Quality Improvement Plan (QIP)

# Narrative for Health Care Organizations in Ontario

March 27, 2024


## OVERVIEW

The IOOF Seniors Homes Inc. is committed to its Residents and the community. We:
• Offer Long-term care, convalescent care, respite care, independent living, assisted living and affordable housing services essential to our community;
• Are sensitive to the difficult challenges our Residents and community face; and
• Continually seek opportunities to serve our Residents more effectively.

The IOOF Seniors Homes Inc. is eager to demonstrate the worth of our services to our community through an accountability framework that allows us to reflect on our successes and areas for improvement from an evidence-based perspective. We:
• Believe that our Residents have much to offer to the Continuous Quality Improvement (CQI) process, and in particular;
• Look forward to opportunities to involve customers, professional colleagues, and our funding body in CQI. Our CQI program includes quality and risk activities which outlines a schedule of audits, policy & procedure manual reviews, completion of person served satisfaction surveys, review of data accuracy and streamlining of processes through Best Practice Guidelines, and supports our annual QIP for 2024/2025.

The IOOF Seniors Homes Inc. values open communication, interpersonal respect, professionalism, and widespread employee participation in organizational decision-making. We:
• Are committed to creating a work environment that is supportive and encourages accountability, responsibility, and professional development;

• Are a charitable, non-profit organization that devotes most of our resources to direct customer service; and
• Believe in simple, accessible administrative processes that allow us to document our work, demonstrate our success, and make informed decisions about organizational change. Our QIP aligns with our strategic direction plan. Through our direction of promoting Resident Quality of Life through Quality Improvement Activities, we have outlined goals and actions that focus on setting the culture for quality improvement.

The IOOF Seniors Homes Inc. sets goals and objectives for attaining the key strategic directions and incorporates the organizations quality plans. We summarize our continuous quality improvement progress and risk management activities in our annual Board Continuous Quality Improvement and Risk Management Report. We adhere to and promote the Residents' Bill of Rights under the Fixing Long-Term Care Act 2021.

## ACCESS AND FLOW

With the onset of the pandemic it was clear that hospital capacity was going to be tested and stressed to its limit. The IOOF Homes has a history of community partnership and collaboration and continued to partner with our local hospital RVH Royal Victoria Regional Health Centre. Following the declaration of the global pandemic in March 2021, the IOOF Homes provided space for RVH to operate a satellite unit along with some supportive services provided by the IOOF Homes i.e. food services and physiotherapy. The RVH-IOOF is a 27-bed satellite located on the IOOF Brooks Street Campus. This unit cares for patients designated as Alternate Level of Care (ALC). This means the patient does not require acute care but requires some type of support that is preventing them from being discharged home. They may be waiting for PSW services at home, require strengthening to return home, waiting for long-term care, or waiting for a retirement home. This partnership has freed up beds within the hospital to create increased capacity during continued surge in demand.

Our Elston Unit Convalescent Care Program re-opened in the fall of 2022 gradually moving from 10 beds to its 20 bed full capacity. The Convalescent Care Unit provides rehabilitative and restorative services for a short term stay of 7 days up to a maximum of 90 days per calendar year. Convalescent Care Residents receive intense physiotherapy and restorative care services daily. Physiotherapy is provided by a full time Registered Physiotherapist and Physiotherapy Support Personnel. The goal of the program is to provide rehabilitation in order for the client resident to return home.

The Odd Fellow and Rebekah Home also provides short term Respite beds in order for caregivers to receive the respite they need to continue to care for their loved ones at home.

The IOOF Seniors Homes provides a continuum of care and our supportive housing and assistive living units have also seen an increase in acuity. As individuals age longer in their homes the demand for long-term care is increasing at the later stages of aging. The IOOF Homes management team works closely with our Housing NP who operates a primary care community based clinic at The Terraces at Heritage Square, an IOOF Homes Life Lease Community and they have become an integral partner for transition planning. Within our Long-Term Care Home, our Medical Director, attending physicians and full time Nurse Practitioner provide direct diagnostic

care and treatment options for our Residents. Our goal has been to identify potentially avoidable ED transfers and work collaboratively with diagnostic programs, RVH and Residents and families to avoid lengthy wait times and potential delay in treatment especially when safe and effective alternatives may be provided in house.

In order to address our communities needs for additional Long-Term Care beds, we are now entering into phase 2 of our Evolution of Care - Long Term Care Redevelopment Campaign. Our goal is to build a new modernized 64 LTC bed wing followed by phase 3 of the redevelopment to revitalize existing space to provide 66 LTC upgraded beds. Pending additional ministry approvals we eagerly anticipate shovels in the ground to begin construction.

## EQUITY AND INDIGENOUS HEALTH

We recognize that as our population continues to age, health equity in long term care facilities is a critical issue that must be addressed. Ensuring all individuals have the same access to quality healthcare and treatment no matter their culture, identity and/or social or economic background is essential for providing quality support during this important life stage.

As an organization we are working on developing our Health Equity vision for the future, how we will foster and promote it, developing an equity survey as well as recognizing diversity events for residents and staff.

The IOOF is dedicated to promoting diversity, equity, inclusion, and belonging in the workplace. We celebrate and welcome the diversity of all staff.

The IOOF is committed to fostering an environment where everyone feels that they belong and that their dignity, beliefs, and identity are respected.

The IOOF is committed to observing and following relevant human rights, equity, and privacy legislation to prevent discrimination based on any prohibited grounds.

The corporation is also committed to developing, learning, and following best practices to improve diversity, equity, inclusion, and belonging in every area of operations.

