Theme I: Timely and Efficient Transitions | Efficient | Priority Indicator

	Last Year		This Year	
Indicator #1 Number of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents. (Bobier Villa)	**15.07** Performance (2022/23)	**14** Target (2022/23)	**X** Performance (2023/24)	**10** Target (2023/24)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Provide refresher education to all staff for Comfort Care Rounds and then implement comfort rounds on Residents identified as being high risk for falls and/or Residents with a precarious health condition.

Target for process measure

- 100% of staff will have been provided a refresher on Comfort Care Rounds by Dec 2022. All high risk Residents will be assessed and considered for comfort rounds

Lessons Learned

In 2022 we provided staff with education on Comfort Care Rounds through SURGE learning. During weekly team huddles the MRC and the team would discuss recent ED visits, high acuity level residents and whether comfort rounds would be a viable intervention to prevent avoidable ED visits.
What we learned is that not all departments were able to attend these huddles either because they were unaware that huddles were taking place or because past huddles had been primarily nursing focused. Comfort rounding is dependent upon all staff participation and without that team approach we were not able to optimally implement comfort rounds in 2022.
Our plan for 2023 is to introduce all departments to Comfort Care rounds through huddles and staff meetings.
The Manager of Support Services and the Manager of Program and Therapy will be invited to participate in team huddles, as will staff in all departments. This will provide equal opportunity to all staff, to ask questions and offer suggestions. This will ensure that all staff have the same understanding and information when implementation begins.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Track and analyze each ED visit by utilizing a formalized tracking system that specifies reason for transfer, diagnosis, who sent the Resident, order and/or treatment received, admission to hospital, preventable transfer.

Target for process measure

- 100% of ED visits will be tracked and analyzed by CQI team at monthly meetings

Lessons Learned

We successfully created a tracking sheet for gathering information on all emergency department visits. At our monthly CQI meetings we reviewed and discussed each ED visit. This allowed us to identify trends in ED visits and we determined that the primary reason for ED visits in 2022 was falls.
Our quality improvement plan for 2023 will address this.

Change Idea #3 ☑ Implemented ☐ Not Implemented

MRC will meet with the staff on each unit on a weekly basis to determine which Residents may benefit from additional monitoring or interventions. Discussion will take place to promote safe mobility in Residents at high risk for falls, to identify sensory impairments requiring interventions, to discuss pain and palliative care management and for other precarious health conditions that may lead to a potential ED visit.

Target for process measure

- Within 3 months 100% of Residents will be reviewed for potential risk of conditions requiring ED transfer.

Lessons Learned

Weekly huddles afford the care team the opportunity to brainstorm ideas about what additional interventions may be beneficial to high risk residents.
Again, a key learning for us was that all staff need to be involved in team huddles. This team approach provides the best quality of care for our Residents and empowers staff to participate in care planning.

Comment

Our overall goal for preventing avoidable Emergency Room visits in 2022 was to track the trends and to determine the reasons that residents were going to the Emergency Room. With that information we gained a better understanding of what we needed to be alert to when assessing residents with a high risk health diagnosis or residents with a potential for a rapidly changing health status.
Our second goal towards reducing the number of avoidable ED visits was through 1) the utilization of communication tools and 2) through improved communication methods between the nursing staff.
We've learned that open communication between all departments/staff is essential for positive outcomes and we have addressed this change in our Quality Improvement Plan.
Moving into 2023 we will build upon improving the communication method used to convey information to all staff (not just nursing staff) specifically as it relates to comfort rounds. We will continue our work on comfort rounds by creating and utilizing a formal referral and evaluation system and by continuing to monitor and evaluate the effectiveness at our monthly CQI meetings.

Theme II: Service Excellence | Patient-centred | Custom Indicator

	Last Year		This Year	
Indicator #3 Percentage of Residents responding positively to the question "Do staff intentionally start with what matters most to you when delivering care?" (Bobier Villa)	**92** **Performance (2022/23)**	**100** **Target (2022/23)**	**100** **Performance (2023/24)**	**--** **Target (2023/24)**

Change Idea #1 ☐ Implemented ☑ Not Implemented

Care Plans to detail Resident Centered language, as directed by Resident/Family.

Target for process measure

- By Dec 2022 100% of care plans will reflect individual care provision including the order of care provision if indicated.

Lessons Learned

In 2022 we began to implement the RNAO BPG of Person and Family Centered Care. An integral component of this guideline is resident Centered Language. We provided education to staff via SURGE Learning about Resident centered language and will continue this process in 2023. Although work has begun on this change idea, one of our project goals is to ensure that Person and family centred care language is reflected in all aspects of documentation in 2023.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Five Things About Me pamphlet will be filled out on the day of admission by the registered staff and/or BSO team. This will be reviewed and updated at the admission care conference. It will be posted on the bulletin board in the Residents room.

Target for process measure

- 100% of new admission Residents will have a completed pamphlet by Dec 2022

Lessons Learned

We continue to capture information about a Resident status by utilizing the Five Things About Me pamphlet, however we are seeking to replace this with a more inclusive and detailed document.

