



ADMINISTRATIVE REPORT

To: WARDEN AND COUNCIL OF THE COUNTY OF FRONTENAC

From: Elizabeth Savill
CAO

Prepared By: Julie Shillington
Administrator of Fairmount

Date Prepared: July 12, 2011

Date of Meeting: August 17, 2011

Re: Fairmount Home – Quality Improvement Activities Update

Background

As set out in the *Long-Term Care Homes Act*, every long-term care home must have a comprehensive quality improvement program that includes mechanisms for evaluation and reporting.

To ensure that Council, the governing body of Fairmount, is kept apprised of quality improvement activities at the home, a Council report will be prepared following each meeting of the home's Quality Assurance and Assessment Committee.

Comment

There is currently a variety of quality improvement activities underway as set out below:

Activity	Reasoning	Current Status	Results
These Are From Trees – placing environmental stickers on paper towel holders	Trying to reduce the use of paper towels in public and staff washrooms	Tried in three washrooms – there was a measurable drop in two of the three	Continue to monitor; now measuring cost savings over six month period
1North Battery Trial – staff were changing batteries for the four nurse call pagers every three to four days – purchased rechargeable batteries to trial	Trying to reduce costs and battery disposal	Rechargeable batteries are being changed about every three weeks	Continue to monitor to see if rechargeable batteries continue to hold charge over time
Volunteer Program Review – Volunteer Survey – survey of volunteers’ opinions on a variety of topics such as the mission statement, program participation, roles, etc.	A survey of volunteers has not been taken in some time. We felt it was important to gauge their satisfaction and opinions	Survey of volunteers is underway	No results to date
Volunteer Individual Program Review — review with programming staff, volunteers and residents involved in each individual program	The program review is being conducted to ensure the programs are meeting the needs of facilitators and participants	First program review, focused on Beauty Break 2 nd Floor, was conducted on July 12 th	Results not yet available
End of Life Pain & Symptoms Checklist – the Palliative Care Team developed a checklist which is being trialed	The goal of the checklist is to support the staff working with end of life residents and their family members	Currently being trialed	Results not yet available
Urinary Tract Infection Algorithm – was developed to support RNs and physicians in their decision whether or not to treat for UTI	The goal is not to treat residents unless they have been confirmed as having a UTI though lab testing	Currently being trialed	Results not yet available

Each quality improvement initiative is tracked through a project charter and filed in the administrative office for easy access by the Ministry inspectors.

Project results will be communicated through Residents’ Council meetings, general staff meetings, family information meetings, the Grapevine Gazette and County Council reports. In future we will also report on our website.

Financial Implications

Many of our activities could result in financial savings however this should not be the only basis on which a quality improvement activity is undertaken.

Sustainability Implications

The Health and Social Services Vision Statement from *Directions for Our Future* reads:

Residents (both permanent and seasonal) are able to access high quality health care and professional social services through a network of care facilities and programs in the Frontenacs. The County fosters the network of health care and social service providers through development, maintenance, attraction and retention programs. It also advocates for a strong health and social services system, supported through effective service delivery agreements.

Our quality improvement program will help us to ensure high quality services are provided to our residents.

Recommendation

That Council of the County of Frontenac receive the *Fairmount Home – Quality Improvement Activities Update* report for information only.

Organizations, Departments and Individuals Consulted and/or Affected

Residents
Volunteers
Family Members
Staff
Ministry of Health & Long-Term Care

Regulation	Change	Action Required
8 (2) – Policies & Records	NEW - Where the Act or Regulation requires the licensee to keep a record, the licensee shall ensure that the record is kept in a readable and useable format that allows a complete copy of the records to be readily produced	Records should be easily accessible to an inspector. Fairmount records are kept on-site according to the timeliness set out in the County's retention by-laws.
12 (2)(a) – Furnishings	Resident beds have a firm, comfortable mattress that is at least 10.16 cm thick unless contraindicated as set out in the resident's plan of care	This has been communicated to the staff responsible for purchasing mattresses.
14 – Shower Grab Bars	Every resident shower has at least two easily accessible grab bars with at least one grab bar being located on the same wall as the faucet and at least one grab bar being located on an adjacent wall	The second grab bars were installed.
15 (1) – Bed Rails	The resident is assessed and his or her bed system is evaluated in accordance with evidence-based practice and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; steps must be taken to prevent resident entrapment taking into consideration all potential zones of entrapment; ensure other safety issues related to the use of bed rails are addressed including height and latch reliability	The process is in place for assessment of bed rails and we have received clarification from the Ministry as to when bed rails are to be considered a restraint. Our restraint policy has been amended to reflect this clarification.
16 - Windows	Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 10 centimeters	Windows have been checked and meet the requirements
18 – Lighting	Corridors & stairwells – "continuous consistent" lighting	Compliant
20 – Cooling Requirements	Ensure that a written hot weather related illness prevention & management plan for the home that meets the needs of the residents is developed in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, & is implemented when required to address the adverse effects on residents related to heat. Shall ensure that, if central air conditioning is not available in the home, the home has at least one separate designed cooling area for every 40 residents.	The home has air conditioning so we are compliant
23 – Compliance with manufacturer's instructions	Ensure that staff use all equipment, supplies, devices, assistive aids & positioning aids in the home in accordance with manufacturers' instructions	This was included in the staff orientation to the Act and is included in new staff orientation. A process to ensure easy access to manufacturer's instructions to be developed.
24 – Renamed from Initial Plan of	NEW - Must include...any risks the residents may pose to others.	Review current written policies to ensure includes requirements of

