Access and Flow | Efficient | Priority Indicator

Indicator #3

Rate of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents. (Terrace Lodge)

Last Year		This Year	
28.81	**20**	**32.37**	**26**
Performance (2023/24)	**Target (2023/24)**	**Performance (2024/25)**	**Target (2024/25)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

Reduce the number of falls by analyzing the contributing factors and implementing resident specific interventions.

Process measure

- Track the number of residents who fell in past 30 days; Track the number of residents who fell more than 3 times in the past quarter; track # of ED visits related to falls

Target for process measure

- reduce # of residents who fell to under 15% by December 2023; reduce # falls for residents with frequent falls to under 8% by December 2023; reduce ED visits related to a fall by 10% by December 2023

Lessons Learned

The number of falls did not decrease from 2022 to 2023. In the winter, spring and fall months we saw an increase in falls from 2022. Over the summer months rates remained unchanged despite having 60% of our residents move to a different room/different home area, in May of 2023.
CQI team members analyzed this occurrence and determined that heightened staff awareness during this period contributed to a lower falls rate during a time when the risk factors were highest. Staff awareness was heightened due to the move; redevelopment training was provided prior to the move which included instructing staff on the potential for increase resident falls and the need to increase surveillance of residents. Additionally, there were extra PSW staff on the home areas for several days post move.

Going forward we will build off of this lesson and introduce comfort rounds to staff as a means of increasing resident surveillance.

Falls and fall related injuries continue to be the main reason for an emergency department visit. The primary reason for a fall is a resident who self transfers while lacking the physical ability to safely do so. Often it is residents with dementia who forget that they cannot safely transfer themselves or ambulate independently. Safety measures are put in place for residents in that category: hip protectors, fall mats, bed and chair alarms are utilized.
With each fall care plans are reviewed and updated as indicated.
Moving into the 2024-2025 QIP we will continue our work on reducing falls and fall related injuries focusing on early intervention and prevention of falls.

Change Idea #2 ☑ **Implemented** ☐ **Not Implemented**

Identify learning needs of all registered staff in having discussions with family and physicians to promote care in place, whenever possible.

Process measure

- # of surveys completed; # of staff completing education

Target for process measure

- 100% survey completion by November 30, 2023; 75 % of registered staff will have completed education by March 2024

Lessons Learned

As it relates to conditions that contribute to repeated emergency department visits, all staff are provided annual education on fall management, restraint and PASD use, continence management, dementia care to support conversations with family regarding ER visits versus onsite care provisions.
Nursing staff are provided additional elearning and onsite education to ensure compliance with ministry standards and to ensure competency is maintained.
In 2023 additional education included documentation and care planning, palliative care , BSO, IV management including equipment and administration of IV solutions, tube feed pump and management.
Moving into 2024-2025 we will continue to provide both online and onsite education.

Experience | Patient-centred | Custom Indicator

	Last Year		This Year	
Indicator #2 Percentage of Residents who respond positively to "I participate in the development of my personalized plan of care." (Terrace Lodge)	**69** Performance (2023/24)	**90** Target (2023/24)	**36** Performance (2024/25)	**NA** Target (2024/25)

Change Idea #1 ☑ Implemented ☐ Not Implemented

The Resident and the Substitute Decision Maker will be encouraged to attend the admission and annual care conferences. Conversations will be resident focused to support individualized plans of care.

Process measure

- # residents/SDM who attend care conferences; # who answer the Resident satisfaction Survey question "I participate in the development of my personalized plan of care" positively.

Target for process measure

- Care conferences will be consistently attended by resident and/or SDM by December 2023; 2023 Resident satisfaction survey will show 75 -100% answered positively to the survey question

Lessons Learned

Resident/SDM attendance at conferences went from 33% to 100% over the course of a year. This is a tremendous improvement. We did this through increased communication with resident/SDM regarding the dates and times of the conferences and by revamping the structure of the conference so that it better reflected the resident/SDM goals for care with a focus on what is most important to residents and families.

Although the change idea was implemented as intended there were some significant findings reflected in the satisfaction survey in 2023. Ratings are as follows;
In 2022, Resident/SDM satisfaction with the participation in care planning was 69% with a 12% dissatisfaction rate and a 19% uncertainty rate.
In November 2023 the satisfaction rate dropped to 36% with a dissatisfaction rate of 4% and an large jump in the uncertainty rate which was captured at 61%.

While we were successful in lowering the number of residents who were dissatisfied with their input into the plan of care, we discovered that using terms like 'care plan participation and involvement' without adding simple context resulted in some confusion and uncertainty as to what the participation expectation was. To address this we are carrying this change idea over into our 2024-2025 QIP and will work to include an explanation of what the plan of care is and how it is used to support resident care, as well as the importance of resident and family input to developing this document.

The majority of the care planning is developed at the time of admission, at the 6 week admission care conference, at the annual care conferences in collaboration with families. Plans of care are reviwed and updated as needed during the quarterly RAI/MDS assessment. However, care planning is ongoing and includes any changes to a residents status or preferances.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Care plan will be reviewed with Resident and SDM/Essential caregiver, in full detail at each care conference and changes will be made to reflect the resident choice(s).

