagram predicts the changes required to accomplish a given aim or outcome. It includes a graphic representation showing the links between an aim (describing the desired result), the things that must change to achieve that aim and specific ideas on how to make the changes. |
| **Why would you use this tool?** |
| Completing a driver diagram during your quality agenda project will help you break down the aim of your project into primary and secondary drivers, and helps you determine what changes to make. By setting a goal or aim and translating it into a logical set of high level factors (primary and secondary drivers) it will help outline what you need to focus on in order to achieve your goal. Driver diagrams are best developed with subject matter experts who understand the different aspects of your project (e.g. statisticians, clinicians, project managers, and governance experts). |

|  |  |  |  |
| --- | --- | --- | --- |
| **Aim** | **Primary Drivers** | **Secondary Drivers** | **Change Ideas** |
| **SMART aim[[5]](#footnote-5)** | **What must be present to achieve our aim[[6]](#footnote-6)** | **What must be present to deliver each primary driver** |  |
| \*It can be helpful to put your measures of each of the aim, primary and secondary drivers here too. | | | |

### Project Charter

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Introduction** | | | | | | | | | |
| A project charter provides a rationale and roadmap for the team's improvement work. The charter outlines the detail of the project and identifies the members of the project team. | | | | | | | | | |
| **Why would you use this tool?** | | | | | | | | | |
| It is helpful to have a detailed understanding of what your quality agenda project entails and how it will be measured. This ensures that all partners understand and agree to the project and their role in it. The charter template will help you to identify gaps within the current proposal that can be addressed at an early point in the project. | | | | | | | | | |
| **Project Name:** | | | | | | | | | | |
| 1. **What are we trying to accomplish?** | | | | | | | | | | |
| **Aim statement (How much improvement? For whom? By when?)** | | | | | | | | | | |
|  | | | | | | | | | | |
| **Problem to be addressed (Defines WHAT broadly)** | | | | | | | | | | |
|  | | | | | | | | | | |
| **Reason for the effort (Defines WHY broadly)** | | | | | | | | | | |
|  | | | | | | | | | | |
| **Expected outcomes and benefits (Defines WHAT specifically)** | | | | | | | | | | |
|  | | | | | | | | | | |
| **What are we not trying to do? (What’s outside the scope of the project?)** | | | | | | | | | | |
|  | | | | | | | | | | |
| 1. **How do we know that a change is an improvement?** | | | | | | | | | | |
| **Measures that will be used to monitor the impact of this improvement effort** | | | | | | | | | | |
| **Process** (Are the parts of the system performing as planned/ have we implemented the processes that we planned to implement (e.g. drivers)?)  **Outcomes** (What is the impact or result of the project?)  **Balancing** (What else might have happened as a result of the changes that have been made?) | | | | | | | | | | |
| 1. **What changes can we make that will lead to improvement?** | | | | | | | | | | |
| In this section you can include details of how the project will be set-up and work in practice (based on the Model for Improvement), including sponsorship, duration and project team. You can also include initial activities and ideas for (Plan-Do-Study-Act) PDSA cycles. This section will include high level milestones and when they will be achieved. | | | | | | | | | | |
|  | | | | | | | | | | |
| **High level milestones** | | | | | **Timeframes** | | | | | |
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| 1. **Project risks (i.e. what are the risks associated with doing the project and with not doing the project)** | | | | | | | | | | |
| A good risk statement should look something like this: [Event that has an effect on objectives] caused by [cause/s] resulting in [consequence/s]. | | | | | | | | | | |
| 1. **Project Team** | | | | | | | | | | |
| **Role in this project (examples only)** | | | | | **Name** | | | | | |
| Sponsor | | | | |  | | | | | |
| Project Lead | | | | |  | | | | | |
| Team member 1 – Data analysis | | | | |  | | | | | |
| Team member 2 – QI expert | | | | |  | | | | | |
| 1. **Other resources required (e.g. space, people, time, training)** | | | | | | | | | | |
| **Resource required** | | | | | **Name** | | | | | |
|  | | | | |  | | | | | |
|  | | | | |  | | | | | |
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| 1. **Project assumptions (e.g. what are we assuming is in place in order to deliver on project)** | | | | | | | | | | |
|  | | | | | | | | | | |
| 1. **Project reporting and governance arrangements** | | | | | | | | | | |
| Ideally this should include an organisational chart and high level plan for reporting within this project | | | | | | | | | | |
| 1. **How do you plan to share learning and results of project?** | | | | | | | | | | |
|  | | | | | | | | | | |
|  | | | | | | | | | | |
| **Pre- approval from other committees (if applicable):** | | | |  | | |  | | | |
|  |  |  | | | |  |  | | | |
| **Agree to proceed:** | **Yes ⬜** | | **No ⬜** | | | **Decision:** |  | | | |
|  | | | | | | | | | | |
| **Project Sponsor/s:** | | |  | | | | | **Date:** |  | |
|  | | |  | | |  |  | | | |

### Measurement Plan

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| **Introduction** |
| A measurement plan is a document that describes relevant details of the measures to be collected and reported. It prompts project teams to discuss and agree exactly why and how data will be collected and reported. It is important to have a measurement plan any time you are reporting data, including as part of a Quality Improvement (QI) project or if you are creating data driven reports. |
| **Why would you use this tool?** |
| This tool can be used in two ways.   1. It can be used to plan the measures in your quality agenda project. This is to make sure that:  * The measure is always tied in to the aim and purpose of the QI project * The measure is collected and reported consistently  1. It can be used to inform your Quality Profile in order to consider and document:  * The rationale and purpose for each measure included * The source data and analysis of each measure |
| **How to complete a measurement plan** |
| For each measure in your project, complete the following items below. |
| **Measure title** |
| What name will be used by everyone to identify this measure? |
| **Measure type** |
| Is this an outcome, process or balancing measure? |
| **Rationale for inclusion** |
| Why is this measure needed? |
| **Operational definition** |
| What operational definition will everyone use to ensure the same thing is measured and understood throughout the project? |
| **Format** |
| What format is the data in? (E.g. number, percentage, rate per 1,000 bed days etc.) |
| **Stratification** |
| Are there known divisions in the data and how it is reported? (E.g. day vs night shift, by diagnostic group, new vs imported cases etc.) |
| **Data source** |
| What is the original source of the data (E.g. safety cross, specific ICT system, manual entry on log book etc.) |
| **Data collection** |
| How is the data collected and reported? (Includes sampling method, frequency, requirement for denominator data etc.) |
| **Display and feedback** |
| How is the data fed back to relevant staff and service users? (E.g. included on a meeting agenda, monthly Quality Profile, posted on a notice board etc.) |
| **Availability of baseline data** |
| Is baseline data available for this measure? (Do you have data from before the beginning of the project that you can use to demonstrate improvement) |
| **Targets or goals** |
| Is there a local project specific or national target/goal set for this measure? (Include the time frame here e.g. 50% reduction by June 2020) |
| **Data quality** |
| Are there any known issues with the quality of data for this measure? (for example for data from incident reporting systems, there is a background level of under-reporting) |
| **Sustainability** |
| Will the measure continue to be collected after the completion of the project? (include steps taken to make part of day-to-day work)  After a project most measures will be discontinued but it is valuable to identify one or two measures that will continue ongoing to ensure the new process is sustained. |
| **Reproducibility** |
| If different staff members retrieved data from the source, would they all get the same result? (e.g. if the data collection system was audited) |
| **Measurement Plan Template** |
| An excel template for completing a measurement plan is available at:  <https://www.hse.ie/eng/about/who/nqpsd/qps-intelligence/qps-intelligence-resources/measurement-for-improvement-resources.html> |

