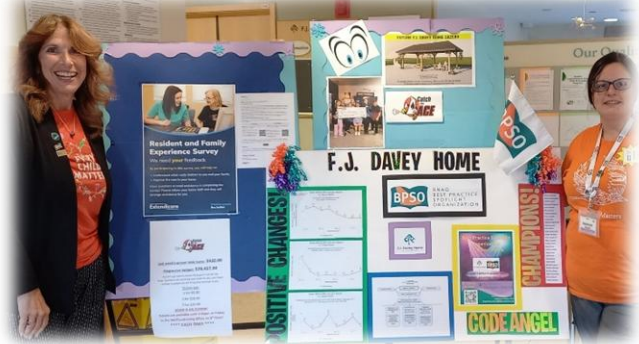


100 years of action and impact Evidence Booster



#BPSOHeroes



RNAO Nursing Quality Indicators for Reporting and Evaluation®

Introduction

The Registered Nurses' Association of Ontario (RNAO) is the professional association representing registered nurses, nurse practitioners and nursing students in Ontario, Canada. Since 1925, RNAO has advocated for healthy public policy, nursing excellence, and empowered nurses to influence health system decisions and improve community outcomes.

Globally recognized for its leadership in guideline development, RNAO excels in creating, implementing, and evaluating evidence-based practice guidelines (BPGs). These BPGs are widely adopted across healthcare sectors, driving improvements on client/person, organizational and health system outcomes. The BPG program is renowned for its rigorous guideline development and transformational approaches, contributing significantly to implementation science, and robust evaluation methodology.

Through the Best Practice Spotlight Organization® (BPSO®) initiative, RNAO partners with the health service organizations and academic institutions to systematically implement BPGs over a three-year period, with biennial renewals. This collaboration fosters a culture of evidence-based practice ensuring sustained and measurable improvements. RNAO's work continues to shape nursing excellence and healthcare transformation worldwide.

To support and advance the evaluation of BPG implementation in BPSOs, RNAO launched Nursing Quality Indicators for Reporting and Evaluation® (NQuIRE®) in August 2012. NQuIRE is an international data system that collects, analyzes, and reports data on indicators reflecting the structures, processes, and outcomes of nursing care. NQuIRE was designed for health-care organizations collaborating with RNAO to systematically monitor their progress and evaluate their outcomes of implementing RNAO BPGs in their organizations.

Evidence Boosters



Evidence Boosters (EB) are two-page infographics that highlight the impact of BPG implementation on clinical and organizational outcomes. EBs feature innovative strategies and success stories that demonstrate how organizations integrate BPGs into their practices, showcasing quality improvement results. BPSOs can generate EBs through NQuIRE using a standardized template, with content rigorously reviewed for quality assurance. EBs serve as valuable resources in internal meetings for sharing thoughts, assigning action items, and promoting interprofessional collaboration. EBs can also enhance conference presentations, webinars, training sessions and newsletters by disseminating evidence-based practice outcomes.

This Special Edition Evidence Booster features four health-care organizations in Ontario, Canada, including two long-term care (LTC) facilities and two acute care settings. The study adopted a robust **mixed-methods approach**, combining quantitative analysis through NQuIRE and qualitative insights gathered via MyBPSO and an unstructured interview guide to collect data from BPSOs, ensuring a comprehensive analysis. Data collection spanned within a four-year period, from 2020 to 2024, capturing a wide range of information that varied across the participating organizations.



Best Practice Guidelines Featured in this Evidence Booster



RNAO.ca/bpg



About RNAO's Best Practice Guidelines

Pain: Prevention, assessment and management (Fourth edition)

The [*Pain: Prevention, assessment and management*](#) (4th ed.) BPG provides nurses and members of the interprofessional team with evidence-based guidance for the prevention, assessment and management of all types of pain across the lifespan.

This BPG is to be used by nurses and members of the interprofessional team across the health care continuum and in all domains of practice caring for persons at risk of or currently experiencing pain.

Person- and Family-Centred Care (2015)

The [*Person- and Family-Centred Care*](#) (2015) BPG promotes evidence-based practices to help nurses and interdisciplinary team become more adept at practicing person- and family-centred care. This evidence-based approach, combined with a perspective that recognizes the place of the person at the centre of health care, can improve persons' experience of and satisfaction with the care and services provided within the health system.

Pressure injury management: Risk assessment, prevention and treatment (2024)

The [*Pressure injury management: Risk assessment, prevention and treatment*](#) (2024) BPG provides nurses, members of the interprofessional team and other collaborators (i.e., administrators and policy-makers) with evidence-based recommendations for risk assessment, prevention, and treatment of pressure injuries. It provides evidence-based recommendations for nurses, and the interprofessional team, and persons and their caregivers across all care settings and sectors. The recommendations address the prevention of pressure injuries for at-risk people, and the assessment and management of those living with pressure injuries.








Preventing Falls and Reducing Injury from Falls (2017)

The [*Preventing Falls and Reducing Injury from Falls*](#) (2017) BPG increases identification of adults at risk of falls across the health-care continuum, including those living in the community and reduce the frequency and severity on adults who fall.

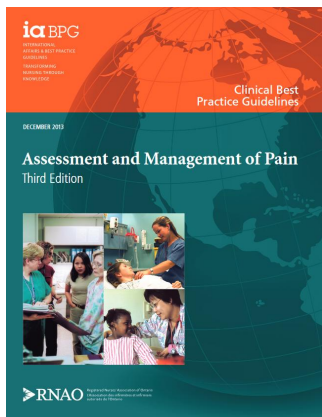
NQuIRE® Indicators for health-care organizations

Data dictionaries

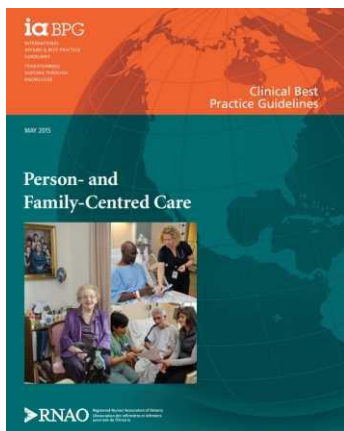
By cluster By guideline category

Online	PDF
Clinical Management	
Assessment & Management of Pressure Injuries for the Interprofessional Team (Third Ed. May 2016)	
Assessment and Management of Pain	
Preventing Falls and Reducing Injury from Falls (Fourth Edition, September 2017)	
Risk Assessment and Prevention of Pressure Ulcers	
Vascular Access (Second Edition, 2021)	
A Palliative Approach to Care in the Last 12 Months of Life (PDF only)	
Foundational	
Person- and Family-Centred Care (May 2015)	

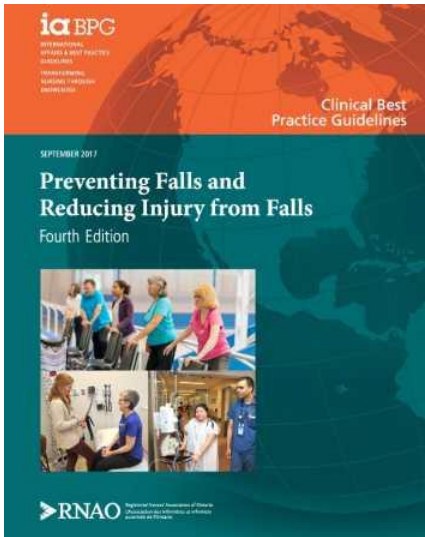
[NQuIRE Data Dictionary page](#)



<i>Assessment and Management of Pain (2013)</i>	
Indicator	Definition
Worsened Pain	Percentage of clients whose pain worsened (higher Pain Scale score on their target assessment than on their prior assessment) during the measurement period

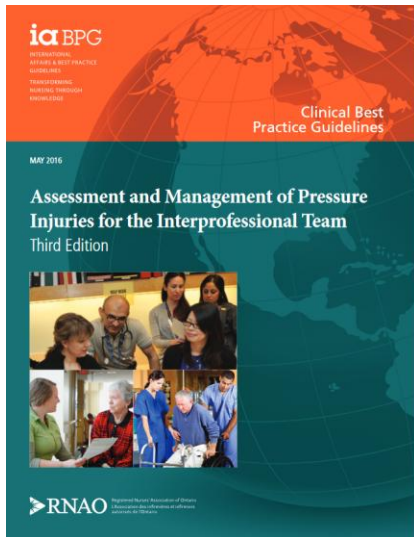


<i>Person- and Family-Centred Care (2015)</i>	
Indicators	Definition
Plan of care	Percentage of persons participating in developing their personalized plan of care
Involvement	Percentage of persons satisfied with their involvement in the planning of care and treatment
Rate of complaints	Rate of complaints received from persons receiving care per 1000 care-days/care visits



