Continuous Quality Improvement Report
Oneida Long-Term Care Home

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DESIGNATED LEAD - Quality Improvement

Introduction to Oneida Long-Term Care Home

Tsi'Nu: Yoyantle Na'Tuhuwatisni - Oneida Long-Term Care Home is a 64-bed Indigenous long-term care home located in Southwold, Ontario in the Oneida Nation of the Thames Territory

Oneida Long-Term Care takes pride in maintaining a culture of quality and resident, family, and staff satisfaction.

Oneida Long-Term Care takes pride in fostering a culture of quality through continuous quality improvement. The Quality Improvement Plan (QIP) for the 2023-2024 year demonstrates alignment with both internal planning processes including strategic planning as well as objectives identified by our system partners such as the Ministry of Long-Term Care (MLTC), Home and Community Care Support Services (HCCSS), Ontario Health (OH), and Health Quality Ontario (HQO).

Quality Improvement Outcomes from 2022-23

Quality Indicator	Performance in 2020-2021	Performance in 2021-2022
Avoidable ED Visits	25.97%	18.50%
Antipsychotic Use without Diagnosis	11.11%	8.00%

QUALITY PRIORITIES FOR 2023/24

Oneida Long-Term Care Home is pleased to share its 2023/24 Continuous Quality Improvement Plan Report.

In 2023/24, we look forward to beginning our journey in becoming a Pre-Designate Best Practice Spotlight Organization (BPSO) with the Registered Nurses' Association of Ontario (RNAO) and implementing Best Practice Guidelines to improve Resident experience and outcomes.

As part of our journey as a Pre-Designate BPSO, we will be implementing Best Practice Guidelines ensuring residents and their families are supported to achieve their personal goals for their health and quality of life. We will be continuing to enhance our approach to palliative and end-of-life care through concentrating on comfort and quality of life for residents experiencing a life-limiting illness and their families.

Furthermore, we will be implementing Clinical Pathways developed by system partners using evidence-based practices to standardize workflow for our staff and ensure that we holistically and safely meet residents' needs, preferences, and goals.

Meeting the requirements of the Fixing Long-Term Care Act, 2021 and Ontario Regulations 246/22, respecting Residents' Bill of Rights, and maintaining an environment that supports evidence-based practices and innovation, remain high priorities for Oneida Long-Term Care Home. Our Continuous Quality Improvement Plan is a roadmap to integrating excellent care, collaboration, and enhancing quality of life for residents in our Home.

The overarching priorities for Oneida Long-Term Care Home's 2023/24 Continuous Quality Improvement are enhancing care outcomes and empowering frontline staff with knowledge and skill by implementing best practice guidelines, supporting innovation in data integration, and maintaining/enhancing Resident, Family and Staff Satisfaction:

- Achieving Excellence in Quality of Life for residents in our Home
- Achieving Resident's Comfort
- Supporting Resident's Transition in our Home
- Meeting Resident's needs, wishes
- Supporting Point of Care Decision Making
- Enhancing screening, assessment and prevention of risk
- Data Integration
- Maintaining Residents' and Staff Satisfaction
- Continue to promote and advocate for the Indigenous population, community, and the importance of ethnic long-term care homes

QUALITY OBJECTIVES FOR 2023/24

1. Achieving Excellence in Quality of Life for residents in our Home through the implementation of Person and Family Centered Care (PFCC), Alternative to Restraints Best Practice Guideline, and the Palliative Approach to Care Guideline
2. Achieving Residents' comfort through the implementation of Pain Assessment and Management Best Practice Guideline and the End-of-Life Care Guideline
3. Supporting Resident transitions in our Home prior to admission through the process of pre-admission conference and on the day of admission through the implementation of the Admission and 24 Hours Assessment and Plan of Care Clinical Pathway
4. Meeting Resident needs, preferences, and goals through the implementation of Clinical Pathways (Resident and Family Centred Care and Pain Assessment and Management) and integration of goals of care discussions during resident care conferences
5. Supporting screening, assessment, risk mitigation, and point of care decision making through the implementation of Assessment Tools and Clinical Pathways that integrate with Plan of Care though Nursing Advantage Canada electronic platform for resident assessments
6. Maintaining Resident, Family and Staff Satisfaction through anticipating needs, prompt response and action

QIP PLANNING CYCLE AND PRIORITY SETTING PROCESS

Oneida Long-Term Care Home is planning a cycle for their Continuous Quality Improvement Report and Quality Improvement Plan (QIP).

