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For Information Only

Pioneer Manor - 2nd Quarter Report

Resolution

For Information Only

Relationship to the Strategic Plan / Health Impact Assessment

This report refers to operational matters.

Report Summary

This report for information was prepared to provide Community Services Committee a quarterly update regarding operational issues and good news stories for Pioneer Manor.

Financial Implications

There are no financial implications associated with this report.

Signed By

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Digitally Signed Jul 26, 19

Health Impact Review
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EXECUTIVE SUMMARY

Pioneer Manor is committed to providing a safe, healthy, and supportive environment by treating residents, families, visitors and employees, with respect and fairness. The Home strives towards a balance between ensuring that residents are safe and ensuring that the quality of life of the residents is not being adversely affected by the safety measures put into place.

GOOD NEWS STORIES

Pioneer Manor Awarded Grant Update

Pioneer Manor was successful in receiving a $25,000 grant through the New Horizons for Seniors Program towards an Outdoor Seniors' Exercise Park. This project involves the redevelopment of space next to an existing walking path on the property of the North East Centre of Excellence for Seniors' Health. A steering committee was formed with local community partners and decisions have been made regarding the location of the park specifically and the selection of five (5) pieces of senior-friendly exercise equipment. The project will further strive to enhance the outdoor space with trees, benches, and signage and garbage receptacles. Furthermore the purchase of Nordic Walking poles that may be signed-out on loan will allow residents to use the poles to exercise independently or participate in a community class on the property. The goal is to also ensure complete accessibility for those with disability with a wide path to the exercise pad which is covered with rubberized tile. The subcommittee is currently submitting requests for additional funding to assist with the preparation of the ground to ensure accessibility and safety for participants. The project was initiated in April of 2019 and runs till the end of March 2020. It is anticipated that the exercise stations will be installed by September with a planned celebration and ribbon-cutting ceremony in early October.

I AM Francophone! Project

I AM Francophone! Project came to a close March 31, 2019 following a year-long initiative as a result of receiving $25,000 grant from the Francophone Community Grants Program. This project aimed to increase resources to enhance French programming to Francophone residents through acknowledging individual personhood and celebrating and encouraging cultural and social identity. In collaboration with community partners sitting on the Home's Steering Committee, project goals were met. Pioneer Manor believes the project was successful in impacting and engaging seniors, young Francophone adults and Francophiles as well as in educating those of the Anglophone population who may have been less familiar with Francophone history and culture. Feedback was very positive. Francophone residents who were previously dis-engaged began attending weekly activities. Entertainers who could entertain in both languages are now more sensitive and aware of the desire to be more balanced with the delivery of Anglophone and Francophone music. Signage has been greatly improved throughout the Home. Throughout the year five (5) significant cultural events were celebrated including the raising of a Franco Ontarian flag on St. Jean Baptiste day.

Going forward, the Home will continue to dedicate staff to the delivery of specific Francophone programming on a weekly basis as well as special cultural events. Pioneer Manor is moving ahead in the coming months with enhanced / improved name tags which will have larger font and more visible using contrast colours as well as identifying language(s) spoken. The Home is exploring the opportunity to re-design the resident room name plates also hoping to identify language preference. Pioneer Manor continues to ensure there is a balance to the entertainment provided on a weekly basis in terms of delivering in both languages. The purchase of supplies and apps will continue to be used. Monthly subscriptions to French language magazines will be maintained and distributed throughout the Home. Technology (such as iPads, smart TVs, iPods) is being used to reach residents in groups as well as those who are best seen on an individual basis. Brochures have historically been translated in both languages, however, moving towards enlarging the brochures and having both languages on the same pamphlet as recommended by the steering committee. Pioneer Manor will continue efforts to recruit volunteers who are bilingual as well as provide language / communicate aids to staff as deemed necessary.

Completing the work for this project has given as good head start for the Home to be able to meet the new annual reporting requirement to the LHIN in relation to Health Service Providers that are not designated under the French Language Services Act (FLSA) nor identified to provide FLS, to develop mechanisms to address the needs of its local Francophone community including the provision of information on local health services that are available in French.

Inspections from Ministry of Health and Long-Term Care (see reference 1 below for definitions)

During the second quarter of 2019 the Ministry of Health and Long-Term Care (MOHLTC) completed one (1) inspection on site and two (2) via telephone.

On April 25th the MOHLTC contacted the Home and reviewed six (6) critical incidents and on May 15th reviewed nine (9) critical incidents that had been submitted by Pioneer Manor to the Ministry. No areas of noncompliance were found.

In June the MOHLTC conducted a "critical incident," "complaint" and a "follow up" inspection resulting in the Ministry finding the Home to be in compliance at the time of this inspection to the two previously issued Compliance Orders received in March 2019. In addition the Home received one (1) Voluntary Plan of Correction (VPC), and two (2) Written Notifications of Non-Compliance (WN) (see attached "Appendix B" for specific details).

Critical Incident Reports

All critical incidents (CI) involving residents must be reported to the Director [under the Act] as designated under the *Long-Term Care Homes Act 2007*. The incidents are documented within the on-line Mandatory Critical Incident System (CIS) and received by the the Ministry of Health and Long-Term Care (MOHLTC) (see reference 2 below for definitions). During the second quarter of 2019 the below CIs were submitted.