Preventing Falls and Reducing Injury from Falls (2017)

Indicators	Definition
Falls risk screening	Percentage of adults screened for falls risk
Falls rate	Rate of falls per 1000 adult care-days/care-visits



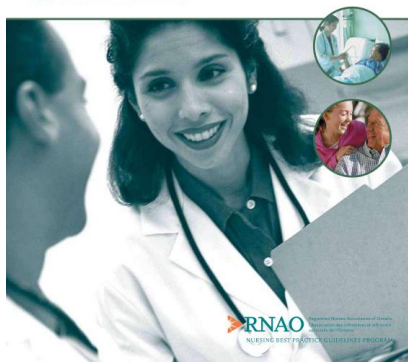
Assessment and Management of Pressure Injuries for the Interprofessional Team (2016)

Indicator	Definition
Pressure injuries (PI) risk assessment	Percentage of persons with PI who received a risk assessment for developing additional PI



Risk Assessment & Prevention of Pressure Ulcers (2005)

Indicator	Definition
Pressure ulcer incidence	Percentage of persons who developed one or more new stage II to IV pressure ulcers during the measurement period





Valleyview Home

[Valleyview Home](#) is located in the heart of St. Thomas, Ontario – a vibrant city known for its strong community spirit and dynamic economic growth. Valleyview Home stands as a beacon of compassionate care and support. Since 1969, this 136-bed long-term care facility, owned and operated by the City of St. Thomas, has been a trusted haven for residents, offering a warm, home-like environment that prioritizes well-being and connection. Valleyview Home has been recognized as a BPSO since 2023.

At Valleyview Home, the core values of respect, compassion, communication, safety, accountability, and teamwork guide every aspect of care. The dedicated team is committed to enhancing the physical, emotional, spiritual, and psychological health of residents, ensuring they feel valued and supported. Through personalized care plans, engaging activities, and meaningful relationships with families and the broader community, Valleyview fosters a sense of belonging and purpose for all who call it home.

As St. Thomas continues to grow, with exciting developments like the upcoming Volkswagen battery plant bringing new opportunities to the region, Valleyview Home remains steadfast in its mission to adapt and evolve. The facility is dedicated to meeting the changing needs of the community while maintaining its high standards of quality care.



L to R: Shelly Charlton, Sylvia Van Meppelen Scheppink, Shelley Thomas, Leslie Morgan, Jennifer Schneider, Isabella Marion, Debbie Lamb

Valleyview Home

Better outcomes, less complaints: Person-and family-centred long-term care

Aim: To examine the clinical outcomes associated with implementing RNAO's *Person-and Family Centred Care* (PFCC) (2015) BPG at a long-term care home in St. Thomas, Ontario.

Measures: The NQuIRE[®] data system was used to determine (a) the percentage of residents participating in developing their personalized plan of care; (b) the percentage of residents satisfied with their involvement in the planning of care and treatment and (c) the rate of complaints received from residents receiving care.

Participation in developing their plan of care




27.1%

From 2022 to 2024, there was an increase in the percentage of persons participating in developing their personalized plan of care.

Satisfaction with the involvement in planning of care and treatment



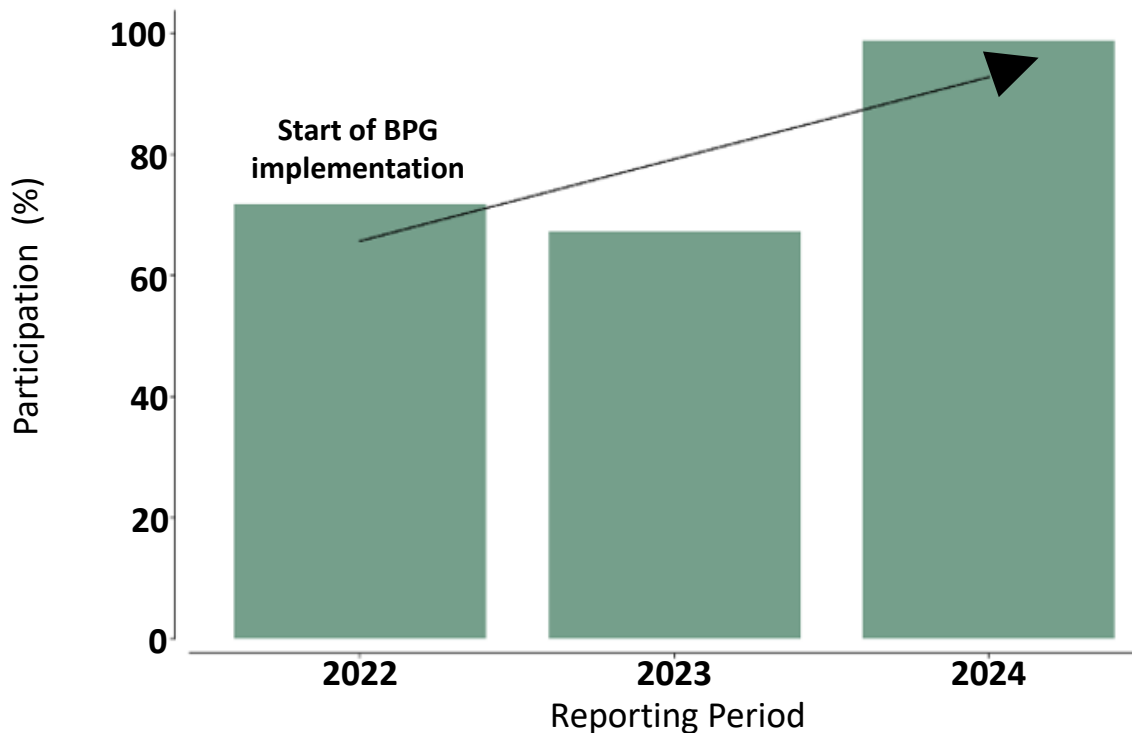
From 2022 to 2024, there was a slight increase in the percentage of persons satisfied with their involvement in the planning of care and treatment

 **0.09** **Rate of complaints**
From 2022 to 2024, the rate of complaints consistently maintained below 0.09.



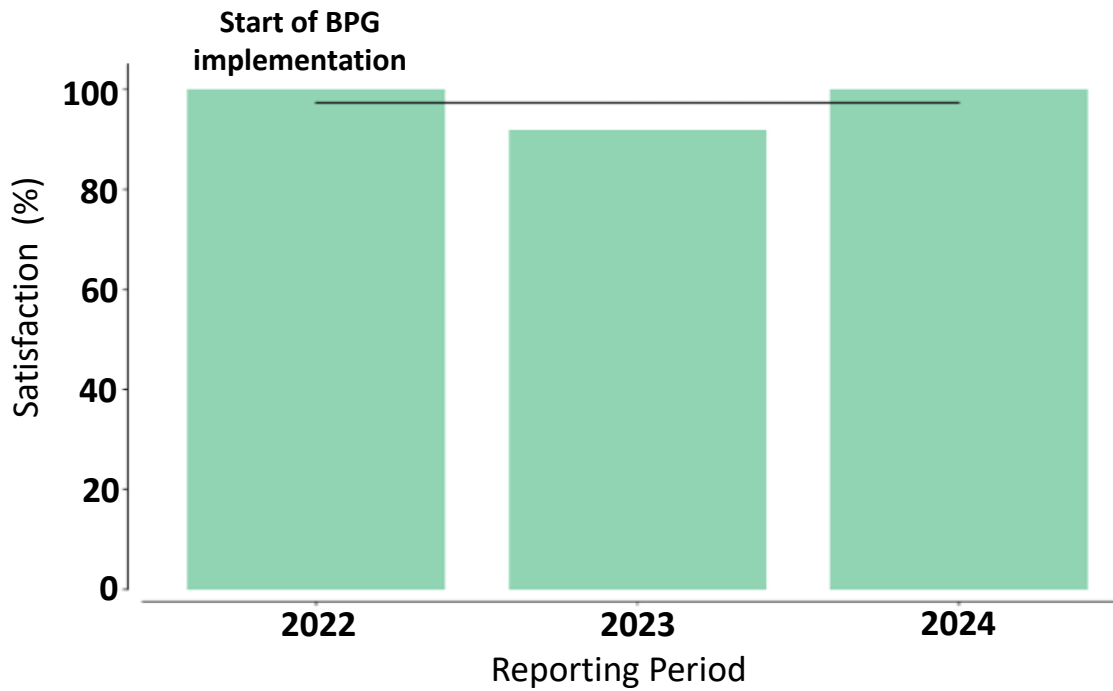
Valleyview Home demonstrated that implementing RNAO's *Person-and Family Centred Care* (PFCC) (2015) BPG led to an increase in residents' participation and satisfaction in developing their personalized plan of care and treatment. This approach led to a reduction in complaints, reflecting improved resident engagement and satisfaction.

