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



NIAGARA HEALTH SYSTEM, WELLAND HOSPITAL SITE, EXTENDED CARE UNIT

AIM		Measure							Change				
			Unit /			Current	_	Target	Planned improvement				
-	-		Population	Source / Period	-	-	Target	justification	initiatives (Change Ideas)	Methods	Process measures	Goal for change ideas	
Effective	Hand Hygiene	Hand Hygiene - Percentage of hand hygiene compliance among staff	% / Residents	Hand Hygiene Audits / Jan -Dec 2015	51585*	70.1	100.00	Maintain 2015/16 target.	1)All staff to be 100% compliant in hand hygiene		Submit results weekly to Decision Support for analysis Post weekly bar graph results for all staff to review.	To stop spread of AROs	. Collaborative link with the Niagara Health System
Resident-Centred	voice" and being able to speak up	The percentage of positive responses regarding food	% / Residents	In-house survey / Jan-Dec 2015	51585*	88.1	89.00	Target set to ensure improvement	1)Maintain or improve the current rating of food services	Assign staff to conduct 2 Dining room services audits/month to assess staff, food presentation and handling	Observational audits Resident surveys Annual satisfaction survey	To promote positive food experience.	
	about the home.	choice, food quality, dining experience, food quantity, availability and helpfulness of food services staff						experienced maintained with an additional 1% improvement		Assign staff to conduct 10 audits/month in each dining room (3) of resident satisfaction in food selection, quality and quantity			
										Assign staff to conduct monthly audits of food services			
										Food committee input into menu with taste testing of new possible products, removal of products that are poor and approval of the seasonal menu with their sign-off			
	Domain 2: "Overall satisfaction"	Percentage of residents who responded positively to the question: "Would you recommend this nursing home to others?" NHCAHPS)	o ositively on: this e to	nts In-house survey / Apr 2015 – Mar 2016 (or most recent 12-month period).		86.4	95.00	Maintain 2015/16 target.	1)Create a homelike environment	Clear communication to residents and families that the NHS is not selling the home's license	Resident Council Communications Family Call out Media release	To maintain a waitlist o individuals who would like to move into the home.	f The home maintains a positive reputation in the community
										Completion of resident room upgrades			
										Resident involvement in all aspects of the home through participation in Resident's Council, Food Committee	Monthly resident survey of programing services Annual Resident satisfaction survey		
										Provision of activities that provide opportunities for meaningful activities	In the moment survey of resident program		
										Provision of programing that is reflective of all residents living in the home.	Gender specific programing		
		Percentage of positive overall resident experience	% / Residents	In-house survey / Jan-Dec 2015	51585*	94.6	95.50	A 1% improvement	1)Develop programs that enhance resident experience and quality of life	Monthly programs calendar will include 2 sensory stimulation programs	Annual Resident Satisfaction Survey Monthly audit of programs Conduct 'In the moment' surveys immediately after specific programs to elicit feedback from residents with limited short term memory Use the pictorial Likert scale to elicit feedback from residents not able to articulate their feedback.	residents in the home	pursuits are a
										Monthly calendar will include 2 programs for cognitive enhancement			
										Increase in 1:1 opportunities for all residents in the home			
										Programing schedule to run over 7 days/week with an increase in evening hours			

