Excellent Care for All

Quality Improvement Plans (QIP): Progress Report for the 2015/16 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 2015/16	Org Id	Current Performance as stated on QIP2015/16	Target as stated on QIP 2015/16	Current Performance 2016	Comments
1	A: Percentage of residents who responded positively to the question: "Would you recommend this nursing home to others?" NHCAHPS) (%; Residents; Apr 2014 - Mar 2015 (or most recent 12mos); In-house survey)	51056	86.01	90.00	88.23	Our home demonstrates great customer service and provision of care as evidenced by 88.23% of survey participants answering that they would recommend this nursing home to others. Despite attempts to promote completion of the survey, only 22 residents/families completed the survey; and only 17 answered this question on the survey - 15 of 17 respondents said "yes". The CQI Team notes that while there are areas to improve upon as identified in the survey, the overall feelings are positive and residents/family express satisfaction on an on-going basis. The most successful change was the development and implementation of a tracking tool for requests/concerns which is utilized to analyze trends and identify areas for improvement at CQI team meetings.

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	Was this change	Lessons Learned: (Some Questions to

QIP (QIP 2015/16)	idea implemented as intended? (Y/N button)	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?
Plan to establish processes to ensure person-centered care is provided according to residents needs, desires, preferences, and that staff are sufficiently flexible to accommodate their individuality.	Yes	Education (person-centered care) provided by RNAO BPG coordinator and this will be an ongoing area of focus annually. Survey results shared with and reviewed by resident council, CQI committee and staff. The resident and family concerns are reviewed monthly at CQI team meetings and, as appropriate, at departmental staff meetings.
In 2015, the resident and family satisfaction survey will be taken to resident council for review and determination of resident-centered questions on survey.	Yes	The resident/family satisfaction survey was updated in 2015 to include this specific question; in consultation with resident and family councils. Survey results for 2015 revealed an 88.23 % positive response to this question.
Recruit volunteer(s) to assist residents with the completion of the survey.	Yes	Despite many attempts to promote and provide assistance to complete the survey, even with increased volunteer involvement, only 22 surveys were completed. Feedback from some residents was that the survey is too long and took residents too much time to complete - this feedback will be implemented into the 2016/17 QIP.
Review of request/concern and handling complaints policy and procedure including how information is communicated to staff, followed up, monitored and audited to identify areas of improvement for resident experience.	Yes	Policy and procedure staff education completed. Policy and procedure will be reviewed annually for consideration to updates. Requests/concerns reviewed at CQI team meetings and as appropriate at departmental staff meetings. Trending of the requests concerns was implemented which has been beneficial in identifying gaps, follow up actions and educational needs.

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2	Number of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents. (%; Residents; Oct 2014 – Sept 2015; Ministry of Health Portal)	51056	18.75	16.00	15.00	Our home demonstrated great progress in this indicator and made a 3.75 % improvement in reducing potentially avoidable ER visits. The most successful change idea was the implementation of a tracking tool which heightened awareness and attention to the reason why and who made the decision to transfer to ER which allows staff to focus on education to further decrease potentially avoidable ER visits. (Example education for family re: services provided in the home, fall prevention and management, implementation of a palliative and end of life care plan focus based on PPS assessments).

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Change Ideas from Last Years QIP (QIP 2015/16)	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?
Early recognition of "at risk residents" for emergency department visits	Yes	High risk rounds informally completed daily during management rounds with each unit. Policy and procedure education (fall prevention and management, alternatives to restraints, pain management, etc.) completed for staff. Resident council education completed re: falls prevention and management and discussions occurring at annual and admission care conferences initiated. 100% of residents plan of treatment for CPR completed. In addition, the implementation of a "care plan focus" for palliative and end-of-life residents was

		successful in communicating wishes and care needs to staff.
Provide early treatment for common conditions; specifically falls- to reduce the # of transfers to hospital related to falls where possible.	Yes	Annual and admission care conferences include discussion re: falls prevention and management. Residents at a high to moderate fall risk are attending PT and/or exercise programs as appropriate (unless refuses). Need for fall prevention interventions (bed/chair alarms, fall mats, hip protectors, etc.) are being considered and implemented at time of assessment as required. Frequent fallers reviewed at falls meetings for root cause analysis.
Education to staff, residents and family members re: palliative and end of life care services available at the home.	Yes	Palliative and end of life care policy updated and implemented and education completed. Staff using palliative care resource binders for family and resident education (e.g. brochures for individual symptom management, etc.) PPS assessments completed with timely follow up according to policy and procedure. Goal to incorporate stats into palliative care team meetings in 2016.
Review of ER visit stats at CQI and PAC meetings to better understand reasons for residents being sent to hospital Emergency Room.	Yes	Stats are reviewed monthly at CQI and quarterly at PAC meetings with relevant discussion for improvement. CQI team identifies potentially avoidable ER visits and provides input into potential practice changes - information is taken to nursing practice meetings for follow up and additional action planning as required. Regular and ongoing review of stats has been successful as it provides a large picture summary of ER visits - a useful tracking tool was developed and implemented for ER visits which provides heightened awareness re: reason for ER visits including who made the decision to send (i.e. family, resident, staff, physician).

