

A C C R E D I T A T I O N 2016 - 2 0 1 9

**RESIDENT**

**SAFETY PLAN**



Holland Christian Homes Inc.

7900 McLaughlin Rd. S., Brampton, Ont. L6Y 5A7

Telephone: (905) 463-7002 ♦ Fax: (905) 459-8667 ♦ web site: www.hch.ca



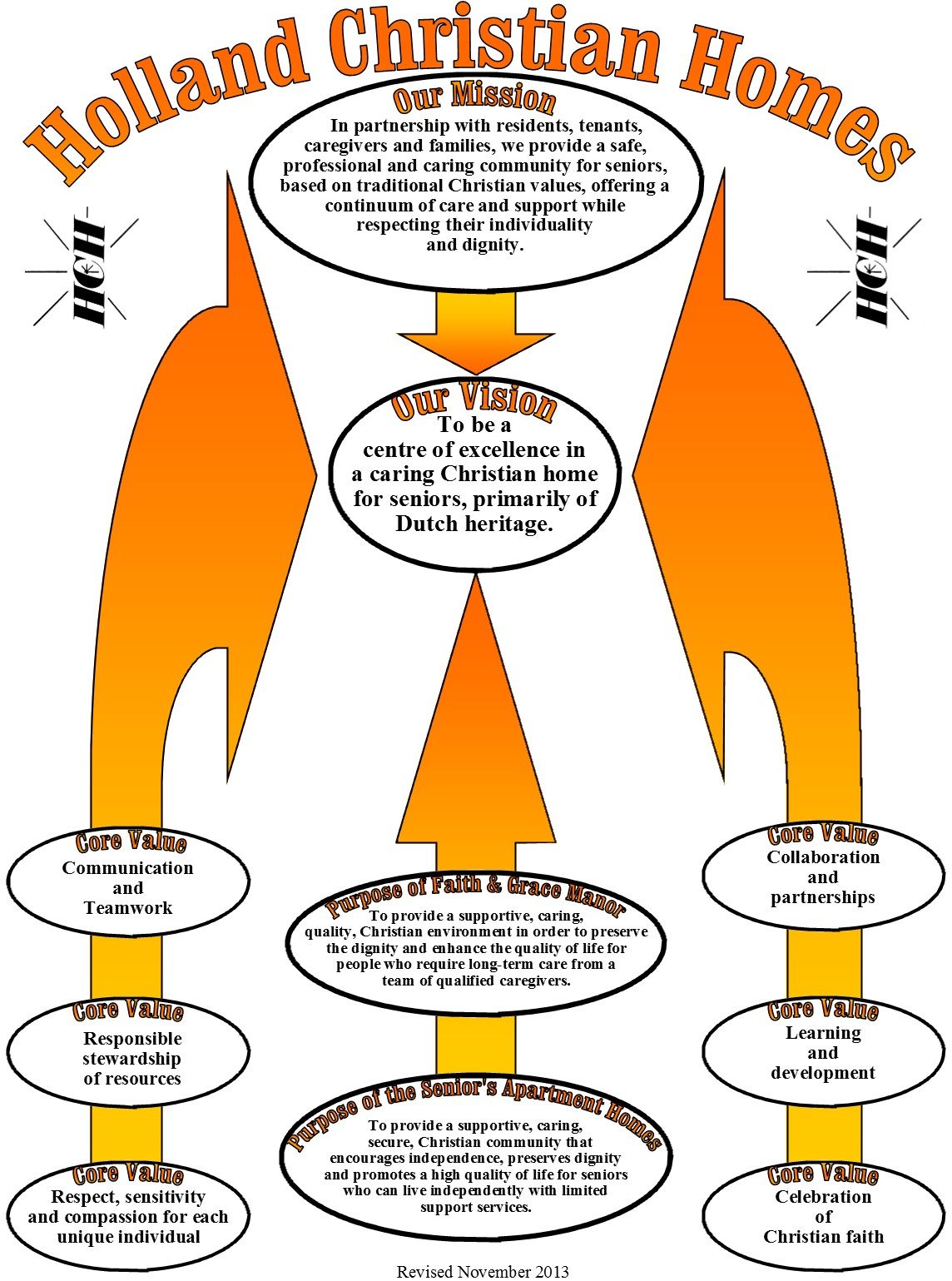
Senior management is committed to guiding the execution of the Long Term Care Resident Safety Plan across all the Holland Christian Homes Long Term Care homes and Seniors Services programs.

Our mission is to provide effective, high-quality, safe and efficient long-term care services in a home-like setting. Our purpose is to ensure our residents feel safe while in our homes. This Resident Safety Plan will drive continuous improvement to quality and safety throughout our Long Term Care homes and Seniors Services programs, and builds upon our mission, vision and values.

