Let's Make Healthy Change Happen.

Quality Improvement Plan (QIP) Narrative for Lennox & Addington County General Hospital

3/29/2019

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 communities we serve. Our goal is to embed our core values “Teamwork, Respect and Communication” into all the services we provide. Our Quality Improvement Plan (QIP) is driven by our corporate mission “To be a progressive hospital meeting the needs of our local communities through our people”. Our 2019/20 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 strategic plan, service accountability agreements, accreditation standards and best practices. This alignment allows better use of resources to the areas where they will have the greatest impact on improving patient satisfaction. Furthermore, our QIP highlights how we use technology to reach our patients in rural under-serviced area; and, how we engage with community partners to increase access to services for patients of varied socioeconomic status.

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 informed the development of change ideas in the QIP.

Describe your organization's greatest QI achievement from the past year

In our 2018/19 QIP we introduced our newly implemented BREATHE program which included a Pre-Discharge COPD Order Set and a combined Cardiac-Pulmonary Rehabilitation Program. The goal of our BREATHE program is to promote self-care for patients with Chronic Obstructive Pulmonary Disease (COPD) while reducing COPD associated respiratory exacerbations and emergency room visits. One of the lessons learned following the launch of the program was that some of our patients were unable to accommodate frequent travel to hospital for BREATHE clinic follow-up visits. Even some patients that were not geographically isolated were found to have limited access to our services simply based on the mobility challenges associated with shortness of breath. In January 2018, the barrier of access and transition home with COPD was overcome with the implementation of virtual health technology including the provision of tablets to discharged patients.

Thirty-five patients have been enrolled since the inception of the BREATHE program. We have prevented 24 re-admissions to hospital by helping the patient manage their symptoms at home. Patients enrolled in the virtual program have saved the time and cost associated with more than 6,000 km in travel to attend the hospital, clinic or ER. Typically, patients stay connected through the virtual program for about three months and once they are well established in the management of their COPD, they rely less on the program and more on their own newly developed self-management skills. They have ongoing access to

the BREATHE clinic and the BREATHE Help Line. BREATHE patients are also regularly participating in respiratory rehabilitation or an exercise program in their community. Patient and family feedback has been positive and has encouraged LACGH to continue with all aspects of the BREATHE program. The COPD readmission rate has dropped from 17% to 3%.

In February 2019, the BREATHE model of care was adapted to meet the needs of patients discharged from LACGH with a diagnosis of Congestive Heart Failure (CHF). The goal of the virtual CHF program is similar to that of the BREATHE program: to promote self-management and reduce emergency room visits. Prior to discharge from the hospital, patients with CHF are familiarized with the virtual health program and review their discharge plan with the CHF nurse. Following discharge, the patient connects with the CHF nurse via the virtual health program and attends our cardiac rehab program. The virtual health program allows hospital professionals to remotely:

- monitor health data and track trends over time including: oxygen saturations, heart rate, blood pressure and weight.
- visually evaluate how the patient is doing including assessment of respiratory pattern, use of accessory muscles, and skin colour.
- “push” information to patients through reminders regarding medication adherence
- schedule clinic visits.
- provide ongoing education and review of the personalized CHF action plan.
- provide guidance to access a patient’s primary care provider (PCP) for management.

The CHF virtual health program allows patients to:

- Call the RN during regular work hours to address any questions they might have regarding management of their CHF.
- Involve family and caregivers in the virtual monitoring with their loved one and connection with the BREATHE program team should they have concerns.

Patient/client/resident partnering and relations

We have a variety of methods to engage patients and families in our quality improvement planning and our quality improvement activities. Information is gathered through:

- Patient satisfaction surveys from various departments in the organization
- Post discharge phone calls to ask about their total care experience. A scripted dialogue encourages feedback about their hospital stay, what we could improve on as well as confirming whether they are settling in well at home and whether they feel they had all the resources they needed when they arrived home.
- Patient and Family Advisory Council (PFAC), who are actively involved as partners in driving quality and safety in all aspects of the patient experience. PFAC is

represented in membership on our Board, the Quality Committee, and our Acute Inpatient, and Emergency Clinical Team.

- Feedback received through compliments and complaints.

