Let's Make Healthy Change Happen.

Quality Improvement Plan (QIP) Narrative for Health Care Organizations in Ontario

Chester Village
CARE WITH DIGNITY

3/28/2018

This document is intended to provide health care organizations in Ontario with guidance as to how they can develop a Quality Improvement Plan. While much effort and care has gone into preparing this document, this document should not be relied on as legal advice and organizations should consult with their legal, governance and other relevant advisors as appropriate in preparing their quality improvement plans. Furthermore, organizations are free to design their own public quality improvement plans using alternative formats and contents, provided that they submit a version of their quality improvement plan to Health Quality Ontario (if required) in the format described herein.

Overview

Chester Village has always believed that a formal Quality Improvement Plan (QIP) is an important element for all of the improvement activities currently underway in our home as it allows us to identify areas in need of improvement, to set goals and to monitor the achievement of these goals. Each area of the plan is reviewed at least quarterly through various team meetings and it is never static, but constantly evolving based on our successes, or sometimes lack of success which will also necessitate a change. It is evidence of our commitment to quality care for our residents.

The 2018/19 QIP for Chester Village was developed with the following priorities in mind:

- To improve upon the resident experience and quality of life
- To continue to decrease our performance with potentially avoidable emergency department visits
- To maintain our performance rate for the inappropriate use of Antipsychotics
- To reduce falls
- To reduce pressure ulcers

These priorities are in alignment with our five interconnected strategic priorities that were developed at our last Strategic Planning session as well as our Mission, Vision and Values which incorporate Dignity, Respect, Compassion, Accountability and Integrity into our everyday work life. In addition, our QIP aligns with regional and system priorities as well as other key stakeholder and partner plans such as the Toronto Central LHIN and our Service Accountability Agreement, MOHLTC annual inspection standards and RQI report, CARF accreditation and RNAO best practice guidelines.

Describe your organization's greatest QI achievements from the past year

Chester Village is very proud of the performance in the Resident Experience Category from the three 'non-mandatory' quality improvement initiatives added to the 2017/18 QIP as a result of the Resident Experience annual Survey.

1. Pleasurable Dining Experience for Residents - Several new change ideas were implemented in 2017 as a result of only 68% of our residents being satisfied with the pleasurable dining experience. We aimed to improve that to 75% satisfaction and succeeded our target by 4%, an 11% improvement from the previous year, indicating a very successful implementation of the initiative.
2. Participation in Programs off the home areas - The quality indicator a significant improvement of all of our improvement activities, increasing from a 55% satisfaction to 88% and surpassed the target by 18%. All of the change ideas for the initiative were successfully implemented and the results confirm that they were the right ideas.
3. Lost laundry and timely return of clothing - This quality indicator saw a marked improvement from 46% to 80% satisfaction with laundry and surpassed the target by 15% for the year. Consistency in making sure change ideas continue to be followed through with will ensure the continued success of this improvement initiative.

Chester Village is also very proud of the success of the 'Excellence in Resident Centered Care' (ERCC) program that was continued in 2017/18 for our front line Personal Support Worker staff. Several of our PSW staff attended the train the trainer for the ERCC program, some as a refresher as they were already trainers, and were recognized by as being exceptional and the best in their class. These front line staff have embraced the responsibility of being a role model and trainer and provided 3 full day education sessions for their peers at Chester Village. We

can now proudly boast that 100 out of 120 PSW employees have been trained on the ERCC model of care.

Note:
1. The key outcome of ERCC is to promote best practices that are consistent with Ministry standards in senior's care environments. ERCC has been developed to help your teams achieve Better Care and Better Outcomes using a person-centred, train-the-trainer approach to advance practice development. Through ERCC, LTC homes and those who work within them can expect to realize the following benefits:
Better resident care outcomes
Consistent approach to care
Increased self-confidence
Increased job satisfaction
Increased staff retention
Five features make ERCC unique:
1. Practical care skills are taught within a resident-centred framework.
2. Visually enhanced learning objects bring course content to life.
3. Highly interactive course allows students to directly apply the content to their practice.
4. Course delivery uses a peer-led train-the-facilitator model where PSWs are trained to deliver the modules to their peers.
5. Graduates receive a course certificate from Conestoga College.