Care to 24-hour Admission Care Plan	including any potential behavioural triggers, and safety measures to mitigate those risks; drugs & treatments required; known health conditions including allergies and other conditions of which the licensee should be aware upon admission including interventions; skin condition including interventions; diet orders including food texture, fluid consistencies and food restrictions.	24-Hour Admission Care Plan
25 – Initial Plan of Care	NEED TO REVIEW THIS SECTION AS COMPLETELY REVISED	Review current written policies to ensure includes requirements of Initial Care Plan
26 – Plan of Care	There is a requirement for the dietitian to do the nutritional assessment upon admission & whenever there is a significant change in the resident's health and do the assessments on nutritional status including height, weight and any risks relating to nutritional care: hydration status & any risks relating to hydration	Review current policies to ensure compliance; the role of the Dietitian was reviewed with the new Dietitian.
29 – Changes in Plans of Care - Consent	NEW - requirement that if a resident is reassessed and the plan of care is reviewed & revised, any consent or directive with respect to "treatment" as defined in the Health Care Consent Act, 1996, including a consent or directive with respect to "a course of treatment" or a "plan of treatment" under that Act, that is relevant, including a regulated document under paragraph 2 of subsection 227(1) of this regulation is reviewed &, if required, revised.	Ensure policies and procedures updated and process in place to ensure compliance
30 – General Requirements for Programs	Ensure that the following is complied with in respect of each of the organized programs under section 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this regulation (falls, skin, continence, pain)	Programs include nursing & personal support; restorative care; recreation; dietary services & hydration; medical services; information & referral assistance; religious & spiritual practices; accommodation services; volunteer program; falls prevention; skin & wound care; continence care & bowel management; pain management – working on updating current goals and objectives based on outcome of strategic planning; review evidence based practices
30 – 1-1	There must be a written description of the program that includes its goals & objectives and relevant policies, procedures & protocols and provides for methods to reduce risk and monitor outcomes including protocols for the referral or residents to specialized resources where required	
30-1-2	Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the	

30-1-3	resident based on the resident's condition The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.	
30-1-4	Keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date those changes were implemented Ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions & the resident's responses to interventions are documented.	Currently developing & confirming evaluation tools
30-2		This was included in staff orientation to the Act and is included in new staff orientation.
31 – Staffing Plan	Include a back-up plan for nursing and personal care staff that addresses situations when staff, including RN, cannot come to work and must be evaluated & updated annually in accordance with evidence based practices &, if there are none, in accordance with prevailing practices. Must keep the date of the evaluation, who participated, a summary of the changes made & the date the changes were implemented Staff shall use safe transferring & positioning devices or techniques when assisting residents	Staffing plan was updated to reflect staffing reductions and is based on current practice. Evaluation to be based on MOHLTC inspection reports; resident & staff satisfaction surveys and incidents/complaints related to staffing levels.
36 – Transferring & positioning techniques		This was included in staff orientation to the Act and is included in new staff orientation.
37 – Personal items & personal aids	NEW - Must be labeled within 48 hours of admission and acquisition and must be cleaned as required	This was included in staff orientation to the Act and is included in new staff orientation. A policy has been developed and distributed.
42 – End of Life Care	NEW - Every resident receives EOL care when required in a manner that meets their needs. Removed the requirement to respond to the immediate needs of other residents, family & staff following the death of a resident. Strategies must be developed and implemented - now includes strategies for residents with cognitive impairment	This was included in staff orientation to the Act and is included in new staff orientation.
43 – Communication Methods		This was included in staff orientation to the Act and is included in new staff orientation.
47 – Qualifications of PSW	Program must be at least 600 hours (school & placement)	Confirmed
48 – Required Programs	Falls prevention & management; skin & wound care; continence care & bowel management; pain management. Must provide for screening protocols & assessment & reassessment instruments. There are additional requirements for all of the four programs	Ministry confirmed must be a "program" – staff must be able to find information from start to end in one place. We currently have a variety of policies and procedures for each program in place but we are currently bringing all the documentation together and determining how the programs are to be evaluated.

