2019/20 Quality Improvement and Safety Plan

01/04/2019

AIM		Measure								Change				
Issue	Quality dimension	Measure/Indicator	Type	Unit / Population	Source / Period	Current performance	Target	Target justification	External Collaborators	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
M = Mandatory (all cells must be completed) P = Priority (complete ONLY the comments cell if you are not working on this indicator) C = custom (add any other indicators you are working on)														
Theme I: Timely and Efficient Transitions	**Efficient**	Number of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents.	P	Rate per 100 residents / LTC home residents	CIHI CCRS, CIHI NACRS / October 2017 – September 2018	17.34	13.00	The current blended average for community and veteran residents is 13.3, which includes short-stay and sub-acute beds. Introduction of 20-bed sub-acute unit for frail elderly MAY have a negative impact on performance in this area (unit opened end of Q1 2018). Significant practice changes introduced in 2015/16. Focus is on sustaining current performance and introducing strategic improvements as needed. It is anticipated that implementation of frailty-informed care across LTC units in 2019 will have a positive impact on performance in this area. Champlain LHIN average = 23.2 (Q3 2017/18 - Q2 2018/19).	Baycrest Health Sciences	1)Sustain hourly comfort care rounds by PSWs to assess pain, positioning, toileting needs, personal environment. Spread practice to Therapeutic Recreation & Creative Arts team.	1) Rounding logs reviewed by PSW Supervisors to determine if hourly rounds are documented by PSWs on all shifts. 2) Nursing leaders to validate PSW rounding practices through shadowing	1) % hourly rounds documented on rounding log 2) % of staff shadowed on day and evening shift that meet rounding expectations	90% compliance for both measures	MOHLTC Priority Indicator. Not a publicly reported indicator. Perley Rideau area for monitoring. Data quality remains a challenge for this area. The MOHLTC's formula is set out in such way that quarterly data is not aligned with annualized performance. Internal data is used for quality improvement purposes.
										2)Spread and sustain process and tools to support SeeMe frailty-informed care across long-stay units	Train staff and physicians and implement tools and approach on long-stay units. Champion model will be used to assist with spread	1) % of residents with completed frailty assessments 2) Number of registered staff champions trained	1) 100% of new admissions on implemented units with completed frailty assessment 2) >6 registered staff	
										3)Ongoing auditing and feedback on use of early reporting system in PCC, including registered staff compliance with follow-up expectations.	Specific plan to be developed by PSW Supervisors	To be developed	To be developed	
										4)Review of ED transfers by Nurse Practitioner to identify residents that could benefit from goals of care discussion. NP to speak to staff about early triggers for ED transfers.	Nurse Practitioner to complete a triage of residents that have been transferred to hospital and identify candidates for change in goals of care	% residents returning from hospital triaged by NP r/t changes in goals of care	100% of residents	
										5)Increase recognition of subtle changes in residents through the use of a gamified learning app (SOS) to prevent unnecessary emergency transfers (in partnership with Baycrest Health Sciences - CLRI)	Series of (20) case studies to be completed by RNs, RPNs, PSWs targeted to their scope of practice - measuring if appropriate actions taken and respondents confidence. Following case studies, staff complete 11 education modules on acute deterioration, and then re-do the initial case studies to identify if improvement occurred.	# of units implemented	6 units by March 31, 2020	
Theme II: Service Excellence	**Patient-centred**	Percentage of complaints received by a LTCH that were acknowledged to the individual who made a complaint within 10 business days.	P	% / LTC home residents	Local data collection / Most recent 12-month period	95	100.00	Timely acknowledgement and resolution of complaints is an LTCHA requirement. As such, complaints must be investigated and resolved within 10 days of receipt. If unable to resolve within 10 days, acknowledgement of complaint must be completed in writing within 10 days, outlining a date when resolution can be expected. Current performance reflects complaints/concerns received from February 1 - October 31, 2018.		1)Strengthen Resident and Family Relations Process, with a focus on the Home's feedback management process: Implement workflow management tool for following up on feedback, including consistent communication with family.	1) Implement workflow management tool (via Surge Learning)	% of Completion	100% completion	Workflow Management Tool will improve Home's ability to track actions taken following receipt of feedback from residents/families.
