2019/20 Quality Improvement Plan for Ontario Long Term Care Homes
"Improvement Targets and Initiatives"

Caressant Care Arthur Nursing Home 215 ELIZA STREET

AIM		Measure						
Issue	Quality dimension	Measure/Indicator	Type	Unit / Population	Source / Period	Organization Id	Current performance	Target

M = Mandatory (all cells must be completed) P = Priority (complete ONLY the comments cell if you are not working on this indicator) C = custom (add any other indicators you ar

Theme I: Timely and Efficient Transitions	**Efficient**	Number of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents.	P	Rate per 100 residents / LTC home residents	CIHI CCRS, CIHI NACRS / October 2017 – September 2018	53441*	16.24	14.00

Theme II: Service Excellence	Patient-centred	Percentage of complaints received by a LTCH that were acknowledged to the individual who made	P	% / LTC home residents	Local data collection / Most recent 12-month period	53441*	100	CB
		Percentage of residents responding positively to: "I would recommend this site or organization to	P	% / LTC home residents	In house data, interRAI survey / April 2018 - March 2019	53441*	74.51	80.00
		Percentage of residents who responded positively to the statement: "I can express my	P	% / LTC home residents	In house data, interRAI survey / April 2018 - March 2019	53441*	75.51	80.00
		Percentage of residents who feel their dining experience is pleasurable.	C	% / LTC home residents	In house data, interRAI survey / Jan 2019 to Dec 2019	53441*	70	75.00
Theme III: Safe and Effective Care	Effective	Proportion of long-term care home residents with a progressive, life-threatening illness who have had their palliative care needs identified early through a comprehensive and holistic assessment.	P	Proportion / at-risk cohort	Local data collection / Most recent 6-month period	53441*	CB	CB

		The home will focus on the reduction of falls.	C	Number / LTC home residents	POC/PCC Audits / Jan 2019 to Dec 2019	53441*	25.6	20.00

		Change	
Target justification	External Collaborators	Planned improvement initiatives (Change Ideas)	Methods

e working on)

Target justification	External Collaborators	Planned improvement initiatives (Change Ideas)	Methods
Target improvement as per Service Accountability Agreement (L-SAA)		1)Identify residents at risk for ED transfer.	Multidisciplinary team meeting conducted weekly to identify those resident at risk starting in April 2019
		2)Reduce total number of ED visits related to falls.	The number of ED visits related to falls will be tracked on a monthly basis by RAI Co-ordinator
		3)Reduce the number of ED visits due to change in condition.	The related to change in condition will be tracked on a monthly basis by RAI Co-ordinator
		4)Review results of Measure at PAC meeting	DOC to summarize reasons for all ED visits from past quarters requesting members of the PAC to recommend new change ideas as needed, December 2019
		5)Review results of Measure at PAC meeting	DOC to summarize reasons for all ED visits from past quarters requesting members of the PAC to recommend new change ideas as needed

All complaints must be acknowledged back to the individual within		1)Encourage residents and families to feel comfortable bringing forward concerns.	Educate staff on resident centred care. Empower staff on effective communication and decision making by multiple educational methods. Educate residents and families on formal and informal complaint process, May 2019.
Seeking % improvement of 5.5% compared to previous year's		1)Increase the number of residents and families completing survey.	Increase awareness of satisfaction survey through newsletters, resident mailings, resident and family council, stressing the importance of completing the survey. Increase the availability of the survey by frequent mail outs and access to on line survey within
Target set by CQI committee		1)Increase knowledge of Resident Bill of Rights, Homes Mission, Vision and Values and complaint process to residents and	Residents and families will be informed through a multitude of communication methods including but limited to; mail outs, resident and family council meetings, admission process, care conferences, open door policy. Staff education through Surge Learning,
Collecting baseline information to set target for improvement		1)Improve resident dining experience	Educate staff on Pleasurable dining expectations. Interview residents on their expectations of pleasurable dining. Ask family on what they see as pleasurable dining.
Collecting Baseline		1)Educate staff, family and residents on palliative care and end of life.	Educate staff upon hire and annually through Surge learning. Discuss Palliative Care Planning with resident and family upon admission, six week care conference, annual care conference and with a significant decline in condition
		2)Educate on Pain Management Program	In collaboration with Nurse Consultant, Educator and Nurse Practitioner, the DOC will educate all Registered Staff on the Pain Management Program
		3)Implementation of the Pain Management Program	DOC to evaluate competency of the Pain Management Program
		4)Evaluate Pain Management Program	Pain Tools 'pre & post', Pain Management Audits, Plan of Care, Program Evaluations, Monthly Pain & Palliative Care Committee Meetings

