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

Yee Hong Centre - Mississauga 5510 MAVIS ROAD

AIM		Measure									Change				
Issue	Quality dimension	Measure/Indicator	Type	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	External Collaborators	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
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 are working on)															
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	1669*	17.48	17.48	Performing well for the complex resident population. Would like to maintain the performance	Mississauga Halton Local Health Integration Network, Mississauga LHIN Rapid response team NP	1)Identify most common reasons for referral to ED	Collect 2018 ED transfers data and analysis for referral reasons grouped by diagnosis, referral time of a day & days of a week. This is to identify any educational needs of the staff in reducing potential avoidable ED visits.	Most common reasons for referrals to ED. (The data for the days and hours of sending residents to ED will serve as supplementary information for reducing avoidable ED visits)	Identify top 5 reasons for avoidable ED visits by June 2019	
											2)Increase utilization of Nurse Practitioner (NP) STAT consultation at the time of resident condition changes to provide timely	Nursing staff to consult NP at resident condition changes for proactive treatment	Total # of NP consultation per quarter for residents who with a potential conditions for ED transfer	Increase NP consultation by 20% for resident who has an ED transfer by	
											3)Discuss advance care planning with residents (cognitively competent) and goals of care with SDM for cognitively incompetent	Inter-professional staff to discuss advanced care planning/goals of care with residents/SDM on admission, at annual care conference, at significant change of conditions and at palliative care team meeting	# of care conference that includes advance care planning/goals of care discussion for the residents	100% of the care conference to include advance care planning/goals of	
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	1669*	100	100.00	Continue to maintain current performance		1)Continue with current practice	Continue with current practice	% complaints acknowledged within 10 business days	100% of complaints to be acknowledged in 10 business days	
		Percentage of residents responding positively to: "What number would you use to rate how well the staff listen to you?"	P	% / LTC home residents	In house data, NHCAHPS survey / April 2018 - March 2019	1669*	33.33	36.67	Since the measure is only focusing on answers 9 and 10, we have decided to focus on a minimum target of 10% increase		1)Identify root causes	Survey results to be shared at Resident council for feedback and suggestion for improvement	# of feedback received from Residents Council	Results shared and feedback obtained: Achieved November 2018	
											2)Enhance Communication within the inter-profession team and residents	Develop Communication board with common simple Chinese (Cantonese and Mandarin) words for daily care routine	Number of nursing units with a communication board for Mandarin and Cantonese	100% nursing units to have communication board	
											3)Enhance Communication within the inter-profession team and residents	Have communication board available (IPad) at the nursing station for non-Chinese staff to use	IPad's to have common Mandarin and Cantonese Chinese words for daily care routine	100% IPads to have common Chinese words for daily routine by March 2019	
											4)Enhance Communication within the inter-profession team and residents	Develop video presentation onto the IPad for PSWs to learn common Mandarin and Cantonese words for daily care routines and communicate with residents	IPad's to have common Mandarin and Cantonese Chinese words for daily care routine	100% IPads to have common Chinese words for daily routine by March 2019	
											5)Enhance Communication within the inter-profession team and residents	Assign at least one Chinese speaking PSW per unit if possible	Ensure at least one Chinese speaking PSW per nursing unit when RN/RPN do weekly PSW assignment	100% shifts to have at least one Chinese speaking PSW by March 2019	
											6)Enhance Communication within the inter-profession team and residents	Train PSW staff in Excellence in Resident-Centered Care (ERCC)	# of PSWs staff attend the ERCC training	40% PSW staff to attend the one day ERCC training by Apr, 2019	
											7)Enhance Communication within the inter-profession team and residents	Managers and inter-professional team members to meet with residents on each floor to hear residents' feedback and concerns.	Number of meetings held with residents by the end of December 2019	At least4 meetings to be held with residents by December 2019	
											8)Involve residents in the plan of care	Involve residents who are competent and are able to participate in their plan of care discussion. Assist the resident to identify their needs and preferences	Number of progress note documentation indicate care plan review/discussion with residents	100% of capable residents to participate in their plan of care by December 2019	
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	1669*	CB	90.00	This is a new indicator. However, current performance is close to the absolute target	Acclaim Health: Palliative care consultant, Mississauga Halton Local Health Integration Network: Palliative care consultant, Mississauga Halton Local Health Integration Network: Rapid response NP	1)Talk with residents, or Substitute Decision Makers if incapable, about their illnesses, prognosis, and goals of care and treatment	Define "in need of palliative care"(using PPS 30 or below) then identify residents according to the definition Create a tracking tool by Clinical Improvement Nurse to keep record of residents identified in 6 months according to PPS scores and	Tracking tool to be designed by CI nurse by March 31, 2019 , track percentage of assessments for residents with PSS 30 or less than 30	100% compliance by December 31 2019	
											2)Talk with residents, or Substitute Decision Makers if incapable, about their illnesses, prognosis, and goals of care and treatment	Discussion of illness, prognosis, goals of care and treatment options for resident's PPS is 30 or less than 30 then documented using Comfort round template or Palliative/Comfort care/symptom management	Number of discussion has been held for residents' PPS is 30 or less than 30	100% of compliance by December 21 2019	
											3)Provide support and education to residents, family members, SDMs and caregivers on Palliative care	Ensure educational resources and tools about palliative care are available for residents, family members, SDMs, and caregivers.	Number of distinct resources available	Achieve 100% compliance	
											4)Provide support and education to residents, family members, SDMs and caregivers on Palliative care	Provide education on palliative care and end of life at resident council and family council	Number of Palliative Care education provided to residents, SDMs and Caregivers	At least 2 Palliative Care education to be provided by December 31, 2019	

