2016/17 Quality Improvement Plan - FINAL DRAFT

Mar 2nd, 2016

AIM		Measure						Change				
Quality dimension	Objective	Measure/Indicator	Unit / Population	Source / Period	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Goal for change ideas	Comments
1) PRIORITIES FOR FOCUSED ACTION												
Safety	**To Reduce Falls**	Percentage of residents who had a recent fall (in the last 30 days)	% / Residents	CCRS, CIHI (eReports) / Q2 FY 2015/16	20.6	19.5	Although the Home will be implementing substantial changes by the end of June 2016, only modest metric improvement is expected by the end of the 2016/17 period due to the delay in the availability of CCRS e-report data (approx. 2 quarters). It is anticipated that metric improvement will become more visible in 2017 and beyond as the data catches up to the clinical changes implemented. Mid-term goal (3 years) is to meet and exceed provincial average, long-term goal (5 years+) is to achieve established benchmark. NOTES: Current performance reflects the blended average of veteran and community residents. Provincial Average = 14.4% (Q2 2015)	1)Assess fall risk on admission, quarterly and following significant change in condition (using Scott Fall Risk Screening Tool)	1) Falls QI Team to conduct monthly chart review in PCC of new admissions to determine if Scott Fall Risk Assessment completed and appropriate interventions put in place. 2) Falls QI Team to conduct monthly chart review in PCC for all residents up for quarterly review to determine if Scott Fall Risk Assessment completed.	1) % of residents with Scott Fall Risk Assessment completed on admission 2) % of residents with Scott Fall Risk Assessment completed prior to quarterly review	80% compliance for both process measures by December 31, 2016.	Leverage best practice e.g. RNAO Best Practice Guidelines: Prevention of Falls and Fall Injuries in the Older Adult; Safer Healthcare Now: Reducing Falls and Injuries from Falls
								2)Fall risk to be discussed at ALL quarterly interprofessional care plan meetings.	Falls QI Team to conduct monthly chart review in PCC to determine if falls were discussed at care plan meeting for all residents up for quarterly review.	% of care plan meeting tools demonstrating evidence that falls discussion occurred.	80% compliance by December 31, 2016.	
								3) Post fall huddle (root cause analysis) conducted by clinical team immediately following each fall	Falls QI Team to conduct monthly chart review to determine how many post fall huddles were completed. Information to be pulled from PCC or paper chart (TBD based on identified method for documenting post fall huddle)	% of falls with documented post fall huddle	75% compliance by December 31, 2016.	
								4)Hourly comfort care rounds by PSWs to assess pain, positioning, toileting needs, personal environment	1) Rounding logs reviewed weekly 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 by December 31, 2016 for both measures	Comfort care rounds to be implemented on all 12 units by June 30, 2016.
Safety	**To Reduce Responsive Behaviours**	Percentage of residents whose behavioural symptoms worsened	% / Residents	CCRS, CIHI (eReports) / Q2 FY 2015/16	20.1	19.3	Although the Home will be implementing some key practice changes by the end of June 2016, only modest metric improvement is expected by the end of the 2016/17 period due to the delay in the availability of CCRS e-report data (approx. 2 quarters). It is anticipated that metric improvement will become more visible in 2017 and beyond as the Home continues to refine how it identifies and manages responsive behaviours. Mid-term goal (3 years) is to meet and exceed provincial average, long-term goal (5 years+) is to achieve established benchmark. NOTES: Current performance reflects the blended average of veteran and community residents. Provincial Average = 13.4% (Q2 2015).	1)Implement structured assessment and screening tools to objectively identify risk factors, and assess residents for delirium, depression, dementia and abuse. Example: Revised Behaviour Mapping tool and supporting process to be implemented Home-wide.	Responsive Behaviours QI team to develop revised Behaviour Mapping tool and supporting process. Appropriate process measure tbd once process completed.	Behaviour Mapping tool and supporting process designed and implemented.	Tool and process implemented on all 12 units by September 30, 2016.	RNAO Best Practice Guideline on: Screening for Delirium, Depression and Dementia Caring Strategies for Older Adults with Delirium, Dementia and Depression Preventing Abuse and Neglect in Older Adults Promoting Safety: Alternative Approaches to the Use of Restraints
								2)Improved documentation of responsive behaviours by interprofessional team.	Responsive Behaviours team to determine expectations related to documentation, determine educational requirements and track education completion.	% of staff trained on documentation requirements	50% of staff trained by September 2016.	
