Quality Improvement Plan (QIP)

# Narrative for Health Care Organizations in Ontario

March 16, 2023

CENTRE DE SOINS PROLONGÉS
ST. JOSEPH'S
CONTINUING CARE CENTRE

Ontario Health

## OVERVIEW

St. Joseph's Continuing Care Centre (SJCCC) is a not for profit organization, accredited by CARF International and located along the St. Lawrence River in Cornwall, Ontario. The land on which SJCCC operates includes the territory of the Haudenosaunee and Algonquin peoples. SJCCC is grateful for the opportunity to work and live on this land and remain committed to, and acknowledge responsibility for building and improving relationships with First Nations, Inuit and Metis peoples as equal partners in all we do. Owned and operated by the Religious Hospitallers of St. Joseph's (RHSJ), our unique facility houses two separate programs under one roof and offers services in the following areas: 150 provincially licensed long-term care beds, referred to as, St. Joseph's Villa (SJV); and a small 58-bed hospital known as Hotel Dieu Hospital (HDH).

Last year, SJCCC celebrated a special milestone commemorating the 125th year anniversary of the RHS's arrival to our city to establish and operate Cornwall's very first hospital. Hotel Dieu Hospital opened its doors to the public in June of 1897. For more than a century, the RHSJ Sisters served our community, never failing to recognize the needs of the sick, the elderly and the very young. The Sister's legacy of holistic and compassionate care remains deeply rooted and is reflected in our Mission, Vision and Value statements. We continue to lead by their example and remain committed to improving the life of our seniors affected by loss of autonomy through illness or injury.

Separate QIP reports have been submitted for our LTC and HDH programs.

LTC goals for the year 2023-24 will focus on the following

modalities:
1. Under Resident Experience, we will continue to explore the number of residents who responded positively to the survey question, "My pain is properly controlled".
2. Safety of Care, we will continue to review residents' not living with a diagnosis of psychosis who were given antipsychotic medications to promote deprescribing efforts.
3. Under the theme "Timely", our home is exploring a new initiative concerning the percentage of residents with life-limiting illness who have had their palliative care needs identified early through a comprehensive and holistic assessment.
4. Under the theme "Efficient", we will continue to follow the number of ED transfers for a modified list of ambulatory care-sensitive conditions* per 100 Long-Term Care residents.

## 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

_____

_____
Board Chair / Licensee or delegate

_____
Administrator /Executive Director

_____
Quality Committee Chair or delegate

_____
Other leadership as appropriate

_____

# Theme I: Timely and Efficient Transitions

**Measure** **Dimension:** Efficient

| Indicator #1 | Type | Unit / Population | Source / Period | Current Performance | Target | Target Justification | External Collaborators |
|---|---|---|---|---|---|---|---|
| Number of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents. | P | Rate per 100 residents / LTC home residents | CIHI CCRS, CIHI NACRS / Oct 2021 - Sep 2022 | 12.50 | 12.00 | Target was missed by 0.5%. Will continue to work on additional strategies to further reduce ED transfers to 12.0% or further over the next fiscal year. | |

## Change Ideas

Change Idea #1 Audit, track and log all incidence of ED transfers identifying those considered avoidable as per list of conditions identified by HQO.

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| Quality Lead (QL) will continue to monitor, track and log all ED transfers and report the results at the monthly Professional Advisory meetings. QL will also continue to review reasons for transfers and conditions at the monthly multidisciplinary meetings for all units and post the ED transfer results on the PCC board for employee review. | Potentially avoidable | 100% of ED transfers will be tracked, analyzed and reported to key stakeholders for trends to further improve this metric. | |

Change Idea #2 Implementation of RNAO-BPG for falls prevention. Falls were identified as the most common reason for ED transfers at the Home.

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| Review ED incidents in Risk Management and progress notes- log incidents and determine reasons for transfer- Forward w/order for OT/PT to follow up with residents with fall concerns. | The number of residents who were sent to the ED as a result of a fall. | 100% of fall incidents will be reviewed and referred to OT/PT when appropriate. Strategies for falls prevention will be explored and implemented to be included in the residents plan of care. | |

Change Idea #3 Commence discussions early on in the admission stage and annually during care conferences with the resident and substitute decision maker (SDM) regarding risks to the residents health and well being as a result of unnecessary ED transfers.

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| 1. Provide information in the admission package for the resident and SDM to review on associated risks r/t transfers to ED and potential hospital admissions such as pressure ulcers, delirium, risk of contracting an ARO and other infections.<br>2. Determine residents frailty score using the Rockwood Clinical Frailty Scale, RAI CHESS score as well as recent lab and diagnostic results when reviewing with resident and family members. | Percentage of residents/SDM's who received information on the associated risks from ED transfers allowing them to make informed decisions concerning their care needs. | Goal was set for 90% last QIP. Will continue to strive for the 90% mark as previously set. | It was noted by the medical director that often family members who were advised of the risks associated with ED transfers still opted to send their loved one to the ED for conditions that could have been managed and treated in-house. |

## Measure

**Dimension:** Timely

| Indicator #2 | Type | Unit / Population | Source / Period | Current Performance | Target | Target Justification | External Collaborators |
|---|---|---|---|---|---|---|---|
| Percentage of residents with life-limiting illness who have had their palliative care needs identified early through a comprehensive and holistic assessment. | C | % / Residents | In house data collection / 6 months (Q1 & Q2) | CB | 80.00 | Our goal is to provide support and ensure the needs of our residents are identified and met early on during their palliative trajectory. | |

## Change Ideas

Change Idea #1 Earlier identification and evaluation of residents whose health is deteriorating and may be approaching a palliative trajectory.

