Quality Improvement Plan (QIP)

Narrative for Health Care Organizations in Ontario

March 27, 2025

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 2025/2026.

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

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. During the pandemic, RVH and the IOOF Homes ran a 27-bed satellite unit located on the IOOF Brooks Street Campus until September 22, 2024. This unit cared for patients designated as Alternate Level of Care (ALC). This partnership freed up beds within the hospital to create increased capacity during the height of the 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 and avoid further hospital or long-term care admission.

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.

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 approvals, we eagerly anticipate shovels in the ground to begin construction in the spring of 2025.

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 a Resident Council. At present the Family Council has not formed in a formal capacity, but the Home does provide an open forum for Family Council at minimum twice per year. 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. 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 were reviewed on March 10, 2025 at the Residents' Council Meeting. with the Management Team on March 5, 2025, and the CQI Committee on March 18, 2025 and at the Board Level on March 26, 2025. The next open forum Family Council meeting is scheduled for April 30, 2025 where the results will be reviewed and participation encouraged. The results of the survey are accessible and posted in the Home. As areas of improvement are identified, each department sets goals to address them. As part of our QIP we are striving to increase engagement in the survey. We are happy to report that in 2024 we doubled the number of surveys received over the previous year.

We continue to receive positive 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

"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

From our Annual Satisfaction Survey:

"They check in to encourage any opportunity to socialize with others, and attend to meals and exercise walking to and from. Also

they encourage his jokes and talking by responding positively."

"I have the sense that everyone respects my mother's dignity."

"I very much appreciate the attention given to my mother's care."

"Staff goes over and beyond the expectations, they treat the residents like family, in the highest regard."

"Staff are amazing!!! They make my mother feel welcome, cared for and heard."

"Mom is living the best she has ever lived, I give credit to all staff."

"I know dad is safe and well looked after."

"Mom loves to participate in all activities...she lives to be social."

"Exceptional care taken in overall cleanliness of residence."

"My thanks to the staff for the excellent care they provide."

"Nursing staff give mom more then 100% care."

96.77% of respondents said they were satisfied or very satisfied with their overall satisfaction with the Home.
93.55% would recommend the Home to a friend or relative

Answering, what do you appreciate most about the Home:

"The genuine kindness, devotion and sensitivity of the caregivers, nurse, administrators."

"I like how staff knows the residents and interacts with them all the time right from the CEO down to the housekeeping and maintenance staff. I once saw the CEO sitting doing a puzzle with a resident. You don't see that in other places."

PROVIDER EXPERIENCE

It remains a challenging time for healthcare organizations, facing 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, providing continuing education to our staff and running vaccination clinics to both Residents and Staff. Our IPAC Lead in collaboration with the management team 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 took a significant toll on long-term care organizations across the globe with unprecedented challenges. At our organization, we were not immune to healthcare worker burnout as a result of decreased staffing levels and increased demands. We continue to make 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. 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.

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

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 the risk for 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 increasing mental

health awareness, stigma reduction, mental health literacy, communication strategies, building resiliency and capacity for self-care and offering tools to management to support staff with mental health challenges or who are in crisis. The goal is to provide our staff with the tools they need to cope with the pressures of long-term care requirements and challenges and thrive at the workplace, by continuing to provide the essential 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.

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.

We have a long standing relationship with our local college, Georgian College, for RN, RPN, PSW, OTA/PTA and REC clinical placements.

SAFETY

Resident safety incidents have an impact on the 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 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 continued to make a reduction of falls a priority. The Home has applied for and has been accepted by the RNAO to be a Best Practice Spotlight Organization designate in the areas of Preventing Falls and Reducing Injuries from Falls. The Home will work on its BPSO designation concurrently while working on the implementation of RNAO Clinical Pathways that integrates Best Practice Guidelines directly into PointClickCare.

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.

PALLIATIVE CARE

The IOOF Homes offer an evidence-based, comprehensive palliative care program to our residents throughout the continuum of life; our interdisciplinary team in partnership with Resident and family incorporates resident-centered care and best practices to deliver a program that aims to provide relief from suffering from pain and symptoms for an improved quality of life for both residents and family.

