Quality Improvement 2023-24: A Year in Review

St. Joseph's Lifecare Centre

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Contents

Preamble

St. Joseph's Lifecare Centre (SJLCB) is the largest Long Term Care Home in Brantford & Brant County comprising of 205 beds. We are inspired by the legacy of our founders, the Sisters of St. Joseph, who are dedicated to compassionate, person-centred care.

St. Joseph's Lifecare Centre is a proud partner in the St. Joseph's Health System. Along with system partners, St. Joseph's Lifecare Centre, Brantford; St. Joseph's Villa, Dundas; St. Mary's General Hospital, Kitchener; St. Joseph's Health Centre, Guelph; and St. Joseph's Home Care, Hamilton, St. Joseph's Healthcare is one of the largest corporations in Canada devoted to healthcare and known for genuine compassion and caring, locally and around the world.

Quality Improvement 2023-24: A Year in Review is the result of the concerted effort of leaders at SJLCB committed to excellence and dedicated to quality care. The report is compliant with The Fixing Long-Term Care Act 2021(Sections 42 and 43) and Ontario Regulation 246/22 (Part III).

Quality Management System

St. Joseph's Lifecare Centre Brantford (SJLCB) is committed to safety and quality at all levels. The quality management system is guided by the six quality dimensions- **safe, timely, effective, efficient, equitable, and patient centered (STEEEP)**.

Patient safety is a key component of quality management system at the Campus. The Campus supports the identification, reporting, investigation, and addressing of critical incidents/sentinel events.

Quality and safety metrics are reported to the operational quality committee- Continuous Quality Improvement (CQI) Committee to monitor and report on quality improvement initiatives. The aim is to transition to an Integrated Quality Management system that incorporates risk management; performance measurement, safety metrics and quality improvement.

The CQI committee makes recommendations and endorses quality improvement initiatives for SJLCB. Reports and recommendations are presented to the Quality, Mission and Ethics Committee of the Board (QME).

The Quality Management System is guided by policy # 1-QL-27 and framework included in in the Appendix A. The CQI Workplan is enclosed in Appendix B.

Integrated Risk Management

SLJCB is committed to identifying, assessing, prioritizing, and managing actual and potential risks effectively and efficiently with the goal of continuous improvement. SLJCB uses Healthcare Insurance Reciprocal of Canada (HIROC), risk register to systematically identify, assess, track, and manage key organizational-wide risks. The process ensures that client care is improved through risk mitigation measures which includes clinical, financial, and organizational risks.

Risk identification is inherent in safety management. Client safety incidents, complaints, claims, publicly reported quality, and safety metrics are deliberated at the unit level and program level and potential risks identified. Accreditation and ministry regulatory requirements are also taken into consideration.

Corporate level risks are reported to the Continuous Quality Improvement Committee and then to the respective subcommittees of the board on a quarterly basis. Operational risks are monitored and managed at the department and program level under the oversight of DOC, ADOC and Clinical Managers of LTC and Hospice and reported to the Campus of Care monthly.

The link between risk, quality and safety is shown below:

Fig. 1. Adapted from Healthcare Insurance Reciprocal of Canada (HIROC), 2023

Key learnings from incident management, complaints and claims are shared with staff, promoting a safety culture with early detection and mitigation of threats.

The top risks for the organization and mitigation strategies are included in the appendix, figure 3. They include:

1. Risk of not attracting and retaining top talent
2. Risk of health care associated infections and outbreaks
3. Risk of aging buildings and lack of resources for maintenance or redevelopment

Please refer to Appendix C for the Integrated Risk Management Framework and Appendix D for the Corporate Risk Report.

Program evaluations

Annual program evaluations are conducted in a cyclical manner to assist in identifying gaps and prioritize initiatives for improvement ensuring quality of life and safety for residents. The program evaluation template is enclosed in Appendix E. The list of program evaluation conducted in 2023-24 is provided below:

	Required Programs	Date of presentation
1.	Nursing and Personal Support Services	June 2023
2.	Pain Management	June 2023
3.	Responsive Behaviours	June 2023
4.	Infection Prevention and Control (+ Pandemic Plan)	June 2023
5.	Palliative Care	August 2023
6.	Restorative Care/Physiotherapy/OT	August 2023
7.	Abuse and Neglect	August 2023
8.	Staffing Care and Services (Staffing Plan)	August 2023
9.	Information and Referral Services	October 2023
10.	Restraints and PASD's	October 2023
11.	Medication Management	October 2023
12.	Falls Prevention & Management (+Falling Leaf Program)	January 2024
13.	Skin & Wound Care	January 2024
14.	Continence Care and Bowel Management	January 2024
15.	Recreational and Social Services	March 2024
16.	Religious & Spiritual Practices	March 2024
17.	Accommodation services (EVS, Linen, Maintenance)	March 2024
18.	Volunteer Services	March 2024
19.	Dietary Services & Hydration	May 2024
20.	Medical Services	May 2024
21.	Education, Training and Development	May 2024
22.	Resident Bill of Rights (Dignity, Choice, Privacy & Collaboration)	May 2024
23.	Preventive Maintenance Program	May 2024

Summary of goals identified for 2023-24

Program	CQI successes 2023-24	Planned improvements for 2024-25

Infection Prevention and Control	• Education has been provided to residents, family, volunteers and staff regarding the importance of hand hygiene, on how to put on and how to remove PPE (personal protective equipment) and posted on the website Documents for Residents & Resident Families (sjlc.ca)
	• Resident Vaccination rate:
	  ○ Influenza- 93.7%
	  ○ COVID XBB- 86%
	  ○ RSV- 87.4%
	• Audits
	• HealthConnex App
		• New IPC program started in PCC in January 2024, now capturing all resident infections
		• Surety touchpoint cleaning auditing system - started in January 2024.
		• Medical equipment have Red/Green sliders to indicate whether dirty or clean.
		• IPAC Committee to initiate in 2024. Currently reported through the Health Professional Advisory Committee (HPAC).