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3	Percentage of residents receiving antipsychotics without a diagnosis of psychosis. Exclusion criteria are expanded to include those experiencing delusions. (%; Residents; Q2 FY 2014/15; CCRS, CIHI (eReports))	51056	28.67	23.00	26.91	Our home has achieved an improvement of 1.76 in this area. A focus on ensuring all diagnosis are captured and the involvement/referral to our internal BSO (Behaviour Supports Ontario) team on admission for residents on anti-psychotic medication has been the most successful changes to practice. Work has also been completed and is ongoing in the adjustment of dosages of these medications; and although these changes are not captured in this performance indicator, it is important in maintaining the quality of resident life.

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Education to team re: antipsychotic usage including current and past statistics - i.e. with appropriate diagnosis	Yes	Medication stats are reviewed at responsive behavior team and PAC meetings. New admission medication lists and diagnosis are reviewed to identify potential areas for medication adjustment/change and follow up by the care team.
Audits of all residents medication list and diagnosis to identify residents on antipsychotics without a diagnosis of psychosis	Yes	A complete audit of medication lists and diagnosis is completed with follow up and will be ongoing. Pharmacy stats are received quarterly and reviewed at PAC.
Policy and procedure review (Restraints) to support reduction of antipsychotic use without a diagnosis of psychosis	Yes	Updated policy and procedure to include chemical restraint information and brochure. Education completed.

Automatic referral to BSO team (internal and external as required) for all new admissions with antipsychotic medication orders (and/or behaviors) without a diagnosis of psychosis; and current residents presenting with new behaviors	Yes	Referrals in place to BSO team by Resident Care Coordinator on admission. Success has been achieved for several new admissions which demonstrated improved resident quality of life. Ongoing medication review and referrals by staff for current residents. Next QIP to build on success by promoting referrals by registered staff for current residents and build on successes achieved to date.

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4	Percentage of residents responding positively to: "What number would you use to rate how well the staff listen to you?" (NHCAHPS) (%; Residents; Apr 2014 - Mar 2015 (or most recent 12mos). ; In-house survey)	51056	88.50	90.00	82.50	Despite attempts to promote completion of the survey, only 22 survey responses were received; and only 16 respondents answered this question on the survey - scores ranged from 5 to 10. Survey results revealed that 75 % of respondents rated 8 or higher for the "how well staff listen to you" question. The most successful change was the development and implementation of a tracking tool for requests/concerns which is utilized to analyze trends and identify areas for improvement at CQI team meetings.

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Review and update the resident & family satisfaction survey to reflect this specific question.	Yes	The resident and family survey was updated to reflect this question and approved by resident council. Despite attempts to promote and provide assistance to complete the survey, only 22 surveys were completed. The work in this area will be ongoing.
Increase staff awareness re: resident-centred care, residents rights and "having a voice"	Yes	Resident rights education completed. Education (person-centered care) provided by RNAO BPG coordinator and this will be an ongoing area of focus annually. Survey results shared and reviewed with resident council, CQI

		committee and staff. The resident and family concerns are reviewed monthly at CQI team meetings and as appropriate at departmental staff meetings.
Education - disease specific -e.g. Parkinson's and Dementia to support staff to better understand the disease specific changes, resident needs and communication challenges.	Yes	Dementia education completed and Alzheimer society also provided inservice education which was well attended. Parkinson education will be provided in 2016 as not able to arrange in 2015.
Communication of resident concerns from resident council, family council and food committee meetings to front line staff as appropriate/applicable.	Yes	The resident and family concerns are reviewed monthly at CQI team meetings and as appropriate at departmental staff meetings. Resident council, family council and food committee meeting minutes are posted for staff and areas of concern identified and followed up appropriately.

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5	Percentage of residents who had a pressure ulcer that recently got worse (%; Residents; Q2 FY 2014/15; CCRS, CIHI (eReports))	51056	3.80	2.80	2.48	Our home was successful in demonstrating an improvement of 1.32 to the % of residents who had a pressure ulcer that recently got worse. The most successful change idea was the introduction of weekly skin assessments completed by the Personal Support Workers (PSW)on the first bath of each week for each resident - this created heightened awareness, accountability and early treatment. An area for ongoing improvement for 2016/17 will be a focus on stage 1 referrals to dietitian for early skin and wound prevention and management.

