Holland Christian Homes

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Continuous Quality Improvement – Final Report for Grace Manor

Grace Manor is part of a larger continuum of care organization, Holland Christian Homes which is located in the City of Brampton and includes another Long-Term Care Home (Faith Manor) and six apartment towers. The mandate of Holland Christian Homes is to provide a supportive, caring, quality Christian environment in order to preserve dignity and enhance the quality of life for people who require long-term care from a team of qualified caregivers. In partnership with residents, caregivers and families, we provide a safe, professional and caring community for seniors based on traditional Christian values, offering a continuum of care and support while respecting their individuality and dignity. Our Quality Improvement Program includes in its scope, the annual development, implementation, monitoring, review, and evaluation of the following activities: Resident and Family Satisfaction Surveys, Accreditation Assessment, Results And Action Plans; Staff Satisfaction Survey And Action Plan; Department Goals/Audits/stats tracking; Funding Agreements, Funding Indicators And Grants; Formal Program Reviews; Advocacy Initiatives (Resident And Family Engagement) – Residents Council, Family Council, Food Committee, Internal Concern Resolution Process; Legislative Requirements / Inspection Reports And Findings; Education And Training.

QUALITY PRIORITIES FOR 2023/24

Grace Manor is pleased to share its 2023/24 Quality Improvement Priorities.

Our long-term strategic plan identifies “Innovation and Excellence” as one of Holland Christian Homes’ 5 key strategic pillars. In 2022, Holland Christian Homes’ strategic plan was refreshed in response to several unprecedented factors which resulted in a fundamentally changed healthcare landscape. These factors included, amongst others, the ongoing impacts of the COVID-19 pandemic, persistent healthcare worker shortage and burnout, increased public attention on long-term care, and increased regulation of an already highly regulated environment. The core pillars of the long-term strategy remain relevant and are reflected in the refreshed strategy which outlines objectives and priorities for 2023-2025.

Grace Manor continues to work with the Holland Christian Homes Board of Directors on the Strategic Plan to further enhance quality care outcomes for our residents for 2023-2025.

The QIP is a roadmap to achieving these objectives while navigating challenges and opportunities in our environment.

Grace Manor's QIP is aligned with our Quality Framework imbedded within Holland Christian Homes' Core Values, and Success Factors. The high-level priorities for this year's QIP are informed by the quality and safety aims under the various pillars of the framework, as determined by the Holland Christian Homes' Board of Directors:

- Safe- Keeping Residents Safe
- Effective- Keeping People Healthy
- Resident Centered
- Efficient
- Accessible- Access to Long-Term Care Homes and Community Support Services
- Appropriately Resourced- Staffing
- Priorities are divided into 3 categories based on the projected scope of work anticipated for the year – focused action, moderate action, and monitoring. Areas for action are included in this report.
- Our QIP Priorities are following Health Quality Ontario Performance Measures and Indicators
  1) Timely and Efficient Transitions
  2) Service Excellence
  3) Safe and Effective Care

QUALITY OBJECTIVES FOR 2023/24 ***(See full Quality Improvement Plan at the end of this document)***

Focused Action:

