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

Caressant Care Bourget 2279 LAVAL STREET

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	51773*	23.29	22.00
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	51773*	100	100.00

	a complaint within 10 business days.						
	Percentage of residents responding positively to: "I would recommend this site or organization to others." (InterRAI QoL)	P	% / LTC home residents	In house data, interRAI survey / April 2018 - March 2019	51773*	79.31	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	51773*	88.89	90.00

		opinion without fear of consequences".						
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	51773*	CB	CB
	Safe	Number of Residents who fell in the last 30 days.	C	Rate per 100 residents / Adult long stay home care clients	CIHI CCRS / July - September 2017; CIHI CCRS	51773*	14.4	13.00

		Percent of Residents on an antipsychotic without the diagnosis of psychosis.	C	Rate per 100 residents / Adult long stay home care clients	POC/PCC Audits / January 1 - December 31, 2019	51773*	11.2	0.00

		Change	
Target justification	**External Collaborators**	**Planned improvement initiatives (Change Ideas)**	**Methods**
e working on)			
In collaboration with our system partners, we will continue to monitor and educate our staff, residents and families		1)Educate families more about services we have available in the facility that can avoid hospital transfers.	Newletters to outline services, discuss in care conferences and also discuss in family council meetings. We will also display on the boards to advertise some of the services.
		2)Evaluate the current effectiveness and availability of in house services	The Director of Nursing or delegate will review hospital transfers and evaluate what in-house services are available at the home versus the transfer.
		3)Decrease the number of ED visits related to falls each month	The number of ED visits related to falls will be tracked monthly by the MDS/RAI employee to establish a baseline measure by July 2019
		4)Establish a protocol to identify at risk residents in order to provide early treatment of common conditions	The Charge RN/DOC will conduct weekly huddles to review and update care plans and discuss at risk residents. They will also collaborate with the PT department.
Maintain Current performance		1)Continue to maintain an open dialogue and 100% compliance with complaints response and management	Immediate address, timely follow up and continue to educate staff, families and residents of complaint process.

		2)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 honor resident/family wishes and preferences
		3)Provide Education and skill building to nursing staff on responding to complaints	In house education, surge learning, 1:1 instruction/role play
Determined by CQI committee as a goal		1)Maintain a high level of resident satisfaction as we have by at least maintaining our current rates of satisfaction.	Ensuring to respond to residents concerns and create holistic care plans that ensures each resident is receiving care services that are specific to their needs and desires. We will also continue to deliver surveys and share results.
		2)Education & support on dementia & behaviours for Residents, Families & Staff by DOC. Supports for community from Alzheimer	DOC will hold internal education sessions by collaborating with community partners. AD will advertise in Resident/Home newsletter.
		3)Address immediate needs of Residents revealed at time of survey.	Volunteer/AD completing survey to follow up with department head to make improvements.
		4)Bus trips for Residents.	AD to organize bus trips with external partner
		5)Provide picnics, fire pit sing alongs and alternatives outside dining choices in high quality environment with comfortable seating.	Picnics or theme lunches to take place in back courtyard by AD, DOC, FNM and ED. TO include BBQ and ability to have meetings outside
Determined by CQI committee		1)Continue to keep staff informed of resident opinions and shared scoring with staff.	provide survey data to staff quarterly in staff meetings, including giving examples of approaches and techniques to encourage openness and post survey highlights on QIP board.

		2)Education & consultation related to anxiety, depression, past trauma stress - session provided to Residents, Families &	AD to advertise in Resident/Home newsletter. Request Corporate media related advertisement.
		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 and policy distributed on admission.
Collecting Baseline		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 RN who will do an annual 'analysis' at the end of the year to establish where improvements can be made
		3)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.
Fall committee goal set		1)Improve risk identification.	DOC in collaboration with PT to provide training on Fall Reduction Program to all nursing staff.
		2)Assessments on Residents to include comprehensive approach and to be done upon admission and required care plan and	Staff member to be assigned to assess resident for falls including history and compliance with strategies upon admission and re-assessed quarterly
		3)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
Monitor the number of residents sent to hospital and the reasons for their transfer.	Identify resident transferred to hospital each quarter	Success will depend on the reception of families to the information and
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	The indicator will be dependent upon Nursing Staff complaint with
The number of ED visits related to falls will be evaluated at quarters 2 and 3 to establish the effectiveness of the change idea	ED visits related to falls will decrease by 10% between July and December 2019	Implementation of Fall reduction strategies and injury prevention also a key
Number of residents at high risk for 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 residents identified at high risk who are transferred to hospital	
Monitor numbers and reason for complaint quarterly as well as outcomes	documentation of numbers of complaints and maintain 100% address within 10	NA

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 time frame for responding 2, 5 and 10 days.	50% of unresolved concerns and request will be reported by the PSW staff by	
The number of PSW staff who receive education on complaint handling	90% of PSW staff will receive education and instruction complaint handling	
Monitor the survey results, particularly those scoring 3 or 4 on the interRAI	Monitor responses quarterly to give us an opportunity to determine if we need to focus on a	
DOC will track attendance. AD will keep record of invitations in newsletters.	Family Members attending each internal support session held in 2019.	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 & community partners
Number of events	To provide 3 events by Oct. 2, 2019.	
Monitor interRAI responses that are scoring 3 or 4.	identify quarterly to determine whether we need to focus on greater positive responses.	

Number of workshop opportunities in the community advertised in the home	1 workshop advertised by December 31st, 2019	
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.	
Pain tool being used 'pre & post' indicates improvement.	100% of residents who experience pain will be assessed 'pre & post' treatment by	
Number of staff in attendance.	100% of Reg. Staff trained on Fall Strategy Program by Dec. 31, 201	
Number of Residents who fall	Decrease in number of Residents who fall to meet our goal by Dec. 31, 2019.	
Number of improvements from audits.	Identify at least 3 documented improvements from audits by Dec. 31, 2019.	

DOC will facilitate communication for improvement.	0 by Dec. 31, 2017	