Quality Improvement planning includes an evaluation of the following factors to identify preliminary priorities:

- Ongoing analysis of performance data over time available from the Canadian Institute for Health Information (CIHI); with areas indicating a decline in performance over time and/or where benchmarking against self-identified peer organizations suggests improvement required
- MDS Indicators Raw Data Reports available in Point Click Care
- Resident, family and staff experience survey results;
- Identified priorities through program evaluations
- Results of care and service audits
- Emergent issues identified internally (trends in critical incidents) and/or externally;
- Input from residents, families, staff, leaders and external partners.
- Mandated provincial improvement priorities (e.g., HQO)
- Acts and Regulations for Long Term Care Homes, other applicable legislations and best practice guidelines

Oneida Long-Term Care Home's Approach to CQI (POLICIES, PROCEDURES AND PROTOCOLS)

Oneida Long-Term Care Home has developed an annual planning cycle for our Continuous Quality Improvement Report and Quality Improvement Plan (QIP).

Quality Improvement planning includes an evaluation of the following factors to identify preliminary priorities:

- Progress achieved in past year based on previous QIP;
- Ongoing analysis of performance data over time available from the Canadian Institute for Health Information (CIHI); with areas indicating a decline in performance over time and/or where benchmarking against self-identified peer organizations suggests improvement required;
- MDS Indicators Raw Data Reports available in PointClickCare (PCC);
- Resident, family and staff experience survey results;
- Identified priorities through program evaluations and recommendations from the Home's Continuous Quality Improvement Committee;
- Results of care and service audits;
- Emergent issues identified internally (i.e., trends in critical incidents, etc.) and/or externally;
- Input from residents, families, staff, leaders and external partners;
- Mandated provincial improvement priorities (e.g., HQO)
- Legislation and Best Practice Guidelines

Oneida Long-Term Care Home's Approach to CQI (POLICIES, PROCEDURES AND PROTOCOLS)

3. Developing and Testing Practice Change(s)

- As a principal Oneida Long-Term Care Home will identify practice changes to implement current evidence based recommendations established by the published Best Practice Guideline(s)
- With the completion of the gap analysis, and program evaluation as required, areas for improvement are identified and will move Oneida Long-Term Care Home towards meeting its aim statement (s).
- Oneida Long-Term Care Home will monitor and track outcomes of practice changes through observation, auditing and data collection.

4. Implementation, Dissemination, Sustainability

- Oneida Long-Term Care Home will consider the following factors when developing implementation of practice change plan:

➢ Outstanding work to be completed prior to implementation (e.g., final revisions to change ideas, embedding changes into existing workflow, updating relevant Policies and Procedures, work flow charts, documentation systems etc.)

➢ Education required to support implementation, including key staff resources

➢ Communication required to various stakeholders, before during and after implementation

➢ Approach for spread across Oneida Long-Term Care Home (to residents, families, staff)

➢ Dissemination at monthly Best Practice Change meetings, conferences, webinars, etc.

Oneida Long-Term Care Home's Approach to CQI (POLICIES, PROCEDURES AND PROTOCOLS)

- Priorities are discussed and established with the interdisciplinary team, including the Leadership Team, Residents' Council, CQI Committee and Professional Advisory Committee. The process is interactive and engages different stakeholders and partners.
- Our QIP targets and practice change ideas are identified and confirmed

Measures include the following types:

Outcome Measures:

- Measures what the team is trying to achieve (the aim)

Process Measures:

- Measures key activities, tasks, processes implemented to achieve aim

Structure Measures:

- Measures systems, and processes to provide high-quality care.

PROCESS TO MONITOR AND MEASURE PROGRESS, IDENTIFY AND IMPLEMENT ADJUSTMENTS AND COMMUNICATE OUTCOMES

- A key component of the sustainability plan is the collection and monitoring of the key project measures over time.
- Run charts and Statistical Control Charts, with established rules for interpretation, are essential to understanding if there has been an improvement or decline in performance.
- Analysis of the Outcome measure(s) will be used to identify if the Home is achieving the desired outcomes or not.
- If not achieving desired outcomes, the team can review the Process measure(s) over time to either confirm compliance with key change ideas (suggesting the change idea may not be as effective at improvement outcomes) 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 gaps in adherence to compliance.

