OANHSS

LTCHA Implementation
MEMBER SUPPORT PROJECT

Quality and Compliance Monitoring by Boards

Appendices: Tools and Resources

Release Date: January 20, 2011

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Please Note Appendix A and B are included in the PowerPoint presentation accompanying this document

ABOUT THIS DOCUMENT

The development of the attached documents are to supplement the material provided in the PowerPoint presentation. This document contains a sample tools and resource materials that may be used by the organization in conjunction with all or parts of the presentation, or separately.

This package, together with the PowerPoint presentation, is intended to be used as a resource for OANHSS member homes to modify and customize, as appropriate. This material can also be used by homes to review their current practices and compare content. Please note: The project team have compiled these materials during the winter of 2010, and as a result, the information is based on the guidance available at this time. Members will need to regularly review the Ministry of Health and Long-Term Care (MOHLTC) Quality Inspection Program to ensure that they obtain updates on the Inspection Program and definitions/clarifications on the Inspection Protocols.

Acknowledgements

OANHSS gratefully acknowledges the contribution of written practices, resources and tools used in the development of this package from St. Demetrius (Ukrainian Catholic) Development Corporation, Belmont House, Dufferin Oaks and Perley Rideau Veteran's Home.

APPENDIX C: Key MOHLTC Inspection Protocols

For Appendix C: Key MOHLTC Inspection Protocols for the Board to know, see attached PDF document included in this package.

APPENDIX D: Quality Committees and Roles – Samples

Preamble
The Inspection Protocol named "Quality Improvement Inspection Protocol" describes the expectations for a Quality Improvement and Utilization Review system that will be reviewed during the annual visit by inspectors and may also be used when a complaint is received by the Ministry. This is a mandatory protocol. There are 2 parts to this protocol:

A. The Inspector will want to see the following for a 'continuous quality improvement' and utilization review system
    a. CQI contact person
    b. CQI Committee, if any
    c. CQI meetings dates
    d. A written description of the system
    e. Records of improvements made to accommodation, care, services, programs and goods provided to the residents
    f. Satisfaction Survey results
B. Annual satisfaction survey administration
    a. Annual process
    b. Reasonable actions to address the results
    c. Seeking input from Residents Council and Family Council, if any, in developing and administering the survey and process and using results fro improvements
    d. Communication to residents occurs on the improvements made
    e. Documented actions taken to address opportunities for improvement

IT IS IMPORTANT TO NOTE THAT THE PROTOCOL DOES NOT REQUIRE A COMMITTEE TO EXIST, BUT THAT THE FUNCTIONS REQUIRED IN THE PROTOCOL ARE ADMINISTERED.

If a CQI committee does not exist, these functions may be carried out by an existing committee, group and person

The attached provide examples of how organizations are managing these requirements through formal committees, at an operational level and board level:

1. St. Demetrius (Ukrainian Catholic) Development Corporation, Board CQI Committee
2. Belmont House, Board CQI Committee and Management Committee
3. Dufferin Oaks, Management Committee
4. Excellent Care for All Act excerpt that describes the role of a CQI Committee. At this time only Hospitals are required to ensure that they have such a committee.

BOARD COMMITTEE EXAMPLE:

Source: ST. DEMETRIUS (UKRAINIAN CATHOLIC) DEVELOPMENT CORPORATION

QUALITY AND RISK MANAGEMENT COMMITTEE OF THE BOARD

TERMS OF REFERENCE

Effective: December 2, 2003
Revised: September 2005
Revised: March 2006
Revised: December 2008
Revised: December 2009

Purpose:

To advise and make recommendations to the Board on issues of compliance, ensuring performance based outcomes related to quality, risk and utilization as part of fulfilling the Board's fiduciary task.

To serve as a forum to identify and resolve ethical issues related to the delivery of care and services at the Care Centre and/or St. Demetrius Residence.

To ensure that all research proposals have received ethics approval by the sponsoring organization with a view to ensuring the safety of research participants

Membership:

- Board Members (4) –Voting Members
- Executive Director - Voting Member
- Medical Director – Voting Member
- Director of Resident Care Services – Nonvoting
- Director of Quality, Organizational Development and Housing – Nonvoting
- Finance Committee Member (Ex Officio)
- Nominating and Governance Committee Member (Ex Officio)

Responsibilities:

- Review and approve reports and make recommendations to the Board in matters related to quality of care, quality of service, resident satisfaction, utilization and risk management initiatives that are consistent with recognized standards and the organization's strategic goals.
- Receive quarterly updates on quality indicators and improvements
- Review significant and unusual incidents/risk management issues and trends.
- Receive summary reports on issues that relate to quality, risk and utilization from external agencies (e.g. Classification, Compliance Review).
- Review approvals by external ethics committees and make recommendations for participation in proposed research projects.
- Establish ad hoc sub-committees as required to address and report back on specific ethical issues.
- Perform such other duties as may be requested by the Board of Directors.

