THE CORPORATION OF THE CITY OF KAWARTHA LAKES

Report VMC2017-06

Victoria Manor Committee of Management

Meeting Date:	**Monday March 20, 2017**
Meeting Time:	**9:30 am**
Meeting Place:	**Victoria Manor Board Room** **220 Angeline St. S., Lindsay**

Subject:	**Victoria Manor 2017/18 Quality Improvement Plan for Ontario Long Term Care Homes**
Author:	**Pamela Kulas**
Signature:	
Title:	**Administrator**

RECOMMENDATION(S):

RESOLVED THAT Report VMC2017-16, *"Victoria Manor 2017/18 Quality Improvement Plan for Ontario Long Term Care Homes"*, be received for information; and

THAT the Chair of the Victoria Manor Committee of Management be authorized to sign said Quality Improvement Plan as attached.

DIRECTOR **OTHER**

Background:

The *Excellent Care for All Act* includes a quality management component whereby all health care organizations in the province will post annual quality improvement plans for public review. The process began five years ago with the posting of Quality Improvement Plans (QIPs) in the hospital sector and, over the course of the last few years, extended to inter-professional primary care organizations, Community Care Access Centres (CCACs), and Long-Term Care (LTC) Homes.

The QIP is an organization-owned plan that establishes a platform for quality improvement that can be used to harmonize efforts to improve quality of care across the health care system. While most health care sectors are familiar with developing QIPs as a way to express quality goals and targets for their organizations, the sectors are at different starting points when it comes to developing QIPs. The expectation is for health care organizations to have their QIPs in place, publicly posted, and submitted to Health Quality Ontario (HQO) by April 1 every year.

HQO developed a comprehensive Quality Improvement Framework that brings together the strengths of several QI science models and methodologies, such as the Model for Improvement from the Institute for Healthcare Improvement, and traditional manufacturing quality improvement methods like Lean and Six Sigma.

HQO grounded their framework in Deming's System of Profound Knowledge to ensure a system-wide view of improvement would be applied to any quality improvement initiative, in any healthcare sector.

The framework consists of six phases, each iterative and designed to build on the knowledge gained from the previous phase.

The QIP for Victoria Manor is attached and focuses on areas of improvement that will enhance the resident experience and is in line with our strategies to improve resident safety and well-being.

Consultations:

Victoria Manor Leadership Team

Attachments:

- 2017-18 Quality Improvement Plans Letter November 25, 2016
- Victoria Manor 2017-18 Quality Improvement Plan (QIP) Narrative for Health Care Organizations in Ontario
- Victoria Manor 2017-18 Quality Improvement Plan (QIP)

2017-18 Annual Priorities for Quality I

Victoria Manor 2017-18 Quality Impr

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Phone: 705-324-9870 ext. 3206	**Director: Rod Sutherland**
E-Mail: rsutherland@city.kawarthalakes.on.ca	

10th Floor
130 Bloor Street West
Toronto ON M5S 1N5
Tel: 416 323-6868
Toll-free: 1 866 623-6868
Fax: 416 323-9261

10e étage
130, rue Bloor Ouest
Toronto ON M5S 1N5
Tél. : 416 323-6868
Sans frais : 1 866 623-6868
Téléc. : 416 323-9261

November 25, 2016

RE: 2017/18 Annual Priorities for Quality Improvement Plans

Dear Colleagues,

Health Quality Ontario is pleased to share the 2017/18 Annual Priorities for Quality Improvement Plans. Each year when we release the priorities, it's an opportunity to reflect together on the progress that we're making to advance quality and achieve improvement across the Ontario health system. The quality improvement underway is impressive, and gradually, as we saw in our Measuring Up 2016 report, we are seeing improvement in several important areas. We want to acknowledge the 1042 hospitals, interdisciplinary team-based primary care organizations, long-term care homes, and community care access centres in Ontario for submitting 2016/17 QIPs this past April and sharing what you've achieved in the previous year – it is a remarkable demonstration of your continued commitment to quality improvement.