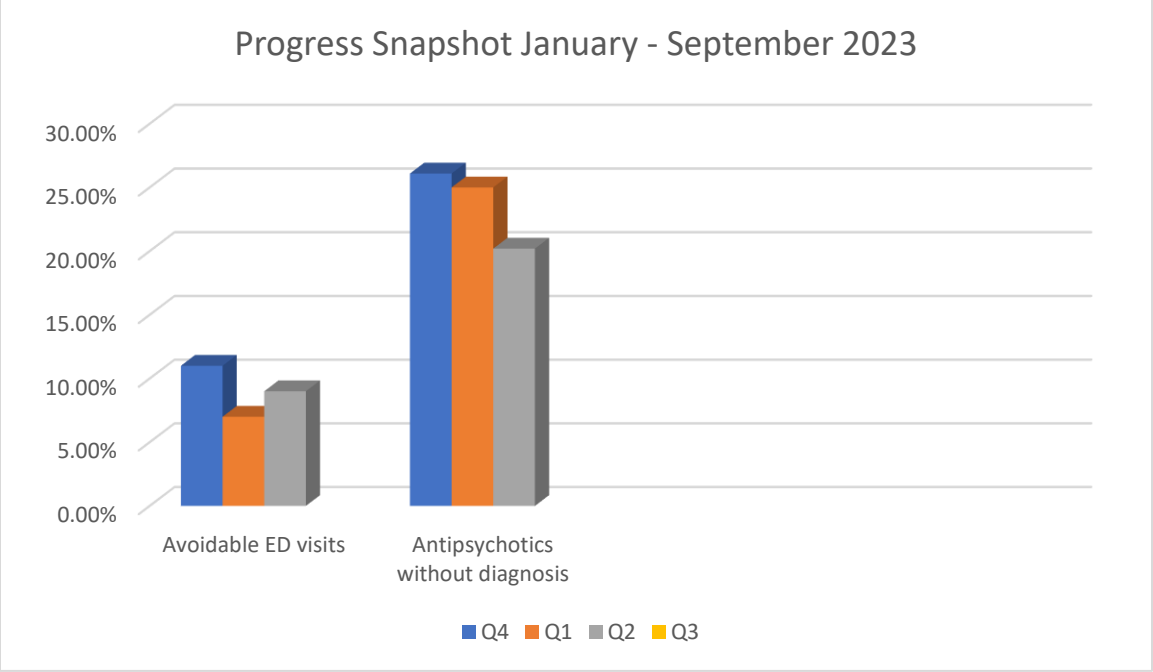
1. Continue to implement the Person-Centered Care Best Practice Guideline through the RNAO to implement our resident care philosophy statement of "Nothing About Me, Without Me".
2. Reduce the percentage of residents on antipsychotics without a diagnosis of psychosis, from 20.95% to 18% and continue to strive for improvement.

Moderate Action:

3. Ensure consistent use of the Palliative Care and End of Life Clinical Support Tools (by Think Research) to ensure optimal Palliative Care and End of Life Program Outcomes.
4. Continue to eliminate staff to resident abuse/neglect (continue to have zero substantiated incidents reported to the MLTC).
5. Reduce the percentage of ED visits from 17.27% to 17% that could be avoidable, PoET individualized form helps to ensure that decision-making is aligned with Ontario's Health Care Consent Act and Fixing Long Term Care Act- Residents Bill of Rights.

6. Enhance the resident quality of life as measured by our in-house Resident/Family Satisfaction Survey by focusing on the areas of Residents responding positively to being heard and expressing opinions without fear of consequences to maintain 95-100% overall satisfaction.

PROGRESS SNAPSHOT JANUARY-SEPTEMBER 2023



QIP PLANNING CYCLE AND PRIORITY SETTING PROCESS

Grace Manor has developed QIPs as part of the annual planning cycle since 2015, with QIPs submitted to Health Quality Ontario (HQO) every April (except in 2021 when this was paused due to the global COVID-19 pandemic). Grace Manor's QIP planning cycle typically begins in January, and includes an evaluation of the following factors to identify preliminary priorities:

- progress achieved in recent years;
- 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
- resident, family, and staff experience survey results;
- emergent issues identified internally (trends in critical incidents) and/or externally;
- input from residents, families, staff, leaders, and external partners, including the MOLTC.
- mandated provincial improvement priorities (e.g. HQO)

Preliminary priorities are subsequently presented and discussed at various forums to validate priorities and identify additional priorities that may have been missed. These forums include the broader leadership team, Resident Council, Family Council, and the Care Committee of the Board of Directors. This is an interactive process with multiple touchpoints of engagement with different stakeholder groups as QIP targets and high-level change ideas are identified and confirmed. The final review of the QIP is completed by the Care Committee, which endorses the plan for approval by the Board of Directors.

GRACE MANOR'S APPROACH TO CQI (POLICIES, PROCEDURES, AND PROTOCOLS)

Every staff has a responsibility for CQI. Grace Manor's nursing, departmental, and administrative policies, combined with practice standards, provide a baseline for staff in providing quality care and service. Interprofessional quality improvement teams, including resident and family advocates, work through the phases of the annual quality improvements.

