2019/20 Quality Improvement Plan

"Improvement Targets and Initiatives"

Bruyère Continuing Care Inc. 43 Bruyère Street

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**
Theme I: Timely and Efficient Transitions	**Efficient**	Percentage of patients who have had a 7-day post hospital discharge follow up for selected conditions (CHCs, AHACs,NPLCs).	Priority	% / Discharged patients	See Tech Specs / Last consecutive 12-month period.	91397* Family Health Teams (Bruyère and Primrose)	Collecting Baseline Data	Collecting Baseline Data	Not clear what % of all hospital discharges required follow-up. Focus of initiatives will be on identifying highest risk patients for follow-up.		1)Continue promoting use of the post-hospitalization follow up tool in the EMR (Primarily for the Nursing team). Add to the discharge summary encounter assistant a re-admission risk screening tool.	Add the "post discharge assessment tool" as an easy "one click" button in the EMR.	1. # patients high risk discharged had appropriate follow-up for the conditions identified/#patients discharged. 2. # high risk discharged patients with completed post discharge assessment	1. 80% of those high risk should have appropriate follow-up within 7 days (follow up could be just the chart review, a phone call or face to face) 2. 80% of high risk patients should have had a post discharge assessment	More data required as it is not clear that all patients discharged require follow-up. Our goal is to have appropriate follow up for patients who are "high risk" either due to medical comorbidities or SES risk factors

Theme I: Timely and Efficient Transitions		Percentage of those hospital discharges (any condition) where timely (within 48 hours) notification was received, for which follow-up was done (by any mode, any clinician) within 7 days of discharge.	Priority	% / Discharged patients	EMR/Chart Review / Last consecutive 12-month period.	91397* Family Health Teams (Bruyère and Primrose)	29	80.00	Our goal is that 80% of all discharge summaries are reviewed to assess if follow is required. Follow up could be by phone or in person with the appropriate team member.		1)We will formalize the process we use for post-discharge assessment. Our change idea will involve working with our RNs, MDs, and pharmacist to gather input on how to improve the tool and improve the process.	Add the "post discharge assessment tool" as an easy "one click" button in the EMR. Meet with our RN/MD/pharmacist to identify opportunities and gaps in our current process. Use our quality committee to formalize a process for post-discharge assessments.	# of discharge summaries that are assessed / total # of discharge summaries.	80% of all discharge summaries will have been assessed (either using the formal discharge assessment stamp or a review of the discharge summary by the MD/MRP).	Our goal is to have appropriate follow up for those patients deemed to be "high risk" either by their comorbidities or socioeconomic factors.

Theme I: Timely and Efficient Transitions	**Timely**	Percentage of patients and clients able to see a doctor or nurse practitioner on the same day or next day, when needed.	Priority	% / PC organization population (surveyed sample)	In-house survey / April 2018 - March 2019	91397* Family Health Teams (Bruyère and Primrose)	50	60.00	Our current performance is adequate compared with the provincial average but we note a decrease year on year in the last few years. Thus we would like to see an improvement over current measure and this was a target we achieved in previous year.		1)1. Explore why we have seen a decrease in this access measure year on year, while maintaining high access in other measures (ie: % receiving an appointment when they needed it) 2. Continue to review our access and make adjustments as needed to schedules (add more designated same-day appointment slots at high times, i.e., after holidays/extended closed periods). 3. Create a walk-in protocol. 4. Assess our same day clinic useage; we have been piloting a Monday afternoon same day clinic to address high demand on Mondays for appointments.	1. Develop and execute a patient survey for clerks to better understand why we can't provide patients with same day/next day when they need it (ie: no appointments? Not convenient? Continuity issue?) 2. Practice Facilitator to review data on walk-in and same day clinic useage	1. Protocol created for walk-ins. 2. # patients offered same day/next day / # patients requesting same/day next day.	1. 100% Walk-in protocol created 2. 80% Denominator: Number of requests for same-day/next day; Numerator: ability to be able to offer same-day/next day.	

