Excellent Care for All

Quality Improvement Plans (QIP): Progress Report for 2017/18 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 2017/18	Org Id	Current Performance as stated on QIP2017/18	Target as stated on QIP 2017/18	Current Performance 2018	Comments
1	"Would you recommend this emergency department to your friends and family?" (%; Survey respondents; April - June 2016 (Q1 FY 2016/17); EDPEC)	962	49.60	51.70	41.5%	Target Not Met, 119 less positive responses than target

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Change Ideas from Last Years QIP (QIP 2017/18)	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?
Implement DashMD	Yes	Dash MD (free mobile app) was implemented across the ED program on November 1st, 2017. Through Dash MD, patient's access information about their stay at NH, manage medications and appointments, find follow up care in their community and access aftercare discharge instructions. The platform also supports patient's satisfaction surveying where feedback is obtained on ED experience.
Implement ED Waiting Room Virtual Queuing	No	Initiative deferred due to implementation of eCTAS.
Develop and expansion to volunteer supports provided in the ED	Yes	The volunteer role has been developed to support patient comfort in the main department. Our volunteers work with our provider team to round on patients and families to improve their ED experience. An opportunity still exists to increase volunteer presence in the waiting room.
Provide information material related to common topics & Emergency department process	Yes	Standardized electronic education content was implemented throughout the ED program to partner with patients on understanding their healthcare options and what to expect in the ED.

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2	"Would you recommend this hospital to your friends and family?" (Inpatient care) (%; Survey respondents; April - June 2016 (Q1 FY 2016/17); CIHI CPES)	962	72.70	74.90	81.5%	Target Met, 127 more positive responses than target

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iRounding (Purposeful rounding)	Yes	Evaluation of the tools required adaptation for specific populations. Introduction to all units (except ICU & ECU) are in progress. We rounding audits are under development to evaluate process for opportunities for improvement and sustainability. This initiative continues to evolve and will be part of the 2018/19 QIP
Real Time in patient satisfaction survey	Yes	Planning is underway to expand the survey to additional units with a goal of standardizing processes for patient input. Occasional challenges occurred with availability of volunteers during the summer months to interview patients.
Post In-Patient Discharge Follow up phone calls.	Yes	This initiative was developed specifically to establish a baseline for patients input on preparedness for discharge without difficulty.

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3	Acute inpatient falls per 1,000 acute inpatient days (harm level 3-6) (Rate per 1,000; All acute patients; January-December; NH Incident Reporting System)	962	1.78	1.69	1.77	Target Not Met, 14 more falls than expected

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Hardwire standard that Falls Risk Assessment and Intervention Tool (FRAT) is completed within 24 hours of admission	Yes	The Falls Steering Committee established a working group to complete focus groups with front line staff around the current Falls Risk Assessment and the interventions. In the review of the FRAT it was deemed the FRAT was completed within 24 hours though did not drive strong implementation of the interventions. In 2018 the Falls Steering Committee will be reviewing different strategies to assist implementing interventions as creating a Falls Care Plan that is easy to follow and developed with front line staff input.
Continue to focus on reducing the average number of falls per month and reducing the severity of all fall incidents to Level 3 or less	Yes	Reducing monthly falls and severity has been an indicator NH has been using for a number of years. This has helped keep the focus on falls on a monthly basis. In addition weekly data is shared to leadership and daily falls are tracked at unit huddles. The focus has shifted to our implementation of our strategic initiatives (We Round) that is evidence based initiative to help decrease falls from purposeful rounding targeting the 5Ps - Possessions, Pain, Personal Needs, Positions and Pump as required. The goal is once We Round is fully implemented we should start to see a decrease in our falls. Another focus for targeting our Falls initiatives is on our Medicine Program which accounts for 68% of our annual falls. The Falls Steering Committee will review its membership to include the medicine units with higher falls to drive this change.

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4	Medication reconciliation at admission: The total number of patients with medications reconciled as a proportion of the total number of patients admitted to the hospital (Rate per total number of admitted patients; Hospital admitted patients; Most recent 3 month period; Hospital collected data)	962	38.00	88.00	86.9% (restated to exclude discharges within 24 hours)	Target Not Met, 494 MedRecs less than target

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Continue to follow the MedRec roll out plan, continue with the surgical program and introduce admission MedRec to PCG, DMH	Yes	A controlled and consistent roll-out plan was a key driver for success (i.e. standard MedRec process)
Improve the quality of surgical BPMHs completed in the pre-op clinic	Yes	Direct education and feedback resulted in improved quality
Improve community pharmacy awareness around NH MedRec process	Yes	Community pharmacy engagement session was successful in terms of useful information exchange opportunity
Extend SCS pharmacy technician shift coverage in ED on weekends	Yes	Initiative was effective by scheduling BPMH coverage to match patient visit or admission times.

