Let's Make Healthy Change Happen.

Quality Improvement Plan (QIP) Narrative for St. Joseph's Health Care London

ST JOSEPH'S HEALTH CARE LONDON

04/01/2016

Overview

St. Joseph's Health Care London's (St. Joseph's) Strategic Plan for 2015-2018 has three strategic priorities related to enhancing the quality and safety of the care we provide to our patients, residents and families. These strategic priorities are:

1. Ensure patients and families are full partners in their care, and in the design, measurement and improvement of care.
2. Embrace the relentless pursuit of safety – everywhere.
3. Optimize transitions through the care system with and for patients, residents and families.

In pursuit of these strategic priorities, St. Joseph's identifies areas where we can improve the care and service we provide to patients, residents and families. St. Joseph's Health Care London is pleased to share its annual Quality Improvement Plan (QIP). The plan is guided by the voices of our patients, and reflects our passion for excellence – always. This plan builds on earlier plans to further improve our performance in the areas of patient safety, patient experience, optimizing transitions and effectiveness of care. All of our Quality Improvement Plan priorities align with our 2015-2018 Strategic Plan.

St. Joseph's values the opinions from patients and family members about the care and service, and regularly obtains feedback about the patient experience via patient, resident and family surveys and other feedback methods, as well as our Patient and Family Councils. We seek input from patients and family members for a variety of purposes including patient safety, design of clinic space and ethics.

Patient Partnerships

To ensure patients and families are full partners in their care, and in the design, measurement and improvement of care, St. Joseph's 2016-17 QIP will focus on development of a framework for patient partnerships, and achievement of specific milestones related to this goal in 2016-17. St. Joseph's has assembled a group of staff, leaders, physicians, patients and community members to form a Patient Partnership Initiative. Surveys are currently underway at Mount Hope Centre for Long Term Care, and our 2016-17 QIP will continue to include goals for two long term care resident experience survey questions. Increasing the percentage of "Excellent" responses in our mental health inpatient surveys, from 14.5% in our most recent survey results (72.6 % positive), will be a continued area of focus.

Relentless Pursuit of Safety

QIP indicators aligned with our goals related to safety include a continued focus on best practices related to hand hygiene and medication reconciliation on admission. In alignment with the relentless pursuit of safety, we will aim to reach zero wrong drug medication errors in 2016-17, with continued focus on processes associated with implementation of new technology.

Minimization of patient falls, and in particular falls resulting in injury, continues to be a high priority at Parkwood Institute's Main Building and Mount Hope Centre for Long Term Care. Our multi-year strategy to reduce falls with injury will build on the achievements in previous QIPs, with a continued focus on hardwiring of best practices across all units and learning from near misses.

Minimization of seclusion and restraint in our mental health programs is also a safety priority. Our QIP plan this year will focus on consistent use of best practices, with a specific goal to complete a staff debriefing at every seclusion and restraint episode for all mental health patients.

Additional QIP safety goals specific to Mount Hope Centre for Long Term Care include reducing worsening pressure ulcers and minimizing the use of restraints.

Effectiveness of Care

Two new goals in our 2016-17 QIP are focused on improving effectiveness of care. A multi-year initiative in our mental health population will focus on specific goals in 2016-17 to identify areas of focus to improve clinical outcomes, in alignment with our recovery-based model of care. A second goal for our long term care patient population sets targets for reducing worsening pain among residents at Mount Hope Centre for Long Term Care, and we will also continue work to reduce the use of anti-psychotic medication in long term care.

Optimizing Access and Transitions

St. Joseph's includes three QIP goals aligned with optimization of transitions and improving access to care. These goals align with priorities for the Southwest LHIN and partnerships with primary care, acute care and community care in our LHIN.

Reducing wait time from referral to initial physician consult has been the focus of a multi-year QIP goal at St. Joseph's Hospital for the Pain Management Program and the Urology Centre. Following implementation of process changes in our 2015-16 QIP, we will set specific targets for chronic pain and Urology cancer patients in alignment with regional and provincial wait time targets.

At Parkwood Institute's Main Building, the Rehabilitation Program will continue a focus on appropriate length of stay and meeting active length of stay targets for moderate and severe stroke patients.

A complete description of all Quality Improvement Plan priorities can be found in our Workplan, which includes detailed information about our objectives, indicators and targets.

QI Achievements From the Past Year

We have been pursuing strategies such as leader rounding on patients to drive our percent excellent survey scores in all programs and services. In 2015-16, we have accomplished significant improvement in patient experience in our Complex Continuing Care Program. The percentage of survey responses rating overall quality of care as “Excellent” increased from 15.6% to 31.3%.

A strategic priority for St. Joseph’s is to embrace the relentless pursuit of safety – everywhere. St. Joseph’s medication safety goal to eliminate patients receiving the incorrect medication has been a significant quality improvement success story, with a sustained decline over the past 2 years from 21 errors in Q3 2013-14 to 4 medication errors in Q3 2015-16. Investment in technology to support medication safety, including computerized provider order entry and closed loop medication administration, support our goal to eliminate specific medication errors (patients receiving the incorrect medication).