The interdisciplinary team at the IOOF Homes is driven to deliver a compassionate palliative care program that promotes the choices, dignity, psychosocial and physical well-being of all that it serves. During the Palliative Care Team Meetings the interdisciplinary team discusses best practices, innovations, and educational needs in collaboration with an established partnership with the North Simcoe Muskoka Hospice Palliative Care Network.

This year, the Home will implement a Palliative Care clinical pathway in collaboration with RNAO and Point Click Care; this pathway will assist in standardizing care delivery and ensure the delivery of palliative care is based on the most up-to-date evidence-based best practice recommendations. Further to implementing a palliative care clinical pathway, the Home has decided to invest, recruit, and hire an additional full-time Nurse Practitioner with a specialty in palliative care; this will lead to a better quality of care for daily life and end-of-life care for our Residents through early identification and implementation of palliative care to relieve physical and psychosocial symptoms, and reductions in transfers to the emergency department.

POPULATION HEALTH MANAGEMENT

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:

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. We are investing in an internal Cognitive Support team comprised of an RPN Lead and two PSWs that will assist in delivering and supporting Residents with evidence based best practices that will significantly improve quality of life. Providing additional training to front-line staff working on our dementia care unit i.e. Gentle Persuasive Approaches (GPA) 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.

The Home has applied for and has been accepted by the RNAO to be a Best Practice Spotlight Organization designate. The Home will work on its BPSO designation concurrently while working on the implementation of RNAO Clinical Pathways that integrates Best Practice Guidelines directly into PointClickCare. This will effectively enhance the quality of Resident-Centered Care in the facility. The addition of evidence-based standardized assessments streamlined care-planning, structured progress notes, and built-in clinical suggestions to guide you through the assessment process, significantly reduces the risk for error-improving overall quality of care.

CONTACT INFORMATION/DESIGNATED LEAD

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OTHER

New Website Launched in 2024:

The IOOF Seniors Homes launched a new website www.IOOF.com in October 2024 that has been widely well received as an essential communication tool for the organization. The rebrand of the IOOF's site incorporates our new branding guidelines and helps residents, families, community members and staff find key information about our organization and services while celebrating the wonderful care our team provides. Employees are also able to access payroll, surge learning, and health benefits through the site in a central location. The new site is fully accessible and exceeds compliancy with AODA guidelines and standards.

The Quality Improvement Plan along with the Annual Continuous Quality Improvement & Risk Management Report is posted on the website.

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, 2025

Board Chair / Licensee or delegate

Administrator /Executive Director

Quality Committee Chair or delegate

Other leadership as appropriate

Access and Flow | Efficient | Optional Indicator

	Last Year		This Year		
Indicator #6 Rate of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents. (Odd Fellow and Rebekah Home)	**16.98** Performance (2024/25)	**16** Target (2024/25)	**18.89** Performance (2025/26)	**-11.25%** Percentage Improvement (2025/26)	**17.50** Target (2025/26)

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. 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).

Target for process measure

- 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

Lessons Learned

Success included presentation with Resident and Family councils. Although the Diagnostic Transfer Program has been utilized, it did not result in a decreased emergency visit. As a result of leadership changes and a change in the admission nurse. The admission package is in progress for review. Further Challenge: pressures for 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 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.

Target for process measure

- 100% compliance by Dec 31, 2024

Lessons Learned

The registered staff are involving the MD/NP but not as consistently as we would have hope. Education continues at registered meetings. Due to leadership changes, tracking of the diagnostic program did not occur.

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 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

Target for process measure

- 100% compliance by Dec 31, 2024

Lessons Learned

Successes included education initially; however with a change in leadership, more emphasis will be placed on sustaining standardized and accepted communication tools upon hire and quarterly for registered team.

Change Idea #4 ☑ Implemented ☐ Not Implemented

Review and Revise Public Reporting Board

Process measure

- 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.

Target for process measure

- 100% compliance by March 31, 2025

Lessons Learned

Public reporting board is updated as per requirements

Comment

Continue to implement a cross-sector review of transfers between LTC and hospital. Education on Advanced Care Planning and Goals of Care conversations for our registered staff and NP. Change Ideas for future improvement include clinical pathway guided by RNAO best practice guidelines which will trigger more timely assessment and intervention by prompting clinicians with follow up recommendations that will help to prevent emergency department transfers. Nurse Practitioners will attend all care conferences to provide education, and facilitate GOC conversations with Residents and families to prevent avaoidable ED transfers.

