2023/24 Quality Improvement Plan
"Improvement Targets and Initiatives"

Bruyere Continuing Care Inc. 43 Bruyere Street, Ottawa , ON, K1N5C8

AIM		Measure									Change				
Issue	Quality dimension	Measure/Indicator	Type	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	External Collaborators	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
M = Mandatory (all cells must be completed) P = Priority (complete ONLY the comments cell if you are not working on this indicator) A= Additional (do not select if you are not working on this indicator) C = Custom (add any other indicators you are working on)															
Theme I: Timely and Efficient Transitions	**Efficient**	Percentage of patients and clients able to see a doctor or nurse practitioner on the same day or next day, when needed.	C	% / PC organization population (surveyed sample)	In house data collection / April 2023- March 2024	91397*	50	60.00	Our current performance is adequate compared with the provincial average but we note a decrease year on year in the last few years. Thus we would like to see		1)Same Day (SD) Appoinment Data Tracking Development. Use SD appointment type to keep track of SD supply and demand. 2. Identify high walk-in users to better understand their care needs	1.a Get clerical team involved in keeping SD data accurate: Add SD in detail of each sameday appointment, regardless if being used by patient or not 1.b Practice Facilitator to review data on walk-in and same day clinic useage 2. Approach individual providers about high walk-in users to provide context to usage	1.a. review with clerical staff (lead clerks) on monthly basis how writing "SD" in front of each sameday appointments is happening by looking up a small number of schedules and calculating # of same day appointments with SD in details/ # SD appointment reviewed 1.b # patients offered same day/next day / # patients requesting same/day next day	2. 80% Denominator: Number of requests for same-day/next day; Numerator: ability to be able to offer same-day/next day.	
		Percentage of those hospital discharges for deemed to be "high risk" patients (either by their comorbidities or socioeconomic factors) where (within 48 hours) notification was received, for which follow-up was done (by any mode, any clinician) within 7 days of discharge.	C	% / Discharged patients	EMR/Chart Review / Last consecutive 12 month period	91397*	29	80.00	Our goal is that 80% of all discharge summaries are reviewed to assess if follow is required. Follow up could be by phone or in person with the appropriate team member.		1)Following previous year's process evaluation, we are implementing a modified stamp using a single form that will include basic data from the discharge summary as well as data collected by RN or clinical staff on follow up after discharge to facilitate data extraction. This form will include items deemed important for the follow up with the patient (i.e. med rec, reason for hospitalisation, readmission within 30 days phone encounter details)	Use our quality committee to evaluate modified process for post-discharge assessments as detailed below, specifically one new element ; the scanners will now be inserting a discharge f/u form into patient chart before messaging the providers. Form process 1. scanners will insert single form into patient chart when receiving a discharge summary report. Will complete their section into form [date of discharge, date of reception of discharge, admission date, other] 2. scanners then send message to providers directly attached to the form to alert them about the discharge summary reception 3. Providers to mark on form if follow up is required or not and then to forward to proper RN or health professional 3. RN or other health professional complete the remaining clinical sections of the form	# of discharge summaries that are assessed / total # of discharge summaries	1. 80% of all discharge summaries will have been assessed (either using the formal discharge assessment stamp or a review of the discharge summary by the MD/MRP)	Our goal is to have appropriate follow up for those patients deemed to be "high risk" either by their comorbidities or socioeconomic factors
Theme II: Service Excellence	**Patient-centred**	Discharge Experience: Overall Discharge experience	C	% / All inpatients	In house data collection / April 2023 - March 2024	932*	50.7	52.00	2.5% Improvement over current performance (up to January 2023)		1)Bruyere @home program.	Bruyere @Home program rolled out for stroke, geri and GS patients	percentage of patients referred to @ home program discharged within 2 days of their expected discharge date.	90% of discharges met discharge date.	
											2)Home First re-launch.	Home first education for AH and clinical Managers	Percentage of AH and CM group provided education	100% is the target for process	
											3)Hospital to Home Patient Experience Program	Quality coordinators to work with programs to review current H2H data to identify 1 targeted opportunity to improve discharge experience	Percentage of programs/units that have implemented a patient discharge experience QI project	100% is the target for process measure	100% of units with community discharges implemented a discharge experience QI project.
