Holland Christian Homes

HCH *Here to Care.*

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

Faith Manor is part of a larger continuum of care organization, Holland Christian Homes which is located in the City of Brampton and includes another Long-Term Care Home (Grace Manor) and six apartment towers. The mandate of Holland Christian Homes is to provide a supportive, caring, quality Christian environment in order to preserve dignity and enhance the quality of life for people who require long-term care from a team of qualified caregivers. In partnership with residents, caregivers and families, we provide a safe, professional and caring community for seniors based on traditional Christian values, offering a continuum of care and support while respecting their individuality and dignity. Our Quality Improvement Program includes in its scope, the annual development, implementation, monitoring, review, and evaluation of the following activities: Resident Satisfaction and Family Experience Surveys, 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

Faith 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.

Faith 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)	31.31	26.00	Target is based on the current Central West LHIN: Avoidable ED visits rate (per 100).	William Osler Health System,, Ontario Health Team, Behavioural Support Ontario, Neurobehavior Team

Change Ideas

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

Methods	Process measures	Target for process measure	Comments
DRC/NP will train registered staff on SBAR Tool	Number of staff trained on the use of SBAR	100% of registered staff trained on SBAR by December 31, 2024.	

Change Idea #2 Utilize recently purchased bladder scanner as a diagnostic tool to prevent ED transfer in individuals with urinary retention

Methods	Process measures	Target for process measure	Comments
DRC/NP will train all registered staff and medical staff on the availability and use of the bladder scanner	Number of registered and medical staff trained on the use of the bladder scanner	100% of registered and medical staff trained on the use of the bladder scanner	

Report Access Date: March 28, 2024

Change Idea #3	The home will arrange a situational care conference following each hospital return to review and update goals of care if required to avoid future unnecessary hospitalizations.		
Methods	Process measures	Target for process measure	Comments
Resident Advocate will arrange situational care conference within one to two week of resident return from the hospital	Percentage of situational care conferences held	100% of residents who have been transferred to hospital will receive a situational care conference within one to two weeks of their return.	

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	100.00	100.00	100% of non-union staff to complete Diversity, Equity and inclusion education (DEI) in 2024 meeting the Service Agreement obligations.	Ontario Health, Rainbow Health

Change Ideas

Change Idea #1 Incorporate Diversity, Equity and inclusion education in 2024			
Methods	Process measures	Target for process measure	Comments
Utilize online training that includes topics of Diversity, Equity and Inclusion for all non-union staff	Non-union staff staff to complete Diversity, Equity and Inclusion (DEI) training in 2024.	100% of non-union staff to be trained on Diversity, Equity and Inclusion (DEI) in 2024.	Total LTCH Beds: 160 Meeting the Service Agreement obligations.

Experience

Measure - Dimension: Patient-centred

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of resident responding positively to: "what number would you use to rate how well the staff listen to you?"	C	% / LTC home residents	In house data collection / 2024	85.00	100.00	Last year's results had a poor response rate. This year the question will be re-worded for clarity.	

Change Ideas

Change Idea #1 To see an increase in the number of residents responding 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	HR will utilize online learning platform (Surge) to offer customer service training	100% of staff trained on customer service in 2024	

Measure - Dimension: Patient-centred

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences".	C	% / LTC home residents	Local data collection / 2024	95.00	100.00	This is a highly important customer service indicator.	

Change Ideas

Change Idea #1 To see an increase in the number of residents responding positively to the question "I can express my opinion without fear or consequences".

Methods	Process measures	Target for process measure	Comments
Incorporate customer service training in 2024 for staff	HR will utilize online learning platform (Surge) to offer customer service training	100% of staff trained on customer service in 2024	

Report Access Date: March 28, 2024

Safety

Measure - Dimension: Safe

Indicator #5	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	10.83	9.00	Current Provincial average is 20.8%. Faith Manor is well below this target and continues to take measures to ensure the appropriate use and prescribing of antipsychotic medications.	William Osler Health System, Neurobehavioural Team, Geriatric Psychiatry, Behavior Support Ontario, Silver Fox Pharmacy

Change Ideas

Change Idea #1	Review new and current residents on antipsychotic medications to determine proper indication for usage and consideration of alternative interventions when warranted.		
Methods	Process measures	Target for process measure	Comments
Utilize the interdisciplinary team approach to reduce antipsychotic medication without diagnosis.	Interdisciplinary Antipsychotic Reduction Committee will review monthly residents that are on antipsychotic medication to determine proper indication for usage and consideration of alternative interventions when warranted.	Utilize the use of the interdisciplinary Antipsychotic Reduction Committee to review 100% of new admissions and current residents that are antipsychotic medications to determine proper indication for usage and consideration of alternative interventions by March 31, 2025.	

Quality Improvement Plan (QIP)

Narrative for Health Care Organizations in Ontario

March 28, 2024

OVERVIEW

Faith Manor is part of a larger continuum of care organization, Holland Christian Homes which is located in the City of Brampton, and includes another Long-Term Care Home (Grace Manor) and six apartment towers. The mandate of Faith 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, 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 medical staff at Holland Christian Homes participates in independent medical record review; infection control; pharmacy and therapeutics review; medical advisory review, mortality review; ethical issue reviews, utilization management, review of transfers to other facilities; and serve on several committees including the CQI Committee.