It's clear from this enormous effort that health care organizations and their teams in Ontario have a strong focus on quality improvement, a focus reflected in many other exciting initiatives currently happening across the province – at the provincial, regional, organizational, and provider levels. Our aim is for the QIPs to serve as an important mechanism to support these significant change efforts and realize the planned benefits to quality of care.

One of the changes you will see in the priorities this year is the shift from focusing on priority indicators for the QIPs to thinking about the underlying quality issues being addressed. By focusing on the underlying issues at stake, organizations can find common ground with other organizations within their sector and in other sectors that are working on the same issues but may be measuring these in different ways. This is consistent with our emphasis on cross-sectoral collaboration and integration of care, where we will work together as a system to achieve a safe, effective, patient centred, timely, equitable, and efficient health care system for people in Ontario. Our hope is that the process of bringing teams together to develop the QIP is supporting and fostering a culture of quality improvement both within each organization and across the system.

We also want to use this opportunity to thank those of you that responded to our survey of QI leads, EDs, CEOs, administrators and Board Chairs across the province to provide your insights on the QIP program – it helps us to understand whether the program is meeting its goals and identify areas for us to improve. We were encouraged by the results of this survey. As an example, more than 70% of board chairs and CEOs said that the program encouraged their organization to talk about quality and quality improvement to a greater extent than before the QIP.

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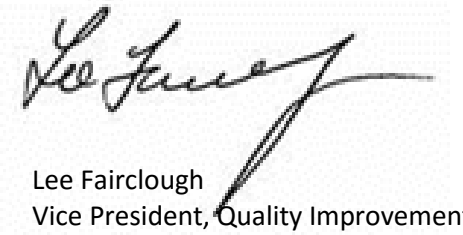
The survey results also provided insight on areas for increased emphasis, one being to encourage more focus on patient engagement and provide information to support organizations in engaging patients in both the development of their QIP and the activities within their QIPs. We hope that organizations view the process of developing a QIP and working on the initiatives described within it as an opportunity to engage with patients in frank discussions and fruitful collaborations on how the quality of their care could best be improved. In fact, we saw that descriptions of patient engagement have increased in all sectors in the 2016/17 QIPs compared with the 2015/16 submissions. To support further improvement, we are pleased to share our recently released guide, *Engaging with Patients and Caregivers about Quality Improvement: A Guide for Health Care Providers*, which was developed in collaboration with patient advisors. We hope organizations will find this resource useful as they embark on their planning for the upcoming 2017/18 QIPs.

The new resources that are available and the changes we have made in response to your feedback are summarized in the attached What's New document. For specific information on the priority issues and indicators for this year, refer to the QIP Guidance Document, the Indicator Technical Specifications for the 2017/18 QIPs, and the QIP Navigator. If you or your team have any questions about the QIPs or about HQO's quality improvement resources, please don't hesitate to contact our team at QIP@HQOntario.ca.

Over the next year, there are many changes underway in our health system. It will be more important than ever to maintain a focus on health care quality during this time, in order to ensure that these changes result in improvements in care for patients. There is much to be proud of in Ontario's health care system, but as always, there remains room for improvement. At Health Quality Ontario, we look forward to working with you, your teams and across organizations to improve the quality of care provided in this province, particularly during the current period of transition. By doing so, we will continue to progress toward our goal of better health for every Ontarian.

Sincerely,

Dr Joshua Tepper
President and Chief Executive Officer



Lee Fairclough
Vice President, Quality Improvement

Let's Make Healthy Change Happen.

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

3/13/2017

This document is intended to provide health care organizations in Ontario with guidance as to how they can develop a Quality Improvement Plan. While much effort and care has gone into preparing this document, this document should not be relied on as legal advice and organizations should consult with their legal, governance and other relevant advisors as appropriate in preparing their quality improvement plans. Furthermore, organizations are free to design their own public quality improvement plans using alternative formats and contents, provided that they submit a version of their quality improvement plan to Health Quality Ontario (if required) in the format described herein.

Overview

Victoria Manor is a 166 bed long term care home that offers a secured home area and a Behavioural Support Ontario Team. The Quality Improvement Plan and the Resident Safety Plan have been part of the Home's strategic and operating plans. Specific objectives in the home's 2016-2019 Strategic Plan have fallen under the following strategic categories of focus:

- Our Residents/Clients
- Our People/ Team members
- Our Community
- Strengthening Support Services

Our home is CARF Accredited.