The Long Term Care Resident Safety Plan is developed in conjunction with the Accreditation Canada Patient Safety Goals within the patient safety areas of culture, work life/workforce, communication, medication use, infection control, falls prevention, and risk management, and their required organizational practices (R.O.Ps). The R.O.P.s are essential practices that our organization must have in place to enhance patient/client safety and to minimize risk.

This document articulates the go forward strategy for quality and safety at the Holland Christian Homes Long Term Care Homes and Seniors Services Programs. Strong multi- disciplinary experience, quality improvement practices, collaboration, and Leadership throughout our programs, services and departments will foster attention to continuous quality improvement and drive improved performance in quality and safety for Residents, families, staff and our community.

**Ken Rawlins, CEO**



*Long Term Care (Grace and Faith Manors) & Assisted Living Services (Towers)*

***2019 Resident Safety Plan***

| **HOLLAND CHRISTIAN HOMES – LTC and Towers**  **RESIDENT SAFETY PLAN** | | | | | | |
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| **PATIENT SAFETY AREA** | **Safety Goal** | **STEPS** | **RESPONSIBILITY** | **ACTION AND TIMELINES** | **OUTCOMES** |
| CULTURE | Adopt Resident Safety as a written, strategic priority/goal | Safety is included in Our Mission Statement  Safety has been added as a written, strategic priority to the LTC Goals & Objectives and the Operational Plans. | Ken Rawlins, CEO, Department Heads | Annually | * The Resident Safety Plan drives continuous improvement of quality and safety throughout our Long Term Care Homes and builds upon our mission, vision and values * Promotes the philosophy of safety, high-quality care and services for our Residents |
| CULTURE | Enable proactive quality and safety leadership | Plan and budget for Leadership training on Improving Patient Safety in Our Organization | Ken Rawlins, CEO,  Department Heads, HR | * Investigate training/ seminars offered on Improving Resident Safety in Our Organization; e.g., Accreditation Canada Patient Safety one day training * Training requirements are discussed at the time of annual budgeting.   Training Provided so Far:   * Senior Leadership Training * Respect in the Workplace - all staff * Customer Service * Registered Staff Leadership * Nurse Leadership and Team Leads for all Specialized Programs such as: Wound Care Management, Responsive Behaviours, Restraints and PASDs, Continence and Bowel Management, and Resident Abuse and Neglect Prevention, and Fall Prevention * End of Life Care * 2 staff certified as Coaches to Train other staff – for GPA in 2017 | * Enables proactive quality and safety Leadership * Achieves optimal quality and safe outcomes for our Residents * Builds an accountable quality and safety culture * Ensures best use of our resources to support quality and safe care * Balances financial and Resident outcomes * Promotes the philosophy of safety, high-quality care and services for our Residents |
| CULTURE | All staff receive training annually to promote and support safe and quality care | An annual training session is prepared with an inter-disciplinary approach  Apply for the PSW funding and train 3 champion PSW staff from each home to deliver this face to face training | Education Coordinator and Administrator – Faith Manor and Education Committee and Human Resources, PSWs | * Provide several 4 hour sessions over several months and all shifts to ensure 100% of all staff have the opportunity to attend the 4 hour training session – started in 2017 and again in 2018 – every year thereafter * Resident Centered Care - PSW Funding received for “Train the Trainer” and over 50 PSW staff were trained (2018) by their fellow PSWs * Use Surge Learning as alternative training method for those staff who cannot attend live sessions * Towers staff receive annual training on such things as: CPR, ADD to be prepared and ensure safety of tenants in the event of medical emergencies | * Equips staff with the tools and accountability to provide quality and safe care * Ensures that all staff hear one clear consistent message with regards to our expectations for safe quality care * Peer to peer training which supports safe, quality, resident-centered care |
| CULTURE | Health & Safety Rounds are an opportunity to enhance the culture of safety by giving front line staff an opportunity to identify areas for improvement. | Joint Health & Safety Committee in our Home do regular safety walk-rounds; provide feedback to staff on lessons learned and improvements made. | Joint Occupational Health & Safety Committee, HR and EVS | * The process involves conducting the rounds, sharing the findings broadly with staff, and developing action plans. * The minutes and / or action plans are posted * EVS and HR and JOHSC will do a joint workplace inspection to identify and rectify any slip, trips and falls hazards. | * The H&S rounds enable clinical staff to see first-hand the benefit of a process that is solely focused on addressing their patient safety concerns. * Rounds provide an opportunity for developing a proactive risk identification system that draws equally on staff and management. JOH&S asks staff about their safety concerns and ensures follow-up discussion takes place to identify action items. |
| CULTURE | Home “Stand-up” Team Meetings | Inter-disciplinary High Risk Team Meetings held daily to review the 24 hour report and discuss issues, concerns specified high risk safety and quality of life resident issues | DRC, Nursing Supervisor and all department heads | * The intent is to discuss common issues, concerns, high risk Residents and ensure all appropriate interventions and actions have been taken to reduce risk and / or harm on a daily basis. | * The daily Inter-disciplinary Team meetings promote culture of safety by identifying or evaluating High Risk Residents who require appropriate interventions and quality actions to remain safe in our homes. * Provides ongoing safety information/education to staff |