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Trial weekly skin assessments by personal support workers (PSW) on the first bath of each week to promote early identification of skin issues at stage 1. The PSW assessments are in addition to registered staff assessments as per policy.	Yes	Weekly skin assessment trial was implemented in one unit and then expanded to the whole home which significantly heightened PSW awareness and accountability for skin care and prevention. The hard copy of the assessment tool was integrated into a user friendly PCC electronic version (January 2016) which directs the PSW to report and document findings to the registered staff at the time of the assessment. 100 % compliance has now been achieved. Education completed. Wound statistics

		monitored monthly.
Regularly scheduled bed mattress audits with a focus on pressure relief and wound prevention and/or worsening.	Yes	Quality mattresses purchased as per bed mattress audit. Ongoing Specialty mattress placement is monitored to ensure those residents with the greatest need/highest risk for worsening pressure ulcers receive specialty mattress.
Ensure referral for nutritional interventions to Registered Dietitian at stage 1; and continued monitoring by dietitian for all residents with a new/worsening pressure ulcer.	Yes	Referrals being sent to dietitian for new/worsening pressure ulcer. Stage 1 referrals inconsistent and the home continues to promote the need for early identification and this change idea will continue in 2016/17 QIP.
Minimize use of physical restraints to reduce pressure and shearing forces for residents with pressure ulcers	Yes	The homes sling provider completed a full sling audit - all units of the home in February 2016. Areas for improvement were identified and will be implemented in the 2016/17 QIP. Residents that are identified as "at risk" and/or that has a pressure ulcer and requires a mechanical lift transfer are reviewed at the skin and wound, and the falls/restraints meetings to develop an action plan to minimize risk.

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6	Percentage of residents who had a recent fall (in the last 30 days) (%; Residents; Q2 FY 2014/15; CCRS, CIHI (eReports))	51056	13.11	10.50	14.76	Although our home shows a slight increase in falls, our statistics demonstrate that the increase is directly related to "frequent fallers" with cognitive impairment and/or are non-compliant to fall prevention interventions and new admissions throughout the year with a high fall risk. The challenge in these situations is finding the balance between fall prevention and management of the cognitively impaired resident (who does not remember to request assistance or use mobility devices) with quality of life including the ability to move freely on the unit. Heightening staff and resident awareness through the change ideas and posting of stats to ensure implementation of appropriate interventions/tools in a timely manner has assisted with reducing the number of negative outcomes related to falls (i.e. fractures, etc.).

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Increase involvement in strength, balance, endurance and flexibility physiotherapy and exercise	Yes	Monthly stats are reviewed at falls and restraints and PAC meetings. Stats are also posted in each home area for families,

programs for high to moderate risk residents through recreation, physiotherapy and restorative care.		residents and staff. The implementation of a recreation department software program which provides detailed information and statistics regarding exercise program participation within the home in late 2015/early 2016 will be more fully evaluated in the next year. All residents are provided with opportunity, encouragement and assistance to attend and participate in exercise programs within the home which focus on: strength, flexibility, endurance and balance.
Prevent and treat osteoporosis by providing calcium, bisphosphonate, and vitamin D supplementation as recommended by Registered Dietitian/Physician.	Yes	Quarterly reports of medication stats from pharmacy received by dietitian and MRC for follow up. An audit tool was not implemented as the dietitian incorporates consideration of supplements with each new admission and as referred.
Ensure individualized toileting routines implemented according to continence assessments and voiding patterns to promote a reduction in the number of falls related to toileting.	Yes	Policy and procedures were updated and education complete. Additional education sessions specific to the voiding record and continence assessments completed in February 2016 which will enable to staff to further develop and implement individualized toileting routines. Progress note headings were updated to include continence bladder, continence bowel to assist staff in better capturing continence and toileting needs. Audits of POC kardex and PCC care plans will be ongoing with education having being implemented in February 2016.
Modify and optimize environmental factors (chair & bed alarms, lighting, footwear, call bell within reach, furniture, mobility equipment) to prevent/minimize risk of falls.	Yes	Fall stats are reviewed monthly and taken to falls committee minimum of quarterly. The fall reports from physiotherapy have been updated to include additional data such as unit, location in the room, etc. A challenge is with unwitnessed falls for cognitively impaired residents - i.e. cause unknown. Education completed for resident council and is occurring at admission and annual care conferences re: fall prevention and management. Staff continue to regularly implement fall prevention measures such as alarms, mats and identify risks in resident rooms (i.e. furniture, clutter, etc.) Appendix D (environmental factors) of the falls policy will soon be implemented into PCC.