We collaborate with community organizations to offer programming which keeps residents active and involved with their families, friends and community.

Our Family Council demonstrates a consistent and strong support to the home. The Resident's Council is well represented.

This plan has been refreshed from 2016 and has been reviewed with all employees, families and residents.

Key values are Respect, Passion, Teamwork, Responsibility and Growth.

Other priorities for the home focus on quality indicators as follows:

1. Reduce falls
2. Reduce worsening of pressure ulcers
3. Reduce use of restraints
4. Reduce ED visits
5. Antipsychotic reduction
6. Resident Satisfaction- Likelihood to Recommend

These 6 priority indicators share alignment with the organizations Strategic Plan, the homes Operational Plan, the Long Term Care Service Accountability Agreements and CARF Accreditation Standards.

The home has a full management partnership with Sienna Senior Living that will facilitate the quality management processes and provide benchmarking standards to work towards.

Key considerations which may impact our 2017 performance include continuing changes in the resident population and acuity specifically the growing number of residents with psychiatric histories who have aged which results in aggressive behaviors.

The addition of a new physician and Nurse Practitioner will serve to be a positive intervention in addressing the above issues.

QI Achievements From the Past Year

Restraint reduction has been significant for 2016. In September of 2015 restraint use was 5.4%; September 2016 restraint use has been reduced to 3.15% in one year.

The process used included monthly Quality and Risk Meetings to assess the degree of effectiveness of the interventions.

Resident and family education was provided on both admission and throughout the past year. These educational sessions were one on one and include the team as a whole. The Victoria Manor newsletter served to provide educational updates to families as well. Staff education and teaching was a part of day to day.

The home achieved a 16% relative reduction in the percentage of residents taking antipsychotic medication without a diagnosis of psychosis over the past year. This reduction has resulted from a focus on appropriate use of antipsychotics. Academic Detailing Service helped staff recognize behaviours likely and unlikely to respond to antipsychotic medication, increasing the use of documentation such as the DOS (dementia observation scale), and bringing providers, staff, and families "on the same page".

In addition the monthly Resident Safety Meetings served to more closely monitor individual residents. Daily reviews of risk related issues to ensure timely response.

It is important to note all levels of the health team were included in these processes to support a collaborative approach.

Population Health

Victoria Manor services adults requiring residential and nursing care. Our home embraces a vision whereby we aim to "awaken our communities to the positive possibilities of life's next chapters" as seniors constitute the majority of the population that we serve. Many of our residents are dealing with physical deficits in addition to cognitive impairments including dementia. We collaborate with Behavioural Supports Ontario and the Alzheimer Society as well as Psychogeriatric Resource Consultants in addressing the unique needs of residents dealing with mental health diagnoses. We partner with our LHINs and local hospitals to ensure our residents receive the highest level of care as they transition across the continuum of care. This collaboration supports our quality improvement initiatives such as reducing avoidable Emergency Department Transfers as well as worse stage 2-4 pressure ulcers. Our home continues to embrace the principles of the CFHI Antipsychotic Project as part of our continued efforts around ensuring appropriate usage of anti-psychotic medications. We actively collaborate with the local Public Health Units in managing outbreaks and as part of our infection control and prevention activities. We have also partnered with service providers such as our clinical database provider, Point Click Care, to provide volunteer opportunities to Point Click Care employees within the home. We offer a Cyber Seniors program aimed at supporting our residents in the use of technology to share, stay in touch, and connect with each other as well as family and friends. We partner with RNAO in ensuring that our home is providing care in line with the latest, evidence-based, best practice.

Equity

We work with a diverse array of clients at Victoria Manor. This community serves not only the traditional seniors population, but also residents dealing with addictions, mental health diagnoses and a history of homelessness. We partner with organizations such as the Center for Addition Mental Health to ensure these residents receive the highest quality of care in addressing their unique needs. Also we work with Public Guardian and Trustee in trying to advocate for the optimal care of these individuals.

