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

Indicator #1	Last Year Performance (2022/23)	Last Year Target (2022/23)	This Year Performance (2023/24)	This Year Target (2023/24)
Number of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents. (Elgin Manor)	22.13	15	15.57	13

Change Idea #1 ☑ Implemented ☐ Not Implemented

Provide refresher education to all staff for Comfort Care Rounds and then implement Comfort Care Rounds on all Residents who have been identified as a very high risk for falls and for Residents with a precarious health condition.

Target for process measure

- 100% of staff will have been provided a refresher course by Dec 2022. 100% of Residents identified as a very high risk for falls will be assessed and considered for Comfort Care Rounds by a fall team member.

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 and through a SURGE learning powerpoint presentation unique to Elgin Manor.
The Manager of Support Services and the Manager of Recreational Programs will be invited to participate in team huddles that pertain to comfort rounds, 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/or treatment received, admission to hospital and where it may have been a preventable transfer.

Target for process measure

- 100% of ED visits will be tracked and analyzed by the CQI team on a monthly basis.

Lessons Learned

A formal worksheet was utilized in 2022. The results of which were shared at each CQI meeting. Trends were tracked and analyzed. It was determined that 13% of our avoidable ED visits were related to falls. This turned our attention to how to prevent injuries, from falls, from occurring. We will focus on this in our 2023-24 QIP.

Change Idea #3 ☑ **Implemented** ☐ **Not Implemented**

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

Target for process measure

- By Dec 2022 100% of Residents will have been reviewed for potential ED transfer.

Lessons Learned

Weekly huddles afforded 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 and not just nursing staff. This team approach provides the best quality of care for our Residents by empowering and encouraging all staff to contribute information or ideas when creating and/or evaluating care plans.

Comment

Although we did not fully achieve our target goal of 15% as it relates to reducing avoidable ED visits we did succeed in reducing avoidable ED visits by 7%.
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 especially residents with a high risk health diagnosis and residents with a potential for a rapidly changing health status.
Our second goal towards reducing the number of avoidable ED visits was through improved communication methods amongst 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 and falls. We will further our work on comfort rounds 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 Resident Care Experience: All staff will wear name tags and staff on duty will be publicly posted. (Elgin Manor)	**53** **Performance (2022/23)**	**75** **Target (2022/23)**	**82** **Performance (2023/24)**	**--** **Target (2023/24)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

Residents, SDM and visitors will be able to identify staff by their colour coded name tag.

Target for process measure

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

Lessons Learned

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.
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 but will not be addressing this as a change idea on the QIP.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Residents and visitors will know which staff is on active duty in each Resident Home Area.

Target for process measure

- By Dec 2022 each unit will have a white board posted and it will contain current staffing information.

Lessons Learned

Elgin Manor educated all staff on the importance of wearing name tags.
Name tag use was also 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, notices were posted identifying which department each coloured tags represents ie royal blue name tags are worn by registered staff, orange is the recreational department.
Key Learning was to catch staff at the beginning of their shift when they were screening in. This involved asking the Visitor Attendants to remind staff to wear their name badges. For staff who have forgotten their name tags, temporary one are provided by the Visitor Attendant and the Administration Assistants.
Second to this we learned that to help us determine how to improve with staff identification methods we need to rephrase the way the question is asked in our survey; last year, the survey combined three questions into one: asked if staff wore names tags, introduced themselves and explained their role. For the 2023 survey we will consider dividing this question up into 3 parts.

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 (Elgin Manor)	**28.57** Performance (2022/23)	**20** Target (2022/23)	**23.33** Performance (2023/24)	**15** Target (2023/24)

Change Idea #1 ☑ Implemented ☐ Not Implemented

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

Target for process measure

- 100% of Residents taking an antipsychotic will have a supporting diagnosis by Dec 2022

Lessons Learned

During 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 of 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 for all Registered Staff who complete RAI/MDS coding and raps that includes the following: ensuring that the Medical diagnosis aligns with the MDS data sheet in PCC and that the care plans reflect this.

Target for process measure

- 100% of all registered staff who complete MDS coding/raps will receive education about how and where to document a diagnosis of psychosis.

Lessons Learned

The MDS Coordinators work with the Manger of Resident Care to ensure that all registered staff receive 1:1 RAI/MDS training. A tracking sheet is maintained by the Coordinators. This training occurs 3-4 months after a registered nurse has been hired and has been comfortably providing direct Resident care. Additionally, registered staff complete annual testing on Coding and Raps.
Education includes SURGE Learning and instruction by the Coordinators on how to recognize delusions and hallucinations.

Change Idea #3 ☑ Implemented ☐ Not Implemented

Upon admission and at the admission care conference: if the Resident is taking a prescribed antipsychotic medication a discussion will take place with the Resident and/or Substitute Decision Makers about the Residents historical use of antipsychotics. Questions about the use of alternative methods for managing responsive behaviors will be asked.

Target for process measure

- By Dec 2022, 50% of Residence who are admitted on an antipsychotic will have admission progress notes that attest to active discussions between the registered staff and Resident (and/or SDM) regarding the use of antipsychotic medications and alternatives tried in the past.

Lessons Learned

Care conferences are lead 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.

Change Idea #4 ☑ Implemented ☐ Not Implemented

Education to frontline staff who document in Point Click Care (PCC); defining and recognizing delusional disorder behaviors in order to document accurately.

Target for process measure

- 100% of frontline staff will have reviewed and have an understanding of what constitutes delusional behavior.

Lessons Learned

Online education was provided to all staff with 100% completion by staff.

Change Idea #5 ☐ Implemented ☑ Not Implemented

An admission assessment form will be developed for assessing Residents who are admitted on an antipsychotic medication.

Target for process measure

- By Dec 2022 the CQI team will have created a form for gathering information on the Residents historical use of antipsychotics.

Lessons Learned

The team reviewed this change idea and made the decision not to pursue the creation of a new and separate form as this information is captured in a multitude of areas that are already incorporated into the e-chart.

Comment

Elgin Manor had a steady increase in the use of antipsychotics and went from 28% to 36%. Once this trend was identified, the CQI team analyzed how and why this was happening and devised a plan to reduce antipsychotic medication for Residents without a diagnosis of psychosis.
The team was able to work with the Physicians and Pharmacist and were able to successfully and safely reduce antipsychotic medication use by more than by 15% over 9 months without a spike in responsive behaviors.
This reduction was done through 1) a review of all antipsychotic medication orders and ensuring that there was a supporting diagnosis for each medication 2) care plan revisions to ensure that there was a care plan in place with a focus on delusional behavior and/or psychosis 3) recognition and documentation of delusional and psychotic behavior in POC and PCC progress notes. This information was also captured on the quarterly RAI of all Residents.
Antipsychotic medication use and alternative methods of managing responsive behaviors continue to be reviewed monthly by the CQI team, Nursing staff, Physician and Pharmacist.
Elgin Manor will continue the focus in this area by providing GPA training to all staff, by the end of August 2023. This will assist staff in recognizing potential triggers and escalating behaviors in Residents with a diagnosis of psychosis and will teach alternative approaches to antipsychotic medication use in managing delusional or psychotic behaviors.