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

Caressant Care Courtland 4850 HWY 59

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	51587*	8.75	8.57
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	51587*	100	100.00
		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	51587*	70.83	75.00

		others." (InterRAI QoL)						
		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 2018 - March 2019	51587*	83.33	85.00

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	51587*	CB	CB
		Percentage of Residents with a worsened stage 2+ ulcer	C	Rate per 100 residents / LTC home residents	POC/PCC Audits / January 1 - December 31, 2019	51587*	2	1.00

	Worsening pain.	C	Rate per 100 residents / LTC home residents	POC/PCC Audits / Jan. 1 - Dec. 31, 2019	51587*	4.26	3.83
Safe	Number of Residents who fell in the last 30 days.	C	Rate per 100 / LTC home residents	POC/PCC Audits / January 1, 2019 to December 31, 2019	51587*	17.65	14.80

		Percent of Residents on an antipsychotic without the diagnosis of psychosis.	C	Rate per 100 residents / LTC home residents	POC/PCC Audits / January 1 - December 31, 2019	51587*	4	2.00

		Change	
Target justification	**External Collaborators**	**Planned improvement initiatives (Change Ideas)**	**Methods**
e working on)			
Target improvement as per Service Accountability Agreement.		1)Review ED Visits monthly to identify processes we can implement in the Home.	DOC to review each ED visit monthly at Registered Staff meetings to identify processes we can improve on.
		2)Review this QIP indicator at PAC meetings to identify areas for improvement to the Home's services.	DOC to summarize the reasons for ED visits for the past quarter for the Professional Advisory Committee members and request input for new processes.
		3)Implement Falls Strategy Program.	DOC to educate staff through in-services and assess through audits.
		4)Increase number of hi-low beds in the Home.	Utilize Funding Program to purchase beds.
All complaints must be acknowledged by the Home within 10 days.		1)All staff made aware of addressing complaints at time reported and resolved within 24 hrs.	Staff Educated on dealing with complaints and urgency.
Target set by CQI Committee	External BSO, Alzheimers Society, Norfolk Project Lifesaver, 4H Club, Church Groups, Mulit-Service Centre	1)Education & support on dementia & behaviours for Residents, Families & Staff by DOC. External community workshop advertised for	DOC will hold internal education sessions by collaborating with community partners. AD will advertise in Resident/Home newsletter.

		2)Address immediate needs of Residents revealed at time of survey.	Volunteer/AD completing survey to follow up with department head to make improvements.
		3)Bus trips for Residents.	AD to organize bus trips with external partner.
		4)Customer Service education to Staff.	ED to provide education.
		5)Demonstrate our leadership & initiative by providing & communicating our partnership with Project Lifesaver & Norfolk County	ED to offer auditorium for 2 day workshop for Project Lifesaver Officers to be trained. ED to engage Corporate & OPP Media Relations Officers. ED to inform Resident Council & Family Members of this initiative in collaboration with OPP.
		6)Improvements to Memory Garden Deck.	ESM to assess, plan and make improvements to boardwalk deck. AD to investigate lighting. AD to collaborate with volunteers to improve landscaping. AD to include Residents in planting & gardening projects.
		7)Provide picnics & alternate dining choices for Residents on outside Memory Garden Deck.	Picnics or theme lunches to take place on the Memory Garden Deck as orchestrated with AD, DOC, ED & FNM.
Determined by CQI Committee	Norfolk Project Lifesaver, Norfolk OPP, External BSO	1)Education & consultation related to anxiety, depression, past trauma stress - session provided to Residents, Families &	ED to provide session with Community Partner. AD to advertise in Resident/Home newsletter. Request Corporate media related advertisement.
		2)Safety discussed at Resident Council.	AD to hold monthly discussions with Resident Council related to safety concerns. Resident/Home newsletter to explain process for reporting potential hazards & concerns.

		3)Education on Abuse & Whistleblowing policies in the home to Residents & Families.	ED to offer education at quarterly Family information sessions. AD to offer at Resident Council Meeting.
Collecting baseline.	Community Volunteers, Norfolk Hospice Support.	1)Identify Residents who should be deemed Palliative within a time frame to allow a comprehensive and holistic assessment.	Registered Staff initiate Palliative Performance Scale when there is a decline.
		2)Complete a formal 'analysis' of the surveys sent including action plans.	Palliative Committee led by AD will do an annual 'analysis' at the end of the year to establish where improvements can be made.
		3)Education on aromatherapy program offered to Staff.	AD will review how aromatherapy will benefit during end of life at education sessions.
		4)Use Pain tool to determine severity of pain & physician/POA engagement for improvement.	Registered Staff to evaluate results of tool & engage physician when further medication changes are necessary. Registered Staff will communicate and respect wishes of Resident/POA throughout the process.
		5)Initiate new Corporate Palliative Assessment tool.	DOC to educate Registered Staff on new tool & train a Champion for support. Registered staff to utilize and implement tool at time of Resident significant decline.
		6)Care conference to be scheduled when deemed palliative.	Reg. Staff to arrange meeting with POA & interdisciplinary team to review care planning.
Target reviewed with CQI committee to reflect 0-1 Resident in the		1)Monthly review of indicator focusing on individual Residents triggered.	DOC follow up with interventions, internal Wound Champion & physician.