Figure 3: Residents' participation in the planning of care (%)



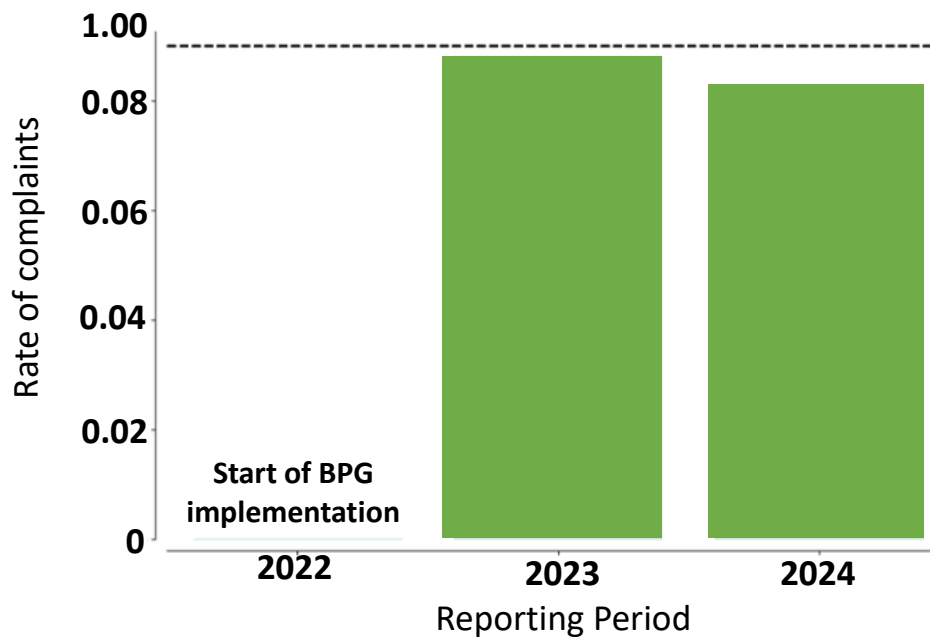
Impact: From 2022 to 2024, there was a 27.1 per cent (from 71.6 to 98.7 per cent) increase in the percentage of residents participating in developing their personalized plan of care.

Figure 4: Satisfaction with involvement in care planning and treatment(%)



Impact: From 2022 to 2024, the percentage of residents satisfied with their involvement in the planning of care and treatment remained at 100 per cent.

Figure 5: Rate of complaints



Impact: From 2022 to 2024, Valleyview Home consistently maintained a complaint rate below 0.09.

Practice Changes

Valleyview Home implemented the *Person-and Family Centred Care* (2015) BPG in 2023 to enhance resident outcomes and optimize their quality of life.

Key initiatives include:

- **Purposeful rounding:** Implemented a structured, proactive rounding to address residents' needs consistently, conducted hourly rounds and follow-ups as needed. A purposeful rounding task in Point of Care (POC) was created and added to document rounding activities. Registered staff will receive alerts for specific concerns, such as pain, identified during rounding. Regular audits are conducted to ensure accurate and thorough documentation.
- **Admission process:** Enhanced the admission process by integrating RNAO Clinical Pathways, ensuring new residents benefit from a more personalized, PFCC approach. Social workers conduct detailed interviews with new residents, documenting essential information to be included in their care plans.
- **Care conferences:** Revised and improved the care conference structure to prioritize a person-centred approach, ensuring active participation from residents, families, and substitute decision-makers. Residents are strongly encouraged to attend their own care conferences, where staff thoroughly review the care plan with them and their families. Discussions focus on modifying the care plan by adding or removing elements based on the resident's preferences and needs. A mandatory section in the care conference assessment requires documentation of any changes made, updates to the care plan, and feedback on whether the resident and family are satisfied with the care provided. Monthly audits are conducted to ensure completeness and accuracy of the documentation. Future enhancements may include refining the assessment with more specific questions to further improve the process.
- **Communication and Involvement:** Fostered a culture of active listening, where staff attentively engage with residents and their identified care partners to ensure care decisions reflect their preferences, values, and changing needs. Regular resident council meetings provide a platform for residents to voice their wants, needs, and concerns. Residents have access to a range of services, including occupational therapy, physiotherapy, music therapy, art therapy, animal therapy, and dental care, ensuring a holistic approach to their wellbeing.

- **Education and staff training:** Continuous staff development through ongoing education and mandatory training modules, completed during orientation and annually. These trainings reinforce the principles of the Resident's Bill of Rights and PFCC, ensuring staff are equipped to deliver compassionate, respectful, and individualized care that aligns with residents' needs and preferences.
- **Care plan:** Registered staff ensure resident care plans are regularly updated to reflect any changes in treatment, interventions, or goals, fostering clear communication across care teams. Personal care booklets, which capture residents' hobbies, preferences, likes/dislikes, and other personal details, are completed collaboratively with residents and families upon admission. This information is integrated into the care plan and monitored during regular chart audits. Open visiting hours are maintained to encourage family involvement, and care plans are sensitive to and inclusive of non-medical aspects of care, ensuring a person-centred approach.





Toronto Grace Health Centre

[The Salvation Army Toronto Grace Health Centre \(TGHC\)](#), located in downtown Toronto, is a 150-bed facility and renowned for compassionate, clinical excellence, and person-and family-centred care. TGHC provides specialized care for individuals with complex medical needs who require Complex Continuing Care, Post-Acute Care Rehabilitation, Palliative Care, and Integrated Transitional Services.

Recognized as a BPSO since 2018, TGHC has demonstrated its leadership in adopting and implementing 11 RNAO BPGs across various clinical areas. These BPGs include: a) *Transitions in Care and Services* (2023); b) *Person-and Family-Centred Care* (2015); c) *Vascular Access* (2021); d) *Assessment and Management of Pressure Injuries for the Interprofessional Team* (2016); e) *Assessment and Management of Foot Ulcers for People with Diabetes* (2013); f) *Preventing Falls and Reducing Injury from Falls* (2017); g) *Assessment and Management of Pain* (2013); h) *Delirium, Dementia, and Depression in Older Adults: Assessment and Care* (2016); i) *Ostomy Care and Management* (2009); j) *Integrating Tobacco Interventions into Daily Practice* (2017); and k) *Preventing Violence, Harassment and Bullying Against Health Workers* (2019).

TGHC is committed to fostering a culture of evidence-based practice across all aspects of care delivery. By embedding these BPGs into daily practice, TGHC has enhanced patient safety and care, and also improved patient outcomes.



L to R: Arlenne Gonzalvo-Atienza, Yolanda De Vega, and Marian Abdelsayed

Toronto Grace Health Centre

Implementing multiple BPGs, improving clinical outcomes

Aim: To examine the clinical outcomes associated with the implementation of RNAO's *Assessment and Management of Pressure Injuries for the Interprofessional Team* (2016) and the *Person-and Family Centred Care* (2015) BPGs at a hospital in Toronto, Ontario.

Measures: The NQuIRE[®] data system was used to determine the percentage of persons (a) with pressure injuries who received a risk assessment for developing additional pressure injury (PI) and (b) the satisfaction with their involvement in the planning of care and treatment.

Risk assessment for developing additional PI

100%

From 2020 to 2024, TGHC maintained and sustained 100 per cent in the risk assessment for developing additional PI.

Satisfaction with the involvement in the planning of care and treatment



5.8%

From 2020 to 2024, there was an increase in the percentage of persons satisfied with their involvement in the planning of care and treatment.