		Percentage of residents responding positively to: "I would recommend this site or organization to others." (InterRAI QoL)	P	% / LTC home residents	In house data, interRAI survey / April 2018 - March 2019	82.00	85.00	Based on international benchmarking data from the interRAI survey, the Home's performance still remains within the international benchmark range; however absolute performance has declined from 87% to 82%. Performance ranked #4 among peer organizations in the SQLI. The focus for 2019/20 is to maintain our consistently high performance in this area, while introducing strategic improvements as needed.	Seniors Quality Leap Initiative (SQLI)	1)Evaluate and grow the Resident and Family Advisor Program	1) Collaborate with the Friends and Family Council and Resident Councils to raise awareness and participation in the Advisor Program. 2) Sustain Family and/or Resident Advisors on QIP teams and working groups (if appropriate)	1) Number of formally trained resident and family advisors (cumulative) 2) Percentage of projects/initiatives with Family/Resident Advisor	1) 15 Advisors by Dec 31 2019 2) 100% of QIP teams include Family and/or Resident Advisors by Dec 31 2019	
										2)Focus on "caring staff" domain of interRAI QoL survey	Collaborate with SQLI on this work. Change ideas could link closely with Joy in Work/Burnout work.	To be identified through SQLI work	To be identified through SQLI work	

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		Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences".	P	% / LTC home residents	In house data, interRAI survey / April 2018 - March 2019	71.00	85.00	Based on international benchmarking data from the interRAI survey, the Home's performance currently sits within the international benchmark range. Performance in this area has declined from 85% to 71%, and Perley Rideau is currently ranked #7 among peer organizations in the Seniors Quality Leap Initiative (SQLI). The deviation of our performance from previous years may be attributable to the sampling methodology for this survey. In 2018, the Perley Rideau focused on surveying a new demographic in the Home "modern veteran" residents, as part of the evaluation of the new program. This population accounted for 17% of all respondents, with the CPS level of these residents differing from the usual population surveyed (CPS 2-3 vs CPS 0-1). The focus for 2019/20 is to introduce strategic improvements as needed.		1)Strengthen Resident and Family Relations Process, with a focus on the Home's feedback management process: - Implement workflow management tool for following up on feedback, including consistent communication with family. - Implement process to bring feedback stories to Board (QLS) - Develop and implement new communication materials (Here to Help Document)	1) Implement workflow management tool (via Surge Learning) 2) New communication material contains key individuals and their function in the team. Under development and will be distributed through the admission office and administrative assists.	% of Work Completion	100% completed by March 31, 2019	Workflow Management Tool will improve Home's ability to track actions taken following receipt of feedback from residents/families.
										2)Continue to support Excellence in Resident-Centred Care (ERCC) training for PSWs (full-day training).	Received funding to support additional training through Conestoga College grant.	1) Additional trainers trained 2) Additional staff trained in ERCC	1) 4 new trainers 2) 80 PSWs trained	MOHLTC Priority Indicator Perley Rideau area for moderate action
Theme III: Safe and Effective Care	**Effective**	Proportion of long-term care home residents with a progressive, life-threatening illness who have had their palliative care needs identified early through a comprehensive and holistic assessment.	P	Proportion / at-risk cohort	Local data collection / Most recent 6-month period	CB				1)Implement "End-of-life care during last days and hours" best practice guidelines from RNAO	Complete gap analysis against BPG and identify priorities for improvement	Completion status	Gap analysis completed and priorities for improvement identified by September 30, 2019	
		Percentage of Residents whose Pain Worsened	C	% / Residents	CIHI CCRS / July - September 2018	19	17.50	Changes in practice aligned with BPG on Pain Management largely implemented in 2018. Goal for 2019 and beyond is to sustain changes. Achieving metric improvement in this area has been difficult as the majority of residents captured here alternate between no pain and less than daily pain (Pain scale of 0 and 1, respectively). This appears to be caused by inconsistencies in how pain is captured in residents' health records, and is currently being addressed. Interestingly, these same residents don't trigger the "Has Pain" QI indicator, and are very hard to eliminate completely due to the over-sensitivity of this particular indicator. Current performance reflects the blended average of veteran and community residents. NOTES: Provincial average = 10.4% (Q2 2018).		1)Ongoing monitoring of PRN usage and education related to appropriate usage	Through monthly High Risk Resident report, identify cases which the use of pain PRN can be improved. Provide in-time education as needed.	Number of months for any unit that has no inappropriate PRN usage cited.	3 months	Not included in MOHLTC Priority Indicator List. Publicly reported indicator (CIHI Your Health System; HQO Long Term Care Performance) Perley Rideau area for focused action (high priority) Aligns with full implementation of RNAO Best Practice Guideline. A sustained decrease in the indicator "percentage of residents who have pain" has been observed. New process for pain monitoring may have a temporary negative impact on our performance, it is anticipated to be resolved once the new process is sustained. The team will use this indicator to support decision making as well.