		Patient experience: Would you recommend this hospital to family or friends if they needed this type of care?	C	% / Discharged patients	Hospital collected data / Aril 2023- March 2024	932*	69.2	70.90	2.5% Improvement over current performance (up to January 2023)		1)Re-institute focused rounding	Nursing always practice refresher education - focused rounding	Percentage of patients who respond always to Q29 of the patient experience survey (Do you see your nurse on a regular basis?)	51.90% target for process measure	2.5% improvement over current
											2)Care Boards usage improvement	Provide training and education on the use of care boards in hospital programs	Percentage of care boards completed with up to date information	80% is the target for process	
											3)All programs to review current patient experience data to identify 1 targeted opportunity to improve patient experience	Quality Coordinators to work with the program/unit to identify areas for improvement and roll out a formal quality improvement project.	Percentage of programs/units that have implemented a patient experience QI project	100% is the target for process	
		Percentage of residents who responded positively to: "I participate in meaningful activities"	C	% / LTC home residents	In house data, interRAI survey / April 2023-March 2024	51651*	22	30.00	Incremental increase in participation targeted for the coming fiscal year		1)Return to pre-pandemic recreation model.	Return to non-cohorted activities (e.g. bingo, live music, mass) and continue to offer small group activities according to the modified activities planned during an outbreak	Number of non-cohorted activities offered monthly	4 at each site per month	
											2)Adjust staffing to offer evening and weekend activities	Implement a Resident Support Aide position which will supplement TRS off hours (RSL) Corporate level recruitment efforts for volunteers	RSA position implemented by June 2023 and increase volunteers assisting with activities by 20% by September 2023. % of residents who respond positively that they have enjoyable things to do in the evenings and % of residents who respond positively that they have enjoyable things to do on weekends	Evenings RSL – 36% REB – 65% Weekends RSL – 21% REB – 34%	
											3)Offer more opportunities for meaningful group sessions with Chaplain	Number of Chaplain led group discussions per month (RSL) - Resident surveys	12 Chaplain led group activities per month at RSL -% of residents who respond positively that they participate in religious activities that have meaning to them L12	RSL – 60% REB – 73%	
											4)Restart resident skill and interest groups, external outings (e.g. Offer knitting club, cooking club)	Empower residents to lead/facilitate activities (e.g., resident council, Java, gardening, musical activities, etc.) - Get to know our residents and their interest/stories (e.g., psychosocial assessment, All About, etc.)	Number of skills and interest groups running monthly (2 at each home) % of residents who respond positively that they have the opportunity to explore new skills and interests	RSL – 20% REB – 25%	

										5)Collect resident quality of life data throughout the entire year	Survey residents throughout the year	Data collection split over at least a 5 month period (currently over 1-2 months)-	Each eligible resident to be approached during the collection times	
		Percentage of residents who responded positively to: "I participate in meaningful activities"	C	% / LTC home residents	In house data, interRAI survey / April 2023-March 2024	53536*	15	30.00	Incremental increase in participation targeted for the coming fiscal year		1)Return to pre-pandemic recreation model.	Return to non-cohorted activities (e.g. bingo, live music, mass) and continue to offer small group activities according to the modified activities planned during an outbreak	Number of non-cohorted activities offered monthly	4 at each site per month	
											2)Adjust staffing to offer evening and weekend activities	Implement a Resident Support Aide position which will supplement TRS off hours (RSL) Corporate level recruitment efforts for volunteers	RSA position implemented by June 2023 and increase volunteers assisting with activities by 20% by September 2023. % of residents who respond positively that they have enjoyable things to do in the evenings and % of residents who respond positively that they have enjoyable things to do on weekends	Evenings RSL – 36% REB – 65% Weekends RSL – 21% REB – 34%	
											3)Offer more opportunities for meaningful group sessions with Chaplain	Number of Chaplain led group discussions per month (RSL) - Resident surveys	12 Chaplain led group activities per month at RSL -% of residents who respond positively that they participate in religious activities that have meaning to them L12	RSL – 60% REB – 73%	
											4)Restart resident skill and interest groups, external outings (e.g. Offer knitting club, cooking club)	Empower residents to lead/facilitate activities (e.g., resident council, Java, gardening, musical activities, etc.) - Get to know our residents and their interest/stories (e.g., psychosocial assessment, All About, etc.)	Number of skills and interest groups running monthly (2 at each home) % of residents who respond positively that they have the opportunity to explore new skills and interests	RSL – 20% REB – 25%	