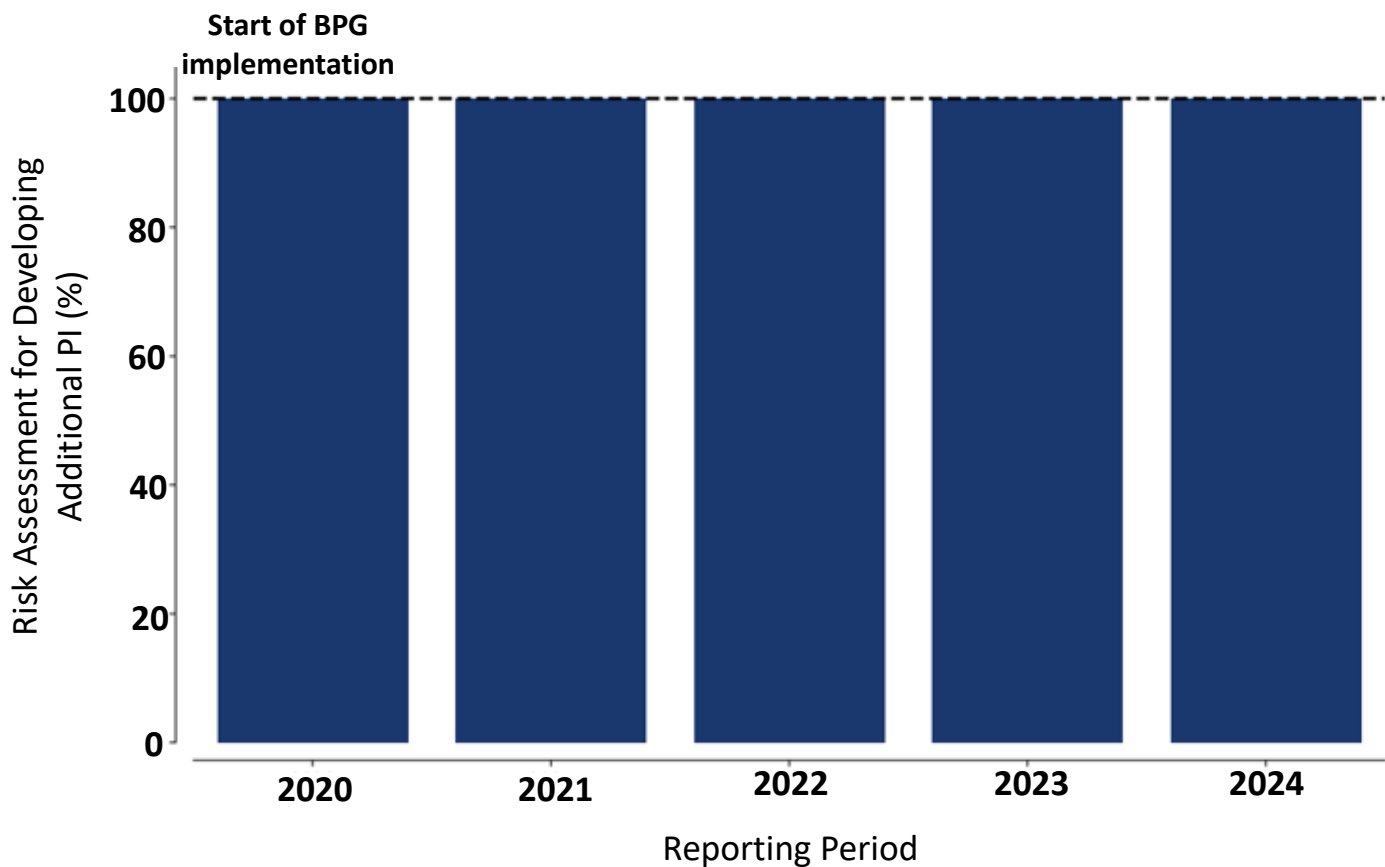
 TGHC demonstrated that the implementation of RNAO's *Assessment and Management of Pressure Injuries for the Interprofessional Team* (2016) and the *Person-and Family Centred Care* (2015) BPGs led to a sustained 100 per cent of persons with PI who received a risk assessment for developing additional PI and an increase in the satisfaction in the planning of care and treatment.

Figure 6: Persons with PI who received a risk assessment for developing additional PI (%)



Impact: TGHC maintained and sustained **100 per cent** in the percentage of persons with PI who received a risk assessment for developing additional PI since the inception.

Practice Changes

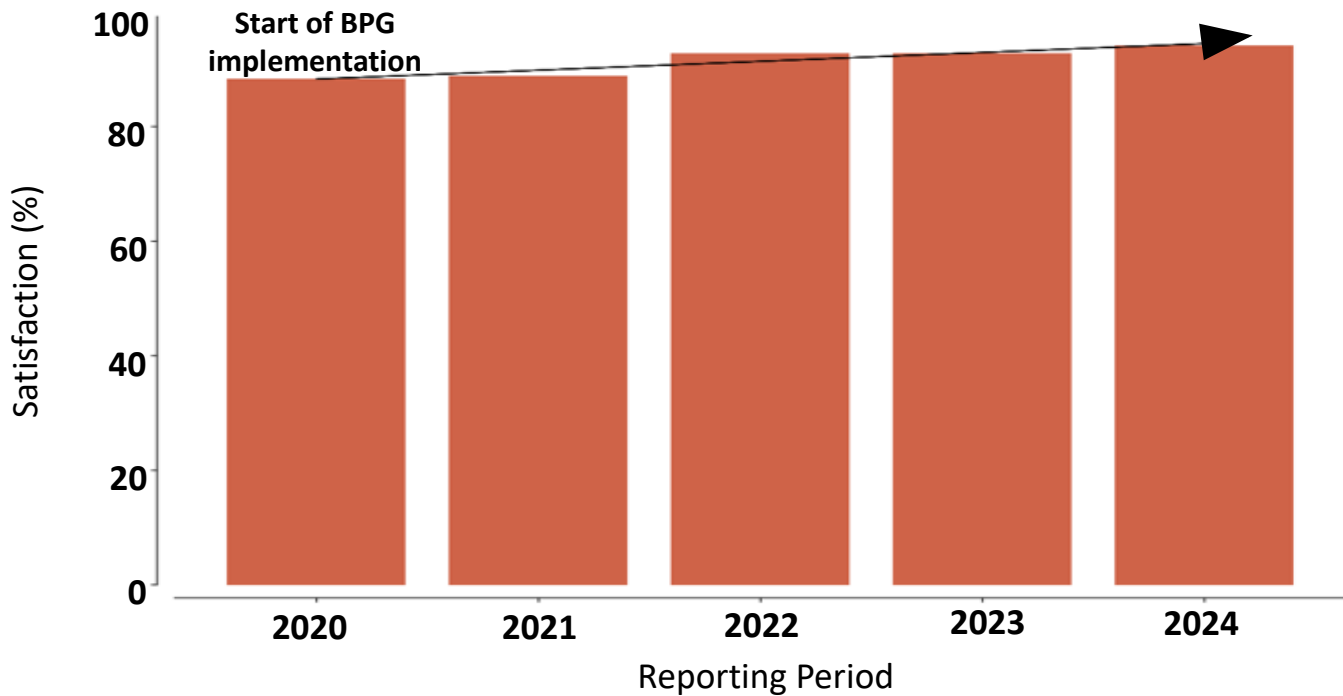
TGHC has implemented *Assessment and Management of Pressure Injuries for the Interprofessional Team* (2016) BPG in 2022 to improve patient care and ensure optimal outcomes for patients with complex medical needs, TGHC focuses on early identification, prevention, and proactive management of PI.

Key initiatives include:

- **Patient outcomes:** Integrated the Braden Scale for risk assessment into their clinical practices. This standardized tool is utilized for every patient upon admission, with weekly assessments, and before transfer or following significant changes in a patient's condition. By identifying patients at high risk for developing PIs, clinical staff can create individualized care plans that address each patient's unique needs, ultimately improving outcomes and reducing the recurrence of PIs.
- **Collaboration with patients and families:** TGHC's Wound Care Team works closely with patients and families to develop individualized, person-centred care plans based on ongoing wound assessments and regularly updated to reflect the current wound status. Preventive measures such as turning, repositioning, and offloading, are tailored to meet each patient's specific needs and goals.
- **Comprehensive wound assessment, treatment, and documentation:** Accurate and timely documentation as per TGHC's policy. The Tissue, Infection, Moisture, Edge of the Wound (T.I.M.E.) framework guides wound assessment and treatment. The Pressure Ulcer Scale of Healing (PUSH) tool is used to track wound healing over time. Pain assessment tools like the Numerical Pain Rating Scale and Pain Assessment in Advanced Dementia tool ensure that any pain associated with the wound or its treatment is addressed promptly.
- **Staff education and training:** Clinical staff are educated on skin and wound assessment technique, as well as prevention strategies. TGHC has implemented standardized wound care protocols based on the severity of the PI. Interventions such as negative pressure wound therapy are used for advanced stages of PIs. Wound care specialists provide ongoing expertise and guidance to both staff and patients. Regular quality improvement audits are conducted to identify areas for enhancement and ensure optimal patient outcomes.