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										2)Sustain pain screening process at admission	Monthly chart review in PCC to determine use of screening tool.	% of residents that have documented pain assessment/screening at admission within 24 hours	80% compliance	
										3)Implement and sustain process to enable consistent care planning for pain (e.g. Pain RAP)	Redesign the process of assessing and care planning for pain on admission. Implement suggested design from frontline staff and resident/family	% of implementation completed	100%	
										4)Implement, spread and sustain structured pain monitoring practices (Pain Monitoring during RAI look back period) to better evaluate resident pain management plan.	Pain QI team to lead implementation of pain monitoring process to identify patterns, triggers and effective pain management strategies for high risk residents.	% of Pain Monitoring completed during RAI look back periods	100% on all Veteran Units by March 31st, 2019	
										5)Implement BPG recommendations focused on monitoring opioids risk	Pain QI team to prioritize recommendations and implement as appropriate	Timely implementation of select recommendations	Select practices implemented on all 12 units by December 31, 2019	
										6)Sustain hourly comfort care rounds by PSWs to assess pain, positioning, toileting needs, personal environment. Spread practice to Therapeutic Recreation & Creative Arts team.	1) Rounding logs reviewed by PSW Supervisors to determine if hourly rounds are documented by PSWs on all shifts. 2) Nursing leaders to validate PSW rounding practices through shadowing	1) % hourly rounds documented on rounding log 2) % of staff shadowed on day and evening shift that meet rounding expectations	90% compliance for both measures	
	Safe	Culture of Safety	C	N/A	N/A			Capacity Building		1)Continue to strengthen education on Just Culture, promoting open communication	Performance Improvement Consultant to lead the implementation of identified actions. Evaluation of success to be completed together with staff engagement survey 2019.	1) Education on Just Culture 2) Include Just Culture category as part of the Root Cause Analysis action planning process 3) Staff familiarity with Just Culture through survey	1) Number of education provided to different groups according to plan 2) Number of Root Cause Analysis discussed the category of incident under Just Culture 3) TBD	Perley Rideau area for moderate action Aligns with Accreditation Canada expectations
										2)Continue to participate in CPSI Patient Safety Week	Continue the practice of Annual Safety Week for the fourth year. Improve participation of staff in the activities.	To be determined	To be determined	
		Infection Prevention and Control Program	C	N/A	N/A			Focus of the work in this area is to strengthen/further develop existing program/infrastructure to minimize risk to residents related to infections.	Public Health Ottawa	1)Sustain hand hygiene audit program	Progress to be monitored by Manager, Infection Control and IPAC committee.	1) Number of hand hygiene observations conducted monthly 2) Hand hygiene compliance rates	1) 450 observations per month 2) 80% compliance	
										2)Continue with target to reach all staff for respiratory protection program (RPP)	All "high risk" staff tested every 2 years. "Low risk" staff tested ad hoc.	% of high risk staff tested	80% or more high risk staff tested by March 31, 2020	High risk = direct care providers and support services. Low risk = all other staff. 499 staff tested since Jan 1 2018.