The complex care needs of our long-term care residents have increased. Residents coming into the home are increasingly frail, more medically complex and for those with various forms of dementia; are displaying increased personal expressions. 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. In order to meet these increased acuity levels, we continue to utilize our community partners to ensure on-going continuum of care.

Our 2024/2025 Quality Improvement Plan will focus on timely and efficient transitions and safe and effective care. The established priorities, targets, and activities will take into consideration how we can best improve resident quality outcomes and safety. Some examples of this include our on-going efforts to reduce falls with continued purposeful hourly rounding for all of our residents. We also 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.

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, EDEN (person-centered) 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. Faith 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.

Faith 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.

Lastly, we recognize the importance of advanced care planning. We 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.

EQUITY AND INDIGENOUS HEALTH

Holland Christian Homes is committed to fostering diversity, inclusion, and cultural competency. Holland Christian Homes seeks to identify opportunities' for ongoing enhanced education and training in the following areas: cultural competency, age, gender identity/expression/orientation, spiritual beliefs, socioeconomic status, disability, and language. When resources are not available internally, Holland Christian Homes will seek to develop resources so that all team members are provided the opportunity to develop a greater awareness and sensitivity to the needs of person's served, stakeholders, and the community.

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.

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 includes antiracism, First Nations, Inuit, Metis, and Urban Indigenous based on Service Accountability Agreement obligations.

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 Faith Manor. Residents and Families are also able to complete CQI suggestion forms and/or concern forms.

Residents participate in our Dining Room 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 who are not mentally capable to complete them.

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, 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. Families and residents were very appreciative of being invited to participate and commented about how much they learned from participation in this day and appreciated the transparency that our home was providing.

The Faith 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.

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.

SAFETY

Senior management is committed to guiding the execution of the Long-Term Care Resident Safety Plan across all the Holland Christian Homes Long Term Care homes and Seniors Services programs.

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 Long-Term Care homes and Seniors Services programs, and builds upon our mission, vision and values.

The Long-Term Care Resident Safety Plan is developed in conjunction with the Patient Safety Goals within the patient safety areas of culture, work life/workforce, communication, medication use, infection control, falls prevention, and risk management. The goal is to enhance resident/client safety and to minimize risk.

This document articulates the go forward strategy for quality and safety at the 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. All staff receive and sign off annually the Code of Conduct reaffirming their commitment to act ethically at all times.

POPULATION HEALTH APPROACH

Faith 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

Sellinor Ogwu
Administrator
sellinor.ogwu@hch.ca
905-463-7002 Ext 5356

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

Sellinor Ogwu, Administrator /Executive Director

Judy Kirby, Quality Committee Chair or delegate

Other leadership as appropriate

QIP PLANNING CYCLE AND PRIORITY SETTING PROCESS

Faith Manor has developed QIPs as part of the annual planning cycle since 2015, with QIPs submitted to Health Quality Ontario (HQO) every April (except in 2021 when this was paused due to the global COVID-19 pandemic). Faith Manor's QIP planning cycle typically begins in January, and includes an evaluation of the following factors to identify preliminary priorities:

- progress achieved in recent years;
- ongoing analysis of performance data over time available from the Canadian Institute for Health Information (CIHI); with areas indicating a decline in performance over time and/or where benchmarking against self-identified peer organizations suggests improvement required
- Resident Satisfaction, Family Experience, and staff engagement 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.

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

Every staff has a responsibility for CQI. Faith Manor's nursing, departmental, and administrative policies, combined with practice standards, provide a baseline for staff in providing quality care and service. Interprofessional quality improvement teams, including resident and family advocates, work through the phases of the annual quality improvements.

DESIGNATED LEAD

We have employed a full-time CQI and Risk Mitigation Specialist for oversight of our risk management quality improvement activities:

Judy Kirby CNM
CQI and Risk Mitigation Specialist
Judy.kirby@hch.ca
905-463-7002 ext.5322

****We encourage all staff, residents, and families to get involved, join a committee, and make a suggestion. Contact 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 suggestions 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, AdvantAGE, and OLTCA benchmarking, professional practice standards (RNAO, etc.), will be used to compare our outcomes and processes with others, identifying areas to focus on continuous quality improvement efforts.
- Central Ontario Health designated quality Indicators as outlined in the L-SAA Funding Accountability Agreements.

- 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 inhouse committee and/or department(s). They are accountable to report goal outcomes annually to the CQI Committee.
- Establishment of high-level interdisciplinary priority improvement targets and initiatives to measure outcomes. This includes establishing the improvement initiative, methods, and results tracking. Such improvement targets and initiatives are measured against the previous year's actual outcome to the current year's improved targeted outcome.

The continuous quality improvement methodology used for acting on the high-level interdisciplinary priority improvement targets and initiatives is as follows:

Step One - SET STANDARDS

Standards are written statements outlining expectations, policies, procedures, and workplace rules related to a goal/improvement initiative. Each goal/improvement initiative will have a standard or a set of rules that tells everyone in Holland Christian Homes what to do, how to do it, and when. The standards determine the program and make it clear what is expected - how, when and from whom. They also clarify what employees can expect from management.