Initiatives to reduce falls with injury have been focus for quality improvement with positive results. Many of our patients and residents are at an increased risk of falling due to conditions affecting their physical strength and stability. At Parkwood Institute’s Main Building, falls with injury have declined from 69 to 46 per quarter over the past two years. At Mount Hope Centre for Long Term Care, there has been a decrease from 78 to 65 per quarter in the same time period.

Integration & Continuity of Care

At St. Joseph’s medication safety technology has been implemented for:

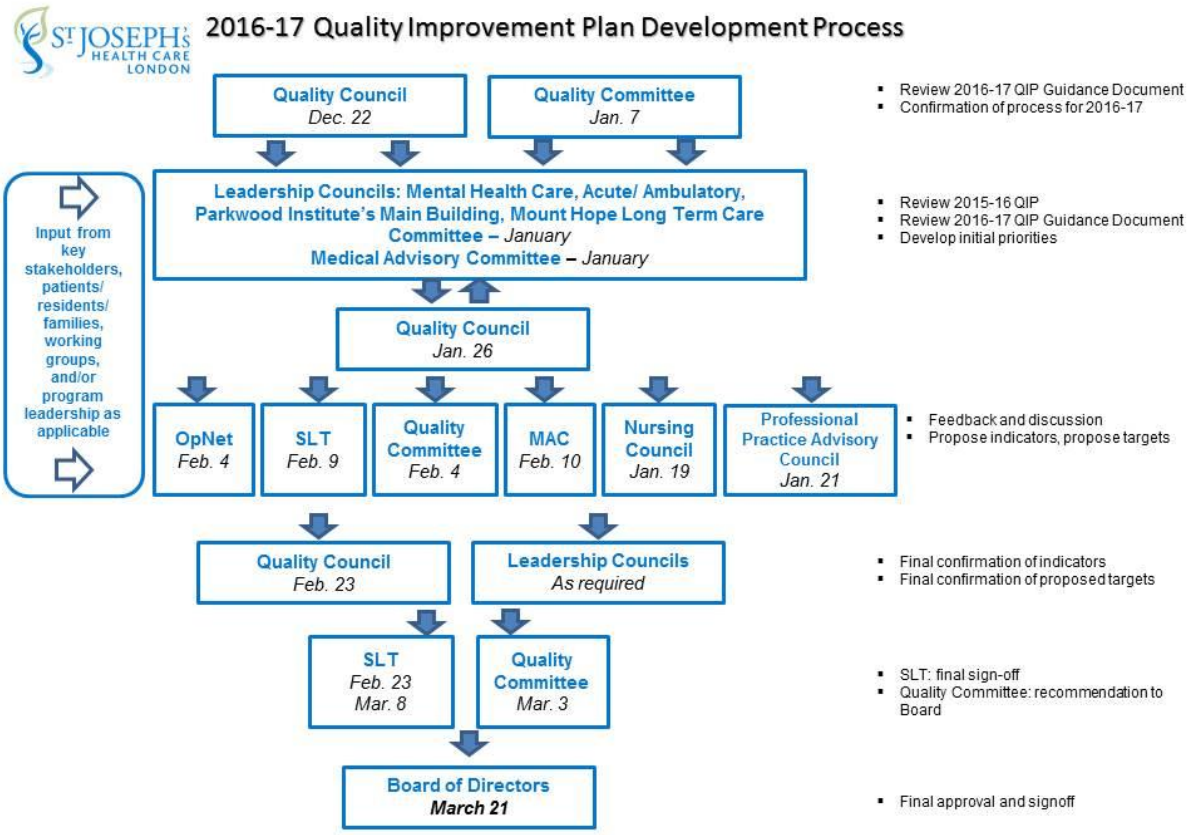
- Computerized Provider Order Entry
- Electronic Medication Administration Record
- Closed Loop Medication Administration
- Electronic Medication Reconciliation

To further enhance these information systems and support patient safety, additional optimization projects are planned in 2016-17.

We are also actively involved and/or leading several collaborations within and outside of our Local Health Integration Network to improve the sharing of information among care providers in order to support and enhance integration and continuity of care.

Engagement of Leadership, Clinicians and Staff

St. Joseph's has a very structured and collaborative approach to determining its strategic quality improvement priorities for the organization. St. Joseph's process involves patient/family, staff, physician, operational, senior leader and board engagement (see diagram below).



Patient/Resident/Client Engagement

In developing our Strategic Priorities for 2015-2018, there was a comprehensive engagement strategy that involved consultation (focus groups, open forums, electronic) with patients, families and community. The development of our 2016-17 QIP included input from patients, residents and families and is summarized in the following table:

Group	Date	Feedback
Corporate Patient Engagement Initiative	December 11, 2015	Current Councils are well engaged, open to giving feedback and input and active
	February 19, 2016	Feedback on identified QIP priorities and specific discussion of patient partnership goal
Mental Health Patient Council	February 17, 2016	Endorsed the proposed indicators Emphasized indicators related to medication reconciliation
Mount Hope Centre for Long Term Care Resident Council	January 26, 2016	Discussion included ideas for further improvements related to 2015-16 QIP indicators, comparison with the provincial long term care average and additional potential indicators for 2016-17. Residents support additional work related to falls, and shared examples of near misses.
Mount Hope Centre for Long Term Care Family Council	January 28, 2016	
Parkwood Institute Veteran's Council	Ongoing	Council engagement and support for activities related to Hand Hygiene and Falls Prevention
St. Joseph's Hospital Patient Council	December 5, 2015	Introduction to QIP
	February 24, 2016	QIP indicators feedback

Performance Based Compensation

Leaders at St. Joseph's at all levels (coordinator, director, senior leader) have clearly established goals for 2016-2017 and where applicable, goals are aligned with QIP priorities. Targets, 90 day plans, and monthly tracking of progress are conducted with leaders.

