2017/18 Quality Improvement Plan
"Improvement Targets and Initiatives"

Riverside Health Care Facilities Inc. 110 Victoria Avenue

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**	Risk-adjusted 30-day all-cause readmission rate for patients with CHF (QBP cohort)	Rate / CHF QBP Cohort	CIHI DAD / January 2015 - December 2015	900*	26.13	24.84	Target is a 5% reduction.	1)Medication Reconciliation performed within 24 hours of admission and on discharge.	Ongoing assessment, process improvement strategies related to improving the Medication Reconciliation performance.	Monthly Medication Reconciliation on Audits to measure compliance. Assess Med Rec Compliance during the scheduled audits.	Audit results equal 100% on admission and 75% on discharge.	
									2)Ensure CHF patients being discherged have a booked follow up appointment with their family physician before discharge.	Chart audits completed on Discharge Instruction Sheet to verify that appointment was booked.	% of CHF patients with booked appointments before discharge.	75%	
									3)Ensure utilization of standardized CHF order sets to ensure appropriate care and treatment.	Education Identifying physician champions Chart Audits	% of CHF patients where the CHF order sets were used.	80%	
									4)Offer clients being discharged with CHF referred to CCAC for the North West Telehomecare program and/or Rapid Response Nurse.	Staff education and completion of chart audits to identify if this option was provided to patient's with CHF.	% of CHF patients discharged with referral to CCAC for Telehomecare program and/or Rapid Response Nurse.	75%	
		Did you receive enough information from hospital staff on what to do if you become worried about your condition or treatment after being discharged from hospital?	% / All acute patients	In-house survey / April 2017 - Dec 2017	900*	CB	CB	Since this indicator has not been measured previously we are collecting baseline data.	1)Update in hospital Inpatient Discharge Telephone Follow-up Survey to include "Did you receive enough information from hospital staff on discharge about to do if you were worried about your condition or treatment after you left the hospital?"	Update Inpatient Discharge Telephone Follow-up Survey to include "Did you receive enough information from hospital staff on discharge about what to do if you were worried about your condition or treatment after you left the hospital?" by April 1, 2017.	Percent of patients contacted out of total discharges for the month.	Refer to process measures.	
									2)Reinforce communication technique "Teach Back" with staff.	Staff meetings, Clinical Newsletter, Nursing Orientation and one on one teaching.	Chart audits will be performed.	75% of audits indicate that "Teach Back" was usad.	
									3)Transition of information for admission to Long Term Care and Convalescence Care.	Implement a checklist. Information is to be sent 24 hours prior to transfer to receiving facility. Educate the staff to the checklist and process of sending information.	Chart audits will be performed.	Audits results will show that 90% of the time information was received by the receiving facility 24 hours prior to transfer.	
	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	54116*	24.14	23.60	Provincial average is used as our target.	1)Continue to monitor this indicator as changes were made on how we access medication from our medication carts on Elderap Residents.	Review CIHI reports on a quarterly basis and identify areas for improvement.	Quarterly review of the % of ED visits by Residents.	Decrease in ED visits by Residents.	Practice in accessing medication from the new medication carts (Acette Cane) for Eldcap residents previously was that they had to be registered as an Emergency Department (ED) patient. However, after reviewing this practice it was found that it was not satisfactory as it was inflating our ER visits as well as increasing visits for Eldcap patients to the ED which was inaccurate as the residents did not attend the ED. Since October 2016 this practice has been changed to reflect the activity correctly and therefore we believe we will see a significant drop in the ED visits for the Eldcap residents.
Efficient	**Staff experience**	Percent of performance conversations completed in 2017 (based on hcal count at January 1, 2017).	% / All active staff in organization	In house data collection / 2017	900*	63	72.00	15% increase (rounded down) in order to ensure that there is a balance achieved between stretch targets and ensuring that the target is reasonably achievable. The 2017 results are already 25% completed and there has been a year to date decline over the previous year. In addition, we continue to be short staffed in key management roles on the long term care front.	1)Performance conversations improved to 63% in the 2016 calendar year. A 15% increase in compliance has been incorporated for 2017 with the objective of, at a minimum, achieving a 72% compliance rate.	1. Annual recognition of strong performers – percent of reviews complete above target of 72%. 2. Annual recognition of strong performers – top 5 in terms of total number of reviews complete. 3. Monthly follow up by senior leadership for those performing below 2017 target of 72%. 4. Email communication from Human Resources to both senior leader and manager where 2016 compliance was below 80%. 5. CEO to initiate communication to senior leader effective September 2017 where performance below target of 72%.	72% remains a constant target for 2017. Please refer to Methods for other Process Measures.	72% of 2017 performance conversation will be completed between January 1, 2017 and December 31, 2017.	
