Terrace Lodge

CQI Initiative Annual Report

April 1, 2024- March 31, 2025

DESIGNATED LEAD(S)

Ashley Temple Administrator
Lindsey Gordon, Education & Quality Improvement Coordinator

Membership includes:

Administrator
Medical Director
Manager of Resident Care
Resident Care Coordinator
Manager of Support Services
Infection Prevention and Control
Manager of Program Therapy
Dietitian
Pharmacist
Physiotherapist
Quality Improvement lead
Personal Support Worker
Nurses
Resident Council Member
Family Council Member

Our Continuous Quality Improvement meetings are combined with our Professional Advisory Committee (PAC) meetings. Meetings occur quarterly on the third Wednesday of the month.

Attendance in person is preferred, however, in the event that members cannot attend in person, a virtual option is available.

In between quarterly CQI meetings Terrace Lodge hosts monthly CQI subcommittee meetings. Information provided by (quarterly) CQI-PAC members is incorporated into discussions at the monthly meetings and to our program evaluations allowing the subcommittee meetings to build upon the discussion from the quarterly meetings.

Our meetings are built upon our vision, mission and value statements:

> **Mission**: The County of Elgin Homes and Seniors Services are committed to creating a caring environment where residents and staff feel safe, respected and valued.

Vision: Through Continuous Quality Improvement, using best practice initiatives, we will be influential leaders in the provision of person-centered care within the long-term care sector.

When initiating change ideas Terrace Lodge strives to meet the Residents rights by placing 'Residents First' as per our **Values**. This is the highest priority at Terrace Lodge and this acronym identifies the organizational values:

R- Resident
E- Education
S- Staff
I - Individualized Care
D- Diversity
E- Excellence
N- Nurturing
T- Teams
S- Safety

F- Family
I- Innovation
R-Restorative Care
S- Satisfaction
T- Technology

Resident and Family Satisfaction Survey
The Manager of Program and Therapy leads the annual review, revisions and distribution of the resident and family satisfaction surveys and serves as a liaison between the CQI committee and Resident and Family Council. Residents are provided an opportunity to review the survey and provide feedback on the questions prior to survey distribution.

The annual satisfaction survey is based on a calendar year opposed to a fiscal year, meaning that the 2024 action plan was developed based on information gathered from the October 2023 survey and the 2025 action plan has been developed using results from the 2024 survey.

The annual Resident and Family Satisfaction survey was completed from October to December 2024.
The Manager of Programs and Therapy presented the results of the survey to the Resident Council at the February Resident Council meeting with a plan for the development of the action plan in March 2025.
Additionally, survey results were communicated to Family Council during the March meeting for input into the 2025 quality improvement plan.
The survey results were shared with the management team and reviewed at the December 2024 CQI committee meetings with department specific information taken back to individual departments for further review.

Action Taken to improve results:
Beginning in January 2024 the CQI team reviewed the areas of focus and formatted a plan to address the areas for improvement that were identified in the Satisfaction survey.
The implementation plan was reviewed at CQI meetings and progress towards goals were discussed by all department managers.
Opportunities for improvement were incorporated into the annual program implementation plans as well as the Health Quality Ontario, Quality Improvement Plan, where applicable.
The Manager of Program and Therapy provided updates at the council meetings.

Survey focus	2023 Survey Results- % of residents/families satisfied	2024 Survey Results **Outcomes**	**Dates the actions were implemented**
How well staff listen to you	97%	92%	Jan - April 2024 ~ incorporated this into the redevelopment training: ensure that resident rights to choose is respected and documented appropriately Annual education completed for all staff
Call bell response time	100%	71%	Ongoing challenges related to construction during the redevelopment project, anticipated to see improvement in this area at project completion. Ongoing audits of call bells when concerns identified and follow up as appropriate.
Staff wear a name tag, introduce themselves and explain their roles	94%	89.65% 96.56% 100% Separated into 3 questions on the 2024 survey	Ongoing managers conducted name tag audits. Managers reminded staff at departmental meetings, huddles and 1:1 during daily walk abouts. New process for ensuring name tags available on 1st day of orientation.
Participation in plan of care	96%	80.77%	Jan 2024- Continued work on Person and Family Centered Care BPG, staff education October 2024 Introduction of an informational pamphlet about the

			plan of care and how families can be involved. Pamphlet to be shared on admission and reviewed as needed are care conferences.
Pleasurable Dining experience temperatures Attractive meal presentation		60% 62.07%	Pleasurable Dining Committee resumed July 2024 and will be ongoing (paused during redevelopment). Food temperature checks as required by dietary staff and reviewed by manager monthly. Show plates to enhance meal presentation