Accountability:
To the Board of Directors

Frequency of Meetings:
Meetings will be held every three months, or at the request of the Chair.

Evaluation:
The function and Terms of Reference of the Quality and Risk Management Committee will be evaluated on an annual basis in December.

BELMONT HOUSE EXAMPLES:

Governance Quality Committee Example

Operational Quality Committee Example

Belmont House
Terms of Reference
Quality, Risk and Safety Management Committee of the Board

ROLE OF COMMITTEE: To be a standing committee of the Board of Directors to:

- Monitor and provide direction for the Quality Improvement program that facilitates quality of life and care for all Belmont House clients;
- Monitor and provide direction to the development of an integrated Risk Management and Safety plan for the Belmont House community;
- Monitor and provide direction for the ongoing management of the program and implementation of policies and procedures regarding the delivery of care and services is in accordance with client, community and government expectations, and meets legislative requirements;
- Monitor and provide direction to Best Practice Projects related to research, education and service delivery.

PRINCIPLES:

- All programs and processes will be implemented in a manner consistent with the mission and values of Belmont House;
- For the purpose of this policy Belmont House community refers to clients, residents, staff, volunteers, visitors, etc;

COMPOSITION:

Chair: Member of the Board appointed annually by the Board of Directors, acting upon the recommendation of the Nominating and Governance Committee.

Members: Members are appointed by the Board of Directors acting on the recommendation of a slate of candidates recommended by the Nominating and Governance Committee:
Minimum of two (2) members of the Board of Directors,
Representative from Long Term Care (either Resident or Family Council)
Representative from Retirement Living Tenant Council
Representative from Belmont Volunteers

Representative (1-2) of the community (this may include Honorary Members or Colleges and Universities)
Executive Director, *ex officio and non-voting*
Medical Director, *ex-officio and non-voting*
Director of Care, *ex-officio and non-voting*
Professional Practice, Quality and Risk Leader *(ex officio and non-voting*

TERMS OF OFFICE: One year renewable or by virtue of office

FREQUENCY OF MEETING: Bi-monthly or at the call of the Chair

RESPONSIBILITIES:

Quality Improvement:

Monitor and provide direction on the Quality Improvement program including performance measures and benchmarks;

Receive, at a minimum, quarterly reports from the Manager's Quality and Risk Management Committee on quality improvement indicators for programs and services and compare them to internal and external benchmarks to ensure that they address the physical, social, psychological, intellectual and spiritual needs of residents and tenants;

Review all reports and surveys conducted by management and external organizations pertaining to quality of life and/or care of the clients of Belmont House and review action plan recommendations arising from the reports and surveys;

Monitor a review process for management to solicit feedback on concerns, issues, suggestions that the Belmont house community may have, and to ensure proper follow-up to address concerns and suggestions;

Integrated Risk Management & Safety:

Monitor and provide direction for the establishment and maintenance of a risk management program;

Receive risk management reports on a quarterly basis or more frequently if necessary and compare them to internal and external benchmarks to ensure that all risks to the Belmont House community have been minimized;

Review Sentinel/Critical events and make recommendation to reduce future risks.

Receive information regarding changes to regulation/legislation and provide direction on proposed plan of action;

Monitor and review progress related to the accreditation process.

Oversee proposed changes to the Belmont House buildings and grounds to monitor issues related to the physical facility so that they are addressed in a manner consistent with the mission, values, and principles, and in accordance with the integrated Quality, Risk and Safety Program;

Demonstrate, through the Chair of the Finance Committee of the Board, that proper financial controls exist over operating and capital expenditures, keeping in mind both the short-and long-term financial viability of the House.

Best Practices:

Support the development of alliances and partnerships in the community that complement the programs and services provided at Belmont House and are in keeping with the strategic plan;

Monitor and provide direction to programs and projects that enhance Belmont House's opportunity to achieve the highest quality or standard regarding:

- educational initiatives,
- models of care, and
- research practices

Reporting:

The Committee through the Chair will make regular reports to the Board of Directors about the progress of the House in achieving quality and risk management objectives.

ACCOUNTABILITY: Responsible to the Board of Directors.

Terms of Reference
Manager's Quality, Risk and Safety Management Committee

Role of the Committee:

- To ensure compliance with relevant legislative and legal requirements related to quality and risk management.
- To act as a resource for managers in the application of quality and risk management practices including the use of performance indicators to mitigate risk and achieve improvements.
- To promote decision-making and actions based on facts and data.
- To ensure that standards of quality and risk management are applied at all levels within Belmont House and that controls, assurance mechanisms, and improvement activities are in place to report to the Quality and Risk Management Committee of the Board on a quarterly basis and as needed.

