2018/19 Quality Improvement and Safety Plan - FINAL

31-Mar-18

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	Target for process measure	Comments
Effective	**Effective Transitions - To Reduce Potentially Avoidable Emergency Department Visits**	Number of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents.	Rate per 100 residents / LTC home resident	CIHI CCRS, CIHI NACRS / Q2 2016/17 - Q1 2017/18	15.14	15	The current blended average for community and veteran residents is 15.14, which includes a portion of eligible convalescent care population. Significant practice changes introduced in 2015/16. Focus is on sustaining current performance and introducing strategic improvements. It is anticipated that implementation of frailty-informed care across LTC units in 2018 & 2019 will have a positive impact on performance in this area. Champlain LHIN average = 23.9 (Q2 2016/17 - Q1 2017/18).	1) Sustain hourly comfort care rounds by PSWs 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	90% compliance for both measures	MoHLTC Priority 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) Spread and sustain process and tools to support frailty-informed care across long-stay units	Train staff and physicians and implement tools and approach on long-stay units. Champion model will be used to assist with spread	1) % of residents with completed frailty assessments 2) Number of registered staff champions trained	1) 100% of new admissions on implemented units with completed frailty assessment 2) >6 registered staff	
								3) Continue communication/information sharing with The Ottawa Hospital upon transfer to ED and return from ED.	Continue collaboration with The Ottawa Hospital ED Process Improvement Team. Conduct monthly audits to measure specific initiatives as they are implemented.	TBD as initiatives identified	TBD	
								4) Evaluate use and effectiveness of Stop & Watch (or similar early reporting process for PSWs)	Specific plan to de developed by PSW Supervisors	TBD	TBD	
								5) Discussions with Nurse Practitioner to focus on changes to goals of care	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	
Effective	**To Reduce Pain**	Percentage of residents whose pain worsened	% Residents	CIHI CCRS / July - September 2017	17.1%	15.0%	Changes in practice aligned with BPG on Pain Management largely implemented in 2017. Goal for 2018 and beyond is to sustain changes. Due to the delay of CCRS e-report data, it is anticipated that metric improvement will become more visible in 2018 and beyond as the data catches up to the clinical changes implemented. Mid-term goal (2 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 = 10.2% (Q2 2017).	1) Ongoing monitoring of PRN usage and education related to appropriate usage	Through monthly High Risk Resident report, identify cases which the use of pain PRN can be improved. Provide in-time education as needed.	Number of month for any unit that has no inappropriate PRN usage cited.	3	Not included in MOHLTC Priority Indicator List Perley Rideau area for focused action (high priority) Aligns with full implementation of RNAO Best Practice Guideline. A sustained decrease in the indicator "percentage of residents who have pain" has been observed. The facility is performing slightly above the provincial average. The team will use this indicator to support decision making as well.
