HCH *Here to Care.*

Holland Christian Homes Inc.
7900 McLaughlin Road South
Brampton, ON L6Y 5A7
T. 905.459.3333
www.**hch**.ca

Continuous Quality Improvement – Initiative Report for Grace Manor 2023 into 2024-2025

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 Satisfaction Survey, Family Experience Survey, Accreditation Assessment, Results And Action Plans; Staff Engagement 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 2024/25

Grace Manor is pleased to share its 2024/25 Quality Improvement Priorities.

Our long-term strategic plan identifies 5 strategic Directions: People Investment, Capital Investment, Branding & Marketing, Innovation & Excellence, and Sustainability & Stewardship as the core of Holland Christian Homes' with 7 strategic goals. Goals include Workplace Culture, Bethany Place, Branding & Marketing, Memory Care (Bethany Place), High Reliability and leading practices in Long Term Care and Assisted Living, Business Development & Fundraising, Data & Implement Technology Infrastructure. In 2023, Holland Christian Homes strategic plan was refreshed in response to several 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 strategic goals were done in collaboration with, teams of staff, external consultant specializing in Strategic Planning, and Board members of Holland Christian Homes. The results were shared with all key stakeholders to get their input. A resident & tenant experience committee were formed for senior management to update members and get feedback as we work to implement these goals.

The QIP aligns with the Strategic Plan, while navigating challenges and opportunities in our environment.

Grace Manor's QIP is aligned with our Quality Framework embedded 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 goals of our Holland Christian Homes 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

QUALITY OBJECTIVES FOR 2024/25

- Priorities are divided into 4 categories based on the projected scope of work anticipated for the year. Areas for action are included in this report.
- Our QIP Priorities are following Health Quality Ontario Performance Measures and Indicators
    1) Access & Flow
    2) Equity
    3) Experience
    4) Safety

Access and Flow

Measure - Dimension: Efficient

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Rate of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents.	O	Rate per 100 residents / LTC home residents	CIHI CCRS, CIHI NACRS / October 1st 2022 to September 30th 2023 (Q3 to the end of the following Q2)	26.97	25.00	align towards provincial average	

Change Ideas

Change Idea #1 Improve communication within the home through the use of the SBAR.

Methods	Process measures	Target for process measure	Comments
DRC/NP will train registered staff on the SBAR Tool.	number of staff trained on the use of SBAR as a means to improve communication.	100% registered staff trained on SBAR 2024.	

Equity

Measure - Dimension: Equitable

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education	O	% / Staff	Local data collection / Most recent consecutive 12-month period	CB	100.00	100% of non union staff to complete Diversity, Equity and Inclusion education (DEI)in 2024.	

Change Ideas

Change Idea #1 Incorporate Diversity, Equity and Inclusion education in 2024.

Methods	Process measures	Target for process measure	Comments
Using on line training that includes topics of Diversity, Equity and Inclusion for all non union staff.	Non union staff to complete Diversity, Equity and Inclusion (DEI) training in 2024.	100% of non union staff trained on Diversity, Equity and Inclusion (DEI) in 2024.	

Report Access Date: March 28, 2024

Experience

Measure - Dimension: Patient-centred

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of residents responding positively to: "What number would you use to rate how well the staff listen to you?"	C	% / LTC home residents	Local data collection / 2024	88.00	100.00	This year the question will be re worded for clarity. We want all staff to listen to residents and all residents to feel listen to and heard.	

Change Ideas

Change Idea #1 Increase to 100% of residents to respond positively to the question "Do you feel listened to" .

Methods	Process measures	Target for process measure	Comments
Incorporate customer service training in 2024 for staff.	Using on line learning platform.	100% of staff trained on customer service in 2024.	

Safety

Measure - Dimension: Safe

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment	O	% / LTC home residents	CIHI CCRS / July 2023– September 2023 (Q2 2023/24), with rolling 4-quarter average	23.98	20.00	To be more align with the Provincial average. Current Provincial average is 20.8%.	

Change Ideas

Change Idea #1 Review of diagnosis and update to add hallucinations delusions and reassessment of RAI coding to reassess resident diagnosis.

Methods	Process measures	Target for process measure	Comments
Utilize interdisciplinary team approach to reduce antipsychotic medication without diagnosis.	Utilize use of interdisciplinary team to review residents on antipsychotic, reassess behavior, care plan and discontinue medication when appropriate. Review of diagnosis and update to add hallucinations delusions and reassessment of RAI coding to reassess resident diagnosis.	Continue to utilize our interdisciplinary team to review 100% of new admissions and current residents that are on antipsychotic medications to determine proper indication for usage by March 31, 2025.	

Quality Improvement Plan (QIP)

Narrative for Health Care Organizations in Ontario

March 28, 2024

OVERVIEW

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 Grace Manor is to provide a supportive, caring, quality Christian environment in order to preserve the 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 Satisfaction and Family Experience Surveys, CARF 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, Dining Room Committee, Internal Concern Resolution Process; Legislative Requirements / Inspection Reports And Findings; Education And Training.