Our executives' compensation is linked to performance in the following ways:

- St. Joseph's President and Chief Executive Officer (CEO) has five per cent of her annual salary compensation at risk related to achievement of annual Quality Improvement Plan indicator targets outlined below.
- All senior leaders (leaders reporting directly to the President and CEO with the exception of the St. Joseph's Health Care Foundation President and CEO) have three per cent of their current annual salary compensation at risk related to the achievement of annual Quality Improvement Plan indicator targets outlined below.
- Integrated senior leaders (those who work at both London Health Sciences Centre and St. Joseph's Health Care London) will have the three per cent of their annual salary at risk split between each organization equivalent to the current cost sharing for their respective roles.
- The President and CEO and senior leaders reporting to the President and CEO will have the same targets.
- The following three indicators will be tied to performance based compensation:
    - Hand hygiene compliance
    - Medication reconciliation
    - Reduction in medication errors involving wrong patient / wrong drug

- Compensation will be awarded as follows:
    - The three indicators carry equal weight (each one is worth 33.3 per cent)
    - For each indicator:
        - Less than 50 per cent of target achieved = none of the compensation at risk will be awarded for that indicator
        - 50 to 99 per cent of target achieved = compensation at risk will be awarded for that indicator pro-rated based on per cent of target achieved
        - 100 per cent or more of target achieved = 100 per cent of compensation awarded for that indicator

Indicator	Current	50 Per cent of Target	Target
Hand hygiene *(Moment 1 Hand Hygiene Compliance - based on 2016-17 Q3 audit results)*	92.6% (Q3 2015-16)	93.8	95%
Medication reconciliation at inpatient admission *(Per cent of inpatient admissions where medication reconciliation was completed at admission)*	90.2% (Q3 2015-16)	92.6%	95%
Medication Safety: Reduce Medication Errors Involving Wrong Patient / Wrong Drug	4 per quarter (Q3 2015-16)	2	0

Sign-off

I have reviewed and approved our organization's Quality Improvement Plan

Philip Griffin
Board Chair

Darcy Harris
Quality Committee Chair

Dr. Gillian Kernaghan
President and Chief Executive Officer

2016/17 Quality Improvement Plan
"Improvement Targets and Initiatives"

St. Joseph's Health Care London - Corporate (excluding Mount Hope Centre for Long Term Care)

AIM		Measure							Change			
Quality dimension	**Objective**	**Measure/ Indicator**	**Unit / Population**	**Source / Period**	**Org Id**	**Current performance**	**Target**	**Target justification**	**Planned improvement initiatives (Change Ideas)**	Methods	Process measures	Goal for change ideas
Effective	**Achieve Effective Recovery-based Patient Outcomes**	Achieve Development Milestones for Improvement in Recovery Outcomes	Milestone Goals / Mental Health / Addiction patients	Hospital-collected data and OHMRS, CIHI / 2016-17	714*	CB	CB	Specific population and baseline measurement to be determined as part of milestone goals. Planned initiatives with milestone goals will be implemented this year.	1)Therapeutic Interventions Implement Safewards Program	Second staff member for a one year time period to lead the QIP work. Conduct current state analysis of the use of recovery-based interventions. Assessment tool selected and analysis completed Introduce Intervention # 1 (Clear Mutual Expectations). Hardwire use of Clear Mutual Expectations. Introduce Intervention #2 (Positive Words) aligned with roll out of Transitions of Care work. Assess readiness for introduction of Intervention #3 (Bad News Mitigation).	Steering Team in place by April 1, 2016. Site-based teams in place by June 1, 2016.	Assessment findings and recommendations on development of recovery –based programming presented to Mental Health Leadership by end of Q1. Achieve implementation of 5/10 Interventions.
									2)Patient Partnerships in Care Update care plans to indicate: a)If patient was present during planning; b)If not present, the date and sign off that the plan was reviewed with the patient, including patient signature	Revise all care plans to incorporate sign off for patients	% of care plans signed by patients or representative of patient	By Q2 50% of all care plans will have patient sign off. Q3 75% of all care plans will have patient sign off. Q4 100% of all care plans will have patient sign off.
Efficient	**Achieve Efficient Length of Stay in Rehabilitation**	Percent of Moderate and Severe Stroke Rehab Patients Meeting Active Length of Stay Target	% / Parkwood Institute Rehabilitation Program patients with moderate or severe stroke	Hospital collected data / 2015-16 Q3	714*	72	85.00	Increase from current performance	1)Improve transition from University Hospital (UH) 7 IP (acute care) to rehab admission.	a) Review day of transfer processes and standardize steps with acute care team and audit by June 30,2016. b) Daily review of cases waiting between Access Office and Resource Nurse to facilitate next day admission(s). c) Access Office daily review of cases waiting in June and October 2016 and reason for delay; Analyze and review metrics for wait time for admission.	a) Percent of admissions with standardized steps for arrival time of 1000 hours completed for day of transfer. b) 100% of waiting cases reviewed daily by Resource Nurse and Access Office. c) Number of cases outside of target admission time and reason for delay.	a) 100% of UH admissions followed standardized day of transfer process. b) 100% of open cases reviewed daily. c) 80% of cases meet target of next day 1000 hours admission.
									2)Improve discharge planning process.	a) Weekly team bullet rounds b) Standard discharge letter	a) 100% of patients for discharge within next 7 days reviewed at bullet rounds. b) Provided to all patients/family within 10 days of admission by social worker.	a) 85% of patients reviewed at bullet rounds will meet discharge date target b) 100% implemented by June 2016
									3)Improve access to ambulatory services	Analyze and review CORP and CSRT data for review of wait time from referral to initial appointment	Percentage of patients who had initial appointments in Q2 reviewed	100% of referrals reviewed for Q2