								3)Develop and implement a process for the immediate management of high risk residents following a physical altercation (to immediately manage risk and identify contributing factors).	Responsive Behaviours QI team to develop relevant process. Appropriate process measure tbd once process completed.	Process and relevant tools designed and implemented.	Process and tools implemented on all 12 units by December 31, 2016.	
								4)Adopt a model of care that promotes consistency in the healthcare worker/resident relationship and considers resident complexity and needs	Nursing Managers will review various factors following the implementation of the new model of care. Fulsome evaluation will also be required 6-12 months post implementation.	1) Model designed and implemented 2) # Healthcare workers / resident	1) Implemented on 12 units by September 30, 2016 2) To be identified based on research (EBP), staff engagement, financial realities, etc.	
Effectiveness	**To Reduce Pain**	Percentage of residents whose pain worsened	% Residents	CCRS, CIHI (eReports) / Q2 FY 2015/16	15.9	15	Only modest metric improvement is expected by the end of the 2016/17 period as changes in practice will not be fully implemented until September 2016. Due to the delay of CCRS e-report data, it is anticipated that metric improvement will become more visible in 2017 and beyond as the data catches up to the clinical changes implemented. Mid-term goal (3 years) is to meet and exceed provincial average, long-term goal (5 years+) is to achieve established benchmark. Current performance reflects the blended average of veteran and community residents. NOTES: Provincial average = 10.7% (Q2 2015).	1) Structured pain assessment and screening tools to objectively identify pain and possible interventions	Pain QI team to develop and implement pain assessment and screening tools. Quarterly chart review in PCC to determine compliance.	1) Process and relevant tools designed and implemented. 2) % of residents that have documented pain assessment/screening at admission 3) % of residents that have documented pain assessment/screening prior to quarterly care plan meeting	1) Process and tools implemented on all 12 units by December 31, 2016. 2) & 3) 80% compliance by December 31, 2016	
								2) Structured pain management and monitoring practices (pharmacological and non-pharmacological) to better control resident pain.	Pain QI team to develop and implement pain management and monitoring practices. Quarterly chart review in PCC to determine compliance related to monitoring practices.	1) Improved pain management and monitoring practices implemented. 2) compliance with monitoring expectations	1) Practices implemented on all 12 units by December 31, 2016. 2) 80% compliance	
								3)Pain assessment and management tools and strategies for residents with dementia	Quarterly review of resident charts in PCC to determine if residents have a documented pain assessment completed	% of residents with dementia who have had a pain assessment completed and documented	80% compliance by December 31, 2016.	
								4)Hourly comfort care rounds by PSWs to assess pain, positioning, toileting needs, personal environment	1) Rounding logs reviewed weekly 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 by December 31, 2016 for both measures	Comfort care rounds to be implemented on all 12 units by June 30, 2016.
2) PRIORITIES FOR MODERATE ACTION												
Effectiveness	**To Reduce Worsening of Pressure Ulcers**	Percentage of residents who had a pressure ulcer that recently got worse	% / Residents	CCRS, CIHI (eReports) / Q2 FY 2015/16	5	4.8	Implementation of change ideas anticipated for beginning of Q3 2016. Due to the delay in CCRS e-report data, significant metric improvement will likely not be visible until 2017 and beyond. Impact of implementation of comfort care rounds home-wide by end of June, may be visible by the end of 2016/17 period. NOTES: Current performance reflects the blended average of veteran and community residents. Provincial Average = 3.3% (Q2 2015).	1)Leverage the Skin and Wound Assessment Team (SWAT) for rapid resident assessment and treatment.	SWAT members to review referrals and consultations quarterly for trends. Review of PCC to be completed at this time to identify issues that were not referred to SWAT.	Number of Skin and Wound Team consultations documented in PCC	SWAT used to full capacity	Skin and Wound Team will use the information to refine criteria for deployment of SWAT
								2) Improve and standardize documentation of skin integrity by the interprofessional team.	Pressure ulcer prevention team to determine expectations related to documentation and determine educational requirements	% of staff trained on documentation requirements	50% of staff trained by September 2016.	The team is currently implementing the RNAO Best Practice Guidelines on Risk Assessment and Prevention of Pressure Ulcers.

