Quality Improvement Plan (QIP)

Narrative for Health Care Organizations in Ontario

March 28, 2024

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, accredited organization located along the shores of the St. Lawrence River in Cornwall Ontario. SJCCC was founded by the Religious Hospitallers of St. Joseph’s (RHSJ). Our unique facility encompasses two separate programs under one roof, St. Joseph's Villa (SJV) which consists of 150 provincially licensed long-term care beds and Hotel Dieu Hospital (HDH), a small 58 bed hospital which houses our slow paced rehabilitation program.

SJCCC has a rich history dating back over 126 years. The Sisters arrived in Cornwall to establish and operate Cornwall's very first hospital. Hotel Dieu opened its doors to the public in June of 1897. For more than a century, the RHSJ Sisters have served our community, never failing to recognize the needs of the sick, 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 Values 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.

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.

Our Mission:
In the spirit of the Religious Hospitallers of St. Joseph, we reveal

God's love and mercy through
compassionate care focused on the body, mind and soul of all those whose lives we touch.

Our Vision:
To Be A Beacon of Hope, on the Journey to Living Your Best Life.

Our Values
Dignity
Spirituality
Innovation
Accountability
Equity
Safety
Hope

Strategic Plan for 2022-2025:
Innovative Care- Includes Montessori Approach; Transformative Spaces and Program Evolution.
Magnet Employer- Recruitment and Retention; A Culture of Ambassadors; Elevating Appreciation and Community Engagement Initiative.
Senior-Friendly Community- Relationship Building; Problem Solving and Legacy Driven.
Integrated Campus of Care- Internal Expansion; External Inclusion and a Full Service Location.

SJCCC is pleased to share our 2024-25 Quality Improvement Plan (QIP) under the following themes:

1. Access and Flow:
-The % of ED transfers for a modified list of ambulatory care-sensitive conditions.
-The % of residents who were identified early who may benefit from palliative care.
2. Safety: We are reflecting on the following 3 modalities:
-The % of residents who fell in the 30 days leading up to their assessment.
-The % of residents without a diagnosis of psychosis who were given antipsychotic medications in the 7 days preceding the residents assessment.
-The % of newly admitted residents with cognition barriers who had 2 identifiers in place on the day of admission.
-Education to increase knowledge on administration of prn medications to reduce incidents of pain and behaviours.

ACCESS AND FLOW

SJCCC is proud to announce the completion of a brand new, state of the art rehabilitation space. This 2400 sq. ft. construction is a first of its kind in our area and will enhance the efficiency and effectiveness of our rehabilitation delivery model on the HDH side, but will also be an important part of the resident's physiotherapy experience who are living in LTC as well. The spacious area allows for multiple group sessions to take place which not only help to improve their strength and endurance but will also have a positive impact on mental health by decreasing feelings of isolation and loneliness. The Ministry of Health and Ontario Health are supportive of local initiatives to ensure people receive the right care, in the right place at the right time. Our new rehabilitation space is the perfect example of this model of care in keeping residents as healthy and conditioned as possible, thereby reducing avoidable ED transfers.

Reducing ED transfers and hospital admissions remains a high priority for our Home. A focus on increasing educational opportunities for preventative management will be explored at a higher level this year. Trends identified through quality data analysis will direct our team in formulating appropriate education modules and implement measures that will help in reducing avoidable ED transfers. SJCCC is fortunate to have a Medical Director and two full-time Nurse Practitioners on staff who are passionate about health teaching and mentoring. Increasing awareness on common chronic conditions known to increase the risk for preventable ED transfers and the importance in recognizing signs of exacerbation in the early stages will improve outcomes.

Task force committees were developed last year to review fall incidents and residents' experiencing significant changes to their health. These committees have proven to be beneficial in commencing treatments and interventions in a more timely manner.

EQUITY AND INDIGENOUS HEALTH

SJCCC is committed to reducing and eliminating disparities amongst diverse populations within our organization and community, through education and by providing a safe space for open dialogue.