Process measure

- Audit of care conference assessment including care conference progress notes and care plan; resident satisfaction survey responses

Target for process measure

- All resident care plans will demonstrate a personalized approach by March 2024; 2023 resident satisfaction survey question responses will demonstrate the indicated improvement target(s)

Lessons Learned

In 2023 a review of the care conference assessment was completed and found that changes were required to improve resident and family engagement. The form was redeveloped in collaboration with the homes management team, the CQI team and resident and family councils. The ultimate goal was to ensure that the new forms reflected the resident and family goals for care rather than care needs identifed by the nursing staff.
Recognizing that the care conferences drive the plans of care we rolled out communication to all staff who contribute to the care conferences to ensure a smooth transition. Each discipline had a section added to remind staff to review and update the care plan with the resident/SDM.

Comment

We will continue to build upon this foundation in our 2024-2025 QIP workplan moving our focus from ensuring attendance to ensuring active participation as well. While current performance is 36 %; the reality is that the score is higher related to uncertainty by those completing the survey in 2023 as to what was actually being rated.

Safety | Safe | Priority Indicator

Indicator #1

Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment (Terrace Lodge)

Last Year		This Year	
15.26	**12**	**19.70**	**15**
Performance (2023/24)	**Target (2023/24)**	**Performance (2024/25)**	**Target (2024/25)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

Provide responsive behavior management education to all staff: education will identify responsive behavior and offer possible alternatives to the use of antipsychotic medication.

Process measure

- Number of staff trained in GPA; # of residents whose use of antispychotic medications for the management of responsive behaviours was reduced (e.g. PRN medication usage)

Target for process measure

- By October 2023, 80% of staff will have received GPA training; By March 2024, audits will reflect up to 20 % decrease in usage of antipsychotic medication for management of responsive behaviours

Lessons Learned

In 2023 Terrace Lodge provided extensive staff training in Gentle Persuasive Approach (GPA) techniques. We conducted the majority of this training in January through to May of 2023 and were successful in training 80% of staff.
Training consisted of 2.5 hours of e-learning followed by 3 hours of classroom instruction.
We recognized early on that all staff play an important role in the care of our residents and so this training was provided to all staff, and not just frontline nursing staff.
Going into 2024 we will continue to offer this training to new staff to assist them in providing optimal care for our residents.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Ongoing monthly auditing of all physician orders to ensure that all Residents who are prescribed an antipsychotic medication have a supporting diagnosis and indication for use.

Process measure

- # of Residents on antipsychotic medication without a supporting diagnosis and/or clinical indication of use; # of care plans that include alternative and/or complementary therapies and potential side effects

Target for process measure

- By January 2024, 80 - 100% of Residents on antipsychotic medications will have a supporting diagnosis and indication for use for all antipsychotic medications. Residents on anti-psychotic medications care plans will specify risk of side effects and potential alternative therapies

Lessons Learned

Over the past year Terrace Lodge has experienced an increase in the use of antipsychotic medication, without a supporting diagnosis or an indication for use. Last year we were below the provincial benchmark but are now on par with the provincial benchmark of 20%. This has been a steady upward trend over the past year, and will continue to be one of our indicators in our upcoming QIP
Audits are conducted monthly with reports reviewed at monthly CQI meetings.In 2023 Terrace Lodge onboarded a new medical director as well as a new nursing manager. Additionally we onboarded a new pharmacy and consultant pharmacist in January 2024. When reviewing antipsychotic use any missing documentation is sent to the registered staff and the attending physician to be updated, this includes an indication for use and a supporting diagnosis.
In addition to monthly audits, orders are reviewed by the pharmacy consultant and the physician on a quarterly basis. Once complete the registered staff ensure the information has been updated in the chart and that the plan of care reflects any changes.
Going forward into 2024-2025 we will continue with our 2023-2024 action plan but add additional measures to support success; we will follow up with individual nurses and provide additional education to ensure that they understand the significance of this goal.

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

Education will be provided to staff on how to document symptoms and episodes of psychosis including delusions and hallucinations.

Process measure

- # of nursing huddles/meetings; # of registered staff trained in RAI/MDS coding; # of residents receiving antipsychotic medications without supporting diagnosis

Target for process measure

- By December 2023 all non-probationary, active registered staff will have received RAI/MDS training. By December 2023 team huddles will routinely include discussions on documentation. # of residents on antipsychotic medications without a supporting diagnosis will reduce by up to 20 % by March 2024

Lessons Learned

Education on how to identify and document delusions and hallucinations was provided to all staff who interact with residents. Education and training consisted of classroom GPA sessions and online SURGE education.
MDS testing for registered staff occurs annually through Relias with the MDS co-ordinator continuing to train newly hired registered nurses on RAI/MDS documentation. This training is offered 3-6 months after the nurses have been hired and are comfortable with all other processes.
Nursing huddles were introduced in the fall of 2023; the MRC/RCC share this responsibility and they communicate gaps in processes which include documentation. Weekly huddles ensure a flow of information and allow for easier follow up. Huddle notes are maintained on the unit for all nursing staff to review.