Pain Management	• SPA-LTC – Palliative care study by McMaster is currently supporting our home in education and implementation of the Palliative Performance Scale (PPS), to better identify early indications of decline, significant change, and improve pain management. • Recently implemented morning huddles and risk rounds where we are better able to identify circumstances of new or worsening pain related to, end of life, significant change in status, etc. • Implementation of monthly risk rounds and daily nursing huddles • Review any indications of pain, new or worsening, significant change in status, discuss interventions, both pharmacological and non-pharmacological	SPA-LTC – Palliative care study. Increase pain audits, monitoring, treatments. Implement new significant change order set. To be reviewed with medication management committee.
Responsive Behaviours and Anti-Psychotic Reduction	Maintained the program 2022 for majority of the year.	Reinstate in-person multi-disciplinary education Increase purposeful activity of residents. Decrease in staff/resident injury related to responsive behaviour
Workforce Planning	• Implemented new policies related to Talent Management, Recruitment and Selection, Service Awards and Recognition, Performance Appraisal • Implemented biannual performance appraisals/performance enablement process • Conducted focus groups with front-line staff based off of the Worklife Pulse survey to gain more information on employee satisfaction, concerns and suggestions.	Reduce overall voluntary and unavoidable turnover Implement General Orientation Program

<table>
<tr>
<td>Prevention of Abuse and Neglect</td>
<td>
<table>
<tr><th>Quarter</th><th>Resident to Resident</th><th>Staff to Resident</th><th>Total reports submitted</th><th>Actions:</th></tr>
<tr><td>Q3 (Oct-Dec ‘22)</td><td>3</td><td>2</td><td>5</td><td rowspan="3">- For new/repeat resident incidents, increased safety protocols are applied
- Including 1:1, safety plan, violence assessment tool (VAT), yellow bracelets to better identify high risk residents.</td></tr>
<tr><td>Q4 (Jan-Mar ‘ 23)</td><td>2</td><td>1</td><td>3</td></tr>
<tr><td>Q1 (Apr-Jun ‘ 23)</td><td>4</td><td>1</td><td>5</td></tr>
<tr><td colspan="4">*Apr-Jun – Determined through investigation that 3 incidents were not substantiated.</td></tr>
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</td>
<td>Reduce the number of incidents in each quarter
Achieve compliance of 100% for online education in Surge Learning

Ongoing aim of zero non-compliance with the MOLTC in the area of Abuse and Neglect; Risk Rounds, morning huddles, ongoing audits: safety plans, Violence Assessment Tool (VAT)
Continue to increase care hours through hiring and through adding/filling new positions to mitigate the risk of abuse/neglect
Involvement of Residents/Families:

Resident and family Council meetings to include updates related MOLTC inspections/outcomes, staffing improvements, other nursing related updates
Frequent and ongoing communication with individual residents and families regarding any challenges or new recommendations identified in risk rounds, huddles, or from referrals/consults

Implementation of a Critical Incident and ministry inspection board for staff to gain more understanding and knowledge on compliance as well as how they play a role and what they can do to help.

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<tr>
<td>Palliative Care</td>
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Creation of interdisciplinary Palliative Champion Team (PCT)
Staff training & empowerment
11 palliative care conferences with residents and caregivers
Strengthening post-bereavement care for families

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Ongoing palliative care conferences (3-4/wk.)
Ongoing staff training (palliative approach, online modules, PPS score education)
Building in sustainability through staff mentorship/palliative leads
Establishing Comfort Care rounds (CCRs)

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<td>Physiotherapy</td>
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Significant reduction in falls from Q1 and Q2
Regular post fall assessments completed
Regularly attended post fall huddles or contributed feedback for fall huddles

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Promote active Lifestyle
Improve status on post-surgery/post fracture

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<tr>
<td>Restorative Care/Nursing Rehabilitation</td>
<td>• Increased falls prevention equipment stock due to falls funding (alarms, bolsters, anti slip socks, adapters, mats, wedges, beds etc.)
• Loaned mobility equipment pool reduced significantly (increased purchasing & rentals through Action Medical)
• Preventative Maintenance completed with Arjo 2022 on all mechanical lifts
• Comprehensive sling audit completed and SJLC audit sheets updated
• 2 new tubs to be installed – 2022 – delay related to flooring replacement need. Rescheduled for early 2023</td>
<td>• Ongoing training to new Restorative staff on Bed entrapment/testing/ “marrying” the bed systems
• Transition from regular full sling to “all day slings” for skin integrity & comfort
• Request ARJO training on sling choice as per resident’s needs
• Continue to upgrade aging equipment through Capital budget.
• Continue reducing loaned mobility equipment.
• Put admission sleep questionnaire online PCC and automatic merge to Progress Note.</td>
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	• New wheelchair scale – October 2021 Kinks worked out & program running smoothly by Spring 2023 • Entering RAI/MDS data to improve accuracy	• Update Restorative interventions that can be triggered in PCC Care plan • Merge Fall Progress assessment into a Progress note (reduce repetitiveness & time-consuming duties) • Update Wheelchair scale policy • Reduce Restraints and continue to educate family & staff on the risks. • Continue to liaison preventative maintenance contracts with ARJO
Medication Management	-Utilized MST funding to purchase an Automated Dispensing Cabinet for our emergency supply box -Completed 2023 MSSA in August 2023 with increased involvement from interdisciplinary team and scored improved from previous years. -An electronic medication incident reporting platform was launched at the end of February 2023, this has improved accessibility to reporting medication incidents, with platform links located on each nursing desktop. Incident reporting has increased allowing us to get a more realistic snapshot of the issues staff are facing in the home thus having more areas to improve for better patient safety.	• Reduce medication incidents relating to antibiotic omissions • Create better communication channels to residents and families surrounding the medication management program. – Through bi-monthly newsletter handouts to resident and families and involvement in family council representation and / or resident council representation at our 2024 MSSA • Improve registered staff knowledge around medication management and best practice standards – Through the implementation of RNAO best practice clinical support tools on PCC to be implemented starting in January 2024
Restraints and PASDs (Personal Assistance Service Device)	• Bed Entrapment Assessment completed on admission, significant change and/or bed system change. • Annual bed entrapment review of bed systems for safety of Rails. • Seatbelt Restraints – Registered staff review daily via EMAR & Restorative reviewed quarterly with SDM and RHA staff to determine removal. PSW staff review daily via POC. • Restraints and PASDs are discussed daily during nursing huddle in the morning, to address any newly initiated Restraints/PASDs, related updates- complications, discontinuation, f/u. • Restraint/PASD Monitoring to aid with reporting to HPAC/Committee meetings. • Standing Doctors Orders Audit – biannually for accuracy • Surge Learning Education	• Update the language when referring to “bed rails” currently to “assist bars”. • MD orders for PASD (for ex. tilt w/c) • Decrease the number of restraints used in the home.
Information and Referral Services	Digital admission package that can be sent directly to family prior to admission to reduce the stress/time of admission day process – A scanned in copy is now available to be sent via email to families to complete.	• Continue to update/change/lessen the paperwork required at admission • Update the “Getting to know you” forms currently in use during admission – with feedback from families and residents - to better capture information that is important to the resident and family, to ensure we can provide access to the right services for individual residents.
Continence Care and Bowel Management	TENA portraits are being completed on the computer. Product review was done by Paula through lunch and learn – review of how to complete TENA portrait assessments on the computer.	• Address individual needs and preferences with respect to continence of the bladder and bowel and bowel management.

