Excellent Care for All
Quality Improvement Plans (QIP): Progress Report for the 2015/16 QIP

St. Joseph's Health Care London – Mount Hope Centre for Long Term Care
*(Please note that St. Mary's and Marian Villa have the same indicators, however are reported separately)

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)	53885	75.00	79.00	NA	As of March 2016, 8 of 10 nursing units complete for Resident experience survey. After outbreaks resolved on 2 nursing units, remainder of resident experience survey will be completed.

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?
Resident satisfaction surveys indicate participation in activities is highly correlated with overall satisfaction in our long term care home. Mount Hope's planned change ideas involve strategies to enhance activities for residents.	Yes	2015 Resident satisfaction surveys indicated that priority areas for focused improvement efforts, based on lower satisfaction areas that are highly correlated to overall satisfaction, included: (1) Enough activities to keep mind active, (2) Staff try to understand feelings, and (3) Staff promptly answer call bells To improve availability of 'enough activities to keep mind active', a new 'Coordinator of Therapeutic Programs'position was created for which interviews are currently underway.
To improve 'staff try to understand feelings', To improve 'staff promptly answer call bells',	Yes	The results of 2015 resident satisfaction surveys were reviewed with 57 staff over 10 information sessions to increase staff awareness of resident concerns. Extensive efforts in recruitment and scheduling have resulted in 75% decrease in incidence of working short and use agency staff.

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2	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)	51490	75.00	79.00	NA	As of March 2016, 8 of 10 nursing units complete for Resident experience survey. After outbreaks resolved on 2 nursing units, remainder of resident experience survey will be completed.

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9	Number of Falls with injury. (Counts; Residents; Q1 to Q3 Apr.1-Dec.31, 2014 Avg; Patient Safety Reporting System)	53885	75.00	67.00	65.00	Oct.1-Dec.31, 2015

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To focus on reduction of falls sustained by new resident admissions, our improvement initiatives involve documentation and education of a falls prevention strategy within 24 hours of admission for new residents.	Yes	Risk for falls is assessed on admission. Interview within the first 24 hours of admission; and used to be within 7 days. If high-risk for falls, risk assessment and interventions placed on care plan, and are initiated. Referral is also placed to Physio for an assessment and prevention interventions. '24 hour care plan' was updated in January 2016 to improve communication of falls prevention interventions in place for new residents. It is reviewed at each shift change, with all staff, for the first 7 days of a resident's admission.
Introduce Falling Star Program Implement Intentional Comfort Rounding (ICR)	Yes	Plans have been made and approved through corporate falls prevention committee to implement prevailing best practice in Summer 2016 of 'falling star' risk identifier to be placed on outside of door to resident room, on mobility aides and on resident wrist. Intentional Comfort Rounding initiated Oct.13, 2015 on 2 pilot nursing sites. Residents at high risk of falls participate in ICR and are checked on 14 times per 24 hour period to ensure falls interventions are in place, including that toileting needs are met and required items are in close proximity to resident.

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15	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))	53885	22.82	20.53	21.92	Indicator results are improved and lower than provincial average 24.9.

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?
increased monitoring and recommendations for change	Yes	Need for Antipsychotics now reviewed quarterly with each RAI Assessment and recommendations made.
quarterly review of non-pharmaceutical interventions	Yes	New standardized tool created for review of each resident and their antipsychotics with Physician and pharmacist. Includes criteria for use and diagnosis.
provide physicians with prescribing patterns as it relates to provincial benchmarks	Yes	New standardized tool created for review of each resident and their antipsychotics with Physician and pharmacist. Includes criteria for use and diagnosis.
Create new standardized tool	Yes	New standardized tool created for review of each resident and their antipsychotics with Physician and pharmacist. Includes criteria for use and diagnosis.

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16	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))	51490	29.56	26.60	21.98	Indicator results are improved and lower than provincial average 24.9.

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increased monitoring and recommendations for change	Yes	Need for Antipsychotics now reviewed quarterly with each RAI Assessment and recommendations made.
quarterly review of non-pharmaceutical interventions	Yes	BSO team meets weekly and reviews effectiveness of non-pharmaceutical interventions on specific residents.
provide physicians with prescribing patterns as it relates to provincial benchmarks	Yes	HQO Physician Practice website link shared with all physicians as well as current stats. Current residents on Antipsychotics reviewed with Physician. Pharmacist and Nurse and documentation of appropriate corresponding diagnosis documented.
Create new standardized tool	Yes	New standardized tool created for review of each resident and their antipsychotics with Physician and pharmacist. Includes criteria for use and diagnosis.

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18	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)	51490	71.00	75.00	NA	As of March 2016, 8 of 10 nursing units complete for Resident experience survey. After outbreaks resolved on 2 nursing units, remainder of resident experience survey will be completed.

