## **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 stated on QIP2015/16	Stated on		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.	
C	change Ideas from Last Years QIP (QIP	6) implem	change idea nented as (Y/N button)	У	our experience carnings? Did the	(Some Questions to Consider) What was with this indicator? What were your key ne change ideas make an impact? What e would you give to others?		
ac in ch	esident satisfaction surveys indicate particitivities is highly correlated with overall satiour long term care home. Mount Hope's pange ideas involve strategies to enhance residents.	ı	improvement correlated to active, (2) St bells To impr	effor overa aff try ove a of Th	rts, based on lower all satisfaction, in the understand feavailability of 'eno derapeutic Progra	indicated that priority areas for focused er satisfaction areas that are highly cluded: (1) Enough activities to keep mind eelings, and (3) Staff promptly answer call bugh activities to keep mind active', a new ms'position was created for which interviews		
	To improve 'staff try to understand feelings', To improve 'staff promptly answer call bells',			The results of 2015 resident satisfaction surveys were reviewed with 57 statement over 10 information sessions to increase staff awareness of resident concernitions are considered in recruitment and scheduling have resulted in 75% decrease in incidence of working short and use agency staff.				

	D 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
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.
(	Change Ideas from Last Years QIP (QIP 2	015/16	Was this change i implemented a intended? (Y/N button)	s experi	ence with this in	ne Questions to Consider) What was your odicator? What were your key learnings? make an impact? What advice would you give to others?
F C I	th) Resident satisfaction surveys indicate participation in activities is highly correlated by severall satisfaction in our long term care hon Mount Hope's planned change ideas involve strategies to enhance activities for residents.	Yes	focused are highl activities (3) Staff activities	improvement effor y correlated to over to keep mind act promptly answer to keep mind act s' position was cr	n surveys indicated that priority areas for orts, based on lower satisfaction areas that rerall satisfaction, included: (1) Enough ive, (2) Staff try to understand feelings, and call bells. To improve availability of 'enough ive', a new 'Coordinator of Therapeutic eated for which interviews are currently	
	To improve 'staff try to understand feelings', mprove 'staff promptly answer call bells',	Yes	57 staff or resident	over 10 information concerns. Extens ulted in 75% deci	ent satisfaction surveys were reviewed with on sessions to increase staff awareness of sive efforts in recruitment and scheduling rease in incidence of working short and use	

ID Measure/Indicator from 2015/16	Org Id		rformance as QIP2015/16	Target as stated on QIP 2015/16	Current Performance 2016	Comments		
<ul> <li>Number of Falls with injury.</li> <li>( Counts; Residents; Q1 to Q3 Apr.1-Dec.31, 20 Avg; Patient Safety Reporting System)</li> </ul>	53885 14	75.00		67.00	65.00	Oct.1-Dec.31, 2015		
Change Ideas from Last Years QIP (QIP 2015/16)	imple inten	change idea mented as ded? (Y/N utton)	experience wi	th this indicator? V eas make an impac	ions to Consider) W Vhat were your key ct? What advice wou ers?	learnings? Did		
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		committee to in 'falling star' risk room, on mobili Rounding initiat high risk of falls hour period to e	nplement prevailing I identifier to be place ity aides and on residual ted Oct.13, 2015 on a participate in ICR a ensure falls intervent	ed through corporate best practice in Sumred on outside of door dent wrist. Intentional 2 pilot nursing sites. Ind are checked on 1-tions are in place, incid items are in close p	ner 2016 of to resident Comfort Residents at 4 times per 24 luding that		

ID Measure/Indicator from 2015/16	Org Id		formance as QIP2015/16	Target as stated on QIP 2015/16	Current Performance 2016	Comments		
10 Number of Falls with injury. ( Counts; Residents; Q1 to Q3 Apr.1-Dec.31, 201 Avg; Patient Safety Reporting System)	51490 14	75.00		67.00	65.00	Oct.1-Dec.31, 2015		
Change Ideas from Last Years QIP (QIP 2015/16)	imple inten	s change idea emented as ided? (Y/N outton)	experience wi	ith this indicator? V leas make an impac	tions to Consider) V Vhat were your key ct? What advice wo eers?	learnings? Did		
#1) 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		prevention com 2016 of 'falling resident room, Comfort Round Residents at hi times per 24 ho	nmittee to implement star' risk identifier to on mobility aides an ding initiated Oct.13, igh risk of falls partic our period to ensure oileting needs are m	red through corporate t prevailing best prace be placed on outsid d on resident wrist. I 2015 on 2 pilot nursi ipate in ICR and are falls interventions ar et and required items	tice in summer e of door to ntentional ing sites. checked on 14 e in place,		

ID Measure/Indicator from	Measure/Indicator from 2015/16			Target as stated on QIP 2015/16	Current Performance 2016	Comments			
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))			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 chang implemented as i (Y/N butto			ed? experience with	this indicator	? What were you	sider) What was your r key learnings? Did the ould 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.					