Standards provide the 'bar' or 'starting point' against which we evaluate whether what we are trying to accomplish or achieve is working. Implementing clear, effective, approved standards is an indication of the strong leadership that is essential for an effective and successful goal/improvement initiative.

Step Two - COMMUNICATE

Communicating standards means ensuring that all appropriate people in Holland Christian Homes have a clear understanding of what is expected of them as employees, and what they can expect from others regarding the goal/improvement initiative. Communication increases awareness of the goal/improvement initiative and encourages employees to give us feedback and tell us their observations about the goal/improvement initiative and how it can be improved.

What is communicated?

- Specific information, rules, or workplace expectations that have been set for the goal/improvement initiative to appropriate people, etc.
- Updates on improvements to meet the goal/improvement initiative.

How we communicate?

We use the most effective means of communication to ensure that everyone in Holland Christian Homes knows what is expected of them. This can mean notices on bulletin boards, emails, meetings, newsletters, posters, pictures, memos, or guest speakers. We have invested in software that allows us the ability to send mass messages using “One Call Now” for staff and “Cliniconex“ for families, which is extremely helpful for immediate messaging. We make sure that literacy and language issues are accommodated.

One of the best ways we communicate positive messages about a goal/improvement initiative is by getting people to actively participate in achieving the goal/improvement initiative. This shows that people value the effort put into achieving the goal/improvement initiative.

To whom we communicate?

We communicate to employees, families, residents, volunteers, and visitors as identified in our goal/improvement initiative standard. This may include all employees or a selection of them. We may need to communicate different information to employees and different information to residents and families. We think about what people need to know and when they need to know it and who needs to know it.

We make communication two-way

We give information and ask for feedback. We make adjustments when employees offer good suggestions and then show them how we used their suggestions.

- We formulate the information in a language and manner that people will understand, and deliver it at a time and place that will maximize their comprehension.
- We vary the ways that we communicate so that new information is noticed and does not become mundane.

Step Three - TRAIN

Training means that management, supervisors, and workers all attain the knowledge and skills appropriate for their jobs. For each goal/improvement initiative, we determine who needs what knowledge and skills, and how they will be developed. To

meet the goal/improvement initiative requirements, training is completed, or verified, within each year (January 1 to December 31).

How training is done?

Workplace training can be delivered in various ways (i.e. In-services, webinars, outside training, etc.). What is important is that the knowledge and skills needed to achieve the goal/improvement initiative are learned and practiced.

Effective training:

- Follows adult learning principles.
- Is delivered in the way that allows employees/residents/families to benefit most. For example, classroom training works where group discussion and sharing of ideas is important.
- For specific training, practical one-to-one hands-on experience training using tools or equipment is needed.
- Computer-based training works where independent learning is needed. We include opportunities to practice and demonstrate what is learned.
- Training is relevant and applicable to the learner's duties.

What training is done?

Training on our standards for each goal/improvement initiative is provided to those who have responsibility and accountability for knowing and using the information. For example, orientation training is important for everyone when they are first hired, when they change locations or jobs, or after a long absence from Holland Christian Homes. Training or retraining in safe work procedures is ongoing. We keep written records of who was trained in what and when the training occurred.

- We vary the ways that we do training to help keep it interesting.
- We use visual aids and real-life case studies as tools for learning.
- We discuss our training needs with other managers to create opportunities to share resources or information.
- We consider train-the-trainer courses, so we can have a qualified trainer to deliver programs on-site.
- We provide a training checklist and sign-off sheet for the supervisor and workers so we are sure each topic is covered and acknowledged.
- We keep training records, meeting notes, sign-off sheets, attendance forms, certificates or record of training and training evaluation forms with our goal documentation.

Step Four - EVALUATE

Evaluating a goal/improvement initiative

Evaluating each goal/improvement initiative is an important process; it helps us make sure we are carrying out the standard, the goal/improvement initiative is properly communicated, and effective training has taken place. It is also an opportunity to see if the goal/improvement initiative is working — is it effective and up-to-date?

Evaluating our goal/improvement initiative helps us to see where the strengths and weaknesses are. We are then better able to make effective improvements with the feedback we receive.

Going through the process of evaluation also helps keep our goal/improvement initiative fresh and top-of-mind for residents, families, volunteers, workers and supervisors as we ask questions and check to see the status of the goal. This is a good time to give positive feedback, which will encourage more good work.

How and when do we evaluate?

Once Steps 1, 2 and 3 have been completed, the evaluation may begin. The evaluation step is completed during the calendar year. However, it may not be practical to evaluate our goal near the end of the year if it was very recently implemented. We follow our action plan and have it implemented no later than February 1st of the following year.

Ways we evaluate:

- Observing: walk around to see if a process or task is being completed according to the standard. This is done during our regular workplace inspections.
- Looking for trends: examine workplace records.
- Asking questions about the implementation of the standard: employees will often give the best feedback.
- Asking a third party: have them look at the work processes and give us feedback.

