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	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)	54389	23.27	18.65	24.39	There was a significant decrease in Avoidable ED transfer by 60% since Q1 of 2018. Q1 = 22; Q2 = 15; Q3 = 9. We have implemented better front line communication regarding potential ED transfer cases by having an outstanding agenda item every weekly floor meeting. We have also provided education in chest assessment conducted by our Nurse Practitioner and also COPD project initiated by Medi-system Pharmacy. Not sure about the auto populated data above. It seems like a cumulative ED visit data from 2017 Q3 to 2018 Q2. However, we monitor Avoidable ED visits. HQO should confirm if they are monitoring ED visit rate or Avoidable ED visit rate? Below data is from MoHLTC for 2018 Q2. Facility Name: YH Markham "ED Visits Rate: 60 # long-term care home residents*: 246 ED Visits Rate (per 100): 24.4 Percent of LTCH residents with an avoidable visit: 17.9

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?**
Strengthening staff knowledge in urgent care and assessment	Yes	In services to staff provided by NP, Pharmacist and Management # of staff educated: Chest assessment: 17 COPD: 21 Fall :15
Developing a system and streamlining of referral to MD and NP before ED transfer	Yes	Regular meeting of front line staff, NP and Nursing Managers about transfer cases and especial cases # of meetings held: 3
Improving diagnostic services for residents to prevent ED transfer	No	Unable to track
Strengthen the Palliative Care and end of life Program	Yes	Provide education for staff and clients regarding the program Staff education: Palliative: 6 Hospice Education: 14 Symptom mgmt.: 28

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2	Percentage of residents responding positively to: "What number would you use to rate how well the staff listen to you?" (%; LTC home residents; April 2017-March 2018; In house data, NHCAHPS survey)	54389	66.70	75.00	33.33	Markham location received 50 written compliments from families in 2018 and 8 written complaints. MKH has also been discussing some real scenarios (family complaints) during floor meetings to get front line staff's views and suggestions. We are going to monitor this indicator more closely in 2019-20 with action items focusing customer service

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Enhance Client/ Family involvement with their cares	Yes	Regular presentation of cares to the client and their families through meetings and conferences 50 positive written compliments were received
Supporting staff in developing and improving listening skills from our residents	Yes	Education will be provided to staff about effective listening and communication 32 staff attended the education

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3	Percentage of residents who were given antipsychotic medication without psychosis in the 7 days preceding their resident assessment (%; LTC home residents; July - September 2017; CIHI CCRS)	54389	19.38	15.50	19.60	Yee Hong Markham has provided 8 in-services regarding behavior management in 2018 and also trained 2 GPA trainers and 30 PSWs. Yee Hong Markham has successfully reduced our usage of anti psychotic by 37.5% from 40 case to 25 within 9 months. We have also strengthened our system on resident behavior monitoring and medication review by doing monthly interdisciplinary meeting.

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Identification of residents with prescribed antipsychotics without diagnosis of psychosis	Yes	Initial meeting of the interdisciplinary team to identify residents Goal achieved & improvements made by December 2018 (39-26 clients)
Analyze behaviors and triggers of residents with antipsychotic medication without diagnosis of psychosis	Yes	Regular meeting of the team to evaluate progress of intervention Achieved target of monthly meeting to evaluate progress 9 meetings in 9 months
Interdisciplinary team involvement in supporting the indicated type of residents	Yes	Interdisciplinary team involvement in supporting the indicated type of residents 129 staff attended the 8 behavior related in-services.
Enhancing family involvement in providing alternatives to antipsychotic medication	Yes	Providing education to family on inappropriate use of anti psychotic medication 16 family members were educated

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4	Reduce falls (Rate per 100 residents; Adult long stay home care clients; July - September 2017; CIHI CCRS)	54389	9.80	8.90	7.40	Yee Hong Markham has decreased the level of 3 and 4 incidents by 12.5% from 2017 to 2018. However, the fall incidents continue to fluctuate quarter to quarter. Markham will include “Reduce Fall Incidents” in the 2018/ 2019 Division QIP.

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Reinforcing of the 4Ps to increase monitoring ofvResidents	Yes	Education and audits of the 4Ps checking Audits completed: 25 audits
Strengthening of the core team members of the Fall Management Team	Yes	Regular weekly post-fall meeting and quarterly discussion of cases Weekly post fall meetings: 100% Achieved
Increase and timely involvement of the frontline staff at every incident	Yes	Immediate post-fall huddle right after the fall Post fall huddle at shift change: 100% Achieved

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5	Reduce the use of restraints (Rate per 100 residents; Adult long stay home care clients; July - September 2017; CIHI CCRS)	54389	3.20	3.00	4.30	Yee Hong Markham has implemented a monthly meeting regarding restraint with the interdisciplinary team. Since then, Markham has reduced the use of restraint from Q1=17 to Q3=6 by 65%.

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Increase staff knowledge about restraint	Yes	Education will be provided to staff about the least restraint procedure. 100% of staff was trained to Least Restraint Policy
Developing of a core team who will review restraint in a more detailed way	Yes	Inter-collaboration with the Falls Management Team Monthly meeting to review restraint (12 completed)
Provision of restraint alternatives such as activities or positioning aid		Strengthening of staff and team knowledge about restraint alternative Involvement of BSRT in reviewing cases and providing recommendation 1.Padded thigh belt 2.Seat belt alarm 3.Lap trays 4.Automatic wheel chair braking system