2021/22 Quality Improvement and Safety Plan

2021-12-13

AIM		Measure							Change				
Issue	Quality dimension	Measure/Indicator	Type	Unit / Population	Source / Period	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
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 / April 2019 - March 2020	14.7	<15	2020/21 target not achieved; however, performance over time has remained stable with no indicators of non-random change. The current blended average for community and veteran residents is 14.7, which includes short-stay and sub-acute beds. Focus is on sustaining current performance and introducing strategic improvements as needed. Champlain LHIN average = 21.9 (Q1 2019 - Q4 2019).	1)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. 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 3) % of staff on night shift that meet night rounding expectations	90% compliance for all 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)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	
									3)Review of ED transfers by Nurse Practitioner (via NLOT program) 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	
Theme II: Service Excellence	**Patient-centred**	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 / January 1 - December 31 2020	73	85	2020/21 target not achieved. Goal is to recover to pre-pandemic levels.	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)	1) Implement workflow management tool (via Quality and Risk Management Module in Surge Learning) 2) Management to develop process to identify stories (positive and negative) that residents/families may want to share with QLS	1)% of Work Completion 2)implementation status	1)100% completed by June 30, 2021 2) process in place by December 31, 2021	MOHLTC Priority Indicator. Perley Rideau area for moderate action. 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 PSW Education Fund for Long-Term Care	# of additional staff trained in ERCC	target TBD	
		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 / January 1 - December 31 2020	83.00	90	2020/21 target not achieved, likely due to impacts of the pandemic. Goal for 2021/22 QIP is to recover to pre-pandemic levels.	1)Continue to leverage 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 & active resident and family advisors (cumulative) 2) Percentage of projects/initiatives with Family/Resident Advisor	1) 15 Advisors by Dec 31, 2021 2) 100% of QIP teams include Family and/or Resident Advisors by Dec 31, 2021	Perley Rideau area for focused action
									2)Participate in Resident QOL Collaborative between SQLI-CFHI (focus on Caring Staff Domain). **IF RECONVENED IN 2021**	Specific change ideas to be identified once diagnostic completed (winter 2020)	To be identified through SQLI work	To be identified through SQLI work	

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Theme III: Safe and Effective Care	**Effective**	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 comprehensive and holistic assessment.	P	Proportion / at-risk cohort	Local data collection (PCC)/July - December 2019	60% [data collection underway for 2020]	80% [TBC - following completion of data collection]	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 process to formalize a plan of care aligned with the findings of these assessments and the resident/SDM preferences.	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) Continue implementing items identified in the gap analysis. 2) Update care plan library - embedding 8 domains of palliative care throughout library. 3) Test & implement process to update care plan with EOL lens based on PPS and CFA results.	1) Implemention status of partially met and unmet recommendations from BPG 2) Completion status of care plan library review & update 3) Implementation of process	1) 100% implementation by December 31, 2021 2) Care plan library updated by September 30, 2021 3) New process implemented on all units by December 31, 2021	MOHLTC Priority Indicator. Perley Rideau area for focused action.
									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	
		Percentage of Residents who Experienced Pain	C	% / Residents	CIHI CCRS / July - September 2020	14.9	14	2020/21 target not achieved. Changes in practice aligned with BPG on Pain Management largely implemented in 2018. Current focus is sustaining and evaluating changes. Current performance reflects the blended average of veteran and community residents. NOTES: Provincial average = 4.5% (Q2 2020); however, the literature suggests proportion of LTC residents with some level of pain is around 40-80%.	1)Sustain Pain Monitoring (aligned with RAI cycle)	Through the support of pain resource nurse, provide education and ongoing feedback to staff. Evaluate results and actions from the pain monitoring. Monthly audit to ensure quality results.	1)% of completion	1)90% completion	Not included in MOHLTC Priority Indicator List. Publicly reported indicator (CIHI Your Health System; HQO Long Term Care Performance) Perley Rideau area for monitoring. Aligns with full implementation of RNAO Best Practice Guideline.
									2)Sustain pain screening and care planning process on admission	Quarterly chart review in PCC to determine use of screening tool.	1)% of residents that have documented pain assessment/screening at admission within 24 hours 2)% of Admission Checklists audited by Managers	90% compliance for both	
									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. 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 3) % of staff on night shift that meet night rounding expectations	90% compliance for all measures	
	Safe	Culture of Safety	C	Overall Weighted Average Safety Culture Score	In-house data, Culture of Safety survey, 2019	2.74 [survey was not conudcted in 2020]	2.9	Capacity Building. Safety Culture Score is on a scale of 1 (low) to 5 (high). Current target reflects the need to complete a full diagnostic to better understand opportunities; as well as the complexity of the issue (changing an organization's culture can be quite difficult).	1)Psychological safety - diagnostic required prior to identification of initiatives	Leadership self-assessment completed fall 2019.	TBD	TBD	Perley Rideau area for focused action Aligns with Accreditation Canada expectations
									2)Continue to strengthen education on Just Culture, promoting open communication	Actions to be aligned with Psychological Safety work.	1) Education on Just Culture 2) Staff familiarity with Just Culture through survey	1) Number of education provided to different groups according to plan 2) TBD	
									3)Continue to participate in CPSI Patient Safety Week	Continue the practice of Annual Safety Week for the fifth year. Improve participation of staff in the activities.	TBD	TBD	

