Let's Make Healthy Change Happen.

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

Nithview Community
A Division of
Tri-County Mennonite Homes
Making Every Day Matter

3/20/2018

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

Nithview Community is a 97-bed long-term care home operated by Tri-County Mennonite Homes (TCMH). The Nithview Community also enjoys a very interactive campus of seniors that reside in our Independent Living and Retirement Suites. Many of our residents in LTC are able to maintain a viable family relationship where one spouse lives in our Retirement setting and the other resides in LTC. These couples are still able to attend social programs together and community/family members actively participate in our daily "tea room" where our community and heartwarming spirit unites. This forum also enables us to foster relationship building between staff, residents and the community, particularly those living with dementia.

The home has struggled this past year with recruiting a sufficient front-line staffing compliment. The home is also employing a new leadership team whose skills have been aligned with an Accountability Framework which focus's on the MOHLTC mandatory programs. This has created a situation where the staff of the home have been forced to think outside the box, in terms of providing quality care to the residents.

Input from Resident Council meetings, Family Council meetings, and External Stakeholder reviews, are used in promoting quality. This year the Home utilized the inspection protocols and program evaluations as set out in the LTC Act/Regulations to evaluate our strengths and create a road-map for continuous improvement.

Moving forward, we are avidly working toward building stronger community networks and partners. We continuously strive to uphold our Mission, “Making Every Day Matter”. As we broaden our programming spectrum we are looking to build capacity within our organization that collaboratively addresses the unique needs of our community.

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

In 2017 our greatest QI achievement was the reduction of ED transfers and hospital admissions. While the remainder of our WWLHIN continued a consistent trend or demonstrated a slight increase in ED visits, Nithview cut their ED transfers by 40%. The basis for this change is related to a change in Pharmacy in early 2017 which has improved dispensing safety and has improved staff processes. The on-site Pharmacist has focused on education and quality initiatives that have stabilized out medication system.

Additionally, the home uses one doctor for all residents. Our physician is on site two days a week and has built a robust relationship with each resident. In the fall we partnered an RN to work alongside the physician to begin working on projects such as eliminating the diabetic diet, improved hydration, enhanced awareness of narcotic use and improving follow up with external stakeholders.

Our new DOC has introduced special care conferences for residents and their families which also directs our care practices and improves communication related to goals/outcomes for residents. The physician participates in these conferences and we are often able to walk through the palliative process on site in a dignified manner that enables our residents to stay at "Home" for their final days with family at their side.

There has also been a decease in hospital admissions. The home has experienced only one outbreak this season and falls with injuries have decreased. We continue to work with our external partners to ensure our residents receive the most effective care. This includes the use of mobile x-ray and lab technicians.

Resident, Patient, Client Engagement

The home has recently adopted a new procedure of inviting Board members to our Quality Committee and our Professional Advisory Committee. We have also expanded the roles in attendance to include community partners and the pharmacy. Our agenda now includes components of education and a review of quality indicators/data. Our in-house quality meetings will include residents who wish to participate.

We continue to offer "education nights" throughout the year where residents and family members are invited to attend a guest speaker presentation. In the last year the best attended education nights covered topics such: wills, role of the POA, and Palliative Care.

Residents and families were invited to participate in creating this year's satisfaction survey and to evaluate the effectiveness of our services. Once again, our scores showed a very favorable outcome and support for the work we do with limited human resources.

We continue to partner with Community Care to offer an on-site Adult Day Care, two days per week. We have begun discussions about the possibility of increasing this program to include weekends and overnight respite. Residents from our LTC and Retirement have attended this program.

Starting in April our Home will partner with the Alzheimer's society to host "Minds in Motion" on site. Once again residents from our LTC and Retirement will benefit from being able to participate in this event. The focus of this program is to stimulate socialization and perform some light exercise/range of motion activities.

We have utilized the increased funding and support for BSO by adding additional staffing and sending staff to off-site educational opportunities. This has enabled us to plan for resident needs related to behaviors and aggression. We have begun utilizing external staff to assist with one-to-one staffing ratios for those residents with limited ability to redirect their behaviors. We have accessed the Ministry's high intensity needs funding to offset costs associated with this staffing model.

