Dearness Home for Senior Citizens 2022/2023 Interim Continuous Quality Improvement Plan Report

Overview:

The Corporation of the City of London - Dearness Home, is a fully accredited Municipal Home owned and operated by the City of London. Dearness is home to 241 permanent residents and provides 2 respite beds for those members of the community who require short term or respite stays; however, since the start of the COVID-19 pandemic, and at the request of the Home and Community Care Support Services (HCCSS) both our respite beds are being occupied by permanent residents for the foreseeable future. Of our total 243 beds, 27 are located on a secure unit, including one of the respite beds. Our mission statement, "Compassionate people enriching the lives of others. Always", keeps us focused on achieving our vision, standards of care and commitment to our residents and supports the Home in achieving success in safety, compliance, and resident satisfaction. Our Continuous Quality Improvement (CQI) team have chosen, for the 2022/23 interim Continuous Quality Improvement Report Plan (QIP), to focus on and address the Health Quality Ontario (HQO) identified priority areas of Potentially Avoidable Emergency Department Visits, Resident Experience in terms of “Having a Voice” and “Being Able to Speak Up About the Home”, and Potentially Inappropriate Antipsychotic Use. In accordance with HQO, our team believes these priority areas are important to the overall health care system and have been particularly impacted by COVID-19 and require attention to support the health system recovery. The Home, in consultation with our CQI team members, also chose to add an additional area of Continuous Quality Improvement to this year’s work plan (see work plan below) under Safe and Effective Care: Falls. Since the start of the pandemic, Falls have increased in our facility and we want to ensure we are placing a strong emphasis on decreasing our numbers in this area. For this QIP, the Dearness Home will strive towards meeting the local South West HCCSS average with respect to ED visits, the Provincial Benchmark for Potentially Inappropriate Antipsychotic Use, as well as Falls, and an in house established respectable Theoretical Best target for Resident Experience. Our strategic direction and the initiatives that support it also align with our Commission on Accreditation of Rehabilitation Facilities (CARF) Accreditation Standards and meet the requirements of our Long-Term Care Service Accountability Agreement (LSAA).

In order to implement our plan for continuous improvement over the remainder of the 2022/2023 fiscal year, our continuous quality improvement lead and chair of the Continuous Quality Improvement Committee, Jason Westbrook, Manager of Support Services and Business Operations, will review our progress monthly with the management team, and quarterly with the Continuous Quality Improvement Committee. Further, the Home’s lead will review and share our progress regularly with relevant stakeholders, including the family and resident councils and the licensee. Along the way, we will ensure we celebrate our successes while allowing for time and space to discuss next steps or changes in strategy in areas we are failing to see improvement.

Reflections Since Our Last Mandatory Health Quality Ontario QIP Submission in 2019/2020:

With the emergence of the COVID-19 virus, we, like most in the health care sector, had to abruptly pivot, reset, and focus the majority of our quality efforts over the last 2 years towards a new formidable threat to the health and wellbeing of those we care for. To say the pandemic has changed our quality improvement work over the last 2 years would not give it the weight or demonstrate the impact it so deserves. The pandemic has disproportionately affected and continues to affect the population we are dedicated to caring for. Further, our staff and all those working and living in congregate settings continue to be at higher risk of infection, yet we carry on our work.

At the height of the first wave, despite varied and ever changing priority areas put forth by various Ministries and levels of government to try to ensure adequate care capacity in our sector, one early and consistent practice enacted in an effort to ease the spread of infection, albeit also taking various forms and frequencies over time, was surveillance testing for staff. Effective COVID-19 surveillance is essential for timely detection of the virus among staff and implementation of necessary infection prevention and control (IPAC) measures, such as contact tracing, isolation and testing to limit risk of transmission. For our Home, we believe our COVID-19 surveillance testing centre to be our greatest quality improvement initiate for the 2020/2021 and 2021/2022 fiscal

years, having contributed to our low infection rates within our resident population and possibly translating to zero deaths directly or indirectly related to the COVID-19 virus within our resident population thus far.

