Let's Make Healthy Change Happen.

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

LONG TERM CARE AND SENIORS SERVICES

County of Simcoe, Long Term Care and Seniors Services

Trillium Manor – Orillia

April 1, 2015

Ontario

Overview of Our Organization's Quality Improvement Plan

The County of Simcoe Long Term Care and Seniors Services is committed to providing high quality, resident centered care and services that improve every Resident's quality of life. It is our vision to work together to ensure safe care, enhance the Resident's quality of life, engage and collaborate with Residents and their families in their care, and show respect, dignity and compassion in all that we do. We continually pursue excellence and embrace continuous quality improvement philosophy, as demonstrated through our 4-year accreditation award with Exemplary standing from our accredited body from 2012-2016.

Our Quality Improvement Plan (QIP) for 2015-16 focuses on our objectives to provide high quality resident care that is safe, accessible, integrated, effective and resident centered. It serves as our roadmap and identifies opportunities to implement changes in practice to achieve better outcomes and meet resident's expectations. Our QIP supports our strategic directions to achieve excellence, enable growth and build successful relationships with key stakeholders. It is aligned with our Long Term Care Service Accountability Agreement (L-SAA), and with our accreditation body's required practices, standards and recommendations.

Our Quality Improvement Plan demonstrates our commitment to improve quality and outlines strategies for ensuring patient safety, delivering optimal care, and achieving high patient satisfaction. Our quality improvement initiatives this year will focus on five key Health Quality Ontario provincial objectives:

- To reduce falls.
- To reduce the worsening of pressure ulcers.
- To reduce the worsening of bladder control.
- To receive and utilize feedback regarding resident experience and quality of life.
- To reduce potentially avoidable Emergency Department (ED) Visits.

The County of Simcoe, Long Term Care and Seniors Services quality improvement goals are aligned with the County of Simcoe's vision, mission, core values and strategic direction; as well as with the Long Term Care and Seniors Services mission and core values, and demonstrate that we committed to providing safe, high quality resident centered care and services.

County of Simcoe Vision, Mission and Values

Vision Statement

Working together to build vibrant, healthy, sustainable communities

Mission Statement

Providing affordable, sustainable services and infrastructure through leadership and innovative excellence

Values

Stewardship: responsible guardians for a sustainable future
Leadership: inspire, empower, lead by example
Integrity: honesty, trust, and transparency at all times
Innovation: creative, progressive, leading edge ideas
Respect: recognizing individualism through fair and equitable interaction
Accountability: Commitment, ownership and follow through and
Co-operation: positive approaches to partnerships, team work and understanding

Long Term Care and Seniors Services Mission and Values

Mission Statement

To provide effective, high quality, safe and efficient long term care services in a home-like setting for the clients and families that we serve.

Values

- High quality of life and independence for each Resident
- A home-like, clean, comfortable, safe and secure environment
- Residents personalizing their own rooms
- Residents living with privacy, dignity and respect
- Meeting Residents' physical, psychological, social, spiritual and cultural needs
- Promoting a healthy and productive work environment for the staff
- Sharing accountability for ensuring the safest possible resident care and services.

Integration and Continuity of Care

Trillium Manor is owned and operated by the County of Simcoe. The municipality operates four long term care homes that work together to standardize processes and create synergistic opportunities for optimal organizational efficiencies and resident outcomes.

Other Partnerships working with our Homes include, but are not limited to:

- ✓ Local Health Links
- ✓ NSM LHIN Quality Initiative Network
- ✓ Integrated Family Health Team and Nurse Practitioner Clinics.
- ✓ Wound Resource Nurses
- ✓ NSM Regional Kidney Care Program
- ✓ Palliative Care Network – Palliative, Pain and Symptom Management Resource Nurse
- ✓ Psychogeriatric Outreach Teams
- ✓ Behavioral Support Teams
- ✓ RNAO Best Practice Resource Nurses
- ✓ Osteoporosis Society
- ✓ NSM Integrated Regional Falls Program

Challenges, Risks and Mitigation Strategies

Challenges	Mitigation Strategies
Increasingly complex care requirements of residents being served, along with the changing expectations, and resource pressures.	Ongoing staff education to best understand and meet the needs of Residents.
Late loss ADL Functioning and ADL Self Performance has been declining steadily over the past few years as we admit more complex, frail elderly into LTC.	Utilization of the Nursing Rehabilitation program to try to improve late loss functioning and improve self-performance abilities.
Ongoing resource pressures to meet the needs of the residents	Advocacy for increased funding opportunities and careful attention to the accuracy of the RAI-MDS process to maximize funding and care planning.