	Random TENA audits completed to see if residents are in the correct product.	• Promote learning about best practice continence care. • Monitor and evaluate resident outcomes and product effectiveness. Product review done yearly with staff. • Continue with TENA assessments. • Maintain good skin care and no related skin issues due to continence products. • Have TENA reps on all shifts to help with direct communication about any issues/challenges for residents and staff.
Skin and Wound Care	-Skin and wound care committee meetings were revamped and reinitiated in March 2023 with meetings occurring quarterly. High interest in joining the committee from nurses and PSW's. -A skin and wound program education pamphlet was created for residents and their families surrounding the skin and wound care program and Pressure injury prevention. This was created in November of 2023. -3 Registered staff successfully completed the Conestoga College essentials to wound care course in March of 2023, 1 Registered staff member successfully completed the York University practical wound care for nurses and received advanced wound care certificate. -A full time Nurse Practitioner was hired in May of 2023. **All CIHI quality indicators have decreased over the past year **	• Continue to educate more registered staff on the essentials of wound care course provided by Conestoga college to increase wound care assessment skills. • Hire a full-time wound care nurse to lead the wound care committee and support front line staff with complex and chronic wounds. • Creation of a standardized treatment guide for registered staff to refer to when providing treatments for different wound types (i.e.., Pressure ulcers, arterial vs venous ulcers, diabetic, etc.).
Falls Prevention	1. The Post Fall Assessment is currently being looked at by the clinical management team and RAI to create a structured assessment that can be created into a progress note to reduce double documentation, this will be a goal in 2024. 2. Restorative Care Referral assessment went live on June 1st, 2023. 3. Purchased equipment 2023: 1 protective helmet, 12 sensor pads, 3 hi-low bed frames, 10 hip protectors, 100 nonslip socks, 10 seat alarms, 10 bed alarms, 10 pull cord alarms, 2 fall mat alarms, 4 transfer poles, 1 anti slip shower mat, 10 bed wedges. 4. 3 hi-lo bed frames were purchased in 2023. *12% decrease in falls in 2023 from the previous year *	• To reduce the quality indicator of residents who have fallen in the last 30 days to 23% (Currently SJLC is 27.7%, LHIN – 17.4%) By the end of December 2024. • Re-implement post fall huddles with the interdisciplinary team at least twice a month beginning in January 2024. • Create and Launch the Post fall assessment UDA that will make a structured progress note by the end of September 2024 • Collaborate with Resident & Family councils to create a quarterly communication surrounding fall statics and / or fall education resources. Continue to utilize falls funding to purchase fall prevention equipment
Volunteer Program	Volunteer total hours for 2023 = 16587 These hours were accumulated in 2617 visits. From an active volunteer pool of 75 individuals. Volunteer Christmas open house celebrated on site appreciation. This was the first on site group recognition event since the onset of the pandemic.	• Create a volunteer email distribution list for updates and communication. • Increase Tuck shop volunteers potentially expanding hours open. • Continue to monitor feedback from residents and family members to place volunteers with residents requesting one to one visit as possible. •

<table>
<tr>
<td>Spiritual Care</td>
<td>Organized spiritual programming totals provided over the course of 2023.

Church services for 2023
<table>
<tr><td>Total Residents</td><td>143</td></tr>
<tr><td>Avg # Part / Offering</td><td>25.54</td></tr>
<tr><td>Avg Part. Score</td><td>2.79</td></tr>
<tr><td>Total Offerings</td><td>52</td></tr>
</table>
Bible Study for 2023
<table>
<tr><td>Total Residents</td><td>17</td></tr>
<tr><td>Avg # Part / Offering</td><td>5.39</td></tr>
<tr><td>Avg Part. Score</td><td>2.94</td></tr>
<tr><td>Total Offerings</td><td>28</td></tr>
</table>
Catholic Mass for 2023
<table>
<tr><td>Total Residents</td><td>69</td></tr>
<tr><td>Avg # Part / Offering</td><td>17.33</td></tr>
<tr><td>Avg Part. Score</td><td>2.84</td></tr>
<tr><td>Total Offerings</td><td>21</td></tr>
</table>
Hymn Sings
<table>
<tr><td>Total Residents</td><td>197</td></tr>
<tr><td>Avg # Part / Offering</td><td>7.22</td></tr>
<tr><td>Avg Part. Score</td><td>2.54</td></tr>
<tr><td>Total Offerings</td><td>239</td></tr>
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Maintain programming seeking feedback on services of choice through various listed resources from Families and Residents.
Reinstate quarterly memorial services to honor residents we have lost.
Work with spiritual care team at Hospice to build a list of spiritual connections in the community to utilize as resident/family requests.

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<tr>
<td>Accommodation Services</td>
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To maintain a consistent high level of service, providing a safe, clean, sanitary, comfortable environment for all residents. Information exchange and updates with residents and families are maintained through open lines of

