2022/23 Quality Improvement Plan for Ontario Long Term Care Homes

"Improvement Targets and Initiatives"

St. Joseph's Lifecare Centre 99 WAYNE GRETZKY PARKWAY, Brantford , ON, N3S6T6

AIM		Measure							Change				
Quality dimension	**Objective**	**Measure/Indicator**	**Unit / Population**	**Source / Period**	**Organization Id**	**Current performance**	**Target**	**Target justification**	**Planned improvement initiatives (Change Ideas)**	Methods	Process measures	Goal for change ideas	Comments
Safety	To Reduce the Use of Restraints	Percentage of residents who were physically restarined (daily)	%/Residents	CCRS, CHI (eReports) / Q2 FY 2021/2022	54507*	5.4	10% Reduction	Establish baseline data post pandemic	1) Continue current process for restraint review and resident safety.	Review of device use on admission and on going. Referrals to PT/Restorative Coaches. Alternatives to use of restraints. Education of staff. Review and education residents and family.	# of restraints in use audit will be completed quarterly	Reduce total # of restraints	As of QI 2022-23, percentage of residents physically restrained is 2.2% (4/183). Rationale: changes in resident population d/t discharge.
									2) Providing Education to families on Restraints in LTC homes	Using in-house physio service to provide education to families through Family Council & online educational resources. For families not on email system information on restraint use can be sent via mail.	# of restraints in use audit will be completed quarterly	To have 90% of families (email list and mail out) and staff educated	Change ideas identified as part of this QIP plan in March 2022 have been reprioritized d/t COVID 19 outbreak management, staffing shortages and compliance action plan requirements.
									3) Educate nursing staff on restraints and alternative equipment intervention program.	Provide program overview at PSW and Registered staff meetings.	# of restraints in use audit will be completed quarterly	To have 90% of PSW and Registered staff educated by September 30th, 2022.	This target date will be re-evaluated d/t refocused efforts to manage COVID 19 outbreaks and associated compliance action plan from May 2022 MLTC inspection.
Safety	Reduce Newly Occurring Stage 2-4 Pressure Ulcers by 10%	Percentage of residents with a newly occurring Stage 2-4 Pressure Ulcer	%/Residents	CCRS, CHI (eReports) / Q2 FY 2021/2022	54507*	4.7	10% Reduction	Establish baseline data post pandemic	The team is aiming to reduce the number of newly acquired stage 2-4 pressure ulcers by 10% through implementation of change ideas.	Dr. Karen Campbell Acheiva Health Sue Grinton (Medline)	1)Provide education on Wound Care Approaches to Nursing staff (RN/RPN/PSW's)	Completion rates of education provided by Dr. Campbell through zoom calls OR video recordings via Surge Learning (e-Learning software)	As of Q1 2022-23, percentage of residents with new stage 2-4 pressure ulcers is 5.6% (9/160). Implement PCC skin and wound app by Nov 2022. This project implementation will include a review of the current wound care protocols according to evidence based practices.
											2) Provide education on Positioning & Transfer Techniques to Nursing Staff (PSWs)	Completion rates of Acheiva Health education video's via Surge Learning (e-Learning software)	Due date for PSW staff training Dec 31-22.
											3) CST (clinical support team) to complete new TRC Wound Assessment Tool and suggest areas of improvement prior to training registered staff.	TRC Wound Assessment tool implemented on PCC December 2020. CST currently working on introductory phase of assessment. CST to provide training to registered staff.	TRC CST tools will be replaced with the PCC skin and wound application.
											4) CST to audit completion rate	Audits will be conducted quarterly.	PCC assessments

											of TRC Wound Assessment Tool		
Safety	Ensure Emergency Preparedness	Mask Fit Testing % Staff Completed Number of current active staff who have mask fit test complete / Total Number of current active staff	% / Current Active Staff	Intenal Data Collection	54507*		100%		1)Maintain the current number of trained fit testers as a minimum	Existing certified fit testers will train new fit testers as required.	Number of fit testers trained and available to run fit testing clinics.	We aim to maintain a minimum of 2 fit testers.	This is a skill development/training initiative. Aligns with the following strategic directions: Focus on Residents First, Lead in Quality and Safety and Optimize Resources. This was not a successful strategy d/t staffing shortages. A mask fit testing company was engaged.
											Minimum number of fit test clinics scheduled per quarter	Goal to hold at least 1 clinic each quarter and on an as needed basis.	This is a process improvement initiative that will increase opportunities for staff to get tested. Aligns with the following strategic directions: Focus on Residents First, Lead in Quality and Safety and Optimize Resources. External agency tested 122 staff July 18-19, 2022.
											Number of current active staff members with an expired mask fit record on file	Decrease # of expired mask fit records	This is a process improvement initiative to ensure that our mask fit testing program is consistently applied and sustainable. Aligns with the following strategic planning direction: Lead in Safety and Quality. External agency to be booked for the Fall 2022.