| CULTURE | Ensure Resident Safety is included in our Policies | Roll out revised Long Term Care Policies | Department Heads | * Education provided to staff on how to access policies on P-drive. * Policies are reviewed on an annual basis by designated Department Heads. * Monthly meetings held with Towers staff where one resident safety policy is reviewed in detail | * All policies are current and include Resident Safety * Policies are kept up to date by using Annual Policy Review Schedule form. * Improves staff access to and knowledge of policies * Provides a consistent approach for staff who work in both Manors and the Towers |
| CULTURE | Adopt the Montessori Philosophy | Train Champions in each home on Montessori Methods.  Allocate resources for Montessori approach including self-directed activities and signage for resident as needed.  Offer on-going information to staff, residents and families on the Montessori Philosophy through newsletters, information boards, and meetings.  Create Montessori Carts for each floor (where needed) and train families and staff on its usage and benefits | Montessori Trained Staff (champions), BSL Program Leads, Activities Staff | * Direct care staff champions have been trained in each home. * ‘Montessori-style’ programs to be incorporated into monthly Program Calendars as appropriate and considered for residents who do not participate in large group programs. * Continuous education with staff, volunteers, residents and families through newsletters, information boards, and meetings. Attend Family and Resident Council Meetings and show the cart and how to use it effectively. | * Provide meaningful activities to assist in reduction of responsive behaviors * Improved resident safety * Allows families to be better engaged with residents through the availability of activities through the use of the Montessori Carts |
| CULTURE | Ensure care is provided within an interdisciplinary approach with open communication | Implement new PACC  IDCC  Format – all care team together rather than only 1 discipline (nursing) | All Departments | * New care conference format implemented – with the entire team (or rep thereof) present along with resident (if competent) and family – has been well received by residents and families * Towers uses Telemedicine to promote and ensure access to timely information by members of the care team * Towers staff are involved in coordinated care plans to meet tenant needs | * Transparency * Improves open communication and builds team to all work together to ensure care plan is reflective of resident needs and that care is being provided in the best and safest way * Access to timely information |
| WORKLIFE/ WORKFORCE | Staff will be aware of their role in Resident Safety | Each job description within LTC has been updated to explicitly outline expectations, roles and responsibilities for Resident Safety | Human Resources | * Changes in job descriptions done in 2016/7. * Ongoing as new positions are developed. * Mandatory Training | * Staff are made aware that everyone shares accountability for Resident Safety |
| WORKLIFE/ WORKFORCE | At time of hiring, staff will receive orientation on their role in Resident Safety | Continually update and standardized New Hire Long Term Care & Seniors Services Employee training manuals including tips on Resident Safety.  Revise the Orientation training Program in the Homes | Human Resources and the Education Committee | * Standardized LTC New Hire Employee manual finalized in 2018. * New Orientation training program developed by Education Steering Committee 2017 * New Mandatory Training Manual created in 2016 | * Orientation program includes resident safety directives and has standardized across homes. * New staff are provided with “Tips – Did you know?” and a “workplace hazards sheet” so they are made aware that they are working in an organization that is committed to providing safe and high quality care to its residents and their families. |
| WORKLIFE/ WORKFORCE | Staff will be aware and educated about their role in Resident Safety | Staff receive annual Resident Safety Training (falls, restraints, fire safety, workplace violence, Hand Hygiene, Infection).  Ethics education is added to the annual mandatory education/ training package in 2019 | Administrator, Faith Manor, Education   * Coordinator and Specialized Program Team Leads | * Staff attend a 4-hour day * of training annually and additional training as identified | * Provide knowledge and encourage behaviours to help promote culture of safety on a small scale, improve quality of care, empower the staff and Residents. * Staff are reminded of the importance of Resident Safety in providing care services through the required programs training. |
| COMMUNICATION | Residents and families will be aware and educated about their role in Resident Safety | Finalize Resident and Family Handbook  In the event of an outbreak  Hand Hygiene  Sign-in sheets with tags  Signage regarding not letting residents out | Continuous Quality Improvement Team, Quality Improvement Program Coordinator, Nursing, Resident Council, Family Council | Resident and Family Handbook was finalized in 2017 and includes ways to maximize safety in the resident’s environment   * safety tips are provided to Residents and families on admission. * In the event of an outbreak, all families and residents receive personal phone calls. * Hand Hygiene signs are posted throughout the buildings. Hand hygiene is reviewed at both Resident Council and Family Council * Included in the Admission Package is information that acknowledges our commitment to Resident Safety | * Information is communicated upon admission to Residents, family and/or designates * Demonstrates our organization’s commitment to Resident Safety * Information is communicated to staff, volunteers, residents, families and/or designates to encourage involvement and promote safety * Information is communicated to the public and conveys our commitment to safety of our Residents. |