These policy and practice changes reflect a comprehensive person-centred approach to PI assessment and management at TGHC.

Figure 7: Persons' satisfaction with their involvement in the planning of care and treatment (%)



Impact: From 2020 to 2024, there was a 5.8 per cent (from 88.3 to 94.1 per cent) increase in the percentage of persons satisfied with their involvement in the planning of care and treatment.

Practice Changes

TGHC has implemented the *Person- and Family-Centred Care* (2015) BPG in 2020 to enhance the overall patient experience and communication, promote transparency, and foster collaboration between healthcare providers, patients, and their families.

Key initiatives include:

Advanced care planning and documentation: Advanced care planning treatment and medical directive forms are completed within 24 hours of patient admission. The forms document patient preferences for medical treatments, particularly in situations where the patient may no longer be able to communicate their wishes. This ensures that the healthcare team can provide care in line with the patient's preferences, particularly during acute health deterioration.

- **Enhanced communication:** Introduced white boards in patient rooms to improve communication between patients, families, and the healthcare team. These boards display information such as the patient's name, the primary care team, daily care goals such as mobility, and upcoming tests or procedures. Interprofessional teams update these boards every shift, ensuring that both patients and families are informed about the care plan.
- **Family meetings for collaborative decision-making:** Family meetings involve the healthcare team, the patient (if able), and family members to discuss care goals, treatment options, and any significant changes in the patient's health. Family members are encouraged to express concerns, ask questions, and participate in decision-making, ensuring they feel heard and involved in the care process.
- **Flexible visiting hours:** Implemented flexible visiting hours to allow family members to visit and provide support to their loved ones, fostering a supportive environment for patients and families.
- **Staff education:** Introduced the Acknowledge, Introduce, Duration, Explanation, Thank you (AEDIT) model for communication to ensure consistent, compassionate, and clear communication with patients and families. Clinical and non-clinical staff are educated on the AEDIT framework and are expected to use it in every patient interaction. AEDIT is part of the Corporate orientation to ensure uniformity in patient communication practices.
- **Satisfaction surveys:** Patient and family satisfaction surveys are completed regularly to gather feedback on the care experience, ensuring that their voices are heard and used to guide ongoing improvements.





William Osler Health System

[William Osler Health System \(Osler\)](#) is a leading hospital system serving over 1.3 million people in one of Ontario's fastest growing and most culturally diverse regions. Osler prides itself on *Going Beyond* to deliver exemplary people-centred care close to home to address their region's complex health needs and support communities in living healthier lives.

Accredited with Exemplary Standing, the highest recognition from Accreditation Canada, Osler exemplifies a relentless pursuit of excellence. As the home of the Osler Research Institute for Health Innovation, the organization integrates cutting-edge research and evidence-based practices to ensure safe, effective, and equitable care. From emergency services to specialized programs, Osler's offerings are designed to meet the complex and evolving needs of its culturally rich community.

Osler's partnership with RNAO as a BPSO since 2021, reflects their unwavering dedication to delivering the highest standard of care to their patients.



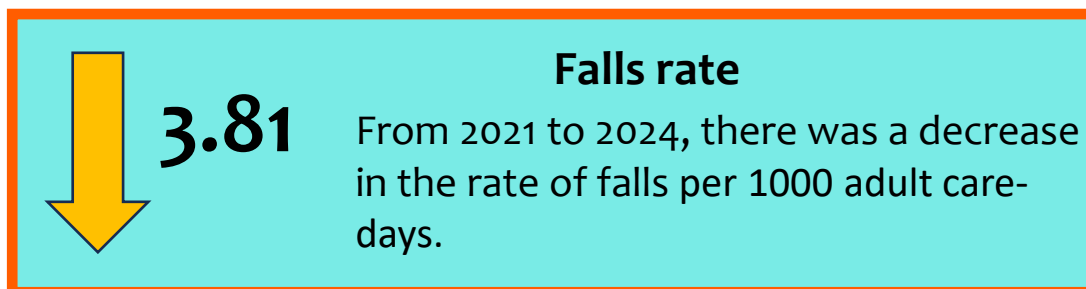
L to R: Alysia Daley, Rachelle DeLeon, Lara MacNeil, Mary Jane McNally, Tiziana Rivera, Urmila Nandy, Carla Arpa, Kimberly Johnston (Cordell), Trish Geerlinks, Bharat Paul

William Osler Health System

Improving falls protocols across multiple sites

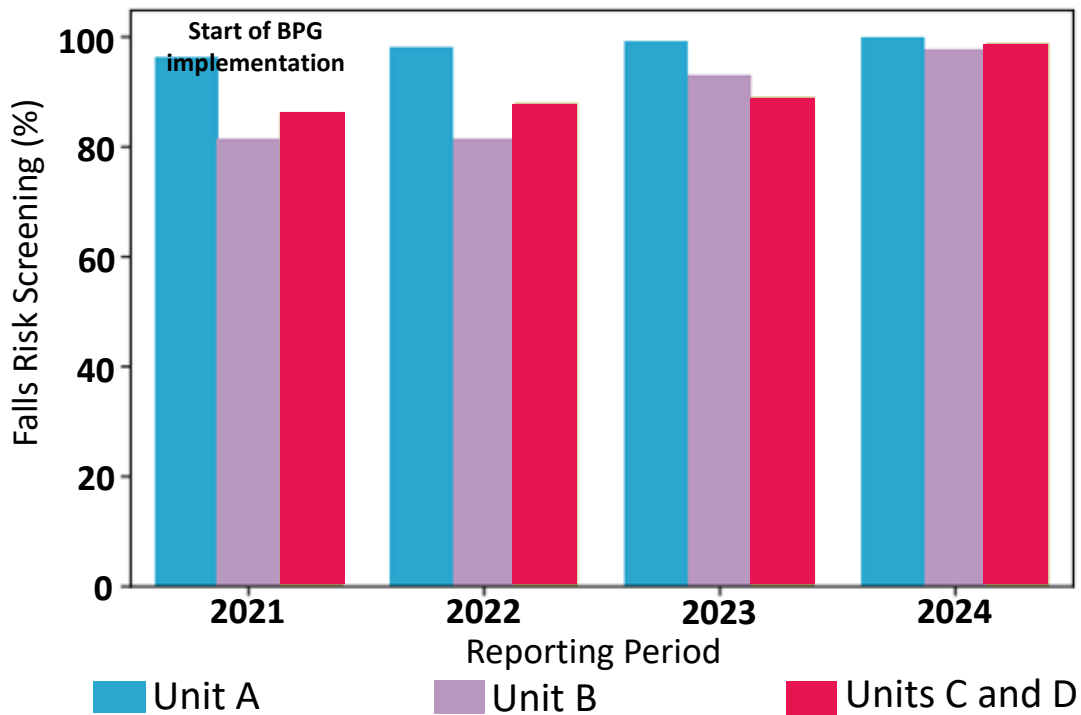
Aim: To examine the clinical outcomes associated with the implementation of RNAO's *Preventing Falls and Reducing Injury from Falls* (2017) BPG across four implementation sites (units) within the William Osler Health System (Osler) in Ontario, Canada.

Measures: The NQuIRE data system was used to determine the (a) percentage of persons screened for falls risk and the (b) rate of falls per 1000 adult care days.