The corporation will strive to create a culturally competent workforce by:

- Maintaining an Inclusion and Belonging Corporate Committee
- Providing adequate training about diversity, equity, inclusion, and belonging;
- Ensuring leadership teams are trained on unconscious bias;
- Encouraging positive attitudes towards cultural differences;
- Raising awareness of and eliminating unconscious biases and the harmful effects of prejudice, discrimination, and microaggressions; and
- Learning from persons with diverse backgrounds and experiences.

## PATIENT/CLIENT/RESIDENT EXPERIENCE

The IOOF Seniors Homes Inc. promotes an environment that supports the rights of Residents/clients; right to dignity, self actualization and independence. Feedback from Residents and/or their representatives is an important component of the continuous quality improvement of the care and services we provide. We have various mechanisms by which feedback is given and/or received.

The Home has both a Resident Council as well as a Family Council. Both councils focus on providing a voice for quality improvements, information sharing and support. Feedback from these Councils is highly encouraged and assists with monitoring and evaluation of programs and service delivery. Most recently the Resident Council initiated a suggestions and compliments box for submissions which they review at their meetings. Continuous Quality Improvement along with engagement around the QIP is a standing agenda item for both councils and these items are brought forward to the Continuous Quality Committee, as well as, both Councils report to the Resident Services Committee of the Board of Directors. Furthermore, the Home sends out Satisfaction Surveys to Residents and their family members on an annual basis. The structure of the survey is reviewed at both Resident and Family Council meetings and input is valued to ensure we capture what matters most to our Residents and families. The results of the annual Satisfaction Survey are reviewed and discussed at both Resident and Family Council meetings, with the Management Team, CQI Committee and at the Board Level. The results are accessible and posted in the Home.

Since the last QIP submission we have received feedback about the quality of care and services provided including:

"We want to thank all the staff for really getting to know us and our preferences. They take extra good care of us and do the little things that matter so much! Resident Council Member

"I feel safe knowing how much you care and thank you for going above and beyond. The staff really come together and give it all they've got." Resident Council Member

"We give compliments to the food services, programming, and environmental staff! They are all so friendly and kind. the home is always clean, there is lots of variety in the food and the programs keep my dad involved. The administrative staff is always so welcoming and helpful in answering all our questions and pointing us in the right direction." Family Council Member

"We chose the IOOF Seniors Homes because of positive referrals. You have more than lived up to your good reputation and we are so happy we chose a not-for-profit LTC home, especially during the pandemic." Family Council Member

"I just wanted to thank you from the bottom of my heart. You have no idea the joy you brought to my mother today she was brought to tears. The fact that you took time out of your day to make this happen, means everything to us. Thank you again for being amazing humanitarians, it's the smallest gestures that mean the most and you gave my mother peace" Community member

"It became very clear to us from the early days of being at IOOF that their was a culture of caring which was obviously embraced by all staff members we had interactions with. This culture is to be celebrated and promoted as it takes effort, compassion and dedication to continually maintain this level of caring." Family member

"I appreciate most that it is a home, and a family for the residents. The staff seem to look forward to seeing the residents they also look forward to seeing them. Positive staff, calm demeanor, everyone caring for the residents"
Annual Satisfaction Survey

"meeting staff who made friendly conversation and also inquired on who we were there to visit...they were able to speak about our resident and on some personal points that made us realize that they were listening to some stories and past history and were definitely getting to know our family member...made the family feel more comfortable in a very tough situation." Annual Satisfaction Survey

"The people at Odd Fellow and Rebekah Home are truly a group of caring individuals and I feel assured that mom is in good hands at all times." Annual Satisfaction Survey

## PROVIDER EXPERIENCE

It continues to be a challenging time for health care organizations with unprecedented human resources challenges. The IOOF Homes is currently implementing innovative practices to improve workplace culture, providing recruitment incentives, and optimizing staff to the full scope of practice.

Our priority continues to be focused on infection control, outbreak protocols, addressing staffing challenges and open communication with our family, staff and visitors. Our IPAC Lead has guided the Home to enhance IPAC measures, auditing PPE and Hand Hygiene, constant education to our staff and running vaccination clinics to both Residents and Staff. Our IPAC Lead and management work closely with community partners such as Public Health, Ministry of Health, Ministry of Long-Term Care, the Infection Prevention and Control outreach team at RVH and various other regulatory authorities.

The Pandemic presented long-term care organizations across the globe with unprecedented challenges. At our organization, we were not immune to health care worker burnout as a result of decreased staffing levels and increased demands. We have made it a priority to provide our staff with the resources and support they need to remain healthy and energized despite demanding circumstances.

We implemented the following supports:
· Contingency plans for staff shortages
· Enhanced Communication to our staff i.e. Town Halls, Synervoice
· Utilization of Staffing Agencies when needed
· Offering educational opportunities whether it be in person or virtual
· Staff appreciation events
· All Hands on Deck Policy

During the pandemic we implemented an "All hands on deck" policy, it is a leadership practice in which managers / supervisors help out during times when a situation occurs that requires extra support for Resident Care and the provision of safe and effective essential services. Management can help alleviate stress for staff and for residents during extremely labour intensive and stressful peak times. Doing so models teamwork while meeting essential resident needs.

Helping out during high stress times has a number of benefits:
· Resident care needs are better met
· Builds strong relationships with staff, residents and families
· Staff stress is relieved
· Breaks the cycle of staff instability
· Managers gain first-hand knowledge of the work-load and

workplace dynamics
· Managers role-model teamwork
· Identifies strong performers, and educational opportunities

The policy supports a culture in which everyone helps each other out. Every day team-work helps our staff and management teams perform at their best, while supporting quality of care provided to residents.