At An Organizational Level

- Oneida Long-Term Care Home is planning to implement different reports to monitor and measure progress on strategic aims such as reports and Quality Improvement modules, best practice indicators based on guideline and clinical pathway implementation, and different analysis tools available within different programs.
- Communication strategies are tailored to the specific improvement initiative. These include, but are not limited to:

➢ Publishing stories and results via the newsletter

➢ Direct email to staff, families and other stakeholders

➢ Handouts and one:one communication with residents, families and staff

➢ Presentations at Resident Councils

➢ Use of Best Practice Champions to communicate directly with peers

Resident and Family Experience Survey

- Resident and Family Experience Surveys are provided to Residents and Families annually.
- The results of the surveys are communicated to Residents, Families, Staff, Residents' Council, the CQI Committee, and the Professional Advisory Committee.
- In collaboration with Residents, Families, Staff, Residents' Council, and CQI Committee Members, we complete a review of all survey responses. We celebrate successes and establish goals for areas identified as needing improvement.

2022 Resident and Family Experience Survey

2022 Resident and Family Experience Surveys were completed on November 30, 2022

Summary of areas home is performing well:

- 96% satisfaction with care delivery based on individual preferences
- 93% satisfaction with communication from home to families

Summary of Areas for Improvement:

- 90% Satisfaction with care response time to resident requests for assistance

Oneida Long-Term Care Home Quality Improvement Priority Indicators

1. **Resident and Family Satisfaction**

Indicator	Current Performance	Target Performance
Residents responding positively to: "What number would you use to rate how well the staff listen to you?"	96.55%	100%
Residents who responded positively to the statement: "I can express my opinion without fear of consequences"	100.00%	Maintain 100.00%
Satisfaction with care response time to resident requests for assistance	90.00%	98.00%

2. **Palliative and End-of-Life Care**

Indicator	Current Performance	Target Performance
% of palliative care residents that have had an interdisciplinary assessment of their holistic palliative care needs	Collecting Baseline	100.00%

Oneida Long-Term Care Home Quality Improvement Priority Indicators

3. Provincial Priority Indicators

Indicator	Current Performance	Target Performance
Avoidable ED Visits	25.97%	18.50%
Antipsychotic Use without Diagnosis	11.11%	8.80%

Practice Changes/ Action Items to Support Quality Improvement

1. **Clinical Implementation:**
- 24 Hours Assessment and Plan of Care
- Implementation of Best Practice Guidelines
- Implementation of Clinical Pathways
- INTERACT Tools

2. **Data Integration (AMPLIFI Project)**
- Match of resident electronic health records between Oneida Long-Term Care and hospital software systems

3. **Safety and Technology:**
- Skin and Wound App.
- Practitioner Engagement and Secure Conversation App.
- Infection Control Program Implementation

4. **Improved Staff Experience:**
- Supporting Point of Care Decision Making: electronic Infection Control Program, electronic Skin and Wound Program
- Experience Survey and Outcome

5. Resident Experience:
- Experience Survey and Outcome
- Residents' Council Feedback
- Actions for improvement

Tsi'Nu: Yoyantle Na'Tuhuwatisni - Oneida Long-Term Care Home - Continuous Quality Improvement Action Plan - 2023

Instructions: Complete Continuous Quality Improvement Action Plan as a part of the CQI Report annually. Create action plan for targeted quality improvement initiatives identified during review of Resident & Family Satisfaction surveys, CQI Audits and Program Evaluations.

