# Maple View Lodge

## Continuous Quality Improvement

### DESIGNATED LEAD -Coralee Boileau

### QUALITY PRIORITIES FOR 2023

Maple View Lodge is pleased to share its 2023 Quality Improvement Plan (QIP). Our ongoing commitment to quality is reflected in our mission to achieve excellence in the health, safety and well-being of our residents with a focus on innovation in person centered and frailty-informed care and service. These factors included, amongst others, the ongoing impacts of the COVID-19 pandemic, persistent healthcare worker shortage and burnout, increased public attention on long term care, and increased regulation of an already highly regulated environment. The core pillars of the long-term strategy remain relevant, and are reflected in the refreshed strategy which outlines objectives and priorities for 2022 - 2025. These objectives include "Sustaining excellence in resident care", as well as embodying a "People First" philosophy. The QIP is a roadmap to achieving both of these objectives, while navigating challenges and opportunities in our environment.

Our QIP is aligned with our Quality Framework, our ongoing collaboration with the Registered Nurses Association of Ontario (RNAO) as a Best Practice Spotlight Organization (BPSO) and based on the Quadruple Aim framework adopted by Ontario Health. The high-level priorities for this year's QIP are informed by the quality and safety aims as follows:

- increase resident and family experience
- reduce preventable harm
- provide the "right care" 100% of the time
- improve health-related quality of life
- improve staff experience

Priorities are divided into 3 categories based on the projected scope of work anticipated for the year – focused action, moderate action and monitoring. Areas for action are included in this report.

## QUALITY OBJECTIVES FOR 2023/24

**Focused Action:**

1. Reduce the percent of residents who had greater than 1 infection from 14.9% to 10%

**Moderate Action:**

2. Increase the percentage of residents who have their palliative care needs identified and documented from 95% to 100%.
3. Reduce the # of residents with unplanned weight loss from 11% to 7%
4. Increase the # of residents who respond positively to, "What number world you use to rate how well the staff listen to you?" from 90% to 95%
5. Reduce the % of residents who have a new Stage 2-4 Pressure Ulcer from 7.2%to 4%

## QIP PLANNING CYCLE AND PRIORITY SETTING PROCESS:

QIPs submitted to Health Quality Ontario (HQO) every April. Our QIP planning cycle typically begins in October, and includes an evaluation of the following factors to identify preliminary priorities:

- progress achieved in recent years;
- ongoing analysis of performance data over time available from NQuIRE and the Canadian Institute for Health Information (CIHI); with areas indicating a decline in performance over time and/or where benchmarking against self-identified peer organizations suggests improvement required
- resident, family and staff experience survey results;
- emergent issues identified internally (trends in critical incidents) and/or externally;
- input from residents, families, staff, students, volunteers, managers and external partners, including the MOLTC.
- mandated provincial improvement priorities (e.g. HQO)

Preliminary priorities are subsequently presented and discussed at various forums to validate priorities and identify additional priorities that may have been missed. These forums include the broader management team, Resident Councils, Stakeholder (Quality) Advisory Committee, Family Council & Occupational Health & Safety Committee. This is an iterative process with multiple touchpoints of engagement with different stakeholder groups as QIP targets and high-level change ideas are identified and confirmed. Final review of the QIP is completed by the Quality Lead, and presented at Professional Advisory Committee where the plan is endorsed for approval by the Administrator of the home. Following this the plan is shared with the Committee of Management.

## APPROACH TO CQI (POLICIES, PROCEDURES AND PROTOCOLS):

The home's nursing and administrative policies, combined with practice standards, provide a baseline for staff in providing quality care and service. As a Best Practice Spotlight Organization our Home utilizes Best Practice Guidelines to evaluate and guide practice. Interprofessional quality improvement teams, including resident and family advisors, work to:

### 1. Diagnose/Analyze the Problem:

Teams use Gap Analysis against relevant Best Practice Guidelines and various QI methodologies to understand some of the root causes of the problem and identify opportunities for improvement. This work can include high level process mapping or value stream mapping, 5 whys, fishbone, etc. Also included in this work is an analysis of relevant data and benchmarking using the NQuIRE and CIHI systems.

### 2. Set Improvement Aims:

Once teams have a better understanding of the current system they aim to improve as well as an understanding of what is important to the resident, an overall improvement aim is identified. This aim will be used to evaluate the impact of the change ideas through implementation and sustainability.

Our improvement team develops aim statements that are Specific, Measurable, Attainable, Relevant, Time-Bound (SMART). A good aim statement includes the following parameters - "How much" (amount of improvement – e.g. 30%), "by when" (a month and year), "as measured by" (a big dot indicator or a general description of the indicator) and/or "target population" (e.g. all residents, residents in specific area, etc.)

### 3. Develop and Test Change Ideas:

With a better understanding of the current system, the improvement team identifies various change ideas that will move us towards meeting its aim statement. During this phase, teams will prioritize alignment with best/prevailing practices when designing preliminary change ideas for testing. Additionally, the team will leverage the Hierarchy for Effectiveness when selecting change ideas, with the team favoring system redesign, process standardization, and force function over education and policy change.

Plan-Do-Study-Act (PDSA) cycles are used to test change ideas through small tests of change. PDSAs provide an opportunity for teams to iteratively refine their change ideas and build confidence in the solution prior to implementation. Change ideas typically undergo several PDSA cycles before implementation.

**4. Implement, and Sustain:**

The improvement team considers the following factors when developing a strong implementation/change management plan:

- Outstanding work to be completed prior to implementation (e.g. final revisions to change ideas based on PDSAs, embedding changes into existing workflow, updating relevant P&P, etc.)
- Education required to support implementation, including key staff resources (e.g. Change Champions)
- Communication required to various stakeholders, both before during and after implementation
- Approach for spread across the home, if completed in a phased approach

At this stage, the team will also identify key project measures to determine if the changes implemented resulted in improvement. This family of measures includes the following types of measures:

Outcome:

- Measures what the team is trying to achieve (the aim)

Process:

- Measures key activities, tasks, processes implemented to achieve aim

Balancing:

- Measures other parts of the system that could be unintentionally impacted by changes

Prior to implementation, improvement teams develop a sustainability plan. The plan identifies the different strategies the team will use to evaluate and address both short term and long-term sustainability of the changes implemented.

## PROCESS TO MONITOR AND MEASURE PROGRESS, IDENTIFY AND IMPLEMENT ADJUSTMENTS AND COMMUNICATE OUTCOMES:

A key component of the sustainability plan is the collection and monitoring of the key project measures over time. Run charts with established rules for interpretation, are essential to understanding if there has been an improvement or deterioration in performance. Analysis of the Outcome measure(s) will be used to identify if the Home is achieving the desired outcomes or not. If not achieving desired outcomes, the team can review the Process measure(s) over time to either confirm compliance with key change ideas (suggesting the change idea may not be as effective at improvement outcomes) or identify gaps in compliance that need to be addressed. Based on the results of this analysis, the team may consider alternative change ideas, provide coaching to staff to enhance compliance, engage with staff to better understand gaps in compliance, etc.

At an organizational level, the home has adopted a report to monitor and measure progress on strategic aims. This report is used for Operational indicators

Communication strategies are tailored to the specific improvement initiative. These include, but are not limited to:

- Posting on BPSO and quality boards
- Publishing narrative explanations and results on the website, on social media or via the newsletter
- Direct email to staff and families and other stakeholders
- Handouts and one to one communication with residents
- Presentations at staff meetings, Resident Councils, Family Council
- Huddles at change of shift
- Use of Champions to communicate directly with peers