We recognize that staff on the front-line are often in the best position to identify opportunities for improvement, so we prioritize their engagement and ensure our leadership team is open to hearing constructive feedback from our staff. The pandemic shed light on the fragility of the LTC infrastructure and the need for staffing resiliency and engagement. It is important that all staff feel heard and supported, so we remain committed to finding creative ways to make sure they are. All staff participate in monthly departmental staff meetings, where staff are encouraged to bring forward any challenges, successes and to identify opportunities for improvement.

Coming through the pandemic our staff have experienced immense strain and their health, both physical and mental, has been impacted. To address staff burnout, a variety of supports have been offered to our staff to ensure that the health and well-being of these essential personnel are safeguarded. These resources include the Employee Assistance Program, Inkblot, Mind Beacon and Dialogue. In response to the pandemic and the mental health toll sustained by front line staff the Canadian Association for Long Term Care partnered with the Mental Health Commission of Canada to design The Working Mind program specific to the long-term care sector. We trained 2 management facilitators in The Working Mind program with the financial support of a grant through the Canadian Association for Long Term Care. We continue this partnership with a commitment to role out The Working Mind program to Management, Administration, Front Line Staff over the next several years. The program focuses on mental health awareness, breaking down stigma, increasing capacity of staff resiliency and offering tools to management to support staff with mental health challenges or who are in crisis. Ultimately, providing our staff with the tools they need to cope with the pressures of long-term care requirements and challenges is paramount to making sure they can continue to provide the care our Residents need and deserve.

Led by our Director of Human Recourses and the Resident Care leadership team we continue to look for innovative recruitment and retention strategies. Through Ontario Health incentive programs we have been successful in utilizing the PSW incentive Clinical Placement Stipend. This program pays an hourly rate during the PSW student's clinical placement to complete their PSW training. Furthermore new PSW graduates have received the Next Phase PSW Investment when they commit to 12 months of employment. With the end of containment funding through the pandemic came the end of our Care Support Assistance funding, however a number of these staff have chosen to enroll in the PSW program thanks to these incentives.

For Registered staff we have had success in recruiting new grads through the Community Commitment Program for Nurses incentive when they commit to 24 months of employment at the IOOF Seniors Homes.

## SAFETY

Resident safety incidents have an impact on quality of care, resident well being and experience as well as care provider morale. Creating a safe environment requires ongoing review, reflection, and learning from resident safety incidents. In light of this, we have a system to improve our resident safety practices. We hold discussions around resident safety incident reports to share what we have learned with the entire team and explore ways to prevent similar incidents from reoccurring in the future. Additionally, resident feedback is consulted in order to ensure that residents are receiving the safest care possible.

The Critical Incident System (CIS) Data Set is an online reporting system used by long-term care homes to submit mandatory reports and incidents, relating to the care of residents.

Various strategies are used to ensure resident safety, sharing of information and incident prevention, such as:

· Variety of committees and Meetings: Weekly interdisciplinary team meetings, Management Risk Rounds, JOHSC, Emergency Preparedness Planning, CQI, Quality Risk Management, Quality Programs etc.
· Care Conferences-Admission and Annually (or as requested)
· Monthly departmental staff meetings-Learning from reflective practice, used to openly discuss what went wrong in each incident, why it happened and how could it be prevented or managed better next time.
· Review of Ministry Guidance Documents, Fixing LTC Act
· Auditing in each department for compliance
· Medication Incident Investigation and reporting
· Annual education for all staff through Surge Learning, in-services, virtual learning

We are acutely aware that falling, particularly falling repeatedly, increases risk of injury, hospitalization, and death in older adults who are frail and have preexisting disease comorbidities (eg, osteoporosis) and deficits in activities of daily living (eg, incontinence). Our interdisciplinary Fall Prevention Team guided by Resident Care leadership has succeeded in lowering falls past the provincial average. This year we aim to maintain their good work and where possible further reduce the incident of falls.

Our Continuous Quality Improvement Program is based on an integrated quality framework. Risk and key performance indicators are analyzed along with subsequent quality improvement initiatives related to the Corporation on an ongoing basis as well as the annual goals and objectives developed by each department.

## POPULATION HEALTH APPROACH

The IOOF Seniors Homes has a long history of providing proactive services to promote health, prevent disease, and help people live well with their conditions. In collaboration with our many health partners we strive to promote a population health-based approach involving a broadened focus. Some of these examples include:

Partnering with Royal Victoria Regional Health Centre (RVH) with the Long Term Care Diagnostic Program in an effort to avoid preventable visits to the ED.

Increasing access and flow by providing the physical space for RVH to run an ALC satellite unit on our premises.

Partnerships with the North Simcoe Muskoka Hospice Palliative Care Network (NSMHPCN) to ensure our Palliative Approach to Care philosophy is well defined in policy and procedure, provide staff education and support and increase Resident and family engagement for advanced care planning. This past year we were successful in providing significant Palliative Care education opportunities and the implementation of a truly interdisciplinary Palliative Care Team.

Collaborating with the North Simcoe Muskoka Specialized Geriatric Services (NSMSGS) Geriatric Mental Health Team and our pharmacy team at Medisystem Pharmacy to ensure the appropriate use of antipsychotic medications. Providing additional best practice evidence based training to front line staff working on our dementia care unit i.e.
Gentle Persuasive Approaches (GPA) Training while promoting a Resident First approach to care.

Collaborating with the North Simcoe Muskoka Specialized Geriatric Services (NSMSGS) to provide innovative use of technology to lesson the effects of the significant risk for social isolation for at risk seniors.