Victoria Manor endeavors to establish themselves as an integral part of the local communities which we serve. Our menu caters to our population's requests and preferences. We work with Public Guardian and Trustee in trying to advocate for the optimal care of these individuals.

Integration and Continuity of Care

Victoria Manor is working alongside many system and community partners in the execution of these quality improvement initiatives. We continue to work with many partners including primary care teams, the Central East LHIN, Community Care Access Centre, Behaviour Support Ontario, local hospitals, suppliers including 3M for wound and skin care, Achieva for falls reduction. We continue to track, analyze and respond to CIHI data on a quarterly basis.

Access to the Right Level of Care - Addressing ALC Issues

At Victoria Manor we have established a great working relationship with CCAC that ensures promptly filling of our vacant beds. All members of our Management team review the CCAC profiles of potential residents for suitability for the unit with the open bed. In an attempt to keep residents out of the hospital the home utilizes the services of the Nurse Practitioner and/or Physician. In addition to the use of the Nurse Practitioner and Physician our home utilizes a number of other methods to keep our residents home such as offering IV therapy in house in partnership with pharmacy and home care services and mobile diagnostics.

Victoria Manor provides respite options to people in the community who require those services.

Engagement of Clinicians, Leadership & Staff

Engagement and contributions from all cohorts of staff are achieved both formally and informally through processes including departmental staff meetings, sharing committee minutes, general staff meetings. Resident and Family council presentations are held regularly with opportunities to contribute.

The culture of engagement, respect and contribution has improved over the past year. This is evidenced from the 2016 employee engagement survey results with an overall improvement of 7.4% in the organizational climate index validating improvements in culture, outlook, leadership and communication.

Resident, Patient, Client Engagement

October of 2016 resulted in an overall resident satisfaction rate of 89.9% an improvement of 1% from 2015. Added to this is the family response rate of 82% satisfaction which demonstrates a culture of engagement and transparency.

The Family Council for Victoria Manor is a dynamic council who work closely with the leadership and resident council to support quality of life and resident focused care. Their meetings are bi-monthly and have an attendance of some twenty (20) to thirty (30) people and the executive are fully engaged in home events.

One of the primary goals of every long term care community is to work collaboratively with residents and families to enhance resident experience. It is imperative that as part of the quality improvement process, the voice of residents and families are included. In our home, resident and family feedback is obtained through their move in and annual care conference as well as Resident Council/Family Council and annual satisfaction surveys. Their input is also sought in annual program evaluations and strategic planning. Areas of improvement are identified and

positive ideas for change are brought forward and incorporated into the development of our operating plan and our annual Quality Improvement Plan. We feel that by incorporating resident and family feedback we are better positioned to drive quality improvement and create a positive resident experience.

Staff Safety & Workplace Violence

Victoria Manor promotes the values of respect, teamwork, and responsibility which are cornerstones to promoting staff safety and preventing workplace violence within the organization. In support of staff safety, the home offers an early safe return to work program for employees as well as education to staff around the hazards that may exist within the workplace and how to work safely. The Joint Health and Safety Committee is in place and policies and procedures exist around all of the above in addition to around workplace violence, harassment and bullying. These include policies and procedures to support staff in dealing with anger in the workplace as well as in recognizing domestic violence in the workplace and in completing a workplace violence risk assessment as well as in investigating a report of workplace violence, harassment and bullying. Emergency codes are in place to ensure that staff can communicate and act appropriately in the event of an emergency situation for the safety of all involved. These emergency codes include "code white" to alert staff to a violent situation within the home. The Quality of Work Life Committee is in place in addition to employee access to confidential counselling services offered through our benefits provider to promote the health and well-being of employees. Additionally, we actively collaborate with local Public Health Units to effectively manage outbreaks in our home as part of our infection control and prevention activities and ensure compliance with Ministry of Labour regulations.

