

Let's Make Healthy
Change Happen.



Quality Improvement Plan (QIP) Narrative for Health Care Organizations in Ontario



TABOR MANOR
serving seniors with excellence, love and dignity

Long Term Care

March 2016

This document is intended to provide health care organizations in Ontario with guidance as to how they can develop a Quality Improvement Plan. While much effort and care has gone into preparing this document, this document should not be relied on as legal advice and organizations should consult with their legal, governance and other relevant advisors as appropriate in preparing their quality improvement plans. Furthermore, organizations are free to design their own public quality improvement plans using alternative formats and contents, provided that they submit a version of their quality improvement plan to Health Quality Ontario (if required) in the format described herein.

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Overview of Our Organization's Quality Improvement Plan

Overview

The objective we focus on in our QIP is aimed at improving resident-centred care, particularly related to improving the food and dining experience for residents. We chose this objective to respond to feedback from long term care (LTC) residents that identified it as an area of lower satisfaction on the 2015 Tabor Manor Resident Satisfaction Survey.

Our QIP aligns with the quality objectives of our organization's strategic plan, and with our Long Term Care Service Accountability Agreement (L-SAA). Further, our QIP aligns with provincial and regional strategies of client-centred care, as well as Seniors Strategy in the province. It is integrated with Health Quality Ontario's (HQO) and the Local Health Integration Network's (LHIN) health services plan that focuses on client experience.

Quality Improvement Achievements from Past Year

Residents and their families have noticed improvement in our laundry service over the past year. We made progress on our objective this past year but have not yet achieved our target. Our progress indicates that we are heading in the right direction. Our "final" measurement may not accurately reflect the extent of our progress because it was taken just over a quarter of the year into our QIP. (Our annual Resident Satisfaction Survey is distributed in August, which was only 4 months after we initiated the work on our QIP). In completing our first full year of the QIP cycle, we discovered the need to modify our Quality Calendar to better align our annual survey season with the QIP cycle, which we have done for the coming year, to improve the accuracy and timeliness of our measurements and feedback cycle. We anticipate that this change will more accurately reflect our success in achieving our objectives.

Integration and continuity of care

Pleasant Manor and Tabor Manor, which are sister homes, have a Quality Council (QC) that oversees the quality improvement strategy and initiatives at both homes. The homes work together and align objectives to create positive change in both locations. We are a member of the Ontario Association of Non-profit Homes and Services for Seniors (OANHSS) Region 2 Administrators group and the Hamilton Niagara Haldimand Brant (HNHB) Long Term Care Homes (LTCH) Network and Niagara Senior Supportive Housing Network (NSSHN), and have been working with these groups to develop quality improvement initiatives.

Engagement of clinicians and leadership:

Our leadership staff were involved in the creation of the objectives and action plans on our QIPs through our LTC Continuous Quality Improvement Committee (CQIC). We have also consulted our LTC Professional Advisory Committee (PAC) and engaged in conversations with Brock & DeGroote School of Medicine, Niagara Campus, as partners in our quality journey. Our management team has obtained certification through Improving & Driving Excellence Across Sectors (IDEAS) training. Our QIP was reviewed and approved by the Pleasant Manor and Tabor Manor Board of Directors on Wednesday, March 23, 2016.

Patient/Resident/Client Engagement

Upon receiving our Resident Satisfaction Survey results, we meet with the Resident Council to discuss the results and establish an area for improvement. Staff create an action plan and report back to the Resident Council and Family Council to let them know how we plan to improve in the identified area.

Sign-off

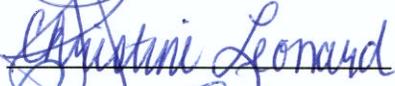
I have reviewed and approved our organization's Quality Improvement Plan



