Let's Make Healthy Change Happen.

Quality Improvement Plan (QIP) Narrative for Health Care Organizations in Ontario

3/24/2017

This document is intended to provide health care organizations in Ontario with guidance as to how they can develop a Quality Improvement Plan. While much effort and care has gone into preparing this document, this document should not be relied on as legal advice and organizations should consult with their legal, governance and other relevant advisors as appropriate in preparing their quality improvement plans. Furthermore, organizations are free to design their own public quality improvement plans using alternative formats and contents, provided that they submit a version of their quality improvement plan to Health Quality Ontario (if required) in the format described herein.

Overview

The Lennox and Addington County General Hospital is committed to providing the highest quality of care possible for the community we serve. Our goal is to embed our core values – Teamwork, Respect and Communication into all the services we provide. Our Quality Improvement Plan is driven by our corporate mission to be a progressive hospital meeting the needs of our local communities through our people. Our 2017/18 Quality Improvement plan (QIP) sets out key strategies to enhance our quality of care, improve safety, increase satisfaction and achieve better clinical outcomes for patients and residents.

Again this year, we have aligned our QIP with our new strategic plan, service accountability agreements, accreditation standards and best practices. This alignment allows better alignment of resources to the areas where they will have the greatest impact on improving patient satisfaction.

Our Quality Improvement Plan was developed in consultation with clinical teams, Staff, patients, residents and members of our Patient and Family Advisory Council. Feedback from patient/resident surveys, incident reviews and the patient relations process were reviewed and assisted with developing change ideas in the QIP.

QI Achievements from the past year

Over the past several years our hospital has been working to improve the patients healing environment, specifically the reduction of noise on the inpatient unit. Studies have shown that the impact of noise on patients, families, and staff is not positive. Excessive noise in the Healthcare environment has many negative impacts such as sleep disturbance for patients, it increases the perception of pain while heightening anxiety and stress and it contributes to distractions resulting in errors by staff. Over the past three years our hospital has been working on reducing the noise in our environment by focusing on noise reduction strategies each year.

This past year, it was identified through patient satisfaction surveys that the patients and families still felt we had excessive noise especially during the evening and night shifts. They identified noisy carts, slamming doors and loud voices at the nurse's desk as the three most common causes of noise.

The auditory impacts of carts were reduced by changing the type of wheels on all of our equipment moving through the patient hallways. Door closers were replaced on specific doors identified by patients in their surveys and staff were educated on the importance of keeping their voices down especially during the evening and night shifts and at shift change.

These relatively minor modifications had a significant impact on improving our patient satisfaction scores related to noise. The overall score for noise levels improved from 56% in February of 2016 to 90% in February 2017. With this significant improvement we feel that we are one step closer to creating a therapeutic environment of care for our patients, families and staff.

Population Health and Equity

Chronic Obstructive Pulmonary Disease (COPD) is the fourth leading cause of death in Canada and a leading cause of morbidity in Canadian adults. Acute exacerbations of COPD are associated with accelerated decline in health and a substantial mortality rate. These acute exacerbations of COPD are a major cause of hospitalization and emergency department visits in our region.

A COPD Clinical Steering Team was launched in January 2016 with regional representation from medicine, nursing, allied professionals, CCAC and patient advisors from all seven hospitals. Our hospital participates in this initiative and the team has conducted a best practice review and has completed a mapping process of a local patient from a patient's initial emergency visit to their eventual discharge in the community. A review of the process identified gaps which the team will continue to work on to ensure a regional best-practice patient journey for the patients in our region. A regional evidence-based pathway (INSPIRE) for COPD will improve the patient experience by ensuring optimal care for every patient at every hospital in the southeast LHIN.

Integration and Continuity of Care

Our priorities are to provide efficient and timely access for patients and to improve our partnerships with external health care providers. We will continue to work collaboratively with the South East Local Health Integration Network, CCAC, our local Health Links, Community Mental Health, Long Term Care and other health care providers. The Lennox and Addington County General hospital continues to collaborate with our community healthcare providers with an understanding that an integrated healthcare system creates efficiency, improves outcomes and supports continuous improvement in quality.

Our hospital continues to partner with the Salmon River Health Links, the local Community Care Access Centre (CCAC) and Community Mental Health to identify patients in our community that are in need of supports. We work collaboratively to ensure they have the appropriate resources in place through the development of a comprehensive care plan to ensure they have the supports needed.

Our hospital also participates in a regional program to reduce wait times and improve intake and assessment for patients requiring hip and knee surgery across the region. We have clinical representation on this committee as well as a patient advisor.

Access to the Right Level of Care – Addressing ALC Issues

LACGH participates in a regional patient flow group that focuses on ensuring patients receive the best care as close to home as possible. This has resulted in a standardized regional repatriation process that has been endorsed and implemented in all seven regional hospitals.

The Convalescent Care unit at LACGH focuses on restoration of strength following deconditioning. The deconditioning could be as a result of hospitalization, surgery or general functional decline. Residents are admitted from anywhere throughout the region and stay for

up to of 90 days. The goal of the program is to recondition seniors to a point where they are able to return safely to their own homes.

Home First is an ongoing philosophy of care that has recently been refreshed at LACGH. The goal is to avoid ALC by supporting patients to return home to wait for the most appropriate setting. The Home First initiative coupled with effective discharge planning has resulted in a decreasing number of ALC patients at LACGH.

Finally, effective regional Chronic disease management, specifically with COPD, will create a standardized, best practice approach to care that will decrease the demands on acute care facilities and the potential of ALC for these patients.