										3)Introduce antimicrobial stewardship (Urinary Tract Infection project with Public Health Ottawa)	Specific improvement plan and goals to be developed by Manager, IPAC and IPAC Analyst	TBD based on identified plan	TBD based on identified plan	
		Number of reported medication errors	C	Count / Residents	MEDeReport [Medical Pharmacies Client Resources] / Sept - Dec 2018	78	50.00	Focus of the work in this area is to strengthen/further develop existing program/infrastructure to minimize risk to residents related to medication administration.		1)Ongoing review of medication error data	Leverage data to make improvements to medication management policy and practice	Initiative dependent	Initiative dependent	
										2)Other initiatives as identified (and prioritized) by ISMP assessment, with continued focus on education.	Medication Management team to complete annual ISMP assessment and prioritize results	Initiative dependent	Initiative dependent	Bar-coding continues to be biggest gap; however, current pharmacy provider unable to support the technology to enable this

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		Number of staff to resident abuse/neglect incidents reported to the MOHLTC through CIS System	C	Number / Residents	Ministry of Health Portal / Jan - Dec 2018	9	0	Resident abuse and neglect (verbal, physical, sexual, financial) is identified as a "never event" at the Perley Rideau, as such, the Home will continuously work towards a goal of 0. Perley Rideau acknowledges the largest contributor to resident abuse is physically responsive behaviours by co-residents. This issue is addressed under the "Reduce Responsive Behaviours" objective in the QIP.		1)Targeted organizational improvements, including policy review, enhanced education and awareness (abuse, reporting and whistle-blowing)	1) Develop and deliver updated education/awareness material (possibly in partnership with Elder Abuse Ontario) 2) Review and update Abuse policy	1a) Education status (for PSWs) 1b) Status of new training video 2) Status of policy review	1a) Education with PSWs completed by September 30, 2019. >200 PSWs quizzed. 1b) New educational video available on Surge by December 31, 2019 2) Policy review completed by March 31, 2019	Leverage BPG on Preventing and Addressing Abuse and Neglect of Older Adults
										2)Focus on promoting teamwork through structured shift report. Focus groups led the team to learn that teamwork is the main contributor and antidote for burnout. Working on structured shift report to ensure that key discussions are happening to promote better team work.	Leverage IHI Framework for Improving Joy in Work, PDSA and subject expert inputs	Implementation and spread of the structured shift report	RN shift report changes implemented across the Home by December 31, 2019.	
		Percentage of residents on antipsychotics without a diagnosis of psychosis	C	% / Residents	CIHI CCRS / July - September 2018	17.4	15.00	Although still performing better than provincial average, facility has seen a deterioration in performance attributable to a change in coding practice that had resulted in fewer residents coded as end-stage disease in the RAI-MDS. A new process to address this issue was introduced Q2 2018, however, metric improvement not yet evident. The facility continues to work with on-site Pharmacy on a process to improve documentation of diagnosis to support prescribing of antipsychotics. NOTES: Current performance reflects the blended average of veteran and community residents. Provincial average = 19.5% (Q2 2018).	Canadian Foundation for Healthcare Improvement (CFHI), Seniors Quality Leap Initiative (SQLI)	1)Continue with Appropriate Use of Antipsychotics (AUA) pilot on G1N	Participation in CFHI-SQLI Antipsychotic Deprescribing Collaborative (started January 2018)	1) % of deprescribing candidates from pilot unit that have AP dose decrease 2) overall decrease in antipsychotic load for deprescribing candidates	1) 70% by December 31, 2019 2) 50% decrease in overall antipsychotic load by December 31, 2019	Not included in MOHLTC Priority Indicator List. Publicly reported indicator (CIHI Your Health System; HQO Long Term Care Performance) Perley Rideau area for moderate action
		Percentage of residents who developed a stage 2 to 4 pressure ulcer or had a pressure ulcer that worsened to a stage 2, 3 or 4	C	% / Residents	CIHI CCRS / July - September 2018	3.9	3.00	Implementation of BPG related to the prevention of pressure injuries has been completed, supported by in-depth education and training for registered staff. Recent improvement in performance (4 consecutive data points all decreasing) combined with statistical evidence of improvement (2 data points below the lower control chart limit in Q1/Q2 2018) suggests the data is catching up to the changes introduced. Targeted improvements will continue throughout 2019/20 to further improve in this area. NOTES: Current performance reflects the blended average of veteran and community residents. Provincial Average = 3.5% (Q2 2018).		1)Sustain practice changes implemented in 2017/18 related to prevention of pressure injuries	Team to conduct chart reviews to evaluate compliance with key practice changes	% of residents with wounds reviewed for accuracy of documentation and assessment, just in time coaching and mentoring provided to staff	100%	Not included in MOHLTC Priority Indicator List. Publicly reported indicator (CIHI Your Health System; HQO Long Term Care Performance) Perley Rideau area for focused action (high priority) Aligns with full implementation of RNAO Best Practice Guideline