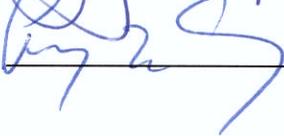
Glen Unruh, Board Chair



Tim Siemens, Chief Executive Officer & Quality Council Chair



Christine Leonard, Director & Long Term Care Quality Committee Chair



Penny Zdichavsky, Nutrition Manager

Quality Improvement Plan – Tabor Manor – Long Term Care

AIM		MEASURE				CHANGE				
Quality Dimension	Objective	Measure/ Indicator	Current Performance	Target for 2016/17	Target Justification	Planned Improvement Initiative (change ideas)	Methods	Process Measures	Goal for change ideas (2016/17)	Comments
Resident Centered	A – 1 Improve the Food	% of positive responses on questions related to variety, presentation, temperature, and taste of food, as indicated on the Tabor Manor Resident Satisfaction Survey.	81% (162 of 199) responses are positive	86% of responses are positive	To improve residents' enjoyment of food. To work toward matching best performance in other categories on Tabor Manor Resident Satisfaction Survey.	Revamp menu & implement new menu that reflects resident feedback, including more variety, resident choice meals, more fresh local produce in summer, and removal of unwanted foods. Monitor resident satisfaction with new menu.	Nutrition Manager will consult Dining Committee for input on menu and will review menu with Committee prior to finalizing. Implement menu Nutrition Manager will hold Dining Committee meetings quarterly and as needed during menu cycle changes to get feedback on new menu. Supervisors will conduct audits every 3 months to determine resident satisfaction on the variety, presentation,	Documentation of Dining Committee input, review, and approval. Menu implemented. Documentation of meetings held in which residents were invited to feedback on menu. Percentage of positive responses.	Dining Committee has been given the opportunity to provide input, has reviewed, and has approved menu prior to implementation, as outlined in meeting minutes. Menu implemented by March 1, 2016. The minutes of four Dining Committee meetings document that residents were invited to feedback on menu. 82% for first quarter 84% for second quarter 86% for third & fourth quarters	We chose this objective because Dietary/Food was identified as an area in which residents were not as satisfied, as identified on our 2015 Resident Satisfaction Survey. In addition, the Residents' Council voted food and dining service as the main issue residents want addressed this year.

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							temperature, and taste of food. Audits will take place in each of our four dining rooms and will involve asking 4 questions to the same 4 people each time to measure progress over time.	Results will be reviewed at Continuous Quality Improvement Committee (CQIC) meetings & Dining Committee meetings.	Minutes of CQIC meetings and Dining Committee meetings document review of audit results.	
						Change brand of coffee served.	Hold coffee samplings for residents to try new brands of coffee, then obtain their feedback on which coffee to purchase.	Documentation of coffee sampling held. Documentation of residents' vote on which coffee to purchase.	Coffee sampling held before March 1, 2016. The coffee residents chose, as documented in meeting minutes and order sheets, was purchased and served by March 31, 2016.	
						Nutrition Manager will improve appearance of plated meals (ie. colour, texture, combinations, etc.).	Nutrition Manager will review combinations of foods on plate and modify to improve appearance of plated meals.	Review by Nutrition Manager and appropriate changes made.	Nutrition Manager has completed review and made changes by March 31, 2016.	

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						Nutrition Manager will create more contrast on plated meals for residents who have a visual impairment so they can better see and enjoy their food.	Serve meals on coloured plates for residents who have a visual impairment, as documented in their care plan.	Nutrition Manager will do random audits to ensure the coloured plates are being used for the appropriate residents.	Coloured plates are being used 100% of the time after March 31, 2016 for residents who have a visual impairment.	
	A – 2 Improve the Dining Experience	% of positive responses on questions related to promptness of service, time provided to eat, assistance provided, and overall dining room experience, as indicated on the Tabor Manor Resident Satisfaction Survey.	92% (183 of 200) responses are positive	95% of responses are positive	To improve residents' enjoyment of the overall dining experience. Though our target is only a 3% increase in satisfaction, it has been set as such because there is little room for any dissatisfaction in a target as ambitious as 95%.	Implement and maintain face cloth program: Each resident gets a warm washcloth at the end of the noon meal to clean their face and hands prior to leaving the dining room.	Communicate program and expectations to staff at interdisciplinary team meeting. Memo will be distributed to staff to redefine this program as an expectation of service. Training on program at inservice.	Program and expectations communicated. Memo distribution. Training provided.	Program and expectations were communicated by March 1, 2016. Memo was distributed by March 1, 2016. Training was provided by June 30, 2016, as documented in inservice material.	

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						<p>We will begin using bread makers/crock pots and/or cooking/baking with residents on the floors to produce aromas to stimulate appetite and involve residents in food preparation.</p>	<p>Supervisors will conduct audits to ensure program is happening, as per audit schedule for Supervisors.</p> <p>Therapeutic Recreation Staff will run cooking/baking programs at least once a month on each floor.</p>	<p>% of days the program happens.</p> <p>Therapeutic Recreation Supervisor will track how many programs are offered each month.</p> <p>Therapeutic Recreation Supervisor will collect qualitative feedback about program from residents and families.</p>	<p>80% for first quarter. 90% for second quarter 100% for third & fourth quarters</p> <p>Therapeutic Recreation Supervisor will have documentation that indicates that a cooking/baking program was held on each floor at least once each month.</p> <p>This is a new program so our goal is to find out how residents and families are thinking and feeling about it.</p>	

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						We will train staff on customer service as it relates to the dining experience, through an inservice.	We will hold an inservice June 30, 2016. This same inservice will be offered at multiple times in order to reach staff who work different shift times.	% of staff in attendance	80% of staff in attendance	