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| Weekly virtual huddles with MD/NP, Nursing, Quality Lead, Resident Relation Advisor & Health and Wellness Coordinator to discuss/review residents experiencing significant changes to their health who might benefit with a palliative approach to care. The process is in alignment with the Gold Standards Framework-Identify, Assess and Plan/Manage. Information is obtained from staff, progress notes, shift reports resident's RAI-MDS CHESS score. PPS, ESAS, Rockwood Clinical Frailty Scale are other tools available. | Percentage of residents who | Aim is for 80% of residents with deteriorating health to be assessed and identified earlier on during the palliative journey. | |

Change Idea #2 More timely conversations with residents concerning a palliative approach to care and EOL care.

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| Resident and Family Relations Advisor will initiate gentle conversations on EOL with residents and family at the 6 week post admission meeting and review annually and prn. Early talks provide the resident/family an opportunity to voice their wishes and to ask pertinent questions in a relaxed setting rather than in times of stress and crisis. | % of residents that had documented conversations regarding the EOL wishes. | 100% of residents will have had documentation surrounding discussions on palliation and EOL at their 6 week post admission. | |

# Theme II: Service Excellence

## Measure

**Dimension:** Patient-centred

| Indicator #3 | Type | Unit / Population | Source / Period | Current Performance | Target | Target Justification | External Collaborators |
|---|---|---|---|---|---|---|---|
| Percentage of residents who responded positively to the statement, "My pain is properly controlled". | C | % / LTC home residents | In-house survey / April 2022- March 2023 | CB | 96.00 | Unable to quantify performance as survey results are still pending. | |

## Change Ideas

Change Idea #1 Improve residents' pain control outcomes using BPG to improve their quality of life.

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| Staff to initiate pain assessments within 24 hours of a resident's admission to establish a baseline and initiate a care plan. Pain ax are completed on admission, quarterly and annually as well as on a prn basis for significant changes. | The percentage of residents who have had a pain assessment within 24 hours of their admission. | Results of this intervention will be reflected in the Residents Survey results. | A review of the data from Dec 1, 2022 to Feb 28, 2023 indicates that 12 residents were admitted during that period and 6/12 had a pain assessment completed within 24 hours of admission. More work is required in this area. |

# Theme III: Safe and Effective Care

**Measure** **Dimension:** Safe

| Indicator #4 | 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 | P | % / LTC home residents | CIHI CCRS / Jul - Sept 2022 | 17.92 | 14.00 | Target not met. Decline in performance noted. Will continue to explore alternative interventions and continue efforts in advocating deprescribing of antipsychotics where appropriate. | |

## Change Ideas

Change Idea #1 Identify residents who were prescribed antipsychotic medications without a diagnoses of psychosis with the goal to deprescribe where appropriate.

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| RAI Coordinator and Quality Lead have been conducting audits on a monthly basis reviewing residents medication and progress notes to determine need for antipsychotic medications. Staff input is requested. Incident reports on aggressive episodes are reviewed in Risk Management. Information is provided to the MD/NP for their review and consideration for de-prescribing. | The number of residents on antipsychotic medications without a dx of psychosis. | Target of 14% not met. Will shift focus on improving current performance by exploring additional BPG strategies and interventions to meet the set target of 14%. | |

| Change Idea #2 | Encourage staff to trial alternate non-pharmalogical interventions prior to administering prn antipsychotic medications to manage responsive behaviours. | | |
|---|---|---|---|
| Methods | Process measures | Target for process measure | Comments |
| 1. Trial GPA techniques first and assess response and effect. 2. Involve BSO, Montessori Coordinator and Recreation staff to assess and provide recommendations and strategies. 3. Trial sensory stimulation (Snoezelen Room) | Percentage of residents with responsive behaviours who are followed by BSO/ Montessori and have documented non-pharmacological interventions added to their care-plan. | 100% of residents with known behaviours are all followed by BSO or Montessori and non-pharmological interventions in their care-plans. Will continue to monitor this. | |

| Change Idea #3 | Increase education and awareness concerning management of responsive behaviours. | | |
|---|---|---|---|
| Methods | Process measures | Target for process measure | Comments |
| 1. GPA and GPA refresher courses are available for all staff in all departments. 2. Send staff for PIECES training and encourage staff to take online courses such as U-First. | The number of staff who have attending training courses for residents with responsive behaviours. | Target of 25% was set for staff attendance in training sessions however only 17% of staff participated in the training last year. | GPA courses were not offered in person during the pandemic but has resumed. |