Bonnechere Manor Continuous Quality Improvement Interim Report

Designated Lead: Trisha Michaelis, Director of Care

Continuous Quality Improvement

Bonnechere Manor is please to share it's 2023/24 Quality Improvement Plan (QIP). The annual QIP outlines the key actions we are committed to implementing to ensure we maintain the highest standards of care through continuous evaluation and improvement of the care and services we deliver.

Process used to Identify Priority Areas for Quality Improvement

Each year, the priority areas for quality improvement are determined based on the recommendations of the Continuous Quality Improvement Committee, approved through Health Committee and County Council, and informed through:

- The results of the Resident and Family/Caregiver Experience Survey
- The County of Renfrew Mission Statement and Strategic Plan
- The Long-Term Care Home (LTCH) Mission Statement and Strategic Plan
- The LTCH Operational Plan
- LTCH Quality Indicators
- Goals and Objectives of the Ottawa Valley Ontario Health Team (OHT)
- Provincial and Legislative requirements and initiatives

These quality improvement initiatives are reflective of our broader organizational strategic plan, and closely align with our Mission, Vision, and Values.

Mission Statement: With a person-centered approach, Bonnechere Manor is a safe and caring community to live and work.

Vision: Leading excellence in service delivery

Values: Honesty and Integrity, Professionalism, Client Service Orientation, Focus on Results

Bonnechere Manor 2023/24 Priority Quality Objectives

Bonnechere Manor quality priorities are themed in accordance with the established long-term care system performance measures and quality indicators developed through **Health Quality Ontario (HQO)**.

Theme I: Timely and Efficient Transitions

Measure Dimension: Efficient

Indicator #1	Type	Unit/ Population	Source/ Period	Current Performance	Target	Target Justification	External Collaborators
Number of ED visits for modified list of ambulatory care – sensitive condition * per 100 long-term care residents.	P	Rate per 100 residents / LTC home residents	CIHI CCRS, CIHI NACRS/ October 2020 - September 2021	15.27	12	Focus will be placed on education for early assessment, intervention and utilization of Nurse Practitioner (NP) to treat residents in home. Maintain current performance as BM is below the provincial average of 16.0	

Change Idea #1 Reduce the number of potentially avoidable ED visits thru early Nursing assessment and reporting to practitioner for symptoms of treatable conditions.

Methods	**Process measures**	**Target for process measure**	**Comments**
1. DOC to resume Monthly tracking of ED transfers via ED tracking tool. 2. Registered staff to report changes in condition in a timely manner to NP or physician. 3. NP will continue to respond to acute change in condition to support early diagnosis and treatment efforts. 4. Improved documentation in progress notes ensuring nursing assessments and nursing process is evidenced.	Residents who have been transferred to ER should have supporting documentation that is evident of the nursing process and supporting appropriate assessments.	1. ED tracking tool will be analysed 4 x/year 2. In-services for documentation and assessments will be provided to Registered staff by our Resident Care Coordinators. 3. Chart Audits will be completed for any resident sent to the ED.	

Change Idea #2 Improved Advanced Care planning with resident/POA/SDM

Methods	Process measures	Target for process measure	Comments
1. Social Worker and NP will ensure goals of care discussions take place at scheduled care conferences. 2. Provide Education to resident/POA/SDM related to advanced directives. 3. Create information related to Advanced Care Planning that would be available to residents/POA/SDM's prior to admission for discussion to be prepared for day of admission discussion	Registered staff will audit admission and Care conference notes to ensure discussions are occurring. Audit advanced directives in charts.	100% documented discussions by SW, NP, Registered Nurse or MRP following admission.	

Theme III: Safe and Effective Care

Measure Dimension: Safe

Indicator #2	Type	Unit/ Population	Source/ Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment	p	% / LTC home residents	CIHI CCRS /	27.34	19.00	Provincial benchmark is 19.3 %.	

Change Idea #1 Optimization of medication through targeted de-prescribing using a planned and supervised process of dose reduction or stopping of medication that might have adverse side effects, or no longer be of benefit to individual residents on a case by case basis.

Methods	Process measures	Target for process measure	Comments
Bonnechere Manor's de-prescribing initiative for the 2023/2024 year will start as a small scale change initiative starting with 2 resident home areas based on drug utilization rates, in addition to a continued focus on antipsychotic usage rates on our Butterfly home area.	Quarterly Drug Utilization reports (DURs)-Average # of medications per unit.	Goal is to reduce overall antipsychotic use to 19%.	New admissions have a higher rate of both antipsychotic use and overall # of medications as a result of efforts to manage care in the community. Many medications must be tapered.

Change Idea #2 BSO Champion and NP will work together to ensure that an antipsychotic medication review is conducted for all residents who are prescribed antipsychotics. Further interventions as needed to decrease use of antipsychotics will be initiated (i.e., DOS mapping, GMH consultations) and follow up with residents physicians.

Methods	Process measures	Target for process measure	Comments
BSO Champion and NP will audit residents charts to ensure that an antipsychotic medication review has been completed in each quarter.	Number of antipsychotic medication reviews completed by the BSO champion and NP	80 % of residents receiving antipsychotics will have antipsychotic medication review completed within the first 6 months.	

Indicator #3	Type	Unit/ Population	Source/ Period	Current Performance	Target	Target Justification	External Collaborators
Falls: This indicator measures the percentage of long-term care (LTC) home residents who fell during the 30 days preceding their resident assessment. The indicator is calculated as a rolling four quarter average. This indicator was jointly developed by interRAI and the Canadian Institute for Health Information (CIHI).	C	% / LTC home residents	CIHI CCRS, CIHI NACRS/ July - September 2021	16.6	14	Provincial Benchmark is 16.7.	