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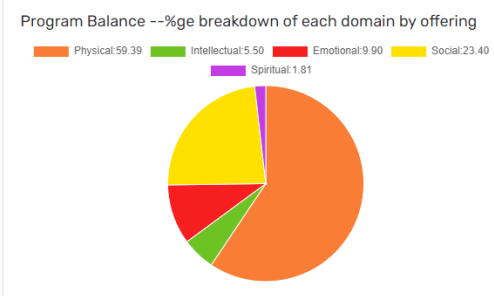
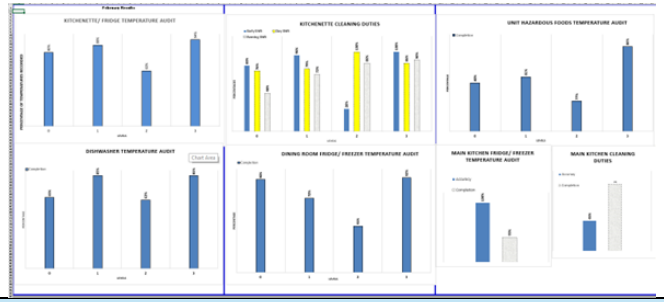
		communication both informally and through Family Council meetings.
Recreation Program	Programs for 2023 Total Offerings This Period 5884 	• Implement satisfaction surveys utilizing activity pro for data collection in group program feedback in real time. This will add another opportunity for resident feedback.
Dietary Services	Current stats for April are (targets): High risk 4%(3%), pureed 14.5%(10%), minced 11.5%(20%), thick fluids 5.5%(4%), supplements 10.5%(6%), total undesirable weight loss 15/7.5%(4-7%). Only 4 of the weight loss are new and the remainder are residents that lost weight and have since stabilized with interventions. 	Food Service – 1) Simplify diets 2) Focus on ensuring residents receive the interventions needed to enjoy their desired quality of life 3) Continue open communication with both residents and families, including monthly food committee meetings and bi-annual residents council attendance. Clinical – 1) To continue to reduce weight loss 2) Reassess need for altered textures 3) Improve tracking of interventions
Medical Services	- Introduction of PCC SecureConversations and PractitionerEngagement - Addition of NP role in June 2023 - Updated admission order set, standing orders, addition of naloxone orders Annual physicals – 2023: 29 with in progress/errors (13%); 7 incomplete (3%)	1) Update annual physical form on PCC 2) Hire second NP to help support existing medical services 3) Implement BOOMR services this year to facilitate timely, secure communication between team members
Education, Training and Development	General orientation completion rate 72.5% Department specific completion rate - 80%	Education is decentralized. Each department/program manager is responsible for the course content for their staff. Plan for next fiscal:

		• Managers to review course load and provide suggestions to add/remove content • Encourage 100% completion rate for courses that are mandated and program specific • Ensure course content are tailored per program requirements
Preventive Maintenance Program	8 new hi/low bed frames (replaced old frames that were not hi/low) 2 of these beds are extra long to accommodate tall residents. (March 14th 3 Frames & Sept 15th 5 New frames) 6 new floor lift batteries (plus 6 new with new equipment) Beds Physical condition Sept 19th/20th Audit – new head/foot boards, wall bumpers, hand controllers replaced in October. January 2024 – Blood Pressure machines sent out for PM & Calibration	Facility Assessment slated for 2024 Change ARJO services from bronze service package to all inclusive Gold package Review Maintenance Portal tasks related to bed repairs and lift equipment repairs 2x a year. Contact Maintenance Care portal Help centre to learn how to add PM job tasks and run reports Add Lifting equipment and Bed Audits to Maintenance portal for tracking purposes Determine economical solution for head of bed being pushed up too close to walls damaging call bell system when bed being moved up/down UPDATE Policies and develop new polices as needed Add BP machines to bi yearly – Calibration and PM service reminder in Maintenance care portal
Resident Bill of Rights (Dignity, Choice, Privacy & Collaboration)	• Residents' Bill of Rights are displayed at the entrance of each Resident Home Area near the dining room entrance • Every new admission package contains the Residents' Bill of Rights • Within six weeks of admission, the resident receives a booklet, Residents' Bill of Rights: Your rights if you live in a long-term care home; CLEO (Community Legal Education/Ontario), February 2023 • Residents' Council standing agenda item to review 2-3 residents' rights at each meeting • Residents' Bill of Rights is part of the orientation package for all new hires • Part of Mandatory Annual Education for all staff: 80.7%	Develop an orientation video for new hires on Residents' Bill of Rights. Engage residents to provide input into the specific areas of focus they feel are important to highlight to staff.

Medication Safety Technology Update

Automated Dispensing Cabinet (ADC) was installed in March 2023 and functional by April 2023. Staff training and ADC biometric fingerprint registration was completed on April 15th, and ongoing for newly onboarded staff

The Clinical Support Tools (CST) funding received for 2022-2023 was used to purchase tablets to implement Point of Care (POC). POC is a program offered through PointClickCare – this program is used by PSWs to document at the point of care. This was implemented in June 2023.

For the funding received for 2023-2024, we plan to implement an RNAO created program to improve patient flow during transitions of care. Nursing Advantage is a clinical content solution that allows Long-term and post-acute care (LTPAC) providers to standardize care delivery with evidence-based clinical content and alerting.

- Improve Outcomes by Leveraging Best Practices Content
- Minimize risk through consistent care delivery
- Increase time savings during admission/care transition

Quality Improvement Plan 2024-25

The interdisciplinary QIP working group selected the following indicators under four priority issues:

1. Priority issue: **Equity**

% of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and antiracism education

Current performance	Target	Target justification	Planned improvement (Change Ideas)	Methods	Process measures	Target for process measures
-	Collecting baseline	This is the first year for this indicator. This indicator was added in alignment to OH guidance. Baseline will be collected per education roll-out.	Provide education and build capacity for EDI amongst staff and leaders for the Campus.	Set up an EDI committee to advance the mandate.	Percentage of leaders who completed EDI training.	Establish baseline as this is a new measure.

2. Priority issue: **Access and flow**

Rate of potentially avoidable ED visits for long-term care resident

Current performance	Target	Target justification	Planned improvement (Change Ideas)	Methods	Process measures	Target for process measures
7.92 (lower is better)	7.92	Our goal is to maintain our current average and stay below the provincial benchmark of 21%	Continue to provide education to residents and family membersin regard to the risks associated with ED transfers.	Continue to educate families and residents about interventions to reduce necessity for ED transfers	Number of educational opportunities for residents and families re: ED transfers.	A minimum of two educational modalities will be provided throughout the year for both residents and families re: ED transfers (i.e., by Dec 31, 2024)
			Provide education to registered staff on assessments and the criteria for [potentially] avoidable ED visits to assist with discerning between avoidable and unavoidable ED visits	Education to staff on potentially avoidable ED visits including MLTC definition.	% of staff provided the educational package	90% of active registered staff will be provided the educational package by Dec 31, 2024.

3. Priority issue: **Experience**

Do residents feel they can speak up without fear of consequences?