All committee meetings begin with land acknowledgement as an expression of gratitude, respect and to honour indigenous heritage and culture.

SJCCC recognizes the importance of keeping the EDI dialogue flowing in order to foster lasting change. To achieve this, EDI is a standing item for discussion on all committee agendas and is also a topic during mandatory general orientation and annual education sessions. Volunteers must also partake in EDI education. To date, 88% of our employees within the organization have completed EDI training/education; employees on leaves account for the outstanding 12%. The expectation is that all employees must complete mandatory education prior to their return to work.

Cornwall is bordered to the south by Kawehno:ke (Cornwall Island) which is a part of the Akwesasne First Nation Territory. The people of Akwesasne are predominantly Kanienkehaka (Mohawk), and the official languages spoken are Mohawk and English. SJCCC recognizes there is much to be learned from developing an understanding, appreciation and incorporation of the holistic approaches to health and well-being that are traditionally a part of Indigenous health practices.

Cornwall lies within the Eastern Townships region, which is part of the 'Bilingual Belt' due to its close proximity to the province of Quebec. SJCCC practices "l'offre active" and has a French Language Services Team in place to maintain effective French language health services within the Centre and to ensure the continued availability, permanence and quality of these services. SJCCC provides services in the French language for those persons who prefer to communicate in French, including all forms of communication. The French Language Services (FLS) Team monitors the process of verifying the level of competence in French for new employees.

SJCCC recognizes holidays, cultural awareness days and holy days that span across many cultures through our social media page and recreational programming. Residents and patients have access to Rendever, a virtual reality platform for seniors which offers many cultural programs for residents to participate in through virtual activities.

SJCCC is proud to be a Catholic based organization that recognizes all faith denominations. SJCCC understands the importance in fostering the spiritual well-being for our residents and patients alike. Mass services are hosted by our resident Chaplin, and are well attended by residents and families. Residents have the option to attend in person, or via a live-streamed broadcast which they can enjoy from the comforts of their room.

Our Wellness and Spiritual Health Coordinator and Community Engagement Officer attend Community of Practice (CoP) sessions with Ontario Centres for Learning (CLRI), Research Institute for Aging (RIA) and Catholic Health International (CHI) and meet regularly with local supports to best identify where changes can be made and implemented.

CLRI Diversity and Inclusion Calendars are posted within the building and highlight days which may represent significant meaning for patients, residents, families and team members alike. Information on religious and spiritual days, cultural celebrations and health promotion days are posted on our electric signage and shared via email with our staff.

A Multi-Faith Reflection Room was implemented last year for employees in need of a quiet space to reflect, meditate or pray.

PATIENT/CLIENT/RESIDENT EXPERIENCE

St. Joseph's Continuing Care Centre (SJCCC) has two active and well-established councils that focus on resident and family experiences. Both councils meet at regular intervals to discuss important topics related to all aspects for seniors' well-being. These platforms allow for collaboration, advocacy and engagement with the common goal in improving the lives and experiences of our residents. SJCCC understands the importance in listening to the voices of those we care for, in order to make improvements allowing us to continue to provide exceptional care and quality service. The management team welcomes feedback generated through these committees, reviewing the concerns at the leadership level to bring forth resolutions. This process allows our team members to be an integral part in the resolution process with the ultimate goal in working collaboratively to provide excellence, innovation, safety and holistic approaches to care. The sharing of lived-experiences provides a basis for continuous quality improvements within our organization.

Residents, family members and stakeholders are asked to participate in the Accreditation process speaking on their own personal experiences.

Residents and families are encouraged to participate in the survey process. Survey completion and collection times have changed from annually to quarterly. This new process allows the organization the opportunity to address concerns on areas noted to have achieved lower survey ratings in order to work towards resolving issues in a more timely, efficient manner.

The Quality Improvement Plan is presented to the Resident and Family Councils for their review followed by a question and answer platform.

