Providence Care

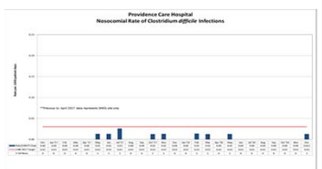
Excellent Care for All

Quality Improvement Plans (QIP): Progress Report for 2018/19 QIP

The Progress Report is a tool that will help organizations make linkages between change ideas and improvement, and gain insight into how their change ideas might be refined in the future. The new Progress Report is mostly automated, so very little data entry is required, freeing up time for reflections and quality improvement activities.

Health Quality Ontario (HQO) will use the updated Progress Reports to share effective change initiatives, spread successful change ideas, and inform robust curriculum for future educational sessions.

Realizing that the QIP is a living document and the change ideas may fluctuate as you test and implement throughout the year, we want you to reflect on which change ideas has an impact and which ones you were able to adopt, adapt or abandon. This learning will help build capacity across the province.

ID	Indicator (Unit; Population; Period; Data Source)	Org Id	Performance stated in previous QIP 2018/19	Performance Target as stated in previous QIP 2018/19	Current Performance 2019	Comments	Change Ideas from Last Years QIP (QIP 2018/19)	Was this change idea implemented as intended? (Y/N)	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?
1	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 reported patient safety data. (Rate per 1,000 patient days; All inpatients; YTD as Q2; HQO public reporting website)	695	0.08	0.22	Q3 - 0.0043/1000 patient days		A)Minimize CDI spores in the health care environment for clients with CDI by cleaning /disinfecting client rooms / equipment with sporicidal product. B)Perform regular Environmental Services (ES) and Infection Prevention and Control (IPAC) audits to review the effectiveness of environmental cleaning. C)IPAC will continue to utilize internal room picture to communicate with ES regarding rooms requiring CDI cleaning.	Y	CDI poses a significant health risk to our patients/clients/residents requiring ongoing monitoring of each case to ensure appropriate precautions are initiated promptly and left in place until treatment has been completed and symptoms resolved. Key learnings include - the importance of a good working relationships both between the unit and their ICP to ensure prompt notification of IPAC occurs; and with the Environmental Services team to ensure appropriate cleaning occurs once precautions are discontinued. in addition, daily rounds by the ICP on each of the units is critical to ensuring the IPAC is aware of each patient/client/resident on precautions. Policies and procedures must be kept up-to-date and reflective of current best practice guidelines and provide clear direction for the front-line users on the management of patients/clients/residents on CDI (Contact Precautions); ICP must also be prepared to address questions and provide "Just-In-Time" (Point of Care) guidance. In addition to policies and procedures all education provided at Orientation sessions or annual nursing education must also be reviewed and revised as necessary.
							IPAC will continue to monitor, and surveille CDI rates, report them quarterly to IPAC Committee meetings.	Y	
							Annual education on applicable IPAC practices such as hand hygiene, CDI testing, use of personal protective equipment, and environmental cleaning.	Y	
2	Food in Long-Term Care: Domains of Food Data Source. (%; LTC home residents; 2018-2019; NRC Picker)	695	Collecting Baseline	67.00	67.80%		Culture Change Workshops for dietary staff.	Y	Reviewed "How do we improve the life of residents in our day to day work?" and "How can we improve?" at weekly meetings.
							Implement “Sunday Dinners” weekly on each floor.	Y	Residents have enjoyed the tablecloths provided each Sunday and special holidays (Easter, Mother's Day, Father's Day, etc.)

