2024/2025 Continuous Quality Improvement Annual Report

Heritage Green Nursing Home Commitment:

Heritage Green Nursing Home is fully committed to the Quality Improvement Initiative, and we are excited to share our second Annual Quality Improvement Report.

1. Introduction

This report outlines the Continuous Quality Improvement (CQI) activities undertaken by Heritage Green Nursing Home to ensure compliance with the Fixing Long-Term Care Act, 2021 (FLTCA) for 2024/2025. It is important to reiterate that this CQI Initiative is designed to identify, monitor, and address areas for improvement while promoting a culture of quality and accountability.

2. Legislative and Regulatory Framework

This report is aligned with:

- Fixing Long-Term Care Act, 2021 (FLTCA), S.O. 2021, c. 39, Sched. 1
- Ontario Regulation 246/22: Establishes quality standards and mandates the development and implementation of a CQI program.
- Ministry of Long-Term Care (MLTC) Directives: Sets expectations for compliance, reporting, and accountability.

3. CQI Governance Structure (Responsibilities)

a) Ongoing responsibilities of the CQI Committee:

- To monitor and report to the long-term care home licensee on quality issues, resident's quality of life, and the overall quality of care and services provided in the long-term care home, with reference to appropriate data.

- To consider, identify and make recommendations to the long-term care home licensee regarding areas of priority for quality improvement in the home.

- To coordinate and support the implementation of the Continuous Quality Improvement initiative, including but not limited to, preparation of the report on the continuous quality improvement initiative.

The Quality Committee includes representatives from the Resident and Family Council, management, designated leads of the home and staff. We started meeting in May 2022 and the Committee meets quarterly to review the quality indicators and the annual resident, family and staff satisfaction surveys, sets quality priorities for our QIP, and supports the creation of this report.

CQI Committee**:** Administrator – Scott Kozachenko
Assistant Administrator (**Lead Designate) – Aleta Agpalo**
Director of Care (Co-Lead) - Dorina Rico
Assistant Director of Care – Talwinder Kaur
Programs Manager – Janine Breukelman
Dietary Manager – Maxine Manning
Housekeeping/Laundry Supervisor – Xiomara Rodriguez
Maintenance Manager – Timothy Duncan
Financial Manager – Jenuka Patel
IT/Health and Safety Manager – Steve Diemert
Pharmacist (Geriatrx) – Frances Grunwald
Medical Director – Dr. Fraser
Dietitian (Lead Dietitian) – Michele Huang
RN/RPN – Charge RN Charlyn Navarro
PSW – Teresa Albay
Resident Council Rep – Isabela Taylor

2024/2025 Continuous Quality Improvement Annual Report

Family Council Rep – Marilyn Pelletier

This CQI Committee will:

a) Monitor, analyze, and review survey data (Resident & Family Satisfaction Survey, Staff Satisfaction Survey)
b) Set and analyze CQI Indicators for each department area and documents in the QIA folder on the PCC database
c) Meet quarterly and analyze data for future QIPS (Health Quality Ontario) and CIHI, as well as the Critical Incidents and Complaint log, and create action plans.
d) Ensure Family Council and Resident Council review questions for the Resident & family satisfaction survey
e) Ensure that the communication outcomes of surveys are shared with the families, residents, and staff.

4. SHARING AND COMMUNICATING RESULTS

A) **Three Key Clinical Quality Indicators with results 2024 - Aligned with the Best Practice Spotlight Organization (BPSO)**

1) Falls and Injury Prevention: Monitor fall rates and implement prevention strategies.

Falls Prevention Indicators	TARGET	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
# of falls - 1st floor		7	14	11	12	8	11	3	14	5	12	11	12
# of falls - 2nd floor		16	17	13	21	18	16	9	9	3	6	9	9
# of falls 3rd floor		4	10	20	6	12	13	15	3	6	11	8	11
TOTAL # of falls /all floors	30/month/all floors	**27**	**41**	**44**	**39**	**38**	**40**	27	26	14	29	28	32

2024/2025 Continuous Quality Improvement Annual Report

2) Reducing Pressure Injuries: Track prevalence and ensure timely intervention.

Skin and Wound Indicators	TARGET	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
# of pressure ulcers 1st floor		2	2	1	0	0	0	1	1	1	1	5	8
# of pressure ulcers 2nd floor		3	6	6	6	7	4	2	3	2	2	2	2
# of pressure ulcers 3rd floor		5	2	2	2	3	3	5	2	2	1	1	3
TOTAL per month	8	10	10	9	8	10	7	8	6	5	4	8	13

3) Resident and Family Centre Care

- Dietary Indicator:

Dietary Indicators	TARGET	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
# of complaints from Resident Council Meetings	3	5	4	6	3	4	6	3	2	2	2	0	3

Resident & Family Engagement

1) Sharing Resident/Family Survey (2023) Results:
   - CQI Quality Committee (April 17, 2024)
   - Family Council Meeting (March 26, 2024)
   - Resident Council Meeting (March 21/2024)
   - PSW Meeting (April 26/2024)
   - Nurse Practice Committee Meeting (April 24/2024)
   - Posted visually on the Family Council Board

2024/2025 Continuous Quality Improvement Annual Report

These Top THREE Priority areas identified from the Resident & Family Satisfaction Survey 2023 were presented during the Family Council Meeting on March 26, 2024.

