Kahnawake Community Health Plan
2012-2013

RATIONALE	The 2010 Health Plan Evaluation identified seven health priorities, however, some community health activities do not perfectly allign to those activities. These activities play an important supportive role in achieving the Community Health Plan.
GOAL	To identify objectives and activities which contribute to home and community care services in the achievement of the health plan.
STRATEGY	To review all community activities and services and ensure they describe their contribution to the health plan.

OBJECTIVES	Main Activities	Target Group	Title Responsible	Calendar/ Dates	Indicators	Data	Health Impact
To ensure a coordinated service delivery for the elders in the community (Logic Model to be developed)	Review all activities performed by HCCS to determine if/how they contribute to the community health plan	All HCCS services	HCCS Manager	2013-2014	Comprehensive HCCS services	Logic models	Effective and efficient services which improves the health in the elder population
To Provide In Home Support to Community (Home Care Program)	To provide clients coordinated care using case management	Client & Family/Caregiver	HCCS Manager HCN Manager Case Managers	Ongoing	Clients access appropriate services in timely manner	Access Database Intake Stats Stat hours of service	No duplication of service Clients receiving well individualized, coordinated & appropriate care
	To assist clients post-surgery/hospitalization with activities of daily living and instrumental activities of daily living	Post Hospitalization and clients with limited ADLS	Home Care Team Leaders Home Health Personal Care Aides	Ongoing	Clients have needs met at home with assistance of Home Health Personal Care Aides	Stat Hours of Service Request for Services Stats	Clients rehabilitate or are able to remain living at home longer vs being place in a long term care facaility
	To provide short term assistance to new mothers with c-section, multiple births, or high risk pregnancy	New Mothers	Home Care Team Leaders Home Health Personal Care Aides	Ongoing	Mothers carry pregnancies to term Improved post op wound healing Mothers cope better, experience less stress therefore improved family adjustment	Stat Hours of Service Request for Services Stats	New mothers are able to cope at home and provide care for newborn infant
	To provide clients with escort to medical appointments when no family member is available	Clients with decreased mobility	Home Care Team Leaders Home Health Personal Care Aides	As needed	Clients able to attend appointments as scheduled	Request for Escorts Stats	Ensures access to health services and attendance to medical appointments
	To assist disabled & elderly with loss autonomy to remain in their homes	> Elderly > Disabled	Home Care Team Leaders Home Health Personal Care Aides	Ongoing	Number of Elders & Disabled remaining at home with support	> Stats > Hours of Service Request for Services Stats	Clients rehabilitate or are able to remain living at home longer vs being place in a long term care facaility
	To provide respite to families for clients who require constant supervision	Elders with loss of autonomy / Alzheimers /Dementia	Home Care Team Leaders Home Health Personal Care Aides	Ongoing	# of families caring for clients	Request for Services Stats > Stats > Hours of Service	Clients rehabilitate or are able to remain living at home longer vs being place in a long term care facaility Prevents caregiver burnout

To assist & support patients and families in Kahnawake through the dying process. (HCN End of Life Care)	To support the patient, their family and/or caregivers through the dying process (patients who chose to die at home).	End of Life clients, their families & caregivers	Home Care Nurse Manager Home Care Coordinator	Evaluate yearly at end of fiscal year for Annual Report	- Total # of end of life care/ palliative care referrals (25). - # of clients who chose to die at home (6). - # of client's who had to be admitted to hospital as a result of lack of resources or support in the home (1)	Feedback from families (use short questionnaire) *must create questionnaire Stats, flow sheets	- Clients will receive the best possible end of life care in their homes. - Families and Caregivers will feel confident and supported while caring for a loved one. - Patient, family and caregivers will have increased ability to cope with a difficult situation. - Community will become aware of our services and may consider using our services in the future as opposed to having to be hospitalized. - More palliative care at home frees up more hospital beds, thus leaving room for clients who require more acute care
	To provide adequate symptom management for palliative care clients	End of Life Patients and their family/caregivers	HCN'S Home Care Nurse Manager	Evaluate yearly at end of fiscal year for Annual Report	Total # of end of life care/palliative care referrals (25). - # of clients who chose to die at home (6) - # of clients who had top be sent out to acute care hospital as a result of being unable to achieve adequate symptom management (1)	Patient Chart Statistics, flow sheets	Adequate symptom management results in patient being able to remain in their homes. - Patient being able to stay in their own environment with their loved ones makes this experience more private, dignified and comforting to all parties involved. When patient is comfortable caregivers are able to rest in the comfort of their home. - Adequate symptom control decreased the need for patient to be transferred or admitted to hospitals (Patient Comfortable)

