Quality Plan 2025

Caressant Care Cobden

March 2025

Caressant Care Nursing and Retirement Homes Ltd.

Background:

At Caressant Care continuous quality improvement (CQI) is a transparent process and an effective way to improve care for residents and to improve practice for team members. Quality improvement is not a linear process, and we believe there are always opportunities to be innovative, optimize, streamline, and revise or develop new processes for clinical and operational effectiveness and efficiency. CQI is an ongoing process and considered an integral part of everyone's work, regardless of role or position within the organization.

Caressant Care is committed to resident-directed, safe, quality care that responds to a resident's physical, psychological, emotional, social, spiritual, and cultural goals and needs and is respectful of every resident's individual identity and history and fostering an inclusive environment that supports continuous quality improvement and innovation.

Introduction:

Input for improvement is obtained in a variety of ways.

Caressant Care participates in a voluntary accreditation process through CARF International. In 2024 we were awarded a 3-year accreditation.

Additionally, Caressant Care seeks input from residents, families, people of importance to residents, and team members through an ongoing survey process. Surveys are summarized semi-annually, and results are shared with residents, team members and families. Opportunities are provided for input and feedback on determined prioritized actions and objectives for quality improvement from residents and families as well as the CQI Committee.

Feedback is sought through resident-driven committees such as Food Committee and Residents' Council where suggestions and concerns can be brought forward.

Information about obtaining feedback, concerns and complaints is shared with residents and their designates at move in, and team members are provided with information on improvement processes and initiatives when onboarding and on an annual basis.

Active engagement is sought through departmental meetings such as Town Halls, and interprofessional meetings such as Professional Advisory Council and Continuous Quality Improvement meetings which are held regularly where Quality Improvement plans are reviewed and discussed.

Priorities and targets are determined through internal and external benchmarks, audits, legislation, program evaluations and other reviews such as the Ministry of Long-Term Care, Ministry of Labour, Public Health Units, or other internal or external stakeholder inspections.

A variety of QI processes and tools may be utilized in the QI process. In addition, an individual Quality Improvement Plan will be submitted to Health Quality Ontario (HQO) on an annual basis.

The attached plan provides our quality commitment priorities that Caressant Care has made to residents, team members, and community partners to improve specific quality issues through focused targets and actions.

Definitions:

Ontario Health is a provincial agency that oversees health care quality. The role of Ontario Health includes, but is not limited to measuring and reporting on how the health system is performing, overseeing the delivery and quality of clinical care services, and setting quality standards and developing evidence-based guidelines to improve clinical care

Resident-Centred Care is a model of senior care that invites, accommodates, and respects residents' personal wishes and desires in health care.

CIHI Canadian Institute for Health Information (CIHI) provides comparable and actionable data and information that are used to accelerate improvements in health care, health system performance and population health across Canada.

The **Ministry of Long-Term Care (MLTC)** is the provincial authority overseeing long-term care in Ontario.

PointClickCare (PCC) is the name of a cloud-based electronic health record system that Caressant Care uses.

Continuous Quality Improvement (CQI) Committee

Our designated QI lead is Betty Hazen.

Our Terms of Reference for the CQI Committee for membership include but may not be limited to: Executive Director, Director of Care, Medical Director, each designated lead of the home, registered dietitian, pharmacy consultant, personal support worker and nursing staff representative, other professionals as well as representatives from Resident and Family Councils, if available.

Main Responsibilities of the CQI Team

1. To monitor and report to the long-term care home licensee on quality issues, residents' quality of life, and the overall quality of care and services provided in the long-term care home, with reference to appropriate data.
2. To consider, identify and make recommendations to the long-term care home licensee regarding priority areas for quality improvement in the home.
3. To coordinate and support the implementation of the continuous quality improvement initiative, including but not limited to, preparation of the report on the continuous quality improvement initiative.

