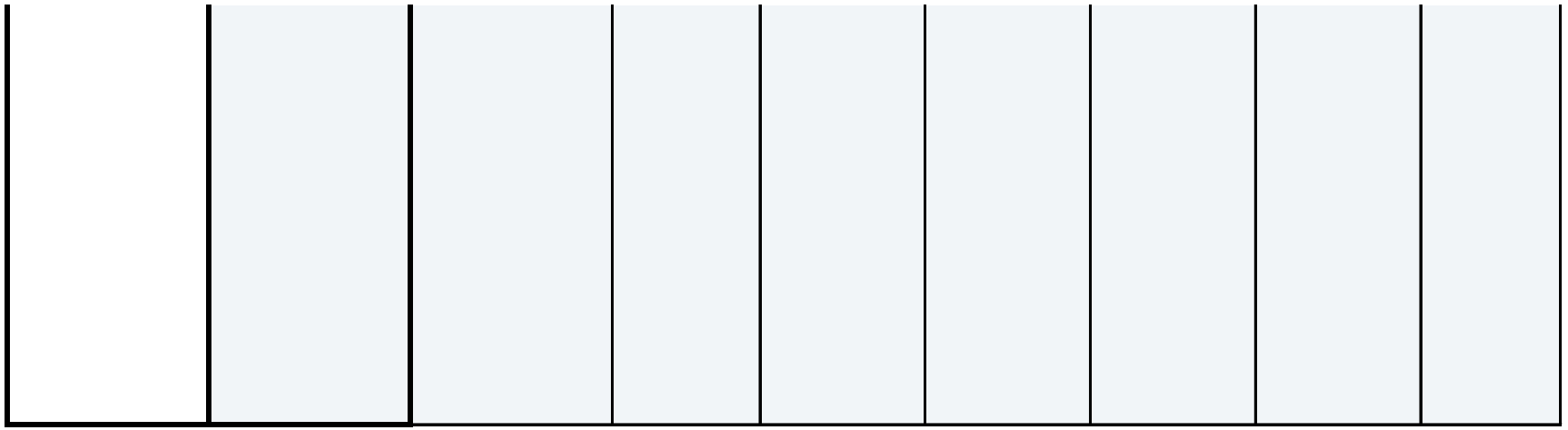
2019/20 Quality Improvement Plan for Ontario Long Term Care Homes
"Improvement Targets and Initiatives"

Caressant Care Woodstock Nursing Home 81 FYFE AVENUE

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	52623*	25.35	23.00
Theme II: Service Excellence	**Patient-centred**	Percentage of complaints received by a LTCH that were acknowledged to the individual who made a complaint within 10 business days.	P	% / LTC home residents	Local data collection / Most recent 12-month period	52623*	94.64	98.00

		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	52623*	80.08	85.00
		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	52623*	75.35	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	P	Proportion / at-risk cohort	Local data collection / Most recent 6-month period	52623*	CB	CB
		Percentage of long-term care home residents who developed a stage 2 to 4 pressure ulcer or had a pressure ulcer that worsened to a stage 2, 3 or 4	C	Number / All patients	CIHI eReporting Tool / Quarterly review	52623*	5.5	3.50
	Safe	The Home will focus on the reduction of falls.	C	Rate per 100 / Residents	CIHI CCRS / April 2019 - March 2019	52623*	21.1	14.00



		Change	
Target justification	**External Collaborators**	**Planned improvement initiatives (Change Ideas)**	**Methods**
e working on)			
Performance is slightly higher than target, the organization will continue to focus on improvements to meet provincial performance.		1)Establish protocol to identify at risk residents in order to provide early treatment of common conditions.	The RCC/RN will conduct weekly huddles to review and update care plans and discuss at-risk residents.
		2)Decrease the number of visits to the Emergency Department (ED) each month related to falls.	The number of ED visits r/t falls will be tracked monthly by the mds/rai coordinator to establish a baseline measure by July 2019.
		3)Evaluate the current effectiveness and availability of in-house services.	The Director of Nursing/designate will review hospital transfers and evaluate what in-house services are available to the home versus transfer.
The home has done well in this area and will continue to improve by ensuring a shorter turnaround time to generate the initial		1)Decrease complaints by enabling staff to resolve concerns/requests at the point of care, ensuring residents needs and wishes	Provide education to staff on effective complaint/request handling practices which focus on Resident Centred Care, staff empowerment through effective communication and decision making to honour resident/family wishes and preferences.
		1)Provide education and skill building to nursing staff on responding to complaints.	In-house education, surge learning, 1:1 instruction/role play.

