# 2022/23 Quality Improvement and Safety Plan - FINAL

2022-07-04

| 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** | **Improve safety culture score** | Culture of Safety | Overall Weighted Average Safety Culture Score (scale of 1, low to 5, high) | In-house data, Culture of Safety survey, 2021 | 2.77 | 2.9 | 2021/22 target not achieved; however performance improved slightly from 2.75 to 2.77. No benchmark data available for comparison. Target reflects the complexity of the issue (changing an organization's culture can be quite difficult and is a long-term endeavour). | 1)Psychological health & safety work - implement Mental Fitness Index action plan | Implementation of short-term, mid-term and long-term actions | 1) Implementation status (short-term)<br>2) Implementation status (mid and long-term) | 1) 100% by June 2022<br>2) 60% initiated by March 2023 | 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 |
| | | | | | | | | 2)Define" psychological health and safety" at Perley Health and outline guiding principles | Iterative development through feedback with key stakeholder groups (e.g. MFI working group, leadership team) | 1)Completion status | 1) Completed by June 30, 2022 | |
| | | | | | | | | 3)Continue to strengthen education on Just Culture, promoting open communication | Actions to be aligned with Psychological Mental Health & Safety work. | 1) Education on Just Culture<br>2) Staff familiarity with Just Culture through survey | 1) Number of education provided to different groups according to plan<br>2) TBD | |
| | | | | | | | | 4)Continue to participate in CPSI Patient Safety Week (typically held last week in October) | Continue the practice of Annual Safety Week. | Staff engagement/participation in key events flagged by the team | TBD as scheduled released | |
| **Better Experience of Care** | **Provide "right" care 100% of the time** | Percentage of Residents who Experienced Pain | % / Residents | CIHI CCRS / July - September 2021 | 11.3 | 10 | 2021/22 target achieved. Changes in practice aligned with BPG on Pain Management largely implemented in 2018. Current focus is on evaluating changes and adjusting as required. NOTES: Provincial average = 4.4% (Q2 2021); however, the literature suggests proportion of LTC residents with some level of pain is around 40-80%. | 1)Review/evaluation of key practices introduced to identify and develop plan of care for managing resident pain (aligned with goals of care) | Evaluation will include internal evaluation of current state and comparison to self-identified peers (e.g. Baycrest) to identify prevailing practice | 1)Completion status | 1)Evaluation completed by August 31, 2022 | Publicly reported indicator (CIHI Your Health System; HQO Long Term Care Performance) Aligns with full implementation of RNAO Best Practice Guideline. |
| | | | | | | | | 2)Identify and implement changes in practice based on evaluation | Tentative - Kaizen event in 2022 (or through intensive small committee work). Changes pending completion of evaluation work | 1) Completion status | 1) Changes identified and ready for testing Oct 2022<br>2) 100% Implementation across facility by March 2023 | |
| | | | | | | | | 3)Sustain hourly comfort care rounds by interprofessional team to assess pain, positioning, toileting needs, personal environment. | 1) Rounding logs reviewed by PSW Supervisors to determine if hourly rounds are documented by PSWs on all shifts.<br>2) Nursing leaders to validate PSW rounding practices through shadowing | 1) % hourly rounds documented on rounding log<br>2) % of staff shadowed on day and evening shift that meet rounding expectations<br>3) % of staff on night shift that meet night rounding expectations | 90% compliance for all measures | |
| **Priorities for MODERATE ACTION** | | | | | | | | | | | | |
| **Better Experience of Care** | **Provide "right" care 100% of the time** | Proportion of long-term care home residents with a progressive, life-threatening illness who were identified to benefit from palliative care, who have their palliative care needs identified through a | Proportion / at-risk cohort | Local data collection (PCC)/ | N/A | >80% | Data represents percentage of residents identified as "end-stage" in RAI-MDS who had palliative/end-of-life care needs documented in plan of care. PPSv2 and CFA consistently used for all long-stay residents to identify palliative/end-of-life care needs. Focus of work in this area will be to develop a | 1)Continue to implement "End-of-life care during last days and hours" best practice guidelines from RNAO. Work includes updating "end-of-life care" and "palliative approach to care" sections of the care plan to support documentation of individualized plan of care for residents requiring palliative care. | 1) Develop End-of-Life program policy aligned with best practice guidelines<br>2) Update care plan library - embedding 8 domains of palliative care throughout library.<br>3) Test & implement process to update care plan with EOL lens based on PPS and CFA results. | 1) Completion status<br>2) Completion status of care plan library review & update<br>3) Implementation of process | 1) Policy completed by October 31, 2022<br>2) Care plan library updated by September 30, 2022<br>3) New process implemented on all units by December 31, 2022 | |

