2016/17 Quality Improvement Plan for Ontario Long Term Care Homes
"Improvement Targets and Initiatives"

GREENWOOD COURT 90 GREENWOOD DRIVE

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
Effective	**To Reduce Potentially Avoidable Emergency Department Visits for LTC Residents**	Number of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents.	% / Residents	Ministry of Health Portal / Oct 2014 – Sept 2015	53738*	16.07	15.00	To implement processes within the home and with resource of Nurse Practitioner to decrease potentially avoidable emergency department visits.	1)Education to residents and family members about Health Care Directives and level of care that is provided within Greenwood Court	To develop a new Health Care Directive with levels of care explained clearly within the document. As a part of this tool, space will be provided for comments from resident and family that clearly states what the resident's health care wishes are in specific circumstances.	Audit post each new admission to ensure that physician has signed the Health Care Directive and is aware of resident's choices. If level of intervention is deemed by physician not to be appropriate, audit to ensure physician has had a discussion with resident and/or POA for care around appropriate level of care.	New Health Care Directive to be developed and implemented by July 2016. New form to be used with all new admissions. Form will be transitioned for current residents during annual care conferences.	
									2)Implementation of the SBAR tool to promote effective communication between physician and staff at the home to relay clinical picture of the resident to determine as a team if transfer is required and appropriate, outside of an emergent situation.	Education to registered staff on resident assessment with support of Nurse Practioner to increase capacity around communication with physician and need for transfer to hospital. Nurse Practitioner to provide education to build capacity of registered staff re: chest assessment and early detection of changes in status as well as symptom management to treat resident at Greenwood Court and limit need for transfer to acute care.	Debrief each transfer to hospital with staff at time of transfer to determine the validity of transfer. Monitor residents who are at high risk for an Emergency Room visit; i.e. residents with COPD, CHF, UTI,changes in mobility, pneumonia, etc, monitor for changes on shift to shift report to determine needs for NP or physician follow up prior to need for transfer to ER.	100% of residents who are transferred to acute care will have a debrief about transfer criteria to evaluate appropriateness of transfer by October 31, 2016.	

									3)To Develop a tracking tool to be utilized for evaluating trends in transfers to Emergency Department that can then be used to improve performance.	To implement the hospital transfer tab on Point Click Care as a method of tracking what day and time of the week a resident is transferred, reason for transfer and who ordered the transfer. This system will allow for monitoring of trends to address concerns.	Registered staff to be trained on the priority need to complete the transfer information fully when any resident is transferred to ER to develop baseline information. Report to reviewed monthly as part of Resident Care meetings with report taken to Quality meetings.	100% of hospital transfers will be tracked utilizing the Hospital tab in PCC by October 31, 2016.	
									4)To complete falls huddle with the interdisciplinary team after each fall to determine trends with resident falls to decrease risk of falls within the home	To educate staff on the completion of a falls huddle. Implementation of policy on evaluation of each resident fall.	To review each resident fall and information from falls huddle monthly with resident care meetings. Results analyzed quarterly with Quality Council meetings with trends reported back to team for implementation of changes.	95% of falls will have a team huddle completed post fall by September 30, 2016.	In the fourth quarter of 2015/2016, there have been 5 resident transfers to ER for assessment post a fall.
Resident-Centred	**Domain 1: "Having a voice" and being able to speak up about the home.**	Percentage of residents responding positively to: "What number would you use to rate how well the staff listen to you?" (NHCAHPS)	% / Residents	In-house survey / Apr 2015 – Mar 2016 (or most recent 12-month period)	53738*	85	85.00	Goal is to maintain our current performance while increasing staff awareness to resident choice initiatives.	1)To increase staff awareness of the frail elderly needs.	To partner with the Alzheimer's Society to provide education as part of mandatory education sessions on simulation training to experience life as a frail elderly resident.	To track the number of staff who have completed the education session. To track comments on staff survey post the education session to monitor trends in staff reaction to the training.	80% of staff will have completed this training by December 31, 2016.	
									2)To enhance dining experience by improving process for offering choice at meals, as well as offering alternate times for meals for residents that require this care.	To have input from all departments on how to enhance meal service for the residents, including the process for offering choice of meals. To provide food choices for residents who want to sleep in in the morning.	Dining audits to be completed monthly in one dining room to audit process of serving meals. To audit resident comments at Resident Council meetings and Food committee meetings around food service and provide feed back to affected staff so process is able to improve.	80% of residents will be extremely satisfied with meal service.	
									3)To implement ACES training for nursing staff to increase client centred care and move away from routines.	To provide education to staff on the ACES philosophy, including tools to implement the philosophy through mandatory education. To post notices and signs to remind staff to the ACES approach to care.	To audit monthly resident satisfaction surveys that were completed that month for trends around client centred care. To audit monthly Resident Council concerns related to client centred care and staff approach.	80% of staff will be trained on ACES approach by November 30, 2016.	