<u>Quality Improvement and Operations</u>

1. QI Initiatives may be identified through various means such as surveys, concerns or complaint review, informal and formal meetings, weekly walkthroughs, or through other program evaluations, audits, or compliance. Once initiatives are determined and identified by the CQI Team they can be addressed on a priority basis, determined through feedback, based on high risk or resident and/or family satisfaction feedback.
2. A QI Plan will be developed and implemented with reporting back to the CQI Team and information will be shared with residents, families, and team members. Transparency is key to success.
3. Policies, procedures, audits, and other resources are available to all team members on our online policy software and can be made available to others on request.

4. Caressant Care continues to revise the quality program with our comprehensive document for reporting and tracking indicators. The "Roadmap to Success" has monthly tasks, meeting templates, scheduled monthly tasks, operational and program evaluations, as well as documenting clinical and operational indicators. This document is posted on a shared drive and can be accessed by both the home and corporate team. This document demonstrates our accountability and commitment to quality.

Brief Summary of Quality Improvement Initiatives fiscal year 2025:

Overview

Caressant Care Cobden has prioritized areas for quality improvement based on recommendations received in 2024 from the Resident's Council, Team meetings, Internal and External Stakeholders, our Professional Advisory Committee, and our Continuous Quality Improvement Committee. Data analysis from 2024 includes results from the Resident and family/caregiver satisfaction surveys, Quality Indicators, Internal Quality Indicator Analysis and Provincial/Legislative requirements and initiatives.

Access and Flow

Optimizing system capacity, timely access to care, and patient flow outcomes and the experience of care for residents is a priority. Caressant Care is working in partnership and across care sectors on initiatives to avoid emergency departments through innovative practices and by ensuring timely access to primary care providers.

Caressant Care Cobden endorses the use of a system to communicate with on-call physicians. This system consistently provides accurate and detailed Resident information to physicians which allows them to make informed decisions regarding Resident care or treatment versus sending Residents to hospital Emergency Departments.

Residents moving into the Home are educated on care options and goals of care through discussion with the clinical leadership team with their family members present. Having knowledge regarding options and plans provides a sense of control in their health journey. Residents and family members are introduced to the vast scope of practice available in the Home.

Building and Environmental Improvements:

We continue to enhance our maintenance program and plan to undertake a comprehensive review of maintenance tasks in 2025 on our online software system to improve asset management, service, and efficiency.

Caressant Care Cobden's Home specific goals for 2025 include:

1. Exterior beautification and improvement plans include restructuring Resident-focused green spaces to improve Resident access, comfort, and enjoyment.
2. Plan to repair and paint the Home's interior walls.
3. Advertising for a volunteer group built of community members, team members and their families, Residents and their loved ones will begin in the spring to take part in the restoration and progressive plans to make the central courtyard 100% accessible and enjoyable for all.
4. The current call bell system will be investigated for replacement.

5. Replacement of windows and window treatments will be a progressive process.

Clinical Programs:

New Clinical Roles: In 2025, we welcome two new clinical team members to the Corporate Operations team: Clinical Analyst and Clinical Educator. The Clinical Analyst role will focus on in-depth monitoring of electronic health records and documentation while the Educator role will provide effective, in-person education to build the capacity of our nursing teams and enhance the resident care experience.

InterRAI: The new Resident Assessment Instrument (interRAI), replacing RAI MDS 2.0, is being adopted across Ontario. All 15 Caressant Care homes were selected for the first pilot group of 50 Homes in the province, positioning us at the forefront of this transition. This initiative provides us with increased support and the opportunity to offer feedback to the MLTC, CIHI, and PCC. The interRAI is a more streamlined assessment tool, and PCC has optimized their software for user-friendly and efficient coding and submissions, showcasing our organization's knowledge, flexibility, and leadership in the sector.

Communication and Technology:

Online Learning Management and Policies: Caressant Care utilizes an online software system that houses our policies, procedures, and our online learning management system. This provides quick access for all team members, is environmentally friendly, with a nimble turnaround time when changes are required. We continue to review and update policies and education and add extensive resources to our library such as "how-to's" and other relevant information.

Electronic Health Records: In 2025, Caressant Care will utilize an application designed by PointClickCare. The companion application to the electronic health record system has been designed specifically for handheld devices. The companion application will connect directly to our electronic documentation system and should promote efficiency, eliminate paper forms, and streamline data flow, which should enable and result in direct care team members spending more time with and providing care to residents in the home.

