Providence Care

Quality Improvement Plan – 2017/18 Workplan

AIM		MEASURE				CHANGE				
Quality Dimension	**Objective**	**Measure/ Indicator**	**Current Performance**	**Target for 2017/18**	**Target Justification**	**Planned Improvement Initiative (change ideas)**	**Methods**	**Process Measures**	**Target for Process Measures**	**Comments**
Effective	**Improve organizational financial health**	**Total Margin**: Percent by which total corporate (consolidated) revenues exceed or fall short of total corporate (consolidated) expenses, excluding the impact of facility amortization, in a given year.	**2016/17** Q2 0.99%	0%	The organization has to have a total margin of greater than 0% to be financially viable and have a positive working capital position.	1) Providence Care will continue to review our cost structure and monitor our monthly financial results to ensure that we achieve the 17/18 target	1) Monthly Financial Performance reports and Financial Monitoring Reports provided to the Board Committee that is responsible for the financial condition review.	1) Monthly Financial Performance reports.	1) Maintain/ improve our HSFR funding results that requires that our actual costs be at or below our expected costs.	Providence Care has a robust and interprofessional HSFR Steering Committee to ensure that our systems are developed to support our financial and statistical data quality

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Person-centered	**Maintain satisfaction scores in Palliative Care**	**Overall Satisfaction for Palliative Care:** "What is your Overall satisfaction with care provided by the team?" (responded satisfied or very satisfied) Internal family survey	**2016/17 Year to Date** Q2 92.3%	92.3%	Maintaining satisfaction levels at or above the current performance is realistic given that the team will be revising the survey to improve its value as well as evaluating quarterly results. The team focus this year will be to highlight the value of the survey in identifying opportunities for change, which will result in more sustainable improvements in the future.	**1-** Improve the Palliative Care Satisfaction Survey ensuring the information collected is a valuable tool for driving improvement. **2-** Improve staff awareness and understanding of satisfaction survey questions and results	**1**-Interprofessional team will review survey questions; eliminating/revising those that are not relevant and adding new ones as appropriate **2-** a-Provide education to Palliative Care team regarding the revised survey **b-**Satisfaction survey to be a standing agenda item at Palliative Care staff meetings & process meetings immediately following quarter survey reports	**1**-% of questions reviewed and revised as necessary by January 1 2017 **2** % of Palliative Care Team who have reviewed education **b-** % of meetings with survey results minuted	**1-** 100% **2-**a-100% **b-** 100%	The goal is to make the satisfaction survey meaningful for both families and staff. Palliative Care wants to develop a survey that provides a valuable opportunity for our families to communicate to those responsible for providing care, the experiences they had while on the Palliative Care unit.

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						3-Monitor quarterly survey results to ensure that all opportunities for improvement are identified.	**3-**Review results and identified opportunities for improvement with The Quality Team	**3**- % of meetings with survey results minuted	**3-**100%	

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	Improve resident experience in Long-Term Care	**Food in Long-Term Care:** Domains of Food Data Source: NRC	**2016/17** (Annual Results) PM Food (satisfied) 66.7%	68.7%	Achieve Canadian rate for food satisfaction of 72.8% over 3 years.	1-)Culture Change Workshops for dietary staff 2-) Develop and engage an interprofessional Dining Enhancement Team	1-)Collaboration between education and dietary manager to design and implement workshops 2-) Interested staff, and residents will collaborate and a test floor will be identified to trial new ideas.	1a)Staff Participate in workshops 1b) Staff will express understanding of content by explaining three main principles presented 2-) Team is Established and test floor is identified.	1a) 50% of staff participate in workshop 1b) 100% of staff in attendance 2-) 100% by May 1, 2017	

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	Increase person centered activities, physical exercise, and accessibility of programming (particularly on evenings and weekends) as well as communication in Long-Term Care	**Activities in Long-Term Care**: Percentage of residents that are satisfied with current activity programming. (Data source NRC)	**2016/17** (Annual Results) PM Activities (satisfied) 66%	69.9%	Current performance is 66%. Below Canadian average of 72.8%. Target based on reaching Canadian average over two years and regaining our 2015 average of 69.9%	1) Increase understanding of resident centered care. 2) Inject person-centered activities into ADL's for those who do not enjoy group activities or those on the Responsive Behaviour Team (RBT) 3) Increase the amount of physical exercise offered to residents.	1-) Full-time staff will attend the Excellence in Resident Centered Care (ERCC) course. 2-) Attend Excellence in Resident Centered Care (ERCC) and Responsive Behaviour Team (RBT) huddles and contribute to care planning 3-) Recreation staff will engage Physiotherapists and Physiotherapy Assistants to assist in designing a safe, fun, and challenging exercise	1) Attendance of Full-time staff at Excellence in Resident Centered Care (ERCC) sessions. 2a) Attendance at Excellence in Resident Centered Care (ERCC) huddles 2b) Attendance at Responsive Behaviour Team (RBT) huddles as requested 3-) Program design and implementation.	1) 100% 2a) 50% 2b) 100% 3-) Minimum of 64 hours per month, home-wide by September 1st.	

