Yee Hong Centre For Geriatric Care 頤康中心

Yee Hong Centre for Geriatric Care – Social Services 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**
Cognitive Condition: To maintain or enhance client's cognitive condition (Community Support Services - Adult Day Programs)	The team uses the Mini-Mental State Examination (MMSE) to follow the course of cognitive changes in ADP clients with dementia at admission and annually. The test assesses orientation, immediate and short-term recall, language, and the ability to follow simple verbal and written commands.	87.01% Last Year 88.6%	≥80%	Maintain	1) Enhance client's cognitive condition through activities focusing on cognitive improvement (ADPs) / calculation, language, memory, orientation, rhythm and vision (SDP) / memory training (MTAC)	• Activities focusing on cognitive improvement	Clients, caregivers and volunteers are invited to provide feedback	100% compliance by Dec 31, 2018
					2) Through carefully designed high paced play sessions, various tools and strategies are used to engage and synchronize with clients to enhance stimulation. Observations of clients' behaviours are focused on things that are relevant and meaningful to the specific individual.	• Play Intervention for Dementia (PID)	Clients, caregivers and volunteers are invited to provide feedback	100% compliance by Dec 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:							
Mood: To maintain or enhance client's mood (Community Support Services - Adult Day Programs	The team uses the Geriatric Depression Scale Short Form (GDS-SF) to monitor the mood of non-severely demented clients attending the ADPs.	2.77 Last Year 3.05	<3.9	Maintain	1) Enhance client's mood by providing educational talks on mood management	• Educational talks on mood management and Humor Therapy; • Promote social stimulation and positive energy through activities	Clients, caregivers and volunteers are invited to provide feedback	100% compliance by Dec 31, 2018
					2) Facilitate knowledge exchange among staff of different units	• Educational talks on knowledge exchange/sharing of program ideas	Staff are invited to participate in knowledge exchange	100% compliance by Dec 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:							
Caregiving Competency: To improve caregiver's perceived caregiving competency (Community Support Services - Caregiver Support & Education Services)	The team seeks caregivers' feedback at the end of each educational workshop	Central LHIN 88.46% CE LHIN 91.84% 89.76% (Central LHIN) 85.71% (Central East LHIN)	70%	Maintain	1) Enhance caregiver's competency through educational workshops and e-learning videos	• Educational workshops and e-learning videos on caregiving	Caregivers are invited to provide feedback	100% compliance by Dec 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 divert potentially avoidable emergency	% of diversion (# of emergency room diverted comparing with #	88% (in the last 3 months	≥80%	Maintain or better than the	1) To identify the client's needs and health condition change in a timely manner	• HSW will observe the change in client's health condition during the service	% care plan reviewed every quarter or when needed	100% compliance by Dec. 31, 2018

department visits (Home Support Services)	of emergency calls)			departmental benchmark	2) To provide immediate response when needed	provision and report to the Supervisor accordingly. • HSW will ask three questions before leaving client's unit; i.e., Do you need to use toilet? Do you have any pain or discomfort? Do you need anything before I leave? • Senior/Program Coordinator will review client's care plan quarterly or when needed. • HSW will ensure that the client is taking medication as scheduled. • HSW will observe and report possible side effect of medication in a regular basis. • HSW will provide post fall security check after client's fall incident by using Home Support Post Fall Security Check Template. • HSW will respond to client's emergency call within 5 minutes • HSW will respond to unscheduled request within 15 minutes	% of client fall received post fall security check % or emergency call responded within 5 minutes	
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:							
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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:							
Timeliness: To provide Home Support service to client on the same day of hospital discharge.	% of client received services on the same day of hospital discharge	100%	Maintain current performance	Maintain	1) To provide Home Support service within the same day of client's discharge from hospital.	• Senior/Program Coordinator will work closely with the client's family and with the hospital discharge planner during hospitalization period. • Senior/Program Coordinator will involve Home and Community Care of LHIN and the client's family to have needed equipment in place before the client is discharge from hospital. • On the day of the discharge, the client's need is reviewed /assessed or anticipated and then home support service is provided accordingly. • If the discharge is anticipated, Senior/Program Coordinator will inform HSW to get them prepared and provide home support service as soon as the client is back from hospital.	% of hospitalization case involving open communication prior to hospital discharge	100% compliance by Dec. 31, 2018

