2025/26 Quality Improvement and Safety Plan - Approved

2025-04-01

Perley Health
Community of Care

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**	Overall Employment Engagement Score	Overall score	In-house data, Employment Engagement Survey, 2024	80%	>80%	As identified in Quality Framework (2020-2025), long-term improvement goal is to maximize staff experience scores, with target threshold of 80% or above. Initial performance target identified as a 5% increase from baseline by 2025 (from 75% in 2019 to 79% in 2025). This target was met (and exceeded) in 2023 and 2024. Current goal is to maintain current performance level.	Follow-up on 2024 Employee Engagement survey results.	Workplan developed following stakeholder engagement of results.	1) Status of workplan development	1) Priorities developed in consultation with staff by end of April 2025	Work in this area aligns multiple streams of work, e.g. Accreditation Canada standards/ROP, Perley Health focus on staff health and wellbeing, psychological health and safety. Improvements in this area help support ongoing focus on recruitment and retention.
		Percentage of staff who responded positively to "I feel safe to provide feedback".	% staff	In-house data, Employment Engagement Survey, 2024	66%	69%	As identified in Quality Framework (2020-2025), long-term improvement goal is to maximize staff experience scores, with target threshold of 80% or above. Initial performance target identified as a 5% increase from baseline by 2025 (from 60% in 2019 to 63% in 2025). This target was met (and exceeded) in 2023 and 2024. A 5% annual improvement over current performance will continue to be applied until long-term goal is met and maintained.	Evaluate and sustain "Connecting Sessions" across leadership team	QI project focused on improving the current practice of leader rounding.	1) % of leaders with direct/indirect care staff (i.e. those providing care and/or service to residents) with an annual goal in Cascade related to Connecting Sessions. Note: this definition includes nursing, allied, TRCA, support services staff.	1) 100% of applicable leaders have an established goal for Connecting Sessions	

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		Percentage of staff that have completed relevant equity, diversity, inclusion and antiracism education.	% staff	In-house data, 2024	Collecting Baseline	Collecting Baseline	This is a new indicator for 2025/26 QIP aligned with provincial LTC QIP priorities	Continue to implement Diversity, Equity and Inclusion (DEI) Plan	Development of multi-year DEI plan has been informed by results and subsequent stakeholder engagement of Diversity Meter survey results. This is a multi-year plan, which includes education/awareness initiatives.	1) Implementation status of DEI plan 2) # of DEI education/training opportunities available to staff (front line, leadership)	1) Implementation of year 2 initiatives completed by December 31 2025 2) TBC - pending finalization of 2025 corporate education plan	**DEI education has been identified as an LTC QIP Priority for 2025/26.** Aligned with other activities under the People First strategy, work in this area help support ongoing recruitment and retention focus.
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 2024	47% resident; 51% family	49%; 53%	As identified in Quality Framework (2020-2025), long-term improvement goal is to maximize resident/family experience scores, with target threshold of 90% or above. These indicators were new additions to the QIP in 2023/24. Initial targets of 5% increase year-to-year have been identified. Results improved for both groups in 2024, but only family results met identified improvement target.	1) Explore feasibility of posting activity calendars digitally throughout the home 2) Explore opportunities for advanced CAS classes 3) Ongoing consultation of Community and Veteran Resident Councils regarding new programming ideas.	Work to be guided by the Resident-Focused QI team.	TBD	TBD	
								1) Complete facility-wide roll-out of the revised tools and processes for the "All About Me" tool, tailored towards social engagement. 2) Introduction of "busy bins" on dementia units	Work to be guided by the Family-Focused QI team.	1) Status of facility-wide roll-out i.e. completing tool with existing residents 2) Status of PDSA on G1N 3) Roll-out across applicable units (pending PDSA results)	1) Completed by June 30, 2025 2) Completed by June 30, 2025 3) Completed by December 31, 2025	
		Percentage of residents who responded positively to "I enjoy meal times"	% / Residents	In-house data, interRAI survey / January 1 - December 31 2024	65%	68%	As identified in Quality Framework (2020-2025), long-term improvement goal is to maximize resident/family experience scores, with target threshold of 90% or above. This was a new indicator to the QIP (added in 2023/24). Initial targets of 5% increase year-to-year have been identified. Results improved in 2024, meeting and exceeding the 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.	1) Roll-out to Ottawa and Gatineau buildings	1) Completed by December 31, 2025	
								Implement use of resident census sheet to take meal orders		1) Roll-out to Ottawa and Gatineau buildings	1) Completed by December 31, 2025	

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							target (56%).	Refresh dining room decor		1) TBD pending availability of funds and completion of design master plan	1)TBD	
								Complete Food Service Review	Third party review to evaluate current infrastructure and provide recommendations for enhancement to resident food	1) Status of review	1) Review completed by December 31, 2025	
Better Experience of Care	**Achieve >90% in resident/ family experience scores**	Percentage of family members that responded positively to Family Communication and Engagement in Care Domains	% / Family members	In-house data, interRAI survey / January 1 - December 31 2024	83.%; 80%	87%; 84%	As identified in Quality Framework (2020-2025), long-term improvement goal is to maximize resident/family experience scores, with target threshold of 90% or above. This was a new area of focus for QIP in 2024/25. Initial target of 5% increase year-to-year has been identified. Performance declined in both areas in 2024.	1) Enhance resident and family centred communication: introduction of post-admission communication strategy and process(es)	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 survey
								2) Enhance resident and family centred communication: re-design admission and annual care conference	New QIP for 2025 - focus on co-designing care conferences with residents and families	1) status of work	1) Initial timelines pending start-up of QI team (March)	
								3) Enhance Welcome Book	New working group to look at evaluating current approach and identifying opportunities to enhance content (with stakeholder engagement)	1) status of work	1) Initial timelines pending start-up of working group (scheduled for spring)	
								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, 2025	