We continue to revise and adjust our electronic health record system for improvements, for example, providing new improved assessments into the care plan library.

Communication: We continue to review our communication strategy, and have increased our use of mobile devices, so we are able to connect residents and people of importance to them virtually. We continue to enhance our use of virtual technology and software to participate in Communities of Practice both internally within Caressant Care and externally with our community partners.

Caressant Care Cobden is transitioning to the Staff Schedule Care programs which enhance team member access to their schedules in real time. Continued technology advancements such as upgrades made to the internet communications in 2024 have been essential in realizing a greater use of technology for our Residents. Improved access to programs and communication continues to benefit all programs in the Home.

Equity and Indigenous Health

Caressant Care is committed to providing improved and equitable access, experience, and outcomes to reduce health inequities in our organization and to ensure appropriate treatment of all individuals regardless of race, gender identity and/or expression.

All team members and management will complete cultural awareness and safety education modules which includes Indigenous Relationship and Cultural Awareness courses and diversity education modules. There is a plan to further enhance services and provide further initiatives in these areas on a broader scale.

Additionally, we have a Cultural Competency, Diversity and Inclusion Plan that is reviewed with actions annually and an Accessibility Plan that addresses and includes any identified barriers on an ongoing basis.

Infection Control:

Caressant Care recognizes the vital link between infection control practices and resident safety. We are continuously enhancing our infection control processes through increased auditing in areas such as hand hygiene, passive screening, PPE usage, and dietary and housekeeping procedures.

We have a dedicated Infection Prevention and Control (IPAC) Lead who supports the home by providing training, education, policy development, and outbreak management. To further optimize our IPAC practices, we carefully review trends and analyze data. Our IPAC Leads receive additional education, training, and participate in community of practice sessions to stay updated and effective.

Leadership Development

Caressant Care recognizes the impact of our leadership team on overall operations and health human resources management and have partnered with a Professional Certified Leadership Coach to continue to provide support for all management team members. These sessions may enhance and build on our current management team members skillset(s) and support a culture of cohesiveness and a more collaborative workplace.

Additionally, in 2025 we are conducting a complete overall review of our performance appraisal system, with a goal to streamline team member reviews and introduce efficiencies and enhancements to improve the experience for both managers and team members.

Resident and Family Experience:

<u>Relationship Focus</u>

Our culture statement is “Caring families, yours and ours together.” In 2025, we are focusing on improving resident and family relationships from the move-in process onward by adopting a relationship-based approach that aligns with and strengthens our culture statement. We will conduct an in-depth review of information packages and perform observational audits with corporate support to enhance the move-in experience. Our goal is to empower our team and families with the tools to build trust and respect as partners in care.

To support this priority initiative, we have partnered with an external consultant to enhance our processes. Our aim is for team members to improve communication, provide personalized care, and offer emotional support for overall well-being. This will enable team members to confidently engage with residents and families, resolve conflicts, and build strong partnerships.

Listening to our Residents and Families

Surveys are conducted throughout the year and summarized semi-annually. The results are carefully reviewed, facilitating timely improvement initiatives. This process also ensures a quick turnaround for any actionable items.

Based on feedback from residents and family members, we have made minor revisions to our 2025 surveys. These revisions include increased opportunities for participation through paper forms, QR codes, online links, and support or assistance via in-person or telephone options. Additionally, we have added an option to provide more detailed information for each category.

Please see attached Resident and Family Experience Survey Summary and Action Plan

Provider Experience

It continues to be a challenging time for health care organizations with unprecedented human resources challenges. Caressant Care endeavors to improve workplace culture, and team member experience by providing education incentives, development opportunities and carefully reviewing and listening to our team members. We conduct an annual Team Member Experience Survey and carefully review survey results and create an action plan to focus on any indicated areas.