2016/17 Quality Improvement Plan
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Patient-centred	**Develop Patient Partnerships**	Achievement of Patient Partnership Development Milestone Goals	Milestone goals / N/a	Hospital collected data / To Be Determined	714*	Collecting Baseline	Collecting Baseline	Specific metrics for baseline measurement to be determined as part of milestone goals. Planned initiatives with milestone goals will be implemented this year.	1)Develop operational foundation for Patient Partnership Project	a) Engage project lead; b) Project charter formulated; c) Project structure created	Project plan developed	Initiate Patient Partnership project in Q1
									2)Review current state of Patient Partnership from a staff / physician perspective	Identify gaps in engagement in the development current state report	Gaps identified, including community partners	Stakeholders to be engaged in current state analysis identified by Q1
									3)Conduct a current state analysis of our Patient Partnership with our patients, families and caregivers	Visioning sessions with patients, families and caregivers as partners	Patient, family and caregiver sessions completed	Understand current state of Patient Partnership from the perspective of our patients, families and caregivers by Q2
									4)Understand current best practices in Patient Partnership	Conduct literature review and environmental scan	Literature review and environmental scan completed	Best practices from leading organizations identified by Q2
									5)Develop framework for Patient Partnership ensuring alignment to current priorities of innovation in ambulatory surgery, rehab and recovery and chronic disease management, and our mission, vision and values	a) Create operational methods to achieve excellence in Patient Partnership b) Engage stakeholders in development and review of proposed framework c) Review framework in keeping with our current priorities of innovation in ambulatory surgery, rehab and recovery and chronic disease management, and our mission, vision, values	Framework developed	Approval of proposed Patient Partnership Framework by SLT and the Board by Q3
									6)Operationalize Patient Partnership Framework	a) Engage patients, family, caregivers, staff, physicians and community partners in Patient Partnership framework b) Implement processes identified in the framework	Stakeholders engaged in implementation of framework; Processes operationalized	Framework Implemented in Q4

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Safe	**Increase proportion of patients receiving medication reconciliation upon admission**	Percent Medication Reconciliation at Inpatient Admission	% / All inpatients	Hospital collected data / Q3 2015-16	714*	90.2	95.00	Increase from current performance	1)Increase feedback to providers	Improve current medication reconciliation completion reports to show data by provider	Percentage of programs with provider-specific data reviewed	100% of clinical programs have a process for regular review of medication reconciliation and feedback to providers < 95%
									2)Enhance medication reconciliation accountability and workflow	Information Technology Services Optimization Project for enhancement of medication reconciliation process	Completion of optimization by Q4	Optimization project complete and accountability (of prescribers and staff) for documentation defined and communicated
									3)Increase quality of medication reconciliation on admission	a) Task force to detail quality end points and barriers to achieve “clean” med rec on admission b) Development of quality measures and baseline for each measure c) Audit process d) Standard process for provider feedback and accountability	a)Percentage of providers receiving information related to quality standards; b)Percent of medication reconciliation meeting quality standards; c)Percentage of providers receiving feedback quarterly related to gaps.	Define and have ability to measure “Quality” for Medication Reconciliation. Standard process for monitoring quality and feedback to providers in place for 100% of inpatient programs by Q3.
	Eliminate Wrong Drug Medication Errors	Number of Medication Errors: Wrong Drug / Wrong Patient	Number / All patients receiving medication administration	Patient Safety Reporting System / Q3 2015-16	714*	4	0.00	Best possible performance	1)Continue to improve compliance with barcode scanning.	Regular review of compliance rates for barcode scanning and follow-up	Compliance rates for barcoding scanning of medications and of patients	100% barcode scanning compliance to eliminate wrong drug/wrong patient medication errors.
									2)Enhanced medication error review with pharmacy and nursing leaders and sustainable process in place for review of errors at a system level	Develop process for inter- professional review of wrong patient /wrong drug incidents	% of incidents with review completed, including patient wristband bar code scan, medication bar code scan, and related alerts.	a) 100% of wrong drug/wrong patient incidents have inter-professional review b) Understanding of root cause, share and apply learnings for prevention

