2017/18 Quality Improvement Plan for Ontario Long Term Care Homes
"Improvement Targets and Initiatives"

St. Patrick's Home of Ottawa
2865 RIVERSIDE DRIVE

AIM		Measure							Change				
Quality Dimension	**Issue**	**Measure / Indicator**	**Unit / Population**	**Source / Period**	**Org. ID**	**Current performance**	**Target**	**Target Justification**	**Planned Improvement Initiatives (Change Ideas)**	**Methods**	**Process Measures**	**Target for Process Measure**	**Comments**
Effective	**Effective Transitions**	Number of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents.	Rate per 100 residents / LTC home residents	CIHI CCRS, CIHI NACRS / October 2015 - September 2016	51688*	22.25	22.25	Our Home is aiming to maintain our current rate for potentially avoidable ED transfers as we are currently below both the Champlain LHIN rate as well as the Ontario rate.	1)Continue to monitor residents who get sent to the ED for assessment.	Review of ED transfers with clinical care staff from the Resident Home Area (RHA). Monthly review of Critical Incident submissions at Quality Improvement and Risk Management as well as the Professional Advisory Committee. Review and possible roll out of Hospital Transfer and STOP&WATCH tools in PCC.	Total # of Admissions to Acute Care from ER; Total # of Deaths at Hospital; Total # of Transfers to ED; Critical Incident System submissions.	Greater understanding and subsequent engagement from staff on the various alternatives to ED transfers.	Staff from each RHA are a vital part of exploring options to reduce the rate of potentially avoidable ED visits.
									2)Continue to educate residents and families on the risks associated with ED visits.	Physicians, RNs and RPNs to have formal discussions at annual and situational care conferences and informal discussions with residents and/or families regarding goals of care with changes in health status.	Total # of Admissions to Acute Care from ER; Total # of Deaths at Hospital; Total # of Transfers to ED; Critical Incident System submissions.	Greater understanding and subsequent engagement from residents and families on the various alternatives to ED transfers.	Residents and their families are a vital part of exploring options to reduce the rate of potentially avoidable ED visits.
									3)Continue to utilize education and promote safety, pain management, palliative measures and fall prevention.	Achieved through interdisciplinary team committees of various required programs who will be responsible for educating and promoting each area.	Total # of Admissions to Acute Care from ER; Total # of Deaths at Hospital; Total # of Transfers to ED; Critical Incident System submissions.	Promoting safety and continuing education for staff on programs such as pain management and falls prevention should lead to decreased ED transfers.	N/A
									4)Formal and informal education and mentoring for PSWs and Registered staff related to early symptom identification and alternative treatments early on.	Establish the practice of using the CHESS score to identify high-risk residents. Increase both formal as well as informal channels for reporting and following up on changes in residents condition and behaviour from PSWs to Registered staff.	Total # of Admissions to Acute Care from ED; Total # of Deaths at Hospital; Total # of Transfers to ED.	Early identification and monitoring of residents at high risk.	Identification of at-risk residents earlier in the course of their disease process will aid in providing the necessary treatments early-on and in-house.
	Improved Continence	% of residents with worsening bladder control during a 90-day period.	% / Residents	CIHI CCRS / April 2016 to Dec 2016	51688*	30.06	25.00	Our goal is to reduce our percentage of worsening bladder control to 25% which was our previous goal, but not achieved in 2016/17.	1)Educate staff on implementing targeted and individualized toileting plans/schedules for residents in a person centred approach, using proven behavioural approaches and techniques that will achieve positive results.	Scheduled toileting plans will be integrated into the resident's care plan and pushed out to POC for documenting. Review coding requirements and ensure quarterly, that coding is correct. Interdisciplinary team meetings at the RHA level (eg. House Council) to review progress and solicit feedback from staff. Review of program at continence team meetings, using lean tools. Develop a PSW lead continence education team to provide education to staff. Mandatory education of the inspection protocol for Continence care and Bowel Management.	# Residents using disposable incontinence products; % of use of disposable incontinence products; daily incontinent product change rate; direct staff and resident/family feedback; review of RAI MDS 2.0 Section H1b	100% compliance with individual toileting plans for residents who qualify in order to reduce the rate of worsening bladder control.	Although we were marginally successful in reducing worsening bladder control in 2016, this additional indicator will remain on our QIP as a priority for 2017/18 as we refocus our efforts and re-establish a more robust Continence Program and associated Committee.