Information Management:

To better understand the needs of our resident population, and to monitor our quality targets, we are using Point Click Care software to its fullest extent, including QIA tracking, MDS assessments, Outcome Scales, and Risk Management. Provincial and Domestic Quality Indicators are collected monthly internally and reported quarterly to County Council. Multiple Domestic Indicators are collected that assist in the analysis of other indicators. CIHI and RAI MDS reports are used in the analysis and reporting of indicators and to trend monthly variances. Review, track and report on the quarterly publically reported Provincial Indicators.

Engagement of Clinicians and Leadership

The County of Simcoe Long Term Care and Seniors Services Division supports quality improvement through a Performance, Quality and Development Department, at the corporate and Home level. The department consists of the Performance, Quality and Development Manager, two Quality and Development Coordinators, and an Education Coordinator at the corporate level; and a Home Quality and Development Coordinator at each Home. The Administrator and Management Staff of the Homes work with the Performance, Quality and Development Team to review and analyze performance indicators and submit quality indicator reports on the status of projects and indicator trends, analysis and action plans. This information is reported monthly to the General Manager of Health and Emergency Services and quarterly to the County Council.

Monthly Quality Management meetings are held at each of the Homes to report on Home specific indicators and project status.

Front line staff and Residents are engaged as part of the quality initiatives through focus teams and risk teams to assess, plan and carry out quality initiatives.

Quality goals and commitments are shared among front line staff, Residents and Families as well as the Leadership Forums monthly. This includes target reviews, action plans and follow up.

Professional Advisory Committees meet quarterly and Medical Advisory Committees meet biannually and engage both Home staff, Public Health representatives, Physician's, Pharmacist's and other service providers.

Patient/Resident/Client Engagement

Feedback from residents and/or resident representatives is an important component for the continuous quality improvement of the care and services that we provide. The County of Simcoe Long Term Care and Seniors Services attempts to involve resident and family members in the design process of new resident-focused programs. Each Home has a committee of long-term care residents called Resident Council, as well as a committee of family members, called Family Council. The Resident Council provides the residents with a voice when it comes to enhancing their daily lives and improving services. The Family Council work to enhance daily living and improve services for the residents as well, but also provide a way for families to give each other the support, encouragement and information they need. Feedback from these Councils helps to evaluate and monitor, and if required change, these services and programs to better meet the residents' needs.

Long-Term Care and Seniors Services send out satisfaction surveys to the Residents, and also to the Families on an annual basis. The results are discussed with the Residents at the Resident Council meeting, and with the families at the Family Council meeting, where feedback is received on the results

as well as the survey process itself. The survey results are also shared in resident and family newsletters, as well as being posted in the homes.

Accountability Management:

All Administrators, Nursing Management staff and Performance, Quality and Development staff are responsible for completing a monthly review of the current status of indicators, with a more in-depth review quarterly, identifying recommendations to improve performance in each category, monitoring metrics monthly and revision the recommendations accordingly.

Sign-off

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

Gerry Marshall,
Warden, COS

Brenda Clark,
County Clerk

Jane Sinclair
General Manager,
Health & Emergency Services

Janice McCuaig
Administrator,
Trillium Manor

AUTHORIZED BY BY-LAW NO. 6437 PASSED BY THE COUNCIL OF THE CORPORATION OF THE COUNTY OF SIMCOE ON Mar 24, 2015

2015/16 Quality Improvement Plan for Ontario Long Term Care Homes
"Improvement Targets and Initiatives"

TRILLIUM MANOR HOME FOR THE AGED 12 GRACE AVENUE

AIM		Measure							Change				
Quality dimension	**Objective**	**Measure/ Indicator**	**Unit / Population**	**Source / Period**	**Organization ID**	**Current performance**	**Target**	**Target justification**	**Planned improvement initiatives (Change Ideas)**	Methods	Process measures	Goal for change ideas	Comments
Safety	**To Reduce Falls**	Percentage of residents who had a recent fall (in the last 30 days)	% / Residents	CCRS, CIHI (eReports) / Q2 FY 2014/15	51857*	20.87	18.78	With the implementation and maintenance of 2 Fall Prevention Intervention Initiatives, along with maintaining interdisciplinary discussions at Quality Risk Rounds and the Required program committee, we will reduce the percentage of Residents falling by 10% over the year.	1)Continue the review of high risk fallers/frequent fallers at Quality Risk Rounds for interventions and strategies for the individuals. Interdisciplinary input will be sought from representatives from all departments in order to come up with solutions. High Risk Fallers, strategies and interventions will also continue to be discussed at the monthly Required Program Committee.	The minutes of Quality Risk Round Meetings will reflect Interdisciplinary discussions along with the discussed strategies and interventions to be implemented. Strategies and interventions will be discussed further at the Required Programs committee and these minutes communicated to Staff during Quality Risk Rounds.	High Risk round minutes and Required Program Committee minutes.	100% of all falls will be discussed and reflected in High risk round minutes. 100% of high risk fallers will be discussed and reflected in Required program committee minutes.	