2019 CI Relating to "Alleged/Actual Abuse/Assault"	Q2	
Number of CI Submitted	29	
Number of CI Resident to Resident	6	21%
Number of CI Staff to Resident	20	69%
Number of Staff to Resident allegations **not substantiated**	11	55%
Number of CIs Visitor to Resident	0	0%
Number of CIs submitted within time lines as per Act	29	100%
2019 Other CI's Submitted		
Incident that causes an injury to a resident for which the resident is taken to hospital and which results in a significant change in the resident's health status	6	
Missing Controlled Substance	0	
Missing Resident less than 3 Hours	1	
Outbreak	0	
Environmental	0	

Complaints / Concerns

The following complaints / concerns were received during the second quarter of 2019

As per section 56 (2) of the Long-Term Care Homes (LTCH) Act 2007 the Home has a duty to respond in writing within 10 days of receiving the concern, request or recommendation from either the Resident or Family Councils. In response to the Councils' concerns the below actions were put into place:

- Resident council requested residents to have access to the resident smoking area twenty-four hours a day. The council was informed them that the Home is currently examining safety measures that would need to be implemented and would communicate when it would be possible. As a start the Home initiated unlocking the smoking area doors at 0500 hours instead of 0600 hours.
- Resident council requested to have less institutional looking privacy curtains in the residents' rooms. The Home will explore but previously we have been unsuccessful due to specifications under the fire code and size requirement
- Resident council requested to a have a system put in place so that the elevators could talk as this would be helpful for those residents with visual impairments. Pioneer Manor's elevators currently do not have voice capabilities, however the Home investigated possibility to install. The council was provided an update stating that sound could be added to the elevators with a significant cost associated with it, and that currently Pioneer Manor does not have a budget for this upgrade and will revisit in 2020. For now the Home will research alternative options to improve signs so residents know what floor they are on.

As per O. Reg. 79/10, s. 101 every written or verbal complaint made to the Home or a staff member concerning the care of a resident or operation of the Home is investigated and resolved where possible, and a response indicating what the licensee has done to resolve the complaint, or that the Home believes the complaint to be unfounded and the reasons for the belief within 10 business days of the receipt of the complaint.

- Eight (8) written concerns were submitted by residents' family member in relation to care issues. All concerns were investigated and family members received written response to concern. All family members were satisfied with response.

Ministry of Labor (MOL)

The MOL was on site on June 27th as response to a critical injury which occurred at Pioneer Manor June 17th where a worker lost consciousness in the workplace. The loss of consciousness was related to a pre existing medical condition that was disclosed to the Home following the incident. No orders were issued.

Safety Messages

Each month a new resident and staff safety message is communicated at all meetings taking place at Pioneer Manor. June's resident safety message was; "Be sun safe. Wear a hat and sunscreen when going outside. Be sure you stay well hydrated by drinking plenty of water". The staff safety message was; "As the weather warms up we can expect the building to warm up as well. In warmer conditions becomes increasingly important for you to remain hydrated to keep your body functioning properly. Make sure to drink regularly throughout your shift. The recommendation for optimal hydration is for 1/2 cup of water every 20 minutes. You may start to become dehydrated even

before you feel thirsty so keep a bottle of water that you are able to access on a regular basis. Don't forget that drinks (even closed water bottles) are not allowed on any carts, as per the Ministry of Labour, due to the potential for cross contamination. Work with your supervisor to determine a safe location where you may leave your water bottle." Pioneer Manor's Health and Safety Newsletter "Safety Check" provides information monthly to staff relating to the types of staff incidents that occurred throughout the previous month, Health & Safety (H&S) policy updates, staff responsibilities etc.

Pre-Shift Stretching Program Update

As one of the improvement areas put in place to address the number of employees on modified duties, on April 26th, the roll out of the pre-shift stretching program for all sections and employees across Pioneer Manor was completed. This program involves the completion of various stretches at the beginning of the shift to prepare employees bodies for physical activity. The goal of the pre-shift stretching is to assist in reducing the number and significance of injuries but also contribute to the overall wellbeing of employees by reducing muscle tension and pain that many experience due to the physical nature of the work activities.

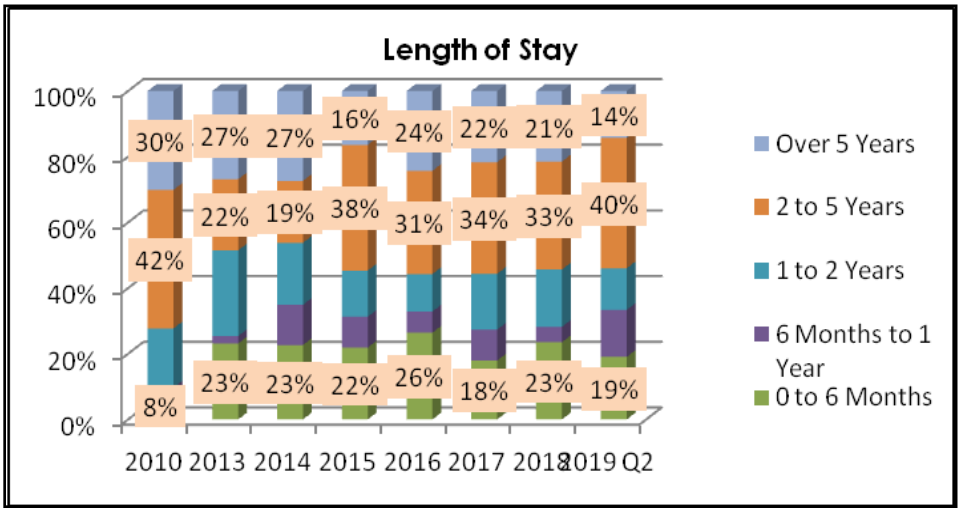
Some takeaways from the roll out were, even when staff members were resistant to the idea, once the program started and their co-workers were participating, most of them joined the group after a very short period of time. Demonstration and instruction was the key; some employees were intimidated by the thought of stretching, as they didn't understand what it would involve. The demonstration and education helped them to be more comfortable. Performing the roll out in small groups and in the Home Area helped reduce the intimidation as well. There are a lot of people working sore. Shoulder pain was the most evident. Explaining to the employees the potential benefits of stretching as a method of reducing their aches and pains hopefully helped to encourage some employees to continue. Several employees commented that after one week of consistent stretching, they experienced a reduction in muscle pain. Support from the Director, Managers and Supervisors goes a long way! There was much more participation during this rollout than during previous attempt in 2011/2012 due to the support that the program had from the Director, Managers and Supervisors. The Home is hopeful the momentum will continue to build.

