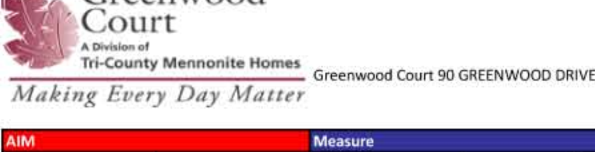
2018/19 Quality Improvement Plan for Ontario Long Term Care Homes
"Improvement Targets and Initiatives"



Greenwood Court 90 GREENWOOD DRIVE

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

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)

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	**Wound Care**	Percentage of residents who developed a stage two to four pressure ulcer or had a pressure ulcer that worsened to a stage two, three or four since their previous resident assessment	A	% / LTC home residents	CIHI CCRS / July - September 2017	53738*	10.12	9.00	To reduce new and worsened stage 2-4 wounds closer to the provincial average	1) To partner with South West Regional Wound Care program for timely access to ET for evaluation of wound assessment with best practice treatment plan to be implemented.	Four resident assessments to be completed as part of the trial through this initiative. All assessment documentation to be gathered by staff for review by ET prior to telephone case review. Review plan of care related to wound assessment so all staff are providing the same wound care. Education to staff on the importance of how to take a wound picture.	Number of residents monthly with new skin breakdown, number of residents with worsening wounds, number of referrals to program quarterly with monitoring of wounds once interventions have been implemented.	75% of referrals will be completed by SWRWCP by October 2018.	
										2) To implement best practice documentation tools for accurate tracking of wound progress.	To partner with IDEAS for best practice documentation tool. Tool to be uploaded to PCC for all staff to access. Education to registered staff on the completion of the tool.	Number of assessments completed using the new documentation tool.	75% of all new skin breakdown will be assessed utilizing the new documentation tool by December 31, 2018.	
										3) To incorporate best practice evidence in preventing skin breakdown by implementing turning and repositioning education to the front line staff.	To develop an education session related to proper positioning of a resident. To present education as part of the mandatory education sessions. To post visual cues of how a resident should be positioned to prevent skin breakdown. Plan of care to reflect positioning needs for residents who have skin breakdown. Referral to Physiotherapist for any residents with a stage 2 wound or higher.	Number of residents with stage 2 or higher wounds. Audit of positioning in bed or chair for residents with stage 2 or higher wounds. Number of wheelchair assessments for residents with a stage 2 wound or higher. Number of low air loss surfaces in use for residents with a stage two or higher wound.	5% of Stage 2 wounds will progress to a stage 3 or 4 wound as a result of positioning and unsuccessful off loading.	
										4) To implement an assessment tool to complete oral assessments.	To meet with RNAO Best Practice resource consultant to complete a gap analysis related to oral care in the home. To identify two key items to implement as a result of the gap analysis. To educate nursing staff on the items as a part of mandatory training sessions and during RAPS and team meetings.	Number of staff trained on the importance of oral care. Number of staff trained to use the new assessment tool for oral care. Number of oral care assessments completed.	100% of new admissions after November 1, 2018 to have an oral care assessment completed with plan of care developed to identify care needs based on assessment.	
Patient-centred	**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	53738*	95.65	96.00	Target set to maintain current level of satisfaction. Number can be affected greatly by the number of responses received due to our small sample number.	1) To improve infection control practices related to laundry processes in the home to promote resident's timely return of their clothes and no concern with a lack of linen in the home.	Home is currently in the process of seeking approval from the MOHLTC for building of a new laundry department at the home. Staff to be educated on the use of the machines. Implementation of staff routines to meet the resident needs for linen and clothing.	Weekly audits of linen supplies on the units. Number of resident concerns monthly related to lost linen or damaged linen. To monitor trends of what days and times there are concerns related to linen supplies.	Laundry department to be built and in full use by October 2018.	
										2) To increase small group programming on the units, in the moment to engage the resident in an activity that is meaningful to them.	Schedule Rec. staff time on each unit for 1.5 to 2 hours, time to be as consistent as possible. Educate staff on the importance of supporting this time with residents and assisting as able in the programming. Weather permitting, encourage activity to occur outside as fresh air often promotes better sleep.	Number of resident to resident incidents. Resident DRS and ISE scores. Resident satisfaction scores.	To have a more visual presence on the unit encouraging residents to engage in activities that are meaningful to them.	
										3) To enhance the admission process to welcome the resident and their family to their new home while ensuring staff are prepared to meet the resident's care needs.	To develop an interdisciplinary care team to review all of the processes involved on admission day and over the next 72 hours. To develop a procedure for the admission process for each department. To educate staff on the procedure and how to communicate to resident and families the information that is required. To develop a pre-screening tool to use to reach out to resident and or family member once bed has been offered to gather information about the resident to be able to prepare ahead of time for care needs. If staffing compliment allows, schedule additional staff member to complete admission process including the obtaining of consents, tour of the home, labeling of personal care items, etc.	Number of residents admitted each quarter. Audit admission check lists to ensure fully completed according to timelines. Results of resident surveys related to satisfaction with admission process.	Team to be formed by July 31, 2018 to review admission process. Staff to be trained on enhancements to the process by September 30, 2018 Enhancements to be implemented by October 1, 2018.	
										4) To provide appropriate texture, menu type and devices for resident to allow resident to eat with dignity.	To explore an integrated menu management software application. To explore the use of a resident management software which will promote accurate updates to the resident's plan of care.	Quarterly audits to be completed of diet orders to plan of care. Number of discrepancies from diet order to plan of care, number of discrepancies at point of service from plan of care.	To promote accurate food service including assistive devices for each resident at every meal.	
