Continuous Quality Improvement – Year End Report 2024/25

DESIGNATED LEAD

Jenny Hickson

Manager of Clinical Services – Director of Care

OVERVIEW

Deep River and District Health recognizes a commitment to quality improvement, safety, and person and family centered care as strategic priorities for the organization. These concepts are identified as foundational supports to ensure strategic goals are achieved and as guiding principles for the organization.

In late 2023, the health campus launched a new strategic plan, which has set the direction for the organization that will guide quality improvement activities and direction of the organization through 2027. The new strategic plan focuses on three key pillars of *People, Growth and Community,* and continues the organizations mission with a clearer purpose to *care for every person like a loved one, within a connected system.* The 2024/25 Quality Improvement Plan (QIP) identified initiatives that support the new strategic direction, identifying actions that support staff, patient and resident safety, improved health equity and access, as well as continued enhancement of the quality of care and services the organization provides. 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 of patient and residents of Deep River and District Health.

The quality improvement activities undertaken by Deep River and District Health in 2024/25 focused on improvements in resident and patient safety, as well as advancing the organization's focus on providing person-centered care and services in long-term care. Initiatives identified for the 2024/25 QIP further serve as a basis for future program planning to support DRDH's focus on providing person-centered care, as well as the strategic pillars of growth and community, and will support activities currently underway to advance two capital development projects. Anticipated to open its doors in 2025, is a new 11,000 square foot Primary Care Building as well as construction of a new 96-bed long-term care home to help meet the growing need for primary care and long-term care in our communities.

ORGANIZATIONAL CONTINUOUS QUALITY IMPROVEMENT

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

Stakeholder involvement in quality improvement is included throughout the quality planning, monitoring and evaluation process and includes input from patients, residents, clients, team members and clinical providers. Stakeholder input is included when developing quality 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's Council that participates in review and development of quality plans, performance monitoring, and program and service monitoring.

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

- Accreditation
    - The organization participates in the Qmentum program under Accreditation Canada, a voluntary process by which organizations are assessed against national best practice standards.
    - In November of 2023, the organization welcomed surveyors from Accreditation Canada which observed all areas of the organization and provided an assessment of DRDH practices against current Canadian best practices. Following this, Deep River and District Health was awarded for the second consecutive occasion the highest level of accredited status possible in Canada, Accreditation with Exemplary Standing.

- Annual Program Evaluations
    - Annual program evaluations are completed for all identified programs under the *Fixing Long-Term Care Act (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 Guidelines takes place in coordination with annual evaluations to ensure the quality of services being provided are in compliance with the *FLTCA 2021*.

- Annual Quality Improvement Plan (QIP)
    - An annual organizational Quality Improvement Plan, inclusive of all departments and areas of the organization is developed on an annual basis and includes:
        - Strategic Areas of Improvement
        - Specific Topics for Improvement
        - Outcome and baseline measures used to determine progress of improvement activities
        - Goal for each improvement activity, along with timeframes for achievement / completion
        - Attribute of Quality the project relates to
        - Provincial mandatory or priority indicators as identified and appropriate

    - Progress on the organizational Quality Improvement Plan (QIP) is updated at least quarterly, with reports provided to the Resident's 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.

- Patient Safety Plan
    - A multi-year plan that identifies long-term strategies and actions to improve safety throughout the organization, with the goal to ensure that there are effective internal safety processes and initiatives in place to address both patient, resident and staff safety.

- Performance Dashboards
    - Quality indicator and outcome measure monitoring is maintained through performance dashboards to ensure reliable information and evidence is available for decision-making and trigger analysis and action when outputs are identified outside of thresholds.
    - Key Performance Indicators and thresholds tracked on dashboards are identified and linked as deliverables under the organization's 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 structures. Departmental dashboards are displayed publically on departmental quality boards and the Corporate Scorecard on the organizational quality board.

- 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 the 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 or identified need for a target population
        - Stakeholder feedback, including surveys, interviews or focus groups
        - Legislative / legal prescience

- The Executive Leadership Team reviews all program evaluations for alignment to strategic objectives, organizational priorities and program deliverables.
- Systemic changes in programming or services, or those that result in a significant change through a program evaluation, will be shared with Resident's Council, as well as within the governance structure of the organization.

- Promotion of a Just Culture - Communication, Reporting and Education
  - Ongoing activities and systems to foster a Just Culture are embedded into operations to support individuals who report and ensure that reports lead to a constructive response. These activities and supports include:
    - Annual education on report requirements, including near misses
    - A standardized reporting system for all events and near misses, which facilitates timely communication and learning
    - A commitment to transparency and the promotion of a culture of learning through proactive communication and education on procedures to follow during adverse events which include full disclosure of harm
  - Quality, risk and safety information, including outcomes of organizational performance, will continue to be communicated to the Board, staff and the public on a regular basis

- Quality Management and Improvement Framework
  - Systems to monitor quality of care and services, and to ensure that clinical and operational practices and procedures are based on and benchmarked against best practice guidelines. This framework includes:
    - Departmental dashboards which provide an overview of quality performance in each operational area and track areas for improvement
    - The annual Quality Improvement Plan which provides guidance and metrics to monitor strategic initiatives