Engagement of Clinicians, Leadership & Staff

The Lennox and Addington County General Hospital engages its staff, leadership and physicians at all levels when developing the QIP. Department specific goals and metrics are developed to support and monitor strategic goals and quality improvement plans. Clinical teams, departmental meetings, Medical Advisory Committee and Board meetings are just a few examples of engagement opportunities. The QIP was presented to the Patient and Family Advisory Council (PFAC), the Quality committee and the Board for feedback.

Resident, Patent, Client Engagement

In order to fully understand our patient's needs, we must first understand what their needs are. We gather information from our patients through patients satisfaction surveys, feedback received through our online website, patient feedback process, patient relations process and through our Patient and Family advisory council.

The information gathered from our patients, residents, caregivers and family members is used to identify successes and opportunities for improvement. Suggested improvements are used to identify areas of focus which drives the development of this QIP.

Staff Safety and Workplace Violence

Updates to the Hospitals policies with respect to Workplace Violence and Harassment were performed in 2016. The Respect and Dignity and Workplace Violence policies were amalgamated into the new Workplace Violence and Harassment Prevention policy. Additional revisions included an expanded definition of workplace harassment, including sexual harassment, and a detailed process regarding complaints and investigation procedures.

Incidents of workplace violence (patient vs staff) are documented in the incident reporting system and followed up by management and presented to the JOHSC. Reports of internal complaints (staff vs staff) are reported and investigated as detailed in the Hospital's Workplace Violence and Harassment Prevention policy.

New employees complete Workplace Violence and Harassment Prevention training during their orientation, and all employees are required to complete an annual review. This training

includes definitions of workplace violence and harassment, reviewing roles and responsibilities, reporting and investigation procedures and handling of complaints. A new education program was developed in 2016 with a focus on workplace bullying and harassment.

The JOHSC facilitates the assessment of risks associated with workplace violence and identifies any action required to eliminate or minimize violence in the workplace. These assessments are reviewed at least annually, or as required following an incident or concern.

New in 2017, the Hospital has implemented Non-violent Crisis Intervention training for all ER staff and select staff in Acute Care. Two individuals have been trained as program trainers and have begun to conduct the training sessions for identified staff.

Performance Based Compensation

The Excellent Care for all Act requires that the compensation of the Executive Officer and other Executives be linked to the achievement of performance targets in the Quality Improvement Plan. The Board in their consideration respects the level of compensation in this organization to be at the minimum end rather than the maximum end. Therefore, the Board has set 3% as the amount to be used this year for the Quality Improvement Plan pay at risk.

To calculate compensation, the Board will look at an achievement of 85% on the selected QIP indicators plus the success on select corporate goals and objectives.

Effective
Develop and implement the use of a standardized discharge summary which will be given to patient/families during discharge.

Weight: 25%

Effective
Develop and implement a standardized discharge checklist to be used at discharge and transfer.

Weight: 25%

Efficient
Re-educate all clinical and support staff (Nutrition service and Environmental Service Workers) on the Home First Philosophy.

Weight: 25%

Person Experience
All Long Term Care patients will have their discharge goals developed and documented and their estimated date of discharge established for all CVC patients within 7 days of admission

Weight: 25%

Contact Information

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Sign-off

I have reviewed and approved our organization's Quality Improvement Plan

Board Chair

Allan MacGregor

Quality Committee Chair

Elaine Stillwell

Chief Executive Officer

Wayne Coveyduck

2017/18 Quality Improvement Plan

"Improvement Targets and Initiatives"

Lennox And Addington County General Hospital 8 Richmond Park Drive

AIM		Measure							Change				
Quality dimension	**Issue**	**Measure/Indicator**	**Unit / Population**	**Source / Period**	**Organization Id**	**Current performance**	**Target**	**Target justification**	**Planned improvement initiatives (Change Ideas)**	**Methods**	**Process measures**	**Target for process measure**	**Comments**
Effective	**Effective transitions**	Did you receive enough information from hospital staff about what to do if you were worried about your condition or treatment after you left the hospital?	% / Survey respondents	CIHI CPES / April - June 2016 (Q1 FY 2016/17)	592*	No current data	100	Stretch target	Improve information sharing at discharge	Develop and implement a standardized discharge summary to be given to patients/families. The summary will include the dates of pre-scheduled appointments	1 Develop discharge summary template in Meditech by October 2017 2 # of patients provided with a completed discharge summary.	80% of patients receiving discharge summary by Nov 2017	
									Identify whether patients have any additional questions and ensure they have the appropriate resources after discharge	Continue to conduct post discharge phone calls within 48 hours of discharge	Review Post discharge phone call data monthly and trend for communication gaps or opportunities to improve.	Monthly review of data	
									Partner with patients to determine whether they feel they are receiving enough information	Add question to patient surveys: Did you receive enough information from hospital staff about what to do if you were worried about your condition or treatment after you left the hospital.	Ensure question is added to both ED and IP surveys before April 2017	100% of surveys will have question added	
		Risk-adjusted 30-day all-cause readmission rate for patients with COPD (QBP cohort)	Rate / COPD QBP Cohort	CIHI DAD / January 2015 – December 2015	592*	21.69	17.35	SELHIN target is to reduce by 20%	Create a standardized discharge checklist of safe discharge practices for COPD patients	Develop and implement a standardized discharge summary checklist for use at discharge and transfer.	# of patients having a completed discharge checklist	July 2017	
									Develop regional COPD care plan for patients in the SE LHIN to improve consistency of care, reduce need for hospital admission, urgent/emergent care. The original plan developed in 2016-17 has been modified to include implementation of CFHI's INSPIRED COPD care plan, thus involving community care providers. Resources to adopt "INSPIRED".	1)Assess resource requirements to implement program at each site 2)Present LHIN-wide COPD management plan to hospital boards for approval	Project milestones are met on time; Working group analyzes LHIN-wide COPD readmission rates before and after introduction of regional COPD care plan	Make evidence-based recommendations for change to reduce readmission rates for patients with COPD in the SE LHIN	
									Support people in our community with COPD by providing education and an exercise program to ensure they are functioning at their highest possible level.	Develop a business case for a pulmonary rehabilitation program at our hospital	Business case to be developed by October 2017	October 2017	
	Effective Transitions	Number of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents.	Rate per 100 residents / LTC home residents	CIHI CCRS, CIHI NACRS / October 2015 - September 2016	54783*	7.02	5.3	Reduce by 25%	Ambulatory care sensitive conditions will be addressed early by the Nurse Practitioner and LTC physician, therefore, reducing the need for ED visits	Residents are assessed and treated in the home where possible. Transfer to the ED occurs only when medically necessary	Monitor quarterly transfers to the ED	Decrease transfers to ED	
									Identify situations where failure to rescue occurred resulting in resident transfer to the ED	Conduct case by case review when ED visit occurs to determine root cause and make recommendations to prevent recurrences.	Charge nurse to conduct case review on each ED transfer with presentation of findings to clinical team.	Ongoing	

