Providence Care

Quality Improvement Plan (QIP) - 2019/20

AIM		MEASURE							Change				
Issue	**Quality Dimension**	**Measure/Indicator**	**Unit/Population**	**Source/Period**	**Current Performance**	**Target**	**Target Justification**	**External Collaborators**	**Planned improvement initiatives (change ideas)**	**Methods**	**Process Measures**	**Target for process measure**	**Comments**
Theme III: Safe and Effective Care	Safe	**Indicator** - Number of workplace violence incidents (overall) **Measure** - Number of workplace violence incidents reported by hospital workers (as by defined by OHSA) within a 12 month period.	Count / worker	Local data collection / January - December 2018	137 (12 month period)	Minimum of 10% increase in reported incidents (>40 per quarter or >160 incidents per year	Our first year focused on collecting baseline information; we believe violence is under-reported and know that patient events of violence tend to be reported as staff incidents only where the situation is more significant or where there are staff injuries; not all code whites are entered into the incident reporting tool.	Kingston Health Sciences Centre (KHSC) Will engage KHSC to assess applicability of KHSC e-learning at Providence Care and model the KHSC customizations that have been done in the RL solutions software to SafetE-Net at Providence Care.	Develop and implement an action plan based on the opportunities for improvement that have been identified in the assessment of the organization's Workplace Violence Program (WVP) with use of the PSHSA Workplace Violence Assessment Checklist tool.	Occupational Health Services (OHS) to lead the development of the action plan, in consultation with the Joint Health and Safety Committee (JHSC) and other stakeholder groups. OHS to coordinate implementation of the Action Plan.	Action Plan is developed with clear timelines for monitoring of progress. % of Action Items on track for completion as per agreed upon timelines.	Action Plan is in place by June 2019. 80% of action items are on track for resolution as per identified timelines.	Will engage KHSC to assess applicability of KHSC e-learning at Providence Care and model the KHSC customizations that have been done in the RL solutions software to SafetE-Net at Providence Care.
									Launch an internal WVP awareness and communication campaign to . increase reporting, . reinforce safe practices and key WVP processes in place to protect staff, and . increase the use of the existing Reflective Practice Tool .	OHS to work with Communications, JHSC, and senior leadership, including CEO, to plan and launch the internal Workplace Violence Program (WVP) awareness and communication plan. Will conduct a staff survey as part of the strategy to improve awareness , sharing survey results with staff.	Campaign launched with various communication strategies used. Staff survey launched. Survey results summarized and shared. % completion of the Reflective Practice Tool after code white events.	All in place before end of Q3. Staff survey completed in Q1 with results analyses and summarized in Q2 50% increase in the use of the Reflective Practice Tool post code white events .	
									Develop and launch our first violence prevention e-learning module.	OHS to work with Leadership & Talent Development (L&TD) to develop the e-learning module.	e-Learning module developed and launched.	Target is to launch the module before the end of Q1.	
									Explore the benefit of reapplying some or all of the Safe Wards Program currently in Forensics, to another unit(s).	OHS , in consultation with key stakeholders, will review the Safe Wards Program to determine its applicability to other units.	Review is undertaken and recommendations made if deemed beneficial for spread to other units.	Review, and any resulting recommendations made prior to year end.	
									Adapt/customize the existing SafetE-Net reporting form in RL solutions to more easily determine whether the reported physical and verbal incidents/hazards/near misses, meet the definition of workplace violence as per the Occupational Health & Safety Act (OHSA) which are the ones reportable under the QIP violence indicator.	OHS to configure and test with front line staff.	Customizations are made in the RL solutions "SafetE-Net."	Configured by the end of Q1.	