									2)Education of staff in Restorative Principles and dementia care.	Rehab/Restorative team to provide formal and informal education throughout the year, with respect to restorative principles. Dementia care training and education to be completed in 2017, with the type(s) of training and total number of staff to be determined.	# Residents using disposable incontinence products; % of use of disposable incontinence products; daily incontinent product change rate; direct staff and resident/family feedback; review of RAI MDS 2.0 Section H1b	Staff to have a greater understanding of restorative principles and dementia care and be able to apply both appropriately while supporting residents.	Restorative principles can lead to greater independence and control over one's continence. Best practices in Dementia care can aid staff in supporting residents in this area.

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									3)Reinvigorate the program by starting from the beginning with the formation of a new team (including residents and families), with a new lead and a focus on Restorative care.	Review the policies and processes around continence care and restorative program utilizing lean tools for interdisciplinary collaboration. Implement a process of the rights: right time (Changed), right size, right product, right application, right disposal. Implement a home based computerized program providing details for each resident's product needs, while simplifying product choice. Pare down the Continence Assessment Tool (CAT).	# Residents using disposable incontinence products; % of use of disposable incontinence products; daily incontinent product change rate; direct staff and resident/family feedback; review of RAI MDS 2.0 Section H1b	100% compliance by staff following the policies. Increased monitoring and auditing from the team and increased documentation and accuracy when completing the CAT.	N/A
									4)Develop a team of PSWs who will educate other PSWs and Reg. staff on the application and assessment (sizing) of continent products, keeping in mind the capabilities of each resident while enhancing their ability to maintain or increase their continence level.	Select a core team of PSWs who will implement a train-the-trainer approach to education.	# Residents using disposable incontinence products; % of use of disposable incontinence products; daily incontinent product change rate; direct staff and resident/family feedback; review of RAI MDS 2.0 Section H1b	Greater overall involvement and understanding of staff working closely with residents who require continent products.	N/A
Patient-centred	**Person experience**	Percentage of residents responding positively to: "What number would you use to rate how well the staff listen to you?"	% / LTC home residents	In house data, NHCAHPS survey / April 2016 - March 2017	51688*	90.2	95.00	This indicator saw a slight decrease of 1.2% in 2016, however our goal continues to be 95% in 2017.	1)Annual resident satisfaction survey will be updated to include the following question - "What number would you use to rate how well staff listen to you?"	Continued engagement of residents and staff in the philosophy of Person Centred Care. Update annual resident satisfaction survey to include: 'What number would you use to rate how well staff listen to you?'	Positive response rate on the annual resident satisfaction survey question - "What number would you use to rate how well staff listen to you?"	Our goal is to promote resident satisfaction and experience by encouraging staff to pay close attention to the individual requests, wishes and needs of our residents. Integrating this question allows us more accurate data reflective of how well staff listen to our residents.	Although the resident survey did not include the exact question: What number would you use to rate how well the staff listen to you? the proxy question used is very similar.
	Resident experience: "Overall satisfaction"	Percentage of residents who responded positively to the question: "Would you recommend this nursing home to others?" or "I would recommend this site or organization to others".	% / LTC home residents	In house data, InterRAI survey, NHCAHPS survey / April 2016 - March 2017	51688*	93.2	95.00	There was a significant gain in this indicator in 2016 with an increase from 83.6% to 93.2%. We feel with continued focus on a culture of Person Centred Care that we can increase to 95%.	1)Continued focus on a culture of Person Centred Care. Eg. Holistic approach to care focusing not just on 'risk' and 'need' but also preferences, wishes, likes and dislikes. Seeing the whole person and their life story rather than just their 'condition'.	Continued budget allocation for staff (managers and front line staff) to attend the Pioneer Network conference. The Mission, Vision and Values will be embedded into staff recognition; performance appraisal process and terms of reference for standing committees to maintain a focus on the resident.	Positive response rate on the Resident Satisfaction Survey for the question "Would you recommend this nursing home to others?"	100% compliance and engagement from all staff on Person Centred philosophy of care.	Although St. Patrick's Home has always supported a person centred philosophy of care, there were gains made in 2016 with substantial investment in education sessions, formal and informal huddles, display boards in the service hallway on each floor and regular discussions at meetings such as RHA House Councils, PSW and Nursing Practice as well as the various program committees. This focus continues in 2017.

