Excellent Care for All

Quality Improvement Plans (QIP): Progress Report for 2018/19 QIP

The Progress Report is a tool that will help organizations make linkages between change ideas and improvement, and gain insight into how their change ideas might be refined in the future. The new Progress Report is mostly automated, so very little data entry is required, freeing up time for reflection and quality improvement activities.

Health Quality Ontario (HQO) will use the updated Progress Reports to share effective change initiatives, spread successful change ideas, and inform robust curriculum for future educational sessions.

ID	Measure/Indicator from 2018/19	Org Id	Current Performance as stated on QIP2018/19	Target as stated on QIP 2018/19	Current Performance 2019	Comments
1	Percentage of residents responding positively to: "What number would you use to rate how well the staff listen to you?" (%; LTC home residents; April 2017-March 2018; In house data, NHCAHPS survey)	51585	92.81	93.70	86.36	

Realizing that the QIP is a living document and the change ideas may fluctuate as you test and implement throughout the year, we want you to reflect on which change ideas had an impact and which ones you were able to adopt, adapt or abandon. This learning will help build capacity across the province.

Change Ideas from Last Years QIP (QIP 2018/19)	Was this change idea implemented as intended? (Y/N button)	Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others?
Welcome resident input on life in the home.	Yes	Survey questions remain unchanged. Feedback captured monthly.
Respond to resident needs	Yes	Staff documenting by exception if a need is unmet. Updated approach/plan of care discussed with care team and resident as required.
Resident participation in care conferences when they are able.	Yes	Care conferences mandated by the MOH. Summary of discussion documented in electronic chart. Action items followed up post meeting.

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2	Percentage of residents who developed a new or worsened stage 2 or greater pressure ulcer. (%; LTC home residents; July-September 2017; CIHI CCRS)	51585	9.00	7.25	11.52	

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Screen and on-going assessment of skin integrity	Yes	There is now a force function to complete weekly assessments in the electronic chart to ensure screening is complete.
Take proactive steps when early identification of skin issues are noted.	Yes	Once a wound is identified a comprehensive wound assessment is initiated using the new Clinical Practice Tool (CPT).
Use interdisciplinary approach in the management of pressure ulcers	Yes	The new CPT generates automatic referrals to interprofessionals to ensure best practice interventions are initiated.
Monitor the development of new or worsened pressure ulcers	Yes	As above weekly reassessments are completed and documented. A wound prevalence report is printed by the Director of Care and reviewed with the care team.
Increase staff knowledge on prevention, identification, treatment of pressure ulcers	Yes	An RN Student lead education project Sept-Dec. 2018-. NH Wound Care Team provided education and support.

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3	Percentage of residents who fell during the 30 days preceding their resident assessment (%; LTC home residents; July - September 2017; CIHI CCRS)	51585	19.53	15.63	17.70	

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Pre-screen residents for their falls risk prior to admission to have falls prevention strategies in place at time of admission	Yes	Pre admit falls with circumstances are reviewed and captured. Interventions are pre planned prior to arrival i.e. floor mats, chair/bed alarms.
Analysis of all falls	Yes	All falls are reviewed real time with care team. A post fall assessment is a force function assessment-mandatory to complete for 24 hrs. post fall. Injury severity and ED visit requirements are tracked.
Education	Yes	Mandatory (MOH) falls and injury prevention education completed annually-last in Nov.-Dec. 2018. MOH fall prevention funding initiative with metric reporting initiated in July 2018.

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4	Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences". (%; LTC home residents; April 2017 - March 2018; In house data, interRAI survey)	51585	89.36	91.10	89.09	

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Encourage reporting of concerns	Yes	Discussed on admission and on 10 random resident during monthly surveys.
Follow up on all concerns	Yes	MOH mandated to respond within 6-10 business days. Templated report captures all elements of concern, actions and response.
Track concerns raised monthly and identify trends	Yes	As above, monthly summary taken to Resident's Council (themes and follow up taken).

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5	Percentage of residents who were given antipsychotic medication without psychosis in the 7 days preceding their resident assessment (%; LTC home residents; July - September 2017; CIHI CCRS)	51585	20.68	18.48	15.50	

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Administrator will share Canadian Institute for Health Information (CIHI) data along with QIP data at the quarterly Professional Advisory Council meeting for analysis.	Yes	Information shared and discussed at PAC meeting. Actions as above shared.
Utilize the MDS 2.0 to conduct a comprehensive medication review correlated to diagnosis of psychosis.	No	Focus on current impacted residents with responsive behaviors ensuring appropriate interventions are in place and necessity of antipsychotics-weaning protocol initiated if appropriate.
Ensure that for any responsive behaviors the first interventions are non-pharmacological.	Yes	Initiation of Music and Memories program and snozelin sensory cart are new helpful non pharmacological interventions introduced.
Optimize staff and physician awareness of and capacity to manage antipsychotic medications	Yes	As above.

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6	Percentage of residents who were physically restrained every day during the 7 days preceding their resident assessment (%; LTC home residents; July - September 2017; CIHI CCRS)	51585	12.14	10.40	11.24	

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Residents using a restraint or Personal Assistance Service Device (PASD) will have a quarterly assessment completed	Yes	Restraint use and assessment report accessed from electronic chart. Continues improvement noted.
Restraint alternatives will be trailed prior to using a restraint device.	Yes	ECU is following MOH regulations.
Continue to promote a least restraint environment by monitoring restraint usage, conduct removal trials with interdisciplinary input and feedback.	Yes	Restraint use reassessed as per policy and MOH regulations, reported reviewed as above.
Education on restraint use and alternatives	Yes	MOH Mandatory annual education for all staff, last completed in Nov.-Dec. 2018.

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7	Percentage of staff practicing proper hand hygiene before and after resident contact. (%; Worker; January-December 2017; In-house survey)	51585	93.02	100.00	91.58	

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Hand Hygiene Audits	Yes	Many huddles held throughout this period. Partnered with NH Infection Control team. Progressive discipline occurred with 2 staff members-sending a clear message to the care team.
Increased visibility	Yes	Daily rounding by Charge nurses, Director of Care and Administrator. Staff recognized for positive actions.
Vary observation times	Yes	As above.