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

Caressant Care Cobden 12 WREN DRIVE

	Measure						
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	P	Rate per 100 residents / LTC home residents	CIHI CCRS, CIHI NACRS / October 2017 – September 2018	54259*	35.63	35.63
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	54259*	100	100.00
		Percentage of residents who responded positively to the statement: "Caressant Care staff	C	% / LTC home residents	In-house survey / Jan 2018 - Dec 2018	54259*	92.7	95.00
		Percentage of residents who responded positively to the statement: "I can express my	C	% / LTC home residents	In-house survey / Jan 2018 - Dec 2018	54259*	100	100.00
		Percentage of residents who responded positively to the statement: "I would recommend	C	% / LTC home residents	In-house survey / Jan 2018 - Dec 2018	54259*	97.98	100.00

Theme III: Safe and Effective Care	**Effective**	Proportion of long-term care home residents with a progressive, life-threatening illness	P	Proportion / at-risk cohort	Local data collection / Most recent 6-month period	54259*	CB	100.00
	Safe	Percentage of residents who developed a stage 2 to 4 pressure ulcer or had a pressure ulcer	C	% / LTC home residents	CIHI CCRS / Oct 2018 - Sep 2019	54259*	1.2	2.60
		Percentage of residents who fell during the 30 days preceding their resident assessment.	C	% / LTC home residents	CIHI CCRS / Oct 2017 - Sep 2018	54259*	12.92	16.94
		Percentage of residents who were given antipsychotic medication without psychosis in the 7	C	% / LTC home residents	CIHI CCRS / Oct 2017 - Sep 2018	54259*	9.57	19.60
		Percentage of residents who were physically restrained every day during the 7 days preceding their	C	% / LTC home residents	CIHI CCRS / Oct 2018 - Sep 2019	54259*	3	4.40

		Change	
Target justification	**External Collaborators**	**Planned improvement initiatives (Change Ideas)**	**Methods**

e working on)

Meet or exceed previous year.	Cardinal Health Canada	1)In collaboration with Cardinal Health Canada, implement their fall prevention recommendations.	The DOC or designate will collect Emergency Department visit data on a monthly basis, identify those related to injuries from falls, review results at QI meetings, implement changes to fall prevention program as needed.
All complaints should be acknowledged and addressed.		1)Post reminders to staff to report complaints immediately.	The Exec Dir will post reminders, results reviewed at QI meetings.
Maintain or improve the current high standard.		1)Post reminders to staff to listen attentively when residents are speaking.	The Exec Dir will post reminders, results reviewed at QI meetings.
Maintain or improve the current high standard.		1)Post reminders to staff to be accepting of resident contributions to the Home's operations.	The Exec Dir will post reminders, results reviewed at QI meetings.
Maintain or improve the current high standard.		1)Post reminders to staff to be remember that we work in the residents' home.	The Exec Dir will post reminders, results reviewed at QI meetings.

All palliative needs should be identified.		1)Implementation of palliative assessment tool.	The DOC or designate will put into use a palliative assessment tool to be reviewed and updated weekly.
Meet or exceed provincial average.		1)Broaden pool of registered staff who have received wound care training outside the Home and in addition to training	The DOC or designate will schedule one or more registered staff members to attend wound care training, results related to wounds will be reviewed at monthly QI meetings.
Meet or exceed provincial average.	Cardinal Health Canada	1)Implement Cardinal Health fall prevention plan.	The DOC or designate will assist Cardinal Health in assessing residents and will implement recommended changes, results to be reviewed at QI meetings.
Meet or exceed provincial average.		1)Monthly review of PCC Analytic data indicating mismatched diagnoses as compared to prescribed antipsychotic medications.	The DOC or designate will review PCC Analytic data on a monthly basis, identify disparities, review results at QI meetings, refer results to physician for review of medication and diagnoses.
Meet or exceed provincial average but must allow for family insistence.		1)Monthly review with POAs/residents reference need for daily restraint.	The DOC or designate will liaise with residents/POAs each month to discuss options to restraints, results to be reviewed at QI meetings.

Process measures	Target for process measure	Comments
The number of Emergency Department visits due to injuries from falls reviewed monthly by the QI team.	31 Dec 2019 have achieved performance of less than 29.9%.	Factors for success include corporate implementation of Cardinal Health
The number of complaints received and acknowledged within 7 days.	By 31 Dec 2019 have responded within 7 days to each complaint.	Factors for success include reading by staff reminders and then acting on
The percentage of resident with a positive response to the survey question.	By 31 Dec 2019 have achieved 95.0% positive responses to the survey question.	Factors for success include reading by staff reminders and then acting on
The percentage of resident with a positive response to the survey question.	By 31 Dec 2019 have achieved 100.0% positive responses to the survey question.	Factors for success include reading by staff reminders and then acting on
The percentage of resident with a positive response to the survey question.	By 31 Dec 2019 have achieved 100.0% positive responses to the survey question.	Factors for success include reading by staff reminders and then acting on

The number of assessments completed, reviewed monthly by the QI team.	By 31 Dec 2019 have completed assessments on those in at-risk cohort.	Factors for success include rapid identification of and
The number of eligible wounds before and after education is completed, reviewed monthly by the QI team.	By 30 Sep 2019 have sent one or more registered staff on wound care training.	Factors for success include practice implementation by registered staff
The number of residents who fell reviewed monthly by the QI team.	By 30 Sep 2019 have achieved performance of less than 16.4%.	Factors for success include corporate implementation of Cardinal Health
The number of residents taking antipsychotics with psychosis reviewed monthly by the QI team.	By 30 Sep 2019 have achieved performance of less than 19.6%.	Factors for success include identifying where ICD should indicate
The number of residents with daily restraints reviewed monthly by the QI team.	By 30 Sep 2019 have achieved performance of less than 4.4%.	Factors for success include ability to successfully educate