											5)Collect resident quality of life data throughout the entire year	Survey residents throughout the year	Data collection split over at least a 5 month period (currently over 1-2 months)-	Each eligible resident to be approached during the collection times	
Theme III: Safe and Effective Care	**Effective**	Percent of patients with social determinants of health (SDH) included in the EMR	C	% / Patients	In specific cohorts at the clinic / April 2022-March 2023	91397*	1	40.00	Identifying SDH has been identified as important in alignment with clinic strategic plan but implementation of change effort has been slow.		1)Community Liaison Clerk to keep track of vulnerable patients by updating appropriate PS Suite cohorts	Identify patients who will be offered to fill out Health Equity Questionnaire by adding them to appropriate cohorts (patients who have been referred FHT Social Workers, or referred by providers as well as selecting patients in the cohort of St. Mary's, Bethany Hope and Cornerstone Housing and Myanmar refugee	% of patients in the the cohort of St. Mary's, Bethany Hope, Cornerstone Housing and Myanmar refugee; referred to the Social Workers or identifed in chart with HEQ information in the chart	40% is the target for process	
											2)Introduce usage of self-reporting new Health Equity Questionnaire (HEQ) for patients by using tablets to allow patients to fill out in waiting room	Track number of patients who were offered to fill out Health Equity Questionnaire (HEQ) (denominator) give them Self reporting Health Equity Questionnaire to fill out in waiting room	Calculate the percentage of patients who completed the questionnaire over the number of patients who were offered to fill out Health Equity Questionnaire (HEQ).	40% is the target for process	
											3)Introduce better tracking of HEQ and social determinants of health by using tools developed and provided by other Champlain FHT (HEQ form, toolbar to track HEQ usage in patient chart)	Track the number where the Health Equity Questionnaire has been completed and documented in the chart.	Calculate the percentage of Health Equity Questionnaires that have completed and documented in the chart.	40% is the target for process	
		Percentage of patients discharged from hospital for which discharge summaries are delivered to primary care provider within 48 hours of patient's discharge from hospital	C	% / Discharged patients	Hospital collected data / April 2023-March 2024	932*	85.7	85.00	Maintain current target		1)Identify barriers to completion: vacation coverage, co-signing with collaborative documentation.	Chart audit, brainstorming with medical chiefs, then department physician meetings. Reminder to pay attention to "Sign" in MEDITECH when it is red. Detailed reports to be provided monthly to department chiefs.	Complete chart audit to determine primary causes for delayed discharge summaries.	100% of discharges on the two lowest performing units will be audited to identify reasons for not meeting the 48 hour timeline, on a quarterly basis.	Indicator performance and target are based on full fiscal year data
		Proportion of primary care patients with a progressive, life-threatening illness who have had their palliative care needs identified early through a comprehensive and holistic assessment.	C	Proportion / at-risk cohort	Local data collection / Most recent 6 month period	91397*	CB	CB	We will be looking at the Number of patients (85+) patients with documented assessment of palliative care needs. New effort so we do not have baseline measure. However we feel a 20% improvement over baseline would demonstrate an improvement at this stage.		1)Elder Care program nurse to create cohort in PS Suite by reviewing patient population 85+ (by registry or by provider referral) to identify if discussion of early advanced care planning has been noted to improve uptake. Identification Criteria: -patient age 85+ - referral from providers	1. Elder Care Nurse to add patient to appropriate PS Suite cohort (ECP- Elder Care Program case load ACTIVE or ECP- Elder Care Program case load DISCHARGE) 2. Elder Care Nurse to note in chart if patient had early advanced care planning discussion	Number of patients who are part of ECP case load who have had advanced care planning discussion /total number of patients in ECP case load	20% increase over baseline	Gathering baseline data

Safe	Number of workplace violence incidents reported by hospital workers (as defined by OHSA) within a 12 month period.	P	Count / Worker	Local data collection / Jan 2022–Dec 2022	932*	58	64.00	The target has been increased to reflect the goal to increasing staff reporting		1)Continue monitoring, coaching and training of the online incident reporting and investigation system. We will also expand the flagging system used to identify patients and visitors who pose a risk of violence to staff to in our Long-Term Care facilities.	In person training on the on-line incident reporting & investigation system is provided to all Directors, managers and supervisors in clinical and operations departments. Remaining management and front-line staff reached via corporate e-mail announcement and Intranet. OHSS reviews violence incidents reports and investigations to ensure all necessary information provided and corrective measures implemented.	Percentage of new managers and directors trained on the reporting system.	100% of new managers/directors trained.	Introduction of on-line system resulted in improved reporting and investigation time, quality, and quantity of information.
