Quality Improvement Plan (QIP)

Narrative for Health Care Organizations in Ontario

March 30, 2023

CAMA WOODLANDS
Long Term Care Home

Ontario Health

OVERVIEW

CAMA Woodlands (CAMA) is a 128 bed Charitable Long Term Care Home facility located in Burlington ON. We are a vibrant member of the Hamilton Niagara Haldimand Brant Local Health Integration Network and Ontario Health West. CAMA has been providing Resident focused quality care in Burlington since 1970. CAMA began with a 12 Resident facility and has continued to expand its services over time. CAMA was a part of the first phase of redevelopment in Ontario and expanded from 64 beds to 128 beds in 2014.

CAMA is owned and operated by the Central District of the Christian and Missionary Alliance Church in Canada and executes the mission, vision and values of this faith based charitable organization for the provision of care to the elderly.
A multidisciplinary approach has been applied to the creation of this

QIP Report that aligns with our Mission, Vision and Value statements. This report also supports the same tenets as expressed by Health Quality Ontario (HQO) and the Ministry of Long Term Care (MOLTC). This investment in time and effort reflects CAMA's commitment to Continuous Quality Improvement through evidence based data.
CAMA Woodlands has been designated a Registered Nursing Association of Ontario (RNAO) Best Practice Spotlight Organization (BPSO). BPSOs are health-care and academic organizations selected by the RNAO through a request for proposals process to implement and evaluate the RNAO's best practice guidelines. The guidelines we had chosen to implement are falls prevention, Person Centered Care and The 3 D's (delirium,depression and dementia).

The partnership between our home and the RNAO focuses on making a positive impact on resident care though evidence-based practice.

CAMA Woodlands prides ourselves on our hard-working, innovative, dedicated front line workers and management team. We work together to bring quality care and enrichment to the residents who live here. We believe that education, innovation and change are essential in improving or maintaining quality care. The Home's Quality Improvement Program includes monthly and quarterly reviews of its QIP Dashboard indicators as well as a yearend review of gains and lessons learned on an indicator by indicator
basis. At the year-end review of outcomes, interventions are added or removed, and targets adjusted to ensure maximum results for the new-year.

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REFLECTIONS SINCE YOUR LAST QIP SUBMISSION

Since the Pandemic, we have not submitted a QIP to HQO. Our last submission was in 2019/20
We did have ongoing QI Team meetings to continue with our in home Quality improvement initiatives.

The top priorities for our Quality Improvement Plan (QIP) is to decrease ED visits, decrease number of prescriptions per resident and resident centered-care.

We are fortunate to have two Nurse Practitioners on staff that will assist us with the first two priorities.
Resident centered care is a multidisciplinary approach.

Our QI committee meets quarterly to discuss our progress, looking at the items from more of a birds eye view. Monthly, the QI team meets to adjust interventions as needed in order to achieve our goals. The committee is made up of the Best Practice Leads, the NP's, Physio, the Director of Care, Administrator, Pharmacy etc. The team is made up of multidisciplinary front line staff. Having these two teams has worked well for us.

PATIENT/CLIENT/RESIDENT ENGAGEMENT AND PARTNERING

CAMA Woodlands has made great strides in the area of Resident involvement in our quality improvement initiatives.

Top priorities of our QIP are related to Resident Satisfaction, Cultural and Spiritual needs of the residents.

Resident satisfaction surveys are done at least twice in the year. Resident's suggestions are recorded and many events planned related to their wants. Residents' council meets monthly and were involved in the QIP planning. A Resident was elected to become the CAMA Ambassador. This resident welcomes new residents and provides them with information about the home. This ambassador also becomes a go-to person should they have questions.
One of our nursing students during her placement here worked on a project to roll out cultural event days. She created a list of the many cultures we have at CAMA and met with different residents to speak to them about their culture.
We planned different cultural awareness days throughout the coming year. Each event includes decorations, music, food and activities related to that culture. These days have been fun for residents and staff.
Going forward, it is our goal to have a resident be involved in interviews with potential staff.

PROVIDER EXPERIENCE

Our staff have been through three years of unknowns, masking, testing, decreased staffing levels and many have burnout.

CAMA has done many things to try and keep their spirits up and maintain a positive work environment.

We have done monthly celebrations involving food and prizes, bonus cheques, thank you cards, custom jackets and lunch bags to name a few. We have increased staffing levels and have done initiatives to hire more staff.

We enrolled staff in and employee assistance program and we brought in guest speakers to talk about self awareness and personal wellness.