The complexity of care needs of our long-term care residents have increased significantly that are being admitted to our home with increasing frailty, more complex medical issues and increased behavioral issues. The majority of our residents have some form of Alzheimer's or dementia and almost all need help with feeding, bathing, toileting and getting in and out of bed. These increased acuity levels; along with the high level of expectation of residents

and families is a challenge when compared to the funding received to meet these needs.
Our 2024/2025 Quality Improvement Plan will focus on Access and Flow, Equity and Indigenous Health, Resident Experience, Provider Experience, Safety and Population Health Approach as required by the Ontario Health Quality Improvement Plan (QIP).
Access and Flow will be achieved through the reduction of unnecessary hospitalizations by the home providing registered staff training on the SBAR Assessment Tool and by continuing to utilize the Prevention of Error Based Transfers (PoET)Program to ensure residents goals, values, wishes, and beliefs are documented in order to assist with goals of care conversations that guides proposed treatment options such as emergency room transfers. Equity improvement will be addressed by requiring 100% of non union staff to complete DEI education. We will enhance Experience by requiring 100% of our staff to be trained in customer service. We continue to provide Safety to our residents through continuing to utilize our interdisciplinary team and review 100% of new admissions and current residents that are on antipsychotic medications to determine proper indication for usage by March 31, 2025. These established priorities, targets, and activities we believe will improve resident quality outcomes.

ACCESS AND FLOW

We are proud of our many partnerships, all of which support integration and continuity of care. Our partnership with Home and Community Care Support Services & the Ontario Health Team ensures LTC applications are processed in a timely manner to avoid any placement delays. Many education and training initiatives which are critical to the success of our Quality Improvement Plan would not be possible without our partnerships with BSO, PSHSA (staff safety), the Regional Infection Control Network, the RGP Program, Wound Care and mobility specialists, and our many contracted service providers (ie. dental, foot-care, pharmacy, physiotherapy, banking, hairdresser etc). Our memberships with AdvantAGE and OLTCA are beneficial to support our advocacy and improvement initiatives.

Leadership team members sit at various sector table groups ensuring we are informed of current trends and changes in the healthcare system affecting our home and resident care. Grace Manor has been very strong proponents of providing as much care as possible without transferring or admitting residents to hospital. We have enhanced our ability to do this through several initiatives. Our full-time Nurse Practitioner has enabled us to provide treatments and diagnosis for our residents to prevent the need to transfer to hospital. When a resident is admitted to hospital, the NP is able to coordinate and facilitate a faster discharge by ensuring care is available upon their return home. In addition, our NP provides training to our registered staff to increase their ability to do critical thinking and increase their skills within their scope of practice. Additionally, we utilize our partners such as the Nurse Lead Outreach Team (NLOT) out of William Osler and a specialized Neurobehavioral Nurse Practitioner Team to assist in management of individuals living with dementia. Our Quality Improvement Plan ensures that these partnerships /networking continue as a priority indicator.

Grace Manor offers a variety of in-house diagnostic and imaging services through our contracted partnerships. This allows the residents to stay in their home to receive services such as blood work, ECG, X-rays/Ultrasound. We have also invested in equipment

such as a bladder scanner and hand-held doppler which can be helpful in preventing avoidable ED transfers. We also utilize technology such as secure video conferencing and e-Consultation through OTN to bring services to the bedside.

We recognize the importance of advanced care planning. We continue to utilize the PoET form to guide conversations related to residents values, wishes, and beliefs around their healthcare. This has been an important tool to help guide conversations related to goals of care, and prevent unnecessary hospital transfers.

Optimizing system capacity, timely access to care, and patient flow ultimately improve outcomes and the
experience of care for our residents. We are working in partnership and across care sectors
on initiatives to avoid unnecessary hospitalizations and avoid visits to emergency departments through improving our communication within the home through the use of the SBAR Tool to align towards the provincial average to ensure the right care in the right place at the right time.

Grace Manor has adopted the Eden Alternative Model as an approach to care, enhancing the environment and resident experience through a more collaborative approach between residents, families and staff.

EQUITY AND INDIGENOUS HEALTH

We have a Diversity, Equity, Inclusion Plan that includes Health Equity, Antiracism, First Nations, Inuit, Metis, and Urban Indigenous (that include existing provincial priorities such as French language health services, Disabilities Act, Black Health Plan, etc.) based on Service Accountability
Agreement obligations.

Holland Christian Homes is an Equal Employment Opportunity employer. We are committed to the elimination of barriers that restrict the employment opportunities.

Holland Christian Homes provides equal employment opportunities for the good of the public without regard to race, color, national origin, ancestry, sex, religious creed, age, mental or physical disability, veteran status, socioeconomic status, medical condition, marital status, sexual orientation, sexual harassment, or pregnancy.

We will continue to provide training requirements for staff are listed in Holland Christian Home's employee manual. Training will not be influenced by race, ethnicity, age, gender, color, religion, national origin, sexual orientation, veteran's status, socioeconomic status, or disability.

All Managers and Leadership at executive level will continue to be trained in equity and indigenous Health programs in order to be ensure that our approaches to care are culturally appropriate as we endeavor meeting community needs and priorities. This type of training will be extended to all staff as well

The home has committed to 100% of non union staff to complete DEI training by March 31, 2025. All staff receive annual code of conduct to affirm they will act ethically at all times.

INDIGENOUS LAND ACKNOWLEDGEMENT

Land acknowledgements are the first step to reconciliation because they allow us to recognize how colonialism continues to impede on the lives of Indigenous generations. Acknowledgement gives us the opportunity to reflect on our privileges as settlers on traditional territory. At Holland Christian Homes, we approach this land acknowledgement with the commitment to walk side-by-side with Indigenous communities by listening and learning from Indigenous voices towards the road to reconciliation.