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| | | through a comprehensive and holistic assessment. | | | | | area will be to develop a process to formalize a plan of care aligned with the findings of these assessments and the resident/SDM preferences. | 2)Sustain process and tools to support SeeMe frailty-informed care on long-stay units. | 1) Ongoing auditing to validate completion of CFA aligned with care conferences on long-stay units. | 1) % of residents on long-stay units with completed frailty assessments | 1) 100% of residents on long-stay units with completed frailty assessment prior to care conference | |
| **Better Experience of Care** | **Reduce preventable harm by 50%** | Number of substantiated staff to resident abuse/neglect incidents reported to the MOLTC through CIS System | # of incidents | Ministry of Health Portal / Jan - Dec 2021 | 3 | 0 | Indicator has been amended for 2022/23 QIP to focus on substantiated incidents vs reported incidents. Resident abuse and neglect (verbal, physical, sexual, financial) is identified as a "never event" at Perley Health, as such, the Home will continuously work towards a goal of 0 substantiated events. Perley Health acknowledges an important 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) BPG gap analysis completed in 2020. Areas of focus include updated education and resources/support for staff, resident/care team involved in abuse/neglect incident 2) Leverage Abuse Awareness Week to offer in-person education on key topics related to abuse/neglect, investigation process, supports/resources for staff | 1) Completion status e.g. enhancements to investigation process and support to those involved<br>2) Employee attendance at Abuse Awareness Week activities | 1) Completed by September 30, 2022<br>2) 60% of staff recorded | Leverage BPG on Preventing and Addressing Abuse and Neglect of Older Adults. Incident investigation work aligned with Psychological Mental Health & Safety work (MFI action plan) |
| **Better Experience of Care** | **Reduce preventable harm by 50%** | Infection Prevention and Control Program | 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. | 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<br>2) Hand hygiene compliance rates | 1) 450 observations per month<br>2) 85% compliance | |
| | | | | | | | | 2)Targeted improvements to COVID response as identified (focus on effectiveness and sustainability) | TBD | TBD | TBD | |
| | | | | | | | | 3)Provide outreach/support to other LTCHs r/t COVID response and other areas | TBD | TBD | TBD | |
| **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 2021 | 19.3 | 19 | 2021/22 target not achieved; however Perley Health is currently performing better than the provincial average (@ 20.3% Q2 2021).<br>Background info: In early 2018, facility opened a 20-bed Specialized Behavioural | 1)Complete data review to understand current drivers of facility-level performance | Corrective action may be required based on data review findings | 1) Completion status of data review | 1) Data review completed September 30, 2022 | Not included in Ontario Health Priority List. Publicly reported indicator (CIHI Your Health system). |

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| | | | | | | | 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. | 2)Adapt and spread Appropriate Use of Antipsychotics process across long-stay units (excluding SBSU) | Participation in CFHI-SQLI Antipsychotic Deprescribing Collaborative (started January 2018) | 1) implementation status | 1) AUA approach implemented on all Gatineau units by December 31, 2022 | |
| **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 2021 | 36.3 | 35 | New indicator for QIP. Median performance since Q3 2019 is 33%. Provincial average = 21.4% (Q2 2021) | 1)Investigate implementation of validated tool for Rec team to identify signs/symptoms of moods/depression (as alternate to current documentation practice). This work includes completed gap analysis | Tool to be used by Rec team during RAI 7-day lookback period instead of Point-of-Care documentation by PSWs. This information would be aligned with RAI-MDS requirements | 1) evaluation status 2) implementation status | 1) evaluation completed by September 30, 2022<br>2) implementation completed December 31, 2022 | This work is aligned with implementation of 3Ds best practice guidelines |
| | | | | | | | | 2) Review/evaluate Suicide Prevention process, including Suicide Risk Assessment tool and identify improvements | Evaluation to be completed by members of the 3Ds QI Team. Changes in practice pending results of evaluation | 1) completion status (evaluation)<br>2) implementation status of changes | 1) evaluation completed by September 30, 2022<br>2) changes in practice implemented by December 31, 2022 | |
| **Better Experience of Care** | **Achieve >90% in resident/ family experience scores** | Percentage of residents who responded positively to Food Scale | % / Residents | In house data, interRAI survey / January 1 - December 31 2021 | 56 | 65 | New indicator for QIP | 1) Further analysis and engagement with residents and families to better understand opportunities for improvement | Work to be lead by Director Support Services and Manager Food & Nutrition/Housekeeping. One guiding committee with mixed membership to be developed (staff, resident, family), with smaller group engagement to gather information | 1) status of work | 1) analysis completed by October 31/22 | |
| | | | | | | | | 2) QI teams to identify both short term and long term strategies for improvement based on analysis and engagement activities | Work to be led by guiding committee | 1) implementation status of short term objectives 2) implementation status of long term objectives | Both to be identified by guiding committees as part of QI work<br>Ideally some implementation completed by Dec 31/22 | |
| | | Percentage of residents who responded positively to Social Life Scale | % / Residents | In house data, interRAI survey / January 1 - December 31 2021 | 34 | 45 | New indicator for QIP | 1) Further analysis and engagement with residents and families to better understand opportunities for improvement | Work to be lead by Manager Therapeutic Recreation and Creative Arts. One guiding committee with mixed membership to be developed (staff, resident, family), with smaller group engagement to gather information. | 1) status of work | 1) analysis completed by October 31/22 | |
| | | | | | | | | 2) QI teams to identify both short term and long term strategies for improvement based on analysis and engagement activities | Work to be led by guiding committee | 1) implementation status of short term objectives 2) implementation status of long term objectives | Both to be identified by guiding committees as part of QI work<br>Ideally some implementation completed by Dec 31/22 | |

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| **Better Client & Population Health Outcomes** | **Maximize health-related quality of life** | Percentage of residents who responded positively to the statement: "The care & support I receive help me live my life the way I want" | % / LTC home residents | In house data, interRAI survey / January 1 - December 31 2021 | 75 | 80 | New indicator for QIP. Median performance since 2015 is 80%. | 1) Deeper understanding required before actions to be identified | Conduct focus groups with residents to understand drivers for this question. Will engage Community Nurse Students to lead this work during their fall placement. This work will tie in Literature review | 1) focus group status | 1) focus group(s) completed by November 30, 2022 | This work aligns with SeeMe philosophy of care |