| COMMUNICATION | Improve communication between physicians / nursing staff and families / residents on medical issues | Hire a Nurse Practitioner | CEO | * 2016 – a Fulltime Nurse Practitioner was hired - shared between the two Manors | * Improved communication and better understanding of medical issues * Prevents residents suffering unnecessary transition and deterioration when they are transferred to the hospital with medical needs that can be taken care in the home. |
| COMMUNICATION | Information/ education for Staff, Resident and Family Council | Provide information /education to Staff, Resident and Family Councils to help understand residents with behavioural and psychological symptoms of dementia | BSL of each Manor | * BSL of each Manor attended Family and Resident Council Meetings to provide information/education on the use of Antipsychotics in Behavioural and Psychological Symptoms of Dementia * Annual Mandatory Training covers this topic along with GPA training for staff | * Creates a supportive environment * Satisfies the unmet needs of Residents * Promotes development of Routines that match the person’s habits and preferences * Improves communication * Increases understanding as to how behaviours can change at different times of the day |
| RESIDENT SAFETY | Protect Residents from harm  Identifies and responds to any conduct that may pose a risk of harm to residents or staff, or to the operation of the Home  Staff Training | Follow Prevention of Resident and Neglect Program Policies, including the reporting requirements and Whistleblowing Protection  Provide annual mandatory training on these policies  Implement RNAO Best Practice Guideline on Prevention of Resident Abuse and Neglect  GPA Coach Training for BSL staff  Purchase equipment needed to protect residents (ie. wanderguard system and door alarms, yellow wander strips etc) | CQI and Education Committees, HR, Administrators | * Whistle-blowing protection under Section 26 of the LTCHA forbids retaliation or threats of retaliation against a person for disclosing anything to an inspector or the MOHLTC Director, or for giving evidence in a proceeding under the LTCHA or during a coroner’s inquest. Under section 26, staff members, officers, and directors cannot discourage these disclosures * Annual Mandatory Training and Essential Knowledge Test completed * Program developed with several policies to comply * Work with RNAO Coach/team to implement best practice guideline – 3 year process (2017 - 2019) * Ongoing – Purchase equipment/supplies to support strategies to prevent wandering into other resident rooms (yellow strips, door alarms, black curtains etc) * Implement strategies to address exit seeking behaviours through use of door key pads, alarms, and install new wanderguard system (2017) with bracelets * BSL Team Leads trained and certified as GPA Coaches (2017) | * Documentation * Transparency * Trust * Accountability * Resident Safety * Ensure staff understand – essential knowledge test - knowledge transfer * Behavioral training offered to staff * Reduced admissions to hospitals due to behaviours * Reduced incidents of resident to resident incidents – keeping residents safe * Risk of elopement minimized and residents protected |
| RESIDENT SAFETY | Protect Disclosure Health Information | Collection and Disclosure of Personal Health Information – annual sign offs for IAR  Staff training on privacy and confidentiality  Implement Connecting Ontario – One Mail  Centralized access for disclosure – Privacy Office | Privacy Officer and LRA and RAI Coordinators | * Secure transmission of RAI Assessments to Health Information Network (HINP) Providers as determined by the LHIN. * Provide access to Connecting Ontario and ONEID by only those who need to have this access | * Resident Health Information is kept secure with the knowledge that only healthcare providers have access to their information * Limits the number of staff accessing confidential information |
| RESIDENT SAFETY | Roam Alert Installation and Testing | Upgrade current wander-guard system  Update process for Roam Alert bracelet testing. | RPNs, PSWs  Maintenance | * The process for Roam Alert has been updated to reflect the testing of the Residents’ bracelets in use. * The new process is that a task was added to POC for the PSW to bring every resident with a wander-guard bracelet to the exit doors every day/evening shift to test it to make sure they are working. * If bracelets are working, PSW simply sign off in POC. If the bracelet is not working, PSW informs the RN / RPN who immediately informs Maintenance by filling out a R4R. | * Added security and safety feature for exit-seeking residents * Ensures check of Resident bracelets * Added safety for Residents by checking bracelets on regular basis. * Easy way to remember to do testing. |
| RESIDENT SAFETY | LIFT Committee | Lift Committee to meet as part of the JOHSC to review lift data / stats related to quantity of lifts / slings, incidents  Annual Training provided to all staff who use the mechanical lifts and / or transfer residents.  Residents are assessed every 3 months or more often as required to ensure proper lifting device or method of lift is being used by staff | Physiotherapist, JOHSC  Restorative Care Leads | * Lift Committee Report is presented at each JOHSC for review and analysis * New Lift audit in place * Annual Mandatory training for staff using mechanical lifts | * Ensures Staff are trained in proper and safe lifting techniques * Monitors and tracks issues related to lifts to ensure safe outcomes * Tracks appropriate inventory to provide safe care |
