Canadian Mental Health Association
Durham

# QUALITY IMPROVEMENT PROGRAM

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# 1.0 QUALITY IMPROVEMENT PROGRAM OVERVIEW

## 1.1 Quality Improvement Program Model

## 1.2 Definition, Purpose and Policy

**Definition:** Quality Improvement (QI) is a philosophy underlying a strategic, integrated management system that monitors and continuously improves the caliber of care and service delivered from a client impact, risk, safety, and utilization perspective.

**Purpose:** The Board of Directors, management and staff of the Canadian Mental Health Association Durham, are committed to the continuous improvement of services, and believe that quality care and service is attainable through an organized Quality Improvement Program based on our vision…

*"…we envision mentally healthy people in a healthy society."*

**Policy:** The Canadian Mental Health Association Durham is committed to providing and continuously improving safe, high quality care and service to clients and families. To support this commitment, The Canadian Mental Health Association Durham has a Quality Improvement Program which integrates and coordinates all quality improvement, risk management, safety, and utilization review activities for all programs administered by the organization.

Board Members shall create and nurture a philosophy and culture of continuous improvement throughout the organization, and shall adopt client safety as a strategic priority. All Board Members, staff and volunteers shall be familiar with the principles of quality, and where appropriate, be involved in quality improvement activities. The program is an organized, coordinated approach to the improvement of client care/service through education, prevention, identification of client needs and expectations, process analysis, outcome measurement, data analysis, improvement and ongoing review.

The Board of Directors is accountable for the quality of care and services provided by the organization. It adopts policies and delegates authority and responsibility for implementing and maintaining organization-wide quality improvement activities to the Chief Executive Officer. Quality Council has responsibility for providing direction, monitoring and coordinating, making recommendations and evaluating all Quality Improvement Program activities and the overall effectiveness of the Program. The Board receives regular reports of the outcome of these activities as part of the reporting process, provides feedback, as appropriate.

## 1.3 General Principles

**Quality Principles** that support our Quality Improvement Program and policy.

**1. Culture:**
We promote a culture, including our mission, vision, values and strategic goals, which reflects community need and demonstrates commitment to safe quality care and service.

**2. Customer Focus**:
We focus on our customers, both external customers and internal staff, whose needs and expectations drive the design of our programs, and whose opinions determine the quality of outcomes of our service.

**3. Leadership:**
We demonstrate at all levels, visible commitment to, and leadership in managing by these principles.

**4. Teamwork:**
We work together, combining our ideas, skills and talents, to improve the quality of our work. We adopt a "just culture" work environment and reinforce, recognize and reward quality improvement contributions. The Canadian Mental Health Association Durham can be viewed as one large team composed of a number of smaller, interrelated teams/programs, each sharing with one another, key information linked to mission, vision, goals and other elements of organizational focus. Each team/program strives to measure and continuously improve the quality of its own outcomes. Everyone is involved in quality leadership and safety and improvement is everyone's responsibility.

**5. Analytical Approach:**
We use, where possible, statistical methods and other problem-solving tools to measure and control our processes, and improve our outcomes. Data analysis directs our decisions.

