Quality Improvement Plan (QIP)

Narrative for Health Care Organizations in Ontario

March 31, 2023

Grey County
Colour It Your Way

Ontario Health

OVERVIEW

The key objective for Lee Manor's 2023/24 Quality Improvement Plan is focused on “Colour It Your Way”, resident led care. We strive to meet or exceed the established benchmarks and provincial averages as identified by the long term care indicators.

The vision of Grey County is to be the place where people feel "genuinely at home and naturally inspired". The County's Corporate Strategic Plan outlines three key goals to guide the organization. Lee Manors Quality Improvement Plan uses these goals as guiding principles for ensuring quality care and service. Specifically, the Quality Improvement Plan aligns with goal number two – “Support Healthy and Connected Communities” and goal number three – “Deliver Excellence in Governance and Service” of the County of Grey Strategic Plan. The 2023/24 Quality Improvement Plan also aligns with our LTC Strategic plan to get the best, be our best and deliver the best which are embedded in our Mission, Vision and Values of the home.

By monitoring indicators, implementing action plans and evaluating outcomes, we ensure that resident quality of life and safety will be supported. Our culture of resident led care using the “Colour It Your Way" values and promise, continues to guide the quality improvement journey.

REFLECTIONS SINCE YOUR LAST QIP SUBMISSION

Grey County Long Term Care relied on our strong foundation of quality processes to face the ongoing challenges that came with the COVID 19 pandemic. Priority was focused on the health, safety and wellness of residents, staff and the community. Engagement and two way communication occurred with all stakeholders. The introduction of the New Fixing LTC Act along with Health Human Resource challenges required a focused investment in building foundational knowledge and skills of team members, family members and Designated Care Partners and residents. We will continue to expand our quality improvement program to incorporate programs initiated during this time. The importance of IPAC programs and plans were highlighted and will continue to play a leading role in our initiatives.

PATIENT/CLIENT/RESIDENT ENGAGEMENT AND PARTNERING

The Pandemic challenged our home to engage and partner with our Residents/Families with the use of virtual technology, newsletters, small groups, surveys etc.

Lee Manor has active Resident and Family Councils. Councils meet regularly where information is provided and received. The Councils are involved in providing feedback and input into the decision making process related to care and services within the care community. These meetings have continued in a hybrid format allowing in-person and virtual connections.

Resident Experience surveys are conducted annually and provide valuable information that guides the development of Quality Improvement Plans for the care community.

Family Experience Surveys are available annually for completion. These results are also considered in the preparation of the Quality Improvement Plan.

The valuable information received through these partnerships led to changes in our delivery of services. Their partnership and advocacy influenced and changed direction for a better lived experience.

A review and evaluation of complaints and concerns received in 2022 provides valuable information that guides the development of Quality Improvement Plans for the care community.

PROVIDER EXPERIENCE

For more than three years long-term care homes have faced immense challenges from the pandemic. Residents and team members of our homes continue to deal with isolation, fear and worry, and higher resident acuity. We are shifting our mindset from pandemic response to pandemic recovery whereby leaders and team members continue to be committed to providing compassionate and quality care. Long-term care homes continue to be centres of innovation, courage, and compassion to ensure the resident and family experience meets their expectations.

Grey County homes prioritized the health, safety, and wellness of not only our residents but for all of our team members. As we worked through the HHR challenges, we partnered with our local YMCA employment services, colleges and government in an effort to relief our staffing crises to provide meaningful career pathways to job seekers and current team members. This partnership recruited prepared, trained and employed more than 150 local individuals for roles in LTC across our region. We developed the Designated Care Partner program which continues to grow to support the residents and support to the team including in an outbreak situation. Policies, procedures, education, and benefits were enhanced to provide the necessary tools and knowledge to ensure the needs of our team members were met. Staffing contingency plans were continuously reviewed and updated. An Emergency Response Team was implemented to provide additional support in a staffing crisis.

In the spirit of our strategic goal of Being Our Best, the leadership teams from all three homes came together for a day of reflection and professional development. The focus of education was change management, building relationships and wellness.

The homes continue to provide equitable access for pandemic protection to staff, students, support workers, volunteers, and families, providing onsite testing and vaccinations. Onsite TB screening was also offered to support newly recruited staff. At many times staff members were offered flexibility to their schedules to support work life balance. Staff wellness was a focus and the homes regularly provided recognition events for their continued commitment to our Colour It Your Way philosophy.

Discussions and planning continue to develop and maintain a culture of wellness and recovery over the coming years.

WORKPLACE VIOLENCE PREVENTION

Lee Manor is committed to a safe work environment, risk assessments have been completed. The Workplace Violence and Harassment Prevention program and Respectful Workplace Statement have been reviewed and revised based on information gathered through the assessments. Education is provided annually to all staff with a commitment to the integration of safe behaviour into day to day operations and to ensure prompt response related to complaints in an objective and sensitive manner.