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Safe	**Increase Hand Hygiene Compliance**	Hand Hygiene Compliance Before Patient Contact (Moment 1)	% / Observed hand hygiene opportunities all sites (LTC excluded)	Hospital collected data / Q3 2015-16	714*	93	95.00	Increase from current performance	1)Further define tiered accountability structure	Refine framework that addresses individual and unit accountability. Engage SLT and MAC.	Structure in place, and processes written/communicated to leadership, accountable to senior leadership and MAC.	Structure is used to monitor and hold operational and physician leaders accountable to ensure compliance plans are in place.
									2)Improve patient and family engagement in ensuring hand hygiene practices	Expand model whereby patients/families and visitors can provide feedback on the healthcare providers hand hygiene practice.	Signs and patient materials include information asking them to participate in ensuring hand hygiene provided as part of their care. Each clinical leader reports on methods used specific to their program.	Each area adopts specific strategies to ensure patients are engaged to facilitate staff/physicians to adopt hand hygiene.
									3)Ensure/validate consistency of audit practice	Develop online module to assess auditors' knowledge/ practice and provide feedback related to any gaps.	Learning Edge completion rate	Module in place.
									4)Improve reliability and functionality of hand hygiene database.	Implement a new database to track compliance with greater report functionality for leaders	Compliance reports from data base	New data base in place with training implemented on its use (auditors, ICPs, and leaders if functionality allows)
									5)Focus strategies to improve likelihood of staff /physicians adopting 3 vital behaviours for hand hygiene compliance in areas where compliance is less than 95%	Use six sources of influence model to create corporate and program specific plans to ensure all staff adopt vital behaviours	Written influence plans	Each area creates and owns specific plan unique to address barriers of compliance identified for their area.
	Increase Staff Debriefing for Seclusion and Restraint Episodes	Percentage of Seclusion and Restraint Episodes with Staff Debriefing Completed	% / All Mental Health inpatient programs	Hospital collected data / Q3 2015-16	714*	25	75.00	Significant increase to drive minimization of the use of seclusion and/or restraint	1)Consistent leader understanding of expectations and accountability regarding debrief process.	a) Education for mental health clinical and operational leaders regarding best practice for debrief and standard process for documentation b) Leaders to role out to staff c) Audit of completed debriefs	a) % of leaders who have completed training b) Number of units with a debrief audit completed c) Number of debriefing reports completed according to standard process.	a) Education complete for 100% of leaders b) Audit completed in Q2 c) 100% of debrief documents completed according to standard process by Q2
									2)Increase frequency of reporting of episodes with debrief for early identification of gaps in debriefing	Automate methodology for counting episodes and % with debriefs, develop methodology for time-outs	Business intelligence development and testing completed for counting and reporting of episodes	Monthly reporting of episodes and % with debrief in place by Q2
									3)Review debriefing tool: ensure patient, environment, staff and organizational contributing factors	Working group confirmed. Process identified for staff to submit feedback and revise tool based on feedback.	Number of staff providing feedback	Debriefing tool finalized by Q2
									4)Improve metrics for monitoring and trending seclusion and restraint hours and increase review	a)Standardize Patient level metric, exclude outliers. b)Quarterly review of metrics by Mental Health Leadership.	a)Median and 90th %ile seclusion and restraint hours per 100 patient hours distributed quarterly b)% of leadership meeting minutes with review of metrics	a)Metrics reviewed quarterly by leadership b)Quantitative indicators finalized for 17/18 Baseline established by Q3 and target for 17/18

2016/17 Quality Improvement Plan
"Improvement Targets and Initiatives"

St. Joseph's Health Care London - Corporate (excluding Mount Hope Centre for Long Term Care)

AIM		Measure							Change			
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Safe	**Reduce Falls with Injury, Parkwood Institute Main Building**	Number of Patient Falls Resulting in Injury	Number / Parkwood Institute Main Building Patients	Hospital collected data / Q3 2015-16	714*	46	45.00	Meet quarterly target and sustain. Falls with injury has declined from 69 in Q3 2013-14 to 55 in Q2 2015-16	1)Continue improvements to Intentional Comfort Round (ICR) processes	a)Stakeholders identified. b)Review of current ICR process c)Review practices from other organizations d)Action plan and communication plan with regular updates e)Auditing of ICR processes	a)Number of programs engaged in ICR review and modifications b)Number of practice reviews from other organizations c)Frequency of site wide and program communications d)Number of applicable units with auditing completed	a)Updated ICR processes confirmed and implemented in all applicable clinical units within Parkwood Main Bldg. by Q2 b)100% of Parkwood Main Building clinical staff receive communication of ICR processes in Q2 and updates in Q3 and Q4 c)100% of applicable units have implemented auditing processes with targets by Q4
									2)Review and assessment of current screening tools at Parkwood Main Building (Morse, Schmidt, RAFT)	a)Review of literature and best practices b)Develop recommendation and present to Corporate Falls Committee c)Implementation plan with timelines	a)Number of Literature reviews completed b)Percentage of approved recommendations implemented.	a)All Parkwood Institute (Main Building) screening tools reviewed in Q1 b)100% of approved recommendation implemented by Q4 in all applicable units
									3)Increase sharing of Program Specific Falls prevention strategies	Program-level review of falls prevention strategies	Number of programs that submit updated information reflecting falls prevention strategies	a)100% of programs submit falls prevention strategies to Corporate Falls Prevention Team b)Program-level strategies posted annually by Q4 and communicated