DESIGNATED LEAD

We have employed a full-time CQI and Risk Mitigation Specialist for oversight of our risk management quality improvement activities:

Loraine Anderson, BN, RN
CQI and Risk Mitigation Specialist
Loraine.Anderson@hch.ca
905-463-7002 ext.5322

****We encourage all staff, residents and families to get involved, join a committee, and make a suggestion. Contact Loraine for more information on how to make a difference!*

Comparative Databases, Benchmarks, Professional and Best Practice Standards:

Holland Christian Homes uses comparative data (such as but not limited to RAI-MDS, CIHI, HQO, and RNAO Best Practice Guidelines) (whenever available) to incorporate a process for continuous assessment with similar organizations, standards, and best practices. This assessment then leads to action for improvement as necessary.

Continuous Quality Improvement Processes and Methodology:

The Continuous Quality Improvement Plan is a framework for organized, ongoing, and systematic measurement, assessment, and performance improvement activities. The components of this plan include:

- A quick fix process will be used for problems that do not need a comprehensive approach to problem-solving and solution implementation (i.e. concern and suggestion forms).
- Quality assessment activities, such as quality of life resident/family satisfaction surveys and staff satisfaction surveys, infection control surveillance, utilization management, and medical record review.
- CQI Summary Report, which provides summary data about selected indicators, prepared for the Board, Continuous Quality Improvement Committee, and medical staff.
- Outside sources/comparative databases, such as RAI-MDS, CIHI, HQO, OLTCA, and AdvantAGE benchmarking, professional practice standards (RNAO, etc.), will be used to compare our outcomes and processes with others, identifying areas to focus on continuous quality improvement efforts.
- Central Ontario Health designated quality Indicators as outlined in the L-SAA Funding Accountability Agreements.
- Quality Improvement Teams consisting of departmental and established interdisciplinary in-house committees which look at particular issues to identify opportunities to improve processes and outcomes through the establishment of goals. Goals are acted upon, monitored, reported at, and evaluated by the applicable in-house committee and/or department(s). They are accountable to report goal outcomes annually to the CQI Committee.
- Establishment of high-level interdisciplinary priority improvement targets and initiatives to measure outcomes. This includes establishing the improvement initiative, methods, and results tracking. Such improvement targets and initiatives are measured against the previous year's actual outcome to the current year's improved targeted outcome.

The continuous quality improvement methodology used for acting on the high-level interdisciplinary priority improvement targets and initiatives is as follows:

Step One - SET STANDARDS

Standards are written statements outlining expectations, policies, procedures, and work rules related to a goal/improvement initiative. Each goal/improvement initiative will have a standard or a set of rules that tells everyone in Holland Christian Homes what to do, how to do it, and when. The standards determine the program and make it clear what is expected - how, when and from whom. They also clarify what employees can expect from management.

Standards provide the 'bar' or 'starting point' against which we evaluate whether what we are trying to accomplish or achieve is working. Implementing clear, effective, approved standards is an indication of the strong leadership that is essential for an effective and successful goal/improvement initiative.

Step Two - COMMUNICATE

Communicating standards means ensuring that all appropriate people in Holland Christian Homes have a clear understanding of what is expected of them as employees, and what they can expect from others regarding the goal/improvement initiative. Communication increases awareness of the goal/improvement initiative and encourages employees to give us feedback and tell us their observations about the goal/improvement initiative and how it can be improved.

What is communicated?

- Specific information, rules or workplace expectations that have been set for the goal/improvement initiative to appropriate people etc.
- Updates on improvements to meet the goal/improvement initiative.

How we communicate?

We use the most effective means of communication to ensure that everyone in Holland Christian Homes knows what is expected of them. This can mean notices on bulletin boards, emails, meetings, newsletters, posters, pictures, memos, or guest speakers. We make sure that literacy and language issues are accommodated.

One of the best ways we communicate positive messages about a goal/improvement initiative is by getting people to actively participate in achieving the goal/improvement initiative. This shows that people value the effort put into achieving the goal/improvement initiative.

To whom we communicate?

We communicate to employees, families, residents, volunteers, and visitors as identified in our goal/improvement initiative standard. This may include all employees or a selection of them. We may need to communicate different information to employees and different information to residents and families. We think about what people need to know and when they need to know it and who needs to know it.