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 our QIP and quality improvement activities. For example, this year the PFAC organized an annual work plan (September 2018 -July 2019) around three improvement goals: question development for the new inpatient satisfaction survey; a new comprehensive and patient friendly website; and an improved discharge process. The Council formed three workgroups to address these goals. The survey workgroup co-developed additional questions for the now implemented inpatient survey. The website workgroup was instrumental in identifying the required elements of a new website by participating in the development of the request for proposal. The discharge workgroup has just recently convened and is on track for success in 2019.

Workplace Violence Prevention

Workplace violence prevention is a priority for LACGH. It is embedded in our Hospital orientation and reviewed annually by all staff. Furthermore, each incident and the improvements identified are reviewed by a multidisciplinary group at every JOHSC meeting, clinical team meeting, Quality Committee meeting, and included in the Board package monthly. Quarterly review of the incident and prevention initiatives are trended in the Hospitals Balanced scorecard.

In 2018/19 LACGH made significant improvements aimed are improving workplace violence prevention. In June 2018, the Public Services Health & Safety Association's Violence, Aggression & Responsive Behavior (VARB) Workplace Violence Risk Assessment tool was used to complete a hospital wide assessment. There were no high risks identified. A total of three medium risks were identified, including:

1. Patient Risk Assessment and Communication:
    - The corrective action for this risk was the introduction of patient flagging within Acute Care, which is considered our highest risk area. A patient flagging (pictograph) is to be applied on the door frame of a patient's room in the event that they have potential/actual behaviors that put the staff/visitors at risk. For those in a wardroom, the small circular sign is to be applied to the white board at the bedside to assist in easily identifying which patients may be a risk. Flags have also built an area within our electronic Medical Record allowing for identification of identifies high-risk patients for both the clerical

and nursing staff. The electronic flag also allows audits to be conducted that evaluate flagging effectiveness.

2. Staff Working Alone:
    - This Risk pertains specifically to Environmental Services who have been provided a personal safety response device. Security is aware of the hours that these individuals are off-site and are available if required. Staff have also been asked to use the buddy system when leaving and if there are concerns.
3. Concerns with blind corners in basement corridor:
    - Security has a scheduled walk through during their shift and improvements have been made to the brightness of the corridor. Mirrors have been installed at all corners. Security cameras are also installed throughout the lower level.

Executive Compensation

It is mandatory under the Excellent Care for All Act (ECFAA) to link compensation for the Chief Executive Officer (CEO) and other executives reporting to the CEO to the achievement of performance targets in our organizations Quality Improvement Plan (QIP). Performance-based executive compensation is linked to achieving specific QIP targets, as well as achieving success on selected corporate goals and objectives. The amount of compensation that is performance-based for the executive team has been set at 3% for 2019/20 year. The performance-based compensation will be tied to the achievement of the following QIP indicators as well as the achievement of selected corporate goals and objectives:

1. The percentage will increase from 79.3% to 82.9% by Feb 28, 2020 for respondents who responded positively to the following question: 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?
2. Develop and implement repatriation screening tool to use when facilitating the repatriation process for ALC/rehab patients from partner hospitals.
3. Reduce the total number of alternate level of care (ALC) days contributed by ALC patients from a rate of 41.39 to 35.
4. A Security Self-Assessment will be conducted using the Public Services Health & Safety Association's Violence, Aggression & Responsive Behavior (VARB) toolkit and an action plan developed based on the assessment findings by June 30, 2019. The expectation is that should a gap be identified through this process that it would also be reduced prior to November 30, 2019.

Contact Information

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Sign-off

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

Board Chair _____

Board Quality Committee Chair _____

Chief Executive Officer _____

Chief Nursing Officer _____

Manager, Quality & Operational Efficiencies _____

2019/20 Quality Improvement Plan

"Improvement Targets and Initiatives"