PATIENT SAFETY

The municipality and our homes prioritize a just culture through a high level of reporting on incidents with an emphasis on opportunities for improvement. Our Colour It promise includes Colouring it with Integrity, this is evident through our transparent communications and engagement of survey results, outbreaks, program reviews, critical incidents etc.

HEALTH EQUITY

The organization provides care and service primarily for the aging population. However, there has been a noted increase in admissions of younger adults with chronic debilitating conditions.

In our Home there is a higher population of residents exhibiting responsive behaviours. As a result partnerships to coordinate care include Behavioural Supports Ontario, the Home's embedded Behavioural Support Team, Regional Geriatric Behaviour Response Team/Mental Health, Grey Bruce Health Services, Owen Sound, and tertiary centers.

Lee Manor is committed to educating team members in utilizing the equity lens in the development of quality improvement initiatives. Moving forward we will make intentional efforts to support equity, diversity, inclusion and belonging for all those who spend time in our home.

Through our Colour It Promise we promote and encourage resident led care and service for each person who calls Lee Manor home. This includes improvements to data collection and working closely with residents to support cultural preferences, meaningful cultural activities, food preferences and spiritual needs.

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 **March 31, 2023**

Scott Mackey, Board Chair / Licensee or delegate

Stacey Goldie, Administrator /Executive Director

Stacey Goldie, Quality Committee Chair or delegate

Tolleen Parkin, Other leadership as appropriate

Theme I: Timely and Efficient Transitions

Measure

Dimension: Efficient

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
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 / Oct 2021 - Sep 2022	19.13	18.50	Current provincial performance is 18.5%, our goal is to match provincial average.	

Change Ideas

Change Idea #1 Knowledge translation to registered staff related to the ambulatory care-sensitive conditions

Methods	Process measures	Target for process measure	Comments
SurgeLearning modules and staff meetings/huddles	Number of registered staff receiving this education	All registered staff (100%) will receive education related to the ambulatory care-sensitive conditions by June 2023	

Change Idea #2 DOC will participate in subregional and regional working groups related to transitions in care initiatives

Methods	Process measures	Target for process measure	Comments
Attendance in committee meetings	Number of meetings attended	75% of scheduled meetings will be attended	

Change Idea #3 Ensure ED transfers are appropriate

Methods	Process measures	Target for process measure	Comments
A/ Monthly review of ED transfers to determine possible alternatives to transfer and to increase knowledge B/ Review statistics quarterly with PAC for input	Number of potentially avoidable transfers to the ED	100% of hospital transfers will be reviewed monthly	

Theme II: Service Excellence

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	92.00	94.00	To improve residents positive responses to the question on how well staff listen to you.	

Change Ideas

Change Idea #1 Give residents a voice to share important information about themselves that will help the care team make them feel genuinely at home.

Methods	Process measures	Target for process measure	Comments
a)The Resident and Family Services Manager will promote resident and family/designate completion of the "Colour It You" form upon move-in to provide insight into the residents values, beliefs, life history and preferences that will be shared with team members. b)Upon move-in, the Recreation team will implement updated Recreation and Social Well-being assessment to be completed with residents/designate to better represent resident history and what is important to them. c)Residents and/or their designate will personalize the memory frame displayed outside their room.	-Number of completed and returned Colour It You forms within 6 weeks of move-in. -Number of personalized memory frames on display outside of each residents room. -Number of completed Resident and Social Well-being assessments. -Number of residents who respond positively to the survey question rating how well staff listen to them.	At least 75% of all new residents who moved into the home in 2023 will have completed and returned their "Colour It You" form. 100% of occupied resident rooms will have a personalized memory frame outside of their room. 100% of residents moving in between April 1-Dec 31st 2023 will have a completed Recreation and Social Well-being assessment in their profile/chart. -There will be a 2% increase in the number of residents who respond positively to the 2023 survey question rating how well staff listen to them.	Total Surveys Initiated: 50 Total LTCH Beds: 150

Change Idea #2 Educate all care team members

Methods	Process measures	Target for process measure	Comments
Staff will be made aware of the importance of the Colour It You information and where it can be accessed for reference via huddles, team meetings, written communication and in-services.	Number of staff educated	By year end all staff will have received education regarding the Colour It You form.	

Change Idea #3 Enhance resident engagement in directing their personalized plan of care.

Methods	Process measures	Target for process measure	Comments
-Review current invitation process for initial and annual resident care conferences. -Ensure residents with CPS score of 3 and less receive an care conference invitation along with a reminder in advance and physical support as required to participate in person. -Share goals of the care conference including the importance of customizing the plan of care to reflect resident preferences and personal goals.	-Number of residents receiving an invitation to attend the initial/annual care conference. -Number of residents attending care conferences.	From April 1-Dec 31st 2023, 100% of residents due for initial/annual care conference with a CPS score of 3 or less will have been invited and encouraged to attend.	

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	92.00	94.00	To improve residents' positive response to the question "I can express my opinion without fear of consequences"	

Change Ideas

Change Idea #1 Encourage residents to actively engage in organized opportunities to share their voice and opinions.