The following items need to be addressed each year in this action plan: QI Indicators (I.E. Skin, ED Transfers, Fall Prevention); Innovation (I.E. MST, PE/SC, Epic PCC integration); Resident/Family Survey action items; BPSO Indicators (i.e. Pain assessment and management, restraints, PFCC); CQI Audits action items and Program Evaluation action items

Item Number	Quality Improvement Indicator	Current Performance	Target Performance	SMART Goal & Quadruple Aim (1. Resident Experience, 2. Outcomes, 3. Care Team Experience, 4. Effective Resource Utilization)	Change Idea	Method	Process Measure	Target for Process Measure	Responsible Person	Date Action was Taken	Outcomes of Actions Completed	Role of Resident/Family Council in Actions Taken	Role of CQI Committee in Actions Taken
1	Number of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents.	25.97%	18.50%	To reduce number of ED visits for modified list of ambulatory care-sensitive conditions per 100 long-term care residents from 25.97% to 18.00% by March 31, 2024	1)Educate/reeducate all direct care staff (registered nursing staff and personal support workers) on the Stop and Watch Program (INTERACT)	Direct care staff will receive education on Stop and Watch Program and sign attendance record confirming receipt of education	# of direct care staff; # of direct care staff that signed attendance record	100% of all direct care staff will receive education/reeducation on the Stop and Watch Program and sign attendance record confirming receipt of education by June 30, 2023	Director of Care/ Designate			**Residents' Council:** Indicators and action plan reviewed with Residents' Council. Feedback elicited from Council when determining priorities and establishing action plan **Family Council:** The Home does not currently have a Family Council, but actively promotes the establishment of a Council	CQI Committee participated in review and selection of indicators, and development of action plan. Status of action plan to be reviewed at CQI Committee Meetings and Committee to provide ongoing guidance to address any identified gaps
					2)Validated communication tool will be used to support decision making regarding transfer to acute care	Registered Nursing Staff will utilize SBAR Communication Form (INTERACT) when communicating change in status to physician/RN(EC) to support with decision making regarding transfer to acute care	# of residents transferred to acute care; # of residents who had SBAR Communication Tool used and documented prior to transfer to acute care	90%* of residents will have SBAR Communication Tool used and documented prior to transfer to acute care by September 30, 2023 (*10% to account for critical/life-threatening circumstances necessitating immediate transfer to acute care)	Director of Care/ Designate				
					3)Track resident transfers to acute care to identify indication(s) for transfer and potentially avoidable ED visits	MDS RAI Coordinator and Director of Care will track resident transfers to acute care monthly to identify indication(s) for transfer and potentially avoidable ED visits	# residents transferred to acute care per calendar month; # of residents documented on tracking sheet per calendar month	100% of all residents transferred to acute care will be documented on tracking sheet monthly in 2023	MDS RAI Coordinator/ Director of Care				
					4)Review and analyze transfers to acute care with interdisciplinary team to identify and discuss potentially avoidable ED visits	Director of Care/Designate will review transfers to acute care at Registered Nursing Staff Meetings monthly to discuss potentially avoidable ED visits; Director of Care/Designate will review transfers to acute care at Professional Advisory Council (PAC) Meetings quarterly to identify and discuss potentially avoidable ED visits	# of monthly Registered Nursing Staff Meeting Minutes that include review of transfers to acute care and potentially avoidable ED visits; # of quarterly PAC Meeting Minutes that include review of transfers to acute care and potentially avoidable ED visits	100% of all monthly Registered Nursing Staff Meeting Minutes will include review of transfers to acute care and potentially avoidable ED visits in 2023; 100% of all quarterly PAC Meeting Minutes will include review of transfers to acute care and potentially avoidable ED visits in 2023	Director of Care/ Designate				