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St. Joseph's Health Care London - Corporate (excluding Mount Hope Centre for Long Term Care)

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Timely	**Reduce Wait Time for Initial Consult in Pain Management Program**	Percentage of New Pain Program Patients With Referral to Initial Physician Consult Wait Time Within Target	% / St. Joseph's Hospital Pain Management Program, New Patients	Hospital collected data / 2015-16 Q3	714*	CB	CB	Target will be set based on provincial target. The Adult Chronic Pain Ministry Network is developing indicators and targets.	1)Improve active review of wait time from initial referral to patient orientation to initial physician consult to inform clinic processes.	a)Physician level reports. b)Review scheduled new consults projected wait time.	a)Frequency of metrics review at Pain Advisory Committee. b)Percent of physicians with review.	Physician level metrics reviewed by end of Q2 and assessed to inform clinic processes
									2)Implement a discharge RN role to increase new physician consult times as patients' transition to the discharge RN.	a)Determine discharge criteria. b)Develop care pathway to transition from physician to discharge RN.	a)Discharge criteria confirmed by end of Q2. b)Discharge RN role implemented by end of July. c)Average monthly clinic hours available for new consult appointments.	Patients transitioned to discharge RN role from physicians and physician appointments for new consult requests has increased by Q4.
	Reduce Wait Time for Initial Consult in Urology Centre	Percentage of Urology Centre Cancer Surgery Patients With Referral to Initial Physician Consult Wait Time Within Target (Wait 1)	% / St. Joseph's Hospital Urology Centre, Prostate and Genitourinary Oncology Surgery (Treatment) patients, Priority 2/3/4	Provincial Wait Time Information System / 2015-16 Q3	714*	45	85.00	The provincial and regional Wait 1 target for Oncology cases is 85% within target. Priority-specific targets: P2 10 days, P3 21 days, P4 35 days. Priority level assigned based on referral information.	1)Develop prospective review of wait time for initial consults booked, for GU and prostate cancer referrals	a)Specific appointment types and mandatory priority level will be used to develop open cases metrics b)Retrospective audit of surgery cases.	a)% of surgery cases with correct appointment type b)% of consults projected beyond target based on scheduling	a)Appointment types by Q2, review with applicable offices by Q2 b)Audit of cases booked for surgery in Q2 c)Process for review of open cases beyond target confirmed by Q3
									2)Increase knowledge of Wait 1 targets for Oncology in Urology service.	a)Decision Support education to offices booking consults for GU/prostate cancer referrals. b)Education and target review with Urologists by operational leadership and Decision Support; surgeon input on further process improvement.	a)Number of offices per month with education in Q1. b)Number of surgeons with Wait 1 and education completed; number of surgeons providing input to processes impacting performance.	a)Applicable offices receive education by end of Q1. b)All offices complete review of Wait 1 metrics and provide feedback by end of Q1.
									3) Complete planning and implement a prostate diagnostic assessment program	Specific space and appointments developed to provide access or prostate patients	Number of referrals received	Appointment types and referrals received by Q2

2016/17 Quality Improvement Plan
"Improvement Targets and Initiatives"

St. Joseph's Health Care London - Mount Hope Centre for Long Term Care

AIM		Measure							Change			
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Effective	**Reduce the Percentage of Residents Experiencing Worsening Pain in LTC**	Percentage of residents experiencing worsening pain	% / Residents	CCRS, CIHI / Q2 2015-16	53885*	16.4	15.00	The target has been set to meet the provincial average.	1)QIP Committee education regarding indicator measurement and MDS coding guidelines	Multidisciplinary collaboration with OT,RN, Regional LTC Palliative Care Pain expert, Pharmacist, Physician and Pain Clinic expert to assess residents experiencing worsening pain for alternate strategies/interventions and evaluate effectiveness	# of referrals per month to the pain and palliative care committee and # of cases reviewed	Gap analysis completed by Sept 2016
									2)Audit residents indicating worsening pain and assess pain, medication, medical conditions and current practice for reducing pain	Multidisciplinary collaboration with OT,RN, Regional LTC Palliative Care Pain expert, Pharmacist, Physician and Pain Clinic expert to assess residents experiencing worsening pain for alternate strategies/interventions and evaluate effectiveness	# of referrals per month to the pain and palliative care committee and # of cases reviewed	Gap analysis completed by Sept
									3)Compare current practices and do gap analysis with best practice RNAO and LTC Community of Practice	Multidisciplinary collaboration with OT,RN, Regional LTC Palliative Care Pain expert, Pharmacist, Physician and Pain Clinic expert to assess residents experiencing worsening pain for alternate strategies/interventions and evaluate effectiveness	# of referrals per month to the pain and palliative care committee and #of cases reviewed	Gap analysis completed by September
	Reduce Use of Antipsychotics in LTC	Percentage of residents receiving antipsychotics without a diagnosis of psychosis (excluding patients experiencing delusions)	% / Residents	CCRS, CIHI (eReports) / Q2 2015-16	53885*	22	21.00	Continue improvement: The facility is currently lower than the provincial average (24.9%).	1)Pharmacy to follow up with ordering Physician on all orders for antipsychotics without a diagnosis of psychosis. Quarterly and annual reassessment of ongoing need for antipsychotics.	Quarterly review of residents with prescribed antipsychotics for; Behaviour management, All medications,and the need for antipsychotics, by Unit RN, Pharmacists and PCPs	All residents on antipsychotics with a diagnosis reviewed annually	Annual Interdisciplinary review
									2)Quarterly and annual reassessment of ongoing need for antipsychotics.	Quarterly review of residents with prescribed antipsychotics reviewed for assessment of behavior management, all medications, ongoing need by Unit RN, Pharmacist and PCP	All residents on antipsychotics with diagnosis of psychosis reviewed annually	Quarterly and Annual resident review