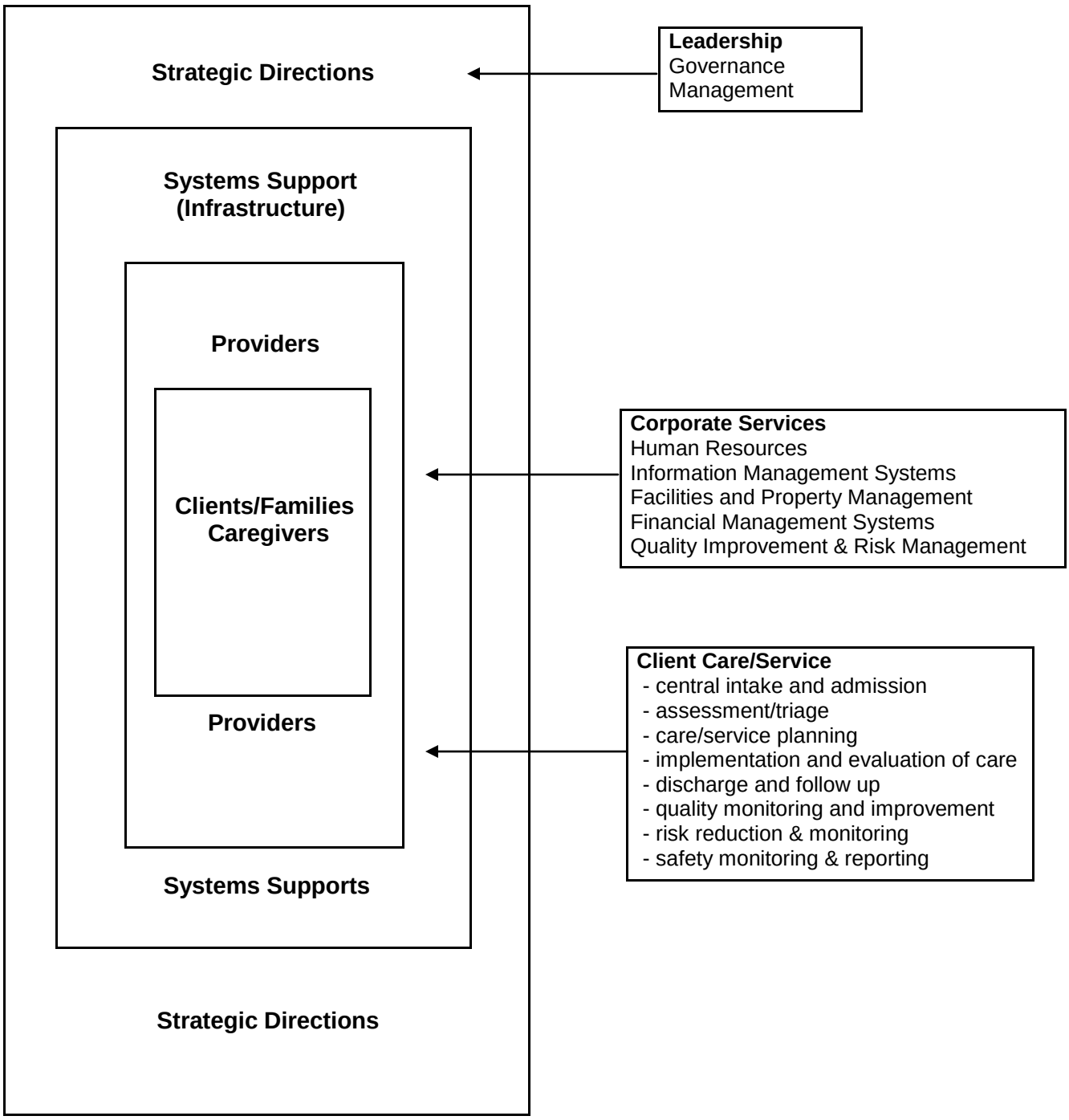
**6. Continuous Improvement:**
We actively pursue quality improvement through a continuous cycle that focuses on assessing, planning, implementing and evaluating improvements of key processes and outcomes in our programs and in the organization.

## 1.4 Client and Family—Focused Organizational Infrastructure

The Canadian Mental Health Association Durham embraces a client and family - focused philosophy. To support and promote this philosophy our organization is:

- driven by **strategically** focused leadership that...
- ensures the provision of a series of interrelated **support systems** that sustain…
- **providers** working within care/service-related processes who...
- deliver care/service to **clients/families** as they proceed through their experience with us.

## 1.5 Our Infrastructure is illustrated as follows:



## 1.6 Quality Improvement Program Components

There are four components to our Quality Improvement Program:

1. Continuous Quality Improvement
2. Risk Management
3. Client Safety
4. Utilization Management

**1. Continuous Quality Improvement**

Our Continuous Quality Improvement process focuses on our performance in meeting the needs of our customers, both internal and external. Our strategy seeks to make things better by improving all aspects of care and service. This is accomplished by monitoring key processes and outcomes to identify opportunities for improvement. Steps in the improvement process are:

- Identify processes to be monitored
- Establish indicators and measure performance
- Identify gaps in performance (improvement opportunities)
- Make improvements
- Document and report
- Continue to monitor

**2. Risk Management**

Our Risk Management system is a four step process

- Identify risks
- Assess and prioritize risks
- Take action to control or manage risks
- Evaluate effectiveness of risk management activities

**3. Client Safety**

- Identify risk to client safety
- Assess risk to client safety
- Take action to control or manage risk
- Evaluate effectiveness of action
- Comply with all Required Organizational Practices (ROPs) of Accreditation Canada

**4. Utilization Management**

Our Utilization Management system is a process by which the organization strives to achieve the highest quality of safe client care and service through optimum use of available resources. The Quality Council review utilization patterns related to client service requirements, services delivered and resources consumed, and initiates or approves changes to improve utilization.

## 1.7 Role Responsibilities

**Board of Directors**

- has the overall accountability for the quality and safety of care and service provided by the organization
- integrates quality into the organization's strategic planning process by merging the quality improvement principles and client safety goals with the strategic business plans
- establishes a "just culture" which embraces the philosophy of client and family-centred care, integrated teamwork and continuous improvement
- ensures an effective, on-going Quality Improvement Program is maintained
- receives regular reports and monitors trends, issues and outcomes

**Chief Executive Officer**

- assumes responsibility for the Quality Improvement Program and its component parts
- manages the culture and allocates resources to support the Quality Improvement Program
- ensures the organization's compliance with relevant laws, regulations, agreements and governing body policies
- ensures specific job descriptions include responsibilities for quality, risk management and client safety activities
- is accountable for the quality and safety of services provided by the various programs/teams

**Director of Corporate Services**

- assumes responsibility for quality improvement, risk management and utilization activities for Corporate Services.

