Yee Hong Centre for Geriatric Care – Markham Division: QIP 2018/19

Aim	Measure				Change Ideas			
Quality Dimension & Objective	**Measure/Indicator**	**Current performance**	**Target**	**Target justification**	**Planned improvement initiatives Change Ideas)**	**Methods**	**Process measures**	**Goal for change ideas**
Effectiveness: To Reduce the Inappropriate Use of Anti psychotics in LTC	% residents on antipsychotics without a diagnosis of psychosis	17.9% Last Year 16.2%	Less than 15%	Same as or better than provincial performance ON Avg. 20.4% YH Avg. 17.7% HQO NA	Identification of residents with prescribed antipsychotics without diagnosis of psychosis	Initial meeting of the interdisciplinary team to identify residents	# of residents identified to be enrolled into the process	Meeting the target by December 31, 2018
					Analyze behaviors and triggers of residents with antipsychotic medication without diagnosis of psychosis	Regular meeting of the team to evaluate progress of intervention	# Monthly statistics of residents identified	
					Interdisciplinary team involvement in supporting the indicated type of residents	Providing education to staff especially frontline staff	# of educated staff	
					Enhancing family involvement in providing alternatives to antipsychotic medication	Providing education to family on inappropriate use of antipsychotic medication	# of educated family	
Progress Report for the May 2018 CQC	Performing well? Yes or No: Had additional change idea that was not included in the QIP? Yes or No: no If Yes, specify: Enter summary here:							
Progress Report for the Aug 2018 CQC	Performing well? Yes or No: Had additional change idea that was not included in the QIP? Yes or No: no If Yes, specify: Enter summary here:							
Progress Report for the Nov 2018 CQC	Performing well? Yes or No: Had additional change idea that was not included in the QIP? Yes or No: no If Yes, specify: Enter summary here:							

Progress Report for the Feb 2019 CQC	Performing well? Yes or No: Had additional change idea that was not included in the QIP? Yes or No: no If Yes, specify: Enter summary here:							
Resident-Centered: Receiving and utilizing feedback regarding resident experience and quality of life. "Having a voice". "how well the staff listen to you"	% residents responding positively to: "What number would you use to rate how well the staff listen to you?" (NHCAHPS)	66.7% Last Year 74.3%	More than 75%	Same as or better than divisional performance ON Avg. NA YH Avg. 57.5%	Enhance Client/ Family involvement with their cares Supporting staff in developing and improving listening skills from our residents	Regular presentation of cares to the client and their families through meetings and conferences Education will be provided to staff about effective listening and communication	# of satisfied families during care conferences # of educated staff	Meeting the target by December 31, 2018
Progress Report for the May 2018 CQC	Performing well? Yes or No: Had additional change idea that was not included in the QIP? Yes or No: no If Yes, specify: Enter summary here:							
Progress Report for the Aug 2018 CQC	Performing well? Yes or No: Had additional change idea that was not included in the QIP? Yes or No: no If Yes, specify: Enter summary here:							
Progress Report for the Nov 2018 CQC	Performing well? Yes or No: Had additional change idea that was not included in the QIP? Yes or No: no If Yes, specify: Enter summary here:							
Progress Report for the Feb 2019 CQC	Performing well? Yes or No: Had additional change idea that was not included in the QIP? Yes or No: no If Yes, specify: Enter summary here:							
Integrated: To Reduce Potentially Avoidable	# emergency department (ED) visits for modified list of ambulatory	21.5	Less than 17	Same as or better than corporate performance	Strengthening staff knowledge in urgent care and assessment	In services will be provided by NP, Pharmacist and Management	# staff educated	Meeting the target by December 31, 2018