Theme III: Safe and Effective Care	**Effective**	Proportion of primary care patients with a progressive, life-threatening illness who have had their palliative care needs identified early through a comprehensive and holistic assessment.	Priority	Proportion / at-risk cohort	Local data collection / Most recent 6 month period	91397* Family Health Teams (Bruyère and Primrose)	Collecting Baseline Data	Collecting Baseline Data	New effort so we do not have baseline measure. However we feel a 20% improvement over baseline would demonstrate an improvement at this stage.	eHealth Centre of Excellence. , Palliative Pain & Symptom Management Consultation Service	1)Gather baseline data: patients who have palliative care stamps/advanced care planning in their charts, dates of stamps and date deceased Explore tools to be used in the EMR(palliative toolbar) Involving nursing team in identifying patients in need of palliative care assessment.	Electronic Medical Record search.	Number of patients identified as "palliative." Number of times palliative care toolbar used.	20% increase over baseline.	Gathering baseline data.

Theme III: Safe and Effective Care	**Safe**	Percentage of non-palliative patients newly dispensed an opioid within a 6-month reporting period prescribed by any provider in the health care system within a 6-month reporting period.	Priority	% / Patients	CAPE, CIHI, OHIP, RPDB, NMS / Six months reporting period ending at the most recent data point	91397* Family Health Teams (Bruyère and Primrose)	5.8	5.80	Maintain performance which is already 15% below provincial average.		1)Reduce number of patients on over 90meq of morphine.	1. Increase the number of MDs using mypractice reports. 2. Build registry of patients on high dose morphine; pharmacist and Chronic Disease Management Nurse will review this list and then collaborate with providers on a strategy to reduce use. We have piloted this approach once in the past year.	1. % of doctors signed up for mypractice reports. 2. Denominator: # patients on over 90meq of morphine, Numerator: #patients offered support by pharmacist and CDMN to reduce opioids. 3. # patients on 90 meq or more of morphine.	1. 65% physicians signed up. 2. 100% over 90meq had their charts reviewed and the MRP/patient explored options to reduce dose of opioids. 3. 15% decrease in # patients in our FHT on >90meq morphine	
Equity	**Equitable**	Percent of patients with social determinants of health (SDH) included in the EMR.	Custom	% / Patients in the the cohort of St. Mary's, Bethany Hope and Cornerstone or referred to the Social Workers with SDH information in the chart.	EMR/Chart Review / Quarterly	91397* Family Health Teams (Bruyère and Primrose)	20	40.00	Identifying SDH has been identified as important in alignment with clinic strategic plan but implementation of change effort has been slow.		1)Increase use of SDH stamp developed last year. This year, we want to track usage, identify if providers are noting SDH challenges in their patients, and identify if providers are noting challenges with use of stamp.	Choosing patients who have been referred FHT Social Workers, as well as selecting patients in the cohort of St. Mary's, Bethany Hope and Cornerstone (denominator) and track the number where the Social Determinants of Health stamp has been completed and documented in the chart.	% of patients in the the cohort of St. Mary's, Bethany Hope and Cornerstone or referred to the Social Workers with SDH information in the chart.	40% of patients in the the cohort of St. Mary's, Bethany Hope and Cornerstone or referred to the Social Workers will have SDH information in the chart.	

Theme II: Service Excellence	**Patient-centred**	Percentage of residents responding positively to: "Staff ask how to meet my needs."	Custom	% / Residents	In house data, InterRAI survey, NHCAHPS survey / April 1 to Jan 31	51651* Résidence St-Louis	49	52.00	6% improvement	SQLI Quality of Life Working Group, University of Ottawa Telfer Quality Program	1)Implement focused rounding. Continue to implement Always Practices.	Pilot on 2 units at RSL (March 18-April 12), refine model and spread to the rest of Bruyere LTC. Finalize implementation of Always Practices	Complete pilot and refine model. Educate staff. Spread to all units by October 2019. Electronic montage on living the Always Practices.	Pilot evaluated by May 2019. 90% of staff formally educated by October 2019. Implemented on all units by Oct 2019.	
Theme II: Service Excellence	**Patient-centred**	Percentage of residents responding positively to: "Staff ask how to meet my needs."	Custom	% / Residents	In house data, InterRAI survey, NHCAHPS survey / April 1 to Jan 31	53536* Élisabeth Bruyère Residence	49	52.00	6% improvement.	SQLI Quality of Life Working Group, University of Ottawa Telfor Quality Program	1)Implement focused rounding. Continue to implement Always Practices.	Pilot on 2 units at RSL (March 18-April 12), refine model and spread to the rest of Bruyere LTC. Finalize implementation of Always Practices.	Complete pilot and refine model. Educate staff. Spread to all units by October 2019. Electronic montage on living the Always Practices.	Pilot evaluated by May 2019. 90% of staff formally educated by October 2019. Implemented on all units by Oct 2019.	