Patient-centred	**Person experience**	"Overall how would you rate the care and services you received at the Emergency Department? add the number of respondents who answered "Excellent" divided by the number of respondents who registered any response to this question.	% / ED patients	In-house survey / April 2017 - December 2017	900*	CB	CB	Since the change to the survey, results are only reflected in the third quarter of 2016/17 FY. It was decided that we need to collect more information in order to have an adequate benchmark/baseline.	1)Review results and look for opportunities to continue to improve the services.	Distribute a total of 50 surveys a month. Improve turn around on results to monthly and submit report to Nursing Leadership. Report results to Senior Leadership, Patient & Family Advisory Council and staff on a Quarterly basis.	Monthly and Quarterly Reports.	Nursing Leadership will receive a monthly report on survey results. Quarterly reports will be distributed as required.	
		"Overall how would you rate the care and services you received at the hospital? add the number of respondents who answered "Excellent" divided by the number of respondents who registered any response to this question.	% / All acute patients	In-house survey / April 2017 - December 2017	900*	CB	CB	Since we made the change to the survey, results are only reflected in the third quarter of 2016/17 FY. It was decided that we need to collect more information in order to have an adequate benchmark/baseline.	1)Review results and look for opportunities to continue to improve the services.	Distribute a total of 50 surveys a month. Improve turn around on results to monthly and submit to Nursing Leadership. Report results to Senior Leadership, Patient & Family Advisory Council and staff on a Quarterly basis.	Monthly and Quarterly Reports	Nursing Leadership will receive monthly report on survey results. Quarterly reports will be distributed as required.	
	Resident experience: "Overall satisfaction"	How would you rate how well the staff listen to you? (This includes all three LTC Homes 52152, 54116, 54296)	% / LTC home residents	In-house survey / Last 12 month period.	900*	95	95.00	Strive to achieve theoretical best, but will expect to maintain current rate.	1)Improve the distribution and response of the Resident Satisfaction Surveys at institution 52152.	A set period of time will be selected in which survey is distributed. Dedicate resources to assist those residents who require assistance in completing survey. For residents who are unable to complete survey, the survey will be mailed to the SDM with a self addressed and stamped envelope.	The percentage of completed surveys returned.	50% completed and returned surveys.	
									2)Improve the overall understanding of the survey questions and how the results assist in identify opportunities for improvement.	Present the Satisfaction Survey at staff meetings. Share results with Resident Council, Family Council and staff. Involve staff in improvement measures.	Number of meetings and information shared.	Number of time reviewed at meetings out of meetings held.	
		I can express my opinion without fear?	% / LTC home residents	In-house survey / Most recent 12 month period	900*	86	90.30	Strieving for a 5% increase in positive responses.	1)Improve the distribution and response of the Resident Satisfaction Surveys at institution 52152.	A set period of time will be selected in which survey is distributed. Dedicate resources to assist those residents who require assistance in completing survey. For residents who are unable to complete survey, the survey will be mailed to the SDM with a self addressed and stamped envelope.	The percentage of completed surveys returned.	50% completed and returned surveys.	
									2)Improve the overall understanding of the survey questions and how the results assist in identify opportunities for improvement.	Present the Satisfaction Survey at staff meetings. Share results with Resident Council, Family Council and staff. Involve staff in improvement measures.	Number of meetings and information shared.	Number of time reviewed at meetings out of meetings held.	
		I would recommend the Home to others?	% / LTC home residents	In-house survey / Most current 12 month period	900*	93	93.00	Strive to achieve theoretical best but will expect to maintain current rate.	1)Improve the distribution and response of the Resident Satisfaction Surveys at institution 52152.	A set period of time will be selected in which survey is distributed. Dedicate resources to assist those residents who require assistance in completing survey. For residents who are unable to complete survey, the survey will be mailed to the SDM with a self addressed and stamped envelope.	The percentage of completed surveys returned.	50% completed and returned surveys .	
									2)Improve the overall understanding of the survey questions and how the results assist in identify opportunities for improvement.	Present the Satisfaction Survey at staff meetings. Share results with Resident Council, Family Council and staff. Involve staff in improvement measures.	Number of meetings and information shared.	Number of time reviewed at meetings out of meetings held.	