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		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.	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) 85% compliance	
									2)Targeted improvements to COVID response as identified (focus on effectiveness and sustainability)	TBD	TBD	TBD	
		Number of medication errors that resulted in potential or actual harm (category D or higher)	C	Count / 10,000 Resident Days	MEDeReport [Medical Pharmacies Client Resources] / Aug 2020	3.7	2.8	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 to identify trends and systemic gaps	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. New eMAR doesn't have this functionality either.
		Number of staff to resident abuse/neglect incidents reported to the MOHLTC through CIS System	C	Number / Residents	Ministry of Health Portal / Jan - Dec 2020	6	0	2020/21 target not achieved. 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 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 incideint 2) Review and update Abuse policy	1) initiative dependent 2) Status of policy review	1) TBD 2) Policy review completed by March 31, 2021	Perley Rideau area for focused action. Leverage BPG on Preventing and Addressing Abuse and Neglect of Older Adults

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		Percentage of residents on antipsychotics without a diagnosis of psychosis	C	% / Residents	CIHI CCRS / July - September 2020	17.5	17	2020/21 target achieved. In Q1 2018, facility opened a 20-bed Specialized Behavioural Support Unit (SBSU). Opening of SBSU resulted in the introduction of a high antipsychotic user group, accounting for ~25% increase in QI indicator. NOTES: Current performance reflects the blended average of veteran and community residents. Provincial average = 18.5% (Q2 2020).	1)Sustain Appropriate Use of Antipsychotics (AUA) process on G1N. Adapt and spread process across long-stay units.	Participation in CFHI-SQLI Antipsychotic Deprescribing Collaborative (started January 2018)	1) additional deprescribing candidates identified and addressed on original pilot unit 2) implementation status	1) 100% of candidates on pilot unit with at least one deprescribing attempt completed by June 30, 2021 2) AUA approach implemented on all Gatineau units by September 30, 2021	Not included in MOHLTC Priority List. Publicly reported indicator (CIHI Your Health system). 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 2020	2.5	2.3	2020/21 target achieved. Implementation of BPG related to the prevention of pressure injuries has been completed, supported by in-depth education and training for registered staff. Performance data over time indicates sustained evidence of improvement, with rate decreasing from 6.3 (Q1 2017) to 2.9 (Q2 2019). Targeted improvements will continue throughout 2020/21 to further improve in this area. NOTES: Current performance reflects the blended average of veteran and community residents. Provincial Average = 3.3% (Q2 2020).	1)Sustain practice changes implemented related to Risk Assessment and Prevention of Pressure Injuries and Assessment and management 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 moderate action
									2)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. 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 3) % of staff on night shift that meet night rounding expectations	90% compliance for all measures	
									3)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%	
									4)Continue focused wound care education for registered staff	Learning Needs Assessment being completed to further identify potential knowledge gap - Support a nurse in the Skin Wellness Assoxiate Nurse (SWAN) program via the Nurses Spcialized in Wound, Ostomy and Continence Canada (NSWOCC) - Support a Nurse to attend "Mind the Gap, Wound Care Institute" viat the RNAO - Continue with "Speed Training" at the bedside based on identified issues - Offer classroom session delivered by a Nurse Spcialized in Wound, Ostomy and Continence	% 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 2020	21	20	2020/21 target not achieved. 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 evidence of improvement originally observed, but has not been sustained; despite >80% compliance with key practice changes. Injury rates from falls suggest that changes implemented have been successful in minimizing the risk of severe injury from falls, with 97% of falls resulting in no injury or minor injury (skin tears, bruises, lacerations), and only 3% resulting in serious or critical injury (hip fracture). Focus for 2020/21 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 = 16.1% (Q2 2020).	1)Sustain changes implemented related to Falls Prevention BPG	Falls QI Team to conduct random audits related to fall prevention process and just-in-time teaching	# of audits completed	TBD based quarterly audits	Not included in MOHLTC Priority Indicator List. Publicly reported indicator (CIHI Your Health System; HQO Long Term Care Performance) Perley Rideau area for monitoring. Aligns with full implementation of RNAO Best Practice Guideline
									2)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. 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 3) % of staff on night shift that meet night rounding expectations	90% compliance for all measures	
		Percentage of residents who were physically restrained (daily)	C	% / Residents	CIHI CCRS / July - September 2020	3.7	3.5	2020/21 target achieved. Significant corrective action implemented Q3 & Q4 2018 in response to statistical decline in performance observed (Q1 2017 - Q3 2018). Restraint rate has declined since this time, with current performance of 5%. No focused activity expected in 2020/21, however, the home will continue to monitor compliance with practice changes to promote sustainability. NOTES: Current performance reflects the blended average of veteran and community residents. Provincial average = 3.2% (Q2 2020)	1)Sustain Positioning Device assessment and care planning process	Quarterly review of sampling of applicable charts (residents with tilt, seatbelt and/or table top) for completeness and accuracy	% of audited assessments completed without error	85% by December 31, 2021	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)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. 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 3) % of staff on night shift that meet night rounding expectations	90% compliance for all measures	

