September 29, 2022

Continuous Quality Interim Summary Report

Continuous Quality Improvement Program

Continuous Quality Improvement Initiative – Section 168 (5) and (6) sets out interim report requirements for the 2022-23 fiscal year. This report must be published on the home's website by July 11, 2022, and provided to the Residents' Council and Family Council, if any. At this time, there is no mandatory template for this report; however, the interim report must contain the following information, as outlined in the regulation:

Continuous Quality Lead

1) Vanda Cozier DOC
2) Kirtsheel, IPAC Health and Quality lead
3) Gary Basran, CEO/CFO

Written Description of the Homes Priority Areas for Quality Improvement, objectives, policies, procedures, protocols for Continuous Quality Improvement Initiatives

The home has a formal interdisciplinary committee accountable for providing oversight and strategic direction on quality improvement activities; this will continue. The CQI Committee develops and approve the Terms of Reference to reflect its mandate. The home will ensure its CQI Committee fulfills the composition requirements and responsibilities described in the Fixing Long-Term Care Act, 2021.

The CEO will:

1. Ensure the interdisciplinary committee, including Residents' Council and Family Council where possible, is established, and functioning as mandated.
2. Ensure an individual is designated as a quality lead for each quality initiative in the home.

The Quality Lead will:

1. Coordinate the home's Continuous Quality Improvement initiative, as assigned.
2. Report to the CQI Committee on the status of quality initiative, as required

Committee Chairperson will:

1. Be responsible for the management and effective functioning of the committee and provide leadership to the committee in fulfilling its mandate and any other matters delegated to it
2. Appoint additional members to the committee to meet the needs of the home and the community it serves.
3. Ensure each member is provided an agenda with minutes and action items resulting from the previous meeting's discussion in advance of a meeting.
4. Make minutes available to employees, the Residents' Council, and Family Council.
5. Ensure meeting minutes include, but are not limited to, the following:

a. Name of the Chair and Note Taker.
b. Names of attending committee members and member regrets;
c. Date of the committee meeting;

d. Names of any quality improvement projects, or surveys being evaluated;
e. High-level minutes and action items;
f. Performance monitoring including reference to quality indicators;
g. Updated Communication Plan which documents dates of communication with the Residents' Council, Family Council, and staff about planned and active projects/activities; and
h. Report at minimum of quarterly or more often as required, to the Board of Director, the Residents' Council, and the Family Council (if applicable) on the status of key quality indicators and the status of quality improvement activities, including barriers to success.

The Committee Members will:

1. Oversee the preparation of the home's three to five-year strategic plans, operational plan and the annual Quality Improvement Plan (QIP).
2. (Re) Develop and annually approve the Committee's Terms of Reference to reflect the committee's mandate.
3. Identify and make recommendations on quality improvement initiatives for review.
4. Integrate planning for local improvement with the company's strategic/ operational objectives.
5. Remove system barriers to implementing and sustaining improvements.
6. Direct, monitor and report on quality improvement initiatives and related issues as they relate to the annual QIP (making use of appropriate data). This includes the review of aggregated critical incident data at least twice per year.
7. Make recommendations, analyze, and monitor performance measures.
8. Evaluate annual satisfaction survey results, to identify opportunities for improvement.
9. Seek the advice of the Residents' Council and Family Council in reviewing and acting on the results.
10. (Re) Appoint a member to be Chairperson annually.
11. Meet quarterly at a minimum. It is recommended that meetings occur on the same day at the same time (i.e., the last Friday of each month).

The CEO will:
Provide a report to the Board on the Committee's status report of key quality indicators and the status of quality improvement activities, including any barriers to success.

Written Description of the Process Used to Identify the Home's Priority Areas for Quality Improvement

Priority Areas Identified are those key performance indicators measured within the facility through MDS-RAI assessments, CIHI data provided quarterly, family/resident feedback, and reviewing tracking and trending of concerns. SCOC will compare these areas of performances against the province, quarterly against itself as well as three other small, Long Term Care facilities to gage its performance as well as identify an external partner in sharing, collaboratively practices supporting ongoing improvement. The report of the survey is given by ALLIANCE GROUP, which is third party.
Each indicator selected has a brief description of the indicator, source the information that is being is reviewed:

- Clinical Indicators (MDS-RAI/CIHI, Internal Tracking System)
- Human Resources Indicators (Internal Tracking quarter over quarter with targets established)
- Community Program Targets (Internal tracking against annual targets set with MSAA)
- Financial Budgetary Review (Quarterly/Monthly Financial Reviews against the budget and forecasting)
- Resident/Family Concerns and Complaints (Quarterly review, track, and trend areas for improvement) are reviewed internally.
- Annual Resident/Family Satisfaction Survey Results
- Current Immediate Risks Identified in the Facility through audits and complaints. The root cause is identified, and problem is resolved when possible.