We make communication two-way

We give information and ask for feedback. We make adjustments when employees offer good suggestions and then show them how we used their suggestions.

- We formulate the information in a language and manner that people will understand, and deliver it at a time and place that will maximize their comprehension.
- We vary the ways that we communicate so that new information is noticed and does not become mundane.

Step Three - TRAIN

Training means that management, supervisors, and workers all attain the knowledge and skills appropriate for their jobs. For each goal/improvement initiative, we determine who needs what knowledge and skills, and how they will be developed. To meet the goal/improvement initiative requirements, training is completed, or verified, within each year (January 1 to December 31).

How training is done?

Workplace training can be delivered in various ways (i.e. In-services, webinars, outside training, etc.). What is important is that the knowledge and skills needed to achieve the goal/improvement initiative are learned and practiced.

Effective training:

- Follows adult learning principles.
- Is delivered in the way that allows employees/residents/families to benefit most. For example, classroom training works where group discussion and sharing of ideas are important.
- For specific training, practical one-to-one hands-on experience training using tools or equipment is needed.
- Computer-based training works where independent learning is needed. We include opportunities to practice and demonstrate what is learned.
- Training is relevant and applicable to the learner's duties.

What training is done?

Training on our standards for each goal/improvement initiative is provided to those who have responsibility and accountability for knowing and using the information. For example, orientation training is important for everyone when they are first hired, when they change locations or jobs, or after a long absence from Holland Christian Homes. Training or retraining in safe work procedures is ongoing. We keep written records of who was trained in what and when the training occurred.

- We vary the ways that we do training to help keep it interesting.
- We use visual aids and real-life case studies as tools for learning.
- We discuss our training needs with other managers to create opportunities to share resources or information.
- We consider train-the-trainer courses, so we can have a qualified trainer to deliver programs on-site.
- We provide a training checklist and sign-off sheet for the supervisor and workers so we are sure each topic is covered and acknowledged.
- We keep training records, meeting notes, sign-off sheets, attendance forms, certificates or record of training and training evaluation forms with our goal documentation.

Step Four - EVALUATE

Evaluating a goal/improvement initiative

Evaluating each goal/improvement initiative is an important process; it helps us make sure we are carrying out the standard, the goal/improvement initiative is properly communicated, and effective training has taken place. It is also an opportunity to see if the goal/improvement initiative is working — is it effective and up-to-date?

Evaluating our goal/improvement initiative helps us to see where the strengths and weaknesses are. We are then better able to make effective improvements with the feedback we receive.

Going through the process of evaluation also helps keep our goal/improvement initiative fresh and top-of-mind for residents, families, volunteers, workers and supervisors as we ask questions and check to see the status of the goal. This is a good time to give positive feedback, which will encourage more good work.

How and when do we evaluate?

Once Steps 1, 2, and 3 have been completed, the evaluation may begin. The evaluation step is completed during the calendar year. However, it may not be practical to evaluate our goal near the end of the year if it was very recently implemented. We follow our action plan and have it implemented no later than February 1st of the following year.

Ways we evaluate:

- Observing: walk around to see if a process or task is being completed according to the standard. This is done during our regular workplace inspections.
- Looking for trends: examine workplace records.
- Asking questions about the implementation of the standard: employees will often give the best feedback.
- Asking a third party: have them look at the work processes and give us feedback.

Some questions we ask:

- Has legislation changed? Are there new best practices in the industry?
- Is the goal/improvement initiative standard being implemented and met?
- Is communication about the standards, both to and from employees, clear and understood?
- Is training to the goal/improvement initiative standards being completed and are employees, residents, families, and volunteers benefiting from it?
- Are employees following the goal/improvement initiative?

Ways we evaluate our goal/improvement initiative:

- We use a program evaluation template and evaluate the goal/improvement initiative as part of an applicable or associated program review.
- We keep logbooks that we refer to at evaluation time. We record the good practices, as well as those needing improvement.
- We keep notes throughout the year. For example, if we do training, audits, inspections, or if there are incidents, then we write them down as we go so that when it is time to evaluate we can refer to your notes.
- We try to build confidence by keeping expectations reasonable. Standards, and ways to evaluate them, will be improved over time.
- We are not afraid of negative results. We cannot improve if we do not try different methods and approaches. We will take action aimed at improving the goal/improvement initiative, even if the evaluation results show problems.