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ST.JOSEPH'S LIFECARE CENTRE BRANTFORD

AIM		Measure								Change				
Quality Dimension	Objective	Measure/Indicator	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	Priority level	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Goal for change ideas	Comments
Safety	**To Reduce Worsening of Pressure Ulcers**	Percentage of residents who had a pressure ulcer that recently got worse	% / Residents	CCRS, CIHI (eReports) / Q2 FY 2014/15	54481*	2.66	1	Provincial Benchmark is 1%	Improve	1)Accurate and completed Weekly Skin Observation Forms	-Educate registered staff on how tool is used and ensure it is being used for residents who are identified as having pressure ulcers -Conduct audits of tool to make sure information is being gathered	-# of staff using assessments, # of completed assessments each month	-100% of residents will have completed Weekly Skin Observation Forms by December, 2015	
										2)Completing Pressure Ulcer Rating Score and Braden Skin Assessment	-Educating registered staff to complete both Pressure Ulcer Rating Score and Braden Skin Assessment -Conducting audits on assessments	# of staff completing assessment each month % of uptake of education each month	100% compliance in use of of Pressure Ulcer Rating Score and Braden Skin Assessment by December 2015	
	To Reduce the Use of Restraints	Percentage of residents who were physically restrained (daily)	% / Residents	CCRS, CIHI (eReports) / Q2 FY 2014/15	54481*	6.38	3	The provincial benchmark is 3%	Improve	1)Providing Education to families on Restraints in LTC homes	Using in-house physio service to provide education to families through Family Council & online educational resources. For families not on email system information on restraint use can be sent via mail.	% of POA/SDM who have changed attitudes on restraints each month.	-1 in-service per year to POA/SDM on restraint use by August, 2015 -100% of POA/SDM given information on use of restraints by March, 2016	
Effectiveness	**To Reduce the Inappropriate Use of Anti psychotics in LTC**	Percentage of residents on antipsychotics without a diagnosis of psychosis	% / Residents	CCRS, CIHI (eReports) / Q2 FY 2014/15	54481*	22.6	15	This is the first time we are looking at this category, an approximate 30% decrease seems feasible	Improve	1)1.) Use of Life Story to introduce non-pharmacological interventions to help decrease responsive behaviours	1.) Life Story: Since January 2014 Lakeside has been using Life Story with residents coming into the home. Once information is collected it is compiled and put into a document and shared across disciplines. We also work with families, LTC homes, Rehab institutions, hospitals to get as much information on managing behaviors so we are more prepared to handle responsive behaviours with residents	1.) # of Life stories on residents in home, # of residents whose behaviours improved without the use of anti-psychotic medications each month	1.) 100% completion of Life Story on new residents or current residents with responsive behaviours or mood disturbances by April, 2015	

										2)2.) Use of Montessori Based programming by Behavioural Activity Aide to help re-direct residents experiencing responsive behaviours or mood disturbances	2.) The use of regular Montessori Based Programming in our secure floor has resulted in a 25% decrease in responsive behaviours. We are looking at taking this to all other floors with the use of a Behavioural Activity Aide. Lakeside has identified residents based on risk. Baselines will need to be collected on CMAI, GDS, and personal engagement scores	2.) # of residents who used montessori based programming to decrease responsive behaviours without the use of anti psychotic medications % of residents with responsive behaviours whose CMAI scores have decreased # of residents with increased personal engagement scores each month	100% of residents experiencing responsive behaviours or mood disturbances will be assessed by Behavioural Activity Aide and customized activities will be created by July, 2015	
										3)3.) Accessing BSOT, PRC, GMHOT, Pain Consultation Teams for support and ensuring information is updated in plan of care	3.) Lakeside has created a decision tree in house to educate staff on how to navigate behavioural resources in the home and externally. Behavioural nurse has been hired to help with supporting external teams & also ensuring information is captured in plan of care	3.) # of residents referred to external teams # of residents whose behavioural symptoms decreased due to the introduction of pain medication instead of anti-psychotics each month.	100% of care plans will be updated with appropriate information by April, 2015 100% of residents with behavioural or pain symptoms will be referred to external team or in-house team by April, 2015	
										4)4.) In house BSO and building a BSO team within the home to respond to behaviours in a timely manner	4.) Education on Building a Behavioural Support team was provided to staff in March, 2014. We will be looking at creating a referral form for in house referrals.	4.) # of referrals to in house team # of Code Whites in home each month.	In House Behavioural team will be implemented by August, 2015	
										5)Weekly Behavioural Rounds with all home areas	-Using BSO Whiteboard on units during rounds to better understand triggers of residents experiencing responsive behaviours -Developing strategies during rounds and documenting what strategies will be used and by whom -Using tools as needed during rounds such as PIECES Framework -providing education on Pro-Attention Plan use, education on GPA techniques, PAINAD, Behavioural Mapping, documentation	# of meetings held # of improved documentation entries per unit # of reduced staff injuries due to responsive behaviours each month	-100% compliance on weekly behavioural rounds with supporting documentation by May, 2015 -80% of responsive behaviour PCC notes need to be complete with no missing information by December 2015 - Reduce staff injuries due to responsive behaviours by 50% by December 2015	
Resident-Centred	**Receiving and utilizing feedback regarding resident experience and quality**	Percentage of residents responding positively to: "What number would you use to rate how well the	% / Residents	In-house survey / Apr 2014 - Mar 2015 (or most recent 12mos).	54481*	CB	90	We are still collecting baseline	Improve	1)Currently collecting Baseline for residents	-Using InterRAI QOL Survey until question is incorporated on a corporate level into the Customer Satisfaction Survey	-Survey will be conducted during residents MDS assessment period once a year	100% of residents who are cognitively able to participate in survey will be surveyed by March, 2016	

