St. Joseph's Continuing Care Centre
Continuous Quality Improvement - Interim Report 2024-2025

Prepared By:
Lynn Theriault
Nursing Care Coordinator, Quality Improvement Lead

Agenda
LTC Quality Assurance Report Quarter 4
Review of the Resident Survey Results.
Surveys completed between the months of December 2024 to March 2024.
Review LTC QIP Report filed to the Ministry March 28, 2024
Review of the CQI Summary Report detailing our LTC initiatives.

Introduction
Continuous Quality Improvement (CQI) is a systematic and ongoing process that identifies areas/gaps for improvement with the development of processes and interventions for sustainable change.

St. Joseph's Continuing Care Centre is committed to improving the quality of life and experiences of the residents we serve. SJCCC is pleased to share its 2024/25 Continuous Quality Improvement Plan (CQIP) with all stakeholders including but not limited to residents, families, service providers and employees.

History
St. Joseph's Continuing Care Centre (SJCCC) has a very rich history, dating back to 1897 when the RHSJ arrived in Cornwall to establish and operate Cornwall's very first hospital, fondly known as Hotel Dieu Hospital. For more than a century, the RHSJ Sisters served our community, never failing to recognize the needs of the sick, the elderly and the very young. The Sister's legacy and tradition of holistic and compassionate care remain deeply rooted within our foundation and these traits are reflected in our Mission, Vision and Value statements and Strategic Plan.

Our Mission: In the spirit of the Religious Hospitallers of St. Joseph, we reveal God's love and mercy through compassionate care focussed on the body, mind and soul of all those whose lives we touch.
Our Vision: To be a Beacon of Hope, on the journey to living your best life!
Our Values: Dignity, Spirituality, Innovation, Accountability, Equity, Safety and Hope.

Strategic Plan (2022-2025)

In 2022 a three year plan was developed in collaboration with the Leadership Team and Board of Directors. The following four core pillars were developed:

- Innovative Care- The Montessori Approach; Transformative Spaces; Program Evolution
- Magnet Employer- Recruitment and Retention; A Culture of Ambassadors; Elevating Appreciation; Community Engagement Initiatives.
- Senior-Friendly Community- Relationship Building; Problem Solving; Legacy Driven.
- Integrated Campus of Care- Internal Expansion; External Inclusion; Full Service Location.

QUALITY OBJECTIVES FOR 2024/25 (See attached Quality Improvement Plan)

High Level Priorities for this years QIP:
Access and Flow
Safe
Timely
Efficient

QIP Priorities are divided into three categories based on their anticipated level of focus as follows:
Focused Action
Moderate Action
Monitoring

Focused Action Areas:

Avoidable ED Transfers:
Under the "Efficient" dimension theme.
We will continue to review the number of avoidable ED transfers for a modified list of ambulatory care-sensitive conditions listed by Health Quality Ontario.
Last Year's Performance: 24.23% -Target not met, with further decline in performance noted.
Previous Year- 12.5%
New Target: 15%
Policy: Not required

Methods for Improvement:

- Track, log and analyze all ED transfers internally to identify trends with preventable transfers; thus, allowing for more timely interventions to be implemented prior to the quarterly provincial report publication.
- Review preventable transfers at the monthly Multidisciplinary meetings, Professional Advisory and Quality Improvement committees.
- Review ED transfers with the interdisciplinary team during weekly Nursing Huddles.
- Complete PCC Significant Change Assessment for residents experiencing a decline in health status.
- Initiate timely communication surrounding goals of care and in limiting transfers to ED with the resident and SDM, when a significant change in health status occurs.
- Education surrounding common chronic conditions to enable registered staff to identify s/s of exacerbation in the early stages to allow for more timely treatment in house.

Note: Falls were identified as the leading cause of avoidable transfers the past year. An indicator specific to falls was included in this year's QIP.

Percentage of residents who fell in the 30 days leading up to their assessment.
New initiative under the "Safe" dimension theme.
Current Performance- 16.55% (CIHI result)
Target: set at 13%
New initiative validation- Residents can experience serious consequences after a fall, including injuries that limit their independence and increase their care needs requiring hospitalizations and surgeries. ED transfers as a result of falls was the leading reason for avoidable ED transfers over the past year at SJCCC.
Policy: 15-a-059 'Resident and Patient Falls Prevention Programme' is in place.
Methods for Improvement:

- Review Risk Management incidents, conduct audits, log and analyze incidents for trends to identify the root cause of falls. Forward information to interdisciplinary team members for prompt follow up when required.
- Discuss fall incidents at the weekly Falls Huddle with the interdisciplinary team members and put strategies and interventions in place to reduce fall incidents.
- Implement the Gap Analysis method from RNAO Best Practice Guidelines for quality improvement objectives.
- Review MDS scores identifying frailty.