								2) Sustain pain screening process at admission	Monthly chart review in PCC to determine use of screening tool.	% of residents that have documented pain assessment/screening at admission within 24 hours	80% compliance	
								3) Design, implement and sustain process to enable consistent care planning for pain (e.g. Pain RAP)	Redesign the process of assessing and care planning for pain. Implement suggested design from frontline staff and resident/family	% of implementation completed	100%	
								4) Implement, spread and sustain structured pain management and monitoring practices (Pain Mapping Tool) to better control resident pain.	Pain QI team to lead implementation of pain mapping tool to identify patterns, triggers and effective pain management strategies for high risk residents.	% of appropriate candidates that have documented pain mapping completed	80% compliance by Dec 31, 2018	
								5) Implement BPG recommendations focused on personalized approaches to care	Pain QI team to prioritize recommendations and implement as appropriate	Timely implementation of select recommendations	Select practices implemented on all 12 units by December 31, 2018	
								6) Sustain hourly comfort care rounds by PSWs 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	90% compliance for both measures	
								7) Review documentation to identify potential gaps related to use of opioids	TBD	TBD	TBD	
Resident-Centred	**Domain 1: "Having a voice" and being able to speak up about the Home.**	Percentage of residents who responded positively to the statement: "What number would you use to rate how well the staff listen to you". (NHCAHPS)	% Residents	In-house survey / 2017 (or most recent 12mos)	N/A	N/A	There is no direct question comparison on the InterRAI QoL survey used at Perley Rideau. Based on international benchmarking data from the interRAI survey, the Home's performance currently sits within the international benchmark range for "Staff act on my suggestions".	1) Spread and sustain process and tools to support frailty-informed care across long-stay units	Train staff and physicians and implement tools and approach on long-stay units. Champion model will be used to assist with spread	1) % of residents with completed frailty assessments 2) Number of registered staff champions trained	1) 100% of new admissions on implemented units with completed frailty assessment 2) >6 registered staff	MoHLTC Priority Indicator Perley Rideau area for moderate action PaTH aligns with listening to and acting on residents suggestions
	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 / 2017 (or most recent 12mos)	86%	85%	Based on international benchmarking data from the interRAI survey, the Home's performance currently sits within the international benchmark range (between median and top 20th percentile). Performance in this area ranked #1 among peer organizations in the Seniors Quality Leap Initiative (SQLI). The focus for 2018/19 is to maintain our consistently high performance in this area, while introducing strategic improvements as needed.	1) Strengthen Resident and Family Relations Process, with a focus on the Home's complaint management process	1) Revise policy and procedure to ensure alignment with LTCHA, ECFAA and Accreditation requirements 2) Streamline process and tool for data collection and analysis	1) P&P implemented 2) New tool implemented	1) New P&P implemented by February 23, 2018 2) New data collection tool implemented by February 23, 2018	

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Quality dimension	**Objective**	**Measure/Indicator**	**Unit / Population**	**Source / Period**	**Current performance**	**Target**	**Target justification**	**Planned improvement initiatives (Change Ideas)**	Methods	Process measures	Target for process measure	Comments
	Domain 3: "Overall Satisfaction"	Percentage of residents responding positively to: "I would recommend this site or organization to others" (interRAI QoL)	% / Residents	In-house survey / 2017 (or most recent 12mos)	87%	85%	Based on international benchmarking data from the interRAI survey, the Home's performance currently sits within the international benchmark range. Performance in this area ranked #1 among peer organizations in the SQLI. The focus for 2018/19 is to maintain our consistently high performance in this area, while introducing strategic improvements as needed.	1) Evaluate and grow 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) Include Family and/or Resident Advisors on QIP teams	1) Number of formally trained resident and family advisors (cumulative) 2) Number of projects/initiatives with Family/Resident Advisor	1) 15 Advisors by Dec 31 2018 2) 100% of QIP teams include Family and/or Resident Advisors by Dec 31 2018	
