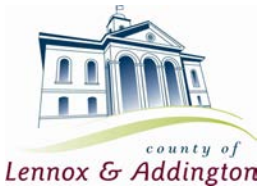
Quality Improvement Plan (QIP)

Narrative for Health Care Organizations in Ontario

March 31, 2023



OVERVIEW

The John M. Parrott Centre (JMPC) is a municipal, not-for-profit, rural long-term care home owned and operated by the County of Lennox & Addington in Napanee, Ontario. We are accredited through CARF accreditation body. JMPC is home to 167 residents. We also have one respite bed. The John M. Parrott Centre operates under the direction of the Director and is regulated by the Ministry of Long-Term Care under the Fixing Long-Term Care Act. The Director reports to the Chief Administrative Officer and to Lennox & Addington County Council.

Our management team and medical team provides guidance and leadership to all other staff of the multidisciplinary team in providing person-centered care and a variety of services to our residents.

The Medical Director has developed an excellent relationship with nurse practitioner colleagues who are an instrumental part of the clinical care team at the home. The Medical Director has the majority of the residents at JMPC and has worked with residents, caregivers, the management team and community partners on many fronts including growing our in-house procedural competency and continuing to incorporate evidence-based medical practice.

Our Mission: The John M. Parrott Centre is an inclusive long term care Home, where residents will be cared for with dignity, respect, empathy and safety; provided by knowledgeable staff, in a home-like environment, while respecting the identity of residents and their quality of life.

Strategic Directions: HHR recruitment and retention; Staff Mental Health and Wellness;

Values: We strive to be CLEAR - Compassion, Leadership, Equality, Accountability and Respect

The John M. Parrott Centre has put forward and commits to quality

initiatives this year that support OHT/Ministry of Health priorities, and are based on feedback from our residents, essential caregivers, families, community partners and staff, and that are in keeping with our strategic directions.
A Senior Friendly lens is applied to services provided at The John M. Parrott Centre. Recognizing the difficulty of our residents to attend appointments outside the Home we look whenever possible to have service provided on site. The physician regularly makes use of e-consult.

REFLECTIONS SINCE YOUR LAST QIP SUBMISSION

In May 2022, we needed to replace the dining and lounge area flooring of our Specialized Care Home area. Residents in this Home area responded so well to being out of this secure area and responded so positively to the freedom of space. We took this to another level and opened the doors to our specialized home area for a few hours twice a day.
Again, positive results were demonstrated. The successes were seen in reduced falls, reduced behaviours and physical aggression, improved sleep and rest along with some incredible social engagements. This continues today, with the doors open for 2 hours in the am and pm. In response to national and provincial efforts to focus on appropriate use of antipsychotic medications the John M. Parrott Centre has been very successful in reducing inappropriate antipsychotic use through a multidisciplinary and collaborative approach involving pharmacy, BSO nurse, the nursing team and geriatric psychiatry to follow an evidence-based approach to antipsychotic prescribing/deprescribing. We worked collaboratively to regularly assess the indication as well as the risk/benefit profile of all residents on antipsychotics. Whenever possible we utilize non-pharmaceutical interventions in place of medications.
For antipsychotics taken without a diagnosis of psychosis we currently sit at 15.7% which is below the Provincial benchmark of 21.2% according to Health Quality Ontario. This psychotropic drug usage achievement has been a collective focus of our physicians, nursing and pharmacy staff throughout the year.
Through active engagement with our monthly collaborative team meetings (with representation from BSO, Geriatric Psychiatry, physician, nursing staff and pharmacy) we have been actively driving this initiative through supportive education to staff and families as well as ensuring and/or acquiring a robust understanding of the clinical meanings behind the behaviour being treated. The building of this knowledge capacity has been supported by the development of a monthly BSO Newsletter that is distributed to staff electronically. In addition, we have utilized a Family Newsletter as frequently as weekly to its current frequency of every two weeks that has also been an excellent platform to provide timely and informative information/education to families and friends of JMPC.
The BSO Nurse provides coaching on approaches, strategies and techniques for preventing and responding to responsive behaviours and de-escalation techniques. Throughout the past 3 years we have had a high volume of staff go through the Dementia Journey program.
Through the pandemic we engaged in some incredible virtual platforms. We were successful in being awarded a grant through New Horizons for Seniors and have rolled out a virtual reality program that we utilize throughout the Home. Our use of zoom during the pandemic provided a powerful connection for residents with their family and friends. We still have some families who utilize this virtual visiting option today.

