2017/18 Quality Improvement Plan
"Improvement Targets and Initiatives"

Extended Care Unit

niagarahealth
Extraordinary Caring. Every Person. Every Time.

Niagara Health System 1200 Fourth Ave

AIM		Measure							Change				
Quality dimension	Issue	Measure/Indicator	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	**Effective Transitions**	Percentage of hand hygiene compliance among staff.	% / Residents	In-home audit / January - December 2016	51585*	94.40%	100.00%	Maintain 2016/17 QIP target.	Perform hand hygiene audits	Perform weekly audits with 'in the moment' feedback for compliance and non-compliance. All managers will discuss the results at staff meetings	Submit all audit results weekly to Decision Support for analysis. Post bar graph weekly for all staff to review.	100% compliance Reduction in the amount of publically declared outbreaks by Public Health	
									Increase visibility	Maintain a constant prescence to contribute to the formation of the 'hand hygiene habit'.	Increased level of engagment and diligience in completing hand hygiene through the use of positive reinforcement	100% hand hygiene compliance	
									Vary observation times	Perform observations at different times throughout the course of the day while maintainging visibility. Provide on the spot feedback when good hand hygiene is performed.	Increased level of engagment and diligience in completing hand hygiene through the use of positive reinforcement	100% hand hygiene compliance	
Patient-centred	**Person experience**	Percentage of residents responding positively to: "What number would you use to rate how well the staff listen to you?"	% / LTC home residents	In house data, NHCAHPS survey / April 2016 - March 2017	51585*	73%	75.00%	To achieve approximately a 3% increase from baseline.	Welcome Resident input on life in the home	Bring Resident input/suggestions forward at Residents Council meetings, Food Committee meetings, monthly surveys reflecting both activities and food services, annual satisfaction survey and informal surveys regarding activities in the home.	Monthly meetings and survey results will provide the 'pulse' check of the residents.	Monthly meetings	
									Respond to Resident needs	All staff take the time to be in the moment with the Resident without interuption by responding to their need or request.	Residents will continue to feel valued and having a contributory voice in the life of the home.	All Residents will continue to feel valued.	
		Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences".	% / LTC home residents	In house data, interRAI survey / April 2016 - March 2017	51585*	80%	82.50%	To achieve approximately a 3% increase from baseline.	Encourage reporting of concerns.	Create an environment where Residents feel concenrs can be brought forward to any staff	Resident's with a concern will bring their concern forward to any staff.	All concerns brought forward.	
									Follow up on all concerns.	Utilize the homes' Concerns management process to follow up on all Resident concerns.	All concerns managed in the home.	Not all concerns brought forward can be resolved but the home will endeavour to achieve successful resolution to 90%.	
									Track concerns raised monthly and idenify trends	Discuss concerns and trends identified with Residents' Council and all staff in the home.	Awareness of concern trends.	Awareness of concern trends.	
Safe	**Medication safety**	Percentage of residents who were given antipsychotic medication without psychosis in the 7 days preceding their resident assessment	% / LTC home residents	CIHI CCRS / July - September 2016	51585*	23.99%	22.61%	Target is set half way between Ontario benchmark and current result.	Conduct comprehensive medication reviews	Utilize the MDS RAI 2.0 to conduct a comprehensive medication review as well as a diagnosis review using the ICD 10 list. Any resident on an antipsychotic without a diagnosis of psychosis with MD will be consulted regarding the use of the medication ensuring its appropriateness.	The physicians of the home will conduct quarterly medication reviews on all residents. The Home's pharmacy will prepare a medication report for discussion at the Professional Advisory Committee (PAC).	To decrease the usage of antipsychotics in residents without a diagnosis of psychosis.	
									Registered Staff Education - antipsychotic usage	The home's pharmacy will provide education tp the Resgistered Staff on the risks and benefits of the use of antipsychotics.	Training to be provided annually to all Registered Staff.	Number of Registered Staff trained	
									All Staff Education - managment of behaviors	Provide training to all staff on the Gentle Pursuasive Approach.	50% of the home's staff have been trained in GPA as of March 2017	Number of staff trained.	
									Collaborate with community partners	Continue to collaborate with community partners of BSO and SMHO	Collaboration	Full collaboration	