This is a high risk area for the organization due to exterior influences which		1)Increase appreciation and respect of Residents' values, preferences, and expressed needs by developing and communicating a quality	The CQI Team will analyse responses received through the annual resident satisfaction survey. The Team will develop actions plans and communicate through special resident and family council meetings in ensure resident/family inclusion. Progress on action plan
The organization is in the process of establishing a corporate benchmark with		1)Provide continued education and awareness of the Residents' Bill of Rights in partnership with the homes' resident's council.	The CQI Lead will request to provide information and seek interest on the part of Residents' Council in co-partnering to implementing an education program centred on "Through Our Eyes". Residents' Council will be asked to identify which "Rights they would like to
The ultimate target is to ensure 100% of residents with a life threatening illness have their palliative care needs met.		1)Provide education for staff, residents and family/SD on palliative care and end-of-life care.	Education will be provided to registered staff upon hire and annually. The Palliative Care Team will provide education to resident and family council and upon request at the time of new resident admission. The PC Team will track progress on care planning details and
		2)Provide enhanced information to newly admitted residents/family concerning the distinction between Palliation and End	The Palliative/Pain Champion at a sister home is drafting a one page insert to be used in the Admission Package, and as a hand-out to review with those families/residents who have the beginnings of a change of status.
The Wound Care team will focus on a reduction of 2% at minimum in order to improve performance to provincial target of 2.7%		1)1)Improved assessment and documentation of wounds by Registered Staff. Implementation of Skin & Wound lead in multiple	Continued education of assessment and intervention by Registered Staff; ensure appropriate documentation and usage of Skin & Wound assessment in Point Click Care. Continued engagement of RNAO best practices. Dietitian to continue to assess residents with pressure
		2)Examine each pressure ulcer incident to determine cause and effect to identify contributing factors and prevent worsening.	Newly acquired pressure ulcers will be assessed by the Wound Care Champion who will conduct a root cause analysis to determine prevention measures. The appropriate treatment will be identified to aide in avoiding potential progression of wound to next
		3)Increased education of PSW staff for early identification and reporting of skin issues when identified during care.	RNAO Best Practice Guidelines education for the Early Identification and Prevention of Pressure Ulcers for Unregulated Care Providers will be provided by the education coordinator for the home.
The home will continue to focus on falls reduction and retain the previous years		1)Development of and education on the proper use of a post fall assessment tool	In collaboration with the Nurse Consultant/Educator, a post fall assessment will be reviewed/revised for trial implementation by the falls committee.

target of 14.0. This target is below provincial average of 16.4. The corporate performance is 14.4 and the home will continue to work towards surpassing the corporate average.		2)Implement post fall assessment for residents who are 1st time fallers to care plan proactive interventions.	The mds/rai coordinator will monitor and track the number of falls receiving post fall assessment of 1st time fallers without injury and 1st time fallers with injury. The mds/rai coordinator will provide a monthly progress report to the falls committee.
		3)Ensure completion of post fall assessment and care planning for residents experiencing falls without injury.	The falls committee with review all fall related incidents, without injury, to ensure a post fall checklist/assessment is completed.
		4)Provide re-education on proper care plan updating related to post fall assessment.	The falls committee/mds-rai coordinator will provide in-service education to Registered staff on care planning post fall.

Process measures	Target for process measure	Comments
Number 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.	The percentage of resident identified as high risk residents who transfer to hospital	This indicator will be coordinated with the Palliative Care QIP. Baseline data will
The number of ED visits r/t falls will be evaluated at quarters 2 & 3 to establish effectiveness of the change idea.	ED visits related to the number of falls will decrease by 10% between July and December	The indicator will be coordinated with the falls QIP for 2019/2020.
The number of residents transferred who did not receive in-house services will be tracked.	100% of all residents who were transferred will be evaluated for in-house	This change idea continues to be carried over annually to identify external
The number of unresolved concerns at the point of care will be tracked utilizing a concern/request form. The CQI Team will track type of concern/request and timeframe for responding, 2, 5 and 10 days.	50% of unresolved "concerns/requests " will be reported by PSW staff by February 28, 2020.	Complaints are responded to within 10 days of receiving. The goal of this
The number of PSW staff who receive education on complaint handling.	90% of PSW staff will receive education and instruction on complaint handling	It is important to note that there is a difference between concerns/request

The number of improvement opportunities which are identified and have action plans implemented.	100% of Resident/Family survey category results scoring below 80%	This is a high risk area for the organization due to exterior influences which
Although this education is in addition to the annual education requirements for staff, the number of staff attending the "Through Our Eyes" education will be tracked and monitored to encourage 100% participation.	The target is 100% of all staff will attend at least 1 component on the "Through Our	This initiative will encompass all or part of the handbook on "Through Our
# of staff and applicable residents/SDM educated; % of residents whose care plan/documentation captures expressed wishes and goals of care to support palliative and end-of-life care.	100 % of staff and applicable residents/SDM will be educated by December 31, 201;	
Number of newly admitted residents/family who receive the enhanced information.	100% of newly admitted residents/family will receive a Palliative/End of	
Review of data by the Wound Care Team in collaboration with the Dietitian ensuring appropriate referrals are occurring for increased nutrition and hydration.	100% of residents will be assessed for skin integrity issues on a weekly basis by July 1, 2019.	The home has had inconsistent success in the monitoring, assessment and
Number of newly acquired pressure ulcers reported	A baseline will be established for newly acquired pressure ulcers	Pressure ulcers continue to be an area of heightened awareness and
The number of PSW's receiving the RNAO education on early identification and prevention of pressure ulcers for unregulated care providers.	100% of PSW's will receive education on early identification and prevention of	
The number of registered staff trained on the post fall assessment.	100% of registered staff will be training on the post fall assessment tool by the falls	

Number of post fall assessments reviewed per month by the falls committee.	100% of residents who are 1st time fallers will receive a post fall assessment by	
The number of post fall assessments completed and care plan updates	The number of falls will decrease by 7.1% to achieve target.	
Number of care plans updated according to post fall assessments.	100% of care plans will be reviewed and updated post fall by the falls committee by	