Equity | Equitable | Optional Indicator

Indicator #5	Last Year		This Year		
Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education (Odd Fellow and Rebekah Home)	CB Performance (2024/25)	100 Target (2024/25)	100.00 Performance (2025/26)	-- Percentage Improvement (2025/26)	100 Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Assign SURGE Learning Module on Diversity, Equity & Inclusion at Work

Process measure

- 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

Target for process measure

- 100% Compliance by Dec 31, 2024

Lessons Learned

Successfully implemented the introductory Surge Module on DEI at work for all staff

Comment

Phased approach over 3 years beginning with introductions to concepts, proceeding with enriched content in DEI education.

Experience | Patient-centred | Optional Indicator

Indicator #3	Last Year		This Year		
	CB	CB	66.67	--	75
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)	Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

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.

Process measure

- 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.

Target for process measure

- 100% compliance by Oct 2024

Lessons Learned

Question was included in then survey, but the challenge included the rating scale was not able to be modified with our survey format. Therefore on conversion we use 3 =6, 4=8 and 5=10.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Increase involvement of Resident Council and Family Council (if any) members in the preparation, delivery and feedback provided of Annual Satisfaction Survey.

Process measure

- 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.

Target for process measure

- 100% Compliance by Nov 2024

Lessons Learned

Increased Resident and Family/POA participation from 13 in 2023 to 31 in 2024

Comment

Increased Resident and Family/POA participation from 13 in 2023 to 31 in 2024

	Last Year		This Year		
Indicator #4	**CB**	**CB**	**87.10**	**--**	**90**
Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences". (Odd Fellow and Rebekah Home)	Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

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.

Process measure

- 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

Target for process measure

- 100% compliance by Oct 2024

Lessons Learned

Question was included in the survey, but the challenge included the rating scale was not able to be modified with our survey format.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Increase involvement of Resident Council and Family Council (if any) members in the preparation, delivery and feedback provided of Annual Satisfaction Survey.

Process measure

- 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.

Target for process measure

- 100% compliance by Nov 2024

Lessons Learned

Increased Resident and Family/POA participation from 13 in 2023 to 31 in 2024

Comment

Increased Resident and Family/POA participation from 13 in 2023 to 31 in 2024

Safety | Safe | Optional Indicator

	Last Year		This Year		
Indicator #1 Percentage of LTC home residents who fell in the 30 days leading up to their assessment (Odd Fellow and Rebekah Home)	**15.67** Performance (2024/25)	**15.50** Target (2024/25)	**20.88** Performance (2025/26)	**-33.25%** Percentage Improvement (2025/26)	**19.50** Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Increase awareness and engagement from direct care staff for our falls prevention and management program.

Process measure

- 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

Target for process measure

- 100% Compliance by Dec 31, 2024

Lessons Learned

Successes included Morning Report review of high risk fallers. Monthly Falls Champions Meeting. Information and minutes are shared. Challenge - ongoing education for current staff as well as new hires.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Identify root cause as to why residents are falling.

Process measure

- 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

Target for process measure

- 100% Compliance by Dec 31, 2024

Lessons Learned

Successfully implemented,

Change Idea #3 ☐ Implemented ☑ Not Implemented

Implement interRai Fracture Risk Scale

Process measure

- 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

Target for process measure

- 100% compliance by Dec 31, 2024

Lessons Learned

Initial discussions to implement were put on hold due to a change in leadership.
Carrying over for 2025 QIP

Change Idea #4 ☑ Implemented ☐ Not Implemented

Implement enhanced 72 hour fall monitoring on residents with a change of status that potentially could increase risk of falling.

Process measure

- 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.

Target for process measure

- 100% Compliance by Dec 31, 2024

Lessons Learned

Successful
Challenge - designating an RPN lead however, change in leadership is responsible for auditing post fall documentation.