### Stakeholder Mapping

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| --- |
| **Introduction** |
| Stakeholder mapping is a way to visually represent the people who are involved directly or indirectly with your project, their level of influence on, and reaction to, the project. The position of a stakeholder grouping may change throughout the project cycle. |
| **Why would you use this tool?** |
| Stakeholder mapping assists you in creating a list of stakeholder groups involved in your quality agenda project and in determining where and how you need to concentrate your communication efforts. |
| **Stakeholder Map** |
| *People’s Needs Defining Change – Health Services Change Guide* contains a number of tools to assist with stakeholder mapping.   |  |  | | --- | --- | | This guide recommends that you first complete the *Interest Influence Mapping Grid* template to help you to understand your stakeholders in terms of their level of interest and influence. It includes guidance on the approach to communicating with each of those groups. | C:\Users\gemmamoore2\Pictures\Interest Influence Grid.png | | Following this, the *Stakeholder Mapping and Analysis Template* will help you identify each stakeholder’s level of accountability in your project, their readiness, interdependencies and how they can assist and influence your project, and identify the type of engagement approach needed. | C:\Users\gemmamoore2\Pictures\Stakeholder Map.png | | The *NQPSD QI Toolkit* provides an alternative template to help you visually represent the people who are involved directly or indirectly with your project and their level of influence on and reaction to the project.  C:\Users\gemmamoore2\Pictures\Stakeholder Map QI Toolkit.png  Links to templates and how to use them can be accessed by clicking on the links below. | | |
| **References** |
| **Interest Influence Mapping Grid** <https://www.hse.ie/eng/staff/resources/changeguide/resources/template-611-interest-influence-mapping-grid.pdf>  **Stakeholder Mapping and Analysis Template** <https://www.hse.ie/eng/staff/resources/changeguide/resources/template-612-guidance-on-stakeholder-mapping-and-analysis.pdf>  **Stakeholder map** <https://www.hse.ie/eng/about/who/nqpsd/qps-education/nat-qi-tool-2-stakeholder-map.pdf> |

### Communications Plan

|  |
| --- |
| **Introduction** |
| A communication plan provides a framework to organise and detail the types and methods of communications, both within your project team and to other stakeholders. |
| **Why would you use this tool?** |
| By completing a communication plan during your quality agenda project you can set out the information that your different audiences (e.g. project team, management, board or leadership team) will need, when they will need it, the purpose and best method to communicate the information. |
| **Communications Plan** |
| The *People’s Needs Defining Change – Health Services Change Guide* contains guidance on developing your engagement and communication plan. It guides you through identifying your audience, the purpose of the communication, content, method, frequency and assigns responsibilities.  C:\Users\gemmamoore2\Pictures\Com and Eng plan.png  The *NQPSD QI Toolkit* provides an alternative template and useful guidance and tips to help you work through the Who, Why, What, How, When and Where in developing your communication plan.  C:\Users\gemmamoore2\Pictures\Com plan.png |
| **References** |
| **Guidance to Develop Engagement and Communication Plan** <https://www.hse.ie/eng/staff/resources/changeguide/resources/template-613-guidance-to-develop-engagement-and-communication-plan.pdf>  **Communications plan and actions** <https://www.hse.ie/eng/about/who/nqpsd/qps-education/nat-qi-tool-5-communications-plan-and-actions.pdf> |

### PDSA Worksheet for Planning Tests of Change

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| --- |
| **Introduction** |
| Plan-Do-Study-Act (PDSA) is a useful tool for documenting a test of change. The traditional PDSA cycle is shorthand for testing a change by developing a plan to test the change (Plan), carrying out the test (Do), observing and learning from the consequences (Study), and determining what modifications should be made to the test (Act). It is useful to add an additional P – (‘Predict’) what will happen. |
| **Why would you use this tool?** |
| The Plan-Do-Study-Act (PDSA) Worksheet will help your team document your tests of change during your quality agenda project. Complete one PDSA Worksheet for each test you conduct. |
| |  |  |  |  | | --- | --- | --- | --- | | **Date:** |  | **PDSA Cycle:** |  | |
| |  |  | | --- | --- | | **Big aim:**  *(What is the overall goal you are trying to achieve?)* |  | | **Small aim:**  *(What is the first step?)* |  |  |  |  |  |  | | --- | --- | --- | --- | | **Describe your first test of change**  (*Every goal will require multiple tests of change)* | **Person responsible** | **When will the test take place?** | **Where will the test take place?** | |  |  |  |  |   **Plan (and Predict):**   |  |  |  |  | | --- | --- | --- | --- | | **List the tasks needed to set up this test of change**  *(include getting ready to measure)* | **Person responsible** | **When to be done?** | **Where?** | |  |  |  |  | | **Predict what will happen when you carry out your test** | **How will you know whether the change is an improvement?** *(What will you measure and how?)* | | | |  |  | | |   **Do:**   |  | | --- | | **Describe what actually happened when you ran your test**  *(Note any unexpected events or problems)* |   **Study:**   |  | | --- | | **Describe your results and how they compared to your prediction**  (Include measures if you have them) | |  |   **Act:**   |  | | --- | | **From your learning above, what modifications you will make to your plan for the next cycle** | |  | |

### Project Checklist

|  |  |  |  |
| --- | --- | --- | --- |
| **Introduction** | | | |
| A project checklist outlines the key tasks involved in your project, who in the project team is responsible for each task and when it is completed. | | | |
| **Why would you use this tool?** | | | |
| This checklist is useful to keep track of the key tasks in your quality agenda project. We have suggested some tasks below. | | | |
|  | **Task** | **To be completed by** | **Completed** |
|  | Agree area for improvement with project champion/sponsor |  |  |
|  | Create (SMART) aim statement |  |  |
|  | Confirm project lead and team |  |  |
|  | Complete driver diagram |  |  |
|  | Align measures to your driver diagram |  |  |
|  | Complete measurement plan |  |  |
|  | Map stakeholders |  |  |
|  | Develop communications and engagement plan |  |  |
|  | Get Project Charter signed off by Project Sponsor |  |  |
|  | Develop understanding of the expectations of those who will use the quality agenda item, e.g. by conducting interviews, workshops, focus groups |  |  |
|  | Develop an understanding of the members level of knowledge of Statistical Process Control (SPC) or other methods that will be used |  |  |
|  | Hold a workshop to agree project aim, objectives, scope, content of a Quality Profile, approach to bringing patient and staff experience on to agenda, and training requirements for members |  |  |
|  | Create the Quality Profile (QP) |  |  |
|  | Create People’s Experience of Quality (PEQ) |  |  |
|  | Present QP and PEQ at meetings |  |  |
|  | Use PDSA cycles to iteratively test and improve QP and PEQ |  |  |
|  | Gather feedback at each meeting to inform improvements |  |  |
|  | Identify actions to sustain change |  |  |
|  | Conduct an evaluation of your project |  |  |
|  | Document, present and share project learning and results |  |  |
|  | Celebrate success and thank key people |  |  |

### Project on a Page

|  |  |
| --- | --- |
| **Introduction** | |
| A project on a page includes the key information on your project viewable on one page. | |
| **Why would you use this tool?** | |
| Compiling your project on a page is a useful resource to develop so that you can share the high level detail of your quality agenda project with key stakeholders. | |
| **Why? What is your Aim?** | |
|  | The **Aim Statement** should provide all relevant information. This should be in a SMART (**S**pecific, **M**easurable, **A**ctionable / Achievable and **R**elevant to **T**imeframe) format. |
| **How will you know that a change is an improvement?** | |
|  | |
| **Outcome Measures. (Did we achieve what we set out to achieve? Usually aligned to aim)** | |
|  | |
| **Process Measures (monitor progress - did we do what we said we are doing? Usually aligned to primary and secondary drivers)** | |
|  | |
| **Balancing Measures (were there unexpected or adverse outcomes elsewhere such as cost?)** | |
|  | |
| **What changes can we make that will result in improvement?** | |
|  | |
|  | |