Safe	**Medication safety**	Percentage of residents who were given antipsychotic medication without psychosis in the 7 days preceding their resident assessment	% / LTC home residents	CIHI CCRS / July - September 2016	52152*	20.63	19.00	To try to achieve Benchmark HQO 2016	1)Continue to monitor this indicator and identify areas for improvement.	Review residents who have been identified as receiving antipsychotic medications without a psychosis in the 7 days preceding their resident assessment.	Percentage of residents who were reviewed	100% within the 7 days preceding the resident assessment.	
									2)Develop and implement a Delirium Screening Tool	Research and develop a Delirium Screening Tool and implement. Educate the staff on the use of the tool.	Chart audits	% of residents receiving antipsychotic medications where the screening tool was used.	
									3)Educate the staff on the appropriate use of antipsychotics.	Education sessions for staff on the appropriate use of antipsychotics. Educate staff on appropriate interventions for responsive behaviors as an alternative to medication.	Percentage of staff attending educational sessions.	100% of staff will attend at least one education sessions.	
		Percentage of residents who were given antipsychotic medication without psychosis in the 7 days preceding their resident assessment	% / LTC home residents	CIHI CCRS / July - September 2016	54116*	36.67	21.20	Provincial Average is being used.	1)Continue to monitor this indicator and identify areas for improvement.	Review residents who have been identified as receiving antipsychotic medications without a psychosis in the 7 days preceding their resident assessment.	Percentage of residents who were reviewed.	100% within the 7 days preceding the resident assessment.	This facility only has 21 Eldcap beds so 1-2 residents receiving antipsychotic medication without psychosis could impact the overall percentage.
									2)Develop and implement a Delirium Screening Tool	Research and develop a Delirium Screening Tool and implement. Educate the staff on the use of the tool	Chart Audits	% or residents where the screening tool was used and antipsychotics were initiated.	
									3)Educate the staff on the appropriate use of antipsychotics.	Education sessions for staff on the appropriate use of antipsychotics. Educate staff on appropriate interventions for responsive behaviors as an alternative to medication.	Percentage of staff who attend education sessions.	100% of staff will attend at least one session.	
		Percentage of residents who were given antipsychotic medication without psychosis in the 7 days preceding their resident assessment	% / LTC home residents	CIHI CCRS / July - September 2016	54296*	21.05	19.00	To continue to strive for improvement we have decided to us the HQO 2016 Benchmark	1)Continue to monitor this indicator and identify areas for improvement.	Review residents who have been identified as receiving antipsychotic medications without a psychosis in the 7 days preceding their resident assessment.	Percentage of residents who were reviewed.	100% within the 7 days preceding the resident assessment	This facility only has 12 Eldcap beds so 1-2 residents receiving antipsychotic medication without psychosis could impact over all percentage.
									2)Develop and implement a Delirium Screening Tool	Research and develop a Delirium Screening Tool and implement. Educate the staff on the use of the tool	Chart Audits	% of residents where the screening tool was used and antipsychotics were initiated.	
									3)Educate the staff on the appropriate use of antipsychotics	Education sessions for staff on the appropriate use of antipsychotics Educate staff on appropriate intervention for responsive behaviours as an alternative to medication.	Percentage of staff who attend education sessions.	100% of staff will attend at least one education session	
	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 / Most recent 3 month period	900*	97.16	100.00	Strive to achieve theoretical best but will expect to maintain current rate.	1)Continue to monitor and strive for 100% compliance.	Ongoing education, audits and reporting.	Monthly Audit results Quarterly reports distributed.	Monthly audits are performed 100% of the time. Quarterly reports have been distributed 100% of the time.	
		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 / Most recent quarter available	900*	99.36	100.00	Strive to achieve theoretical best but will expect to maintain current rate.	1)Continue to monitor and reinforce the importance of Medication Reconciliation at the time discharge.	Perform Chart Audits, Sharing Audit results.	Audit Results Quarterly Reports	Audit results show that 70% of the time Medication Reconciliation is done within 24 hours of admission.	
Timely	**Timely access to times/services**	Response time by on call surgical team from time notified to incision time for Emergency C-sections.	% / Emergency C-sections	Chart Audits / April - December 2017	900*	CB	85.00	Based on SOGC/moreOB guidelines 30 minutes	1)To ensure that the response times are according to the SOGC/moreOB Guidelines are being met.	Audit all Emergency C-Section Charts.	Percent of cases where the response times are being met according to guidelines.	85% of charts audited indicate that guidelines are met.	