Excellent Care for All

Quality Improvement Plans (QIP): Progress Report for 2016/17 QIP

The Progress Report is a tool that will help organizations make linkages between change ideas and improvement, and gain insight into how their change ideas might be refined in the future. The new Progress Report is mostly automated, so very little data entry is required, freeing up time for reflection and quality improvement activities.

Health Quality Ontario (HQO) will use the updated Progress Reports to share effective change initiatives, spread successful change ideas, and inform robust curriculum for future educational sessions.

ID	Measure/Indicator from 2016/17	Org Id	Current Performance as stated on QIP2016/17	Target as stated on QIP 2016/17	Current Performance 2017	Comments
1	B: Percentage of residents responding positively to: "I would recommend this site or organization to others." (InterRAI QoL) (%; Residents; Apr 2015 – Mar 2016 (or most recent 12-month period). ; In-house survey)	51522	90.00	93.00	91.20	This survey question was on both our resident satisfaction surveys, and family satisfaction surveys. Response rates were higher this year for both groups. We had a slight improvement over last years results and we exceed results for aggregate Extendicare Homes (average 80.1% top quartile 90.2%).

Realizing that the QIP is a living document and the change ideas may fluctuate as you test and implement throughout the year, we want you to reflect on which change ideas had an impact and which ones you were able to adopt, adapt or abandon. This learning will help build capacity across the province.

Change Ideas from Last Years QIP (QIP 2016/17)	Was this change idea implemented as intended? (Y/N button)	Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others?
Same as above	Yes	Same as the other overall satisfaction questions. See details under indicator 3.
Making a whole variety of improvements based on extensive feedback on our satisfaction surveys was intended to improve this and other measures of overall satisfaction.	No	This indicator was not targeted directly for improvement, but instead there were extensive efforts to address specific areas on our satisfaction survey in hopes that overall satisfaction rates would improve.

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2	Number of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents. (Rate per 100 residents; LTC home residents; Oct 2014 – Sept 2015; CIHI CCRS, CIHI NACRS)	51522	31.53	28.50	20.60	We have a downward trend which is desirable.

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Assemble and communicate with a well represented LTC Emergency Department Utilization Improvement Team promoting ongoing dialogue on this issue. Use Ministry road map document as a guide.	Yes	We initially created this team to get us started but later migrated the responsibility to nursing management and the QIP Advisory team. The ministry roadmap provided excellent direction as we began working on this indicator.
Rework 6 week care conference to focus on plan of care moving forward, expectations of resident and family, setting realistic goals.	Yes	This was a big improvement. Far less time is now spent reviewing the past year, but rather planning care and comfort measures for the future.
Sharing a variety of educational resources with various stakeholders about avoiding ED transfers. Do more education on primary prevention of illnesses and injuries that may ultimately lead to transfers if not well managed. Consider needs of physicians, nurses, other staff, families, residents.	Yes	Many stakeholders, including public on tours, doctors, nurses and family members were provided with education along the way. The physicians in particular reviewed data several times and that may have served as a motivator. End of life/Palliative Care/Advanced Directives education sessions were provided to residents and families by two of our Physicians and the Administrator/DOC/ADOC. A detailed summary of those meetings was shared with our registered staff, as well as with families.
Explore mobile interventions like ultrasound and x-ray or hydration delivery methods to see if a few additional transfers can be avoided	Yes	Mobile x-ray is in place on a routine, not on demand, basis for the time being. When the service is in our area, they are willing to come on demand. We explored the possibility of

by employing such services.		bringing ultrasound testing to the Home but the company was not able to provide the service to our geographic area at this time.
Enhance communication between the hospital and The Pines.	Yes	Met with the Chief of Staff and drafted a letter of understanding of areas to work on for both parties. Moving some of them forward now. Some will appear on next year's QIP.
Applied for NP funding to focus on reducing ED visits and behavioral supports.	Yes	Application was not successful.

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3	Percentage of residents responding positively to: "What number would you use to rate how well the staff listen to you?" (%; LTC home residents; Apr 2015 – Mar 2016 (or most recent 12-month period); In house data, NHCAHPS survey)	51522	54.00	56.00	35.50	This was another measure of overall satisfaction. The focus groups themselves were an intervention of sorts to listen to residents, and share that we heard them by offering tangible results. For this reason, it was surprising to have fewer respondents rate this question with a 9 or 10. It will be important to look closely at the distribution of the data (when available) to learn more about the responses and plan ways to address this indicator.