Caressant Care Cobden continues to develop its multi-disciplinary team which has resulted in an effective holistic approach to Resident care during their health journey. The addition of BSO and Restorative Care champions is benefitting not only our Residents, but also our front-line care teams. Team building efforts planned for 2025 include team volunteerism opportunities, appreciation events and increased communication.

Safety

Caressant Care continues to conduct a comprehensive review of the Health and Safety Program with an expanded role at corporate office including internal health and safety policies and development of policies, programs and education aimed at enhancing health and safety compliance and accident reduction as well as promoting a culture of safety.

Caressant Care Cobden maintains robust programs to reduce risk and injury to the Home's Residents. Each Resident has a uniquely designed Plan of Care which is steered by the Home's programs and policies.

Front-line care teams and nursing team members are educated on early identification of potential injury and interventions to prevent environmental and personal risk.

Falls remain the greatest risk for injury among our Residents. The addition of Restorative Care Team Champions was initiated in January 2025. This team provides Restorative Care seven days per week in the Home and has reduced fall risk and related injuries. Part of the Restorative Care Team's mandate

includes increasing strength and dexterity, maintaining functional ability for Residents who ambulate with assistive devices and working towards mobility goals specific to the Residents on the Restorative Care caseload.

Palliative Care

Caressant Care endeavours to provide high-quality palliative care. We have an interprofessional committee that meets bimonthly throughout the year where palliative care, pain, trends, success, and concerns are discussed. Our palliative care program strives to help the resident and their family/caregiver to: address physical, psychological, social, spiritual, and practical issues, and their associated expectations needs, hopes, and fears; prepare for and manage end of life choices and the dying process; cope with loss and grief; treat all active issues and prevent new issues from occurring; and promote opportunities for meaningful and valuable experiences, and personal and spiritual growth.

The goals of our program include but are not limited to, relieve suffering for residents and family members, improve quality of life during illness and death, provide a dignified death for residents, provide support and resources to residents, team members and families, develop and evaluate individualized care plans to ensure specialized care needs are met and consider physical, emotional, psychological, social, cultural, and spiritual needs.

Education is provided to all nursing team members on orientation and annually regarding palliative care and end of life.

People with a serious illness have their palliative care needs identified early through a comprehensive and holistic assessment with timely access to support. Goals-of-Care Discussions are in place with consent and Advance Care Planning.

We have three indicators related to palliative care/end of life as part of our performance measurement and management program that are documented and monitored monthly.

Caressant Care Cobden is restructuring two palliative care carts for the use of family and friends who will be holding vigil at their loved one's bedside. Peaceful comfort for Residents, their family and friends during end-of-life care continues to be an attainable goal. Improved communication related to palliation begins at move in and continues throughout the health journey through end-of-life. Care team members receive compliments from families and friends for their exceptional care, attention and compassion.

Population Health Management/Community Partnerships

As part of our Caressant Care strategic planning process data and information was gathered regarding Ontario's population for health and social needs. These insights helped to inform the design of our strategic and operational plans for initiative-taking, person-centred, cost-effective, equitable, and efficient solutions with the goal of improving the health needs of current and future residents while reviewing current and future trends regarding care and well-being. Opportunities for various community and business partnerships were identified and included in these plans.

Caressant Care Cobden has added a Restorative Care/BSO PSW champion team to the Home. The programs developed by the champions are overseen by the BSO Lead RPN and are offered 7 days per week. There has been an overwhelming positive response from Residents, families, and care teams regarding the benefit of this program. The champions have included Residents and care team members in redecoration of the two activity rooms used to provide one-to-one and small group meaningful activities.