# Part Two: Producing a Quality Profile

### Designing your Quality Profile

|  |
| --- |
| **Introduction** |
| This is a tool that provides an overview of what a Quality Profile is, and includes a number of steps to help you in designing your own Quality Profile. |
| **Why would you use this tool?** |
| A Quality Profile is a tool that provides a picture of quality of an organisation or service. It consists of a suite of quality indicators or measures analysed in a way that drives and demonstrates improvement.  This tool details a number of steps that you may use to design a Quality Profile for your service or organisation. |
| **Overview of a Quality Profile** |
| The purpose of a Quality Profile is to provide insights into quality and patient safety data, and to support understanding of variation over time and across an organisation or service. Information is presented in the Quality Profile in a format that supports understanding of this variation and can be used for decision making.  The principles of a Quality Profile include:   * A Quality Profile should consist of the ‘critical few’ indicators or measures, i.e. the minimum number of measures that together provide a picture of quality. It is not advisable to include all possible measures in a Quality Profile. * A Quality Profile should provide a balanced picture of the quality of care, including across the domains of quality (e.g. safe, effective, person-centred, timely, efficient, equitable, better health and wellbeing), and should include a view across the different services provided. * A Quality Profile should be timely; the data should be updated regularly and the Quality Profile should be used and discussed routinely (e.g. monthly). * A Quality Profile should be flexible, and the suite of measures should be reviewed and updated on an agreed schedule (e.g. annually) to ensure the information in the Quality Profile remains relevant. * A Quality Profile is owned by the service or organisation. The content of the Quality Profile is determined by the service and should include information that is important to that service. It may include information that is only available locally. * A Quality Profile should be an honest appraisal of the quality of care provided that highlights areas where good quality care is delivered, as well as identifying areas for improvement.   A Quality Profile is not:   * It is not nationally mandated set of measures (e.g. data submitted nationally for performance reporting, safety statements etc.), although it may include measures used in these reports where you consider these key priorities for your service. * It is not a guarantee of quality or safety. However, it supports you in understanding the quality of your service and thereby is a driver of quality and safety. * It is not static; a key aspect of the Quality Profile is that it remains relevant and will change over time. * It is not only for management; it should be shared with staff for learning and improvement. * It is not a financial report; while financial measures are important they are generally not included in a Quality Profile. |
| **Step 1: Identify your sponsor and establish your Quality Profile project team** |
| It is important to identify a senior project sponsor in your organisation at an early stage. Project sponsorship is key to setting up an effective multidisciplinary team. The sponsor should be in a leadership position and ideally, would be in a position to ensure that staff are facilitated to be part of the project team. Your sponsor may be the same sponsor for a larger quality agenda project, or your sponsor may be specific to your Quality Profile development project.  In setting your Quality Profile project team, the team lead should be part of the service for which the Quality Profile is being developed. The team should be multidisciplinary and include representation from each of the professional groups in the service. It is also important to consider how best to include team members with experience in QI methodologies, information management and data analysis. |
| **Step 2: Consider what are the important principles of your Quality Profile** |
| Your Quality Profile will be unique to your service and will be designed you. Once you have identified your sponsor and established your project team, it may be helpful to consider how the principles of a Quality Profile will apply to your specific design, and once developed how you collectively commit to using your Quality Profile.  Suggestions for discussion:   * We commit to being inquisitive. We will seek to understand the quality of care we provide. We will ask the right questions. * We will present information in a way that can be used to demonstrate and drive improvements in quality of care. * We will agree the frequency of production of the Quality Profile, and we will commit time for discussion of the Quality Profile on a regular basis. * We will commit time for reviewing and updating our Quality Profile to ensure it remains responsive to our needs. * We recognise that we need both hard/ quantitative measures and also qualitative and ‘softer’ measures in order to triangulate and get a balanced view of care. * We will be realistic, and we understand that the Quality Profile cannot provide a guarantee of quality and safety in our service. We will seek to include measures that can honestly answer questions now on the quality of our service, and we will put plans in place to collect additional information where required. * We will use the information in our Quality Profile for learning and action to improve quality. |
| **Step 2: Choose your measures for inclusion in your Quality Profile** |
| A Quality Profile consists of only the ‘critical few’ measures. An important step in designing your Quality Profile is choosing the ‘critical few’ measures that accurately reflect the important aspects of quality in your area or organisation and that provide a balanced picture of quality.  **Tool 10** details a number of steps to help you in a choosing the suite of measures for inclusion in your Quality Profile. |
| **Step 3: Choose your methodology for displaying and interpreting your measures** |
| It is important to choose a suitable methodology for analysing and displaying the measures in your Quality Profile. The methodology should support your service in understanding variation, and in using the information in your Quality Profile to demonstrate and drive improvement.  We often see data on quality of care presented in a way that is not helpful in understanding and reacting to variation. The practice of comparing a current value to a target or another previous value fails to filter out noise (random variation within the normal range), which can lead to an overreaction to the perceived change. Furthermore, this practice fails to highlight potential signals, which can, in turn, lead to failure to react appropriately.  Presenting your data graphically in run charts or in Statistical Process Control (SPC) charts helps us to understand the variation in the data and to use it for learning and improvement.  A run chart is a graphical display of data plotted in order over time. Run charts are useful when starting out on an improvement project when you don’t have enough data to create a reliable SPC chart. **Tool 11** provides an overview of the anatomy of a run chart and **Tool 12** provides a guide to interpreting signals in run charts.  An SPC chart consists of data plotted in order, usually over time. It includes a centre line and upper and lower control limits. SPC charts help us in understanding the variation in the data, and are used to distinguish potential signals from random variation within a normal range. This permits appropriate reaction to significant signals when present, while at the same time ensures that normal variation is not interpreted as a signal requiring action. **Tool 13** provides an overview of the anatomy of an SPC chart and **Tool 14** provides a guide to interpreting variation in SPC charts.  There are a number of different types of SPC charts that are frequently used in health care. The type of chart used depends on the type of data being analysed, and it is important to select the appropriate type of chart for your data. **Tool 15** provides a guide to assist you in selecting the appropriate type of SPC chart for your data.  While SPC charts are typically used to analyse variation over time, it is also possible to use SPC charts to display data for different groups (such as hospitals) within control limits. This particular type of SPC chart is called a funnel plot. **Tool 16** provides an overview of the anatomy of a funnel plot. |
| **Step 4: Apply chosen methodology to your measures** |
| Once you have decided whether to use run charts or SPC charts for your measures, the next step is to create the charts and apply the appropriate rules for interpreting the charts.  If you have decided to use SPC charts, **Tool 17** provides information on accessing an Excel template that can be used to produce different types of SPC charts.  If you have decided to use run charts, **Tool 11** provides links to some resources that may be useful in developing your run charts.  In addition, **Tool 18** provides an overview of QI Charts which is an Excel add-in tool that can be used to produce run charts and SPC charts.  Whether you decide to use SPC or run charts it is essential that the rules for detecting special cause (unexpected) variation in SPC charts or the rules for detecting non-random signals in run charts are applied as appropriate. The SPC Excel template described in **Tool 17** includes the functionality to automatically apply the SPC rules and highlight the special cause variation. |
| **Step 5: Produce your Quality Profile and Test the Suite of Measures** |
| Once you have applied either the run chart or SPC methodology to your measures, it is now time to produce your Quality Profile based on the agreed design for your service. In addition to including the run charts or SPC charts for your chosen measures it is recommended that you include a short narrative describing the findings from the application of the rules to interpret the charts.  It is also important to document exactly how each indicator was created, including source data and analytic methods. **Tool 3** provides an overview of a Measurement Plan which is a useful template to ensure all relevant aspects are considered.  It is recommended that you test this suite of measures in your Quality Profile using an agreed methodology (e.g. PDSA cycles). Consider incrementally adding measures over an agreed time period to your Quality Profile. |
| **Step 6: Evaluate your Quality Profile** |
| Having designed, produced and tested your Quality Profile it is important that you evaluate it. For example, you may wish to evaluate if it meets the principles and objectives as agreed during the design phase. Does it meet the needs of your organisation? It is being used for learning and action to improve quality? Is sufficient time being dedicated to discussing the Quality Profile on a regular basis?  Part Four: Evaluation and Feedback of this toolkit provides useful tools and resources to help you capture feedback from committee, board and leadership members and to evaluate your project. |
| **Step 7: Review and update your Quality Profile** |
| After developing your Quality Profile it is important to schedule a review of your Quality Profile to ensure the information in the Quality Profile remains relevant for your service. For example, consider scheduling an annual workshop to review the suite of measures and replace and add new measures as required. |

