2024/25 Quality Improvement and Safety Plan - FINAL

2024-04-01

QUALITY FRAMEWORK		Measure						Change				
Pillar	Aim	Measure/Indicator	Unit / Population	Source / Period	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
Priorities for FOCUSED ACTION												
Better Provider Experience	**Embody a "People First" Philosophy**	First-year retention	Rate	In-house data, 2023	74%	75%	Short term goal for this indicator is to maintain current performance. Long term target will be development following deeper analysis of key opportunities, improvement benchmarks, etc.	Develop and implement Diversity, Equity and Inclusion (DEI) Plan	Development of multi-year DEI plan pending review and engagement of DEI survey results (survey closed fall 2023, results to be available Jan 2024)	1) Plan development 2) Implementation status 3) # of DEI education/training opportunities available to staff (front line, leadership)	1) Plan developed by June 30, 2024 2) Implementation of year 1 initiatives underway starting July 2024 3) TBC based on DEI survey results, development of Corporate Education Plan	**DEI education was identified as an LTC QIP Priority for 2024/25.** Work in this area aligns multiple streams of work, e.g. Accreditation Canada standards/ROPs, Perley Health focus on staff health and wellbeing (MFI), psychological health and safety, Psychologically Safe Leaders, Employee Engagement
		Percentage of staff who responded positively to "I feel safe to provide feedback".	% staff	In-house data, Employment Engagement Survey, 2023	63%	67%	As identified in Quality Framework, long-term goal is to maximize experience score, with desired target of 80% or above. Initial performance target identified as a 5% increase by 2025 (from 60% in 2019 to 63%).	Implement "Connecting Sessions" across leadership team	QI project focused on improving the current practice of leader rounding.	1) Implementation status 2) % of leaders with annual goal in Cascade related to Connecting Sessions	1) Launched by March 31, 2024 2) 100% of leaders have an established goal for Connecting Sessions	
		Overall Employment Engagement Score	Overall score	In-house data, Employment Engagement Survey, 2023	80%	84%	As identified in Quality Framework, long-term goal is to maximize employee engagement score, with desired target of 80% or above. Initial performance target identified as a 5% increase by 2025 (from 75% in 2019 to 79%).	Follow-up on 2023 Employee Engagement survey results	TBD - actioning Employee Engagement Survey results	TBD	TBD	

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Better Experience of Care	**Achieve >90% in resident/ family experience scores**	Percentage of residents who responded positively to "I participate in meaningful activities". Percentage of family members who responded positively to "My family member participated in meaningful activities in the past week"	% / Residents	In-house data, interRAI Resident survey; interRAI Family survey / January 1 - December 31 2023	47% resident; 45% family	49%; 47%	As identified in Quality Framework, long-term goal is to maximize experience score, with desired target of 90% overall positive experience scores. These indicators were new additions to the QIP in 2023/24. Short-term targets of 5% increase year-to-year have been identified.	1- Introduce activity calendar changes including addition of new trivia program (pending results of current PDSAs). 2-Explore feasibility of posting activity calendars online and on TVs in unit dining rooms. 3- Ongoing consultation of Community and Veteran Resident Councils regarding new programming ideas.	Work to be guided by the Resident-Focused QI team.	1) Status of PDSAs for activity calendar changes and new trivia programming	1) PDSAs to be completed January 30, 2024	
								Facility-wide roll-out of the revised tools and processes for the "All About Me" tool, tailored towards social engagement.	Work to be guided by the Family-Focused QI team. PDSAs currently underway.	1) Implementation of new process on one unit (TBC) 2) Facility-wide roll-out	1) Implementation on first unit completed by May 31, 2024 2) Completed by December 31, 2024	
								Explore expanding availability of "Magic Tables" across the facility	Initial discussions with key stakeholders have been held to identify priority locations for new devices. Some procurement support is available from CABHI D+A program.	1) # of additional devices installed	1) 2-3 devices installed by March 31, 2025	
		Percentage of residents who responded positively to "I enjoy meal times"	% / Residents	In-house data, interRAI survey / January 1 - December 31 2023	53%	56%	As identified in Quality Framework, long-term goal is to maximize experience score, with desired target of 90% overall positive experience scores. This is a new indicator to the QIP (added in 2023/24). Short-term target of 5% increase year-to-year has been identified.	Implement daily table rotation for meal service using unit calendar - to allow for different tables to be served first on a rotational basis	Work to be led by Dining Experience QI Team (includes resident, family and staff membership). R2N has been identified as the initial PDSA unit - pending results of PDSAs, change ideas will be modified and implemented step-wise across the facility starting in Rideau building.	1) Status of PDSA on R2N 2) Roll-out through Rideau building 3) Roll-out across facility	1) Completed Feb 29, 2024 2) Started by end of April 2024 3) Completed by December 31, 2024	
								Implement use of resident census sheet to take meal orders		1) Status of PDSA on R2N 2) Roll-out through Rideau building 3) Roll-out across facility	1) Completed Feb 29, 2024 2) Started by end of April 2024 3) Completed by December 31, 2024	
								Refresh dining room decor		1) TBD pending availability of funds	1)TBD	
Better Experience of Care	**Achieve >90% in resident/ family**	Percentage of family members that responded positively to Communication or	% / Family members	In-house data, interRAI survey /	TBC	TBC	New area of focus for QIP in 2024/25. Specific indicator to be confirmed following engagement with key	1) Implement Resident and Family Centred Care (RFCC) Best Practice Guidelines (BPG)	This work will be leveraging the RNAO's RFCC BPG	1) status of work	1) Implemented facility-wide by March 31, 2025	This work links to the Caring Staff domain of the Resident QOL