Lennox And Addington County General Hospital 8 Richmond Park Drive

AIM		Measure										Change				
Issue	Quality dimension	Measure/Indicator	Type	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	External Collaborators		Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
M = Mandatory (all cells must be completed) P = Priority (complete ONLY the comments cell if you are not working on this indicator) C = custom (add any other indicators you are working on)																
Theme I: Timely and Efficient Transitions	**Timely**	**The time interval between the Disposition Date/Time (as determined by the main service provider) and the Date/Time Patient Left Emergency Department (ED) for admission to an inpatient bed or operating room.**	**MANDATOR**	**Hours / All patients**	**CIHI NACRS / October 2018 – December 2018**	**592***	**11.7**	**9.95**	**15% reduction**			**1. Improve timeliness of transfer admitted patients from the ER to the ICU. 2. Evaluate the time interval between ER admission to the operating room.**	**1. ER to ICU Task Force will engage in a root cause analysis and PDSA testing of an improvement. 2. Collect baseline time to OR disposition for ER admits.**	**1. Root cause and PDSA cycle completed. 2. Monthly audit of ER to OR disposition times reviewed by the Quality Committee**	**1. First PDSA cycle complete by January 31, 2020. 2. Monthly review will be commence by the June 2019 Quality Committee Meeting.**	
	Efficient	Average number of inpatients receiving care in unconventional spaces or ER stretchers per day within a given time period.	P	Count / All patients	Daily BCS / October - December 2018	592*	2.74	2.47	10% reduction	Home and Community Care, KHSC, and QHC.		Collaborate with regional hospitals and home and community care partners to better prepare patients for repatriation to LACGH.	Develop a repatriation screening tool for Charge nurses to use when facilitating the repatriation process for ALC/rehab patients from partner hospitals.	Screening tool with be developed and used.	Tool will be developed by October 31, 2019. Ongoing evaluation of effectiveness of tool	
		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	P	Rate per 100 inpatient days / All inpatients	WTIS, CCO, BCS, MOHLTC / July - September 2018	592*	41.39	35	HSAA target	University of Waterloo		Prevent deconditioning of ALC patients.	1. Improve weekend activation of ALC patients by leveraging the Senior Friendly Work group to develop standard work for a weekend activation program. 2. Spread the CVC med pass program to the Acute and ICU Units to decrease malnutrition and establish a sustainable nutrition routine for hospital patients. 3. Implement an early mobilization program	1. Count of activated patients 2. Nutrition champions will audit implementation and compliance of med pass program in the acute and ICU units. Compliance is defined as the patient being provided the supplement as ordered. 3. Evaluate implementation and compliance with program.	1. Monthly reporting to clinical teams 2. Med Pass implemented by Dec 31, 2019. Targeted compliance rate is 90%. 3. Evaluation completed by Sept 30, 2019	
Theme II: Service Excellence	**Patient-centered**	Percentage of complaints acknowledged to the individual who made a complaint within five business days	P	% / All patients	Local data collection / Most recent 12 month period	592*	100%	100%	Maintain current performance.			1. Align LACGH standard practices with their revised OHA recommended practices for managing patient feedback. 2. Improve 90th percentile of time acknowledged and agreed upon follow-up plan from 3 days to 2 day. Patient and Hospital agree on next steps/plan for concern resolution.	1. Modify all LACGH policies related to patient complaints, including CVC policies, to incorporate the 2018 OHA recommended practices. 2. Modify the LACGH balanced scorecard to include complaint acknowledgement timelines and target. 3. Educate staff on the revised patient feedback process.	1. Policy approved. 2. Revised balanced scorecard and feedback report implemented. 3. Email and virtual board announcement of change.	1. All process measures implemented by May 31, 2019 2. Ongoing monitoring of compliance by Quality Committee	
		Percentage of respondents who responded positively to the following question: 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?	P	% / Survey respondents	CIHI CPES / Most recent consecutive 12-month period	592*	79.3	82.9	Top 2 Box NRC Average as of Feb 2019			Engage with the PFAC to improve the information received prior to patient discharge.	Together with a PFAC patient discharge workgroup work with clinical teams to design and implement a discharge process change that support of the patient/family that focuses on self-advocacy.	1. Present PFAC recommendations to clinical teams. 2. Together with PFA, representatives from the clinical teams will co-develop and test a patient centered change improvement.	1. Plan developed by June 30, 2019 2. Change testing to begin by November 31, 2019 3. Improvement of monthly indicator by March 31, 2020	**Note:** Baseline top box score is 60% and this is what the QIP navigator captures. LACGH used and in-house survey last year. To improve comparison between years LACGH has chosen to report on the top 2 box as opposed to the top box scores for this CPES question.