We have integrated a platform into our PCC system through JUBO Health that pulls the vital sign readings directly into the EHR. (This includes, blood pressure, oximetry, temperature, glucometer, heartrate.

PATIENT/CLIENT/RESIDENT ENGAGEMENT AND PARTNERING

Our Resident and Family Survey is conducted annually in the fall to receive feedback to inform our QIP. We use the results to look at areas for improvement as well as identifying areas where we are doing well. For the past six years, we have conducted the survey via Survey Monkey in collaboration with 6 other other area long term care homes. At our Home, in 2022, we had a total of 101 responses. This included 63 responses from POA's/families and 38 from residents (100% of residents with a CPS of less than 3). We were very pleased to see our results from POA/Families increase by almost 50% from the previous year. Our target is to have the combined responses of good/very good above 80%. Our greatest growth in satisfaction came from our dietary related questions inclusive of variety, quality and quantity of foods and nourishments which we were thrilled to see. In fact, we were very pleased this year to have only one indicator below 80%. The indicator that we are focused on improving is in the satisfaction of our physiotherapy services provided in the Home. While this indicator did track 20% higher than the previous year, it is still sitting at 71% satisfaction.
We have completed our annual program evaluations incorporating input from Resident and Family Council as well as a variety of front line staff through various methods inclusive of surveys, 1:1 discussion, debriefing of exercises, interdepartmental committees and departmental team meetings.
Both Resident and Family Council have actively participated in the development and revision of our palliative/end of life policies, Abuse policy, admission process, brochure development for end of life, and COVID visiting policy. The Director worked closely in 2020, 2021 with the Family Council President. The President took a lead role in facilitating communication with families and then sharing with the Director FAQ's so that the Director could answer these for all families in our weekly family newsletter. This streamline of communication was very effective in supporting all persons (staff included) to feel confident, supported, and informed of what was occurring in the Home.
We utilize our two councils to get input on educational opportunities that residents / families feel would be beneficial for staff to receive. We also gain input from Family Council on opportunities for education that they would like. In 2022, we facilitated two GPA sessions with a total of 22 family members. Again in 2023 we plan to host another two of these sessions.
In 2022, we welcomed a resident and a Family Council representative onto our Quality Improvement Team. This has been a productive and informative addition to the discussions that take place during this meeting. One of the items that came forward late in 2022 was the need to declutter some of the residents clothing closets (especially for clothes that no longer fit the resident). A paperbag system of quality improvement will be initiated in April 2023 to improve this issue.

PROVIDER EXPERIENCE

In 2019, the County of Lennox & Addington rolled out a Peer Support Program that extends across all of the County services. A full suite of training was provided (and is ongoing) to the members of this team. JMPC has 4 members on this team. Any County staff member can reach out at any time to ANY member of this team.

They are there as a listening ear or to help to connect the individual with resources, brainstorm etc.
In late 2020, a group of staff volunteered to form what is now called the Spirit Squad. This group has provided a wide variety of fun activities that give levity, laughter and enjoyment to many staff members. These events range from crossword puzzles, colouring, food events, theme days, team games etc. They have been positively received and very appreciated by staff. Some of the events are combined with resident events which enhances the sense of community and pride.
Early in COVID, the County redeployed our museum and library staff to work at JMPC. This was a fantastic way for us to learn about the work of these two departments but also for them to learn about our work at JMPC. The variety of activities that they introduced us to was very interesting and inspiring. There support was incredibly appreciated by the JMPC team and helped us to not experience the extreme staffing crisis that we have heard was the case in other LTC Homes. We also rolled out Resident Support Aides by May of 2020 as this was a position we had planned to introduce prior to COVID. This also helped set us up for an incredibly different and positive experience compared to other LTC Homes.
The County has provided Mental Health First Aid training to 6 of our staff at JMPC and also coaching, mentoring and leadership training to the Leadership team.
The Director provided daily email updates to all staff to help ensure a consistent sharing of information that was timely and clear. This provided comfort to staff and ensured they were informed to the best extent possible.
The County's EAP program is regularly discussed at attendance meetings, investigations or in general conversations with staff so that everyone is well aware of this opportunity that is available for staff to access.
In April of 2023 we are embarking on the Your Health Space program offered by the Ministry that is in line with our Strategic Priorities to focus on our staffs mental health and wellness.