| RESIDENT SAFETY | Emergency Codes | Codes are practiced regularly to prepare staff for any type of emergency  Annual training  Fire Drills | HR and Education Committee,  Disaster Coordinator | * Staff attend a 4 hour face to face mandatory training session on all codes annually * Code drills performed randomly throughout the year on all shifts * Fire Department observes annual fire drill (Vulnerable Occupancy) | * Staff know how to respond in an emergency to ensure resident safety * Staff feel more confident in an emergency * Residents and Families feel safe in the home |
| MEDICATION USE | Client identifiers | The team uses at least two resident identifiers before providing any service or procedure. | Registered Nursing Staff | * Staff use at least two client identifiers before administering medications; i.e., Picture on PCC/POC and Emar Identification bracelets * Verbal cues * Towers staff receive regular training on safe handling of drugs. * Towers staff use blister packs which are checked regularly by registered staff to reduce med errors and to promote safe medication management | * Assures Residents’ Safety (the “r’s”) |
| MEDICATION USE | Ensure the safe use of high risk medications | Registered Staff are aware of High Alert Medication  Provide additional education to staff on the safe use of high risk medications.  Monthly audits completed  New Signage posted on med carts – to limit medication errors/distractions | Pharmacy, Directors of Resident Care | * High Alert Medication alerts are provided on PCC for every high alert medication - posted by the Pharmacy * Medication Inservices provided annually by pharmacy to nursing staff * Medication audits done monthly by pharmacy, results shared and acted upon by DRC * Signage posted on med carts to ask others not to disturb during med pass * Towers staff | * Staff will be kept aware of any drug safety issues happening within the province * Reduce risk of medication errors * Additional education will reinforce staff knowledge on the safe use of high risk medications. * High risk medications are flagged on Emar as well as packaged individually in strip packages; e.g., Coumadin |
| MEDICATION USE | Ensure pharmacy is operating efficiently and safely  Proper equipment and supplies are readily available and systems in place to monitor pharmacy practices | Tender out Pharmacy Contract for the Manors  Ensure contracts identify equipment and supplies provided by company | CEO, Director of Finance, DRCs and Administrators | * Summer 2018 * Transition to new pharmacy – train staff on new practices or procedures * Provide new equipment (new med carts) to staff and train on usage | * A pharmacy that operates in a manner consistent with safe medication practices * New equipment and supplies to ensure safe medication delivery and storage |
| MEDICATION USE | MACPAC Meetings – new detailed reporting on Medication Errors and Drug Utilization | Develop new reporting form for Medication Errors and Drug Utilization | Medical Directors, Administrators, DRC, NP and Pharmacy | * new detailed reporting form developed for reporting Medication Errors and Drug Utilization * form used for analysis at MACPAC | * better detailed reporting on Medication Errors and Drug Utilization * Improved discussion and analysis of trends and actions taken to reduce medication errors |
| INFECTION CONTROL | The organization tracks and trends infection rates and educates staff on best practices regarding infection control | The organization routinely tracks and trends infection rates; analyzes the information to identify trends, clusters  Homes have adopted the PIDAC and Peel Public Health Processes as Best Practices | Infection Control Nurse, CQI Team, ICC | * Indicators are collected for C-Diff, MRSA, Skin Wound, Urinary Tract Infections, ESBL, VRE and other infections that are lab confirmed not elsewhere classified * Education was provided to staff regarding the importance of hydration, ongoing fluid management and good peri-care in the prevention of UTIs as part of mandatory training * TNO – N-95 mask-fit testing took place * TNO – Food Handler Course taught * Staff trained in how to clean up biological spills, use of PPE, HIV and blood-borne diseases * Flu Clinics provided annually to all residents and staff and volunteers | * Reduce rate of Infections * Resident improved health * Staff are trained and knowledgeable and understand how to implement and follow good infection prevention and control techniques * Risks Assessments are more effective |
| INFECTION CONTROL | The organization evaluates its compliance with accepted hand- hygiene practices by implementing Just Clean Your Hands Program | Just Clean Your Hands program is implemented.  Hand Hygiene audits are performed  Results are used to make improvements | Infection Control Nurse, and ICC, CQI Team | * Education Sessions occur annually and attendance is tracked (included in Mandatory Training) * Audits are performed quarterly using audit tool * Results are communicated at CQI Committee meetings and Infection Control Committee meetings in Towers and action plans are developed to make improvements * Results are posted in homes for Residents and families to view and published in CQI newsletters and reviewed at Family and Resident Council meetings | * Reduce Infection rates * Increase Resident safety * Continual monitoring in effect * Staff are trained and knowledgeable * Volunteers and service providers understand how to apply the hand hygiene protocol through in-services |