I am proud of how are home has gone through the pandemic. Being present and leading by example are key.

WORKPLACE VIOLENCE PREVENTION

Workplace Violence is a strategic priority in our organization, and we take the global issue very seriously.

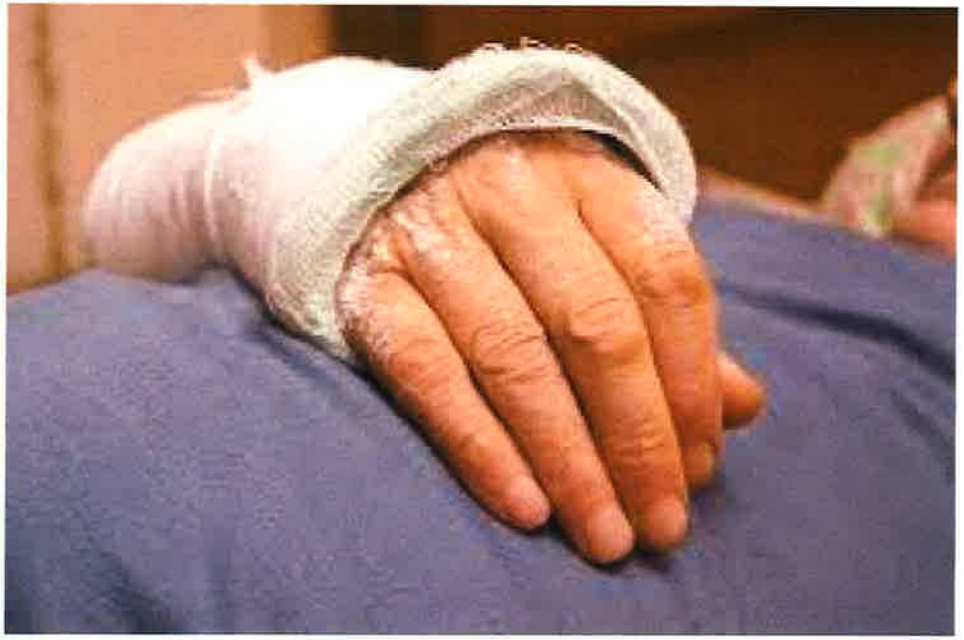
A risk assessment was completed and we reviewed and revised our workplace violence and harassment policy to align with the Ontario Occupational Health and Safety Act (including Bill 168 and 132). All staff, students and volunteers are trained upon hiring and annually.

Any reports of harassment or violence are taken seriously, investigated thoroughly and dealt with by administration and the health and safety committee.

PATIENT SAFETY

Patient safety data is collected by the Director of Care (DOC) and each incident is reviewed by her. The DOC meets with the person/people involved in the incident to ensure corrective action is taken. All incidents are shared with the family member/POA of the resident.

These incidents are then used as examples in an in-service with the front line staff. For example, if a resident was injured during a transfer, proper transfer techniques will be reviewed with all Personal Support Workers.



HEALTH EQUITY

IF any of our residents have socio-economic concerns we refer them to a social worker. The social worker helps them with any resources they may need.

All of our residents are treated equitably and fairly. We do not discriminate against race, religion or gender identity. The residents that live at CAMA come from different cultural and religious backgrounds.

Even though CAMA Woodlands is a designated Alliance faith-based home we do not refuse admission to anyone.

CONTACT INFORMATION/DESIGNATED LEAD

For more information you may contact us at:

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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 31/23

Board Chair / Licensee or delegate

Administrator /Executive Director

Quality Committee Chair or delegate

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	15.15	12.00	We set our goal at 12%. We feel this is an area we can improve on.	

Change Ideas

Change Idea #1 Reviewing the transfers to ED monthly Record each transfer to hospital on tracking sheet that was developed.

Methods	Process measures	Target for process measure	Comments
Record each transfer to hospital on tracking sheet that was developed. Include the reason for transfer, who made the decision to transfer (ie- Family, MD/NP, Nurse. All transfers to be reviewed monthly by DOC.	All transfers to be recorded and reviewed.	100% of all transfers will be recorded and reviewed each month.	

Change Idea #2 Staff Education to try to reduce the number of ED transfers.

Methods	Process measures	Target for process measure	Comments
Educate all registered staff on the importance of avoiding unnecessary transfers to hospital.	All registered staff will be educated on ED avoidable visits in 2023. A focus will be placed on registered staff's assessment skills with an emphasis on the availability of outside services ie. x-ray, ultrasound which can be done in the home.	100% compliance with education sessions by December 31/23.	

