2023/24 Quality Improvement Plan for Ontario Long Term Care Homes

"Improvement Targets and Initiatives"

St. Joseph's Lifecare Centre 99 WAYNE GRETZKY PARKWAY, Brantford , ON, N3S6T6

AIM		Measure							Change				
Quality dimension	Objective	Measure/indicator	Unit /	Source / Period	Organization Id	Current performance	Target	Target	Planned improvement	Methods	Process measures	Goal for change ideas	Comments
Efficient	To reduce avoidable emergency department visits	Number of residents transferred to ED per quarter	%/Residents	CCRS, CIHI / Q4 22-23 (Baseline), compared with data from Q1-Q3 23-24	54507*	Q3 = 7 total ED transfers (3.5%); LHIN is 5.3%; Ontario average 6%	Reduce by 10% per quarter		1) Hire a full time Nurse Practitioner to support ED Avoidance	HR team to post job application on multiple forums and set interviews. DOC to review applicants to select a candidate who aligns with organizational values.	Continue to monitor number of ED visits, compare data before and after hiring NP.	Have a Nurse Practitioner on Staff Full Time by December 2023.	
									2) Providing Education to residents and families regarding existing challenges and risks with unnecessary ED visits	Using Community Nurse Practitioner as primary education resource. Putting education online to surge learning for those who were unable to attend live sessions. Will track completion through attendance and Surge Learning reports.	Provide education to families through family council and online educational resources and links via email/mail; Staff education regarding internal resources (NP/MD) to reduce ED visits	To have 90% of families (email list and mail out) and staff educated by end of Q2 - September 2023	
									3) Educate and empower nursing staff by stregthening assessment skills, timely involvement of MD, discussion with family re goal/plan of care	Respiratory Therapist - Proresp & Community Nurse Practioner to provide both in person and online training to registered staff.	Educating registered staff on respiratory assessment / chest assessment	To have 90% of Registered staff educated by end of Q2 September 2023.	
Patient-centred	Ensure residents feel they have a voice and are listened to by staff and feel they can speak up without fear of consequences		%/Residents	Resident Satisfaction Survey 2022 (Baseline) vs. 2023 Results; Accreditation Resident Survey	54507*	2021 Satisfaction survey question re: Dignity, "Do you feel the staff treat you with respect and dignity? For example, do staff take the time to listen to you and are staff helpful when you request assistance?"; 2021 Resident response: Yes - 70%, Yes, sometimes - 27%, No - 3%; Family Response: Yes - 66%, Yes, sometimes - 33%, No - 2%.	Target, to reach a minimum of 80% "Yes" in resident response to the aformentioned question surrounding diginity		1) Providing educational resources (ie., Phamplets, presentations,) to family and resident councel respectively, on resident advocacy; 2) Provide educational material to all new admissions starting in April 2023 regarding residents right to have a voice; 3) Provide education to staff via surge learning on residents right to speak up and the importance of providing a safe environment for residents to express needs/concerns	Using Advantage ontario resources and material from the Ministry of Long term care creating powerpoint, phamplets and fact sheets to present to families and use on Surge learning platform for staff	Number of residents and family who have received education/education resources	Provide a presentation to Both Familiy and residents counsel by end of Q3 December 2023	
											Have resident actively involved in post admission and annual conference. Add to admission checklist, audit to ensure materials are being issues to resident/family during admission.	Provide 100% of all new admissions after April 2023 with an informational pamphlet on residents right to have a "voice"	
											Social service worker hired full time time. Implement a resident wellness check/advocacy as part of routine role/tasks, monthly goal of minimum 10 residents	To have 90% of all staff educated via surge learning by the end of Q3 December 2023; Reach minimum of 10 resident wellness visits by SSW per month by December 2023	
Safety	Reduce inappropriate use of antipsychotics	Percentage of residents with Antipsychotic order with/without dx of psychosis		PAC report (CareRx), internal data collection / Q4 22-23 (Baseline), compared with data from Q1-Q3 23-24	54507*	Q2 - 26.45%; Ontario average 29.14%			Complete review with CareRx to determine and obtain a full list of residents with prescribed antipsychotics; Review each resident case with MD to determine if resident meets criteria for Dx of Psychosis; Discuss deprescribing for those who have PRN antipsychotics that have not been used in a period greater than 1 month.	Review quarterly at Responsive behaviours and antipsychotic reduction (RBAR) committee meetings, with CareRX and Facility RBAR team	Monthly Antipsychotic use reports	Reduce the overall number of antipsychotics used in the facility by 10% by December 2023	
										Have facility pharmacist review antipsychotic use quarterly and make recommendations to the prescribers about deprescribing	Quarterly Medication Review Audit provided by pharmacy	100% of residents will have medication reviews with the intent to look at decreasing antipsychotic use on a quarterly basis.	
										Implement education for all staff on assessment and non-pharmacological interventions	Obtain BSO referral numbers quarterly; RBAR committee meetings to be held quarterly; Assign Teepa Snow education and education on non-pharmacological interventions to Surge Learning; Have recreation therapist newly certified in Dementiability provide caregiver/staff support on non-pharmacological interventions.	Complete education for 90% staff on Surge Learning by September 2023	