Quality Improvement Plan Process

Quality improvement planning cycle and priority setting process
To identify preliminary priorities an evaluation of the following occurs:

- Inspection reports: Ministry of Long-Term Care, Ministry of Labour, Public Health, Fire Marshall, Joint Health and Safety
- Complaints, Requests, Concerns and Input: Concern/Request forms, Resident Council input, Family Council input, Written complaints, Critical Incident reports.
- Operational Analysis: Program Evaluations, Policy Review recommendations
- Time Studies/Focused and Routine Audits
- Public website reporting
- MDS/RAI – Indicator review
- Departmental Audits
- Ongoing analysis of performance data over time available through CIHI; with areas indicating a decline in performance over time and/or where benchmarking against self identified peer organizations suggests improvement required
- Mandated provincial improvement priorities

Preliminary priorities are presented and discussed at various forums to validate priorities and to identify additional priorities that may have been missed. These forums include weekly leadership team meetings, monthly project management meetings, Resident Council, Family Council, Joint Health and Safety Committee, PAC-CQI team, CQI subcommittee meetings, staff meetings and Committee of Management.

The process used is one of building, refining, and improving a project or initiative. Teams create and revise the process until they're satisfied with the end result. This process is a trial-and-error

methodology that brings the project closer to its end goal but requires engagement and communication with various stakeholders along the way.
Final review of the QIP is completed by the CQI team, approved by resident council then reported to the Committee of Management. The final QIP is submitted to Health Quality Ontario.

Approach to CQI (policies, procedures and protocols)

County of Elgin Homes policies, combined with practice standards, provide a baseline for staff in providing quality care and services. We have an interdisciplinary CQI team, which includes resident and family advisors, that meet monthly, with subcommittees that report to the CQI team, as they work through the phases of the model to:

1. **Diagnose/Analyze the Problem**
   Teams use various QI methodologies to understand some of the root causes of the problem and identify opportunities for improvement. This work can include process mapping or value stream mapping, 5 Whys, fishbone. Also included in this work, is an analysis of relevant data and the completion of a gap analysis of the relevant RNAO Best Practice Guidelines.

2. **Set Improvement Goals**
   An improvement aim is identified once the teams have a grounded understanding of what is most important to the Resident. This aim will be used to evaluate the impact of the change ideas through implementation and sustainability.
   At Terrace Lodge improvement teams develop goals that are SMART goals: Specific, Measurable, Attainable, Relevant, Time-Bound.

3. **Develop and Test Change Ideas**
   With a better understanding of the current system, improvement teams identify various change ideas that progress towards meeting the goal. During this phase, teams will prioritize alignment with best practices when designing preliminary change ideas for testing.
   Plan-Do-Study-Act (PDSA) cycles are sometimes used to test change ideas through small tests of change.
   PDSA's provide an opportunity for teams to iteratively refine their change ideas and build confidence in the solution prior to implementation. Change ideas typically undergo several PDSA cycles before implementation. These changes are reflected in the project management minutes, team meeting minutes and communicated to staff via communication boards and huddles.

4. **Implement and Sustain**
   Improvement teams consider the following factors when developing a strong implementation/change management plan:
   - Outstanding work to be completed prior to implementation (e.g. final revisions to change ideas based on PDSA's, embedding changes into existing workflow, updating relevant policies and procedures, etc.)
   - Education required to support implementation, including key staff resources i.e. team leaders
   - Communication required to various stakeholders, before, during and after

implementation which includes resident and family council, staff, committee of management

At this stage, teams will also identify key project measures to determine if the changes implemented resulted in improvement. This includes the following types of measures:
Outcome:
• Measures what the team is trying to achieve (the goal)
Process:
• Measures key activities, tasks, processes implemented to achieve goal
Balancing:
• Measures other parts of the system that could be unintentionally impacted by changes