| INFECTION CONTROL | Review Best Practices for Cleaning, Disinfection and Sterilization of Medical Equipment/ Devices | Collect evidence that reprocessing processes are taking place.  Examine and improve reprocessing processes where indicated  Speak to HME to increase # of w/c cleaning clinics | Infection Control Nurse, IC Committee | * Medical Devices policy has been developed * Collect evidence that reprocessing processes are taking place. * Examine/improve reprocessing processes where indicated. * Cleaning is tracked through checklists for:   Walkers, wheelchairs, tubs, therapeutic surfaces, assistive devices (POC).  HME now providing quarterly w/c cleaning clinics | * Reduce risk of contracting an infection * Increase Resident Safety * Continual monitoring in effect * Staff are trained and knowledgeable * Resident wheelchairs are properly cleaned 3 times yearly by professional company to ensure smells and infections are reduced |
| FALLS PREVENTION | Falls Prevention Strategy is evaluated regularly | Falls Prevention is a Required Program under MOHLTC Acts and Regulations.  Post Falls Huddles to be held  Participation in RNAO Best Practice Falls Guideline  Development of a Program not only policies – to address falls  Training for staff on Falls Prevention Program  Purchase of falls equipment  Specialized Care Team to review stats  Tender the Physiotherapy contract | Falls Leads, CEO, Administrators, Education | * A new Falls Program developed rather than a falls policy * The Falling Leaf Program” has been implemented in FM, while the “Falling Stars” has been implemented in GM. * Monthly in Homes * Quarterly to CQI * Review results from Annual Falls Prevention Evaluation * In 2016, a Specialized Care Team was formed to deep dive into “falls” (and other areas) occurring in our homes to be able to prevent increased falls and to improve strategies and identify risks. * Falls is part of mandatory training * Audits being completed * Post Falls Huddles being completed on the unit – after each fall – multi-disciplinary approach * Purchase supplies needed for fall prevention * New Physiotherapy Contract signed (specializing in LTC and falls prevention), ADP authorizer, OT – increased hours of on-site PT and PTA. * Participation in RNAO Best Practice Falls Guideline – FM implementing “purposeful rounding”. | * In-depth review of Falls occurring in homes * Prevention of increased falls * Improved Strategies to reduce risks of increased falling. * Having equipment readily available to help prevent falls and serious injury/trauma from falls * An interdisciplinary approach to safe care |
| VIOLENCE IN THE WORKPLACE PREVENTION | Violence occurring in the Homes is evaluated regularly e.g.,  Residents to Residents,  Residents to Staff, Staff to Residents  In addition, Resident Aggressive behaviors are tracked | Violence in the Workplace is a Program under the Public Services Health & Safety Association (PSHSA).  Homes report incidents on a quarterly basis to the CQI Committee Chair who prepares indicators that are reviewed by the CQI Committee members and the Board of Directors.    Indicators are also provided to the Joint Health & Safety Committees in the homes for their feedback.  HCH’s Health and Safety Statement is reviewed annually by the Joint Health & Safety (JHSC) Committee and through an annual policy manual review. The Policy is used for all divisions within HCH.  How to report Violence in the Workplace has been included in the Common Orientation training for new staff hired.  Human Resources Department conducts an organization- wide risk assessment every 3 years to ascertain the risk of workplace violence and shares the results with all staff. (2018)  Resident aggressive behaviors are tracked monthly and support is sought through Behavioral Support Leads and Psychogeriatric Resource Consultants (Neuro Behavioural Support Team).  Staff Training | HCH Joint Health & Safety Committee, CQI Team | * Every three years:   Confidential Violence in the Workplace Employee perception Survey is performed with the intent to identify any potential areas or situations for violence.   * Participation in this survey is crucial in identifying and preventing workplace violence. * Report results are shared with the Joint Health and Safety Committee. * Action Plans are developed to address concerns * As requested or required for staff - HR purchased personal safety alarms for staff. * The results are also shared at the Annual Program Review Day – with residents, Board members, families, staff and volunteers present. * Staff Training Provided during mandatory training (code of conduct, workplace violence, bullying, harassment etc) * Extra training occurred in 2018 regarding Respect in the Workplace for 100% of staff | * Zero Tolerance for violence in our home * Residents feel safe in our home * Whistle Blowing Protection for Staff who report * Regular review is conducted. * Violence is investigated and acted upon * Program Evaluation is conducted annually with families, residents, staff, volunteers and Board input * Compare results to previous years * Strategies to prevent violence is implemented and re-evaluated to ensure resident safety * Staff understand their responsibilities to promote a safe workplace |
| Violence in the Workplace Prevention | To ensure Staff personal safety by providing a method for alerting other staff when help is required. | Ongoing - purchased personal safety alarms for staff.  Consulted with Joint Health & Safety Committee and agreed on using personal safety alarms for staff.  Alarms ensure that all staff have a method of calling for assistance in cases where their safety may be in jeopardy.  Code White Drills practiced  Code White Training | Joint Health & Safety Committee, Management and Staff | * Ongoing * Annual Mandatory Training sessions * Audits – drills – random throughout the year – records kept of participation * Code White Training provided during the annual mandatory training to all staff * Red / White Card Posted in every work area identifying to staff if a potential threat exists – maintaining confidentiality but alerting people to ask about what they should do to protect themselves | * Improved method for staff to communicate and respond when in need of assistance in cases where their safety may be in jeopardy. * Staff are more confident to respond to all types of emergencies * Alerting staff, residents, families and visitors of a potential threat or safety issue |