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	experience scores	Engagement Domains		January 1 - December 31 2023			stakeholders in Q2/Q3 2024.	2) Identify and implement specific strategies to enhance interpersonal communication with families e.g. post-admission check-ins, modifications to care conferences, supportive education for staff etc.	Specific interventions to be identified and developed in collaboration with families	1) status of implementation 2) status of education	1) Key initiatives implemented by December 31, 2024 2) pending finalization of 2024 Corporate Education Plan	survey
								3) Develop (explore developing) a resident and family ambassador program	Key areas of support could include - support at admission and beyond (for residents and families), meaningful activities/friendships, All About Me process, helping to understand certain aspects of LTC	1) Program development status	1) Target to have first phases of program developed by December 31, 2024	
								4)Continue to leverage the Resident and Family Advisor Program	Sustain Family and/or Resident Advisors on QIP teams and working groups (if appropriate)	Percentage of active QI teams with Family/Resident Advisor	100% of QIP teams include Family and/or Resident Advisors by Dec 31, 2024	
Better Experience of Care	**Achieve >90% in resident/ family experience scores**	Percentage of residents that responded positively to "This place feels like home to me"	% / Residents	In-house data, interRAI survey / January 1 - December 31 2023	41%	43%	As identified in Quality Framework, long-term goal is to maximize experience score, with desired target of 90% overall positive experience scores. This is a new indicator for QIP in 2024/25. Short-term target of 5% increase year-to-year has been identified. Unlikely to see movement in this fiscal year, as progress will be limited to research and analysis.	1) Engage residents to understand key drivers for this issue	Specific methods to be determined e.g. focus groups, 1:1 interviews with trained facilitators, etc. This could also include reviewing literature (existing models)	1) Status of work	1) To have initial collection of data by December 31, 2024	Some of this work may link to Family Survey question "There are comfortable places to visit with my family member here"
Priorities for MODERATE ACTION												