Our centre is staffed by an external agency who has consistently guaranteed staffing by nurses in the centre seven days a week. The centre operates to ensure all shifts (days, evenings, and nights) have access to surveillance testing (the centre also ensure all visitors and contractors are tested in accordance with legislation) and that all staff are tested by the testing centre staff two times per week using a Rapid Antigen Test (RAT). Staff also have the option to complete an additional Polymerase Chain Reaction (PCR) test within a seven day period should they choose. The testing centre staff maintain a spread sheet of all staff tested and send a list to the relevant managers near the end of each week indicating which staff, if any, have not met their twice weekly testing requirement. The managers then directly follow-up with the staff to ensure compliance.

Additionally, if or when a staff member has symptoms consistent with the COVID-19 virus, they are immediately given a RAT and PCR test in the testing centre, must await a negative result of both tests, and be symptom free prior to returning to work. If the staff member is at work and they become symptomatic they attend directly to the testing centre prior to leaving the facility. If a staff member becomes symptomatic while off duty, the testing centre offers a drive through service whereby the staff member remains in their vehicle and the testing centre staff exit the building and attend to the symptomatic staff member outside of the facility to maintain the best possible infection control practices.

While costly, the Home believes this system for surveillance testing has saved lives and decreased the overall burden of infection in the Home and the greater community. As the pandemic continues on its trajectory we will, as we have throughout, continue to adapt and change processes and practices, including in our testing centre, as this virus dictates.

Resident Partnering and Relations

Dearness Home's mission is “Compassionate people enriching the lives of Others. Always” and we strive to accomplish this by engaging our residents and families in numerous ways. We promote transparency with residents and families by requesting their participation in various activities such as quality improvement projects, satisfaction surveys, various committees, and active Resident and Family councils. More generally, we also openly share Ministry inspection reports, quarterly indicator results, accreditation survey results and concerns and successes in the Home. On an individual basis, we also involve residents and/or families by discussing their unique needs, preferences and concerns and then building their plan of care based on these discussions.

While the pre-pandemic era made developing and maintaining these relationships through the methods outlined above relatively simple in retrospect, the pandemic created many challenges and opportunities, forcing us to become innovative and create new ways to meaningfully connect. Starting with the first wave of the pandemic, social norms, including face to face interactions and meetings were upended for the larger community, but even more so for our sector when mandates to prevent spread of the virus were put into place that either prevented in person interaction entirely, except for the provisions of direct care, or at least significantly limited the amount of interaction depending on the stage and timing of the pandemic. This became a significant challenge most notably for our Family and Resident Councils, Resident Food Committee, and annual care conferences. Our Home was determined to maintain our connections and relationships through these meetings and conferences leading us to reach out to our corporate partners requesting adequate equipment to support communication between residents, families, and our team. The corporation was able to respond to our call for assistance and provided a large number of iPads not being used at the time throughout the corporation to ensure all of our residents who wanted to participate in any meetings had the ability. Our recreation team supported the residents in setting up the technology for each meeting and various managers provided tech support to family members on how to navigate their cellular phones and various video calling/meeting apps. As a result, throughout the pandemic, despite being given leeway by the

Ministry of Health to temporarily pause all committees and care conferences, the Home was able to continue with all Resident and Family Council meetings, Resident Food Committee meetings, and annual care conferences without interruption.

Workplan

Theme: Timely and Efficient Transitions	Measure	Population	Source/Period	Current Performance	Target	Target Justification	Planned Improvement (Change Idea)	Methods	Process Measure	Target for Process Measure
Efficient	Number of ED visits for modified list of ambulatory care-sensitive conditions per 100 LTC residents	Rate per 100 residents / LTC home residents	CIHI CCRS Oct 2020-Sept 2021	24.14	17.5	Target chosen to meet local SW HCCSS average	1) Educate staff regarding resident centered fall prevention interventions 2)Enhance the BSO program	Physiotherapist will identify units with 10 or more falls per month and discuss with unit staff (PSWs and RPNs on days and evenings) specific resident centered fall prevention interventions Increase the hours of the BSO nurse from PT to FT	Percentage of units with 10 or more falls per month who participate in targeted fall prevention intervention meetings Number of hours weekly the BSO RPN works in the assigned BSO role	100% of units with 10 or more falls per month will have a targeted meeting from August 2022-March 31 2023 On average during the 2022/2023 fiscal year, the BSO RPN will work 32 of the assigned 40 hrs per week in the BSO role

