2018/19 Quality Improvement Plan
"Improvement Targets and Initiatives"

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Niagara Health System 1200 Fourth Ave
Extended Care Unit

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

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Effective	**Wound Care**	Percentage of residents who developed a new or worsened stage 2 or greater pressure ulcer.	C	% / LTC home residents	CIHI CCRS / July - September 2017	51585*	9.00%	7.25%	1.7% towards stretch target of Ontario Average.	Screen and on-going assessment of skin integrity	1. Pre-screen all applications for risk for skin breakdown 2. Conduct head to toe skin check by Personal Support Workers (PSWs) on first bath for potential skin integrity issues and weekly skin assessments by the registered staff 3. Quarterly review of all residents 4. Conduct skin assessment on all residents returning from hospital	100% of skin assessments conducted as scheduled.	Reduce the rate of pressure ulcers to target.	Residents entering into LTC have multiple comorbidities, making them medically more complex with higher PSI scores.
										Take proactive steps when early identification of skin issues are noted.	1. Implement therapeutic surfaces when needed , the home has recently purchased 4 new surfaces that can be implemented at Stage 1 or 2, and have the capability to be converted to an air surface for stage 3 or 4 wounds 2. Nutritional referral to dietician for supplementation 3. Implementation of turning and repositioning schedule 4. If appropriate work with LHIN CCAC to have a seating assessment conducted 5. Where appropriate use SLIPP sheets to prevent friction injury to the skin	Care plans will be adjusted to reflect the required interventions	100% of Care plan audits will reveal that the appropriate interventional strategies have been implemented on impacted patients (with skin issue)	
										Use interdisciplinary approach in the management of pressure ulcers	1. Referral to dietician 2. Collaborate with the Nurse Practitioner in pressure ulcer treatment 3. Interdisciplinary team will discuss residents as appropriate at the weekly Minimum Data Set (MDS) meetings	Documentation of interventions to be trialed by the resident along with outcomes.	Use of standardized documentation tools for patient with skin issue	
										Monitor the development of new or worsened pressure ulcers	Rate of pressure ulcers will be reviewed at the monthly Leadership/Quality/Risk Management meetings and at the Professional Advisory Committee meetings. Conduct an analysis of the 'Geomattress Surface' and if residents on that surface are developing wounds.	Data analyzed and reviewed for trends. Any actionable ideas will be implemented.	Interdisciplinary leadership and physicians will be involved in wound care monitoring, analysis and recommendations	
										Increase staff knowledge on prevention, identification, treatment of pressure ulcers	1. Use of standardized assessment and documentation tools to ensure all staff are using the same language to communicate regarding a pressure ulcer. 2. Staff education provided by the Nurse Practitioner Led Outreach Team for all staff (Registered and unregistered) 3. Use of Surge for additional information regarding wounds and their treatment.	On-going education with attention to promote pressure ulcer prevention with attendance recorded. Staff will attend either a live event or a Surge Learning event.	Staff (100%) engagement in the recognition and treatment of ulcers.	