- Resident Satisfaction Survey
  - Annually a survey to measure the satisfaction of Residents is completed in long-term care, in accordance with the Fixing Long-Term Care Act, 2021 (FLTCA 2021). Survey development is done in consultation with Residents and Family Council, and results are shared with the Council, organizational leadership and governance.
  - The 2024 Annual Resident Satisfaction Survey was conducted between July and August 2024 with a 92% response rate from the 12 surveys distributed. Overall satisfaction across all areas was measured at 66%. The following table demonstrates year over year satisfaction results by category, with satisfaction measured as positive response rating:

Category	2022	2023	2024
Privacy	83%	92%	82%
Food and Meals	80%	86%	58%
Safety and Security	74%	83%	94%
Comfort	66%	77%	74%
Daily Decisions	70%	71%	61%
Respect by Staff	91%	95%	77%
Staff Responsiveness	91%	95%	73%
Staff-Resident Bonding	54%	74%	54%
Activities	55%	63%	55%
Personal Relationships	29%	31%	36%

- Survey highlights and analysis are below:
  - The category of “Safety and Security” was the highest scoring category, scoring at 94% satisfaction overall and improvement year over year.
  - The most improved category from 2023 to 2024 was “Personal Relationships,” showing a 5% increase from the previous year and consistent improvement year over year.
  - Based upon the results collected, the categories identified as requiring some improvement are “Staff-Resident bonding” scoring 54% satisfaction, “Activities” scoring 55% satisfaction, and similar to previous years’ data, the category of “Personal Relationships” continues to score relatively low at 36% satisfaction. Food and Meals satisfaction also dropped significantly to 58%.
  - The category with the most significant change was “Food and Meals” satisfaction, which dropped from 86% last year to 58% this year. A closer review of the data is provided below:

B. Food and Meals– Satisfaction:

	Never	Rarely	Sometimes	Most of Time	Always	No Answer/ Unknown
Get favourite foods here			6	2	3	
Can eat when I want	1		3	4	3	
Have enough variety in meals		2	3	2	4	
Enjoy mealtimes			2	2	7	
Food at right temperature	1		5	2	3	

  - Action was initiated based on the continued low “Personal Relationships’ results, the ‘Activities’ scores and the shift in ‘Food and Meals’ satisfaction. A Food and Recreation Committee was initiated in 2024, which is separate from the Resident’s Council providing dedicated time and resources to support discussions and improvements in these key areas of focus.

- The 2024 Resident Satisfaction Survey results were reported to the Resident's Council Members on October 17, 2024, where recommendations based upon the results were discussed. The report will be also shared with the LTC Continuous Quality Improvement Committee on April 28, 2025.
- In response to resident feedback on the 2024 survey results, a key resident satisfaction measure is included on the 2025/26 QIP; the percentage of residents responding positively to*: "I participate in meaningful activities".* Improvement initiatives aimed at the creation of meaningful relationships and activities for residents have been included for 2025/26, in consultation with both the Resident's Council and the Patient and Family Advisory Council.

- Risk Management Framework- Identification and Mitigation System
  - A series of systems embedded into operational processes to ensure a systematic process is in place for risk identification, assessment and mitigation through all of its operations. This framework includes:
    - Regulatory compliance assessments
    - All Hazard Risk Identification and Assessments
    - Failure Effect Mode Analysis exercises
    - Incident reporting system, including investigations and incident reviews that support a Just Culture

PRIORITY AREAS FOR QUALITY IMPROVEMENT FOR 2025/2026

As the organization continues its progress along its newly refreshed strategic direction, 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's Council (RC).

The priority items for continuous quality improvement in 2025/26 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 three key indicators:
   - Positive response to the statement *"I participate in meaningful activities"*
     - In 2023/24 and 2024/25, the Home collected baseline data for this indicator through the Resident satisfaction Survey.
     - Improvement activities are tracked through the organization's QIP, with outcome measures reported annually post survey completion.
   - Resident Satisfaction Surveys are planned to be provided for residents in July 2025. Results will be evaluated in the fall of 2025 by the Residents and Family Council and the Long-Term Care Continuous Quality Improvement Committee.

2. Promotion of diversity, equity and inclusion as measured by successful implementation of new services and staff education:
    - Targeted action plan based off EDI-LTC Assessment tool to be completed in 2025.
    - Percentage of staff who have completed relevant equity, diversity, inclusion, and anti-racism (EDI-AR) education.

3. 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 resulting in lost time due to injury by improving staff knowledge related to de-escalation skills to avoid/minimize workplace violence that escalate to physical violence. This will be supported through non-violent crisis intervention training, violent incident drills and improving the use of a standardized debriefing process.
    - Program improvement activities are tracked through the organizations QIP, and outcome measures are reported on a quarterly basis.

EXECUTIVE COMPENSATION

Executive performance based compensation is linked to achievement of strategic priorities. The CEO, EVP/CFO, CNE/VP Clinical Services, and the Chief of Staff compensation frameworks are in keeping with the Broader Public Sector Executive Compensation Act. As such, each role includes performance based pay (pay at risk). The Board of Directors approves strategic priorities on a yearly basis along with performance targets for activities that support advancement of quality.

In 2024/2025, executive compensation was linked on the Quality Improvement Plan to achievement of actions to advance all of the organization's strategic priorities under the pillars of *People, Growth and Community*. Identified on the Quality Improvement Plan under related to LTC operations included actions to improve resident engagement and satisfaction, as well as workplace violence prevention. These strategic action items improve the safety, accessibility and quality of care and services provided to residents throughout the organization both today and into the future.

CONTACT INFORMATION

Janna Hotson, Chief Executive Officer - janna.hotson@drdh.org