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

Terrace Lodge 475 TALBOT STREET EAST

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	Comments
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	53117*	27.46	24.00	The Home has set a target that aligns with the provincial average which will reflect a 12.6% improvement/reduction in potentially	1)Care planning for chronic disease management before exacerbation of symptoms/crisis. This change idea was initiated in	Reinforce Care planning for chronic disease management at the admission care conference and provide ongoing to support to resident and family to make certain there is an understanding of expected progression and interventions available at the Home	# of care plans with disease specific interventions; # of care conferences that include ER visits, disease progression discussion and the use of the revised care conference tool; # of staff educated; % reduction of potentially avoidable ER visits	100 % of care plans will include disease specific interventions by March 31, 2019;	This change idea was initiated in the 2017/18 QIP and will continue for the 2018/19
										2)Introduction of a revised risk management checklist to support the early identification of changes in resident status and timely	Revision of risk management tool by management with registered staff input. Education re: revised tool by management. Implementation of risk management tool by registered staff. Audits of completion of tool by MRC/RCC at the point of care. Review of ER visit stats	# of staff educated; # of risk management tools completed with appropriate follow up/interventions; % reduction of potentially avoidable ER visits	100% of staff will be educated by July 31, 2018; 100 % of tools completed	The risk management tool has recently been revised to support early
	Wound Care	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	A	% / LTC home residents	CIHI CCRS / July - September 2017	53117*	3.34	3.20	The Home has demonstrated improvement in this indicator in the 2017/18 QIP and has set a target of a 4.19 % improvement to align with the provincial average.	1)Increase the # of wound care champions/team members to 1-2 PSW's/unit and 1 Registered staff/unit to support wound	The Home will actively participate in the SWRWCP which will provide resources and additional educational opportunities to a variety of disciplines. The registered staff wound champions will engage and educate colleagues during weekly rounds and 1/4ly	# of staff recruited to the wound team and additional training; # of staff members involved in weekly wound rounds; % of reduction in the number of residents with new/worsening pressure ulcer	4 additional PSWs and 2 additional registered staff will be recruited by December 31,	The RNAO wound institute is only offered once/year however a
										2)Audits of weekly pressure ulcer/wound care assessment for all residents with skin integrity issues.	Education for registered staff by MRC and wound care champion. Weekly audits of assessments to ensure thorough, accurate completion by MRC/RCC/wound care champions. Care plan audits of applicable residents by MRC/wound care champion to follow up	# of staff educated; # of assessments and audits completed; # of care plans that reflect the identified skin integrity issues and goals of care; % of improvement to the worsening pressure ulcer indicator	100 % of registered staff will be educated by July 1, 2018; 100 % of assessments	
										3)Implementation of individualized plan of care to reflect the residents needs and preferences for rest periods which support	Education for staff by management and wound care team. Education for resident and family by wound care team/registered staff at care conferences and as per changes in skin integrity/new or worsening ulcers. Audits of care plans by MRC/RCC monthly	# of staff educated; # of applicable resident and family educated; # of audits completed; % of improvement in the indicator worsening pressure ulcers	100 % of staff educated by July 31, 2018; 100 % of applicable residents/families	A barrier to this change idea will be non-compliance of resident and/or
Patient-centred	Person experience	Percentage of residents responding positively to: "What number would you use to rate how well the staff listen to you?"	P	% / LTC home residents	In house data, NHCAHPS survey / April 2017-March 2018	53117*	92	100.00	2017 survey results indicated that only 2 of the 26 respondents provided a lower than satisfactory rating; therefore the Home feels that the goal of	1)Revision of the multidisciplinary care conference assessment tool to support a more inclusive, thorough review of resident	Revision of the multidisciplinary care conference assessment tool by management. Education of registered staff on the revised tool by the management team. Implementation of the tool by registered staff and managers. Audits of use of the tool by	# of staff educated; # of multidisciplinary care conference assessment tool completed; audit results; statistics related to the # residents/family would use to rate how well staff listen	100 % of staff educated by May 31,2018; 100 % of multidisciplinary care conference	A barrier to achieving 100 % could be resident/family expectation
										2)Annual satisfaction surveys to be distributed throughout the year at all annual care conferences to support more timely	Add the annual resident satisfaction survey to the multidisciplinary care conference assessment tool. Educate staff on the use of the tool. Ensure the survey is accessible at annual care conferences and encourage resident/family to complete and return the survey.	# of completed annual satisfaction surveys; # of staff educated; % of increase in how well staff listen to you indicator	50 % of surveys handed out an the care conference completed by December 31,	A barrier to this change idea may be the willingness of residents and
		Percentage of residents who responded positively to the statement: "I can express my	P	% / LTC home residents	In house data, interRAI survey / April 2017 - March 2018	53117*	CB	CB	We do not have this exact question in our survey, therefore will	1)We do not have this exact question in our survey, therefore will not be working on this quality indicator - we have selected	none	none	none	We do not have this exact question in our survey, therefore will not be
		The percentage of residents whose care plan accurately captures the residents' expressed wishes for palliative and end-of-life care.	C	Rate per 100 residents / LTC home residents	In-home audit / April 1, 2018 - March 31, 2019	53117*	CB	CB	This indicator is being carried over from the 2017/18 QIP, therefore, baseline data will be collected for 2018/19.	1)Policy and procedure review with a focus on education, documentation, conversations and goals of care/care planning for the	2 staff to participate in the IDEAS project with HQO and HPCO; policy and procedure review; Education of staff; Education of residents/SDMs; Implementation of policy; Audit and analysis of care planning and documentation	% of staff, residents/sdm educated; # of care plans capturing required information/documentation	100 % of registered staff will complete education by December 31,	The IDEAS project begins April 2018 x 6 months; policy and procedure
