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)	53117	85.00	100.00	100.00	100% of the 33 respondents responded positively to the question. 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.

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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?
Review the resident/family survey and adjust questions asked to accurately capture the resident experience.	Yes	Resident/family survey questionnaires taken to resident and family councils annually for input. Surveys are changed to reflect that input. For 2016, the survey will be conducted to ensure responses are timed with the development for the 2017/2018 QIP and the CQI Team annual goals.
To increase the number of resident/family satisfaction surveys completed.	Yes	A family night was held to encourage increased participation in the survey. As a result, 33% responses were received to the survey.
Implementation of the QIP within the facility	Yes	The QIP is communicated and posted. There continues to be opportunity to

		heighten awareness amongst staff and family to ensure understanding and meaning behind the QIP.
Review of our 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	The CQI Team has identified and recommended the implementation of a "meeting" binder which is accessible to all staff to ensure flow of communication relative to resident and family wishes and concerns.

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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)	53117	20.15	18.00	27.50	Although the change ideas were implemented, the home did not meet it's target by 9.5. While they may be many identifiable reasons for in increase in ED visits, the CQI team will continue to focus on this area and drill down to identify common reasons which can be implemented into new change ideas.

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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 all staff.
Provide early treatment for common conditions - specifically falls to reduce the # of transfers to hospital related to falls	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.	No	Stats were not consistently tracked and analysed.

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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))	53117	32.19	20.00	25.43	Improvements have been made by 6.76 due to partnership with the pharmacist and regular/quarterly reviews by pharmacist and physicians. The Home continues to work towards the target of 20.0

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Policy and procedure review to support reduction of antipsychotic use without a diagnosis of psychosis	Yes	Communication of the policy combined with continual education of registered staff.
Collaborative interdisciplinary approach to identifying residents without a supporting diagnosis for antipsychotic use.	Yes	Education to physician relative to success.
Automatic referral to BSO team (internal and external as required) for all new admissions with antipsychotic medication orders without diagnosis of psychosis (with goal of reducing/eliminating antipsychotic medications).	Yes	Inclusion of the internal and external BSO team in review of change ideas can be increased. Non-pharmaceutical intervention are important to assist in reducing the need of antipsychotics.
Education re: alternatives to antipsychotics for residents, families and staff.	Yes	Review occurs at care conference and continues to be a focus.

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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)	53117	CB	95.00	84.00	81% of survey respondents answered the question of What number would you use to rate how well the staff listen to you. Of the responses, the average score was 84% positive. Survey responses did not completely capture information such as "why" the respondent felt they were not being listened to. This will continue to be a focus for 2017/2018 survey.

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Survey to reflect the question "How would you rate how well the staff listen to you?"	Yes	81% of survey respondents answered the question of What number would you use to rate how well the staff listen to you. Additional "drill down" of reasons why are important to find.
To increase the number of resident/family satisfaction surveys completed.	Yes	This target was achieved however, overall number of responses is 33% of 100 or more potential. It was an increase from previous years.
Increase staff awareness re: resident -centered care, residents rights and "having a voice".	Yes	Implementation of primary care continues to assist in this area.
Communication of resident concerns from resident council, family council and food committee meetings to front line staff as applicable	Yes	Meeting binder established so staff may review any comments, requests, concerns.

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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))	53117	1.83	1.40	2.53	The increase in pressure ulcers has been related to the residents admitted with pressure ulcer initiated in the community or hospital, i.e., resident with recent amputation and multiple core morbidities, palliative admissions increased.

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Ensure skin and wound assessments (weekly wound assessment, Braden scale, and skin assessments)are completed as per skin and wound policies	Yes	Weekly audits conducted and assessments utilising the Braden scale as per skin and wound policies...."Wound Wednesday"
Provide registered staff opportunities for education and training (at orientation and regular intervals on best practices related to pressure ulcer identification)	Yes	Education surround policy and procedures, nutrition and assessments.
Improve the fluid intake for all residents identified as having poor fluid intake.	Yes	Education of residents, family and staff to increase awareness were effective in improving fluid intake.
To ensure residents with impaired skin integrity or who are at high risk for impaired skin integrity have the appropriate pressure relieving devices in place.	Yes	Continued on-going audits of pressure relieving equipment devices to ensure effectiveness of device.

