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

Cambridge Country Manor 3680 SPEEDSVILLE ROAD RR# 31

AIM		Measure						
Quality dimension	Issue	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) A= Additional (do not select from drop dow								
Effective	**Effective Transitions**	Number of ED visits for modified list of ambulatory care–sensitive conditions* per 100	P	Rate per 100 residents / LTC home residents	CIHI CCRS, CIHI NACRS / October 2016 - September 2017	51907*	21.74	20.00
	Wound Care	Percentage of residents who developed a stage 2 to 4 pressure ulcer or had a pressure ulcer	A	% / LTC home residents	CIHI CCRS / July - September 2017	51907*	2.76	2.75
Patient-centred	**Person experience**	Percentage of complaints received by a long-term care home that were acknowledged to the	A	% / LTC home residents	Local data collection / Most recent 12 month period	51907*	100	100.00
		Percentage of residents responding positively to: "What number would you use to rate how well	P	% / LTC home residents	In house data, NHCAHPS survey / April 2017- March 2018	51907*	X	1.00
		Percentage of residents who responded positively to the statement: "I can express my	P	% / LTC home residents	In house data, interRAI survey / April 2017 - March 2018	51907*	100	90.00
	Resident experience: "Overall satisfaction"	Percentage of residents responding positively to: "I would recommend this site or organization to	P	% / LTC home residents	In house data, interRAI survey / April 2017 - March 2018	51907*	100	80.00

		Percentage of residents who responded positively to the question: "Would you	P	% / LTC home residents	In house data, NHCAHPS survey / April 2017 - March 2018	51907*	X	1.00
Safe	**Medication safety**	Percentage of residents who were given antipsychotic medication without psychosis in the 7	P	% / LTC home residents	CIHI CCRS / July - September 2017	51907*	16.9	16.00
	Safe care	Percentage of residents who fell during the 30 days preceding their resident assessment	A	% / LTC home residents	CIHI CCRS / July - September 2017	51907*	10.66	10.50
		Percentage of residents who were physically restrained every day during the 7 days preceding their	A	% / LTC home residents	CIHI CCRS / July - September 2017	51907*	0	0.00

	Change			
Target justification	**Planned improvement initiatives (Change Ideas)**	**Methods**	**Process measures**	**Target for process measure**
ın menu if you are not working on this indicator) C = custom (add any other indicators you are working on				
The comorbidities of residents, along with residents who have	1)A review of the acute-episodic NP program and a recent increase in ED sends, along with consultation with Homes that have the	Monitor the sends, and maintain data of NP availability, response time, and send prevention.	Decrease of emergency sends	15% of the resident population will have an ED visit.
the Home's performance is strong, as the Provincial Average was	1)The Home recognizes the number of residents who interventions will not be successful with due to their frailty, dementia or being at	Wound champion management lead will track worsening wound including data on whether or not the intervention could be successful and if not, was it due to frailty, dementia or end stage.	Number of worsening wounds that could not be improved due to due to frailty, dementia or end stage.	As this is a baseline being developed, by percentage of residents, there is no target
The Home responds to any complaint identified as part of the ongoing	1)Continue to have the Executive Director meet with all new residents/POAs/SDMs to review the open door policy	Executive Director will meet with all new residents/POAs/SDMS	Number of meetings with new families/residents	100% from April 1 2018 to march 31 2019
The Home does not use the NHCAPHPS survey. 1 is entered as a	1)Continue to have residents' meet casually and share their experiences living in the Home.	The resident co-chair chair of the Through Our Eyes Committee will bring feedback forward at various staff meetings.	There will be one TOE meeting each month.	12 TOE meetings
The Home in the last survey has 100% for resident response and	1)To further engage staff in understand the resident experience:	1. Using equipment and situations for staff to experience the life of a resident 2. Having BSO team have weekly huddles with staff	1. Number of staff having the resident experience initiative 2. The number of huddles by BSO	1. 20 staff 2. 20 huddles
The Home on the 2017 survey had 100% of residents and 82% of families	1)The Home would benefit from a rebuild. Residents and Staff note that the Home is maintained but as it is old, space and design	The Home rebuild was announced by the WWLIN in 2016. The Home has supplied all necessary documents to the Ministry of Health and continues to wait for the go-ahead. The Home will continue to advocate with the MOH for a go-ahead to rebuild.	Ministry Go-ahead	See above

the Home does not use the NHCAHPS survey. 1 is entered as a	1)See QI indicator number 8.	See QI indicator number 8	See QI indicator #8	See indicator #8
According to Q2 of CIHI of 2017/2018 is 12%. The provincial	1)The Goal is to maintain, and to continue the initiatives that have been embedded in the Home's practice.	Continue to: 1. Identify residents upon admission 2. BSO review and consultation with Home physician on on-going basis 3. Involvement of the IPRC at the LHIN BSO to review individual resident cases 4. Pharmacy quarterly review 5. Interdisciplinary care planning with	Number of residents who are given antipsychotic medication without psychosis	No more than 16% of residents who are given antipsychotic medications
Although the Home's performance is strong and less than the	1)The Home will track the number of falls related to dementia, and for whom the typical best practice interventions were not	The DOC will track the number of falls related to dementia, and for whom the typical best practice interventions were not effective.n	Number of residents who had a fall during the 30 days preceding their resident assessment who also because of their dementia the best practice interventions for fall prevention and safety were not effective. i.e. resident does not tolerate or understand hip protectors.	As the Home is developing a baseline, thee is no target.
The Home currently does not use restraints.	1)The Home will continue to use the current approaches, which have been effective in reducing the number to 0.	Residents/POAs/SDMs are made aware upon admission of the risks of restraints and the other more appropriate interventions/alternatives.	Number of restraints	Zero

Comments
The Home continues with multiple interventions to reduce sends to
It is hoped in doing this, the Home can have a better understanding of
It is an expectation that all complaints are acknowledged, investigated and
The Home asked the following questions in their survey and the results were as
Families and residents have seen the plans for the rebuild and attended the

The Home does not use the NHCAHPS survey. However, the RAI one being used
The Home is cognizant based on their annual data that the predominate risk