Quality Improvement Plan (QIP)

Narrative for Health Care Organizations in Ontario

March 31, 2023

Ontario Health

OVERVIEW

The key objective for the Rockwood Terrace 2023/24 Quality Improvement Plan is focused on “Colour It Your Way” resident led care. We strive to meet or exceed the established benchmarks and provincial averages as identified by the long term care indicators.

The vision of Grey County is to be the place where people feel "genuinely at home and naturally inspired". The County's Corporate Strategic Plan outlines three key goals to guide the organization. The Rockwood Terrace Quality Improvement Plan uses these goals as guiding principles for ensuring quality care and service. Specifically, the Quality Improvement Plan aligns with goal number two – “Support Healthy and Connected Communities” and goal number three – “Deliver Excellence in Governance and Service” of the County of Grey Strategic Plan. The 2023/24 Quality Improvement Plan also aligns with the Long Term Care Strategic Plan of "Getting the Best, Being our Best and Delivering the Best which are embedded in the Mission, Vision and Values of the home.

By monitoring indicators, implementing action plans and evaluating outcomes, we ensure that resident quality of life and safety will be supported. Our culture of resident led care using the “Colour It Your Way" values and promise continues to guide the quality improvement journey.

REFLECTIONS SINCE YOUR LAST QIP SUBMISSION

Grey County Long Term Care relied on our strong foundation of quality processes to face the ongoing challenges that came with the COVID 19 pandemic. Priority was focused on the health, safety and wellness of residents, staff and the community. Engagement and two way communication occurred with all stakeholders. The new Fixing Long Term Care Act along with the health human resources crisis has required a focused investment in building knowledge and skills for team members, family members, designated care partners and residents. We will continue to expand our quality improvement program to incorporate programs initiated during this time. The importance of IPAC programs and plans were highlighted and will continue to play a leading role in our initiatives.

PATIENT/CLIENT/RESIDENT ENGAGEMENT AND PARTNERING

The Pandemic challenged our home to engage and partner with our Residents/Families with the use of virtual technology, newsletters, small groups, surveys etc.

Rockwood Terrace has active Resident and Family Councils. Councils meet regularly where information is provided and received. The Councils are involved in providing feedback and input into the decision making process related to care and services within the care community.

Resident Experience Surveys are conducted annually and provide valuable information that guides the development of Quality Improvement Plans for the care community.

Family Experience Surveys are available annually for completion. These results are also considered in the preparation of the Quality Improvement Plan.

The valuable information received through these partnerships led to changes in our delivery of services. The partnership and advocacy influenced and changed direction for a better lived experience.

Evaluation of complaints and concerns received in 2022 provides valuable information that guides the development of Quality Improvement Plans for the care community.

Grey County is redeveloping Rockwood Terrace in Durham. A new facility is being built to expand services for seniors. The new home will be larger, and will include 128 long-term care beds. The new home will be located beside the existing building in Durham.

Resident experience is central to all planning and design of the home. We engaged with residents, family members, and team members working in the home to ensure our the design will work for everyone.

PROVIDER EXPERIENCE

For more than three years long-term care homes have faced immense challenges from the pandemic. Residents and team members of our homes continue to deal with isolation, fear, worry and increased resident acuity. Care Communities are shifting from pandemic response to recovery and the leaders and team members continue to be committed to providing compassionate and quality care. Long-term care homes continue to be centres of innovation, courage, and compassion to ensure the resident and family

experience meets their expectations.

Grey County homes prioritize the health, safety, and wellness of not only our residents but for all of our team members. As we worked through the human resource challenges, we partnered with our local YMCA Employment Services and Colleges and Government in an effort to relieve the staffing crisis and provide meaningful career pathways to job seekers and current team members. This partnership recruited, prepared and trained more than 150 individuals for roles in long term care across our region.

The Designated Care Partner program continues to grow and support the residents but also provide support to the team including in an outbreak situation. Policies, procedures, education, and benefits were enhanced to provide the necessary tools and knowledge to ensure the needs of our team members were met. Staffing contingency plans were continuously reviewed and updated.

In the spirit of our strategic goal of Being Our Best, the leadership teams from all three homes came together for a day of reflection and professional development. The focus of education was change management, building relationships and wellness.

