Narrative

Overview

Copernicus Lodge is a not-for-profit charitable organization that operates a 228-bed long-term care home in the Parkdale-High Park ward, in southwest Toronto. Locally, our Roncesvalles Village neighborhood continues to re-invent itself: the out-migration of Polish residents and aging of the remaining group continue to challenge fund-raising efforts, marketing, and volunteer recruitment.

Within Copernicus Lodge, we continue to be called upon to become more creative in our resource use and prioritization of work. We have responded to constraints and changing composition of the management team and Board with adaptability and grace. This year, we can re-imagine our direction with a new strategic plan and look forward to updating our three-year operational plan to reflect the new priorities.

Despite significant pandemic challenges and impact on clinical and administrative operations, Copernicus Lodge successfully launched several quality initiatives:

i) an antipsychotic stewardship program, an achievement we are most proud of improved collaboration across multiple disciplines, improved communication and documentation across disciplines and drove a 10% reduction in the percentage of long-term care home residents without psychosis who were given antipsychotic medication in the seven days preceding
ii) investment in the capacity and size of the BSO team
iii) bedrail elimination
iv) creative programming during isolation and outbreaks
v) a cultural identity committee comprised of staff, families, and residents
vi) focus on improving vaccine hesitancy

As part of our quality program, a set of well-designed indicators that capture operations across the organization have been designed and will be reported to the Board as of Q2. Among them are clinical data, benchmarked against Ontario norms. Respectful of LTC operational challenges, and possibility of escalating labour unrest, the 2023/2024 QIP will be limited to addressing the required QIP indicators:

i) Number of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents.
ii) The percentage of residents responding positively to: "What number would you use to rate how well the staff listen to you?"
iii) Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences".
iv) Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment

The Quality Improvement Program QIP has been shared with the Board, the management, all staff, and internal stakeholders to ensure understanding, awareness, and buy-in.

Patient/client/resident partnering and relations

Pandemic restrictions challenged everyone to re-think how communication, involvement in process improvements, socialization and support would continue, given the pandemic restrictions. Most challenging in this environment was the delivery of recreational and social activities to residents and families. Early in 2020, Program and Services implemented programs of behind glass visiting, back garden table visits, Zoom, FaceTime and other means of virtual contact. We were able to stream daily Mass to every RHA to compensate for prohibition of physical presence. And we experienced - as did everyone worldwide - how inadequate that virtual support was to maintaining meaningful contact and the heavy toll it exerted on psychological well-being of our seniors. When the weather and Directives allowed, we also made creative use of our outdoor space to facilitate in-person meetings**.**

It was equally challenging updating families against the background of often hostile press coverage. Nevertheless, we updated existing email contacts and internal communication systems to reach families and Substitute Decision Makers (SDM). Additionally, we implemented Cliniconex messaging app which is linked to our EHR to facilitate contact with families, utilized email, text or voice to contact families. Virtual Zoom meetings to stay in touch with families and staff were held weekly, biweekly then monthly at the height of the pandemic. We also created links between management to Family Council, which, in turn, updated families and interested parties through various social media. Finally, the invitation to participate in the annual satisfaction survey represented a powerful means for residents and families to suggest areas of improvement.

The introduction of new software and creative programming has strengthened our Program and Services activities in the face of on-going staff shortages. And a creative approach to on-boarding volunteers led by a new Coordinator promises to be a highly attractive draw for volunteers.

Adding to sources of support for residents and families was the one-to-one interventions by our Social worker. And throughout the pandemic, religious and end of life programming and support continued to comfort and support residents and families.

Physician rounding and in-house on-call was also provided daily for the better part of the pandemic; availability of consultants remotely strengthened capacity to address resident issues in house safely, and consultants – e.g., Baycrest – continued to be available remotely.

Provider experience

In the face of the unprecedented challenges of the past two years - impossible working conditions - staff across the organization have exceeded expectations with tireless effort and compassion. Stretched to capacity, many suffered burn-out, became infected with COVID, forfeited holidays, and made sacrifices to ensure safe environment for residents. And while one would like to begin this section with a statement that the “State of the Union” is strong, it would be untrue.

Providers across all operational areas are stressed, over-worked, and face more challenges in the day-to-day work environment with colleagues and families. Although management has sought to keep in touch with regular Zoom meetings, continued open door policies, and appreciation events at holidays and randomly thanked staff on all shifts, the changes wrought by the pandemic have had a demoralizing effect on employees.

The new requirements for additional time for resident care have been met for residents but had a significant financial cost and impact on morale, especially the use of agency staff. It has not been lost on either party that co-workers working shoulder to shoulder may be earning twice or three times the hourly rate as their neighbor. This disparity is one of many unintended consequences of strengthening requirements in the face of shortages across all sectors. Further, the decision taken to make permanent the PSW raise increase, while merited, created wage compression between registered staff and did nothing to improve morale. Other departments shared their concern that the top up was only awarded to one group.