## CONTACT INFORMATION/DESIGNATED LEAD

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## SIGN-OFF

It is recommended that the following individuals review and sign-off on your organization's Quality Improvement Plan (where applicable):

I have reviewed and approved our organization's Quality Improvement Plan on March 27, 2024

John R. Nicholas — March 27, 2024
Board Chair / Licensee or delegate

[signature] — March 27, 2024
Administrator /Executive Director

[signature] March 27, 2024
Quality Committee Chair or delegate

[signature] — March 28, 2024
Other leadership as appropriate

[signature] — March 28, 2024

## Access and Flow | Efficient | Priority Indicator

| Indicator #5 | Last Year | | This Year | |
|---|---|---|---|---|
| Rate of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents. (Odd Fellow and Rebekah Home) | **16.90** Performance (2023/24) | **15** Target (2023/24) | **16.98** Performance (2024/25) | **16** Target (2024/25) |

**Change Idea #1** ☑ Implemented ☐ Not Implemented

Educate Staff, Residents and families about in-house interventions to address medical issues that do not necessitate the need for an ED visit.

**Process measure**

- 1) Registered Staff (RN/RPN) will receive monthly updates on hospital transfers/ED visits, focusing on avoidable ED visits, identified trends and reasons for transfer. 2) Resident and Family will receive literature in the admission package and during each admission discussion related to Advance Directives and treatment options, routinely at each Admission/Annual Care Conference, through discussion when a Resident experiences a change in health status and annually at Resident and Family Council meetings.

**Target for process measure**

- 100% of staff/Res/family educated about in-house interventions to address medical issues that do not necessitate the need for an ED visit by Dec 31, 2023.

**Lessons Learned**

1. Communication of ED transfers occurs on a regular basis as it happens, however the monthly updates were not consistently completed. Will focus on this area in the coming QIP and ensure it is on the monthly staff meeting standing agenda and evaluate the factors that precipitated the need for transfer and whether it could have been avoided. 2. Literature provided with admission nurse. Lesson learned that material needed to be reviewed and revised and initial revisions have been completed.
Further Challenge: pressures from POA/SDM to transfer regardless of education provided

**Change Idea #2** ☑ Implemented ☐ Not Implemented

Early recognition of at-risk residents for emergency department visits

**Process measure**

- 1)The Registered Nurses will involve the MD/NP for early intervention/treatment, update the 24hr building report for monitoring and access the Long Term Care Home Diagnostics Program. Ongoing education will be provided during monthly registered staff

**Target for process measure**

- 100% compliance by Dec 31, 2023

### Lessons Learned

Diagnostic Program has not been utilized to the extent that it was originally intended due to other options in house and/or lack of SDM consent. Determined that the 24hr report is not effective and not the appropriate monitoring tool. Challenge: Vacant NP position for 4 months and change in leadership within Resident Care including DRC, ADRC along with Registered staff turnover

### Change Idea #3 ☑ Implemented ☐ Not Implemented

To standardize the communication between nurse and physician for more efficient decision making.

**Process measure**

- 1) Education will be provided to all Registered Staff upon hire, during monthly staff meetings and resource tools ie: SBAR will be posted at each nursing station for reference.

**Target for process measure**

- 100% compliance by Dec 31, 2023

### Lessons Learned

SBAR was introduced but requires additional awareness as utilization is low
Challenge: staffing pressures and shortages during ongoing pandemic.

Registered staff meetings have become too lengthy to include all initiatives on a monthly basis – lesson learned to review quarterly. Determined on floor huddles as the appropriate avenue for communication and education.

### Change Idea #4 ☑ Implemented ☐ Not Implemented

Initiate Public Quality Indicator Board

**Process measure**

- 1) Information boards will posted in the main lobby for staff, Residents and Family to review, updated montly.

**Target for process measure**

- 100% compliance by Dec 31, 2023

## Lessons Learned

Decision to post quarterly and annually as a summary of CQI/Risk activities on the public reporting board.

**Equity | Equitable | Custom Indicator**

| | Last Year | | This Year | |
|---|---|---|---|---|
| **Indicator #1** Health Equity-recognizing and reducing disparities of health outcomes, access and experience of diverse populations (Odd Fellow and Rebekah Home) | **CB** Performance (2023/24) | **CB** Target (2023/24) | **CB** Performance (2024/25) | **NA** Target (2024/25) |

**Change Idea #1** ☑ Implemented ☐ Not Implemented

Developing our Health Equity vision for the future, how we will foster and promote it.

**Process measure**

- 1) DEI committee to meet quarterly 2) Diversity events planned throughout the year for staff, residents' and family to participate in 3) Education and Resources provided to staff, Residents and family at resident/family council, staff meetings and information boards in the lobby.

**Target for process measure**

- Fully implemented by Dec 31, 2023

**Lessons Learned**

1. Successfully established DEI Committee which meets quarterly. 2 Diversity events including Black History Month, Pride Month with Flag Raising, Orange Shirt and National Day for Truth and Reconciliation honoured. 3. Information was provided and shared as planned
Lesson learned: how diverse our staff force has become and will continue to diversify along with our Resident population following the same trend in time.

**Experience | Patient-centred | Priority Indicator**

| | Last Year | | This Year | |
|---|---|---|---|---|
| **Indicator #3**<br>Percentage of residents responding positively to: "What number would you use to rate how well the staff listen to you?" (Odd Fellow and Rebekah Home) | **CB**<br>**Performance (2023/24)** | **CB**<br>**Target (2023/24)** | **CB**<br>**Performance (2024/25)** | **CB**<br>**Target (2024/25)** |

**Change Idea #1** ☑ Implemented ☐ Not Implemented

The question first will be incorporated into the Annual Resident Satifaction Survey

**Process measure**

- We will include this indicator in our Satisfaction Survey distributed in fall of 2023 and include a plan for this in our 2024 QIP.

