Quality Improvement Plan (QIP)

Narrative for Health Care Organizations in Ontario

March 27, 2024

Copernicus
A place to call home

Ontario Health

OVERVIEW

CL is a charitable, not for profit home with 228 licensed LTC beds, and 200 apartments located in the Parkdale/Roncesvalles community. LTC includes 2 short-stay beds, offering respite care for caregivers in need of temporary relief. At the heart of Copernicus Lodge is a holistic, resident-focused approach, a Christian environment and strong Polish heritage.

The neighborhood continues to change around us, and in parallel, so has our resident profile compared to 5 years ago: Our residents tend to be older: Most are in their eighth, ninth and tenth decade. Many more than previously are being admitted from acute care Hospital (84.6378%), have a greater complex care need, and 25.8 % are admitted on psychotropic medication.

In concert with every LTC home in the province we continue to be challenged by staffing shortages, crisis admissions, and changing legislative requirements. We reviewed our quality and risk structure and aligned our Terms of Reference with the requirements of the new legislation and regulations.

In the past year, CL saw a number of changes in senior management staff, including a new CEO. This year, as we move out of the pandemic and into a more stable leadership environment, we will also re-imagine our strategic plan and update the three-year operational plan to reflect the priorities. Our operational and project work reflects Ontario Health directions, LSAA, relevant legislation, and issues arising from quality and risk surveillance.

In spite of the transitional nature of the past year, important projects made significant progress including multiple successes

related to document management – electronic and paper - and transitioning to Extendicare policies. We look forward to continuing work in both areas. In addition, important quality initiatives related to inventory management are already underway.

ACCESS AND FLOW

As part of the integrated referral and placement system, we have little power to improve wait times for admission at CL or access to long term care.

That being said, improvements were made in addressing resident flow – both internally and across the system: The Behavioral Support team has actively facilitated prompt movement of behaviorally disorganized residents to our Dementia Care unit for recalibration of care - including medications. This has resulted in minimal disruption to the ecology of the originating units.

Review of specialized programs has reduced the necessity to transfer residents to acute care for management: For example, the falls program has been modified to reduce avoidable visits, as have our pain and skin and wound care processes. Family focused interventions by physicians and staff, and improved capacity to manage challenging palliative symptom management issues have reduced to well below provincial average our avoidable transfers to acute care. Supporting and educating residents and family at the End of Life have proven to be powerful tools in lowering avoidable hospitalizations, and strength of nursing staff, physicians and consultants providing support has similarly helped drive this number down.

We continue to work with the NLOT team to provide ongoing support for nursing staff through the emergency mobile nursing services. We have transitioned to support from SJHC to align better geographically and proximity to our home. A Nurse Practitioner from SJHC is now supporting us as part of the NLOT team. Finally, a second assistant DOC and a nursing supervisor has been added to support staff in person across all shifts.

We continue to work to lower avoidable hospitalizations through new models of care, timely and focused physician support and family and resident education.

EQUITY AND INDIGENOUS HEALTH

Ontario Health is committed to driving improved and equitable outcomes to reduce health inequities across the province. At CL, with the changing composition of our provider and resident bases, it is important that everyone feels welcomed, safe and valued.

Human Resources has recently crafted a diversity, equity, and inclusion policy statement, with vision, mission, and values, which fulfills our Service Accountability Agreement obligations. It has been rolled out to management staff, and the intent is to roll this out to front-line staff, with the aim of completing training by Q4 for all employees. DEI is now included as a part of annual SURGE learning mandatory training.
CL continues to include education related to AODA and Code of Conduct to all incoming employees, and annually during mandatory training.

PATIENT/CLIENT/RESIDENT EXPERIENCE

Perceptions of service quality are gleaned through interaction with residents and families, Resident and Family Council input,

complaints data, and on survey feedback sought annually from residents and families. This data is shared at all levels of the Organization, and quality plans are formulated to address preventive and corrective actions targeted at identified areas for improvement.

Resident and Family Councils continue to meet, and have representation on the Continuous Quality Improvement Committee, where they have the added opportunity of sharing concerns and observations with all participating staff across departments.

During the past year, with the lifting of COVID restrictions by the provincial government, Program and Services re-instituted group- and RHA-pecific activities, including use of outside contractors. CL is also gradually resuming work with secondary schools, inviting students back into the home to volunteer with recreational activities. This has been an important driver of increased satisfaction.

As has the increased PSW staffing mandated by legislation which has improved the scope and depth of care delivery for residents. In addition, we are addressing staff shortages not only with aggressive recruitment and retention policies, but also by utilizing multiple agencies to fill in any gaps.