Emergency Department Visits	care sensitive conditions* (ACSC) per 100 long-term care residents	Last Year 19.8		ON Avg. 23.7 YH Avg. 16.9 HQO NA	Developing a system and streamlining of referral to MD and NP before ED transfer Improving diagnostic services for residents to prevent ED transfer Strengthen the Palliative Care Program	Regular meeting of frontline staff, NP and Nursing Managers about transfer cases and especial cases Improvement of diagnostic and laboratory services if possible. Provide education for staff and clients regarding the program	# of meetings held # of services provided beyond the service provider's regular visits # of staff and clients that have received the education	
Progress Report for the May 2018 CQC	Performing well? Yes or No: Had additional change idea that was not included in the QIP? Yes or No: no If Yes, specify: Enter summary here:							
Progress Report for the Aug 2018 CQC	Performing well? Yes or No: Had additional change idea that was not included in the QIP? Yes or No: no If Yes, specify: Enter summary here:							
Progress Report for the Nov 2018 CQC	Performing well? Yes or No: Had additional change idea that was not included in the QIP? Yes or No: no If Yes, specify: Enter summary here:							
Progress Report for the Feb 2019 CQC	Performing well? Yes or No: Had additional change idea that was not included in the QIP? Yes or No: no If Yes, specify: Enter summary here:							
Safety: To Reduce Falls	% residents who had a recent fall (in the last 30 days)	9.8% Last year 8.4%	Less than 9%	Same as or better than HQO Benchmark ON Avg. 15.0% YH Avg. 8.6% HQO 9%	Reinforcing of the 4Ps To increase monitoring of Residents Strengthening of the core team members of the Fall Management Team Increase and timely involvement of the frontline staff at every	Education and audits of the 4Ps checking Regular weekly post-fall meeting and quarterly discussion of cases Immediate post-fall huddle right after the fall	# of audits done Fall statistics Fall statistics	Meeting the target by December 31, 2018

					incident			
Progress Report for the May 2018 CQC	Performing well? Yes or No: Had additional change idea that was not included in the QIP? Yes or No: no If Yes, specify: Enter summary here:							
Progress Report for the Aug 2018 CQC	Performing well? Yes or No: Had additional change idea that was not included in the QIP? Yes or No: no If Yes, specify: Enter summary here:							
Progress Report for the Nov 2018 CQC	Performing well? Yes or No: Had additional change idea that was not included in the QIP? Yes or No: no If Yes, specify: Enter summary here:							
Progress Report for the Feb 2019 CQC	Performing well? Yes or No: Had additional change idea that was not included in the QIP? Yes or No: no If Yes, specify: Enter summary here:							
Safety: To Reduce the Use of Restraints	% residents who were physically restrained (daily)	3.2% Last Year 4.1%	Less than 3%	Same as or better than HQO Benchmark ON Avg. 5.3% YH Avg. 2.4% HQO 3%	Increase staff knowledge about restraint Developing of a core team who will review restraint in a more detailed way Provision of restraint alternatives such as activities or positioning aid	Education will be provided to staff about the least restraint procedure Inter-collaboration with the Falls Management Team Strengthening of staff and team knowledge about restraint alternative Involvement of BSRT in reviewing cases and providing recommendation	# educated staff # regular meetings # available positioning aid or restraint alternative interventions identified by the team	Meeting the target by December 31, 2018
Progress Report for the May 2018 CQC	Performing well? Yes or No: Had additional change idea that was not included in the QIP? Yes or No: no If Yes, specify: Enter summary here:							

Progress Report for the Aug 2018 CQC	Performing well? Yes or No: Had additional change idea that was not included in the QIP? Yes or No: no If Yes, specify: Enter summary here:
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Progress Report for the Feb 2019 CQC	Performing well? Yes or No: Had additional change idea that was not included in the QIP? Yes or No: no If Yes, specify: Enter summary here:

Yee Hong Centre
For Geriatric Care
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Yee Hong Centre for Geriatric Care – Markham Division: Quality Improvement Plan 2017/18 Progress Report