Theme III: Safe and Effective Care	**Safe**	Percentage of residents who developed a stage 2 to 4 pressure ulcer or had a pressure ulcer that worsened to a stage 2, 3 or 4 since their previous resident assessment.	Custom	% / Residents	CIHI CCRS / Q3 2019-20 (Jul-Sept 2019)	51651* Résidence St-Louis	5.5	4.00	Target was 3% in 2018-2019 - did not meet. Gradual improvement approach (3% for 20-21).	Universit y of Ottawa Telfor Quality Program, RNAO	1)Implementati on of focused rounding. Enhanced use or data and reporting to ensure follow-up and just in time education (ex: on assessments, management, etc). Education.	Pilot on 2 units at RSL (March 18-April 12), refine model and spread to the rest of Bruyere LTC. Audits on regular wound re-assessments. Enhance reporting and tracking and using PCC capabilities (ie: number of wounds, stages, progress, etc). Review and launch updated online module on Pressure Ulcers. Enhance education to families, residents and staff on prevention.	Implementatio n of Rounding (see Falls), Number of monthly audits on wound assessments and re-assessments (+ follow-up). Number of monthly reports describing wounds (ex: number of wounds, stages, progress, etc). Online module revised and launched. Number of families/reside nts and staff educated.	12 monthly audits. 12 monthly reports. Revised online module. 100% staff educated (through Rounding education). 5 relevant families/residents educated.	

Theme III: Safe and Effective Care	**Safe**	Percentage of residents who developed a stage 2 to 4 pressure ulcer or had a pressure ulcer that worsened to a stage 2, 3 or 4 since their previous resident assessment.	Custom	% / Residents	CIHI CCRS / Q3 2019-20 (Jul-Sept 2019)	53536* Élisabeth Bruyère Residence	4.6	4.00	Target was 3% in 2018-2019 - did not meet. Gradual improvement approach (3% for 20-21).	University of Ottawa Telfor Quality Program, RNAO	1)Implementation of focused rounding. Enhanced use of data and reporting to ensure follow-up and just in time education (ex: on assessments, management, etc). Education.	Pilot on 2 units at RSL (March 18-April 12), refine model and spread to the rest of Bruyere LTC. Audits on regular wound re-assessments. Enhance reporting and tracking and using PCC capabilities (ie: number of wounds, stages, progress, etc). Review and launch updated online module on Pressure Ulcers. Enhance education to families, residents and staff on prevention.	Implementation of Rounding (see Falls). Number of monthly audits on wound assessments and re-assessments (+ follow-up). Number of monthly reports describing wounds (ex: number of wounds, stages, progress, etc). Online module revised and launched. Number of families/residents and staff educated.	12 monthly audits. 12 monthly reports. Revised online module. 100% staff educated (through Rounding education). 3 relevant families/residents educated.	
Theme III: Safe and Effective Care	**Safe**	Percentage of residents who fell during the 30 days preceding their resident assessment.	Custom	% / Residents	CIHI CCRS / Q3 2019-20 (July-Sept 2019)	51651* Résidence St-Louis	17.8	15.00	Target was 14 in 2018-2019 - did not meet.	University of Ottawa Telfor Quality Program, RNAO	1)Implement focused rounding.	Pilot on 2 units at RSL (March 18-April 12), refine model and spread to the rest of Bruyere LTC.	Complete pilot and refine model. Educate staff. Spread to all units by October 2019.	Pilot evaluated by May 2019. 90% of staff formally educated by October 2019. Implemented on all units by Oct 2019.	