	of life. "Having a voice".	staff listen to you?" (NHCAHPS)											
		Percentage of residents responding positively to: "I can express my opinion without fear of consequences." (InterRAI QoL)	% / Residents	In-house survey / Apr 2014 - Mar 2015 (or most recent 12 mos).	54481*	CB	90	This is our first time reporting in this area and we currently do not have a benchmark.	Improve	1)Currently Lakeside does not have this question on the Customer Satisfaction Survey. At a corporate level it is being looked at and will be added in the future. We will start to collect our baseline using the interRAI QOL survey for the timbering.	-Conducting survey with all residents who are able to participate in survey. -Surveys will be conducted on yearly basis	-Survey will be completed during MDS assessment period for each resident	100% of surveys to be completed on residents who are cognitively able to do so by March, 2016	
	Receiving and utilizing feedback regarding resident experience and quality of life. "Overall Satisfaction"	Improving Pleasurable Dining Experience	% / Residents	In-house survey / April 2015- April 2016	54481*	71	90	Our last Customer Satisfaction Survey indicated a decrease from 76.9% to 71%. We would like to raise the % to 80% by April, 2016	Improve	1)Improving Dining Room Experience in all home areas	We have looked at dining room experience on our secure unit and improved meal service through using Lean principles. We will improve dining room experience using the following methods: -Using PDSA and completing a PDSA template to see what issues are happening and coming up with a plan collaboratively to help improve service -Use of 5 why's to understand root cause of problem area -Using customer satisfaction surveys on Pleasurable Dining Experience to see what areas need improvement	# of improved scores on Pleasurable Dining Experience surveys # of staff satisfied with changes in dining room service % of respondents in annual Customer Satisfaction Survey who are satisfied with overall dining room atmosphere	-Improve overall dining room experience by 25% on Customer Satisfaction Survey by September, 2015 -Increase scores on Pleasurable Dining Experience Surveys by 40% by December, 2015	This area was looked at in our Lean Initiative as it was identified in our 2014 Customer Satisfaction Survey that we had a decrease from 76.9% to 71.0% in overall dining room atmospher e
Integrated	**To Reduce Potentially Avoidable Emergency Department Visits**	Number of emergency department (ED) visits for modified list of ambulatory care sensitive conditions* (ACSC) per 100 long-term care residents	% / Residents	Ministry of Health Portal / Q3 FY 2013/14 - Q2 FY 2014/15	54481*	25.81	18	Provincial score is 23.82 we would like to aim for 18	Improve	1)1.) Collaborating with Pain Palliative Consult Team from Dorothy Ley Hospice to help residents who are experiencing pain & using pain assessment tools appropriately	-Providing education to staff on Palliative Care & Pain Management - Using PAINAD and Pain Assessments to identify pain in residents - Providing reminders at Pain, Palliative, Ethics committee meetings	# of residents with decreased scores on pain assessments # of residents who are admitted to palliative care in hospital each month	100% completed PAINAD and Pain assessments by August, 2015 100% of residents experiencing pain that is not being resolved are being referred to Pain Palliative Consult Team by May, 2015	
										2)Educating Families on Advanced Directives and choosing appropriate Level of Care	-Education from Ethicist at UHN on Advanced Care Planning -Palliative education from Hospice to help families understand palliative care and end of life	# of residents going to ED each month	-1 Education Session on Advanced Directives has to be provided by December, 2015	

										3)Use of Mobile Nursing Team	-Educating staff of resources available -Educating family on benefit of having Mobile Nurses involved rather than going right to ED	# of referrals to Mobile Nursing Team # of residents sent to hospital without seeing Mobile Team # of families who agree to use Mobile team first prior to ED visit	100% education provided to staff on using Mobile Nursing Team by May, 2015	