2016/17 Quality Improvement Plan
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St. Joseph's Health Care London - Mount Hope Centre for Long Term Care

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Resident-Centred	**Resident Experience - Recommend**	% Yes to "Would you recommend this facility?"	% / Residents	NRC Picker / Annual	53885*	Collecting Baseline	Collecting Baseline	Annual Survey in-progress, results pending. We will set a target for 2016-17 based on a 5% increase from the pending results.	1)Hiring a coordinator of therapeutic programs to address improved satisfaction results - eg. Increase activities on evenings and weekends.	New Coordinator to review satisfaction results and work with appropriate internal and external groups to address gaps (Add depending on top 3 identified in survey).	Number of coordinator roles filled by date	one coordinator role filled by end of Q1
									2)Based on Mar 2016 Resident Satisfaction Survey, implement change ideas to address top 3 priorities where we had a low score and highest correlation to overall satisfaction - eg. Activities, food, call bells.	New Coordinator to review satisfaction results and work with appropriate internal and external groups to address gaps (Add depending on top 3 identified in survey).	Number of priorities with change ideas implemented	3 out of 3 priorities have change ideas implemented by Q3
	Resident Experience - Voice	% Yes to "Do you feel you can express your opinions and feelings?"	% / Residents	NRC Picker / Annual	53885*	Collecting Baseline	Collecting Baseline	Annual Survey in-progress, results pending. We will set a target for 2016-17 based on a 5% increase from the pending results.	1)Implement an automated complaint management system	Director quarterly report review of resident/family complaints at staff meetings for awareness from a Residents' perspective	# of staff meetings where residents voice/complaints are shared	Shared at 4 meetings per year
									2)Communicate summary report for the Board, Staff, Resident and Family Councils at regular intervals	Director completes summary report of complaints and follow up for the Board and Quality Council bi-annually	The # of Director summary reports.	Bi-annual reports for both committees
									3)Include resident/family council representatives on Patient Engagement Corporate discussions to ensure resident and families are partners in their care.	Operational Leaders to share resident concerns/complaints at monthly staff meetings to ensure awareness and engagement in resolutions	At least one Mount Hope Resident or Family council representative included in Patient Engagement Corporate discussions.	The voice of long term care families is heard at corporate patient engagement sessions.

2016/17 Quality Improvement Plan
"Improvement Targets and Initiatives"