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							program to be facilitated by recreation staff.			
						4-) Increase attendance at evening and weekend programming.	4-) Engage volunteers and Personal Support Workers to assist with bringing residents to the elevator and picking them up from the activity at a designated time.	4-) Increased attendance at evening and weekend programs	4-) 10% increase by August 1, 2017	
						5-) Increase availability of programs in areas beyond the scope of the rec staff e.g.: men's group, art lessons	5-)Reach out to community organizations to recruit	5-)# of new volunteers recruited	5-)4 by June 1, 2017	
						6-) Find meaningful volunteer roles for residents at Providence Manor	6-) In-house volunteer recruitment	6-) # of new volunteers recruited	6-) 4 by June 1, 2017	

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						7-) Increase communication to staff, residents, and families at Providence Manor	7-) Facilitate a closed Facebook page	7-a)Facebook page will be designed and approved 7-b) Facebook page will be engaging	7-a) Will be live by June 1, 2017 7-b) Will have 100 followers by August 1st	

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Safety	**Minimize the use of physical restraints in Mental Health**	**Physical Restraints in Mental Health:** Number of quarterly assessments where restraint use occurred in last 3 days divided by the number of full quarterly assessments in time period. **NOTE* This indicator captures the use of chair to prevent rising, mechanical, & physical / manual restraint. This indicator does not include chemical restraint, acute control medication or seclusion.**	**2016/17** Q1 14.3% (percentage represents rolling four quarter averages ending at the quarter listed)	**13.8%**	The focus for this indicator objective has been changed to restraint use occurring at quarterly assessment vs. previous indicator related to restraint use occurring at the admission assessment. As such, work around this indicator will follow a new 2-year plan. This work is one component of the core strategies developed and planned by the committee aimed at reducing restraint use. Year 1 is focused on critically reviewing and analyzing CIHI and SafetE-Net data to gain a better understanding of current practice of restraint use 3 days prior to the quarterly	1. Critically review available CIHI and SafetE-Net physical restraint data each month at the Hospital Restraint Minimization committee to better understand current practice of use and to identify opportunities for improvement and further education needs based on best practice and legislation. 2. Improve tracking of restraint use by creating mandatory fields to capture the types and use of protective device restraints in our internal incident reporting system SafetE-Net.	1. Review and analyze restraint data provided by Decision Support and Quality and Risk. 2. Customize upgraded internal incident reporting system to capture protective device restraints.	1. The percentage of data received that is reviewed and analyzed by the committee. 2. The percentage of key fields are made mandatory in the internal incident reporting system.	1. 100% of the data provided will be reviewed and analyzed by the Hospital Restraint Minimization Committee to better understand current practice, look for root cause and identify opportunities for improvement with a focus on minimizing restraint use. 2. 100% of the key fields are mandatory.	

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					assessment in our Seniors Mental Health Program where we have identified the highest quarterly occurrence. This will then inform our work for year 2 where the focus will be on implementing and measuring identified change ideas geared towards further minimizing restraint use. We recognize we are above the Provincial average and have set a maintenance target however; this systematic approach over 2 years will lead to improvements that are achievable and sustainable.	3. Communicate restraint data with teams to enhance the understanding of current practice and ensure a consistent understanding of restraint definitions.	3. Reviewing of restraint data as a standing item at all Quality Team and staff meetings.	3. The percentage of Quality team and staff meeting agendas that have reviewing restraint data as a standing item.	3.100% of Quality Team and staff meetings agendas will have reviewing restraint data as a standing item.	