Composition:

Chair: Chief Executive Officer
Members: Director of Care
Professional Practice, Risk and Quality Management Leader
Director of Support Services
Manager Human Resources
Director of Finance and IT
Director Retirement and Marketing Services
Supervisor Housekeeping
Maintenance Supervisor

Frequency of Meetings:

Monthly or as required

Responsibilities:

- To create an environment of continuous improvement by modeling the principles of quality improvement and developing an infrastructure for quality**.**
- To review reports, quality initiatives, performance indicators and benchmarks to ensure that the principles of quality improvement become "the way we do business".
- To maintain an inventory of current quality initiatives, approve future initiatives and make recommendations where appropriate.
- To develop processes to assist in achieving the goals and objectives as outlined in the strategic plan.
- To ensure the facility meets accreditation standards as outlined by the Accreditation Canada and is prepared for accreditation surveys.
- To ensure that care and services meet the standards as outlined in provincial legislation, Long Term Care Homes Act and Belmont policies and guidelines.

- To ensure that Belmont policies and guidelines related to employees follow the Collective Agreement and relevant provincial legislations and regulations.
- To identify and assess risk, risk control actions, evaluation and reporting of risk management program and prevention of repeated occurrences.
- To ensure that staff receive education regarding elements of quality and risk management.

Accountability:
Quality, Risk and Safety Management Committee of the Board

DUFFERIN OAKS EXAMPLE:

Dufferin Oaks: Operation Quality Committee Example

TITLE:	**Quality Services Committee**		**DEPT:**	**Dufferin Oaks**
EFFECTIVE:	**September 1983**		**MANUAL:**	**General**
REVISED:	**October 2010**		**SECTION:**	**Quality Services**
			POLICY #:	**GN 8-021**
AUTHORITY:	**Administrator**		**Administrators Approval:**	
Review Date & Initials				

POLICY

A Quality Management program will be established to monitor and review quality management activities in the Home and to confirm that the mission and objectives of the Home are being met.

PURPOSE/GOALS

1. To ensure optimal resident care and services through the auditing of established criteria and standards.
2. To ensure appropriate indicators of performance are identified and monitored for all aspects of resident care and service.
3. To monitor community health status and needs establishing priorities for programs and services.
4. To promote the philosophy of continuous quality improvement providing team members with the necessary knowledge and skills to implement the process.
5. To promote the philosophy of the home.
6. To ensure compliance with the LTCHA and regulations and other applicable legislation.

These goals are accomplished by:

1. Involving staff and clients in planning and the evaluation process.
2. Ensuring each discipline's quality management program monitors the areas needing attention and follow-up.
3. Ensuring each discipline's quality management program is compatible with the mission of the home.
4. Ensuring audits/indicator analysis and plans of actions are effective, comprehensive and directed to improving/maintaining quality of life of residents.
5. Monitoring meaningful performance indicator to identity areas requiring improvement and/or success of quality improvement activities implemented.
6. Encouraging the sharing of quality management knowledge and activities between departments to eliminate duplication of efforts

7. Providing a means of ongoing evaluation and documentation of the effectiveness of actions tried to overcome deficiencies.
8. Communicating Quality Management Activities to residents, families, staff and other stakeholders.
9. Ensuring mechanisms are in place to monitor compliance with the LTCHA and Regulations and other applicable legislative requirements.
10. Ensuring a program is in place to monitor and reduce risks to staff, visitors, residents, and volunteers.
11. To encourage and support quality circles in the resolution of problems to improve service.
12. Communicating to the Administrator and Committee of Management issues to be addresses in formulating future planning for quality resident care.

COMMITTEE MEMBERS

Administrator
Director of Care
Assistant Director of Care
Manager of Food Services
Office Manager – Secretary to the Committee
Program & Support Services Manager
Facility Manager
Housekeeping & Laundry Manager
Manager of DCCSS

DUTIES AND RESPONSIBILITIES:

Administrator:

a. Ensures the appointment of a Home QM Committee
b. Receives and reviews reports of the Home QM Committee
c. Reviews and monitors action taken on recommendation of QM activities.

Quality Management Coordinator – Appointed by the Committee:

a. Chairs Home QM Committee meetings.
b. Prepares and circulates agendas in advance of meetings
c. Ensures meeting proceedings are documented.
d. Coordinates Quality Improvement reports to Committee of Management, Resident Council, Family Council and staff.
e. Prepares annual Home QM calendar

Quality Management Committee:

a. Meets a minimum of quarterly
b. Reviews QM reports submitted by Departments/Committees/Teams to determine if the audits being conducted meet the QM Program's goals and objectives.
c. Recommends revisions to Departmental QM programs as appropriate.

d. Monitors follow up action plans to ensure deficiencies identified/objectives are addressed.
e. Conducts an annual committee evaluation and develops an annual action plan.

Department Managers:

a. Ensure a Departmental QM program is in place.
b. Establish criteria and standards for programs and areas of service.
c. Identify areas which require regular monitoring i.e. critical procedures, problem areas etc.
d. Develop and implement an annual Departmental QM schedule.
e. Develop and implements plans of actions to correct deficiencies noted.
f. Report to Home QM Committee on Departmental QM activities.

