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2023-2024 CONTINUOUS QUALITY IMPROVEMENT INITIATIVE REPORT

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Priority Areas for Quality Improvement	Sprucedale Care Centre's Quality Improvement Plan serves as the foundation for the commitment of the home to continuously improve the quality of the person-centered care it provides. Presently Sprucedale has several quality improvement initiatives, these are all listed in our Annual QIP 23/24 Program. ○ Continue to reduce unnecessary Emergency department visits. ○ To continue to reduce the inappropriate use of anti-psychotics upon admission. ○ Least Restraint last resort policy in the home. This is an ongoing initiative to minimize the use of Restraints. ○ Infection Control- UTI reduction/Antibiotic use ○ Palliative Care Program ○ Skin and Wound/ Continence Care Program ○ Clinical Pathways RNAO- Admission Process/Persons Family Centered Care/Delirium. Pain and Falls ○ Communication -admission, readmission, documentation, improvement with referral and plan of care identified as well as physician communications via fax. ○ Upgrade current aesthetics of the tub rooms.
Process to Identify Home Priority Areas	Avoidable ED visits are down from January's stats- 21 Avoidable ED visits according to data extracted; April stats noted to be down at 19. With January noted 5.9 were from falls, April noted at 9.2 from falls. No other conditions listed to be high enough to be reportable. Monitor Performance indicators via PCC and Health Quality Ontario. Anti-psychotic use- Current performance of 2.38%- Ontario average of 20.80%. Restraint use- Current performance of 4.39%- Ontario average of 2.98%

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	Infection Prevention Program. IPC – Infection prevention and control Module implemented through PCC- this new module will help us manage and report infections and monitor antibiotic usage to help. drive better outcomes. As well Healthconnex.ai program has given us the ability to *utilize auditing program to identify any areas needed to improve education and best practices.* UTI Reduction- -education- public health Ontario program -Ongoing surveillance -Physician collaboration for, assessment, interventions, documentation Looking for storage ideas for equipment such as bedpans, urinals. Staff not having accessible equipment, then leaving it in resident bathrooms. Creating a more specific cleaning audit (housekeeping, nursing cooperative) Best practice IPAC measure. Skin & wound/ Incontinence Program PCC Skin & Wound care Module addition. Implementation of the RNAO Best Practice Guidelines Clinical Pathways-Which will include and address the following this year: 1. Admission Process 2. Person, Family centered Care } completed 3. Delirium 4. Falls 5. Pain } Go Live February 2024 Palliative and Pain Program enhancement. Currently we are involved with the Ontario Learning center 2022-2023 Collaborative Project to sustain a palliative approach to care in LTC. We have developed goals to align with the fixing long Term care act. Identified lack of information on admissions and readmissions needed a more standardized approach to ensure that all info was being communicated. And to ensure follow up completed. Stay in line with CNO standards.

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	Tub room enhancement- currently the rooms are more of institutionalized look. Would like them to look more inviting and home like.
Process of Monitoring & Measuring Quality Improvement Initiatives	Avoidable Ed visits- Will continue current interventions in place to reduce ED visits by 2%. - Root cause analysis of ED visits completed by DOC.ADOCs to identify areas for further education. Review at monthly Reg. Staff meetings. Also reviewed at Professional Advisory Committee, quarterly. (PAC) - SBAR tool created to help staff communicate efficiently with physicians. - Identify residents at higher risk of readmission to hospital if coming back from hospital to early. By identifying earlier communication with hospital and physician best outcome. Also identify resident upon admission for increased RISKS, due to comorbidities and health status. - Incorporating AMPLIFI to assist. - Early communication with families to identify DNR and health care directives on 6-week, admission conference and annually. - Inappropriate use of anti-psychotics this is an ongoing initiative in the home. - Residents are reviewed on admission by ADOC, BSO Team, Pharmacy, Physician complete a thorough med reconciliation upon admission. - BSO team and pharmacy work closely with the families to communicate and educate and collaborate families on the use, risk, and alternatives. - BSO RPN does review on admission and quarterly on all residents with behaviours. - PIECES education is continued yearly so that all Registered Staff have the goal of obtaining this information. Restraints- ongoing interventions in place, Current indicators are reflective of PASD being used however the RAI coding indicates that they are restraints. E.g., chair that prevents rising, tray tables.