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									2)Ongoing education/training with staff. ie. GPA, Person Centred Philosophy, annual mandatories (Abuse, IPAC, etc.); Dementiability training	A more streamlined and systematic approach to ongoing education and training throughout the year on a suite of topics specific to the delivery of high-quality, person centred care.	Positive response rate on the Resident Satisfaction Survey for the question "Would you recommend this nursing home to others?"	100% compliance and engagement from all staff on the new "Person Centred" philosophy and mandatory in-services throughout the year.	Education and training for all staff is vital for understanding and delivering the type of high quality, individualized care our residents deserve.
	Resident experience: Activities & Programs Satisfaction	% of residents responding positively to the statement "Overall I would rate the social/recreation programs excellent" on the resident satisfaction survey	% / Residents	In-house survey / Jan to Dec 2016	51688*	77.3	83.60	Our goal is to improve resident satisfaction with recreation programs offered within the home and to increase communication of programs offered, returning to the 2015 level of satisfaction of 83.6%.	1)Education for staff on programs offered within the home.	Recreation staff to be present at House council meeting and communicate programming within the home.	Positive response to survey question 'Overall, I would rate the social and recreational programs as excellent.' Improved positive responses in all questions on the Resident Satisfaction Survey related to Recreation programs.	To increase resident statisfaction with recreation and social programs within the home and provide an increased awareness of programs offered within the home and to encourage residents and family participation and input.	It's important for all staff to be aware of the various activities and programs offered within the Home so they may in turn advocate and communicate these programs to residents and families.
									2)Provide opportunities for residents and family members to be active in determining what programs are offered within the home.	Purchase Activity Pro Gold so families will have access to recreation participation information. Encourage residents and families to attend House Reflection groups in order to gain a greater awareness and understanding of the various programs offered within the Home and to provide feedback and input for potential improvements.	Positive response to survey question 'Overall, I would rate the social and recreational programs as excellent.' Improved positive responses in all questions on the Resident Satisfaction Survey related to Recreation programs.	To increase resident satisfaction with recreation and social programs within the home and provide an increased awareness of programs offered within the home and to encourage residents and family participation and input.	It is vital for the success of the Recreation program that residents and families have a voice regarding their preference and choice of activities offered within the Home.
									3)Revaluate the current activity calendar and implement changes to reflect large home based programs.	Research how other homes are advertising programs within their organizaton and then base changes on best practices.	Positive response to survey question 'Overall, I would rate the social and recreational programs as excellent.' Improved positive responses in all questions on the Resident Satisfaction Survey related to Recreation programs.	To increase resident satisfaction with recreation and social programs within the home and provide an increased awareness of programs offered within the home and to encourage residents and family participation and input.	Eg. There will be a set rotation of RHA based and larger social programs offered in the evening in a visible area of the home.
									4)Provide education for recreation staff on DementiAbility and Music and Memory Programs.	Three staff will be attending DementiAbility Training. Music and Memory training for 2017 will be ongoing in addition to the staff and volunteers currently trained .	Positive response to survey question 'Overall, I would rate the social and recreational programs as excellent.' Improved positive responses in all questions on the Resident Satisfaction Survey related to Recreation programs.	To increase resident satisfaction with recreation and social programs within the home and provide an increased awareness of programs offered within the home and to encourage residents and family participation and input.	Training and education has started for Dementiability (March, 2017) and Music and Memory (January, 2017) and will continue throughout the year.
									5)Staffing change on 1st floor.	Implemented staffing change on March 1st 2017 on Galway to enhance programming in order to effectively meet the needs of this resident population.	Positive response to survey question 'Overall, I would rate the social and recreational programs as excellent.' Improved positive responses in all questions on the Resident Satisfaction Survey related to Recreation programs.	To increase resident satisfaction with recreation and social programs on Galway.	Reassignment of staff started in March 2017 . There will be a set rotation of RHA based and larger social programs offered in the evening in a visible area of the home.

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	Resident experience: Laundry	% of residents responding positively to the statement "I always get my clothing back from laundry" on the resident satisfaction survey	% / Residents	In-house survey / Jan to Dec 2016	51688*	74.2	77.00	Our aim is to reduce the occurrence of missing laundry items and in-turn raise the percentage of residents responding positively to the question "I always get my clothing back from laundry" on our resident satisfaction survey. 2016 saw a 4.7% increase on this indicator from 71.6% to 74.2%.	1)Process and Value Stream Mapping to be completed with a review of the entire laundry 'life-cycle' in order to identify and remove waste and inefficiencies.	Comprehensive review of the Home's ability to accurately track personal items sent to laundry. ie. Better tracking system. Regular check-ins with residents, staff and families. Track all (specific) laundry items for trends and action. Maintain newly created position to deliver personal laundry to resident rooms in 2017.	% of residents responding positively to this question on the annual resident satisfaction survey - "I always get my clothing back from the laundry".	100% compliance from all staff at all points of the process through to the end of 2017.	There are various points along this process where gaps have been identified. Eg. are clothing items being sorted correctly at the source? Are new items being delivered to laundry with the proper labeling requisition? Are items returned to the correct resident's wardrobe? Process mapping was not completed in 2016 due to time and resource limitations within the QI program, however, this activity is still warranted and will remain a change idea for 2017/18.