WORKPLACE VIOLENCE PREVENTION

The pandemic has had a significant impact on people across the world. The stress it has caused for people have been immense. For those of us in healthcare, who have worked through this pandemic, there is no doubt we have been impacted. At JMPC, we recognized the critical need in developing support systems both internally and externally for our staff. In June 2021, 1o staff were trained in Working Minds program which the participants found to be insightful and empowering. We also engaged our staff in Ontario's CLRI Workplace Mental Health in LTC Training. Our leadership team received training in Oct 2021 on Workplace Incivility, Bill 132 Preventing Sexual Violence and Harassment, Bill 168 Respectful Workplace and accessibility training. Additionally we had 6 front line staff engage in 2 /6 modules entitled Building Resiliency and Mental Health Training". Unfortunately, COVID impacted this education and the remaining 4 modules have not yet resumed.
We have had 55 staff go through the Living the Dementia Journey 1 day workshop which has served as a review and reminder of the reason for behaviors and the potential interventions that would be useful to try.
We conduct an annual Workplace violence survey of the staff which allows us to target our education and support.
We have shared with staff our ability to create personalized Safety Plans for staff who require this should they feel this is something that would be important for them to feel safe while at work.
In 2022, we added Bathroom emergency call bell feature to ensure staff could very quickly communicate that they needed assistance.
At the recommendation of staff, we now schedule two staff on nights in our specialized care home area.

PATIENT SAFETY

We have a healthy dialogue with Registered staff following near misses or medication errors. Consideration is given to the workflow of the error and if any of our existing procedures are contributing to these errors. Staff are provided an opportunity to reflect on strategies to mitigate future same/similar errors. We provide education back to all Reg staff where appropriate as it relates to med errors and any learnings that have come from them as a result. This non-disciplinary approach has served the Home well and staff are very comfortable in reporting these errors as they are confident it will lead to productive discussion and improved processes overall.
We have routinely offered a peer med review opportunity which staff have found supportive to their clinical practice. We have provided and continue to provide education to our staff, families and residents of the importance of reducing distractions for the nurse when she is at the medication cart. We do not put phone calls through to the nurse during medication pass times in an effort to reduce interruptions as well. We utilize a 5 S approach to the set up of all 6 med carts so that it is easy for part time registered staff who access a variety of med carts depending on the shift they are working. The medication rooms and medication carts all have a consistent layout and placement of items. This not only increases efficiency but also workflow.

We have weekly and monthly RAP and Collaborative meetings. At these meetings there is rich discussion as to residents lived experiences and how best we can support them in their journey now that they are at JMPC. It is at these meetings that many non-pharmacological interventions are presented and were discovered to be effective but perhaps not widely known by the rest of the team. By having these multidisciplinary discussions these effective practices can be clearly documented/careplanned for all to utilize.

We open the doors of our specialized Home area for two hours every morning and two hours every afternoon. We have been doing this for a year come May 2023 with incredibly positive results. Since doing this, we have seen our falls statistics dramatically decline; Responsive behaviours have declined and in conjunction with that a decline in the use of PRN/routine medications to manage some of these responsive behaviours. Residents are sleeping better at night and there are less physical altercations. When this Home area goes into an outbreak and we are unable to open the doors for those 4 hours per day, we quickly see an escalation in falls, responsive behaviours and physical altercations.

HEALTH EQUITY

Upon reflection in March of 2022 when we were reviewing/updating our mission, vision, and values the team felt it was very important to ensure we articulated the value we placed on inclusivity, respect and identity of residents and staff alike. As a result this was made clearer in the March 2022 version of our Mission Statement. We celebrate Pride Day, Christian holidays (ie Christmas, Easter, Shrove Tuesday etc), and support Indigenous cultural ceremonies.

In addition, we embarked in 2023 on a culturally themed month whereby the activation department share video tours, culturally themed foods, and focused programming for the residents. So far this year residents have learned about Ireland, Italy, Holland and Up next is Cinco de May.

We have just recently begun the program of SPEP (Supervised Practice Experienced Partnership) that supports Internationally Educated Registered staff to work in Ontario LTC Homes. To date, we have not had any successful candidates but are hopeful that we will receive one soon.

On March 8 2023, we introduced a first draft of our policy statement and framework which will provide us with a roadmap to achieving growth in our Diversity, Equity and Inclusion (DEI) awareness and practices. We have requested staff feedback by mid April and look forward to developing further this important guide and actively participating in this meaningful work.