Key Performance Indicators

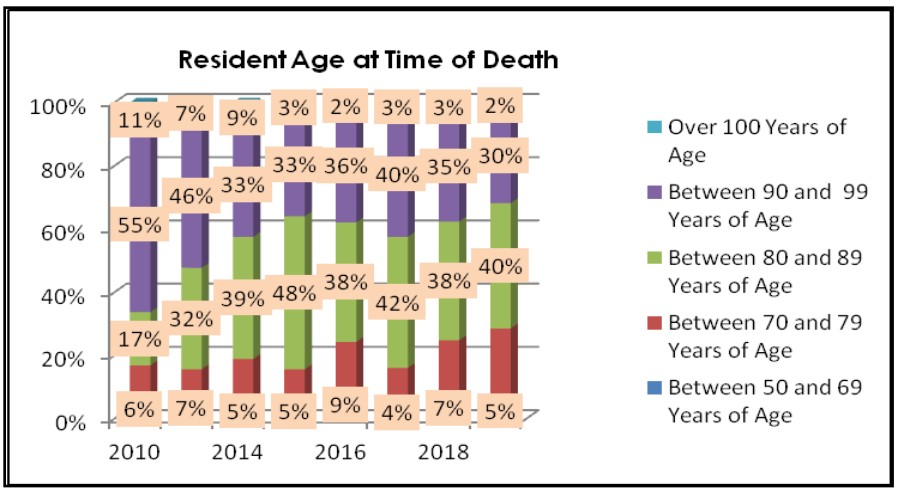
Long-Term Care Home Availability (as of June 2019)					
Facility Name	**Beds**	**# on waitlist for Basic Bed**	**# on waitlist Private Beds**	**Average beds available/month**	**Total # waiting**
Pioneer Manor	433	423	200	7	567
North East LHIN	1554			43	1133

Resident Care Stats (433 Residents)		2017	2018	Q1&2 2019
Admissions	Total for Year	97	144	73
Readmissions	Total for Year	186	115	37
Discharges	Total for Year	1	9	5
Deaths	Total for Year	106	149	63
Emergency Room Visits	Total Visits per Year	183	253	68
	% Residents Admitted to Hospital	53%	50%	54%
Internal Transfers	Total for Year	102	107	46
Occupancy Rate	Required greater than 97%	99%	99%	99%

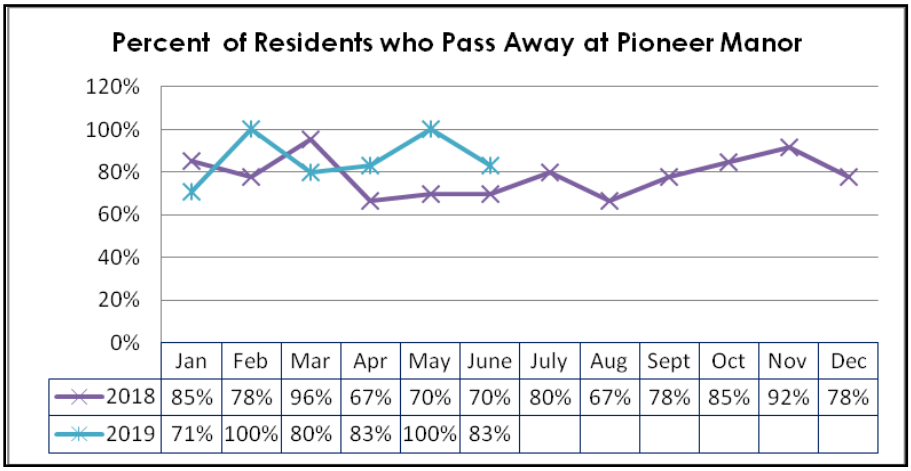
Facility Name	Q1 FY 2017/18	Q2 FY 2017/18	Q3 FY 2017/18	Q4 FY 2017/18	Q1 FY 2018/19	Q2 FY 2018/19	Q3 FY 2018/19
Pioneer Manor	6.8%	5.1%	4.1%	7.6%	8.4%	7.4%	6.3%
North East LHIN	8.5%	8.6%	8.2%	9.0%	9.1%	8.4%	7.9%
Ontario	7.2%	7.7%	7.4%	7.8%	7.4%	7.7%	6.4%
Chart based on data provided by the MOH April 2019. The percentage is not reflective of the Home's bed count of 433 beds, but the unique number of individuals who occupied a bed at any time during the quarter and were over the age of 65 at time of admission to the ED							



To date 54% of residents who passed away were residents at Pioneer Manor were greater than two years compared to 72% in 2010



To date 32% of residents were over 90 years of age at time of death compared to 66% in 2010



	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
2018	85%	78%	96%	67%	70%	70%	80%	67%	78%	85%	92%	78%
2019	71%	100%	80%	83%	100%	83%						

To date 86% of residents passed at away at Pioneer Manor compared to 81% in 2018.