SJCCC is committed to continuous quality improvement initiatives as outlined in the 'Fixing Long-Term Act 2021' guidelines. Meetings to discuss QIP initiatives are held with all stakeholders in the Spring.

PROVIDER EXPERIENCE

SJCCC is fortunate to have so many dedicated and caring employees working at our Centre. This year, 41 exemplary staff members were celebrated at the annual employee service award ceremony. Together, they share 610 years of combined service! Three outstanding employees have been with the organization for over 40 years!

The Sister Rosalia Cobey award ceremony takes place annually in the spring. Last year, eight very deserving employees were nominated by their peers for their many acts of kindness and who live by the motto, 'Caring People, Helping People'. A new and exciting initiative for staff has been developed this year. The 'Gold Heart Award' will be given to three very deserving nominees who display compassion, dedication and leadership on their units.

Being a magnet employer is important to SJCCC and was highlighted as a goal on our 2022-25 Strategic Plan. Staff recruitment and retention strategies remain an integral part of that plan. Efforts in hiring and reducing staff turnover rates by fostering a positive work atmosphere, promoting engagement, and encouraging a healthy work-life balance are essential for retaining staff.

Healthcare workers are in high demand and SJCCC recognized that

changes to our recruiting and onboarding processes were necessary in order to meet the demands for hiring. A more timely approach in scheduling interviews and in making job offers to new hire prospects is now more important than ever with the competition and influx of job opportunities that are available within the healthcare sector.

A new survey was created geared towards new employees experiences during the first few months of hire. The survey results are reviewed by HR and the leadership team to look at exploring ways to better support new hires in the early phases of employment, thereby improving retention rates.

General orientation days increased to twice monthly, enabling new staff the opportunity to commence working much sooner. Orientation learning modules are available online for flexibility and convenience.

SJCCC recently recruited a part-time Infection Control Resource Nurse to assist the IPAC lead. We are also very fortunate to have two full-time Nurse Practitioners at our Centre.

Funding for education and career advancement is available via the Bridging Educational Grant in Nursing (BEGIN) program. A number of our employees have taken advantage of this incredible opportunity.

Ensuring our team members have access to the proper tools that are necessary to perform their job effectively and efficiently is important. This past year SJCCC invested in upgrading our vital sign towers and IV pumps, replacing outdated models. The Centre also purchased a portable bladder scanner unit. This scanner will help to improve patient outcomes by identifying issues with urinary retention, reducing risk for infection
that may help reduce avoidable ED transfers.

Worklife Pulse Committee identifies opportunities to enhance work-life balance for employees. Staff appreciation meals and events such as bowling and skating parties were just but a few of the many social events that were organized for employees and their families. Staffing polls and surveys were forwarded to staff for their input on suggestions that will enhance work-life balance and wellness in the workplace.

The Hub is a unique space based on a micro market concept and is a place for staff to refuel and recharge when at work. Hot beverages from the specialty coffee bar are available free for staff working on statuary holidays, as a way to show our appreciation for all they do!

Wellness and Nutritional Workshop classes were introduced last year. These workshops help foster healthy lifestyle options for nutrition, creating a positive mindset and incorporating physical movement to aid in supporting mental health and well-being.

A Reflection Room® is available for staff to use when in need of some quiet time to reflect, gather thoughts, meditate or pray.

Policies on workplace psychological health and safety and disconnecting from work are in place. These policies are important elements in ensuring the well-being of our staff and for creating a positive work-life balance for all employees.

All staff have access to the Employee Assistance Program.

Weekly House Huddles was initiated in the fall. The purpose of these huddles is to provide a platform for staff to speak on challenges they are encountering on their units, as well as areas where they feel they are excelling in. The intent is to share successes and ideas for resolutions to problems and for process improvements.

Quarterly Town Hall meetings led by the ED of the home are held quarterly . Discussions are surrounding operations, recruitment and retention initiatives and reviewing survey results.