The homes continue to provide equitable access for pandemic protection to staff, students, support workers, volunteers, and families, providing onsite testing, vaccinations and on-site TB screening for new team members. At many times staff members were offered flexibility to their schedules to support work life balance. Staff wellness was a focus and the homes regularly provided recognition events for their continued commitment to our Colour It Your Way philosophy.

Discussions and planning continue to develop and maintain a culture of wellness and recovery over the coming years.

WORKPLACE VIOLENCE PREVENTION

Rockwood Terrace is committed to a safe work environment. Risk assessments have been completed. The Workplace Violence and Harassment Prevention program and Respectful Workplace Statement have been reviewed and revised based on information gathered through the assessments. Education is provided annually to all staff with a commitment to the integration of safe behaviour into day to day operations and to ensure prompt response to related complaints in an objective and sensitive manner.

PATIENT SAFETY

The municipality and our homes prioritize a just culture through a high level of reporting on incidents with an emphasis on opportunities for improvement. Our Colour It promise includes Colouring it with Integrity and this is evident through our transparent communications of survey results, outbreaks, program reviews, critical incidents etc. and engagement with stakeholders.

HEALTH EQUITY

The organization provides care and service primarily for the aging population. However, there has been a noted increase in admissions of younger adults with chronic debilitating conditions.

In our Home there is a higher population of residents exhibiting responsive behaviours. As a result partnerships to coordinate care include Behavioural Supports Ontario, the Home's embedded Behavioural Support Team, Regional Geriatric Behaviour Response Team/Mental Health, Grey Bruce Health Services, Owen Sound, and tertiary centers.

Rockwood Terrace is committed to educating team members in utilizing the equity lens in the development of quality improvement initiatives. Moving forward, intentional efforts are being made to support equity, diversity, inclusion and belonging for all who spend time in our Care Community.

Through our Colour It Promise we promote and encourage resident led care and service for each person who calls Rockwood Terrace home. This includes improvements to data collection and working closely with residents to support cultural preferences, meaningful cultural activities, food preferences and spiritual needs.

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 30, 2023**

Scott Mackey, Board Chair / Licensee or delegate

Karen Kraus, Administrator /Executive Director

Karen Kraus, Quality Committee Chair or delegate

Lucinda Walter, Other leadership as appropriate

Theme I: Timely and Efficient Transitions

Measure

Dimension: Efficient

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Number of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents.	P	Rate per 100 residents / LTC home residents	CIHI CCRS, CIHI NACRS / Oct 2021 - Sep 2022	12.40	12.00	To continue to reduce inappropriate ED visits.	

Change Ideas

Change Idea #1 To ensure ED transfers are appropriate.

Methods	Process measures	Target for process measure	Comments
1. Include educational material in the admission package related to Long Term Care In House Treatment of UTI and End of Life Care. 2. Provide education to the BSO Team and Team members in general related to effective management of responsive behaviour and Code White review.	1. The number of new admission packages that include UTI and End of Life Care pamphlets. 2. The number of BSO Team members that complete the Foundation Course. The number of in-services provided from the Geriatric Outreach Team and Code White review completed.	1. 100% of admission packages contain informative pamphlets. 2. 100% of in house BSO team completed BSO Foundation Course. 3. Geriatric Outreach inservices provided bi-annually. 4. Code White Review completed and documented.	

Theme II: Service Excellence

Measure

Dimension: Patient-centred

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of residents responding positively to: "What number would you use to rate how well the staff listen to you?"	P	% / LTC home residents	In house data, NHCAHPS survey / Apr 2022 - Mar 2023	88.64	90.00	To improve resident satisfaction and support the Colour It Your Way promise	

Change Ideas

Change Idea #1 To improve awareness of professional and effective customer service.

Methods	Process measures	Target for process measure	Comments
To provide an in-person customer service event to supplement on-line training related to customer service.	The number of team members who received the additional customer service education.	100% of team members will attend the in-person event or review recorded version.	Total Surveys Initiated: 44 Total LTCH Beds: 100

Measure

Dimension: Patient-centred

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences".	P	% / LTC home residents	In house data, interRAI survey / Apr 2022 - Mar 2023	91.00	91.00	To maintain resident satisfaction and support the Colour It Your Way promise.	