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	Reduce potentially inappropriate use of anti-psychotics in Long-Term Care	**Potentially inappropriate use of anti-psychotics in Long-Term Care:** Reduce the Percentage of residents receiving antipsychotics without a diagnosis of psychosis (Data source: CIHI CCRS)	**2016/17** Q1 26.9% (unadjusted)	Stretch target over two years 25.1%	Stretch target allows two years to establish a benchmark and develop a program (currently in year two)	1-) Benchmark true number of residents taking antipsychotics with no diagnosis of psychosis, unused PRN's, and no improvement to health outcomes or quality of life 2-) Monitor resident response to antipsychotic medication 3-) Increased staff awareness of anti-psychotic medication its effectiveness, benefits, risks proper documentation	1-) Chart audits & medication review for those receiving antipsychotic medication 2-) Health team collaboration to assess the resident before any new order or discontinued order for an anti-psychotic 3-) Information sessions for physicians & registered staff facilitated by pharmacy, and/or psychogeriatric team	1-) Process for chart audits and medication reviews 2-) Team collaboration process developed. Medical residents, nursing, Personal Support Workers, and family included. Responsive Behaviour Team (RBT) if they have been involved 3-) Sessions for team to be implemented at Professional Advisory Committee sessions	1-) 100% of charts to be audited 2-) 100% of residents will be assessed by the health care team prior to prescribing or prescribing changes 3-) Annually or as needed	The 2017/18 plan is to build on the benchmark established by chart audits, med reviews and health team collaboration, and focus on determining the number of residents who are prescribed and take antipsychotic medication with no improvement to health outcomes or improvement to quality of life and plan in collaboration with the medical team to initiate a reduction in the antipsychotic medication

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	Reduce hospital acquired infection rates in Providence Care Hospital	***Clostridium Difficile* Infection:** Number of patients newly diagnosed with hospital-acquired CDI, divided by the number of patient days in that month, and multiplied by 1,000 - consistent with publicly reportable patient safety data.	**2016/17** Q2 0.08	0.30/1000 patient days	Target based on Hospital Service Accountability Agreement (HSAA) performance target (will include all of Providence Care Hospital)	1. Minimize *Clostridium difficile* infection (CDI) spores in the health care environment. Perform regular audits to review effectiveness of environmental cleaning, facilitated by Infection Prevention and Control Practitioners (IPCP). Infection Prevention and Control (IPAC) will continue to utilize internal room picture to communicate with Environmental Services staff about CDI cleaning required. IPAC will continue to monitor, and surveille CDI rates, report them to IPAC and Joint Health & Safety Committee (JSHC)	1.) Environmental audits using audit tool developed and maintained by Infection Prevention and Control (IPAC) Services. Reviewed on a quarterly basis. Excel spreadsheet Room picture distributed weekly to Environmental Services Staff by IPCPs.	1.) Percentage of IPAC committee meetings covered i.e. on agenda. Quarterly these audits will be reviewed. Reviewed weekly by IPAC using Room picture.	1.) 100%	Environmental cleaning is important to limit the number of spores in an environment that might be exposed to feces. Spores enter a patient through ingestion; proper hand hygiene by patients/clients/staff and visitors can help limit the ingestion of spores. CDI cleaning also eliminates spores in the environment; in order to minimize these spores, sporicidal cleaning is required. This is achieved by regular communication between IPCPs and Environmental Services Staff.

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						meetings. 2. Annual Education on applicable IPAC practices such as: hand hygiene, CDI testing, use of personal protective equipment, and environmental cleaning.	2a.) Have this indicator on the agenda. This information will be shared by one of the IPCPs at Antibiotic Stewardship Program (ASP) meetings. 2b.) Education Sessions.	2a.) Percentage of IPAC committee meetings. 2b.) Percentage of current and new hire staff who receive IPAC education annually.	2a.) 100% 2b.) 100%	Audits to include bathtub cleaning and equipment cleaning. Spread of the organism or the spore is of primary concern, with more emphasis on antibiotic stewardship, proper hand hygiene and environmental cleaning.