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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))	53117	7.49	7.49	9.75	Data includes "frequent fallers" related to behavioural issues and diagnosis (PSP) related to one resident. This residents falls frequency skewed the overall stats. Early indication is that the stats will decrease for 2016/2017.

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Medication review will be completed quarterly and will include fall risk factors such as medication side effects, poly pharmacy, inappropriate use of antipsychotics, appropriate use of bone supplements (calcium, vitamin D, etc.) as required.	Yes	Pharmacy consultant plays a vital role in implementation of this change idea.
Policy and procedure assessments/tools - Post fall screening for resident/environmental factors (appendix D) will be completed after every fall to identify risks factors and implement interventions/strategies to reduce risk for falls (Appendix A).	Yes	Important to monitor daily through 24 hour report to ensure post fall assessments completed.
Policy and procedure assessment tool - continence assessment (to identify individualized voiding patterns) is completed and implemented for each resident.	Yes	With the continued improvements being made through primary care psw staff will monitor and implement individualized toileting routines.
To ensure that referrals are made to the BSO team, as appropriate, for falls that may be related to responsive behaviours.	No	This change idea not completely implemented. Falls r/t incontinence and behaviours are monitored whoever follow-up required increased diligence. There also has been no direct correlation observed between incontinence/behaviours/falls. Further

		analysis is required.
Increase involvement in exercise and physiotherapy programs for residents that have a moderate to high fall risk; and/or have fallen	No	A new system for tracking has been implemented which will assist in monitoring program involvement.

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7	Percentage of residents who were physically restrained (%; Residents; Q2 FY 2014/15; CCRS, CIHI (eReports))	53117	32.63	16.00	32.18	Although our home demonstrated only a slight decrease 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 a PASD by CIHI - specifically that PASDs (Physical assistance service device) 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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To evaluate all residents using restraining devices to determine if such	Yes	Education continues to be an area which requires focus.

devices are used as a PASD versus a restraint		
Policy and procedure assessment tool - continence assessment (to identify individualized voiding patterns) is completed and implemented for each resident.	Yes	This change idea did not connect well with the issue of restraints as initially thought.
Ensure restraint assessments and tools are utilized as per policy (decision tree, initial and 1/4 alternatives to physical restraints, consent form, restraint audit tool) and Point of Care (POC) hourly monitoring of restraints	Yes	Education to psw is important to ensure knowledge of psad's and restraints, i.e., seatbelts, bedrail, etc.
Educate residents and families on the definition and purpose of physical restraints	Yes	Brochure has been helpful to increase awareness and education family specifically.

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8	Percentage of residents with worsening bladder control during a 90-day period (%; Residents; Q2 FY 2014/15; CCRS, CIHI (eReports))	53117	20.62	19.00	23.66	Our home had a slight increase in this indicator. n increased education focus on voiding records and continence assessments during 2016 will assist the home in demonstrating improvement in this area for the 2016/17 QIP.

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Implement an individualized toileting routine for each resident upon admission and significant change in status.	Yes	The home will work on identifying any areas which could be improved upon in the area for 2016/2017.
Reduction in use of caffeine and alcohol to improve continence and ensure adequate fluid intake targeting those residents with worsening bladder control.	Yes	The home does not serve caffeinated coffee. Alcohol is only by Dr. order.
Review medications at the quarterly medication review to identify medications that may have an impact on continence to determine if medication adjustments can be made.	No	This was reviewed however minimal changes could be made d/t diagnosis and medication requirements.
Increase participation in physiotherapy and exercise programs to maintain/improve mobility for those residents that toilet with minimal assistance.	Yes	Pelvic floor exercises have been incorporated into regular exercise programs.