								2) Undertake food services review	Director Food Services to engage with residents and staff on benchmarking best practices, redesigning menu and recommending/implementing changes to food services system.	1) Number of benchmarking sites 2) Timeliness of review and recommendations 3) % Resident satisfaction with food on 2019 InterRAI QoL survey	1) Minimum 3 sites benchmarked by August 30 2018 2) Review and recommendations completed by Dec 31s 2018 3) 10% improvement in resident satisfaction with food by 2019	
								3) Conduct a gap analysis to better understand the drivers of social life	Collaborate with SQLI to complete gap analysis	TBD	TBD	Initial work in this area will focus on how homes address mood/depression and the linkage between this and good social life (quality of life)
Safe	**Medication Safety - To Enhance Evidence-Based Use of Antipsychotics in LTC**	Percentage of residents on antipsychotics without a diagnosis of psychosis	% / Residents	CIHI CCRS / July - September 2017	15.1%	12.0%	Although still performing better than provincial average, facility has seen a deterioration in performance attributable to a change in coding practice that has resulted in fewer residents coded as end-stage disease in the RAI-MDS. The facility has been working on a process with Pharmacy to improve documentation of diagnosis to support prescribing of antipsychotics. NOTES: Current performance reflects the blended average of veteran and community residents. Provincial average = 20% (Q2 2017).	1) Conduct chart review to identify potential candidates for deprescribing	Participation in CFHI-SQLI Antipsychotic Deprescribing Collaborative (commencing January 2018)	1) # of staff that have participated in Collaborative Launch Workshop 2) % of residents on pilot unit with completed chart review	1) >15 staff and champions attending Launch Workshop in March 2018 2) 100% of residents on pilot unit have completed chart review by September 30, 2018	MoHLTC Priority Indicator Perley Rideau area for moderate action
Safe	**To Reduce Worsening of Pressure Ulcers**	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	% / Residents	CIHI CCRS / July - September 2017	6.2%	3.0%	Implementation of BPG related to the prevention of pressure injuries has been completed, supported by in-depth education and training for registered staff. Due to the delay in CCRS e-report data, significant metric improvement will likely not be visible until 2018 and beyond. Mid-term goal (2 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 = 3.2% (Q2 2017).	1) Sustain practice changes implemented in 2017/18 related to prevention of pressure injuries	Team to conduct chart reviews to evaluate compliance with key practice changes	TBD	TBD	MOHLTC Additional Indicator Perley Rideau area for focused action Aligns with full implementation of RNAO Best Practice Guideline
								2) Begin implementation of best practice guideline related to the treatment of pressure injuries	Conduct gap analysis to identify opportunities for improvement	TBD based on identified priorities	TBD	
								3)Sustain hourly comfort care rounds by PSWs 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	90% compliance for both measures	
								4) Establish a wound champion network	TBD	Number of champions	TBD	
Safe	**To Reduce Falls**	Percentage of residents who fell in the past 30 days	% / Residents	CIHI CCRS / July - September 2017	18.5%	18.0%	Significant work completed in this area from 2016-2017. Metric improvement evident in 2017/18 as facility achieved identified target for improvement (18.5%). Focus for 2018/19 is sustainability of changes and performance. Mid-term goal (2 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 = 15.6% (Q2 2017).	1) Sustain changes implemented in 2016 & 2017	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	MOHLTC Additional Indicator Perley Rideau area for moderate action Aligns with full implementation of RNAO Best Practice Guideline.
								2) Implement, spread and sustain team communication tools including: - Fall risk logo	Develop and test a new transfer logo process designed to reduce waste. Process revisions will include the following: Standardize language used in transfer logos to match RAI language and improve the workflow associated with changing transfer requirements in order to maintain accuracy.	% of transfer logo audits in the resident's room that match the care plan	Implementation by July 2018: 100% of transfer status requirements match the care plan	
								3) Sustain hourly comfort care rounds by PSWs 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	90% compliance for both measures	

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								4) Focused data review and evaluation on units where metric improvement not yet achieved	TBD	TBD	TBD	
								5) Conduct gap analysis against updated BPG for falls to identify additional areas for improvement	Team to complete gap analysis to identify opportunities to further improve practice	TBD based on identified priorities	TBD	