Theme II: Service Excellence		Percentage of complaints received by a LTCH that were acknowledged to the individual who made a complaint within 10 business days.	P	% / LTC home residents	Local data collection / Most recent 12-month period	54783*	100%	100%	Maintain current performance		1. Align LACGH standard practices with their revised OHA recommended practices for managing patient feedback. 2. Improve 90th percentile of time acknowledged and agreed upon follow-up plan from 3 days to 2 day. Patient and Hospital agree on next steps/plan for concern resolution.	1. Modify all LACGH policies related to patient complaints, including CVC policies, to incorporate the 2018 OHA recommended practices. 2. Modify the LACGH balanced scorecard to include complaint acknowledgement timelines and target. 3. Educate staff on the revised patient feedback process.	1. Policy approved. 2. Revised balanced scorecard and feedback report implemented. 3. Email and virtual board announcement of change.	1. All process measures implemented by May 31, 2019 2. Ongoing monitoring of compliance by Quality Committee	
		Percentage of residents responding positively to: "Did you feel prepared to go home?"	C	% / LTC home residents	In house CVC survey	54783*	90%	100%			Increase communication between care team and resident regarding preparation for discharge early in the resident's stay.	Implement (pre-book) care conferences with resident and appropriate care team members within 2 weeks of resident admission.	Audit of care conferences completed within 2 week time frame.	Audit completed within three months of implementation.	
		Percentage of staff training requirements implemented pertaining to the Older Adult Strategy	C	Count of staff training requirements complete/total training staff requirements	Local Data Collections	592*	0%	100%	Senior Friendly QIP target/LSAA	Home and Community Care	Use the SfCare Self-Assessment Report Card to guide staff education.	1. Senior friendly educational session will be provided to the Quality Committee of the Board and the Patient & Family Advisory Council (PFAC) 2. All staff will be provided with training sessions on senior friendly care handouts, including at orientation. 3. An education series will be provided on each of the 7 care topics (delirium, continence, mobility, nutrition, pain, polypharmacy, social engagement) 4. A PFAC Senior Friendly Champion will be identified.	Re-assessment of sfCare Training Compliance.	Re-assessment complete by March 15, 2020	
Theme III: Safe and Effective Care	**Safe**	**Number of workplace violence incidents reported by hospital workers (as by defined by OHSA) within a 12 month period.**	**MANDATORY**	**Count / Worker**	**Local data collection / January - December 2018**	**592***	**9 (as of January)**	**9**	**Reduction of incidents from previous year.**	**G4S**	**1. Improve the effectiveness of the LACGH security program. 2. Improve the incident reporting system.**	**1. Conduct a Security Self Assessment using the Public Services Health & Safety Association's Violence, Aggression & Responsive Behavior (VARB) toolkit and develop an action plan based on the assessment findings. 2. Upgrade the current incident reporting software to a more user friendly platform and educate staff on use.**	**1. Safety Self-Assessment Action Plan complete. 2. Change implemented based on results from Self-Assessment. 3. Incident Management System upgrade completed. 4. Staff educated on how to use the upgrade incident management program.**	**1. Complete by June 30, 2019 2. Implemented by Nov 30, 2019. 3/4. Implemented and Staff educated by Jan 31, 2020**	
		Percentage of weekly weights of residents documented that exceed the expected weight variance.	C	% of outliers for resident weights/all LTC residents	Local Data Collection	54783*	CB	CB	Improve performance		Collect baseline measures of residents documented that exceed the normal weight variance. Implement a change that reduces the number of outliers.	1. Monthly review of the consistency of resident weekly weights to evaluate accuracy of measurement with case review of accuracy outliers. 2. Develop standard process, including documentation, of measuring resident's weight with and without supportive equipment. 3. Study the results of the change.	1. The consistency of resident weekly weights with case review of accuracy outliers will be reviewed by the CVC Clinical Team. 2. Change idea Implemented 3. The change improvement impact data will be reviewed by the Quality Committee.	1. Baseline audit completed by July 31, 2019. 2. One improvement idea developed and implemented by November 15, 2019. 3. Collection and study of the change data completed by Feb 28, 2020. Improvement is expected with the implemented change.	Improved accuracy of resident weight improves the accuracy of medication prescribing.
	Effective	Proportion of hospitalizations where patients with a progressive, life-threatening illness have their palliative care needs identified early through a comprehensive and holistic assessment.	P	Proportion / at-risk cohort	Local data collection / Most recent 6 month period	592*	X		Collect Baseline	Regional Palliative Care Network.	Collect baseline measures.	Coordinate a clinical working group to identify a population of patients and collect baseline measures early identification of palliative care needs.	1. Working Group in collaboration identify group of patients to collect baseline Measures on. 2. Electronic patient record modified to capture baseline measure. 3. Baseline Measures collected.	1. Completed by May 31, 2019 2. Completed by Aug 31, 2019 3. Begin collecting by Sept 1, 2019.	

