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
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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.	

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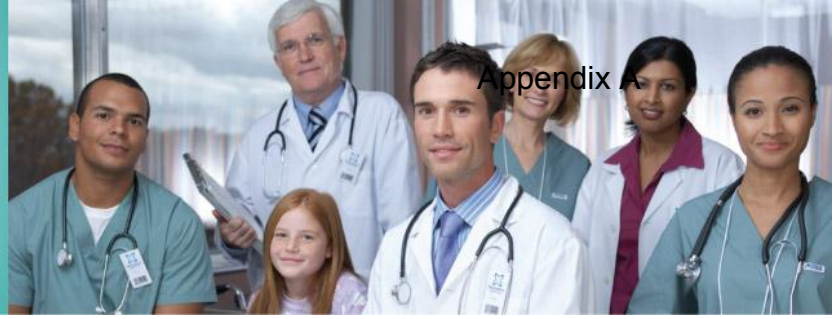
Safe and Effective Care	**Safe care**	Falls in long stay home care patients	C	% / LTC home residents	CIHI CCRS / 2018	52162*	21.56	15.00	Our target of 15% was not achieved in 2017/18.	1)Alternate data collection systems and tracking to identify patterns/trends will be explored.	Falls Management Committee 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
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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.	

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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.	