Resident, Patient, Client Engagement

Chester Village engages the residents and their families/caregivers by inviting them to participate in an annual satisfaction survey to determine areas of improvement. This data allows us to develop the "how satisfied the residents are" area of the QIP. In 2018, after the results of the 2017 annual satisfaction survey were analyzed by the senior management team, the following action plans were developed and have helped to shape the basis for the 2018/19 QIP in the area of resident experience: 1) To improve upon how well the staff "listen" to the residents and 2) To increase the variety of meals provided. Residents and Family members will be engaged to participate in focus groups to assist the departments in "drilling" down to identify the source of the issues that resulted in poor scores in these two areas and then that information will be used to make improvements in those areas.

Chester Village also invites a family member from the Family Council to participate on the Quality Care Committee of the Board and report back to the Family Council on our quality projects and the progress we are making. All of these reports are regularly shared with the Resident Council as well for their input.

Collaboration and Integration

Chester Village continuously works with our system partners in our development and execution of our quality improvement initiatives in order to best meet the needs of our resident population and to ensure the continuity of care.

In collaboration with our partners, we have several initiatives already underway to better link care across the continuum. Some examples of this include:

- Partnering with the Behavioural Supports Outreach Team (BSOT), Psychogeriatric Resource Consultant (PRC) and the Psychogeriatric Outreach Program (POP) team members to participate in our monthly Behavioural Rounds. This allows us to identify residents in advance who may need to be admitted to behavioural support programs and to work directly with those people who will be involved in their transition to and from the program.

- Partnering with an ET specialist (wound therapy), community dermatologist and Women's Hospital wound care clinic to assist us in our Skin and Wound Care program with minimal disruption to the resident's regular routine
- Partnering with Achieva Health Physiotherapy in the development, implementation, training and monitoring of our falls prevention program

In 2017, Chester Village completed the refresher training and privacy requirements as part of the connecting Ontario program by the Toronto Central LHIN. Connecting Ontario allows us to follow our resident's movement across the health care continuum and have real time access to their health reports while in hospital for example. We will continue to utilize the full benefits of the program as we add more users and as more of our neighbourhood hospitals come one board.

Also in 2017, Chester Village re-established their partnership with the NLOT (Nurse Led Outreach Team) with weekly visits to residents for follow up and assessment in the hopes of eliminating unecessary visits to the ER departments. We have had success in reducing our average and continue to work on strategies in our 2018/19 QIP to address this issue.

Engagement of Clinicians, Leadership & Staff

In 2016, Chester Village implemented a new program that was to improve upon the way we collect, analyze and report on our quality data through a new Quality and Risk Management Program (QRM). A new RPN position was created to take the lead on this new and exciting initiative. While we did not get as far with this initiative as we would have liked to in 2016, we have continued to work to expand to all departments in 2017/18 with success.

Our Senior Management team is the driving force behind many of our quality initiatives to ensure alignment with Chester Village's Strategic Plan as well as all other goals of our home. Our quality initiative projects are then appropriately resourced out to the committee that is responsible for monitoring the QIP where all levels of staff will participate in the initiative to ensure its success. All committee members that are involved with any of the QIP indicator initiatives discuss together change ideas, performance targets and improvement plans. They are responsible to monitor the initiative and to ensure targets are achieved and to adapt their plans as they progress through the year. The QIP is then recommended for approval to the Quality Care Committee of the Board.

Population Health and Equity Considerations

Population Health

Chester Village serves mainly the elderly population in our community. The majority of our residents come to us from the local and surrounding areas. The average age of our residents is 86.06 years with 75% being female and 25% male. 37% of our residents are over the age of 90 and we currently have 4 residents over the age of 100, an astounding fact that we would not have seen 15 years ago. Over 58% of our residents are diagnosed with some form of dementia. We work closely with many local partners to educate our staff on how to best care for the elderly with dementia. The Alzheimer's and Parkinson's society provide us with educational resources, in-house workshops and tools to help us look after our residents. All of this is incorporated into our everyday quality improvement activities to assist us in making daily life for the residents of the best quality that it can be.

Equity

Chester Village has worked to incorporate an equity lens into our quality improvement initiatives through the following measures:

1. Providing cultural competency training for all staff and volunteers through e-learning modules, "live" inservices, organizing cultural diversity events in house and supporting attendance at events outside of Chester Village.
2. Supporting our Chinese home area of 29 residents with materials such as menus and monthly activity calendars in the Cantonese language, as well as offering translation services through staff and volunteers available as often as possible.
3. Holding focus group sessions with residents, families and staff to drill down to the real issues of dissatisfaction from the annual resident and family experience survey.

Incorporating a health equity lens to our work will help us to ensure our commitment to addressing these systematic inequities that may exist in our health sector.