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Efficient	**Access to right level of care**	Total number of alternate level of care (ALC) days contributed by ALC patients within the specific reporting month/quarter using near-real time acute and post-acute ALC information and monthly bed census data	Rate per 100 inpatient days / All acute patients	WTIS, CCO, BCS, MOHLTC / July – September 2016 (Q2 FY 2016/17 report)	592*	43.75	30.25	SELHIN target identified in HSAA agreement	Conduct a Home First refresh	Re-educate all clinical and support staff (Dietary & Environmental Service) on the Home First Philosophy	Monitor ALC patient numbers monthly at clinical team meetings and Quality meeting	Education to be completed by April 30, 2017	
									Find alternate setting for patients awaiting LTC placement in order to free up hospital acute care beds.	Expand partnerships with community for ALC patients to receive care in alternate setting while they wait LTC placement at the facility of their choice	Set up a formal process by October 2017.	October 2017	
Patient-centred	**Palliative care**	Percent of palliative care patients discharged from hospital with the discharge status "Home with Support".	% / Palliative patients	CIHI DAD / April 2015 – March 2016	592*	100	100	Maintain	Ensure that patients discharged from hospital to community to receive end of care at home, are supported by resources needed	Partner with CCAC and Hospice to ensure all resources are arranged and in place prior to discharge	Monitor monthly to ensure 100% of patients are discharged with support.	Ongoing	
	Person experience	"Would you recommend this emergency department to your friends and family?"	% / Survey respondents	In house data / Sept 2016 (Q2 FY 2016/17)	592*	88%	93%	5% improvement	Improve the flow of patients in the ER in order to reduce wait times.	Implement and pilot a Non urgent Clinic to divert CTAS 4 & 5 patients during peak times.	Review patient satisfaction survey results to identify whether improvement initiatives are positively affecting patient satisfaction.	Conduct additional patient satisfaction survey following introduction of Non Urgent clinic and RPN pilot	
									Decrease wait times for ER admits to IPU bed	Pilot RPN in ER – responsible for managing flow of ER admits.	Monitor wait times in from triage to IPU bed.	April 2017	
									Decrease repeat visits for Mental Health Patients	Develop comprehensive suicide assessment.	Monitor readmit rates	Monitor rates quarterly reported to ACER	
									Increase support available to Mental Health Patients.	Partner with Community Mental Health for on site crisis worker.	Community Mental Health worker on site	Dec 2017	
		"Would you recommend this hospital to your friends and family?" (In Patient Care)	% / Survey respondents	In house data/ January 2016	592*		100%	Maintain current performance of 100%	Use visual management tools to communicate expected date of discharge (EDD) to patients and families	Consistent use of inpatient room bedside communication boards to communicate EDD to patients and families.	% of inpatient communication bedside boards with up to date EDD. This measure will be tracked by visual audits done monthly	90% compliance	
									Improve patient experience.	Initiate Intentional rounding and improve electronic charting	Intentional rounding evident in routine audits and documentation	May 2017	
	Person experience	Percentage of residents responding positively to: "What number would you use to rate how well the staff listened to you	% / LTC home residents	In house data, April 2016 -Jan 2016	54783*	93%	98%	Improve by 5%	Satisfaction survey given to resident at discharge	Question on survey asking residents if they felt listened to	Information obtained from surveys to be summarized and reviewed. Results will drive process improvement	100% of residents to be given satisfaction survey	
									Post discharge phone calls conduced to every resident.	Post discharge phone calls conducted within 2 weeks of discharge	Information obtained from follow up calls to be summarized and reviewed. Results will drive process improvement	100% of phone calls to be made within 2 weeks post discharge	
		Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences".	% / LTC home residents	In house data, interRAI survey / Jan - Dec 2016	54783*	98%	100%	Stretch target is to achieve 100%	Continue with Patient centred care strategies to include patients in decision making	Residents and families are involved in care plans and goals for discharge .	Discharge goals and EDD established for all CVC patients within 7 days of admission	Conduct random audits to ensure all residents have discharge goals and EDD completed with input from Residents and families	