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								3) Streamline the products available for use in wound care to ensure a standardized approach to caring for wounds; appropriate resource utilization and excellent care to residents.	1) Using LEAN methodology, conduct a 5s of the supply room and standardize inventory management process. 2) The Pressure Ulcer prevention team to Develop standard protocols (SOPs) for the management of different categories of wounds. (process measures to be determined)	1) Cost of wound care supplies 2) Process and relevant tools designed and implemented.	1) 20% reduction in cost of wound care supplies by December 31, 2016 2) Process and tools implemented on all long-term care units by December 31, 2016.	
								4)Hourly comfort care rounds by PSWs to assess pain, positioning, toileting needs, personal environment	1) Rounding logs reviewed weekly 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 by December 31, 2016 for both measures	Comfort care rounds to be implemented on all 12 units by June 30, 2016.
Effectiveness	**To Reduce Worsening Bladder Control**	Percentage of residents with worsening bladder control during a 90-day period	% / Residents	CCRS, CIHI (eReports) / Q2 FY 2015/16	28.6	28	Focus in this area for 2016/17 is limited to product selection and inventory management. Impact of implementation of comfort care rounds home-wide by end of June, may be visible by the end of 2016/17 period. NOTES: Current performance reflects the blended average of veteran and community residents. Provincial Average = 18.2% (Q2 2015).	1)Streamline the products available for use to ensure a standardized approach , appropriate resource utilization and excellent care for residents.	Using LEAN methodology, conduct a 5s of the supply room and standardize inventory management process.	1)Cost of incontinence care supplies	10% reduction in cost of incontinence care supplies by December 31, 2016	
								2)Hourly comfort care rounds by PSWs to assess pain, positioning, toileting needs, personal environment	1) Rounding logs reviewed weekly 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 by December 31, 2016 for both measures	Comfort care rounds to be implemented on all 12 units by June 30, 2016.
Integrated	**To Reduce Potentially Avoidable Emergency Department Visits**	Number of emergency department (ED) visits for modified list of ambulatory care sensitive conditions* (ACSC) per 100 long-term care residents	% / Residents	Ministry of Health Portal / Oct 2014 - Sept 2015 (Q2 2014 - Q1 2015)	33.5	33	Focus for 2016/17 is to sustain and spread changes identified in 2015 across the Home.	1)Deploy a nurse practitioner (NP) through the Nurse Led Outreach Team (NLOT) program to provide advanced assessment, consultation and treatment capacity.	IDEAS Team to conduct monthly chart review to determine if NP was consulted prior to ED transfers.	% of transfers to the ED where the NP was consulted prior to decision transfer	2) 75%	NP has been available in Ottawa building since Jan 2015 and was deployed in the Rideau and Gatineau buildings in December 2015.
								2)Develop and adopt a standardized process for resident assessment post return from hospital, involving the NP.	1) Monthly chart review by IDEAS team to determine how many residents were seen by NP upon return from hospital (for all 30-day re-transfers) 2) Monthly review of e-INTERACT data in PCC by IDEAS team to determine 30 day re-admission rate.	1) % of residents seen by NP upon return from a 30-day re-transfer 2) % of residents readmitted within 30 days (rates for those with a NP consult and those without)	1) 90% 2) 10%	Currently in place in the Ottawa building. Practice needs to be sustained and spread across the Home in 2016
								3)Build onsite laboratory and x-ray capacity through establishment of onsite collection and phlebotomy as well as onsite x-ray	Monthly review of transfers through e-INTERACT reporting system in PCC to determine rationale for ED transfers.	Number of ED transfers for lab/x-ray	Reduction of 50% once services are established	
								4)Early recognition and intervention of acute changes in condition through use of STOP & WATCH alerts in Point of Care.	IDEAS team to conduct monthly review of Stop & Watch data in PCC to determine registered staff response.	% of Stop & Watch alerts actioned by registered staff within same shift	80% compliance by December 31, 2016	Currently in place in the Ottawa building. Practice needs to be sustained and spread across the Home in 2016
								5)Improve communication/information sharing with The Ottawa Hospital upon transfer to ED and return from ED.	IDEAS team to conduct monthly audits to determine if complete documentation provided upon return from ED	% of ED returns with complete documentation	70% compliance by December 31, 2016	New process for communication upon return from ED currently being piloted with The Ottawa Hospital.