Methods	Process measures	Target for process measure	Comments
a)Support participation in resident council and encourage resident feedback and recommendations to make improvements in the home. b)Recreation staff will schedule monthly program planning meetings for residents to voice their preferences and recommendations for activities and events commencing March 2023.	# of Resident Council Response Forms completed monthly. # of residents attending Resident Council meetings each month. # of resident actively engaged in program planning meetings.	-Every Resident Council Meeting will result in resident feedback regarding service delivery and a minimum of 1 response form. At least 10 program planning meetings will be held in 2023. 2% increase in the positive response to the question "I can express my opinion without fear of consequences" on the resident experience survey conducted by December 31, 2023.	Total Surveys Initiated: 50 Total LTCH Beds: 150

Change Idea #2 Educate residents and family members regarding the complaints process.

Methods	Process measures	Target for process measure	Comments
-The Resident and Family Services Manager will highlight the complaint process as outlined in the Move-In Handbook with all new residents/family at move in. -Complaint process will be highlighted in the monthly newsletter.- Complaint process will be posted in the home for residents and visitors to review.	-Number of new residents moving in per month receiving information related to complaints, Number of newsletters highlighting complaint process in the calendar year. Monthly audit ensuring complaint process is posted.	Information regarding complaints will be reviewed with all new move-in resident/designate, communicated in the newsletter x2 and will be posted in the home.	

Measure

Dimension: Patient-centred

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of long-term care home residents with worsened stage 2-4 pressure ulcer	C	% / LTC home residents	CIHI CCRS / Oct - Dec 2022	2.90	2.60	The provincial performance Q3 is 2.4% and the home is performing at less than this benchmark. Our target is a 10% reduction in worsened stage 2-4 as an initial goal to improve performance and bring the home closer to provincial averages.	

Change Ideas

Change Idea #1 Develop an intervention algorithm based on PURS score and an intervention guidance tool

Methods	Process measures	Target for process measure	Comments
Review literature and work collaboratively with the interdisciplinary team to create documents that will guide staff in translating risk assessment into preventative or healing interventions	The development of the completed algorithm and guidance tool	The algorithm and guidance tool will be completed by May 30, 2023	

Change Idea #2 Nurses will ensure that all pressure ulcer triggered RAPS assess, implement, and evaluate the interventions for skin and wound utilizing the new guidance tools

Methods	Process measures	Target for process measure	Comments
Weekly review of RAPS documentation and coaching and mentoring of staff	Number of pressure ulcer triggered RAPS that include assessment, implementation and evaluation of skin and wound interventions	100% of pressure ulcer triggered RAPS that include assessment, implementation and evaluation of skin and wound interventions	

Change Idea #3	Education of registered staff on the use of the new algorithm, guidance tools, and documentation requirements for residents with identified risk of or presence of pressure ulcers		
Methods	Process measures	Target for process measure	Comments
On-line modules, huddles, staff meetings and in-services	Number of registered staff attendance in skin and wound education	100% of registered staff will attend education on skin and wound care	

Measure

Dimension: Patient-centred

Indicator #5	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of long term care residents who developed a new stage 2 - 4 pressure ulcer	C	% / LTC home residents	CIHI CCRS / Oct - Dec 2022	3.10	2.90	Provincial performance is 1.9%. Our target of 2.9% is a reduction of 6.4% which is reasonable as an initial goal to improve this performance	

Change Ideas

Change Idea #1	Education of PSW staff regarding prevention, interventions and early identification and reporting of pressure related skin injuries.		
Methods	Process measures	Target for process measure	Comments
On-line modules, huddles, meetings and in-services	Number of PSWs attending education	80% of PSWs will attend skin and wound education sessions or complete on-line modules	

Change Idea #2	Ensure that all residents with a PURS score of 3 or more have care plans with identified interventions		
Methods	Process measures	Target for process measure	Comments
Weekly documentation audits and staff coaching and mentoring	number of residents with PURS scores of 3 or more will have skin and wound care plans with interventions	100% of residents with PURS scores of 3 or more will have skin and wound care plans with interventions	

Theme III: Safe and Effective Care

Measure

Dimension: Safe

Indicator #6	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	16.92	16.92	Current provincial performance (fiscal Q2 2022/23) is 21.4%. The home's current performance is well below the provincial average and Our goal is to continue this trend.	

Change Ideas

Change Idea #1 Ensure that residents prescribed antipsychotics align with documented medical diagnosis

Methods	Process measures	Target for process measure	Comments
Review resident diagnosis with prescribed medications quarterly	Number of residents who are prescribed antipsychotic medications have a medical diagnosis review quarterly	% of these resident charts will be reviewed quarterly	

Change Idea #2 To Explore alternatives to antipsychotic use

Methods	Process measures	Target for process measure	Comments
A referral to the BSO team will be made to explore alternatives to antipsychotic medications for residents without a diagnosis of psychosis who are receiving those medications	Number of BSO referrals for those residents prescribed antipsychotic medications without a diagnosis of psychosis	% of residents without a diagnosis of psychosis who are receiving antipsychotic medication will be reviewed by the BSO team to explore alternative interventions quarterly	