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		Percentage of residents whose behavioural symptoms worsened	C	% / Residents	CIHI CCRS / July - September 2020	16.7	16.5	2020/21 target achieved. The Home has implemented a number of key practice changes and training initiatives since 2016/2017 including Behaviour Mapping, MMSE, ABC meetings, ABC huddles, high risk meetings. Statistical evidence of improvement observed in 2019, with current rate at 17.8%. Introduction of a 20-bed Specialized Behavioural Support Unit (Q1 2018) has not negatively impacted this indicator to date. Focus in 2020/21 will be to sustain the practice changes introduced from 2016 through March 2020. NOTES: Current performance reflects the blended average of veteran and community residents. Provincial Average = 13% (Q2 2020).	1)Sustain structured assessment and screening tools, e.g. Behaviour Mapping, ABC Huddles following high risk incidents	1) 3Ds team to complete review of sampling of behaviour mapping tools and analysis for compeltion and quality 2)3Ds team to review Risk Management reports to confirm compliance with ABC Huddle process	1) % of audited mapping tools completed without error 2) Compliance with ABC Huddle process	1) 80% of mapping tools completed without error by December 31, 2021 2) 80% compliance for residents with high risk behaviour by December 31, 2021	Not included in MOHLTC Priority Indicator List. Not a publicly reported indicator. Perley Rideau area for moderate action. Aligns with full implementation of RNAO Best Practice Guideline.
									2)Test & implement improvements to high risk meetings (to be renamed Interprofessional Rounds) - based on evaluation completed by nursing students in 2019	Leaders of 3Ds QI team to work with other QI leaders to develop approach based on recommendations. New approach to be piloted in Gatineau building.	1) implementation status	1)100% implemented in Gatineau building by June 30, 2021 2)100% implemented across all other units by September 30, 2021	
		QI Capacity	C	N/A	N/A			Capacity Building	1)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	Not included in MOHLTC Priority Indicator List Perley Rideau area for moderate action
									2)Implement the "Developing & Sustaining Nursing Leadership" best practice guideline by RNAO	Focus on the development of an evidenced based mentorship program tailored for the nursing team	specific strategies tbd	TBD	