Holland Christian Homes

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Continuous Quality Improvement – Final Report for Faith Manor

Faith 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 (Grace 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

Faith 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.

Faith Manor continues to work with the Holland Christian Homes Board of Directors on the creation of an updated Strategic Plan with new objectives 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.

Faith 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 the full Quality Improvement Plan (QIP) at the end of this document*)

Focused Action:

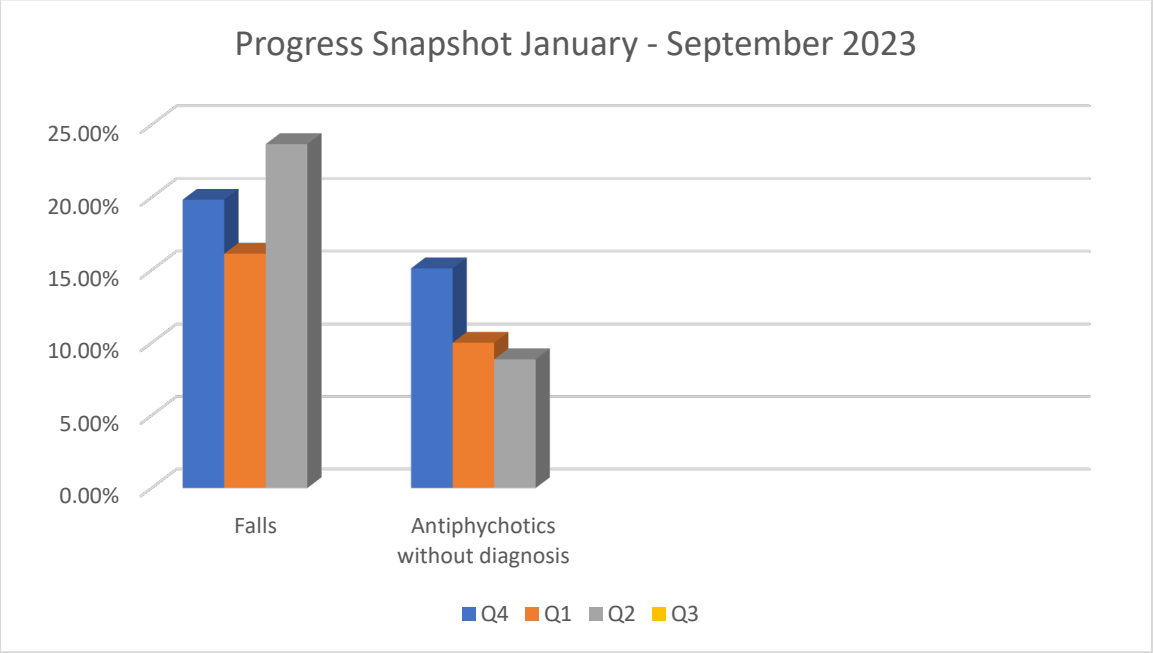
1. Continue to implement the Person-Centered Care Best Practice Guideline through the RNAO to implement our resident care philosophy statement of "Nothing About Me, Without Me".
2. Reduce the percentage of residents who fell in the last 30 days from 21.1% to 18% to align with provincial average by optimizing our Falls Prevention Program Outcomes.

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. Continue to achieve benchmark performance of 9.5% of residents on antipsychotics without a diagnosis of psychosis, and continue to strive for improvement.

6. Enhance 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

Faith 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). Faith 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.

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

Every staff has a responsibility for CQI. Faith 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 suggestions 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, AdvantAGE, and OLTCA 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 inhouse 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 workplace 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 have invested in software that allows us the ability to send mass messages using “One Call Now” for staff and “Cliniconex“ for families, which is extremely helpful for immediate messaging. 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 is 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. We also welcome and embrace resident and family involvement in our committee(s).