	To provide aftercare and support to families & caregivers after the loss of a palliative care pt.	Family members and Caregivers Staff (Debriefing often necessary for staff after difficult loss)	HCN & Home Care Coordinator Technician in Administration (Homecare Nursing)	April 1st, 2012.	# of families that were contacted by Homecare Program (11). # of families that were went sympathy cards by Homecare Program (5) # of families that were referred to other services (1).	Stats, flow sheets, check lists.	Family & caregivers feel a sense of comfort that HCCS services team is also concerned about them and not only about the person who just passed away. Community has confidence in services of HCCS

To use a client centered approach to assist them to achieve their optimal level of health and prevent further complications due to their pre-existing health concerns (HCN Tertiary Prevention)	For clients to maintain or improve their current health status	Tertiary Care Clients Homecare patients, their families, caregivers, health care workers.	HCN Manager Home care Nurses	Home visits can be made anywhere from twice daily to Monthly. Yearly during Flu Shot Campaign and ongoing for Pneumovax	Total # referrals to Tertiary Prevention /Long Term Care Homecare during fiscal year (70) ▪ Frequency of visits required on admission ▪ # of patients requiring acute care interventions (unscheduled nursing or doctors visits) ▪ # of patients requiring transfer to off reserve hospitals ▪ # of patients requiring acute care admissions to KMHC (due to deterioration of condition, complications or non-compliance) (New Year) # of persons who are vaccinated by HomeCare Nursing	Stats, flow sheets Pt. file (ie.evolutives) Flu Shot Stat Sheets Patient's charts (Devise pneumovax Stat Sheet)	Good percentage of clients health will be stable Coordinated, appropriate care at home with less duplication of services Increased client part- icipation in their care plan Increased family / caregiver participation in patient's care plan Improved client outcome Complications found early therefore patient able to be treated in their homes. Results in decrease need for acute care hospitalization. When patient received adequate care, support and resources in the home they are able to stay at home longer and avoid the need for premature admission for LTC Increased protection against the Flu & Pneumonia Decreased number of casses of Flu & Pneumonia.
	To prevent further deterioration of their disease process or to decrease the adverse symptoms r/t their disease process (ie. Diabetes, Cardiovascular Disease)	Tertiary Care Clients	HCN Manager Home Care Nurses	Home visits can be made anywhere from twice daily to Monthly.	• Total # referrals to Tertiary Prevention/Long Term Care Homecare during fiscal year (70). • Total # of complications ie. Wound infections, new wounds (spontaneous), CHF, Chest Pain, uncontrolled Blood Glucose etc. (Next Year) • # of admissions to KMHC (Next Year) • # of admissions to acute care hospital (Next Year) • # of years in program before admission to LTC (average number is 7 years) Longest pt. stayed in program was 10 years	Stats, flowsheets	Optimal symptom management in this client group results in the following; • Decreased need for acute care interventions from nurse or physician (emergency visits in OPD) • Improved symptom management and early intervention • Decrease need for acute care hospitalizations • Tertiary Care clients achieve their optimal level of health • Improved quality of life

Utilization of Therapeutic Care Plans (TNP's). Utilization of Integrated Service Plans (ISP's) will ensure improved coordination of care for all home health tertiary clients (this would include "activities of exception")	Tertiary Care Clients	Homecare /Mental Health Nurses & Case Managers	To be done upon admission to Home care Nursing and updated on a regular basis	Total number of Homecare Nursing Patients with TNP done (111 out of 163). Total number of Home care Nursing Patients who have an ISP done (Blair has this number) Total number of patient Kardex`s that include standardized nursing interventions (aquess or other recognized source) (Next year)	HCCS Data Base Nursing Stats, flow sheets, and patient files.	• Improved communication between nurses • Patients priority needs clearly identified • Clients are more confident in managing their illness or situation knowing that they have comprehensive plans in place (which they took part in creating). • Increased client & family / caregivers participation in their care • Client satisfaction r/t care and education they receive • Client receive coordinated care
To ensure that the care that clients receive by the HHA'S, Family and any other non professional is well supported and guided by trained professionals (Nurses, Physicians) ie. Direction sheets for activities of exception, *Care Maps	Tertiary care clients Family, HHA and any other non-professional caregiver	HCN Manager & HC Coordinator	When acts are delegated to HHA by Nurses training & supervision must be done by the patient's Nurse. Routine theoretical training given to the HHA by Home Care Coordinator (a Nurse) or a guest educator on a monthly basis (All patients receiving assistance from HHA will have direction sheet)	Client Satisfaction questionnaire's completed with sufficient amount of Homecare Clients • # of incidents related to "Activities of exception" • # of clients who receive services from a HHA who have a direction sheet (Next Year). • # of incident reports involving HHA's (9)	Results of Client Satisfaction Questionnaire's filled out Incident reports of errors in medication and/or activities of exception involving HHA, family and all non-professional caregivers Incident reports r/t collaborative effort between nurses & HHA.	-Patient Safety issues improved as a result of us implementing changes based on the types of incidents that we see concerning the collaboration between nurses and HHA or informal caregivers.