Collaboration and Integration

In light of the limited availability of human resources, we have partnered with St. Louis Continuing Education Centre to promote our Home to potential new PSW students. Currently we have four students attending the PSW certificate course who will be employed by the Home following their training. Nithview Community is providing funding assistance to these students in this unique partnership. The Home continues to attend recruitment fairs in order to select further candidates to enter the PSW program beginning in the fall. In the summer of 2017 the home was fortunate to have several RN students working through the summer which helped us to give our regular staff the much-needed break they needed.

Our partnership with Conestoga College has brought PSW and RPN students into the Home. Our staff are empowered to help teach students and the residents enjoy seeing the new faces. This also provides an opportunity for the Home to recruit qualified staff once they have graduated from the program as they are familiar with our Home and policies and we know how they interact with the residents.

Our Home is a member of the Ontario Association of Not-for-Profit Homes and Services for Seniors (AdvantAGE). This partnership promotes networking, education and advocacy for our managers who are then able to share this information with our staff teams.

We continue to collaborate with Public Health for assistance with the flu vaccine program, kitchen inspections and infection control best practices. A member of the Public Health team attends our Professional Advisory Committee to give update to the members on trends arising in the community.

In the past year we were visited by the Ministry of Labor and the Ministry of Health in their inspection roles. We have collaborated with these officials to establish sustainable work plans for continued growth and improvement.

We are working closely with 3M for wound care best practice improvements, as well we have partnered with Surge Learning which has enabled us to provide our mandatory education to staff in an electronic platform. With Surge we can track the staff's progress on their training journey and offer in-class training for those who find a hands-on approach a more viable alternative for them.

Our Physio provider has also partnered with us to provide some key staff training. This staff person also assists us with WSIB cases where physical demands analysis is needed in order to bring staff back to work.

Engagement of Clinicians, Leadership & Staff

Nithview Community continues to work with our Medical Director, Dietitian, Physio, Pharmacy and oxygen providers to ensure a seamless approach to the needs of our residents. Additionally, we work on a case-by-case basis with a Psycho-

Geriatric specialist for those residents that require a more in-depth approach to harmful behaviors. From a risk perspective we are working closely with our Pharmacist to maintain a medication safety and risk incident program.

We have partnered with our local transport company and our hospital to ensure our dialysis residents are able to navigate through the trips back and forth with the Home so that optimum health outcomes can be achieved.

We have partnered with our Nursing Outreach Nurse to assist us with complex care to help guide us through nursing practices that are more complex. This resource assists the nursing staff with planning care, education and guiding decision making.

Our Board of Directors have representatives on both our Professional Advisory Committee and our Quality Improvement Committee. Through their participation in these committees, they are given opportunities to be more fully engaged in planning for our residents' needs currently and into the redevelopment phase.

Our Home has benefited greatly by having two Gentle Persuasive Approaches (GPA) instructors on staff. This is a program designed to teach staff ways to disengage residents who are becoming aggressive or resistant to care. Our instructors also provide training to external agencies and across our Tri-County continuum. We have formed a partnership with Surge Learning to form a platform of on-line education for staff. Additionally, three of our RN's have completed the RNAO Best Practice on-line learning.

Through our partnership with Sienna we have been working on improving Data collection and funding through our RAI program. Additionally, Sienna has been valuable in aiding with auditing and training staff to complete inspection protocols or program evaluations.

Population Health and Equity Considerations

Within our Home we have moved from a clinical diagnosis of dementia in 51% of our residents in 2016 to 67% of residents in 2017. Our population is 37% male and 62% female. In a review of the top three diagnosis in the home it is lead by Neurological disorders, up from 75.4% in 2016 to 83.7% in 2017. This is followed by cardiac conditions from 76.5% to 81.7%, and musculoskeletal from 61.8% to 64.4%.

In 2017 our Home did not refuse any residents for admission. There were 34 admissions, 9 (26%) of which were crisis admissions.