	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 / Jul - Sept 2022	51651*	23.74	21.00	Target set to ensure incremental change towards provincial average.		1)Update data on residents prescribed antipsychotics, including new starts, prn, and administration rates to identify appropriate residents for deprescribing	Audits to take place	Conduct audits on all residents who are prescrbed anti-psychotics	Regular audits is the target	
										2)Interdisciplinary team to identify resident needs and deprescribe accordingly	Conduct interdisciplinary discussions for opportunities to begin or continue gradual dose reduction, create enhanced care plans with non pharmaceutical interventions, as appropriate, and deprescribe accordingly	Conduct interdisciplinary discussions via different forums	Regular interdisciplinary reviews	
	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 / Jul - Sept 2022	53536*	29.17	26.00	Target set to ensure incremental change towards provincial average.		1)Update data on residents prescribed antipsychotics, including new starts, prn, and administration rates to identify appropriate residents for deprescribing	Audits to take place	Conduct audits on all residents who are prescribed anti-psychotics	Regular audits to take place	
										2)Interdisciplinary team to identify resident needs and deprescribe accordingly	Conduct interdisciplinary discussions for opportunities to begin or continue gradual dose reduction, create enhanced care plans with non pharmaceutical interventions, as appropriate, and deprescribe accordingly	Conduct interdisciplinary discussions via different forums	Regular interdisciplinary reviews	
	Percentage of non-palliative patients newly dispensed an opioid prescribed by any provider in the health care system.	P	% / Patients	CAPE, CIHI, OHIP, RPDB, NMS / 6 month period ending Mar 31, 2022	91397*	3.5	5.80	Maintain performance which is already 15% below provincial average.		1)Reduce number of patients on over 90meq of morphine.	Increase the number of MDs using mypractice reports 2. Build registry of patients on high dose morphine; pharmacist and Chronic Disease Management Nurse will review this list and then collaborate with providers on a strategy to reduce use. We have piloted this approach once in the past year.	1. % of doctors signed up for mypractice reports. 2. Denominator: #patients on over 90meq of morphine, Numerator: #patients offered support by pharmacist and CDMN to reduce opioids. 3. # patients on 90 meq or more of morphine.	1.75% physicians signed up. 2. 100% over 90meq had their charts reviewed and the MRP/patient explored options to reduce dose of opioids. 3. 15% decrease in # patients in our FHT on >90meq morphine 4. 10% increase over baseline; qualitative data from survey	
	Patient falls (for every 1000 patient days)	C	% / All inpatients	RIMS/Meditech / April 2023-March 2024	932*	3.76	3.80	Maintain current performance		1)Programs to roll out program specific targeted falls intervention	Programs where falls are above target will review available falls intervention strategies and identify a priority intervention for the program	Percentage of programs/units where falls rate that have implemented targeted falls interventions	100% is the target for process	
	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 since their previous resident assessment	C	% / LTC home residents	CIHI CCRS / July-September 2023	51651*	7.4	6.50	Target set to ensure incremental change towards provincial average.		1)Engagement of teams in unit based target setting (ex: pressure injuries per month)	Involve interdisciplinary team through meetings and committees	Monthly target reports shared to assess current status	8 monthly reports shared	
										2)Emphasizing and sustaining focused rounding	Reinforce and review expectations	Regular reviews of PCC documentation reports by administration	70% is the target for process measure	
										3)Additional training offered on Skin and Wound care (eg: CRLI module, in-services)	Education for staff	Staff complete education	100% of all registered staff	
										4)Staffing adjustments on units with higher ADL needs (through 4 hours of care)	Review needs and assign staffing accordingly	New positions filled by fall 2023	100% of positions filled	
										5)Monitoring of PURS and acute care stays - for increased risks (focus on 2AB, 3AB and EBR 5Y)	Audits to be completed	Administration to complete audits	Quarterly audits completed by administration	
										6)Education to residents and loved ones (ie: nutrition, resistance to positioning, new information brochure, etc.)	Education to residents and loved ones	Administration to offer different formats of training (brochure, education session etc) for residents and loves ones	2 educational formats to be offered within the next year	

										7)Implement new continence assessment tool and program	Roll-out (education and implementation)	Targeted approach for roll-out	100% of new admissions have this assessment completed within 21 days of admission	
	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 since their previous resident assessment	C	% / LTC home residents	CIHI CCRS / July-September 2023	53536*	5.7	5.00	Target set to ensure incremental change towards provincial average.		1)Engagement of teams in unit based target setting (ex: pressure injuries per month)	Involve interdisciplinary team through meetings and committees	Monthly target reports shared to assess current status	8 monthly reports shared	