Evaluation (Monthly, Quarterly, Annual):

Our CQI Plan is evaluated monthly during our CQI committee working groups where all CQI activities for all programs and services offered within Faith 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 Faith 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 15, 2023

Resident Council: February 15, 2023

DATE OF THE ANNUAL EVALUATION AND WHO PARTICIPATED

Our 2022 Annual Programs Review and Evaluation occurred on **April 5, 2023.**

The following people participated:

#	Name	Position
1.	Lisa Alcia	CEO
2.	Tracy Kamino	VP of Operations
3.	Aleksandra Grzeszczuk	Administrator
4.	Liana Chandran	DRC
5.	Dr. A.S. Thind	Medical Director
7.	Jody Clarke	Director of Programs & Services
8.	Cecilia Owusu	PSW
9.	Chantelle Barnes	Laundry Aide
10.	Sorin Dorobeti	LTC HK & laundry Manager
11.	Barbara Leja-Plaza	Resident Advocate
12.	Amanda Ally	Restorative Nurse
13.	Michael Wells	Director of HR
14.	Prudence Blake	Specialized Program Team Lead
15.	Pastor Bodini	Pastor

16.	Judy Kirby	Dietary Manager
17.	Julie Determan	RN
18.	Magna Fordjour	BSL
19.	Marlene Ragbir	Activation Staff
20.	Sophia Laidley	RPN
21.	Loraine Anderson	CQI & Risk mitigation Specialist
22.	Romayne Manners	IPAC Lead
23.	Tanushca Lala	Registered Dietician
24.	Case Geleynse	Board Member
25.	Glenda McKay	Volunteer Coordinator
26.	Omer Rodgers	Maintenance Manager
27.	Kamaljeet Sekhon	Education Coordinator
28.	Timen Jensen	Resident Council President
29.	Marcia Richards	Dietary
30.	Afnan El-Bogi	Dietary
31.	Linet Abeysena	Dietary
32.	Pranav Amin	Pharmacy
33.	Neva Dennis	PSW
34.	Zumreta Begovic	ADRC

OVERALL SUMMARY – OUR 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. 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 Faith 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"

Faith Manor Nursing Home 7900 MCLAUGHLIN ROAD SOUTH, Brampton , ON, L6Y5A7

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	53424*	22.4	21	The home will continue to strive for continuous improvement and strive to meet the provincial average.	William Osler Health System, Ontario Health	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% of newly admitted residents this quarter received an updated conversation and individualized summary on goals of care, wishes, values and beliefs	100% of newly admitted residents this quarter received an updated conversation and individualized summary on goals of care, wishes, values and beliefs	100% of newly admitted residents this quarter received an updated conversation and individualized summary on goals of care, wishes, values and beliefs	
											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.	Training on this tool is ongoing	Go-live May 15, 2023	PreviewED is in use	
											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	100% of residents identified in the reports will be reviewed at monthly interdisciplinary meetings.		Apr-June 2023 (5 residents CHESS score 3 or higher) All on a palliative approach to care/ EOL plan of care and clinical assessment tool completed. j5c report (2) residents	Jul-Sept palliative approach to care/EOL plan of care and clinical assessment tool completed. CHESS report (17) and J5C report (2) residents identified and EOL		
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	53424*	CB	100	The home strives to work towards 100% of residents responding positively.	Registered Nurses Association of Ontario	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% of Capable residents = (8)	100% of Capable residents = (6)		
											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.		N/A	100% after June 29 2023		
		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	53424*	CB	100	The home strives to work towards 100% of residents responding positively.		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		FLTCA and Resident Rights (2) Reviewed at Monthly Resident Council Meetings	FLTCA and Resident Rights (2) Reviewed at Monthly Resident Council Meetings	FLTCA and Resident Rights (2) Reviewed at Monthly Resident Council Meetings	
Theme III: Safe and Effective Care	**Effective**	Percentage of long-term care home residents who fell in the last 30 days	C	% / LTC home residents	CIHI CCRS / July-September 2022	53424*	21.1	18	The home is striving to reach provincial average or better.		1)To continue to implement the "Preventing Falls and Reducing Injury from Falls" from the Registered Nurses Association of Ontario (RNAO).	% of residents receiving purposeful rounding.	100% of residents will receive purposeful rounding by December 31, 2023		Purposeful rounding completed for 100% of residents this quarter.	Purposeful rounding completed for 100% of residents this quarter.	Purposeful rounding completed for 100% of residents this quarter.	
	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	53424*	10.19	9.5	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.		100%	100%	100%	

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HOW ARE WE DOING AT FAITH MANOR?