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antipsychotics with Physician and pharmacist. Includes criteria for use and

antipsychotics with Physician and pharmacist. Includes criteria for use and

provide physicians with prescribing

patterns as it relates to provincial

Create new standardized tool

benchmarks

Yes

Yes

ID Measure/Indicator fro	om 2015/16	Org Id	Current Performance as stated on QIP2015/16	Target as stated on QIP 2015/16	Current Performance 2016	Comments			
16 Percentage of residents receiving without a diagnosis of psychosis are expanded to include those expended to include those expended to include those expended (%; Residents; Q2 FY 2014/15; (eReports))	51490	29.56	26.60	21.98	Indicator results are improved and lower than provincial average 24.9.				
Change Ideas from Last Years QIP (QIP 2015/16)	e idea tended1 )	with this indicator	? What were y		What was your experience s? Did the change ideas give to others?				
increased monitoring and recommendations for change	Yes		Need for Antipsychoti recommendations ma		ed quarterly with ea	ach RAI Assessment and			
quarterly review of non- pharmaceutical interventions	Yes			BSO team meets weekly and reviews effectiveness of non-pharmaceutic 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.						

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			
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.			
Change Ideas from Last Years QIP (QI 2015/16)		Was this change ide implemented as intended? (Y/N button)	experienc	ce with this indic	e Questions to Consider) What was your cator? What were your key learnings? Did in impact? What advice would you give to others?			
#1) To improve timeliness of complaint management through incremental investment recruitment and retention of additional nursing management staff.	ıt,	Yes	began wor	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 Dire participation at monthly resident and family council meetings. Initiate use of 'concern forr Intentional comfort Rounding implementation Mount Hope.	ms'.	Yes	Mar.31, 20 Mount Hop numbers re complaints Councils). January 20 concerns a resident re rounding'(I documents pain, posit needs are	on 16, complaint makes. Next steps to esolved to complaint to each of Gene Director attended 16, initiated use and follow-up with equests or needs, CR), piloted on 2 and checks on resisioning, proximity of the complete to	omplaint trends, for the period Sept.1/15 to an agement software 'FM Pro' was initiated for include quarterly overview analysis of ainant's satisfaction, and reporting of tral Staff Meetings, Family and Resident all Resident and Family council meetings. In of 'concern forms' to more clearly document in 10 days. To ensure timely follow-up to we initiated 'intentional comfort and units, Oct.13 2015. ICR includes 14 dents per 24 hour period to inquire about of needed items and ensuring personal ICR involves leader rounding on residents to			

ID Measure/Indicator from 2015/16	Org Id	Curre Performar stated QIP201	nce as on	Target as stated on QIP 2015/16	Current Performance 2016	Comments
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.
Change Ideas from Last Years	QIP (Q	IP 2015/16)	idea imp inten	nis change plemented as ded? (Y/N utton)	experience with	I: (Some Questions to Consider) What was your this indicator? What were your key learnings? ideas make an impact? What advice would you give to others?
development of a new tool to improbetween PCPs and registered staff staff to the specific area of concerninterventions can be initiated and a care plan before ulcers develop or	t registered at nursing a residents'	Yes		copy skin monitori New electronic ski and implemented or registered staff for	ing of skin issues from PCPs to RPN, new hard ng tool implemented in March 2015. n assessment (Point Click Care) tool developed October 2015 with automatic electronic alert to further assessment and follow-up. Improved ult in consistent tool use and follow-up.	
Dedicated Wound RPN temporary pilot Consult Resident and Family ( RAI MDS Team New Continence F care products	s Dedicated	Yes		effective February increased auditing interventions. Res January 2016 as to pressure ulcer indi MDS coding team concentrated educ RPNs) New, higher 2016. Focus group	etion of wound treatments and interventions, 2016, launched pilot full time RPN position. Also monitoring of implementation of wound care ident and Family Councils were consulted in orecommendations for change to improve icators. In October 2015, initiated dedicated RAI to improve data validity and reliability through cation of 22 individuals (versus previous 100 er quality, continence product launched February ovoiced concerns about new skin care products to and product changed on pilot floors in February	

