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

Bayhaven Nursing Home 499 HUME STREET

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	51831*	8.11	8.11	Maintain current performance which is significantly below provincial average of 23.6 per 100 LTC home residents (CIHI)	1)Bay Haven will monitor and maintain current performance	Bay Haven will monitor and maintain current performance	Number of visits per 100 LTC home residents (CIHI)	Number of visits per 100 LTC home residents (CIHI)	Bay Haven has demonstrated sustainable change in this area which has resulted in one of the lowest rates for Avoidable ED visits in the North Simcoe Muskoka LHIN
Patient-centred	**Person experience**	Percentage of residents responding positively to: "What number would you use to rate how well the staff listen to you?"	% / LTC home residents	In house data, NHCAHPS survey / April 2016 - March 2017	51831*	80	88.00	10 % improvement over current performance. (Bay Haven Resident Satisfaction Survey 2017)	1)Review and revise the Resident Satisfaction Survey to ensure it will capture the resident experience and identified indicator questions	1) Resident Satisfaction Survey will be revised by the CQI team to capture relevant feedback related to resident experience. 2) Revised survey will be presented to Residents' Council in April 2017 for feedback and approval. 3) Surveys will be sent out May 2017. 4) The results will be tabulated by the Quality Assurance Coordinator and presented to the Continuous Quality Improvement Committee by no later than July 31, 2017. 5) Immediate corrective actions will be completed within 4 weeks; themes will be identified	Percentage of residents who respond top 2 box (very good or excellent) to the question "how well do staff listen to you?"	88 % of residents will respond top 2 box to the question "how well do staff listen to you?"	Bay Haven's Strategic Direction provides a strong emphasis on both Residents' Rights and the Resident Experience
									2)Review and develop opportunities to enhance resident and family education about "Resident Experience". This will support improvement in all person experience indicators	1) Explore opportunities to develop brochures, posters, flyers to provide education to both residents and family members about resident experience. 2) Include a user friendly process to allow residents/families to provide feedback about processes at Bay Haven in the absence of a Family Council i.e) suggestion box	Education will be developed and communicated by December 31, 2017	Education will be developed and communicated by December 31, 2017	Bay Haven has struggled to implement a Family Council despite a fulsome recruitment process. Feedback from families suggests that because Bay Haven is a small home, they know who to speak with if there are any concerns or issues, therefore a structured committee has not been required
									3)Review and develop staff education to increase understanding of the "Resident Experience." This will support improvement in all person experience indicators	1) Quality Assurance Coordinator will review Resident Experience resources to identify learning materials which will be relevant for the Bay Haven population 2) Resources will be developed into a learning package for Bay Haven staff 3) Feedback on the learning package will be obtained from the Continuous Quality Improvement team, a minimum of 3 residents and 3 families to ensure the education will satisfy the direction to improve the resident experience 4) Staff education will be provided through scripted huddles provided by Department Managers and possibly Surge Learning	Percentage of staff receiving education on Resident Experience by December 31, 2017	100% of full time and part time staff will receive education on the Resident Experience by December 31, 2017	
		Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences".	% / LTC home residents	In house data, interRAI survey / April 2016 - March 2017	51831*	87	95.70	10% improvement over current performance (Bay Haven Resident Satisfaction Survey 2017)	1)Identify themes and opportunities for improvement based on the Resident Satisfaction Survey results. This will be included in the overall plan to improve the Resident experience	1) The Quality Assurance Coordinator will interview residents and/or family members who scored less than top 2 box on the annual or admission Resident Satisfaction Survey 2) Themes will be identified from both the survey and interviews to identify opportunities for improvement	Number of residents who score top 2 box to the statement: "I can express my opinion without fear of consequences"	95.7% of residents surveyed will respond top 2 box to the statement: "I can express my opinion without fear of consequences"	
									2)Review process for managing complaints; identify themes from complaints; staff education re: complaint procedure	Develop standardized process for managing and tracking complaints to assist in early identification of trends	Number of complaints managed following standardized process	100% of complaints will be managed and tracked following a standardized process by November 30, 2017	