Step Five - ACKNOWLEDGE SUCCESS AND MAKE IMPROVEMENTS

Based on the results of our evaluation, we look for opportunities for improvement and create a documented plan or recommendations to implement changes. When evaluation indicates a need for improvement, we use cooperative mechanisms to significantly improve our performance.

Our objectives include:

- Raise performance to Holland Christian Homes standards.
- Raise Holland Christian Homes standards and expectations.

We keep everyone informed of the plans for improving the goal/improvement initiative such as:

- Sending a letter from the Board of Directors/department heads congratulating all staff for their contribution to meeting the goal/improvement initiative.
- Run an article in the CQI newsletter or on the website highlighting successes.
- Include commendations in the minutes of the annual general meeting.
- Acknowledge and congratulate those who have contributed to our goal/improvement initiative. We do this by publicly recognizing Holland Christian Home's overall performance and improvements and individual contributions to improved performance. We also explore employee recognition, incentive programs, and performance appraisals.

These 5 steps are used in a repeating cycle to allow continuous reflection and improvement of the care and services provided to our residents.

Communication:

The Continuous Quality Improvement Committee provides oversight and functions as the central clearing house for quality data and information collected throughout the home. The CQI Committee tracks, trends, and aggregates data from all sources to prepare reports for the Board of Directors and the medical staff. A quarterly CQI newsletter is published to update residents, tenants, families, staff, and volunteers.

Education:

All staff and volunteers are given the responsibility and authority to participate in our Continuous Quality Improvement Plan. To fully accomplish this, all volunteers and staff are provided with education regarding the CQI Plan during their initial orientation, and on an annual basis thereafter. This education will include a description of the CQI Plan and how they fit into the plan, based on their particular job or volunteer responsibilities. Education is also provided to contractors and agencies who are involved in resident care.

Evaluation (Monthly, Quarterly, Annually):

Our CQI Plan is evaluated monthly during our CQI committee working groups where all CQI activities for all programs and services offered within Grace Manor are benchmarked against our set goals and action plans are revised to ensure a focus on continuous improvement. Our established CQI Committee meets quarterly with identified key stakeholders, including representation from family/resident councils where Grace Manor reviews quarterly metrics and completes a comparative analysis of all action items and sets further action priorities. Our overall CQI Plan (and all associated activities, program matrices, benchmarks) is evaluated on an annual basis for effectiveness in achieving the goal of assuring that the most appropriate quality of care and services are being provided to our residents, tenants, and clients. This will be done following the Holland Christian Homes standard template provided for this purpose. A summary of activities, improvements made, care delivery processes modified, projects in progress, and recommendations for changes to this CQI Plan, are compiled and maintained on file.

Documentation and Reporting:

A detailed summary of activities, improvements made, care delivery processes modified, projects in progress, and recommendations for changes to this Quality Improvement Plan, are compiled and maintained on file. In addition to regular CQI updates, a detailed formal summary highlighting the quality improvement activities for the year will be prepared and posted publicly within the home and on the Holland Christian Homes website.

RESIDENT AND FAMILY ANNUAL SURVEY *(Please see the results of the survey at the end of this document)*

A resident and family survey is completed annually at the end of the calendar year. An action plan is developed utilizing the results from the survey, including dates actions were implemented and the outcomes of the actions taken. The data from the survey and the action plan are shared with resident and family council as well as shared on the CQI board in each Manor for staff, families, and visitors to view.

DATE OF REVIEW OF SURVEY RESULTS BY FAMILY & RESIDENT COUNCIL:

Family Council: February 14, 2023

Resident Council: February 21 & 22, 2023

DATE OF THE ANNUAL EVALUATION AND WHO PARTICIPATED

Our 2022 Annual Programs Review and Evaluation occurred on **April 4, 2023**

The following people participated:

#	Name	Position
1.	Lisa Alcia	CEO
2.	Tracy Kamino	VP of Operations
3.	Justine Dudziak	Administrator
4.	Albert Armah	DRC
5.	Dr. Omar Elahi	Medical Director
6.	Jenna Shaddick	Nurse Practitioner
7.	Jody Clarke	Director of Programs & Services
8.	Sheila Dyer	PSW
9.	Dora Quarshie	BSL
10.	Sorin Dorobeti	LTC HK & laundry Manager
11.	Kristine Nielsen	Resident Advocate
12.	Michael Wells	Director of HR
13.	Pastor Bodini	Pastor
14.	Rohit Sharma	Dietary Manager
15.	Cheryl Abid	Activation Staff

16.	Calendia Maku	Activation Staff
17.	Rosa Manuela	PSW
18.	Marc Van Beusekom	Chair of Family Council
19.	Loraine Anderson	CQI & Risk mitigation Specialist
20.	Nisha Pandey	IPAC Lead
21.	Chloe Turgeon	Registered Dietician
22.	Case Geleynse	Board Member
23.	Janine Walters	Emergency Management Coordinator
24.	Jennifer House	PSW
25.	Kamaljeet Sekhon	Education Coordinator
26.	Kelly Crane	Laundry Aide
27.	Sandra Walker	PSW
28.	Puneet Gill	RAI Coordinator
29.	Sujitha Jayakumar	HR Manager
30.	Manisha Bhati	PSW

OVERALL SUMMARY - 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 deterioration 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 compliance, etc.

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

- Posting on the Grace Manor Quality Improvement Boards, in common areas and in staff lounges
- Publishing stories and results on the website, on social media or via the CQI newsletter
- Direct email to staff and families and other stakeholders
- Handouts and one: one communication with residents
- Presentations at staff meetings, townhalls, Resident Councils, Family Councils
- Huddles at change of shift
- Use of Champions to communicate directly with peers

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2023/24 Quality Improvement Plan for Ontario Long Term Care Homes
"Improvement Targets and Initiatives"

Grace Manor 45 KINGKNOLL DRIVE, Brampton , ON, L6Y5P2

AIM		Measure									Change							
Issue	Quality dimension	Measure/Indicator	Type	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	External Collaborators	Planned improvement initiatives (Change Ideas)	Process measures	Target for process measure	Comments	Q1 Progress Report	Q2 Progress Report	Q3 Progress Report	Q4 Progress Report
M = Mandatory (all cells must be completed) P = Priority (complete ONLY the comments cell if you are not working on this indicator) A= Additional (do not select if you are not working on this indicator) C = Custom (add any other indicators you are working on)																		
Theme I: Timely and Efficient Transitions	**Efficient**	Number of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents.	P	Rate per 100 residents / LTC home residents	CIHI CCRS, CIHI NACRS / Oct 2021 - Sep 2022	54492*	17.27	17	The home will continue to strive for continuous improvement and strive to meet provincial average.		1)Continue to operationalize the Prevention of Error-based Transfers Project in order to reduce avoidable ED visits.	% of new admission residents and % of residents at Annual Care Conferences that receive a conversation and individualized summary on goals of care, wishes, values and beliefs.	100% of new admission residents and 100% of residents at Annual Care Conferences will receive a updated conversation and individualized summary on goals of care, wishes, values and beliefs by December 31, 2023.		100% completed this quarter.	100% completed this quarter		
											2)To implement the Preview-ED Observational tool to detect the onsent/exacerbation of four top causes of preventable ED visits: Pneumonia, UTI's, Congestive Heart Failure, Dehydration.	# of avoidable hospital transfers	The Preview-ED tool will be completed for all resident who trigger indicators after the go-live date of May 15, 2023.	The Day PSW staff will complete the questions on POC and any triggers will be documented by the Nursing Staff, and subsequently, nursing leadership will complete the Preview-ED tool.	rolled out this quarter	successful roll meeting 2xweek as a touch base with Ontario Health 1:1		
											3)Promptly identify and complete an inter-professional review for residents who are experiencing a change in health status	# of residents identified on the 2 reports will be reviewed monthly (chess score and JSC score)	100% of residents identified in the reports will be reviewed at monthly interdisciplinary meetings.		The total residents during Q1 (April 1, 2023- June 30, 2023) at Grace Manor is 2 for CHESS score and 0 for J5C sore.	The total residents July -Sept 2023 3 CHESS score and 0 for J5C.		
Theme II: Service Excellence	**Patient-centred**	Percentage of residents responding positively to: "What number would you use to rate how well the staff listen to you?"	P	% / LTC home residents	In house data, NHCAHPS survey / Apr 2022 - Mar 2023	54492*	CB	100	The home strives towards 100% residents responding positively.		1)Continue to implement the Person Centered Care Best Practice Guidelines through the RNAO.	% of residents participating in care conference meetings.	100% of capable residents invited to participate in care conference meetings.		100% invited	100% invited		
											2)The home will implement the RNAO Nursing Advantage Module of Person and Family Centered Care on June 29 2023.	# of residents with PFCC assessments completed upon admission	100% of newly admitted residents.		start roll out end of this quarter	100% completed this quarter		
		Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences".	P	% / LTC home residents	In house data, interRAI survey / Apr 2022 - Mar 2023	54492*	CB	100	Will strive to meet 100% in the next Annual Resident Family Satisfaction Survey.		1)To continue educate residents on the updated Fixing Long-Term Care Home Act and the enhanced Resident Rights.	# of residents engaged in education through resident council meetings.	All resident council members		reviewed FLTC and review 3 Residents Bill of Rights at each Resident Council Meeting	reviewed 3 Resident Bill of Rights this quarter.		
Theme III: Safe and Effective Care	**Safe**	Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment	P	% / LTC home residents	CIHI CCRS / Jul - Sept 2022	54492*	20.95	18	The home will continue to maintain baseline and strive for continuous improvement.		1)Continue to review and monitor through an interdisciplinary Antipsychotic Reduction Committee, new admissions and current residents that are on antipsychotic medication to determine proper indication for usage and consideration of alternative interventions when warranted.	% of new admissions and current residents that are on antipsychotic medication will be reviewed and monitored to determine proper indication for usage.	100% of new admissions and current residents that are on antipsychotic medications will be reviewed and monitored to determine proper indication for usage by March 31, 2024.		Q4 100% completed this quarter. antipsychotic medication usage 26.09% up from 2.14% Q1 (Apr-Jun) reviewed usage 24.36% down 3.42% from last quarter.	100% reviewed this quarter antiphsycotic usage 24.36% down 3.42% from last quarter.		