53 – Responsive Behaviours	Many additional requirements including internal reporting protocols, written information;	Nurse Practitioner has developed the Pain Management program and is currently implementing across the home after an initial trial on one unit. Program was presented to family members during the family information session.
54 – Altercations & other interactions between residents	Enhanced to cover potentially harmful altercations & must be an interdisciplinary assessment	The policy was revised and shared with staff during orientation to the Act. It is also part of the new staff orientation.
55 – Behaviours & altercations	NEW – must have procedures & interventions to assist residents & staff who are at risk of harm or who are harmed as a result of a resident's behaviours; requirement for advising staff of residents with behaviours at the beginning of shift	The policy was revised and shared with staff during orientation to the Act. It is also part of the new staff orientation.
57 – Integration Restorative Care	RC approaches must be integrated into the care that is provided to all residents	As noted above this is in place within the policy. A new shift report format was developed to ensure communication of responsive behaviours occurs at the beginning of each shift.
58 – Transferring & positioning	NEW – when transferring & positioning residents, staff shall use devices & techniques that maintain or improve, wherever possible, the residents' weight bearing capability, endurance & ROM	This was shared with staff during orientation to the Act and is also part of the new staff orientation. Policy review still to be undertaken.
62 – Social Work	Need to ensure written description of the social work & social work services provided in the home & that the work meets the residents' needs	We need to review our current policy.
64 – Designated Lead – Restorative Care	The designated lead is over the entire restorative program, including therapy services. Changed registration with the "appropriate" college of a regulated health profession to "a" college....	The lead is the Restorative Care RPN.
65 – Rec & social programs	Must provide information to residents about community activities that may be of interest to them	This is being done through Residents' Council and community bulletin board.
66 – Designated Lead – Recreation	Qualifications only apply to leads designated after July 1, 2010	Designated lead is current the Director of Resident Care.
68 – Nutrition care & hydration	The development of P&P must be with a registered dietitian who is a "member of the staff" at the home. Have added the requirement for a system to monitor & evaluate the food & fluid intake of residents with identified risks related to nutrition & hydration	We will ensure that dietitian is involved in policy and procedure development in this area.
70 – Dietary Services	Includes "snack" planning	The snack menu is in place.
71 – Menu Planning	Includes snacks; requires that the "planned menu items" are offered & available at each meal & snack	The meal and snack menus are in place. Cooks are documenting anytime a substitution is required.
72 – Food Production	NEW – requirements to keep for seven years weekly records that	We need to update our policy and procedure however these

73 – Dining & snack services	specify the number of meals prepared for non-residents and the revenue & internal recoveries made related to the sale or provision of any food and beverage prepared in the home, including revenue & internal recoveries made from cafeteria sales & catering. Also need P&P for the safe operation and cleaning of equipment related to the food production system & dining & snack service	records will be kept for the required time on site. The new dietary manager will be reviewing the policies and procedures for cleaning of the equipment.
75 – Nutrition Manager	Have added "proper techniques to assist residents with eating, including safe positioning of residents who require assistance". Also added "appropriate seating for staff who are assisting residents to eat"	During the mock inspection the inspectors noted a concern related to positioning of residents in one home area however no further information was provided. This requirement was shared with staff during orientation to the Act and is also part of the new staff orientation.
76 – Cooks	Revised the formula – 40.96 hours required at FMT – is up to the Director how the hours per week fulfilling non-manager duties impacts on the required hours	Current manager is contracted through Sodexo and is on site 40 hours/week.
77 – Food Service Workers	Changed the requirement from one cook on site daily to one cook who works at least 35 hours per week in that position on-site at the home. The cook must have chef training or culinary management diploma from a program that meets the standard established by the Ministry of Training, Colleges and Universities	The requirements set out in our job description meets the requirements. We have two cooks on each day.
78 – FSW Training & Qualifications	Changes the requirement – 403.2 per week required at FMT – the Director can take into consideration the number of hours per week spent on non-resident food production when determining compliance.	Currently 413 hours/week which would include the hours for the cafe and Meals 2 Go. We will need to wait for our formal inspection to see how the Ministry determines the time spent on non-resident food production.
81 – Individualized medical directives & orders	Must have the Food Service Worker training program or have completed within 3 years of being hired; FSW who are employed at the home before Oct 1/10 & do not have the FSW program must complete a food handler training program within 3 months	We have changed our job offer letters to reflect the three years the staff has to complete the FSW program.
82 – Attending Physician or RN EC	NEW – no medical directive or order can be used with respect to a resident unless it is individualized to the resident's condition & needs	Compliant
85 – Religious & Spiritual Practices	Attending regularly at the home to provide services – includes assessments Additional requirements re hearing & visual impairment; different requirements for designated lead	Compliant The Coordinator of Religious & Spiritual Care is the designated lead. A hearing system is available for the hearing impaired and large print and overheads are available for those with visual impairment.