### Quality Profile Design: Choosing your Measures

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| **Introduction** |
| This is a tool to help you in choosing your measures for inclusion in your Quality Profile. |
| **Why would you use this tool?** |
| A Quality Profile consists of only the ‘critical few’ indicators or measures. It is not intended that it includes all possible measures of quality. An important step in designing your Quality Profile is choosing these ‘critical few’ measures.  This tool details a number of steps that may help you in a choosing a suite of indicators that accurately reflects the important aspects of quality in your area or organisation and that provides a balanced picture of quality. |
| **Step 1: Identify Important Aspects of Quality** |
| Begin byidentifying what are the individual aspects of care or service provision that are important when looking at quality. Aspects of quality are the broad areas of quality that are important (e.g. pressure ulcers, re-admission rates, medication errors) rather than specific indicators or measures. Suggestions to help identify the important aspects:   * Conduct pre-workshop interviews with stakeholders. Use open questions, such as “Are there specific aspects of service provision or care that you feel are particularly important when looking at quality? What keeps you up at night?” * Conduct a review of international best practice to identify aspects of quality that are monitored and reviewed by exemplar organisations * Review relevant local and / or national reports, dashboards and indicator suites to identify important aspects of quality that are commonly reported on * Consult with local and / or national subject matter experts to identify what are the important aspects of quality to them |
| **Step 2: Refine the List of Important Aspects of Quality** |
| Refine the initial list of the important individual aspects of quality through a suitable process.  **Example:** Ask a small team of clinical and data experts to review and score each aspect of care based on appropriate criteria. Criteria could include how reflective the aspects are of quality of care, how important they are, and whether they are structure, process or outcome measures.  If the refined list is still considered too long, consider further refining into a proposed list and a reserve list based on the input of subject matter experts. |
| **Step 3: Develop Materials for the Important Aspects of Quality** |
| Develop materials to support the Board/Committee/Leadership team understanding of each aspect of care or service provision.  **Example:** Produce flashcards that summarise what the aspect relates to and why it is important. Consider identifying which domain(s) of quality the aspect falls under, and consider using icons or different colours to distinguish between different services. |
| **Step 4: Workshop with Key Stakeholders** |
| Review the refined list at a workshop with stakeholders. Group tasks to achieve this could include:   1. Agree the ideal number of measures for the Profile 2. Agree criteria to apply to the selection exercise to ensure a balanced picture of quality. Criteria could include:    * Balance across domains of quality    * Measures that reflect whole system performance    * Balance across services (e.g. acute / community, inpatient / outpatient)    * Over-representation avoided    * Measures that are currently available    * Outcome measures where possible    * Areas of particular political, public or local attention and focus    * Other important local criteria 3. As a group, review each of the aspects of quality in the refined list. Discuss the merits of each aspect of quality. Consider removing aspects, adding aspects from the reserve list and adding any additional aspects that are identified during the discussion. If conducting an in-person workshop consider using flashcards or similar on the walls or flipcharts to support the discussion and enhance visualisation of the potential final selection 4. As a group, agree a draft selection of the important aspects of quality. Review this draft selection together to check for balance according to the criteria already identified 5. Agree the final selection of aspects of quality |
| **Step 5: Identify Measures** |
| Identify or develop measures that accurately reflect the agreed aspects of quality. This may require consultation with subject matter experts to identify the best way of measuring the particular aspect of quality, and with data holders / producers to determine the feasibility of reporting the measure.  **Example:** Staphylococcus aureusBloodstream Infections were identified as an important aspect of quality. After consulting with the Clinical Lead for Healthcare Associated Infections and with the Business Intelligence Team, it was determined that the best measure to be included in the Quality Profile was the monthly rate of new cases of hospital acquired staphylococcus aureus bloodstream infection per 10,000 bed days used. |
| **Step 6: Test the Suite of Measures** |
| Test this suite of measures using an agreed methodology (e.g. PDSA cycles) to produce your Quality Profile. Consider incrementally adding measures over an agreed time period. Consider adding the indicators incrementally to allow Board/Committee/Leadership team sufficient time to discuss and understand each new indicator. |

### Anatomy of a Run Chart

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| **Introduction** | |
| A run chart is a graphical display of data plotted in order over time. Run charts are a useful tool for understanding variation when you don’t yet have sufficient data for an SPC chart. | |
| **Why would you use this tool?** | |
| Run charts can assist in understanding variation. They are used to examine data for trends or other patterns that occur over time. Run charts visually depict the history and patterns of variation in an indicator or measure. Plotting data regularly on a graph shows when shifts and changes occur and can help identify if and when problems or improvements appear.  This tool provides an overview of the anatomy of a run chart and links to further run chart resources.  **Tool 12** provides guidance on interpreting run charts. | |
| **Anatomy of a run chart** | |
| A run chart consists of data plotted over time. It includes a centre line based on the median of the data. The target / goal line is not technically part of a run chart, but it can sometimes be useful to display it to help focus improvement efforts and will usually be included if run chart is being used to inform oversight and assurance processes.  A ‘run’ is defined as one or more consecutive data points on the same side of the median.    Centre Line (Median) | |
| **When should I use a run chart?** | |
| Run charts are valuable when:   * You want to look at data over time in a simple way * You are starting a project with no baseline data and/or have few points of data (less than 12) * You do not need in depth analysis of the process being charted * You have limited statistical expertise available.   As you progress with your project, if you have 12+ points of data you can use SPC Charts. SPC charts are like run charts with the addition of upper and lower control limits based on statistical calculations. These limits allow for more robust statistical analysis. | |
| **Example of a run chart** | |
| **Percentage of patients with a hip fracture undergoing surgery within 48 hours, by month** | |
| **Resources** | |
| **Run Chart Template** |
| A template for creating run charts is available here:  **https://www.hse.ie/eng/about/who/nqpsd/qps-intelligence/qps-intelligence-resources/measurement-for-improvement-resources.html**  In the Excel template, enter your raw data and optionally labelling information into the grey cells. The chart will update automatically. You can format the chart as you would any excel chart to customise. |
| **Run Chart Video** |
| A video explaining run charts is available on the HSE YouTube channel  <https://www.youtube.com/watch?v=ySbhsX-y8zE> |
| **Run Chart QPS Talktime** |
| A 40 minute talk on run charts is available on the QPS Talktime page:  <https://www.youtube.com/watch?v=9pD3PhwRJg0> |