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Resident-Centred: Timely acknowledgement of complaints	% of complaints acknowledged to the clients who made a complaint within 6 to 10 business days	100%	100%	maintain	• To provide immediate acknowledgement when the complaint is received	• Upon the receipt of complain, the person who received the complaint will provide acknowledgement	% of acknowledgement make within 6-10 days	100% compliance by Dec 31, 2018
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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:							
Timeliness: To provide service to newly admitted client within 7 days of admission	% of service provision within 7 days of admission	100 % in the last year	100%	Maintain	1) To identify client's care needs 2) To develop care plan jointly with client and family to meet client's care needs 3) To provide home support services according to client's needs within 7 days of admission	1) Identify client's needs by reviewing the transfer documents via IAR or HPG or conduct an assessment with client and family using InterRAI CHA, 2) Sign needed document; consent, service agreement, etc. 3) Perform safety and risk assessment and check if the equipment needed for the provision of services are in place 4) Create care plan with input from client and caregiver 5) Create a service schedule considering client's preference and needs	% of service agreement signed % of individualized service schedule done for client % of care plan made for client % of care planning involving client % of safety and risk assessment done with client	100% compliance by Dec 31, 2018
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To reduce avoidable hospital re-admission within 7 days of hospital discharge	% of client re-admission to hospital within 7 days of hospital discharge	7.5% (in the last three months)	≤10%	Maintained or better than the current benchmark	1) To identify client needs and health condition change right after the hospital discharge 2) Adjust care plan to meet the changing needs 3) Provide the service according the changing needs 4) Monitor client's condition	1) HSW/Coordinator visit the client on the same day of hospital discharge to review client's condition and care needs 2) To provide immediate service to client at the same day of hospital discharge such as: security check, meal service, medication reminder, 3) Work with client/family/ pharmacist to ensure client follow the medication regime. 4) Re - assess the client need using InterRAI CHA and review the discharge note 5) To develop a revised care plan with input from client and family 6) Increase the number of security check to ensure that client's condition is well-monitored 7) To encourage client and family to follow – up with family doctor or specialist when needed	% of visit at the same day of hospital discharge % of service provision at the same day of hospital discharge % of the return assessment	100% compliance by Dec 31, 2018

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<table>
<tr><th>Quality Dimension & Objective</th><th>Planned improvement initiatives Change Ideas)</th><th>Methods</th><th>Process measures</th><th>Goal for change ideas</th></tr>
<tr><td rowspan="2">Cognitive Condition: To maintain or enhance client’s cognitive condition (Community Support Services - Adult Day Programs)