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Patient-centred	Person experience	Percentage of residents responding positively to: "What number would you use to rate how well the staff listen to you?"	P	% / LTC home residents	In house data, NHCAHPS survey / April 2017-March 2018	51585*	92.81%	93.70%	1% improvement from year end result	Welcome resident input on life in the home.	1. Bring resident input/suggestions/ideas forward at Resident's Council, Food Committee meetings, monthly surveys reflecting both therapeutic recreation activities and food services. 2. Conduct an annual satisfaction survey and informal surveys regarding the services in the home.	Monthly meetings and monthly surveys will provide the 'pulse check' of the residents	Continue to improve on current rating by 1%.	
										Respond to resident needs	All staff will take the time to be in the moment with the resident without interruption by responding to their need or request.	Resident's will continue to feel valued. Residents will continue to offer suggestions/ideas for the home.	Continue to improve on current rating by 1%.	
										Resident participation in care conferences when they are able.	1. Educate residents and families from the point of admission about the importance of being engaged in their care planning. 2. Wherever possible interview resident when conducting the MDS Resident Assessment Instrument (RAI) I 2.0 assessment. 3. Utilize the care conferences to listen to residents and make changes to their care.	Care conferences will have participation by either the resident or family 75% of the time.	Continue to improve on current rating by 1%.	
		Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences".	P	% / LTC home residents	In house data, interRAI survey / April 2017 - March 2018	51585*	89.36%	91.10%	2% improvement from year end result	Encourage reporting of concerns	Create an environment where resident's feel that their concerns can be brought forward to any staff of the home.	Resident's with a concern will bring their concern forward	All concerns are brought forward.	
										Follow up on all concerns	Utilize the home's concerns management process to address, investigate and follow up on all resident concerns	All concerns addressed using the Issues and Concerns form.	Not all concerns brought forward can be resolved but the home will endeavor to achieve successful resolution 90% of all concerns raised.	
										Track concerns raised monthly and identify trends	Discuss concerns and trends identified monthly with Resident's Council, Leadership/Quality/Risk, and home's staff.	Reduction of the concerns raised through staff awareness.	Continue to improve on current rating by 1%.	

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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	51585*	20.68%	18.48%	2.2% point improvement on unadjusted rate as move toward stretch target of provincial benchmark	Administrator will share Canadian Institute for Health Information (CIHI) data along with QIP data at the quarterly Professional Advisory Council meeting for analysis.	1. At the quarterly meetings, pharmacy will provide data on psychotropic drug use in the home as compared to other LTC homes the pharmacy serves 2. Quarterly QIP data will be reviewed by the Professional Advisory Committee.	Documented meeting discussion on psychotropic use	Reduction in the use of antipsychotics without a diagnosis of psychosis to target	
										Utilize the MDS 2.0 to conduct a comprehensive medication review correlated to diagnosis of psychosis.	1. Using the MDS 2.0 and medication profile, conduct a chart review, and consult physician where no diagnosis is in place when the drug is in use. 2. Consult the physician for alternatives if no diagnosis supports the use of an antipsychotic	Quarterly medication reviews by home's MDS staff, pharmacy and physician	To decrease the usage of antipsychotics in residents without a diagnosis of psychosis.	
										Ensure that for any responsive behaviors the first interventions are non-pharmacological.	1. Utilize Dementia Observation System (DOS) charting to determine patterns in responsive behaviors. 2. Involve family to support non-pharmacological interventions 3. Involve the Behaviour Supports Ontario (BSO)/psychogeriatric team 4. Expand Music & Memory program. 5. Team meetings to discuss those residents with responsive behaviors and non-pharmacological interventions 6. Obtain a Mobile Sensory Cart (Snoozelin) to assist in preventing/de-escalating responsive behaviors. 7. The use of animated pet therapy to redirect thereby preventing the behavior from occurring.	The number of residents with responsive behaviors that have non-pharmacological interventions.	To decrease the usage of antipsychotics in residents without a diagnosis of psychosis.	
										Optimize staff and physician awareness of and capacity to manage antipsychotic medications	1. Education for staff conducted by the pharmacy and Nurse Practitioner of the Nurse Led Outreach Team. 2. Education for physicians conducted by the pharmacy.	Number of educations sessions provided by the pharmacy and Nurse Led Outreach Team	1 pharmacy education session for the 4 physicians to attend . 1 pharmacy education session for front line staff. 1 Nurse Led Outreach team education session for front line staff.	