Some questions we ask:

- Has legislation changed? Are there new best practices in the industry?
- Is the goal/improvement initiative standard being implemented and met?
- Is communication about the standards, both to and from employees, clear and understood?
- Is training to the goal/improvement initiative standards being completed and are employees, residents, families, and volunteers benefiting from it?

- Are employees following the goal/improvement initiative?

Ways we evaluate our goal/improvement initiative:

- We use a program evaluation template and evaluate the goal/improvement initiative as part of an applicable or associated program review.
- We keep logbooks that we refer to at evaluation time. We record the good practices, as well as those needing improvement.
- We keep notes throughout the year. For example, if we do training, audits, inspections, or if there are incidents, then we write them down as we go so that when it is time to evaluate we can refer to your notes.
- We try to build confidence by keeping expectations reasonable. Standards, and ways to evaluate them, will be improved over time.
- We are not afraid of negative results. We cannot improve if we do not try different methods and approaches. We will take action aimed at improving the goal/improvement initiative, even if the evaluation results show problems.

Step Five - ACKNOWLEDGE SUCCESS AND MAKE IMPROVEMENTS

Based on the results of our evaluation, we look for opportunities for improvement and create a documented plan or recommendations to implement changes. When evaluation indicates a need for improvement, we use cooperative mechanisms to significantly improve our performance.

Our objectives include:

- Raise performance to Holland Christian Homes standards.
- Raise Holland Christian Homes standards and expectations.

We keep everyone informed of the plans for improving the goal/improvement initiative such as:

- Sending a letter from the Board of Directors/department heads congratulating all staff for their contribution to meeting the goal/improvement initiative.
- Run an article in the CQI newsletter or on the website highlighting successes.
- Include commendations in the minutes of the annual general meeting.
- Acknowledge and congratulate those who have contributed to our goal/improvement initiative. We do this by publicly recognizing Holland Christian Home's overall performance and improvements and individual contributions to improved performance. We also explore employee recognition, incentive programs, and performance appraisals.

These 5 steps are used in a repeating cycle to allow continuous reflection and improvement of the care and services provided to our residents.

Communication:

The Continuous Quality Improvement Committee provides oversight and functions as the central clearing house for quality data and information collected throughout the home. The CQI Committee tracks, trends, and aggregates data from all sources to prepare reports for the Board of Directors and the medical staff. A quarterly CQI newsletter is published to update residents, tenants, families, staff, and volunteers.

Education:

All staff and volunteers are given the responsibility and authority to participate in our Continuous Quality Improvement Plan. To fully accomplish this, all volunteers and staff are provided with education regarding the CQI Plan during their initial orientation, and on an annual basis thereafter. This education will include a description of the CQI Plan and how they fit into the plan, based on their particular job or volunteer responsibilities. Education is also provided to contractors and agencies who are involved in resident care. We also welcome and embrace resident and family involvement in our committee(s).

Evaluation (Monthly, Quarterly, Annual):

Our CQI Plan is evaluated monthly during our CQI committee working groups where all CQI activities for all programs and services offered within Faith Manor are benchmarked against our set goals and action plans are revised to ensure a focus on continuous improvement. Our established CQI Committee meets quarterly with identified key stakeholders, including representation from family/resident councils where Faith Manor reviews quarterly metrics and completes a comparative analysis of all action items and sets further action priorities. Our overall CQI Plan (and all associated activities, program matrices, benchmarks) is evaluated on an annual basis for effectiveness in achieving the goal of assuring that the most appropriate quality of care and services are being provided to our residents, tenants, and clients. This will be done following the Holland Christian Homes standard template provided for this purpose. A summary of activities, improvements made, care delivery processes modified, projects in progress, and recommendations for changes to this CQI Plan, are compiled and maintained on file.

Documentation and Reporting:

A detailed summary of activities, improvements made, care delivery processes modified, projects in progress, and recommendations for changes to this Quality Improvement Plan, are compiled and maintained on file. In addition to regular CQI updates, a detailed formal summary highlighting the quality improvement activities for the year will be prepared and posted publicly within the home and on the Holland Christian Homes website.

OVERALL SUMMARY – OUR PROCESS TO MONITOR AND MEASURE PROGRESS, IDENTIFY AND IMPLEMENT ADJUSTMENTS AND COMMUNICATE OUTCOMES

A key component of the sustainability plan is the collection and monitoring of the key project measures over time. Analysis of the Outcome measure(s) will be used to identify if the Home is achieving the desired outcomes or not. If not achieving desired outcomes, the team can review the Process measure(s) over time to either confirm compliance with key change ideas (suggesting the change idea may not be as effective at improvement outcomes) or identify gaps in compliance that need to be addressed. Based on the results of this analysis, the team may consider alternative change ideas, provide coaching to staff to enhance compliance, engage with staff to better understand gaps in compliance, etc.