Staff:

a. Are knowledgeable of departmental and home policies and procedures.
b. Participate in CQI/QM activities
c. Assist Department Head to establish and evaluate criteria and standards.

RECORDS MANAGEMENT:

1. Each Department will maintain files of all quality management activities including the supporting documentation used to calculate audit results and performance indicators.
2. CQI report summaries will be presented at quarterly Quality Services Committee meetings and a copy provided to the secretary to be included in the official committee records.
3. Performance indicators are tracked in the Point Click Care QIA module and mangers/teams report on the analysis of the data quarterly.
4. The committee secretary will maintain records of all committee agendas, minutes and CQI reports.
5. Minutes only will be distributed to committee members.

EXCERPT FROM EXCELLENT CARE FOR ALL ACT, 2010 Being Implemented in Hospitals

QUALITY COMMITTEE

Quality committee to be established

3. (1) Every health care organization shall establish and maintain a quality committee for the health care organization.

Composition of quality committees

(2) The membership, composition and governance of quality committees shall be as provided for in the regulations.

Accountability

(3) Every quality committee shall report to its responsible body.

Responsibilities of quality committees

4. Every quality committee has the following responsibilities:

1. To monitor and report to the responsible body on quality issues and on the overall quality of services provided in the health care organization, with reference to appropriate data.
2. To consider and make recommendations to the responsible body regarding quality improvement initiatives and policies.
3. To ensure that best practices information supported by available scientific evidence is translated into materials that are distributed to employees and per-sons providing services within the health care organization and to subsequently monitor the use of these materials by these people
4. To oversee the preparation of annual quality improvement plans.
5. To carry out any other responsibilities provided for in the regulations.

APPENDIX E: The Inspection Report Judgement Matrix and Orders

The Inspection process is new in its format, in the tools that are being used by the Inspectors, in the competencies being required by the Inspectors, and by the use of the new Inspection Protocols that will be assessed during the annual site visit.

The attached Judgment Matrix is being used by the Inspectors to measure compliance to the legislation in relation to severity and scope of the non compliance together with the compliance history of the home. The frequency of non compliances (whether the observation seems to be isolated, a pattern on non compliance or widespread), will be weighted into the measure.

The home can voluntarily act on written notifications, suggested plans of corrections and Director Referrals. However the homes must respond to all 6 types of orders.

Due to the prescriptive nature of the legislation and the regulations, the pilot experience has demonstrated that a home may receive more non compliance than has been previously experienced. This does may not mean that the home is at risk, but rather that there are opportunities for improvement. The Home will be deemed to be at risk if it is assessed to be a Level 3 or 4 where non compliance has a pattern or is widespread.

The MOHLTC Judgment Matrix Used by Inspectors and Actions Required by Home

Judgment Matrix			
Level 4 Immediate Jeopardy	WN, VPC, CO, WAO, DR	WN, VPC, CO, WAO, DR, MMO	WN, VPC, CO, WAO, DR, MMO, RL, IM
Level 3 Actual Harm	WN, VPC, CO, WAO, DR	WN, VPC, CO, WAO, DR	WN, VPC, CO, WAO, DR, MMO
Level 2 Min or potential harm	WN, VPC, CO, DR	WN, VPC, CO, WAO, DR	WN, VPC, CO, WAO, DR, FS
Level 1 Minimal harm	WN, VPC, DR	WN, VPC, CO, DR	WN, VPC, CO, WAO, DR
	Level 1 Isolated	Level 2 Pattern	Level 3 Widespread

Inspector

Director

WN	Written Notification
VPC	Voluntary plan of correction (Licensee to prepare a written plan of correction for s.152. 2. achieving compliance, to be implemented voluntarily)
DR	Director Referral – Inspector to issue a WN and make a referral to the Director
Types of Orders	
CO	Compliance Order
WAO	Work & Activity Order
FS	Financial Sanction (Order that funding be returned or withheld)
MMO	Mandatory Management Order
RL	Revocation of License (when non-compliance with LTCHA)
IM	Interim Manager

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Types of Orders, Parties that Issue Orders, and Actions Required

Type of Order	Action	Issued By
Compliance Order (CO)	Order licensee to (a) do / refrain from doing anything to achieve compliance, or (b) prepare, submit and implement plan for achieving compliance	Inspector or Director
Work and Activity Order (WAO)	Order licensee to (a) allow ministry employees or agents/contractors under ministry authority to perform any work/activity at LTC home that is necessary, in the opinion of the person issuing the order, to achieve compliance; (b) pay reasonable costs of the work/activity	Inspector or Director
Financial Sanction (FS)	Order funding be returned or withheld	Issue by Director
Mandatory Management Order (MMO)	Order licensee (at licensee's expense) to retain one or more persons (approved by Director) to manage/assist in managing LTCH	Issue by Director
Revocation of License (RL)	Order revoking a license (and where required, order providing LTCH to be occupied and operated by interim manager)	Issue by Director

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APPENDIX F: Quality Monitoring Frameworks, Indicators and Scorecards – Samples

Preamble:

Indicators guide decision making, validate opinions, provide benchmarks, provide objectivity, and mainly are measurements. They are the tools managers, boards, teams, committees and individuals use to ensure that what they are doing is actually achieving the results they want to achieve.