A plaque is displayed in the entrance the Manor stating the following:

"Holland Christian Homes acknowledges that its operations are located within Treaty 19 (Ajetance Treaty) territory, the treaty lands of the Mississaugas of the Credit. We further recognize that these lands comprise the traditional territory of several indigenous peoples, including the Wendat, Haudenosaunee and Anishinaabeg (including the Mississaugas of the Credit First Nation). We are grateful to work and provide care within these lands, which continue to be home to many diverse First Nations, Métis and Inuit peoples. With a spirit of reconciliation, Holland Christian Homes is committed to walking side-by-side with indigenous communities, respecting their long-standing relationships with the land, and learning from their traditions and stewardship practices."

The above acknowledgement is read and acknowledged at special meetings of the organization and whenever external partners meet at HCH.

CULTURAL COMPETENCY, DIVERSITY, AND INCLUSION ACTION PLAN

To further enhance Holland Christian Homes commitment to cultural competency, a Cultural Competency, Diversity, and Inclusion Action Plan is reviewed and updated annually.

The plan is updated as needed to ensure that our team members, residents, tenants, and other stakeholders develop awareness and sensitivity specific to the diversity of our service population. This plan addresses diversity in terms of culture, age, gender, identify/expression, sexual orientation, spiritual beliefs, socioeconomic status, language, and other factors relevant to Holland Christian Homes service population.

Goals of the Cultural Competency, Diversity, and Inclusion Action Plan

1. To assess the cultural diversity of stakeholders within Holland Christian Homes
2. To recognize cultural and multi-faith celebrations
3. To recognize that food plays a significant role in cultural diversity and faith traditions
4. Develop and maintain communication tools to enhance team member and resident engagement
5. Continue to engage and develop partnerships with community stakeholders to further enhance our tag line of "Here to Care"
6. Advance Indigenous Health Strategies and Outcomes
7. Advance equity, inclusion, diversity, and anti-racism strategies to improve health outcomes
8. To recognize that cultural considerations are not limited to ethnicity but include spiritual beliefs, language, financial status, gender identity/expression/orientation, disability, and other attributes.

PATIENT/CLIENT/RESIDENT EXPERIENCE

Holland Christian Homes is committed to operating our long-term care homes with transparency and accountability. We support and encourage ways that provide opportunities for residents and families to stay engaged in all aspects of the home. Our poster called, "Your Voice Counts" lets residents and families know how they can get involved and share in the management of our home and create a voice for all residents at Grace Manor. Residents and Families are also able to complete CQI suggestion forms and/or concern forms.

Residents participate in our Dining Room Food Committee and Residents Council. Families participate in Family Council. There is a designated staff assistant to ensure these councils are easily able to meet and have their meetings documented. The leadership team is made aware of concerns, complaints and comments and there is immediate follow-up by Leadership/Administration. Residents and families also participate in our annual program reviews and evaluations. An annual Resident Satisfaction Survey was completed by competent residents (with or without impartial assistants) and SDMs for care for residents completed a Family Experience Survey.

We conducted our annual program evaluation day for the year 2023 in which we reported on and evaluated 31 programs and set goals for those programs to be completed in 2024. Staff, CEO, managers, board members, Medical Director, RPN, PSW (and other front line staff from each department) family and resident council representatives, a pastor, and residents all participate in this evaluation day. It was a great opportunity for everyone to share in the successes and to learn more about how we will work to improve in the areas needing improvement.

The Grace Manor leadership team and staff are engaged in an organizational wide (Holland Christian Homes) quality improvement program. We have developed many programs which are interdisciplinary through committees, evaluations, huddles, and communication methods such as audits, reports, in-services and feedback forms. These programs and initiatives are coordinated through our CQI Program Coordinator who compiles the results in the form of reports which provide feedback and direction for future initiatives.

All volunteers and employees of Holland Christian Homes are expected to participate in ongoing and systematic quality improvement efforts through quality assessment activities, such as annual staff satisfaction surveys, specialized program review meetings, infection control surveillance, utilization management, and medical record review.

Our interdisciplinary specialized program teams 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 team and/or department(s). Front line staff and even residents and families are often engaged through this process.

The home incorporates experience information from our Annual Resident Satisfaction Survey, Family Experience Survey, and working collaboratively with Resident Council and Family Council about care experiences, survey results and quality improvement action plans. This information is shared with stakeholders, Resident Council and Family Council.

PROVIDER EXPERIENCE

Holland Christian Homes (HCH) tagline of being "Here to Care" sets the foundation of our community that we are serving on a day-to-day basis. Our community consists of our vulnerable seniors that reside in the manors, our families, stakeholders, and our dedicated staff that help us fulfill our mission.

Holland Christian Homes believes that the organizational health and wellness are important to each individual employee. Individual health may affect the ability of employee's contribution to meet the mission and values of HCH. To promote a positive and healthy culture in the workplace, HCH has organized a dedicated Workplace Social and Wellness Committee. This committee will plan and execute social events to help HCH promote a culture of engagement, belonging and fun among all HCH employees e.g staff appreciation week, holiday parties etc.

HCH values the opinions and suggestions of staff for improving the work environment while enhancing resident care at Holland Christian Homes. In addition to the Workplace Social and Wellness Committee, HCH invites all staff to be a voluntary member of 12 additional committees that steer the organization's goals and objectives to enhance the quality of care we provide to enhance the resident experience. We believe that including staff members as members of these committees brings an important perspective, allowing their voice to be heard, as key members of the HCH family.