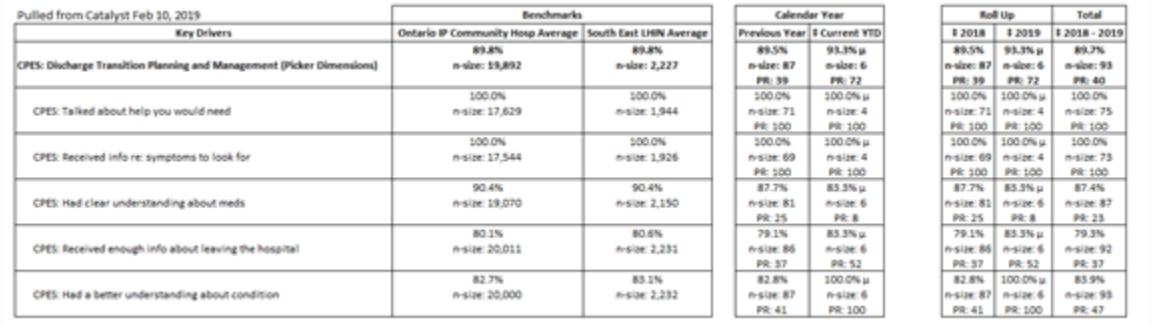
Excellent Care for All

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 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 2018/19	Org Id	Current Performance as stated on QIP2018/19	Target as stated on QIP 2018/19	Current Performance 2019	Comments
1	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; April - June 2017(Q1 FY 2017/18); CIHI CPES)	592	91.00	95.00	89.30	To increase the validity of measurement the NRC IP Survey was used instead of the in-house survey. A roll up of the top 2 box responses to all 5 Discharge Transition Planning and Management (Picker Dimensions) questions were used to compare to other SE LHIN hospitals and other community hospital averages. LACGH results are comparable to other community hospitals and Ontario community hospitals. The largest area for improvement is noted in providing enough info to patients/families about leaving the hospital.



Pulled from Catalyst Feb 10, 2019

Key Drivers	Benchmarks: Ontario IP Community Hosp Average	Benchmarks: South East LHIN Average	Calendar Year: Previous Year	Calendar Year: Current YTD	Roll Up: FY 2018	Roll Up: FY 2019	Total: FY 2018 - 2019
CPES: Discharge Transition Planning and Management (Picker Dimensions)	89.8% n-size: 19,892	89.8% n-size: 2,227	89.5% n-size: 87 PR: 39	93.3% µ n-size: 6 PR: 72	89.5% n-size: 87 PR: 39	93.3% µ n-size: 6 PR: 72	89.7% n-size: 93 PR: 40
CPES: Talked about help you would need	100.0% n-size: 17,629	100.0% n-size: 1,944	100.0% n-size: 71 PR: 100	100.0% µ n-size: 4 PR: 100	100.0% n-size: 71 PR: 100	100.0% µ n-size: 4 PR: 100	100.0% n-size: 75 PR: 100
CPES: Received info re: symptoms to look for	100.0% n-size: 17,544	100.0% n-size: 1,926	100.0% n-size: 69 PR: 100	100.0% µ n-size: 4 PR: 100	100.0% n-size: 69 PR: 100	100.0% µ n-size: 4 PR: 100	100.0% n-size: 73 PR: 100
CPES: Had clear understanding about meds	90.4% n-size: 19,070	90.4% n-size: 2,150	87.7% n-size: 81 PR: 25	83.3% µ n-size: 6 PR: 8	87.7% n-size: 81 PR: 25	83.3% µ n-size: 6 PR: 8	87.4% n-size: 87 PR: 23
CPES: Received enough info about leaving the hospital	80.1% n-size: 20,011	80.6% n-size: 2,231	79.1% n-size: 86 PR: 37	83.3% µ n-size: 6 PR: 52	79.1% n-size: 86 PR: 37	83.3% µ n-size: 6 PR: 52	79.3% n-size: 92 PR: 37
CPES: Had a better understanding about condition	82.7% n-size: 20,000	83.1% n-size: 2,232	82.8% n-size: 87 PR: 41	100.0% µ n-size: 6 PR: 100	82.8% n-size: 87 PR: 41	100.0% µ n-size: 6 PR: 100	83.9% n-size: 93 PR: 47