86 – Accommodation Services	NEW – requirement to have written agreements with service providers who are not employees; written P&P to monitor and supervise persons who provide occasional maintenance or repair service to the home pursuant to the written agreement required. These P&P may take into account whether the person is subject to the requirements for a criminal reference check and declarations set out in subsections 215 (1) to (5)	Contracts are in place. Contractor orientation packages were issued. Policy and procedures in place for regular monitoring of contractors.
90 – Maintenance	Additional references to the maintenance of mechanical lifts; equipment, devices, assistive aids and positioning aids; HVAC systems must be inspected at least every six months; gas or electric fireplaces are inspected by a qualified individual at least annually; temp of water serving all bathtubs, showers & hand basins used by residents does not exceed 49 degrees C and not less than 40 degrees C; excludes maintenance of residents' personal belongings	Appropriate processes are in place. We need to ensure written policies and procedures reflect the current practice. The heat units in the electric fireplaces have been disconnected therefore they do not need to be inspected.
92 – Designated Lead – EVS	Clarifies can be one person leading housekeeping, laundry & maintenance. The educational requirements are only in force for leads hired after the Act comes into force	Current lead is Manager of Environmental Services. We will need to update the qualifications in the job description.
93 – Pets	NEW – must have a written policy	We comply as we already have a policy. We must ensure that proof of immunization is on file.
94 – Volunteer program	A staff member must monitor or direct a volunteer whenever it is necessary to ensure the safety of a resident	Compliant.
96 – Policy to promote zero tolerance	Additional requirements for policy including training on the relationship between power imbalances between staff & residents	This was shared with staff during orientation to the Act; is included in our zero tolerance for abuse/neglect policy and is also part of the new staff orientation.
97 – Notification re incidents	Must notify the resident's POA immediately if we become aware of an alleged, suspected or witnessed incident of abuse/neglect that resulted in a physical injury or pain that causes distress to the resident; must notify within 12 hours (was 24) of any other alleged, suspected or witnessed abuse.	Contained in revised policy
98- Police Notification	Must notify police of alleged, suspected or witnessed abuse or neglect if we suspect it may constitute a criminal offence.	Contained in revised policy
99 – Evaluation	Requirements for analysis/evaluation	Contained in revised policy
101 – Dealing with complaints (verbal & written)	Must be immediate investigation if the complaint alleges harm or risk of harm to one or more residents. NEW - There is no requirement to document & trend verbal complaints if they are	This was shared with staff during orientation to the Act and is also part of the new staff orientation. Our complaint policy was updated.

	resolved within 24 hours of the complaint being received	
107 – Critical Incidents	Need to review current policy to ensure compliance with Regulations	Policy has been updated.
109 – Minimizing of Restraining	Policy needs to deal with the use of physical devices; need to do detailed review of rest of section as many references to the Act added	Policy has been revised and shared with staff during orientation to the Act and is also part of the new staff orientation. We are awaiting clarification from the Ministry on when a bedrail is considered a restraint.
115 – Quarterly medication management system review	If the pharmacy service provider is a corporation a pharmacist from the pharmacy must participate	Contained in current policy.
116 – Annual Evaluation	There must be an annual interdisciplinary evaluation of the effectiveness of the medication management system using an instrument designed specifically for this purpose	We need to review current policies and procedures and confirm the evaluative instrument to be used.
117 – Medical Directives & Orders – Drugs	Must be reviewed at any time the resident's condition is assessed or reassessed in developing or revising the resident's plan of care; no medical directive or order for the administration of a drug to a resident can be used unless it is individualized to the resident's condition & needs.	We need to review current policies and procedures.
118 – Information	Removed the requirement to have antidote information in every Resident Home Area	We need to check to see what is posted in each RHA meets the requirements
119 – Pharmacy Service Provider	If the provider cannot provide drugs on a 24-hour/7 day/week basis they must arrange for the provision by another pharmacy	Compliant
138 – Absences	Except in an emergency a physician or NP has to authorize the medical or psychiatric absence, in writing. If a medical or psychiatric absence notice must be given within 24 hours before the resident leaves the home to the resident's substitute decision-maker, if any, and to any other person as the resident or SDM designates. If circumstances don't permit the 24-hours notice then as soon as possible. NEW – if the resident leaves the home for a casual/vacation absence the care required must be provided in writing by the physician or NP to the resident; staff must communicate the need to take all reasonable steps to ensure that the care required to be given is received; that the home will not be responsible for the care, safety and well-being of the resident during the absence and that the resident/SDM assumes full responsibility; the need to notify the	Our policies and procedures have been updated as well as the resident welcome booklet. This was shared with staff during orientation to the Act and is also part of the new staff orientation.

	Administrator if the resident is admitted to hospital during the absence or if the resident's date of return changes	
215 – Criminal Reference Check – July 1/11	New - Staff/Volunteers – for all over 18 must be conducted by a police force & be conducted within six months before hired/accepted and must include a vulnerable sector screen. Must make a declaration as set out in 215(4) if conducted within last six months. Not required for Medical Directors or NPs	Our processes have been amended to reflect the changes. HR is currently rewriting the policy.
216 – Training & Orientation	Must ensure volunteers & staff receive training & orientation as set out in section 76 & 77 of the Act (see attached). Program must be evaluated & updated annually.	Staff received a full orientation to the Act. The management team met in May to start to develop the training program for staff to ensure compliance. The volunteer orientation program has been revised to meet the Act.
218 – Orientation	Includes written procedures for handling complaints & the role of staff in dealing with complaints; safe & correct use of equipment including therapeutic equipment, mechanical lifts, assistive aids and positioning aids that is relevant to the staff member's responsibilities; cleaning & sanitizing of equipment relevant to staff member's responsibilities.	New staff orientation package updated. New staff now meet with manager prior to end of orientation period.
219 – Retraining	Annual retraining required but retraining on mission & Acts, Regs & policies of Ministry not required unless there has been a change in the person's responsibilities. Annual training assessments shall be conducted annually. Training & retraining in IP&C must include hand hygiene; modes of infection transmission; cleaning & disinfection practices & use of PPE.	Management team met in May to start to develop the training program for staff to ensure compliance. Work is ongoing.
221 – Additional training – Direct Care staff	There is additional training required – must be annual and there are specifics for responsive behaviours & restraints	As noted above.
223 – Orientation for Volunteers	Orientation requirements are set out in section 77 of the Act and this Regulation provides the additional information required to be provided at the time of orientation.	Compliant
224 – Information	Lists the information required to be provided to residents, family members & persons of importance in addition to that under section 78 of the Act	The resident welcome booklet was updated. During mock inspection noted that the phone number for the "licensee" (head of Council) was not in the booklet. We have updated this with the County's main phone number.
225 – Posting of Information	Information to be posted in the home in addition to that set out in section 79 of the Act.	Information is posted as set out.
227 – Regulated Documents	Defines regulated documents referred to in section 80 of the Act – need to review.	Our admission agreement was reviewed and revised by legal. During the mock inspection it was noted that when unfunded