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Better Experience of Care	**Achieve >90% in resident/ family experience scores**	Percentage of residents that responded positively to Staff Responsiveness Domain	% / Residents	In-house data, interRAI survey / January 1 - December 31 2024	79%	84%	New priority area for 2025/25 QIP. Overall domain score identified as placeholder until specific domain question confirmed	1) Establish QI team to identify indicator of focus	New QIP focus for 2025. Work to be guided internally (data analysis and engagement with residents) as well as externally (through focused work of SQLI)	1) Status of work	1) Indicator identified and team established by September 30, 2025	Staff Responsiveness has been identified as an area of focused improvement by Seniors Quality Leap Initiative (SQLI)
Priorities for MODERATE ACTION												
Better Experience of Care	**Provide "right" care 100% of the time**	Percentage of Residents who Experienced Pain	% / Residents	CIHI CCRS / July - September 2024	11.4	11	2024/25 target (10.4%) not achieved, however, performance over time shows overall improvement, with all data points since Q1 2022 falling below the average line. NOTES: Provincial average = 3.9% (Q2 2024); 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, pain monitoring approach and tools, care planning approach, etc.)	This work will be led by Pain QI team	1) Status of workplan	1) Implementation of identified changes completed by December 31, 2025	Publicly reported indicator (CIHI Your Health System; HQO Long Term Care Performance) Aligns with full implementation of RNAO Best Practice Guideline.
								2)Continue roll-out of PainChek pilot across facility (pending results of pilot evaluation)	Work to be supported by Pain QI Team and Clinical Quality Lead	1) Status of workplan	1) Evaluation and decision completed by February 15, 2025	
Better Experience of Care	**Provide "right" care 100% of the time**	Percentage of residents that were transferred to hospital within 30 days of death	% / Residents	Local data collection (PCC)/Jan - Mar 2025	Collecting Baseline	Collecting Baseline	Target to be set once following collection of baseline data.	1)Enhanced Palliative and End-of-life education/resources for the interprofessional team, including Palliative Volunteers: -deliver NHWD content to interprofessional team and volunteers -provide Palliative Skills Day content to all nurses -develop Palliative Skills "Day" for PSWs -develop and deliver "diversity at EOL" stories/case studies for dept meetings	NHWD (New Hire Welcome Day) education developed in-house by SMEs. PSW skills day content to be developed in partnership with external SMEs	1a) # of existing staff that have received NHWD education 1b) % of palliative volunteers that have received NHWD education 2) # of nursing staff that have received skills day education 3) # of PSWs that have received new education 4) # of staff that have participated in sessions r/t diversity at EOL	1a) 100 by March 31, 2026 1b) 100% by June 30, 2025 2) 50 RNs/RPNs by December 31, 2025 3) 50 PSWs by March 31, 2026 4) 100 staff by December 31, 2025	

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								2)Enhance and sustain process for Comfort Care Carts (10) and Chairs (10)	Waiting on branding for 4 carts. Stocking of cart storage room.	1) Status of workplan	1) New process launched by May 31, 2025	
								3) Develop consistent after death processes to address visual inequity between veteran and community residents (i.e. when deceased resident escorted out of facility)	New area of focus for Palliative QI team in 2025	1) Status of workplan	1) New processes implemented by September 30, 2025	
								4) Enhance resources for residents/families	Focus on written (possibly digital) materials available to families on comfort care cart	1) Status of workplan	1) Designated materials created and added to cart by June 30, 2025	
								5) Re-design admissions/annual care conferences	New QIP team launching January 2025. Focus on co-design with residents and families	1) Status of workplan	1) New process launched by January 1, 2026	

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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 2024	24.8	23.8	2024/25 target was achieved; performance over time moving in positive direction. Current performance remains above provincial average @ 19.6 Q2 2024. 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, Perley Health introduced a 20-bed Specialized Behavioural Support Unit (SBSU) for residents with high risk behaviours. This resulted in the introduction of a high antipsychotic user group, accounting for ~25% increase in QI indicator.	1)Participate in Healthcare Excellence Canada's Antipsychotic Optimization Collaborative (Sparking Change)	This work to be led by Clinical Quality Lead in collaboration with MDs/NPs, Pharmacy Committee and 3Ds team	1) status of HEC project (aligned with key project milestones)	1) 100% completion of HEC project milestones	**Identified as an LTC QIP Priority for 2025/26.** Publicly reported indicator (CIHI Your Health system).
Better Experience of Care	**Provide "right" care 100% of the time**	Number of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents.	Rate per 100 residents / LTC home residents	CIHI CCRS, CIHI NACRS / July - Sept 2024	4.8	<5	Goal has been elevated to active QIP work. Although average performance continued to perform better than provincial average (@6.9 Q2 2024), some of the most recent data points exceed our annual goal of <5.	1)Review/audits of all transfers to ED to identify local opportunities for improvement as well as systemic trends	To be completed by Managers Resident Care (@ unit level) and Clinical Quality Lead (@ facility level)	1) % of transfers reviewed	1) 100%	**Identified as an LTC QIP Priority for 2025/26. This work aligns with SeeMe, RFCC, EOL Care**
								2)Participate in Community Paramedic/LTC Program (pilot)	Focused on falls with suspected or actual injuries	1) Pilot launched 2) % of falls that resulted in call to community paramedics	1) Pilot launched by February 10 2025 2) 70% by March 31 2025	
								3)Deliver nursing competency training on variety of topics related to ED transfers (clinical competencies, SeeMe, goals of care, acute health event mgmt)	To be developed by internal SMEs	1) % of RNs that have completed the competency training	1) 100% of RNs by December 31, 2025	