Target	Planned improvement (Change Ideas)	Methods	Process measures	Target for process measures
Aiming for a stretch target of 80% considering that only 75% was attained in QIP 2023-24.	To enhance awareness and knowledge of the many ways residents can facilitate their communication and feedback within the home.	1. Promote the role of the homes' Social Worker as an open line of communication for residents. 2. Educate families and residents at the time of admission around the homes open door policy for concerns and feedback.	All residents and families will be made aware of the different means of communication feedback in the home.	100% of all residents and families will have awareness of how they can communicate and provide feedback in the home.
	Ensure that every resident and SDM are given the opportunity to be actively involved in their individual MDCC meetings and the monthly Resident and Family Council meetings in the home. (MDCC- Multi Disciplinary Care Conference)	Every resident and/or SDM is invited to both the individual MDCC meeting and monthly Resident and Family Council meetings verbally by home's Resident and Family Services Coordinators and Life Enrichment Manager.	Ensure that all residents and or SDM have received an invitation to participate in their individual MDCC meetings and the monthly Resident and Family Council Meetings with the results tracked.	100% of residents and/or SDM's will receive notification or an invitation to both their individual MDCC meetings and the monthly Resident and Family Council Meetings.

4. Priority issue: **Safety**

% of long-term care residents who fell in the last 30 days

Current performance	Target	Target justification	Planned improvement (Change Ideas)	Methods	Process measures	Target for process measures
27.7% Q2 2023-24 (adjusted rate)-CIHI	23%	12% decrease in falls in 2023 from the previous year. Falls managed by an interdisciplinary team. A new falls risk assessment tool was introduced in 2023.	Minimize risk of injury associated with falls	1. Ensure all residents have fall prevention equipment 2. Ensure all residents have a fall's focus in their care plan, using an interdisciplinary approach	1. Percentage of residents with fall prevention equipment 2. Percentage of residence with a fall's focus in their care plan using an interdisciplinary approach	1. 100% of residents who have fallen/identified at risk of falling to have appropriate fall prevention equipment by Q4 2024-25. 2. 100% of residents who have fallen/identified at risk of falling to have a fall's focus in their care plan by Q4 2024-25.
			Increase staff awareness of residents at risk for falls, personnel at all levels will be able to identify their roles and responsibilities to contribute positively to mitigate resident fall risk.	Discuss fall incidents data on each unit during the weekly quality huddles.	Falls Committee to discuss, analyze falls and review trends.	Reduce number of fall incidents to 23% by Dec 31, 2024.

The QIPs are deliberated monthly at the QIP Working Group meeting and reported to CQI on a regular basis. The reporting cycle will follow the planning cycle outlined below:

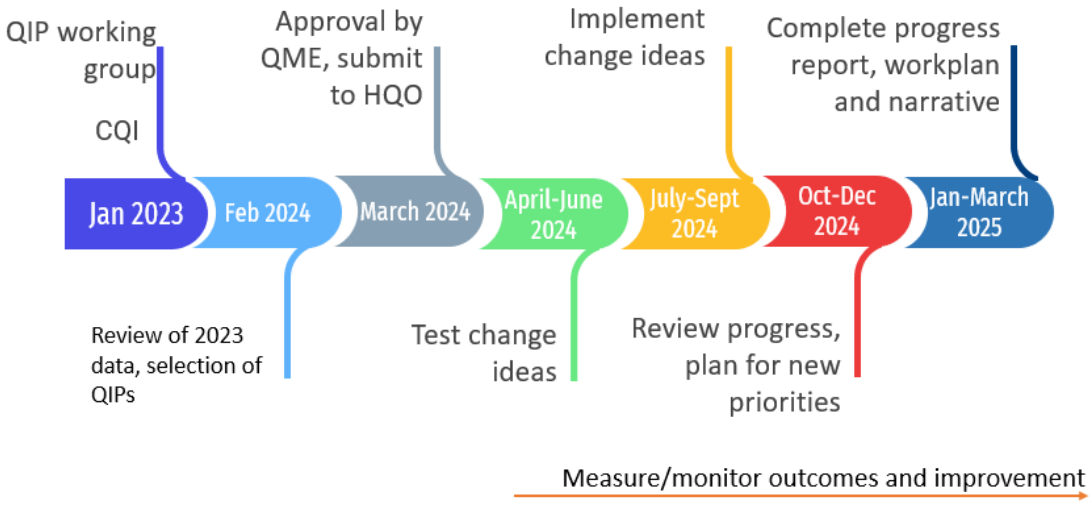


Fig. 2 QIP 2024-25 Planning Cycle

Resident and Family/caregivers experience

SJLCB operates an active Resident and a Family Council that meets monthly providing feedback

on aspects of care, food choices and quality of life. The executive members of both the Councils sit on Continuous Quality Improvement (CQI) Committee, our operational quality and safety committee that aims at reducing disparities and co-designing improvements. We also have resident and family representation on our QIP working group, that helps shape our improvement efforts year after year.

Since 2011, the three St. Joseph's Health System (SJHS) Long-Term Care Homes (LTCHs) in Guelph, Brantford, and Dundas have worked in partnership to implement the Long-Term Care (LTC) Resident and Family Satisfaction Surveys. These surveys give residents and their family members the opportunity to provide their view on the quality of care and services provided. This ongoing collaboration involves the use of common standardized survey tools and methods, and allows for comparison of performance across the three LTCHs, and subsequently, shared learning and partnering on quality improvement initiatives.

Resident survey

The three St. Joseph's Health System (SJHS) Long-Term Care Homes (LTCHs) in Guelph, Brantford, and Dundas collectively implement the Long-Term Care (LTC) Resident Satisfaction Survey each year. This survey gives residents the opportunity to provide feedback on the quality of the care and services that they receive, and the collective approach allows the three sites to compare results between the homes. The data was collected between June and August 2023.

Response Rate

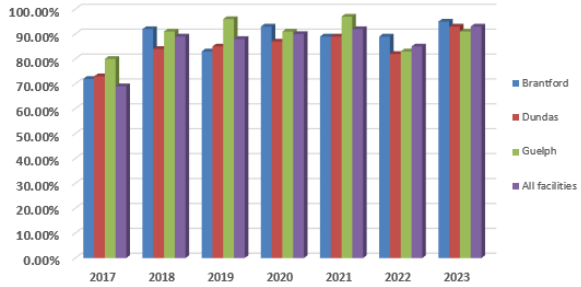
Of the 404 residents approached to be interviewed, 268 residents completed a survey: 82 from Guelph, 142 from Dundas, and 44 from Brantford. This represents an overall response rate of 66% of eligible residents.

Survey Results

Overall quality of care and services:

Across the three LTCHs, 84% of residents rated the overall quality of care and services as "good" or "excellent". Furthermore, the majority of residents (93%) indicated that they would ("Yes") or would sometimes ("Yes Sometimes") recommend the LTCH to others.