Access to the Right Level of Care - Addressing ALC

Chester Village Long-Term Care Home is able to support the ALC initiatives in our LHIN in three main areas:

1. Nurse Led Outreach Team (NLOT) – in 2017, Chester Village re-engaged with the NLOT to assist us in reducing our ED visits by having them visit our residents who may be at high risk for readmission to hospital. They now perform all hypodermoclysis on site for our residents, avoiding admissions to hospital beds.

2. Expanding our Palliative Care Program – Chester Village is working hard at identifying and accessing all available external palliative care resources to help us educate staff, residents and families about palliative care in the "Home" and to offer full palliative services in our home so that residents can remain here as they near their end of life which will avoid what can be sometimes lengthy hospital stays.

3. Participating in "Think Research" which provides the Home with the tools and resources necessary to adopt the Best Practice Guidelines in several key areas. Chester Village is currently working on incorporating the Diabetes Management guideline as a best practice and will hope to decrease ED visits in the future related to this diagnoses.

Opioid Prescribing for the Treatment of Pain and Opioid Use Disorder

Chester Village has a Pain Management program that includes the following objectives:
•To improve and maintain a resident's optimal functional level and quality of life.
•To optimally control pain for all residents.
•To reduce incidence of unmanaged pain.
•To ensure best practice interventions for residents with pain.
•To monitor and track trends related to pain management.

Our non-pharmacologic interventions include these techniques:
*Therapeutic spa
*Activities (structured, snooezelen, music)
*Physio/OT Program
*Restorative Nursing
*Proper use of assistive devices
*Behaviour Management

Our external resources that assist us with pain management are:
*Clinical Nurse Specialist Palliative Integrated LTC Program (MGH)

*Pain Consultant from Palliative Pain and Symptom Management
*PRC and POP when pain is related
*Pharmacy Consultant
*External pain clinic
*Spasticity Clinic

Workplace Violence Prevention

Chester Village is committed to the prevention of workplace violence. We have put a policy in place that defines behaviour that constitutes workplace violence as well as outlines the procedures for reporting and resolving incidents of workplace violence. Chester Village is committed to providing a working environment free of violence by ensuring that all workplace parties are familiar with the definitions of workplace violence and their individual responsibilities for prevention and corrective action. To establish this policy, Chester Village has consulted the joint health and safety committee and the following legislation governing workplace violence in Ontario:

- The Occupational Health and Safety Act
- The Criminal Code of Canada
- The Ontario Human Rights Code
- The Workplace Safety and Insurance Act, 1997
- The Compensation for Victims of Crime Act
- The Regulated Health Professions Act

The management of Chester Village recognizes the potential for violence in the workplace and therefore will make every reasonable effort to identify all potential sources of violence to eliminate or minimize these risks through the Workplace Violence Prevention program. Chester Village provides education to all employees on our workplace violence prevention program on an annual basis, works closely with the union to bring issues to the attention of management and investigates all claims in a professional and prompt manner to resolve the issue as quickly as possible and to the satisfaction of all parties involved.

Contact Information

If you would like to learn more about any of the activities outlined in our QIP, please contact:

Gina Santos, Director of Care gina@chestervillage.ca

Cynthia Chiappetta, CEO cynthia@chestervillage.ca

Sign-off

It is recommended that the following individuals review and sign-off on your organization's Quality Improvement Plan (where applicable):

I have reviewed and approved our organization's Quality Improvement Plan

Board Chair / Licensee or delegate _____ (signature)
Administrator /Executive Director _____ (signature)
Quality Committee Chair or delegate _____ (signature)
Other leadership as appropriate _____ (signature)

2018/19 Quality Improvement Plan for Ontario Long Term Care Homes
"Improvement Targets and Initiatives"