Healthcare Equity is an important element of the work we do. Given the high degree of residents with a diagnosis of dementia, it is the vital role of the healthcare team to ensure that those residents whose voice has been lost due to complex health matters are given the same access and provision of care as those who can speak for themselves. At times this requires us as professionals to navigate the health system with the "residents' needs" guiding our decision making and interaction with friends/family. We are compelled to act when inequity is evident, up to and including taking legal measures or undertaking a capacity assessment of a resident.

It is important to be mindful that one resident's rights do not supersede another resident. Our Care Planning must reflect the strengths and goals of each individual and create effective and evaluated measures to continue to promote the resident's integrity at all stages of life.

Access to the Right Level of Care - Addressing ALC

Within our Nithview Community we are fortunate to have various levels of care from Independent Living, Assisted Living, Retirement and LTC. Over the past year there have been several opportunities where residents residing in our Retirement Home have been able to stay in place with additional supports until a LTC bed became available. Additionally, our Home has established three unfunded beds within our LTC structure that permits residents to reside in a safer environment with appropriate care until their spot becomes available in one of our licensed beds.

Through our special care conferences, we work in close partnership with the resident and their family to access the right level of treatment from the community on an out-patient basis. We endeavor to educate our families and caregivers on the risks associated with hospital stays, invasive procedures or life sustaining measures.

We have partnered with our LHIN to access funding related to the purchase of bariatric equipment to alleviate some of the hospital pressures for hard-to-place residents.

We have initiated a relationship with our local hospital to ensure that residents are returned to our Home with appropriate clinical outcomes that are aligned with our scope of practice.

Given our quality indicators for ED transfers and hospital admissions are very low, we demonstrate our commitment to holistic continuum of care within the LTC Home.

Opioid Prescribing for the Treatment of Pain and Opioid Use Disorder

Nithview Community has Palliative and Pain and symptom Management Committee in place for those residents who exhibit pain or have worsening pain. Through collaboration with pharmacy, attending physician, nursing, spiritual and recreation, our Home is addressing residents' needs for appropriate pain management based on their current medical needs. Our goal is to reduce or eliminate occurrences of worsening pain by taking proactive approach. Multidisciplinary team meets weekly to review current residents care needs.

We recognise that there are scenarios where residents require opioid treatment for management of chronic complex pain symptoms. Our Home has Medication Management program in place to manage risk. Also, our Home reviews drug utilization reports monthly and quarterly (PAC) and in collaboration with pharmacy initiates quality intervention strategies.

Our Home has three RNAO best practise champions that follow RNAO best practise standard on Assessment and management of pain.

Nithview Community maintains an ongoing relationship with Waterloo Wellington Hospice and collaborates utilizing clinical support available on a regular basis. Our Home continues to utilize education opportunities as they are offered to increase clinical skills and improve core of Pain and Symptom Management Program. Currently our Home has multiple Registered staff members educated on Pain and Symptom Management, Fundamentals of Palliation and CAPCE.

Workplace Violence Prevention

In light of our staffing challenges we are taking measures to ensure staff are educated on the risks of caregiver burnout and the potential to take risks due to their mental well being. We will be partnering with the Canadian Mental Health to look at developing a more comprehensive approach to care and fatigue as well as compassion fatigue.

We are undertaking a new approach to investigations and will be installing cameras in the home as a means to protect staff as well as to validate their good deeds.

In our Surge Learning platform, we have Mental Health and Wellness courses as well our education lead will also be adept at identifying staff who may require some intervention before a serious matter occurs.

We trend and track near misses, and WSIB. In the last year our WSIB incidences have increased due to the workload issues. Our Home has focused on staff appreciation events to ensure we provide ongoing venues to let staff know they are valued and appreciated. Our Home also provides ongoing OH&S training for staff in order to maintain the competency as certified safety members of the Safety Committee.

We will focus this coming year on utilizing Code White more consistently so that staff know they are never alone in a situation where they may feel threatened. Further, we will continue to partner with our community to enhance our staff in the Behavior Support Ontario program that enables us to manage resident behaviors is a dignified manner.

We will continue to collaborate with the MOH to self-report mandatory reports via the CIS system. Full investigations and disclosure will be undertaken.

Contact Information

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Other

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

Board Chair / Licensee or delegate _____

Administrator /Executive Director _____

Quality Committee Chair or delegate _____

Other leadership as appropriate _____