									2)Refresher education with staff Re: Sorting at the source with new 4-bin carts, proper requisition for labeling clothes, etc.	Education and review of process with staff. Regular check-ins with residents, staff and families.	% of residents responding positively to this question on the annual resident satisfaction survey - "I always get my clothing back from the laundry".	100% compliance from all staff at all points of the process through to the end of 2016.	Sorting at the source increases efficiency and maximizes performance of both nursing as well as laundry services. 1 new 4-bin laundry cart was purchased per RHA which includes the 4th bin for garbage which the staff were asking for. 1 more 4-bin cart is required per RHA and will be purchased this year.
	Resident experience: Reducing Agency Staff	% of nursing hours contracted out to external agencies.	% / Residents	In-home audit / Jan to Dec 2016	51688*	5.8	1.50	There was an increased utilization rate through 2016 however there were significant reductions made in the last quarter of 2016 and a decreasing trend to date in 2017.	1)Process mapping review of scheduling office processes to ensure maximum efficiency and effectiveness.	Scheduling processes initiated for the Scheduling Clerks and the RN's, including scenarios regarding how to achieve maximum staffing efficiencies with minimum Agency usage. Scheduling Clerks required to complete a daily assessment of staffing patterns throughout the Home including use of agency staff. Scheduling Clerks and RNs to seek permission to use agency staff and/or approve OT from the VP of Nursing or the Manager of HR. Follow up weekly (or daily where needed) with scheduling clerks to monitor. Review and discussion of what is working and what is not by department head and QI Lead.	# of Agency Hours - PSWs; # of Agency Hours - RPNs; # of Agency Hours - RNs; Daily work sheets for ongoing position coverage. Review of agency hours across all 3 positions (PSWs, RPNs and RNs) monthly.	Our goal is to streamline processes and maximize the use and integration of system tools in order to save time and resources that can be better spent on core scheduling activities, some of which should lead to less dependence on external agency partners.	Efficiency in processes will be reviewed to ensure maximum scheduling effectiveness. Stability and consistency in operational processes is the priority and goal.

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									2)Continue partnership with local colleges for PSW, RPN and RN students.	Students from all 3 disciplines (PSWs, RPNs and RNs) are continuing to complete their placements on an ongoing basis throughout the year. Explore opportunites through RNAO regarding the new grad initiative for new RN and RPN graduates. Additionally, continue to hire more RN and RPN students as PSWs; consequently providing more exposure to the Home for all Nursing classifications.	# of Agency Hours - PSWs; # of Agency Hours - RPNs; # of Agency Hours - RNs; Daily work sheets for ongoing position coverage. Review of agency hours across all 3 positions (PSWs, RPNs and RNs) monthly.	Our goal is to increase our visibility with local colleges in order to solicit a higher number of potential candidates that align with our mission, vision and values.	We are extremely excited to see students back in our Home after a hiatus of about 2 years due to a change in the working environment and morale brought about by the move to our new Home in December 2013.
	Resident experience: Taste of Food	% of residents responding positively to the statement "My meals are tasty" based on the resident satisfaction survey.	% / Residents	In-house survey / Jan to Dec 2016	51688*	76.5	78.00	Internal target based on the opinion and aspirations of our leadership and nutritional services teams, building on our synergy from 2016.	1)Implement a 'Taste panel' made up of staff and residents.	A log book documenting the various taste panel activities. Informal check-in with staff, residents and families for feedback on meals.	Annual Resident Satisfaction Survey Question "My meals are tasty"; Weekly, monthly and/or quarterly dietary feedback cards.	100% compliance with new panel of tasters through to the end of 2017	Having engagement and participation from staff and residents on the taste of the food should lead to better results in this area. This change idea did not meet its full potential in 2016 as taste panels were not implemented across all RHAs as intended. This change idea continues to hold merit however and we will implement all aspects of this initiative in 2017/18.
