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

Terrace Lodge 475 TALBOT STREET EAST

AIM		Measure						
Quality dimension	Objective	Measure/Indicator	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification
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	% / Residents	Ministry of Health Portal / Oct 2014 – Sept 2015	53117*	27.5	24.60	Continue to target provincial average.
	To Reduce the Inappropriate Use of Anti psychotics in LTC	Percentage of residents receiving antipsychotics without a diagnosis of psychosis. Exclusion criteria are expanded to include those experiencing delusions.	% / Residents	CCRS, CIHI (eReports) / July – September 2015 (Q2 FY 2015/16 report)	53117*	25.43	20.13	The Team achieved a reduction of 6.76 in this area and are currently .43 above provincial average of 25.0% Although aggressive, the Team's goal is to achieve a target of 20 for 2016/2017.
	To Reduce Worsening Bladder Control	Percentage of residents with worsening bladder control during a 90-day period	% / Residents	CCRS, CIHI (eReports) / July – September 2015 (Q2 FY 2015/16 report)	53117*	23.66	18.00	Qur current performance of 23.66 is above the provincial average of 18.2 and we will work towards this goal in 2016/2017

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	% / Residents	In-house survey / Apr 2015 – Mar 2016 (or most recent 12-month period)	53117*	84	89.00	Terrace Lodge continues to strive to ensure optimum care to its Residents.
	Domain 2: "Overall satisfaction" (choose A or B).	A: Percentage of residents who responded positively to the question: "Would you recommend this nursing home to others?" NHCAHPS)	% / Residents	In-house survey / Apr 2015 – Mar 2016 (or most recent 12-month period).	53117*	100	100.00	Terrace Lodge continues to strive to provide optimum care and service to the Residents.
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)	53117*	9.75	9.00	Cuurrent performance is below the provincial average 14.2%. Benchmark is 9%
	To Reduce the Use of Restraints	Percentage of residents who were physically restrained	% / Residents	CCRS, CIHI (eReports) / July – September 2015 (Q2 FY 2015/16 report)	53117*	32.18	16.00	The provincial average is 6.7 % and the benchmark is 3%. Our home

								has set a target of 16.0 for the 2016/17 QIP. A challenge to success is the current application of a PASD" by CIHI - specifically that PASDs which are
	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)	53117*	2.53	2.00	Our home demonstrated and increase in this indicator from the previous QIP but remain below the provincial average of 3.3%. Benchmark 1%

Change				
Planned improvement initiatives (Change Ideas)	Methods	Process measures	Goal for change ideas	Comments
1)Track the number of visits to the Emergency Department (ED) each month by cause: fall, potentially preventable	Utilization of manual monthly tracking sheet.	Percentage of residents at high risk for an ED visit who had a change in condition documented on the shift to shift report (or progress notes) in the 24 hours prior to ED visit.	There will be a 5% decrease in the number of preventable ER visits by December	One change idea will be focused upon until we obtain baseline data to then work
1)Audits of all residents medication list and diagnosis to identify residents on antipsychotics without a diagnosis of	Quarterly audits (including drug utilization stats) by pharmacy and/or nursing. Analysis of stats by falls and restraints committee and PAC. Follow up with physicians re: diagnosis review and potential medication adjustment. Referral to BSO team for follow up of any	# of residents on antipsychotic medications without a supporting diagnosis; # of residents whose antipsychotic medications discontinued successfully; # of referrals to BSO post medication discontinuation	100 % of residents whose medications are discontinued will be referred to BSO; 100 % of	
2)Referral to BSO internal team for current residents (not currently being seen by BSO) on antipsychotic medications without a	Review process and referral form with BSO team. Educate registered staff on process/criteria for referral for current residents. Start on one home area and spread to other home areas as permitted.	# of referrals to BSO team for current residents on antipsychotic medication without a supporting diagnosis; # of residents with successful discontinuation of antipsychotic medications	Review of process and referral form with BSO team in April 2016. Education for	
3)Regularly review behaviour and resident needs	Create standardized risk assessment algorithm for situations of escalating behaviour; for escalating behaviour, use standardized assessment tools to assess risk, utilising tools provided through the Quality Compass.	The number of BSO referrals reviewed by the BSO imbedded team will increase by 10% monthly by December 2016.	50% of BSO referrals will be provided with non-pharmacological interventions as	
1)1.Medication review (quarterly) to identify medications that have a negative effect on bladder control and determine if	Pharmacy to provide 1/4 medication reports to identify medications that have a negative effect on bladder control . Medication reports to be reviewed at continence team meetings, 1/4 reviews and MDS RAI assessment/coding with a focus on residents with	# of residents with medication changes that promote improved bladder control # of residents with worsening bladder control	100% of residents with worsening bladder control will include a focus on medication	This was a change idea in 2015/16 QIP but we did not meet our target so further
2)2.Implement individualized toileting routines according to continence assessment and voiding record patterns	Education for staff re:voiding records, continence assessments, appropriate products. Review and revisions of continence assessment and process.Audits of care plans to ensure individualized toileting routines in place for residents with worsening bladder control-	#of care plans for residents with worsening bladder control that have an individualized toileting routine: # of residents using the most appropriate product(s) as determined by voiding record and/or continence assessments and voiding records accurately completed:	100% of staff will complete education !00% o0d assessments and care plans for	This was a change idea in the 2015/2016 QIP which requires further