Risk Identified
What risk does this indicator identify, potential or possible?

Risk Mitigation Strategy
What is the mitigation plan to address this risk?

A Written Description of a Process to Monitor and Measure Progress, identify and implement adjustments and communicate outcomes for the home's priority areas for Quality Improvements through CQI Committee meetings.

Quality Improvement Action plan
1) Quality Initiatives/ Leading Edge Practices
Brief description summarizing the need, team, problem, or opportunity identified timeline and evaluation measures. We also monitor action plan through audits and CQI meetings. Continuous feedback, develop a communication plan to update all stakeholders, staff, families, and resident council as standing agenda. The triggering quality indicators are marked red and are discussed in the CQI meeting.

Quarterly Dashboards
2) Integrated Quality Scorecard and Clinical dashboards.
Clinical templates created to provide a quick overview of facilities key performance indicators status compared against the organization in comparison to previous quarter, against the province, and 3 other LTC facilities approximately the same size for clinical data. Facility integrated quality scorecard updated with key sections across all departments. This will be updated quarterly, discussed at professional Advisory Committee (PAC), shared at Quality and Risk meeting with the Board and distributed to staff, Family/Residents' Council quarterly.

Priority Areas:
- Infection Prevention and Control
- Recruitment and Retention of Staff
- Continuous Improvement in Quality of Care delivered.

CURRENT QUALITY PRIORITIES:

1) **Infection Control and Prevention**

1.The home will embrace and foster an environment where infection prevention and control is integrated into day-to-day operations. The consistent application of routine practices and additional precautions in the work environment by all staff will reduce the risk of disease-causing organisms.
2. Everyone in the home will continually use routine practices to prevent the spread of infections. All staff will assess the level of risk related to exposure to blood, body fluids, implement and follow the required routine practices and additional precautions when providing care or services to residents. The home will provide all required supplies and equipment needed for routine/standard precaution practices.
3. The home will have a Trained IPAC Practitioner/Lead.

2) Continuous Recruitment and Retention

Recruitment in health care, especially in LTC continues to be a struggle, many new staff have left, the long-term employees are retiring, and the province just doesn't have enough health care workers which stresses the already over stretched staffing modules. Biggest push has been creatively creating PSW education programs, opening avenues for internationally designated nurses and allied health care providers and use incentives to bring in more staff into this profession.

SCOC has an employed HR Coordinator to take on this project to screen, schedule, onboard and close the gaps in staffing vacancies within the facility.

Supports Provided to:

1. Review applications, telephone screen, schedule interviews
2. Coordinate team to actively participate in interviews urgently
3. Identify gaps in open/ vacant positions, review and asses the need
4. Track references, onboard and release into vacancies
5. Calculate additional funding, hours of care and continue recruitment.
6. Promote ongoing Incentive to retain staff once hired e.g., Educational, and monitory Incentives.
7. Ongoing monitoring of scheduling practices to identify gaps and provide corrective interventions

Over the past 2.5 years the pandemic has significantly affected staffing and scheduling, an already challenged area in health care with the aging staff population, decreased numbers of professionals entering this sector, and impact of a heavily scrutinized, regulated health care governing body. Change over in staff, collective bargaining agreements interpretation and breakdown of existing practices compounded the already frail system.

Implement Supports to conduct deep dive and conduct root cause analysis to correct and re-implement processes:

1. Establish short- and long-term goals; review all processes
2. Current recruitment for PSW is ongoing as we continue to better understand the issues/gaps in scheduling.
3. Daily huddles with Nurse Manager to assess scheduling gaps.
4. Focus on process, schedules, and identifying gaps so they can be addressed.

3) Antipsychotic Reduction Initiative

One of our main goals as an organization, post-acute pandemic, is Antipsychotics being a difficult indicator to reduce yet most important targets to achieve by developing sustainable process to review antipsychotic usage.

Support is provided to Long Term care facilities to achieve the best outcome possible collaboratively.

1. sharing practices through regular scheduled meetings
2. discuss goals and results, answer questions, overcome barriers and share ideas
3. designated representative, Antipsychotic Lead (Registered Nurse), the internal Behavioural Supports Lead well in tune with all new admission, residents triggering worsening behavioural responses and critical incidents
4. targeted controlled approach to identify using validated tools to review, assess, evaluate, and measure outcomes related to responsive behaviours

4) Resident/Family Satisfaction Survey Results meets required Quality Benchmark.

Annual resident and family satisfaction surveys provide organizations insight in identifying areas for improvement or strengthening processes to satisfy the resident/family this service was originally developed to service. Person Family Centred Care places these members in the centre of the circle requesting, receiving, and evaluating care delivery impacting care areas. In consultation with the Residents' Council. Family Council and Staff, SCOC will identify the residents voice in conjunction with validation from family members through focused groups to review the survey results from which the quality projects are selected.