											5)Increase assessment skills of nursing staff (RN/RPN) on early identification of palliative care	Provide education for nurses regarding early identification of the need for a palliative approach to care	Percentage of nurses who attend training	At least 80% of nurses to be trained by December 31, 2019	
											6)Increase assessment skills of nursing staff (RN/RPN) on early identification of palliative care	Train RN/RPN in facilitating conversations around illnesses, goals of care and treatment options by MH Palliative Care network or Palliative care consult	Percentage of nurses who attend training	At least 80% of nurses to be trained by December 31, 2019	
											7)Implement fall prevention on repeated falls.	• On a monthly basis, nurse managers to send emails updating staff and inter-professional team of the frequent fallers (residents who fall two times or more in a month) those are on the "falling star" program. A 'star' sticker to be placed on the residents' mobility	Number of fall incidents occurred during the identified time frame every month/quarterly	20% reduction in fall incidents during the identified timeframe by	
											8)Implement fall prevention on repeated falls.	Conduct fall prevention safety rounds at specific time frame for frequent fallers or residents at high risk of falls as per care pla During safety rounds, PSWs use the 4Ps (Pain, Positioning, Placement and Personal Needs) approach on these residents at the time frame when	Number of falls prevention safety rounds for frequent fallers	20% reduction in fall incidents during the identified timeframe by	
											9)Implement fall prevention related to responsive behavioral management	BSO lead to join the Fall Prevention inter-professional meeting monthly Clinical Improvement nurse will closely work with BSO Lead and BSO Lead Assistance on fall prevent strategies related to responsive behavior Use of technology if appropriate such as	Number of fall incidents related to responsive behavior	10% reduction in fall incidents related to responsive behavioral by	
	Safe	% residents who had a recent fall (in the last 30 days)	C	Rate per 100 residents / Residents	CIHI eReporting Tool / Quarter	1669*	7.9	7.60	An achievable target based on current performance	Mississauga Halton Local Health Integration Network: Palliative care, pain and symptom management	1)Conduct root cause analysis in post fall huddles	Nurses use the "post-fall team meeting "progress note template to document the discussion outcomes after each meeting	Percentage of post fall huddles completed every quarter	Post fall huddles for each quarter to be 100%. Compliance by December 31	
											2)Conduct root cause analysis in post fall huddles	Inter-professional team members (activation worker, social worker, PT, and OT) attend floor	Percentage of post fall huddles completed every quarter	Post fall huddles for each quarter to be 100%. Compliance by December 31,	
											3)Analyze fall data to identify pattern/trend of falls and also repeated falls	Prepare and review report on repeated fallers monthly and quarterly	Number of fall incidents caused by repeated falls	20% reduction of fall incidents caused by	
											4)Analyze fall data to identify pattern/trend of falls and also repeated falls	Identify trend and pattern from the fall data	Number of fall incidents caused by repeated falls	20% reduction of fall incidents caused by repeated fallers	
											5)Analyze fall data to identify pattern/trend of falls and also repeated falls	Leverage Clinical Improvement nurse to conduct in-depth case review for frequent fallers	Number of fall incidents caused by repeated falls	20% reduction of fall incidents caused by repeated fallers	
		% residents who has a pressure ulcer that has become worse recently	C	Rate per 100 / Residents	CIHI eReporting Tool / Quarter	1669*	1.8	1.60	An achievable target based on current performance.	Mississauga Halton Local Health Integration Network NP/LHIN wound care specialist or ET service from LHIN, Cardinal health ET services	1)Promote residents' skin integrity	Identify residents who are at high risk for impaired skin integrity during admission/re-admission/significant change Daily monitoring/identify resident who is at high risk of impaired skin integrity	Number of resident who is at high risk for home acquired pressure ulcer has been discussed at the floor meeting	100% high risk residents case discussion at floor meeting by December 31 2019	
											2)Promote residents' skin integrity	Implement preventative measures such as turning and reposition, therapeutic mattress, heel protector etc.	According to Pressure Sore Risk Assessment – Braden Scale during admission, re-admission or when there is a significant change in condition	100% high risk residents case discussion at floor meeting by December 31 2019	
											3)Promote residents' skin integrity	Residents with high risk for pressure ulcers are discussed at floor meeting weekly	According to Pressure Sore Risk Assessment – Braden Scale during admission, re-admission or when there is a significant change in condition	100% high risk residents case discussion at floor meeting by December 31 2019	
											4)Managing Impaired skin integrity at early stage	• Identify root causes for home acquired ulcers or when resident has a pressure ulcer that has gotten worse • Leverage Clinical Improvement nurse to conduct in-depth case review • Make timely referral to internal wound care champions/Clinical Improvement	• Decrease number of home acquired pressure ulcer	20% reduction of home acquired pressure ulcer during the identified	
											5)Enhance communication within the inter-professional via monthly inter-professional team meeting	Inter-professional team members (nurses, activation, pharmacist, dietitian, PT, and OT) meet monthly to discuss each case. Share the preventative measures at the floor meeting by Clinical Improvement nurse or ADRC	Number of case home acquired pressure ulcer and those with worsened pressure ulcer reviewed and shared with staff at floor meetings	100% compliance by December 31, 2019	
											6)Provide the education to RN/RPN /PSW on wound care Management annually and as needed	Education session on wound care products will be provided to RN/RPN through ET/clinical educator from Cardinal Health	Number of wound care product education session provided to RN/RPNs	At least 4 education sessions to be provided to nursing staff by Dec 2019	
											7)Provide the education to RN/RPN /PSW on wound care Management annually and as needed	Education session provided to PSWs on wound care/pressure ulcer provided by Clinical Improve nurse	Number of wound care education session provided to PSWs	At least 4 education sessions to be provided to nursing staff by Dec 2019	