Change Idea #5 ☑ Implemented ☐ Not Implemented

Enhanced monitoring of medications that can increase the risk associated with falls

Process measure

- 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

Target for process measure

- 100% Compliance by Dec 31, 2024

Lessons Learned

Successfully reviewing medications for Residents that are at high risk. Education provided. Improvement to include referrals to pharmacy on a more consistent basis.

Comment

Change Ideas for future improvement include implementation of admission and fall prevention clinical pathway guided by RNAO best practice guidelines to assess and address falls risk. Implementation of an internal cognitive support team that will assist in minimizing and managing responsive expressions that heighten the risk for falls for residents and co-residents.

	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)	**37.98** Performance (2024/25)	**34.18** Target (2024/25)	**29.37** Performance (2025/26)	**22.67%** Percentage Improvement (2025/26)	**22** Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Training sessions on Gentle Persuasive Approach (GPA)

Process measure

- 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) as part of the second year of a 3 year implementation. 25% of other staff will be trained throughout the Home.

Lessons Learned

Successful training occurred with KC

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. 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

Target for process measure

- 100% compliance by Dec 31, 2024

Lessons Learned

Successes included MD/NP completing admission reviews. Challenges include updates to PCC with diagnosis tab by registered staff.

Change Idea #3 ☑ Implemented ☐ Not Implemented

Utilize external resources such as GMH team and psychogeriatric consultants to support residents with responsive behaviours and 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 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.

Target for process measure

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

Lessons Learned

Successfully implemented, however the challenge was maintaining the tracking of the caseload with a change in leadership over the course of the year.

Comment

Train more certified coaches in GPA, train more RNs. RPNS in GPA.Train staff from additional home areas. Change Ideas for future improvement include implementation of admission clinical pathway guided by RNAO best practice guidelines to assess diagnosis for antipsychotic use. Implement the internal cognitive support team.

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 / Oct 1, 2023, to Sep 30, 2024 (Q3 to the end of the following Q2)	18.89	17.50	We aim to reduce the rate from our current status by 7.36 and feel this is a realistic target based on previous performance and current challenges with acuity and frailty at the time of admission. The home plans to recruit a full-time nurse practitioner with a Palliative Care background. The hope is to have earlier identification of symptoms leading to better management by treating earlier and having informative goals of care conversations that respect resident choice and preferences.	Royal Victoria Regional Health Centre, Long Term Care Diagnostic Program, 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 through planned education sessions as well as care conferences.

Methods	Process measures	Target for process measure	Comments
#1) NP will take the lead in educating Staff, Residents, and families about in-house interventions to address medical issues that do not necessitate the need for an ED visit at admission, 6 week care conference, annual care conferences, and change in condition. #2) Increase employee, Resident and family awareness of the Ambulatory Care Sensitive Conditions, advanced care planning, alternatives to ED transfers and the role of MD/NP for in-house care. #3) Progress will be tracked by the Resident Care Department Leadership Team. 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/NP) and CARE Team (PAC/CQI) will receive quarterly updates on hospital transfers/ED visits, focusing on avoidable ED visits, identified trends, and reasons for transfer. #2) Additional training of registered staff regarding Advance Care Planning and Goals of Care conversations with residents and POAs in collaboration with the North Simcoe Muskoka Hospice Palliative Care Network (NSMHPCN) or other external organizations. #3) Adding an additional full time NP to the care team, in order to enable them to routinely attend care conferences, 1:1 conversations with residents families on goals of care & advanced care planning. NPs work collaboratively to identify symptoms earlier leading to better management through earlier intervention and facilitation of goals of care conversations that promote informed resident-centered care decisions. Utilization of external NPs through RVH.	#1) Quarterly summary updates to identify trends with goal for continuous improvement #2) comprehensive annual review #3) track education provided #4) tracking NP attendance at Care Conferences	Due consideration must be given to the level of acuity and frailty at the time of admission to LTCH.

Change Idea #2 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 and training will be provided to all Registered Staff upon hire, quarterly at registered staff meetings and resource tools ie: SBAR will be utilized. 2) Implementation of Acuity Dashboard in PCC upgrade.	100% compliance by Dec 2025	

Change Idea #3 Early recognition of at risk residents for ED visits

Methods	Process measures	Target for process measure	Comments
#1) Registered Nurses will assess and monitor those residents at risk by using PCC assessments, Progress note types and Clinical Pathways Assessments. Outcome of assessments/change in condition(s) will flag/trigger the registered staff to contact NP/MD as necessary.	#1) The Registered Nurses will involve the MD/NP for early intervention/treatment and where indicated.	#3) 100% of residents at risk for ED visits will be referred to NP/MD for assessment.	