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Quality dimension	**Issue**	**Measure/Indicator**	**Unit / Population**	**Source / Period**	**Organization Id**	**Current performance**	**Target**	**Target justification**	**Planned improvement initiatives (Change Ideas)**	**Methods**	**Process measures**	**Target for process measure**	**Comments**
	Resident experience: "Overall satisfaction"	Percentage of residents who responded positively to the question: "Would you recommend our Convalescent Care program to others?"	% / LTC home residents	In house data, survey /Jan - Dec 2016	54783*	100%	100%	Maintain current performance	Satisfaction survey given to resident at discharge	Question on survey asking residents if they felt listened to	Information obtained from surveys to be summarized and reviewed. Results will drive process improvement.	100% of residents to be given satisfaction survey	
									Post discharge phone calls conduced to every resident.	Post discharge phone calls conducted within 5 working days of discharge	Information obtained from follow up calls to be summarized and reviewed. Results will drive process improvement.	100% of residents receive follow up phone call within 5 working days of discharge.	
Safe	**Medication safety**	Medication reconciliation at admission: The total number of patients with medications reconciled as a proportion of the total number of patients admitted to the hospital	Rate per total number of admitted patients / Hospital admitted patients	Hospital collected data / Q3 Oct - Dec 2016	592*	94%	100%	Stretch target is to achieve 100%	Monitor compliance monthly and address gaps with all missed opportunities on an individual physician basis	Pharmacist attends daily rounds and highlights missed opportunities to ensure timely follow up with hospitalist Optimization of electronic documentation	Monthly compliance rates reviewed by Quality committee	Ongoing	
									Reduce medication errors and improve patient safety	Ensure Bedside Medication Verification process is being followed	Conduct monthly BMV scanning audits and review by clinical team	Ongoing	
		Medication reconciliation at discharge: Total number of discharged patients for whom a Best Possible Medication Discharge Plan was created as a proportion the total number of patients discharged.	Rate per total number of discharged patients / Discharged patients	Hospital collected data / Q3 Oct - Dec 2016	592*	99%	100%	Goal is to achieve and maintain 100%	Monitor compliance monthly and address gaps with all missed opportunities on an individual physician basis	Pharmacist attends daily rounds and highlights missed opportunities to ensure timely follow up with hospitalist Optimization of electronic documentation	Monthly compliance rates reviewed by Quality committee	Ongoing	
	Medication safety	Percentage of residents who were given antipsychotic medication without psychosis in the 7 days preceding their resident assessment	% / LTC home residents	Medisystems / Apr - Oct 2016	54783*	0%	0%	Based on data provided by Medisystem, our goal is to maintain current performance.	Optimize drug utilization. Our resident population is rehab and therefore the use antipsychotic is quite low.	Conduct drug utilization statistical review on a quarterly basis	Pharmacy to conduct and present quarterly results of review at clinical team meetings	Quarterly review of medication use by clinical team	
Timely	**Timely access to care/services**	Total ED length of stay (defined as the time from triage or registration, whichever comes first, to the time the patient leaves the ED) where 9 out of 10 complex patients completed their visits	Hours / Patients with complex conditions	CIHI NACRS / January 2016 – December 2016	592*	9.68	8.8	SELHIN target identified in HSAA	Trial an over capacity ER Clinic to reduce the numbers of CTAS 4 & 5 patients in the ER and increase flow, therefore, reducing the PIA for patients.	Dedicated resources and time will be in place to implement trials during peak times.	Weekly and monthly tracking of PIA times, LWBS and ED LOS. Reporting of data to Quality and clinical teams	Monthly review at clinical teams. Quarterly to Quality.	
									Improve process to transfer admitted patients from the ER to the IP unit.	Develop guidelines for the admission process to expedite movement of patients to the IP unit once the decision to admit has been made.	Monitor and report time to admit.	Ongoing	

Excellent Care for All

Quality Improvement Plans (QIP): Progress Report for 2016/17 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 reflection 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.

ID	Measure/Indicator from 2016/17	Org Id	Current Performance as stated on QIP2016/17	Target as stated on QIP 2016/17	Current Performance 2017	Comments
1	% by which patient EMS score increases from admission to discharge. (# residents whose EMS improved at discharge; # residents receiving OT; No current data; In-house survey)	54783	CB	85.00	86.50	EMS scores are completed on all residents on admission and at discharge. The goal is to increase each residents EMS score by >10 prior to discharge.

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 had an impact and which ones you were able to adopt, adapt or abandon. This learning will help build capacity across the province.

Change Ideas from Last Years QIP (QIP 2016/17)	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?
All residents will show improvement in their documented EMS.	Yes	We have had great success with the Convalescent Care Program in that we are seeing the majority of our residents increasing their EMS score to > 10 which allows them to transition back to their home and avoid an acute care admission or in many cases admission to a LTC facility.

ID	Measure/Indicator from 2016/17	Org Id	Current Performance as stated on QIP2016/17	Target as stated on QIP 2016/17	Current Performance 2017	Comments
2	% of occupancy of 22 beds (Average) (%; Residents; April 2015 - Dec. 2015; Hospital collected data)	54783	87.50	80.00	87.00	Occupancy is consistently over 80%.

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Ongoing communication /meetings with referral services. i.e.. hospital partners and community to maintain occupancy rate.	Yes	Geographic referral patterns have expanded.