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	Improve hand hygiene rates in Providence Care Hospital	**Hand hygiene compliance before patient/patient environment contact:** The number of times that hand hygiene was performed before initial patient/patient environment contact divided by the number of observed hand hygiene indications for before initial patient/patient environment contact multiplied by 100 - consistent with publicly reportable patient safety data	**2016/17** Q2 92.8%	87.5%	Our target is set based on the provincial average. Based on the Provincial Average Fiscal April 2015-March 2016 of 87.32% for before patient/patient environment. (Will include all of PCH)	1.) Maintain number of audits performed. 2.) Monthly and quarterly reporting of hand hygiene rates and audits.	1.) Utilizing the Handy Metric Audit tool. Audits will performed by Infection Control and Prevention Practitioners (IPCPs), volunteers, students and possibly return to work employees. 2.) Performance will be posted on each unit. As well as quarter results sent to each unit via email and reported to IPAC committee.	1.) Number of hand hygiene audits per fiscal year. 2.) Percentage of required meetings and intervals where hand hygiene rates are reported.	1.) ≥300 2.) 100%	Continuance of regular monitoring by IPCPs of audits performed on a weekly, monthly and quarterly basis will help to ensure our target is being met. Reports to Managers and staff will provide awareness of hand hygiene rates for specific units and programs as well as highlight where improvements can be made. Structural changes such as the addition of staff hand hygiene sinks will likely improve rates. Assessment on admission of client's ability to perform hand-hygiene will be

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						3.) Post monthly hand hygiene rates on each unit.	3.) Post posters or input posters on the shared monitor devices on all audited units.	3.) Percentage of audited units with hand hygiene rates posted each month.	3.) 100%	conducted. Patients/Clients will also be taught when and how to sanitize and/or wash hands. Hand sanitizer to be available at or near patient/client bedsides. Hand hygiene information will be provided in the patient/client handbooks. This information will assist in educating patient/clients and their families about the importance of hand hygiene and proper technique. Rates posted on audited units will also increase patient/client and family engagement in hand hygiene rates.
						4.) Increase awareness of hand hygiene program for staff, patients/clients and families.	4.) Posters or visual monitor devices, patient, client, resident and family handbooks and Infection Prevention and Control (IPAC) staff talking to stakeholders will increase awareness of the Hand Hygiene Program.	4.) Percentage of audited units with posters displayed that inform people of our hand hygiene (HH) program	4.) 100%	

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						5.) Ongoing Education i.e. annual session, Just in Time feedback, and on an as needed basis.	5.) Education Sessions. Patients/Clients and families will receive education on the importance of hand hygiene via patient/client and family handbooks and by IPCPs as requested.	5.) Percentage of current and new hire staff who receive Infection Prevention and Control (IPAC) education annually.	5.) 100%	Hand hygiene rates will also continue to guide direction of IPAC education.

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	Reduce responsive behaviours in Long-Term Care	**Responsive Behaviours:** The number of residents with Aggressive Behaviour Score (ABS) at or above 5 during assessments on admission, quarterly, or as needed.	**2016/17** Q2 59.9%	57%	This is a conservative target as Providence Manor has been consistently and considerably higher than the Ontario average and the % has steadily climbed since 2014 Q3	1.-) RBT(Responsive Behaviours Team) will increase knowledge of resident centered care 2-)Clarify RBT Charter, TOR, Process, and Sustainability Plan 3-)Facilitate interprofessional Team huddles using PIECES 3 question template when a referral has been received, resident has expressed 3 or more incidents of responsive behavior as reported through safety net and/or when their ABS increases to 4 or above as reported by MDS-RAI assessment data.	1-)Team members will attend ERCC (excellence in resident centered care) course 2-)Re-align members of the team, resume regular meetings 3-).Increase engagement with staff on floor as well as recreation and/or NP consultants, RAI assessors, Spiritual Health	1-)Successful completion 2-)Team is re-aligned and receiving referrals 3-)% of the time team huddles occur according to the criteria outlined	1-)100% of members 2-)By June 1st 3-)60%	We have changed our data source this year from using SafetE-Net data to using the MDS-RAI data. The MDS-RAI assessment tool is an objective measurement that is utilized by the same three nurses in the home. Aggressive Behaviour Score (ABS) measures physical and verbal aggression, socially inappropriate/disruptive behavior (e.g., disrobing, throwing food, screaming) during the 7-days prior to the assessment.

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						4-)Provide Education regarding RBT's scope of practice, process, and goals	4a-)New Employee Orientation for Direct Care Staff and annual Medical Resident orientation.	4a-)Education Provided	4a-)100% of orientation sessions	
							4b-)Present at: Registered Staff Meeting	4b-)Once per year and as requested	4b-)At least 1 presentation per year	
							4c-)Family Council	4c-)Once per year and as requested	4c-)At least 1 presentation per year	
						5-)Increase communication with families	5-)Families will be contacted when a referral is received, resident has expressed 3 or more incidents of responsive behavior are reported and/or when their ABS increases to 4 or above as reported by MDS-RAI assessment data	5-)Families will be contacted, updates, and engaged in the RBT process.	5-)100% of families contacted	