Communication strategies are tailored to the specific improvement initiative. These include, but are not limited to:

- Posting on the Faith Manor Quality Improvement Boards, in common areas, and in staff lounges
- Publishing stories and results on the website, on social media, or via the CQI newsletter
- Direct email to staff and families and other stakeholders
- Handouts and one: one communication with residents
- Presentations at staff meetings, townhalls, Resident Councils, Family Councils
- Huddles at change of shift
- Use of Champions to communicate directly with peers

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

See Below

ccess and Flow | Efficient | Priority Indicator

	Last Year		This Year	
Indicator #5 Rate of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents. (Faith Manor Nursing Home)	**22.40** **Performance (2023/24)**	**21** **Target (2023/24)**	**31.31** **Performance (2024/25)**	**26** **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

Report Accessed: March 28, 2024

100% of new admissions received conversations about goals of care, wishes, values and beliefs. By having these conversations we were 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 the resident's wishes, values and beliefs.

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
Faith Manor: Avoidable ED visit rate (per 100) is 31.3
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. What is not reflected in the statistics, is that treatments have often been started for these medical conditions, however the residents health deteriorates necessitating transfer. Several of the "potentially avoidable" conditions would not be appropriate to manage in an out patient setting (i.e. sepsis, seizures, fractures, worsening pneumonia/CHF/COPD ect.)

Celebrations:
-Collaborated with the Neurobehavioural team for appropriate prescribing of antipsychotic medications and behavioural management.
-Funding for a full-time nurse practitioner
-No non-compliance for medical services
-Excellent attendance at care conferences by the medical team (100%)

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

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

Report Accessed: March 28, 2024

We successfully implemented Preview-ED Observational Tool for a 100% of our resident by our set target date. Unfortunately, we did not see a significant improvement in our ED transfer statistics. The top 5 avoidable ED transfer reasons in the LHIN report are Falls, Pneumonia, Mental health conditions, Septicemia and CHF. What is not reflected in the statistics, is that treatments have often been started for these medical conditions, however the residents health deteriorates necessitating transfer.

Several of the "potentially avoidable" conditions would not be appropriate to manage in an out patient setting (i.e. sepsis, seizures, fractures, worsening pneumonia/CHF/COPD ect.)

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.

Collaboration with the Neurobehavioural team for appropriate prescribing of antipsychotic medications and behavioral management resulted in residents with dementia not being transferred to hospital for further assessment regarding personal expressions. We also saw an increase in residents or SDM requests to be sent to transferred to hospital hence increasing the number of transfers. No non-compliance for medical services.

Comment

Long-Term Care QIP Potentially Avoidable ED transfers by LHIN Report - Q3 2022/23 - Q2 2023/24
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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 responding positively to: "What number would you use to rate how well the staff listen to you?" (Faith Manor Nursing Home)	**CB** **Performance (2023/24)**	**100** **Target (2023/24)**	**NA** **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% of residents were invited to attend care conferences in 2023. By asking this question we are getting increased attendance and 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 new admissions PFCC assessments completed on admission. This was effective to ensure care plans and language reflected the residents choice and therefore improving care outcomes. Enhancing our philosophy of Person-Centered Care.

Comment

This indicator was selected for QIP last year however response options are different than our response options for this year. Therefore, it is not possible to use this indicator for our home. Had we created a custom indicator, then we would have a current performance of 69%. Unfortunately this question had a poor response rate of 27%. After consulting with our Resident and Family Councils the Councils did not approve HQO scale response. However, we did include the HQO questions.

	Last Year		This Year	
Indicator #4 Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences". (Faith Manor Nursing Home)	**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

FLTCA and two Resident Rights selected each month and reviewed at Monthly Resident Council Meetings.

Resident Bill of Rights reviewed at the Resident Council Meetings enhances resident knowledge of what care is provided; enhances engagement and positive resident feedback. We are seeing an increase in attendance at Resident Council Meetings.

Report Accessed: March 28, 2024

Comment

This indicator was selected for QIP last year however response options are different than our response options for this year. Therefore, it is not possible to use this indicator for our home. Had we created a custom indicator, then we would have a current performance of 95%. After consulting with our Resident and Family Councils the Councils did not approve HQO scale response. However, we did include the HQO questions because it informs the care we provide to the residents.

Safety | Safe | Priority Indicator

	Last Year		This Year	
Indicator #2 Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment (Faith Manor Nursing Home)	**10.19** **Performance (2023/24)**	**9.50** **Target (2023/24)**	**10.83** **Performance (2024/25)**	**9** **Target (2024/25)**

Report Accessed: March 28, 2024

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

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.

Comment

Collaboration with the Neurobehavioural team for appropriate prescribing of antipsychotic medications and behavioral management resulted in residents with dementia not being transferred to hospital for further assessment regarding personal expressions. We also saw an increase in residents or SDM requests to be sent to transferred to hospital hence increasing the number of transfers. No non-compliance for medical services.

Safety | Effective | Custom Indicator

	Last Year		This Year	
Indicator #1 Percentage of long-term care home residents who fell in the last 30 days (Faith Manor Nursing Home)	**21.10** **Performance (2023/24)**	**18** **Target (2023/24)**	**18.40** **Performance (2024/25)**	**NA** **Target (2024/25)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

To continue to implement the "Preventing Falls and Reducing Injury from Falls" from the Registered Nurses Association of Ontario (RNAO).

Process measure

- % of residents receiving purposeful rounding.