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Grace Manor

2022 Satisfaction Survey

Action Plan

Areas to Improve	Goals (to be carried out in 2023)	Person/s Responsible	Date Completed
Personal Care and Services (Nursing, Continence, and Communication)	Nursing and Personal Support To provide re-education to 100% of the direct care staff on the importance of providing Resident-focused care by October 2023. To provide re-education on all aspects of grooming to 100% direct care staff by October 2023. Continence Will create a pop-up booth to engage residents and families about the Continence Care and Bowel Management program in partnership with the Restorative Care program and have an awareness day by May 2023. Communication To provide re-education to 100% of the direct care staff on the importance of effective communication and sharing information in a timely manner by October 2023.	All Department Heads/Education Coordinator All Department Heads/Education Coordinator Continence Team Lead All Department Heads/Education Coordinator	
Programs, Activities, Spiritual, Participation	To increase auditing of calendars prior to them being posted to ensure that there is variety, availability and, quality of programs during the days, evenings and, weekends each month starting March 2023.	Director of Programs/Activity Staff	

	Will create a pop-up booth to engage residents and families about the recreation/activities program and have an awareness day during Activity Professional Week by March 2023. Will evaluate the current Pastoral program to ensure that the needs of the residents and families are met under the Religious and Spiritual Practices objectives by September 2023.	Director of Programs/Activity Staff Director of Programs/VP of Operations/Pastor/ Administrator	March 26-31
Meal Service, Snacks, and Dietitian	To educate dietary on plating at the point of service to ensure that the food temperatures are held consistently before consumption and increase monthly audits by May 2023. Will utilize heated Cambro cart to deliver food to the room in case of an outbreak to maintain food temperatures in the safe zone by April 2023 Will purchase and implement flavour caddies on each RHA that will hold a variety of sauces and spices that residents can add to their meals as per individual preference by June. 2023 Engage residents and family members about menu planning and rotation during post-admission and annual	Dietary Manager/FSS Dietary Manager/FSS Dietary Manager/FSS Dietary Manager/FSS	Feb. 2023 April 2023 June 2023 March 2023