	Develop a client satisfaction questionnaire for HCCS clients	Tertiary care clients	HCCS Manager HCN Manager	April 1st, 2012	Questionnaire results	Completed questionnaires Compilation and analysis of questionnaire data	Services will be more client driven Will help identify areas of improvement
	Develop a worker satisfaction questionnaire for all workers within HCCS (stimulate Work life Pulse Questionnaire from accreditation)	All employees of HCCS	HCCS Manager HCN Manager	April 1st, 2012 Develop tool used at KMHC and adapt for HCCS. Conduct by April 1st, 2012.	Questionnaire results	Completed questionnaires Compilation and analysis of questionnaire data	Reponses will help address issues and concerns voiced by employees of HCCS Satisfied workers provide better client care
	Mental Health • To stabilize, improve & maintain mental health clients	Severe & Persistent Mental Health Clients	Homecare Nurse Manager . • Mental Health Nurses . • Mental Health Team . • Steering Committee	Regular Home, Office or Hospital visits can vary from twice daily to monthly.	Total number of MH Patients (will calculate Monday) • # of clients at ILC followed assisted with medication by HHA (8 out of 11) • # of incident reports r/t non compliance (3) • # acute hospitalizations	• Pt. Progress notes • Stats	When a person's mental health improves their overall health is more likely to improve • Mental Health Clients become more productive members of their community • Improved family situation which contributes to overall community
	To ensure early diagnosis & intervention for our psycho-geriatric patients	Pshcho-geriatric patients	Home care Nurse Manager . Mental Health Nurse . Home Care Nurse . Physician	Same as Above	# of mini mental exams indicating memory issues . # of referrals to Mental Health Nurse for assessment . # of referrals to memory clinics	Stats	Early intervention in this area results in better patient outcomes ie. Pt. starts Day Program and becomes familiar with hospital environment, results in better transition to hospital when Pt. reventually requires long term care. . Early implementation of plan for patient reduces potential for caregiver stress and burnout.
	To maintain or improve the level of functioning of persons who have learning / developmental disabilities.	Persons with learning / developmental disabilities	Home care Nurse Manager . Mental Health Nurse . Home Care Nurse	Home visits can be anywhere from twice daily to monthly.	# of referrals for persons with learning / developmental disabilities	Stats	Early implementation of plan for patient reduces potential for caregiver stress and burnout. We have been seeing our number of referrals increase in this area partly due to the fact that this particular patients population is aging and so are their parents. . Many of these patients will be requiring long term care placement within the next few years because their aging parents are no longer strong or well enough to take care of them.

To provide safe and efficient care on a short term basis (HCN Home Hospital)	To assist client to address an acute health care issue (this includes post-hospital care)	Home Hospital clients	Home Care Nurse Manager and Nurses	Ongoing All activities in this section are done as these clients come in based on their needs, so difficult to specify dates.	Total # of referrals to Home Hospital/Short Term Care within fiscal year (54) # of Home Hospital patients who had more than 1 admission to Home Hospital within fiscal year (4 and 2 of those pts. had 3 admissions) # of complications ie. Infections (None this year) # of complications that resulted in readmission to hospital (Next Year). # to KMHC # to CHAL or outside hospital	Stats, flow sheets, patient files, HCCS Data Base	Appropriate health outcomes Improved health status Home Hospital return to baseline in appropriate time frame
	To ensure that clients receive care promptly when there is a change in their status	Home Hospital clients	Home Care Nurse Manager and Nurses	Ongoing	# of incident reports r/t delay, mistake or lack of care. (20, but majority were pharmacy errors that the nurses picked up)	Incident reports	Appropriate health outcomes when patients receive the appropriate care in a timely fashion Clients receive the best care possible
	To ensure that clients receive care using a client centered approach	Home Hospital clients	Home Care Nurse Manager and Nurses	Ongoing	# of home hospital clients evaluated with this form (Short Term Assessment) within 48 hours of admission to program vs total number of clients admitted for short term care. (Blair) # of TNP Forms [illegible]	HCCS Data Base Audit of Pt. files	Pt. centered care ensures that the pts. Individual needs are met Team approach ensures that all pts needs are addressed Pt. receives well coordinated care Treatment requirements are clear
	To reduce the incidence and spread of super bugs amongst Homecare Care clients.	Home Hospital clients	Home Care Nurse Manager and Nurses	Ongoing, evaluated at end of each fiscal year by April 1st	# of persons who are MRSA or ERV positive when they are admitted into our program. (we probably have this number) # persons who became MRSA or ERV positive following treatment in our program. (None)	Registrar of positive clients Pt. chart Flow sheets	Appropriate infection control measures will decrease the spread of super bugs