Holland Christian Homes partners with an Employee and Family Assistance Program that provides onsite counseling support and shares important resources to staff such as: Highlighting Resilience: Bouncing back from Burnout, Coping with Anxiety, Adjusting after the Pandemic Response, Feeling Safe and Engaged, Fostering Trust and Commitment.

It continues to be a challenging time for health care organizations with unprecedented human resources challenges. Our home is currently implementing innovative practices to improve workplace culture, through employee engagement surveys and outcome analysis and development of action plan in areas of needed improvement and is shared with staff. Action plan includes but is not limited to recognition events, manager/supervisor open door policy, succession planning, staff wellness committee to further enhance our employee satisfaction.

SAFETY

RESIDENT SAFETY PLAN

Senior management is committed to the Resident Safety Plan.

Our mission is to provide effective, high-quality, safe and efficient long-term care services in a home-like setting. Our purpose is to ensure our residents feel safe while in our homes. This Resident Safety Plan drives continuous improvement to quality and safety throughout our home and builds upon our mission, vision and values.

Our Resident Safety Plan is developed in conjunction with CARF accreditation and Patient Safety Goals within the patient safety areas of culture, work life/workforce, communication, medication use, infection control, falls prevention, and risk management, and their required organizational practices. (R.O.Ps). The R.O.P.s are

essential practice that our organization must have in place to enhance resident safety and to minimize risk.

This document articulates the go forward strategy for quality and safety at Grace Manor, Holland Christian Homes Long Term Care Homes and Seniors Services Programs. Strong multi- disciplinary experience, quality improvement practices, collaboration, and Leadership throughout our programs, services and departments will foster attention to continuous quality improvement and drive improved performance in quality and safety for Residents, families, staff and our community.

The Resident Safety Plan is readily available to all residents, families and staff. The Plan is reviewed and updated annually.

POPULATION HEALTH APPROACH

Population health–based approaches involve a broadening focus to include being proactive in meeting the
needs of our residents. This includes providing proactive services to promote health, prevent disease,
and help people live well with their conditions in every interaction. We provide care from a person centered approach.
and work in partnership with other health providers as needed to care for the unique needs of our residents within our home.
Grace Manor understands the importance of preventative health approach. As such, we have several inhouse clinics such as Eye Clinics, Dental Clinics, Foot Care Clinics, Hearing Devices. Additionally, we have in-house laboratory and diagnostic imaging services that come into the home and this can be helpful in chronic disease management. We work closely with Public Health to ensure that our vaccination is up to date. We have an Infection Prevention and Control (IPAC) Program, a full-time Lead and Committee that focuses its efforts on policies and procedures on IPAC with a goal of reducing the risk of transmission of infections agents, surveillance, hand hygiene program, education for residents, staff and families. The IPAC Lead ensures that enhanced precautions are strictly observed and carried out by all department staff at all times. This is managed through various activities daily, monthly or annually as required.

CONTACT INFORMATION/DESIGNATED LEAD

Justine Dudziak
Administrator
justine.dudziak@hch.ca
905-463-7002 EXT. 5255

SIGN-OFF

It is recommended that the following individuals review and sign-off on your organization's Quality Improvement Plan (where applicable):

I have reviewed and approved our organization's Quality Improvement Plan on **March 28, 2024**

Tracy Kamino, Board Chair / Licensee or delegate

Justine Dudziak, Administrator /Executive Director

Judy Kirby, Quality Committee Chair or delegate

Other leadership as appropriate

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 MHLTC.
- Health Quality Ontario (HQO)
- Central West Ontario Health Team (CWOHT)

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 CEO, who then shares with the Care Committee of the Board.

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:

Judy Kirby CNM
CQI and Risk Mitigation Specialist
Judy.Kirby@hch.ca
905-463-7002 ext.5240

****We encourage all staff, residents and families to get involved, join a committee, and make a suggestion. Contact Judy 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 satisfaction, family experience surveys, staff engagement 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.
- Medical Directors attend quarterly and annual Continuous Quality Improvement reviews to provide input on activities, assessments and performance improvement. They are held accountable to their contract.

- 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 the 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.

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

Quality Improvement Plan / Progress Report on the 2023/24 QIP

See Below

Access and Flow | Efficient | Priority Indicator

	Last Year		This Year	
Indicator #4 Rate of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents. (Grace Manor)	**17.27** **Performance (2023/24)**	**17** **Target (2023/24)**	**26.97** **Performance (2024/25)**	**25** **Target (2024/25)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

Continue to operationalize the Prevention of Error-based Transfers Project in order to reduce avoidable ED visits.

Process measure

- % 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.

Target for process measure

- 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.

Lessons Learned

100% of new admissions receive conversation about goals of care, wishes, values and beliefs. By having these conversations we are able to ensure we have captured what is important to each resident and have meaningful discussions that direct the team in providing care that aligns with resident's wishes, values and beliefs.

Change Idea #2 ☑ Implemented ☐ Not Implemented

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.

Process measure

- # of avoidable hospital transfers

Report Accessed: March 28, 2024

Target for process measure

- The Preview-ED tool will be completed for all resident who trigger indicators after the go-live date of May 15, 2023.

Lessons Learned

Successfully implemented preview ED observational tool for 100% of our residents by out target date. Unfortunately, we did not see a significant improvement on our avoidable hospital transfer statistics.

Change Idea #3 ☑ Implemented ☐ Not Implemented

Promptly identify and complete an inter-professional review for residents who are experiencing a change in health status

Process measure

- # of residents identified on the 2 reports will be reviewed monthly

Target for process measure

- 100% of residents identified in the reports will be reviewed at monthly interdisciplinary meetings.