CONTACT INFORMATION/DESIGNATED LEAD

Bobbie Joe Blackburn - QI Lead
Angela Malcolm - Director

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 31, 2023**

Brenda Orchard
Signed with ConsignO Cloud (2023/04/03)
Verify with verifio.com or Adobe Reader.

Brenda Orchard, Board Chair / Licensee or delegate

Angela Malcolm
Signed with ConsignO Cloud (2023/04/03)
Verify with verifio.com or Adobe Reader.

Angela Malcolm, Administrator /Executive Director

Bobbie-Joe Blackburn
Signed with ConsignO Cloud (2023/04/03)
Verify with verifio.com or Adobe Reader.

Bobbie Joe Blackburn, Quality Committee Chair or delegate

Other leadership as appropriate

Theme I: Timely and Efficient Transitions

Measure

Dimension: Efficient

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Number of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents.	P	Rate per 100 residents / LTC home residents	CIHI CCRS, CIHI NACRS / Oct 2021 - Sep 2022	10.82	8.00	We currently sit well below the provincial target for this indicator.	

Change Ideas

Change Idea #1 Post for a full time nurse practitioner.

Methods	Process measures	Target for process measure	Comments
Advertise on our website, social media platforms.	Are we able to recruit?	Nurse Practitioner commences full time employment by June 1 2023.	This position was posted in Nov 2022 with zero candidates applying. County Council added dollars (in their 2023 budget deliberations) to the existing Ministry allotment in hopes of a positive outcome.

Change Idea #2 Build knowledge and skill capacity of the Registered staff team for IV starts.

Methods	Process measures	Target for process measure	Comments
Purchase a practice arm; Obtain equipment necessary; engage a NP to facilitate a training program; schedule training;	Number of existing RN's and RPN's who are currently comfortable (prior to training) with IV starts. Number of RN's who received training. Number of RPN's who received training. Number of times in the first 6 months of 2023 that IV infusion occurs in house. Number of times in the second 6 months of 2023 that IV infusion occurs in house. Satisfaction of Registered staff who received training that states they have a greater than 75% comfort level on this new skill.	60% of RN's and RPN's receive training on starting an IV. Provision of this skill in house at least 5 times in first 6 months of 2023. Provision of this skill in house at least 10 times in the second 6 months of 2023.	

Theme II: Service Excellence

Measure

Dimension: Patient-centred

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of residents responding positively to: "What number would you use to rate how well the staff listen to you?"	P	% / LTC home residents	In house data, NHCAHPS survey / Apr 2022 - Mar 2023	10.81	92.00	We scored between 89-92% on this indicator through our annual resident satisfaction survey therefore will not be working on this measure.	

Change Ideas

Change Idea #1 Through our resident satisfaction survey we ask 3 questions that help to inform this indicator.

Methods	Process measures	Target for process measure	Comments
Question in our resident satisfaction survey "Nursing staff actively listen to me" (89%) Question in our resident satisfaction survey "I'm always asked if I want to participate in Home activities" (87%) Question in our resident satisfaction survey "All staff care about any issues I may convey, I feel listened to" (92%) Family Satisfaction Survey question "Staff actively listen to me. Listen and acknowledge what I'm saying" (94%) Review of suggestions brought forward in Dining Council vs what was implemented throughout 2023. Review of suggestions brought forward at Resident Council and Family Council vs what was implemented throughout 2023.	Have all Resident and Family Satisfaction results in these identified questions score no lower than 90%. Dining Council and Resident Council suggestions will be incorporated 75% of the time. Family Council suggestions will be incorporated at least 50% of the time.	90% or above score for resident and family satisfaction survey on identified questions outlined in the method. 75% Dining and Resident Council suggestions will be incorporated as requested. Family Council suggestions will be incorporated at least 50% of the time.	Total Surveys Initiated: 37 Total LTCH Beds: 168 Currently (2022 Satisfaction survey results) have the following questions from our satisfaction survey scoring below 90%: Nursing actively listen to me:89% I'm always asked if I want to participate in Home Activities: 87%

Measure

Dimension: Patient-centred

Indicator #3	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".	P	% / LTC home residents	In house data, interRAI survey / Apr 2022 - Mar 2023	CB	97.00	We have scored 97% in this area and will therefore not be working on this indicator.	