Goal	To assist & support patients and families in Kahnawake through the dying process.							
Objectives	**Main Activities**	**Target Group**	**TITLE RESPONSIBLE**	**Calendar / Dates**	**Indicators**	**Data**	**Health Impact**	**REMARKS**
To support the patient, their family and/or caregivers through the dying process (patients who chose to die at home).	- Provide coordinated care in the home. - Use Case Management System which would include all team members such as: Patient, family, caregivers, Nurses, MD's, HHA, OT, PT, Clergy, Traditionalists, etc. (whoever is involved in pts. Care) - Link patient and/or family/caregivers with appropriate resources.	End of Life clients, their families & caregivers	Home Care Nurse Manager Home Care Coordinator	Evaluate yearly at end of fiscal year for Annual Report	- Total # of end of life care/ palliative care referrals (25). - # of clients who chose to die at home (6). - # of client's who had to be admitted to hospital as a result of lack of resources or support in the home (1)	Feedback from families (use short questionnaire) ***must create questionnaire** Stats, flow sheets	- Clients will receive the best possible end of life care in their homes. - Families and Caregivers will feel confident and supported while caring for a loved one. - Patient, family and caregivers will have increased ability to cope with a difficult situation. - Community will become aware of our services and may consider using our services in the future as opposed to having to be hospitalized. - More palliative care at home frees up more hospital beds, thus leaving room for clients who require more acute care	HCCS is very proud of our end of life care program and we have always received good feedback from the community regarding this service
To provide adequate symptom management for palliative care clients	- Regular patient assessment - Liaison with physicians, specialists as well as any other professional health care providers - Providing appropriate pain control measures - Addressing basic patient needs such as nutrition, respiratory status, hydration status, elimination patterns, skin integrity, rest & activity, sollitude & social interaction.	End of Life Patients and their family/caregivers	HCN'S Home Care Nurse Manager	Evaluate yearly at end of fiscal year for Annual Report	Total # of end of life care/palliative care referrals (25). - # of clients who chose to die at home (6) - # of clients who had top be sent out to acute care hospital as a result of being unable to achieve adequate symptom management (1)	Patient Chart Statistics, flow sheets	Adequate symptom management results in patient being able to remain in their homes. - Patient being able to stay in their own environment with their loved ones makes this experience more private, dignified and comforting to all parties involved. When patient is comfortable caregivers are able to rest in the comfort of their home. - Adequate symptom control decreased the need for patient to be transferred or admitted to hospitals (Patient Comfortable)	Team members being able to contribute to these positive outcomes gives workers a sense of confidence, comfort and peace being able to help people in this precious time. - Great feeling when team has been able to assist to fulfill the wish of our patients and their families. Clients are always given the option to chose where they want to die.
To provide aftercare and support to families & caregivers after the loss of a palliative care pt.	To provided initial phone call when we are informed that the person has died To send a sympathy card to the family the week following the death	Family members and Caregivers Staff (Debriefing often necessary for staff after difficult loss)	HCN & Home Care Coordinator Technician in Administration (Homecare Nursing)	April 1st, 2012.	# of families that were contacted by Homecare Program (11). # of families that were went sympathy cards by Homecare Program (5)	Stats, flow sheets, check lists.	Family & caregivers feel a sense of comfort that HCCS services team is also concerned about them and not only about the person who just passed away. Community has confidence in services of HCCS	In Kahnawake fastest transmitter of news is word of mouth. If people were happy with the services provided to them the word will get out fast in the community (the same could be said for what they perceive did not go well).
	To check in with the family and caregivers (both formal and informal) to see how they are coping afterwards and link them with appropriate services if necessary (2 weeks after the funeral)				# of families that were referred to other services (1).			

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Goal	To provide safe and efficient care on a short term basis							
Objectives	**Main Activities**	**Target Group**	**Title Responsible**	**Calendar/ Dates**	**Indicators**	**Data**	**Health Impact**	**REMARKS**
To assist client to address an acute health care issue (this includes post-hospital care)	Follow-up and continued interventions post –hospitalization treatment or procedure which includes: a global assessment, treatment, procedures and interventions ie. vital sign, dressing changes, suture removal, client teaching etc.	Home Hospital clients	Home Care Nurse Manager and Nurses	Ongoing ***All activities in this section are done as these clients come in based on their needs, so difficult to specify dates.***	Total # of referrals to Home Hospital/Short Term Care within fiscal year (54) # of Home Hospital patients who had more than 1 admission to Home Hospital within fiscal year (4 and 2 of those pts. had 3 admissions)	Stats, flow sheets, patient files, HCCS Data Base	Appropriate health outcomes Improved health status	Poor outcomes are often r/t other pre-existing health conditions that the client already had experienced i.e./diabetes, morbid obesity, non-compliance, etc.

