Quality Improvement Plan (QIP)

Narrative for Health Care Organizations in Ontario

March 11, 2024

Ontario Health

OVERVIEW

Watford Quality Care Centre is a small older 63 bed Long Term Care Home in rural Ontario. Because of our small size it is important to remember this when reviewing any statistic as it takes less residents to contribute to a percentage then in a larger home. The objectives of our QIP for the following year are to enhance resident care and outcomes. These include pressure ulcers, falls, pain management, antipsychotic medications use, resident satisfaction and Suicidal Ideations.

• The QIP aligns with other planning processes at Watford Quality Care Centre (WQCC). This includes the strategic plan and an operational plan with goal setting for the Service Accountability Agreements with the LHIN is addressed through meeting, corporate direction and community partners. WQCC is an accredited organization through CARF and we were accredited in March 2022, receiving an exceptional report. We utilize the accreditation standards and required organizational practices to evaluate and continuously improve upon the care we provide.

• Our quality improvement plan is a reflection of the quality indicators selected provincially and also includes quality improvement priorities identified corporately.
QI Achievements From the Past Year
Watford Quality Care participated in the CARF accreditation process and achieved 100% of over 1250 standards reviewed during the survey.

Watford Quality Care Centre is also a Certified Best Practice Spotlight Organization (BPSO) by the Registered Nurses Association of Ontario and we achieved this high honor during the three years

of the Covid 19 Pandemic.

Our primary focus for the 3 year Certification with the BPSO was Pain control, Diabetic Ulcers and Customer Satisfaction.

Now that the home has obtain this Certificate we will continue to improve Practices and this years highlight is Suicidal Ideation. We are the first home to use this practice as our Spotlight

We continued to achieve 0% of residents with restraints. We have processes in place for many years that help to keep us in this range. These processes include education to the families, residents and staff.

We have upgraded our survey to the residents and families to include the questions that the QIP wants to look at. The results were very satisfying as we did achieve greater than 87% in satisfaction.

This year we have hired a Part time social Worker that comes into the home twice weekly to support resident s. Families and the staff.

Integration and Continuity of Care

• Our home strives to create strong connections with our community partners including the LHINS to determine quality initiatives required to enhance resident care. In addition we partner with BSO and Alzheimer society, Geriatric outreach and the Palliative care network to further improve care needs of our residents.

• Attendance and participation at a variety of local meetings including: Infection Control (SLICC), Activity Directors and LTC Operators Group and The Administrators of Lambton County. This allows our team to stay current in the field as well as the needs in the community. We collaborate with other professionals giving us the opportunity to advocate for seniors in our community.

Engagement of Clinicians, Leadership & Staff

• Our leadership is engage in the community as well as the internal systems. Our Medical Director, Pharmacy and Social Worker also sit on our Professional Advisory Committee where we review the CIHI data results of our home.

• Annually we hold a strategic planning session to review goals and objectives and set the strategic direction for the home. In preparation for the session we conduct a number of surveys that include; staff, residents and families. This information assists the team in developing areas of strength and weakness.

• Our leaders are the link between quality improvements, resident and front line staff. In addition, a resident and family council members are active and engaged in our quality improvement process.

• We strive to be leaders in the development of Best Practices by supporting the pursuit of continuing education of our team, families, residents, volunteers and community.

Resident, Patient, Client Engagement

• We encourage participation in quality programs. A report on the progress of QIP is given to the Residents council and Family council

at least annually and in the Newsletters as projects are completed.

• We regularly engage our residents and families through resident council and family council meetings.

• We respond promptly to all family and resident concerns or questions.

• We believe in an optimal level of care which recognizes and attempts to meet the physical, emotional, intellectual and spiritual needs of each individual and their families. We promote the individuality of each resident by recognizing their need for individual worth and dignity.

REFLECTIONS SINCE YOUR LAST QIP SUBMISSION

The last three years have been the most challenging years here at Watford Quality Care Centre. We had to overcome many obstacles that were put in our way during the Covid-19 Pandemic. It has been very difficult for our residents, families and staff, our home had to work in a new innovative way to over come all of these diverse issues. Too look at the positive the Pandemic opened up new possibilities for engagement. Our home was on and off lock downs which meant we had to operate in a new capacity. We introduced virtual visits through Zoom and Facebook. We had families visit through the residents bedroom windows and we played tic tac toe on those windows for interaction between residents and loved ones. Entertainment would play outside so our residents could still enjoy music. We started the WQCC Facebook page in hopes that families and loved ones could see how much our residents were still being engaged in thoughtful activities and this page became a portal for families to see that there still was joy in the home.

Of course we had many hurdles to over come. We struggled with staffing, receiving supplies, Covid 19 outbreaks and the biggest hurdle that we overcame was the mental health of our residents. Our focus thought this entire process was the safety for all, our residents, staff and families.