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
M = Mandatory (all cells must be completed) P = Priority (complete ONLY the comments cell if you are not working on this indicator) A= Additional (do not select from drop down menu if you are not working on this indicator) C = custom (add any other indicators you are working on)														
Effective	**Effective Transitions**	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 2016 - September 2017	54653*	28.83	27.83	Gradual decrease to bring performance closer to the provincial average of 24%	1)Implement the best practice guideline on Diabetes/Hypoglycemia management by using Clinical Support Tools (CST) by Think Research.	The Home will work with Think Research in the implementation of this initiative. All nurses will be trained and all residents that qualify with the criteria for participation will be included.	Number of nurses that are trained. Number of residents that qualify versus number of residents that participate with the initiative.	100% of nurses will be trained by May 31, 2018. All qualified residents will participate when the program goes live by June 1, 2018	
										2)Broaden the criteria for high risk residents that are seen weekly by the NLOT team.	Include residents with multiple falls and with injurious falls and residents with unstable respiratory conditions including COPD, Asthma and Pneumonia.	Educate all nurses regarding the inclusion of residents with multiple falls and with injurious falls and residents with unstable respiratory conditions including COPD, Asthma and Pneumonia. Nurses will add these inclusion to the NLOT weekly list for rounds. Measure the residents admitted to ED with multiple falls and with injurious falls and residents with unstable respiratory conditions including COPD, Asthma and Pneumonia.	100% of registered staff will be educated. Decrease the number of residents admitted to ED with multiple falls and with injurious falls and residents with unstable respiratory conditions including COPD, Asthma and Pneumonia by 5% compared to last year.	
										3)Educate the PSW's on physical assessments of resident with respiratory conditions.	The PSW's will be educated on respiratory system and understanding respiratory conditions including asthma, COPD and Pneumonia to develop basic physical assessment skills. This will increase confidence in their basic assessment skills and reporting abilities to the nurses.	Measure the number of PSW staff that are educated on respiratory system and understanding respiratory conditions including asthma, COPD and Pneumonia.	100% of PSW's will be educated by March 31, 2019.	

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
	Wound Care	Percentage of residents who developed a stage 2 to 4 pressure ulcer or had a pressure ulcer that worsened to a stage 2, 3 or 4 since their previous resident assessment	A	% / LTC home residents	CIHI CCRS / July - September 2017	54653*	4.16	3.20	The Home endeavors to work closely towards provincial average	)Increase residents, family, POA awareness on pressure ulcer risk, prevention and management	Develop a skin & wound care program brochure for residents, families and POA	Number of resident, families and POA's that received the wound care program brochure	All residents that can understand the brochure; all current family members/POA; all new admissions will be provided with the new skin & wound care program brochure.	
										)Utilize the new PSW skin and wound care champions to bring the education to the front line staff.	The skin and wound care team currently conducts monthly PSW champion meetings and education. The PSW champions informally share their knowledge to the front line staff during care. The Home will use a documented "clip Board" in-service to reach as many PSW staff on 4 education topics related to skin and wound care.	The number of education done by PSW champions using "clip board" in services The number of staff educated by PSW champions through the "clip board" in services	There will be 4 education topics related to skin and wound care that will be shared through "clip board" in services. 60% or more of PSW staff will complete each education topic.	
Patient-centred	**Person experience**	Percentage of complaints received by a long-term care home that were acknowledged to the individual who made a complaint	A	% / LTC home residents	Local data collection / Most recent 12 month period	54653*	100	100.00	The Home expects that all individuals who put forth a complaint will receive an acknowledgement within 10 business days.	1)				The Home maintains an excellent performance rating for this indicator and will not be working on any improvements at this time but will continue to monitor.
		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	54653*	75	77.00	77% is the 3 year average for this indicator.	1)Coach and mentor staff on listening to residents creatively.	The department heads and coaches will coach and mentor the staff every month on a common theme in the next twelve months. The Resident care team will identify the monthly coaching themes that will be used for all staff.	Number of staff coaching and mentoring sessions held per month.	There will be 1 staff coaching and mentoring session held per month for the next 12 months.	

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
										2)Implement a 5 minute non care related daily conversation for all staff to residents.	A special committee will create a structured program to implement the "5 minute non care related daily conversation". All staff will be educated on the new program. The program will be implemented in the Home.	There will be a structured program to implement the "5 minute non care related daily conversation" and staff education to follow. The program will be implemented after the staff education.	The new program will be created by June 2018. Staff education will be completed by September 2018. This new program will be in place by September 2018.	
										3)Cue cards will be used as a staff reminder to sustain the implementation of Excellence in Resident Centered Care (ERCC).	The ERCC trainers will create cue cards to be posted in staff only work spaces. These cue cards will serve as reminders in assisting the staff to better their communication with the residents as per the best resident centered practices learned in their training.	Number of new cue cards used per month.	There will be 2 new cue cards added every month.	
		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	54653*	81	75.00	3 year average for this indicator is 75%	1)				The Home maintained a performance rate that is better than the target and the 3 year average. The Home will not be working on this indicator but will continue to monitor.
	Resident experience: "Overall satisfaction"	Percentage of residents who responded positively to the question: "Would you recommend this nursing home to others?" (NHCAHPS)	P	% / LTC home residents	In house data, NHCAHPS survey / April 2017 - March 2018	54653*	79	75.00	3 year average for this indicator is 74%.	1)				The Home maintained a performance rate that is better than the target and the 3 year average. The Home will not be working on this indicator but will continue to monitor.