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5	Percent of complex continuing care (CCC) residents who fell in the last 30 days. (%; Complex continuing care residents; TBD; CCRS, CIHI (eReports))	962	19.20	10.00	14.0	Target Not Met, 22 more patients with a fall

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Integrate Falls Prevention Strategies & 5P rounding documentation into the complex care daily flow sheet Develop an audit tool to monitor compliance of documention of falls prevention strategies and 5 P rounding Q shift.	Yes	The We Round initiative was formally implemented across the Complex Care Program. The audit tool adopted for monitoring compliance is the post fall audit tool utilized in the safety walkabouts. Documentation of fall prevention interventions has been consistently captured on the updated daily flow sheets.
Initiate Post-Fall Medication Reviews For all level 4 falls on one complex care unit.	Yes	Pharmacy has developed a formal tool that aligns with the Falls policy. Implementation of the process across the program is in progress.
Initiate Monthly Safety Walkabouts With a focus on falls prevention & to share and discuss audit results and/or other identified opportunities for improvement.	Yes	All units have participated in a safety round. A suggestion to develop a post fall nursing clinical protocol is recommended due to variance of practice i.e. post fall assessment across the program. This is an opportunity for all clinical areas. A draft document has been developed and will be forwarded to the Corp. Falls Steering Committee.

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6	Percentage of hand hygiene compliance among staff. (%; Residents; January - December 2016; In-home audit)	51585	94.40	100.00	93.02%	Target Not Met, 142 less hand washing incidents than target

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Perform hand hygiene audits	Yes	There is still opportunity for improvement.
Increase visibility	Yes	Positive feedback has led to staff feeling comfortable in approaching all staff in the home to respond with ‘good hand hygiene’ when observed, as well as pointing out misses.
Vary observation times	Yes	This approach has assisted with ensuring compliance on all shifts

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7	Percentage of residents responding positively to: "What number would you use to rate how well the staff listen to you?" (%; LTC home residents; April 2016 - March 2017; In house data, NHCAHPS survey)	51585	73.00	75.00	92.81%	Target Met, 25 more positive responses than target

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Welcome Resident input on life in the home	Yes	This reassures resident that they are important and their input is key to what we do.
Respond to Resident needs	Yes	This indicator has fostered staff development to go beyond ‘resident centred’ to be in the moment with the resident by responding to the resident need/request, or sharing therapeutic time with the person.

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8	Percentage of residents who fell during the 30 days preceding their resident assessment (%; LTC home residents; July - September 2016; CIHI CCRS)	51585	15.82	13.30	19.53%	Target Not Met, 24 more residents with a fall than expected

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Pre-screen Residents for their falls risk prior to admission	Yes	This process has ensured equipment is available at the time of admission to mitigate injury as a result of a fall.
Balance the need for restraints and independence.	Yes	The home has expanded the inventory as well as use of innovative techniques to help prevent falls. The majority of falls occur in the bed and are from the bed. The Encore bed allows the home to expand the bed deck to create a wider surface to assist in the prevention of rolling out of bed. The home has also purchased surfaces with built in ‘bumpers’ along the surface perimeter. The home has made use of posey roll guards to help prevent ‘rolling out of bed’.
Analyze all falls	Yes	Falls are discussed weekly as part of the MDS meetings with front line staff.
Complete medication reviews	Yes	Reviews are conducted quarterly and as part of the post falls analysis

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9	Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences". (%; LTC home residents; April 2016 - March 2017; In house data, interRAI survey)	51585	80.00	82.50	89.36%	Target Met, 10 more positive responses than target

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Encourage reporting of concerns.	Yes	This created a clear line of communication to the Residents Council to discuss concerns brought forward, as well as the resolution to those concerns. Trends were also identified.
Follow up on all concerns.	Yes	This has led to the creation of an environment that residents feel comfortable in bringing their concerns forward to any staff of the home and are secure in the knowledge that they will be acted on.
Track concerns raised monthly and identify trends	Yes	Trends are tracked monthly, and discussed at both Residents Council Meetings and at the Leadership/Quality/Risk Management meetings.