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	100.00	100.00	We have reached our target in 2024. In 2025 we will be expanding DEI educational content and believe we can reach the same target.	

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, 2025	Total LTCH Beds: 162 Phased approach over 3 years. We are in year 2 of 3 which began with the introduction and is proceeding with enriched content for DEI 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	66.67	75.00	Although the majority of residents/family (POA) have responded positively to this question, our goal is to increase response rate.	

Change Ideas

Change Idea #1 #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 2025. 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 Dec 31,2025	Total Surveys Initiated: 31 Total LTCH Beds: 162 Question was included in the survey, but the challenge included the rating scale was not able to be modified with our survey format. Therefore on conversion we use 3=6, 4=8 and 5=10.

Change Idea #2	#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 2025 (May-Sept) regarding format, in Oct regarding delivery and in 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 Dec 31, 2025	Increased Resident and Family/POA participation from 13 in 2023 to 31 in 2024

Change Idea #3	In response to the satisfaction survey comments, improve the communication system by upgrading existing hardware and processes related to the routing of external phone calls.		
Methods	Process measures	Target for process measure	Comments
Management will assess and subsequently secure upgraded hardware that better meets the needs of the home.	1.Review current processes related to follow up of phone calls and how they are escalated internally to ensure prompt response times. 2. Implement new hardware. 3. Educate staff on hardware and processes.	Multi- year initiative, alongside redevelopment, initial phase to be implemented by March 31, 2026.	

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	87.10	90.00	Although the majority of residents/family (POA) have responded positively to this question, our goal is to increase response rate.	

Change Ideas

Change Idea #1 #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 2025. 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 Dec 31, 2025	Total Surveys Initiated: 31 Total LTCH Beds: 162 Question was included in the survey, but the challenge included the rating scale was not able to be modified with our survey format. Therefore a conversion was used.

Change Idea #2	#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 Dec 31, 2025	Increased Resident and Family/POA participation from 13 in 2023 to 31 in 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 1 to Sep 30, 2024 (Q2), as target quarter of rolling 4-quarter average	20.88	19.50	We aim to reduce the rate from our current status by 6.61% and feel this is a realistic target based on previous performance and current challenges with acuity and frailty at the time of admission and throughout their stay. The home is in the process of recruiting a second full-time nurse practitioner who will be an active participant in the fall prevention program to identify risk factors, change in status etc. Enhanced staffing to aid in hourly/purposeful rounding to address and identify at-risk residents. Increasing the staff to resident ratio will help staff to meet Resident personal needs in a timely manner.	NSMSGS Geriatric Mental Health Team, Psychogeriatric Physician, MediSystem Pharmacy

Change Ideas

Change Idea #1	Increasing staff engagement and accountability, using a targeted team approach to proactively address basic Resident needs, will prevent and decrease the number of falls that occur in the home.		
Methods	Process measures	Target for process measure	Comments
#1) Purposeful rounding with the 4 P approach and interdisciplinary team approach to Fall Prevention Program. Resident Care Leadership will be responsible to track progress. #2) Education on Purposeful Rounding in Surge Learning platform and unit huddles. #3) Education upon hire on purposeful rounding for all staff in the LTCH.	#1) Purposeful rounding to decrease number of falls, decrease injury related to falls included documented hourly rounds performed by PSWs. Standing Agenda item at Monthly PSW staff meetings and on unit huddles. #2) Sharing information from our Mon Morning Report/Risk Report Review of High-Risk Fallers with home area specific huddles. #3) Provide education to all staff regarding fall prevention and management at time of onboarding and ongoing using evidence based best practice encompassed in RNAO Clinical Pathways.	100% compliance by Feb 28, 2026.	Due consideration must be given to the level of acuity and frailty at the time of admission to LTCH.