This Year: 88.6%

Target: >=80%</td><td>3) Enhance client’s cognitive condition through activities focusing on cognitive improvement (ADPs) / calculation, language, memory, orientation, rhythm and vision (SDP) / memory training (MTAC)</td><td>• Activities focusing on cognitive improvement</td><td>Clients, caregivers and volunteers are invited to provide feedback</td><td>100% compliance by Dec 31, 2017.</td></tr>
<tr><td>4) Through carefully designed high paced play sessions, various tools and strategies are used to engage and synchronize with clients to enhance stimulation. Observations of clients’ behaviours are focused on things that are relevant and meaningful to the specific individual.</td><td>• Play Intervention for Dementia (PID)</td><td>Clients, caregivers and volunteers are invited to provide feedback</td><td>100% compliance by Dec 31, 2017.</td></tr>
<tr><td>2017 May Progress Report</td><td colspan="4">1. ADPs, SDP and MTAC provided activities focusing on cognitive improvement. Clients, caregivers and volunteers were invited to provide feedback in the regular CSS CQI Committee meetings and monthly Members’ Council meetings. Feedback of clients, caregivers and volunteers was positive.
2. PID sessions were held for clients and caregivers in the Mississauga ADP and MTAC. PID training sessions were also provided to staff and volunteers. Clients, caregivers and volunteers were invited to provide feedback. Feedback of clients, caregivers and volunteers was positive.</td></tr>
<tr><td>2017 August Progress Report</td><td colspan="4">1. ADPs, SDP and MTAC continue to provide activities focusing on cognitive improvement. Clients, caregivers and volunteers provided positive feedback in the CSS CQI Committee meeting in June and monthly Members’ Council meetings.
2. A workshop on dementia care was provided to ADP clients, caregivers and volunteers in June and achieved 100% client satisfaction.
3. PID sessions continue to be provided in the Mississauga ADP and MTAC. A PID training session was provided to staff and volunteers in May/June.</td></tr>
<tr><td>2017 November Progress Report</td><td colspan="4">1. ADPs, SDP and MTAC continue to provide activities focusing on cognitive improvement. Clients, caregivers and volunteers provided positive feedback in the CSS CQI Committee meeting in September and monthly Members’ Council meetings.
2. A two-session volunteers’ training on dementia care was provided to Day Program volunteers in September and received positive feedback.
3. PID session continue to be provided in the Mississauga ADP and MTAC.</td></tr>
<tr><td>2018 February Progress Report</td><td colspan="4">1. ADPs, SDP and MTAC continue to provide activities focusing on cognitive improvement. Clients, caregivers and volunteers provided positive feedback in the monthly Members’ Council meetings.
2. A staff training on PID was provided to McNicoll ADP and Markham ADP staff in January and received positive feedback.
3. PID session continue to be provided in the Mississauga ADP and MTAC. Markham ADP staff took turns to observe PID sessions at the MTAC.</td></tr>
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Quality Dimension & Objective	Planned improvement initiatives Change Ideas)	Methods	Process measures	Goal for change ideas
Mood: To maintain or enhance client's mood (Community Support Services - Adult Day Programs	1) Enhance client's mood by providing educational talks on mood management	• Educational talks on mood management and Humor Therapy; • Promote social stimulation and positive energy through activities	Clients, caregivers and volunteers are invited to provide feedback	100% compliance by Dec 31, 2017.
This Year: 3.05 Target: <3.9	2) Facilitate knowledge exchange among staff of different units	• Educational talks on knowledge exchange/sharing of program ideas	Staff are invited to participate in knowledge exchange	100% compliance by Dec 31, 2017.
2017 May Progress Report	1. ADPs provided activities including educational talks to enhance client's mood in a pleasant social environment. Clients, caregivers and volunteers were invited to provide feedback in the regular CSS CQI Committee meetings and monthly Members' Council meetings. Feedback of clients, caregivers and volunteers was positive. 2. A McNicoll SDP staff was transferred to Markham ADP in December 2016. McNicoll ADP, SDP and Markham ADP staff met and shared program ideas in April 2017. Staff of different units were invited to share their knowledge and skills.			
2017 August Progress Report	1. McNicoll ADP worked with the Heart & Stroke Foundation and provided the first Living with Stroke Program in the Chinese community in June/July. 12 clients and caregivers successfully completed the program. 2. McNicoll ADP, SDP and Markham ADP staff shared program plans and scheduled to share program ideas in September.			
2017 November Progress Report	1. ADPs continue to provide activities including educational talks on mood management and humor therapy, and promote social stimulation and positive energy in daily service provision. Clients, caregivers and volunteers provided positive feedback in the September CSS CQI Committee meeting and monthly Members' Council meetings. 2. McNicoll ADP, SDP and Markham ADP staff will share program ideas in November.			
2018 February Progress Report	1. ADPs continue to provide activities including educational talks on positive psychology, and encourage clients to get to know each other in daily service provision. Clients, caregivers and volunteers provided positive feedback in the monthly Members' Council meetings and monthly volunteers' meetings. 2. McNicoll ADP, SDP and Markham ADP staff shared program ideas and discussed ways to engage clients.			

Quality Dimension & Objective	Planned improvement initiatives Change Ideas)	Methods	Process measures	Goal for change ideas
Caregiving Competency: To improve caregiver's perceived caregiving competency (Community Support Services - Caregiver Support & Education Services) This Year: 89.76% (Central LHIN) 85.71% (Central East LHIN) Target: 70%	1) Enhance caregiver's competency through educational workshops and e-learning videos	• Educational workshops and e-learning videos on caregiving	Caregivers are invited to provide feedback	100% compliance by Dec 31, 2017.
2017 May Progress Report	1. Educational workshops were provided regularly. New e-learning videos were uploaded to the e-learning website quarterly. Caregivers were invited to provide feedback at the end of educational workshops and e-learning videos. Feedback of caregivers was positive.			
2017 August Progress Report	1. Caregiver Education and Support Services continue to provide educational workshops regularly and upload 3 new e-learning videos to the e-learning website quarterly. Caregivers provided positive feedback at the end of each workshop and video, as well as in the CSS CQI Committee meeting in June.			
2017 November Progress Report	1. Caregiver Education and Support Services continue to provide educational workshops and upload 3 new e-learning videos to the e-learning website every quarter. Caregivers provided positive feedback at the end of each workshop and video, as well as in the CSS CQI Committee meeting in September.			
2018 February Progress Report	1. Caregiver Education and Support Services continue to provide educational workshops and upload 3 new e-learning videos to the e-learning website every quarter. Caregivers provided positive feedback at the end of each educational workshop.			