Goal	To provide safe and efficient care on a short term basis							
Objectives	**Main Activities**	**Target Group**	**Title Responsible**	**Calendar/ Dates**	**Indicators**	**Data**	**Health Impact**	**REMARKS**
					# of complications ie. Infections (None this year) # of complications that resulted in readmission to hospital (Next Year). # to KMHC # to CHAL or outside hospital		Home Hospital return to baseline in appropriate time frame	
To ensure that clients receive care promptly when there is a change in their status	Prompt referral to appropriate professional / establishment	Home Hospital clients	Home Care Nurse Manager and Nurses	Ongoing	# of incident reports r/t delay, mistake or lack of care. (20, but majority were pharmacy errors that the nurses picked up)	Incident reports	Appropriate health outcomes when patients receive the appropriate care in a timely fashion Clients receive the best care possible	Nurses have been proactive in reviewing their patient's meds regularly, they have been catching an increased amount of pharmacy errors

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Objectives	**Main Activities**	**Target Group**	**Title Responsible**	**Calendar/ Dates**	**Indicators**	**Data**	**Health Impact**	**REMARKS**
To ensure that clients receive care using a client centered approach	Clients receive a thorough global assessment of their needs using the short form Multiclientele	Home Hospital clients	Home Care Nurse Manager and Nurses	Ongoing	# of home hospital clients evaluated with this form (Short Term Assessment) within 48 hours of admission to program vs total number of clients admitted for short term care. (Blair) # of TNP Forms completed within 48 hours of admission to program. (Next Year)	HCCS Data Base Audit of Pt. files	Pt. centered care ensures that the pts. Individual needs are met Team approach ensures that all pts needs are addressed Pt. receives well coordinated care Treatment requirements are clear	This objective is being met.

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Goal	To provide safe and efficient care on a short term basis							
Objectives	**Main Activities**	**Target Group**	**Title Responsible**	**Calendar/ Dates**	**Indicators**	**Data**	**Health Impact**	**REMARKS**
To reduce the incidence and spread of super bugs amongst Homecare Care clients.	Patients will be screened upon admission into our program when transferred from an outside hospital Pts. will be screened when transferred to another area of care ie. KMHC, respite, active or LTC. Implementation of Infection Prevention Control measures within the pts. Home Staff & family (caregivers) education regarding infection control measures Pt. teaching	Home Hospital clients	Home Care Nurse Manager and Nurses	Ongoing, evaluated at end of each fiscal year by April 1st	# of persons who are MRSA or ERV positive when they are admitted into our program. (we probably have this number) # persons who became MRSA or ERV positive following treatment in our program. (None)	Registrar of positive clients Pt. chart Flow sheets	Appropriate infection control measures will decrease the spread of super bugs	This objectives is being met, no documented cases from cross-contamination.

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Goal	To use a client centered approach to assist them to achieve their optimal level of health and prevent further complications due to their pre-existing health concerns							
Objectives	**Main Activities**	**Target Group**	**Title Responsible**	**Calendar/ Dates**	**Indicators**	**Data**	**Health Impact**	**REMARKS**
For clients to maintain or improve their current health status	Routine nursing visits based on the pts. individual health needs Ongoing monitoring (assessment) of client's health condition which includes the following interventions: • Dressing Changes (Diabetic Ulcers, Chronic Wounds) • Blood Glucose Monitoring • Vital Signs • Blood Tests • Foot Care etc. • Weight - Facilitating health care management via education & counselling re: Weight Management Healthy Eating Addressing addiction issues which include food addictions (with clients & caregivers)	Tertiary Care Clients	HCN Manager Home care Nurses	Home visits can be made anywhere from twice daily to Monthly.	Total # referrals to Tertiary Prevention /Long Term Care Homecare during fiscal year (70) ▪ Frequency of visits required on admission ▪ # of patients requiring acute care interventions (unscheduled nursing or doctors visits) ▪ # of patients requiring transfer to off reserve hospitals ▪ # of patients requiring acute care admissions to KMHC (due to deterioration of condition, complications or non-compliance) (New Year)	Stats, flow sheets Pt. file (ie.evolutives)	Good percentage of clients health will be stable Coordinated, appropriate care at home with less duplication of services Increased client part- icipation in their care plan Increased family / caregiver participation in patient's care plan Improved client outcome Complications found early therefore patient able to be treated in their homes. Results in decrease need for acute care hospitalization. When patient received adequate care, support and resources in the home they are able to stay at home longer and avoid the need for premature admission for LTC	Achieving our goal of keeping clients at home for as long as possible • Less hospitalizations will have a positive impact on many areas ie. Nosocomial infections, financial impact, decreased loss of autonomy, less hospital beds tied up • 2010 Community Health Plan identified top 7 health priorities in community, must keep these conditions at the forefront of our care: • Substance Abuse / Addictions • Mental Health issues • Learning / Develop-mental Disabilities • Cardiovascular Disease (Hypertension) • Cancer • Diabetes • Obesity

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Objectives	**Main Activities**	**Target Group**	**Title Responsible**	**Calendar/ Dates**	**Indicators**	**Data**	**Health Impact**	**REMARKS**
	- Continue to use case management system to ensure that pt. receives coordinated care and is able to access all available resources - Prevention & Health Promotion Activities via Immunizations i.e., Flu Shots, Pneumovax Shots (This includes education and the distribution of tools)	Homecare patients, their families, caregivers, health care workers.		Yearly during Flu Shot Campaign and ongoing for Pneumovax	# of persons who are vaccinated by HomeCare Nursing	Flu Shot Stat Sheets Patient's charts (Devise pneumovax Stat Sheet)	Increased protection against the Flu & Pneumonia Decreased number of casses of Flu & Pneumonia.	Flu shots available to all Home Care patients as well as their families & caregivers. Home Care Nurses hold separate Flu Shot Clinics i.e. Golden Age Club, Young Adults Program (ILC) and for staff of HCCS. All clinics are mostly successful.