AIM		Measure							Change				
S	Ohioni		Unit /	6	.	Current		Target	Planned improvement				
	-	Measure/Indicator		Source / Period		performance	Target	justification		Methods	Process measures	Goal for change ideas	
Safe	To Reduce Falls	Percentage of residents who had a recent fall (in the last 30 days)	% / Residents	CCRS, CIHI (eReports) / July – September 2015 (Q2 FY 2015/16 report)	51585*	19.64	13.30	Maintain 2015/16 target	1)Prior to admission, the resident will be pre- screened for their falls risk	The MDS RAI 2.0 will be reviewed for falls risk when application is received and prior to admission	Implementation of falls prevention strategies at time of admission	All residents at risk will have safety strategies implemented at time of admission	residents are becoming
									2)When a resident is identified as a fall risk, they will be assessed	Use of standardized physiotherapy assessment tool Use of the MDS RAI 2.0 quarterly, annually or when there has been a significant change in condition.	Assessment by the physiotherapist and use of a standardized assessment tool to report on individual's progress and participation in their individual treatment plan Quarterly Falls Risk Assessment completed by the registered staff using a standardized assessment tool.	To maintain or increase muscle strength, endurance, and balance to prevent falls	
									3)All falls will be analyzed	Use of the post fall assessment tool Analysis of falls with the pharmacist to determine if the fall is related to medication	Successful Fall - Falls will occur but with no injury All injury prevention strategies were in place at the time of the fall All falls will be reviewed by the Falls Prevention and Restraint Reduction Committee which includes a pharmacist	All staff engaged in falls prevention.	The home encourages resident independence and quality of life. The home promotes a least restraint environment which will result in an increase in falls.
									4)Use visual cues for residents at risk for a fall	Place a 'falling star' to the resident's room door to alert all staff in the home of the falls risk	Intervention included in the resident's care plan	Engage all staff	Visual reminder to all staff to 'peek in' and check on the resident
									5)Interprofessional Medication Reviews	Review of medications quarterly by pharmacist and physician	Avoid polypharmacy Avoid the use of antipsychotics which cause a drop in BP	Reduce the incidence of falls related to medications	F
	To Reduce the Use of Restraints	f Percentage of residents who were physically restrained	% / Residents	CCRS, CIHI (eReports) / July – September 2015 (Q2 FY 2015/16 report)		12.24	10.40	Stretch target is to meet provincial average in 3 years, improve	1)Initiate alternatives to restraints prior to their implementation	Least restraint philosophy guides the practices of all staff in the home	Review of Policy with staff annually Education of Policy with all newly hired staff	/ Stretch target to meet provincial average in 3 years, to improve 2%/year	
								2% per year		Staff education on the least restraint philosophy, use of restraints and resident rights			
										When a restraint is to be used, start with the interventions with the least restraining properties first.	The only restraining device permitted for use in the home is a seatbelt that the resident cannot undo or a tabletop that the resident cannot remove		
									2)Use of standardized tool for the documentation of restraint use	Use of standardized restraint assessment tool on Point Click Care®	Assessments will be performed quarterly		
									3)Consistent communication strategies for staff to indicate restraint use	Interdisciplinary Falls Management and Restraint Reduction Committee Use of luggage tags to indicate type of restraint used on wheelchair. Use of 'side rail logos' posted at resident bedside to indicate bed rail use.'	Monthly meetings by Committee to discuss residents using restraints. Use an interdisciplinary approach when considering trials to discontinue the need for the use of a restraint.		The decision to use a restraining device is made using a collaborative process that involves the family as well

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
Safe cont'd	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	51585*	3.94	3.30	Maintain 2015/16 target	1)Prior to admission, the resident will be pre- screened for pressure ulcers	The MDS RAI 2.0 will be reviewed for being at risk for developing or being actively treated for pressure ulcers when application is received and prior to admission	Implementation of appropriate wound care strategies at time of admission		Residents entering LTC are more medically compromised.
				2015/16 report)						Early identification of skin issues or contributing factors that potentially can lead to pressure ulcer development	Staff education on wound identification and wound care		
									2)Implementation of Swift Slide sheets	Appropriate residents will have Swift Slide sheets implemented and used on their beds to reduce shearing forces	Residents using Swift/Slide sheets will not have a disruption of tissue integrity	To focus on prevention of pressure ulcers	
									3)Implement interventions to promote skin integrity	Use of Skin and Wound Policy and Procedure guidelines for treatment of wounds for the appropriate wound stage	Standardized Wound Assessment tool to be used.	Use of standardized tools for documentation of wounds	
										Referrals to the Dietician, Food Services Supervisor when skin integrity is compromised	Resident care plan indicates interventions that are implemented to promote tissue healing and skin integrity.		
											Monthly meetings by the Skin and Wound Management Committee to discuss wounds Use an interdisciplinary approach when considering trials to discontinue the need for the use of a restraint.	Collaborative professional team approach for treatment	