| RISK ASSESSMENT | Team Leads and Managers generate regular reports about their department or team’s performance | Indicators are tracked, standardized in order to meet all health sector requirements (QIPs) while also looking at high risk areas to the organization.  CQI Chair quarterly reporting – to teams, Board and residents and families | CQI Chair, Team Leads | LTC indicators are reported on a monthly, quarterly and annual basis into a spreadsheet.   * Performance Indicators are reviewed:   Quarterly @ CQI and Specialized Care Team Meetings  (Indicators are tracked through QIP and Excel spreadsheets).   * CQI Chair runs a quarterly report highlighting achievements and where we are falling behind on performance. This report is reviewed and analyzed by all team members at the quarterly specialized programs and CQI team meetings. * Reports of the results are also provided to the Care Committee of the Board of Directors. * CQI Board – NEW posts reports results to residents/families and visitors * CQI News – newsletter available to everyone – reports on “how we are doing” | * Indicators are tracked and reviewed on a regular basis by the Continuous Quality Improvement Committee, Specialized Care Teams and the Care Committee of the Board. * Follow-up and Improvements to programs are noted within reports. * Quality Improvement Plans (QIPs)-- High Risk Indicator data (Falls, Incontinence, Restraints, Wounds, Subscribing of anti-psychotics, potential avoidable emergency department visits), are collected, analyzed, trended and reported with recommendations / action plan on a quarterly basis. |
| RISK ASSESSMENT | Hire a CQI Staff in our Homes to collect data, track and analyze quality and safety risks and implement improvements as needed | Define roles and responsibilities of CQI staff in all homes  Create job description for new position | CEO, Administrator’s Senior Leadership Team and Human Resources | * Roles have been defined. * The Manors share a QI Program Coordinator to collect data, track and analyze quality and safety risks and make improvements. | * A Quality Improvement Coordinator to collect, analyze and monitor data * Quality Improvement Coordinator provides reports to Quality Improvement Committee and Specialized Care Team Committee * Assesses community health needs to establish priorities * Promotes the philosophy of safety, high-quality care and services for our Residents |
| RISK ASSESSMENT | Health Quality Ontario – Quality Improvement Plan (QIP) | Each home will develop and implement a QIP  Results will be shared amongst the homes to establish Leading practices | CQI Coordinator, CQI Team | * Quality Improvement Plan is developed annually for each home. Results will be evaluated at year- end and improvements will be implemented across the homes * QIPs are reviewed/ evaluated at quarterly quality meetings. If actions are not effective in creating data improvement, revisions are implemented. * QIPs results are shared with CEO for further direction. Board of Directors also receives results quarterly. | * Continued quality monitoring of services and reduction of risk * Improved Resident safety * Opportunity to share Leading practices * Transparency |
| RISK ASSESSMENT | Homes will address in a timely manner all issues raised from MOHLTC RQI to ensure Resident Safety is being met | Homes will work in conjunction with Quality Team to develop Action Plans to address all findings  MOHLTC Inspection – Compliance Tracking and monitoring | Administrators and all staff | * Review on a monthly basis to determine if audits are required based on results. * To meet compliance, action plans are developed and followed up as per schedule. | * MOHLTC Home inspection areas of non-compliance are addressed and improvements implemented * Assess risks level * Minimize Risk to the Organization * Improve Resident Safety |
| RISK ASSESSMENT | Focus on Safety and Continued Quality Improvement and Performance Program | Provide Quarterly quality reports to CQI Team for discussion at Quarterly Quality Team meetings.  Quarterly Quality Reports are submitted to CEO for further direction. | Home Quality CQI Program Coordinator, CQI Team | * Each member of the Quality team contributes to the content of the report ensuring new issues, improvements and resolutions are reported for all our homes (monthly) | * Monitor and track indicators * Senior Management is kept informed of current activities, safety issues, risk factors, improvements and resolution * Minimize Risk to the Organization * Improve Resident Safety * Transparency |
| RISK ASSESSMENT | Home  Departmental  Audits | Audits and Audit Schedule to be implemented: Each Department and Team will determine which audits will be completed for the upcoming year and the frequency with which these audits will occur.  Audits will be analyzed and plans of action directed to improving/ maintaining quality of life and safety of our Residents will be developed  Ongoing evaluation and documentation of the effectiveness of actions taken will be conducted and results communicated to staff, Residents and families  Issues to be addressed for formulating future planning will be communicated to senior management  Electronic system for audit tracking | CQI and Specialized Care Committees | * 2017 – audit schedule and audit form completion * 2018 - Put audits on surge learning for easy access and for alerting action items for assigning, recording and tracking audits completed | * Ongoing process of quality improvement and management * Optimal Resident Care and Services * Appropriate Indicators of performance are identified and monitored for Resident safety. * Community health needs are being addressed * Promotes the philosophy of continuous quality improvement * Assess risks level * Minimize Risk to the Organization * Improve Resident Safety |