**Target for process measure**

- We aim to have responses to this new question in our survey to capture a baseline for comparative purposes in our future QIP. Our goal will be to have residents response of 9-10 on the scale.

**Lessons Learned**

Response rate for the survey was low. Promote at Resident Council and Family Council and also provide assistance from staff to complete i.e. by appointment or at drop in clinic

| **Indicator #4** Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences". (Odd Fellow and Rebekah Home) | Last Year | | This Year | |
|---|---|---|---|---|
| | **CB** | **CB** | **CB** | **CB** |
| | **Performance (2023/24)** | **Target (2023/24)** | **Performance (2024/25)** | **Target (2024/25)** |

**Change Idea #1** ☑ Implemented ☐ Not Implemented

The question first will be incorporated into the Annual Resident Satifaction Survey

**Process measure**

- We will include this indicator in our Satisfaction Survey distributed in fall of 2023 and include a plan for this in our 2024 QIP.

**Target for process measure**

- We aim to have responses to this new question in our survey to capture a baseline for comparative purposes in our future QIP. Our goal will be to have residents response of 9-10 on the scale.

**Lessons Learned**

Response rate for the survey was low. Promote at Resident Council and Family Council and also provide assistance from staff to complete i.e. by appointment or at drop in clinic

**Safety | Safe | Priority Indicator**

| | Last Year | | This Year | |
|---|---|---|---|---|
| **Indicator #2** Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment (Odd Fellow and Rebekah Home) | **35.11** Performance (2023/24) | **31.59** Target (2023/24) | **37.98** Performance (2024/25) | **34.18** Target (2024/25) |

**Change Idea #1** ☑ Implemented ☐ Not Implemented

Training sessions on Gentle Persuasive Approach (GPA)

**Process measure**

- 1) Our focus will be on training staff working on Kempenfelt Court (secure unit) as this unit has the highest number of residents with responsive behaviours and use of antispychotics.

**Target for process measure**

- Focus will be on training 75% of the staff working on Kempenfelt Crt (secure unit). 25% of other staff will be trained throughout the Home.

**Lessons Learned**

2 sessions of GPA were conducted focusing on staff who work on Kempenfelt Court Dementia Care (Secure) Unit staff.
Challenge: staff rotation due to assignment changes or posting to work on other home area units

**Change Idea #2** ☑ Implemented ☐ Not Implemented

Identify and review the number of residents who take antipsychotic medication.

**Process measure**

- 1. MD/NP will complete all new admission reviews with each new admission. 2. List will be prepared by the MediSystem Pharmacist quarterly and provided to the DRC. 3. Audit will be completed quarterly by the RAI Coordinator/Lead. 4. Diagnosis updates will be completed by the RAI Coordinator upon a new diagnosis being identified. 5. A summary will completed and reported on quarterly at the CQI committee meeting.

**Target for process measure**

- 100% compliance by Dec 31, 2023

**Lessons Learned**

1. MD/NP are reviewing at admission. 2. Pharmacy provider reports numbers and percentage stats however we recognized that the report does not give as much detail as could be useful. Lesson learned: run a more detailed report and review with medical team individual cases – Quarterly med review including diagnosis and medication reconciliation – ensure antipsychotic medication use match diagnosis with NP involvement. 3. Not consistently available due to other work demands, lesson learned pull report as part of the public reporting and Home Quality Committee to not duplicate reporting. 4. Lesson learned RPN Charge Nurse responsible – and will use the resource of the RAI Coordinator as needed i.e. residents returning from hospital with new diagnosis. 5. Completed by pharmacy and summary is reported on quarterly at the CQI Committee Meeting.

**Change Idea #3** ☑ Implemented ☐ Not Implemented

Utilize external resources such as GMH team and psychogeriatric consultants to support residents with (responsive behavioursand other mental health concerns)receiving antipsychotic medications.

**Process measure**

- 1) We will track number of residents referred to the GMH Team and/or psychogeriatric consultant who are receiving antipsychotics. 2) Registered staff will receive education on the referral process for GMH team and our Psychogeriatric MD. 3) This information will be reported on quarterly at the CQI committee meeting.

**Target for process measure**

- 25% of residents receiving antipsychotic medication with be referred the GMH Team and/or psychogeriatric consultant.

**Lessons Learned**

1. Tracking referrals. Lesson learned: more formalized tracking needed to include a review of antipsychotic use. Referral psychogeriatric consultant – recommendations made – more in depth evaluation reviewing diagnosis, medications - post referral follow up.
Formalize the process and documentation of referral on individual basis.
Consultation note in PCC
2. Completed and staff are aware of the referral process.
3.Lesson learned to report at the Home Quality Working Committee

## Access and Flow

### Measure - Dimension: Efficient

| Indicator #1 | Type | Unit / Population | Source / Period | Current Performance | Target | Target Justification | External Collaborators |
|---|---|---|---|---|---|---|---|
| Rate of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents. | O | Rate per 100 residents / LTC home residents | CIHI CCRS, CIHI NACRS / October 1st 2022 to September 30th 2023 (Q3 to the end of the following Q2) | 16.98 | 16.00 | We aim to reduce the rate from our current status by 0.98 and feel this is a realistic target based on previous performance and current challenges with staffing consistency and continuity. | Royal Victoria Regional Health Centre,<br>Long Term Care Diagnostic Program,<br>North Simcoe Muskoka Hospice Palliative Care Network (NSMHPCN) |

### Change Ideas

**Change Idea #1** Educate Staff, Residents and families about in-house interventions to address medical issues that do not necessitate the need for an ED visit.