Change Idea #2	Implement enhanced 72 hour fall monitoring on residents that trigger on the acuity dashboard of Point Click Care.		
Methods	Process measures	Target for process measure	Comments
#1) The charge nurse will review the acuity dashboard, will ensure assessment of the Resident occurs and will initiate a 72-hour enhanced fall risk monitoring tool if deemed appropriate. The Resident Care Leadership team will monitor the acuity dashboard and ensure appropriate follow-up has been completed.	#1) 72 hour enhanced falls risk monitoring tools implemented with medication changes and increased acuity from baseline that increases Resident's risk for falls. #2) Monitor Resident for 48 Hours for Pain post fall #3) Head Injury Routine for 72 hours post fall #4) Care plan fall interventions reviewed by registered staff and PSW post fall. Changes made as necessary. #5) Prevent falls and reduce injury through the use of RNAO Clinical Pathway. #6)Completion of Risk Management in PCC upgrade- related to falls.	100% Compliance by Feb 28, 2026	Due consideration must be given to the level of acuity and frailty at the time of admission to LTCH.

Change Idea #3 Using an interdisciplinary approach, a medication review will be conducted to identify medications that can increase the risk of falls and investigate non-pharmacological interventions as alternatives.

Methods	Process measures	Target for process measure	Comments
#1) In collaboration with the Interdisciplinary Team and/or external partners a post fall medical review will be conducted. #2) 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 #3) Referral to internal NP/MRP/CST and/or external partners on an as needed basis.	100% compliance by Feb 28, 2026.	Due consideration must be given to the level of acuity, frailty, and polypharmacy at the time of admission to LTCH.

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 1 to Sep 30, 2024 (Q2), as target quarter of rolling 4-quarter average	29.37	22.00	Our goal is a 25% reduction. We feel that this is an achievable goal as we have made positive progress with this indicator. With the implementation of the Cognitive Support Team and Clinical Pathways we feel we will continue to make significant progress in the reduction of antipsychotic usage without a diagnosis. Predictable challenges include residents being admitted with a lack of support from community such as primary care physician or NP, leading to risk of polypharmacy and poor monitoring.	NSMSGS Geriatric Mental Health Team, MediSystem Pharmacy, Psychogeriatric Physician

Change Ideas

Change Idea #1 #1) Training sessions on Gentle Persuasive Approach (GPA) #2) Train more GPA certified trainers to provide education/training.

Methods	Process measures	Target for process measure	Comments
#1) Training will be offered to selected staff throughout the LTCH #2) Progress will be tracked by the Resident Care Department Leadership Team in collaboration with the Director of Quality, Risk & Programs.	#1) Our initial focus will be to train all of our Registered Staff and our internal Cognitive Support Team. #2) Training sessions will be subsequently provided to staff in all departments/designations throughout the LTCH.	#1)100% of registered nurses & internal CST will be GPA trained by Dec 31, 2025. #2) 25% of all other staff will be GPA trained throughout the Home by Feb 28, 2026.	

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/re-admission of each Resident and identify and document a diagnosis to support/validate the use of antipsychotic medication. 2. Obtain list of all Residents with an active prescription for antipsychotic medication from the pharmacy. 3. 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 a review with each new admission/re-admission. #2) Detailed antipsychotic usage report will be prepared by the MediSystem Pharmacist quarterly and provided to the DRC to review with medical team during PAC Meeting. #3) Individual cases will be reviewed with NP/MD during Quarterly med review to ensure diagnosis matches medication reconciliation. #4) Diagnosis updates will be completed by the Registered Staff i.e. Residents returning from hospital with new diagnosis	100% compliance by Feb 28, 2026	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	#3) Utilize internal Cognitive Support Team and external resources such as Geriatric Mental Health team and psychogeriatric consultants to support residents with responsive behaviours/expressions and other mental health conditions, 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/expressions who might benefit from non-pharmacological interventions from the in ternal CST and 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 and Quarterly PAC Meeting	#1) We will track number of residents referred to the internal CST, external GMH Team and/or psychogeriatric consultant with a review of resident receiving antipsychotics. #2)This information will be reported on quarterly at the CQI committee meeting.	100% of residents receiving antipsychotic medication without a diagnosis in the LTCH will be referred to the internal CST who may collaborate with external 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. Indicators0