							Increase resident engagement and opportunities for feedback.	Y	Attendance at Resident Food Advisory has tripled since Recreation Staff now porter residents to meeting and have made it an activity. Round table is done at each meeting to increase resident engagement and feedback.
3	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. (%; All inpatients; Fiscal YTD as of Q2; Hospital collected data)	695	89.00	87.50	Q3 - 85.4%		Maintain or increase number of audits performed.	Y	The engagement of the front-line workers and more recently Patient Experience Partners has provided the IPAC Service with several opportunities to ensure recent improvements can be sustainable moving forward. Creating a safe environment for any and all questions or concerns to be shared allowed us to identify key misunderstandings about the auditing process; the importance of ensuring ABHR dispensers were strategically located within workflow process (allowing easy access); and clarification on what is included in the Patient Environment vs Hospital Environment and where the 4Moments can be incorporated when moving between them. Another key learning came when clarification was sought on when and how to incorporate appropriate glove usage into the 4 Moments.
							Monthly and quarterly reporting of hand hygiene rates and audits.	Y	
							Post monthly hand hygiene rates on each unit.	Y	
							A)Reinforce that Hand Hygiene performance is an organizational priority for client and staff safety B) Increase awareness of hand hygiene program for staff, patients/clients and families.	Y	
							Ongoing Education, i.e. annual session, Just in Time feedback, and on an as-needed basis. Develop a Hand Hygiene education module on LMS.	Y	
4	Number of workplace violence incidents reported by hospital workers (as by defined by OHSA) within a 12 month period. (Count; Worker; January - December 2017; Local data collection)	695	Collecting Baseline	Collecting Baseline	137 (12 month period)	**Q1-** 32 physical incidents (Hazardous situation/No Injury n=11, Injury/No First Aid required n=11, Injury/First Aid reported n=10), 3 verbal incidents where employee reported feeling their physical safety was at risk. **Q2**- 34 physical (Hazardous situation/No Injury n=21, Injury/No First Aid required n=4, Injury/First Aid reported n=9), 2 verbal incidents where employee reported feeling their physical safety was at risk. **Q3**- 32 physical (Hazardous situation/No Injury n=22, Injury/No First Aid required n=7, Injury/First Aid reported n=2, lost time injury claim n=1), 4 verbal incidents where employee reported feeling their physical safety was at risk. The lost time injury claim resulted in 60 hours of time lost from work and 56 hours of modified duties.	Conduct a review of the organization's Workplace Violence Prevention Program (WVP) and develop an action plan to address gaps/areas for improvement.	Y	Organizational review of the WVP program conducted and to respond to some of the identified gaps, improvements/changes were implemented, including for example, development of workplace violence signage, development of new policies (Staff Incident Reporting Policy, Domestic Violence Policy) and implementation of Debriefing and Reflection after all incidents of violence. RL solutions software was customized to better capture and prompt incident investigation with inclusion of findings and controls/improvements implemented with further changes to better capture and report on incidents of violence planned for implementation April 1/19. The PSHSA risk assessment tool was implemented for completion of unit/dept. risk assessments and we are working with the community programs to determine whether the PSHSA tool will work in that setting. Finally, we were able to build an interface so that the Behavioural Alert (violence risk flag) would flow through from the electronic patient chart (ePR) to the Room Sign Monitor as a mechanism of ensuring all staff were aware of an increased risk for violent behaviour. As of Feb 22 SafetE-Net customizations are partially complete with remainder to be done by March 31/19 Risk Assessments launched Jan. 2019
							Make changes/customizations to the reporting system (SafetE-Net) to capture more detailed information, specific to incidents of violence.	Y	
							A) Conduct our annual WPV risk assessments for all areas/units with more focused/in depth reviews in clinical areas at highest risk of violence. B) Develop action plans to address the identified areas of opportunity	Y	
							Explore options for communicating an increased risk of violence (e.g. flagged patients) to non-clinical staff who do not have access to the electronic patient record (ePR)	Y	
5	Overall Satisfaction for Palliative Care: "What is your overall satisfaction with care provided by the team?" Responded satisfied or very satisfied). Internal family survey.	695	95.30	90.00	95.8 (Q3 YTD)	Survey questions revised/changed and implemented April 1, 2018 allowing feedback from family to be specific and inclusive of all services offered to this patient population. Survey feedback collated and results reviewed	Improve the Palliative Care Satisfaction Survey ensuring the information collected is a valuable tool for driving improvement.	Y	Average score remains above 90%. New format is providing more accurate data regarding therapies and team support provided. Lowest score has been around Admission to Palliative Care unit with the most frequent comment being that it would have been better if they could be admitted sooner.