The following documents are examples of indicators being used in Ontario within the Health or Long Term Care Homes Sector. In addition, OANHSS gratefully acknowledges the contribution of Perley Rideau Veterans Home for sharing their recent example of the Performance Monitoring Framework under development (as of January 2011).

Examples of Quality Monitoring Indicators, Score Cards and Frameworks

1. From Ontario Health Quality Council (OHQC), used for comparative reporting, public reporting and system improvement provincially
2. From Kaplan and Norton Balanced Scorecard, the authors of "The Balanced Scorecard"
3. From a Local Health Integration Network (LHIN) Accountability Framework
4. Example from a Long Term Care Home in Ontario – Perley Rideau Veteran's Home

Ontario Health Quality Council Framework: The 9 Attributes of Quality that reflect a High Performing Health System

Attributes of Quality	Description	Indicator to measure attribute for LTC
Accessible	**People should be able to get timely and appropriate healthcare services to achieve the best possible health outcomes.**	• Median days to placement from acute care, community and overall to LTC
Effective	**People should receive care that works and is based on the best available scientific c information**	• Maintaining and improving bladder/bowel function • Providing appropriate mental healthcare • Maintaining cognitive functioning • Maintaining appropriate weight • Preservation of activities of daily living • Providing appropriate pain control
Safe	**People should not be harmed by an accident or mistakes when they receive care**	• Avoidance of infection • Avoidance of pressure ulcers • Avoidance of falls • Avoidance of restraint use • Avoidance of potentially inappropriate prescribing • Avoidance of abuse • Avoidance of emergency department visits
Resident Centered	**Healthcare providers should offer services in a way that is sensitive to an individual's needs and preferences.**	• Staff responsiveness to concerns • Encouraged to participate in decisions involving care as much as wanted • Enough and meaningful activities • Feel free to speak up/not afraid staff will punish resident • Overall quality of care/services in the home • Residents fell at home • Possible additions from survey
Equitable	**People should get the same quality of care regardless of who they are and where they live.**	
Efficient	**The health system should continually look for ways to reduce waste, including waste of supplies, equipment, time, ideas and information.**	
Appropriately Resourced	**The health system should have enough qualified providers, funding, information, equipment, supplies and facilities to look after people's health needs.**	• Staff satisfaction measures (tentative) • Worker injury rates (tentative)
Integrated	**All parts of the health system should be organized, connected and work with one another to provide high quality care**	• Median days to placement from acute care, community and overall to LTC
A focus on Population	**The health system should work to**	• Maintaining and improving