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Better Experience of Care	**Provide "right" care 100% of the time**	Percentage of Residents who Experienced Pain	% / Residents	CIHI CCRS / July - September 2023	10.9	10.4	2023/24 target (11%) achieved, with performance remaining stable. Changes in practice aligned with BPG on Pain Management largely implemented in 2018. NOTES: Provincial average = 3.8% (Q2 2023); however, the literature suggests proportion of LTC residents with some level of pain is around 40-80%.	1)Enhance existing pain documentation practices (including evaluation of current pain assessment tools, standardizing MDS coding based on numerical pain scales, care planning approach, etc.)	This work will be led by Pain QI team	1) Status of workplan	1) Implementation completed by December 31, 2024	Publicly reported indicator (CIHI Your Health System; HQO Long Term Care Performance) Aligns with full implementation of RNAO Best Practice Guideline.
								2)Trial technological solution for assessing pain in residents with cognitive and communication impairments (PainChek)	In partnership with CABHI D+A program. Work to be supported by Pain QI Team and Clinical Quality Lead	1) Status of workplan	1) Trial underway in Gatineau building by June 30, 2024	
								3)Introduce SOPs when residents have MDS Pain Scale scores of >=2	Work to be led by Clinical Quality Lead, in collaboration with Pain QI Team and MDs	1) Status of workplan	1) Process developed and implemented by June 30, 2024	
Better Experience of Care	**Provide "right" care 100% of the time**	Percentage of residents that die at Perley Health that have a "meaningful death" (to the resident)	% / Residents	Local data collection (PCC)/	TBC	100%	Palliative Care QI team to identify appropriate indicators (outcome/process) to measure this priority	1)Enhanced Palliative and End-of-life education for the interprofessional team	Education developed by in-house SMEs (including Psychogeriatric and Palliative RN, Spiritual Care Practitioner, Manager Education & KT). To be introduced in revamped Corporate Orientation Day	1) New education embedded in corporate orientation 2) Plan for providing education to existing staff (in-person)	1) Completed April 1, 2024 2) Plan developed and underway in 2024.	
								2)Introduce and sustain process for revamped Comfort Care Carts (6) and Chairs (2)	Waiting for (4) additional chairs.	1) Status of workplan	1) Process finalized by March 31, 2024	
								3) Develop and implement EOL rituals (e.g. symbol for resident door, in dining room, unit recognition) - pending consent from resident/POA re: disclosure	Initial phase of work to focus on raising awareness, building informal processes. Future phases to include re-introduction of "angel walks" etc. Engagement with Resident Councils.	1) Status of workplan	1) Initial prototypes for discussion at Resident Councils by March 31, 2024 2) Implementation of symbols, consents by June 30, 2024	

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								4) Enhance care planning r/t EOL - focus on "dignity"	Planning for this work to begin in January 2024. Workplan tbd	TBD pending initial work of group	TBD pending initial work of group	
								5) Implement care conference enhancements (agenda, goals of care tool, role clarity for physicians/nurses) and education.	Work to be done in collaboration with physicians	1) status of workplan	1) implemented by December 2024	
Better Experience of Care	**Provide "right" care 100% of the time**	Percentage of residents on antipsychotics without a diagnosis of psychosis	% / Residents	CIHI CCRS / July - September 2023	26.4	25	2023/24 target not achieved; provincial average @ 20.6 Q2 2023. Short-term target is 5% decrease year-over-year. Long-term target is to remain consistently at or below 20% (aligned with prov average and our historic baseline). Background info: In early 2018, facility opened a 20-bed Specialized Behavioural Support Unit (SBSU), a short-term unit for residents with high risk behaviours. Opening of SBSU resulted in the introduction of a high antipsychotic user group, accounting for ~25% increase in QI indicator.	1)Develop and introduce a SOP for deprescribing aligned with best practice.	This work to be led by Clinical Quality Lead in collaboration with MDs, Pharmacy Committee and 3Ds team	1) implementation status	1) Process developed and implemented by June 30, 2024	**Identified as an LTC QIP Priority for 2024/25.** Publicly reported indicator (CIHI Your Health system).
Better Experience of Care	**Provide "right" care 100% of the time**	Percentage of Residents Whose Mood From Symptoms of Depression Worsened	% / Residents	CIHI CCRS / July - September 2023	29.7	28	2023/24 target (31.5%) was achieved. Provincial average = 20.6% (Q2 2023). Target is 5% decrease year-to-year. Long-term target to be at or better than provincial average.	1) Implement evidence-based clinical assessment tool (PHQ-9) and supporting process to support more consistent screening of depression	Tool was selected and tested in 2023. 3Ds team currently developing implementation plan to support roll-out across the facility.	1) status of implementation plan	1) Facility-wide roll-out by December 31, 2024	This work is aligned with implementation of 3Ds best practice guidelines

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								2) Introduce evidence based Suicide Risk Assessment tool and improved process	Evaluation to be completed by members of the 3Ds QI Team. Perley Health has identified GSIS as the preferred tool and through COE will be participating in a research study to evaluate a short version of the tool designed for LTC	1) status of work (dependent on research study workplan)	1) tbd pending research ethics approval	