# Continuous Quality Improvement –Year End Report 2022/23

## DESIGNATED LEAD

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The Deep River & District Hospital, the North Renfrew Family Health Team, and the Four Seasons Lodge Long-Term Care Home, identifies as strategic priorities for the organization, a commitment to quality improvement, safety, and person (resident, patient and client) and family centered care. These concepts are identified as foundational supports to ensure strategic goals are achieved and as guiding principles for the organization.

Our ongoing commitment to quality is reflected in our mission, vision and values as well as in our strategic plan, which identifies both *People: continuing to provide excellent, compassionate services* and *Seniors: we will seek opportunities to support our aging population as it grows over the coming years* as two of the organizations four key strategic pillars.

The 2023/2024 Quality Improvement Plan (QIP) supports the ongoing integration of services across all sectors, as well as engagement in promoting quality of services overall. Items addressed in the QIP have been identified based on risk assessment, legislative compliance, patient and resident feedback, collaborative quality improvement initiatives with OHT partners and anticipated future needs.

## ORGANZIATIONAL CONTINUOUS QUALITY IMPROVEMENT

The organization has *Quality Improvement Plan* and *Quality, Risk and Safety Framework* policies in place which outline a comprehensive, coordinated, facility-wide program for monitoring, evaluating and improving the quality of care, services, programs, accommodation and goods provided to patients, residents and clients.

An annual Organizational Quality Improvement Plan, inclusive of all departments and areas of the organization is developed and includes:

1. Strategic Areas of Improvement
2. Specific Topics for Improvement
3. Outcome and baseline measures used to determine progress of improvement activities
4. Goal for each improvement activity, along with timeframes for achievement / completion
5. Attribute of Quality the project relates to

6. Provincial mandatory or priority indicators as identified and appropriate

The Organizational Quality Improvement Plan (QIP) is updated at least quarterly. Reports are provided to the Resident and Family Council, Long-Term Care Continuous Quality Improvement Committee, Patient and Family Advisory Committee as well as the Quality, Risk and Safety Committee of the Board quarterly.

Mechanisms used by the organization to identify, monitor, report and improve quality, risk and safety included:

- Patient Safety Plan
  - To ensure that there are effective internal safety processes and initiatives in place to address both patient, resident and staff safety concerns

- Risk Management: Identification and Mitigation
  - To ensure a systematic process is in place for risk identification, assessment and mitigation throughout all of its operations
  - Regulatory compliance is addressed within the risk management framework
  - Investigations and incident reviews follow an established procedure and support a Just Culture, allowing for a thorough systems analysis

- Quality Management and Improvement
  - To ensure that clinical/operational practices and procedures are based on, and benchmarked against, best practice guidelines
  - Departmental dashboards provide an overview of quality performance in each operational area and highlight areas for improvement
  - The annual Quality Improvement Plan provides guidance and metrics to monitor strategic initiatives
  - Supports work/life balance strategies that address staff engagement, safety, retention, and recruitment

- Communication, Reporting and Education
  - Fostering a Just Culture that is supportive of individuals who report and will ensure that such reports lead to a constructive response
  - A standardized reporting system for all events and near misses will facilitate timely communication and learning
  - Transparency is ensured through proactive communication and education to all stakeholders on procedures to follow during adverse events which include full disclosure of harm.
  - Quality, risk and safety information will be communicated to the Board, staff, and the public on a regular basis

A system to monitor the quality of service delivery and program outputs is maintained throughout the organization, consisting of:

- Corporate and Departmental Dashboards
  - Quality indicator and outcome measure monitoring is maintained through dashboards to ensure reliable information and evidence is available for decision-making and trigger analysis and action when outputs are identified outside of thresholds.
  - Indicators and thresholds tracked on dashboards are identified and linked as deliverables under the strategic pillars. Thresholds and targets are determined via internal or external benchmarking, or to indicate completion of action items.
  - Dashboards are reported and reviewed through appropriate organizational and governance committee structure. Departmental dashboards are displayed publically on

departmental quality boards and the Corporate Scorecard on the organizational quality board.

- Resident Satisfaction Survey
  - Annually a survey to measure the satisfaction of Residents and Family is completed in long-term care, in accordance with the *Fixing Long-Term Care Act, 2021 (FLTCA 2021)*. Survey development and results are shared with the Residents' and Family Council, as well as with leadership and governance.
  - The 2022 Annual Resident Satisfaction Survey was conducted throughout September and October 2022. The total response rate for 2022 survey was 82%, with 100% of respondents requiring some assistance to complete the survey. Based on resident feedback of the survey design, the 2022 survey was updated with a visual satisfaction scale using a modified faces scale with good reception by respondents. Overall satisfaction across all areas of the survey was measured at 70%, an increase of 1% from the previous year's survey. The following table demonstrates year over year satisfaction results by category, with satisfaction measured as positive response rating:

| Category | 2022 | 2021 | Difference |
|---|---|---|---|
| Privacy | 83% | 89% | ↓ 6% |
| Food and Meals | 80% | 62% | ↑ 18% |
| Safety and Security | 74% | 100% | ↓ 26% |
| Comfort | 66% | 81% | ↓ 15% |
| Daily Decisions | 70% | 60% | ↑ 10% |
| Respect by Staff | 91% | 89% | ↑ 2% |
| Staff Responsiveness | 93% | 80% | ↑ 13% |
| Staff-Resident Bonding | 54% | 74% | ↓ 20% |
| Activities | 55% | 43% | ↑ 12% |
| Personal Relationships | 29% | 14% | ↑ 15% |

  - Survey highlights and analysis are below:
    - "Staff Responsiveness" scored highest at 93% satisfaction, followed closely behind by "Respect by Staff" being the second highest scoring category with 91% satisfaction.
    - In comparison to the previous year's data, "Food and Meals" saw an increase in satisfaction by 18%, along with the category of "Personal Relationships", which although still continues to remain the lowest overall category, satisfaction increased by 15%.
    - There was a notable decrease in the categories of "Safety and Security" decreasing by 26% as well as "Staff and Resident Bonding," decreasing by 20% satisfaction from the previous year.