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ST.JOSEPH'S LIFECARE CENTRE BRANTFORD

AIM		Measure								Change
Quality Dimension	Objective	dicator	Population	Period	Id	performanc	Target	justification	Priority level	initiatives (Change Ideas)
Safety	To Reduce Worsening	Percentage of residents	% / Residents	CCRS, CIHI (eReports) /	54481*	2.66	1	Provincial Benchmark	Improve	1)Accurate and completed 2)Completing Pressure
	To Reduce	Percentage	% /	CCRS, CIHI	54481*	6.38	3	The	Improve	1)Providing Education to
Effectiveness	To Reduce the Inappropriate Use of Anti	Percentage of residents on antipsychotics without a	% / Residents	CCRS, CIHI (eReports) / Q2 FY 2014/15	54481*	22.6	15	This is the first time we are looking at this category, an	Improve	1)1.) Use of Life Story to 2)2.) Use of Montessori 3)3.) Accessing BSOT, PRC, 4)4.) In house BSO and 5)Weekly Behavioural
Resident-Centred	Receiving and utilizing	Percentage	% /	In-house	54481*	CB	90	We are still	Improve	1)Currently collecting
		Percentage	% /	In-house	54481*	CB	90	This is our	Improve	1)Currently Lakeside does
	Receiving	Improving	% /	In-house	54481*	71	90	Our last	Improve	1)Improving Dining Room
Integrated	To Reduce Potentially Avoidable	Number of emergency department	% / Residents	Ministry of Health Portal / Q3	54481*	25.81	18	Provincial score is 23.82 we	Improve	1)1.) Collaborating with 2)Educating Families on 3)Use of Mobile Nursing

Methods	Process measures	Goal for change ideas	Comments
-Educate registered staff on how tool is	-# of staff using assessments,	-100% of residents will	
-Educating registered staff to complete	# of staff completing	100% compliance in	
Using in-house physio service to	% of POA/SDM who have	-1 in-service per year to	
1.) Life Story: Since January 2014	1.) # of Life stories on	1.) 100% completion	
2.) The use of regular Montessori	2.) # of residents who used	100% of residents	
3.) Lakeside has created a decision tree	3.) # of residents referred to	100% of care plans will	
4.) Education on Building a Behavioural	4.) # of referrals to in house	In House Behavioural	
-Using BSO Whiteboard on units	# of meetings held # of	-100% compliance on	
-Using InterRAI QOL Survey until	-Survey will be conducted	100% of residents who	
-Conducting survey with all residents	-Survey will be completed	100% of surveys to be	
We have looked at dining room	# of improved scores on	-Improve overall dining	This area
-Providing education to staff on	# of residents with decreased	100% completed	
-Education from Ethicist at UHN on	# of residents going to ED	-1 Education Session	
-Educating staff of resources available -	# of referrals to Mobile	100% education	