Let's Make Healthy Change Happen.

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

Greenwood Court
A Division of
Tri-County Mennonite Homes
Making Every Day Matter

3/13/2018

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

Greenwood Court is a community of care located in Stratford, Ontario. Greenwood Court consists of 45 bed Long-Term Care, 20 retirement suites and 85 independent apartments. The home is fortunate to have the support of our retirement and independent residents who support our long-term care residents in assisting to porter to and from programming as well as visit with in our communal lounges. Greenwood Court is divided into two units, one 15 bed memory care unit and a 30-bed unit where residents have a range of clinically complex care needs.

Greenwood Court is one of three divisions of Tri-County Mennonite Homes and we share the mission statement of "Making Every Day Matter". Quality initiatives are driven by feedback we receive from residents, families and friends, staff, volunteers and external stakeholders and all are related back to the mission statement.

Recruitment and retention continues to be an ongoing concern. Two years ago, the home struggled to be compliant with having a Registered Nurse 24/7. Now the home struggles to recruit and retain qualified and caring PSW staff as well as qualified Food Service Workers. We have partnered with local colleges in supporting work exploration placements for potential applicants, have attended job fairs, are hosting an education/job fair at the home in March 2018 to attract staff to the role of the PSW program and Food Service Workers, have partnered with Partners in Employment to sponsor a staff member in completing the PSW program, supporting high school co-op students to attract them to become PSW's as well as inviting potential staff to complete a volunteer shift where they follow a staff member to get a full grasp of the role prior to joining the team. Enhancements to our on boarding program were implemented in 2017 and this will continue to be expanded into 2018. Staff are our most valuable commodity and we want to ensure the time and monies invested in training is effective in welcoming the new staff to the home, ensuring they are prepared to meet the requirements of the position but most importantly that we Make Every Day Matter for them as well.

The home continues to analyze MDS-RAI data and outcome scores, as performance indicators for the programs that we have developed. Reviewing this data weekly, with the RAPS meetings and monthly, at the Resident Care/Quality meetings, has increased staff awareness of the importance of these tools. The home continues to be higher than the provincial average for number of residents who have fallen in the previous 30 days as well as the number of residents with worsened stage 2-4 wounds. These indicators will be a focus for the 2018/2019 Quality Improvement Plan.

The process for welcoming a resident to our home has been identified by the team as an area that we can do better, and this is another focus for this year. Engaging residents in the moment will be another area that we target as we know residents who are engaged are less likely to feel lonely and depressed which can lead to other behaviours.

Our 2018 L-SAA demands an ongoing commitment to Palliative Care. Tri-County Mennonite Homes has a partnership with the Stratford-Rotary Hospice which will be built on site at Greenwood Court. This very welcomed community service has peaked everyone's interest to improve the end of life care that we provide at our home and we continue to reach out and implement best practice approaches to care.

Other areas the home needs to meet for 2018 include the development of a training plan for health service providers to understand their role in improving the Indigenous patient experience and cultural competency training.

The home must also work towards using a specified linguistic variable from the French Language Service toolkit to ensure we are addressing the needs of the local Francophone community.

A Family Satisfaction Survey was completed in the fall of 2017 and results have just been received. The results will be analyzed to develop an action plan for implementation of areas where the home did not meet the expectations of our customers.

Monthly, resident surveys are reviewed as a part of our Quality team meetings to ensure any concerns are resolved to ensure the resident's needs are met in the way they want them to be met.

The changing landscape of care is also on the forefront of our home's quality journey. The need to finalize the home's approach to MAID as well as Medical Marijuana to ensure our staff are educated and comfortable to address resident requests for information on these topics if raised.

Quality is an ever-changing journey and our Quality Plan is a document that promotes the home to move forward with projects identified knowing that the plan may need to be adjusted based on a change in the needs of our residents to ensure need to ensure we are Making Every Day Matter for everyone.

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

Improving our communication to resident's and families has been a priority focus for this past year. This was part of the Quality Plan by increasing awareness and knowledge of Advance Care Planning and the home continues to promote conversations with residents and family members on what a resident's values and priority of care is at the time of a change in health status. Any time a resident has returned to the home post a hospital transfer, facility staff discuss with the resident and/or family the outcome of the transfer and plan for what the resident would want if this occurs again. Education about what care services the home can provide alleviate concerns that a resident may suffer if they do not go to hospital and repeating these conversations improve trust between the resident and staff.

The addition of the Nurse Practitioner to our care team has supported the registered staff in their assessments of a resident who is experiencing a change in condition and has promoted more accurate and timely communication with families and physicians. The Nurse Practitioner has also built positive communications with residents and families and supports the staff through resident care transitions.

The results of our Family Satisfaction Survey support this initiative. Family members were asked "do you get adequate information from the staff about the resident's medical condition and treatment?" In 2014, feedback was 65% of respondents felt we met this indicator. In 2017, 83% of respondents felt we met this indicator, an increase of 18%.