ID	Measure/Indicator from 2015/16	Org Id	Current Performand stated of QIP2015/	e as n	Target as stated on QIP 2015/1	Performance	Comments
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.
	Change Ideas from Last Years	QIP (G	NP 2015/16)	imple:	nis change idea mented as ded? (Y/N utton)	experience with t	(Some Questions to Consider) What was your this indicator? What were your key learnings? deas make an impact? What advice would you give to others?
cc al th	#1) 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.					skin monitoring tool New electronic skin implemented Octobe staff for further asse	g of skin issues from PCPs to RPN, new hard copy implemented in March 2015. assessment (Point Click Care) tool developed and er 2015 with automatic electronic alert to registered ssment and follow-up. Improved processes will ool use and follow-up.
Co M	edicated Wound RPN temporary onsult Resident and Family Coun DS Team New Continence Produ oducts	icils De	dicated RAI	Yes		effective February 20 increased auditing/m interventions. Reside 2016 as to recomme indicators. In Octobe to improve data valid of 22 individuals (ver continence product I concerns about new	ion of wound treatments and interventions, 016, launched pilot full time RPN position. Also nonitoring of implementation of wound care ent and Family Councils were consulted in January endations for change to improve pressure ulcer er 2015, initiated dedicated RAI MDS coding team dity and reliability through concentrated education rsus previous 100 RPNs) New, higher quality, launched February 2016. Focus group voiced skin care products to purchasing agents and pilot floors in February 2016.

ID Measure/Indicator from 2015/16	Org Id	Current	Performance as state on QIP2015/16	Target as stated on QIP 2015/16	Current Performance 2016	Comments		
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.		
Change Ideas from Last Years QIP (G	QIP 201	5/16)	Was this change idea implemented as intended? (Y/N button)	learnings? Did the cl	me Questions to Cons this indicator? What hange ideas make an ould you give to other	were your key impact? What		
Change idea to improve the accuracy of dorestraint use includes staff education as to the definition of restraint devices verses person service devices. Mount Hope will monitor documentation through an auditing process	he legis al assis ata for o improv	slated stance		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 suppleast restraint use. Quarterly monitoring of restraints and falls completed.				
Dedicated RAI MDS coding team Reassess restraints at 6 week post admission meeting		f		Unit dedicated coders for RAI and MDS submissions were recruited and educated in restraint definition/coding and consistent documentation. We believe this results in improdata validity and reliability. Also instituted reassessment of restraints at 6 week post admission meeting with Physicial Revised 6 week documentation to reflect prompt reassess and documentation.				

ID Measure/Indicator from 2015/16	MASSIFA/Indicator from 2015/16			erformance as Targ n QIP2015/16 on		Current Performance 2016	Comments	
<ul><li>Percentage of residents who were physically restrained</li><li>(%; Residents; Q2 FY 2014/15; CCRS, CIHI (eReports))</li></ul>	51490 3	30.74	27.		6	32.17	Target not achieved and restraint use increased.	
Change Ideas from Last Years Qi	IP (QIP 2	:015/16)	Was this char idea implemen as intended? ( button)	ited	your experion learnings?	ence with this indica	ons to Consider) What was ator? What were your key as make an impact? What we to others?	
#1) Change idea to improve the accura restraint use includes staff education as definition of restraint devices verses pe service devices. Mount Hope will monitoconsistent measurement of restraints and documentation through an auditing production.	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 suppleast restraint use. Quarterly monitoring of restraints and falls completed.					
Dedicated RAI MDS coding team Reas restraints at 6 week post admission me	Yes	Unit dedicated coders for RAI and MDS submis recruited and educated in restraint definition/coconsistent documentation. We believe this rest data validity and reliability. Also instituted reast restraints at 6 week post admission meeting will Revised 6 week documentation to reflect promand documentation.		definition/coding and ve this results in improved ituted reassessment of meeting with Physician/RN.				

ID	Measure/Indicator from 2015/16	Org Id	Current Perfore stated on QIP		Target as stated on QIP 2015/16	Current Performance 2016	Comments
	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
CI	nange Ideas from Last Years QIP (QIP 2015/16)	in	this change idea nplemented as ntended? (Y/N button)	experience	earned: (Some Quest e with this indicator? ange ideas make an give to	? What were your ke	y learnings?
wo wh inv	ntinence Committee to review all residents with rsening bladder control and identify residents for om to develop an individualized toileting plan to olve prompted voiding, habit retraining and timed ding.	No		2016 and ad indicator in findividualize	ost and Quality in Londvised that this indicated that this indicated turne years. Identified to toileting plan implering and timed voiding.	or would no longer be specific residents for nented involving prom	a priority whom an

ID	Measure/Indicator from 2015/16	Org Id	Current Perforr stated on QIP		Target as stated on QIP 2015/16	Current Performance 2016	Comments
	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
Cł	nange Ideas from Last Years QIP (QIP 2015/16)	Was this change idea implemented as intended? (Y/N button)  Lessons Learned: (Some Questions to Consequence with this indicator? What were Did the change ideas make an impact? What were Did the change ideas make an impact?					y learnings?
witl for to i	Continence Committee to review all residents n worsening bladder control and identify residents whom to develop an individualized toileting plan nvolve prompted voiding, habit retraining and ed 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.			