ID	Measure/Indicator from 2016/17	Org Id	Current Performance as stated on QIP2016/17	Target as stated on QIP 2016/17	Current Performance 2017	Comments
3	% of patients staying (Days; Residents; Q3 2015-2016; Hospital collected data)	54783	100.00	100.00	100.00	All residents are discharged within 90 days.

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Change Ideas from Last Years QIP (QIP 2016/17)	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?
Maintain LOS less than 90 days.	Yes	All residents are discharged within 90 days. ELOS on admission assists with this planning. Most residents are discharged home with or without support. Very few are repatriated to sending facility.

ID	Measure/Indicator from 2016/17	Org Id	Current Performance as stated on QIP2016/17	Target as stated on QIP 2016/17	Current Performance 2017	Comments
4	% of residence with new pressure ulcers within the past 7 days. (%; All residents who acquire new pressure ulcers after admission to facility.; No current data available; Hospital collected data)	54783	CB	0.00	CB	The current process for collecting data is under review.

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Change Ideas from Last Years QIP (QIP 2016/17)	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?
Complete Braden Scale risk assessment on admission. Wound Care prevalence.	Yes	Braden Scale and surveillance tool is completed. This was a challenging indicator with an ambulatory population who commonly has surgical wounds.
Complete skin pressure ulcer audits.	Yes	The Wound Care champion does assessment/reassessment weekly and documents on patient record and wound care surveillance tool.

ID	Measure/Indicator from 2016/17	Org Id	Current Performance as stated on QIP2016/17	Target as stated on QIP 2016/17	Current Performance 2017	Comments
5	% of residents on antipsychotics without a diagnosis of psychosis. (%; Residents; Apr. 2015 - Nov. 2015; Medi-Systems)	54783	5.00	5.00	0.00	Because we are a convalescent care unit as apposed to a true LTC facility the use of antipsychotics are minimal.

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Change Ideas from Last Years QIP (QIP 2016/17)	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?
Optimize drug utilization.	Yes	Antipsychotics are not normally used for patients in Convalescent Care. The admission criteria eliminates most residents who would require such medication.

ID	Measure/Indicator from 2016/17	Org Id	Current Performance as stated on QIP2016/17	Target as stated on QIP 2016/17	Current Performance 2017	Comments
6	% of residents who had a recent fall (in the last 30 days). (%; Residents; Apr. - Dec. 2015; Point Click Care)	54783	6.00	10.00	13.00	Small numbers of residents sometimes can impact current performance.

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Change Ideas from Last Years QIP (QIP 2016/17)	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?
To reduce the number of falls.	Yes	Comprehensive falls program in place.
To reduce # of recurring falls.	Yes	Each resident has an individualized care plan with the goal of eliminating or reducing falls. Repetitive falls were related to competent patient who were aware of the consequences of their action.
Review Falls Program.	Yes	Falls incidents are reviewed in detail annually as part of the program review and recommended improvements implemented. All residents at risk are assessed by Physiotherapy.
Preventative measures in place.	Yes	The hospital is currently introducing hourly CARE rounds. Non slip socks are provided to resident as risk.

ID	Measure/Indicator from 2016/17	Org Id	Current Performance as stated on QIP2016/17	Target as stated on QIP 2016/17	Current Performance 2017	Comments
7	% of residents who meet EDD. (%; Residents; Q3 2015-2016; Hospital collected data)	54783	100.00	100.00	NA	Process for data collection is under review.

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Change Ideas from Last Years QIP (QIP 2016/17)	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?
Establish LOS on Admission for all residents by physio.	Yes	Expected LOS is determined with the Resident & family within 7 days of admission. Although this date may change, it is important for the patient as well as the care team to work toward an ELOS.

ID	Measure/Indicator from 2016/17	Org Id	Current Performance as stated on QIP2016/17	Target as stated on QIP 2016/17	Current Performance 2017	Comments
8	% of Residents with 10 EMS score. (%; All residents admitted with EMS score of	54783	CB	85.00	81.00	The EMS score is an excellent indicator of physical mobility.

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Ensure residents are discharged with >10 EMS score.	Yes	The goal of the Convalescent Care program is to improve physical function. By evaluating each resident on admission and at discharge we were able to demonstrate quantitative patient success. EMS > 10 is also indicative of LTC avoidance.

ID	Measure/Indicator from 2016/17	Org Id	Current Performance as stated on QIP2016/17	Target as stated on QIP 2016/17	Current Performance 2017	Comments
9	% of residents with worsening pressure ulcers. (%; All residents with pressure ulcers.; Apr. 2015 - Aug. 2015; Hospital collected data)	54783	8.00	3.00	30.00	Because our numbers are low one pressure ulcer can impacts data significantly.

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Change Ideas from Last Years QIP (QIP 2016/17)	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?
Compliance with best practice guidelines.	Yes	Education provided for staff members to become "Pressure Ulcer Champion" and was assigned responsibility to complete skin assessments. All nursing staff are required to completed a wound care learning module.
Complete skin assessments on admission and weekly thereafter.	Yes	Would Care Champion does weekly assessments/reassessments and documents on patients record and the wound care surveillance tool.

ID	Measure/Indicator from 2016/17	Org Id	Current Performance as stated on QIP2016/17	Target as stated on QIP 2016/17	Current Performance 2017	Comments
10	% of those who answered always/most of time to question 16 on survey. "Did you feel there was enough activities to meet your needs? (%; Residents; No current data; In-house survey)	54783	CB	90.00	100.00	Residents are very satisfied with the program.

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Change Ideas from Last Years QIP (QIP 2016/17)	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?
Follow up phone for those discharged from Convalescent Care.	Yes	Great way to obtain feedback from residents on their experience and suggestions for improvement.