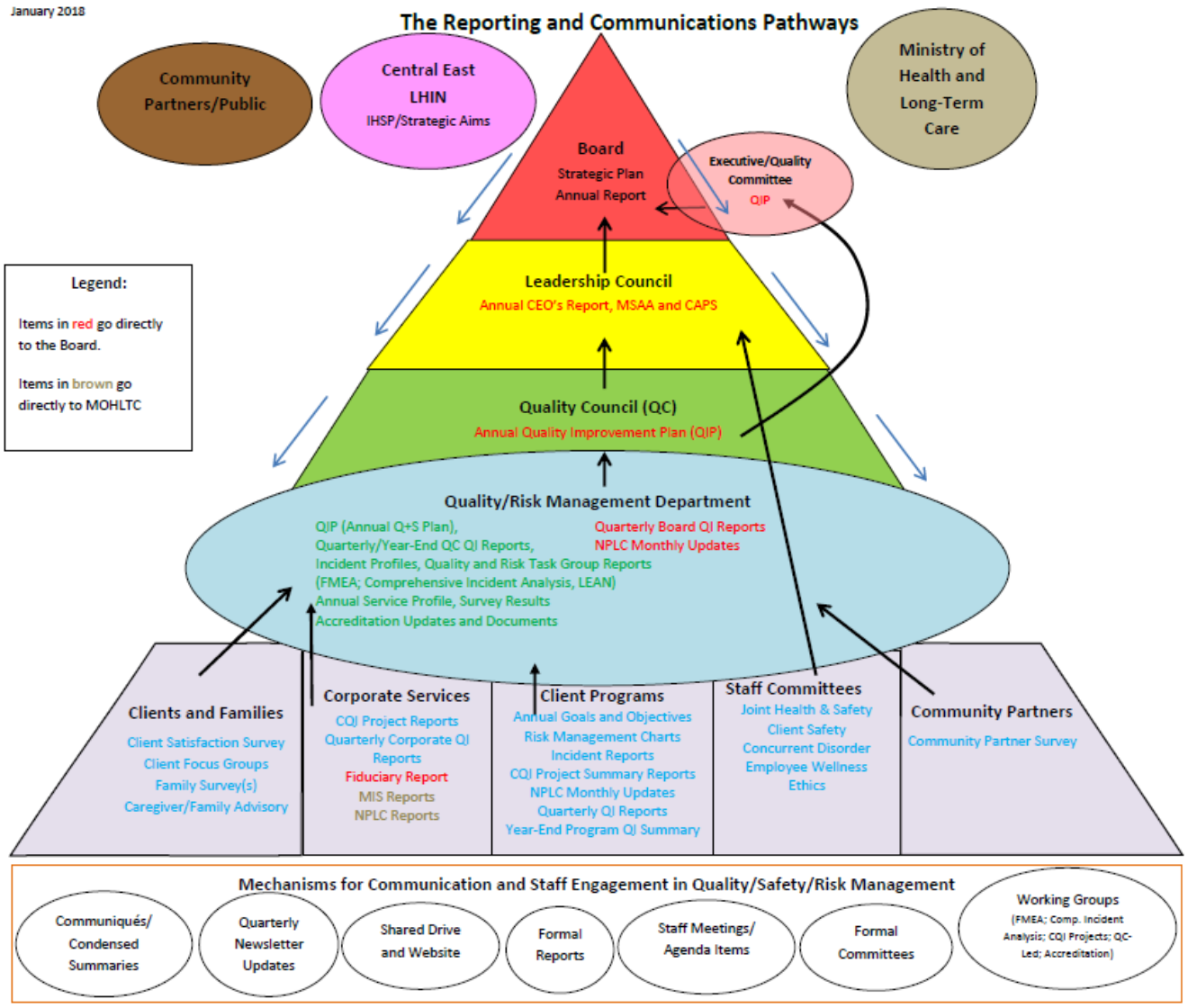
**Program Managers and Coordinators**

- are responsible for the quality improvement, client safety and risk management activities in their respective programs
- are responsible for the quality and safety of the client services and supports provided by their various programs, including ensuring access to services, both internally and externally, client follow-up, and client and provider satisfaction.

**Quality Council**

- is responsible for providing direction, coordination, monitoring and evaluation of all aspects of the Quality Improvement Program. *(See Quality Council Terms of Reference – Appendix A)*

## 1.8 Reporting and Communication Pathways



# 2.0 PROGRAM COMPONENTS

## 2.1 Continuous Quality Improvement

In keeping with the philosophy of continuously improving the quality of care and service, the Programs/Teams undertake a 6 step process:

**1. Identify Key Processes and Outcomes**
These are processes and outcomes that are vital to a program/team's success e.g. intake of clients, assessing needs, providing service, maintaining equipment, managing risks, storing information etc.

**2. Measure Key Processes and Outcomes**
Identify and monitor *indicators* that will show if the desired results are produced. *An indicator is a measurement tool used as a guide to monitor and evaluate the quality of care and service.* Think of an *indicator* as a red light appearing on your car's dashboard…it doesn't specify the problem, but it does alert you that something isn't right and requires some investigation. Each Program/Service Team is responsible for developing, monitoring, analyzing data, identifying trends and reporting on indicators specific to their Program, and taking or recommending action to be taken to make desired improvements.