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10	Percentage of residents who were given antipsychotic medication without psychosis in the 7 days preceding their resident assessment (%; LTC home residents; July - September 2016; CIHI CCRS)	51585	23.99	22.61	20.68%	Target Met, 7 less residents than expected

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Conduct comprehensive medication reviews	Yes	Reviews are being completed.
Registered Staff Education - antipsychotic usage	Yes	The education has been provided by the Nurse Practitioner from the Nurse Led Outreach Team.
All Staff Education - management of behaviors	Yes	Approximately 70% of the home's staff have been trained in the use of the Gentle Persuasive Approach in the management of responsive behaviors.
Collaborate with community partners	Yes	With the support of decision support, metrics have been identified to measure the success of the iPOD as a treatment modality to reduce antipsychotic use. Working as part of the iEQUIP team with Brock University, the home has implemented the Music & Memory Program.

ID	Measure/Indicator from 2017/18	Org Id	Current Performance as stated on QIP2017/18	Target as stated on QIP 2017/18	Current Performance 2018	Comments
11	Percentage of residents who were physically restrained every day during the 7 days preceding their resident assessment (%; LTC home residents; July - September 2016; CIHI CCRS)	51585	14.78	10.40	12.14%	Target Not Met, 7 residents more than expected

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Improve current restraint program and initiate alternatives prior to the initiation of a restraint	Yes	All new admissions are assessed for the need of a side rail. Residents who have experienced a condition change are also assessed for the need of a side rail.
Use of standardized assessment and documentation tools	Yes	Consistent documentation practices have been established amongst registered staff.
Consistent communication by the Falls Prevention and Restraint Management Committee to the staff working in the home.	Yes	Weekly discussion with the front line staff has empowered them to make recommendations to reduce the need for restraints being used.
Implement a process to reduce the use of bed rails.	Yes	100% of residents were assessed for their need for the use of a side rail, reducing the use of bedrails from 14 to 2.

ID	Measure/Indicator from 2017/18	Org Id	Current Performance as stated on QIP2017/18	Target as stated on QIP 2017/18	Current Performance 2018	Comments
12	Percentage of residents with a newly occurring Stage 2 or higher pressure ulcer. (%; Resident Assessment; October 2015-September 2016; CIHI Data)	51585	4.25	3.30	4.09%	Target Not Met, 3 more residents than expected

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Pre-screen Residents for pressure ulcers prior to admission	Yes	A gap was identified in the notification of the dietician when any skin integrity issues arise. A specialized progress note was created for a nutritional referral. A report can now be run for the note, providing easier information sharing with the dietician.
Increase staff knowledge on how to prevent pressure ulcers, early identification and reporting to registered staff.	Yes	Education is provided by the Nurse Led Outreach Team.
Standardized methods and products used to treat pressure ulcers.	Yes	Standardized documentation has ensured consistent practice and communication between registered staff members.
Implement interventional strategies at stage 1/2 of pressure ulcer development to prevent worsening.	Yes	New surfaces have been purchased that can provide therapeutic treatment for stage 1 / 2 wounds. The surface can be easily converted to an air surface if required.
Analyse all cases of poor skin integrity within the home and report on any trends	Yes	Discussion has occurred at Leadership/Quality/Risk Management meetings as well as at meetings with front line staff for input and intervention. These suggestions have not yet been tried.

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13	Rate of psychiatric (mental health and addiction) discharges that are followed within 30 days by another mental health and addiction admission (Rate per 100 discharges; Discharged patients with mental health & addiction; January 2015 - December 2015; CIHI DAD,CIHI OHMRS,MOHTLC RPDB)	962	11.40	10.80	13.56 all 12.3 NH proxy	Target Not Met, 44 more patients readmitted than expected

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Provide evidence informed inpatient care to adequately address and stabilize psychiatric status.	Yes	Care pathways have been beneficial in promoting evidence based care. Care is standardized and consistent across diagnostic groups.
Ensure an appropriate discharge plan and delivery of appropriate support services to transition care from an inpatient to outpatient setting.	Yes	Patient engagement and acceptance of discharge planning is problematic at times. Accessible transitional supports to meet needs varies.
Provide treatment alternatives to rehospitalization in low or no risk situations.	Yes	Day Hospital is an alternative which currently operates with a lower intensity stream and an intensive one. Continued efforts are in place to promote this service as an alternative.
Enhance relapse prevention through use of long acting injectables.	Yes	The Care pathways that were implemented within the inpatient service promote the use of long acting injectables. Decision-making logic is embedded to move more quickly to LAIs especially in the presence of non-adherence. Patient and family education resources have been standardized related to LAIs.