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7	Percentage of residents who were physically restrained (%; Residents; Q2 FY 2014/15; CCRS, CIHI (eReports))	51056	14.07	11.00	15.66	Although our home demonstrated a slight increase in physical restraints, significant work has been done in our home re: policy and practice. A barrier to the success of our plan is the current application of PASD by CIHI - specifically that PASDs (Physical assistance service devices) which are being utilized to support a residents activities of daily living are being captured as a physical restraint. As a result, our physical restraint statistics are higher than the actual # of physical restraints in use. The most successful change idea was the implementation of our updated policy and procedure with 2 new brochures (restraints and PASDs, chemical restraints), tracking tool and assessments for PASD's, algorithm to assist staff in appropriately capturing a device as a restraint or PASD, and a clear restraint discontinuation tool/process.

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Review physical restraint process prior to admission with the goal of	Yes	All potential admission paperwork is reviewed and restraint use identified.

being a least restraint home.		Conversations to promote a least restraint practice occur during tours of the home and literature (brochures) has been developed and is distributed as required to assist residents and families to understand the potential risks and benefits related to the use of restraints and PASDs. Falls and restraints committee meetings include a review of all restraints including new admissions.
Education for residents, families and staff on the definition and purpose of physical restraints and alternative measures to physical restraints and PASDs.	Yes	Updated policy and procedure staff education completed as well as provider inservice (PT) and audits (e.g. mechanical lift provider). Brochures for families and residents were developed and are readily available and handed out as needed. Resident council falls/restraints education session provided. New tools and assessments implemented with updated policy.
Ensure restraint assessments and tools are utilized as per policy (e.g. decision tree,initial and 1/4 alternatives to physical restraints consent form, etc.) to assess risk and to ensure alternatives tried and evaluated prior to implementation of physical restraint.	Yes	Monthly audits completed as part of the PASD and restraint audit tool demonstrate compliance to the use of tools, orders, consent, care plan, etc. An area of focus for the next QIP will be further implementation of alternatives to restraints.
Each resident with a physical restraint will be reassessed monthly and will include an analysis of the reason for ongoing use of restraint (risk)and assessment to determine if reasonable to discontinue use of physical restraint at that time	Yes	Audit completed monthly and reviewed with front line staff and falls/restraint committee to identify potential for reduction in physical restraints. Success has been achieved in the area of reduction in the use of bed rails and appropriately capturing devices as a PASD. This work will be ongoing.

ID	Measure/Indicator from 2015/16	Org Id	Current Performance as stated on QIP2015/16	Target as stated on QIP 2015/16	Current Performance 2016	Comments
8	Percentage of residents with worsening bladder control during a 90-day period (%; Residents; Q2 FY 2014/15; CCRS, CIHI (eReports))	51056	12.17	12.00	13.81	Our home had a slight increase in this indicator. A recent education focus on voiding records and continence assessments in February 2016 will assist our home in demonstrating improvement in this area for the 2016/17 QIP.

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Implement individualized toileting routines according to continence assessment and voiding patterns.	Yes	Policy and procedures were updated and education complete. Additional education sessions specific to the voiding record and continence assessments completed in February 2016 which will enable the staff to further develop and implement individualized toileting routines. Progress note headings were updated to include continence bladder, continence bowel to assist staff in better capturing continence and toileting needs. Audits of POC kardex and PCC care plans have not been completed due to education being implemented in February 2016 - this will be further evaluated in the next QIP with ongoing promotion of individualized toileting routines.
Medication review (quarterly) to identify medications that have a negative effect on bladder control and determine if medication adjustments would be appropriate.	No	Pharmacy has recently provided medication stats re: medications that may impact bladder control; however, the work regarding the analysis of the stats will begin in April 2016.
To improve data accuracy and staff/resident participation, trial/change to a reduction in 7-day voiding record to 3-day	Yes	The voiding record was successfully changed to a 3 day record in all home areas. A review of the voiding records and continence assessments revealed that staff would benefit from refresher

voiding record.		education on these topics - education completed in February 2016. This indicator will be an area of focus in the 2016/17 QIP
For new admissions, introduction of a new incontinence product on a trial basis that accurately tracks bladder incontinence through use of a computerized chip.	No	Discussions with our incontinence product provider company occurred in 2015. However, the decision was made to await further test/trial results within the industry before pursuing a trial in our home.