CQI Team set goal to lower by 10%.		1)Additional education to nursing staff.	DOC to provide additional education in-service to staff.
		2)Review new pain policies.	DOC to review new pain policies with all nursing staff.
		3)Review Residents triggered by this indicator on a monthly basis.	DOC & RAI to review resident status/interventions & engage physician. Reg. Staff to follow up with pain tool.
Decrease by 6% by Dec. 31, 2019 to meet Corporate benchmark.		1)Improve risk identification.	DOC to provide training on SAFE Program to all nursing staff.
		2)Improve falls prevention; management & implementation of program.	DOC to provide education on SAFE & utilization of environmental modifications around beds, bathrooms and seating.
		3)Identify risk factor interventions & provide safe Resident transfers.	DOC to educate and lead staff in providing safe Resident Transfers promoting SAFE Program & utilizing training sessions on lifts & chair alarm products.
		4)Assessments on Residents to include comprehensive approach.	DOC to train staff to review considerations such as Resident transfer; mobility aids; fall monitoring devices; clothing and footwear. Activities & Health Management to include restorative exercise equipment; nutrition; blood pressure monitoring; and toilet scheduling.
		5)Fall Program audits to be used to evaluate where improvements can be made.	Registered Staff to utilize audit tools to evaluate equipment used. ESM to utilize audit tool to evaluate entrapment and mattresses.

The Home recognizes admissions on anti-psychotics that will be		1)Monthly review of triggered indicator by RAI & DOC.	Follow up with physician, Resident/POA & pharmacy to review alternatives & diagnosis.

Process measures	Target for process measure	Comments
Number of ED visits per month	Review of all ED visits on a monthly basis at Registered Staff meetings to be implemented by	
Number of ED visits	Implement 1 change idea from PAC by Dec. 31, 2019.	
Number of Reg. Staff educated.	100% of Reg. Staff trained on new Fall Strategy Program by Dec. 31, 2019	
Number of beds added to inventory.	Utilize appropriate funding by adding, 2 additional beds by Dec.31, 2019.	
Number of complaints not acknowledged within 10 days.	100% of complaints acknowledged by Dec. 31, 2019	
DOC will track attendance. AD will keep record of invitations in newsletters.	5 Family Members attending each internal support session held in 2019. 20 Staff	This initiative to be completed in collaboration with Alzheimer's Society &

Each identified need will have follow up recorded.	Each identified need to be addressed on each survey within 10 days.	
To be reflected on Resident Survey related to 'outdoors'& general 'recommendation to the Home'.	April to December 8 bus trips for Residents by Dec. 31, 2019.	In collaboration with internal volunteers & Multi-Service Centre.
Number of Staff in attendance.	30 staff to attend by Dec. 31, 2019.	
Home's auditorium to host OPP training on Project Lifesaver.	One workshop to be offered over 2 days by Dec. 31, 2019.	
Number of Residents who would recommend this Home.	Repairs, lighting & decorating completed by June 9, 2018	
Number of events.	To provide 3 events by Oct. 2, 2019.	
Number of workshop opportunities.	1 workshop offered by Dec. 31, 2019.	
Monthly documentation in Resident Council Minutes. Process documented in newsletter by AD.	All concerns identified, investigated and followed by ED through Complaint	

Resident survey indicator.	Increase to meet goal noted in measure by Dec. 31, 2019.	
Follow up Palliative survey sent post death.	Set benchmark of family satisfaction by Dec. 31, 2019.	
Surveys to reflect satisfaction of our Palliative Program.	80% satisfaction from Survey Analysis completed by Dec. 31, 2019.	
Staff attendance.	40% of staff educated by Dec. 31, 2019.	
Pain tool being used 'pre & post' indicates improvement.	100% of residents who experience pain will be assessed 'pre & post' treatment by	
Number of Reg. Nursing staff to be trained. Champion in the Home.	100% of Reg. Nursing staff trained and a Champion recognized by Dec.	
# of care conferences	One care conference for each Resident deemed palliative initiated by Apr. 1,	
Number of wounds.	100% of wounds healed within 3 mths. of occurrence.	

Number of nursing staff trained.	50% of nursing staff trained by Dec. 31, 2019	
Number of staff in-serviced.	100% of Registered staff review new pain policies by June 1, 2019.	
Number of Residents with worsening pain.	100% of Residents triggered each month evaluated by physician.	
Number of staff in attendance.	100% of Reg. Staff trained on new Fall Strategy Program by Dec. 31, 2019	
Number of nursing staff.	To educate all Registered Staff by Dec. 31, 2019.	
Number of falls.	Decrease in number of Residents who fall to meet target by Dec. 31, 2019.	In-services with lift, physio and chair alarm contractors.
Number of Residents who fall	Decrease in number of Residents who fall to meet target by Dec. 31, 2019.	Utilization of SAFE Program.
Number of improvements from audits.	Identify at least 3 documented improvements from audits by Dec. 31, 2019.	

DOC will facilitate communication for improvement.	2% (1 Resident) by Dec. 31, 2017	