Infection Control

Tracking of infection control rates and analysis of the information to identify clusters (note inherited cases are brought into the Home from the community).

Number of New Cases	2019 Q2
Methicillin Resistant Staphylococcus Aureus - inherited	4
Methicillin Resistant Staphylococcus Aureus - acquired	1
Vancomycin-resistant Staphylococcus aureus – inherited/acquired	0
Extended Spectrum Beta Lactamase - inherited	1
C. Difficile.	0

During the second quarter of 2019 Pioneer Manor had no outbreaks declared by the local public Health Unit.

Falls Prevention

During the second quarter of 2019, one hundred and ninety-seven (197) residents [45.5%] participated in the Falls Prevention Program receiving one to one physiotherapy.

Monthly audits of universal precautions were completed by committee members. Among the concerns needing attention were: loose bed rails, light not working, call bell in washroom not working, bedrail photo missing, mats left on floor. All issues addressed.

Ongoing monthly audits of bedrail use by night shift RN Supervisors assessing consistency between the daily census and practice, second component assessing consistency between resident care plans and practice were completed during the second quarter of 2019. Any errors noted were corrected.

To prevent resident injury at the end of the second quarter there were eighty (80) residents using chair or chair pad sensors, one hundred and forty (140) residents using bed sensors five (5) residents with infrared sensors, and eight (8) residents were prescribed hip protectors.

At the end of the second quarter, there were thirty-three (33) residents using restraining devices (restraints and personal assistive safety devises [PASDs]) excluding bedrails as per CIHI definition. There were ten (10) restraints and seventy-nine (79) PASDs (43 of which are bedrails) used.

Employees on Modified Work (MW)

Several improvement ideas have been put in place to address the number of employees on modified duties as a result of occupational injury or illness. At the beginning of 2019, Pioneer Manor had an average of twenty-two (22) employees on MW with a goal of decreasing to seventeen (17) by the end of the year. At the end of the second quarter of 2019 the Home is at an average of sixteen (16) employees. In June the average went to an all time low of eleven (11) employees.

Facility Services

Remedial painting continued throughout the Home. Monthly generator test was completed during each month of the second quarter including a load bank testing.

Additionally, air conditioning in the York Wing of the Home was improved. The patio glass enclosure on one of the patios of the First Floor Lodge (Secure Area) was removed to allow the residents direct access to the secure Winter Garden.

At the beginning of April three employees' vehicles were vandalized during the night shift. The Director met with the staff involved, the JHSC and had a security assessment completed by Brendan Adair, Manager of Security and By-Law Services. In an effort to deter future occurrences and enhance the visibility, all of the existing lighting starting in the back parking lot was replaced with brighter LED lighting. The Home's

video surveillance was updated with newer cameras, and more video surveillance signs were installed. To proactively remove items that could be used to vandalize vehicles a monthly site inspection conducted by Maintenance personnel of the parking lot was initiated. A new camera has been installed that once set up will be fed to a dedicated monitor screen at TDS and their security guard (when at desk) will be able to see if something is happening on Pioneer Manor property and contact 911 if needed.

Emergency Preparedness

During the second quarter annual fire alarm testing and inspection were completed.

	2019 Q2
Monthly fire drills on all three shifts	Monthly
Code White (situation with actual/potential violent or out of control person)	35
Code Yellow (missing resident)	1
Code Blue (medical emergency)	1

Update 2019 Strategic Issues & Opportunities

Build and enhance the volunteer base at Pioneer Manor:

- The Home currently has a total of one hundred and fifty-four (154) volunteers; seven (7) new volunteers were recruited this quarter
- 2267 volunteer hours for the quarter, in May the Home had a record high of 802 hours!!!
- Annual Volunteer Recognition event for Pioneer Manor Volunteers was held in April
- Participated in Job Fair Recruitment for newcomers at Lexington Hotel in May
- Additional recruitment campaign started with Volunteer Sudbury, new portal for volunteer job postings
- Attended PAVRO conference in Ottawa in May - networking and best practices in areas of recruitment, retaining and engagement opportunities
- Attended job recruitment fair in Toronto in May
    - Over 150 participants, many highly-skilled in the engineering area, some were physicians in their country of origin
    - Participants were mainly from Nigeria, India, Cuba, Haiti and South Africa
    - Many asked how they could become qualified as PSWs. Particular interest in how spouses could become PSWs
- Participated in the Seniors Fair at Carmichael Arena in June

Complete implementation of Kronos TeleStaff scheduling software module, which will allow better employee access to current schedules, electronic submission of time-off requests and shift exchanges, and integration between the call-out and scheduling components.