	care conferences to increase awareness of the menu cycle by Dec. 2023. Will enhance the ambiance of the dining room with appropriate decorations in consideration of IPAC protocols by June 2023	Dietary Manager/ Programs Director	Feb. 2023
Accommodation (Housekeeping, Laundry, Maintenance)	All outstanding repairs and renovations will be completed by May 2023 Will operationalize the installed Building Automation System (waiting for sensors) to aid in the early detection of any issues with domestic heating/cooling/hot water by December 2023.	Director of Facilities Director of Facilities/	
Medical Services	-At the quarterly MAC-PAC meeting on February 15, 2023, the medical services handout provided at admission will be reviewed and updated to provide residents and families information regarding MD/NP availability and how to connect with the MD/NP. The revised updated copy will be made available to residents and families. Copies will be made available at the screening stations and the next billing cycle and provided to residents who are their own POA. During the February 15, 2023, MAC/PAC meeting, Physicians and Nurse Practitioners will be reminded to	Physicians/NP	March 2023

	review lab results and change in treatment with residents or SDMs (if the resident is cognitively impaired) to ensure that residents and SDMs are informed about changes to their medical status through phone communication. Performance evaluations will be completed with Medical Directors, NPs, and attending physicians by May 1, 2023	Physicians/NP VP of Operation/Administrator	Feb. 15, 2023
Contracted and Volunteer Services	-To work with the communications department to create a poster to inform residents and families about the volunteer program in order to increase awareness of the program by March 2023. Contracted Services -Will change the dental provider to ensure full-service dental care to increase residents' and family satisfaction by April 2023 -To invite Contracted Services Representatives to the resident and family information night to increase awareness of the services and products available at the Manors by November 2023.	Director of Programs/Volunteers Coordinator Administrator/VP of Operations Administrator/DRC	April 14, 2023 January 2023 Oct. 18, 2023

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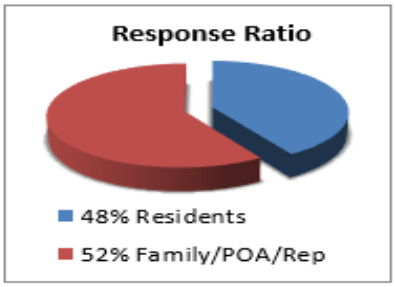
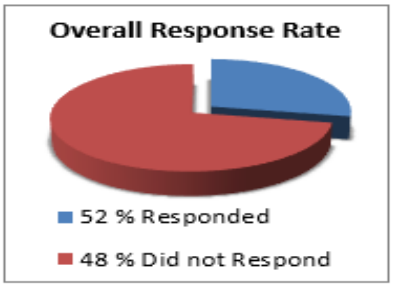
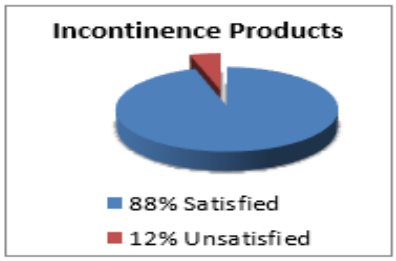
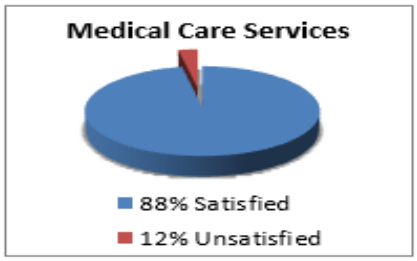
HOW ARE WE DOING AT GRACE MANOR?

2022 LONG TERM CARE RESIDENT / FAMILY SATISFACTION SURVEY RESULTS









HQO Questions	Yes	No
Do staff listen to you?	93%	7%
Do you feel comfortable expressing your opinions without fear of reprisal?	95%	5%
Would you recommend our home to others?	88%	12%
Response Rate (Total # of Surveys Received)	61/106 (58%) 32 Families/SDM 29 Residents	

Other	Yes	No
Contracted and Volunteer Services	91%	9%
Communication	89%	11%
Participation	93%	7%