Theme III: Safe and Effective Care	Safe	**Indicator** -Physical Restraints in Seniors Mental Health **Measure** - 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. (Data Source: CIHI/OMHRS) 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.	Percentage	OMHRS; CIHI / October 2016 - September 2017	31.9% YTD (Q3)	35%	In 2018/19 this indicator was revised to focus on physical restraint use at quarterly assessment in our Seniors Mental Health Program where it had been identified as having the highest occurrence. A 3 year strategy was developed to focus on continuing to review and critically analyze physical restraint use in Seniors Mental Health while implementing and measuring identified change ideas geared towards further minimizing use as well as minimizing the number of devices applied in keeping with our least restraint philosophy. This year, year 2 the target has been set at 35% which represents a further reduction of 12.5% from our Year 1 goal of 40%. Our 3 year goal is to minimize the use and the number of devices applied by critically reviewing and analyzing client specific needs.	none	1.Continue to critically review and analyze individual client specific restraint use each month at the Seniors Mental Health Protective Device working group to identify and implement strategies and alternatives to restraint use, identify opportunities to minimize the number of devices required for each client, and to identify opportunities to trial discontinued use.	1.Review individual client specific use of restraints at monthly meetings.	1.The percentage of monthly meetings where individual client specific use is reviewed and analyzed.	1.100% of the meetings will be to review and analyze all client restraint use	
									2. Implement daily team safety huddles during the first 3 days of a new admission with a focus on implementing strategies to mitigate or minimize the use of restraints.	2.Review all newly admitted client restraint use daily in the first 3 days of admission.	2.The percentage of newly admitted clients where restraint use is reviewed daily for the first 3 days.	2.100% of newly admitted clients will be reviewed daily during the first 3 days of admission.	
									3. Implement a process to engage client's SDM in a discussion when there is an identified opportunity to trial a discontinuation or change in restraint device(s) being utilized.	3. A team member will contact the SDM to discuss identified opportunities to trial discontinuation or change in restraints/devices.	3. The percentage of clients with restraint changes whose SDM is engaged in discussion related to restraint.	3. 100% of the clients SDM will be engaged in discussion related to restraint.	
Theme III: Safe and Effective Care	Safe	**Indicator** - Hand Hygiene Compliance Before and After Patient Contact **Measure** - hand hygiene compliance rate by the indication, before initial patient or patient environment contact or after patient or patient environment contact	Percentage	Self-Reporting Initiative (SRI); MOHLTC	85.40%	88%	Recent trending reflects an improvement in hand hygiene rates. This improvement has been the outcome from three initiatives launched in September 2018; establishing and engaging with front-line workers in the Hand Hygiene Working Group which created unit champions who worked with the Infection Control Practitioners (ICPs) to bring concerns forward to be either be clarified or remedied; the roll out of a mandatory Hand Hygiene online learning module increased awareness and knowledge about the 4 Moments, and new signage increased visual reminders.	HandyAudit	Continue with Hand Hygiene auditing meeting/exceeding minimum number of audit targets set for each unit in the hospital setting; and expanding to each community program and each resident care area.	Use of HandyAudit tool in both the hospital and the long term care home; standardizing a paper audit tool for the community programs.	Hand hygiene compliance measured before initial patient/patient environment/resident/resident environment/client/client environment. Hand hygiene compliance measured after patient/patient environment/resident/resident environment/client/client environment.	Number of audits established for community teams and the long term care home; 88% compliance target met	
									Continue with the Hand Hygiene Working Group (engaging front-line workers and Patient Experience Partners). Opportunities to broaden representation to include community services workers and the long term care home.	Continue regular meetings incorporating new memberships.	Invitations to community teams and the home for members to join.	New members identified and able to attend monthly meetings.	
									Develop targeted tasks specific reference documents incorporating the 4 Moments into other moments in the care continuum.	Job shadow other care team members to ensure hand hygiene is being incorporated into care activities that are performed away from the bedside.	Development of tools (posters, fact sheets, etc.) to address other opportunities to incorporate hand hygiene into care performed away from the bedside.	Roll out of tools to other care team members completed.	