		charges change there must be firm documentation of notice of change and confirmation of charge from the resident. As well in several areas e.g. dine outs a specific price is not listed so must change to reflect a range of possible costs.
228 – Continuous Quality Improvement	Sets out requirements for QI program	QI Program now in place and first meeting of the Quality Assessment & Assurance Committee has been held.
229 – IP&C Program	Sets out requirements for program	Our current policies and procedures were reviewed and the need to ensure that resident immunization includes diphtheria and tetanus has been added.
230 – Emergency Plans	Set out in section 87(1) of the Act – sets out how plans shall be developed and tested.	We have reviewed our current plan to identify gaps and establish a training plan. Identified gaps included a chemical spills plan (not completed) and a violent outburst plan (we have one for violent residents but not for violent intruders). A tabletop violent outburst scenario to assist us in developing our plan is being scheduled for October.
233 – Retention of Resident Records	Must be kept for 10 years after discharge	Current retention by-law being reviewed by Deputy Clerk.
234 – Staff Records	Sets out the minimum requirements for the record	Current retention by-law being reviewed by Deputy Clerk.
236 – Retention of Staff Records	Must be kept for at least 7 years after employment ceases	Current retention by-law being reviewed by Deputy Clerk.
241 – Trust Accounts	Must be non-interest bearing (by January 1/1/1); cannot hold more than \$5k for a resident, commingle funds or charge a service fee (Jan 1/1/1); must have written P&P for the management of the trust accounts & petty cash trust money (specific requirements included) and provide a copy to each resident & person acting for the resident who has money in the trust account – need to forward to Treasury	Compliant.
245 – Non-allowable resident charges	Defines non-allowable charges	This is included in the resident admission agreements
Section – Charges for Accommodation; Statements; Accounts & Records; Non-arm's length transactions		Have forwarded to Treasury



QUALITY IMPROVEMENT PROGRAM

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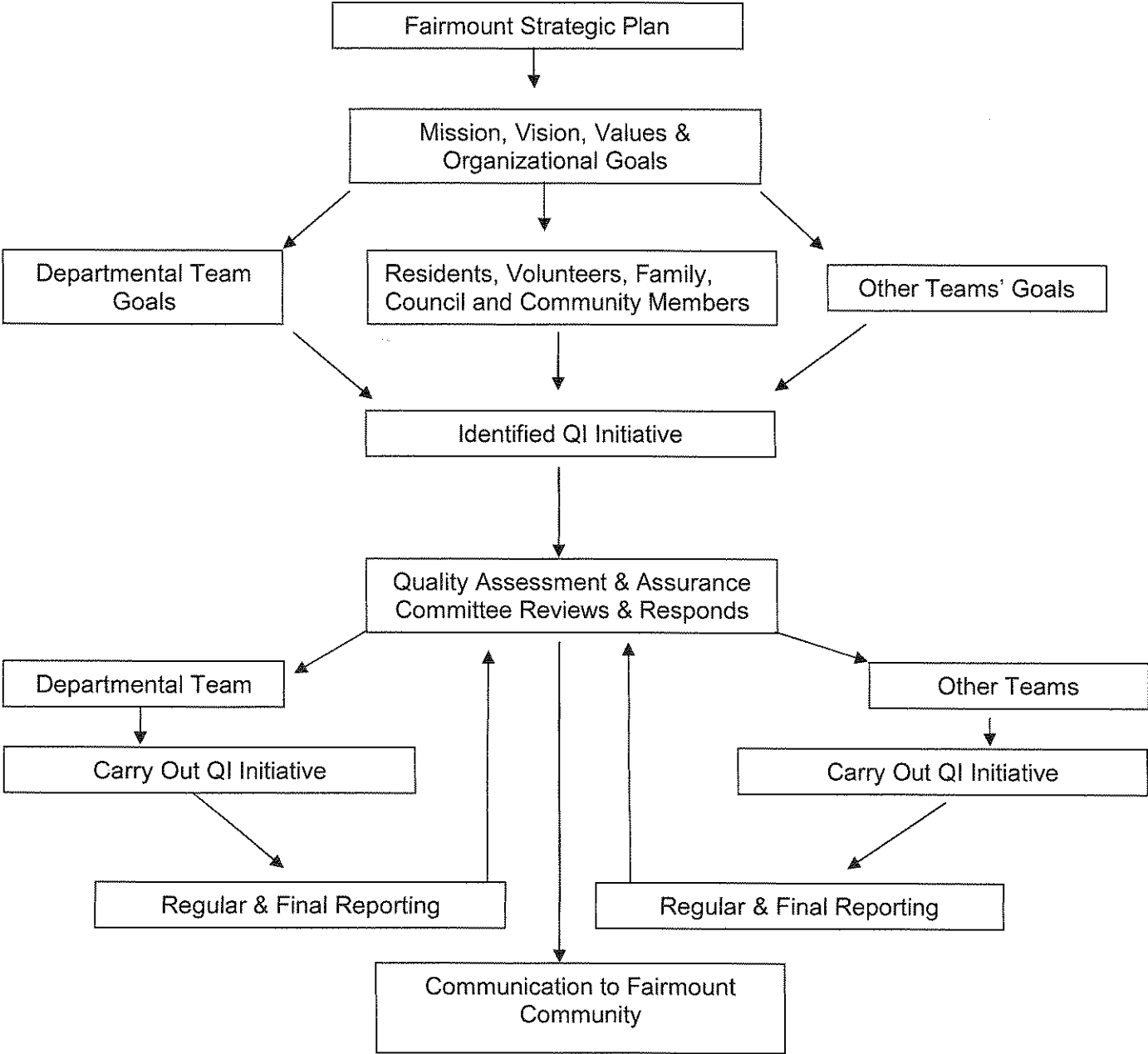
Program Evaluation