	%; Palliative patients; YTD - As of Q2; In-house survey)					and assessed to identify trends and potential areas for further examination.	Improve awareness and understanding of satisfaction survey questions and results.	Y	
6	Percentage of complaints acknowledged to the individual who made a complaint within three to five business days. (%; All patients; Most recent 12 month period; Local data collection)	695	Collecting Baseline	100.00	97.10%	While Providence Care did not meet 100% in Q1, the change ideas put in place have enabled Providence Care to reach and sustain the 100% target. Q1 - 93.5% (29 out of 31 complaints); Q2 - 100%; Q3 - 100%.	Members of the Department of Quality & Risk Management will configure the electronic feedback system (wE-Care) to enable accurate capture of data related to acknowledgement of complaints. An alert will be sent to MRP's on day 5 if complaint has not yet been acknowledged.	Y	By virtue of the bulk of our complaints being submitted to our Patient Relations Coordinator, complaints are acknowledge within 5 days of receipts. Additionally, the system has been configured to send an alert to the Most Responsible Manager on every day from date of submission until acknowledgment. We have learned that utilization of an electronic system supports process consistency, and supports complaint acknowledgements are within the legislated time period.
7	Physical Restraints in Seniors Mental Health: Number of Seniors Mental Health quarterly assessments coded with physical restraint use in the 3 days prior to the assessment in the quarter divided by the total number of Seniors Mental Health quarterly assessments in the in the quarter.(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.) (%; Mental health patients; Fiscal; CIHI OMHRS)	695	50.90	40.00	Q3 - 27.3%		Continue to critically review available CIHI and SafetE-Net physical restraint data each month at the Hospital Restraint Minimization committee and bi-weekly at the Seniors Mental Health Protective Device working group meeting to better understand current practice of use and to identify opportunities for improvement, and further education needs based on best practice and legislation	Y	Through tracking, reviewing, and critically analyzing client specific device use the team applied the CIHI restraint definition to determine whether a device was applied as a restraint versus a positional device to ensure consistent coding and understanding. At each monthly Seniors Mental Health Protective Device working group meeting all client device use was reviewed and opportunities to discontinue or trial a removal of a device was identified. The team has been successful at not only minimizing individual client restraint use but significantly reducing the number of devices being applied to each client. For example, at Q1 2018/19 there was as total of 13 clients with orders for various and multiple protective device restraints that could be applied and in use daily for a total of 31 devices (for clarity, 1 client could have 4 types of protective devices ordered and in use e.g. lap belt and table top). By the end of Q3 2018/19 there is a total of 10 clients with orders for protective devices and 18 potential devices that could be in use. At Q3 our QIP indicator Year To Date average is 33.3% which is a decrease of 4.9% from 38.2% in 2017/18 and a total improvement of 12.3%. At 33.3% we have achieved our 2018/19 target of 40% by a 16.75% margin. The team has found that by virtue of this being a corporate QIP indicator and endorsed by the Senior Leadership Team the Seniors Mental Health team have been empowered to have difficult conversations that has resulted in a culture shift toward restraint minimization. The value of the collaborative interprofessional team dialogue, contribution, and participation can not be underestimated with regards to its impact on the culture shift.
							Continue bi-weekly SMH team meetings to review and analyze client specific restraint use with a focus on identifying and implementing strategies and alternatives to restraint use including opportunities to trial discontinued use.	Y	
							Continue to communicate restraint data with teams to enhance the understanding of current practice and ensure a consistent understanding of restraint definitions.	Y	

8	Reduce the percentage of residents receiving antipsychotics without a diagnosis of psychosis. (%; LTC home residents; Fiscal quarter; CIHI CCRS)	695	22.60	21.60	27.3 % (rolling quarter average)		Focused audits to identify residents that have a history or current episode of psychosis that is not accurately reflected in their chart.	Y	Most of the audits found that any residents with a history or new episode of psychosis has been reflected in the charting and a diagnosis is present. A very small number of residents have a missed psychotic episode or history of psychosis recorded. It had been hoped that the change idea would have had a great impact on the indicator. A more detailed and accurate history is needed prior to admission to identify: #1 if there are any psychosis present or history of such. #2 if someone is on a antipsychotic medication and the indicators for such medication.
							Medication monitoring and review remain ongoing from previous year to determine if they can be tapered down or discontinued all together.	Y	This was a continuation from the previous year and remain ongoing. Challenges were faced in obtaining staff and family agreement to have these medications tapered down.
9	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. (%; Other; Fiscal quarter; OHRS, MOH)	695	0.99	0.00	0.15% (Q3)	At Q3, December 31, 2018, the total margin for the organization is 0.15%. We have met the target and the forecast is for a breakeven position at March 31, 2019, which will meet the QIP target of 0% for 2018/19.	Providence Care will continue to review our cost and revenue structures and monitor our monthly financial results to ensure that we achieve the 18/19 target	Y	With the fiscal challenges and the uncertainty of Ministry funding when we were completing the 2018/19 budget, contingency plans were developed and implemented to achieve the target. This target is an important one from a stewardship perspective and for the organization to sustain the operations in the future the working capital position must be solid. Monthly monitoring and reporting of the organizations working capital position is required.