**3. Identify Gaps in Performance**
Identify desired targets for performance for each indicator, and identify gaps between actual and desired performance. Where indicators identify a level of performance below the desired target, (i.e. an opportunity for improvement), action is required.

**4. Implement Improvement**
Action may be a relatively simple corrective solution which may be implemented by an individual or the team, or it may require a more formal approach to identify the root cause(s). If an improvement initiative will impact other programs/services or staff, or will require additional resources (time, staff, money), a proposal should be submitted for consideration, approval and support.

**5. Document and Report**
Improvements made are documented through varies reporting tools i.e. *CQI Project Summary Report (See CQI Project Summary Report—Appendix F).* A copy of the Report is sent to the Quality Improvement and Risk Management Lead. All reports are shared with Quality Council, Team Leaders and Coordinators, staff, and are available on the shared drive.
Documentation of improvement initiatives includes at least:

- when/how the issue/problem was identified
- individual(s) involved
- a statement of the issue/problem/opportunity for improvement
- actions taken or solution implemented
- the impact or result of the change on the client, staff or on the organization
- measure/indicators
- target/target justification

**6. Continue to Monitor**
Continue to monitor the improved process as before.

### 2.1.1 Quality Improvement Plan

The Canadian Mental Health Association Provincial Quality Task Group supported by the Canadian Mental Health Association Ontario and chaired by the Canadian Mental Health Association Durham's Chief Executive Officer explored community indicators for community mental health programs that could populate a future Quality Improvement Plan for this sector.

In 2015, The Canadian Mental Health Association Ontario passed this mental health initiative onto Addictions and Mental Health Ontario and to the Ministry of Health and Long-Term Care through Health Quality Ontario where it is currently under review for development of an agreed upon standardized tool that can be used in the mental health sector.

Accreditation Canada defines a Quality Improvement Plan as a *"detailed organizational work plan that includes essential information on how to manage, deploy, and review quality throughout an organization."*

The Canadian Mental Health Association Durham's Quality Improvement Plan (*See Quality Improvement Plan—Appendix B)* has been developed by Leadership, Quality Council with input from Team Leaders and Coordinators to align with the organizations Strategic Plan and Objectives. The Quality Improvement Plan will serve to assist the organization in having:

- a systematic and integrated approach to improving organizational performance;
- shared accountability for quality;
- enhance and support the organizations commitment to quality and systems thinking;
- assist in communicating the organizations plans, goals, and objectives; and
- assist in documenting improvements and monitoring progress.

The Ministry of Health and Long-Term Care requires all Nurse Practitioner-Led Clinics, community health centers, and family health teams, to submit Quality Improvement Plan's annually. The Canadian Mental Health Association Durham's Nurse Practitioner-Led Clinic was proactive in piloting its own Quality Improvement Plan in 2012 and since 2013-2014 has successfully completed and submitted a Quality Improvement Plan annually to Health Quality Ontario.

## 2.2 Risk Management Program

### 2.2.1 Definition, Purpose, Policy

**Definition:** **Risk is** *anything that may result in danger, loss or injury, or may compromise the achievement of the organization's objectives*. Risk can relate to the health and well-being of clients, staff, visitors, volunteers, or public; property; reputation; environment; organizational functioning; financial stability and other things of value. *(See Organizational Risk Management Framework—Appendix C)*

**Risk Management is** *a continuous, proactive management process to identify, manage and communicate risk, and inform strategic decisions that contribute to the achievement of the organization's overall objectives.*

It is impossible to eliminate all risks. Organizations must tolerate a level of instability, unpredictability and risk as they fulfill their mission and pursue their goals and objectives.

**Purpose:** Risk Management is about dealing with uncertainty. Our Risk Management Program helps us make more informed choices and decisions, as they relate to the safety, protection and well-being of our clients, staff, visitors, volunteers and our organization, by providing the framework and processes to enable us to assess, monitor, analyze and act on our data. Risk and safety activities are incorporated into all program and service operations, and are carried out at all levels of the organization. Everyone is a risk manager.

**Policy:** The Canadian Mental Health Association Durham is committed to *"providing exceptional, integrated, community care within a high quality and healthy environment where risks are managed effectively".* Risk and adverse events most often represent a series of system and process failures rather than individual error. The Canadian Mental Health Association Durham fosters a "just culture" work environment that focuses on a "systems" approach to identifying, understanding, reducing and reporting risks and adverse events.

All Board Members, staff and volunteers:

- shall be familiar with all aspects of the Risk Management Program, and current accreditation safety requirements, their respective roles and responsibilities,
- shall participate in risk management activities, as appropriate,
- have a duty to report incidents or non-compliance with relevant legislative requirements

The Board receives regular reports on the outcome of risk management activities as part of the Quality Improvement Program reporting process, provides feedback, and evaluates the overall effectiveness of risk management. The Board adopts policies and delegates the authority and responsibility for implementing organization risk management and safety activities to the Chief Executive Officer.