St. Joseph's Health Care London - Mount Hope Centre for Long Term Care

AIM		Measure							Change			
Quality dimension	**Objective**	**Measure/ Indicator**	**Unit / Population**	**Source / Period**	**Org Id**	**Current performance**	**Target**	**Target justification**	**Planned improvement initiatives (Change Ideas)**	Methods	Process measures	Goal for change ideas
Safe	**Reduce the Use of Restraints in LTC**	Percentage of residents who were physically restrained	% / Residents	CCRS, CIHI (eReports) / July-September 2015 (Q2 FY2015/16 Report)	53885*	32.8	25.00	This is a priority focus for the facility - significant reduction target.	1)Admit resident based on "no restraint" policy and monitor the impact on occupancy	a) Revise current admission policy and criteria to address changes in admission process for restraints. b) Educate staff on change in practice. c) Create family education related to risk and alternatives to restraint use.	a) Meet with Admission RN to review current assessment practices and ensure best practice. b) Revise tools to support new policy and practice	No residents admissions that will require restraints post July
									2)Reassess all residents reviewing pharmaceutical and non-pharmaceutical alternatives and educate all staff on social and physical risks of using restraints and potential alternatives	a) Assess all current residents with restraints by developing Interdisciplinary required programs committee structure and use best practice tools- eg. Residents First to ensure use of high leverage change ideas and clarify accountabilities to meet HQO targets. b) Define structured unit process for resident individualized reassessment of restraints to include; screening protocol, documentation, accountability, education of staff and family, policy revision. c) OT assessment for seating to see if better fit improves reduction in restraint use. d) Use of tools for alternatives to restraints including alarms, activities, and IDT annual assessments.	a) Launch monthly IDT meetings with minutes by May. b) Conduct unit by unit resident restraint assessments. Create unit assessment tool.	Launch Committee by May- 8 meetings in 2016. New unit resident restraint assessment tool
									3)Benchmark with other like LTC Homes who have demonstrated a reduction in the use of restraints over past 2 years.	a) Review HQO site for bench mark homes that meet reductions in restraints and define key contact. b) Solicit most successful strategies. c) Create benchmark survey tool.	Review benchmark outcomes with QIP team for assessment of successful strategies. # of homes identified	Create benchmark survey tool. Complete benchmark survey
									4)Assess the need for additional current alarms and place on capital for purchase if required. Investigate other alarms eg. Posey Clip Alarm	Create trial assessment on Pose Clip Alarms and assess for effectiveness as alternate to restraints	Complete trial assessment on new Posey Clip Alarms	New alarms if trial successful
									5)Develop Family/Resident Education Brochure defining restraint policy	Create brochure	Complete brochure and add to home tour and admission package	Family/Resident brochure
	To Reduce Falls with Injury in LTC	Number of Falls with Injury	Number / Residents	Hospital collected data / 2015-16 Q3	53885*	65	62.00	Falls with injury has declined from 78 in Q3 2013-14 to 65 in Q3 2015-16. Continue Improvement: The facility is lower than the provincial average for falls in last 30 days.	1)Implement LTC Standard labeling for high risk residents "Falling Star"	a) Assess volume and incidence of falls within 7 days of admission- Audit Patient Safety Reporting System (PSRS) and compare with new admissions. b) Create the policy, process, locations for falling star, education for staff and evaluation plan	Develop the specific policy and process for falling star by June 2016	July 1st-Dec 31st- 6 month trial for Falling Star
									2)Intentional Comfort Rounds (ICR) implementation based on inclusion criteria	Clarify ICR inclusion criteria (eg. high risk falls, skin breakdown). If audit in #1 shows new admission higher risk for falls, add new admission to ICR criteria.	ICR documentation by staff and leaders	100% ICR documentation for residents that meet a CPS score of 3 and under
									3)Increase volume of hi-low beds	50 additional hi-low beds ordered post Apr 1	Purchase complete	On site by June 2016

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AIM		Measure							Change			
Quality dimension	**Objective**	**Measure/ Indicator**	**Unit / Population**	**Source / Period**	**Org Id**	**Current performance**	**Target**	**Target justification**	**Planned improvement initiatives (Change Ideas)**	Methods	Process measures	Goal for change ideas
Safe	**To Reduce Worsening of Pressure Ulcers in LTC**	Percentage of residents who had a worsening Pressure Ulcer	% / Residents	CCRS, CIHI (eReports) / 2015-16 Q2	53885*	5.3	4.00	Continue improvement	1)Ensure optimal inventory and use of all therapeutic surfaces, positioning devices, incontinent products including; a)Assess the need for additional positioning devices eg. Wedges, tilt chairs for high risk residents. b) Assess current residents for appropriateness for alternating pressure device and highest priority for new or alternating pressure mattress. c)Assess current inventory of alternating pressure mattresses. d) In-service staff on best practices for use of all therapeutic surfaces. e) ensure optimal use of incontinence briefs. f) purchase additional alternating pressure mattresses.	a) RAI Consultant and Unit RN to review all high risk residents for skin breakdown or worsening ulcer and prioritize high risk residents needing new or alternating pressure mattress. Audit current mattress inventory. b) Create capital replacement plan. c) Supplier to facilitate refresher staff in-services on use of alternating pressure devices and incontinence products	a) Revise inventory list to identify current users. b) Reconcile list with all residents at risk for skin breakdown to ensure all have the equipment required or capital equipment plan to meet needs. c) Staff refresher education.	Staff refresher education by Dec 31st 2016
									2)Ensure optimal staffing for wound care; a) Refresher education for all staff regarding positioning, available tools and revise current practice of rounding to meet best practice positioning guideline(Q2 hours). b) Implement 6 month trial of wound care RPN at Marian Villa. c) Dedicate 2 days per month RN wound care specialist to ensure evidence based practice and products are utilized.	a) Implement additional positioning round on night shift for high risk residents. b) hire dedicated wound care RPN for trial	a) Intentional Comfort Rounding (ICR) documentation reflects repositioning completed for high risk for skin breakdown residents. b) WorkBrain analysis post 6 month trial for RN/RPN hours (less # of working short shifts)	RPN shifts 5 days/week and RN 2 days/month
									3)Collaborate with clothing boutique and family to ensure proper fitting clothes with adaptations as needed	Unit RNs to identify all residents with inappropriate clothing for follow-up with the families or clothing boutique for appropriate sizes	# of referrals to clothing boutique	One referral/month
									4)Collaborate with Vendors and staff to ensure optimal use of skin care and products to meet clinical quality specifications	Multidisciplinary sub group to review all Corporate available skin care products and cost comparison to assess the right product for skin care	# of meetings that occurred with minutes	Appropriate products in use without breach of contract.