

Quality Improvement Plan (QIP)

Narrative for Health Care Organizations in Ontario

March 31, 2023



OVERVIEW

The key objective for the Grey Gables 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 Grey Gables 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 is 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 intro of the new FLTCA, along with HHR crisis has required a focused investment in building foundational knowledge and skills of 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.

Grey Gables implemented a trial 20 bed BSTU unit, this unit is to support rural Ontario residents with increased behaviours.

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.

Grey Gables 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 lead to changes in our delivery of services. Their partnership and advocacy influenced and changed direction for a better lived experience.

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

PROVIDER EXPERIENCE

For more than three years long-term care homes have faced

challenges from the pandemic. Residents and team members of our homes continue to deal with isolation, fear, worry and increased resident acuity. Our teams are moving from pandemic response into recovery, the leaders and team members continue to be committed to providing compassionate and quality care for all. Long-term care homes continue to be centers for innovation, courage, and compassion to ensure the resident and family experience meets their expectations.

Grey County homes prioritized the health, safety, and wellness of not only our residents but for all of our team members. As we continue to work through the human health resources challenges, we partnered with our local YMCA employment services and colleges and government in an effort to relieve our staffing crisis and provide meaning career pathways to job seekers and our current team members. This partnership recruited prepared trained and employed more than 150 local individuals for roles in LTC across our region. We developed the Designated Care Partner program continues to grow to support the residents but also provided 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 for vaccinations and onsite TB screening for new staff. 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

Grey Gables 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 and engagement of survey results, outbreaks, program reviews, critical incidents etc.

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. Grey Gables has implemented a 20 bed BSTU. As well 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.

Grey Gables 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 home.

Through our Colour It Promise we promote and encourage resident led care and service for each person who calls Grey Gables 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 31, 2023**

Scott Mackey, Board Chair / Licensee or delegate

Shannon Cox, Administrator /Executive Director

Shannon Cox, Quality Committee Chair or delegate

Cynthia Merrifield, 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	X	0.00	Current Performance is below the ability to collect data.	

Change Ideas

Change Idea #1 Continue with routine processes ie. Doctors notified prior to sending Residents to the ED, Doctors will assess and recommend treatment.

Methods	Process measures	Target for process measure	Comments
Educate Registered staff and Doctors of process	Number of ED visits/transfers that were preventable	Maintain the current number of ED visits	

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	96.97	98.00	To improve Residents positive response to the question on "how well staff listen to you"	

Change Ideas

Change Idea #1 Increase the Resident response to the question "What number would you use to rate how well staff listen to you?" in the annual survey.

Methods	Process measures	Target for process measure	Comments
Add to circle of care meeting agenda with regards to how we are colouring it for the needs of our Residents	Number of front line care providers educated on the Colour it philosophy. Number of residents who respond positively to the survey question rating how well staff listen to them.	1% increase in residents responding positively when asked how well staff listen to them.	Total Surveys Initiated: 33 Total LTCH Beds: 66

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	93.94	96.00	To improve Resident's positive response to the question "I can express my opinion without fear of consequences"	

Change Ideas

Change Idea #1 Continue the change idea of Respect Residents Values, preferences and Expressed needs

Methods	Process measures	Target for process measure	Comments
Educate Employees on the new FLTCA regarding Resident Rights and Resident Centered Care through surge learning.	Number of Residents responding positively to survey question	average greater than 95% in the positive response to the question "I can express my opinion without fear of consequences" on the resident satisfaction survey by December 2023.	Total Surveys Initiated: 33 Total LTCH Beds: 66

Measure **Dimension:** Patient-centred

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Proportion of LTC 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 - March 2024	CB	100.00	Currently collecting baseline data	

Change Ideas

Change Idea #1 Education related to End of Life Care

Methods	Process measures	Target for process measure	Comments
LHIN Palliative Care Nurse to provide bi-annual onsite in-services to team members related to palliation versus end of life. 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 pamphlet.	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" pamphlet. 100% of Residents that are identified for end of life care will receive the educational pamphlet.	

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 resident specific.

Methods	Process measures	Target for process measure	Comments
CHESS, PSI, PPS (frequently 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 team support is provided.	Percentage of residents identified in transitional phase will have an individualized holistic assessment and plan of care.	100% of residents identified in transitional phase will have an individualized holistic assessment and plan of care.	

Measure **Dimension:** Patient-centred

Indicator #5	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of long-term care home residents who developed a stage 2 - 4 pressure ulcer	C	% / LTC home residents	CIHI CCRS / Oct-Dec 2022	2.20	2.00	Provincial performance is 4.8%. Our performance target is 2% which is a reduction of 0.2% which is reasonable as an initial goal to continue to improve this performance.	

Change Ideas

Change Idea #1 Education of PSW and Registered staff regarding prevention, interventions and early identification and reporting of pressure related skin injuries.

Methods	Process measures	Target for process measure	Comments
Online modules, huddles, meetings and in-services	number of PSW's and Registered staff attending education	80% of PSW's will attend skin and wound education sessions or complete on-line modules	

Change Idea #2 Ensure that all residents with a PURS score of 3 or more have care plans with identified interventions

Methods	Process measures	Target for process measure	Comments
Weekly documentation audits, staff coaching and mentoring	number of residents with PURS scores of 3 or more will have skin and wound care plans with interventions	100% of residents with PURS scores of 3 or more will have skin and wound care plans with interventions	

Theme III: Safe and Effective Care

Measure Dimension: Safe

Indicator #6	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	13.82	12.00	Current provincial performance (fiscal Q@ 2022/23) is 21.4%. The home's current performance is well below the provincial average and our goal is to continue this trend.	

Change Ideas

Change Idea #1 Ensure that residents prescribed antipsychotics align with documented medical diagnosis

Methods	Process measures	Target for process measure	Comments
Review resident diagnosis with prescribed medications quarterly	Number of residents who are prescribed antipsychotic medications have a medical diagnosis review quarterly	100% of these resident charts will be reviewed quarterly	

Change Idea #2 To Explore alternatives to antipsychotic use

Methods	Process measures	Target for process measure	Comments
A referral to the BSO team will be made to explore alternatives to antipsychotic medications for residents without a diagnosis of psychosis who are receiving those medications.	Number of BSO referrals for those residents prescribed antipsychotic medications without a diagnosis of psychosis.	100% of residents without a diagnosis of psychosis who are receiving antipsychotic medication will be reviewed by the BSO team to explore alternative interventions quarterly.	