Target for process measure

- 100% of residents will receive purposeful rounding by December 31, 2023

Lessons Learned

100% of residents received purposeful hourly rounding. All staff received orientation and annual training on Purposeful hourly rounding.

Comment

Because Purposeful hourly rounding is provided to all staff during orientation, we have seen an increase in care involvement of staff from all departments. Reporting to nursing staff on the 4Ps (Pain, Possessions, Position, Personal needs) necessitating immediate care delivery

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 20, 2024.**

The following people participated:

#	Name	Position
1.	Tracy Kamino	CEO
2.	Sellinor Ogwu	Administrator
3.	Kamal Sekhon	DRC
4.	Dr. A.S. Thind	Medical Director
5.	Jody Clarke	Director of Programs & Services
6.	Maria Dennis	PSW
7.	Chantelle Barnes	Laundry Aide
8.	Behijie Mulaj	LTC HK & laundry Manager
9.	Barbara Leja-Plaza	Resident Advocate
10.	Amanda Ally	Restorative Nurse
11.	Michael Wells	Director of HR
12.	Prudence Blake	Specialized Program Team Lead
13.	Pastor Bodini	Pastor
14.	Afnan El-Bogi	Dietary Manager
15.	Magna Fordjour	BSO
16.	Marlene Ragbir	Activation Staff
17.	Ilona Cuerdo	RPN
18.	Judy Kirby	CQI & Risk mitigation Specialist
19.	Romayne Manners	IPAC Lead
20.	Tanushca Lala	Registered Dietician
21.	Case Geleynse	Board Member
22.	Glenda McKay	Volunteer Coordinator
23.	Omer Rodgers	Maintenance Manager

24.	Sujitha Jayakumar	HR/ Education Coordinator
25.	Timen Jensen	Resident Council President
26.	Ahmed Tifora	Dietary
27.	Relinda PeBenio	RN
28.	Helen Carleiro	Housekeeping staff
29.	Pranav Amin	Pharmacy
30.	Ingrid Malmburg	Emergency Management
31.	Donna Wood	Board of Directors
32.	Venus Bayani-Dimayaga	Dietary Supervisor

RESIDENT SATISFACTION AND FAMILY EXPERIENCE 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. Family Manor conducted the Family Experience Survey and the 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.

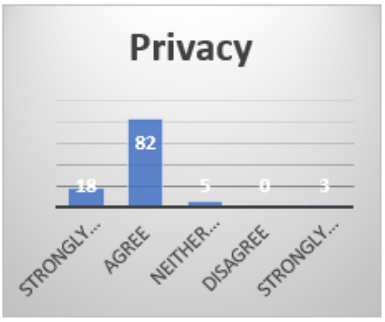
DATE OF REVIEW OF SURVEY RESULTS BY FAMILY & RESIDENT COUNCIL:

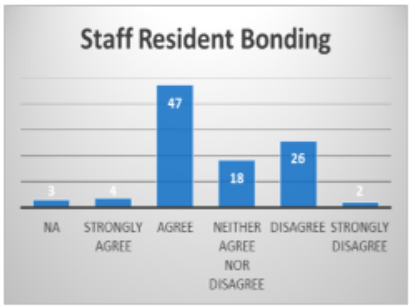
Family Council: February 21, 2024

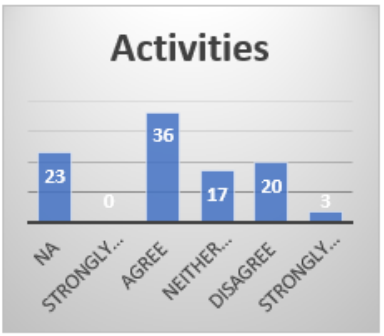
Resident Council: March 22, 2024

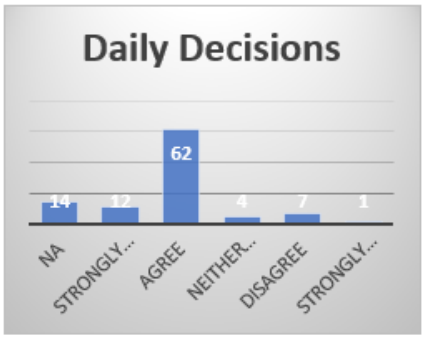
HOW ARE WE DOING AT FAITH MANOR

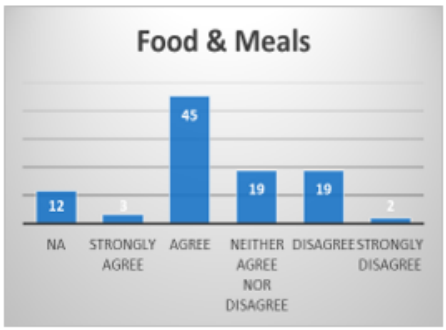
Resident Satisfaction

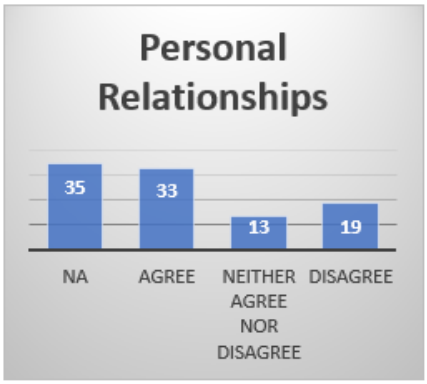


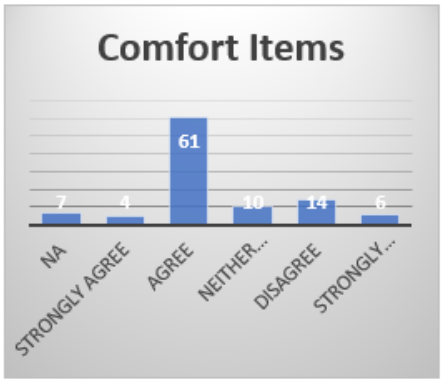


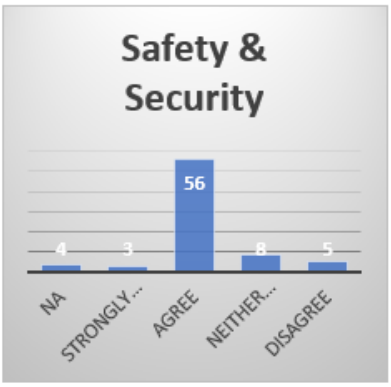


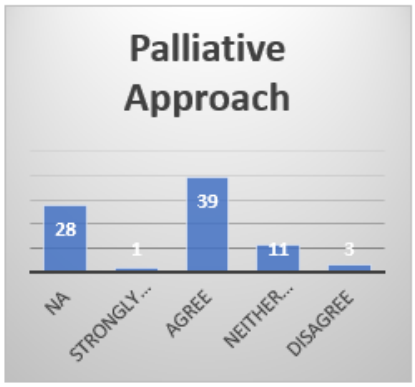








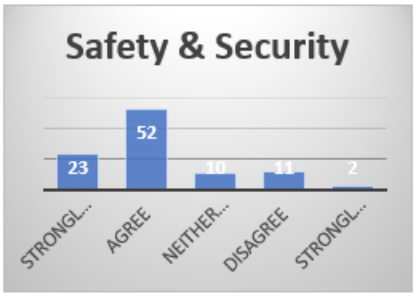


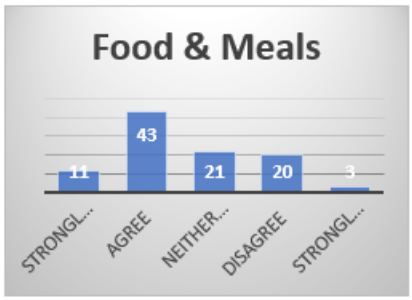


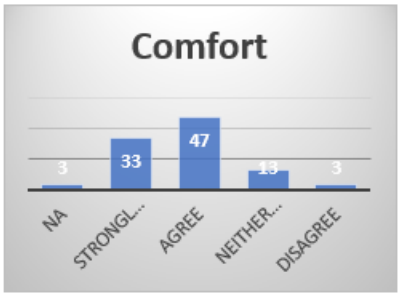
HQO Questions	Agree	Maybe	Disagree
I Feel supported, heard, and understood by the staff	50%	44%	6%
I can express my opinions without fear of Consequences	65 %	30 %	5 %
I would Recommend This Home	89 %	11 %	0 %