Contact Information

For more information please contact Pamela Kulas, Administrator at 705-324-3558 ext. 1414 or by email at pkulas@city.kawarthalakes.on.ca

Sign-off

It is recommended that the following individuals review and sign-off on your organization's Quality Improvement Plan (where applicable):

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

Board Chair / Licensee or delegate
Administrator /Executive Director
Quality Committee Chair or delegate
CEO/Executive Director/Admin. Lead _____ (signature)
Other leadership as appropriate _____ (signature)

2017/18 Quality Improvement Plan for Ontario Long Term Care Homes
"Improvement Targets and Initiatives"

Victoria Manor Home for the Aged 220 ANGELINE STREET SOUTH

AIM		Measure							Change				
Quality dimension	Issue	Measure/Indicator	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
Effective	**Effective Transitions**	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	CIHI CCRS, CIHI NACRS / October 2015 - September 2016	51897*	39.81	37.00	Work towards decreasing the number of unnecessary ED transfers	1)Utilize Quick ADT Transfer Portal in Point Click Care for all transfers out of home.	Education to all registered staff on how to use the portal in Point Click Care will be given. DOC/ADOC will analyze and trend the data monthly and share back at Registered staff meeting monthly.	100% of Registered staff will have had the education on the use of the portal by December 31, 2017	All transfer will be captured through Quick ADT portal.	
									2)Track and trend ED visits on a monthly basis by running and analyzing the portal reports.	Review number of resident transfers to hospital every month.	ER transfer tracking form including details of who, when, why and outcomes. Will review transfers at the monthly resident safety meetings and quarterly PAC meetings.	Reduce ER transfers by 7%	
									3)Utilize community diagnostic services	Registered staff will communicate with MD/NP to utilize our community portable diagnostic services to provide services in home for all non acute needs.	Services utilized in home will assist in decreasing unnecessary ED transfers.	ED transfers will show a decline.	
Patient-centred	**Resident experience: "Overall satisfaction"**	Percentage of residents who responded positively to the question: "Would you	% / LTC home residents	In house data, InterRAI survey, NHCAHPS survey / April 2016 - March 2017	51897*	89	89.00	Given the outstanding results of 2016, will maintain status quo for	1)Continue with processes such as liaise with resident and family councils	Continue as 2016 methodology which yielded the current results	Continue as 2016 methodology - "I am willing to recommend this care community to a friend"; "My quality of life at this care community"; "The quality of services at this care community".	Encouraging residents to have a voice.	Given the outstanding results of 2016, will maintain status quo for this
Safe	**Medication safety**	Percentage of residents who were given antipsychotic medication without psychosis in the 7 days preceding their resident assessment	% / LTC home residents	CIHI CCRS / July - September 2016		25.43	24.00	Due to the level of acuity our goal is to set a realistic target and decrease percentage of residents who were given anti-psychotic medication without psychosis in the 7 days preceding their resident assessment. The ultimate goal to meet the provincial average	1)Review the number of residents receiving antipsychotic medication each month at resident safety meeting and compare the number against the previous month(s).	Review MDS outcomes (CPS, ABS) to evaluate appropriateness of use. Discuss alternative mediations with physician and care team (nurse, physician, pharmacy). Communicate outcomes and direction of care to staff and families.	Review the number of residents who have been discontinued from antipsychotics or have been switched to alternative medications over a month.	To reduce the number of residents receiving antipsychotic medications without a supporting diagnosis by 3.0% on each resident home area over a quarter.	Will review outcomes at the monthly resident safety meetings and quarterly PAC meeting.
									2)All new residents moving in will have a review completed to validate the need to continue, reduce or eliminate anti-psychotic medication use.	Anti-psychotic medication will be identified by Registered staff upon admission and flagged for review. The BSO team will initiate the review gathering information relevant to the use of the medication and diagnosis, medical hx and behaviors and share this information with Medical Director and/or Nurse Practitioner. The interdisciplinary team will then decide to validate, reduce or eliminate the use of anti-psychotic medication.	All new residents moving in will have a review completed with possibility of validating, decreasing or eliminating the use of anti-psychotic medication.	100% of all new residents moving in who are on anti-psychotic medication will be reviewed for validation, reduction or elimination of anti-psychotic medication	