Our main Quality Improvement Plan focused on Infection Control. We implemented the following measure and continue our efforts on:

1) Implemented a fully trained Full Time Registered Nurse to provide the home with a comprehensive Infection Prevention and Control Program.

2) Implemented staff designated to perform daily active screening and monitoring of visitors to make sure they had all of the requirements needed to safely visit residents.

3) Purchased the Accushield Machine and Program that monitored visitors screening and vaccines.

4) Ensuring that PPE was always readily available and stocked for at least three weeks in case of Outbreak

5) Daily Infection Control Audits completed on Hand Hygiene, Proper Donning and Doffing of PPE and routine audits of the cleaning that was performed by the housekeeping staff.

6) Public Health and Bluewater health performed monthly I.C

audits.

7) Mass emails implemented for Staff and Power of Attorneys to have seamless communication of any challenges or updates from the Ministry of Health regarding restrictions and Covid 19 Pandemic

8) Consistent collaboration between Public Health, Ministry of Health and IPAC hubs

9) New innovations with staffing that promoted safety and support.

PATIENT/CLIENT/RESIDENT ENGAGEMENT AND PARTNERING

As the home continues its recovery from the COVID-19 pandemic, patients, residents and families have helped identify priority initiatives needed in the home. Our Resident and Family Council struggles with members due to the low acuity of our residents and the lack of family members wanting to join the council. We are consistently trying to recruit new members though advertisement both online and within the home.

The home continues to have an active Family and Resident council that meets on a regular basis to review and develop Policies and programs. They also talk about upcoming events and news that the home is involved with and will recommend any improvements or initiatives that could enhance the care.

At this time we are trying to relaunch our volunteer program as the home recovers from the COVID-19 pandemic. Our Residents benefit from regular participation from our volunteer community but since the Pandemic many volunteers have not returned. We are actively advertising for the need of volunteers and once we have new applicants they will receive formal training and orientation.

We continue to communicate with families via email and keep them up to date on all relative news and changes with in the home.

We actively utilize information from the critical incident reporting and MLTC inspections. Results are discussed at CQI and utilized to guide the development of the goals and objectives for quality improvement. Incidents and inspection results are also shared at Resident Council and input is sought. Minutes document this and are in turn shared at the CQI meetings.

Resident satisfactory surveys have been initiated yearly and overall satisfaction is over 87% among our residents and their families.

PROVIDER EXPERIENCE

The Covid Pandemic has greatly impacted all of our staff both physically and mentally. We have had to come up with inventive ways to keep staff healthy, happy and engaged.

We introduced the Staff Wellness Room that consisted of essential oils, message chair, foot message, snack and headphones with soothing music. Staff were taking breaks and lunch in this room and on occasion would ask to leave the floor for a brief moment of piece.

Verbiage was posted around the home to help support the staff with contacts for Social Services, Therapy and Suicide Prevention.

Management accommodated staff work schedules to support work/life balance. This did help to reduce the amount of staff going off for mental health leaves due to burn out.

Newly hired Social Worker to support staff when needed.

Hired many agency staff to fill in wherever we had staff void so the staff did not work too short or too often.

The entire staff were gifted team shirts that stated " tough times don't last. Tough teams do. FRONTLINE WARRIORS on the front and WE FIGHT AS ONE on the back.

Management handed out many gifts with inspirational words on them, pampered kits for the staff to take home that consisted of bath bombs and soap. Lots of food to help them get through their days with some sweets!

We had 2 Carnivals for both staff and residents throughout the Pandemic that included, fry truck, ice cream truck, cotton candy, horse carriage rides an live music.

Each month we did 50/50 draws that was initiated and ran by the staff.

CONTACT INFORMATION/DESIGNATED LEAD

Designated Leads for the Quality Improvement are:

Tanya McGill Administrator tmcgill@watfordqualitycarecentre.ca
Olivia Wallis Director of Nursing owallis@watfordqualitycare.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 on **April 11, 2023**

Gary Westgarth, Board Chair / Licensee or delegate

Tanya McGill, Administrator /Executive Director

Olivia Wallis, Quality Committee Chair or delegate

Other leadership as appropriate

Access and Flow

Measure - Dimension: Efficient

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Rate 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 / Oct 2021 - Sep 2022	16.95	16.00	Newly graduated RNs plus two new Physicians	

Change Ideas

Change Idea #1 Hire a Nurse Practitioner

Methods	Process measures	Target for process measure	Comments
Continue to recruit for a Part Time NP	Number of Interviews with NP per Month	One part time NP was contracted from an Agency during Pandemic and no longer is employed. Trying to continue to recruit, no interest as of yet.	