The home has recently updated the end of life survey that is sent to our families six weeks after the passing of their resident. To date, four surveys have been received and 100% commented that they were kept informed of changes in the resident status, what treatment regimen the staff were following and explaining what medications were being used.

The use of the One Call system also promotes communication to all families at the same time of any change in the home, i.e. an outbreak and what protocols are being taken.

Communication is an area that we will also be working on improving but we are very proud of the successes we have had over the past year and will continue to build on this foundation.

Resident, Patient, Client Engagement

Resident and Family engagement continues to be a priority at Greenwood Court.
Resident Council members provide feedback in the development of the Quality Improvement Plan. The Director of Care met with the members to review the progress report on the previous plan, to review concerns brought forward throughout the year to discuss if other residents are experiencing similar concerns and to review the action plan to ensure the residents are satisfied with the results.

An education board was posted in the home to explain to the residents and families and visitors what our priority indicators were for the previous year and updates will be posted to let all know about our successes and areas where we still need to work towards meeting our goal.

Our family education nights provide another opportunity for the staff to share the quality journey with our residents and family and provide a live forum for questions and feedback. A Family Satisfaction Survey was completed in 2017 and the results will be used to develop the Quality Plan for this year.

Resident surveys are completed prior to the resident's admission conference and the annual care conference. All residents with a CPS score of three or lower are interviewed and feedback relayed to the appropriate staff for resolution of any concern prior to conference.

Monthly food committee meetings also provide a forum for residents to review quality initiatives in the home. Food is a very personal subject and gathering together to discuss menu and recipe options as well as feedback on the meal, provide valuable data for the department to make improvements. This meeting was also changed to an afternoon meeting which has increased the attendance by 10% as more residents are able to participate.

The home continues to promote customer service in the home so that all staff are aware of a resident concern and are passing it on quickly to the appropriate manager so that the issue can be addressed, and resident feedback received on the resolution of the concern.

Collaboration and Integration

Improving the resident experience is the focus for our Quality Improvement Plan and we recognize that we do not travel this journey alone.

The home has a positive relationship with the local Alzheimer's Society, who has facilitated care meetings to help staff develop initiatives to meet specific residents' needs. The Alzheimer's Society also hosted a care giver support group, for families caring for residents with dementia at the home, which provided support to our resident's families who are struggling with this disease. They support our staff with training as well such as the GPA refresher days.

Our BSO team is active within the home and reaches out to our Seniors Mental Health team for additional support when current interventions are not effective for a resident. Staff have focused on increasing their own understanding of residents with dementia, making use of the Teepa Snow training videos and implementing some techniques such as the GEMs and hand over hand care giving approaches.

We have utilized OTN for virtual referrals to specialists, with this being facilitated by our Nurse Practitioner. This saved a resident from having to travel to London, for a physician appointment, allowing the specialist and resident to talk face to face, via OTN.

The Director of Care participates in bi-weekly calls when resident need dictates, with the Palliative Care providers in the Stratford area. Together they offer suggestions into resident care needs. This call is led by the Pain and Symptom Management Co-Ordinator, and offers alternative care approaches, that can be trialed within the home to prevent a transfer to hospital. We have also used the consultant physician to help manage end of life care for a resident/family with great success.

The home has reviewed with the hospital's Quality Assurance Program, the care of a resident who was transferred to Acute Care and returned home, to Greenwood Court, to ensure the best care possible was provided to the resident.

Our Nurse Practitioner has partnered with RNAO on best practice topics such as hypertension and Oral Health which the home then reaps the benefit from. The NP is also part of a support group of NPs' in LTC who share ideas and experiences to improve the care our residents receive.

Our NP and DOC also participate in monthly Regional Geriatric Co-operative meetings along with community, Acute Care, Placement, VON, One Care, and provincial representation review and plan for the care of residents with dementia and behaviours.

Our consultant pharmacist plays an important role in health teaching to our residents and family members as well as to our staff. The online resources that are available for our staff to access at any time but also with quick responses to questions.

Both the ED and DOC are active members of the Huron-Perth Facility Operators group where sharing of best practices occur and review of external stakeholder's impact on the homes occurs. Planning for advocating for the seniors in our care is the ultimate goal.

Our home actively participates in a Quality Leads Committee where the Quality Leads from our surrounding Not-for-Profit Long-Term Care Homes gather: to review RAI data from each of our homes; to share initiatives that are working well and that may be trialed in another home; to discuss best practices and to be a resource for each other.

The Executive Director is the co-chair for the Long-Term Care Homes Network and this provides the home with additional resources for best practice, and to provide feedback to the SWLHIN to promote quality care.