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Safe	Safe care	Percentage of residents who fell during the 30 days preceding their resident assessment	A	% / LTC home residents	CIHI CCRS / July - September 2017	51585*	19.53% unadjusted rate	15.63%	Target set to Ontario unadjusted benchmark	Pre-screen residents for their falls risk prior to admission to have falls prevention strategies in place at time of admission	1. Placement of the 'Falling Star' magnet on the door frame of the resident's room to alert all staff of the falls risk. 2. Provision of a high-low bed, exit alarms, falls matts. 3. Referral to Physiotherapist for gait and balance assessment 4. Engagement in meaningful activities	A/ Reduction in the number of falls in a month B/ Minimal to no injury should a fall occur C/ Post fall analysis of interventional strategies in place.	to decrease the number of falls to target	Reduction of the percentage of residents who fall by 2018, by setting a realistic target based on falls prevention strategies.
										Analysis of all falls	1. Analysis of falls by the interdisciplinary team, to review each fall 2. Development of individualized care plans outlining falls prevention strategies 3. Engage the resident and family in strategies to reduce falls	Review residents with more than one fall in the past 3 months weekly. Discuss change ideas, interventions to be trialed. Changes documented in the resident care plan and in meeting minutes. B/ Falls data shared with the home's Leadership/Quality/Risk Management meetings and with the Professional Advisory Committee	100% of falls will be analyzed	
										Education	1. Nurse Practitioner of the Nurse Led Outreach Team to conduct education on falls reduction strategies for staff 2. Physiotherapist to conduct education sessions for residents on how they can participate in falls reduction interventions	On-going education with attention to promote safe mobility, with attendance recorded.	to decrease the number of falls. 100% of staff to participate	

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Safe	**Safe care**	Percentage of residents who were physically restrained every day during the 7 days preceding their resident assessment	A	% / LTC home residents	CIHI CCRS / July - September 2017	51585*	12.14%	10.40%	Continue with QIP 2017/2018 target. Work toward reducing and moving toward the provincial targets by improving our current performance.	Residents using a restraint or Personal Assistance Service Device (PASD) will have a quarterly assessment completed	Complete MDS RAI 2.0 quarterly assessments to determine if the PASD/Restraint needs have changed	100% of those residents with PASD/Restraints will be reviewed quarterly	To reduce restraint use to target.	
										Restraint alternatives will be trailed prior to using a restraint device.	When required the restraint will be discussed at the weekly interdisciplinary MDS meeting to determine the need for the device, alternatives to be trialed	Minutes recorded of discussion held at weekly meetings when restraint discussions are held.	To reduce restraint use to target.	
										Continue to promote a least restraint environment by monitoring restraint usage, conduct removal trials with interdisciplinary input and feedback.	1. Restraint usage will be discussed at the weekly MDS meetings as appropriate. 2. Restraint usage will be reviewed at the monthly Leadership/Quality/Risk Management meetings and at the Professional Advisory Committee meetings.	The number of restraints and they type will be tracked monthly and the statistics will be shared at the Leadership/Quality/Risk Management and Professional Advisory Committee meetings	To reduce restraint use to target.	
										Education on restraint use and alternatives	Education to be provided by the Resource nurse on PASD/Restraint devices and alternatives.	Staff will attend either a live event or view educational learnings	100 % staff participate in educational activities	
	Safe care	Hand Hygiene	C	% / Worker	In-house survey / TBD	51585*	93.02%	100%	Expect 100% compliance	Hand Hygiene Audits	Weekly hand hygiene audits conducted by home's leadership with immediate feedback for compliance and non-compliance.	Results submitted weekly to decision support with bar graph indicating performance for staff to review performance. Discuss at staff meetings	A/ 100% compliance B/ Reduction in Outbreaks called by Public Health	
										Increased visibility	The leadership presence in the home, actively providing immediate feedback, contributes to the formation of the hand hygiene habit.	Increased level of engagement with front line staff with increased diligence in completed hand hygiene through the use of positive reinforcement.	100% compliance	
										Vary observation times	Perform observations at a variety of times through the day, while maintaining visibility. Provide immediate feedback for compliance and non-compliance.	Increased level of engagement with front line staff with increased diligence in completed hand hygiene through the use of positive reinforcement.	100% compliance	