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. (Terrace Lodge)	**34.62** **Performance (2022/23)**	**31** **Target (2022/23)**	**28.81** **Performance (2023/24)**	**20** **Target (2023/24)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

Improved discussions with residents and families regarding Palliative Care model/approach to care, using CAPCE tools to steer discussion regarding Care Directives

Target for process measure

- 100% of charts will be audited within the 1st month two months for a baseline. 100% of care conferences and new admissions will be reviewed for data collection from the new/updated Care Directives.

Lessons Learned

Although improved discussions are occurring with residents and families about Palliative care approaches as per the goal on the 2022 QIP, it was identified that additional education and training for staff would be beneficial in supporting conversations. Our goal for 2022, therefore shifted mid year and we turned our attention to the best method for educating staff on Palliative care approaches.
Palliative Care training for registered staff was implemented in the fall of 2022 and will continue into 2023. The goal is to have all Registered Staff trained in Palliative Care by the end of 2023. This training is virtual and is hosted through The Ontario Centre for Learning, Research and Innovation in Long-Term Care. The course title is All-In Palliative Care: The Team Approach to LTC (All-In).

Change Idea #2 ☑ Implemented ☐ Not Implemented

Chart Review for each Emergency Room visit

Target for process measure

- 100% of all ER transfer charts will be reviewed

Lessons Learned

The Resident Care Coordinator (RCC) gathers, tracks and analyses each unscheduled Emergency room visit. Discussions take place with the staff involved in the transfer and information is collected that includes whose decision was it to send the Resident, the reason for transfer, the admission diagnosis, the treatment and whether the visit was potentially avoidable. The RCC reviews the chart notes and the hospital ED reports looking for documentation that captures precipitating events, symptoms, changes in baseline, medication changes, etc. in the week prior to the ED transfer.
It was determined that in 2022, 15% of the reason for Emergency room transfer at Terrace Lodge was related to falls. This is above the provincial benchmark and an area of focus that we will address in our QIP.

Comment

Terrace Lodge avoidable Emergency room visits have been decreasing in number for the past year. In September of 2021 we were at 35% and subsequently set a goal of reducing ED visits to 31%. We were successful in not only meeting this goal but we surpassed it. As of December 2022 we are at 29%.
Moving forward into 2023-2024, the Terrace Lodge team will continue to work on our goal of reducing Emergency room visits by measures indicated in our workplan; namely through education and by increasing staff understanding and utilization of comfort rounds for high fall risk Residents.

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

	Last Year		This Year	
Indicator #3 Resident Care experience: staff not introducing themselves or wearing a name tag (Establish a therapeutic relationship with the person using verbal and non-verbal communication strategies) (Terrace Lodge)	**82** **Performance (2022/23)**	**100** **Target (2022/23)**	**97** **Performance (2023/24)**	**--** **Target (2023/24)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

Residents, SDM, visitors 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

Our quality improvement goal for Service Excellence in 2022 was to provide residents, families and visitors with a quick and easy means of identifying staff who were on active duty, specifically by use of name tags.
Name tag use discussed at team huddles, 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 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, temporary name tags are provided by the Visitor Attendant or the Administration Assistants.

Comment

We were successful not only in attaining our target goal but we surpassed it.
Moving into 2023 we will continue to promote and audit for the wearing of name tags. We will do this as part of our Person and Family Centered Care Best Practice Guideline.
Additionally we will introduce the use of name boards on every unit.

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

Indicator #2	Last Year		This Year	
Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment (Terrace Lodge)	**12.24** Performance (2022/23)	**12.24** Target (2022/23)	**15.26** Performance (2023/24)	**12** Target (2023/24)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Ongoing monitoring

Target for process measure

- 100% monthly review.

Lessons Learned

While we did not directly address this in our 2022 QIP we did continue to track and analysis this data at our monthly CQI meetings.
RAI/MDS stats indicate that are numbers have slowly been increasing and although we continue to remain below the provincial average, we will be creating an active plan for improvement in this area.
Change measures include MDS RAI training for all registered staff, GPA education for all staff which teaches staff how to identify responsive behaviors and offers alternative to, or complements the use of, PRN antipsychotic medications. Additionally we will engage in ongoing monthly auditing of all physician orders to ensure that all Residents who take an antipsychotic have a supporting diagnosis and indication for use and that the care plans reflect this.

Comment

RAI/MDS stats indicate that our numbers have slowly been increasing and although we continue to remain below the provincial average, we will be creating an active plan for improvement in this area.