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Share this data with Residents Council, focus group style with volunteer residents, then with families and staff. Ask for feedback on strategies they feel might improve scores. Share our management open door policy and that staff and families members can communicate feedback to Administration if they wish and we will get back to them with responses. Explain anonymous ways of sharing feedback as well.	Yes	This indicator really just related to those residents who were cognitively well enough to participate in the focus groups and partake in our survey.
Groups of volunteer residents will meet weekly for 5 or 6 weeks to review various sections of the resident satisfaction survey results (Activities, dietary, nursing, support services etc).	Yes	These meetings went very well. One important learning is that it is really important to think about accessibility issues when conducting meetings like this. That may mean using a

		microphone consistently, as well as adapting conversations to those with cognitive impairment. Knowing the group of residents well will improve the extent to which valuable feedback evolves from the meetings. Managers found it inspiring to hear from residents directly, and that motivated us to create an extensive action plan.
Creation of a comprehensive action plan to address as many aspects of our Resident and Family Satisfaction survey results as possible.	Yes	This working document was revisited multiple times by the management team who took responsibility for addressing as many issues as possible in the surveys, big or small. Many improvements were put in place.

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4	Percentage of residents who fell during the 30 days preceding their resident assessment (%; LTC home residents; July – September 2015 (Q2 FY 2015/16 report); CIHI CCRS)	51522	20.53	20.53	22.68	Our actual falls increased probably because our restraints are decreasing. The important thing to report however is that our percentage of falls without an injury or change of status is decreasing. The flip side of that is that only about 20% of falls result in an injury or change of status due to all the special measures in place to decrease injuries if falls do occur.

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Our post fall assessments need to be more comprehensive and should include physical status of person and current injuries resulting from the fall. Staff should receive more education on what to look for during assessments.	Yes	New fall assessments have been implemented. The education was provided at the time of the new Falls Management policy roll-out and ongoing as needed.
All residents on the Falling Leaf Program will be reviewed monthly for use of fall mats, hip protectors, as well as bed and chair alarms, also checking on restraint use. Feedback will be sought to determine if any other measures need to be in place for these high risk residents. Assess whether a physio referral is needed or whether restorative programming might be helpful.	Yes	Each resident flagged on the monthly quality indicators are reviewed by the interdisciplinary team at the monthly Core Committee meeting. Care plans are updated accordingly.
Families of residents on the Falling Leaf Program need more education on fall mats, hip protectors, bed and chair rails.	Yes	The family distribution list received a customized fact sheet titled "Falls Prevention Tip Sheet".
We have purchased 10 new hi-lo beds. We	Yes	As the priority need changes the

need to ensure that residents at the highest risk for falls from a bed are appropriately using these beds. If the beds demonstrate a reduction of falls, consideration will be given to purchase more beds.		most high risk is provided the hi-lo bed.
New Fall Management roll-out and related education of same.	Yes	All registered staff reviewed the new policies and procedures. The new assessments were discussed and implemented. All residents who sustained a fall are monitored for 72 hours post-fall for any significant changes in status.

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5	Percentage of residents who responded positively to the question: "Would you recommend this nursing home to others?" or "I would recommend this site or organization to others". (%; LTC home residents; Apr 2015 – Mar 2016 (or most recent 12-month period). ; In house data, InterRAI survey, NHCAHPS survey)	51522	61.00	65.00	63.60	Responses to this indicator improved slightly with almost 64% of residents indicating "definitely yes". 100% of all residents chose either "definitely yes" or "probably yes", which indicates all responses were positive. No residents chose the neutral or negative responses.

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Same series of meetings described above.	Yes	Well attended meetings with very good participation by residents.

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6	Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences". (%; LTC home residents; Apr 2015 – Mar 2016 (or most recent 12-month period). ; In house data, interRAI survey)	51522	84.00	86.00	90.00	Again, this is a measure of overall satisfaction. This was quite an improvement but we need to continue to reinforce mechanisms for feedback and protections against consequences.

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Same as above.	Yes	Residents were much better informed this year about the satisfaction survey itself as a mechanism for expressing their opinions without fear of consequences.

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7	Percentage of residents who were given antipsychotic medication without psychosis in the 7 days preceding their resident assessment (%; LTC home residents; July – September 2015 (Q2 FY 2015/16 report); CIHI CCRS)	51522	28.42	26.00	25.93	Our target was achieved this year with more room for improvement. All residents currently receiving antipsychotics are reviewed quarterly to ensure assessment has been completed. The dosage and frequency of the medications in relation to diagnosis are also reviewed at that time, as well as on an as needed basis. This is on ongoing process and all Physicians are familiar with this review.