### 2.2.2 Risk Management Process

Risk Management is a proactive management process that provides a framework for identifying risks and deciding what to do about them. Our process has four basic steps:

**Step 1 Identifying Risks (actual or potential)** *(See Risk Impact Scale – Appendix D)*

Risks are identified through a variety of mechanisms - including but not limited to:

- inspections (e.g. fire, safety, etc.)
- prospective and retrospective analyses (e.g. FMEA, Root Cause Analysis, etc.)
- monitoring activities (e.g. audits, survey results, analysis of indicator data, complaints, etc.)
- outside authorities (e.g. legislation, accreditation survey, literature etc.)
- reports (e.g. incident, occupational health and safety, finance, security, etc.)
- insurance claims
- preventive maintenance activities

**Step 2 Assessing and Prioritizing Risks (likelihood of occurrence and impact)**

This is an evaluation exercise. *(See Workplace Risk Assessment Form – Appendix E)*

**Step 3 Taking Actions to Control or Manage Risks**

Not all risks can be eliminated but risks can be managed. Managing risks involves two activities:
a) controlling the risks, and
b) financing the losses.

Risk control and financing strategies:

- **Avoidance** of risk - activity is stopped or not undertaken because it is too risky
- **Transference** of risk – risk is assumed by another party by transferring the activity
- **Prevention/Reduction** of risk (and loss) – activities to reduce or prevent mishaps (eg. fire drills, investigating client complaints, back-up power source, back-up computer systems)
- **Retention** of risk - the organization assumes financial responsibility for the loss, because the cost of coverage is greater than the anticipated loss.

**Step 4 Evaluating Risk Management Activities**

The Board reviews the performance of the organization in terms of overall safety, frequency and severity of losses, law suits, adverse events and other incidents, and losses which occurred but were not identified, to determine its overall effectiveness.

In addition to the above strategies for managing risks, the organization:

- recruits capable board members and well-qualified staff
- provides an orientation program for all new staff, students and volunteers
- provides clear, comprehensive job descriptions and sound policies and procedures
- supports professional development at all levels of the organization
- creates an organizational culture that promotes a “just culture” environment for identifying safety issues and concerns, and emphasizes and rewards safe practices, risk management, quality improvement and systems thinking and behaviour
- uses an ethical framework for decision-making

**Documentation**

Risk management activities are incorporated into all program and service activities**,** and are documented by a variety of methods including, but not limited to:

- incident reports
- audit reports
- inspection reports
- annual program or team objectives
- prospective analysis reports
- minutes of committee meetings
- quality improvement reports and CQI Project Summary Reports
- accreditation reports and recommendations

**Reporting**

A summary of safety and risk indicators is included in the Quality Improvement Report which is provided to the Board quarterly, or more frequently if needed.

## 2.3 Client Safety

Client Safety underlies all care and service activities at every level at The Canadian Mental Health Association Durham. Clients' needs and their safety are assessed from the earliest point of contact and are reassessed at regular intervals during their experience with The Canadian Mental Health Association Durham, and/or as circumstances change.

The process for assessing, documenting and reporting Client Safety is similar to the Risk Management Process described above:

- identify risk to client safety
- assess risk to client safety
- take action to control or manage risk
- evaluate effectiveness of action

In addition, every effort is taken to comply with all current, relevant safety standards and Required Organizational Practices (ROPs) of Accreditation Canada.

## 2.4 Utilization Management

### 2.4.1 Utilization Management Program

The Board of Directors is accountable for the effective utilization and management of The Canadian Mental Health Association Durham's resources in the provision of services to the community it serves. This accountability is demonstrated by the Board's regular review of services provided, and the physical and human resources required to do so. Responsibility and authority for developing and implementing a process for review of activities is delegated to the Chief Executive Officer. The Board supports interagency collaboration, cooperation and partnering to maximize effective utilization of community resources and to enhance client care.

### 2.4.2 Utilization Management Process

Management conducts utilization review activities on an organization-wide basis, in order to:

- provide meaningful and timely information to all stakeholders, (including funding ministries, staff, clients, Directors, etc.) which describes key characteristics of The Canadian Mental Health Association Durham's clients and the services they require;
- identify and analyze trends in order to plan an appropriate range of services, determine resource allocation and forecast resource requirements as part of the strategic planning process;
- plan, develop and implement continuous quality improvement activities;
- ensure that The Canadian Mental Health Association Durham provides services in accordance with its mission, vision and goals, objectives and priorities.

A summary of program-based, utilization and EMHware data is reviewed at least annually by Quality Council and reported to the Quality Committee of the Board by the Chief Executive Officer. Aligned with the Continuous Quality Improvement and Risk Management Programs, service intensity and case load indicators are identified, monitored and regularly reported as part of The Canadian Mental Health Association Durham's Quality Improvement Program reporting process. These indicators help evaluate whether a level of excellence in care and service is being achieved, with minimal risk, with optimal utilization of available resources.