Aim	Change Ideas			
Quality Dimension & Objective	**Planned improvement initiatives Change Ideas)**	**Methods**	**Process measures**	**Goal for change ideas**
Safety: To Reduce Falls This Year: 7.6% Last Year: 8.8% Target: <9%	• Analyze fall data to identify pattern of falls	Share fall monthly report to nursing staff and interprofessional team	# of floor meeting	100% compliance by December 31, 2017
	• Continue to implement interprofessional Post-Fall meeting	Each fall will be discussed in the interprofessional post –fall meeting	# of post fall meeting	100% Compliance by December 31, 2017
	• For frequent fallers, reduce their overall number of falls	Conduct Morse Fall assessment for residents with 2 falls in 30 days	# of Morse Fall assessment conducted	100% Compliance by December 31, 2017
	• Implement the 4P's approach during the hourly safety check	Ask PSW to share the effectiveness of the 4P's approach and how this approach can help the residents	# of sharing session	100% Compliance by December 31, 2017
2017 May Progress Report	• We have scheduled a re-introduction in-service of our 4p's approach to the frontline staff that will take place in the next 2 months. During this time, audits will be done to evaluate compliance and staff will be asked for feedback regarding its effectiveness. • We have been doing Morse Fall Assessment if clients have fallen twice within a 30 days period. This is being checked by our ADRC for full compliance. • Every fall incidents are being discussed on the floor during fall huddles (after incident) weekly post-fall meetings.			
2017 August Progress Report	• 4Ps was re-introduced to the staff. In-services were done on each floor 32 staff attended. Audit will start this August for compliance. • The 48 hours hourly post-fall safety check was introduced in June. • Post-fall huddle tool is currently being reviewed. • Fall Prevention Program to be presented to the Family Council this August. • Fall data are being shared with the staff.			
2017 November Progress Report	• Regular sharing of fall statistics to staff during meeting continues • 4ps approach and 48 hrs post post- fall safety check is on going • Post-fall huddle tool reviewed and to be implemented in December • Fall Prevention Program was presented to FC in August. • Slight decreased of fall incidents from Q1 to Q2. However, no significant change from Q2 to Q3. **Q1** = 83 falls; **Q2** = 74 falls; **Q3** = 73 falls.			
2018 February Progress Report	• Decreasing trend of fall incidents from all 4 quarters: **Q1 = 83 falls; Q2 = 74 falls; Q3 = 73 falls; Q4 = 68** • Home reviewed and adapted a new post-fall huddle tool which is more objective type and easier to complete. • 4ps will be reviewed to the staff February 2018 to reinforce compliance by staff • Education will be provided in first quarter of 2018 for residents/ staff about fall prevention • Purchased more fall prevention equipment like fall mattress, hi-lo bed and bed alarms • Each unit is currently conducting post-fall huddle every fall incident and also weekly post-fall meeting. Morse Fall Scale is being done as per policy.			

Aim	Change Ideas			
Quality Dimension & Objective	**Planned improvement initiatives Change Ideas)**	**Methods**	**Process measures**	**Goal for change ideas**
Safety: To Reduce Worsening of Pressure Ulcers This Year: 3.0% Last Year: 1.9% Target: <1%	• Enhanced monitoring of pressure ulcer by wound care champions	Monthly Report back session for wound care champions thro' floor meeting	# of report back Session	100% Compliance by December 31, 2017
	• Manage skin issues as early as possible: ○ Identify root causes ○ Early referrals to dietitian when the resident is noted to have skin integrity problem ○ Use of pressure relief surface as appropriate	Wound Care Champion document the interventions on monthly wound note	# of monthly wound note completed	100% Compliance by December 31, 2017
2017 May Progress Report	• Wound care cases are being discussed on weekly floor meetings. • High risk wound care cases are being discussed on monthly management meetings. • Regular referral to the NP/ CCAC Wound Care Specialist for wound care management of complex cases. • Skin and wound referral form has been updated to reflect a standardized referral system.			
2017 August Progress Report	• Lunch and learn regarding wound care products was done on June 14th • Plan to purchase more air mattress to support the program • Less Home Acquired Pressure Ulcer this quarter compared to previous quarter. • Streamlining of wound care referral to the allied health team has been introduced by making just one referral to all allied health.			
2017 November Progress Report	• More open communication and involvement with the MSH NP regarding wound care • % of worsened pressure ulcer stage 2-4 is still below corporate and provincial average. • The plan to purchase more air mattress is still pending.			
2018 February Progress Report	• Worsened Pressure Ulcer results from CIHI Q1 -1.1%; Q2 – 1.1%; Q3 – 1.0% • Procurement of more pressure relieving mattress and staff education on same set in first quarter of 2018. • Re-training of floor champions is set this 2018. • Management has been reviewing all wounds on a monthly basis and wound care champions are meeting every quarter.			