										2)Emphasizing and sustaining focused rounding	Reinforce and review expectations	Regular reviews of PCC documentation reports by administration	70% is the target for process measure	
										3)Additional training offered on Skin and Wound care (eg: CRLI module, inservices)	Education for staff	Staff complete education	100% of all registered staff	
										4)Staffing adjustments on units with higher ADL needs (through 4 hours of care)	Review needs and assign staffing accordingly	New positions filled by fall 2023	100% of positions filled	
										5)Monitoring of PURS and acute care stays - for increased risks (focus on 2AB, 3AB and EBR 5Y)	Audits to be completed	Administration to complete audits	Quarterly audits completed by administration	
										6)Education to residents and loved ones (ie: nutrition, resistance to positioning, new information brochure, etc.)	Education for residents and loved ones	Administration to offer different formats of training (brochure, education session etc) for residents and loves ones	2 educational formats to be offered within the next year	
										7)Implement new continence assessment tool and program	Roll-out (education and implementation)	Targeted approach for roll-out	100% of new admissions have this assessment completed within 21 days of admission	
	Resident falls (for every 1000 resident days)	C	% / LTC home residents	CIHI CCRS / July-September 2023	51651*	9.92	10.30	Target set to ensure incremental change towards provincial average.		1)Engagement of teams in unit based target setting (e.g., falls per month)	Involve interdisciplinary team through meetings and committees	Monthly target reports shared to assess current status	8 monthly reports shared	
										2)Emphasizing and sustaining focused rounding	Reinforce and review expectations	Regular reviews of PCC documentation reports by administration	70% is the target for process measure	
										3)Reviewing and enhancing fall squad huddles to better understand why, when, what contributing factors, etc. to the falls and determine an interdisciplinary approach	Interdisciplinary meetings	Hold regular interdisciplinary meetings to review identified frequent fallers	Interdisciplinary team documents, reviews and follow-up in a shared electronic space	
										4)Increasing staff and specialized support in higher fall risk areas (through 4 hours of care	Review needs and assign staffing accordingly	New positions filled by fall 2023	100% of positions filled	
										5)Standard shift report	Enhancing and standardizing shift reports	Design and implement a standardized shift report	Shift report designed and implemented	
										6)a) Enhancements to care conferencing and b) education to loved ones (winter-spring 2023; new information brochure)	a) Standardized care conferences b) Education	a) Standardizing care conferences b) Develop a brochure on fall prevention	a) standardized care conferences for all residents b) Brochure developed and distributed	
										7)Antipsychotic reduction (ongoing)	As per the antipsychotic indicator	As per the antipsychotic indicator	As per the antipsychotic indicator	
										8)Visual identification on rooms of high risk fallers (TBD if we include for this year or work on items ahead first)	Identification on rooms of high risk fallers	Pilot visual identification on rooms (at least one unit)	100% of frequent fallers rooms identified for pilot unit	
	Resident falls (for every 1000 resident days)	C	% / LTC home residents	CIHI CCRS / July-September 2023	53536*	4.63	4.90	Target set to ensure incremental change towards provincial average.		1)Engagement of teams in unit based target setting (e.g., falls per month)	Involve interdisciplinary team through meetings and committees	Monthly target reports shared to assess current status	8 monthly reports shared	
										2)Emphasizing and sustaining focused rounding	Reinforce and review expectations	Regular reviews of PCC documentation reports by administration	70% is the target for process measure	

											3)Reviewing and enhancing fall squad huddles to better understand why, when, what contributing factors, etc. to the falls and determine an interdisciplinary approach	Interdisciplinary meetings	Hold regular interdisciplinary meetings to review identified frequent fallers	Interdisciplinary team documents, reviews and follow-up in a shared electronic spaced	
											4)Increasing staff and specialized support in higher fall risk areas (through 4 hours of care)	Review needs and assign staffing accordingly	New positions filled by fall 2023	100% of positions filled	
											5)Standard shift report	Enhancing and standardizing shift reports	Design and implement a standardized shift report	Shift report designed and implemented	
											6)a) Enhancements to care conferencing and b) education to loved ones (winter-spring 2023; new information brochure)	a) Regular care conferences b) Education	a) Standardizing care conferences b) Develop a brochure on fall prevention	a) standardized care conferences for all residents b) Brochure developed and distributed	
											7)Antipsychotic reduction (ongoing)	As per the antipsychotic indicator	As per the antipsychotic indicator	As per the antipsychotic indicator	
											8)Visual identification on rooms of high risk fallers	Identification on rooms of high risk fallers	Pilot visual identification on rooms (at least one unit)	100% of frequent fallers rooms identified for pilot unit	