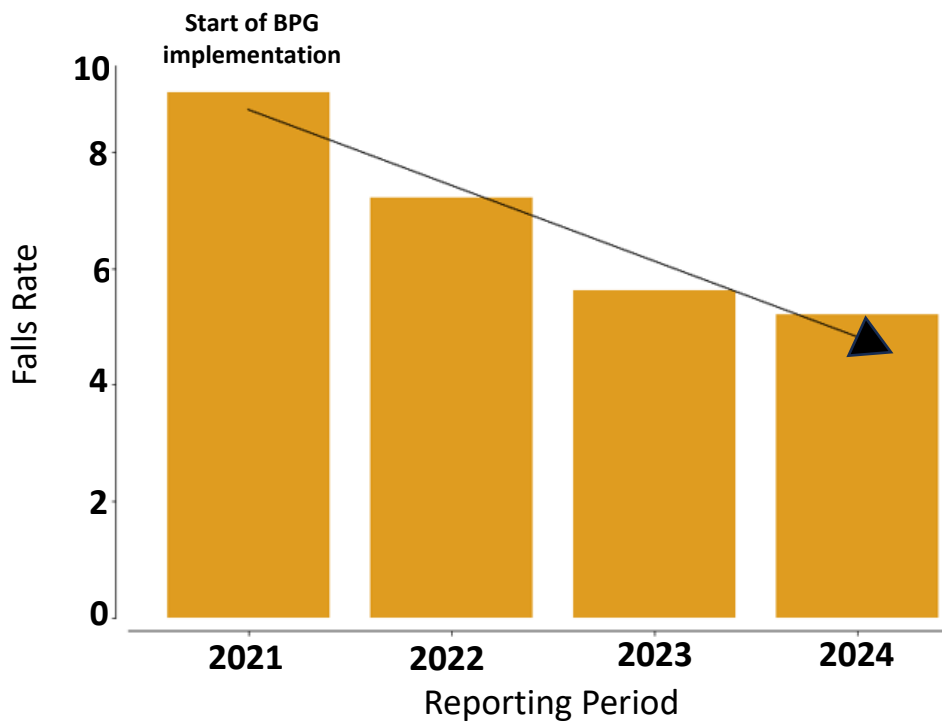
Osler demonstrated that the implementation of RNAO's *Preventing Falls and Reducing Injury from Falls* (2017) BPG led to an increase in the percentage of persons screened for falls risk and a decrease in the rate of falls.

Figure 8: Falls risk screening (%)



Impact: From 2021 to 2024, on average there was a 11.3 per cent (from 87.3 to 98.6 per cent) increase in the percentage of persons screened for falls risk.

Figure 9: Falls rate



Impact: From 2021 to 2024, there was a 3.81 (from 9.03 to 5.22) decrease in the rate of falls.

Practice Changes

Osler has implemented the *Preventing Falls and Reducing Injury from Falls* (2017) BPG in 2021 to enhance patient safety.

Key initiatives include:

- **Decision tree tool:** Developed and implemented a bedside rail usage decision tree tool in 2024 across 22 units, including inpatient medicine and surgical units at Osler's Brampton Civic and Etobicoke General hospitals.
- **Falls Prevention working group:** Created two protocols to guide clinical staff in supporting the policies and procedures for falls: the "High Fall Risk Clinical Protocol" and the "Post Fall Clinical Protocol". These protocols were implemented in Spring 2024 across Osler's inpatient medicine and surgical units. A subgroup of the Falls Prevention working group reviewed the literature and identified the Bedside Mobility Assessment Tool (BMAT) as a best practice tool for Safe Patient Handling and Mobility, replacing the non-validated IN MOTION tool to improve patient safety and care practices. The Emergency Department (ED) Falls working group was established, with monthly meetings including representation from clinical managers, educators, and point of care staff. The group focuses on enhancing Falls Prevention practices tailored to the unique challenges of the ED setting.
- **Best Practice Champions:** Educated and supported over 35 Best Practice Champions in Falls Prevention at Osler. Champions provide ongoing education, audit current practices, and offer insights on necessary practice changes. Tools and resources were developed and recently updated to reflect the new clinical protocols and bedside rail documentation.
- **Policy changes:** Updated the Falls Prevention and Management policy to include references to the BMAT, new protocols, high-risk identification binder stickers, and updated language regarding bedside rails. The Falls and Risk Assessment-Neonatal, Pediatrics Inpatient and Ambulatory Care (including Mental Health) policy was also reviewed and updated to reflect these changes.
- **Staff education:** Revised the nursing orientation program to ensure all new hires receive the necessary falls prevention education. Annual completion of the Fall Prevention Learning Module has been created and implemented to ensure ongoing knowledge and adherence to best practices.



F.J. Davey Home

[F.J. Davey Home](#) is nestled in the heart of Sault Ste. Marie, Ontario, and it is more than just a long-term care (LTC) facility. It is a thriving community designed to feel like home, with 374 beds spread across three levels, this innovative nursing home redefines long-term care by blending comfort, functionality, and a personalized touch.

The F.J. Davey Home is thoughtfully organized into Resident Home Areas (RHAs), each uniquely named by the resident themselves. As you explore, you'll discover charming spaces like *Apple Orchard*, *Birch Lane*, *Cedar Grove*, and *Driftwood Beach*, each designed to evoke the cozy familiarity of home. Stepping through the "front door" of an RHA, you're welcomed into an inviting living room—the heart of the space where residents gather, relax, and connect. Adjacent are the dining room and a dedicated activity room, fostering community and engagement. Resident rooms, located down two corridors, offer privacy while remaining close to shared spaces, including a serene spa area for relaxation and self-care.

At the center of each RHA is the Charting Centre, ensuring nursing staff are easily accessible to residents and their families. This thoughtful design balances care with comfort, creating a seamless blend of functionality and homelike warmth. F.J. Davey Home has been recognized as a BPSO since 2018.



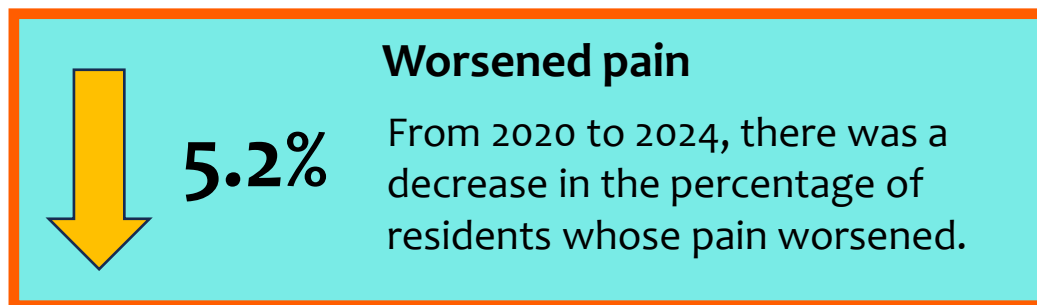
L to R: Palma Gervasi, Kerri Tanner, Jessica Reed, Kerri Favaro, Melanie Greenwood, Jennifer Lavoie, Stephanie Pinder, Sandi Campbell, Janet Chee, Sue Sweeney

F.J. Davey Home

Less falls and pressure injuries in long-term care

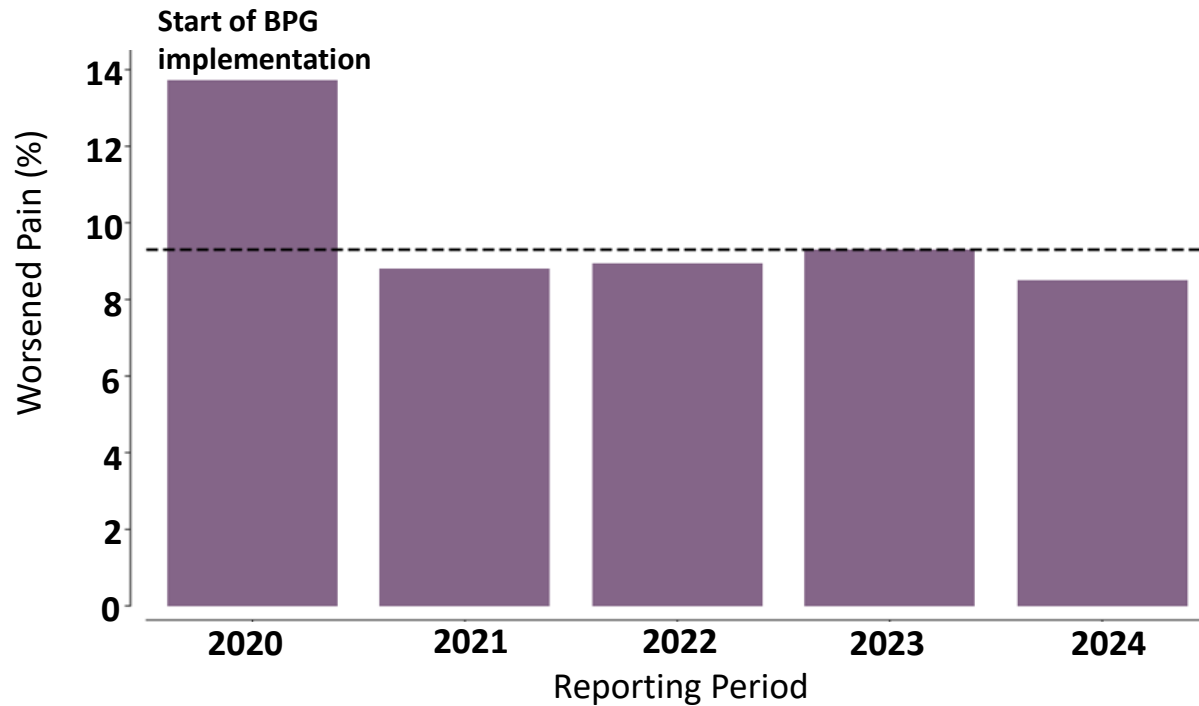
Aim: To examine the clinical outcomes associated with the implementation of RNAO's *Assessment and Management of Pain* and *Risk Assessment and Prevention of Pressure Ulcers* BPGs at a long-term care home in Sault Ste. Marie.