Theme III: Safe and Effective Care	**Safe**	Percentage of residents who fell during the 30 days preceding their resident assessment.	Custom	% / Residents	CIHI CCRS / Q3 2019-20 (July-Sept 2019)	53536* Élisabeth Bruyère Residence	20.8	15.00	Target was 14 in 2018-2019 - did not meet. Impacted by bed system project implementation.	University of Ottawa Telfor Quality Program, RNAO	1)Implement focused rounding.	Pilot on 2 units at RSL (March 18-April 12), refine model and spread to the rest of Bruyere LTC.	Complete pilot and refine model. Educate staff. Spread to all units by October 2019.	Pilot evaluated by May 2019. 90% of staff formally educated by October 2019. Implemented on all units by Oct 2019.	
Theme III: Safe and Effective Care	**Safe**	Percentage of residents who were given antipsychotic medication without psychosis in the 7 days preceding their resident assessment.	Custom	% / Residents	CIHI CCRS / Q3 2019-20 (Jul-Sept 2019)	51651* Résidence St-Louis	19.5	20.00	Improve to 20% (below prov average) - previous target was 21%.	CFHI Collaborative	1)Ongoing deprescribing initiatives.	Complete participation in CFHI collaborative and maintain.	Number of residents discontinued. Number of residents decreased.	2 discontinued. 2 decreased.	
Theme III: Safe and Effective Care	**Safe**	Percentage of residents who were given antipsychotic medication without psychosis in the 7 days preceding their resident assessment.	Custom	% / Residents	CIHI CCRS / Q3 2019-20 (Jul-Sept 2019)	53536* Élisabeth Bruyère Residence	21.8	20.00	Improve to 20% (below prov average) - previous target was 21%.	CFHI Collaborative	1)Ongoing deprescribing initiatives.	Identify cohort of staff to deprescribe (per CFHI collaborative methods) and maintain.	Number of residents discontinued. Number of residents decreased.	2 discontinued. 2 decreased.	

Theme I: Timely and Efficient Transitions	**Timely**	Percentage of patients discharged from hospital for which discharge summaries are delivered to primary care provider within 48 hours of patient's discharge from hospital.	Priority	% / Discharged patients	Hospital collected data / Most recent 3 month period	932* Hopsital Programs at EBH and SVH	72.1	75.00	PFAC and HQO priority: 75% represents a 4.3% improvement from current performance.		1)Identify barriers to completion: vacation coverage, co-signing with collaborative documentation.	Chart audit, brainstorming with medical chiefs, then department physician meetings. Reminder to pay attention to "Sign" in MEDITECH when it is red.	Complete chart audit to determine proportion of discharge summaries that were essentially completed, but not signed.	100% of discharges on the two lowest performing units will have been audited to identify reasons for not meeting the 48 hour timeline.	
Theme I: Timely and Efficient Transitions											2)Provide reminders to the physicians in the two lowest performing departments to prioritize completion and signing.	Use peer and leadership encouragement to prioritize completing and signing the discuarge summaries.	Meet with physicians in the two lowest performing departments.	100% of physicians in the two lowest performing departments will have been met with.	
Theme II: Service Excellence	**Patient-centred**	Patient experience: Would you recommend this hospital to family or friends if they needed this type of care?	Custom	% / All inpatients	Local data collection / 2019-20	932* Hopsital Programs at EBH and SVH	81.1	82.50	Target based on initial target set in 2018-19 (revised to reflect patient admission/discha rge weighting)		1)Ensure that always practices are being sustained across hospital programs.	Provide education at the unit level to all staff regarding the expectations related to the revised always practices bundle.	Nursing Professional Practice to conduct quarterly audits of Always Practices on all inpatient units.	90% of of always practice are demonstrated during the audit.	