- The project is ongoing, currently in the final testing phase of the project. Estimate one months before able to go live

Quality Improvement Plans

As per the "*Excellent Care for All" Act 2010* legislation Pioneer Manor is required to create annual quality improvement plans (QIP). On April 1, 2019, Pioneer Manor submitted, the "2018-2019 QIP Progress Report", "2019-2020 QIP Work Plan" and the "2019 – 2020 Narrative" to the MOHLTC (see attached "Appendix A" for specific details).

Indicator	2018/19 Targeted Improvement	2019 Current Performance	Comment
Number of Emergency Room visits per 100 long-term care residents	To decrease from 19.25% to 15%	21.63%	With iternal reporting the numbers were more favorable
Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences" indicator.	To increase from 78% to 80%	61.54%	Did not reach goal
Prevalence of residents who indicate they have enjoyable things to do here on evening's indicator.	To increase from 38% to 50%	49%	Did not reach goal but did see an improvement from 2018
Percentage of residents who responded positively to the question, "I would recommend this site or organization to others?"	To increase from 77.27% to 80%	78%	Did not reach goal but did see an improvement from 2018
Percentage of residents who responded positively to the question: "Would you recommend this nursing home to others?"	Maintain 90%	96%.	Reached goal
Percentage of residents who fell	To decrease from 21.56% to 15%	17.70%	Did not reach goal but did see an improvement from 2018
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	To maintain 5%	4%	Reached goal
Percentage of residents who were given antipsychotic medication without psychosis	To decrease from 22.62% to 21%	21.10%	Did not reach goal but did see an improvement from 2018

For the 2019-2020 year Pioneer Manor's QIP the Quality Improvement Committee decided on five (5) indicators to work on. The number of ED visits per 100 long-term care residents indicator, the percentage of residents who responded positively to the

question, "I would recommend this site or organization to others?", the percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences" indicators, the number of reported musculoskeletal injuries to staff (occupational) and the number of workers on modified duty as a result of occupational injury/illness indicators.

Reference 1

The Long-Term Care Home Quality Inspection Program (LQIP) safeguards residents' well-being by continuously inspecting complaints and critical incidents, and by ensuring that all Homes are inspected at least once per year. This is achieved by performing unannounced inspections and enforcement measures as required, and ensuring that actions taken by the government are transparent. The MOHLTC conducts complaint, critical incident, and follow up, comprehensive and other types of inspections. An RQI inspection is a comprehensive, systematic two-stage inspection.

For each instance where 'non-compliance' with the legislation has been identified during an inspection a decision must be made by the inspector on the appropriate action to take, including whether to impose a sanction that is an Order. At minimum the inspector will issue a **Written Notification of Non-Compliance (WN**). Whether further action is required is based on an assessment of the following factors; severity and scope of harm (or risk of harm) resulting from the non-compliance and the licensee's past history of compliance for the last 36 months. Actions taken may include; **Voluntary Plan of Correction (VPC),** which is a written request for the Home to prepare a written plan of correction for achieving compliance to be implemented voluntarily. The Home is not required to submit the plan to the ministry. There is no required compliance date set out in the inspection report. **Compliance Order (CO)**, which is an order for the licensee to do anything, or refrain from doing anything to achieve compliance with a requirement under this Act or; prepare, submit and implement a plan for achieving compliance with a requirement under this Act. The Home is required to follow the Order to achieve compliance with the LTCHA within the timelines for compliance set out in the Order. **Work and Activity Orders (WAO)**, which is an order for the Home to allow employees of the ministry, or agents or contractors acting under the authority of the ministry, to perform any work or activity at the LTC Home that is necessary, in the opinion of the person making the order, to achieve compliance with a requirement under this Act; and to pay the reasonable costs of the work or activity. The Home is required to follow the Order to achieve compliance with the LTCHA within the timelines for compliance set out in the Order. **Written Notification and Referral to the Director (WN & Referral**) is a written notification to the Home that they have referred the matter to the Director for further action by the Director. *(LTCHA, 2007, C.8 s. 152 – 154)*.

Reference 2

The LTCH Act defines a CI as an event which poses a potential or actual risk to the safety, security, welfare and/or health of a resident or staff member or to the safety and security of the facility which requires action by staff and/or outside agencies.

- A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the MOHLTC Director:
  - Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident,
  - Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident,
  - Unlawful conduct that resulted in harm or a risk of harm to a resident
  - Misuse or misappropriation of a resident's money,

- Misuse or misappropriation of funding provided to a licensee under this Act,
- An emergency, including fire, unplanned evacuation, or intake of evacuees that affect the provision of care or the safety, security or well being of one or more resident of a LTC Home.

- A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall within one (1) business day report the information upon which it is based to the MOHLTC Director:
  - An unexpected or sudden death, including a death resulting from an accident or suicide,
  - A resident who is missing for three hours or more,
  - Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing,
  - An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act,
  - Contamination of the drinking water supply,
  - An environmental hazard, including a loss of essential services, flooding, breakdown or failure of the security system or a breakdown of major equipment or a system in the home that affects the provision of care or the safety, security or well-being of residents for a period greater than six hours,
  - A missing or unaccounted for controlled substance,
  - A medication incident or adverse drug reaction in respect of which a resident is taken to hospital,
  - An injury in respect of which a person is taken to hospital and that resulted in a significant change in the resident's health condition

2018/19 Quality Improvement Plan for Ontario Long Term Care Homes
"Improvement Targets and Initiatives"