## SUMMARY

All quality improvement, risk management, safety and utilization management processes are ongoing and oriented toward problem identification, remediation, and continual improvement of performance and outcomes. The Board of Directors is accountable for the overall quality and safety of services provided and for creating a culture that supports a philosophy of continuous improvement. The Board delegates to the Chief Executive Officer, the authority and responsibility for implementing, managing, coordinating, monitoring and evaluating the effectiveness of all aspects of the Quality Improvement Program, and receives regular reports on relevant data and information, key issues of concern, and overall effectiveness of actions taken.

# APPENDICES

## Appendix A—Quality Council Terms of Reference

Subject: **Quality Council – Terms of Reference**

**Purpose:**

The Quality Council is appointed by the Chief Executive Officer to provide leadership, promote, monitor, support, coordinate and evaluate Canadian Mental Health Association Durham's Quality Improvement Program and its component parts. The Council will meet every two months or as required.

**Duties:**

- ensure the ongoing development and implementation of Canadian Mental Health Association Durham's Quality Improvement Program;
- be familiar with all aspects of the Quality Improvement Program, as well as the expectations and the standards of Accreditation Canada;
- receive and review quarterly and annual Quality Improvement Reports
- review and analyze significant quality, safety, risk and utilization indicator data in order to identify system failures, risks, trends and problems;
- develop and coordinate the accreditation process, review reports and recommendations, and coordinate required follow up;
- make changes and/or recommendations regarding policies, procedures and processes, arising from the Quality Improvement Program or Accreditation process;
- receive, evaluate, and approve CQI proposals;
- monitor, support and coordinate approved CQI projects, and receive regular progress reports;
- provide resources as appropriate, for quality improvement, risk management and accreditation activities;
- evaluate the Quality Improvement Program and its component parts, at least every two years, and within a year following an accreditation survey, to ensure alignment with Canadian Mental Health Association Durham's mission, vision and organizational priorities;
- monitor, coordinate and follow up on client and staff satisfaction surveys and identify opportunities for improvement;
- regularly communicate with client service and support teams to provide feedback regarding their quality improvement activities;
- report monthly through the CEO's Report to the Executive Committee of the Board and to the Board of Directors;
- report quarterly through the Chief Executive Officer (2X) and the Quality Improvement and Risk Management Lead (2X) to the Quality Committee of the Board;
- report quarterly through the Chief Executive Officer to the Board of Directors, as an information agenda item.

**Membership:**

Chief Executive Officer
Director, Corporate Services
Director, Programs & Services
Manager, Executive Office
Nurse Practitioner Led Clinic - Lead
Coordinators: Finance & Admin; Housing & Case Management; Programs and Services
Quality Improvement & Risk Management Lead
Team Leads (Ad hoc)

# Appendix B—Quality Improvement Plan

## Quality Improvement Plan

Year:

Canadian Mental Health Association Durham

| AIM | | MEASURE | | | | CHANGE | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Quality dimension | Objective | Measure/Indicator | Current performance | Target for (year) | Target justification | Planned improvement initiatives (Change Ideas) | Methods | Process Measures | Goal for change ideas | Comments |
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*Strategic Objectives (SO)
Strategic Objective 1
Strategic Objective 2
Strategic Objective 3
Strategic Objective 4
Strategic Objective 5

| | |
|---|---|
| CORE | Core objectives are essential for high quality services. It is expected that, if applicable, all MHA organizations will adopt these objectives |
| OPTIONAL | Optional objectives are important, though not essential. |
| DEVELOPMENTAL | Developmental objectives need further discussion as it may be difficult to implement in a standardized manner across all MHA organizations |

## Appendix C—Organizational Risk Management Framework

Canadian Mental Health Association Durham

### Organizational Risk Management Framework

| Business Risk<br>Risk that may relate to the delivery of care that include external in internal factors impacting on the operations of the organization | Resource Risk<br>Risk that relates to the resources used by the organization to accomplish its mission | Compliance Risk<br>Risks that originate from the requirement to comply with a regulatory framework, polices, directives and legal agreements |
|---|---|---|
| **Quality Care & Client Safety**<br>Admission, Transfer & Discharge<br>Client Assessment<br>Care & Service Accessibility<br>Care/Service Plan<br>Informed Consent<br>Treatment & Procedures<br>Consults, Referrals and Information<br>Medication Management | **Human Resource Relations**<br>Human Resource Planning<br>Recruitment & Hiring<br>Competency & Staff Development<br>Performance Management<br>Compensation & Benefits<br>Labour Relations | **Environment, Health & Safety**<br>Environment Impact<br>Hazardous Material Management<br>Occupational Health & Safety<br>Infection Prevention and Control<br>AODA Accessibility |
| **Corporate Governance**<br>Strategic Goals & Objectives<br>Performance Measurement & Reporting<br>Culture & Ethics<br>Research<br>Community Partnerships & Alliances<br>Organizational Structure | **Human Resource Relations**<br>Funding Allocation<br>Planning & Budgeting<br>Financial Management & Reporting<br>Insurance<br>Fraud, Law Suits | **Legal & Regulatory**<br>By-Laws<br>Legislation & Regulations<br>Contracts & Agreements<br>Professional Licensing & Credentials |
| **Operations & Business Support**<br>Quality & Risk Management<br>Supply Chain Management<br>Facilities & Property Management<br>Health Information Management & Security<br>Communication<br>Emergency & Disaster Management | **Information, Systems & Technology**<br>Infrastructure<br>Access Control<br>Network Security<br>Data Integrity<br>User Support | **Policies**<br>Client Care Policies<br>Administrative/Governance Policies<br>Internal Guidelines<br>External Guidelines<br>Personnel Policies<br>Research & Ethics Framework & Guidelines |
| **Reputation & Public Image**<br>Public Relations<br>Media Relations<br>Client Relations<br>Government Relations | **Physical Assets**<br>Asset Management<br>Capital Construction<br>Equipment Acquisition & Maintenance<br>Equipment Obsolescence & Replacement | **Standards**<br>Accreditation<br>Professional Regulatory Bodies<br>Standards Committees<br>Informed Practice<br>Professional Council |