Spring 2025 is going to be an exciting time for the Home with volunteers, community partners and Residents working together to revamp the safe outdoor Resident space. Plans are under way for group activities that will enhance the quality and functionality of this area. A celebration honoring Residents and volunteers is being planned for the grand opening scheduled for early summer.
The Home's BSO Lead RPN provides education, support, and training to all care teams beneficial in improving communication and therapeutic relationships between care teams and Residents.
Caressant Care Cobden benefits from weekly Social Worker visits. Our recreation program enlists a variety of community volunteers who provide entertainment and religious services to our Residents.
The Home is near to an elementary school which brings students into the Home to celebrate with our Residents; Valentine cards, Hallowe'en treats and Christmas cards and singing bring a youthful joy to all.
Caressant Care Cobden is a resource for local schools whose students want to explore care communities for their volunteer hours prior to graduation. There have been several students who have moved on to assuming careers in the health and care fields.
The Home provides an atmosphere of growth and development for nursing students completing their clinical placements. The Home's nurses mentor nursing students and Personal Support Workers in their final consolidation hours prior to certification and graduation.
The clinical leadership team maintains an effective relationship with both local hospitals, enhancing care transitions for our Residents who transition between the Long-Term Care Home and the Hospital for admissions, appointments, and emergency services.

Resident-Centred Care
We continue to promote our resident-centred philosophy with a continued focus on language in 2025. We plan to discuss and engage team members at each meeting with a brief discussion of language and examples of resident-centred care, as well as other initiatives throughout the year.
All Home team members are educated regarding Resident Rights; monthly team meetings are useful in clarifying information and answering team member questions regarding individual situations.

Attachments include:

Resident and Family Experience Survey Summary and Action Plans 2025
QIP Information Workplan 2025

Resident Experience Survey Summary and Action Plan

Date:
17 January 2025

Number of Participants:
57

Top 3 Successes:
1. Would recommend the Home- (95%)
2. Health-Incontinence products meet need, get needed health services- (96%)
3. Resident focus-can express opinions freely- (95%)

Top 3 Areas of Improvement:	Plan:	Responsible Person(s):	Date:
1. Team Members-communication. Team members ask how needs can be met 2024 score 88%	• Team members will be made aware of how the survey results reflect our Residents' perception of how we communicate. • Education will be provided focusing on a Resident's right to participate in their care and make choices. • Education and reminders will be provided to care teams to be less task oriented and more focused on the immediate needs/wants of each Resident by asking questions and responding to Resident's requests and input.	RCC-team huddles DOC-monthly practice meetings	January 2025 Ongoing support and leadership
1. Food and Meals-variety, provision, serving 2024 score 88%	• Survey results shared with FNM and nourishment teams. • Team members from all disciplines will be reminded of the Pleasurable Dining process to ensure Residents are enjoying meals in an optimal environment. • Regularly scheduled nutrition services meetings are held in the Home where Residents have their individual concerns addressed. Residents are encouraged to attend.	FNM Nourishment teams Activity Supervisor RCC/DOC/PL ED	January 2025 Ongoing support and leadership Audits will continue by FNM and Clinical Leadership Team (RCC, DOC, PL)
1. Daily Decision Items-bathing/showering 2024 score 82%	• Clinical Leadership with the help of care team members and with input from Residents/Families will audit the bath schedule for Resident choices and will implement changes as able to satisfy Residents' bath times and preferred method (shower or bath)	RCC DOC PL Care Team	Implement January 2025, assess at move in date for new Residents and throughout the year for Resident changes in requests

Survey Feedback:

Shared with:	Date:	Comments:
Residents	17 January 2025	Shared and discussed at residents' council meeting
Families	17 January 2025	Sent out with monthly PAP statement package; posted on public quality board (outside of Willow Lane)
Team Members	21 January 2025	Posted for staff review; will be included in January staff meetings (all departments)
Others (Please specify)	21 January 2025	Posted on public quality board (outside of Willow Lane)

Family Experience Survey Summary and Action Plan

Date:
17 January 2025

Number of Participants:
17

Top 3 Successes:
1. Would recommend our Home-(100%)
2. Health and Wellness-getting the health services needed-(100%)
3. Privacy-feeling that privacy is respected-(100%)