Lessons Learned

100% of residents who experienced a change in health status were identified and reviewed at monthly interdisciplinary meetings. All residents with a CHESS score 3 or higher on a palliative approach to care/ EOL plan of care had a clinical assessment tool completed.
Celebrations:
Collaborated with the Neurobehavioural team for appropriate prescribing of antipsychotic medications and behavioural management.
Funding for a full-time nurse practitioner however, we have some resident's or SDM who still request to be sent to hospital.
No non-compliance for medical services
Excellent attendance at care conferences by the medical team (100%)

Comment

Long-Term Care QIP Potentially Avoidable ED transfers by LHIN Report - Q3 2022/23 - Q2 2023/24
Central West LHIN: Avoidable ED Visits Rate (per 100) is 26
Ontario: Avoidable ED visits Rate (per 100) is 21
LHIN data is reported in rates per 100 residents (Number of avoidable ED visits / Number of LTC home residents) x 100.
Our current benchmark does not reflect an accurate comparison on data, our numbers are reported as actual events while the LHIN rates are calculated based on 100 residents. LHIN reports are also reported several quarters behind making live comparison difficult. Raw numbers from LHIN report never match our raw numbers, this is likely due to how medical conditions are being coded in the ED.
The top 5 avoidable ED transfer reasons in the LHIN report are Falls, Pneumonia, Mental health conditions, Septicemia and CHF.

Experience | Patient-centred | Priority Indicator

	Last Year		This Year	
Indicator #3 Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences". (Grace Manor)	**CB** **Performance (2023/24)**	**100** **Target (2023/24)**	**NA** **Performance (2024/25)**	**NA** **Target (2024/25)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

To continue educate residents on the updated Fixing Long-Term Care Home Act and the enhanced Resident Rights.

Process measure

- # of residents engaged in education through resident council meetings.

Target for process measure

- All resident council members

Lessons Learned

Resident Council meetings reviewed two Resident Bill of Rights at each resident council meeting. By providing this information we are seeing a greater engagement, collaboration and positive feedback by residents.
This indicator was selected for QIP last year however our response options are different than our response option for this year. Therefore it is not possible to use this indicator for our home. After consultation with our Resident and Family Council our councils did not approve the HQO scale response indicators, however, we did ask the HQO question. Had we created a custom indicator then we would have current performance of 84%.

Report Accessed: March 28, 2024

	Last Year		This Year	
Indicator #2 Percentage of residents responding positively to: "What number would you use to rate how well the staff listen to you?" (Grace Manor)	**CB** **Performance (2023/24)**	**100** **Target (2023/24)**	**CB** **Performance (2024/25)**	**NA** **Target (2024/25)**

Report Accessed: March 28, 2024

Change Idea #1 ☑ Implemented ☐ Not Implemented

Continue to implement the Person Centered Care Best Practice Guidelines through the RNAO.

Process measure

- % of residents participating in care conference meetings.

Target for process measure

- 100% of capable residents invited to participate in care conference meetings.

Lessons Learned

100% percent of residents were invited to attend care conferences in 2023. By asking this question we are getting increased attendance and more participation.

Change Idea #2 ☑ Implemented ☐ Not Implemented

The home will implement the RNAO Nursing Advantage Module of Person and Family Centered Care on June 29 2023.

Process measure

- # of residents with PFCC assessments completed upon admission

Target for process measure

- 100% of newly admitted residents.

Lessons Learned

100% of all new admissions were using PFCC assessments in 2023. This was effective to ensure care plans and language reflected the residents choice and therefore improving care outcomes.

Comment

This indicator was selected for QIP last year however our response options are different than our response option for this year. After consultation with our Resident and Family Council our councils did not approve the HQO scale response indicators, however, we did ask the HQO question. Therefore it is not possible to use this indicator for our home. Had we created a custom indicator then we would have current performance of 88%.

Report Accessed: March 28, 2024

Report Accessed: March 28, 2024

Safety | Safe | Priority Indicator

	Last Year		This Year	
Indicator #1 Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment (Grace Manor)	**20.95** Performance (2023/24)	**18** Target (2023/24)	**23.98** Performance (2024/25)	**20** Target (2024/25)

Change Idea #1 ☑ Implemented ☐ Not Implemented

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.

Process measure

- % of new admissions and current residents that are on antipsychotic medication will be reviewed and monitored to determine proper indication for usage.

Target for process measure

- 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.

Lessons Learned

We are moving in the direction of improvement we increased training to staff. Although our current performance is higher from last year our most recent data has indicated that we are doing better.

Report Accessed: March 28, 2024

DATE OF THE ANNUAL CQI PROGRAM EVALUATION AND WHO PARTICIPATED

Our 2023 Annual Programs Review and Evaluation occurred on **February 29,2024**

The following people participated:

#	Name	Position
1.	Tracy Kamino	CEO
2.	Justine Dudziak	Administrator
3.	Jenny Steward	DRC
4.	Benz Tran Ngvyen	RPN Program Lead
5.	Dr. Omar Elahi	Medical Director
6.	Jenna Shaddick	Nurse Practitioner
7.	Jody Clarke	Director of Programs & Services
8.	Sanjeet Kaur	PSW
9.	Dora Quarshie	RPN Program lead
10.	Behije Mulaj	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.	Pamela Whiteley	Activation Staff
16.	Obinna Okator	RPN
17.	Venus Bayani	Food Service Supervisor
18.	Fred Benedikt	Family Council Secretary
19.	Judy Kirby	CQI & Risk Mitigation Specialist
20.	Luyen Loc	IPAC Lead
21.	Chloe Turgeon	Registered Dietician
22.	Case Geleynse	Chair of the Board