Resident-Centred	**Domain 1: "Overall Satisfaction"**	Percentage of residents responding positively to: "I would recommend this site or organization to others" (interRAI QoL)	% / Residents	In-house survey / Apr 2015 - Mar 2016 (or most recent 12mos)	84%	85	Based on international benchmarking data from the interRAI survey, the Home's performance currently sits below the 80th percentile.	1)Spread the "We Are Here To Help" communication aid to all units	1) Management team to complete posters highlighting care team members including names, photos, role description and contact information. 2)Magnetic whiteboard, updated daily, to be used For PSW, RPN and RN staff. Resident Care Leaders to conduct monthly audit to determine completion.	1) Number of units with "We are Here to Help" posters on Family Communication Boards 2) % daily whiteboards updated	1) 12 units (100%) completed by July 1st, 2016 2) 80% compliance by Dec 31, 2016	
								2) Enhance training and education for staff regarding effective management of resident responsive behaviours	1)Develop and deliver training aligned with the corporate education plan including: Targeted staff education delivered by Psychogeriatric Resource Nurse and Behavioural Support PSW (Antecedent, Behaviour, Consequence (ABC) meetings: High Risk Rounds; Gentle Persuasive Approach(GPA); GPA walk and talks; PIECES training; and dementia training.	Percent of staff trained in a variety of educational opportunities as per established targets	80% of staff trained based on established targets	Priority identified by Family and Friends Council to enhance resident experience and safety. Will be aligned with the QI team working to reduce responsive behaviours.
	Domain 2: "Having a voice" and being able to speak up about the Home.	Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences". (InterRAI QoL)	% Residents	In-house survey / Apr 2015 - Mar 2016 (or most recent 12mos)	88%	88	Not an area of focus for 2016/17. Based on international benchmarking data from the interRAI survey, the Home's performance currently sits at the 80th percentile.					
Enabling	**Build a Culture of Safety**	N/A	N/A	N/A	N/A	N/A	Capacity building	1) Formalize a modified root cause analysis tool for rapid review and learning following incidents and near-misses.	Small team led by Chief Nursing Officer to develop and implement tool, and track its use.	1) Modified RCA tool developed and implemented 2) Frequency of use of RCA tool	1) Tool completed and launched 2) 1 modified RCA/quarter	
								2) Integrate safety and quality into structured conversations between management and staff. Hardwire Leader Rounding on direct reports. Standardize the safety/quality question (develop annual calendar of quality/safety topics).	Leaders to track rounding completion monthly, bi-monthly or quarterly based on identified rounding requirements (which vary based on number of direct reports)	% staff rounded on during designated timeframe	90%	

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								3) Align approved Safety Incident Management and Sentinel/Adverse Events policies, Finalize and roll-out all supporting tools and templates (e.g. timeline tools, algorithms, report templates, RCA guidelines)	Developed policies to be revised for further alignment and tools to be refined prior to final approval and implementation.	Applicable policies and tools approved and implemented.	100% of applicable policies and tools rolled out by June 30, 2016	
								4) Provide at least quarterly education for all staff about safety including education on effective disclosure and reporting of incidents. [continued Lunch & Learns, increased focus on the educational aspects of RCA/RCA Lite].	Mgr Education & Projects to track and report on educational opportunities provided as well as attendance	1) Number of safety-related lunch & learns offered quarterly 2) staff completion of safety-related content on Surge learning	1) 1 safety-related lunch & learn per quarter (minimum) 2) >50%	
								5) Improved medication incident reporting through implementation of online tool developed by Pharmacy provider.	Pharmacy staff and medication management committee to plan for and monitor transition to new incident reporting system.	% of staff trained on new incident reporting system	100% of registered staff trained on new system by December 31, 2016 (actual launch date tbd - system currently in pilot phase)	
								6) Integrate roles and responsibilities for resident safety principles into job roles/responsibilities. Relevant content to be included in all new job descriptions developed and as existing job descriptions are reviewed.	Content to be developed and incorporated into all new job descriptions and those up for revision in 2016.	Number of new/revised job descriptions containing required content	100% of new/revised job descriptions	Accreditation requirement (Leadership 10.7). Safety question embedded into rounding. Job description review underway r/t risk profile.