### Guidance on Interpreting Run Charts

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| **Introduction** | |
| Run charts can assist in understanding variation and are used to examine data for trends or other patterns that occur over time. There are four rules that are used to help interpret run charts by detecting non-random patterns (i.e. signals) in the data. | |
| **Why would use this tool?** | |
| An important part of using run charts is the identification of non-random or unusual patterns in the data. These are patterns that are unlikely to have occurred by chance alone, and so can be considered ‘signals’ of change. While some patterns may obviously be unusual, others may not initially appear to be unusual without application of the rules. It is important to apply all four rules described below. | |
| **Four rules for detecting non-random signals in run charts** | |
| 1. **A run of 6 or more consecutive points above or below the centre line (a shift)** | 1. **A trend of five or more consecutive points all going up or down** |
| 1. **Too few or too many runs**   A run is a series of points in a row on one side of the centre line (median). Too few or too many runs is a signal of a non-random pattern. To determine the number of runs count the number of times the line connecting the data points crosses the centre line and add one. Consult Table 1 to determine whether the number of runs is within the expected range, or whether there are too few or too many (indicating a non-random pattern). | 1. **An astronomical data point (an obviously different value that everyone would agree is highly unusual)** |
| **Table 1: Upper & lower limits for number of runs**   |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | **N** | **Lower Limit** | **Upper Limit** | **N** | **Lower Limit** | **Upper Limit** | **N** | **Lower Limit** | **Upper Limit** | **N** | **Lower Limit** | **Upper Limit** | | **10** | 3 | 9 | **23** | 7 | 17 | **36** | 13 | 25 | **49** | 19 | 32 | | **11** | 3 | 10 | **24** | 8 | 18 | **37** | 13 | 25 | **50** | 19 | 33 | | **12** | 3 | 11 | **25** | 8 | 18 | **38** | 14 | 26 | **51** | 20 | 33 | | **13** | 4 | 11 | **26** | 9 | 19 | **39** | 14 | 26 | **52** | 20 | 34 | | **14** | 4 | 12 | **27** | 10 | 19 | **40** | 15 | 27 | **53** | 21 | 34 | | **15** | 5 | 12 | **28** | 10 | 20 | **41** | 15 | 27 | **54** | 21 | 35 | | **16** | 5 | 13 | **29** | 10 | 20 | **42** | 16 | 28 | **55** | 22 | 35 | | **17** | 5 | 13 | **30** | 11 | 21 | **43** | 16 | 28 | **56** | 22 | 36 | | **18** | 6 | 14 | **31** | 11 | 22 | **44** | 17 | 29 | **57** | 23 | 36 | | **19** | 6 | 15 | **32** | 11 | 23 | **45** | 17 | 30 | **58** | 23 | 37 | | **20** | 6 | 16 | **33** | 12 | 23 | **46** | 17 | 31 | **59** | 24 | 38 | | **21** | 7 | 16 | **34** | 12 | 24 | **47** | 18 | 31 | **60** | 24 | 38 | | **22** | 7 | 17 | **35** | 12 | 24 | **48** | 18 | 32 |  |  |  |   **N** = Total number of data points on the run chart that do not fall on the centre line  **Lower** **Limit** = Lower limit for the number of runs (less than this number of runs is too few)  **Upper Limit** = Upper limit for the number of runs (more than this number of runs is too many)  **Source**: Provost L, Murray S. The Healthcare Data Guide: Learning from Data for Improvement. San Francisco: Jossey-Bass, Publication, 2011 | |

### Anatomy of a Statistical Process Control Chart

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| **Introduction**  Lower Control Limit | |
| A Statistical Process Control chart is a graphical display of data plotted in order with a centre line and upper and lower control limits. SPC charts help us in understanding the variation in the data, and are used to distinguish potential signals from random variation within a normal range. | |
| **Why would you use this tool?** | |
| SPC charts are a useful tool in understanding variation and for distinguishing between expected and unexpected variation. This permits appropriate reaction to significant signals when present, while at the same time ensures that normal variation is not interpreted as a signal requiring action.  This tool provides an overview of the anatomy of an SPC chart.  **Tool 14** provides guidance on interpreting SPC charts. | |
| **Anatomy of an SPC Chart** | |
| An SPC Chart consists of data plotted in order, usually over time (weeks, months etc.). It includes a centre line based on the average of the data. It also includes upper and lower control limits based on statistical calculations (3 sigma deviations from the average).  The control limits are based on the variation in the observed data. The control limits reflect the expected range of variation within the data, and do not reflect the desired range of variation in terms of quality of care. The probability of any data point falling outside of the control limits by chance alone is very small.  The target / goal line is interpreted differently to the other lines in the chart. It is not determined by the data and so is not normally part of an SPC chart, but it can be useful to display it to help focus improvement efforts. | |
| **Example of an SPC chart** | |
| **Percentage of patients with a hip fracture undergoing surgery within 48 hours, by month** | |
| **Resources** | |
| **Tool 17** provides information on accessing an Excel template that can be used to produce different types of SPC charts.  **Tool 18** provides an overview of QI Charts which is an Excel add-in tool that can be used to produce run charts and SPC charts. | |
| **References** | |
| Provost L, Murray S. The Healthcare Data Guide: Learning from Data for Improvement. San Francisco: Jossey-Bass, Publication, 2011 |

### Guidance Note on Interpreting Statistical Process Control Charts

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| **Introduction** | |
| Statistical Process Control charts can assist in understanding variation and can distinguish between expected (common cause) and unexpected (special cause) variation. There are five rules that are used to interpret SPC charts by detecting non-random patterns (i.e. unexpected variation) in the data. | |
| **Why would use this tool?** | |
| An important part of using SPC charts is the identification of non-random or unexpected patterns in the data. These are patterns that are unlikely to have occurred by chance alone, and so can be considered ‘signals’ of unexpected variation. While some patterns may obviously be unusual, others may not initially appear to be unusual without application of the rules. It is important to apply all five rules described below. | |
| **Five rules for detecting special cause (unexpected) variation in SPC charts** | |
| 1. **A single point outside the control limits (this doesn’t include points exactly on the limit)** | 1. **A run of 8 or more consecutive points above or below the centre line** |
| 1. **A trend of at least 6 consecutive points all going up or down** | 1. **Two out of three consecutive points near a control limit (in the outer one-third)** |
| 1. **A series of 15 consecutive points close to the centre line (in the inner one-third)** |  |

### Guidance Note on Common SPC Chart Types

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| **Introduction** | |
| Statistical Process Control charts can assist in understanding variation and can distinguish between expected (common cause) and unexpected (special cause) variation. There are a number of different types of SPC charts that are used, depending on the type of data. | |
| **Why would use this tool?** | |
| When using SPC charts it is important to choose the appropriate type of chart for your data. There isn’t a one-size-fits-all chart. While there are various algorithms available for selecting the appropriate chart, this guidance note describes the most commonly used SPC charts in health care and some examples of when to use them. The control limits are calculated differently for each of the different types of SPC charts, but the interpretation of the charts remains the same.  Note that there are a small number of assumptions and requirements for developing effective charts; it is important to consult these in addition to selecting the appropriate chart. | |
| **SPC chart types frequently used in health care** | |
| **C Chart**  A **C chart** is used for **counts** of undesirable or unexpected events, e.g. number of errors, number of falls, number of complaints, number of pressure ulcers. | **U Chart**  A **U chart** is used for **rates** of undesirable or unexpected events, e.g. rate of falls per 10,000 bed days, readmission rate per 1,000 discharges, rate of pressure ulcers per 1,000 patients. |
| **P Chart**  A **P chart** is used for **percentage** or proportion data e.g. percentage of patients in ED for less than 24 hours, percentage of hip fracture patients undergoing surgery within 48 hours. | **T Chart**  A **T chart** is used for the **time between** rare events e.g. number of days between device related bloodstream infections, number of days between retained foreign objects. |
| **I Chart**  An **I chart** (also known as an Individuals or Xmr chart) is used for activity data or counts of expected events, e.g. number of inpatients admissions, number of ED attendances. | **X Bar Chart**  An **X Bar chart** (often paired with an S chart showing the standard deviation) is used for averages, e.g. average length of stay, average turn-around time for a specific test. |
| **References** | |
| Provost L, Murray S. The Healthcare Data Guide: Learning from Data for Improvement. San Francisco: Jossey-Bass, Publication, 2011 | |