Quality Improvement Plan - 2011

GENERAL STATEMENT

Fairmount Home is committed to the continuous improvement of our services to our residents, staff, volunteers and the greater Fairmount community.

We have developed a structured quality improvement program to allow the organization and management of quality initiatives as follows:



GOALS OF THE QUALITY IMPROVEMENT PROGRAM

1. To provide a culture of continuously improving systems, methods and processes to improve the Home's services to its residents, staff, volunteers and the greater Fairmount community.
2. To ensure the quality improvement program is interdisciplinary.
3. To ensure a process is in place for the identification of quality initiatives.
4. To ensure the coordination and monitoring of quality initiatives.
5. To ensure communication of quality initiatives.
6. To ensure adequate documentation is kept of all quality initiatives.

Mission, Vision, Values & Organizational Goals

Mission Statement

Fairmount is an accredited long-term care home for 128 residents, dedicated to providing the best quality of life to those who live and work here.

The Fairmount community fosters a creative and responsive environment in which all members – staff, families, volunteers, students, community partners and the residents themselves – respect and promote the strengths and abilities of each other, especially those for whom this is home.

A full range of high quality programs are provided with the caring expertise of a dedicated, multi-disciplinary, team, responding to the unique needs and wishes of our residents.

All members of our Community are advocates for all those who live and work here.

Fairmount Vision Statement

In response to changing needs of residents and the community, we will continue to develop and implement innovative “best practices” and programs. We will continue to foster and grow an environment of mutual respect for residents and all members of our caring community.

We will promote the principles and practices of Continuous Quality Improvement for all aspects of Fairmount’s caring community, and we will maintain the ethical balance between innovation and resident choice, safety and risk management.

Building on the foundation of strong relationships, Fairmount will seek to increase the involvement of the wider community by bringing our citizens into Fairmount through the sharing of our expertise, our location, and our excellent programming. Fairmount will also reach out into the wider community as a leader and participant, sharing its knowledge and resources to plan and implement activities that will improve the lives of the elderly throughout the entire area.

Fairmount Values

C - Caring and Compassionate	C – Community-Oriented
R - Responsive and Respectful	O – Opportunity and Openness
E – Expertise, Enabling	M – Meaningful and Mindful
A – Acceptance, Advocacy, Appreciation	M – Motivated
T – Team Work	U – Unique
I – Independent and Innovative	N – Neighbourly
V – Vibrant, Visionary	I – Inclusive
E – Ethical	T – Togetherness
	Y – YOU – our focus

Fairmount's Goals

1. To ensure all members of the Fairmount Community are knowledgeable and accepting of our Mission, Vision and Values, and put them into practice all day, every day.
2. To ensure a holistic life style will be maintained for all residents, including responding to their unique needs and wishes, related to learning and desired experiences, to satisfy their physical, social, emotional, spiritual and mental needs.
3. To be a positive learning environment for all staff, volunteers, residents and their families based on best practices and mutual respect, creativity and innovation.
4. To continue the development of a "best practices" standard for all aspects of Fairmount's caring community.
5. To be an innovative environment fostering the development and application of new ideas that will enhance the living and working environment.
6. To develop and implement a strategy for recruitment, training, retention and succession planning to ensure an exceptional group of staff and volunteers.
7. To take a leadership role in the planning and development of the Local Health Integration Network, and in working with other local, area and provincial organizations and people, to ensure the highest quality of care and programming for the long term care sector.
8. To enhance the knowledge of our citizens throughout the area about Fairmount and the activities and services it provides.