SAFETY

St. Joseph's Continuing Care Centre strives for the highest standards in quality care for residents and patients surrounding medication safety management. SJCCC took part in the Medication Safety Technology Program geared to enhance technologies and strengthen medication safety in Long-Term Care. Many initiatives have already been implemented with the funding received, such as TaperMD; ePrescribing 2.0 and the installation of barcode scanners on all medication carts. This year, funding will go towards purchasing two automated medication dispensing cabinets which will further enhance medication administration safety.

CADD infusion pump training was implemented this year. Programmable pumps offer a safer, more consistent delivery of pain medication for residents receiving palliative care. Continuous

and intermittent doses reduce lag times in administration, ensuring the resident's comfort. This device also eliminates the need for multiple syringe draws, thereby reducing the risk of narcotic related medication errors. This process also eliminates the need to conduct double signage drug waste.

Pointclickcare has invited our organization to partake in a pilot project to trial their Laboratory and Imaging Integration software. Integrated lab and imaging ordering eliminates fax and manual follow up that can delay order processing and results capture. Notification alerts are sent to the care providers when results arrive and are easily accessed from the resident's dashboard.

All medication incidents including near miss events are entered into Point Click Care (PCC) Risk Management system. Incidents are reviewed and investigated by the Quality Lead to determine the level of risk involved to the resident/ patient and root cause analysis. Medication errors are reviewed with the staff involved and strategies are provided to prevent future incidents. Medication related quality statistics are posted on the PCC bulletin boards at the end of each month for staff to review. Medication errors are discussed quarterly at the Joint Pharmacy and Therapeutics and the Quality Improvement Committee meetings.

POPULATION HEALTH APPROACH

SJCCC is proud to be affiliated with The Great River Ontario Health Team (GR OHT). The Team collaborates with other local health and service providers in order to improve the healthcare needs of the population we serve within our community.

In the beginning stages of OHT development, our Home hosted a meeting, inviting other LTC Administrators from the community and region to generate important conversations, share experiences and to foster positive collaborative relationships between like-minded individuals. A strong correlation has been formed with our Akwesasne partners, thus, providing the team with invaluable insight on areas of focus to better support the indigenous population.

The Executive Director for SJCCC chairs the GR OHT Finance Committee; participates at the French Language table and participates on the Steering Committee and Collaboration Council. Other representatives from our organization are also present at the committee table.

The Great River OHT Steering Committee and Collaboration Council developed a Frailty Project Team to provide information, guidance and co-design expertise in support of the OHT mandate to improve healthcare for older adults; with the ultimate goal to improve care, provide safe solutions and support to delay admission into long term care for as long as possible. Programs that are offered through Hotel Dieu Hospital assist to facilitate this mandate in keeping seniors in their homes longer. SJCCC slow paced rehabilitation program is a progressive, dynamic and goal-oriented program which aids in improving ones functional ability while working towards facilitating a safe transition back home or to a retirement setting.

Remote Care Monitoring (RCM) is an enhancement and extension of our rehabilitation program. Patients are monitored on a 'virtual ward' with the use of tablet devices allowing patients the opportunity to reach out to the RCM team members with concerns for up to 30 days post discharge from the physio program. This

program has been instrumental in preventing avoidable ED visits as well as re-admissions back to hospital. SJCCC admits over 400 patients per year into the rehab program with an average length of stay of 45 days. The RCM program works closely with many community partners, such as Geriatric Emergency Management (GEM) and with the Paramedics Falls Program. Approximately 25% of the RCM referrals come from the Paramedics program, 25% from surrounding hospitals and 50% are from our rehabilitation program. Typically there are approximately 40 patients at any given time on the virtual ward.

