Lennox and Addington County General Hospital (LACGH) Long-Term Care (LTC) Continuous Quality Improvement (CQI) Initiative

2022-23 Interim Report

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The Lennox and Addington County General Hospital is committed to providing the highest quality of care possible for the communities we serve. Our LTC Home's overarching mission is to provide every resident with quality care. Our goal is to embed our core values "Integrity, Respect, Excellence, Patient Centeredness, Innovation, and Collaboration" into all the services we provide. Our Home's vision is that it will continue to be a respected leader in the community by providing compassionate, comforting and individualized long-term care in a homelike environment.

CQI Priorities

Our Corporate (Hospital and LTC) Quality Improvement Plan (QIP) is driven by our corporate mission "to be a progressive rural health system, dedicated to improving the health of our patients and our communities". Our 2022/2023 QIP sets out key strategies to enhance our quality of care, improve safety, increase satisfaction and achieve better clinical outcomes for patients and residents.

This year, we have created a custom QIP which is aligned with our strategic plan priorities of Patients, People, Population and Value; and, the quadruple aim, our 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 people's satisfaction and outcomes. Furthermore, our QIP highlights how we are prioritizing the safety of patients, residents, and staff as well addressing health system issues, around our CQI priority domains of: safety, timeliness, equity, efficiency, effectiveness, and patient/resident centerdness.

CQI Initiative and Objective

The LTC CQI initiative is built into the corporate QIP and is within the quality domain of resident safety. The objective of the LTC CQI initiative is to reduce the percentage of long-term care home residents, not living with psychosis, who were given antipsychotic medications by 50%; thereby going from 22% at baseline to 11% at the end of the fiscal year. The change ideas and methods tied to meeting the objective include:

Change ideas	Methods
1. Developing a data collection plan 2. Reviewing all medications of residents for effectiveness 3. Increasing Staff/ Resident/ Caregiver knowledge in regards to psychotropic medications 4. Incorporating palliative care concepts in work.	1. Engaging the Senior Friendly working group regarding the behavioral management related to the use of anti-psychotic medication in older adults and patients with dementia. 2. Engaging Medisystems/Pharmacy Team to review and analyze anti-psychotic medication use; and, review long-standing prescriptions of anti-psychotics of 2 months or greater for indication, effectiveness and safety. 3. Implement a deprescribing pathway 4. Provide educational opportunities and add education to Moodle to increase Staff/Resident/Family knowledge in regards to anti-psychotic medications. 5. Develop Delirium Order Set

CQI Planning Cycle and Priority Setting Process

LACGH has developed corporate QIPs, and CQI indicators, as part of the annual planning cycle since 2015, with QIPs submitted to Health Quality Ontario (HQO), now Ontario Health (Quality), annually in line with provincial deadlines. Our QIP planning cycle typically begins in September, and includes an evaluation of the following factors to identify preliminary priorities:

- progress achieved in recent years;
- ongoing analysis of performance data over time available from the Canadian Institute for Health Information (CIHI); with areas indicating a decline in performance over time and/or where benchmarking against self-identified peer organizations suggests improvement required
- resident, caregiver and staff experience survey results;
- emergent issues identified internally (trends in critical incidents or patient relations) and/or externally (e.g. OHTs and pandemic recovery);
- input from residents, families, caregivers, staff, leaders and external partners, including the MOLTC.
- mandated provincial improvement priorities (e.g. HQO)

Preliminary priorities are subsequently presented and discussed at various forums to validate priorities and identify additional priorities that may have been missed. These forums include the broader leadership team, clinical teams, the Patient and Family Advisory Council, and the Quality Committee of the Board of Directors. This is an iterative process with multiple touchpoints of engagement with different stakeholder groups as QIP targets and high-level change ideas are identified and confirmed. Final review of the QIP is completed by the QC in February, which endorses the plan for approval by the Board of Directors in March.