									2)Implement Falls Reduction programs for high risk fallers specific to Resident needs	Expand the Heightened monitoring program across the home that was started on one unit last year which has been proven to not only decrease the number of falls but also time spent by nursing staff on post falls. This method is suitable for those Residents with a CPS score of 0-3. This improvement initiative involves asking 5 Questions. As well, initiate and Roll out the Falling Leaves program, starting on the Severn unit January, reaching all units by June 2015.	% of identified high risk fallers with an implemented heightened monitoring strategy.	Both Fall Reduction Initiatives will be FULLY rolled out by the end of June 2015. At this time, 75% of high risk fallers (those Residents with 2 or more falls in 30 days) will have an associated fall risk strategy implemented.	
									3)Increase Resident participation in the Nursing Rehabilitation Program and improve consistency of Nursing Rehabilitation principles.	Implement the duties for the Nursing Rehab Resource Nurse which includes assessments of Residents on admission, as well as for those Residents with a significant change in health status. The Nursing Rehab Resource Nurse will evaluate the success of interventions of Residents on the program quarterly. Through this implementation, there will be an increased number of residents on the program.	# of Residents on the Nursing Rehabilitation program.	Increase number of residents on program to 15% of all Residents	
									4)Improved Falls documentation training and monitoring	Falls documentation flow sheets distributed to all nursing staff via the Quality Binder along with Head injury flow sheet. Documentation will be audited weekly and follow up of improper documentation will be included in end of day Quality Risk Rounds Report to the Director of Resident Care and Nurse Manager	% of Residents with falls that have the correct falls documentation in their electronic Record.	75% of electronic records of residents with falls will have correct documentation for associated falls by December 2015.	

To Reduce Worsening of Pressure Ulcers	Percentage of residents who had a pressure ulcer that recently got worse	% / Residents	CCRS, CIHI (eReports) / Q2 FY 2014/15	51857*	3.61	3.07	With the support provided to the Wound Care Resource Nurse, along with Education to staff, auditing of wound assessments and scheduling skin assessments quarterly, Trillium Manor will reduce the incidents of worsening pressure ulcers by 15% over the next year.	1)Wound care resource nurse to monitor wounds, liaise with Physicians for treatment options and to support the completion of wound assessments.	Provide support to the Wound Care Resource Nurse in the completion of weekly wound assessments and ensure coding is completed accurately.	# or Residents monitored by Wound Care nurse	75% of Residents with wounds to be monitored by Wound Care Resource nurse	
								2)Ongoing education and support to registered staff and PSW's on wound prevention and maintenance.	Increase staff training on wounds: Wound information and education will be created specifically for PSWs providing education on Stage 1 ulcers and protocols. Registered Staff will be assigned to complete Surge learning modules. A visual wound tip sheet and process document will be created and disseminated to all staff through the Job routine section in the Quality binders.	% of Staff trained on wounds.	85% of staff trained on wounds by November 2015	
								3)Monthly auditing of status of wounds to ensure assessment completion and complete monitoring of wounds.	Manager, in conjunction with the Wound Care resource nurse to complete and analyze wound surveillance record. The Results from wound surveillance record to be reported monthly to via the Quality management meetings.	% of Residents with wounds with wound assessments completed weekly.	90% of Residents with wounds will have wound assessments completed weekly by October 2015	
								4)Skin Assessments are included in the quarterly assessments in order to ensure that no skin issues are missed.	Registered staff completes Skin Assessment in conjunction with the MDS when coding section M. This requires that the registered staff physically view Resident’s skin. The process is scheduled and monitored by the RAI coordinator	# of scheduled Skin Assessments completed	90% of scheduled Skin Assessments completed by December 2015	