Measures: The NQUIRE[®] data system was used to determine the percentage of residents (a) whose pain worsened and (b) who developed one or more new stage II to IV pressure injuries (PI) during the measurement period.



F.J. Davey Home demonstrated that the implementation of RNAO's *Assessment and Management of Pain* and *Risk Assessment and Prevention of Pressure Ulcers* BPGs led to a decrease in the percentage of residents whose pain worsened and who developed one or more new stage II to IV PI.

Figure 1: Residents whose pain worsened (%)



Impact: From 2020 to 2024, there was a 5.2 per cent (from 13.7 to 8.5 per cent) decrease in the percentage of residents whose pain worsened.

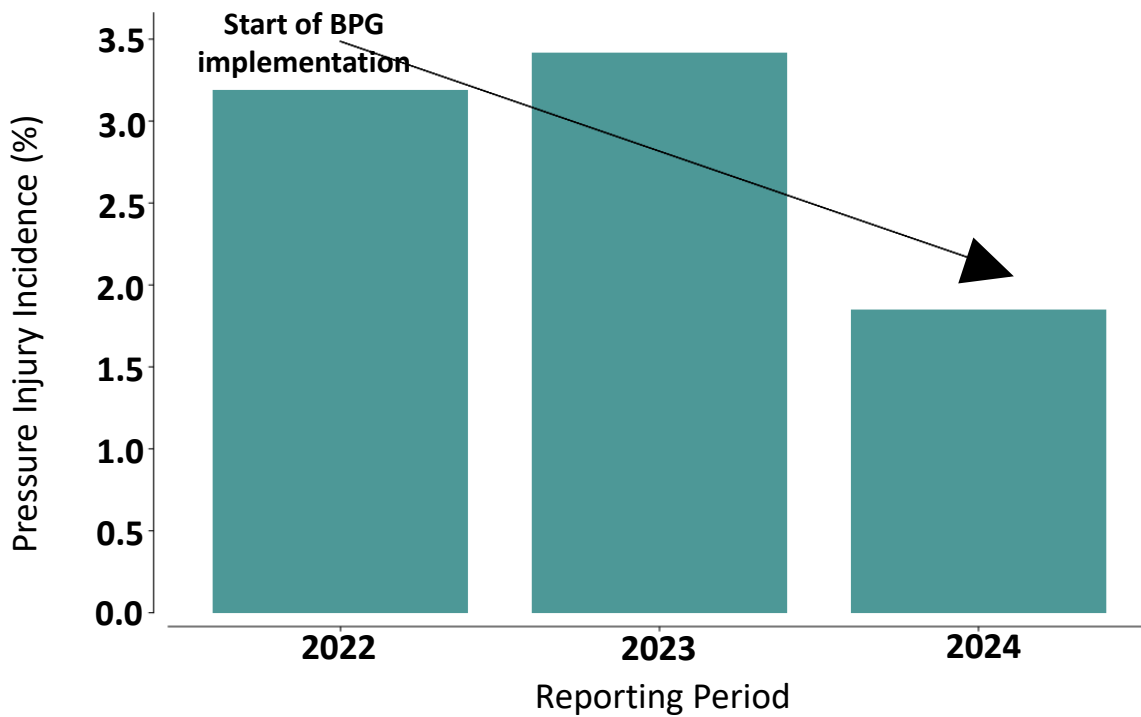
Practice changes

F.J. Davey home implemented the *Assessment and Management Pain* (2013) BPG in 2018 to enhance the confidence and competence of health professionals in assessing and managing the presence or risk of any type of pain.

Key initiatives include:

- **Ongoing staff education:** Delivered in real time and during monthly nursing meetings.
- **Pain assessments:** Completed upon admission, re-admission, and in the presence of pain (e.g., when administering as-needed analgesics), followed by post-analgesic evaluations to determine effectiveness.
- **Evaluation of analgesic use:** Ongoing consultations of scheduled and as-needed analgesic use with doctors or nurse practitioners as required.
- **Pain assessment with behaviour changes:** Conducted in collaboration with Behavioural Supports Ontario (BSO).
- **Pain management:** Ongoing identification and management of pain with the use of pharmacological and non-pharmacological interventions.

Figure 2: Residents who developed one or more new stage II to IV PI (%)



Impact: From 2022 to 2024, there was a 1.6 per cent (from 3.2 to 1.8 per cent) decrease in the percentage of residents who developed one or more new stage II to IV PI.

Practice changes

In 2019, F.J. Davey home began the implementation of the *Risk Assessment and Prevention of Pressure Ulcers (2002)* BPG to establish early intervention strategies for preventing, managing, and identifying individuals at risk of PI.

Key initiatives include:

Wound Care Champion: Trained through the Skin Wellness Associate Nurse (SWAN) program and leads weekly interdisciplinary rounds with nurses, nurse practitioners, most responsible physician, Nurses Specialized in Wound, Ostomy and Continence Canada (NSWOCC) at Sault Area Hospital (SAH), the wound clinic, dieticians and physiotherapists. The Wound Care Champion ensures consistent assessment and documentation of wounds including pressure injuries, venous stasis, arterial wounds, diabetic foot ulcers, surgical incisions, and worsening skin breakdowns. The team are certified and have completed the RNAO Champions Workshop. Additionally, the team attends the national NSWOCC conference annually in May to connect with experts and vendors, stay informed about product selection, best practices, and educational opportunities, ensuring the highest standard of wound care.

- **Education and training:** Committed to advancing staff expertise through a robust program of continuing education, including internal and external workshops, monthly meetings, and enrollment in advanced wound care courses such as wound debridement and lower limb management. The team collaborate closely with Solventum (3M) through monthly product selection meetings, fostering open communication with vendors to stay informed about innovative products. Staff are also actively pursuing educational opportunities to transform the approach to wound care in LTC settings. This includes exploring the implementation of IV therapy for wounds with confirmed infections and securing funding for training and adoption of negative pressure wound therapy.
- **Documentation and audits:** Developed a comprehensive in-house tracking system for all residents with skin impairments, including those with a Pressure Ulcer Risk Scale (PURS) score of 3 or higher, and have established 100% skin-focused care plans as of November 2024. To ensure adherence to guidelines, monthly audits are conducted on eight residents, with a focus on maintaining Preventive Skin Integrity Maintenance as a core goal for each care plan. Staff collaborate closely with Resident Assessment Instrument (RAI) coders to ensure precise coding of pressure injuries (PI) in the RAI-Minimum Data Set (MDS) assessment.
- **Equipment and supplies:** Prioritized the use of advanced equipment and supplies to enhance resident care, including pressure guard mattresses, wheelchair cushions, Cavilon skin protectants, regular positioning protocols, and techniques such as floating heels to prevent PI. The team is actively exploring innovative treatments, such as COBAN Compression System, to improve outcomes for residents with advanced wounds.
- **Medical Directives:** Currently in the process of rolling out pressure injury medical directives, which have been formally approved by the medical director. These directives aim to standardize and enhance the care provided to residents at risk or experiencing pressure injuries, ensuring timely and evidence-based interventions.
- **Interprofessional collaboration:** Referrals are addressed within a 48-hour timeframe to ensure prompt attention to all impairments. Staff maintain consistent communication with the management team to discuss program progress, identify necessary changes, and gather input on future goals through Continuous Quality Improvement (CQI) and Professional Advisory Committee (PAC) meetings.

