LONG-TERM CARE HOMES AND SERVICES DIVISION
ACHIEVEMENT OF 2008 OPERATING OBJECTIVES
Fudger House

Objective	Success	Indicators of Achievement
Governance		
1. To participate in the implementation of the provincial LTC-MH Framework for LTCHs.	Achieved	• The Long-Term Care Homes and Services (LTCHS) Division was retained by the Ministry of Health and Long-Term Care (MOHLTC) to lead an inter-sectoral Long-Term Care-Mental Health (LTC-MH) steering committee, to develop and implement a LTC-MH framework. Our General Manager was the Chair of the Steering Committee. This work was completed in 2008, with a further phase planned for community. • Fudger House has a PIECES-trained Nurse Manager in the leadership role for implementation of the LTC-MH framework. • Two Nurse Managers have completed the Enabler Training and/or the Behavirourl Response Program. • Established in-house education sessions to train Behavioural Response Nurses (BRNs) collaboratively with our Psychogeriatric Resource Consultant (PRC). We have 4 BRNs: one on days, one on evenings and 2 on nights. • Scheduled Personal Care Aides to attend the *U-First* training (increased from 13 to 25 in 2008). • Encouraged staff to take advantage of education training offers by the Alzheimer's Society of Toronto. • Continue to seek advice and assistance from the PRC. General inservices provided by our PRC included topics on Depression, Delirium and Schizophrenia. Specific Mental Health presentations were provided by the PRC to the Nursing Practice Committee and the group of U-First grads. • Continue to work with the LTC-MH outreach team established by the ministry. • Plan to train more PIECES nurses in 2009.
2. To participate in the division-wide 2009 accreditation survey under the Qmentum Program.	Achieved	• Administrator is a member of the Division Qmentum Steering Committee. • Four of the homes, including Fudger House, were due for an accreditation re-survey in 2008. They were required by Accreditation Canada (AC) to submit an interim report to address any and all recommendations from

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		the 2005 survey and provide evidence in meeting the 2008 Required Operational Practices (ROPs). • Received confirmation from Accreditation Canada that the interim reports submitted to address the recommendations made in the 2005 survey visits have fully addressed any and all recommendations. Accreditation Canada noted that all the reports were very comprehensive. • All managers attended the "Qmentum for Managers" training session in July/August 2008. • Multiple sessions on "Introduction to Qmentum" were offered to all staff on all shifts in September 2008. • Information sessions on the two instruments: Worklife Pulse Survey and Patient Safety Culture Survey were presented to all staff. • Over 180 staff members completed the Worklife Pulse and Patient Safety Cultures Surveys. • Frontline staff and managers completed the Long-Term Care Self Assessment. • All managers completed the Effective Organization Self Assessment. • Received Quality Performance Roadmap (QPR) from Accreditation Canada in January 2009. The QPR will be used to establish action plan and prepare for the survey visit in May 2009.
3. To continue to strengthen the home's system of integrated quality management.	Achieved	• Unit team members use unit specific indicators and indicators based on determined priorities in selecting QI initiatives and/or QI projects. • Evidence in QI monitoring reports and QI storyboards that staff are more focused on outcome measures, re-evaluation and establish alternatives as appropriate. • Conducted two QI projects and numerous QI initiatives. • Published articles about Fudger House quality work in Homefront newsletter. • Worked with other divisional colleagues to create LGBT toolkit (with indicators) • Evidence that staff understand the value of continuous quality improvement through staff meetings, performance reviews, etc.

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		• Provided Root Cause Analysis (RCA) education to all managers. Subsequently conducted a RCA on outbreak management.
4. To continue to enhance the culture of safety related to workers, residents, clients, families, volunteers and the general public through a team approach.	Achieved	• Joint Health and Safety Committee (JHSC) and Home Management Committee (HMC) both take a leadership role in fostering a safety culture in the home. • There is evidence of JHSC effectiveness through: improved monthly workplace safety inspections, audits, surveys; joint delivery of Muscular Skeletal Disorders (MSD) training, with the supervisor of staff education, to all staff; review and provide input to revised/new health and safety polices; meeting with Ministry of Labour during their visits; outbreak management; pandemic and disaster planning; incident reporting and analysis; coordinate annual health and safety and infection control week; support inservice training on asbestos removal. • Did numerous environment changes as a result of recommendations from JHSC and HMC. These included but not limited to: bathroom renovations to improve space, heating and ventilation; installation of 7 new water flush eyewash stations; replacement of 3 stairwell doors with elongated window inserted to provide better visibility of oncoming people; replace worn out concrete surfaces at receiving dock etc. • Evidence that the culture of safety continues to emerge and improve among staff. Great improvement of staff vaccination rate to over 90%. Staff are aware to report all accidents including near misses. Staff are more knowledgeable regarding their role and responsibilities in health and safety. • Implemented the Code White policy. • Evidence that health and safety is a standing agenda item on HMC, unit/department staff meetings and general staff meetings. • Provided infection control and fire safety information sessions to Residents' Council and Family Committee. • The Community Relations Officer of the 51 Division of Toronto Police Service presented an information forum on safety to residents, families, staff and volunteers. He shared how