ID	Measure/Indicator from 2016/17	Org Id	Current Performance as stated on QIP2016/17	Target as stated on QIP 2016/17	Current Performance 2017	Comments
11	% of unintended weight loss/gain +/-5% in a month. (%; Residents; May 2015 - Jan. 2016; Hospital collected data)	54783	13.00	0.00	9.00	All residents are weighted on admission and assessed by the Dietician. Weights are done weekly during hospital stay and monitored by the Dietician.

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Change Ideas from Last Years QIP (QIP 2016/17)	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?
Completion of admission nutritional assessment and ongoing throughout the residents stay as required.	Yes	Great process to identify unintended weight loss/gain.
Nutritional assessment on admission and review of weights.	Yes	All residents receive an assessment by the Dietician and are weighed on admission.

ID	Measure/Indicator from 2016/17	Org Id	Current Performance as stated on QIP2016/17	Target as stated on QIP 2016/17	Current Performance 2017	Comments
12	“Overall, how would you rate the care and services you received at the ED?”, add the number of respondents who responded “Excellent”, “Very good” and “Good” and divide by number of respondents who registered any response to this question (do not include non-respondents). (%; ED patients; October 2015; In-house survey)	592	89.00	89.00	92.00	The team continues to trial improvement strategies and measure indicators.

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Change Ideas from Last Years QIP (QIP 2016/17)	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?
"Improve timeliness and quality of communication and information exchange."	No	

ID	Measure/Indicator from 2016/17	Org Id	Current Performance as stated on QIP2016/17	Target as stated on QIP 2016/17	Current Performance 2017	Comments
13	B: Percentage of residents responding positively to: "I would recommend this site or organization to others." (InterRAI QoL) (%; Residents; Apr 2015 – Mar 2016 (or most recent 12-month period). ; In-house survey)	54783	100.00	100.00	100.00	Residents are very satisfied with the program. We get many positive comments.

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Change Ideas from Last Years QIP (QIP 2016/17)	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?
Follow up phone calls for those discharged from CVC.	Yes	Great way to obtain feedback from residents on their experience and suggestions for improvement. Paper Patient Satisfaction survey is also given to each resident on discharge. Results of survey is collated and shared with the team.

ID	Measure/Indicator from 2016/17	Org Id	Current Performance as stated on QIP2016/17	Target as stated on QIP 2016/17	Current Performance 2017	Comments
14	CDI rate per 1,000 patient days: Number of patients newly diagnosed with hospital-acquired CDI during the reporting period, divided by the number of patient days in the reporting period, multiplied by 1,000. (Rate per 1,000 patient days; All patients; January 2015 – December 2015; Publicly Reported, MOH)	592	0.31	0.31	0.00	No C-diff infections reported for past 18 months.

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Change Ideas from Last Years QIP (QIP 2016/17)	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?
We will continue to focus on reducing the number of patients diagnosed with a hospital acquired infection across the organization. We will achieve this through ongoing corporate wide focused efforts to achieve compliance with best practice guidelines for hand hygiene, environmental cleaning, staff and patient education and a dedicated focus on antibiotic stewardship.	Yes	Monthly review of hand hygiene compliance. Monthly cleaning audits raise awareness to Environmental Service workers and remind staff of importance of following PIDAC cleaning standards. Revamp of antimicrobial stewardship program helped us identify further gaps that we are focusing on in 2017.

ID	Measure/Indicator from 2016/17	Org Id	Current Performance as stated on QIP2016/17	Target as stated on QIP 2016/17	Current Performance 2017	Comments
15	ED Wait times: 90th percentile ED length of stay for Admitted patients. (Hours; ED patients; January 2015 - December 2015; CCO iPort Access)	592	34.20	30.70	39.46	New nursing lead initiative to decrease LOS for admitted patients. We are anticipating a decrease in wait times as a result. We are monitoring monthly.

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Change Ideas from Last Years QIP (QIP 2016/17)	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?
Determine whether the use of investigative technologies is appropriate.	No	

ID	Measure/Indicator from 2016/17	Org Id	Current Performance as stated on QIP2016/17	Target as stated on QIP 2016/17	Current Performance 2017	Comments
16	Medication reconciliation at admission: The total number of patients with medications reconciled as a proportion of the total number of patients admitted to the hospital (Rate per total number of admitted patients; Hospital admitted patients; most recent quarter available; Hospital collected data)	592	89.00	100.00	94.00	Compliance continues to improve. We are approaching our target of 100%.

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Change Ideas from Last Years QIP (QIP 2016/17)	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?
Identify barriers and develop strategies for improvement.	Yes	Our Chief of Staff is dedicated to improving the Med Rec compliance rates. She follows up with all physicians as missed opportunities occur.
Reduce medication errors and improve patient safety.	Yes	Our pharmacists are dedicated to meeting with patients prior to discharge to ensure they fully understand their discharge meds. In 2016 we moved to electronic based med rec.

ID	Measure/Indicator from 2016/17	Org Id	Current Performance as stated on QIP2016/17	Target as stated on QIP 2016/17	Current Performance 2017	Comments
17	Medication reconciliation at discharge: Total number of discharged patients for whom a Best Possible Medication Discharge Plan was created as a proportion the total number of patients discharged. (Rate per total number of discharged patients; Discharged patients ; Most recent quarter available; Hospital collected data)	592	89.00	100.00	99.00	There was a significant improvement over last year. We achieved 100% for several months in 2016/17.