										2)Begin implementation of best practice guideline related to the treatment of pressure injuries	Conduct gap analysis to identify opportunities for improvement	To be determined based on identified priorities	To be determined based on identified priorities	
										3)Sustain hourly comfort care rounds by PSWs to assess pain, positioning, toileting needs, personal environment. Spread practice to Therapeutic Recreation & Creative Arts team.	1) Rounding logs reviewed by PSW Supervisors to determine if hourly rounds are documented by PSWs on all shifts. 2) Nursing leaders to validate PSW rounding practices through shadowing	1) % hourly rounds documented on rounding log 2) % of staff shadowed on day and evening shift that meet rounding expectations	90% compliance for both measures	
										4)Grow and sustain wound champion network	Wounds, Continence and Ostomy Nurse highlights issues observed and teaches; asks champions to raise issues they have seen and provides JIT education to champions who spread the education to their units.	Number of Wound Rounds for Champions Held	8 Wound Rounds for Champions held on days and evenings	
										5)Conduct mini root cause analysis for all new pressure injuries	Mini RCAs led by wound/continence/ostomy nurse	% of new pressure injuries with a completed mini-RCA	100%	
										6)Continue focused wound care education for registered staff	Learning Needs Assessment being completed to further identify potential knowledge gap	% of staff who have completed targeted education	100%	

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		Percentage of residents who fell in the past 30 days	C	% / Residents	CIHI CCRS / July - September 2018	20.2	19.50	Significant work completed in this area from 2016 through mid 2018, with the Home completely implementing the Preventing Falls and Reducing Injury from Falls Best Practice Guidelines. Statistical improvement evident (3 points near lower control limit from Q4 2016 - Q2 2017), with performance consistently under the centreline. Performance appears to be stable at this time. Additionally, injury rates from falls suggests that changes implemented have been successful in minimizing the risk of severe injury from falls, with over 90% resulting in no reported injury, and approximately 8% resulting in minor injuries (skin tears, bruises, lacerations). Focus for 2019/20 will remain on sustaining changes and performance. No new interventions planned at this time. NOTES: Current performance reflects the blended average of veteran and community residents. Provincial Average = 15.8% (Q2 2018).		1)Sustain changes implemented in 2016 & 2017	Falls QI Team to conduct random audits related to fall prevention process and just-in-time teaching	# of audits completed	TBD based on audits every second month	Not included in MOHLTC Priority Indicator List. Publicly reported indicator (CIHI Your Health System; HQO Long Term Care Performance) Perley Rideau area for continued monitoring Aligns with full implementation of RNAO Best Practice Guideline.
										2)Sustain hourly comfort care rounds by PSWs to assess pain, positioning, toileting needs, personal environment. Spread practice to Therapeutic Recreation & Creative Arts team.	1) Rounding logs reviewed by PSW Supervisors to determine if hourly rounds are documented by PSWs on all shifts. 2) Nursing leaders to validate PSW rounding practices through shadowing	1) % hourly rounds documented on rounding log 2) % of staff shadowed on day and evening shift that meet rounding expectations	90% compliance for both measures	
		Percentage of residents who were physically restrained (daily)	C	% / Residents	CIHI CCRS / July - September 2018	11.7	6.40	The Home had achieved significant improvement in this area as a result of changes implemented in 2012/13, with average restraint use improving over time from 19.7% to 6.4% (period ending Q4 2016). The Home has recently seen a statistical decline in performance (6 consecutive points increasing from Q1 2017 - Q2 2018). Significant corrective action implemented Q3 & Q4 2018, with internal data indicating a current restraint rate closer to 5%. Target of 6.4% identifiedfor 2019/20 in recognition of the 3 month delay in publicly reported data and "4-quarter rolling average" methodology. No focused activity expected in 2019/20, however, the home will closely monitor compliance with recently implemented changes to promote sustainability. NOTES: Current performance reflects the blended average of veteran and community residents. Provincial average = 4.6% (Q2 2018)		1)Managers informed when new restraints recommended by OT	Managers to conduct monthly review of new restraints at high risk meetings to discuss need, appropriateness and effectiveness	% of new restraints discussed at high risk meetings	100% of new restraints discussed as of April 1, 2019	Not included in MOHLTC Priority Indicator List. Publicly reported indicator (CIHI Your Health System; HQO Long Term Care Performance) Perley Rideau area for continued monitoring
										2)Audit and feedback related to new Positioning Device assessment and care planning	All completed assessments audited for completion and accuracy for Jan-June 30, 2019. Sample size to decrease as accuracy increases	% of audited assessments completed without error	80% by December 31, 2019	