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| 1. Increase employee, Resident and family awareness of the Ambulatory Care Sensitive Conditions, advanced care planning, alternatives to ED transfers, role of MD/NP for in-house care, alternatives to restraints and safe mobility, hydration, continence. 2. Progress will be tracked by the Resident Care Department Leadership Team on a monthly basis. Data on the change ideas will be collected, analyzed, reviewed and reported on quarterly at the Home Quality Working Committee and the Continuous Quality Improvement Committee. | 1. Registered Staff (RN/RPN) will receive monthly updates on hospital transfers/ED visits, focusing on avoidable ED visits, identified trends and reasons for transfer 2. Registered Staff (RN/RPN) will receive additional training re Diagnostic Transfer Program with RVH 3. Further revisions to the admission package i.e. Advanced Directives, treatment options, Diagnostic Transfer Program 4. Additional training of registered staff regarding Advance Care Planning and Having Open Discussions in collaboration with the North Simcoe Muskoka Hospice Palliative Care Network (NSMHPCN). | 1. 12 monthly meetings per year 2. 50% of Registered Staff to Receive training first year and 50% 2nd year of implementation 3. By September 2024 to complete revision of admission package | |

**Change Idea #2** Early recognition of at-risk residents for emergency department visits

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| 1. Registered Nurses will assess and monitor those residents at risk 2. Progress will be tracked by the Resident Care Department Leadership Team on a monthly basis. Data on the change ideas will be collected, analyzed, reviewed and reported on quarterly at the Home Quality Working Committee and the Continuous Quality Improvement Committee. | 1. The Registered Nurses will involve the MD/NP for early intervention/treatment and where indicated access the Long Term Care Home Diagnostics Program. 2. Ongoing education and discussions at monthly registered staff meeting 3. Co ADRC will review monthly trends and analyze if the Diagnostic program has been utilized where potentially could have been. | 100% compliance by Dec 31, 2024 | |

**Change Idea #3** To standardize the communication between nurse and physician for more efficient decision making.

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| 1. Registered Staff (RN/RPN) will receive education on the SBAR tool for assessment, communication & documenting changes to resident condition prior to contacting the physician. 2. Progress will be tracked by the Resident Care Department Leadership Team on a monthly basis. Data on the change ideas will be collected, analyzed, reviewed and reported on quarterly at the Home Quality Working Committee and the Continuous Quality Improvement Committee. | 1. Education will be provided to all Registered Staff upon hire, during monthly staff meetings and resource tools ie: SBAR will be utilized. 2. Include SBAR in new staff Department Orientation and discuss the QIP Priorities 3. RAI Coordinator to present quarterly reports and be involved in education and training | 100% compliance by Dec 31, 2024 | |

**Change Idea #4** Review and Revise Public Reporting Board

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| 1. Quality Indicators (including avoidable ED visits), Provincial target benchmarks to enhance our Quality Improvement Program and share this information with our staff, residents and family. 2. Progress will be tracked by the Resident Care Department Leadership Team in collaboration with the Director of Quality, Risk & Programs and RAI Coordinator on a quarterly basis and summary posted an minimum annually. | 1. Public Information board will be updated with the posting of the Annual Quality & Risk Report, Annual QIP and the CIHI Provincial Benchmark Indicators on a quarterly basis in the main lobby for staff, Residents and Family to review. | 100% compliance by March 31, 2025 | |

# Equity

## Measure - Dimension: Equitable

| Indicator #2 | Type | Unit / Population | Source / Period | Current Performance | Target | Target Justification | External Collaborators |
|---|---|---|---|---|---|---|---|
| Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education | O | % / Staff | Local data collection / Most recent consecutive 12-month period | CB | 100.00 | Using our online mandatory learning platform SURGE Learning all staff will be assigned the module on Diversity Equity Inclusion Training | |

### Change Ideas

**Change Idea #1 Assign SURGE Learning Module on Diversity, Equity & Inclusion at Work**

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| Director of HR will assign the SURGE Module on Diversity, Equity & Inclusion at Work to all staff. Dir HR will monitor for effectiveness. | 1. assign the SURGE Module on Diversity, Equity & Inclusion at Work to all staff. 2. HR Assistant will send reports to Management for follow up | 100% Compliance by Dec 31, 2024 | Phased approach over 3 years beginning with introductions to concepts proceeding with enriched content of education |

## Experience

### Measure - Dimension: Patient-centred

| Indicator #3 | Type | Unit / Population | Source / Period | Current Performance | Target | Target Justification | External Collaborators |
|---|---|---|---|---|---|---|---|
| Percentage of residents responding positively to: "What number would you use to rate how well the staff listen to you?" | O | % / LTC home residents | In house data, NHCAHPS survey / Most recent consecutive 12-month period | CB | CB | Collecting comparable baseline data. | |

### Change Ideas

**Change Idea #1** Ensure Question is including in the annual Satisfaction Survey for Residents and POA with the same rating scale as would be in the NHCAHPS Survey to collect comparable baseline data.