Great RIVER ONTARIO HEALTH TEAM

ÉQUIPE SANTÉ ONTARIO DU Grand FLEUVE

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 28, 2024**

Paul Desnoyers, Board Chair / Licensee or delegate

Gizanne Lafrance -Allaire, Administrator /Executive Director

Matt Despatie, Quality Committee Chair or delegate

Lynn Theriault, Other leadership as appropriate

Access and Flow | Efficient | Priority Indicator

Indicator #4	Last Year Performance (2023/24)	Last Year Target (2023/24)	This Year Performance (2024/25)	This Year Target (2024/25)
Rate of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents. (St. Joseph's Continuing Care Centre)	12.50	12	24.23	15

Change Idea #1 ☑ Implemented ☐ Not Implemented

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

Process measure

- Potentially avoidable

Target for process measure

- 100% of ED transfers will be tracked, analyzed and reported to key stakeholders for trends to further improve this metric.

Lessons Learned

100% of all ED transfers were tracked and analyzed for trends by the Quality Lead. Statistics are reviewed at monthly PAC meetings and are posted on the PointClickCare electronic bulletin boards for staff to review. Will continue with this initiative.

Change Idea #2 ☑ Implemented ☐ Not Implemented

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

Process measure

- The number of residents who were sent to the ED as a result of a fall.

Target for process measure

- 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.

Lessons Learned

The number one reason for ED transfers continue to be in relation to falls; accounting for 8.8% of preventable ED transfers. Falls Task Force meetings were created to help reduce the rate of fall and to mitigate injuries. This initiative has proven to be successful and therefore will continue.

Change Idea #3 ☐ Implemented ☑ Not Implemented

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.

Process measure

- 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.

Target for process measure

- Goal was set for 90% last QIP. Will continue to strive for the 90% mark as previously set.

Lessons Learned

The plan was to introduce the talks for this at the point of admission; however this is not consistently being done. A barrier to initiating this conversation is that staff find there is a lot of information to cover at the point of admission and there isn't enough time to discuss.

Change Idea #4 ☑ Implemented ☐ Not Implemented

This past year we created a Falls Task Force to review resident falls and implement fall strategies to mitigate injuries after the Home experienced higher than normal rate of fractures as a result of falls.

Process measure

- No process measure entered

Target for process measure

- No target entered

Lessons Learned

Task Force meetings have proven to be beneficial in reducing fall rates and injuries since its conception and therefore we will continue with this initiative.

Comment

Target not achieved; therefore will continue to work toward meeting the provincial average.

Access and Flow | Timely | Custom Indicator

Indicator #3

Percentage of residents with life-limiting illness who have had their palliative care needs identified early through a comprehensive and holistic assessment. (St. Joseph's Continuing Care Centre)

Last Year		This Year	
CB	**80**	**80**	**NA**
Performance (2023/24)	**Target (2023/24)**	**Performance (2024/25)**	**Target (2024/25)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

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

Process measure

- Percentage of residents who

Target for process measure

- Aim is for 80% of residents with deteriorating health to be assessed and identified earlier on during the palliative journey.

Lessons Learned

Performance in this category in identifying residents who would benefit from palliative care early in their trajectory showed a steady increase throughout quarters 1-3. Q1 was at 63.3%, Q2 increased to 72.7% and in Q3 we met our 80% goal. Initiating bi-weekly huddles to review residents who noted to have a significant change and/or functional decline helped to increased awareness and initiating changes to the plan of care earlier in the process.

Change Idea #2 ☑ Implemented ☐ Not Implemented

More timely conversations with residents concerning a palliative approach to care and EOL care.

Process measure

- % of residents that had documented conversations regarding the EOL wishes.

Target for process measure

- 100% of residents will have had documentation surrounding discussions on palliation and EOL at their 6 week post admission.

Lessons Learned

More timely conversations with resident's and SDMs increased as a result of the huddles.

Comment

The Home will continue to improve in this category with a new target of 85%.