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Objectives	**Main Activities**	**Target Group**	**Title Responsible**	**Calendar/ Dates**	**Indicators**	**Data**	**Health Impact**	**REMARKS**
To prevent further deterioration of their disease process or to decrease the adverse symptoms r/t their disease process (ie. Diabetes, Cardiovascular Disease)	Routine nursing visits based on the pts. Individual needs Ongoing monitoring (assessment) of client's health condition which includes the following interventions: • Dressing Changes (Diabetic Ulcers) • Blood Glucose • Monitoring • Vital Signs • Routine Weights • Blood Tests • Foot Care etc. Prevention & Health Promotion Activities which include addressing lifestyle issues such as : Healthy Eating, Physical Activity and Addictions	Tertiary Care Clients	HCN Manager Home Care Nurses	Home visits can be made anywhere from twice daily to Monthly.	• Total # referrals to Tertiary Prevention/Long Term Care Homecare during fiscal year (70). • Total # of complications ie. Wound infections, new wounds (spontaneous), CHF, Chest Pain, uncontrolled Blood Glucose etc. (Next Year) • # of admissions to KMHC (Next Year) • # of admissions to acute care hospital (Next Year)	Stats, flowsheets	Optimal symptom management in this client group results in the following; • Decreased need for acute care interventions from nurse or physician (emergency visits in OPD) • Improved symptom management and early intervention • Decrease need for acute care hospitalizations • Tertiary Care clients achieve their optimal level of health • Improved quality of life	Tertiary Care Clients are Home and Community Care largest client group and the bulk of our services are aimed at this group

Goal	To use a client centered approach to assist them to achieve their optimal level of health and prevent further complications due to their pre-existing health concerns							
Objectives	**Main Activities**	**Target Group**	**Title Responsible**	**Calendar/ Dates**	**Indicators**	**Data**	**Health Impact**	**REMARKS**
	• Teaching and facilitating health care management (with clients & caregivers) • Continue to use case management system to ensure that pt. receives coordinated care and is able to access all available resources				• # of years in program before admission to LTC (average number is 7 years) Longest pt. stayed in program was 10 years			

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Goal	To use a client centered approach to assist them to achieve their optimal level of health and prevent further complications due to their pre-existing health concerns							
Objectives	**Main Activities**	**Target Group**	**Title Responsible**	**Calendar/ Dates**	**Indicators**	**Data**	**Health Impact**	**REMARKS**
Utilization of Therapeutic Care Plans (TNP's). Utilization of Integrated Service Plans (ISP's) will ensure improved coordination of care for all home health tertiary clients (this would include "activities of exception")	• Implement *TNP's as directed by the OIIQ and ensuring that ISP'S are implemented as agreed upon by all parties. • To implement standardized nursing interventions geared to the needs of the tertiary care client. • *To obtain information regarding standardized nursing intervention via aqesss (program should be available for all Native Communities in Quebec by April 1st, 2010), in French only, we are currently waiting for English Translations)	Tertiary Care Clients	Homecare /Mental Health Nurses & Case Managers	To be done upon admission to Home care Nursing and updated on a regular basis	Total number of Homecare Nursing Patients with TNP done (111 out of 163). Total number of Home care Nursing Patients who have an ISP done (Blair has this number) Total number of patient Kardex`s that include standardized nursing interventions (aquess or other recognized source) (Next year)	HCCS Data Base Nursing Stats, flow sheets, and patient files.	• Improved communication between nurses • Patients priority needs clearly identified • Clients are more confident in managing their illness or situation knowing that they have comprehensive plans in place (which they took part in creating). • Increased client & family / caregivers participation in their care • Client satisfaction r/t care and education they receive • Client receive coordinated care	Implementation of Case Management has assisted clients in taking a more active role in the care they receive. The OIIQ implemented Therapeutic Nursing Plan across the province effective April 2009. All nurses in HCCS have received training regarding the tool. The majority of Tertiary Prevention Patients have a TNP completed on them however nurses often don't have time to complete them for new clients in the appropriate set timeframe. •HCN Manager completed audit July 2011