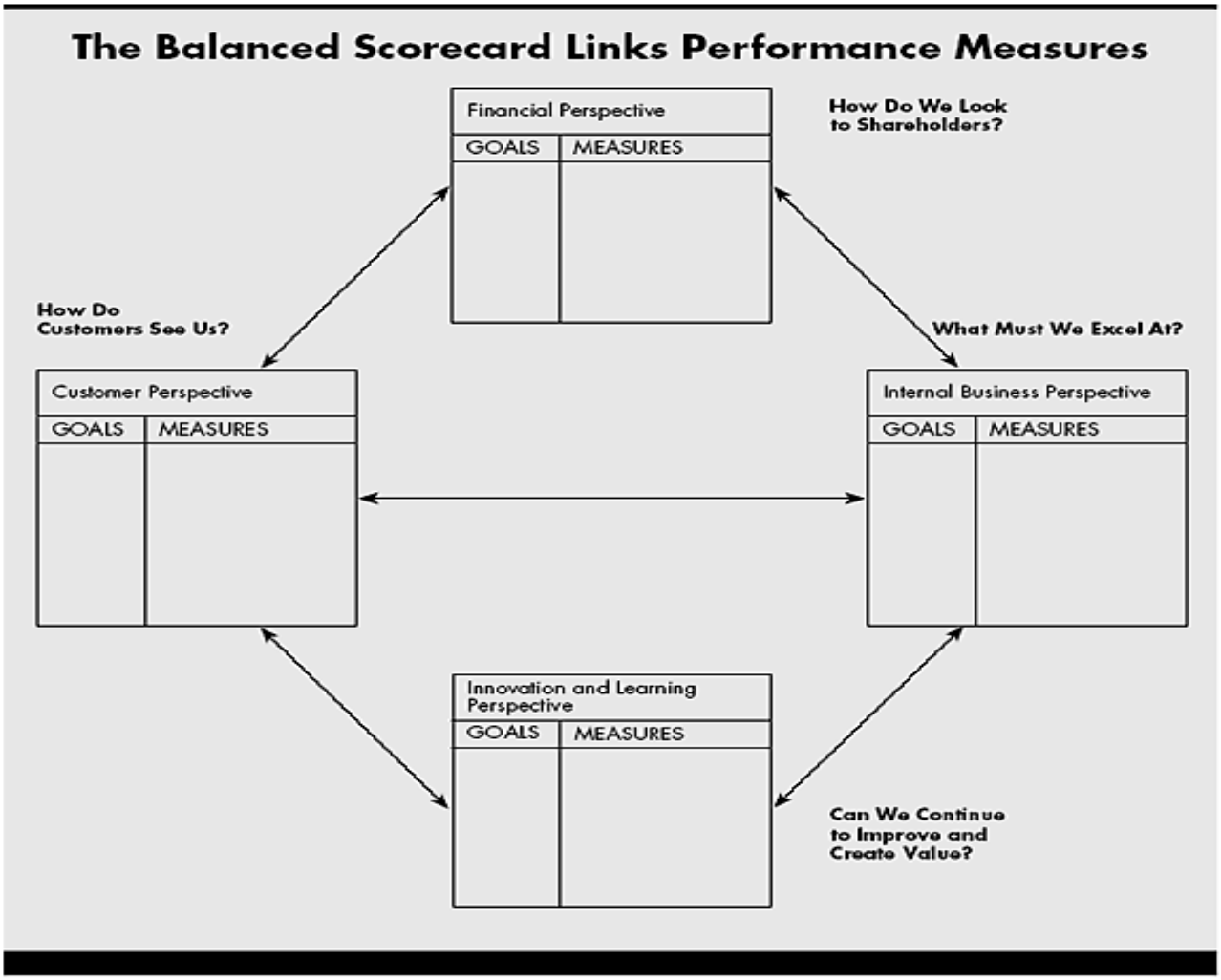
Attributes of Quality	Description	Indicator to measure attribute for LTC
Health	**prevent sickness and improve the health of the people of Ontario.**	bladder/bowel function • Providing appropriate mental healthcare • Maintaining cognitive functioning • Maintaining appropriate weight • Preservation of activities of daily living • Providing appropriate pain control

Kaplan and Norton: the Balanced Scorecard:

The tool developed by Kaplan and Norton is a strategic planning monitoring tool that ensures there is a comprehensive framework that looks at ALL key aspects of the organization, not just the financial aspect that has been the traditional focus.

Since the creating of the “Balanced Scorecard” concept, there have been many iterations of this model by various industries, business consultants, associations and organizations.

In health care, reporting on more than the financial dimension is not new, however in the past 10 years organizations have developed a strategic scorecard using the Kaplan and Norton model, and have also developed “report cards” that depict the health of the organization from many dimensions. Frameworks for the latter are also developed by Accreditation bodies such as Accreditation Canada and CARF International as well the awarding organization the National Quality Institute via their standards for excellence.



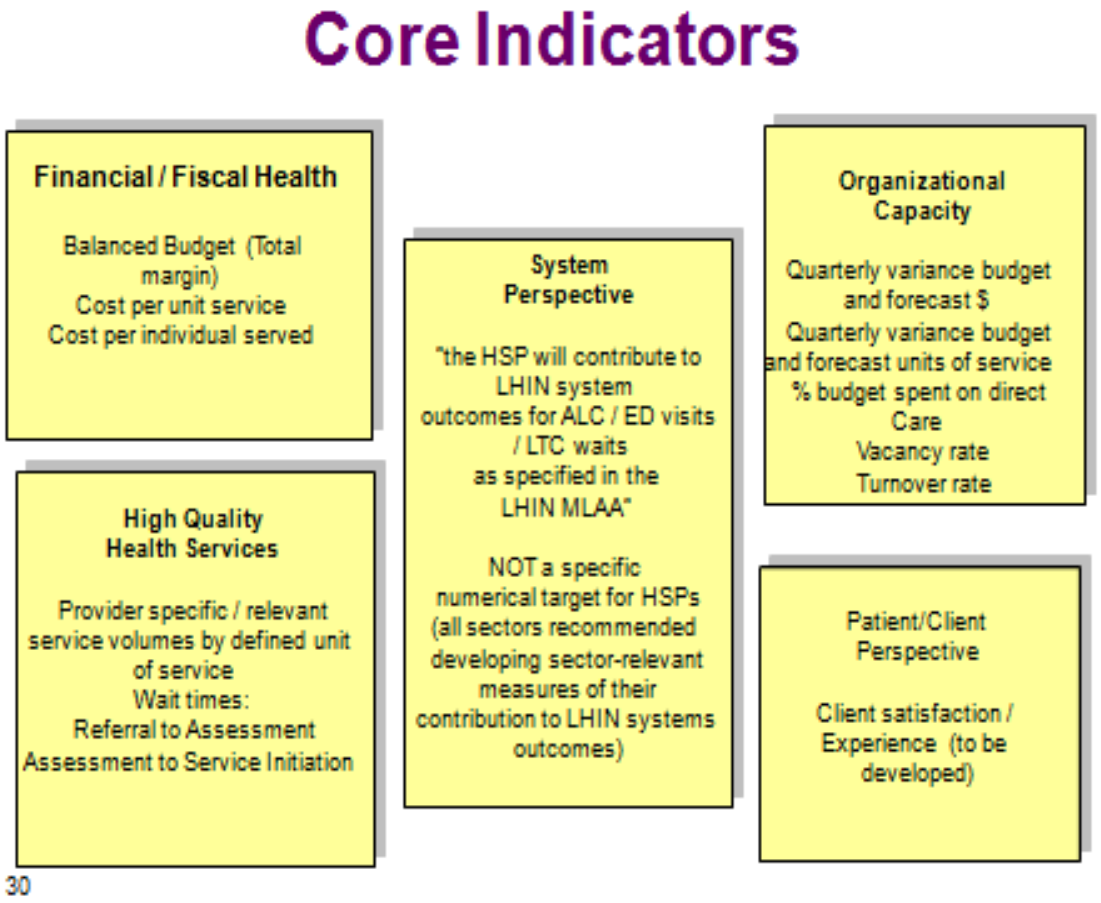
1. Customer perspective. Today's typical corporate mission says something general about customers. The balanced scorecard requires specific measures of what customers get—in terms of time, quality, performance and service, and cost.