Organized/Required Programs

There are a variety of organized or required programs that the Home must provide under different pieces of legislation. These include, but are not limited to:

1. Nursing & Personal Support Services
2. Restorative Care
3. Recreational & Social Activities
4. Dietary Services & Hydration
5. Medical Services
6. Information & Referral Assistance
7. Religious & Spiritual Practices
8. Accommodation Services
9. Volunteer Program
10. Falls Prevention & Management
11. Skin & Wound Care
12. Continence Care & Bowel Management
13. Pain Management
14. Health & Safety
15. Medication Management
16. Infection Prevention & Control
17. Training & Orientation

Departmental and other teams are in place to support quality improvement activities in all organized and required programs.

QUALITY IMPROVEMENT ROLE OF TEAMS

There are a variety of teams in place to support quality improvement at Fairmount. The quality improvement activities of each team are vital to the overall success of the quality improvement program at Fairmount.

Each team is required to:

- a) Establish its purpose and review on an annual basis
- b) Establish measureable goals which must align with its purpose and the goals of the organization and review on an annual basis
- c) Establish measures to track its progress in meeting its goals
- d) Review opportunities for quality improvement and identify quality improvement initiatives to be brought forward for review to the Quality Assessment and Assurance Committee (QAAC).
- e) Carry out quality improvement initiatives once approved by the QAAC.

The Interdisciplinary Program Evaluation form will be used to help each team keep track of all of its goals, measures and quality improvement initiatives.

HOW DO I BRING FORWARD AN IDEA FOR QUALITY IMPROVEMENT?

Ideas for quality improvement can come from a variety of sources which can include, but is not limited to:

- a) Audit results
- b) Inspection results
- c) Complaints
- d) Survey results
- e) Incident reports
- f) Risk identification forms
- g) Observation
- h) Staff meetings
- i) Resident and/or Family Committees
- j) County Council
- k) Publications

Everyone at Fairmount is encouraged to look for and bring forward improvement opportunities. If you see an area where improvement is needed and you have some ideas about how to do so you can bring it forward verbally or in writing to one of the following:

- a) The Administrator
- b) The Director of Resident Care
- c) The Assistant Director of Care
- d) The Manager of Environmental Services
- e) The Manager of Food Services
- f) Residents' Council
- g) County Council

Whoever receives your idea will ensure it is forwarded to the appropriate team for discussion.

Quality improvement initiatives identified by team members should be taken forward to the team for discussion and then forwarded to the Quality Assessment and Assurance Committee in the required format (see section entitled Submission of Quality Initiatives to the QAAC).

ROLE OF THE QUALITY ASSESSMENT & ASSURANCE COMMITTEE (QAAC)

The purpose of the interdisciplinary Quality Assessment and Assurance Committee (QAAC) is to:

- a) Prioritize, coordinate and evaluate quality initiatives at Fairmount.
- b) Provide a forum for discussion and dialogue on matters of quality and risk at Fairmount.
- c) Receive reports from and provide feedback to teams.
- d) Communicate quality initiatives and their outcomes to stakeholders, including but not limited to staff, volunteers, Residents' Council, Family Council and County Council,
- e) Act as a resource in relation to continuous quality improvement.

Membership includes the following individuals:

- a) Administrator
- b) Director of Resident Care
- c) Assistant Director of Care
- d) Manager of Environmental Services
- e) Manager of Food Services
- f) Volunteer & Special Events Coordinator
- g) Nurse Practitioner

All quality initiative project proposals must be reviewed and approved by the QAAC.

HOW TO SUBMIT QUALITY IMPROVEMENT INITIATIVES TO THE QAAC

Teams considering quality initiatives will primarily use the **Model for Improvement** strategy which is built on the following three questions:

- What are we trying to accomplish?**
- How will we know if a change is an improvement?**
- What changes can we make that will result in an improvement?**

Once the three questions have been answered the teams will develop, test and implement the change strategies through a series of small PDSA (Plan, Do, Study, Act) cycles.

The *Long-Term Care Improvement Guide* from the Ontario Health Quality Council will be used to guide quality teams through each step of the quality initiative as follows:

- a) Defining the quality problem
- b) Establishing the AIM Statement
- c) Defining the changes
- d) Identifying the measures
- e) Plan-Do-Study-Act Cycles

Each team will use a **Project Charter Worksheet** which sets out the purpose, scope, measures and targets for success. It also identifies the key members of the team and specifies the time and resources to be invested as well as the anticipated benefits.

The Project Charter Worksheet must be submitted to the Quality Assessment & Assurance Committee for review prior to implementation of the initiative.

Upon approval from the Quality Council the team will carry out the quality initiative and report back to the Quality Council using the **PDSA Worksheet**.