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		one can sign up for the community alert mailing list.
Proactive & Supportive Organization		
5. To participate in the development of a divisional plan that will enhance volunteer involvement of youth and the 55+ age group cohort.	Achieved	• The Coordinator of Volunteer Services is a member of the divisional working group of establishing strategies to recruit 55+ age group volunteers. • Posted volunteer positions (daytime, Monday to Friday) on the Volunteer Toronto website, Craig's List website and local churches. Increased volunteer applications of 55+ by 25%. Increased active volunteers by 10%. • The Coordinator of Volunteer Services met with the Director of Prime Time Learning at Ryerson University to identify opportunities for outreach to mature students. • The Coordinator of Volunteer Services attended Volunteer Fairs at various local schools such as Jarvis Collegiate, Monarch Park Collegiate, Danforth Tech and St. James Town Youth Group for recruitment of youth volunteers. • Increased youth volunteer applications by10%. • Increased youth volunteers in Fudger House by 12%. • Increased youth volunteers from St. James Town Youth Group by 10%.
6. To simplify and streamline customer service functions at the home's level.	Achieved	• The home implemented the recommendations from the divisional Customer Service Function post implementation review. • Clarified the role of the Support Assistant C (employees in the customer service role) by the Division. Their main function is to provide customer service to residents, families, visitors, and staff for call-in work. They should refer staff to his/her manager for all other questions related to scheduling, except for call-in work. This role clarification reduced the number of conflict situations at the reception area. This improved the efficiency and effectiveness of the Support Assistant C at the reception area. • The Support Assistant Cs offer great support and reassurance for our residents in the main lobby area.

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		• Established an internal communication log and tracking form for communication among the Support Assistant C in doing call-in replacements. This helps to avoid any miscommunication and errors.
7. To pilot the updated TimeKeeper system.	Achieved	• Participated in the pilot program which was launched in February 2008. • All managers, with payroll responsibility, attended training provided by Head Office staff. • Did parallel run of the new and updated system for a few consecutive pay periods. • The new system went "live" in March 2008. • Fudger House is currently operating on the updated system exclusively. • A number of deficiencies have been identified during the pilot. • It is recommended that the home and Head Office to jointly conduct an evaluation prior to rolling out the system.
8. To have each unit care team implement and evaluate enhanced falls prevention strategies that reduce the risk of and the number of injuries from falls by a minimum of 20% in 2008.	Partially Achieved	All units implemented strategies to reduce the risk of fall and injuries in 2008. Strategies included: • Completion of Falls Risk Assessment on admission for all residents, and Phase 2 Falls Assessment for residents who fall following admission. • Discussed risk and /or falls at ad hoc and annual care conferences. • Referrals made to PT and/OT as indicated when falls occurred or risk of falls identified. • Installed Arco rail to assist transfers and non-slip floor strips at bedsides to reduce risk of slipping during transfers. • All beds had been replaced with hi-low electric beds which are kept in the lowest position for residents at risk for falls. Bedside floor mats are also used to reduce risks of injury for residents who may climb or fall out of beds. • Encouraged residents and families to purchase hip protectors which have been found to reduce risk of hip fractures. (The home has purchased hip protectors in various sizes and styles, so that they are quickly available when the need is identified. • Installed lower toilet seats on 2 West where most of the Chinese residents are quite petite.

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		• Falls Prevention is a standing agenda item on Resident Care and Services Committee meetings. Nurse Management Team provides monthly report, analysis and action plan. • Enrolled a RN and a PCA as the Best Practice Champions. They attended the fall prevention training in 2008 and will participate in a QI project on falls in 2009. • Despite the implementation of the above strategies, we did not meet our target in reducing the number of injuries by 20% in 2008.
9. To continue to implement the psychogeriatric and mental health services framework to maximize successful admission placements and strengthen collaboration with both the CCACs and Pyschogeriatric Outreach Teams.	Achieved	• Established a structure framework with our Psychogeriatric Outreach Team. • Our Psychogeriatric Outreach Program (POP) Social Worker visits one day per week. • Our POP Psychiatrist visits once per month. • Behavioural Response Nurses work with the POP Social Worker and coordinate the Psychiatrist visits. • In 2008, the Outreach Team and our Behavioural Response Nurses did 147 and 75 assessments respectively. • With the collaboration of the Outreach Team, we were successful in accessing beds in placing two of our residents on temporary leave to other facilities for psychogeriatric assessments. This collaboration also strengthened our relationship with the receiving facilities.
10. To operate the home in a manner that maintains compliance with applicable legislation, while maintaining innovation and creativity.	Achieved	• There were no unmet standards/criteria issued during the 2008 annual compliance review. • We received one unmet standard during a special visit in September 2008. Our action plan was submitted within 10 days of the visit and our plan was accepted in full with no changes. • We continue to monitor/sustain our action plan.
11. To assess and enhance staff's assessment and care provision skills in providing end-of-life care to residents.	Partially Achieved	• The video on "Principles of Palliative Care" was offered to all staff on all shifts. One hundred and five (105) staff attended. A very moving video. It triggered a lot of discussion among staff. They shared lessons learned regarding how we can improve in providing end-of-life care to our residents.

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		• Introduction of the "comfort basket" by Programs and Services. • The Rehabilitation Assistant presented the program at each unit's multidisciplinary team meeting. • Referrals were made for complementary care, music therapy and spiritual and religious care services. • Multidisciplinary teams discussed resident on palliative care at monthly meetings. • Two audits completed in 2008 reflected the effectiveness of the program. • Area to improve: earlier identification of palliative care