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 2018/19)	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 whether patients have any additional questions and ensure they have the appropriate resources after discharge.	Yes	Patients were contacted by a nurse via phone post discharge to determine if they had any additional questions and the appropriate resources after discharge. The responses were mostly positive. When a question or resource gap was identified the nurse on the phone was able to quickly remedy the issue. Weekly summaries of telephone discharge responses are reviewed by the senior leadership team, Quality Committee, and PFAC.
Improve information sharing at discharge.	Yes	

ID	Measure/Indicator from 2018/19	Org Id	Current Performance as stated on QIP2018/19	Target as stated on QIP 2018/19	Current Performance 2019	Comments
2	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 ; October – December (Q3) 2017; Hospital collected data)	592	98.78	100.00	99.09	Compliance continues to exceed the provincial average.

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Change Ideas from Last Years QIP (QIP 2018/19)	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?
Monitor compliance monthly and address gaps with all missed opportunities on an individual physician bases.	Yes	Compliance was monitored and continues to be perfect or near perfect monthly. All missed opportunities were addressed on an individual physician basis. Critical to the success was the involvement by the pharmacy team and the Chief of Staff.

ID	Measure/Indicator from 2018/19	Org Id	Current Performance as stated on QIP2018/19	Target as stated on QIP 2018/19	Current Performance 2019	Comments
3	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; October 2016 - September 2017; CIHI CCRS, CIHI NACRS)	54783	5.43	5.00	X	Data has been suppressed due to low volume.

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Change Ideas from Last Years QIP (QIP 2018/19)	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?
Ambulatory care sensitive conditions will be addressed early by the Nurse Practitioner and LTC physician. Any situations where failure to rescue results in an ED visit will be reviewed by the team.	Yes	All case reviews have indicated that the ED visits were appropriate.

ID	Measure/Indicator from 2018/19	Org Id	Current Performance as stated on QIP2018/19	Target as stated on QIP 2018/19	Current Performance 2019	Comments
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)	592	CB	CB	9.00	The Public Services Health & Safety Association's Violence, Aggression & Responsive Behavior (VARB) Workplace Violence Risk Assessment tool was valuable in systematically identifying risks to staff.

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Change Ideas from Last Years QIP (QIP 2018/19)	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?
Use the Violence Aggressions & Responsive Behavior (VARB) tools to reduce workplace violence incidents and impact of aggressions, violence and responsive behaviors.	Yes	There were no high risks identified. A total of three medium risks were identified and addressed, including: 1.Patient Risk Assessment and Communication 2.Staff Working Alone: This Risk pertains specifically to Environmental Services who have been provided a personal safety response device. Security is aware of the hours that these individuals are off-site and are available if required. Staff have also been asked to use the buddy system when leaving and if there are concerns. 3.Concerns with blind corners in basement corridor: Security has a scheduled walk through during their shift and improvements have been made to the brightness of the corridor. Mirrors have been installed at all corners. Security cameras are also installed throughout the lower level.
Improve communication regarding potentially violent patients.	Yes	We introduced behaviour alert patient flagging within Acute Care, which is considered our highest risk area. A patient flagging

(pictograph) is to be applied on the door frame of a patient's room in the event that they have potential/actual behaviors that put the staff/visitors at risk. For those in a wardroom, the small circular sign is to be applied to the white board at the bedside to assist in easily identifying which patients may be a risk. Flags have also built an area within our electronic Medical Record allowing for identification of identifies high-risk patients for both the clerical and nursing staff. The electronic flag also allows audits to be conducted that evaluate flagging effectiveness.

ID	Measure/Indicator from 2018/19	Org Id	Current Performance as stated on QIP2018/19	Target as stated on QIP 2018/19	Current Performance 2019	Comments
5	Percentage of patients identified with multiple conditions and complex needs (Health Link criteria) who are offered access to Health Links approach (%; All inpatients; Most recent 3 month period; Hospital collected data)	592	CB	90.00	60.00	The volume of patients who meet the Health Links criteria is higher than the resources/services that are available to the patient in the community.