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Objectives	**Main Activities**	**Target Group**	**Title Responsible**	**Calendar/ Dates**	**Indicators**	**Data**	**Health Impact**	**REMARKS**
To ensure that the care that clients receive by the HHA'S, Family and any other non professional is well supported and guided by trained professionals (Nurses, Physicians) ie. Direction sheets for activities of exception, *Care Maps	***Ongoing*** 'Practical' Follow-up on education provided to HHA by HCCS Coordinator and Home Care Nurses when required ***Implementation*** of 'direction sheets' for activities of exception. **Implementation** of Care Maps for clients receiving care from Home Health Aids	Tertiary care clients Family, HHA and any other non-professional caregiver	HCN Manager & HC Coordinator	When acts are delegated to HHA by Nurses training & supervision must be done by the patient's Nurse. Routine theoretical training given to the HHA by Home Care Coordinator (a Nurse) or a guest educator on a monthly basis (All patients receiving assistance from HHA will have direction sheet)	Client Satisfaction questionnaire's completed with sufficient amount of Homecare Clients • # of incidents related to "Activities of exception" • # of clients who receive services from a HHA who have a direction sheet (Next Year). • # of incident reports involving HHA's (9)	Results of Client Satisfaction Questionnaire's filled out Incident reports of errors in medication and/or activities of exception involving HHA, family and all non-professional caregivers Incident reports r/t collaborative effort between nurses & HHA.	-Patient Safety issues improved as a result of us implementing changes based on the types of incidents that we see concerning the collaboration between nurses and HHA or informal caregivers.	Our team continues to make improvements in this area. All patients who receive assistance with medication from a HHA have a medication sheets for the HHA to follow. This sheets often serve as direction sheets however when directions have to be more detailed, nurses have been creating separate Direction Sheets specific to activity of exception.

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Goal	To use a client centered approach to assist them to achieve their optimal level of health and prevent further complications due to their pre-existing health concerns							
Objectives	**Main Activities**	**Target Group**	**Title Responsible**	**Calendar/ Dates**	**Indicators**	**Data**	**Health Impact**	**REMARKS**
Develop a client satisfaction questionnaire for HCCS clients	Investigate different questionnaires, test and finalize Review tools that already exist and customize it to our needs	Tertiary care clients	HCCS Manager HCN Manager	April 1st, 2012	Questionnaire results	Completed questionnaires Compilation and analysis of questionnaire data	Services will be more client driven Will help identify areas of improvement	Feedback from completed questionnaires may assist in identifying areas where improvement is required
Develop a worker satisfaction questionnaire for all workers within HCCS (stimulate Work life Pulse Questionnaire from accreditation)	Review tools that already exist and customize it to our needs	All employees of HCCS	HCCS Manager HCN Manager	April 1st, 2012 Develop tool used at KMHC and adapt for HCCS. Conduct by April 1st, 2012.	Questionnaire results	Completed questionnaires Compilation and analysis of questionnaire data	Reponses will help address issues and concerns voiced by employees of HCCS Satisfied workers provide better client care	Responses could give an indicator of level of worker satisfaction and also take into account their suggestions of how to improve overall program thus improving patisent care

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Objectives	**Main Activities**	**Target Group**	**Title Responsible**	**Calendar/ Dates**	**Indicators**	**Data**	**Health Impact**	**REMARKS**
Mental Health • To stabilize, improve & maintain mental health clients	• Perform Initial Mental Assessme. • Assess medication needs both oral and injections. ▪ Refer to Psychiatry or any required discipline • Work with clients Case Manager on ISP plans ie, attending other appts. • Consult & work with family members as well as support workers • Meet with pts. on regular basis or as needed • Meet with Mental Health Team on regular basis • Liaison, Consult, Intervene & Educate	Severe & Persistent Mental Health Clients	Homecare Nurse Manager . • Mental Health Nurses . • Mental Health Team . • Steering Committee	Regular Home, Office or Hospital visits can vary from twice daily to monthly.	Total number of MH Patients (will calculate Monday) • # of clients at ILC followed assisted with medication by HHA (8 out of 11) • # of incident reports r/t non compliance (3) • # acute hospitalizations (Next Year) • # of crisis interventions ie. Outbursts, disputes. (Next Year) • # Mental Health Patients who have Case Manager or Primary care worker involved in their care (Next Year)	• Pt. Progress notes • Stats	When a person's mental health improves their overall health is more likely to improve • Mental Health Clients become more productive members of their community • Improved family situation which contributes to overall community health • Less hospitalizations of these clients decreases the risk for nosocomial infections, less changes to medications, more stable community care • Improved communication between all service providers, improved coordination of care.	Since the inception of the Mental Health Program in 2003, their intervention has contributed to many community members achieving improved Mental Health. . • This improvement has taken a large burden off other services that are within the community such as the Fire Brigade, Katei Memorial Hospital's In-Patient Department, The Kahnawake Peacekeepers as well as KSCS and the community at large.