### Anatomy of a Funnel Plot

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| **Introduction**  Lower Control Limit | |
| Funnel plots are a particular type of Statistical Process Control chart, where instead of displaying the data over time, they are used to display the data for different groups within control limits. | |
| **Why would you use this tool?** | |
| Funnel plots are a useful and easy to interpret tool for analysing variation across a system (e.g. across hospitals, local areas, wards etc.). This tool provides an overview of the anatomy of an SPC funnel plot. | |
| **Anatomy of a funnel plot** | |
| An SPC Chart consists of data plotted in order. It includes a centre line based on the average of the data. It also includes upper and lower control limits based on statistical calculations (3 sigma deviations from the average). The control limits of a funnel plot are calculated in the same way as an SPC chart over time, but the data are ordered by denominator size rather than by time. This gives a funnel shape to the SPC chart. Points that are above or below the control limits in a funnel plot are an indication of special cause (unexpected) variation.    The control limits are based on the variation in the observed data. The control limits reflect the expected range of variation within the data, and do not reflect the desired range of variation in terms of quality of care. The probability of any data point falling outside of the control limits by chance alone is very small. | |
| **Example of a funnel plot** | |
| **Percentage of patients with a hip fracture undergoing surgery within 48 hours, by hospital** | |
| **Resources** | |
| **Tool 17** provides information on accessing an Excel template that can be used to produce different types of SPC charts, including funnel plots.  **Tool 18** provides an overview of QI Charts which is an Excel add-in tool that can be used to produce run charts and SPC charts, including funnel plots. | |
| **References** | |
| Provost L, Murray S. The Healthcare Data Guide: Learning from Data for Improvement. San Francisco: Jossey-Bass, Publication, 2011 |

### NQPSD Template for Creating SPC Charts

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| **Introduction**  Lower Control Limit |
| Analysing and displaying healthcare data using Statistical Process Control methodology can result in improved understanding of the variation in the data, and can identify signals in the data requiring action that otherwise may have been missed. This tool introduces the NQPSD template developed to support you in creating SPC charts. |
| **Why would you use this tool?** |
| One of the main barriers to using SPCs is the lack of user friendly and widely accessible software to create the different types of SPC charts. A further barrier can be necessity to apply the five rules for detecting special cause variation.  The QPS Intelligence Team have developed an Excel template to support you creating SPC charts and identifying special cause variation. The template will support you creating a number of graphs:  • P Chart  • P Prime Chart  • U Chart  • C Chart  • I Chart  • P Funnel  • P Prime Funnel  • U Funnel.  This tool automatically produces the rules, and identifies signals in the format, that are used by HSE. |
| **NQPSD SPC Excel Template for SPC charts** |
| The calculations in the template are automated. Users need to copy and paste their data and select the type of chart they wish to use. The template creates the chart and displays the special cause (unexpected) variation based on the 5 rules for analysing SPC charts. |
| **Resources** |
| The template can be downloaded here: <https://www.hse.ie/eng/about/who/nqpsd/qps-intelligence/version-beta-spc-template-qpsi-21-10-22.xlsx>  The template contains an Intro page describing how to use it, with further videos to support users available here: <https://www.hse.ie/eng/about/who/nqpsd/qps-intelligence/qps-intelligence-resources/measurement-for-improvement-resources.html> |

### An Introduction to QI-Charts

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| **Introduction**  Lower Control Limit |
| QI-Charts is installable software (Add-In) that provides optional commands and features for the production of SPC charts and run charts in Microsoft Excel and is an alternative to the NQPSD template for SPC (Tool 17). This tool introduces the features of QI-Charts. |
| **Why would you use this tool?** |
| QI-Charts is an alternative tool to create run charts and SPC charts. |
| **QI-Charts Add-In** |
| QI charts can be added into Microsoft Excel and can be used to create run charts and the most frequently used SPC charts. However, QI charts do not include the HSE rules and format for identifying signals, which have to be added manually. |
| **Further information** |
| HSE has a licence for QI-Charts. For further information on how to access QI-Charts email [QPSI@hse.ie](mailto:QPSI@hse.ie) |

# Part Three: People’s Experience of Quality Guidance

### Designing People’s Experience of Quality Agenda Item

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| **Introduction**  Lower Control Limit |
| **Why Is this Important?** Listening and engaging with patient and staff experiences at executive, board or committee level offers several opportunities:   1. Quality in healthcare is described as care that is safe, effective, efficient, equitable, timely, leads to better health and wellbeing **and is person centred**. To understand if care is person centred we need to ask patients, service users, families and staff about their experience. 2. A comprehensive view of quality requires several perspectives and therefore, including patients, service users, families and staff experiences makes an important contribution to providing a **fuller picture** of how quality, or failures of quality, are experienced by those who use and provide our services. 3. It provides an opportunity to gain a **deeper understanding** of the quality of care in our services. 4. It can help **ground** conversations and action in the reality of people’s experiences. 5. By placing it first on the agenda, it **sets an example** of the importance of engaging with patients, service users, families and staff experiences for the rest of the organisation to follow.  **Best Practice** International evidence of best practice confirms the inclusion of person centred patient, service user, family and staff experiences during board, committee or leadership team meetings. The Australian Commission on Safety and Quality in Healthcare has identified board participation in defining safe and high-quality care and the review of key quantitative and qualitative quality outputs as essential to a healthcare board’s role in managing quality (Australian Commission on Safety and Quality in Health Care, 2015). A recent report in the UK based on input from board members of healthcare boards revealed that board members considered the discussions of lived experience of healthcare helpful in keeping the board focused on quality (Smith et al., 2021). To engage in a true dialogue about quality of care, boards should be interested in the story behind the numbers rather than just looking at the indicators (Oerlemans et al., 2018). |
| **Why would you use this tool?** |
| This tool is helpful when planning the development of patient, service user, family or staff experiences to share at board, committee or leadership meetings. |
| **Designing and Planning to Present People’s Experiences at Executive, Board or Committee Meetings** |
| Ideally conduct a co-design workshop with the members of the executive, board or leadership group to agree:   * Quality and safety topics that may be of interest to the group * To triangulate or match people’s experiences with other agenda items/ topics * The methods/ how people’s experiences will be presented e.g. videos, a patient attending their meeting to share their experience, qualitative research findings presentations * Whose experiences they wish to be presented – patient, service users, families, staff * The time allocated to the item at their meetings * A plan to evaluate and get feedback from members (e.g. feedback forms, interviews) to ensure the item meets the executive, board or leadership group’s needs  **Which Experiences?**   * **General and individual**: General or overall experiences (e.g. survey data) and individual experiences (e.g. a patient story) offer different and valuable insights * **Making the most of existing data**: such as patient and staff surveys, complaint and compliment data or qualitative research findings * **Timely:** Recent patient, service user, family and staff experiences can offer more opportunities for engagement and action * **Triangulation:** patient, service user, family and staff experiences can illuminate the lived experience of a specific measure of quality |
| **References and Background Reading** |
| Australian Commission on Safety and Quality in Health Care 2015. *Guide to the National Safety and Quality Health Service Standards for health service organisation boards*. Sydney, Australia: Australian Commission on Safety and Quality in Health Care.  *Better Together: The Health Services Patient Engagement Roadmap*. Health Service Executive 2022. <https://www.hse.ie/eng/about/who/qid/person-family-engagement/resourcesqid/hse-better-together-patient-engagement-roadmap-book.pdf>  Martin, et al (2022), "Board level “Picture-Understanding-Action”: a new way of looking at quality", International Journal of Health Governance, Vol. 27 No. 1, pp. 105-117. <https://doi.org/10.1108/IJHG-05-2021-0047>  Martin et al (2023) “Applying a new approach to the governance of healthcare quality at Board level” International Journal of Health Governance - Paper Forthcoming  Oerlemans, A. J. M., De Jonge, E., Van Der Hoeven, J. G. & Zegers, M. 2018. A systematic approach to develop a core set of parameters for boards of directors to govern quality of care in the ICU. Int J Qual Health Care, 30, 545-550.  *Quality and Safety Data for Decision Making Case Study: Co-designing the Quality Agenda with the HSE Leadership Team* (2023) - <https://www.hse.ie/eng/about/who/nqpsd/qps-intelligence/qps-intelligence-resources/quality-and-safety-data-for-decision-making-case-study.pdf>  Smith, C., Grayson, W., Botea, L. & McCulloch, S. 2021. *What every board member needs to know about improvement and quality assurance.* Good Governance Institute and Perfect Ward. |