Theme III: Safe and Effective Care	Effective	**Indicator** - Early identification: Documented assessment of palliative care needs for an early, at-risk cohort **Measure** - Proportion of hospitalizations where patients with a progressive, life-threatening illness have their palliative care needs identified early through a comprehensive and holistic assessment.	Proportion / at-risk cohort	Local data collection / Most recent 6 month period	collecting baseline	collecting baseline	This is a new indicator. The organization needs to complete an environmental scan to determine the appropriate target patient population, and appropriate assessment tools to meet the objectives of this indicator.	Queen's University	Selection of a population and context-appropriate palliative care needs assessment tool: 1. Goal is to automate the HOMR tool at KHSC 2. Work with Information Management & Technology and Project Management teams to determine whether the tool should be built within PCS or SHiiP and then what the resources required will be 3. Determine baseline for the 'denominator' (# of hospitalizations where patient is identified in need of palliative care in the most recent 6 months) 4. Once above is defined and clearly identified the focus of first phase for QIP, the next step will be assessment and documentation to be achieved over a multi year progress. The end goal will be development of an work plan for the implementation of the selected palliative care needs assessment tool, including communication and sustainability plans. If needed and feasible, development of software implementation work plan to support electronic needs assessment. documentation.	Establish an interprofessional working group that includes internal stakeholders, as well as stakeholders from Queen's University, to monitor progress achieved at KHSC and assess viability of PCH adopting the HOMR tool applications. Consult / engage with IT to determine IT infrastructure needed to support electronic needs/assessment/documentation.	By end of fiscal 2019/20 the working group will be able to determine if PCH can utilize work done at KHSC to implement HOMR to identify palliative patients requiring further assessment and can outline the plan to review/assess/select appropriate assessment tools for the following fiscal year.	To work with KHSC to identify patients needing palliative care assessment following transfer from KHSC acute setting to PCH sub acute setting and document assessment plans accordingly to accompany patient on future transitions and discharges from PCH to community.	a. Aligning to acute care and Queen's Division of Family Medicine for collaboration on this indicator b. Once KHSC has automated HOMR and identified patients; PCH can more fully partner to share who has been identified (i.e. can this be flagged through ePR?) with the goal that PCH continues to provide care aligned to what has been initiated at KHSC (continuity of care)

									Identify potential opportunities for enhancing patient transitions (e.g. transition from acute and/or sub-acute hospital care to LTC, or transition to home) through the appropriate sharing of the most recent palliative care needs assessment findings, and ensuring ongoing assessments along the patient's full continuum of care.			Palliative Care Needs assessment and care transitions is discussed at regular Kingston Palliative Care Partnership Group meetings.	Participation with Kingston Palliative Care Partnership Group can help to guide future work plans goal and objectives for this key stakeholder group, setting the stage for future spread of successful palliative care needs assessment work implemented at organization-specific levels.
Theme III: Safe and Effective Care	Effective	**Indicator** - Improve organizational financial health **Measure** - 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	Community/Hospital/ Long Term care Home	Local data / Finance / Internal	Q3- 0.15%	0%	Financial health is an important factor as we move forward. Stewardship of the resources available to us needs to continue to insure a positive working capital position.	Ministry of Health and South East LHIN	Monthly Financial and Statistical reporting and communication to all staff to insure that as an organization we are all aware of our financial health.	Monthly Financial Performance Reporting with commentary to all levels of the organization. Formal reporting to the Board, Senior Leadership Team, Operations Committee, Management Team Forum and staff. At each level there is an opportunity for review and questions to be asked.	Monthly Financial and Statistical Reports	The target is good business practice and needs to be in place to meet the South East LHIN/Ministry of Health and Long-Term Care Accountability Agreements for the Hospital, Community Programs and Long-Term Care Home operations.	Providence Care continues to develop robust systems to insure that our systems support our data quality standards on the financial and statistical information front.
Theme III: Safe and Effective Care	Effective, Patient-centred, Safe	Measure - % of Residents Experiencing Worsened Symptoms of Depression among long-term home residents		(Data Source CIHI)	28.6% (CIHI 2nd quarter 2018-2019)	26.50%	This target allows 2 years to bring PM in-line with current provincial rate		Determining clinical diagnosis of depression for residents with high Depression Rating Scale (DRS) and determine whether the resident is prescribed antidepressant medications	Utilize Geriatric Depression Scale for residents with high (DRS) scores to assist in determining clinical diagnosis of depression Chart reviews to determine if resident is prescribed antidepressant medications.	Education will be provided to Nurses, PSWs and families about depression by July1, 2019 Information from geriatric depression scale and chart reviews to be shared with medical team and spiritual Health care provider to provide therapies as needed. Education about depression to be provided at orientation	100%	Important quality of life measure and care at the home level can affect performance.