23.	Ingrid Malmberg	Emergency Management Coordinator
24.	Glenda McKay	Volunteer Coordinator
25.	Kamaljeet Sekhon	Education Coordinator
26.	Debbie Campbell	Housekeeping
27.	Sonya Paul	RPN
28.	Puneet Gill	RAI Coordinator
29.	Sujitha Jayakumar	HR Manager
30.	Erika Gill	Food service Worker
31.	Jeevan Athwal	HR Manager
32.	Omer Rogers	Senior Manager of Environmental Services

RESIDENT AND FAMILY ANNUAL SURVEY

A resident satisfaction and family experience survey is prepared annually, in consultation with the residents and family council. Once consultations are completed the survey is distributed. The residents and family are given time to complete the survey. Grace Manor conducted the Family experience Survey and Resident Satisfaction Survey on Nov. 19 till Dec 17, 2023. Once the data from the survey are in they are distributed to family council and reviewed with the residents. At this time an action plan is developed. Residents council then provides feedback and documented for input into the action plan. Family Council holds meetings to give feedback with regards to their input into the action plan. The action plan is then reviewed with both residents and family council for a final review, and adjustments, utilizing the results from the survey, including dates actions were implemented and the outcomes of the actions taken. The action plan is then shared with resident and family council as well as shared on the CQI board in each Manor for staff, families, and visitors to view.

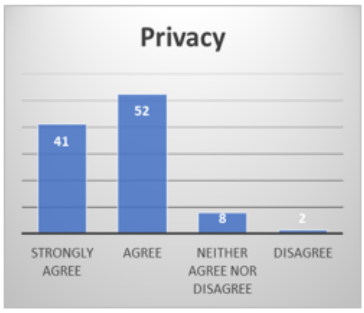
DATE OF REVIEW OF SURVEY RESULTS BY FAMILY & RESIDENT COUNCIL:

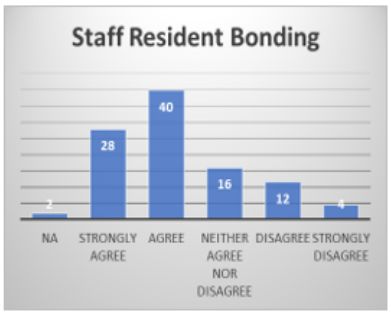
Family Council: February 26,2024

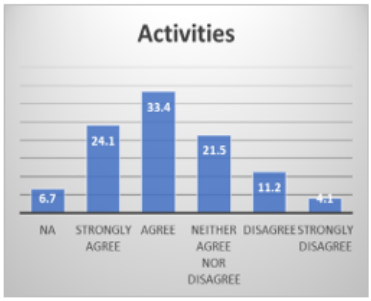
Resident Council: March 1, 2024

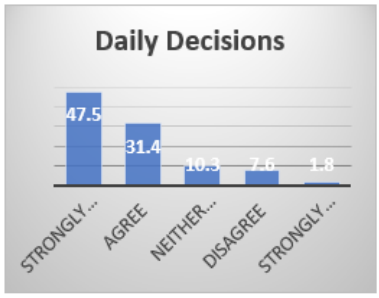
HOW ARE WE DOING AT GRACE MANOR

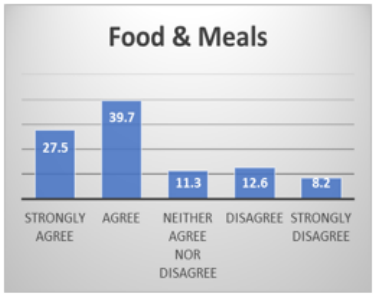
Resident Satisfaction

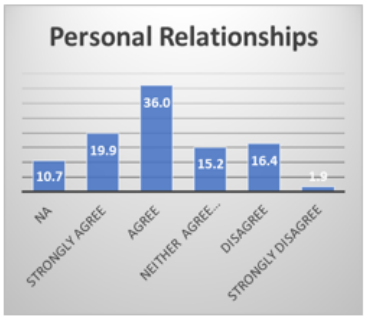


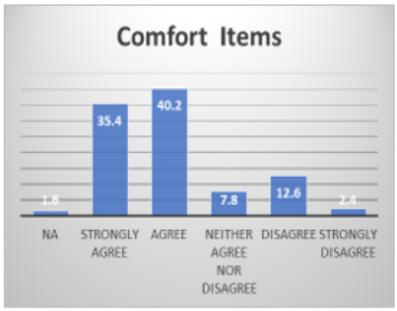


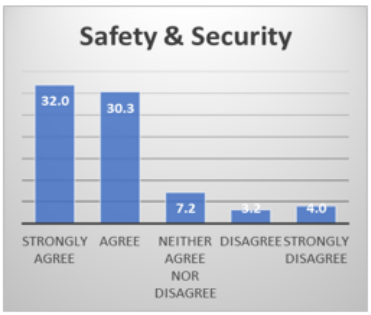


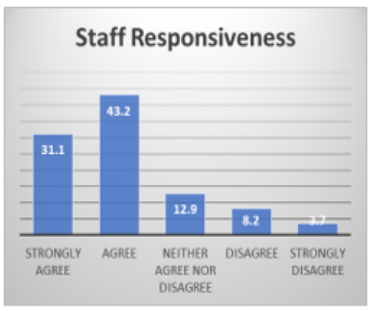


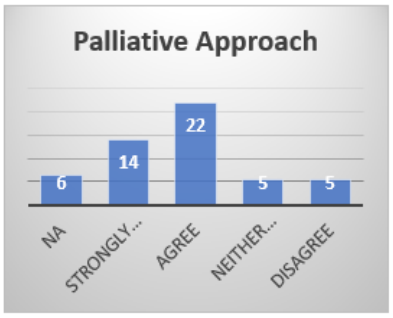


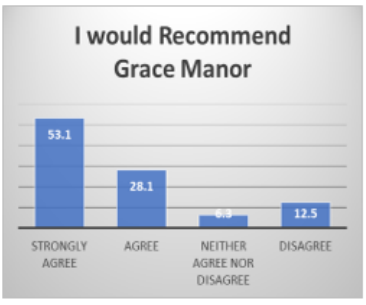








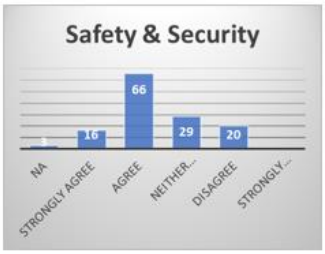


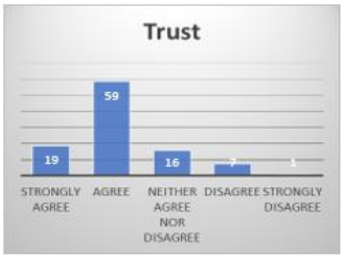


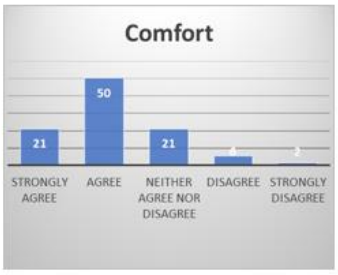
HQO Questions	Agree	Maybe	Disagree
I Feel supported, heard, and understood by the staff	88 %	3%	9 %
I can express my opinions without fear of Consequences	84%	12%	4%
I would Recommend This Home	81%	6%	13%

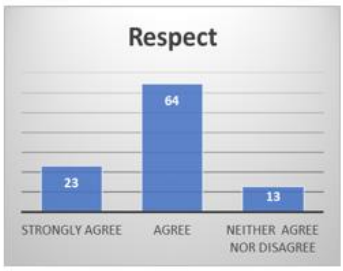
HOW ARE WE DOING AT GRACE MANOR

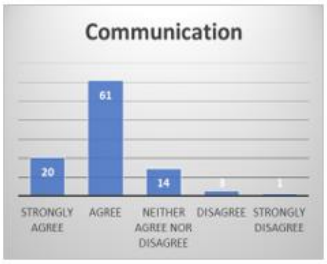
Family Experience

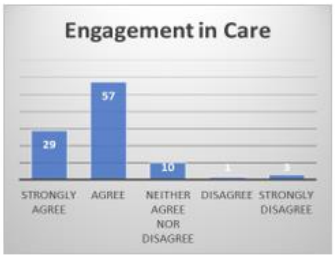


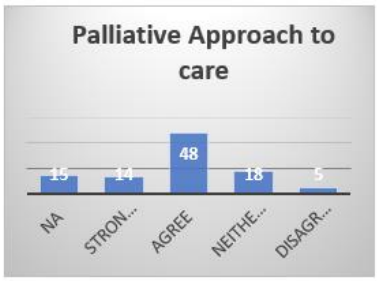












Grace Manor

2023 Resident Satisfaction Survey

2023 Family Experience Survey

Action Plan

Our Grace Manor Annual Resident Satisfaction and Family Experience Survey was conducted November 5, 2023 with a deadline of December 15 2023. The CQI coordinator tabulated both resident satisfaction and family experience survey results that were then shared February 2024 with both Resident and Family Council. It was decided between both councils that a combined action plan would be the approach this year and thus our temporary action plan working group was formed that included residents, family and staff all together.

The survey sample size was the following; 37of the 44 residents (identified as able to complete) participated in the 2023 survey (breakdown of resident numbers:114 on census, 44 identified as able to complete, 24 new admissions not included and 6 empty beds). The 35 of the 84 families participated in the 2023 survey (breakdown of family numbers:114 on census, 24 new admissions not included and 6 empty beds). Residents participated through volunteer assistance to complete the online monkey survey link if needed and families participated with the online survey monkey link directly. Below is the action plan to be completed in 2024 based on the results of the 2023 Resident Satisfaction and Family Experience Surveys.

"I would recommend this home", 2023 78% target for 2024 85%

Areas to Improve	Action Plan (to be carried out in 2024)	Person Responsible	Date Completed
Personal Care and Services • **Privacy** • **Resident Bonding** • **Respect** • **Daily decisions** • **Personal relationships** • **Comfort** • **Staff Responsiveness** • **Trust** • **Communication** • **Visiting Experience**	• PSW Staff to be re-educated on the Resident Bill of Rights by May 15, 2024. This will be reviewed and discussed in monthly staff meetings. • Revise outbreak communication to ensure timely communication through clinicconnex, and website information update February 2024. • Nursing Staff to be re-educated on effective communication with residents of varying degrees of cognitive decline and customer service approach using the surge learning module by October 31, 2024. • Staff to be re-educated on the bathing/grooming/oral care/ toileting routines by April 15, 2024. • Re-educate staff by December 15, 2024 on the "who am I" posters and review how to carry out the areas identified by the resident/family. Complete at least 25 demonstrations - 5 on each unit.	DRC, ADRC, Ed Co DRC, ADRC, Ed Co, Tenant Business Services, RA IPAC Lead DRC, ADRC, Education Coordinator DRC, ADRC DRC, ADRC, Admin, Dept Heads	Ongoing Completed Feb.24 Completed and ongoing