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	53738*	14.93	14.50	The home has focused on this priority indicator for the previous three years and have been successful in decreasing rate to 14.93 from 37.76 in 2015. The home has witnessed an increase in behaviours that are not successfully managed alone with non-pharmacological interventions but there is not a diagnosis of psychosis so not sure we are able to reduce this rate much more than this.	1) To implement visual cuing throughout the unit to direct residents to an activity to engage versus wandering into another resident's room.	Recreation staff to research best practice evidence related to cuing tools- colour, font, pictures to use. Recreation staff to install cues in the hallway to direct residents as well as in the lounge space and dining room to cue residents what to do in this area.	Number of CIS monthly related to resident to resident abuse number of resident's with an ISE score of two or lower.	Visual cuing to be installed throughout the memory care unit by September 2018.	
										2) Increase staff and resident's understanding of dementia and that all behaviour has meaning.	Education session for residents and family on Dementia and the changes that may occur. Sessions to include small group gatherings and may use the Teepa Snow videos as a resource. Education to front line staff on sleep and dementia by the NP to increase awareness of the importance of sleep and tracking when a resident sleeps.	Number of residents in attendance at education sessions, number of front line staff in attendance at education sessions. Number of resident complaints about another resident's behaviours.	5% of resident concerns raised will be related to another resident's behaviour.	
										3) To implement a Java Memory Care Program group aimed at resident's with a CPS score of three or higher in our memory care unit.	Key staff to be trained on how to host a Java Memory Care program and which residents would benefit most from. To educate staff on unit of the program and need to meet in an area where residents will not be distracted by other residents. To document level of participation during session for each resident.	To track changes in ABS and ISE scores for residents who participate in Java program. To track DOS charting that is occurring for any resident involved in the Java program. To track CIS related to resident to resident abuse that occurs between residents on the unit.	Java memory Care Program to be held in our memory care unit two times each month starting in April 2018.	
										4) Monthly multidisciplinary Antipsychotic rounds with consultant pharmacist, NP, BSO staff, front line staff caring for resident, RAI lead and any other staff required to review residents who are using antipsychotic medications who do not have a diagnosis of psychosis.	Educate staff on the accurate completion of DOS charting. Review DOS charting, progress notes and POC documentation for incidents of agitation, aggression, change in behaviour. Update plan of care with interventions identified to reduce trigger for behaviour if able to identify. Educate staff on the use of non-pharmacological interventions when caring for resident with behavioural changes.	Number of residents monthly using an antipsychotic medication without a diagnosis of psychosis. Number of residents reviewed monthly. Number of resident to resident incidents.	80% of residents to be reviewed monthly who are using an antipsychotic medication without a diagnosis of psychosis.	
	Safe care	Percentage of residents who fell during the 30 days preceding their resident assessment	A	% / LTC home residents	CIHI CCRS / July - September 2017	53738*	28.82	24.00	Residents are being admitted frailer to the home. Greenwood Court allows residents to live with choice and this results in some resident choosing to live with risk. This indicator is priority indicator for the home to track trends and move closer to the provincial average.	1) To implement a side rail assessment tool to determine if the resident requires the use of the quarter side rail for bed mobility or to transfer from bed to chair.	To develop a side rail assessment policy to be implemented in the home. Staff to be trained on the policy and the implementation of the policy. Education sessions to be held for residents and family members to inform of the change to the policy with focus on the proof that side rails can increase falls and risk of injury.	Number of falls each month, number of residents who fell each month, number of residents who require side rails who fell, number of assessments completed each month	50% of residents will have a side rail assessment completed by October 31, 2018 with the remaining 50% completed by March 2019	
										2) To promote best practice evidence in preventing/reducing injury related to falls by promoting the use of Vitamin D, Calcium and medications such as Prolia in preventing fractures related to falls.	Consultant pharmacist to review medication regime for each resident quarterly and make recommendations related to therapeutic dosages for Vit. D and use of Prolia as an alternative to a Bisphosphonate if appropriate To review any male residents with a history of fracture to recommend addition of Prolia to prevent further injury.	Quarterly - number of residents on Vitamin D at the therapeutic dose of 2000 units daily, number of residents who qualify for Prolia and receive appropriately, number of residents on bisphosphonates	90% of residents will be on a therapeutic dose of vitamin D by October 31, 2018.	
										3) To complete a falls huddle with the team to improve conversation and sicuss strategies to prevent future falls.	To implement a falls huddle tool. To educate staff on the completion of the huddle tool. To complete the huddle on the shift the resident fell.	Number of residents who fell, number of residents who staff gathered to review fall using huddle tool, number of residents who fell at specific times	75% of falls will be reviewed with the use of a huddle tool by December 31, 2018.	
										4) To implement a hydration program focusing on meal service beverages as a way of eliminating falls risk related to dehydration.	An interdisciplinary team will be formed including staff from dietary, recreation and nursing to review hydration at meal times. To review current documentation system for documenting fluid intakes of residents. Provide education for front line staff on the importance of hydration and accurate documentation.	Number of residents who fell more than once in 30 days, amount of fluid consumed daily for residents who fell more than once in 30 days.	75% of residents who fell more than twice in a month will be meeting their required fluid intake daily and if not possible, plan of care will reflect why this is not possible.	