Palliative Care:
Under the theme "Timely" dimension. We will continue to work towards improving the percentage of residents who have had their palliative care needs identified early through a comprehensive and holistic assessment.
Target Set- 80%

Last Year's Performance- Target reached during Q3 when 80% of residents were successfully identified early on during their palliative trajectory and interventions were put in place in a timely manner leading to positive outcomes.
New Target Set: 85% (per quarter)
Goal: The intention is to yield a more consistent result each quarter.
Policy- 11-a-22 Palliative Care Approach policy in place.
Methods for Improvement:

- Discussions surrounding goals of care for residents on a comfort care and/or palliative care trajectory and those who are starting to show signs of declining medically are reviewed weekly at the Nursing Huddle. This process allows for early discussions and more timely interventions.
- Review with the team RAI palliative scores-CHESS- identifies frailty and health decline and PSI- Residents with a PSI of 9 or greater is indicative of decline possibly resulting in death within 6 months.
- Monitor/assess residents experiencing increased falls as this is an indicator of frailty.

Moderate Action Areas:

Optimizing PRN Medication Administration:
New Initiative under "Patient Centred" dimension theme.
Target set- 100% of registered staff will receive education for optimizing PRN medication usage to improve pain management and reduce incidence of responsive behaviours.
New Indicator Validation: PRN medication administration audits conducted for specific residents with responsive behaviours and/or increased pain revealed that PRN administration was often under utilized by registered staff.
Methods for Improvement:

- Learning objectives for registered staff surrounding PRN usage to be developed.
- Pain assessments for residents with dementia experiencing agitation and increased responsive behaviours.
- Utilize the " Faces Pain Scale" for residents with dementia that cannot express their needs verbally when agitation to determine if pain is the root cause of behaviours.

Percentage of LTC residents without a diagnosis of psychosis who received antipsychotic medication:
Moderate action indicator under the dimension "Safety of Care". Antipsychotic medication can increase confusion, increase risk of falls and increase risk of death in the elderly. Tapering and deprescribing antipsychotic medications leads to better resident outcomes.
Our Performance- 16.98%
Target- The 14% target was not achieved, however, an improvement from the previous years score of 17.9% was noted. We have successfully surpassed the provincial average benchmark of 19%, however, we will continue to strive to reduce this metric further.
Target for this year: to remain at 14%.

Policy: 14-a-20 “Chemical Restraint and Behavioural Modifiers” and;
11-a-205 ResponsiveBehaviours Management in LTC are in place
Methods for Improvement:

- Statistics obtained through CIHI are reviewed on a quarterly basis.
- Audits and chart reviews to analyze trends with behaviours. Implement strategies to reduce frequency of incidents.
- Medication reviews are completed quarterly by prescribers/pharmacist/ reg staff allowing for opportunities to taper and deprescribe antipsychotic medications when appropriate.
- Residents admitted with antipsychotic medications undergo a med review at the post admission care conference. Discussions surrounding tapering and deprescribing are highlighted.
- BSO and Montessori staff provide alternative non pharmacological interventions for staff to trial that help to reduce behaviours.

Identifiers in place for residents with cognitive impairments on admission:

Moderate Action under the “Safe” dimension:
Status: New Initiative
Performance- To be determined.
Goal- To reduce risk of medication errors for newly admitted residents. 100% of residents with cognitive impairments rendering them unable to self identify will have at minimum 2 identifiers in place on the day of admission. Photo to be uploaded onto the medical chart and an ID bracelet applied.
New Indicator Validation- Photo and bracelets are not consistently initiated during the admission process which was determined to be the root cause for a medication incident.
Policy- 11-a-158 “Resident and Patient Identification” is in place.
Methods for Improvement:

- During the admission process the resident will be assessed to determine cognitive status and recall ability. If a resident is unable to self identify, an ID bracelet will be applied and a photo will be uploaded into the system for the residents safety at the time of admission.
- Google document was created to list residents requiring an ID bracelet for statistics tracking purposes.