									2)Cooks touring the Resident Home Areas (RHAs) for direct resident feedback concerning the taste of food.	Informal check-in with staff, residents and families for feedback on meals. Implement comment cards or dietary feedback cards to use while touring the RHAs and resident dining areas.	Annual Resident Satisfaction Survey Question "My meals are tasty"; Weekly, monthly and/or quarterly dietary feedback cards.	100% compliance from cooks on all Resident Home Areas (RHAs) through to the end of 2017.	Having the cooks tour the RHAs and resident dining areas ensures direct resident feedback in a timely fashion concerning the taste of food.
									3)Implement a new dietary auditing tool for use by the Food Service Supervisors (FSS).	Continue monthly dietary audits using the updated auditing tool.	Annual Resident Satisfaction Survey Question "My meals are tasty"; Weekly, monthly and/or quarterly dietary feedback cards.	100% compliance from FSS completing audits through to the end of 2017.	Regular and ongoing audits continue to play a key part of the quality improvement efforts related to dietary and nutritional services. Food Service Supervisors (FSS) on all shifts will complete the auditing process and provide feedback to the cooks and dietary aides, including proper procedures for various tasks.
Safe	**Medication safety**	Percentage of residents who were given antipsychotic medication without psychosis in the 7 days preceding their resident assessment	% / LTC home residents	CIHI CCRS / July - September 2016	51688*	15.47	15.00	St. Patrick's Home is already well ahead of the mark on this Quality Indicator as we are trending lower than the ON provincial average. A	1)Highlight all residents receiving antipsychotics on the three month med review in order to bring greater awareness to each attending physician.	Review of applicable medications including antipsychotics at care conferences and regular medication reviews. Discussion with physicians and staff regarding alternatives.	Ongoing and regular review of antipsychotic use. % residents taking antipsychotics without the diagnosis of psychosis.	Regular monitoring/auditing of all residents currently taking antipsychotics with the aim to deprescribe at every available opportunity, knowing that we will probably only reduce slightly since we are already at such a low rate of antipsychotic use.	Although we are ahead of the Ontario provincial average for this indicator, we will endeavor to improve upon our own rate.

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		assessment						average. A modest 3% improvement will allow us to reach our absolute target of 15%.	2)Responsive Behaviour Education for the interdisciplinary team.	The interdisciplinary Responsive Behaviour Committee, including residents and families will provide direction to the home with respect to reducing behaviours from a non-pharmacological perspective, therefore reducing the need for medication related to responsive behaviours.	Ongoing and regular review of antipsychotic use. % residents taking antipsychotics without the diagnosis of psychosis.	Non-pharmacological interventions for reducing Responsive Behaviours will be explored with the goal of reducing dependence on antipsychotic medication.	N/A
	Safe care	Percentage of residents who developed a stage 2 to 4 pressure ulcer or had a pressure ulcer that worsened to a stage 2, 3 or 4 since their previous resident assessment	% / LTC home residents	CIHI CCRS / July - September 2016	51688*	2.86	2.50	St. Patrick's Home is aiming to improve our percentage of worsening pressure ulcers to 2.5%, which is 0.4% better than the current provincial average of 2.9%.	1)Education for the Wound Care Lead in Best Practice of developing a skin and wound care program.	The Skin and Wound Care program will continue to utilize a dedicated Skin and Wound Care Champion that will be afforded the replacement time to deal directly with more individualized targeted skin care treatments.	# of STAGE I Ulcers; # of STAGE II Ulcers; # of STAGE III Ulcers; # of STAGE IV Ulcers; # of ulcers worsening in last month - from stage II to III to IV; # of INTERNALLY acquired ulcers within last month (Stages I - IV).	100% completion of education by Wound Care Lead	RNAO Best Practice Workshop
									2)Develop a standardized program of preventative care and a protocol for actual wound impairments.	The Skin and Wound Care Team will be interdisciplinary including resident and family members. Streamline processes to ensure proper assessments, documentation and care planning completed	# of STAGE I Ulcers; # of STAGE II Ulcers; # of STAGE III Ulcers; # of STAGE IV Ulcers; # of ulcers worsening in last month - from stage II to III to IV; # of INTERNALLY acquired ulcers within last month (Stages I - IV).	Monthly to Quarterly meetings to develop process utilizing the Best Practice resources, including using external practices.	A structured auditing process is required to ensure compliance with changes after education is provided.