Safe care	Percentage of residents who developed a stage 2 to 4 pressure ulcer or had a pressure ulcer that worsened to a stage 2, 3 or 4 since their previous resident assessment	% / LTC home residents	CIHI CCRS / July - September 2016	51897*	4.82	4.50	Working towards the provincial average to decrease percentage of residents who developed a stage 2 to 4 pressure ulcer or had a pressure ulcer that worsened to a stage 2, 3 or 4 since their previous resident assessment.	1)Implement a BIN system in treatment carts on all 4 units with a quick reference binder for policy, BPG and 3M products used for ulceration or interference with skin integrity.	Review current policy algorithms and BPG's and create quick reference sheets. Sheets will include photo of each category of skin tear and pressure injury with steps to cleanse, prep and dress wound with 3M products. Each labelled BIN will hold only those 3M products needed for each individual category/pressure injury. 3M	All 4 home areas will have identical stocked carts and reference material.	All registered staff will follow the same policy and procedures with BPG for treatment of identified skin injuries.	
								2)Education to all Registered staff to correctly identify stages of pressure injuries and skin tear categories.	Education to be provided by 3M	100% of Registered staff will receive the education	100% of Registered staff will be educated by Dec. 31, 2017	
								3)Education to all PSW staff for identification of early detection of skin breakdown and initiate preventative measures.	Education to be provided by 3M	100% of PSW's will receive the education	100% of PSW's will be educated by December 31, 2017.	
								4)Weekly risk management will include residents with a PURS score of 3 or more.	RAI-C will add this to the weekly MDS risk report that is shared with Registered staff. Registered staff will continue to review weekly report at 10@10 meeting. Registered staff will ensure that identified residents have preventative measures in place and are noted in the care plan.	Preventative measures will be reviewed for every identified resident of a PURS score of 3 or more on the quarterly RAI assessment.	Every resident with a PURS of 3 or more will have preventative measures identified in their nursing care plan.	
	Percentage of residents who fell during the 30 days preceding their resident assessment	% / LTC home residents	CIHI CCRS / July - September 2016	51897*	24.69	23.00	Working towards the provincial average to reduce the percentage of residents who had unintentional changes in elevation during the 30 days preceding their quarterly resident assessment.	1)MDS coding will reflect all unintentional changes in elevation.	RAI team to review all risk management documentation for found on floor incidents to assess for factors that would indicate an unintentional change in elevation occurred.	Falls will be coded when factors indicate that an unintentional change in elevation has occurred.	Decreased number of actual falls coded.	
								2)Education to Registered Staff to review any new or existing medication that could be a factor in causing or increasing a risk for a fall. Antihypertensives, antipsychotics, antidepressants, anticoagulants, blood glucose levels etc.	Education to be provided by Medical Pharmacy.	100% of staff will receive this education.	100% of staff will be educated by December 31, 2017	
	Percentage of residents who were physically restrained every day during the 7 days preceding their resident assessment	% / LTC home residents	CIHI CCRS / July - September 2016	51897*	3.15	3.10	Working towards the provincial average to reduce the percentage of residents who were physically restrained everyday during the 7 days preceding their quarterly resident assessment.	1)Ensure all residents who currently are using restraints have the appropriate documentation completed routinely.	Audit resident charts for those currently using restraints to identify any gaps in process for use of a restraint. Those identified with gaps will have a restraint alternative review completed and ensure that all the right consents have been obtained, it is reflected in the quarterly med review and that the care plan is reflective of current use.	All residents who use a restraint will have a complete process review for the appropriate documentation.	All residents who use restraints will be clearly identified and reviewed on a quarterly basis with all the appropriate documentation in place and up to date.	
								2)Education to all Registered staff on restraint use process.	Registered staff will have Policy review and education on the process of restraint use and ongoing review of that use. This will include assessments, consents, orders, restraint alternatives and care plan/POC documentation.	100% of Registered staff will receive education on the process of use for a restraint.	100% of Registered staff will have received the education by June 30, 2017	
								3)Education to all PSW staff on the difference between a restraint vs a PASD as per policy.	Education to be provided by the falls lead.	100% of all PSW's will receive the education.	100% of all PSW's will be educated by December 31, 2017	