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Objectives	**Main Activities**	**Target Group**	**Title Responsible**	**Calendar/ Dates**	**Indicators**	**Data**	**Health Impact**	**REMARKS**
					• # of Mental Health Patients who have a Nurse as their Case Manager • # of cancelled appointments.			
To ensure early diagnosis & intervention for our psycho-geriatric patients	Initial Psycho-geriatric assessment done by Home Care (Mini Mental) or Mental Health Nurse . Refer patient to specialized memory clinic for a more thorough assessment . Implement appropriate treatment plan i.e., Medication, Day Programs, Respite, Long Term Care Placement	Pshcho-geriatric patients	Home care Nurse Manager . Mental Health Nurse . Home Care Nurse . Physician	Same as Above	# of mini mental exams indicating memory issues . # of referrals to Mental Health Nurse for assessment . # of referrals to memory clinics	Stats	Early intervention in this area results in better patient outcomes ie. Pt. starts Day Program and becomes familiar with hospital environment, results in better transition to hospital when Pt. reventually requires long term care. . Early implementation of plan for patient reduces potential for caregiver stress and burnout.	We have seen improvements in this area as a result of Home Care Nurses taking a pro-active approach in seeking early intervention for their patients who showed signs of early memory loss.

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Goal	To use a client centered approach to assist them to achieve their optimal level of health and prevent further complications due to their pre-existing health concerns							
Objectives	**Main Activities**	**Target Group**	**Title Responsible**	**Calendar/ Dates**	**Indicators**	**Data**	**Health Impact**	**REMARKS**
To maintain or improve the level of functioning of persons who have learning / developmental disabilities.	Collaborate with Case manager and caregivers to develop long term plan this clientele. . Provide nursing care and follow up to patients. . Provide support and follow up to patients, their families, and care	Persons with learning / developmental disabilities	Home care Nurse Manager . Mental Health Nurse . Home Care Nurse	Home visits can be anywhere from twice daily to monthly.	# of referrals for persons with learning / developmental disabilities	Stats	Early implementation of plan for patient reduces potential for caregiver stress and burnout. We have been seeing our number of referrals increase in this area partly due to the fact that this particular patients population is aging and so are their parents. . Many of these patients will be requiring long term care placement within the next few years because their aging parents are no longer strong or well enough to take care of them.	

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Program: HOMECARE PROGRAM

Goal	To Provide In Home Support to Community						
Objectives	**Main Activities**	**Target Group**	**Title Responsible**	**Calendar/Dates**	**Indicators**	**Data**	**Health Impact**
To provide clients coordinated care using case management	Initial Assessment Reassessment every 6 months Integrated Service Plan meetings with client, family & service providers	Client & Family/Caregiver	HCCS Manager HCN Manager Case Managers (Case Workers & Home Care Nurses)	Ongoing	Clients access appropriate services in timely manner	Access Database Intake Stats Stat Hours of Service	No duplication of service Clients receiving well individualized, coordinated & appropriate care
To assist clients post-surgery/hospitalization with activities of daily living and instrumental activities of daily living	>Washing >Dressing >Grooming >Meal Preparation >Housekeeping >Laundry >Errands & Groceries	Post Hospitalization and clients with limited ADLS	Home Care Team Leaders Home Health Personal Care Aides	Ongoing	Clients have needs met at home with assistance of Home Health Personal Care Aides	Stat Hours of Service Request for Services Stats	Clients rehabilitate or are able to remain living at home longer vs being place in a long term care facaility

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To provide short term assistance to new mothers with c-section, multiple births, or high risk pregnancy	Housekeeping / Laundry Meal Preparation Groceries / Errands	New Mothers	Home Care Team Leaders Home Health Personal Care Aides	Ongoing	Mothers carry pregnancies to term Improved post op wound healing Mothers cope better, experience less stress therefore improved family adjustment	Stat Hours of Service Request for Services Stats	New mothers are able to cope at home and provide care for newborn infant
To provide clients with escort to medical appointments when no family member is available	Escorts to appointments & therapies	Clients with decreased mobility Clients with decreased mental status	Home Care Team Leaders Home Health Personal Care Aides	As needed	Clients able to attend appointments as scheduled	Request for Escorts Stats	Ensures access to health services and attendance to medical appointments

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To assist disabled & elderly with loss autonomy to remain in their homes	Housekeeping/Laundry Assisting with medications Assisting with personal care Meal preparation Escort for trips outside the home	> Elderly > Disabled	Home Care Team Leaders Home Health Personal Care Aides	Ongoing	Number of Elders & Disabled remaining at home with support	> Stats > Hours of Service Request for Services Stats	Clients rehabilitate or are able to remain living at home longer vs being place in a long term care facaility
To provide respite to families for clients who require constant supervision	In Home Respite	Elders with loss of autonomy / Alzheimers /Dementia	Home Care Team Leaders Home Health Personal Care Aides	Ongoing	# of families caring for clients	Request for Services Stats > Stats > Hours of Service	Clients rehabilitate or are able to remain living at home longer vs being place in a long term care facaility Prevents caregiver burnout