Safe	**To Reduce the Use of Restraints**	Percentage of residents who were physically restrained (daily)	% / Residents	CIHI CCRS / July - September 2017	6.7%	5.5%	The Home has achieved significant improvement in this area as a result of changes implemented in 2012/13, with average restraint use improving over time from 19.7% to 6.4%. Improvements appear to be sustained, however, performance has recently risen above the provincial average (5.0% as of Q2 2017). Target of 5.5% remains unchanged as most recent data has not consistently been at or better than the identified target of 5.5%. No focused activity expected in 2018/19, however, the home will continue to monitor restraint practices at the Home. NOTES: Current performance reflects the blended average of veteran and community residents.	1)Conduct quarterly 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%	MOHLTC Additional Indicator Perley Rideau area for continued monitoring
								2) Sustain hourly comfort care rounds by PSWs 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	90% compliance for both measures	
								3) Evaluate effectiveness of restraint assessment tool	Team to evaluate tool to determine if achieving desired outcomes - assisting with clinical decision making, efficient, etc.	1) evaluation completed 2) revised tool developed and implemented	1) evaluation completed by July 31, 2018 2) new tool implemented by December 31, 2018	
Safe	**To Reduce Responsive Behaviours**	Percentage of residents whose behavioural symptoms worsened	% / Residents	CIHI CCRS / July - September 2017	20.3%	19.0%	The Home implemented a number of key practice changes and training initiatives in 2016/2017 including Behaviour Mapping, post incident reviews (ABC meetings) and high risk meetings. However, only modest metric improvement observed to date due to the complexity of responsive behaviour management and the lack of timely CCRS e-report data (data lags by approx. 2 quarters). It is anticipated that metric improvement will become more visible in 2018 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 2017).	1) Sustain and evaluate structured assessment and screening tools implemented in 2016 & 2017 - Behaviour Mapping	Develop audit process and tool for sustainability of behaviour mapping	Run quarterly report on Behaviour mapping summary note and cross reference with "Criteria to initiate behavior mapping" which includes: identified high risk new admission, escalation in physically responsive incidents, change in condition or other (as identified or assessed by registered staff). % of residents that meet behaviour mapping criteria that have documented behaviour mapping.	80% of residents by September 2018	Not included in MOHLTC Priority Indicator List Perley Rideau area for focused action (high priority) Aligns with full implementation of RNAO Best Practice Guideline. This work will also align with PaTH. Work related to monitoring/evaluating antipsychotic medication is part of the RNAO's Advanced Practice Fellowship
								2) Sustain and evaluate high risk meetings	Manager of Resident Care (Gatineau Building), in collaboration with 3Ds QI team, to develop and implement evaluation plan	1) compliance of monthly high risk meetings across the home 2) completion of evaluation re: effectiveness of meetings	1) 100% compliance on all units 2) evaluation completed by September 30, 2018	
								3) Test, implement and spread screening and assessment / reassessment practices - MMSE, ABC Huddles	1) Finish educating registered staff on MMSE tool 2) ABC Huddles introduced at shift reports and linked to RAI cycle and high risk behaviour. Chart review conducted monthly to determine compliance	1a) % of day and evening registered staff trained on MMSE 1b) % of MMSEs completed within 14 days of admission. 2a) ABC Huddles implemented across the Home 2b) Compliance with ABC Huddle process	1a) >80% trained by December 31, 2018 1b) 80% of residents with MMSE completed within 14 days admission by December 2018. 2a) 100% implementation by December 31, 2018 2b) 80% compliance for residents with high risk behaviour by December 31, 2018	
								4) Full implementation of the dementia-related recommendations of the RNAO BPG related to the assessment and care of delirium, dementia and depression	3Ds QI team conducted gap analysis against BPG and is currently working to implement all recommendations that were identified as "partially met"	Implementation of all recommendations identified as "partially met"	100% recommendations implemented across the Home by March 31, 2019	

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								5) Test, implement and sustain process for the monitoring and evaluating antipsychotic medications	BPSO Lead developing tool and process to enable consistent monitoring and evaluation of antipsychotic medications. Chart review to determine compliance with process.	% of med changes that comply with identified process	80% by December 31, 2018	