APPROACH TO CQI (POLICIES, PROCEDURES, AND PROTOCOLS)

LACGH's clinical and administrative policies, combined with practice standards, provide a baseline for staff in providing quality care and service. Our approach to CQI utilizes the Model for Improvement to guide QI activity. Interprofessional quality improvement teams, including resident and family advisors, work through the phases of the model to:

1. Diagnose/Analyze the Problem
    a. Teams use various QI methodologies to understand some of the root causes of the problem and identify opportunities for improvement. This work can include process mapping or value stream mapping, Gemba, 5 whys, fishbone, etc. Also included in this work, is an analysis of relevant data and completion of a gap analysis against relevant Best Practice Guidelines and benchmarks.
2. Set Improvement Aims
    a. Once teams have a better understanding of the current system they aim to improve as well as an understanding of what is important to the resident, an overall improvement aim is identified. This aim will be used to evaluate the impact of the change ideas through implementation and sustainability.
    b. Improvement teams develop aim statements that are Specific, Measurable, Attainable, Relevant, Time-Bound (SMART). A good aim statement includes the following parameters - "How much" (amount of improvement – e.g. 30%), "by when" (a month and year), "as measured by" (a big dot indicator or a general description of the indicator) and/or "target population" (e.g. all LTC residents, residents in specific area, etc.)
3. Develop and Test Change Ideas
    a. With a better understanding of the current system, improvement teams identify various change ideas that drive progress toward the aim statement. During this phase, teams will prioritize alignment with best/prevailing practices when designing preliminary change ideas for testing. Additionally, teams leverage the Hierarchy for Effectiveness when selecting change ideas, with teams favouring system redesign, process standardization, and force function over education and policy change.
    b. Plan-Do-Study-Act (PDSA) cycles are used to test change ideas through small tests of change. PDSAs provide an opportunity for teams to iteratively refine their change ideas and build confidence in the solution prior to implementation. Change ideas typically undergo several PDSA cycles before implementation.
4. Implement, Spread and Sustain
    a. Improvement teams consider the following factors when developing a strong implementation/change management plan:
        i. Outstanding work to be completed prior to implementation (e.g. final revisions to change ideas based on PDSAs, embedding changes into existing workflow, updating relevant P&P, etc.)

   ii. Education required to support implementation, including key staff resources (e.g. Change Champions)
   iii. Communication required to various stakeholders, both before during and after implementation
   iv. Approach for spread across the facility, if completed in a phased approach

b. At this stage, teams will also identify key project measures to determine if the changes implemented resulted in improvement. This family of measures includes the following types of measures:
   i. Outcome: Measures what the team is trying to achieve (the aim)
   ii. Process: Measures key activities, tasks, processes implemented to achieve aim
   iii. Balancing: Measures other parts of the system that could be unintentionally impacted by changes

c. Prior to implementation, improvement teams develop a sustainability plan. The plan identifies the different strategies the team will use to evaluate and address both short term and long-term sustainability of the changes implemented.

Process to Monitor and Measure CQI Progress, Identify and implement Adjustments, and Communicate Outcomes

A key component of the sustainability plan is the collection and monitoring of the key project measures over time. QIP outcome data is presented and reviewed by clinical teams and the Quality committee of the Board on a monthly basis. Analysis of the outcome measures is used to identify if the Home is achieving the desired outcomes or not. If not achieving desired outcomes, the process measures over time are reviewed to either confirm compliance with key change ideas (suggesting the change idea may not be as effective at improvement outcomes) or identify gaps in compliance that need to be addressed. Based on the results of this analysis, alternative change ideas may be considered, coaching to staff may be provided to enhance compliance, or engagement with staff may occur to better understand gaps in compliance, etc.

Communication strategies are tailored to the specific improvement initiative. These include, but are not limited to:

- Posting on unit quality boards, in common areas and in staff lounges
- Publishing stories and results on the electronic communication boards or via the newsletter
- Direct email to staff and caregivers and other stakeholders
- Handouts and one-on-one communication with residents/caregivers
- Presentations at staff meetings, clinical team meetings, Patient and Family Advisory Council, etc.
- Huddles at change of shift
- Use of Champions to communicate directly with peers
- Two way discussion at virtual screen-side chat events between leadership and staff