  - The 2022 Satisfaction Survey results were reported to the Resident and Family members at the October 20th, 2023, Residents and Family Council meeting where recommendations based upon the results were discussed. The report was also shared with staff members at the Four Seasons Lodge Departmental Meeting on October 18th, 2023, the LTC Continuous Quality Committee on November 15th, 2023, and with the Patient and Family Advisory Committee January 16th, 2023.
  - In response to resident feedback on the 2022 survey results, key resident satisfaction measures were included on the 2023/24 QIP, including the percentage of residents responding positively to "What number would you use to rate how well the staff listen to you?" and the percentage of residents who responded positively to the statement "I can express my opinion without fear of consequences".

- Annual Program Evaluations
    - Annual program evaluations are completed for all identified programs under the *FLTCA 2021* and any others as identified by the organization to evaluate services, identify goals for improvement and measure compliance to legislation.
    - Evaluation of related Long-Term Care Inspection Protocols will take place in coordination with annual evaluations to ensure quality services are being provided according to the *FLTCA 2021.*

- Program and Service Evaluation
    - Program and Service Evaluations are completed to support efficient use of organizational resources and effective delivery of programs and services to clients, patients and residents.
    - A Program and Service Evaluation is completed prior to implementation of new programs or services, periodically when there is a change in service or program delivery, and at least once every two years upon the completion of a program or service or as determined by the program manager. Program and Service Evaluations may be initiated outside of predefined timeframes by the manager or executive lead of any program or service.
    - Program development and delivery is based on assessed need, including but not limited to:
        - Population demographics, target population
        - Stakeholder surveys/interviews/focus group – perceived need and value
        - Legislative / legal prescience

The Executive Leadership Team reviews all program evaluations for alignment to strategic objectives, organizational priorities and program deliverables.

Stakeholder involvement and input is included throughout the quality monitoring and evaluation process and includes input from patients, residents, clients, staff and clinical providers.

Stakeholder input is included when developing goals, conducting needs assessments, program development, monitoring and evaluation of services. The organization continues to have an active Patient and Family Advisory Council and Resident and Family Council that participates in review and development of policies and procedures

**PRIORITY AREAS FOR QUALITY IMPROVEMENT FOR 2023/2024**

As the organization continues its recovery from the COVID-19 pandemic, patients, residents and families have helped identify priority initiatives within the organization as members of the Long-term Care Continuous Quality Improvement Committee, Patient and Family Advisory Council (PFAC) and Resident and Family Council (RAFC).

The priority items for continuous quality improvement in 2023/24 have been identified as below:

1. Promotion of person-centered care and a home-like environment, as measured by resident satisfaction scores in the following two key indicators:
    - Positive response to the question “What number would you use to rate how well the staff listen to you?" on the Home’s annual Resident Satisfaction Survey.
        - In 2022/23 the Home collected baseline data for this indicator through the 2022 Resident Satisfaction Survey.
        - Improvement activities are tracked through the organizations QIP, with outcome measures reported annually posted survey completion. Results

indicated top box scores from all respondents.
    - Positive response to the statement “I can express my opinion without fear of consequence” on the Home’s annual Resident Satisfaction Survey.
        - In 2022 the Home collected baseline data for this indicator through the 2022 Resident Satisfaction Survey. Results indicated a majority of top box responses, however there were respondents with negative satisfaction, flagging this as an area for improvement.
        - Improvement activities are tracked through the organizations QIP, with outcome measures reported annually posted survey completion.
    - Resident Satisfaction Surveys are planned to be provided for residents in July 2023. Results will be evaluated in the fall of 2023 by the Residents and Family Council and Long-Term Care Continuous Quality Improvement Committee.

2. Safety of the workplace, as measured through the number of workplace violence incidents reported by workers:
    - The organization has identified a goal to decrease workplace violence incidents by 10% from previous year by building and improving staff knowledge, skill and confidence to avoid/minimize workplace violence related to dementia. Improvement activities include providing Gentle Persuasive Approach (GPA) education to staff as well as relaunching of the Behavioral Support Ontario (BSO) Program Improvement activities are tracked through the organizations QIP, and outcome measures are reported on a quarterly basis.

**Strategic Plan Refresh**

A refresh of the organization’s current strategic plan, covering 2018-2022, will begin in 2022/23 with the plan to finalize and launch in 2023/24. The strategic plan sets the high level direction of the organization and will set the strategic directions which will collectively focus and steer organizational quality improvement efforts for the coming years.

Through consultation with patients, residents, employees, physicians, the Board of Directors and external partner organizations the strategic plan will drive quality and patient and resident safety through ensuring that the organization’s mission, vision and values are aligned with current provincial and national health care directions as well as the needs of the community.

Activity will occur in 2023/24 to align improvement activities with the refreshed strategic plan and priorities, including adjusted performance reporting, key performance indicators and public reporting of organizational quality performance.