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Change Ideas from Last Years QIP (QIP 2018/19)	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 identify weekly the inpatients with multiple conditions and complex needs that meet Health Links criteria. Ensure there is a process in place to offer them access to Health Links prior to discharge.	Yes	An electronic report was developed to identify inpatients with multiple conditions and complex needs that meet Health Links criteria. The Patient Flow Coordinator used this report in consultation with the clinical care team to offer patient's access to Health Links prior to discharge.

ID	Measure/Indicator from 2018/19	Org Id	Current Performance as stated on QIP2018/19	Target as stated on QIP 2018/19	Current Performance 2019	Comments
6	Percentage of residents who fell during the 30 days preceding their resident assessment (%; LTC home residents; Oct - Dec 2017; Hospital collected data)	54783	6.56	6.50	9.36	No falls in CVC resulted in moderate, severe, or critical harm to the resident.

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 2018/19)	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?
Our resident population is rehab and, therefore encouraging mobility is a key focus, which increases our resident risk of falls. All resident falls will be reviewed by the multidisciplinary team.	Yes	A multi-disciplinary team reviewed each of the falls that occurred in CVC in 2018-19 as a group and then at the CVC clinical team. Contributing factors to the higher fall rate included: the low number of residents (22 at max. capacity), the average LOS (~45 days), residents who fall are more likely to fall again, and the nature of the rehab program the number of falls.
Assess the washroom environment to determine any improvement opportunities.	Yes	Improvements were made to three bathroom doors that were heavier than the other resident doors. The heavier door was a contributing factor in one resident fall.

ID	Measure/Indicator from 2018/19	Org Id	Current Performance as stated on QIP2018/19	Target as stated on QIP 2018/19	Current Performance 2019	Comments
7	Risk-adjusted 30-day all-cause readmission rate for patients with COPD (QBP cohort) (Rate; COPD QBP Cohort; January - December 2016; CIHI DAD)	592	19.03	17.12	3.20	This program is exceeding outcome expectations and will be spread to CHF.

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Assist patients to manage COPD at home which will decrease ER visits and hospital admissions related to COPD.	Yes	One of the lessons learned following the launch of the program was that some of our patients were unable to accommodate frequent travel to hospital for BREATHE clinic follow-up visits. Even some patients that were not geographically isolated were found to have limited access to our services simply based on the mobility challenges associated with shortness of breath. In January 2018, the barrier of access and transition home with COPD was overcome with the implementation of virtual health technology including the provision of tablets to discharged patients. Thirty-five patients have been enrolled since the inception of the BREATHE program. We have prevented 24 re-admissions to hospital by helping the patient manage their symptoms at home. Patients enrolled in the virtual program have saved the time and cost associated with more than 6,000 km in travel to attend the hospital, clinic or ER. Typically, patients stay connected through the virtual program for about three months and once they are well established in the management of their COPD, they rely less on the program and more on their own newly developed self-management skills. They have ongoing access to the BREATHE clinic and the BREATHE Help Line. BREATHE patients are also regularly participating in respiratory rehabilitation or an exercise program in their community. Patient and family feedback has been positive and has encouraged LACGH to

continue with all aspects of the BREATHE program. The COPD readmission rate has dropped from 17% to 3%.

ID	Measure/Indicator from 2018/19	Org Id	Current Performance as stated on QIP2018/19	Target as stated on QIP 2018/19	Current Performance 2019	Comments
8	The percent of residents with an EMS score of 10 at discharge. (%; LTC home residents; 2017 data collection tool; Hospital collected data)	54783	76.00	80.00	77.00	The CVC unit will use root cause analysis to identify improvement opportunities for 2019-20.

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On admission every resident is assessed to identify their EMS score.	Yes	Improvement was made in current performance; however, the variability of the indicator (50%-100%) indicates that the root cause has not yet been determined.

ID	Measure/Indicator from 2018/19	Org Id	Current Performance as stated on QIP2018/19	Target as stated on QIP 2018/19	Current Performance 2019	Comments
9	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 - September 2017; WTIS, CCO, BCS, MOHLTC)	592	28.80	39.00	41.39	

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To continue to coordinate discharge planning process with both LHIN HACC and Health Links.	Yes	Discharge planning continues to be coordinated well with community partners due to a dedicated patient flow resource who attends daily rounds.
Prevent further deconditioning of residents by improving nutrition.	Yes	All inpatients are screened for malnutrition. If at risk, a RD will meet with the patient and develop an individualized action plan.