2022 LONG TERM CARE RESIDENT / FAMILY SATISFACTION SURVEY RESULTS

Personal Care Services

89% Satisfied
6% Unsatisfied

Food Services

85% Satisfied
15% Unsatisfied

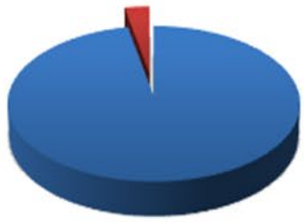
Living Environment

95% Satisfied
5% Unsatisfied

Response Ratio

79% Residents
21% Family/POA/Rep

Overall Satisfaction



97% Satisfied
3% Unsatisfied

Overall Response Rate

54% Responded
46% Did not Respond

Incontinence Products

95% Satisfied
5% Unsatisfied

Medical Care Services

92% Satisfied
8% Unsatisfied

Programs & Activities

89% Satisfied
11% Unsatisfied

HQO Questions	Yes	No
Do staff listen to you?	88%	12%
Do you feel comfortable expressing your opinions without fear of reprisal?	95%	5%
Would you recommend our home to others?	97%	3%
Response Rate (Total # of Surveys Received)	80/149 (54%) 17 Families / SDM 63 Residents	

Other	Yes	No
Contracted and Volunteer Services	91%	9%
Communication	87%	13%
Participation	90%	10%

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Faith Manor

2022 Satisfaction Survey

Action Plan

Areas to Improve	Action Plan (to be carried out in 2023)	Person Responsible	Date Completed
Personal Care and Services (Nursing, Continence, and Communication)	Nursing and Personal Support Will increase the frequency of the call bell audits to twice weekly to evaluate the response time of direct care staff and determine corrective actions by March 2023	Team Leads and ADRC DRC/ADRC	March 31, 2023

	Will implement audits of the who am I initiative monthly to evaluate the effectiveness of the Person-Centered Care Approach with direct care staff by June 2023 Will re-educate 100% of direct care staff on residents' rights regarding privacy and dignity via Surge Learning by September 2023 Continence Will create a pop-up booth to educate 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 Will enroll 50% of registered staff in the Clinical Nursing leadership (CNL) series through CLRI to improve their leadership skills by October 2023	DRC/ADRC Continence Lead/DRC/ADRC DRC/ADRC/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. Will create a pop-up booth to educate residents and families about the recreation/activities program and have an awareness day during Activity Professional Week by March 2023.	Programs Director/Activity Staff Programs Director/Activity Staff	March 27-31

	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.	Programs Director/VP of Operations/Pastor/ Administrator	
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 implement taste testing for nursing staff in each home area to maintain quality control. Engage residents and family members about menu planning and rotation during post-admission and annual care conferences to increase awareness of the menu cycle by Dec. 2023. Will purchase and implement flavor 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 April 2023. To educate/re-educate all direct service staff on pleasurable dining and etiquette to enhance the dietary experience for residents by Feb 2023.	Dietary Manager/FSS Dietary Manager/FSS Dietary Manager/FSS Dietary Manager/FSS Dietary Manager/FSS	Feb. 2023 November 2023 Ongoing July 2023 Complete May 2023
Accommodation	-Will operationalize the installed Building Automation System (waiting for sensors) to aid in the early detection of	Director of Facilities	

(Housekeeping, Laundry, Maintenance)	any issues with domestic heating/cooling/hot water by December 2023.		
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 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 Physicians/NP VP of Operation/Administrator	Feb. 15, 2023 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 to increase awareness of the program by March 2023.	Programs Director/Volunteers Coordinator	April 14, 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.	Administrator/VP of Operations Administrator/DRC	Jan. 2023 Sept. 2023