Overall Resident Satisfaction



Overall Resident Satisfaction (Would You Recommend)							
Comparator	2017	2018	2019	2020	2021	2022	2023
Brantford	72.00%	92.00%	83.00%	93.00%	89.00%	89.00%	95%
Dundas	73.00%	84.00%	85.00%	87.00%	89.00%	82.00%	93%
Guelph	80.00%	91.00%	96.00%	91.00%	97.00%	83.00%	91%
All facilities	69.00%	89.00%	88.00%	90.00%	92.00%	85.00%	93%

Based on "Yes" and "Yes Sometimes" response

Annual target is 80%

Overall Resident Satisfaction (Quality of Care)							
Comparator	2017	2018	2019	2020	2021	2022	2023
Brantford	80.00%	40.00%	73.00%	95.00%	84%	76.00%	91%
Dundas	84.00%	75.00%	82.00%	86.00%	89.00%	82.00%	85%
Guelph	80.00%	40.00%	90.00%	94.00%	96%	84.00%	78%
All facilities	81.00%	52.00%	82.00%	92.00%	90.00%	81.00%	85%

***Based on "Good" or "Excellent" responses*

**2020 SJHS LTC survey not completed due to pandemic impact.*
*2022 Pulse Survey Completed ~ Shortened version of SJHS LTC survey**

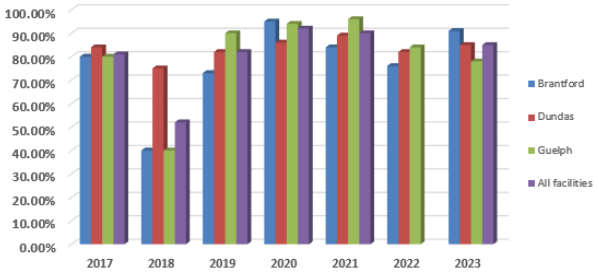


Fig. 3 Resident Satisfaction Survey 2023

Family survey

Data collection for the Family Satisfaction Survey took place between June and August 2023 for the three St. Joseph's Health System Long-term care homes.

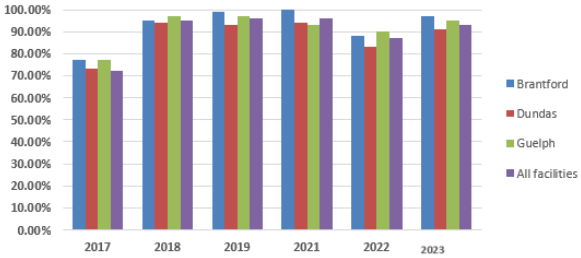
Response Rate

Across the three SJHS LTCHs, 185 out of 866 family members and significant visitors completed a survey. This represents an overall response rate of 21%.

Survey Results

Across the three LTCHs, 47% of family members and significant visitors rated the overall care and services provided in their respective LTCH as "Excellent" and an additional 41% rated it as "Good". Most family members and significant visitors (93%) said "Yes" or "Yes sometimes", they would recommend the LTCH to others needing LTC.

Overall Family Satisfaction

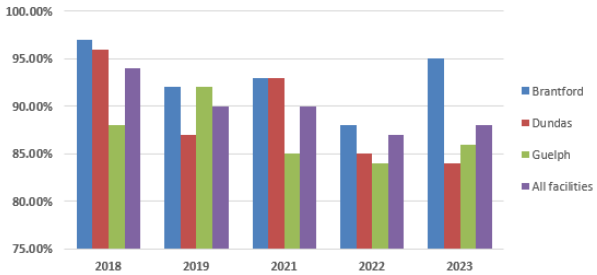


Overall Family Satisfaction 2021 (Would You Recommend)						
Comparator	2017	2018	2019	2021	2022	2023
Brantford	77.00%	95.00%	99.00%	100%	88.00%	97.00%
Dundas	73.00%	94.00%	93.00%	94.00%	83.00%	91.00%
Guelph	77.00%	97.00%	97.00%	93%	90.00%	95.00%
All facilities	72.00%	95.00%	96.00%	96%	87.00%	94.00%

***Based on "Yes" and "Yes Sometimes" response (no annual target)*

Overall Family Satisfaction 2021 (Quality of Care)						
Comparator	2017	2018	2019	2021	2022	2023
Brantford	77.00%	97.00%	92.00%	93.00%	88.00%	95.00%
Dundas	73.00%	96.00%	87.00%	93.00%	83.00%	84.00%
Guelph	77.00%	88.00%	92.00%	85.00%	90.00%	86.00%
All facilities	72.00%	94.00%	90.00%	90.00%	87.00%	88.00%

***Based on "Good" or "Excellent" responses*



*2020 SJHS LTC survey not completed due to pandemic impact.
2022 Pulse Survey Completed ~ Shortened version of SJHS LTC survey**

Fig. 4 Family Satisfaction Survey 2023

2023 Resident and Family Survey Action Plan

Feedback	Action	Progress
Staffing	Tracking our Data to understand trends and opportunities	• Continue to decrease use of agency staff • Turnover rate is lowest since 2020 from 12% to 1% • Process improvements to Recruitment Process • Unplanned absences lowest since 2021, 62.6% to 31.4%
Facility	Comfortable to live with regards to temperature	• 3 rooftop air conditioning units RTAC units replaced-1, 4, and 7 servicing the north and south loop area of the resident locations and the core area of the facility. • Challenges to maintain consistent temperatures encountered during installation and removal process. • Steady and comfortable temperature setting is expected as we approach the final stages of project completion.
	Look to where we can refresh; upgrade	• Have begun refresh of common areas (paint, furniture) • Refresh of paint will expand to neighbourhood units • Memory boxes
Care Plan Meetings	Improve	• New Social Worker position to focus on annual care plan meetings • Working with other care team partners (i.e. Drs, Physio, BSO) to increase participation at care plan meetings
Activities	More activities catering to men	• Over the last six months our programs have been attended by gender as listed • All – 96.42 %; Male only - 0.14 %; Female only – 3.43% • Our current population is 68% female to 32% male • We offer a men's group monthly. • Recreation staff are to seek resident feedback at unit monthly meeting specific to seek "male catered" activity ideas and suggestions. • Resident council to be asked for feedback specific to seek "male catered" activity ideas and suggestions. • Men's group attendees to be provided opportunity to seek ideas and suggestions for "male catered" programs.
Complaints	Improve Complaints Process	• Created new complaints tracking tool
Resident Experience	Ensure "I can express my opinion without fear of consequences".	• Included in QIP 2024-25