2	Percentage of residents responding positively to: "What number would you use to rate how well the staff listen to you?"	96.55%	100.00%	To increase percentage of residents responding positively to: "What number would you use to rate how well the staff listen to you?" from 96.55% to 100.00% by December 31, 2023	1)Educate/reeducate staff on Residents' Bill of Rights and Person Centred Care	Staff will attend an in-service on Residents' Bill of Rights and Person Centred Care, and sign confirmation of receipt of education form	# of staff that attended in-service validated by signed confirmation of receipt of education form	100% of staff will attend in-service on Residents' Bill of Rights and Person Centred Care, and sign confirmation of receipt of education form by August 31, 2023	Administrator/ Director of Care/ Designate			**Residents' Council:** Survey results and action plan reviewed with Residents' Council. Feedback elicited from Council when determining priorities and establishing action plan **Family Council:** The Home does not currently have a Family Council, but actively promotes the establishment of a Council	CQI Committee participated in review and selection of indicators, and development of action plan. Status of action plan to be reviewed at CQI Committee Meetings and Committee to provide ongoing guidance to address any identified gaps
					2)Resident requests for information and concerns will be standing agenda item at daily staff huddles	Resident requests for information and concerns will be standing agenda item at daily staff huddles and documented in meeting minutes	# of daily huddle meeting minutes that include review of resident requests for information and concerns	100% of daily huddle meeting minutes will include review of resident requests for information and concerns from April 2023 - March 2024	Administrator/ Director of Care/ Designate				
					3)Timely response to resident requests for information and concerns	Departmental Managers will respond to resident requests for information and concerns within 1 business day. All requests for information and concerns will be tracked and reviewed weekly at Leadership Meeting	# of resident requests for information and concerns that were responded to within 1 business day	95%* of all resident requests for information or concerns will be responded to within 1 business day from April 2023 - March 2024 (5%* to account for extenuating circumstances that may delay response within 1 business day)	Departmental Managers				
3	Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences".	100.00%	100.00%	To maintain percentage of residents who respond positively to the statement: "I can express my opinion without fear of consequences" at 100% by December 31. 2023	1)Maintain resident awareness of procedure for reporting issues, concerns, and complaints	Procedure for issues, concerns, and complaints to be a standing agenda item at monthly Residents' Council Meetings	# of Residents' Council Meeting Minutes that include review of procedure for issues, concerns, and complaints	100% of monthly Residents' Council Meeting Minutes from April 2023 - March 2024 will include review of procedure for issues, concerns, and complaints	Administrator/ Programs Manager			**Residents' Council:** Survey results and action plan reviewed with Residents' Council. Feedback elicited from Council when determining priorities and establishing action plan **Family Council:** The Home does not currently have a	CQI Committee participated in review and selection of indicators, and development of action plan. Status of action plan to be reviewed at CQI Committee Meetings and Committee to provide ongoing guidance to address any identified gaps
					2)Maintain resident awareness of Residents' Bill of Rights and Home's advocacy of Residents' Bill of Rights	Residents' Bill of Rights to be standing agenda item at monthly Residents' Council Meetings	# of Residents' Council Meeting Minutes that include review of Residents' Bill of Rights	100% of monthly Residents' Council Meeting Minutes from April 2023 - March 2024 will include review of Residents' Bill of Rights	Administrator/ Programs Manager				