Safe	**To Eliminate Risk of Resident Abuse**	Number of staff to resident abuse/neglect incidents reported to the MOHLTC through CIS System	#/Residents	MOHLTC Critical Incident Reporting System / Jan - Dec 2017	4	0	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. Focus in 2018/19 is to use the Model for Improvement to better understand contributing factors to potential resident abuse/neglect.	1) Conduct a gap analysis to better understand different drivers of resident abuse,	Leverage BPG on Preventing and Addressing Abuse and Neglect of Older Adults	Gap analysis completion	Gap analysis completed and priorities identified by June 30, 2018	
								2) Focus on staff wellness and resilience	Leverage IHI Framework for Improving Joy in Work	Gap analysis completed	Gap analysis completed and priorities identified by September 30, 2018	
								3) Continue to raise awareness of abuse, reporting and whistle-blowing	1) Abuse awareness week 2) Evaluate current education program	1) % of staff that attended abuse awareness week activities	1) >75% attendance	
Safe	**Medication Safety - To Improve the Medication Management Approach**	Number of reported medication errors	#/Residents	MEDeReport [Medical Pharmacies Client Resources] (July-September 2017)	48	40	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) Monitor usage of the medication incident reporting system.	1) Leverage data to make improvements to medication management policy and practice	TBD	TBD	
								2) Other initiatives as identified (and prioritized) by ISMP assessment	Medication Management team to complete ISMP assessment and prioritize results	TBD	TBD	
								3) Evaluate and improve medication reconciliation for short-stay residents	Pharmacy and team to complete a current state analysis to understand opportunities for improvement	TBD	TBD	
Safe	**To Strengthen Infection Prevention and Control Program**	N/A	N/A	N/A	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) 80% compliance	
Safe	**Build a Culture of Safety**	N/A	N/A	N/A	N/A	N/A	Capacity building	1) Enhance modified root cause analysis tool and process for rapid review and learning following incidents and near-misses.	Performance Improvement Consultant and small team to evaluate current process and implement changes as appropriate.	1) Modified RCA tool evaluated and changes recommended and implemented 2) Frequency of use of RCA tool	1) Tool evaluated and enhanced by Sept 30, 2018 2) 1 modified RCA/quarter	Not included in MOHLTC Priority Indicator List Perley Rideau area for moderate action Aligns with Accreditation Canada expectations

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								2) Continue to strengthen education on Just Culture, promoting open communication	Performance Improvement Consultant to lead the implementation of identified actions. Evaluation of success to be completed together with staff engagement survey 2018.	1) Education on Just Culture 2) Include Just Culture category as part of the Root Cause Analysis action planning process 3) Staff familiarity with Just Culture through survey	1) Number of education provided to different groups according to plan 2) Number of Root Cause Analysis discussed the category of incident under Just Culture 3) TBD	
								3) Continue to participate in CPSI Patient Safety Week	Continue the practice of Annual Safety Week for the third year. Improve participation of the activities.	TBD	TBD	
								4) Review Resident Safety Incident Management Program and associated policies	Develop revised program and associated policies	Approval of revised program	Approved by March 31, 2018	
Enabling	**Build QI Capacity**	N/A	N/A	N/A	N/A	N/A	Capacity building	1) Continue to train and educate leaders and front line staff in quality improvement through internal and external programs. Leverage existing external program (IDEAS, etc.) and incorporate QI training into internal educational opportunities (LDIs).	Focus efforts on QI training for staff involved in QIP teams. 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 2018. 2) QI content delivered at QIP team training sessions 3) Number of front line staff/supervisors attending external QI educational opportunity	1) QI education provided at ≥1 Leadership Development Institute(s) in 2018 2) ≥10 3) >10	Not included in MOHLTC Priority Indicator List Perley Rideau area for moderate action
								2) Plan and implement changes to RAI MDS process	RAI MDS Coordinator, Mgr. - QI and RAI, and team to implement enhancements to PCC (as required); documentation practices; RAI and care planning process; analysis and decision support activities	1) % key staff receiving training on new RAI and care planning process 2) Timely implementation of phase 1 of RAI enhancements 3)% of care plans reviewed and locked by care team on time 4) Decision support measures TBD following development of plan	1) 100% staff trained on new RAI process by May 1, 2018 2) Phase 1 implemented by March 1, 2018 3) 90% care plans reviewed and locked by care team by December 31, 2018 4) TBD	
								3) 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	