% of falls per month to be reduced by 5.5% to better align with corporate targets		1)Education on Falls Prevention Program for all staff, including proper completion of Post Fall Assessment, Risk	In collaboration with Nurse Consultant, Educator and external consultants a SAFE falls program will be introduced to support the Home in its fall prevention program. Education on Falls Prevention Program through Surge learning for all staff.
		2)Ensure the implantation the SAFE Falls program in conjunction with the falls prevention program and tools	ADOC will track the number of falls, completed falls assessments and report stats to the falls committee for further interventions on reducing falls.
		3)Ensure each resident will be assessed immediately post fall, by a multidisciplinary team. Registered nurse to	Use of Code care for each fall. Post Fall Investigation will be completed. Risk Management initiated in PCC by registered staff, Fall Assessment complete and care plan updated as necessary.
		4)Evaluate effectiveness of the Falls Prevention Program.	Review all require falls prevention documentation by Falls Committee. Ensure fall prevention interventions are discussed and implemented from multidisciplinary team approach and documented in the Plan of Care.
		5)New Falls Prevention equipment	Utilize Fall Prevention funding to purchase HI/LOW beds, alarms, falls mats, mattress', etc by December 2019

Process measures	Target for process measure	Comments
Number of residents at high risk identified through fall history, previous ED visits and established co-morbidities.	The percentage of our high risk residents transferring to hospital	
The number of ED visits related to falls will be evaluated monthly by Registered Staff and reported at monthly CQI meetings and quarterly PAC meetings on the effectiveness of the change idea, April 2019	Reduce ED visits related to falls	
The number of ED transfers related to change in condition will be evaluated monthly by Registered Staff and reported at monthly CQI and quarterly PAC on the effectiveness of the change idea, April 2019	Reduce ED visits related to change in condition	
# of ED visits from CIHI Oct 2017-Sept 2018 compared to CIHI Oct 2018-Sept 2019	seek a reduction of ED visits	
# of ED visits in 2019 compared to 2018	reduce # of ED visits from 2018 to 2019	

Establish tracking tool for informal and formal concerns, report to CQI team type of concerns and response time frames, May 2019.	Increase in informal complaints responded to immediately.	
Reviewing the quantity of returned surveys, quarterly.	Increase response rate to 60% of resident/family completing survey annually.	Due to the minimal responses to our surveys in 2018 we feel it is
Survey results to be discussed quarterly at CQI meetings and adjustments to the plan created through analyzing data.	Increase response rate to 60% of resident/family completing survey annually. 100% of	Due to the minimal responses to our surveys in 2018 we feel it is
Staff to be educated through Surge Learning, guest speakers and role play activities. Mini questionnaire offered to residents and families, supported by councils. Preferences on dining experience discussed upon admission. Data collected through food committee,	100% education through Surge learning for staff. 100% of residents given the	
The percentage of staff educated on palliative care through Surge Learning. The percentage of resident identified in their plan of care who have expressed their wishes on palliative and end of life care.	100% of staff educated annually. 100% of residents with expressed wishes of palliative	
# of Registered Staff trained on the Pain Management Program	100% of all Registered Staff trained on Pain Management Program, March	
Registered Staff to complete competency testing on the Pain Management Program	100% of all Registered Staff have completed competency testing on the Pain	
Residents identified with pain have their pain managed	100% Residents identified with pain have their pain managed in accordance with	

The number of registered staff trained on both the internal falls prevention program and the SAFE falls program.	100% of registered staff trained on falls prevention program by July 2019	
Number of post fall assessments reviewed monthly by falls committee.	100% of resident that had a fall received a post fall assessment, July 2019	
ADOC to collect monthly data on number of falls, Post fall assessment and Fall assessment, Risk Management and physio referrals.	100% of all falls have completed a Post fall assessment and Fall assessment,	
The number of falls monthly assessed by the Falls Committee	To reduce the number of falls per month.	
quantity of falls prevention equipment in the Home	Available Falls Prevention equipment in the Home is available for all Resident	