Theme: Safe and Effective Care	Measure	Population	Source/Period	Current Performance	Target	Target Justification	Planned Improvement (Change Idea)	Methods	Process Measure	Target for Process Measure
Safe	Percentage of LTC residents without psychosis who were given antipsychotic medication in the	%/LTC home residents	CIHI CCRS/ July-Sept 2021	19.81	19	Target chosen to meet provincial benchmark	1)Implement Antipsychotic Rounding	Monthly pharmacist will run a report on antipsychotic usage and identify the unit with the highest usage. Rounding meetings on the unit with interdisciplinary care team will be held to review.	Number of antipsychotic rounding meetings held in the 2022/2023 fiscal year (April 1 2022-March 31 2023)	12 antipsychotic rounding meetings will be held in the 2022/2023 fiscal year

	7 preceding their resident assessment									
	Percentage of residents who fell during the 30 days preceding their resident assessment	%/LTC home residents	HQO data from 2020/2021 fiscal year	15	9	Target chosen to meet provincial benchmark	1)Implement targeted antipsychotic usage and falls prevention meetings	Monthly following the Antipsychotic Rounding the ADOC overseeing the falls program will meet with the physiotherapist to review frequent fallers (if any) who are on antipsychotics on the identified unit	Number of targeted call prevention meetings held in the 2022/2023 fiscal year	12 targeted meetings will be held in the 2022/2023 fiscal year
							2)Implement the Resident of the Day program	Resident care plans will be reviewed and updated by all members of the nursing team on a specific unit (i.e. PSWs, RPNs, and RNs) – overseen by the Restorative Care Coordinator	Percentage of residents who have their care plans reviewed through the Resident of the Day program	50% of residents will have their care plans reviewed through the resident of the day program in the 2022/2023 fiscal year
							3)Educate staff regarding resident centered fall prevention interventions	Physiotherapist will identify units with 10 or more falls per month and discuss with unit staff (PSWs and RPNs on days and evenings) specific resident centered fall prevention interventions	Percentage of units with 10 or more falls per month who participate in targeted fall prevention intervention meetings	100% of units with 10 or more falls per month will have a targeted meeting from August 2022-March 31 2023

Theme: Service Excellence	Measure	Population	Source/Period	Current Performance	Target	Target Justification	Planned Improvement (Change Idea)	Methods	Process Measure	Target for Process Measure
Resident-Centred	Percentage of residents responding	% / LTC home residents	In house data Survey April	88.43	95	Target chosen as in in-house theoretical	1) Residents will directly participate in Continuous Quality	Resident representative to attend Continuous	Number of CQI committee meetings attended by a resident representative	A resident representative will attend 2 CQI

	positively to "What number would you use to rate how well the staff listen to you?"		2021-March 31 2022			best benchmark	Improvement in the Home	Quality Improvement Committee Meetings	from October 1 2022-March 31 2023	committee meetings from Oct 2022-Mar 2023
	Percentage of residents who responded positively to the statement " I can express my opinions without fear of consequences"	% / LTC home residents	In house data Survey April 2021-March 31 2022	86.13	95	Target chosen as in-house theoretical best benchmark	1)Residents will have increased access and exposure to the management team	Morning interdisciplinary / management huddle will be held in the activity room on a specified unit	Number of morning huddles held on any given unit monthly	Each unit will have morning huddle in their activity room 1x monthly

Policies, Procedures and Protocols

Relevant policies, procedures and protocols to be references in addressing and working through our Continuous Quality Improvement Plan include, but are not limited to, the Antipsychotic Rounding Procedure, Interdisciplinary Fall Prevention and Management Unit Meetings Procedure, Falls policy, Medication Advisory and Professional Advisory Committee Terms of Reference, Medication Review Policy, Call-in Shift Replacement Procedure, Continuous Quality Improvement Committee Terms of Reference, Continuous Quality Improvement Committee Policy, Quality Improvement Program Policy, and Morning Nursing Huddle Procedure.