### Qualitative Interviewing Tips and Techniques

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| **Introduction** |
| The purpose of interviewing a patient, service user, family or staff member is to hear and capture the person’s unique experience of the quality of care in our health service. |
| **Why would you use this tool?** |
| As part of your PEQ, you may interview people about their experiences of using or working in the health service to share at meetings. You may interview someone when recording a video for instance. Below are some useful tips when conducting an interview. |
| **Interview Tips and Techniques** |
|  |
| **Further Reading** |
| *Patient and Staff Stories Toolkit for developing stories*, NQPSD Incident Management Team:  <https://assets.hse.ie/media/documents/Patient_and_Staff_Stories_Toolkit_-_Version_1.pdf> |

### Supporting a Person to Share their Experience at Meetings

|  |
| --- |
| **Introduction** |
| Patients, service users, families or staff members can attend a board, committee or leadership meeting to share their experience virtually or in-person. |
| **Why would you use this tool?** |
| To ensure the patient, service user, family or staff member have a positive experience while attending the meeting. |
| **Supporting a person to share their experience at meetings** |
| **Prior to Meeting**  As far in advance of the meeting as possible, hold a first briefing meeting to explain why the person has been asked to share their experience:   * Outline the purpose of the item at the executive, board or committee meeting. * Provide an information sheet and consent form and ensure you have informed consent and that the person is happy and comfortable sharing their story. * Remind them that participation is voluntary. * Explain the time given to this item. * Enquire if they would like to share any information before the meeting to provide background to their story.   Shortly before the meeting, hold a second briefing meeting to prepare the person:   * Outline logistics of the meeting; date, time, share meeting dial in details or location. * Explain what to expect, the structure of the meeting, and to prepare for questions. * Encourage them to describe their experience using their own words focusing on what is important to them. * Ensure the person is comfortable attending and has had an opportunity to ask any questions or voice any concerns.  **During the Meeting**   * Encourage them to have a supportive person attend with them. Many people may feel more comfortable with a family member, liaison or colleague being present.  **After the Meeting**   * Hold a debriefing meeting to:   + Thank the person for their participation.   + Capture their feedback of sharing their story to identify if any improvements can could be incorporated in the process to ensure future participants have a positive experience. * When the draft meeting minutes are received, confirm with patient/staff member that they are an accurate reflection and re-check whether they would like their name included. |

### Guidance on Developing Patient, Service User and Staff Videos and Stories

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| **Introduction** |
| The NQPSD Incident Management Team have developed a step-by-step guide on the creation of patient, service user and staff stories and videos. The *Patient and Staff Stories Toolkit for developing stories* outlines twelve steps to be undertaken:   * Step1: Identifying stories for inclusion and exclusion * Step 2: Enabling participation * Step 3: Stages of story collection and publication * Step 4: Video stories * Step 5: Specific considerations when developing a story * Step 6: Governance checklist * Step 7: Consent form * Step 8: Storyteller information * Step 9: Active listening guide * Step 10: Patient Safety Strategy * Step 11: Action planner and tracker * Step 12: Sign-off |
| **Why would you use this tool?** |
| This tool is useful resource when you are creating videos or stories to be shared at board, committee or leadership meetings. |
| **Access the toolkit** |
| *Patient and Staff Stories Toolkit for developing stories*, NQPSD Incident Management Team:  <https://assets.hse.ie/media/documents/Patient_and_Staff_Stories_Toolkit_-_Version_1.pdf>  *Better Together: The Health Services Patient Engagement Roadmap.* Health Service Executive 2022. <https://www.hse.ie/eng/about/who/qid/person-family-engagement/resourcesqid/hse-better-together-patient-engagement-roadmap-book.pdf> |

### Sample Information Sheet and Consent Form

|  |
| --- |
| **Introduction** |
| Informed consent involves a process of ensuring participants get information, can ask questions and understand any risks involved in their participation. |
| **Why would you use this tool?** |
| A sample information and consent form is provided to below outlining the key information a patient, service user, family or staff member needs before they agree to share their experience. The information provided should include:   * The background and purpose of the People’s Experience of Quality agenda item * What is being asked of them * That their participation is entirely voluntary * How long it will take * What will happen to the information they share with the board or committee * Contact information if they have any questions |

#### **Sample Information Sheet**

The purpose of this document is to provide information on the People’s Experience of Quality agenda item and to outline what taking part would involve for you. Before you decide whether or not you wish to take part, you should read the information provided below carefully and take time to ask questions. If you decide not to take part, your decision will not affect your future healthcare. You can also change your mind about taking part any time you like by withdrawing your consent. You do not have to give us a reason.

**What is the People’s Experience of Quality Agenda Item?**

This agenda item involves the HSE Safety and Quality Committee looking at how quality and safety are experienced by people who use and work our health system.

**Why am I being asked to take part?**

We would like to hear about your experiences of using the healthcare system, both good and bad. You can provide valuable feedback on health services to give the committee a better understanding of what matters to patients. Your story will provide a broader picture of quality and a patient’s experience of healthcare.

**What will this involve?**

If you decided to take part we will arrange a time that is convenient to you in a suitable location. We will cover any travel expenses or arrange transport. If you are willing to tell us about your experience, we will ask you to sign a consent form before sharing your personal story.

The interview will take **approximately 45 minutes to one hour**. We will not ask you for detailed personal information or questions about your medical treatment or results – we want to hear about your experience of using the health system and how you feel about your experience. The interview can be tape recorded or written notes can be taken, depending on your preference.

**What will happen with the information I give during the interview?**

Your experience and story will be shared with the HSE Safety and Quality Committee at their next meeting. You can decide whether you want your name used or not, in which case we could use a pseudonym or false name. The draft minutes of the meeting can be forwarded to you and we will re-check whether you would like your name included or not.