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Change Ideas from Last Years QIP (QIP 2016/17)	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?
"Improve safety and efficiency of the In-Patient patient medication administration process by changing the medication administration record (MAR) from paper-based to electronic document."	Yes	Fully implemented. Monthly audits are conducted to ensure compliance with scanning prior to administering meds. Compliance was a bit of a challenge when first implemented but nursing staff are now better understanding the patient safety benefits and compliance is improving. Physicians and pharmacy are now completing the med reconciliation electronically which makes the process and auditing much easier.

ID	Measure/Indicator from 2016/17	Org Id	Current Performance as stated on QIP2016/17	Target as stated on QIP 2016/17	Current Performance 2017	Comments
18	Number of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents. (Rate per 100 residents; LTC home residents; Oct 2014 – Sept 2015; CIHI CCRS, CIHI NACRS)	54783	20.31	10.00	7.02	Our LTC facility is a CVC unit and as such our patient population is very different than traditional LTC. We have very few patients requiring ED visits.

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Change Ideas from Last Years QIP (QIP 2016/17)	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?
Residents are assessed and treated in the home where possible. Transfer to ER occurs only when necessary.	Yes	Residents are assessed on a regular basis by either the Nurse Practitioner or the Physician.
Identify situations where failure to rescue occurred resulting in Resident transfer to ER.	Yes	All situations where we failed to rescue were reviewed to identify how we can be more proactive in the future in order to avoid transfers to the ER.

ID	Measure/Indicator from 2016/17	Org Id	Current Performance as stated on QIP2016/17	Target as stated on QIP 2016/17	Current Performance 2017	Comments
19	Overall, how would you rate the care and services you received at the hospital?" (inpatient), add the number of respondents who responded "Excellent", "Very good" and "Good" and divide by number of respondents who registered any response to this question (do not include non-respondents). (%; All patients; Feb. 2015; In-house survey)	592	95.00	95.00	100.00	We receive very positive feedback from our Acute Care patients.

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Change Ideas from Last Years QIP (QIP 2016/17)	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?
Improve end of life experience for patients and their families.	Yes	Hospice is part of our interdisciplinary team and is a great support for patients and their families at our hospital.
Ensure bedside communication boards are being updated and accurate.	Yes	Bedside communication boards have significantly improved the communication with patients. The estimated date of discharge also helps with LOS as patients & families are fully aware of the goal for discharge.

ID	Measure/Indicator from 2016/17	Org Id	Current Performance as stated on QIP2016/17	Target as stated on QIP 2016/17	Current Performance 2017	Comments
20	Percentage of acute hospital inpatients discharged with selected HBAM Inpatient Grouper (HIG) that are readmitted to any acute inpatient hospital for non-elective patient care within 30 days of the discharge for index admission. (%; Discharged patients with selected HIG conditions; July 2014 – June 2015 ; CIHI DAD)	592	17.09	16.00	20.47	Data is normally 3-4 quarter behind. Makes it very difficult to measure effectiveness of improvement strategies.

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Change Ideas from Last Years QIP (QIP 2016/17)	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?
Connect patients with Health Links prior to discharge.	Yes	Ongoing collaboration with the Salmon River Healthlinks to identify patients in our community that are high needs to develop comprehensive care plans. Healthlinks rep are also attending weekly rounds to assist with the discharge of these ALC patients.
Enhance NP role in supporting patients at home.	Yes	Challenges with NP resources prevented us from implementing this initiative.

ID	Measure/Indicator from 2016/17	Org Id	Current Performance as stated on QIP2016/17	Target as stated on QIP 2016/17	Current Performance 2017	Comments
21	Percentage of residents responding positively to: "What number would you use to rate how well the staff listen to you?" (%; LTC home residents; Apr 2015 – Mar 2016 (or most recent 12-month period); In house data, NHCAHPS survey)	54783	93.00	95.00	93.00	This indicator is reviewed quarterly by the CVC clinical team. Recommendations for improvement are reviewed and implemented. Follow up phone calls are occurring following discharge to obtain verbal feedback/recommendations for improvement.

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Change Ideas from Last Years QIP (QIP 2016/17)	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?
Follow up phone for those discharged from Convalescent Care.	Yes	Great way to obtain feedback from residents on their experience and suggestions for improvement. This question is included in the residents satisfaction survey given to each resident at discharge.

ID	Measure/Indicator from 2016/17	Org Id	Current Performance as stated on QIP2016/17	Target as stated on QIP 2016/17	Current Performance 2017	Comments
22	Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences". (%; LTC home residents; Apr 2015 – Mar 2016 (or most recent 12-month period). ; In house data, interRAI survey)	54783	CB	95.00	98.00	Current performance is an improvement from last year.

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Change Ideas from Last Years QIP (QIP 2016/17)	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?
Follow up phone for those discharged from Convalescent Care.	Yes	Great way to obtain feedback from residents on their experience and suggestions for improvement. Question is also on the paper satisfaction survey given to each resident on discharge.

ID	Measure/Indicator from 2016/17	Org Id	Current Performance as stated on QIP2016/17	Target as stated on QIP 2016/17	Current Performance 2017	Comments
23	Risk-adjusted 30-day all-cause readmission rate for patients with CHF (QBP cohort) (Rate; CHF QBP Cohort; January 2014 – December 2014; CIHI DAD)	592	25.92	23.30	32.61	Up to date data is not available. Difficult to measure effectiveness of improvement strategies. Hospital will focus on COPD QBP for 2017/18 QIP.