## Appendix D—Risk Impact Scale

Canadian Mental Health Association Durham

**Canadian Mental Health Association Durham**
**Risk Impact Scale**

| Category | 1-Negligible | 2-Minor | 3-Moderate | 4-Major | 5-Severe |
|---|---|---|---|---|---|
| Financial | Potential financial loss of < $10,000 | Potential financial loss of $10,000-$50,000 | Potential financial loss of $50,000-$200,000 | Potential financial loss of $200,000-$500,000 | Potential financial loss of $500,000+ |
| Human | Potential for minor injury requiring first aid treatment | Potential for injury or illness resulting in medical attention and several days off work | Potential for injury of illness resulting in short-term hospitalization | Potential serious long-term injury | Potential for death, permanent disability, or ill-health |
| Legal/Compliance | Minor internal dispute that can be remedied with external intervention | Potential for compliance, contractual or regulatory breaches with external implications | Confirmed compliance, contractual or regulatory breaches. Specific activated required to remedy the situation | Significant penalties and/or costs to remedy legal and/or compliance breaches | Severe penalties to company and/or staff |
| Operational | No noticeable impact on operational functions | Short-term disruptions to operational function | Significant disruptions to operational functions | Extended disruptions to operational functions | Collapse of operational functions |
| | No noticeable impact on supply chain | Short-term disruptions to supply chain | Significant disruptions to supply chain | Extended delays to supply chain | Total supply chain failure |
| | Minimal change to work conditions | Short-term increase in working hours | Sustained deterioration in working conditions | Long-term deterioration in working conditions resulting in increased sick leave and potential resignations | Unacceptable conditions resulting in workplace injuries/illness and resignations |
| Reputational | Adverse impact that can be remedied immediately | Adverse impact that is short term and reversible at minimal cost | Adverse impact with potential for significant damage | Impacts requiring long term remedial attention | Irreversible damage to band and reputation |
| Strategic/Market | Localised concern- no impact on long term viability | Detrimental to short-term profitability and/or strategic direction | Detrimental to mid-term profitability and/or strategic direction | Significant long-term impacts. Will require change to strategic direction and objectives | Business viability in question |

# Appendix E—Workplace Risk Assessment Form

## WORKPLACE RISK ASSESSMENT FORM

INSTRUCTIONS:

**STEP 1:** Complete columns A – H. Print clearly. Use additional forms if necessary. Refer to back of form for the instructions on completing columns C – G.

**STEP 2:** Determine the Control(s) for the risk.

**STEP 3:** Complete columns I – K. Refer to back of form for the instructions on completing columns I – K. Determine Follow-up/actions required. Columns L –N act as the Actions Plan.

Canadian Mental Health Association Durham

Department:_____

Completed by:_____

Date:_____

**Assess** **Control** **Response**

**Recognize**

| | | Risk Evaluation | | | | | Current Controls | | | | Risk Response | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | C | D | E | F | G | H | I | J | K | L | M | N |
| A – Work Process, Work Area or Job<br>List either a process, a work area or a job. Do your homework – look at history, reports, documentation, talk to employees, etc. | B – Potential Risk Description<br>Ask yourself – What could happen while doing this job? Ex. Fall, workplace illness, client behaviour, aggression, etc. Identify the potential risk. A risk is something with the potential to cause harm or injury. Consider all contributing factors (PEMEP): People, Equipment, Material, Environment and Process. | Exposure (1-6) | Occurrence (1-6) | Probability (A-E) | Consequences (1-5) | Risk Rating (H-M-L) | Identify things in place now which control, eliminate or reduce the exposure to the hazard – such as guards, procedures, checklists, training, signs, personal protective equipment, etc. | ADEQUACY OF CONTROLS (1-6) | CAPABILITY TO RESPOND (1-6) | Risk Priority Rating (1-4) | Follow-Up Actions | Date Completed | Status |
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Legend – Risk Assessment