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
		Percentage of residents responding positively with the question, "There is enough variety in my meals"	C	% / LTC home residents	In-house survey / January-December 2017	54653*	66	70.00	The Home will aim above the 3 year average of 67%.	1)There will be resident focus groups held in each of the seven (7) home areas to identify the resident's needs and expectations for enough variety of meals.	The Food Services Manager and Food Services Supervisor will lead a focus group with residents for each home area to discuss what they would like to see in improvements to their variety of meals.	Number of focus group to discuss enough variety of meals.	There will be seven (7) focus groups, 1 per home area.	
										2)Increase "special meal" during lunch and dinner in addition to special events and holiday meals already planned.	The Food Services manager will add a "special meal" to the menu once a month in addition to special events and holiday meals already planned.	Number of "special meals" served in a year.	One "special meal" every month will be served.	
										3)A selected committee composed of residents and led by Food Services manager will review the menu for possible changes to increase variety of meals every 6 months.	During the menu review, the Food Services manager will meet with residents from different home areas to review the menu and incorporate possible changes to increase variety of meals.	Number of menu reviews with residents that specifically focus on variety of meals.	2 menu review with residents will be completed in a year that specifically focus on variety of meals.	
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	54653*	15.67	15.00	The Home is already below benchmark of 19% but managed to perform better by 0.47% from last year. The Home should be able to go down another 0.67% this year.	1)Capacity building of front line staff in providing resident centered care that includes increased ability to manage responsive behaviours with non-pharmacologic interventions	The Excellence in Resident Centered Care (ERCC) course will be offered to PSW's	Measure the number of PSW staff trained in ERCC	80% (96 out of 120) or more of PSW's will be ERCC trained by March 2019.	
										2)Continue use of all responsive behavior management external resources to decrease use of antipsychotic medications.	Refer all residents with challenging responsive behaviours to Behavioural Support Outreach Team (BSOT) and Psychogeriatric Resource Consultant (PRC). Use Psychogeriatric Outreach Program (POP) as required when non-pharmacologic interventions fail.	Number of residents with challenging responsive behaviours. Number of residents with challenging responsive behaviours that have been referred to BSOT and/or PRC.	100% of residents with challenging responsive behaviours will be referred to the BSOT and/or PRC.	

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
	Safe care	Percentage of residents who fell during the 30 days preceding their resident assessment	A	% / LTC home residents	CIHI CCRS / July - September 2017	54653*	16.56	15.60	The Home is just slightly above provincial average and should be able to have an absolute target of 0.96% lower to be within provincial average.	1)Implement daily rounds between 3-4pm to target the time frame where the highest number residents that fall are noted.	All evening staff will have a rotating schedule between the PSW's and the nurse to do rounds every 15 minutes between 3-4pm.	Measure the number of falls between 3-4pm monthly.	Decrease the number of falls between 3-4pm from 8% to 6% of the total number of falls	
										2)Target all residents with multiple falls (more than once per month) and/or injurious falls to review and implement strategies to prevent recurrence.	The Falls Best Practice Guideline team will closely review all residents with multiple falls and/or injurious falls monthly and recommend strategies that will be implemented by the front line staff.	Measure the number of residents that fall multiple times or have injurious falls every month.	Decrease the number of residents that fall multiple times or have injurious falls from an average of 29 residents per month to 25.	
										3)Re-education of all staff on the Home's Falling star program and review of all resources available for residents.	A mandatory re-education on the Home's Falling star program and review of all resources available for residents will be completed for all staff.	The number of staff re-educated on the Home's Falling star program and review of all resources available for residents.	100% of all staff re-educated.	
										4)Increase residents, family, POA awareness on the Home's falls prevention and management program	Develop a falls prevention and management program brochure for residents, families and POA	Number of residents, families and POA's that received the falls prevention and management program brochure	All residents that can understand the brochure; all current family members/POA; all new admissions will be provided with the new falls prevention and management program brochure	

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
		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	54653*	1.49	1.49	The Home maintained a performance rate that is always below the provincial rate and the provincial benchmark of 3%.	1)				The Home maintained a performance rate that is always below the benchmark of 3% and will not be working on this indicator but will continue to monitor.