In this inflationary environment, with rents and food costs skyrocketing, the Ontario government appeal of the court decision that struck down a law limiting wages for public-sector workers created further resentment. Among these "heroes"" of the pandemic there is growing anger and frustration. How long the resilience will last – especially this year of contract renegotiations, is a critical unanswered question.

In February (2023) an employee engagement survey was launched - unfortunately data collection has been extended due to minimal participation.

Perhaps the greatest disappointment and challenge to everyone working in the sector is to admit that you will never be able to provide the care/service you know you want to and come to some accommodation with that sad fact.

Workplace Violence prevention
2019 saw updating of all procedures, policy and forms related to this topic. The Program review reported 12 instances of "bullying/harassment" in 2022. Six remain under investigation, four were substantiated, two resulted in discipline and two resulted in no discipline. Areas of consideration for the future include training re: managing difficult employees and workplace violence training.

Patient/Resident Safety
A variety of long-standing practices address resident safety. *Medication safety* and error analysis in partnership with pharmacy address medication errors and have for years. Debriefing at quarterly Medical Advisory meetings, and direct and timely follow-up with individuals or all staff as appropriate have been in place for years. Several incidents sparked process redesign, and house-wide staff education – e.g., disposal of fentanyl patches.

Regular monthly care conferences have been the practice for years and continue, albeit remotely. These have always represented opportunities to address errors, error identification, improvement in practice and feedback from residents and their families/SDM. Remote consultations with physicians and specialists are also employed to address patient/residents' safety.

Admission medication reconciliation is a valuable tool for medication safety. The IPAR (Inter-Professional Admission Review) program was launched in September, 2022. It helps to ensure resident medications are accurate and alleviates Registered staff workload on the day of admission.

Over the past couple of years, CL has expanded its use of technology in support of Patient safety: Risk Management (incident report) module in PCC, Skin and Wound and IPAC Module, and the WRITI system for ordering / prescribing medication have been implemented. Use of technology has not only reduced

error incidence, but improved efficiencies in care delivery. Automation in incident reporting has facilitated reporting and analysis.

The introduction and growing prominence of the BSO group in the last two years, and the arrival of a new IPAC Lead have already had a salutary effect on the practice. Both can provide support and immediate feedback re: clinical practice/ approach to anyone delivering care or other services in the building. Additionally, cameras have been added to common areas for staff, residents, visitors, and contractor safety.

Health Equity

A set of three events have motivated a second significant project – Respecting Cultural Diversity and building cultural competence. Firstly, during the pandemic, and recently with Bill **7: *More Beds Better Care Act*,** we have seen more non-Polish persons transferred from alternate level of care (ALC) beds into this cultural environment. The newcomers are understandably innocent of customs, language, and mores. Although this small cohort appears to be acclimating nicely to their neighbours and the surrounds, some family members have been less than welcoming – seeing their presence as an incursion into exclusively Polish grounds. Secondly, further enriching our work environment but threatening to some existing staff and

families, is the changing composition of the caregivers. No longer is recruitment able to retain Europeans, and particularly Polish workers. Rather, many incoming staff are from the Asian subcontinent and elsewhere. Obviously, they also overwhelmingly lack appreciation for the language, customs, foods, and ceremonies uniquely Polish. Similarly, the Polish staff is ignorant of the other workers traditions. Many have formed solid working relationships with Polish workers and are slowly mastering some words; others have not. CL has cultural celebrations of a diversity of ethnic backgrounds for all staff and residents to learn about their new co-workers. Finally, last year, a diverse group, including Program & Services, the Board, members of Family Council and others, was formed to address creating a program to ensure that cultural diversity was appreciated. Not only to preserve cherished traditions by Polish seniors, but to teach and include non-Polish seniors and staff in this rich tradition. Two roles have been implemented: A Cultural Ambassador is a Board Director who has a portfolio for culture. This individual will help non-Polish leadership deal with challenging issues. The second position is being posted: the Communication and Heritage Director is a combined role of the Communications Director and will also be responsible for heritage for the organization – with internal and external stakeholders, especially staff onboarding, cultural events, community engagement, translation, etc.

Reflections since your last QIP submission

Resident and staff safety have been top priority throughout the pandemic. In addition to new legislation and regulations and reporting requirements, many frontline staff were placed on unpaid LOA due to vaccine hesitancy and a refusal to comply with the mandatory COVID vaccination policy. Twenty-six staff remain on unpaid Leave of Absence (LOA.) The retirement of direct caregivers led to a transformation in the composition and culture of the workforce, and we lost our volunteers. There has been significant turnover in senior and middle management destabilizing the leadership team throughout the pandemic.

Quality improvement is an essential part of resident care and quality of life. However, there are many barriers to implementing quality improvement initiatives. These include lack of funding, lack of qualified staff, training and resources, management turnover rates, reputational damage, and lack of trust throughout the sector; resistance to change and lack of data systems and analytics infrastructure**.**

The organization will work toward optimal standards regardless of the existing challenges but will ensure these operational realities are reflected in the workplan.

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