- **Interprofessional collaboration cont'd:** The home is exploring the possibility of having the wound care physician at SAH conduct monthly rounds within the home, rather than requiring residents to travel for consultations. While the current physician is unable to participate at this time, this remains an active goal as part of their commitment to enhancing accessibility and continuity of care.
- **Resident outcomes:** Surpassed the national benchmark of 2% or less for residents with pressure-related injuries for over six consecutive months. The home's approach focuses on addressing and managing pain and symptoms associated with wounds, treating the whole person, and helping the care team understand how these wounds impact quality of life. The staff emphasize education on differentiating between healable, maintenance, palliative, and non-healing chronic wounds, ensuring that each resident receives holistic and tailored care to meet their specific needs.

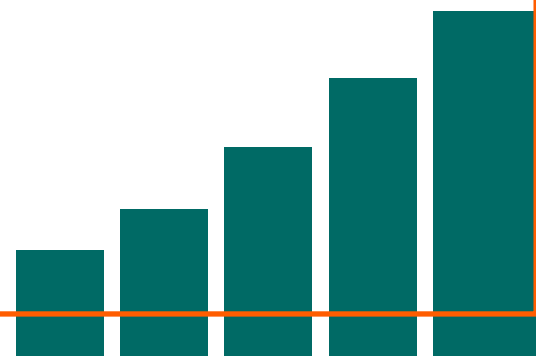


Conclusion

Nursing-Sensitive Indicators: NQuIRE will result in BPSO-validated structure, process and outcome indicators. These clinical indicators, as well as nursing-sensitive indicators derived from the wide range of recommendations and good practice statements that are addressed in RNAO's BPGs. In collaboration with the BPSOs and other researchers, RNAO expects to advance the understanding of the relationships between structural factors and clinical processes that influence patient outcomes. Our collective work will enable nursing to actively contribute to the safety and quality agendas and promote evidence-based policy decisions at the organizational and health system levels.

Evidence-Based Decision Making: NQuIRE data informs where and how RNAO's BPGs are enhancing nursing practice and patient outcomes, as well as organizational and health system performance. Such data will guide the RNAO BPG program and facilitate evidence-based decision-making to promote effective utilization of nursing resources. It will also highlight practical areas for further investment in nursing best practices.

Research Opportunities: Through formal authorization, researchers will have the opportunity to leverage NQuIRE to test nursing-sensitive indicators, refine reliable and valid measurement tools, and identify trends in nursing practice and person outcomes. This will significantly contribute to advancing knowledge generation in the field.



References

Grinspun, D. (2018). Transforming nursing through knowledge: The conceptual and programmatic underpinnings of RNAO's BPG program. In D. Grinspun & I. Bajnok (eds.), *Transforming nursing through knowledge: Best practices for guideline development, implementation science and evaluation* (pp. 3-25). Sigma Theta Tau International.

Naik, S., Loft, M., Autea, M., Medeiros, C., Singla, S., Kim, S. P., ... & Grinspun, D. (2024). A case study on the assessment of sustaining evidence-based practice changes and outcomes using the Nursing Quality Indicators for Reporting and Evaluation[®] (NQuIRE[®]) data system. *MedEdPublish*, 14(46), 46.

Naik, S., Voong S., Bamford, M., Smith, K., Joyce, A., & Grinspun D. (2020). Assessment of the Nursing Quality Indicators for Reporting and Evaluation (NQuIRE) database using a data quality index. *Journal of the American Medical Informatics Association*, 27(5), pp. 776-782.

Registered Nurses' Association of Ontario (RNAO). (2013). *Assessment and Management of Pain*. <https://rnao.ca/sites/rnao-ca/files/AssessAndManagementOfPain2014.pdf>

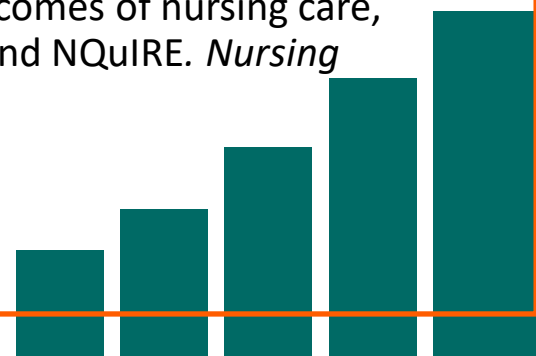
Registered Nurses' Association of Ontario (RNAO). (2016). *Assessment and Management of Pressure Injuries for the Interprofessional Team*. https://rnao.ca/sites/rnao-ca/files/Pressure_Injuries_BPG.pdf

Registered Nurses' Association of Ontario (RNAO). (2015). *Person- and Family-Centred Care*. https://rnao.ca/sites/rnao-ca/files/FINAL_Web_Version_0.pdf

Registered Nurses' Association of Ontario (RNAO). (2017). *Preventing Falls and Reducing Injury from Falls*. https://rnao.ca/sites/rnao-ca/files/bpg/FALL_PREVENTION_WEB_1207-17.pdf

Registered Nurses' Association of Ontario (RNAO). (2005). *Risk Assessment and Prevention of Pressure Ulcers*. https://rnao.ca/sites/rnao-ca/files/Risk_Assessment_and_Prevention_of_Pressure_Ulcers.pdf

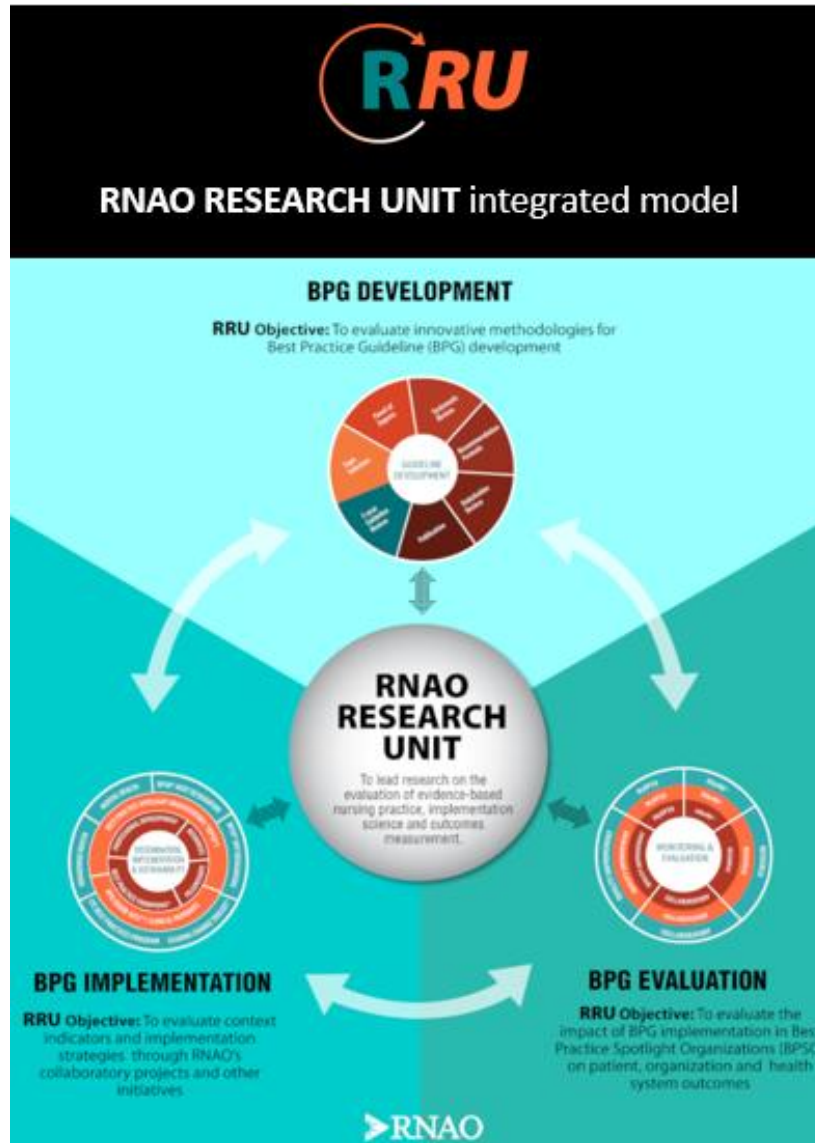
VanDeVelde-Coke, S., Doran, D., Grinspun, D., Hayes, L., Sutherland Boal, A., Velji, K., White, P., Bajnok, I., & Hannah, K. (2012). Measuring outcomes of nursing care, improving the health of Canadians: NNQR (C), C-HOBIC and NQuIRE. *Nursing Leadership*, 25(2): 26-37.



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