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

Supportive Housing

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.

Overview of Our Organization’s Quality Improvement Plan

Overview

The objective we focus on in our QIP is aimed at improving client-centred care, particularly related to improving the food and dining experience for clients. We chose this objective to respond to feedback from Supportive Housing (SH) clients that identified it as an area where there is room for improvement on the 2015 Tabor Manor Supportive Housing Client Satisfaction Survey.

Our QIP aligns with the quality objectives of our organization’s strategic plan, and with our Multi-Sector Service Accountability Agreement (M-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.

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.

Challenges, risks and mitigation strategies

Our challenge will be to achieve the performance goal because client satisfaction with food is very subjective. A major risk is that we will work hard to make changes aimed at improvement but will see no actual improvement in satisfaction because food preferences are very personal to each client and are dependent on a plethora of factors. Despite this challenge, we have decided to try to improve satisfaction with food and dining because it is a necessary, important and, hopefully enjoyable, part of our clients’ days.

We have chosen to mitigate this risk by implementing changes to not only the food itself, but to the dining experience as well, to help clients have a better overall experience at meal times. Our hope is that changes like a freshly painted dining room with posted menus and a warm washcloth to clean one’s hands and face after a meal will create a more enjoyable experience, despite what the client ate for lunch that day. We have also made efforts to get client feedback on our existing menu and suggestions of meals they would like to see on future menus, so we can create a menu with client preference and feedback in mind.

Information management:

Our organization uses annual Supportive Housing Client Satisfaction Surveys to obtain data and feedback from our clients so we can better understand their needs. As mentioned above, our QIP objective is drawn directly from our 2015 Supportive Housing Client Satisfaction Survey as a means of responding to client feedback. Our goal is to improve client satisfaction in the identified area on the 2017 Supportive Housing Client Satisfaction Survey.

Engagement of clinicians and leadership:

Our leadership staff were involved in the creation of the objectives and action plans on our QIPs through our SH Continuous Quality Improvement Committee (CQIC). We have 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

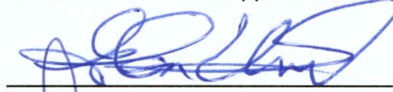
Upon receiving our Supportive Housing Client Satisfaction Survey results, staff identify an area for improvement and create an action plan. We then report back to the Tenant Council to let them know how we plan to improve in the identified area.

Accountability management:

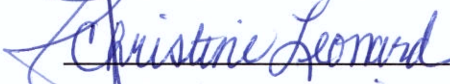
Our progress on our QIP objective will be reviewed quarterly at CQIC meetings and then reported on at QC meetings. The objective on our QIP is incorporated into our supervisors’ annual performance plans through our performance management system, to be reviewed and assessed throughout the year and in their annual performance reviews.

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 & Supportive Housing Quality Committee Chair

____________________ Megan Challice, Supportive Housing Coordinator

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Quality Improvement Plan – Tabor Manor – Supportive Housing

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**
Client-Centred	A – 1 Improve the Food & Dining Experience	% of positive responses (7 or higher) on question related to dining room service, as indicated on the Supportive Housing Client Satisfaction Survey.	60% (9 of 15) responses were positive	70% of responses are positive	To improve clients' enjoyment of food and the overall dining experience To work toward matching best performance in other categories on Tabor Manor Supportive Housing Client Satisfaction Survey.	Revamp menu & implement new menu that reflects client feedback, including more variety, client choice meals, more fresh local produce in summer, and removal of unwanted foods.	Nutrition Manager will consult Dining Committee for input on menu and will review menu with Committee prior to finalizing.	Documentation of Dining Committee input, review, and approval.	Dining Committee has been given the opportunity to provide input, has reviewed, and has approved menu prior to implementation, as outlined in meeting minutes.	We chose this objective because dining room service was identified as an area in which Supportive Housing Clients were not as satisfied, as identified on our 2015 Supportive Housing Client Satisfaction Survey.
							Implement menu	Menu implemented.	Menu implemented by March 1, 2016.	
						Monitor client satisfaction with new menu.	Nutrition Manager will hold Dining Committee meetings quarterly and as needed during menu cycle changes to get feedback on new menu.	Documentation of meetings held in which clients were invited to feedback on menu.	The minutes of four Dining Committee meetings document that clients were invited to feedback on menu.	
							Supportive Housing Supervisor will conduct a baseline audit and then conduct audits every 3 months to determine client satisfaction on the	Percentage of positive responses. Results will be reviewed at	69% for first quarter 75% for second quarter 81% for third & fourth quarters Minutes of CQIC meetings and Dining	

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							variety, presentation, temperature, and taste of food. Audits will involve asking 4 questions to the same 4 people each time to measure progress over time.	Continuous Quality Improvement Committee (CQIC) meetings & Dining Committee meetings.	Committee meetings document review of audit results.	
						Change brand of coffee served.	Hold coffee samplings for clients to try new brands of coffee, then obtain their feedback on which coffee to purchase.	Documentation of coffee sampling held. Documentation of clients' vote on which coffee to purchase.	Coffee sampling held before March 1, 2016. The coffee clients chose, as documented in meeting minutes and order sheets, was purchased and served by March 31, 2016.	
						Nutrition Manager will improve visual 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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						Implement and maintain face cloth program: Each client 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 team meeting.	Program and expectations communicated.	Program and expectations were communicated by March 1, 2016.	
							Memo will be distributed to staff to redefine this program as an expectation of service.	Memo distribution.	Memo was distributed by March 1, 2016.	
							Training on program at inservice.	Training provided.	Training was provided by June 30, 2016, as documented in inservice material.	
							Supervisors will conduct audits to ensure program is happening, as per audit schedule for Supervisors.	% of days the program happens.	80% for first quarter. 90% for second quarter 100% for third & fourth quarters	
						We will begin using bread makers/ crock pots and/or cooking/baking with clients to produce aromas to stimulate appetite	Therapeutic Recreation Staff will run a cooking/baking program at least once a month.	Therapeutic Recreation Supervisor will track how many programs are offered each month.	Therapeutic Recreation Supervisor will have documentation that indicates that a cooking/baking program was held at	

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						and involve clients in food preparation.			least once each month.	
								Therapeutic Recreation Supervisor will collect qualitative feedback about program from clients and families.	This is a new program so our goal is to find out how clients and families are thinking and feeling about it.	
						We will train staff on customer service as it relates to the dining experience, through an inservice.	We will hold an inservice before 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	
						Improve physical dining room space	Hire a painting company to paint the walls in the dining room.	Dining room painted.	Dining room painted by June 30, 2016.	

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						Post daily menu and full menu cycle to better include clients in the dining experience.	Install tasteful frames in which to post menus. Supportive Housing Coordinator will audit to ensure menus are posted daily.	Frame installation. Daily menus posted.	Frames installed by March 31, 2016. Menus posted 100% of the time.	