Change Idea #3 Information to be provided to residents and families on internal resources available to try to prevent ED transfers.

Methods	Process measures	Target for process measure	Comments
Information sheet to be created outlining the resources available to our residents so that avoidable ED visits do not have to happen.	Information sheets to be given to families and residents upon admission to our facility and to families of residents who currently live here.	Information about avoidable ED visits to be provided 100% of the time. Deadline for information sheet to be completed by September 2023. Sheets will be available in the facility and will be added to the admission packages.	

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		94.00	55 of our residents we able to complete the survey in February 2023. We used a scale of 0-5, 5 being the best. 90% of our residents surveyed gave us a rating of 3 or higher	

Change Ideas

Change Idea #1 Customer Service Initiative

Methods	Process measures	Target for process measure	Comments
Educating staff on the importance of taking time to listen to residents.	Resident satisfaction surveys to be completed three times a year, February, June and September.	To ensure 100% of staff are trained are trained on GPA by December 31/23	

Change Idea #2 Improved Resident Satisfaction

Methods	Process measures	Target for process measure	Comments
Specific resident satisfaction survey to ask more in-depth questions to obtain clearer responses.	Survey with grading to measure satisfaction to be completed three times a year.	To obtain a 94% or higher, rating the home 3 or higher on a scale of 0-5.	We used a scale of 0-5 which makes it easier for our residents to answer the question.

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		90.00	55 of our residents we able to complete the survey in February 2023. We used a scale of 0-5, 5 being the best. 72% of our residents surveyed gave us a rating of 3 or higher	

Change Ideas

Change Idea #1 Ensure residents are aware that they are in charge of their care and have a voice.

Methods	Process measures	Target for process measure	Comments
Educating staff on how important it is that residents can express their opinions without worrying about consequences.	In-house survey to be conducted three times a year. New education to be developed for all staff.	Residents know their rights and are free to voice their opinions. To reach our target of 90%. 100% of staff to be trained by Dec 31/23. Education will be for all new hires and annually.	

Change Idea #2 Residents to be aware of their rights.

Methods	Process measures	Target for process measure	Comments
Ensure all residents/families are aware of resident rights.	In-house satisfaction survey to be conducted three times a year, February, June and September	Rights to be addressed at residents council and in family newsletter. Goal is to achieve a rating of 90% or higher of residents rating us 3 or higher on a scale of 0-5.	We used a scale of 0-5 to make it easier for our residents to answer the question.

Measure

Dimension: Patient-centred

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Polypharmacy, the overall average of the number of medications our residents are taking on a daily basis.	C	Other / LTC home residents	Local data collection / April 2023-December 2023	11.80	9.00	Our goal is to reduce the number of medications that our residents are taking on a daily basis, that may not be required.	

Change Ideas

Change Idea #1 To reduce the number of medications our residents are regularly taking.

Methods	Process measures	Target for process measure	Comments
Quarterly medication reviews completed by the Nurse Practitioners. Pharmacist review at quarterly PAC meetings.	Each medication is reviewed by the NP's to see if that medication is a benefit to that resident.	The MD/NP's will discontinue any medications that are not a benefit to the overall health of our residents.	

Theme III: Safe and Effective Care

Measure

Dimension: Effective

Indicator #5	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
The proportion of residents with a progressive, life-limiting illness, that are identified to benefit from palliative care, who subsequently have their palliative care needs assessed using a comprehensive and holistic assessment.	C	Proportion / LTC home residents	Local data collection / April 2023-March 2024	CB	100.00	We have set our target at 100%. We feel that we meet the needs of our residents in regards to their pain and palliative needs. We have developed a new assessment tool to help our residents receive the care they deserve.	

Change Ideas

Change Idea #1 All residents will have their palliative needs assessed.

Methods	Process measures	Target for process measure	Comments
Assessment tool (Interdisciplinary Assessment of Palliative Care Needs) to be completed in point click care. Data to be entered in care plan.	Assessment to be completed on admission, yearly or and when there is a change in residents health status.	100% of all residents will be assessed.	

Change Idea #2 Getting palliative care needs met.

Methods	Process measures	Target for process measure	Comments
1. Palliative care carts will be provided by the nurses for all residents at their end of life. Included on the cart are personal care items, reading materials for family members and a CD player for music. 2. A dove is placed on a resident's door to alert other residents and visitors that the resident and family would appreciate quiet time together.	Education for all direct care staff on palliative/end of life care.	100% of all residents will have their care needs met. 100% of staff will be educated by December 31/23.	