										3)Sustain hourly comfort care rounds by PSWs to assess pain, positioning, toileting needs, personal environment. Spread practice to Therapeutic Recreation & Creative Arts team.	1) Rounding logs reviewed by PSW Supervisors to determine if hourly rounds are documented by PSWs on all shifts. 2) Nursing leaders to validate PSW rounding practices through shadowing	1) % hourly rounds documented on rounding log 2) % of staff shadowed on day and evening shift that meet rounding expectations	90% compliance for both measures	

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		Percentage of residents whose behavioural symptoms worsened	C	% / Residents	CIHI CCRS / July - September 2018	20.3	19.00	The Home has implemented a number of key practice changes and training initiatives since 2016/2017 including Behaviour Mapping, MMSE, ABC meetings, high risk meetings. Metric improvement has not been observed to date due to the complexity of responsive behaviour management; however practice changes have prevented a decline in performance, with performance remaining stable since 2016. Facility-wide metric improvement moving forward will likely be confounded by the introduction of a 20-bed Specialized Behavioural Support Unit (Q2 2018). Focus in 2019/20 will be to sustain the practice changes introduced from 2016 through March 2019. NOTES: Current performance reflects the blended average of veteran and community residents. Provincial Average = 13.1% (Q2 2018).		1)Sustain structured assessment and screening tools e.g. Behaviour Mapping (DOS); MMSE	3Ds team to audit completed Behaviour Mapping to identify opportunities for improvement. 3Ds team to collect compliance data for MMSE completion and audit for accuracy in scoring	1) % of Behaviour Mapping with no issues identified 2) compliance with MMSE within 14 days of admission	1) 80% 2) 100% by December 31, 2019 2) 80% MMSE scoring accuracy	Not included in MOHLTC Priority Indicator List. Not a publicly reported indicator. Perley Rideau area for focused action (high priority) Aligns with full implementation of RNAO Best Practice Guideline. This work will also align with frailty-informed care
										2)Sustain and evaluate high risk meetings	Manager of Resident Care (Gatineau Building), in collaboration with 3Ds QI team, to develop and implement evaluation plan	1) compliance of monthly high risk meetings across the home 2) completion of evaluation re: effectiveness of meetings	1) 100% compliance on all units 2) evaluation completed by September 30, 2019	
										3)Spread and sustain structured assessment and screening tools, e.g. ABC Huddles following high risk incidents	3Ds team to review Risk Management reports to confirm compliance with ABC Huddle process	1) ABC Huddle implementation status 2) Compliance with ABC Huddle process	1) 100% implementation by March 31, 2019 2) 80% compliance for residents with high risk behaviour by December 31, 2019	
										4)Spread and sustain process for the monitoring and evaluating antipsychotic medications	Chart review to determine compliance with process.	1) implementation status 2) compliance with AP monitoring criteria	1) 100% implementation by March 31, 2019 2) 80% by December 31, 2019	
		QI Capacity	C	N/A	N/A			Capacity Building		1)Continue to train and educate leaders and front line staff in quality improvement through internal and external programs. Leverage existing external program (IDEAS, etc.) and incorporate QI training into internal educational opportunities (LDIs).	Focus efforts on QI training for staff involved in QIP teams. Senior Leaders to continue identifying front line staff, supervisors and managers to attend external QI educational opportunities.	1) QI content delivered at Leadership Development Institutes in 2019. 2) QI content delivered at QIP team training sessions 3) Number of front line staff/supervisors attending external QI educational opportunity	1) QI education provided at =1 Leadership Development Institute(s) in 2019 2) =10 3) >10	Not included in MOHLTC Priority Indicator List Perley Rideau area for moderate action
										2)Plan and implement changes to RAI MDS process	RAI Coordinator, Mgr. - QI and RAI, and team to implement enhancements to PCC (as required); documentation practices; RAI and care planning process; analysis and decision support activities	1)% of care plans reviewed and locked by care team on time 2) Decision support measures TBD following development of plan	1) 90% care plans reviewed and locked by care team ON TIME by December 31, 2019 2) TBD	
										3)Continue with RNAO Best Practice Spotlight Organization activities	Through BPSO Liaison and Champion, continue implementation of Best Practice Guidelines and supporting activities to build quality capacity with staff working at the point of care.	Contract deliverables to be achieved annually	100% of contract deliverables to be completed on time	
										4)Implement the "Developing & Sustaining Nursing Leadership" best practice guideline by RNAO	Complete gap analysis against BPG and identify priorities for improvement. Offer nursing leadership workshops throughout the year.	1) gap analysis completion 2) # of nursing leadership workshops held	1) Gap analysis completed and priorities for improvement identified by September 30, 2019 2) 3 workshops held by December 31, 2019	