**If you have any questions or would like further information please contact:**

Provide contact details: name, role details, phone and email address

**Participant Information Sheet**

#### **Sample Consent Form**

**Consent Form**

Please circle your response to following:

|  |  |  |
| --- | --- | --- |
| I have read and understand the information contained in the information sheet | Yes | No |
| I understand that my participation is voluntary | Yes | No |
| I understand that I am free to withdraw at any time without giving a reason | Yes | No |
| I understand that I am not obliged to answer any questions if I don’t want to, or if the subject makes me uncomfortable | Yes | No |
| I consent to the interview being tape recorded | Yes | No |
| I have had the opportunity to ask questions and all my questions have been answered | Yes | No |
| I consent to being interviewed for the purposes of the Directorate Patient Experience of Quality project | Yes | No |
| I would like my name to be used during the Directorate meeting | Yes | No |
| I would like to view the draft meeting minutes | Yes | No |

|  |  |
| --- | --- |
| Participant Signature |  |
| Participant Name in Print |  |
| Date |  |

|  |  |
| --- | --- |
| Interviewer Signature |  |
| Interviewer Name in Print |  |
| Date |  |

**If you have any questions or would like further information please contact:**

Provide contact details: name, role details, phone and email address

# Part Four: Evaluation and Feedback

### Feedback on Project

|  |
| --- |
| **Introduction** |
| Feedback and ideas for improvement are important information to gather throughout your project. |
| **Why would you use this tool?** |
| Feedback can inform improvements so that changes can be incorporated in future iterations. |
| **Feedback Forms** |
| Feedback from the members of the board, committee or leadership team can be captured in a variety of ways throughout your quality agenda project. This includes:   * Feedback forms * Individual interviews with executive, board or committee level board and committee members (see interview tips and techniques in **Tool 20**) * Observation of group discussions at board and committee meetings * Informal conversations with board and committee members   Using a combination of the methods above will offer the best all-round information. Remember to capture any informal feedback and your observation notes at workshops and meetings.  Sample feedback forms are included on the following pages to help you consider questions you may want to ask to get feedback on your People’s Experience of Quality and Quality Profile. |

**Please respond to each statement by circling your response in the table below**

1. The content of the People’s Experience of Quality presentation was **engaging**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Strongly Agree | Agree | Neutral | Disagree | Strongly Disagree |

2. This agenda item provided me with **insight** into People’s Experience of Quality

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Strongly Agree | Agree | Neutral | Disagree | Strongly Disagree |

3. I would like to use this format again at **future meetings**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Strongly Agree | Agree | Neutral | Disagree | Strongly Disagree |

4. The **time given** to the ‘People’s Experience of Quality’ was adequate

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Strongly Agree | Agree | Neutral | Disagree | Strongly Disagree |

**Have you any comments or feedback on the Patient and Staff Experience of Quality**? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Thank you for your feedback.

**Sample Feedback Form: Quality Agenda Item**

We would appreciate your feedback by completing this short survey on the Quality Agenda Item as presented at today’s meeting.

Thank you for your feedback.

**Sample Feedback Form: Quality Agenda Item**

We would appreciate your feedback by completing this short survey on the Quality Agenda Item as presented at today’s meeting.

Please respond to each statement by circling your response in the table below

1. The length of the Quality Profile: *(please tick relevant)clinical*

|  |  |  |
| --- | --- | --- |
| Is too short | About right | Too long |

The Quality Profile

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 2a) Is clearly presented | Strongly  Disagree | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Strongly  agree |

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 2b) Is useful in understanding how the HSE is performing in relation to quality of care over time | Strongly  Disagree | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Strongly  agree |

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 2c) Is useful in understanding variation across health and social care services | Strongly  Disagree | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Strongly  agree |

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 2d) The supporting text provides me with enough information to allow me understand what the indicator is measuring and how it is performing | Strongly  Disagree | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Strongly  agree |

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 2e) The new measure on Percentage of people waiting <13 weeks following a referral for routine colonoscopy or OGD is a useful addition | Strongly  Disagree | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Strongly  agree |

I am confident in my understanding of the information presented in the Directorate Quality Profile

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Strongly  Disagree | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Strongly  agree |

4. The time given to discuss, assess and make recommendations on the information provided in the Directorate Quality Profilewas:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Strongly Agree | Agree | Neutral | Disagree | Strongly Disagree |

Have you any comments or feedback on the Directorate Quality Profile?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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### After Action Reviews

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| **Introduction** |
| An After Action Review (AAR) is a structured review process used to review the work of a group. It seeks to rapidly identify strengths, weaknesses, and areas for improvement. |
| **Why would you use this tool?** |
| After completing segments of your project or after a specific action e.g. holding a workshop, it may be helpful to look back at the process and what you learned from it by conducting an AAR. |
| **After Action Review** |
| After Action Review (AAR) focuses on 4 questions which seek to ascertain what the team expected to happen, what actually happened, why was there a difference between expected and actual and what can be learned from the event:    AARs are ideally conducted by a facilitator, but can be led by a member of the project team. The time required to conduct an AAR varies between 1 to 2 hours for a formal review, while informal AARs may be a short 15 minute conversation to help identify issues and how to overcome them. |
| **Further Resources** |
| An After Action Review template is available on the NQPSD website: <https://www.hse.ie/eng/about/who/nqpsd/qps-education/nat-qi-tool-15-after-action-review-aar-.pdf>  The NQPSD Incident Management Team have developed guidance for conducting After Action Reviews. The guidance document is available on our website: <https://www.hse.ie/eng/about/who/nqpsd/qps-incident-management/incident-management/aar-guidance-for-services.pdf> |

### Self-Evaluation Guide and Workbook

|  |
| --- |
| **Introduction** |
| Undertaking an evaluation of a project can help in several ways:   * Accountability: the findings can be used to demonstrate to stakeholders, what you are doing and how well you are doing it. * Support decision-making and planning: you can use the findings to decide if innovations should be continued, improved, expanded or curtailed. * Learning and continuous improvement: an evaluation can answer questions about what works and why it works. |
| **Why would you use this tool?** |
| The NQPSD Self-Evaluation Guide and workbook will guide you in the steps required to conduct a robust evaluation of your quality agenda project. |
| **NQPSD Self-Evaluation Guide and Workbook** |
| The NQPSD Self-Evaluation Guide and Workbook takes you through six steps for self-evaluation, as outlined below:  Blank templates are included in the workbook to assist planning the evaluation of your project. |
| **Access the NQPSD Self-Evaluation Guide and Workbook** |
| The National Quality & Patient Safety Directorate Self-Evaluation Guide and Workbook can be downloaded from our website: <https://www.hse.ie/eng/about/who/nqpsd/qps-intelligence/qps-intelligence-resources/measurement-for-improvement-resources.html> |



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| --- | --- |
|  | Engage with us on twitter @NationalQPS or by email at [nqps@hse.ie](mailto:nqps@hse.ie) |

1. *Board on Board with Quality of Clinical Care’ Quality Improvement Project: Case Study Report* (2015) <https://www.hse.ie/eng/about/who/nqpsd/qps-intelligence/board-on-board-quality-mmuh.pdf> [↑](#footnote-ref-1)
2. *Bringing the Board of Directors on Board with Quality and Safety of Clinical Care at Temple Street Children’s University Hospital: A case study and Toolkit* (2018) <https://www.hse.ie/eng/about/who/nqpsd/qps-intelligence/chi-temple-street-case-study-and-toolkit.pdf> [↑](#footnote-ref-2)
3. *Quality and Safety Data for Decision Making Case Study: Co-designing the Quality Agenda with the HSE Leadership Team* (2022) <https://www.hse.ie/eng/about/who/nqpsd/qps-intelligence/qps-intelligence-resources/quality-and-safety-data-for-decision-making-case-study.pdf> [↑](#footnote-ref-3)
4. Martin, et al (2022), "*Board level “Picture-Understanding-Action”: a new way of looking at quality*", International Journal of Health Governance, Vol. 27 No. 1, pp. 105-117. <https://doi.org/10.1108/IJHG-05-2021-0047> [↑](#footnote-ref-4)
5. SMART aims:

   • Specific: who, what, where, when, how

   • Measurable: numeric goals

   • Actionable and Achievable

   • Relevant to stakeholders and organisation

   • Timeframe: short cycles of tests, by when [↑](#footnote-ref-5)
6. Consider clinical/ technical drivers and the six petals of the Framework for Improving Quality as your primary drivers. [↑](#footnote-ref-6)