Experience | Patient-centred | Custom Indicator

Indicator #2

Percentage of residents who responded positively to the statement, "My pain is properly controlled". (St. Joseph's Continuing Care Centre)

Last Year		This Year	
CB	**96**	**96.60**	**NA**
Performance (2023/24)	**Target (2023/24)**	**Performance (2024/25)**	**Target (2024/25)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

Improve residents' pain control outcomes using BPG to improve their quality of life.

Process measure

- The percentage of residents who have had a pain assessment within 24 hours of their admission.

Target for process measure

- Results of this intervention will be reflected in the Residents Survey results.

Lessons Learned

All residents have a pain assessment completed on their chart, however, only 55% of residents had a pain assessment done within 24 hours of admission. Despite this the survey results were positive indicating 96.60% of residents felt their pain was well controlled.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Biweekly huddles was initiated for residents exhibiting pain and/or behaviours this past year.

Process measure

- No process measure entered

Target for process measure

- No target entered

Lessons Learned

Chart reviews were conducted with the interdisciplinary team members for residents experiencing significant changes to their condition, as well as those on a palliative trajectory.

Comment

Target exceeded therefore will focus our efforts on utilization of prn medications.

Safety | Safe | Priority Indicator

	Last Year		This Year	
Indicator #1 Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment (St. Joseph's Continuing Care Centre)	**17.92** Performance (2023/24)	**14** Target (2023/24)	**16.98** Performance (2024/25)	**14** Target (2024/25)

Change Idea #1 ☐ Implemented ☑ Not Implemented

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

Process measure

- The number of residents on antipsychotic medications without a dx of psychosis.

Target for process measure

- 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%.

Lessons Learned

14% target not met. Decline in performance noted as in the previous year. Will explore alternative methods to lower this metric. Will review numbers of residents per units on antipsychotic medications per unit, rather than percentage building wide.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Encourage staff to trial alternate non-pharmalogical interventions prior to administering prn antipsychotic medications to manage responsive behaviours.

Process measure

- Percentage of residents with responsive behaviours who are followed by BSO/ Montessori and have documented non-pharmacological interventions added to their care-plan.

Target for process measure

- 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.

Lessons Learned

Change Idea in place- Interventions for are in place for all residents who are followed by BSO.

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

Increase education and awareness concerning management of responsive behaviours.

Process measure

- The number of staff who have attending training courses for residents with responsive behaviours.

Target for process measure

- Target of 25% was set for staff attendance in training sessions however only 17% of staff participated in the training last year.

Lessons Learned

GPA full sessions have resumed and refresher courses are also offered.

Comment

The Home will continue to strive for continuous improvement with a goal to eventually reach the provincial average,

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)	24.23	15.00	The Home did not meet the projected target of 12.0%, likely as a result of influx in fall rates.	

Change Ideas

Change Idea #1 Tracking of trends for avoidable transfers will be completed weekly.

Methods	Process measures	Target for process measure	Comments
Quality Lead to monitor, track and log the ED transfers and report results monthly at PAC and multidisciplinary meetings as well as the weekly Nursing Huddle resident reviews. ED transfer statistics are posted monthly on the PCC electronic bulletin boards for staff to review.	Trends seen with avoidable ED transfers	100% transfers to the ED will be tracked, analyzed and reported when trends are seen.	ED transfers related to falls will be tracked under the indicator % of falls.

Change Idea #2	Monitoring of frail residents and residents having a sudden change to their health status on the onset to initiate prompt medical follow up and access to treatments sooner.		
Methods	Process measures	Target for process measure	Comments
Review progress notes shift reports to flag residents showing signs of decline and a significant change and report findings to NP/MD. Nursing huddles held weekly to discuss frail residents and sudden declines to residents health. A review of the ED transfers that occurred are reviewed.	Residents at the onset of decline who were assessed by medical staff.	100% of residents noted to be showing a decline in health will be forwarded to medical staff for review during early onset.	