									4)To engage residents in meaningful activities in place versus focusing on large group activities.	Program staff will focus on "activities on the go" where they are able to sit with a resident in the lounge, in their room, in the hall and engage in a program that meets the residents needs at the time. Staff to continue to promote the Music for Memories project as music has been proven to have a positive reaction for residents. Staff to attend Teepa Snow education for further insight into resident interactions.	Track the number of staff who attend Teepa Snow education in June Track the number of residents who have i-Pods loaded with individual play lists. To review resident comments at Resident council related to programs within the home.	Resident program calendars monitoring individual resident engagement in activities to be completed and distributed quarterly to resident and/or next of kin for monitoring of participation. This will be initiated by October 31, 2016. Resident program calendars monitoring individual resident engagement in activities to be used as a resource for admission and annual care conferences by July 31, 2016. To track the number of staff who have participated in Teepa Snow training in June 2016.	To date, 28 residents currently have I-pods loaded with personal play lists. Goal is to have all residents with personally loaded I-pods by December 31, 2016.
Domain 2: "Overall satisfaction" (choose A or B).	Percentage of families who responded positively to "staff answered all of our questions and provided quality care to our resident at end of life."	Number / Family members whose resident has passed away	In-house survey / April 2016-March 2017	53738*	CB	85.00	As this is a new initiative for the home, we need to develop baseline data to analyze trends and set goals for improvement.	1)To increase staff knowledge and comfort in having end of life conversations with residents approaching end of life as well as their family members.	To analyze end of life surveys for feedback from families post this experience to gain information on the journey that they and their family member had in order to improve experience for other residents To talk with residents who are end of life to evaluate effectiveness of staff communication explaining process	Education to staff with mandatory education sessions about end of life conversations; examples of how to have conversations around dying, education about what resources are available to provide to residents and family about end of life journey.	To have 80% of staff attend education session on End of Life conversations.	

									2)To partner with MOH on educational resources available for LTC staff.	To provide opportunities for staff to complete Hospice Palliative Care Education- Three staff currently enrolled in Fundamentals of Hospice Palliative Care. 1 staff member enrolled in CAPCE program	Track staff who have attended education sessions and change management ideas that have been implemented as a result of the education. To track staff that have expressed interest in education opportunities and make opportunities available to them as they become available.	Staff to successfully complete educational programs and implement knowledge gained from these experiences into practice by October 2016	
									3)To develop a communication tool to share through all departments when a resident is end of life and staff will be aware of their role in promoting a quality death	Interdisciplinary meetings to gather input into what information each department requires to be knowledgeable about the care needs of a resident who is End of Life.	Number of residents with a PPS of 40% of less- track monthly. To track use of communication tool monthly for residents who have a PPS of 40% or less.	80% of residents will have an End of Life care plan developed and communicated to all departments by October 31, 2016.	
									4)Policy Development: To build an End of Life program which promotes dignity, respect and living while a resident is dying and for staff of Greenwood Court to implement this program.	Educate staff on the Square of Care and implement this tool as part of the plan of care for residents who are End of Life. Implement Palliative Performance scale as a validated tool to determine end of life so that all staff are aware of what conversations to have with resident and family.	Meet with residents who have a PPS score of 40% or less to discuss care needs and goals to determine if home is successful in promoting living while dying. Evaluate End of Life surveys for comments from families re: care to resident when End of Life.	Residents and their significant others who are identified as being End of Life will have opportunity to discuss end of life goals for treatment as all staff will be aware of the focus of care.	