CL is beginning to prepare for our initial Accreditation Canada visit, later in the year. We will be addressing quality expectations as outlined by the Qmentum Long-Term Care Accreditation Program

PROVIDER EXPERIENCE

The quality initiatives described above have improved the scope of feedback from external stakeholders, and internal care recipients. We have also greatly improved timeliness and relevance of communication using PCC, and other software to ensure that family, substitute decision makers and staff are updated.

It continues to be a challenging time for health care organizations with unprecedented human resources challenges – including shortages, higher turnover rates, and staff burnout. In spring of 2023, the Social Engagement & Diversity Committee was formed. Its terms of reference are “to promote a positive and engaged workplace culture in Copernicus Lodge. The committee aims to develop strategies and initiatives that foster employee engagement, job satisfaction, inclusivity, diversity, and well-being. It will develop initiatives and programs that foster an environment of respect, equity, and belonging”, and complement the DEI education.

Survey results identified many opportunities for improvement/actionable items.

Many initiatives – such as appreciation events at holidays - and randomly thanking staff for their service continue. Small projects have also been completed to improve employee satisfaction: For example, after living with COVID re-imaged locker rooms, they have been updated, and restored to meet staff needs and expectations.

EAP continues to be available as needed.

SAFETY

The CL commitment to resident safety is reflected in our committee structure, where accountability for oversight for risk and safety reside. We have instituted an integrated Balanced scorecard to support fulsome reporting quarterly which is shared with the CQI committee, and then with the Quality & Risk Mgt. Sub-committee of the Board. Internal committees have family representation which improves transparency.

A variety of long-standing practices address resident safety. Regular monthly care conferences have been the practice for years and continue. New order entry software was introduced, which minimizes the risk of transcription errors as well as having a salutary effect on the process efficiency.

Medication safety and error analysis in partnership with pharmacy address medication errors; 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. In 2023, through MST funding, the home instituted biometric emergency medication carts.

Agendas on all Specialize Program agendas include safety discussions as is appropriate. Annual review of those programs is in part to ensure that safety issues are fulsomely addressed.

Incident reporting by staff through the Risk Management module in PCC was upgraded to use software which has fully automated and facilitated report running, and review.

POPULATION HEALTH APPROACH

Although Ontario government public policy is funding Health Teams across the province to “ensure that every person in Ontario can have the support of an Ontario Health Team,” long term care providers are still not yet on the list of eligible providers and organizations. We strongly support a more inclusive model re: this important nexus:

At maturity, OHTs, a pillar of Ontario’s current health-system transformation, will be clinically and fiscally accountable for delivering a full and coordinated continuum of services based on population-health needs of their attributed populations.
This transformation represents an important opportunity for addressing key challenges faced by long-term care in Ontario but requires careful consideration about how the intersections between OHTs and long-term care homes will operate.
REF: McMaster Health Forum. Rapid Synthesis: Intersections between Ontario Health Teams and Long-term Care 30-day response
https://www.mcmasterforum.org/docs/default-source/product-documents/rapid-responses/intersections-between-ontario-health-teams-and-long-term-care.pdf?sfvrsn=8285adfa_8

We continue to work closely with the Unity health network; and collaborate with a variety of providers including.

? Toronto Public Health
? laboratory
? radiology
? neuropsychiatric resource
? ET

? chiropody
? dental
? optical

and other specialists to optimize resident care in house.

CONTACT INFORMATION/DESIGNATED LEAD

Designated Lead:
L. Chandran,
Director of Operations

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 25, 2024**

Ted Opitz, Board Chair / Licensee or delegate

Liana Chandran, Administrator /Executive Director

Marc Buklis, Quality Committee Chair or delegate

Aleksandra Grzeszczuk, Other leadership as appropriate

Access and Flow

Measure - Dimension: Efficient

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Total number of days in Outbreak	C	Days / LTC home residents	In-home audit / Jan - Dec 2024	128.00	110.00	several opportunities related to both environmental cleaning, supply inventory and clinical practice identified re: opportunities for improvement	

Change Ideas

Change Idea #1 Update inventory of environmental and personal cleaning chemicals to meet Ministry guidelines

Methods	Process measures	Target for process measure	Comments
1. Identify, segregate and dispose of outdated products in Storage, in the Kitchen, and in clinical areas 2. Select and stock approved supplies 3. Institute calendar of quarterly checks re: expiration dates 4. Educate staff re: proper use as required	1. No. outdated/inappropriate products identified, segrated and disposed of. 2. Completed audits sent to appropriate manager (EVS -environmental), and DOC (clinicaL) and IPAC lead for all products 3. Staff education to or concurent with product roll-out	1. 100% 2. 100% 3. 80% excluding absent/LOA staff	