Top 3 Areas of Improvement:	Plan:	Responsible Person(s):	Date:
1. Comfort Items-a pleasant and accessibly outdoor experience. 2024 score 87%	• Plan to restructure the main outdoor Resident space in the spring • Gazebos were purchased in 2024 by Resident Council-these will be installed after the current area is cleared • Volunteer opportunities for the community (ex: Civitan Club), team members and their families, and Residents and their families will be advertised to maintain the outdoor space creating a collaborative approach to Resident comfort and satisfaction.	ESM Activity Supervisor	Spring 2025
1. Health and Wellness-participates in meaningful activities - 2024 score 63%	• Additional Restorative Care hours will provide physical interactions with Residents on their caseload seven days per week • Activity Program has secured a full-time activity person (Feb 1/25) who will be a beneficial addition in providing a greater amount of exceptional activities and programs under the leadership of the Activity Supervisor.	Restorative Care Team Activity Team	Initiated January 2025
1. Personal Relationships-has people to spend time with him/her if they wish. 2024 score 50%	• Additional team members and hours have been implemented through the BSO discipline to provide daily meaningful 1:1 and small group interactions through conversations, activities and crafts. Comfort measures provided by this team will include doll therapy and Montessori interventions such as fiddle blankets etc.	Clinical Leadership BSO Team	Initiated January 2025

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Safety

Measure - Dimension: Safe

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of LTC home residents who fell in the 30 days leading up to their assessment	O	% / LTC home residents	CIHI CCRS / July 1 to Sep 30, 2024 (Q2), as target quarter of rolling 4-quarter average	18.36	15.00	To enhance Resident safety by reducing fall-related injury the Home's target is a 3.36% reduction in falls from our current performance as we move towards our target exceeding the provincial average.	

Change Ideas

Change Idea #1 1. The Home will continue to assess Residents on admission, quarterly and with changes in health status to determine level of risk for each Resident. Early identification of high risk will allow the initiation of appropriate interventions to mitigate fall related injury.

Methods	Process measures	Target for process measure	Comments
1. Increase communication with interdisciplinary huddles and collaboration within the team and our community partners to identify high fall risk Residents and review the possibility to provide added fall prevention and injury reduction through care plan updates using assistive devices. The addition of Restorative Care/BSO PSW team will prove to be a positive addition to the fall prevention program. Data will be monitored and reviewed monthly at fall prevention meetings and quarterly at	1. Identify Residents with a change of health status and apply appropriate interventions and education regarding fall prevention and injury reduction. Identify and monitor falls resulting in hospital transfers. Track all meetings using the multidisciplinary tool that all departments can access for reference. Shift huddles occur at every change of team shift with a registered team member for the use of reporting Resident changes and identifying risk factors. Identified high risk Residents are	1. SBAR process has been initiated to provide full Resident details to on-call physicians responding to 100 % fall-related incidents/injuries. 2. Process initiated for faxing to pharmacy reports of individual Resident falls (100 %) to determine if pharmacology is a factor. Pharmacy provides suggestions for physician follow up.	The home will plan to reduce the number of residents who fell in the 30 days leading up to their assessment to 15% by the end of the fiscal year.

	the Professional Advisory Committee meetings. 2. Restorative Care/BSO Team members will provide education to Residents, families and the multidisciplinary team for better support. Education to include fall prevention, injury reduction, care plan management, safety monitoring and use of fall prevention equipment. Education will be completed at move in, care conferences and with change of treatment or change in health status. Program education is started with move in and will be ongoing through the trajectory of Resident's stay. Medication education will be provided to support Resident needs and all changes will be communicated to ensure understanding by Residents and/or caregivers.
	supported by external partners (Medical Director, Attending Physician's, Pharmacy, etc.) and internal Restorative Care/BSO Team. Extensive review of care plans is completed at time of fall risk and/or when a Resident is identified as a high risk. Care plan changes will be adapted to support each Resident with the collaboration of their caregiver. Care conferences are completed at 6 weeks, annual and as needed to ensure that the Resident, family/caregiver needs are met for communication and education. Quarterly newsletters are also distributed. 2. Mandatory fall prevention and injury reduction education will be completed annually by all team members. Fall Program will be reviewed by clinical leadership annually and when required to ensure all team members are following tasks and adapting appropriate interventions to meet Resident specific needs. Monthly fall meetings will be completed and teams will have access to documented minutes for review. Behavioural Support Nurse will add interventions where required to assist in care plan adaptations to support Residents.