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Change Ideas from Last Years QIP (QIP 2016/17)	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?
Review the GAP-HF (Guidelines Applied in Practice for Heart Failure) adapted from the University of Ottawa Heart Institute and identify any improvement opportunities.	No	This change idea will be conducted in the 2017/18 year.
Develop methods to re-inforce the importance of making an appointment with the family physician within 7 days post discharge for patients with CHF.	No	This change idea will be incorporated into the discharge summary and discharge check list change idea identified in our 2017/18 Quality Improvement Plan.

ID	Measure/Indicator from 2016/17	Org Id	Current Performance as stated on QIP2016/17	Target as stated on QIP 2016/17	Current Performance 2017	Comments
24	Risk-adjusted 30-day all-cause readmission rate for patients with COPD (QBP cohort) (Rate; COPD QBP Cohort; January 2014 – December 2014; CIHI DAD)	592	9.40	8.46	21.69	Reviewing methods for collecting data. Regional steering committee working towards evidence based pathway for COPD.

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Change Ideas from Last Years QIP (QIP 2016/17)	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?
"Develop a regional care plan for COPD patients in the SE LHIN for the purpose of reducing the acute care readmission rate. "	Yes	A COPD Clinical Steering Team was launched in January 2016 with regional representation from medicine, nursing, allied professionals, CCAC and patient advisors from all seven hospitals. Our hospital participates in this initiative and the team has conducted a best practice review and have completed a mapping process of a local patient from a patient's initial emergency visit to their eventual discharge in the community. A review of the process identified gaps which the team will continue to work on to ensure a regional best-practice patient journey for the patients in our region. A regional evidence-based pathway for COPD will improve the patient experience by ensuring optimal care for every patient at every hospital in the southeast LHIN.

ID	Measure/Indicator from 2016/17	Org Id	Current Performance as stated on QIP2016/17	Target as stated on QIP 2016/17	Current Performance 2017	Comments
25	The number of critical drug medication errors in the past month. (%; medication incidents resulting in critical insident.; April 1, 2015 - Jan. 31, 2016; Hospital collected data)	54783	0.00	0.00	0.00	Critical drug incidents are rare. We will continue to monitor and review/analyze critical incidents if they should occur.

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Change Ideas from Last Years QIP (QIP 2016/17)	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?
Annual pharmacy program evaluation including the ISMP self assessment.	Yes	Annual evaluation is reviewed by the CVC Clinical team and improvements identified.

ID	Measure/Indicator from 2016/17	Org Id	Current Performance as stated on QIP2016/17	Target as stated on QIP 2016/17	Current Performance 2017	Comments
26	Total number of alternate level of care (ALC) days contributed by ALC patients within the specific reporting month/quarter using near-real time acute and post-acute ALC information and monthly bed census data (Rate per 100 inpatient days; All inpatients; July 2015 – September 2015; WTIS, CCO, BCS, MOHLTC)	592	41.20	27.50	43.75	New Social Worker has been successful in moving some ALC patients to a more appropriate bed. We anticipate the current performance will improve in 2017.

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Change Ideas from Last Years QIP (QIP 2016/17)	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?
"Identify patients with delirium in order to implement appropriate interventions and improve their success once they return home."	Yes	Cognitive Assessment tool has been implemented. Patients over the age of 65 are screened for delirium. Home First program refresh with philosophy “if you come from home, you can expect to return to home”. Health Links has joined weekly multidisciplinary team rounds. Electronic interface has been completed with CCAC. Automatic notification when a CCAC patient presents in the ER.
Enhance our ER Diversion by integrating with local agencies to provide supports for ALC patients at home.	Yes	On going collaboration with Healthlinks, CCAC and community mental health.
Continue to implement Health Links across the care continuum for medically complex patients.	Yes	On going collaboration with Salmon River Healthlinks.

ID	Measure/Indicator from 2016/17	Org Id	Current Performance as stated on QIP2016/17	Target as stated on QIP 2016/17	Current Performance 2017	Comments
27	Would you recommend this ED to your friends and family?" add the number of respondents who responded "Yes, definitely" (for NRC Canada) or "Definitely yes" (for HCAHPS) and divide by number of respondents who registered any response to this question (do not include non-respondents). (%; ED patients; Oct. 2015; In-house survey)	592	93.00	93.00	88.00	We continue to focus on wait times and patient flow initiatives.

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Change Ideas from Last Years QIP (QIP 2016/17)	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?
Improve overall wait time with specific focus on PIA.	No	No improvement to PIA.
Improve work flow.	Yes	Nurse directed patient flow initiative has resulted in significant improvement to admitted patient LOS.
Senior friendly ER.	Yes	Senior Friendly initiative will be expanded to include CAM tool in ER.

ID	Measure/Indicator from 2016/17	Org Id	Current Performance as stated on QIP2016/17	Target as stated on QIP 2016/17	Current Performance 2017	Comments
28	Would you recommend this hospital (inpatient care) to your friends and family?" add the number of respondents who responded "Yes, definitely" (for NRC Canada) or "Definitely yes" (for HCAHPS) and divide by number of respondents who registered any response to this question (do not include non-respondents). (%; All patients; Feb. 2015; In-house survey)	592	100.00	100.00	100.00	Very positive feedback. We will continue to make improvement changes based on patient recommendations from feedback.

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"To improve continuity and transitions in care. Contacting patients following discharge enables staff to answer patients' questions and clarify or reinforce discharge instructions."	Yes	All patients discharged from the IPU are contacted to ask about their inpatient stay. This is considered an extension of hospital care & assists patient who may have questions after return home.