Change Idea #2 SBAR use prior to all potential ED visits

Methods	Process measures	Target for process measure	Comments
Education provided on the effective use of the SBAR and mandatory use prior to any ED visits	# of SBAR used prior to ED visit	SBAR was not used prior to ED visits during the Pandemic. This decrease in use is the explanation for our increase in percentage. SBAR is now reintroduced.	

Change Idea #3 Registered staff receive training and education on managing potentially preventable conditions.

Methods	Process measures	Target for process measure	Comments
Nurse Practitioner/Pharmacist/Physician provide Education to staff	# of Registered Staff # of training sessions #of registered staff attending training	100% of registered staff attending sessions taught by the Physician during their visit on Doctor day.	

Change Idea #4 Monitor the reasons the residents are transferred to ED

Methods	Process measures	Target for process measure	Comments
RAI Coordinator to monitor why the resident was transferred to ED. PAC committee to review the data to determine if there are ways they could have been prevented.	# of residents sent to the ED # of residents returned to the home #of residents admitted #of residents with COPD or/and CHF #of residents returned to ED and returned with infections DX (pneumonia, UTI diagnosis)	100% of residents that have been sent to the ED have been reviewed fo cause of transfer with Physician and staff.	

Experience

Measure - Dimension: Patient-centred

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
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 / Apr 2022 - Mar 2023	CB	CB	Our home survey is rated in percentage. 89% is hat our residents rate how well the staff listen. Our target is 90%	

Change Ideas

Change Idea #1 Residents are given an opportunity to complete a survey to answer this QIP question

Methods	Process measures	Target for process measure	Comments
Summer student or delegate facilitates the resident surveys	# of residents # of residents who completed the survey.	36% completion of the survey. The number is low due to our low acuity of population. Rating 3.41 out of 5.	

Change Idea #2 All staff to receive training on Customer Service

Methods	Process measures	Target for process measure	Comments
A module on Customer Service is posted in the training for both orientation and annual training	# of staff # of new staff # of staff completing annual training # of new staff completing training	100% of staff completed the Customer Service training module	

Change Idea #3 BPSO initiated new report sheet that is personalized to each resident for better resident centered care

Methods	Process measures	Target for process measure	Comments
Report sheet for al nursing staff is posted for each wing in the home on each shift and include pertinent information about each resident. pain, behavior, incontinence, nutrition ect. BPSO team and RN updates this report sheet as needed.	Resident Survey satisfaction outcome.	Improved person centered care. Resident survey reveals over 88% satisfaction	

Measure - Dimension: Patient-centred

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences".	P	% / LTC home residents	In house data, interRAI survey / Apr 2022 - Mar 2023	CB	CB	How home surveys in percentage. our outcome was 88.24% of the residents Can express their opinion without fear. Our target is 90%	

Change Ideas

Change Idea #1 Every resident shall have the opportunity to complete a resident survey on Surge annually asking this QIP question

Methods	Process measures	Target for process measure	Comments
Activities summer student or delegate facilitates the completion of Resident surveys.	# of residents # of residents who have completed the survey.	36% of residents completed this survey	

Change Idea #2 All staff to review the policy of Whistle Blower Annually

Methods	Process measures	Target for process measure	Comments
The Whistle Blower policy is posted in the training modules for orientation and annual Mandatory Education on Surge	# of staff # of staff completing mandatory training # of staff completing orientation training	100% of staff have completed the training for the Whistle Blower policy	

Safety

Measure - Dimension: Safe

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment	P	% / LTC home residents	CIHI CCRS / Jul - Sept 2022	29.88	20.00	Provincial benchmark is 17%	

Change Ideas

Change Idea #1 Review of current residents taking antipsychotic medications and determine if they are appropriate or if they can be discontinued.

Methods	Process measures	Target for process measure	Comments
review the diagnosis and the charts for the reason why they are taking the medications. Provide education pamphlets on the use of antipsychotics to families who have any concerns regarding changing the residents medications	# of residents on antipsychotics that do not have a diagnosis of psychosis or schizophrenia	10% of residents on antipsychotics that do not have proper diagnosis. Improvement noted with new Physicians making sure diagnosis are capture in PCC	

Change Idea #2 Ensuring accurate documentation regarding the use antipsychotic medication in the elderly

Methods	Process measures	Target for process measure	Comments
reviewing RAI data to ensure that residents with hallucinations or delusions are documented accurately on the RAI assessment	# of residents on antipsychotic medications #of resident who experience hallucination/delusions/ # of residents that have hallucinations/delusions that are not documented in the RAI	92% of resident who have hallucination/delusions are documented on the RAI Quarterly	

Change Idea #3 Education provided to staff on Dementia Care and Responsive Behaviors

Methods	Process measures	Target for process measure	Comments
Provided education modules on the proper way to respond to residents with dementia for the staffs orientation and mandatory education on Surge Learning.	# of staff # of staff who completed the training	100% of the staff completed the assigned training.	