Change Idea #2	Re-design current management of isolation linens by personal care and Laundry staff to ensure accurate identification, timely segregation, and correct washing of isolation materials		
Methods	Process measures	Target for process measure	Comments
1. Map current processes on clinical units, and in the laundry 2. Identify areas of weakness 3. Design corrective actions with involved staff 4. educate staff 5. Roll-out improved practices and audit randomly for effectiveness	1. Map "as is" process with representatives from both groups to ensure accuracy 2. identify gaps/omissions/errors, and opportunities for improvement 3. Redesign process with staff input 4. educate staff in both areas 5. Implement	1. Define problem using all involved parties to ensure accurate description of the process "as is". 2. With DOC, Mgr EVs and staff representatives create a redesign that reflects best practice and is feasible 3. Trial the improved process and re-adjust if or as necessary 4. Educate staff, 5. Implement process	

Equity

Measure - Dimension: Equitable

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education	O	% / Staff	Local data collection / Most recent consecutive 12-month period	CB	95.00	Management group requires orientation to this important topic. Presented in FEB 2024 to managers by Mgr. HR	

Change Ideas

Change Idea #1 Educate all management/administration staff to major concepts diversity/equity and inclusion prior to roll-out to non-mgt. employees

Methods	Process measures	Target for process measure	Comments
1. Mgr. HR, with Board of Director input, to draft Policy statement, with mission and vision	1. DEI Policy approved by Board of Directors, and 2. rolled out organization wide	100% of all n staff complete the DEI mandated SURGE learning by end of the calendar year	Draft completed as of mid FEb 2024; approval pending

Change Idea #2 introduce DEI concepts to non-management staff

Methods	Process measures	Target for process measure	Comments
require 2 short, SURGE activities as part of annual mandatory retraining of staff	SURGE compliance	100% of employees, excluding those away due to LOA	

Experience

Measure - Dimension: Patient-centred

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Implement CHESS score - to triangulate with SPICT score for use during care conferences, especially re: deteriorating residents The CHESS score (Changes in health end stage disease and signs and symptoms) and the J5c (end stage disease 6 months or less to live) report will be run from PCC to identify residents that are experiencing a change in health status.	C	% / LTC home residents	In house data collection / Quarterly	CB	90.00	This additional assessment represents a new collaboration with the RAI MDS coordinator, and process change for staff. Target excludes residents enrolled in the end of life program hysicians have expressed interest in triangulating the CHESS score with the SPICT: Residents identified in this category CHESS 3 or higher and residents identified on the J5c report will be discussed at quarterly meetings or care conferences. The team will review resident status, any referrals that need to be initiated, the need to communicate changes with the family/book conference, health care wishes, current interventions etc.	

Change Ideas

Change Idea #1 Addition of assessment instrument (CHESS) complimentary to SPICT, to quarterly and ad hoc care conferences related to change in condition

Methods	Process measures	Target for process measure	Comments
RAI MDS coordinator/member of nursing management team to run reports out of PCC re: CHESS score and make available to registered staff 2. add to PPC field - care conference [assessment field] spaces for SPICT and CHESS scores	no. of quarterly summary reports generated that meet criteria of two score reporting	95% of resident care conferences shall have SPICT and SCHESS scores available for participants to ground discussion	Members of the nursing management team can run reports when cross coverage is necessary.

Safety

Measure - Dimension: Safe

Indicator #4	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	O	% / LTC home residents	CIHI CCRS / July 2023– September 2023 (Q2 2023/24), with rolling 4-quarter average	23.35	22.00	Fully one quarter of all new admissions to LTC are entering on prescribed anti-psychotics, and often other psychotropics	

Change Ideas

Change Idea #1 Enhanced collaboration of BSO team members and nursing and personal support staff with RAI MDS coordinator

Methods	Process measures	Target for process measure	Comments
1. Institute a weekly review of the RAI/MDS schedule of all residents who are triggering inappropriately prescribed antipsychotic 2. The BSO lead or alternate to assess those residents to determine if they are experiencing delusions, hallucinations that can be coded during the look back period 3. Identify specific documentation suggestive of the presence of delusions (all types) and hallucinations in residents receiving anti-psychotic medication 4. Educate staff on requirements for enhanced detail in documentation	1. Educate BSO team members of clinical signs suggestive of delusions/hallucinations 2. BSO group to educate PSWs 3. Education of registered nursing staff of those same clinical signs and the need for detailed documentation when prompted by PSW/BSO reporting (ie during MDS lookback period).	1. 100% BSO team members 2. 95% registered staff - excluding those on LOA	Detailed documentation by nursing and personal care staff will facilitate medical documentation that truly reflects resident status. The presence of documented symptoms will enhance the probability of accurate reporting by RAI MDS, and truly reflect the measure being reported to CIHI