AIM		Measure							Change				
Quality dimension	Issue	Measure/Indicator	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
	Safe care	Percentage of residents who fell during the 30 days preceding their resident assessment	% / LTC home residents	CIHI CCRS / July - September 2016	51585*	15.82%	13.30%	Maintain 2016/17 QIP target.	Pre-screen Residents for their falls risk prior to admission	At the time of admisison, falls prevention strategies will be implemented i.e. high-low beds, exit alarms, fall matts. A referral will be made to the physiotherapist for gait and balance assessment.	The MDS RAI 2.0 will be reviewed for falls risk when the application is received and prior to admission.	The home has adopted the philosophy of a 'Successful Fall' which acknowledges that a fall will occur but no injury results as all injury prevention strategies were in place and were successful.	The home encourages resident independence and quality of life. The home works to achieve an environment of least restraint which will result in an increase of falls.
									Balance the need for restraints and independence.	The use of visual cues for resident's at risk i.e. 'Falling Star' on the door frame of the resident's room to alert all staff in the home of the risk. To introduce and engage the resident at risk in meaningful activities i.e. exercise groups to promote balance and strength.	Individualized plan of care to reflect prevention strategies.	100% compliance	
									Analyze all falls	All falls will be reviewed by the Falls Prevention and Restraint Reduction Committee. Falls will also be discussed at staff meetings, Leadership/Quality/Risk Manangement Committee meetings and the Professional Advisory Council, along with any recommendations from the Falls Prevention and Restraint Reduction Committee	On-going education with attention to promote safe mobility, conducting a comprehensive Fall Risk Assessment and Post Fall Assessment.	100% of falls analyzed	
									Complete medication reviews	A review of resident medications will be conducted quarterly by the MD and the pharmacist	Reduce the number of medications that a resident is on thus reducing the risk of polypharmacy and adverse drug interactions. Avoid the use of antipsychotics which can lead to hypotension and lead to an increase in falls	Medication reviews completed quarterly	
		Percentage of residents who were physically restrained every day during the 7 days preceding their resident assessment	% / LTC home residents	CIHI CCRS / July - September 2016	51585*	14.78%	10.40%	Maintain 2016/17 QIP target.	Improve current restraint program and initiate alternatives prior to the initiation of a restraint	Least Restraint philosophy guides the practices of all staff in the home. Educate residents (where cognitively capable), families and staff that the goal is to minimize restraints. When a restraint is to be used, start with interventions that have the least restraining properties.	Monitor MDS RAI 2.0 data quarterly for restraint usage. Through observation and assessment remove restraints when no longer indicated.	To reduce the number of restraints (seatbelts, tabletops or bed rails) in use.	Many families struggle with allowing the resident their right to live at risk. As such families insist on the use of a restraint device (seatbelt) for additional safety.
									Use of standardized assessment and documentation tools	Use of Assesment tool on Point Click Care, the Treatment Assessment Record, standardized Restraint Flow Sheet etc for comprehensive documentation on restraint use	Audits will be conducted quarterly for completion of assessments and documentation. Individual resident plan of care will accurately reflect the resident's use of a restraint.	All tools standardized	
									Consistent communication by the Falls Prevention and Restraint Management Committee to the staff working in the home.	The Falls Prevention and Restraint Management Committee will review those residents using restraint devices, when to consider trials to discontinue restraint use, audit results etc and make reccommendations to be communicated with all staff in the home.	The Falls Prevention and Restraint management committee will have an interdisciplinary approach and will meet monthly.	Monthly meetings	
									Implement a process to reduce the use of bed rails.	At time of admission residents will be assessed for their need to use bed rails using a standardized assessment tool. The assessment will be conducted quarterly thereafter. Educate families on when it is appropriate to use bed rails	Monthly audits of bed rails being used and identifying whether they are being used as a restraint or Personal Assistive Service Device (PASD)	All residents assessed at admission	

AIM		Measure							Change				
Quality dimension	Issue	Measure/Indicator	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
	Safe care	Percentage of residents with a newly occurring Stage 2 or higher pressure ulcer.	% / Resident Assessment	CIHI Data/October 2015-September 2016	51585*	4.25	3.30	Maintain 2016/17 QIP target.	Pre-screen Residents for pressure ulcers prior to admission	The MDS RAI 2.0 will be reviewed for pressure ulcer risk or actively being treated for an ulcer when the application is received prior to admission.	At time of admission appropriate wound care strategies will be implemented. A comprehensive All new residents Skin and Wound assessment will be conducted on the day of admission to establish a baseline.	The home will focus on screening, early identification and resident specific interventional strategies to prevent the development of worsening pressure ulcers	Residents entering into LTC have multiple comorbidities, making them medically more complex with higher PSI scores
									Increase staff knowledge on how to prevent pressure ulcers, early identification and reporting to registered staff.	Home's Resource Nurse will arrange education sessions for all staff on wounds and their care. The information on Surge Learning will be current for all staff to access.	% of staff provided education	100% of all registered and PSW staff of the home will receive education on the Home's Skin & Wound Policy and Procedure. Wound Care education will be provided annually to staff.	
									Standardized methods and products used to treat pressure ulcers.	Work with the Niagara Health Wound Care Specialist to establish standardized guidelines for use of products/treatment for each stage of pressure ulcer.	% of staff provided education	100% of all registered staff will have education on the standardized guidelines for the use of products/treatment for each stage of pressure ulcer	
									Implement interventional strategies at stage 1/2 of pressure ulcer development to prevent worsening.	When tissue integrity is comprimised, referrals will be made to the Food Services Supervisor, and Dietician. Interventional strategies will be implemented i.e. Swift Slide Sheets, Therapeutic Surfaces. New beds purchased for the home will have the Ultramax Geomattresses to prevent friction shear and promote healthy skin integrity. Collaborate and work with the Nurse Practitioner for the management of severe wounds.	The individual resident's plan of care	The individual resident's plan of care will reflect the interventional strategies implemented.	
									Analyse all cases of poor skin integrity within the home and report on any trends	The Skin and Wound Management Committee will meet monthly to monitor skin integrity, make practice recommendations.	The Skin and Wound Management Committee reports will be reviewed monthly by the Home's Leadership/Quality and Risk Management Committee.	Reports reviewed monthly.	