Quality Plan 2025

Caressant Care on McLaughlin Road

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 as well as Family Councils, 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 Pauline Kendrick, Executive Director.

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

McLaughlin is working toward improving goals of care documents upon move in and annual care conferences. We have implemented a resident and family focused move in process so that residents and families feel secure and comfortable with the process. We continue to improve our orientation and onboarding process so that team members are educated so that they may provide the best quality of care.

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.

We have partnered with our community supporting resident access to care in the right place at the right time. Our home has community partnerships with nurse practitioners, NPSTAT, and imaging services to support unnecessary emergency department visits.

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. Some planned environmental goals or improvements for 2025 are to replace actuators, floor tiles and some furniture throughout various areas.

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.

Improving Efficiencies: We plan to start using high-speed scanners which go directly to the pharmacy in Q.2 for processing prescription orders. This should expedite the ordering process, decrease opportunities for errors and additionally promotes residents' confidentiality.

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.

<u>Listening to our Residents and Families</u>

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 Plans

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.
We strive to improve relationships between the home and team members. We enjoy team member appreciation days, Surge challenges, and we have dedicated Orientation and Lift Champions. Team members celebrated special occasions, for example at Christmas management served a hot meal and we had special gift giveaways for team members.
Although recruitment and retention continues to be a challenge, we have achieved approximately 97% of our own team. Workplace culture has improved, and we will continue to listen to and meet the needs of the team members.
We will continue to educate our staff in the Gentle Persuasive Approaches (GPA) and DementiAbility.

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.

We continue to educate team members annually to support implementing safety interventions and reducing resident incidents. We will be training Falls Champions to educate and offer support to peers in home areas.

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.
McLaughlin currently has 7 team members enrolled in the Fundamentals of Palliative Care.

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.

We have partnered with Maxwell Management Group to onboard International Nurses, which will benefit the home. Sir Sandford Fleming College and McLaughin have also partnered for PSW placements.

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.

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

Resident Experience Survey Summary and Action Plan

Date:
March 3, 2025

Number of Participants:
27

Top 3 Successes:
1. Resident focus- can decide what to wear- 100%
2. Would recommend us – 93 %
3. Residents feel they have a voice and are heard – 96 %

Top 3 Areas of Improvement:	Plan:	Responsible Person(s):	Date:
1. Food – 67 %	Work with residents for improvement	FNM	ongoing
2. Team members engage in friendly conversation – 67 %	Continue to educate Residents rights. Alls team members need to promote /initiate conversations	All staff	ongoing
3. Team members ask how needs can be met – 70%	Huddles with team members – reasonable requests	All staff	ongoing

Survey Feedback:

Shared with:	Date:	Comments:
Residents	February 2025	Nothing brought forward
Families	February 2025	Nothing brought forward
Team Members	February 2025 February 2025	Nothing brought forward
Others (Please specify)		

All request for follow up are complete:

- [x] Yes
- [ ] No

Family Experience Survey Summary and Action Plan

Date:
March 3, 2025

Number of Participants:
9

Top 3 Successes:
1. Feel privacy respected – 88%
2. Get health services needed – 78 %
3. Team members engage in friendly conversation – 75 %

Top 3 Areas of Improvement:	Plan:	Responsible Person(s):	Date:
1. Participates in meaningful activities – 38%	Recruiting staff for activities to offer more programs and times, keep asking residents what it is they would like	Activity Director	ongoing
2. Team members ask how needs can be met – 57 %	Education for team members and communication	All staff	ongoing
3. Can bathe/shower at chosen time – 40%	Honor requests from residents	Nursing	ongoing

Survey Feedback:

Shared with:	Date:	Comments:
Residents	February 2025	No responses
Families	February 2025	Families at Family Council expressed that they are pleased with care
Team Members	February 2025	No responses
Others (Please specify)		

All request for follow up are complete:

- [x] Yes
- [ ] No

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	21.50	18.50	The goal is to reduce % of falls and to move closer to the current provincial average (15.5 %).	

Change Ideas

Change Idea #1	We will continue to strive to reduce our current performance by identifying each resident with a high fall risk. Each resident will be monitored and we will work within the care team (internal and external- medical director, physicians, and caregivers) and collaborative partners for proper identification of residents needs and interventions which can be provided by our home.

Methods	Process measures	Target for process measure	Comments
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. Data will be monitored and reviewed monthly at fall prevention meetings and quarterly at the Professional Advisory Committee meetings. 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 and equipment.	Identify residents with a change in 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 shift change with a registered team member for the use of reporting residents changes and risk factors. Identified high risk residents are supported by external partners. Extensive review of care plan is completed at time of fall risk and /or a resident is identified as a high risk. Care plan changes will be adapted to support each resident with the collaboration of their caregiver. Fall program will be reviewed by clinical leadership annually and when required to ensure staff are following tasks and adapting appropriate interventions to meet resident specific needs.	The home will plan to reduce the number of residents who fell in the 30 days leading up to their assessment to 18.5 % by the end of the fiscal year.	