								7) Implement IPAC enhancements. a) Implement recommendations from 2015 IPAC review. b) Develop and implement antimicrobial stewardship program (with a focus on UTIs). c) Improved hand hygiene compliance (focus on moment #1). d) Refine Outbreak Management Program	Progress to be monitored by Infection Control Coordinator and IPAC committee.	a) Percentage of components implemented b) Key practice changes identified and implemented c) number of hand hygiene observations conducted monthly d) percentage of required components implemented	a) 50% by May 2016, 80% by December 31, 2016 b) 100% key changes implemented by September 2016 c) 360/month d) 80% of required components by May 2016	
Enabling	**Build QI Capacity**	N/A	N/A	N/A	N/A	N/A	Capacity building	1) Train and educate leaders and front line staff in quality improvement through internal and external programs. Leverage existing external (IDEAS, IHI, etc.) and incorporate QI training into internal educational opportunities (LDIs). Develop Perley Rideau QI curriculum for front line staff and Management.	Group of QI SMEs (COO, CNO, Perf Imp Consultant, Mgr Ed & Products) to develop internal program. 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 2016. 2) Number of front line staff/supervisors attending external QI educational opportunity	1) QI education provided at ≥1 Leadership Development Institute(s) in 2016 2) ≥10	
								2) Establish capacity and methods for enhanced data collection, review and analysis	Ongoing refinements to Organizational Performance and Risk Monitoring Framework as required (under direction of the Chief Operating Officer and in consultation with the Board of Directors)	1) Development and reporting on indicators related to non-LTC programs and services for seniors 2) Performance data made available through Communication Boards quarterly	1) Reporting on 75% of new indicators by April 2016. Reporting on 100% of new indicators by September 2016. 2) 100% compliance with quarterly performance reporting with run/control charts by April 2016.	
3) PRIORITIES FOR MONITORING												
Safety	**To Reduce the Use of Restraints**	Percentage of residents who were physically restrained (daily)	% / Residents	CCRS, CIHI (eReports) / Q2 FY 2015/16	5.8	5.5	Significant improvement achieved over past 3 years, with the Home continuing to see benefits from the changes implemented in 2012 and 2013. No focused activity expected in 2016/17, however, the home will continue to monitor restraint practices at the Home. NOTES: Current performance reflects the blended average of veteran and community residents. Provincial Average = 6.7% (Q2 2015).	1)Conduct audit of restraint use at the Home.	RAI RPNs to conduct an audit of restraint use and compare to existing documentation in PCC. Documentation to be amended to reflect clinical practice.	Restraint use	<6%	
								2)Hourly comfort care rounds by PSWs to assess pain, positioning, toileting needs, personal environment	1) Rounding logs reviewed weekly 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 by December 31, 2016 for both measures	Comfort care rounds to be implemented on all 12 units by June 30, 2016.
Effectiveness	**To Reduce the Inappropriate Use of Anti psychotics in LTC**	Percentage of residents on antipsychotics without a diagnosis of psychosis	% / Residents	CCRS, CIHI (eReports) / Q2 FY 2015/16	9.3	9	Significant improvement has been observed since 2012 Q3. Although not an area of focus for 2016/17, the Home will continue to monitor performance in this area. NOTES: Current performance reflects the blended average of veteran and community residents. Provincial average = 25% (Q2 2015).	1)Conduct data and practice review to better understand differences in veteran and community performance.	Data and practice review completed and required changes in practice identified.	Completion of data review	Data review completed by September 2016.	