										2)Education for staff, residents and family/SDM regarding palliative and end-of-life care, expressed wishes, consent, care	2 staff participate in the IDEAS project to develop an approach to support the LTC sector; Utilization of the resource manual to be released spring 2018; Education of staff and applicable residents and families	# of staff and applicable residents/SDM educated; % of residents whose care plan/documentation captures expressed wishes and goals of care to support palliative and end-of-life care	100 % of staff and applicable residents/SDM will be educated by December 31,	The IDEAS project work will provide tools and process to support this
	Resident experience: "Overall satisfaction"	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	53117*	95.24	100.00	The goal of a 5% increase and return to 100 % of respondents recommending the Home is achievable based on the previous survey results. The	1)Host an information session for all residents/families/stakeholders (e.g. auxiliary, foot care, PT, etc.) to provide	Development of an agenda by the management team. Obtain input from resident/family council regarding agenda, time of day, potential speakers, etc. Schedule and send out invitations in billings, website, and post within the Home by MPT. Ensure satisfaction surveys	# of attendees; # of surveys completed; statistics related to the indicator of would you recommend this Home to others	25 % of residents/families will attend; 10 % increase in the # of surveys completed	New management and services provided in the Home supports an
										2)Implementation of the "Bringing the Residents Bill of Rights Alive" initiative into the Home to heighten awareness regarding	Attend webinar regarding initiative (management team). Education for staff, residents, families re: program by MPT. Develop a committee of residents, family and staff (MPT). Implementation of the program	# of staff interested in the program that are educated; # of staff, residents, families that participate in the program; successful implementation of the program; % of improvement to the indicator of would you recommend this Home to others	100 % of staff interested in participating in the program will be educated by	The "Bringing the Residents Bill of Rights Alive" initiative has recently been
Safe	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	53117*	14.94	14.50	The Home currently sits well below the provincial average of 20 % and the benchmark of 19 % so has set a marginal target of a 2.95%	1)Provide education to BSO team including coding and access to monthly pharmacy reports that provides information	Education of the BSO team by pharmacist consultant re: access and interpretation of reports (online); Analysis of the reports by the BSO team; Family, resident, physician, BSO team discussion re: goals of care and care planning of non-pharmacological	# of staff educated; # of reports analyzed monthly; % of reduction in the use of anti-psychotics without a supporting diagnosis; # of care plans updated with non-pharmacological interventions/strategies	100 % of BSO staff will be educated by May 1, 2018; 100 % of reports analyzed monthly	Ongoing BSO team development and implementation of tools and
										2)Analyze the sleep patterns of all applicable residents on anti-psychotic medications without a supporting diagnosis in	DOS mapping with a focus on night time activity/sleep by PSW staff; Audit of sleep and rest pattern in the care plan by registered staff and management; Education of staff on the impact of disrupted sleep pattern on responsive behaviours by BSO team members	# of applicable residents on an antipsychotic without a supporting diagnosis with DOS mapping completed; # of residents on an antipsychotic without a supporting diagnosis who have had their care plan audited; # of staff educated; % of reduction in the use of	100 % of residents on antipsychotic without a supporting diagnosis have	The findings from the DOS mapping may/may not support the reduction in the
	Safe care	Percentage of residents who fell during the 30 days preceding their resident assessment	A	% / LTC home residents	CIHI CCRS / July - September 2017	53117*	7.2	7.20	The Home is well below provincial average of 15.6 % and the benchmark of	1)When frequent and high risk fallers are reviewed by the falls and restraints committee, a progress note will be completed	Falls and restraints committee will review high risk and frequent fallers; progress note will be made at the time of committee review.	# of falls and restraint committee meetings; # of high risk and frequent fallers reviewed at meetings; # of high risk and frequent fallers who have a progress note completed regarding the meeting and action plan; % reduction in the # of falls by high risk/frequent fallers	monthly Falls and Restraints meetings beginning June 2018. 100 % of	
		Percentage of residents who were physically restrained every day during the 7 days preceding their resident assessment	A	% / LTC home residents	CIHI CCRS / July - September 2017	53117*	41	20.00	The Home statistics do not align with the provincial average of 5% and has set a goal of reducing physical restraints by 50 % by March 31,	1)Education of staff, residents, and families regarding the risks related to the use of physical restraints, PASDs and	Ongoing surge learning by all staff; Contracted service provider education (OT, PT); Audit and analysis of restraint usage by RCC; Weekly restraint huddles to include discussion re: who, when, why, and how physical restraints are being used and opportunities to	# of physical restraints and PASDs by unit; # of staff educated; # of applicable residents/families educated; # of audits completed with analysis; % of reduction in physical restraints	50 % reduction in restraint usage and 10 % PASD by march 31, 2019; 100 % of staff	The Home statistics that are publicly reported capture PASD usage due to the
										2)Introduction of a revised risk management checklist whenever a restraint is considered for use to support alternative	Revision of the risk management checklist by management. Education regarding the revised tool by management. Implementation of risk management tool by registered staff. Audits of completion of tool at the point of care by MRC/RCC. Review of physical restraint	# of staff educated # of risk management tools completed with appropriate follow up and interventions % of reduction in physical restraints	100 % of staff educated by July 31, 2018 100 % of tools completed beginning August	The risk management tool will be revised to support positive

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)