The Leadership team including the RAI coordinator participate in Region 3 meetings from AdvantAge, the Not-For-Profit Association to which our home belongs. These meetings provide another forum for sharing best practice approaches.

Engagement of Clinicians, Leadership & Staff

Choose Your Focus was the topic to direct all team members to reflect on what is the priority in the moment. How do we "Make Every Day Matter" for the residents, families, visitors and staff if we are not choosing the priority focus. This topic encouraged staff to share their feelings and provide feedback in a safe area of how to make choices that benefit all, not belittle.

Monthly resident care meetings promote the interdisciplinary team to meet to review outcome measures from RAI data and develop action plans to meet resident needs. The timing of these meetings was adjusted in this year to include the home's Physiotherapist and the Nurse Practitioner. Quarterly, our Hospice Volunteer coordinator is also present to review the residents who are being supported by volunteers from the community.

Quarterly, board members are now in attendance and provide feedback at the Professional Advisory Committee meetings and this brings a different perspective to action plans of the home. External Stakeholder reviews are taken to the frontline staff so that action plans, if required are developed from the ground roots up with then reports back on the success of the action plan.

Staff were encouraged to provide feedback in the development of our Quality Plan with pages posted throughout the home for staff to answer questions about how they meet the quality indicators, how we communicate this data, areas for improvement, etc. so that this data is then incorporated into this year's plan.

In-the-moment huddles will be a focus for the upcoming year to promote quality conversations on the unit right where the care is occurring. Making all staff accountable for quality improvements is the only way we will be successful in seeing improvements.

Population Health and Equity Considerations

Greenwood Court is located in Southwestern Ontario and serves residents from the city of Stratford, the surrounding rural area, and also from across the province as children move their elderly parents to this area to be closer to them. Perth County is considered to be over bedded for Long-Term Care beds despite the emergency closing of 60 LTC beds two years in the same community. Most residents have waited over 450 days to come and live here with the exception of the rising need for crisis placement, most who are no longer able to meet their own care needs due to varying degrees of dementia. According to CIHI (2017 Q3 data), 73% of residents have a diagnosis of dementia including Alzheimer's or dementia other than Alzheimer's.

Residents are coming to live at Greenwood Court in more frail conditions, having significantly more complex care needs and further along in their aging process. 20% of residents have a diagnosis of Parkinson's disease, 18% diabetes, 77% with Heart Disease including 66% with hypertension, 22% with osteoporosis and 13% with CVA. 20% of our residents are male and 80% are female.

Health Equity:
How does Greenwood Court ensure that a resident who is part of a more vulnerable population has access to the resources they require to promote the same health outcomes as the general population. This includes the use of OTN for a resident to be able to have an appointment with a specialist where the resident was not able to physically travel the distance to the appointment.

The use of care conferencing meetings with Acute Care staff provides our home with data about existing practices that are working for a resident, so that we are able to adopt these practices prior to the resident moving in.

The use of language cards with translations of more common words are used for our Dutch and Italian speaking residents. The use of white boards to write out conversations with our hearing-impaired residents are techniques the staff use to promote equal care.

Staff are acutely aware of the needs of our residents with vision impairment with staff advocating for enhancements such as coloured dishes, coloured placemats, verbal descriptions of meal choices and placement on the plate.

As part of our commitment to the 2018 L-SAA, staff will be participating in education on how our health system impacts the indigenous experiences and what changes we can make to improve this system.

Access to the Right Level of Care - Addressing ALC

Greenwood Court has one of the longest wait times for placement in the Southwest LHIN. This number is also reflective of the fact the home has only 45 beds so wait times are exaggerated.

The home is structurally built with 32 beds in our Colonial unit but are only licensed for 30 beds which allows the home to provide placement for two residents who are waiting to move into our Long-Term Care home or who may be in a crisis in the community. A resident is then able to wait for Long-Term Care placement while being supported in a care facility in our Non-Funded beds. The staff of Greenwood Court will attend care conferencing meetings at the hospital to have a better understanding of the care needs of a resident prior to him/her moving into the home.

Clinical Connect is another tool that the home is able to access current health information when a Long-Term Care resident has been transferred to Acute Care. This allows the staff of the home to prepare for the resident's care needs to be able to return to the home in a timely fashion when they are determined medically stable for discharge.

Collaboration with Acute Care and the home's pharmacy also facilitates transfers back to Long-Term Care. The home is able to determine what medications would be required when the resident returned to the home and before our on-call pharmacy is able to provide the medications to the home. Acute care is able to send initial doses of medications, with the exception of narcotics, so that a resident's transition is more seamless and current treatment can continue.

Opioid Prescribing for the Treatment of Pain and Opioid Use Disorder

Pain management is an ongoing focus of the home at our monthly resident care meetings where we analyze the outcome scores specifically looking at worsening pain. CIHI stats for quarter two of 2017 show that our home has 18.2% of our residents have worsened pain where the provincial stats for the same period are 9.9% and the SWLHIN results are 12.6%. Residents that had pain during the same period results was 4.2% where the provincial average was 5.9% and the results for the SWLHIN were 7.2%.