Quality Improvement Successes: 2023-24

Notable advancements implemented in the clinical areas include:

1. Digital Pens – January 2023
2. Online Medication incident reporting system – February 2023
3. ADC Cabinet (Ebox) – May 2023
4. POC – Implemented June 2023
5. ED diversion protocols (Triage triangle) - July 2023
6. Project Amplify – August 2023
7. Wound Care app – October 2022
8. Secure conversations – October 2023
9. HIROC (Health Insurance Reciprocal of Canada) Safety Grant 2023

Quality Improvement Priorities: 2024-25

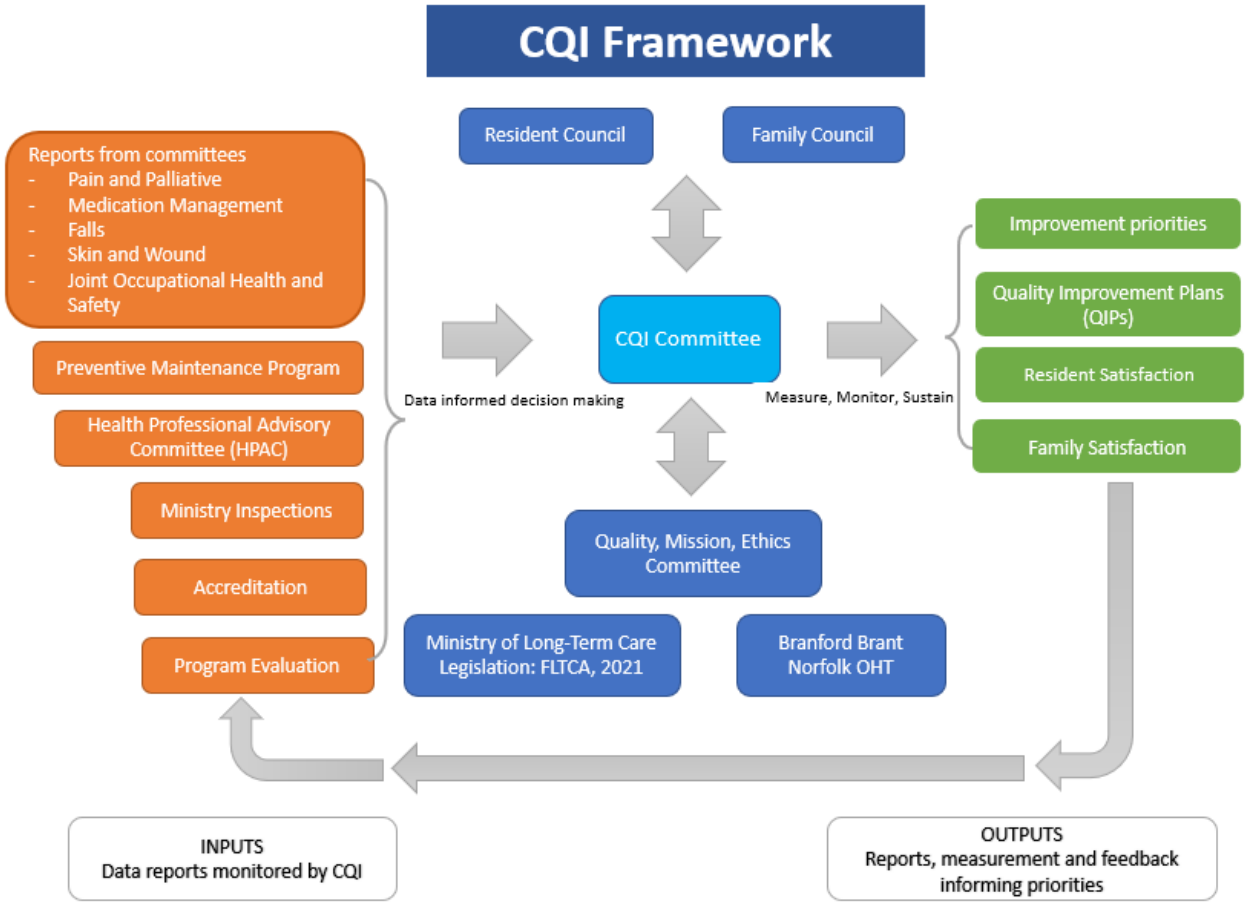
- Establish interdisciplinary post falls huddles
- Implement Quality Huddles on units

Conclusion

St. Joseph's Lifecare Centre remains committed to continuous quality improvement and continue to work in collaboration with stakeholders to improve the quality of care and services offered for our residents. *Quality Improvement 2023-24: A Year in Review* reflects on the achievements and successes of the past year and highlights our commitments for 2024-25.

Appendix

A. Continuous Quality Improvement Framework



B. CQI Committee Work Plan

St. Joseph's Lifecare Centre
CQI Committee Work Plan
August 2023– July 2024
Meeting Date – 3rd Wednesday of the month 10:30 - 11:30 a.m.

August –16th	MRP	March 20th	MRP
CQI - Program Evaluations	DOC	CQI - Program Evaluations	DOC
CQI - Quality Management and IRM policy approval	DOC	CQI - Mandatory Committee Reports	DOC
CQI - Incident, Compliments, Complaints reporting templates to the Board	DOC	CQI - QIP 2023-2024 Update	DOC
CQI - Accreditation Update	DOC	CQI- LTC Public Report	LTC Administrator
October – 18th	**MRP**	**May 15th**	**MRP**
CQI - Program Evaluations	DOC	CQI - Program Evaluations	DOC
CQI - Mandatory Committee Reports	DOC	CQI - Mandatory Committee Reports	DOC
CQI - QIP 2023-2024 Update	DOC	CQI - Risk Report	DOC
CQI - Instrument Summary	DOC	CQI - CCRS Indicator Report	DOC
CQI - LTC Resident and Family Survey Report	LTC Administrator	CQI- Q4 Complaint Reporting	LTC Administrator
CQI - Workplan Review	DOC		
CQI - Accreditation Update	DOC		
CQI- Risk Report	DOC		
December	**MRP**	**July 17th**	**MRP**
No Meeting	DOC	CQI - Program Evaluations	DOC
	DOC	CQI - Mandatory Committee Reports	DOC
	DOC	CQI- QIP 2024-25 Update	DOC
January– 17th	**MRP**	**Items as Required**	**MRP**
CQI - Program Evaluations	DOC	Regulatory Changes	DOC
CQI - LTC Public Report	DOC	Ministry Inspection Reports	DOC
CQI - Mandatory Committee Reports	DOC		
CQI- CCRS Indicator Report	LTC Administrator		
CQI - Q1,Q2,Q3 Complaint Reporting	LTC Administrator		