Safe	**To Reduce Worsening of Pressure Ulcers**	Percentage of residents who had a pressure ulcer that recently got worse	% / Residents	CCRS, CIHI (eReports) / July – September 2015 (Q2 FY 2015/16 report)	53738*	7.41	5.60	Focus is to improve systems within the home as initial step with goal to then see an improvement in CIHI data.	1)To Partner with community resources to ensure best practice resources are available within Greenwood Court but also to ensure continuity of care when admitting a resident from community with a wound	To Partner with SWRWCP South West Regional Wound Care Program to: 1. Access to SWRWCP Website Resources; 2. Opportunity to contribute to resource development; 3. Access to Healthchat – network of wound care champions and specialists; 4. Wound Care Champion support; 5. Program facilitated cross sector wound surveillance and accountability; 6. Enhancing your own quality improvement – QIPs and publically reporting CIHI data (HQO); 7. Program monitoring and evaluation; and,8. Program facilitated cross sector collaboration for improving relationships and transitions of care	To track the education sessions that staff have attended that have been offered by SWRWCP and the change management ideas that have been implemented as a result of new skills, knowledge gained through these sessions.	To have formed a positive relationship with SWRWCP and staff accessing these resources by November 2016.	
									2)To audit that skin prevention protocols are being utilized fully to prevent skin breakdown from worsening.	Monthly wound pictures will be shared with all staff to increase awareness of the wounds that are present within the home as well as changes, healing or worsening of the wounds and any other changes in skin breakdown monthly. To access education being offered by SWRWCP which includes skin prevention and product options for front line staff.	To implement weekly audits of skin and wound assessments to ensure all documentation is complete including appropriate departments included in multidisciplinary assessment. To analyze resident PURS (Pressure Ulcer Risk Scale) results monthly to determine who is at high risk for wound breakdown and ensure all appropriate interventions implemented. Focus will be on residents with a worsening PURS.	2% of internally acquired wounds will worsen.	
									3)Skill development- to provide education to Nursing front line care givers on Incontinence Associated Dermatitis to promote early identification of IAD and prevent further skin breakdown	Utilize IADIT as a training tool for all front line staff at mandatory training Weekly skin rounds with front line staff so that they are aware of what IAD looks like and that care is being provided as per plan of care. Trial implementation of using skin care wipes for peri care in the Heritage unit to track and change in skin integrity.	Monthly, evaluate the number of skin breakdown including stage one wounds and rashes which may indicate a risk of IAD. Monthly evaluation of plan of care for residents with IAD to monitor for worsening conditions	5% of residents within the home will experience IAD.	

									4)Skill Development: To build capacity within the front line staff for early identification and reporting of stage 1 pressure ulcers to prevent progression.	Educate staff on the use of the PURS scale to identify who is at higher risk for skin breakdown. Evaluate resident's at higher risk for skin prevention techniques as part of their plan of care which may include: turning routines, education around proper positioning of residents in bed and in chair, use of skin prevention skin care products, use of pressure reducing surfaces on bed and in chair.	Weekly updates of any wounds or areas of concerns to monitor status. Interdisciplinary team meetings to drill down to cause of breakdown and develop a plan of care to remove cause.	2% of stage 1 wounds will worsen to stage 2 wounds.	