2018/19 Quality Improvement Plan
"Improvement Targets and Initiatives" Bethammi Nursing Home

St. Joseph's Care Group 35 North Algoma Street Box 3251

AIM		Measure								Change				
Quality dimension	Issue	Measure/Indicator	Type	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.	P	Rate per 100 residents / LTC home residents	CIHI CCRS, CIHI NACRS / October 2016 - September 2017	Bethammi	23	21	Decrease visits by 10% based on current improvement trend. Performance below Ontario average 24	1)Continue to review emergency department transfer data to identify trends and understand reasons for transfers.	Long term care home clerk will maintain list of emergency department transfers including reason for transfer. The list will be reviewed monthly at the Quality, Safety, Risk Committee.	Percent of emergency department transfers reviewed each month.	100%	This change idea is a continuation from 2017-18.
										2)Utilize Situation, Background, Assessment, Recommendation (SBAR) Communication methodology to assist with early identification of change in resident's condition.	Registered staff utilize SBAR when communicating with physician to determine whether resident should be transferred to emergency department. Transfers reviewed monthly at the Quality, Safety, Risk Committee.	Percentage of transfers that were appropriate each month.	90%	
										3)Provide education to registered staff.	Physician and Nurse Practitioner will provide education to staff related to services available to prevent an emergency department transfer and provide education to enhance registered staff clinical skills to manage potential avoidable conditions in the home.	Percentage of registered staff receiving training.	100%	This change idea is a continuation from 2017-18.
	Resident experience: "Overall satisfaction"	"How would you rate the overall quality of care you (or your family member) have received?" Good and Excellent	C	% / Survey respondents	In house data collection / 2017	Bethammi	75.7	79.5	Increase current performance by 5% 2016 results = 78%	1)Improve satisfaction survey methodology.	Administrator and research staff bring existing survey and methodology to Resident and Family Council for input.	Satisfaction survey and process updated.	June 2018	
										2)Improve quality of care and safety.	Utilizing information received from Resident & Family Council, critical incidents, complaints & concerns and compliance to improve quality of care and safety processes. This work will be led by the Administrator.	Percentage of staff re-educated and trained on new processes.	100%	
Safe	Medication safety	Percentage of residents who were given antipsychotic medication without psychosis in the 7 days preceding their resident assessment	P	% / LTC home residents	CIHI CCRS / July - September 2017	Bethammi	14	14	Target based on maintaining current performance as below Ontario average of 20%.	1) Review all residents prescribed antipsychotic medication with currently no symptoms of delusions and hallucinations documented.	Develop a report to capture residents prescribed antipsychotic medication with no symptoms of delusions and hallucinations documented. The Pharmacist and Physician will review report on quarterly basis. Monitored by Quality, Safety, Risk Committee.	Percentage of residents receiving a review who were prescribed antipsychotic medication with currently no symptoms of delusions and hallucinations.	100%	This priority also supports reducing resident falls as there is a link with antipsychotic medication use and falls

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	Safe care	Percentage of residents who were physically restrained every day during the 7 days preceding their resident assessment	A	% / LTC home residents	CIHI CCRS / July - September 2017	Bethammi	16.3	10	Reduce by 39%. This is an interim target to move towards Ontario average of 4.8%	1)Regular review of restraint use.	An interdisciplinary restraint team will be developed to review and reduce restraint use. Registered staff will review restraint use on a monthly basis.	Percentage of residents with restraint reviewed.	100%	This change idea is a continuation from 2017-18.
										2)Provide information for residents and families around the risks of restraint use.	Include restraint use information as part of admission and annual care conference process.	Percentage of care conferences where restraint information is provided	100%	This change idea is a continuation from 2017-18.
	Workplace Violence	Number of workplace violence incidents reported by long-term care home workers (as defined by OHSA) within 12 month period.	C	Count / Worker	Local data collection / 2017	Bethammi	22	22	Target based on not exceeding current performance.	1)Communication to all program areas to schedule and complete an assessment of risks of violence for their area.	1) Workplace Violence Assessments will be scheduled and conducted within a 12 month period beginning Fall 2017 to identify the risk of violence. The assessments with be scheduled and facilitated by Occupational Safety Department, and a cross representation of each team will be present for the assessment.	Violence Risk assessments will be completed within 12 month period by March 31, 2019.	75%	FTE = 178
										2) Complete a Code White evaluation after each code white incident.	2) A code white evaluation to be completed by teams involved after each code white incident and submitted to Occupational Safety Department. Communication to managers and teams will be provided on the requirement to complete code white evaluation forms after each code white and submitted to Occupational Safety. A survey will be conducted of all departments to determine compliance.	Percentage of managers responding to Code White Audit Survey. Percentage of code white incidents with completed evaluation.	100%	

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Timely	**Timely Access**	Number of Days to fill bed from date of vacancy. Date of admission minus date bed is available.	C	Days / Residents Admitted	Strata Referrals-NW Homecare / July to Dec 2017	Bethammi	7	5	NW LHIN Target	1)Improve long-term care home bed vacancy process.	Within Strata Referral System, Resident engagement coordinator ensures that all bed vacancies are marked "available" and ensures all "pending" residents are accepted for bed matching.	Percentage of bed vacancies entered as available on date when available. This is monitored monthly by the Administrator.	100%	
										2)Establish process to meet with VP Home & Community Care to facilitate timely bed matching when bed available.	VP Seniors' Health and Administrator will meet with VP Home & Community Care.	Process established	April 2018	