Measure

Dimension: Effective

Indicator #6	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
3 day bowel and bladder diary to be completed 3 weeks post-admission	C	% / LTC home residents	In-home audit / April 2023- March 2024	CB	100.00	Our goal is to ensure all residents receive the assessment, so their continence needs are met.	

Change Ideas

Change Idea #1 3 day bowel and bladder diary to be completed 3 weeks post admission.

Methods	Process measures	Target for process measure	Comments
Admission nurse will trigger a reminder for the nurse to assign the diary 3 weeks after admission.	PSW's will complete 3 day diary on paper and hand in back to the nurse to review.	100% of all new residents will have a bowel and bladder diary completed.	

Measure

Dimension: Effective

Indicator #7	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
All recommendations from BSO for new or existing residents will be communicated to all nurses and PSW's.	C	% / Worker	In house data collection / April 2023-December 2023	CB	100.00	Sharing this information will ensure our residents receive the best care possible	

Change Ideas

Change Idea #1 BSO will provide list of all residents that they are seeing to the charge nurse and floor nurse when they are in visiting.

Methods	Process measures	Target for process measure	Comments
Communications from BSO will also be sent in the form of an email to the clinical manager, educator and the nurses email.	Any new admitted residents that have been seen by BSO in the community or hospital will be referred to the BSO for transition by the nurse doing the admission. All recommendations from BSO will be entered in the residents care plan/kardex and communication books. Huddles and pieces sessions can also be arranged with BSO to help staff learn how to provide the best care for the resident.	100% of all information will provided to the staff caring for the resident.	

Measure **Dimension:** Safe

Indicator #8	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	9.09	8.00	We have set our target at 8%. All of our residents medications are reviewed quarterly by our NP's with the collaboration of our Pharmacist and RAI coordinator we feel this goal can be achieved.	

Change Ideas

Change Idea #1 Identify all residents that are on anti-psychotic medication without a current appropriate diagnosis.

Methods	Process measures	Target for process measure	Comments
Medication reviews to be completed on all residents currently on anti-psychotic medications quarterly.	Compile a list of residents on anti-psychotic medications that do not have a diagnosis.	100% of residents on anti-psychotic medications will have a review to see if these medications are necessary.	

Change Idea #2 Ensure that the right diagnosis is captured in the RAI/MDS.

Methods	Process measures	Target for process measure	Comments
Quarterly reviews. Pharmacist review quarterly at PAC meeting.	Quarterly audits.	100% of residents with a psychiatric diagnosis are coded in RAI/MDS correctly.	

Measure **Dimension:** Safe

Indicator #9	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of residents who fell in the 30 days preceding their resident assessment	C	% / LTC home residents	CIHI portal / 2021-2022	14.30	13.00	We feel that this new target is obtainable and we are working on several change ideas to help us achieve this target.	

Change Ideas

Change Idea #1 Identify residents who are at high risk for falls.

Methods	Process measures	Target for process measure	Comments
Complete the falls risk assessment tool (FRAT) on all admissions and quarterly. Post-fall assessment to be completed by the nurse after each fall in PCC.	100% of assessments to be completed on PCC. All falls to be recorded in risk management will be reviewed and will be checked to ensure a post-fall/huddle assessment was completed before being signed off.	All residents to be assessed on admission and quarterly thereafter. 100% of the falls charted will have a post-fall assessment completed as well.	

Change Idea #2 Monthly Interdisciplinary Falls Meetings.

Methods	Process measures	Target for process measure	Comments
Daily tracking sheets implemented to record falls to be completed by PSW's. Weekly meetings on Wednesday to review falls, establish patterns and implement interventions. Review the previous months falls/ tracking sheets and ensure interventions are in place.	Meetings to be held every month.	100% compliance.	

Change Idea #3 Staff Education.

Methods	Process measures	Target for process measure	Comments
Falls prevention education to be assigned to all staff annually.	Completion of mandatory falls training.	100% compliance with mandatory training.	

Measure

Dimension: Safe

Indicator #10	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
All PSW's will receive training in skin and wound protocols.	C	% / Health providers in the entire facility	In house data collection / May 2023-December 2023	100.00	100.00	New skin and wound education will be developed and given to all PSW's working in our home.	

Change Ideas

Change Idea #1 New education will be developed by the wound care nurse in collaboration with the skin and wound team.

Methods	Process measures	Target for process measure	Comments
Education will be delivered in an in-person format.	Attendance records will be kept for group sessions if a PSW is not able to attend 1:1 training will be provided.	100% of all PSW's will receive in-person training in 2023.	