PLEASE NOTE: Input from Resident & Family Council Members, BPSO, RNAO, and Resident & Family Centred Care Members, were attained in the development of the priority areas below CQI Council provided input on the targets/activities to complete.

THREE PRIORITY AREAS and results:

Priority #1: Nursing Care:

1) Consistent Staff

Goals identified:

a) Reduce the number of agencies used
Result: Currently, only using two main Agencies for PSWs and two main agencies for registered staff

b) Postings for PSWs/Nurses (Target: Hire three new PSWs each month and three new RPNs each month)
Result: # PSWs hired 2024: 17 PSWs
Registered Staff hired 2024: 4 RPNs

Priority #2: Communication

a) Goal: Increase availability of nurses and doctors on duty to increase communication with families

- **Activities/Results:**
1) Phone on top of nursing station with phone extensions to call Unit/Charge RN (Result: new phone system installed March 2025

- voicemail boxes messages updated – more user friendly for callers – easier access to nursing stations & management)
  2) Send eblast to families nursing extensions (posted on Family Resident Council Board) – Result: completed
  3) Communication Binder for Families/front desk or call/email (Reception Desk is staffed 9am to 5pm Monday – Sunday inclusive) – Relays messages to Charge Nurse (Ext 163); Reception Desk EXT 136 voicemail box checked every day; Nursing Station Extensions - have voicemail boxes); Note Communication Binder not completed due to privacy issues, which may occur at front desk
- 4) Increase Family/Resident Communication with Doctors when new residents are admitted:
  Result: a) New Fact Information Form has been developed by the Admissions Team – information of the New Resident is provided to the Medical Team/Nursing Team/Departmental leads; Medical Doctors meet the New Resident within the first week of admission – attends the first / ongoing Care Conference

- **5)** Referrals to Doctors from Unit Nurses (process for checking past referrals) – Unit Nurses provides referrals online through the electronic resident database (PCC – Point Click Care) – if the family requests to meet with the Medical Doctor – a meeting is arranged by the Unit/Charge RN by phone call or e-referrals – depending on urgency of matter

2024/2025 Continuous Quality Improvement Annual Report

Priority #3: Laundry Concerns

a) Missing Clothes/damaged or Resident clothes brought to another room

Laundry Indicators	TARGET	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
# of lost clothing	**6**	10	12	15	8	8	5	5	6	4	5	4	5

Annual Cycle for Heritage Green Nursing Home

January to March:

- Complete Program Evaluations for the Mandatory Programs (e.g. IPAC, Skin & Wound, Fall Prevention, Continence Care, Responsive Behaviour, Restorative Care, Zero Tolerance for Abuse, CQI and Medication Management
- Analyze results of the Staff Satisfaction Survey AND Resident/Family Satisfaction Survey and present results to staff and resident/family council

April to June:

- Communicate Outcomes to Residents & Staff and Families
- Submit QIP program to HQO by April 1st each year
- Create Action Plans (2) for each Satisfaction Surveys (Staff Satisfaction and Resident/Family) – set SMART goas/Measures/targets – begin implementation

2024/2025 Continuous Quality Improvement Annual Report

July to September:

- The Family Council will review the Resident and Family Satisfaction Survey questions (adjustment to the survey based on feedback) – each year before launching survey
- Review the targets of ACTION PLANS (every quarter at the CQI Committee – are we meeting the targets? Do we need adjustments? Are we in compliance?)

October – December:

- Start analyzing data for QIP (1 - % of potentially avoidable ED visits; 2 – Resident experience; 3 - % of LTC residents not living with Psychosis)
- Review QIA indicators on PCC (every quarter)
- Plan for continued services or new/enhanced priority areas
- Send out the Resident and Family Satisfaction Survey to all Residents/families

Description of Process and Procedures to monitor and measure progress, identify and implement priority areas/communicate outcomes:

1. **QIP Planning Cycle and Priority Setting Process**

- Heritage Green has created QIPs (Quality Improvement Plans) as part of the annual planning cycle – QIPs are submitted to Health Quality Ontario every April

2. **PROCESS:** Monitor/measure progress, identify and implement adjustments and communicate outcomes – analysis of the outcomes (smart goals targets from the Family/Resident Survey Action Plan, the Staff Satisfaction Action Plan targets (TBD), the QIA indicators on PCC and the QIP targets;) by the CQI Team will be used to identify if Heritage Green is achieving the desired outcomes not.

- If not reaching the desired outcomes, the team can review the process measures (s) & make recommendations, over time to either confirm

- compliance with key change ideas or identify gaps in compliance that need to be addressed. Based on the results of this analysis, the team may consider alternative change ideas, provide coaching to staff to enhance compliance, engage with staff to better understand the gaps in compliance, etc. changes/compliance/gaps

3. Communication Strategies:

- Posting on board in the education room (BPSO indicators also posted)
- monthly PSW and Registered staff meetings
- Presentations at staff meetings, Resident Council