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	-Interventions are in place, care planned, consents, POC documentation and monitoring of resident when in use. The four residents that are utilizing these types of PASDs are for repositioning only and or for activities of daily living. Not one used for restraining purposes. Education is given my Registered Staff if family are requesting Restraints. Focused on education with Reg. staff on assessment, symptoms, algorithm for when to obtain urine cultures. Creation of structured progress note for suspect UTI. Re-education for PSW on tub disinfecting. Collaboration with MDs in reduction of antibiotic prescribing for asymptomatic bacteriuria. J/F/M-29 samples, 23 positive (79% +) 100% treated with antibiotics. A/M/J-28 samples, 11 positives (39%+) 72% treated with antibiotics. Continue to see a decrease in the number of samples sent and inappropriate use of antibiotics. Skin and wound integrity for our residents. Currently looking to enhance our current practices with the new addition to our Skin and Wound Care module in point click care to drive better management of critical issues for our residents and home. To enhance transparency and consistency and streamlines decision making process and to create better outcomes for our residents. Creation of a new Skin & Wound Care/Continence committee is completed with representation from PSW, RN, RPN, Prevail Rep. Dietician, Meeting monthly. -Creating product referral and follow up to ensure appropriate action in place for interventions. Improve Communication. Slider sheet/ Pad audit create goal to follow best practice to remove pads. Education provided to all nights and evening staff. Palliative and Pain Program enhancement. Currently we are involved with the Ontario Learning center 2022-2023 Collaborative Project to sustain a palliative approach to care in LTC. We have developed goals to align with the fixing long Term care act. Revision of resident/ family information pamphlet

	Monthly palliative meetings, review and reflect and change ideas if needed. Reorganized palliative carts that were needed. Working with CRLI coordinator to ensure best practices in place. Meeting every other month. Pain- Current Pain/BSO RPN who is CAPCE trained, audits Pain medication, PRN use reviewed residents quarterly, further recommendations and referrals. 9 Staff have attended the Fundamentals of palliative care that was hosted here in the home. Safety-Pain related assessment tool related to sedations (MSSA) creation. Continue to send staff to receive CAPCE when needed. Creation of a new Admission and Readmission Progress note was created by SF. To capture multi focused assessment for residents. To address all systems including, impression or plan to guide nurses into development of resident plan of care, referrals or recommendations needed. SBAR communication tool for MD consults and response for orders fax sheet created to ensure appropriate communication and legible and standard duration to meet pharmacy requirements. Tub room enhancement this is on going and will be taken to the staff committees to assist with new ideas to change current environment.
Survey- Written Record	Staff Engagement & Work life and Workplace Violence survey conducted annually between June-July Resident Family Engagement Survey Conducted annually between June-July. Surveys are reviewed prior to completion to add or remove necessary questions if required, and results are also shared with the following stakeholders. Resident council Family council

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	Continuous Quality Improvement Team Health and Safety Team Leadership Professional Advisory Committee Registered And Non-Registered Staff Committee Department Monthly Meetings. Once all parties have been able to review results, established actions plans are created with improvement ideas, and then discussed again at future meetings.
Survey Actions- Written Record	Sprucedale conducts the following surveys yearly. • Resident and Family Satisfaction Survey • Staff Engagement & Work Life Survey • Workplace Violence Survey The surveys provide insight into Resident, Family and Staff perceptions and satisfaction with the services we provide, and to identify if we are meeting the expectations or lacking in any area. Questions have reviewed with Staff committees, Resident, Family councils. Only changes noted were to revert to pre-covid survey questions for 2023. No other changes needed to current questions at this time. The goal for all surveys is to increase response rates from 60% to 75%. Will send out the survey, as well as weekly reminders.
Report Date	July 10 2023