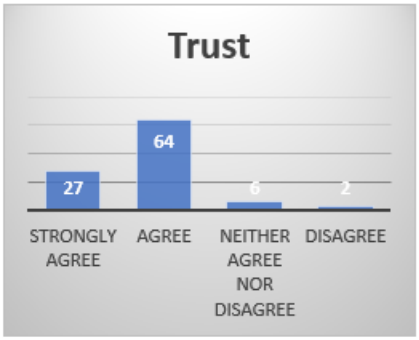
HOW ARE WE DOING AT FAITH MANOR

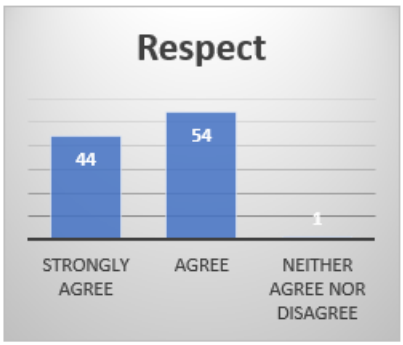
Family Experience

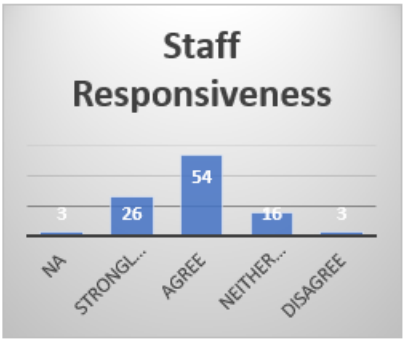


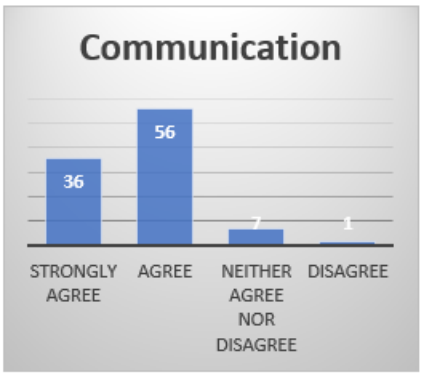


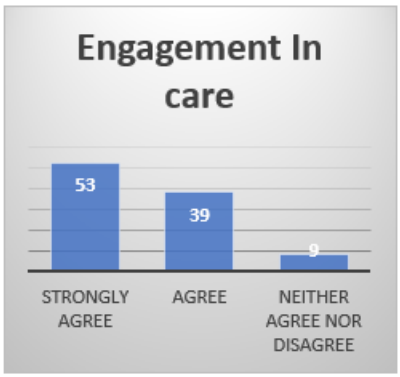


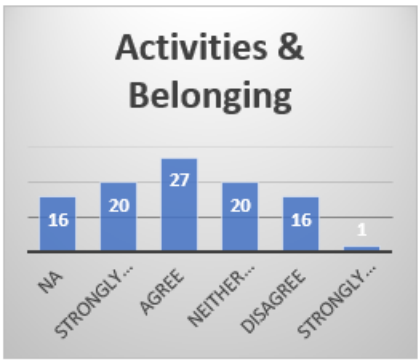


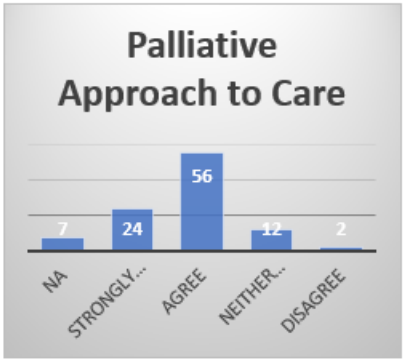












Faith Manor

2023 Resident Satisfaction Survey

2023 Family Experience Survey

Action Plan

Areas to Improve	Action Plan (to be carried out in 2024)	Person Responsible	Date Completed
Personal Care and Services • **Privacy** • **Resident Bonding**	• Educate families and resident on staff ratios during family and resident council • Working with HR to hire new staff (Especially the Registered Staff) to reduce the agency use	DRC/ADRC DRC/ADRC	April 30,2024 May 16,2024

• **Respect** • **Daily decisions** • **Personal relationships** • **Comfort** • **Staff Responsiveness** • **Trust** • **Communication** • **Visiting Experience**	• Reimplement Legacy program for residents. • Train staff on Customer service and Person-Centered Care. • Re-train staff on Handover Shift report and responsibilities • Add "All About Me" Section into Resident Care Plan	Resident Advocate Education Coordinator Home Area Leads In Collaboration with Activation	
• **Programs/Activities** • **Spiritual Care** • **Participation**	• Enhance programs for the monthly theme for men's group programs i.e. Superbowl, Stanley cup which are targeted for the men-use our male staff to implement this. • Team up with Food services on fresh fruit Fridays/seasonal events • Revisiting intergenerational groups • Revisiting kids' corner play with program/ environment subcommittee • Provide education/resources to residents, staff & families with new spiritual care coordinator- bring awareness to the program and all services currently in place, programs that will be added to enhance the overall delivery • To review current outing program; look at ways to increase residents' opportunities to have a change of environment: I.e. walk off the floor	Director of Programs/rec team, dietary, pastoral team	April 2024 June 2024 – ongoing May to June 2024 May 2024- edition Tie that Binds; Information at Resident council on the new hire of this position March 2024; note on

	through the complex, outside in the courtyard (during seasonal times), walk to plaza, walk to the Tulip restaurant for a coffee tea social; plan for larger outings per ¼ (within budget of department and residents). Plan to have volunteer and student support during peak times. • Enhancing the resident spot light (Old legacy) program, to be person centered quarterly		dashboard on PCC April 2024; invite to June family council mtg 2024-ongoing introductions to front line staff, manager meetings April to present 2024
Meal Service • **Snacks** • **Dietitian**	• Re-educate family members during family council meetings on show plates • Review 3-week cycle menu and snacks to family members during family council meetings • Re-educate dietary staff and other registered staff on tray meal service plating to ensure that it is requested upon completing the dining room residents first and that is the food is only plated upon service to ensure accurate food temperature. • Review show plates selection with residents during food committee meeting • Review 3-week cycle menu and snacks with residents during food committee meeting • Implement opportunities for residents to assist pre and post meal set up by May 15, 2024.	Dietary manager, Food Service Supervisor, Registered Dietitian	May 3,2024

Accommodation • **Housekeeping** • **Laundry**	• Increase public washrooms audits in order to ensure constant cleanliness due to residents accidents	Housekeeping/Nursing staff	April 30,2024 Ongoing
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. RA/PM, DRC, ADRC	Resident Advocate DRC; Team Members	
Volunteer	• Enhance volunteer recruitment efforts to increase volunteer base and support resident group activities. (porter to bingo, hymn sing)	Volunteer coordinator, RA/PM, Director Program Services	
Environmental, Safe and Secure Maintenance	• Support resident safe outdoor outings in the summer months with the involvement of summer students	Activation/Nursing	