Change Idea #3	Provide education to staff on s/s of common chronic conditions to report to medical staff on the onset- to initiate more timely treatments in house.		
Methods	Process measures	Target for process measure	Comments
NPs and Pharmacy to provide appropriate education sessions on s/s of common chronic conditions to initiate prompt medical care.	The number of residents who were flagged early during an exacerbation so that medical treatment could be started in a more timely manner.	100% of registered staff will receive education on common chronic conditions to help reduce ED transfers.	

Measure - Dimension: Efficient

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Identifying residents early who may benefit from palliative care.	C	% / Residents	CIHI CCRS / Jan 2024- Jan 2025	80.00	85.00	The target of 80.0% was achieved in the 3rd quarter. Our new goal has increased to 85% per quarter.	

Change Ideas

Change Idea #1 To identify residents earlier in their palliative trajectory to improve comfort care outcomes. Complete the appropriate assessments and enter plan of care.

Methods	Process measures	Target for process measure	Comments
Review PCC CHESS and PSI scores; assess residents who are experiencing an increase in falls as this could be an indicator of frailty. Plan of care to identify comfort care approach and palliative care.	The percentage of residents whose palliative/comfort care needs were identified early.	We met our target of 80%. New target set at 85%	

Change Idea #2 Initiation of CADD pumps on LTC for palliative residents to optimize pain and symptom management.

Methods	Process measures	Target for process measure	Comments
CADD pump education and training to be provided to all registered staff.	Percentage of registered staff who received CADD pump training	100% of registered staff to receive the appropriate training.	

Experience

Measure - Dimension: Patient-centred

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Education on administration of prn medications to reduce pain and behaviours will be provided to all registered staff.	C	Number / Staff	In house data, InterRAI survey, NHCAHPS survey / April 2024- Dec 2025	CB	100.00	All registered staff will be provided training on prn medication usage to manage pain and behaviours to improve outcomes.	

Change Ideas

Change Idea #1 Education objectives for PRN medication usage will be developed and reviewed with all registered nursing staff.

Methods	Process measures	Target for process measure	Comments
NP to develop educational objectives for registered staff concerning PRN medication administration to improve pain and behaviour outcomes.	The percentage of staff who received education on prn medication.	100% of registered nurses will receive education on PRN medications for pain and behaviours.	

Safety

Measure - Dimension: Safe

Indicator #4	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	16.55	13.00	Target performance is based on the Provincial rate.	

Change Ideas

Change Idea #1 A reduction in fall rates- goal to be lower than the provincial average.

Methods	Process measures	Target for process measure	Comments
Conduct audits, analyze for trend and root cause of falls. Implementation of RNAO Best Practice Guidelines for falls prevention strategies and the information obtained at the RNAO Gap Analysis workshop for prevention of falls in older adults. Maintain Fall Huddles to discuss residents who have a higher than average fall	Percentage of falls quarterly.	Precentage of falls will decrease to 13%.	This initiative is also in line with the Homes plan to reduce avoidable ED transfers and falls rank the highest of preventable transfers for our Home.

Change Idea #2 Implementation of RNAO-BPG for falls prevention. Falls were identified as the top reason for avoidable transfers in our Home.

Methods	Process measures	Target for process measure	Comments
Initiate strategies obtained through RNAO BPG and the Gap Analysis Workshop for prevention of injuries from falls in older adults. Strategies such as ensuring residents at high risk for falls are all considered for bone strengthening medications, implementation of hip savers garments and donning of proper, non slip footwear.	The number of residents sent to the ED as a result of a fall.	100% of fall incidents will be reviewed by Quality Lead and brought forth to the OT/PT/MD/NP for review and assessment. Fall stats will also be reviewed at the Fall Task Force Huddles.	100% of fall incidents will be reviewed by Quality Lead and brought forth to the OT/PT/MD/NP for review and assessment. Fall stats will also be reviewed at the Fall Task Force Huddles.

Measure - Dimension: Safe

Indicator #5	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	16.98	14.00	Did not meet target of 14.0. Will shift focus on improving current performance by exploring new initiatives and strategies in order to improve outcomes.	