4	Percentage of LTC residents with a progressive, life-threatening illness who have had their palliative care needs identified early through a comprehensive and holistic assessment	Collecting Baseline	Theoretical Best 100%	100% of LTC residents with a progressive, life-threatening illness will have their palliative care needs identified early through a comprehensive and holistic assessment by March 31, 2024	1)Residents with a progressive, life-threatening illness will have their palliative care needs identified early through a comprehensive and holistic assessment on admission (within 6 weeks or sooner if death is imminent) and following significant change in status using Palliative Care Assessment in PointClickCare	Monthly audit of completion of Palliative Care Assessment in PointClickCare for new admissions and residents experiencing significant change in status	% of residents that received comprehensive assessment using Palliative Care Assessment in PointClickCare within 6 weeks of admission or following significant change in status	100% of residents will receive comprehensive assessment using Palliative Care Assessment in PointClickCare within 6 weeks of admission or following significant change in status in 2023	Director of Care/ Designate			**Residents' Council:** Action plan reviewed with Residents' Council. Feedback elicited from Council when determining priorities and establishing action plan **Family Council:** The Home does not currently have a Family Council, but actively promotes the establishment of a Council	CQI Committee participated in review and selection of indicators, and development of action plan. Status of action plan to be reviewed at CQI Committee Meetings and Committee to provide ongoing guidance to address any identified gaps
5	Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment	11.11%	8.00%	To reduce percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment from 11.11% to 8.00% by March 31, 2024	1)Review current residents to determine who is receiving antipsychotic medication without clinical indication	Interdisciplinary team (physician, pharmacist, registered nursing staff) will review resident reports in Electronic Health Record platform and reports from Pharmacy to determine residents who are receiving antipsychotic medication without clinical indication	# of residents receiving antipsychotic medication reviewed	100% of current residents receiving antipsychotic medication will be reviewed to evaluate indication for use by June 30, 2023	Director of Care/ Designate			**Residents' Council:** Indicators and action plan reviewed with Residents' Council. Feedback elicited from Council when determining priorities and establishing action plan **Family Council:** The Home does not currently have a Family Council, but actively promotes the establishment of a Council	CQI Committee participated in review and selection of indicators, and development of action plan. Status of action plan to be reviewed at CQI Committee Meetings and Committee to provide ongoing guidance to address any identified gaps
					2)Assess residents who are receiving antipsychotic medication without clinical indication to determine eligibility for reduction	A baseline assessment using the Cohen-Mansfield Agitation Inventory (CMAI) Scale – Long Form will be conducted by Registered Nursing Staff for residents receiving antipsychotic medication without clinical indication	# of residents receiving antipsychotic medication without clinical indication that were assessed using CMAI	100% of residents receiving antipsychotic medication without clinical indication will be assessed using CMAI by September 30, 2023	Director of Care/ Designate				
					3)Residents receiving antipsychotic medication without clinical indication who are eligible for reduction will be placed on antipsychotic reduction plan	Residents receiving antipsychotic medication without clinical indication who are eligible for reduction following assessment using Cohen-Mansfield Inventory Scale (score less than 80/203) will be placed on antipsychotic reduction plan	# of residents who are eligible for reduction; # of residents who are eligible for reduction and placed on antipsychotic reduction plan	90%* residents who are eligible for reduction will be placed on antipsychotic reduction plan by December 31, 2023 (*10% to account for resident/substitute decision maker refusal to provide consent to be placed on antipsychotic reduction plan)	Director of Care/ Designate				
					4)Quarterly medication reviews by interdisciplinary team (Attending Physician, Pharmacist, Nursing) for residents receiving antipsychotic medication to include review of antipsychotic medication to evaluate efficacy and potential/actual risks, and to assess eligibility for reduction	Monthly audit of quarterly medication reviews to determine number of reviews completed for residents receiving antipsychotic medication that included review of antipsychotic medication to evaluate efficacy, potential/actual risks, and eligibility for reduction	# of quarterly medication reviews completed for residents receiving antipsychotic medication; # of quarterly medication reviews for residents receiving antipsychotic medication that included interdisciplinary review to evaluate efficacy, potential/actual risks, and eligibility for reduction	100% of quarterly medication reviews where residents are receiving antipsychotic medication included interdisciplinary review to evaluate efficacy, potential/actual risks, and eligibility for reduction in 2023	Director of Care/ Designate				
6	Satisfaction with care response time to resident requests for assistance	90.00%	98.00%	To increase satisfaction with care response time to resident request from 90.00% to 98.00% by December 31, 2023	1)Conduct audits of call bell response time	Establish an auditing process for review of call bell response times	Audit process established	Audit process established	Director of Care/ Designate			Residents' Council: Indicators and action plan reviewed with Residents' Council. Feedback elicited from Council when determining priorities and establishing action plan Family Council: The Home does not currently have a Family Council, but actively promotes the establishment of a Council	CQI Committee participated in review and selection of indicators, and development of action plan. Status of action plan to be reviewed at CQI Committee Meetings and Committee to provide ongoing guidance to address any identified gaps
						Initiate audit, collect data to report back to interprofessional team	# of audits completed/ # audits where target performance met	100% of audits reviewed will include a response time of 5 minutes or less	Director of Care/ Designate				
						Communication audit results to residents, families and staff at monthly Resident Council Meetings and Staff Meetings.	# of Residents' Council Meeting Minutes and Staff Meeting Minutes that include review of call bell response time	100% of monthly Residents' Council Meeting Minutes and Staff Meeting Minutes from April 2023 - March 2024 will include review of call bell response time	Director of Care/ Designate				

Date/Method Action Plan Communicated to Residents:	
Date/Method Action Plan Communicated to Family Members:	
Date/Method Action Plan Communicated to Residents' Council:	
Date/Method Action Plan Communicated to Family Council:	Home does not currently have a Family Council, but actively promotes establishment of Council
Date/Method Action Plan Communicated to Staff:	