	To Reduce the Use of Restraints	Percentage of residents who were physically restrained (daily)	% / Residents	CCRS, CIHI (eReports) / Q2 FY 2014/15	51857*	2.31		.	1)				Status Quo - to maintain the current level of restraints at Trillium Manor that exceeds the provincial benchmark.
Effectiveness	**To Reduce Worsening Bladder Control**	Percentage of residents with worsening bladder control during a 90-day period	% / Residents	CCRS, CIHI (eReports) / Q2 FY 2014/15	51857*	36.84	31.31	Through education of staff and the implementation of bladder and bowel diaries to inform the creation of toileting routines specific to Residents, Trillium manor will reduce the incidents of worsening bladder function by 15% over the next year.	1)Education of front line staff on prevention of incontinence	Develop and deliver through SURGE learning an education module on the prevention of incontinence for Nursing Staff. Track completion of module by staff.	% of staff who have completed prevention of incontinence training	75% of staff will have completed training by November 2015	
									2)Research into Residents with a change in coding and identify those who would benefit from prompted voiding and toileting routines.	The RAI Coordinator will ensure accurate coding and assessment of Residents. Using best practice criteria to establish protocols, Bladder and Bowel diaries will be trialed on a sample of Residents. Learnings from this trial will be analyzed and then both bladder and bowel diaries will be rolled out to all those that trigger worsening continence.	% of Residents with worsening continence and qualify based on established criteria that have bladder and bowel diaries completed.	95% of Residents with worsening continence and qualify based on established criteria will have bladder and bowel diaries completed on or before the end of August 2015.	
									3)Initiate criteria for candidates for : prompted voiding, scheduled toileting	The Analysis of Bladder and Bowel diaries will inform the development of toileting routines. Toileting routines will be initiated on a sample of residents. This trial will be analyzed, refined and rolled out to all of Trillium manor Residents. These routines will be documented accordingly in care plans.	% of Residents with established Toileting routines implemented who were identified as benefiting from this intervention through the bladder and bowel diary analysis.	5% of Resident who were identified as benefiting from this initiative will have implemented a toileting routine by November 2015	

	To Reduce the Inappropriate Use of Anti psychotics in LTC	Percentage of residents on antipsychotics without a diagnosis of psychosis	% / Residents	CCRS, CIHI (eReports) / Q2 FY 2014/15	51857*	41.33		.	1)				Indicator not currently selected as Trillium Manor is focusing on other quality improvement priorities.
Resident-Centred	**Receiving and utilizing feedback regarding resident experience and quality of life. "Having a voice".**	Percentage of residents responding positively to: "What number would you use to rate how well the staff listen to you?" (NHCAHPS)	% / Residents	In-house survey / Apr 2014 - Mar 2015 (or most recent 12mos).	51857*			.	1)				Resident and family satisfaction monitored with annual satisfaction survey. No concerns at this time.
		Percentage of residents responding positively to: "I can express my opinion without fear of consequences." (InterRAI QoL)	% / Residents	In-house survey / Apr 2014 - Mar 2015 (or most recent 12 mos).	51857*			.	1)				Resident and family satisfaction monitored with annual satisfaction survey. No concerns at this time.

	Receiving and utilizing feedback regarding resident experience and quality of life. "Overall Satisfaction "	Percentage of residents responding positively to: "Would you recommend this nursing home to others?" (NHCAHPS)	% / Residents	In-house survey / Apr 2014 - Mar 2015 (or most recent 12mos)	51857*			.	1)				Resident & family satisfaction monitored with annual satisfaction survey. Not an improvement target for 2015. Will Maintain Status quo - 95% or better of respondents stating yes to this question.
		Percentage of residents responding positively to: "I would recommend this site or organization to others." (InterRAI QoL)	% / Residents	In-house survey / Apr 2014 - Mar 2015 (or most recent 12 mos)	51857*			.	1)				Not a current question on our survey. Currently use the question in AIM ID #8
Integrated	**To Reduce Potentially Avoidable Emergency Department Visits**	Number of emergency department (ED) visits for modified list of ambulatory care sensitive conditions* (ACSC) per 100 long-term care residents	% / Residents	Ministry of Health Portal / Q3 FY 2013/14 - Q2 FY 2014/15	51857*	23.64		Collecting and tracking data to create a baseline in 2015	1)To create and implement a process for collection of data in order to create a baseline for this indicator.	Create a progress note in Point Click Care for the Registered Nurse to complete when a Resident is transferred to the Emergency Department for modified list of ambulatory care sensitive conditions.	# progress notes completed for residents transferred to ED for modified list of ACSC per 100 long-term care residents	100% of all transfers to ED for modified list of ACSC will have an associated progress note completed.	Creating a baseline for this indicator in order to determine future targets.