Theme II: Service Excellence											2)Ensure that always practices are being sustained across hospital programs	Use data from the patient experience survey to determine patient reported satisfaction always practices.	% of surveyed patient responding 'always' to survey questions related to always practices Q25. Were you involved as much as you wanted to be in decisions about your care and treatment? Q26. Were your family or friends involved as much as you wanted in decisions about your care and treatment? Q27. Were you involved in the change of shift reporting between nurses at your bedside around 3:30 in the afternoons? Q27. Do you see your nurse on a regular basis?	90% of surveyed patient responding 'always' questions related to always practices	

Theme II: Service Excellence											3)Implement the discharge checklist – Overview of roles and responsibilities for all staff following a transfer/discharge.	Provide education to staff in hospital programs on roles and responsibilities related to cleanliness as part of the transfer/discharge process.	Percentage of staff who received education.	80% of staff educated.	
Theme III: Safe and Effective Care	**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.	Priority	Proportion / at-risk cohort	Local data collection / Most recent 6 month period	932* Hopsital Programs at EBH and SVH	CB	CB	As there is currently no formal indicator in place, we are collecting baseline data for this year.	Champlain Association of MEDITECH Partners (CHAMP)	1)Integrate the RESPECT tool within the Electronic Patient Record (EPR).	Work with Bruyere Information Systems and Bruyère Research Institute to explore options to integrate the RESPECT tool in MEDITECH.	Integration of the RESPECT tool.	Integration completed.	We will be working to establish a common understanding across partners of the tools used for identification of patients with a progressive, life-threatening illness and for assessment of their palliative care needs with a regional group which includes: • Centretown Community Health Centre • Champlain Hospice Palliative Care Program • Champlain

															Local Health Integration Network (LHIN) Home & Community Care • Glengarry Nurse Practitioner-Led Clinic • Pembroke Regional Hospital • Sandy Hill Community Health Centre • Somerset West Community Health Centre • The Ottawa Hospital • The Ottawa Hospital Family Health Team
Theme III: Safe and Effective Care											2)Screen patients with the RESPECT tool.	Use completed MDS assessments to screen all Complex Continuing Care patients with the RESPECT tool.	Percentage of Complex Continuing Care admissions who have been screened with the RESPECT tool.	80% of Complex Continuing Care admissions will be screened with the RESPECT tool.	

Theme III: Safe and Effective Care	Safe	Number of workplace violence incidents reported by hospital workers (as defined by OHSA) within a 12 month period.	MANDATORY	Count / Worker	Local data collection / January - December 2018	932* Hopsital Programs at EBH and SVH	30	33.00	10% increase in reporting of violence incidents.More sophisticated reporting system ongoing training for new and current staff, 2 clinical units at SVH provided GPA training in 2018.	Ministry of Labour R& D group	1)December 2018 implemented on-line incident reporting & investigation system to make it easier for staff to report all incidents including violence. System includes violence specific investigation tool for managers. Monitoring, coaching and training will continue throughout 2019.	In person training on new on-line incident reporting & investigation system provided to all Directors, managers and supervisors in clinical and operations departments. Remaining management and front-line staff reached via corporate e-mail announcement and Intranet. OHSS reviews violence incidents reports and investigations to ensure all necessary information provided and corrective measures implemented.	100% of managers to be trained on the new reporting system.	100% of managers trained.	FTE=902. Introduction of on-line system resulted in improved reporting and investigation time, quality, and quantity of information.

Theme III: Safe and Effective Care		Falls (per 1000 patient days).	Custom	% / All inpatients	RIMS and Meditech / April 1 to Jan 31	932* Hopsital Programs at EBH and SVH	3.81	3.40	Maintain existing target.		1)Establish a corporate Fall Risk Reduction Committee.	Develop/approve committee terms of reference.	By May 2019, the corporate Fall Risk Reduction Committee will have drafted terms of reference and a workplan for review and approval.	Fall Risk Reduction Committee Terms of Reference and workplan approved.	
Theme III: Safe and Effective Care											2)Pilot Nurse Practice Leader (NPL) fall incident review process	Provide NPLs with access and education to review fall incidents	NPLs on 3 North at Saint-Vincent Hospital and Level 6 Geriatric Rehabilitation at Elisabeth Bruyere Hospital will have access and training to follow up on fall incidents	100% of falls reported on 3 North and Level 6 will have had follow up done with the NPL.	
Theme III: Safe and Effective Care											3)Review and revise Fall Risk Reduction program to improve patient rates of falls.	Review fall prevalence and RIMS data to identify key adjustments to the Fall program.	Use fall prevalence statistics and Risk and Incident Management System (RIMS) data to identify and implement adjustments to the Fall Risk Reduction program.	Fall Risk Reduction program revised to integrate recommended changes.	