<table>
<tr><th>Quality Dimension & Objective</th><th>Planned improvement initiatives Change Ideas)</th><th>Methods</th><th>Process measures</th><th>Goal for change ideas</th></tr>
<tr><td>Integrated: To divert potentially avoidable emergency department visits

Recent Result (last 3 months): 85%

Target: >80%</td><td>1) To identify the client's needs and health condition change in a timely manner
2) To provide immediate response when needed</td><td>• HSW will observe the change in client's health condition during the service provision and report to the Supervisor accordingly.
• HSW will ask three questions before leaving client's unit; i.e., Do you need to use toilet? Do you have any pain or discomfort? Do you need anything before I leave?
• Senior/Program Coordinator will review client's care plan quarterly or when needed.
• HSW will ensure that the client is taking medication as scheduled.
• HSW will observe and report possible side effect of medication in a regular basis.
• HSW will provide post fall security check after client's fall incident by using Home Support Post Fall Security Check Template.
• HSW will respond to client's emergency call within 5 minutes
• HSW will respond to unscheduled request within 15 minutes</td><td>% care plan reviewed every quarter or when needed
% of client fall received post fall security check

% or emergency call responded within 5 minutes</td><td>100% compliance by Dec. 31, 2017</td></tr>
<tr><td>2017 May Progress Report</td><td colspan="4">The programs are on the right track .
Home Support Worker continues to follow the protocol to monitor the health condition change of client and provides assistance in a timely manner.
Senior/program coordinator will review the care plan quarterly or if needed.
Mutual Leaning on care issue and sharing of Emergency Response Incidents are conducted in every staff meeting to alert and train the staff in helping client with health condition change or sudden fall.</td></tr>
<tr><td>Recent Result (last three months) : 92.4%
Target : >80%

2017 August Progress Report</td><td colspan="4">HSW continues to follow the protocol to monitor the health condition change of client and provides necessary assistance in a timely manner.
Coordinator will review the care plan quarterly or if needed.
Mutual learning on care issue and Emergency Response Incidents are shared with HSWs in the staff meeting as to equip themselves how to handle such incidents with competence.</td></tr>
<tr><td>Recent Result (last three months) :88.2%
Target:>80%

2017 November Progress Report</td><td colspan="4">Home support Worker continues to follow the protocol to monitor the health condition change of client and provides assistance in a timely manner.
Senior/program coordinators will review the care plan quarterly or if needed.
Mutual learning on care issue and emergency response incidents are shared with HSWs in the staff meeting to train the staff in helping clients with health condition changes or sudden fall.</td></tr>
<tr><td>2018 February Progress Report</td><td colspan="4"></td></tr>
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Quality Dimension & Objective	**Planned improvement initiatives Change Ideas)**	**Methods**	**Process measures**	**Goal for change ideas**
Timeliness: To provide Home Support service to client on the same day of hospital discharge. This Year: 100% Target: 100%	To provide Home Support Service within the same day of client's discharge from hospital.	• Senior/Program Coordinator will work closely with the client's family and with the hospital discharge planner during hospitalization period. • Senior/Program Coordinator will involve CCAC and the client's family to have needed equipment in place before the client is discharge from hospital. • On the day of the discharge, the client's need is reviewed /assessed or anticipated and then home support service is provided accordingly. • If the discharge is anticipated, Senior/Program Coordinator will inform HSW to get them prepared and provide home support service as soon as the client is back from hospital.	% of hospitalization in which open communication takes place.	100% compliance by Dec. 31, 2017
2017 May Progress Report	100% for providing same day services to clients returning home from hospital . Clients and their family members are reminded to inform us if they are going to be discharged from hospital so that we can get prepared to provide services as soon as they are back home .			
2017 August Progress Report	100% for providing same day services to clients returning home from hospital Clients and their family members are reminded to let us know when they are going to be discharged from hospital so that we can provide services within the same day of discharge form hospital.			
2017 November Progress Report	100% for providing same day services to clients returning home from hospital Clients and their family members are reminded to inform us if clients are going to be discharged from hospital so that we can provide services as soon as they are back home from hospital			
2018 February Progress Report				