Pioneer Manor 960 Notre Dame Avenue Sudbury Ontario

AIM		Measure								Change				
Quality dimension	Issue	Measure/ Indicator	Type	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comment
M = Mandatory (all cells must be completed) P = Priority (complete ONLY the comments cell if you are not working on this indicator) A= Additional (do not select from drop down menu if you are not working on this indicator) C = custom (add any other indicators you are working on)														
Effective	**Effective Transitions**	Number of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents.	P	Rate per 100 residents / LTC home residents	CIHI CCRS, CIHI NACRS / October 2016 - September 2017	52162*	19.25	15.00	Target not met in previous year, but down from 2016/17. Will continue to work on this.	1)Review and analyze emergency transfers.	Program Coordinators to review ER transfers noted on 24 hour report and discuss at daily huddle with Manager of Resident Care and other Program Coordinators together. Re-instruction of RN/RPN staff will occur if transfer was deemed unnecessary/inappropriate.	All emergency transfers discussed and analyzed.	100% of transfers justified or reviewed with responsible staff where required.	
										2)Track and review ER Transfers with physician group.	Transfers tracked including who initiated the transfer (resident, family, care staff) and which residents were admitted to hospital as a result of transfer. This is then reviewed at quarterly Pharmacy & Therapeutics Committee with input from Medical Director, Manager of Resident Care, Physician, Nursing Program Coordinators.	As above.	All ER transfers will be reviewed/ discussed with as needed/just-in-time education to staff, residents, families as required when transfers were deemed unnecessary.	
Patient-centred	**Person experience**	Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences".	P	% / LTC home residents	In house data, interRAI survey / April 2017 - March 2018	52162*	78	80.00	Goal is to maintain or improve current performance.	1)Deliver customer service education to staff to enhance the resident/family to staff experience.	In-person education through inservices and counselling sessions through a psychologist to review methods for dealing with challenging situations involving residents and their families.	Will track sessions offered, as well as, attendance at sessions.	70% of staff will attend at least one customer service session in one year.	
		Prevalence of residents who indicate they have enjoyable things to do here on evenings.	C	% / Adult long stay home care clients	In-house survey / 2018	52162*	38	50.00	On 2017 survey, 15% indicated they had enjoyable evening activities most of the time and 24% of respondents said all of the time.	1)Increase visibility of evening and weekend programs in Winter Park, our large congregate activity space.	Offer more programs at these times and advertise more broadly within the Home.	Activity calendar will reflect additional activities.	Attendance/participation in evening programs will measurably increase.	
										2)Initiate francophone programming to address the francophone population.	Programs specifically targeted to french-speaking residents and offered in french will be more available.	Activity calendar to reflect an increase in such activities.	Attendance/participation in evening programs, by francophone residents, will increase.	
	Resident experience: "Overall satisfaction"	Percentage of residents responding positively to: "I would recommend this site or organization to others." (InterRAI QoL)	P	% / LTC home residents	In house data, interRAI survey / April 2017 - March 2018	52162*	77.27	80.00	Goal is to meet or exceed current performance	1)Improve staffing consistency.	With introduction of a new staffing module and recommendations from previous in-house Operational Review Committee, the goal is to more consistently have a full staffing complement on duty, as well as, keep the assigned staff member per resident more consistent from day to day.	Staffing shortages.	Number of shifts worked short, in the nursing department, will decline.	
										2)Deliver customer service education to staff to enhance the resident to staff experience.	In-person education through inservices and counselling sessions through a psychologist to review methods for dealing with challenging situations involving residents and their families.	Will track sessions offered, as well as, attendance at sessions.	70% of staff will attend at least one customer service session in one year.	
		Percentage of residents who responded positively to the question: "Would you recommend this nursing home to others?" (NHCAHPS)	P	% / LTC home residents	In house data, NHCAHPS survey / April 2017 - March 2018	52162*	90	90.00	Previous target of 68% was surpassed.	1)Improve staffing consistency.	With introduction of new staffing module and recommendations from previous Operational Review Committee, the goal is to more consistently have a full staffing complement on duty, as well as, keep the assigned staff per resident more consistent from day to day.	Staffing shortages.	Number of shifts worked short will decline.	
										2)Deliver customer service education to staff to enhance the resident to staff experience.	In-person education through inservices. Counselling sessions reviewing methods of dealing with challenging situations involving residents and families.	Will track sessions offered, as well as, attendance at sesssions.	70% of staff will attend at least one session in the year.	
Safe and Effective Care	**Medication safety**	Percentage of residents who were given antipsychotic medication without psychosis in the 7 days preceding their resident assessment	P	% / LTC home residents	CIHI CCRS / July - September 2017	52162*	22.62	21.00	Goal is to maintain or improve current performance which is better than the provincial and LHIN averages.	1)Monitor antipsychotic drug use and review/discuss with medicine, nursing, and pharmacy.	Remain as a standing item on the quarterly Pharmacy & Therapeutics Committee and Medical Advisory Committee.	Report of antipsychotic use produced quarterly.	Report of antipsychotic use reviewed and discussed quarterly.	
										2)"Monitoring of Antipsychotic Use in Dementia" form to be used by physicians to record antipsychotic use in residents with a diagnosis of dementia.	Form utilized to ensure an appropriate diagnosis is identified for the resident and entered in the health record.	Forms/results reviewed at quarterly Pharmacy & Therapeutics Committee and Medical Advisory Committee.	% of residents who were given antipsychotic medication without psychosis in the preceding 7 days to remain at current level or decrease.	