2. Internal business perspective. Focus on the core competencies, processes, decisions, and actions that have the greatest impact on customer satisfaction. ECI developed operational measures for submicron technology capability, manufacturing excellence, design productivity, and new product introduction. Company managers then made sure to "decompose" the measures to department and workstation levels, where much of the action took place.

3. Innovation and learning perspective. Measures in this area indicate future success. They measure continual improvements to existing products and processes and introduction of new products with expanded capabilities. Milliken & Co. implemented a "ten-four" improvement program, requiring reductions in key adverse measures (defects, missed deliveries, and scrap) by a factor of ten over four years.

4. Financial perspective. Financial measures are essential for indicating whether executives have correctly identified and constructed their measures in the three foregoing areas—but they can also help determine future direction. For example, a chemical company created a daily financial statement. Putting income and expense values on every production process helped plant supervisors see where process improvements and capital investments could generate the highest returns.

Local Health Integrated Networks' Indicator framework and Core Indicators



Sample: Perley Rideau Veterans Home
Performance Monitoring Framework – Draft as of January 2011

Strategy #1: Excellence in Resident Care and Service	Actual	Target	Strategy #2: Ensure Sustainability	Actual	Target
# of Personal Care Providers per Week			% Compliance with L-SAA Indicators		
% of Residents with Little or No Activity			% Compliance with 10-Year Financial Projection		
Resident/Family Satisfaction			Ratio of Veterans' Affairs Funding to Total Funding		
# of Process-Driven ER Transfers			% of Funding Derived from Preferred Accommodation Envelopes		
% of Residents with Daily Physical Restraints			% of Funded Annual Capital Reserve Requirement		
% of Residents with Medication Reconciliation upon Admission/Transfer					
Incident Rate					
Participation Rate at Resident Care Plan Interviews					
% Compliance with *LTCHA* Inspection Protocols					
Guest House Occupancy Rate					
# of Persons on Wait List who List PRVHC as First Choice					
Strategy #3: Maintain a Quality Workforce	**Actual**	**Target**	**Strategy #4: Lead and Advocate for Change**	**Actual**	**Target**
% Positive Employee Satisfaction			# of Managers/Leaders Participating in Groups/Committees External to the Organization		
% Positive Employee Engagement			% Compliance with Communication Objectives		
Frequency of Accidents			Achievement of National Quality Awards/Designations		
% of Shifts Filled					
% Compliance with *LTCHA* Inspection Protocols					
Training $ per FTE					
% Staff with Completed Performance Reviews					
% Compliance with Developmental Plans					
Ratio of Positive to Negative Exits					
Work-Life Survey Results					
Ratio of Staff Hours to Agency Hours					

APPENDIX G: Quality System Strengthening: Types of questions to ask

Types of Possible Questions to Ask to Ensure the Organization has a Quality System that complies with LTCHA 2007

The following are possible questions that the board, Administrator, senior management, quality managers/coordinators, Accreditation Coordinators, chairs of appropriate Committees, etc can ask to ensure the implementation of and compliance to the new legislation, in no particular order:

1. **How is the Home preparing for implementation of the new legislation?**
    a. What types of policies/procedures are being revised?
    b. How is mandatory staff training being planned for and implemented?
    c. What are the new programs being developed to support the QIPs? What is the critical path for developing these programs?
    d. How do we know we have the knowledge and competencies to address the requirements of the Quality Inspection Protocols?
    e. Do we have the resources to support the transitional period? Do we have the resources to sustain the system?
2. **What is the impact of the LQIP?**
    a. How does the type of information being received now by the Board, Quality Committees, Senior management etc change?
    b. What level of detail does a Committee, group, individual and Board need to know about how the home is meeting the protocols?
    c. How do we connect the protocols to indicators the home is monitoring now or will be monitoring? How do these indicators validate compliance to the protocols, or initiate improvements to the outcomes?
    d. How do the requirements in the protocols change the quality framework?
3. **Inspection Process Readiness**
    a. How ready are we for a quality inspection visit?
    b. What are the areas of possible non compliances? What are the risk implications of these non compliances?
    c. What is/are the barriers to being in compliance?
    d. What are the results of the actual Inspection Report? Do we need to appeal any non compliance?
    e. What is the action plan to address non compliance areas?
    f. How are we aligning this process to the Accreditation process? What is the same?
4. **How will the home manage the information from the Inspection Report?**
    a. What is the Board/CEO/ Residents Council's plan to do with the report once it is received by both parties?
        i. What is the approach to addressing the improvements and non-compliances?
        ii. What is the communication approach?
            1. To all residents
            2. To Family
            3. To Staff
            4. To management

5. To the Board
6. To other key stakeholders, if necessary

b. How does the home ensure that the managing of the contents of the report is managed within the appropriate roles in the organization
   i. Operational improvements are delegated appropriately
   ii. Governance oversight is appropriately implemented
   iii. Residents Council's role in providing input into quality improvement

5. Impact on the way we do business

a. How has the new legislation impacted on Committees and key roles in the organization?
b. What are the capital and infrastructure implications of the LTCHA for our home?
c. What are the anticipated organizational culture changes?
d. How do the recommendation from the report tie into the overall Quality Improvement plan of the organization?
e. How do we align the Inspection report and process with the Accreditation process which also provides the home with information to build and update a Quality Improvement Plan?
f. How does the home set priorities for improvements within the report, and all other aspects of the quality improvement plan?

6. Are we providing leadership to the fundamental principles of the act and laying the foundation of the quality program/system of the home?

a. How do we know we provide resident-centred care?
b. How do we remain committed to the health and well-being of Ontarians living in long-term care homes now and in the future?
c. How do we strongly support collaboration and mutual respect amongst residents, their families and friends, long-term care home providers, service providers, caregivers, volunteers, the community and governments to ensure that the care and services provided meet the needs of the resident and the safety needs of all residents;
d. How do we recognize the principle of access to long-term care homes that is based on assessed need;
e. How do we firmly believe in public accountability and transparency to demonstrate that long-term care homes are governed and operated in a way that reflects the interest of the public, and promotes effective and efficient delivery of high-quality services to all residents;
f. How do we firmly believe in clear and consistent standards of care and services, supported by a strong compliance, inspection and enforcement system;
g. How do we recognize the responsibility to take action where standards or requirements under this Act are not being met, or where the care, safety, security and rights of residents might be compromised;
h. How do we affirm our commitment to preserving and promoting quality accommodation that provides a safe, comfortable, home-like environment and supports a high quality of life for all residents of long-term care homes;
i. How do we recognize that long-term care services must respect diversity in communities;
j. How do we respect the requirements of the *French Language Services Act* in serving Ontario's Francophone community;
k. How do we recognize the importance of fostering the delivery of care and services to residents in an environment that supports continuous quality improvement;
l. How are we committed to the promotion of the delivery of long-term care home services by not-for-profit organizations?

APPENDIX H: Useful Links and Resources

1. Websites:
    a. http://oanhss.org for the Association website
        i. Section on the LTCHA 2007
        ii. Inspection Protocols
        iii. Training Materials for staff
        iv. Webinars and webcasts
    b. http://www.ltchomes.net for the Ministry site (requiring a password)
        i. LTCHA 2007 Section
        ii. Webinars and Webcasts
    c. http://www.health.gov.on.ca/english/public/program/ltc/26_reporting.html
        i. Reports on Long Term Care Homes, Public Information
        ii. Excellent Care for All Act ; http://www.health.gov.on.ca/en/ms/ecfa/pro/legislation
    d. http://www.ohqc.ca/en/index.php for the Ontario Health Quality Council website
        i. Quality Monitor Report and framework
2. Publications:
    a. The Balanced Scorecard, Kaplan and Norton
    b. What we Heard: Long Term Care Quality Consultation 2008, A Common Vision of Quality in Ontario Long Term Care Homes
    c. Quality Monitor, Ontario Health Quality Council 2010 Report
    d. September 2010- Aging in Ontario: An ICES Chartbook of Health Service Use by Older Adults
    e. The Sharkey report: http://www.health.gov.on.ca/english/public/pub/ministry_reports/staff_care_standards/staff_care_standards.html