QIP Planning Cycle and Priority Setting Process:

St. Joseph Continuing Care has been participating in the QIP process since 2015. We create a quality plan based on multiple factors such as ongoing analysis of performance data through Canadian Institute for Health Information (CIHI) to determine whether we are improving, maintaining or declining with our objectives. Provincial benchmarks are reviewed which allows us to compare our home to other LTC homes within the province. Mandated provincial initiatives also dictate what areas all Homes must focus on. Lessons learned from previously submitted QIP reports inform priorities for the next QI plan. This is an iterative process with multiple touchpoints of engagement with different stakeholder groups as QIP targets and high-level change ideas are identified and confirmed. Final review of the QIP is completed by the Quality

Lead, and presented to the Quality Improvement Committee before it is forwarded to the Board of Directors.

QIP is an important quality measurement, resource and communication tool which is developed and submitted annually to the Ministry. Areas that drive our annual QIPs are based on the following criteria:

- Canadian Institute for Health Information (CIHI) statistics
- Performance data from Quality Indicators and provincial benchmarks through HQO
- RNAO Best Practice Guidelines (BPG)
- Resident, family and employee satisfaction surveys
- Results based on Internal data collection-auditing process
- Critical Analysis review- assessing for trends.
- Review of Critical Incidents
- Review of Risk Management incidents-trends
- Recommendations identified under the Fixing Long-Term Care Act, 2021.

Process for Monitoring and Measuring Progress:

- Quality indicators are reviewed during Quality Improvement committee meetings as well as Leadership and Professional Advisory Committee meetings.
- Weekly nursing huddle meetings.
- Monthly Multidisciplinary meetings
- Internal audits
- Quarterly statistics from CIHI

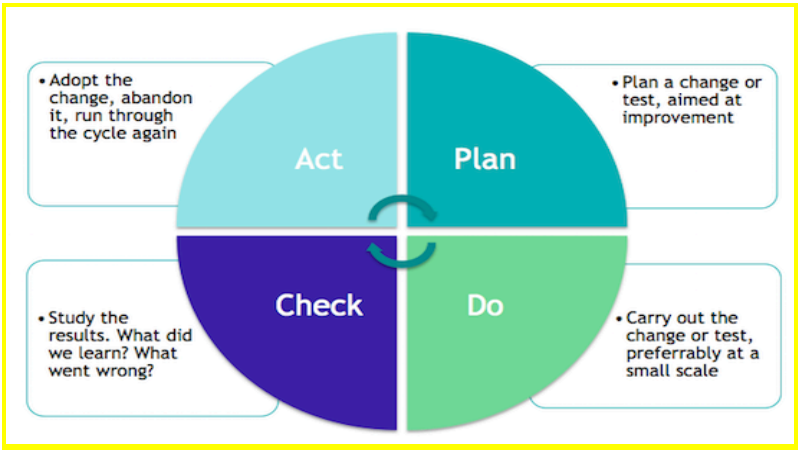
Process to Communicating Quality Outcomes:

- Discussions held during Huddles
- During Leadership and Partnership meetings
- PAC and QI meetings
- Quarterly reports to the Board of Directors
- Annual posting of QIP on website and internally on bulletin board
- *New- Quarterly quality updates will be posted on the bulletin board in the main hallway and sent to all employees via email.
- Posting of statistics on PCC Boards.
- Share reports with the Resident and Family Councils

<u>Continuous Quality Improvement Models:</u>

SMART Framework: Allows for effective prioritization of goals and objective development. SMART acronyms stand for: Specific, Measurable, Attainable, Relevant and Timely.

Plan-Do-Check-Act (PDCA) Cycle: The PDCA (Plan-Do-Check-Act) cycle is an interactive problem-solving strategy to improve processes and implement change. The PDCA cycle is a method for continuous improvement. Rather than representing a one-and-done process, the Plan-Do-Check-Act cycle is an ongoing feedback loop for iterations and process improvements. By following the PDCA cycle, teams develop hypotheses, test those ideas, and improve upon them in a continuous improvement cycle.



Achievements and Successes from the Past Year:

- SJCCC celebrated a new state of the art 2400 sq foot rehabilitation space that was completed this spring.
- EDI Education- 88% of employees completed EDI mandatory education over the course of the past year. The remaining 12% must complete their education upon their return to work.
- Resident Survey collection times changed from annually to quarterly. This new process allows for a more timely process in identifying issues and gaps leading to actionable changes.
- Recruitment and successful hiring of an IPAC Support Nurse.
- Purchase of new diagnostic equipment- IV pumps, vital sign towers, and a bladder scanner.
- A new Multi Faith Reflection space was created for staff to reflect, meditate and pray.
- Two automated medication dispensing cabinets were purchased through government funding opportunities.
- Three year CARF Accreditation awarded May 2024.
- CADD pump training completed for all RNs.