									3)Education of the team after development. Initiation of an electronic record for wound assessments and monitoring	Engage the Skin and Wound Care Team on how to educate staff on the processes to ensure the education is delivered in a way that staff can understand and incorporate in their daily routines.	# of STAGE I Ulcers; # of STAGE II Ulcers; # of STAGE III Ulcers; # of STAGE IV Ulcers; # of ulcers worsening in last month - from stage II to III to IV; # of INTERNALLY acquired ulcers within last month (Stages I - IV).	100% of staff using the assessments educated. 100% of Nursing staff educated on their roles and responsibilities for the program.	N/A
		Percentage of residents who fell during the 30 days preceding their resident assessment	% / LTC home residents	CIHI CCRS / July - September 2016	51688*	11.56	11.50	Our aim is to maintain our fall rate which is currently below the provincial average while continuing to reduce our restraint use.	1)Review and revise the falls program, developing a new interdisciplinary committee including family members and residents, which will revew and revise policies and procedures related to falls.	Interdisciplinary team meetings at the RHA level (eg. House Council) to review progress on falls and solicit feedback from front line staff, residents and/or family. Review of program at Fall Prevention team meetings, including education on the changes in progress. Utilize the guideline from the Centre for Effective Practice.	Total # of Falls that occurred within the month. Total # of Residents Who Fell within a month. Total # of serious injuries from Falls eg. Fracture Prevalence of Residents who fell (%). Prevalence of total falls (%) that occurred within the month.	Fully revised program of Fall Prevention and Injury reduction.	Continue falls analysis. Collaborate between programs to reduce falls.
									2)Develop a documentation process (Including Post Fall Assessment) that is easily completed, ensuring accuracy and ongoing review of the resident's needs and preferences.	Develop an algorithm for falls that is easy to follow for all staff and family members. Update the Post Fall Assessment to automatically create a structured progress note that helps to ensure continuity of documentation and follow up. Use the assessment and establish a process for feedback to ensure staff can effectively use the guideline.	Total # of Falls that occurred within the month. Total # of Residents Who Fell within a month. Total # of serious injuries from Falls eg. Fracture Prevalence of Residents who fell (%). Prevalence of total falls (%) that occurred within the month.	Streamlined approached to assessing, documenting and monitoring a resident's fall risk and individualized support to minimize falls. 100% compliance of registered staff in completing the Post-Fall Assessment and the Risk management section of PCC.	A more streamlined and standardized approach to falls management should lead to a greater awareness of risks related to falls and more individualized and timely interventions. Both the Post Fall assessment and Risk Management must be completed in order to track falls and identify trends in a more efficient way.
									3)Develop a series of potential new interventions, including various approaches from a variety of sources.	Use materials researched as well as Best Practice Guidelines related to fall prevention.	Total # of Falls that occurred within the month. Total # of Residents Who Fell within a month. Total # of serious injuries from Falls eg. Fracture Prevalence of Residents who fell (%). Prevalence of total falls (%) that occurred within the month.	Expand our knowledge and use of various tested and proven falls management techniques and interventions.	We must continue to look for new ways to reduce falls and serious injuries related to falls while continuing with current strategies that have had success.

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									4)Restorative Education to ensure maximum use of the program to maintain and/or slow the rate of decline of resident mobility.	Develop a Restorative Care Team that is interdisciplinary in nature (including residents and family members), with a core function of educating others on the merits of the program, including the prevention of physical decline in resident mobility.	Total # residents on a restorative program Total # of Falls that occurred within the month. Total # of Residents Who Fell within a month. Total # of serious injuries from Falls eg. Fracture Prevalence of Residents who fell (%). Prevalence of total falls (%) that occurred within the month.	Increased support/assistance from front-line staff implementing restorative programs related to reducing falls such as Active and Passive Range of Motion and the Walking Program.	Improvements in Restorative Care Programming can have a positive effect on a resident's mobility, in turn reducing the overall number of falls.
		Percentage of residents who were physically restrained every day during the 7 days preceding their resident assessment	% / LTC home residents	CIHI CCRS / July - September 2016	51688*	9.24	7.00	Our plan is to further reduce our restraint use by 2.25% in 2017.	1)Review the definitions of restraints and PASDs and develop an algorithm that is easy to follow for all staff and family members.	The Falls Prevention Team is responsible to review policies and make recommendations around restraints. Educate staff on the policies and offer education to family members on restraint usage and risks associated with restraints	# of PASDs (PERSONAL ASSISTIVE SERVICE DEVICES); # of PHYSICAL RESTRAINTS; Prevalence of physical restraints.	Use lean tools through the interdisciplinary team and through out implementation of changes ensuring frontline staff have input and guide the direction using best practice. Use the Guideline from the Centre of Effective Practice.	N/A