	• Identify 5 staff (1 from each home area) who can become the HCH Champions of Eden in 2024. Enroll these 5 staff in the "tracks" training program to become champions in the Eden Alternative approach (timing will depend on Eden management). Hold monthly meetings with the champions to assist in carrying out the "who am I demonstrations", and other person-centered care initiatives.	ADMIN, DRC, ADRC, Dept Heads, Education Co	Timeline depending on Eden training Schedule
	• Empower the registered staff with leadership training to ensure enhanced PSW interactions with residents to promote informal ex-change and reduce loneliness through Surge Learning by November 15, 2024.	DRC, ADRC, Education Coordinator	
	• Review the lost items protocol during registered and laundry staff meeting by April 2024.	DRC, ADRC, Laundry Housekeeping Mgr.	Completed, ongoing
	• Remind the PSW staff to double check clothing labels before dressing residents as per job description during monthly staff meeting by April 2024. Survey result 2023 77% agree target for 2024 85% agree.	DRC, ADRC	Completed and ongoing

• **Programs/ Activities** • **Spiritual Care** • **Participation**	• Create an adhoc men's committee to find out what they would like to do per neighborhood and increase programing specific for men and gather those with similar interests such as baseball, car racing by June 15, 2024.	RA, Activity Coordinator Designate Spiritual Coordinator /Pastor Recreation staff	Implemented to Mar/Apr calendars and going forward
	• Implement a monthly King or Queen for a day program incorporating "all about me", "who am I" by April 24, 2024. • Implement independent purposeful engagement activity kits to reduce boredom on each resident home area by May 15, 2024. • Enhancing the resident spotlight (Old legacy) program, to be person centered- quarterly - evidence of it on calendar of events by April 15, 2024.	Activity Coordinator, Rec staff Dir of Programs/Services /Recreation, Admin	Implemented March /April and going forward Implemented and ongoing
	• Hire a Spiritual Care Coordinator to ensure understanding of resident spiritual needs/preferences and enhance the overall delivery of spiritual programming to meet standards of MHLTC/FLTCA by April 1, 2024. • Change the Resident Advocate role to include/ Activation Program Manager to provide additional over sight to provide meaningful activities to the activity programming by February 20, 2024. • Implement opportunities for residents to assist pre and post meal set up by April 15, 2024.	Dir of Programs/Services /Recreation staff/residents Dir of Programs/Services /Recreation, RA/PM, Dietary Manager RA/Activity Coor, Dietary Manager	Completed started April 10th Completed Feb. 5,2024. Completed. Shared with RC April. Will continue to encourage

	Survey result 2023 46% agree target for 2024 70% agree.		resident engagement.
• **Meal Service** • **Snacks** • **Dietitian**	• Re- educate residents on spice caddies through Resident Council and Food Committee Meeting by April 15, 2024. • Provide a steak option during BBQ months in summer to increase satisfaction by August 30, 2024. • Enhance the dining experience through improved ambience such as music, decor and greeting residents as they enter by March 15, 2024. • Ensure taste caddies are regularly replenished and placed on tables by March 2024. Survey result 2023 58% agree target for 2024 75% agree.	Dietary Manager Dietary Manager RA/Activity Coor, Dietary Manager, Dietary Manager	Completed April 22/24 Completed through variety of music offered has increase, table decor seasonal improved - ongoing Completed and ongoing

Accommodation • **Housekeeping** • **Laundry**	• Inform residents and families through memo and at admission that the bedside has a top-drawer lock option and key provided by April 30, 2024. • Re- train laundry staff to deliver laundry to the correct room through staff meeting by April 30, 2024. No specific questions that fell into this section results came solely from survey comments.	Laundry HSK MGR Laundry HSK MGR	RC informed April 22/24 Completed and on going
Resident Advocate Palliative Care/ End Of life	• Supply Care Plan at every 6-week, post admission care conference, and as requested for annual care conference meetings and at any time to review and ensure Palliative approach to care. Survey result 2023 69% agree target for 2024 75% agree.	RA/PM, DRC, ADRC	Implemented and ongoing
Medical Services	• At the admission and annual care conferences, families and residents will be reminded of the process to speak with the physician or nurse practitioner. • At the quarterly MAC-PAC meeting in February 2024, physicians will be reminded to communicate with residents and families any significant changes to resident's health status (labs, medications, diagnosis). No specific questions that fell into this section results came from survey comments.	NP NP, Admin.	Implemented ongoing completed

Volunteer	• Enhance volunteer recruitment efforts to increase volunteer base and support resident group activities. (porter to bingo, hymn sing) we had 194 active volunteers in 2023. No specific questions that fell into this section results came solely from survey comments.	Volunteer coordinator, RA/PM, Director Program Services	Additional 53 volunteers onboarded in 2023 with total volunteers' hours of 1,854.03 or (FTE ratio) 6.54
Environmental, Safe and Secure Maintenance	• Improve call bell alert system through purchase and installation of new Specralink phones on each home area by April 20, 2024. Survey result 2023 65% agree target for 2024 75% agree.	Director Environmental Services	Completed April 22, 24