**Columns C & D – Exposure & Occurrence**: Select the description (1-6) below that best matches the frequency of exposure and likelihood of occurrence for the risk.

| C. Frequency of exposure | D. Likelihood of occurrence |
|---|---|
| 1 – Continuous | 1 – Very likely (has happened/is expected) |
| 2 – Frequent | 2 – Likely (probable – it could happen) |
| 3 – Occasional (1 per week) | 3 – Rare (seldom, but possible) |
| 4 – Unusual (1 per month) | 4 – Very Rare (very seldom, but possible) |
| 5 – Rare (few per year) | 5 – Very Unlikely (slight possibility) |
| 6 – Very Rare (yearly or less) | 6 – Practically Impossible |

**Exposure (1 – 6) + Occurrence (1 – 6) = Probability (A – E)**

**Column E – Probability**: is the combination of likelihood of exposure and the likelihood of occurrence. Locate the number (1-6) down the left side of the chart that describes the likelihood of exposure of the risk. Locate the number that describes the likelihood of occurrence across the top of the chart. The box where they meet (A – E) is the probability rating.

| Likelihood of Exposure \ Occurrence of Likelihood | 1 | 2 | 3 | 4 | 5 | 6 |
|---|---|---|---|---|---|---|
| 1 | A | A | B | C | C | D |
| 2 | A | B | B | C | D | D |
| 3 | B | B | C | D | D | D |
| 4 | B | C | C | D | D | E |
| 5 | C | C | D | D | E | E |
| 6 | C | D | D | E | E | E |

**Column F – Determination of Risk**: is the combination of probability of an event and the potential consequences if it should occur (risk to people, property or environment. Select the description (A–E) below that best match the consequences if an incident should occur.

| E. Probability | F. Consequences |
|---|---|
| A – common or repeating | 1 – fatality or permanent disability, significant loss |
| B – known to occur or "has happened" | 2 – serious injury or illness with lost time or other loss |
| C – could occur or "I've heard of it happening" | 3 – moderate injury or illness with lost time or other loss |
| D – not likely to occur | 4 –minor injury or illness with lost time or other loss |
| E – practically impossible | 5 – no injury, illness, lost time or other loss |

**Probability + Consequences = Determination of Risk (1 – 25)**

| Consequences \ Probability | A | B | C | D | E |
|---|---|---|---|---|---|
| 1 | 1 | 2 | 4 | 7 | 11 |
| 2 | 3 | 5 | 8 | 12 | 16 |
| 3 | 6 | 9 | 13 | 17 | 20 |
| 4 | 10 | 14 | 18 | 21 | 23 |
| 5 | 15 | 19 | 22 | 24 | 25 |

**Column G – Risk Rating**: is the number where the Probability letter meets the consequences number on the chart above. The Risk Rating (H, M, L) helps determine the priority for determining controls.

| | |
|---|---|
| **HIGH = 1 – 6** H | Serious or significant risk – a high priority for immediate control or elimination |
| **MEDIUM = 7 – 15** M | Moderate risk – medium priority for controls as soon as possible |
| **LOW = 16 – 23** L | Minor risk – lower priority for controls |
| **RARE = 24 – 25** L | Insignificant risk – low priority for controls |

**Column I – Adequacy of Controls:** Helps to determine the level of adequacy of controls currently in place.

| | |
|---|---|
| 1 | Poor |
| 2 | Adequate |
| 3 | Pass |
| 4 | Strong |
| 5 | Very Strong |
| 6 | Bullet Proof |

**Column J & K – Capability to Respond & Risk Priority:** Determine the capability to respond with current controls in place in order to evaluate if current controls require revision(s). Select the level of capability from the table below and score against the Risk Priority (Column K).

| Capability | | Risk Priority Rating |
|---|---|---|
| High capability | 5 - 6 | 4 L |
| Medium | 4 - 5 | 3 L |
| Low | 2 - 3 | 2 L |
| Unable | 1 - 2 | 1 H |

## Appendix F—CQI Project Summary Report

The purpose of this report is to record a brief summary of quality improvement initiatives taken by individuals, programs and/or teams.

*Please forward a copy to: Quality Improvement and Risk Management Department*

**Name of Initiative:** _____ **Date Reporting:** _____

**Individuals Involved**_____

**PART A** ----------To be completed prior to implementing change----------

*Assess:*
**Statement of the Problem/Opportunity for Improvement:**

**When and How the Problem was Identified:**

*Plan:*
**List Corrective Actions/Options Being Considered:**

**List Best Practice(s) Implemented:**

**Desired Outcomes:**

**How Will You Evaluate the Outcome:**

**PART B** ---------- To be completed following evaluation ----------

*Implement*
**Solution(s) Implemented/Action(s) Taken:**

*Evaluate*
**Impact of the Change on the Client, Staff and/or Organization (include outcome measures):**

**Cost/Resources Used, if any:**

**Signature of Person Reporting:**_____
**Date:**_____