5. **Process to communicate outcomes**

Communication strategies are tailored to the specific improvement initiative. These include, but are not limited to:

- Posting on unit quality boards, in common areas and in staff lounges
- Publishing stories and results on the website, on social media or via the newsletter
- Direct email to staff and families and other stakeholders
- Handouts and 1:1 communication with residents
- Presentations at staff meetings, Resident Council, Family Council
- Huddles at change of shift
- SURGE Learning
- Use of Champions to communicate directly with peers
- RNAO BPSO Knowledge Exchange and engagement sessions

The team ensures that regular reviews of the changes to ensure sustainability remains viable. This is typically conducted at the monthly CQI meetings and the project management meetings.

2025/2026 Terrace Lodge, Health Quality Ontario Quality Improvement Plan

The Terrace Lodge CQI committee develops and submits a Quality Improvement Plan (QIP) to Health Quality Ontario annually. The QIP includes a progress report which captures the progress/lessons learned while the narrative summarizes the CQI journey in the prior year's QIP. The workplan outlines the aims, measures and change ideas for the 2025/2026 QIP.

Quality Objectives for 2025/2026 Health Quality Ontario QIP

FOCUSED ACTION:

1. Access and Flow
    - Reduce the rate of potentially avoidable emergency departments visits by 20 % through:
        - Utilization of the standard RNAO Nursing Advantage Canada, Clinical Pathways assessments (Admission, Fall Prevention, Pain assessment)

    - Partnerships with local hospital, Facilities Operator Group (FOG) and pharmacy to continue work on "Transitions in Care" between hospital and long-term care
    - Recruitment of a Nurse Practitioner through the Hiring More Nurse Practitioners funding initiative to support early identification/screening/assessment/care planning
    - Implementation of Comfort Care Rounds for residents identified as being high risk for falls or having a precarious health condition
2. Equitable
    - Achieve 100 percentage of staff (all levels) who have completed relevant equity, diversity, inclusion and anti-racism education through:
        - Development and implementation of a DEI policy specific to long-term care home resident care and services utilizing the CLRI diversity tool kit
        - Implementation of an enhanced orientation and onboarding process utilizing CLRI preceptor program

3. Resident Experience:
    - Improve the rate of Resident/Substitute Decision Maker satisfaction to 100% as it relates to Residents feeling they have a voice and are listened to by staff through:
        - Increased communication regarding avenues/opportunities for residents/SDM to provide feedback and learn about home updates.
        - Implementation of RNAO Clinical Pathways Person and Family Centred Care Assessment and related care planning

4. Safety
    - Reduce the number of Residents who fall in the 30 days leading up to their assessment by 30 % through the implementation of the RNAO Clinical Pathways Falls Assessment
    - Reduce the % of Residents by 7%, without a supporting diagnosis or indication for use, who were given an antipsychotic medication in the 7 days preceding their resident assessment through the implementation of the RNAO Clinical Pathways Admission Delirium Assessment

MODERATE ACTION: Program Evaluations

These are reviewed and updated quarterly at PAC-CQI.

1. Medication Program: annual ISMP assessment, medication incident analysis and reduction in medication incidents to less than 1 by Dec 2025
2. Skin and Wound: improvements to the committee, training and implementation of Skin and Wound app to support baseline and out of range data, early identification and onsite treatment and reduction in worsening wounds/potential for ED visits
3. Restraints: Reduction in bed rails, increase # of staff trained to conduct a bed entrapment assessment
4. Continence: reduction in worsening incontinence
5. Falls: embedded in HQO QIP, reduction in falls and injuries
6. Responsive Behaviors: improvements to meeting structure/process, staff education

7. Restorative Care: maintain 10% of residents on the program, increase # of staff educated in restorative care

For further information please refer to the Terrace Lodge QIP progress report, narrative and workplan. The QIP is available on the County of Elgin Homes website https://www.elgincounty.ca/elgin-county-long-term-care-homes/ and posted on the QIP board located within the Home. The progress report details the action taken and the outcomes of the actions for the 2024/2025 QIP.