COMMUNICATION & DOCUMENTATION

Formal communication to stakeholders about the quality initiatives undertaken at Fairmount may be conducted by the Quality Assessment & Assurance Committee (QAAC) through a variety of methods including, but not limited to:

- a) Grapevine Gazette
- b) Staff Intranet
- c) Fairmount Website
- d) Quality Improvement Board
- e) Lobby Displays
- f) Reports to Residents' Council
- g) Reports to Family Council
- h) Reports to County Council

Detailed documentation must be maintained throughout the quality initiative process and the final documentation package must include:

- a) Minutes of all team meetings including the date, time, location and names of those in attendance
- b) The Project Charter Worksheet
- c) All PDSA Worksheets

All documentation must be forwarded to the QAAC. The QAAC will ensure documentation regarding communication of the initiatives is kept with the final documentation package.



PROGRAM EVALUATION

Program:	Quality Improvement
Policy/Regulation reference	
Screening Protocols Used (if applicable)	
Assessment/Reassessment Instruments Used (if applicable)	
Program goals	
Measures	
Methods used to promote achievement of goals	
Methods used to monitor outcomes	
Referral process for specialized resources (if applicable)	
Location of documentation regarding resident-specific action taken	
Quality initiatives approved by Quality Assessment & Assurance Committee	
Annual evaluation of the program	

Date of annual evaluation	
Persons participating in the annual evaluation	
Summary of changes made to the program as a result of the evaluation	
To whom and how were changes communicated?	

QUALITY IMPROVEMENT PLAN – 2011

Goal #1

A comprehensive list of current quality improvement activities and measures will be prepared by the Management Team for submission to the appropriate teams by February 15, 2011.

Measure – List of QI measures completed

Responsible: Administrator

Goal #2

Fairmount will have 100% of its departmental goals and measurements completed by May 31, 2011.

Measurement = # departments with goals & measurements completed/# of departments

Responsible: Department Heads

Goal #3

100% of the teams (non-departmental) will have their goals and measurements completed by June 30, 2011

Measurement = # teams with goals & measurements completed/# of teams

Responsible: Team Chairs

Goal #4

100% of all teams will receive Model for Improvement strategy training by October 31, 2011

Measurement = # of teams that received training/# of teams

Responsible: QAAC

Goal #5

80% of teams will have a Project Charter Worksheet for at least one quality initiative for submission to the QAAC by December 31, 2011

Measurement = # teams with Project Charter Worksheet/# of teams

Responsible: Team Chairs

For the purposes of this plan the departments are identified as:

1. Nursing & Personal Support Services
2. Restorative Care
3. Recreational & Social Activities
4. Dietary Services & Hydration
5. Medical Services
6. Information & Referral Assistance
7. Religious & Spiritual Practices
8. Accommodation Services
9. Volunteer Program

For the purposes of this plan the Non-departmental Teams are identified as:

1. Falls Team
2. Wound Care Team
3. Intestinal Health/Continence Care Team
4. Pain Management Team
5. Health & Safety Committee
6. Professional Advisory Committee
7. Education Committee
8. Labour-Management Team
9. Management Team
10. Pleasurable Dining Committee
11. Psychogeriatric Team
12. Environment Team
13. Information Management Team
14. Restorative Care Team
15. Palliative Care Team



PLAN-DO-STUDY-ACT FORM

Objective for this PDSA Cycle

Date:

Is this cycle used to:

- Develop or test or implement a change?

What question(s) do we want to answer on this PDSA cycle?

PLAN:

Plan to answer questions: Who, What, When, Where?

Plan for collection of data: Who, What, When, Where?

Predictions (for questions above based on plan):

DO:

Carry out the change or test, collect data and begin analysis.

STUDY:

Complete analysis of data.

Compare data to predictions and summarize what was learned.

ACT:

Are we ready to make a change? Adopt Adapt Abandon

Plan for the next cycle.

PDSA Reference # _____

Mission Statement Palliative Care	Missing Resident Plan	Resident Bill of Rights Complaints	Policy on Abuse & Neglect Mandatory Reporting Whistle Blowing Protection Abuse Recognition & Prevention	WHMIS IP&C - hand hygiene, modes of infection, cleaning & disinfection use of PPE
Community Disaster Plan Bomb Threat Plan Chemical Spills Loss of heat in cold weather Evacuation				

November	December			
Rec & Social Religious & Spiritual	Medical Services Utilization of Drugs kept in emergency drug supply		Annual Written Evaluations	

MMS (Quarterly) Complaints (RV)	Medication Incidents (WE) Adverse Drug Reactions (WE) Drug Destruction & Disposal (A)		Quarterly Written Evaluations (WE), Audits (A) or Reviews (RV)	
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Use of Restraints (WE) Daily Count Sheets (controlled substances) (A) Symptoms (RV)	Use of Restraints (WE) Daily Count Sheets (controlled substances) (A) Symptoms (RV)		Monthly Written Evaluations (WE), Audits (A) or Reviews (RV)	
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Minimizing of Restraints Application, use & potential dangers of physical devices used to restrain & PDSA's Safe & correct use of therapeutic equipment & adaptive aides	Contenance care & bowel management Pain Management		Annual Mandatory Training Annual Mandatory Training - NPC Annual Plan Testing q3 Years Testing Accreditation - q3 years	
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