	Resident experience: "Overall satisfaction"	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	In house data, InterRAI survey, NHCAHPS survey / April 2016 - March 2017	51831*	94	99.90	Stretch target to meet standard of excellence (Bay Haven Resident Satisfaction Survey 2017)	1)Obtain real time resident and family feedback through "pulse check" surveys, to improve the overall resident experience	) CQI team to develop "pulse check" survey to identify opportunities to improve upon the resident experience. (3-5 questions) 2) Survey will be completed on minimum of 3 residents or family members per month 3) Identified concerns will be corrected by the appropriate Department Manager as required 4) Themes will be reviewed at monthly CQI meeting and opportunities for improvement will be discussed	Number of "pulse check" surveys completed and reviewed monthly	3 "pulse check" surveys will be completed and reviewed monthly; process to be fully implemented by December 31, 2017	
									2)Incorporate standardized, scripted questions into Annual Care Conference to identify opportunities for improvement in the Resident Experience	1) Review current Annual Care Conference format 2) Incorporate minimum of 5 "resident experience" questions into Care Conference template 3) Quarterly audits of process 4) Themes will be discussed at CQI	Number of Annual Care Conferences following standardized, scripted resident experience questions	80% of Annual Care Conferences will incorporate resident experience questions by September 2017	Target of 80% selected as not all families are able to attend the Annual Care Conference
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	51831*	18.63	18.63	Monitor and maintain or improve level which is below provincial average of 21.2% (CIHI)	1)Bay Haven will continue to monitor and maintain at or below our current level	Bay Haven will continue to monitor and maintain at or below our current level	Per CIHI data	Per CIHI data	Bay Haven will continue to monitor and maintain or improve our performance in this area. After review of the residents currently receiving antipsychotics, it was identified that there would be limited opportunity for improvement with this target. The focus will be directed to preventing future unneccessary antipsychotic prescription
	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	51831*	4.93	4.43	10 % improvement over current performance (CIHI-unadjusted rate)	1)Standardize the shift report process to ensure consistent communication to all team members regarding pressure ulcer risk and interventions; PDSA new report tool	1) Develop Shift Report tool to provide consistency in communicating resident care needs. Staff feedback will be obtained throughout the development process 2) PDSA new Shift report tool with full implementation by September 30, 2017	Percent of shift reports utilizing new report tool by September 30th, 2017	100 % of shift reports will utilize new report tool by September 30th, 2017	
									2)Standardized wound care rounds	Develop standardized process for discussing wound issues; include development of auditing tool	% of wounds reviewed following standardized process	100% of wounds will be reviewed following a standardized approach by December 31, 2017	
									3)Complete gap analysis of Skin and Wound Care Program to identify opportunities for improvement	1) Gap analysis completion with Clinical Nurse Manager, Wound care leads, Director of Nursing	Gap analysis completion by August 31, 2017	Gap analysis completion by August 31, 2017	
		Percentage of residents who fell during the 30 days preceding their resident assessment	% / LTC home residents	CIHI CCRS / July - September 2016	51831*	12.93	12.93	Maintain or improve upon current performance which is below the provincial average of 15% (CIHI-unadjusted rate)	1)Revise current process of analyzing falls and fall trends	1) Revise Falls Analysis tool incorporating best practice guidelines into new tool. PDSA revised tool and plan for full implementation by December 31, 2017	Percentage of falls analysed using evidence base tool by December 31, 2017	100 % of falls will be analysed using evidence base tool by December 31, 2017	
									2)Standardize the post fall investigation process for Registered Staff to ensure consistency in assessments	Develop post fall investigation tool to provide standardized approach to post fall assessments, referrals process and communication process	Percentage of falls investigated following standardized approach by December 31, 2017	100% of falls will be investigated following standardized approach by December 31, 2017	
									3)Standardize the shift report process to ensure consistent communication to all team members regarding fall risk and interventions.	1) Develop Shift Report tool to provide consistency in communicating resident care needs. Staff feedback will be obtained throughout the development process 2) PDSA new Shift report tool with full implementation by September 30, 2017	Percent of shift reports utilizing new report tool by September 30, 2017	100% of shift reports will utilize new report tool by September 30, 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	51831*	3.02	3.02	Maintain current performance which meets the Provincial benchmark of 3 % and exceeds the provincial average of 5.6%	1)Bay Haven will continue to monitor and maintain at or below our current level	Bay Haven will continue to monitor and maintain at or below our current level	Percentage of residents who were physically restrained every day during the 7 days preceding their resident assessment	Per CIHI data	Bay Haven will continue to monitor and maintain at or below our current performance level