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| CEO, Director of Quality Risk & Programs, Exec Admin Assistant will ensure question is included in the survey by Oct 2024. The Director of Quality, Risk & Programs will monitor progress. | Question will be included in the Annual Satisfaction Survey provided to the Residents and POA/SDM using the same working and rating scale 0-10 as would be in the NHCAHPS Survey. | 100% compliance by Oct 2024 | |

| Change Idea #2 | Increase involvement of Resident Council and Family Council (if any) members in the preparation, delivery and feedback provided of Annual Satisfaction Survey. | | |
|---|---|---|---|
| Methods | Process measures | Target for process measure | Comments |
| Director of Quality, Risk & Programs, Manager of Program Support & Volunteer Services and Social Services Coordinator will engage the Resident and Family Council throughout 2024 (May-Sept regarding format Oct regarding delivery and Nov Providing Feedback. Director of Quality, Risk & Programs will monitor progress. | 1. Director of Quality, Risk & Programs will share the change idea and target with the Manager of Program Support & Volunteer Services and Social Services Coordinator who are staff resources to the Resident and Family Councils. 2. MPSVS and SSC will meet with councils to discuss their valuable input regarding format and delivery. 3. MPSVS and SSC along with Recreation Facilitators will schedule a survey clinic and offer assistance to Residents and Family members to complete survey on Survey Monkey and encourage Residents to provide feedback. | 100% Compliance by Nov 2024 | |

## Measure - Dimension: Patient-centred

| Indicator #4 | Type | Unit / Population | Source / Period | Current Performance | Target | Target Justification | External Collaborators |
|---|---|---|---|---|---|---|---|
| Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences". | O | % / LTC home residents | In house data, interRAI survey / Most recent consecutive 12-month period | CB | CB | Collecting comparable baseline data. | |

### Change Ideas

| Change Idea #1 | Ensure question is including in the annual Satisfaction Survey for Residents and POA with the same rating scale as would be in the interRAI Survey to collect comparable baseline data. | | |
|---|---|---|---|
| Methods | Process measures | Target for process measure | Comments |
| CEO, Director of Quality Risk & Programs, Exec Admin Assistant will ensure question is included in the survey by Oct 2024. The Director of Quality, Risk & Programs will monitor progress. | Question will be included in the Annual Satisfaction Survey provided to the Residents and POA/SDM using the same wording and rating scale (never - always) as would be in the interRAI Survey | 100% compliance by Oct 2024 | |

| Change Idea #2 | Increase involvement of Resident Council and Family Council (if any) members in the preparation, delivery and feedback provided of Annual Satisfaction Survey. | | |
|---|---|---|---|
| Methods | Process measures | Target for process measure | Comments |
| Director of Quality, Risk & Programs, Manager of Program Support & Volunteer Services and Social Services Coordinator will engage the Resident and Family Council throughout 2024 (May-Sept regarding format Oct regarding delivery and Nov Providing Feedback. Director of Quality, Risk & Programs will monitor progress. | 1. Director of Quality, Risk & Programs will share the change idea and target with the Manager of Program Support & Volunteer Services and Social Services Coordinator who are staff resources to the Resident and Family Councils. 2. MPSVS and SSC will meet with councils to discuss their valuable input regarding format and delivery. 3. MPSVS and SSC along with Recreation Facilitators will schedule a survey clinic and offer assistance to Residents and Family members to complete survey on Survey Monkey and encourage Residents to provide feedback. | 100% compliance by Nov 2024 | |

# Safety

## Measure - Dimension: Safe

| Indicator #5 | Type | Unit / Population | Source / Period | Current Performance | Target | Target Justification | External Collaborators |
|---|---|---|---|---|---|---|---|
| Percentage of LTC home residents who fell in the 30 days leading up to their assessment | O | % / LTC home residents | CIHI CCRS / July 2023– September 2023 (Q2 2023/24), with rolling 4-quarter average | 15.67 | 15.50 | Currently below provincial average of 16.4. Our goal will be to maintain and aim to lower the target performance by 1% | |

### Change Ideas

| Change Idea #1 Increase awareness and engagement from direct care staff for our falls prevention and management program. | | | |
|---|---|---|---|
| Methods | Process measures | Target for process measure | Comments |
| Purposeful rounding with the 4 P approach and interdisciplinary team approach to Fall Prevention Program. Resident Care Leadership will be responsible to track progress. | 1. Purposeful rounding to decrease number of falls, decrease injury related to falls included documented hourly rounds performed by PSWs. 2. Mon Morning Report/Risk Report Review of High Risk Fallers where interdisciplinary team reviews falls and looks for patterns to discuss further interventions and follow up. 3. Monthly Falls Champions Meeting comprised of interdisciplinary team of DRC, NP, RPN, PSW, Mgr of Programs, PT, Restorative Care Coordinator, RC Education Coordinator, MgrEnvServ and Dietary Rep 4. Provide education at meetings regarding fall prevention i.e. frailty as risk factor for falls, Fracture Risk Scale 4. Minutes shared with team and registered staff/charge nurse for Resident home areas | 100% Compliance by Dec 31, 2024 | |

| Change Idea #2 Identify root cause as to why residents are falling. | | | |
|---|---|---|---|
| Methods | Process measures | Target for process measure | Comments |
| At Falls Champions meeting to identify reasons/root causes for falls. Resident Care Leadership will be responsible to track progress. | 1. Possible root causes determined to be included in post fall assessment in PCC 2.Quarterly Bedrail audits review, remove or install depending on need and level of risk | 100% Compliance by Dec 31, 2024 | |

| Change Idea #3 Implement interRai Fracture Risk Scale | | | |
|---|---|---|---|
| Methods | Process measures | Target for process measure | Comments |
| Education Coordinator, RNs, RPNs, NP will implement the interRai Fracture Risk Scale. Resident Care Leadership will be responsible to track progress. | 1. Educate Registered staff on the use of the interRai Fracture Risk Scale to identify level of risk from low (1-3) to high (4-8). 2. Introduce specific interventions based on level of risk ie. Low Risk - prevention strategies including Vit D, Calcium, Exercise and at High Risk consider additional strategies including osteoporosis med and hip protectors | 100% compliance by Dec 31, 2024 | |