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Tours conducted will mention or address the issue of antipsychotic drugs. Also, an information sheet will be added to both the tour package and the admission binder and this will include our homes commitment to decrease inappropriate use of antipsychotics and restraints, as well as decreasing inappropriate ED visits.	Yes	This was done consistently for approximately 2-3 tours a week for the year. Interesting discussions took place with potential new residents and families. It is never too early to start discussions on this important topic.
6 week care conference will include a discussion of this issue. Add to care conference check list.	Yes	All medications are reviewed at the time of the care conferences. A medication list is provided to the specific resident and/or SDM/POA.
Monthly, at Nursing Core meetings on behaviors, one or two additional residents will be selected for consideration of a possible reduction or elimination.	Yes	The antipsychotic usage list for all residents is reviewed monthly at the Responsive Behaviour Committee meetings. Individual case studies are discussed with

		the highest risk residents.
Identify one or more videos or other interesting resources to share on this topic with different audiences (docs, staff, residents/families)	Yes	Early in the year some resources were shared. The PRC provides monthly Responsive Behaviour Support Sessions with a variety of topics related to dementia care.
For any resident with flagged behavioral issues, utilize BSO on admission and during the first 6 weeks of placement.	Yes	We have utilized the BSO team during admission transitions from home settings to Long Term Care as well as any new responsive behaviours are exhibited within the first 6 weeks. This has been worthwhile.
	No	

ID	Measure/Indicator from 2016/17	Org Id	Current Performance as stated on QIP2016/17	Target as stated on QIP 2016/17	Current Performance 2017	Comments
8	Percentage of residents who were physically restrained every day during the 7 days preceding their resident assessment (%; LTC home residents; July – September 2015 (Q2 FY 2015/16 report); CIHI CCRS)	51522	10.03	9.00	4.64	There has been a significant reduction in the use of restraints. Quarterly restraint assessment continue and an individual plan of care is implemented. All new admissions are provided information on the restraint reduction plan of the home and the risks of usage are explained to both the residents (when applicable) and families/SDM/POA's. This is an indicator that we will continue to work on on core teams but we will not continue to showcase it on our QIP.

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There is still uncertainty among some of our staff about whether or not side rails may sometimes be needed to help keep very large residents in bed for instance, or for positioning. Offering feasible alternatives to restraints along with education may be important for those situations for staff as well as residents.	Yes	Alternatives such as fall mats, hi-lo beds, bed alarms, one rail for positioning are consistently offered. There are still residents, staff and families who feel more comfortable with the use of two rails.
Roll out a 'least restraint' policy for staff	Yes	Our new policy was successfully rolled out. Discussions ensued at Resident Home Area style staff meetings about the importance of this issue. There is a better understanding among staff now of rationale for least restraints, and alternatives.
Tours conducted will address the issue of restraints. Also, info will be	Yes	Information on restraints was shared on virtually all tours. Our tour package

added to both the tour package and the admission binder.		contains information on restraints and other indicators, and families often comment on this information, making a positive reference to it. If and when residents and/or families request restraints on admission, the RAI Co-ordinator provides education on the risks related to their usage and reviews our least restraint policy.
Targetted email to all families (bccd) who have a family member using a side rail or seat belt. Add visual literature to explain entrapment.	No	Alternatively, we did targeted counselling discussions with residents who were choosing to use rails and belts, and this was productive. We felt this was more appropriate than directing the messages to families since the residents were capable of making the decisions themselves. By invitation, the Resident Council received a detailed explanation of the least restraint policy and the risks related to the use of restraints.
Core Program Committee re-vamped.	Yes	The Core Program Committee has been restructured to include the interdisciplinary team to review all of the high risk residents related to the quality indicators. The Committee meets monthly and make any recommendations, discuss with families, meet with front line staff post meetings and update individual care plans as needed.

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9	The number of volunteer hours per month and year. (Counts; N/a; 2016; volunteer software)	51522	CB	CB	7990.00	This figure is hours per year, only including individual hours, not groups.

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Encourage more families, as partners in care, to volunteer at The Pines either formally or informally. Utilize our family distribution list to communicate opportunities. Determine whether reciprocal arrangements might naturally exist (eg if a family member is going away, another may be able to do some extra visiting enhancing. connections).	Yes	Families may not always want to be formal volunteers, but are often willing to help when needed. It is better to approach them after a month or two, rather than at admission. It is helpful to mention opportunities for volunteering as early as during a tour.
Connect with our Activities Department about specific Montessori Methods activities that our volunteers might wish to be involved in.	No	Aspects of Montessori Methods are being used as an approach among volunteers (eg like one to one visiting, and incorporating roles, history), but specific programs are more often and best led by our formally trained activity staff.
Each month share an updated volunteer request form on our new website.	Yes	This was posted consistently on the website, but not tracked so it was difficult to determine how many people saw this. However, in 2107 we plan to more frequently post this on our family distribution list for better exposure.
Profile volunteers who are family members in the volunteer spotlight and on the web.	Yes	4 spotlights were profiled and then recirculated via a newsletter for all families. This initiative will continue over the next few years as it is well worthwhile.
Opportunities for volunteering were	These new	

mentioned on tours when appropriate. Volunteer application now goes into our admission binder.	initiatives seemed to be well received.