Pharmacy statistics show that in January 2018, 15% of our residents have an order for narcotic medication and 78% of residents have an order for a non-narcotic analgesic such as acetaminophen or ibuprofen order. This statistic includes a PRN order. Some residents also use an antidepressant for pain relief.

The front-line staff are very responsive in offering warm blankets, massage with heat rub, re-positioning, a drink, sit and hold a resident's hands, as ways to provide pain relief without the use of medications.

End of Life Directives were reviewed with the registered staff, NP, Medical Advisor and Consultant Pharmacist to promote timely pain management for residents. Registered staff will obtain orders when they note a change in resident's condition to ensure we have the orders and do not have to wait to start pain management.

The home also added Naloxone to the ER box this year to be able to treat a narcotic overdose if required. An education session was held for the registered staff by the NP and consultant pharmacist to ensure all staff are comfortable with how to administer the emergency medication and what the indications for use would be.

One RN completed the CAPCE program and three more staff completed the Fundamentals of Hospice Palliative care program. This valuable education increases the awareness of appropriate use of narcotics, when to use what medication and what to watch for.

Implementation of every shift checks for the presence of a Fentanyl patch and patch-for-patch program continued to prevent diversion of the drug. This is also audited monthly by the consultant pharmacist and Director of Care with medication audits.

The home is currently developing a draft policy related to the use of Marijuana for pain relief. We have not had a need to use, but aware that this may come in the very near future.

We have supported residents with a history of substance abuse but have not managed a resident who is acutely struggling with addiction. The home is aware of community supports through Senior's Mental Health, Canadian Metal Health as well as Choices for Change and would reach out for support as well as accessing whatever supports the resident may currently have.

Workplace Violence Prevention

Greenwood Court promotes the values of respect, teamwork and responsibility, which are the cornerstone to promoting staff safety and preventing workplace violence within the home.

As we provide care and services to vulnerable individuals who are living with dementia, in addition to other chronic medical conditions that have responsive behaviours associated with them; we encourage all staff to report all incidents of workplace violence so that potential triggers are identified, and plan of care can be updated.

Education for staff occurred to promote this valuable reporting, as staff begin to see a resident interaction that happens with each care touch point as something that just happens, and no longer see it as an incident that needs to be reported. However, this is the information that is so important to ensure we have implemented interventions to keep our staff and our residents safe.

Our internal BSO team works closely with the front-line staff to identify potential triggers for responsive behaviours and works diligently to find the meaning behind the behaviour. We are able to access additional supports through the Alzheimer's Society and Senior's Mental Health to reduce the risk of violence while supporting staff. Action plans are developed to engage the support of all departments and not just nursing staff in decreasing the risk of unpredictable responsive behaviors.

Mandatory training focused on using the PIECES model to approach each change in behavior, using this template to work through what may be the cause behind the behaviour. GPA refresher education sessions were held with 70% of our Nursing Department attending this training.

The home will access one-to-one support for a resident with extensive responsive behaviours to ensure their own safety, as well as the safety of the other residents and staff. This funding is not guaranteed however, at the time, nor are there appropriately trained staff to access at the time when this is needed.

New resident applications are reviewed to identify potential risks and conversations with current care providers as well as the care coordinators from the LHIN to ensure a safe transition to the home and unit occur. At times, an admission may need to be postponed due to the dynamics currently on the unit, for fear a new client may escalate what is already happening. Again, this is done in collaboration of the care team at the home as well as support from the placement team at the LHIN.

Health & Safety training was once again, part of the agenda for staff mandatory training days in 2017. All staff who attended, participated in a Health & Safety Scavenger Hunt, in which they were required to find specific

Health & Safety items or scenarios. This exercise proved to be a valuable learning experience for new staff, and longer-serving staff received an important reminder as to locations of SDS sheets, eye wash stations, and the names of their Joint Health and Safety Committee members.

Harassment and Bullying will be a priority education topic for all staff as identified by our corporate Health and Safety Committee.

Greenwood Court, as a division of Tri-County Mennonite Homes, makes available an Employee Assistance Program to all staff and staff are encouraged to reach out to this valuable, confidential resource.

Contact Information

Greenwood Court
90 Greenwood Drive,
Stratford, Ontario
N5A 7W5
519-273-4662

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

ORIGINAL SIGNATURES ARE ON DOCUMENT POSTED IN THE HOME

Board Chair / Licensee or delegate _____ Brenda Howorth

Administrator /Executive Director _____ Joyce Penney

Quality Committee Chair or delegate _____ Judy Johnson

Director of Care _____ Mary Anne Weller