Change Ideas

Change Idea #1 To improve awareness of professional and effective customer service.

Methods	Process measures	Target for process measure	Comments
To provide an in-person customer service event to supplement on-line training related to customer service.	The number of team members who received the additional customer service education.	100% of team members will attend the in-person event or review recorded version.	Total Surveys Initiated: 100 Total LTCH Beds: 100

Measure

Dimension: Patient-centred

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Proportion of long-term care home residents with a progressive, life-threatening illness who have had their palliative care needs identified early through a comprehensive and holistic assessment.	C	% / LTC home residents	In house data collection / April 2023-March2024	89.00	89.00	If a resident has an exacerbation of acute medical condition resulting in sudden death, the holistic assessment would not be able to be completed.	

Change Ideas

Change Idea #1 Education related to End of Life Care

Methods	Process measures	Target for process measure	Comments
LHIN Palliative Care Nurse Educator to provide bi-annual on-site in-services to team members related to palliation versus end of life care. Written material provided/available (via pamphlets) to family, resident, team members and visitors related to palliative care and end of life.	Percentage of team members who receive education related to palliative and end of life care. Pamphlet included in all admission packages Percentage of residents that are identified for end of life care that have received the phamphlet.	30% of team members will receive education related to palliative and end of life care. 100% of admission packages will include the "Dying with Dignity in Long Term Care" pamphlet. 100% of residents that are identified for end of life care will receive the educational pamphlet.	Resource pamphlets made available via partnership with McMaster University End of Life and Palliative Care initiative.

Change Idea #2 Baseline palliative score obtained upon admission to guide the direction of care provision and establish a plan of care.

Methods	Process measures	Target for process measure	Comments
All new residents will be assessed for Palliative Performance Scale (PPS) upon admission to establish a baseline.	Percentage of new admissions that have been assessed for a Palliative Performance Scale upon admission.	100% of new admissions have been assessed for a Palliative Performance Scale upon admission.	This is in addition to the diverse assessments utilized to define directions for the palliative care approach.

Change Idea #3 When the resident is transitioning from palliative status to end of life, a holistic assessment and support system is developed that is residents specific.

Methods	Process measures	Target for process measure	Comments
CHESS, PSI, PPS (frequency adjusted based on symptoms) will be completed triggering preparation of individualized end of life plan of care. Once resident is in active end of life, palliative Dula support is provided.	Percentage of residents identified in transitional phase will have an individualized hollistic assessment and plan of care.	100% of residents identified in transitional phase will have an individualized hollistic assessment and plan of care.	

Theme III: Safe and Effective Care

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	P	% / LTC home residents	CIHI CCRS / Jul - Sept 2022	0.85	10.00	To remain below provincial benchmark related to this indicator. Unknown status of new admissions makes it difficult to establish current performance as a target.	

Change Ideas

Change Idea #1 To continue current interventions related to appropriate use of antipsychotic including monitoring residents for delusions/hallucinations, identifying palliative/end of life residents and accurate identification of mental disorder diagnosis. Maintenance of a stable in-house BSO Team and physician support are critical.

Methods	Process measures	Target for process measure	Comments
Ensure adequate utilization of resources and knowledge by the interdisciplinary team.	Percentage of residents receiving antipsychotic medication without psychosis.	10% or less of residents receive antipsychotic medication without psychosis.	

Measure

Dimension: Safe

Indicator #6	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of residents who have fallen.	C	% / LTC home residents	CIHI CCRS / July-September 2022	19.80	16.60	To meet provincial average	

Change Ideas

Change Idea #1 To decrease the number of residents who fall.

Methods	Process measures	Target for process measure	Comments
Complete GAP analysis of fall program with support of RNAO Best Practice Nurse and implement recommendations. Implementation of Five P's (intentional rounds). Risk assessment completed for all new admissions and fall prevention initiatives implemented on day of admission.	Percentage of residents that have fallen.	Less than 16.6% of residents will fall.	It is important to note that although we are above provincial average related to this indicator, the number of fractures as a result of a fall are negligible. This reflects the effective fall prevention initiative.