Comment

We achieved 100 % - our target, and recognize the value and importance of continuing this work in 2023.

Indicator #4

Resident Care experience; All staff will wear name tags (Bobier Villa)

Last Year		This Year	
78	**100**	**91**	**--**
Performance (2022/23)	**Target (2022/23)**	**Performance (2023/24)**	**Target (2023/24)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

Resident and Visitors will know who is on duty and will be able to identify staff by their name tags which are colour coded according to departments.

Target for process measure

- By Dec 2022 100% of staff will be wearing name tags 100% of the time.

Lessons Learned

Bobier Villa educated all staff on the importance of wearing name tags. This was discussed at each team huddle, at project management meetings and at monthly CQI meetings. Notices were posted throughout the home reminding staff of the importance of wearing name tags. Additionally, we posted notices that identified which department the coloured tags represented i.e. royal blue name tags are worn by registered staff, orange is the recreational department, etc.
When screening staff at the start of their shift, the Visitor Attendants remind staff to wear their name badges. For staff who have forgotten their name tags, a temporary one is provided by the Visitor Attendant and the Administration Assistants.
We successfully implemented the use of a name board, posted centrally, in clear view for all to see, on which all on-duty staff write their names. This was created to make it easier for Residents, SDM and Visitors to identify who is on duty that day and who to seek out if they have questions or comments.

Comment

Our quality improvement goal for Service Excellence in 2022 was to provide residents, families and visitors with an quick and easy means of identifying staff who were on active duty. We were successful in achieving this but did not quite reach our goal of 100% Resident/Family satisfaction with this. Moving into 2023 we will continue to promote the use of the name board and name tags as part of our Person and Family Centered Care Best Practice Guideline.
With Resident Council approval, in the 2023 survey, we will consider rewording how the question is asked as the wording in the 2022 survey consisted of 3 parts without the option of rating just one area.

Theme III: Safe and Effective Care | Safe | Priority Indicator

	Last Year		This Year	
Indicator #2 Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment (Bobier Villa)	**7.14** Performance (2022/23)	**6** Target (2022/23)	**3.08** Performance (2023/24)	**3** Target (2023/24)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Auditing of all physician orders for all Residents taking an anti-psychotic medication (both atypical and typical) with the focus on ensuring all orders have a supporting diagnosis.

Target for process measure

- 100% of our Residents will have a supporting diagnosis when taking any anti-psychotic medication by the end of Dec 2022.

Lessons Learned

At each monthly CQI meeting the team reviews all antipsychotic medication use within the Home. We follow the line of use starting with the physician order ensuring that the medication includes an indication for use. The team reviews the assessments and the progress notes of residents using an antipsychotic. The care plan is reviewed to ensure that the antipsychotic use has been captured; side effect awareness and alternative interventions are included.
Additionally, the registered staff, the Pharmacist and Physician review each of these medications on a quarterly basis to ensure appropriate use and dosage and to scan for any potential drug interactions.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Education to Register staff who complete MDS coding; ensure medical diagnosis aligns with MDS data sheet in PCC and that care plans reflect this. Education to all front line staff defining delusional disorder or delusional responsive behaviors.

Target for process measure

- 100% of frontline registered staff will receive education on MDS coding by Dec 2022.

Lessons Learned

The MDS RAI Coordinators work with the Manger of Resident Care to ensure that all registered staff receive 1:1 MDS/RAI training. A tracking sheet is maintained by the Coordinators. This training occurs 3-4 months after a registered nursing staff member has been hired and has been comfortably providing direct Resident care.
Additionally, registered staff complete annual testing on Coding and Raps.
Education, as it relates to antipsychotic use, includes SURGE Learning and instruction by the Coordinators on how to recognize delusions and hallucinations.
Further to this, definition and recognition of delusions and hallucination, was provided to all staff via SURGE Learning.

Change Idea #3 ☑ Implemented ☐ Not Implemented

Education to Substitute Decision Makers and Residents about alternative methods for managing responsive behaviors.

Target for process measure

- 50% of audited admission progress notes and conference notes, will attest to active discussion between either the MD or register staff and Res/SDM regarding alternative means of managing responsive behaviors. Goal date is end of year

Lessons Learned

Care conferences are led by the registered staff utilizing an integrated method to ensure that pertinent information is shared. This includes a review of the medications that the Resident takes as well as the kardex care plan. During this review alternative methods for managing responsive behaviors are discussed with the Substitute Decision Maker.
Moving into 2023 are goal is to improve this focus by beginning our discussions during the admission process and documenting this in the progress notes and care plan.

Comment

Our target goal for 2022 was reduce antipsychotic use, in residents without a diagnosis of psychosis, from 7 % to 6%. In 2022 we far exceeded our target and reduced to 3% without an increase in responsive behaviors.
Antipsychotic medication use and alternative methods of managing responsive behaviors are under frequent review by the CQI team, Nursing staff, Physician and Pharmacist. We are well below the the provincial average. We will continue to monitor our performance trends and will implement a quality improvement plan if trending towards the provincial average.