Aim	Change Ideas			
Quality Dimension & Objective	**Planned improvement initiatives Change Ideas)**	**Methods**	**Process measures**	**Goal for change ideas**
Safety: To Reduce the Use of Restraints This Year: 3.8% Last Year: 5.7% Target: <3.0%	• Reduce the use of restraints by better managing high-risk residents	Floor nursing staff to identify high-risk cases for review. Discuss the use of restraints in quarterly restraint committee and care conferences.	Number of meeting discussions including high-risk resident cases on the restraint list	100% compliance by December 31, 2017
	• Document why bed rails are used and review every quarter, remove bed rails as early as possible	Documentation on Bed Rails Assessment and quarterly review	# of Bed Rail Assessment	100% compliance by December 31, 2017
	• Reduce the use of restraints by providing education to families	Health professionals will provide education to families through family council once a year. Education will include the pros & cons on the use of restraints.	Number of physical restraint education session done in family council meeting on an annual basis	100% compliance by December 31, 2017
2017 May Progress Report	• Restraint is included on our monthly high risk cases wherein residents on restraint are being discussed and evaluated. • Bed Rails Assessment is being done on admission and evaluated on a quarterly basis. Evaluation is now documented on PCC. • Management will be giving education to the family about the proper use of restraint in July at the Family Council Meeting.			
2017 August Progress Report	• Monthly check and review of restraints continue. • Bed rail risk assessment is currently being reviewed. • Bed Entrapment Assessment will be reviewed. • Use of least restraint and PASD Program to be presented to the family Council this coming August. • Education of on Bed Rail Assessment for the staff will be done this quarter.			
2017 November Progress Report	• Re-education of staff regarding bedrails has been conducted with an above 90% of staff received the training. • Bedrail risk assessment and policy has been revised. • Family education regarding bedrail safety is to be conducted this month. • All current residents that are using bedrails will be reassessed as per the new policy.			
2018 February Progress Report	• 100% of residents were re-assessed against bedrail use. • 100% of staff were re-trained about the risk and benefits of bedrails. • Procurement of bed rail alternatives, Hi-Lo beds and conversion of old CS7 beds to eliminate the risk of bedrail entrapment related to accidentally touching the remote control • Monthly restraint review by interdisciplinary is ongoing; ED presented the Physical Restrain Education at the FC in 2018 • 100% of the 200 beds has been re-assessed for bedrail.			

Aim	Change Ideas			
Quality Dimension & Objective	**Planned improvement initiatives Change Ideas)**	**Methods**	**Process measures**	**Goal for change ideas**
Integrated: To Reduce Potentially Avoidable Emergency Department Visits This Year: 19.8% Last Year: 15.6% Target: <18.4%	• Promote the discussion and regular review of advanced care planning and the adherence to it to avoid last minute end of life transfer to ED	Implement Advance care planning on admission or as early as possible; and communicate with the care team	# of Advance care planning conducted	100% compliance by December 31, 2017
	• Discuss care needs of high-risk residents at every change of shifts	Reinforce the shift reporting on the care needs of high risk residents on	Manager performs random audit on the inter- shift reporting # of avoidable ED visit	100% compliance by December 31, 2017 100% compliance by December 31, 2017
2017 May Progress Report	• Advance Care Planning is being discussed on admission or within the first 3 months after admission by the Social Worker. This will then prevent any unnecessary transfer to ED if ACP has been completed by the client. • High Risk Cases that have the potential of an ED transfer during the shift are now being highlighted on shift report to provide more monitoring to the resident.			
2017 August Progress Report	• Strengthening of the Palliative Care Program is ongoing. • UTI protocol is currently being reviewed. • COPD Program in coordination with Medisystem is ongoing.			
2017 November Progress Report	• COPD program was placed on hold in this quarter due to other sites thought of considering to join. MKH will go ahead with the plan again this quarter. • Communication with MSH NP and her involvement on potential transfer has improved. • MKH plan of involving NP with regards to UTI protocol.			
2018 February Progress Report	• A meeting was held by the Nursing Managers with the Nurse Practioner on Jan 16, 2018. The team had identified common reasons for transfer and had suggested of ways to further screen the ED transfer. A regular meeting will be held quarterly by this team. • High risk clients are being discussed on floor meetings and hand over • Better communication of high risk clients because of staff communication binder which the staff needs to sign and acknowledge • Discussion of advance care planning is still a challenge with some families. Home will still continue to work on this • In 2017, 32 out of 36 new admission had CPR/ NO CPR decision on admission which is 89%. • Home to continue the program for next calendar year			