| Change Idea #4 Implement enhanced 72 hour fall monitoring on residents with a change of status that potentially could increase risk of falling. | | | |
|---|---|---|---|
| Methods | Process measures | Target for process measure | Comments |
| Resident Care Management will ensure the RPNs will initiate a 72 hour enhanced fall monitoring tool for any Resident identified at increased risk of falls. Resident Care Leadership will monitor for effectiveness. | 1. 72 hour enhanced fall monitoring tools implemented with medication changes 2. Monitor Resident for 48 Hours for Pain post fall 3. Head Injury Routine for 72 hours post fall 3. DRC to designate a Fall Lead RPN who will conduct a Fall Prevention documentation audit, conduct post fall huddle, ensure head injury routine initiated when needed, post fall assessment and appropriate referrals are made ie. PT, RD. | 100% Compliance by Dec 31, 2024 | |

| Change Idea #5 Enhanced monitoring of medications that can increase the risk associated with falls | | | |
|---|---|---|---|
| Methods | Process measures | Target for process measure | Comments |
| In collaboration with Pharmacist, NP/MD conduct reviews to identify medications that can increase the risk of falls and consider alternatives. Resident Care Leadership will be responsible to track progress. | 1.Medication reviews completed on residents that are high risk of falling that include a focus on medications that may contribute to increased falls. 2. Pharmacist to include education on medications that contribute to falls to NP/RN/RPNs | 100% Compliance by Dec 31, 2024 | |

## Measure - Dimension: Safe

| Indicator #6 | Type | Unit / Population | Source / Period | Current Performance | Target | Target Justification | External Collaborators |
|---|---|---|---|---|---|---|---|
| Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment | O | % / LTC home residents | CIHI CCRS / July 2023– September 2023 (Q2 2023/24), with rolling 4-quarter average | 37.98 | 34.18 | Our goal is a 10% reduction. We feel that this is an achievable goal as there are several factors to take into consideration including the long term effects of the Pandemic has had on our residents mental health and more residents being admitted with mental health diagnosis/medications associated with same. | Medisystem Pharmacy, NSMSGS Geriatric Mental Health Team |

### Change Ideas

| Change Idea #1 Training sessions on Gentle Persuasive Approach (GPA) | | | |
|---|---|---|---|
| Methods | Process measures | Target for process measure | Comments |
| 1. Will be offered to staff selected from all departments. 2. Progress will be tracked by the Resident Care Department Leadership Team in collaboration with the Director of Quality, Risk & Programs and PSW Lead (Certified GPA Coaches). | Our focus will be on training staff working on Kempenfelt Court (secure unit) as this unit has the highest number of residents with responsive behaviours and use of antispychotics. | Focus will be on training 75% of the staff working on Kempenfelt Crt (secure unit) as part of the second year of a 3 year implementation. 25% of other staff will be trained throughout the Home. | |

| Change Idea #2 Identify and review the number of residents who take antipsychotic medication. | | | |
|---|---|---|---|
| Methods | Process measures | Target for process measure | Comments |
| 1. Complete a full review of medications upon admission of each Resident and identify a diagnosis to support/validate the use of antipsychotic medication where prescribed. 2. Obtain list of all Residents with an active prescription for antipsychotic medication from the pharmacy. 3. Complete audits of all Resident RAI data that indicates a current prescription for antipsychotic medication without a diagnosis and consult with MD/NP to identify a diagnosis where possible; cross reference with list provided by Pharmacist. 4. Resident diagnosis list in PCC will be updated with any new diagnosis. 5. Progress will be tracked by the Resident Care Department Leadership Team and reported on at the Home Quality Working Committee. | 1. MD/NP will complete all new admission reviews with each new admission. 2. Detailed report will be prepared by the MediSystem Pharmacist quarterly and provided to the DRC to review with medical team. 3. Individual cases will be reviewed with NP/MD during Quarterly med review to ensure diagnosis matches medication reconciliation 4. Consult with RAI Coordinator/Lead who audits for residents who are missing a diagnosis. 5. Diagnosis updates will be completed by the RPN Charge Nurse responsible i.e. Residents returning from hospital with new diagnosis 6. A summary will be completed and reported on quarterly at the CQI committee meeting by Medisystem Pharmacy | 100% compliance by Dec 31, 2024 | Due consideration must be given to the appropriate use of antipsychotic medication for treatment of certain responsive behaviours and anxiety related disorders. Note trends for new admissions include increased acuity, mental health concerns, increased use of antipsychotic medications without supporting diagnosis. |

| Change Idea #3 | Utilize external resources such as GMH team and psychogeriatric consultants to support residents with responsive behaviours and other mental health concerns, receiving antipsychotic medications | | |
|---|---|---|---|
| Methods | Process measures | Target for process measure | Comments |
| 1. Registered Staff (RN/RPN) will assess, monitor and report any resident presenting with challenging responsive behaviours who might benefit from non-pharmacological interventions from the GMH team. For Pharmacological/non-pharmacological interventions staff will inquire about a referral to our psychogeriatric consultant MD. 2.Progress will be tracked by the Resident Care Department Leadership Team and reported on at the Home Quality Working Committee. | 1. We will track number of residents referred to the GMH Team and/or psychogeriatric consultant with a review of resident receiving antipsychotics. 2. Formalize the process and documentation of referral on an individual basis 3.Post referral to psychogeriatric consultant follow up including a more in depth evaluation reviewing diagnosis and medications. 4.This information will be reported on quarterly at the CQI committee meeting. | 25% of residents receiving antipsychotic medication will be referred to the GMH Team and/or psychogeriatric consultant. | Due consideration must be given to the appropriate use of antipsychotic medication for treatment of certain responsive behaviours and anxiety related disorders. Note trends for new admissions include increased acuity, mental health concerns, increased use of antipsychotic medications without supporting diagnosis. |