C. Integrated Risk Management Framework

Adapted from Integrated Risk Management- Delivering Improved Outcomes, Deloitte UK 2016

D. Risk Report

REF #	Risk category	Risk name	Description	Risk level (current)	Monitoring / indicators	Adequacy of	Controls	Gaps	Constraints
1-HR-01	Human Resources	Risk of not attracting and retaining top talent	Nurses represent the highest proportion of healthcare workers globally and play an instrumental role in healthcare which has been heightened in the ongoing fight against COVID-19. Health workforce data from 2020 indicates that there are upwards of 448,000 nurses across four roles: registered nurses, registered psychiatric nurses, licensed practical nurses/registered practical nurses, and nurse practitioners (Canadian Institute for Health Information (CIHI) 2021b, 2021a). While we are seeing an exodus of nursing staff, this phenomenon is not unique to nursing as we are seeing similar trends in other classifications making some positions challenging to fill. According to a Canadian Medical Association Journal news article published in 2021 (Varner 2021), health job vacancies in Canada were at a record high of 100,300—up 56.9% from 2019 and with Canadian hospitals having the highest vacancy rate of any sector. It is more important than ever for healthcare organizations to continuously review staffing data, analyze trends, welcome feedback, implement change, provide opportunities for growth and recognition in order to retain our valuable staff but to also attract talent to our organization in order to ensure we are providing optimal care to our residents and patients.	High	Caring people report- Quarterly Exit interviews (employee resignation and dropping staff levels- e.g. full time to casual) Worklife pulse action plan Employee satisfaction - Worklife Pulse 2023 Staff focus group session- Sept 28	Medium	Caring people report Enhanced orientation program Identify trends from exit interviews		Budget Resources Time Scope
IC-01	Care	Risk of Healthcare Associated Infections and outbreaks	Best practice: All LTCHs in Ontario shall develop, provide and evaluate an active, effective IPAC program that meets the mandate and goal to decrease the risk of health care-associated infections and improve health care safety. Due to the congregate nature of LTCHs, residents are often impacted by outbreaks of respiratory or gastrointestinal infections. Residents are more likely to develop severe disease due to their advanced age, comorbidities and a high degree of frailty. Lack of resources impact the delivery, monitoring and surveillance of infections.	Medium	Hand hygiene audits Dining room audits Infection surveillance using HealthConnex	Medium	1. IPAC audits are the responsibility of one person. No back up in place 2. Dining room audits- Ministry Compliance Order in March 2023 and currently ....Audits are now fallen off and no data is currently recorded. 3. Healthcare Associated Infection (HAI)- not currently captured on Healthconnex 4. Equipment disinfection- staff are not compliant 5. IPAC Committee- not currently in place	Gaps 1.Hand hygiene audits- RPNs to support 2.Dining room audits- PSWs to complete 3.Healthconnex- not currently used by RNs for infection surveillance 4.Equipment disinfection- staff are not compliant. Agency staff doing night shifts do not clean equipment 5.Roles and responsibilities for clinical staff not clearly delineated Constraints: Budget for IPAC to be identified. Schedule for clinical staff to complete HH and Dining room audits	Budget for IPAC to be identified. This will then be used as wages for support service staff to complete HH audits. Schedule for clinical staff to complete HH and Dining room audits
AD-01	Facilities	Risk of aging buildings and lack of resources for maintenance or redevelopment	While total health care spending has increased over the last 20 years, Canadian capital investment in health infrastructure has fluctuated, with a noted decline in recent years. Healthcare institutions across the country must regularly dip into funds allocated to updating infrastructure to provide patient care.	Medium	Capital budget planning Funding- government/ Foundation Internal process- Maintenance Care Report (audits and demand order) Facility Assessment Report (2019) Physical controls- back-up systems (elevator and lighting) Emergency Code tests	Medium	Maintenance Care Report Audits Budget for repair and maintenance	Maintenance Care Report Audits Budget for repair and maintenance	Budget- quotes to suit the budget Cost Time- delay in procurement and delivery of goods, trade availability Scope

E. Program Evaluation Template

ST. JOSEPH'S Lifecare Centre BRANTFORD

2023 Program Evaluation Report

PROGRAM:	
Purpose of evaluation (Annual, Major change)	
Date of evaluation	
Persons who did the evaluation (include roles)	
Written brief Description of the Program	
Policy/Standards number/name that were used for this program evaluation OR recent updates to policies?	
Data sources reviewed: "√" all that apply	☐ Incident Reports (If yes, which one_____) ☐ Annual QIP progress tracking ☐ CIHI and/or other priority indicators (SJHS scorecard) ☐ PCC real time data ☐ Complaints/compliments/suggestions for improvement from res/fam/staff ☐ Risk Framework Profile ☐ Resident/Family Satisfaction Survey Outcome ☐ Accreditation Canada ROP, Standards, or survey follow-up recommendations ☐ Best practice guidelines (source: _____) ☐ MOH inspection outcome (date of inspection: _____) ☐ Resident/Family Council ☐ Walk-Abouts ☐ Focused audits/monitoring tools ☐ Other: _____
Legislation and directives reviewed (i.e. list which ones)	☐ Inspection Protocols ☐ Accreditation Canada ROP's
Reviewing the FLTCA and Regulations	Did you review the applicable parts of the FLTCA and Regs that relate to this program - Yes or No Is your program complaint - Yes or No If no, please identify the areas that we are not and explain what your goals are to address this:

On-going maintenance/monitoring activities (explain)	
Are there areas in place to reduce risk of harm? (explain)	
Procedure for referrals to this program (explain)	
Equipment Used (i.e. assistive devices, positioning aids etc)	
Any changes in the program since last review, *including dates changes were made*	
How are improvements being sustained?	
How are residents/families being engaged re: changes/improvements – please list.	
Outcomes expected from the program	
Actual outcomes achieved – please describe in words and show graph (s) to illustrate were possible. (what program goals were achieved this year)	
Goals & objectives for the coming year (please make sure one of the goals is how you will involve residents/families in the upcoming year)	

Updated: January 2023