Quality Dimension & Objective	Planned improvement initiatives Change Ideas)	Methods	Process measures	Goal for change ideas
Resident-Centred: Receiving and utilizing feedback regarding resident experience and quality of life. "Having a voice". **Listen to you:** This Year: 74.3% Last Year: 60.0% Target: >74.3%	• Empowering residents through direct dialogues with management	Direct dialogues between Executive Directors through residents' meetings on each floor to identify	# of residents attending meetings with EDs	100% compliance by December 31, 2017
	• Promote customer services regularly and in annual staff training	Education through annual staff training	#of staff attend annual staff training	100% compliance by December 31, 2017
	• Enhancing staff's awareness of person centred care approach	Focused corporate training on person centred care	# Educational conducted to staff	100% compliance by December 31, 2017
	• Reinforce the Resident's Bill or Rights and whistle blowing policy.	Education through annual staff training and departmental meeting	# of education provided to staff	100% compliance by December 31, 2017
Not afraid to speak up: This Year: 75.0% Last Year: 81.6% Target: >81.6%	• Apply just culture in the management of concerns	Managers apply Just Culture on managing concerns on staff	# of concerns were addressed	100% compliance by December 31, 2017
	• Provide information on care program, encourage resident/family to provide feedback and let them know what we have done with their feedback	Prepare care program information in layperson language, present to members of resident and family councils and seek their feedback	# of Care program information is presented to each family and resident council meeting.	100% compliance by December 31, 2017
2017 May Progress Report	• Bi-monthly meetings are being held by management and the resident council to hear their views regarding the care and facility services being provided. • Customer Service is included in our annual staff training to promote high standard of client's satisfaction and accommodation. • Supervisors and Managers are being oriented and trained on "just culture" to manage Staff's concerns. • Resident's Bill of Rights and Whistle Blowing Policy are both being discussed in our mandatory annual staff training. • 2 Care Programs will be discussed in the upcoming Resident Council Meeting. • A total of 8 Resident meetings were conducted from Jan to March, there were 138 residents participated in the meetings to provide feedback on services delivery.			
2017 August Progress Report	*Education on Resident's Bill of Rights, Customer Service, Whistle Blowing Policy, Just Culture were all done during the Annual Staff Training last July. * 2 Care programs will be presented in September on FC Meeting.			
2017 November Progress Report	• Resident and family surveys were both conducted this quarter and results were shared to the management and staff. • Action Plan is to be done for the below 70% satisfaction as per the survey. • Direct dialogues between staff and family/ resident continues as needed. • Fall Prevention Program and Physical Restraint and PASD programs were presented this quarter			
2018 February Progress Report	• Monthly Resident Council Meeting is currently effective in addressing concerns on a timely manner. • 100% of the staff have been trained on Whistle Blowing and Bills of Rights of Residents. • All the care program has been presented to the resident and family council in 2017.			

Quality Dimension & Objective	Planned improvement initiatives Change Ideas)	Methods	Process measures	Goal for change ideas
Resident Centred: Receiving and utilizing feedback regarding resident experience and quality of life. "Overall Satisfaction" This Year: 94.0% Last Year: 90.0% Target: >90.0%	• Continue to promote person-centered care	Reinforce the person-centered care practice	# of concern received from resident regarding the person centered care	100% compliance by December 31, 2017
	• Complete a FMEA on lost laundry items - MKH	Perform FMEA on lost laundry to identify gaps and make improvement accordingly	Improvement plan in place	100% compliance by December 31, 2017
2017 May Progress Report	• Facility is collecting all concerns brought by residents or family regarding person-centered care provision. Our home aims to attend to these concerns as soon as possible. At the moment, no concerns were received by the facility. • FMEA is in progress and will be completed before the end of the reporting year.			
2017 August Progress Report	• FMEA regarding laundry problem is still outstanding. • New Procedures in monitoring missing clothes were developed by facility department. • There will be a bi-annually check per room to check on misplaced or unlabeled clothing using students and modified staff.			
2017 November Progress Report	• Bi-annually check per room for misplaced or unlabeled clothing is still outstanding as student or modified staff is not available yet. • Meeting was held to solve the issue of missing clothing was done and some solutions are being tried at the moment.			
2018 February Progress Report	• FMEA for Laundry about missing clothing had been implemented and still on going • Aside from quarterly Lost and Found Week, each unit will have a lost and found box for unlabeled clothes that clients and family can check on a daily basis. • All concerns raised by family or clients have been investigated and addressed and a more structured complaint and follow up process are being implemented.			