2018/19 Quality Improvement Plan for Ontario Long Term Care Homes
"Improvement Targets and Initiatives"

Pioneer Manor 960 Notre Dame Avenue Sudbury Ontario

AIM		Measure								Change				
Quality dimension	**Issue**	**Measure/ Indicator**	**Type**	**Unit / Population**	**Source / Period**	**Organization Id**	**Current performance**	**Target**	**Target justification**	**Planned improvement initiatives (Change Ideas)**	**Methods**	**Process measures**	**Target for process measure**	**Comment**
M = Mandatory (all cells must be completed) P = Priority (complete ONLY the comments cell if you are not working on this indicator) A= Additional (do not select from drop down menu if you are not working on this indicator) C = custom (add any other indicators you are working on)														
Safe and Effective Care	**Safe care**	Falls in long stay home care patients	C	% / LTC home residents	CIHI CCRS / 2018	52162*	21.56	15.00	Our target of 15% was not achieved in 2017/18.	1)Alternate data collection systems and tracking to identify patterns/trends will be explored.	Falls Management Committee to establish indicators	New indicators established	New processes in place by June 2018	
										2)Monthly fall prevention/least restraint messaging to be communicated to resident care staff.	Monthly message distributed and communicated to staff through monthly team meetings and posted in resident home areas.	Safety messages created and distributed.	Messages distributed monthly.	
		Percentage of long-term care home residents who developed a stage 2 to 4 pressure ulcer or had a pressure ulcer that worsened to a stage 2, 3 or 4	C	% / LTC home residents	CIHI CCRS / July to September 2018	52162*	4.97	5.00	Working to maintain improvement that was achieved last year.	1)Implement a pre-printed wound care order set to reflect our wound care protocols for the various wound stages/types. Protocols reflect best practices and will facilitate implementation of the correct protocol for the specified wound.	Develop pre-printed order sheet.	New order sheet will be in place and utilized for all new or worsening pressure wounds.	New process will be in place by June 2018.	

Let's Make Healthy Change Happen.

Quality Improvement Plan (QIP) Narrative for Health Care Organizations in Ontario

3/30/2019

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

Pioneer Manor is a 433 bed municipal Home owned and operated by the City of Greater Sudbury.
The Home established a Quality Council in 2016 and is in the process of finalizing the quality indicators it wishes to track on a go forward basis.
In addition to Council, there are various other teams/committees charged with managing quality within the organization including responsive behaviours, pain and palliative care, continence care, skin and wound management, falls management.
The Home currently administers two surveys to residents/families annually; a quality of life and satisfaction survey. These are currently being merged into one survey which we hope will equate to a better overall response rate, more indicative of our residents' experience.

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

The Home underwent a survey through Accreditation Canada and received a 3-year accreditation award.

Additionally, we embarked on training of four (4) Personal Support Workers (PSWs) as trainers who then delivered a full day session to fourty (40) of our most senior, full time PSWs on every shift in Excellence in Resident Care.

Patient/client/resident partnering and relations

The various committees have solicited resident and family participation and continues to be challenged in this area.
Again, recently, we have approached both groups through Resident and Family Councils to ask for their participation in our activities. We are awaiting a response.

Contact Information

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Sign-off

It is recommended that the following individuals review and sign-off on your organization's Quality Improvement Plan (where applicable):

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

Board Chair / Licensee or delegate _____ (signature)
Administrator /Executive Director _____ (signature)
Quality Committee Chair or delegate _____ (signature)
Other leadership as appropriate _____ (signature)

2019/20 Quality Improvement Plan for Ontario Long Term Care Homes
"Improvement Targets and Initiatives"