Change Idea #1 1.Complete a new GAP analysis of the Falls Prevention Program. 2. Identify and define roles of the Champion/Lead Registered staff member to lead the Falls Prevention Program and to deliver educational sessions as required.

Methods	Process measures	Target for process measure	Comments
Resident Care Coordinator lead for falls or designate (Falls Champion) will educate all registered staff regarding the process for management of falls importance of safety huddles, medication reviews for frequent falls, effectiveness of interventions and individualized care plans.	Percentage of completed education sessions	100% of Registered staff	

Change Idea #2 Reinitiate the interdisciplinary Fall Risk Committee.

Methods	Process measures	Target for process measure	Comments
Membership will include an interdisciplinary team that supports collaborative discussions to attain reduced falls in the home to meet clinical indicators.	Planned monthly meetings- will review falls and identify those residents that fell despite interventions in place. Collaborative discussions to identify if other interventions would be appropriate.	Monthly meetings to be completed at 100%.	

Indicator #4	Type	Unit/ Population	Source/ Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of long-term care home residents who developed a stage 2 to 4 pressure ulcer or had a pressure ulcer that worsened to a stage 2, 3 or 4				2.7	2.00	There has been an upward trend this year therefore an improvement of 1% is reasonable.	

Change Idea #1 A reduction in pressure wounds will be evidenced quarterly.

Methods	Process measures	Target for process measure	Comments
Revise the present policy and program to include an interdisciplinary model of care that focuses on prevention strategies and treatments according to best practices. Review current best practices for wound care and skin integrity. Develop education for Registered staff and PSWs with respect to the wound care program and their roles. Meet with Medline to streamline product selection and usage- Essentially standardizing treatment and interventions for wounds. Implementation to incorporate using pictures for wounds on the residents PCC charts for monitoring and comparison between dressing changes.	Registered staff will be able to assess and provide treatment to stage 1 and 2 wounds. Referral to Nurse Practitioner is utilized for stage 3 and 4 wounds.	90% of Registered staff will complete education on the Wound and Skin Integrity Program. 100% of residents with a stage 3 or 4 wound will be assessed by the Nurse Practitioner.	

Description of Quality Improvement Procedures and Protocols

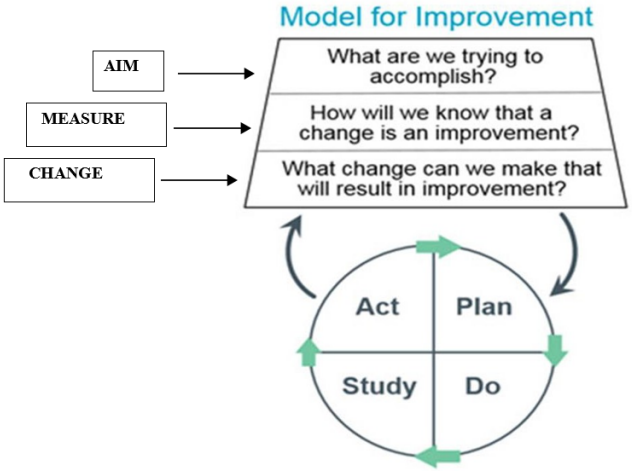
Bonnechere Manor uses Health Quality Ontario's comprehensive Quality Improvement Framework to guide Quality Improvement Initiatives. The Health Quality Ontario (HQO) QI Framework consists of six (6) phases. Each phase is iterative and designed to build on knowledge gained in the previous phase. The HQO six phases of QI are:

Process to Monitor & Measure Progress & Identify & Implement Adjustments

The Continuous Quality Improvement designated lead(s) within the home apply science-based models and methodologies supported by HQO to facilitate both the "thinking" and "doing" perspectives of the quality improvement process. The **Model for Improvement** (developed by the Associates in Process Improvement) helps to support focused "thinking", and the "doing" perspective is achieved through **PDSA (Plan-Do-Study- Act) Cycles** designed to test and implement change ideas. This structured approach is supported through

application of situationally appropriate QI support tools (i.e. 5-Why's, Fishbone, Pareto Charts, Run Charts, etc.).

Model for Improvement:



Types of Measures: Four (4) types of measures are used measure progress in quality improvement.

1. **Outcome Measures**: are "the voice of the resident" (or population to be impacted by the change), and capture system performance (i.e. reduction in falls).
2. **Process Measures**: are "the voice of the workings of the system", and capture the changes quality improvement efforts make to the steps (inputs) that contribute to system outcomes (i.e. percentage of times staff apply best practices).
3. **Balancing Measures**: determine whether changes designed to improve one part of the system are causing problems in other parts of the system.
4. **PDSA Measures**: are collected with each test of change (PDSA cycle), and provide knowledge about the effect of each change attempt on the process and the system.

Communication Plan & Record of Quality Initiative Evaluation(s)

Communication Plan: Health Quality Ontario's Communication Plan Tool is used by the QI lead(s) to create clarity around who the communications are intended for, what the frequency of the communications will be, and the key messages and methods to be employed. The Communications Plan ensures that planned changes are communicated to the various audiences that the changes will impact, and help's to avoid gaps in communication that can result in a lack of buy-in for the project overall.

Evaluation: The Bonnechere Manor Continuous Quality Improvement Committee (CQIC) meets quarterly to make recommendations regarding priority areas for quality improvement in the home, to coordinate and support the implementation of quality improvement initiatives, and to monitor and report on quality issues. Through the CQIC, a record is maintained which sets out the names of the persons who participated in evaluations of improvements. This record is included in the annual Continuous Quality Improvement Initiative Report.