Change Ideas

Change Idea #1 Questions in our annual Resident and Family Satisfaction Survey

Methods	Process measures	Target for process measure	Comments
Annual survey completed with residents by our local high school students completing their placement with us to help ensure a reduced bias or discomfort for the person being supported in completing the survey. Number of organized training sessions to residents by the BSO nurse to support a sense of community and empowerment when engaging with a resident peer who is experiencing responsive behaviours. Number of Essential Caregivers/General Visitors receiving an organized training session to build knowledge and capacity to support those who struggle to interact with an individual experiencing responsive behaviours.	Specific questions that relate to this indicator: Resident Survey: I can express my opinion without fear of consequence. (97%) I feel safe and secure with staff. (97%) I feel safe and secure with residents. (89%) I feel safe and secure in the Home environment. (97%) Family Satisfaction Survey question: I am comfortable approaching staff with my concerns. (92%)	Maintain a score of 90% or greater for all of these identified questions. Train at least 20 Essential Caregivers/General Visitors in GPA. Provide at lest 3 thirty min training sessions for residents via the resident council format.	

Measure

Dimension: Patient-centred

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Improve worsened pain indicator (per CIHI) which currently exceeds the provincial average by 8%.	C	% / Residents	CIHI CCRS, CIHI NACRS / Oct 2022 - Oct 2023	16.50	8.00	We are currently exceeding the provincial benchmark in CIHI for this indicator.	

Change Ideas

Change Idea #1 Utilize continuous infusions for a more stable control of pain.

Methods	Process measures	Target for process measure	Comments
For those experiencing worsened pain, will actively consider continuous infusion route at least 60% of the time.	Identify each month who is experiencing worsened pain. Identify how many of those individuals have a documented progress note related to the consideration of continuous infusion.	60% of those identified with worsened pain will have a progress note confirming the consideration of continuous infusion as a route for the pain medication.	

Change Idea #2 Pain and Palliative Lead will audit those who are experiencing worsened pain scores.

Methods	Process measures	Target for process measure	Comments
Pain scores sent out monthly to Reg staff, pharmacist, physician, RSC, Dietitian, BSO nurse Quarterly opiod, tylenol and NSAID usage is reviewed at the PAC meeting. Virtual Reality program and other non-pharmacological interventions are identified in the residents care plan for at least 2 types of appropriate interventions.	100% of the residents who are on the pain score list have an analysis of their pain regime by the Pain and Palliative lead RN. Every resident identified on the pain list has at least 2 non-pharm interventions listed to reduce the pain.	100% of the residents on the pain score list will have an analysis of their pain regime by the lead RN every month from April 2022 - Dec 2022. Everu resident will have at least 2 non -pharm interventions listed in their care plan related to their pain by June 2023 and ongoing.	

Theme III: Safe and Effective Care

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	P	% / LTC home residents	CIHI CCRS / Jul - Sept 2022	16.09	14.00	We are below the provincial benchmark in this area by 6.4%. We will continue to monitor.	

Change Ideas

Change Idea #1 Deprescribing rounds led by our BSO Nurse that occur monthly.

Methods	Process measures	Target for process measure	Comments
Meet monthly with a collaborative team of clinical staff, physician, pharmacist and geriatric psychiatry to identify opportunities to deprescribe.	Continue to stay below the provincial average of antipsychotic use without a diagnosis. BSO nurse will review every antipsychotic to ensure a diagnosis is attached to the order.	Stay under 20% based on CIHI data of residents receiving an antipsychotic without a diagnosis. 95% of antipsychotics ordered will have a diagnosis attached to the order by June of 2023 and this will be maintained throughout 2023.	We currently sit at 15.1% as per CIHI's most recent data (July-Oct 2022)

Equity

Measure

Dimension: Equitable

Indicator #6	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Diversity, Equity and Inclusion training will be provided to all staff and to Resident Council by November 1 2023.	C	% / LTC home residents	In-home audit / April 2023 - December 2023	0.00	100.00	All staff will require this training. We will start with residents council and build from there.	

Change Ideas

Change Idea #1 Share first draft of Diversity, Equity and Inclusion framework to obtain feedback from staff.

Methods	Process measures	Target for process measure	Comments
Provide draft copies of policy. Provide definitions and initial knowledge around the topic. Meet with a multidisciplinary team as to how to incorporate this into our daily lived experiences.	Obtain feedback from 30% of the staff by April 15 2023. Incorporate language into departmental meetings as well as committees. Annual staff survey in November 2023 will include at least one DEI question.	Feedback from 30% JMPC staff to Human Resources by April 15 2023. Discussed at departmental and committee meetings to assist with the knowledge spread each time they meet until July 2023 then as needed.	