| RISK ASSESSMENT | Incident report will be completed for all events during the process of care that result in a negative or unanticipated outcome (CIS)  Incidents may also be reported by staff, Residents, families or other stakeholders in the form of complaints/concerns.  Resident and Family Council minutes, Staff Meetings, CQI Meetings and Satisfaction Survey Results.  New concern form | RISK Management Program:  All adverse events complaints, concerns, critical incidents, violence in the workplace, abuse & neglect are reported through the Risk Management Program for tracking, following up and investigating, if required.  Potential or actual events will be identified.  Nursing Teams to review all 24HR reports, and incident reports to ensure follow up action is taken when required.  Potential or actual events will be investigated; improvements to process will be developed and communicated to the Care Team.  Should there be concern for the Safety of Residents, staff or others a communication with directives will be issued immediately to staff to mitigate the issue.  Events will be reviewed through the CQI Committee and Care Committee of the Board of Directors to evaluate processes to ensure safety. | CQI Committee  Nursing Leadership  Administrators  Joint Health & Safety Committees | * Ongoing as needed * New Concern form implemented in 2016 to document and track and concerns and to ensure appropriate follow-up * Information shared at Resident/Family Council Meetings | * Immediate Action is taken * Assess risks level * Minimize and mitigate Risk to the Organization * Improve Resident Safety * Identifies areas that may require systematic improvements * MOHLTC is notified when critical incident is identified * Improved customer service in the timely response to Family/Resident complaints and concerns * Ability to identify and mitigate negative outcomes |
| RISK ASSESSMENT | Required Programs: To ensure Annual Evaluations are completed for all required programs as set out in the LTCH Act and Regulations (Falls, Skin/ Wound Care, Continence Care/ Bowel Mgmt and Pain Mgmt), as well as other required programs: Complaints Mgmt, Satisfaction Survey, contracted Services, Infection Prevention and control, Nursing and Support Services Staffing Plan, Restraint, Responsive Behaviors, Palliative Care, Med. Mgmt, Medical Services, Prevention of Abuse, Dietary Services and Hydration, Staff Orientation and Training, and Quality Improvement Program | To provide guidelines for Program  Evaluation as required.  To maintain a process to evaluate the effectiveness of programs related to evidence based practice or prevailing practice.  To assess and continually improve the safety, quality of care and services provided to Residents.  To maintain a formalized Performance Management System that incorporates elements related to quality, safety, risk, ethics and resource utilization.  To utilize both process and outcome measures to evaluate organizational performance.  Hold a one day event to review all programs and services – reporting on how our organization met goals and targets related to safety and care and other quality of life issues  Invite residents, families, Board members , staff and volunteers to be a part of this day | Appropriate inter- disciplinary team, CQI Committee, program leads | * Annually in February * One day meeting held with lunch served to involve all levels of the organization * Separate day for each Manor * Family Council and Residents Council also present a report Goals of the program are established annually * Each Committee/ Team will submit the results of the * Program Evaluation to the CQI Committee with recommendations for improvement, if any * Opportunities for improvement will be discussed and approved at the CQI and Specialized Care Team Meetings * Statistics are posted for viewing by families and residents * A record of quality improvement initiatives and outcome measures will be documented * The results are also shared at the Annual Program Review Day – with residents, Board members, families, staff and volunteers present. | * Meet LTCH Act and Reg. * Continued Quality Improvement Process * Reduces and mitigates risks to the organization * Provides performance measurements * Improves Resident * Safety * Identifies trends in program deficiencies that may require changes in care processes * Information shared with staff, residents and families * Transparency * Program Evaluation is conducted annually with families, residents, staff, volunteers and Board input * Families and residents and volunteers and staff feel a part of the team, part of goal planning and changes being made * Being transparent on how we are or not achieving our goal in providing safe and quality care * Opportunity to share and celebrate accomplishments, while discussing opportunities or improvement |
| RISK ASSESSMENT | Strong Community partnerships for supporting Behaviour Management | Behavioral  Support  Ontario Project (BSO)  RGP program for training and support  Utilize Hi Intensity Needs Funds  Neurobehavioural Support Team and Geriatrician | CWLHIN BSO  BSL  RGP  BSL | Utilize Hi Intensity Needs Funds – 1:1 staffing to be provided as required  Partner with RGP and Neurobehavioral Support Team to address resident responsive behaviours / challenges with family acceptance of behaviours etc  RGP Training provided regularly on specific topics as required | * Behavioral training offered to staff by experts in the field * Community partnerships enhanced ie. Neurobehavioural Support Nurses to work with staff to problem solve and come up with viable interventions to improve the situations and the quality of life of the Resident experiencing behavioural issues. * Reduced admissions to hospitals due to behaviours * Reduced incidents of resident to resident incidents – keeping residents safe * Staff feel supported through extra help for 1:1 residents |