3)3. Introduction of a new admission process and product for continence management in a effort to maintain and/or improve	Education completed February 2016 will be implemented for new admissions in March 2016. Implementation of lightest incontinent protection product (e.g. blue strip versus brief) during the 2 day voiding record assessment. Introduction of a "male	Audit use of product change forms. Audit of incontinent supply orders; # of residents with worsening bladder control with a focus on new admissions.	15% improvement in bladder control for new admissions . Product change forms will be	
1)Increase the number of positive responses by 5% by December 31, 2016.	Identify what specifically residents and family feel they do not have a voice concerning suggestions for the home through a targeted survey. Identify common concerns/needs and implement PDSA cycle. Re-survey by fall, 2016.	Number of survey responses will increase from 2015 by 5%.	88% of survey respondents will indicate a rating of 8 or more on the satisfaction survey.	One change idea is being identified as further change ideas will be implemented as
1)Terrace Pride Initiative	Interdisciplinary team involving staff, residents and their families to organize "Terrace Pride" events to build morale in the home. Residents will be recruited through Resident's Council and families will be recruited through Family Council. Team to plan events to build pride in	Number of events held by interdisciplinary team	Four events held in 2016-2017	
2)Implementing a weekly routine of collecting resident satisfaction data	The Quality Improvement Committee plans on asking 5 residents to rate the quality of service they received that day on a scale of 1-10 each day. Any complaints identified will become part of the CQI process. Data will be grouped in monthly intervals.	Numerator is number of residents interviewed each week. Denominator is number of interview able residents.	100% of interview able residents interviewed at least once by September 30,	
1)Individualized toileting routines implemented according to the continence assessment, focusing on Moderate to high risk	Care plan audits of toileting routines. Educational program for staff regarding individualized toileting routines and continence assessment.	Reduction in the number of falls related to resident attempts to self toilet. Individualized toileting routines for moderate to high risk fallers.	To be at or below the Provincial average . Decrease the number of falls by 10% by March	Our home will strive to reduce the number of falls related to continence issues
2)Review /revision of falls report from Risk Management and physio provider. Include root cause analysis to better target Risk	Falls/restraint collaborate with physio , review falls risk report.Educate staff to complete detailed risk management and utilize the information from these reports to develop individual strategies. Audit tool will be completed and reviewed at each committee meeting	100% of falls risk management will be completed correctly. Monthly review with team and physio provider to complete a root cause analysis.	100% of risk mnagement will be completed. Reduction in falls related to root	
3)White board will be in place to identify stats (such as residents at moderate to high risk for falls, # of days since the last fall, etc.) to	White boards to be implemented for each unit with education for staff. Stats to be updated monthly - e.g. Residents identified by the completed risk assessments and physio review will be listed.	# of falls by unit and # of frequent fallers by unit.	Staff will have a better understanding/heighthened awareness of where /why falls	
1)Multidisciplinary approach and analysis of resident situation prior to implementing any physical restraint to ensure	Education for staff on process Review and revise restraints policy Monthly audits MRC and/or RCC to be consulted prior to any implementation of physical restraints to ensure alternatives to restraints have been fully trialed prior to consideration of a physical restraint.	# of alternatives sufficiently trialed with supporting documentation prior to implementation of restraint; # of staff completing education; # of physical restraints.	0 % of physical restraints will be implemented without consultation of	Our home will continue to track the # of PASDs and the # of physical restraints

2)Audits and analysis of the use of bedrails as a physical restraint with the goal of eliminating bedrails wherever possible.	Bed safety audits. Education for staff, residents and families on appropriate bed rail use. Target one home area at a time - with focus on new admissions then current residents.	# of bed rails being used as a physical restraint; # staff completing education; # of success stories - i.e. # of residents where bed rails were eliminated and resident did not have a fall within the first 1/4.	Bed safety audit will be completed by May 31, 2016. Every new admission will be	Our home will continue to track the # of PASDs and the # of physical restraints
3)Reduce the % of residents who utilize a restraint by 50% and implement measures to realize this target reduction	Conduct site visits to other LTC Homes who have implemented a " No/Least Restraint" policy to learn best practices to reduce restraint usage.	% of restraints utilized monthly	To further reduce restraints by 50% by March 31, 2017 by focusing on "no/least restraint"	Our target is based on strategies that can be implemented to
1)Ensure the referral to dietitian for nutritional interventions at Stage 1.	Education for Registered and PSW staff to promote the stage 1 pressure ulcer referral process. Audits of stage 1 pressure ulcers to identify if referral to dietary for nutritional interventions has been completed.	# of new or worsening pressure ulcers # stage 1 ulcers # stage 1 ulcers with a referral to dietary for nutritional interventions	100% of stage 1 ulcers will be referred to dietitian. Reduce the # of pressure	Change idea was part of our 2015/2016 QIP but not fully implemented and
2)Promotion of approved usage and placement of the mechanical lift slings while the resident is sitting up in the chair to minimize risk of	Develop and implement an audit tool . Staff education by equipment provider. Review stats at skin and wound committee meetings minimally quarterly.	# of pressure ulcers that get worse; # residents with a pressure ulcer that require mechanical lift and sling for transfers and repositioning; # pressure ulcers per unit.	Increase staff awareness re: skin integrity and pressure ulcer prevention. 0 % of	Increased complexity of care with current resident population that
3)To ensure that residents at moderate to high risk for impaired skin integrity are identified to staff and appropriate interventions in	Review of admission, quarterly and daily skin assessments to identify residents at risk. White Board in place with stats to heighten awareness re: residents at risk and interventions in place.	Audit tool to identify residents and interventions in place, status and effectiveness of treatments. White board to identify resident, skin integrity status and interventions.	Increased staff awareness re: moderate to high risk residents and interventions.	