Pioneer Manor 960 NOTRE DAME AVENUE

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**
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Theme I: Timely and Efficient Transitions	**Efficient**	Number of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents.	P	Rate per 100 residents / LTC home residents	CIHI CCRS, CIHI NACRS / October 2017 – September 2018	52162*	21.63	15.00	Target for last year not previously met, so we continue to aim for a significant reduction.		1)Review and analyze emergency transfers.	As started in 2018, the Resident Care Coordinators review ER transfers daily at huddle to determine the appropriateness and identify when alternatives may have been utilized, such as the Emergency Department Outreach Service. Re-instruction of RN/RPN staff occurs if the transfer was deemed unnecessary. Based on internal measures, this has proven effective. The Home participates with other local LTC Homes, the hospital, and the North East LHIN to address the transition of residents within and from LTC to hospital. Will be exploring the use of the PREVIEW-ED tool, to be used by PSWs for early detection of health issues which has been shown to significantly reduce hospital admissions in other settings.	All emergency transfers discussed, analyzed, and logged.	100% of transfers justified or reviewed with responsible staff, where required.	In-house analysis, over an 8 month period, shows only 2% of emergency transfers were potentially avoidable. All others justified based on physician order, mental health crisis, need for acute intervention (with admission to hospital), or resident/family request for transfer out.
Theme II: Service Excellence	**Patient-centred**	Percentage of residents responding positively to: "I would recommend this site or organization to others." (InterRAI QoL)	P	% / LTC home residents	In house data, interRAI survey / April 2018 - March 2019	52162*	78	90.00	While results of this survey equated to 78%, the Resident Satisfaction Survey conducted later in the year showed a 96% satisfaction rate.		1)Increase access to support and financial assistance to residents.	Staff the Reception desk/banking area on all days including statutory holidays.	Will be reflected in Satisfaction Survey results.	More residents indicating their overall satisfaction with our Home compared to previous year.	
											2)Revised Customer Service policy and Concern Management policy being rolled out throughout the Home.	Focus will be on identifying and addressing concerns before they escalate to the complaint stage.	To quantify through a newly revised Resident Satisfaction/Quality of Life Survey to be administered in fall 2019.	To achieve a more substantial survey return rate that will be more reflective of overall resident opinion.	
		Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences".	P	% / LTC home residents	In house data, interRAI survey / April 2018 - March 2019	52162*	61.54				1)				Continuing to concentrate on overall satisfaction.
Theme III: Safe and Effective Care	**Effective**	Proportion of long-term care home residents with a progressive, life-threatening illness who have had 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	52162*	CB	CB	We believe we are doing well in this area but need to gather more detailed information in order to measure change.		1)Will be exploring new tools to help ensure the Palliative Care Performance Tool is effectively implemented and, therefore, residents who would benefit from palliative care are identified in a timely manner.	Implement the Palliative and End of Life Management Clinical Support Tool, offered through Think Research, to provide evidence-based decision support by incorporating hospice palliative care best practices and documenting identification and decision making in the resident's electronic record in PointClickCare.	New tool implemented before end of 2019.	To be determined.	
		Number of reported musculoskeletal injuries to staff (occupational).	C	Number / Worker	In house data collection / 2019	52162*	166	149.00	Represents a 10% decrease over 2018.		1)Pre-shift stretching program.	Pre-shift, staff are led through a stretching program to warm up and prepare themselves for the physical demands of the work that they will be completing.	Compliance with pre-shift stretching.	Stretching program embedded in the workday as a regular practice.	
											2)Safety Meetings	Post injury, staff participate in a safety meeting with the Health & Safety Facilitator and/or Rehabilitation & Claims Officer to review the causative incident and increase body mechanics awareness. The improved investigation process will help address causal factors immediately following the incident with the employee reporting the injury. Formal safety meetings will occur with an employee after the third reported incident in a 12-month period. These involve the Health & Safety Facilitator, employee, and Supervisor.	Each staff member reporting an MSK will participate in a safety meeting.	Prevention of repeat incidents.	

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**
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Theme III: Safe and Effective Care Cont	**Effective Continue**	Number of workers on modified duty as a result of occupational injury/illness	C	Rate / Worker	In house data collection / 2019	52162*	22	17	We are in process of gathering data in order to measure progress moving forward.		1)Pre-shift stretching program.	Pre-shift, staff are led through a stretching program to warm up and prepare themselves for the physical demands of the work they will be completing.	Compliance with pre-shift stretching.	Stretching program becomes a normal part of the workday.	
											2)Standard Operating Procedures.	Standard Operating Procedures have been developed re: use of mechanical floor lifts, ceiling lifts, work handling, etc. One SOP will be reviewed each month at staff meetings and all SOPs are accessible to all employees via electronic means.	SOPs available for all high risk procedures.	SOPs accessed and utilized by staff.	
											3)Case Management	In-house case management applied to assist in returning staff to regular duties in a safe and timely manner.	Rehabilitation & Claims Officer remains actively involved in monitoring all employees on modified duties. Plans are progressed in a timely fashion upon receipt of suitable medical information.	Rehabilitation & Claims Office involved with 100% of the modified workers.	

Compliance Visit Report

Appendix B

Dates	**June 10 to 14, 2019 exit on June 14/19**	**Report received on July 8, 2019**
Purpose of Visit	Follow up on 2 Compliance Orders, 2 Complaints and CIs	2019- 786744-0018 CI Inspection Report → 1WN 2019 -786744- 0019 Follow up Inspection Report →1VPC, 1WN 2019 -786744-0020 Complaint Inspection Report →1 WN
Number of Inspectors	3 Inspectors → Steven Naccarato, Loviriza Caluza and Shelley Murphy	
Notes From Exit - Areas on non compliance identified		**Finding Pioneer Manor received from above reports**
CO re Resident Abuse and Review of Medication Incidents	• The Home is now in compliance	• Previously issued Order(s) were found to be in compliance at the time of this inspection
Medication Management	• Reporting of missing Controlled Substances → an incident that occurred during the 2019Q1 was not reported to the Ministry • Not following the Prescriber's direction →administering a medication 2 hours earlier than ordered.	• No findings
Plans of Care	• Not documenting in the POC part of the resident's electronic chart each time a resident is toileted. Care Plan states toilet 3 times per day staff are toileting 3 times per day but only documented in POC once	• **WN**→failed to ensure that the outcomes of the care set out in the plan of care is documented in the resident's electronic medical record (EMR), the resident's plan of care states to toilet the resident three (3) times per shift, they saw staff were toileting the resident three (3) times per shift but they only documented in the EMR once. Education will be provided to the personal support workers regarding this.
Resident Abuse	• Non compliant with policy • Reporting a incident late	• **VPC**→failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with. The three of the critical incidents they reviewed in relation to allegations of staff to resident abuse the allegation was substantiated and the employee was disciplined. The fact that the allegation was substantiated is a violation to the act re zero tolerance and therefore the Home was noncompliant with the LTCH Act 2010.
CI reporting	• Did not indicate the name of the employee on a CI report	• **WN**→ failed to include name of any staff member involved as part of the information provided on the CI report regarding a allegation of staff to resident abuse.