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#1) To improve timeliness of complaint management through incremental investment, recruitment and retention of additional nursing management staff.	Yes	2 new full time positions called 'Long Term Care Support Specialists' began work at Mount Hope in August 2015. Significant time has been invested in responding to concerns and inquiries.
initiate complaint management software Director participation at monthly resident and family council meetings. Initiate use of 'concern forms'. Intentional comfort Rounding implementation at Mount Hope.	Yes	To monitor and report on complaint trends, for the period Sept.1/15 to Mar.31, 2016, complaint management software 'FM Pro' was initiated for Mount Hope. Next steps to include quarterly overview analysis of numbers resolved to complainant's satisfaction, and reporting of complaints to each of General Staff Meetings, Family and Resident Councils). Director attended all Resident and Family council meetings. In January 2016, initiated use of 'concern forms' to more clearly document concerns and follow-up within 10 days. To ensure timely follow-up to resident requests or needs, we initiated 'intentional comfort rounding'(ICR), piloted on 2 nursing units, Oct.13 2015. ICR includes 14 documented checks on residents per 24 hour period to inquire about pain, positioning, proximity of needed items and ensuring personal needs are met. In addition, ICR involves leader rounding on residents to ensure needs are met.

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19	Percentage of residents who had a pressure ulcer that recently got worse (%; Residents; Q2 FY 2014/15; CCRS, CIHI (eReports))	53885	4.08	3.10	4.49	Target not met. An opportunity exists to increase resources allocated to dedicated wound specialist role to ensure all wound care interventions implemented in a timely manner.

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development of a new tool to improve communication between PCPs and registered staff to alert registered staff to the specific area of concern, so that nursing interventions can be initiated and added to a residents' care plan before ulcers develop or worsen.	Yes	To improve reporting of skin issues from PCPs to RPN, new hard copy skin monitoring tool implemented in March 2015. New electronic skin assessment (Point Click Care) tool developed and implemented October 2015 with automatic electronic alert to registered staff for further assessment and follow-up. Improved processes will result in consistent tool use and follow-up.
Dedicated Wound RPN temporary full time 6 month pilot Consult Resident and Family Councils Dedicated RAI MDS Team New Continence Product New skin care products	Yes	To improve completion of wound treatments and interventions, effective February 2016, launched pilot full time RPN position. Also increased auditing/monitoring of implementation of wound care interventions. Resident and Family Councils were consulted in January 2016 as to recommendations for change to improve pressure ulcer indicators. In October 2015, initiated dedicated RAI MDS coding team to improve data validity and reliability through concentrated education of 22 individuals (versus previous 100 RPNs) New, higher quality, continence product launched February 2016. Focus group voiced concerns about new skin care products to purchasing agents and product changed on pilot floors in February 2016.

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20	Percentage of residents who had a pressure ulcer that recently got worse (%; Residents; Q2 FY 2014/15; CCRS, CIHI (eReports))	51490	3.70	2.80	6.03	Target not met. An opportunity exists to increase resources allocated to dedicated wound specialist role to ensure all wound care interventions implemented in a timely manner.

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21	Percentage of residents who were physically restrained (%; Residents; Q2 FY 2014/15; CCRS, CIHI (eReports))	53885	33.00	29.70	33.44	Target not achieved.

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Change idea to improve the accuracy of documented restraint use includes staff education as to the legislated definition of restraint devices verses personal assistance service devices. Mount Hope will monitor data for consistent measurement of restraints and to improve documentation through an auditing process.	Yes	All residents with restraints audited for need and accurate coding. In consultation with resident/family/care providers. Extensive individualized resident restraint reassessment completed so restraints could be removed whenever possible. Education algorithm tool developed for staff education to support least restraint use. Quarterly monitoring of restraints and falls is completed.
Dedicated RAI MDS coding team Reassessment of restraints at 6 week post admission meeting	Yes	Unit dedicated coders for RAI and MDS submissions were recruited and educated in restraint definition/coding and consistent documentation. We believe this results in improved data validity and reliability. Also instituted reassessment of restraints at 6 week post admission meeting with Physician/RN. Revised 6 week documentation to reflect prompt reassessment and documentation.

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22	Percentage of residents who were physically restrained (%; Residents; Q2 FY 2014/15; CCRS, CIHI (eReports))	51490	30.74	27.66	32.17	Target not achieved and restraint use increased.

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23	Percentage of residents with worsening bladder control during a 90-day period (%; Residents; Q2 FY 2014/15; CCRS, CIHI (eReports))	53885	26.40	23.76	23.42	Target achieved

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Continence Committee to review all residents with worsening bladder control and identify residents for whom to develop an individualized toileting plan to involve prompted voiding, habit retraining and timed voiding.	No	Attended 'Cost and Quality in Long Term Care' conference in Oct 2016 and advised that this indicator would no longer be a priority indicator in future years. Identified specific residents for whom an individualized toileting plan implemented involving prompted voiding, habit retraining and timed voiding.

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24	Percentage of residents with worsening bladder control during a 90-day period (%; Residents; Q2 FY 2014/15; CCRS, CIHI (eReports))	51490	32.89	29.60	30.18	Target achieved

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