Change Ideas

Change Idea #1 Identify residents who were prescribed antipsychotic medication without a diagnoses of psychosis and continue efforts to deprescribe when able.

Methods	Process measures	Target for process measure	Comments
RAI Coordinator and Quality Lead continue to audit residents charts, PCC risk management incidents and RAI-MDS to determine the reasons for antipsycotic medication usage. Information is provided to the MD/NP for their review and consideration for deprescribing.	The number of residents on antipsychotic medicationss without a dx of psychosis.	Target not reached however a decrease from previous QIP was noted. Previous performance was 17.92 and we are currently at 16.98%	

Change Idea #2 Trial alternate non-pharmalogical interventions as first line in lieu of administrating antipsychotic medications to manage responsive behaviours.

Methods	Process measures	Target for process measure	Comments
Trial use of GPA strategies and assess response being mindful of approach. BSO/Montessori to provide support and recommendations in order to manage behaviours and enter those that are effective onto the plan of care. Trial sensory stimulation (Snoezelan room), warm blanket, music therapy, distraction and allow residents to calm prior to reapproaching.	Percentage of residents with responsive behaviours who are followed by BSO/Montessori and have documented non-pharmacological interventions in plan of care.	100% of residents with responsive behaviours without a dx of psychosis followed by BSO/Montesorri will have non pharmacological interventions entered into their plan of care.	

Change Idea #3 Conduct chart and eMAR audits for residents who have to identify residents who no longer require antipsycotic medications and request consideration for deprescribing when appropriate.

Methods	Process measures	Target for process measure	Comments
RAI coordinator to perform quarterly audits and prn to assess for coding accuracy. Review ABS score, review PCC risk management incidents for behaviours and those not displaying behaviours will be flagged for MD/NP review to consider deprescribing.	The number of residents with an order for antipsycotic medications that remains relevant.	100% of residents will have a full chart and medication review quarterly to determine if antipsychotic meds are still required and or appropriate.	Currently there are 28 residents on antipsycotic medication without a diagnosis of psychosis. Will try to work on strategies to decrease in this number every quarter.

Change Idea #4 Engage BSO to review potential triggers determined to cause responsive behaviours.			
Methods	Process measures	Target for process measure	Comments
BSO to review triggers and assist in implementing strategies to support staff in better managing responsive behaviours on units.	Number of residents assessed for triggers to behaviours by BSO.	All residents identified with orders for antipsychotic medications without a dx of psychosis will be assessed by BSO.	

Change Idea #5 Residents admitted with antipsycotic orders will undergo a med review at their post admission care conference to discuss tapering.			
Methods	Process measures	Target for process measure	Comments
MD/NP will review antipsycotic medications with the resident/SDM and make recommendations for tapering if deemed appropriate.	The number of newly admitted residents that have antipsychotic medications on admission that are reviewed and recommended appropriate for deprescrbing.	All new residents on antipsychotic medications will have a medication review at their post admission care conference meeting.	

Measure - Dimension: Safe

Indicator #6	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Identifier process in place for all residents with cognition impairments who are not able to communicate their name.	C	% / LTC home residents	In-home audit / Jan 2024- Jan 2025	CB	100.00	100% of residents with cognitive impairments will have a minimum of 2 identifiers to very resident's identity upon admission.	

Change Ideas

Change Idea #1 Newly admitted resident's with cognitive deficits to have a minimum of 2 identifiers to verify their identity.

Methods	Process measures	Target for process measure	Comments
During admission assess cognition of the resident and if they are not able to answer poised questions or responde/state name, then an identification bracelet must be applied and a photo of the resident is to be taken and uploaded onto the medical chart during the admission process. Add resident's name to Google Spreadsheet for ID Bracelets.	The number of residents requiring a bracelet due to cognitive deficits.	100% of residents will have 2 identifiers if they cannot state name.	