LTC Quality Improvement Showcase Poster Presentations

January 31, 2023

Acknowledgement

This work was supported by Healthcare Excellence Canada (HEC). HEC works with partners to spread innovation, build capability and catalyze policy change so that everyone in Canada has safe and high-quality healthcare. Through collaboration with patients, caregivers and people working in healthcare, we turn proven innovations into lasting improvements in all dimensions of healthcare excellence. Launched in 2021, HEC brings together the Canadian Patient Safety Institute and Canadian Foundation for Healthcare Improvement.

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Toronto Seniors Services and Long-Term Care

Bendale Acres

Increasing Access to End of Life Care

What challenge did you work to improve?

- Reducing the number of residents passing away without an end of life care conference
- Reducing the number of residents passing away without being identified as at end of life care.

What did you implement?

- Hold more end of life conversations with residents and families during the admission process, and improve staff understanding and preparation for sensitive conversation
- Consistently identifying changes in resident condition and applying the Palliative Performance Scale (PPS)
- Engaging all who are available when the resident is identified as being at 20% and implement care plans.

What happened?

- Survey administered to family members (past and present) to gain feedback on receptiveness to end of life conversations within 6 weeks of admission
- Care conference template being developed for use in conversations about end of life care, at admission, when health status changes, and other times.

What are you most proud of?

- Changes in the way our staff communicate with residents and family members regarding end of life care and its' significance to overall resident care
- Having more of a focus on end of life care discussions early on in adjustment to long-term care stay
- Increased education and awareness for our resident and family members in relation to end of life care supports.

Bendale Acres QI Team

Poster Presentation Overview

Bendale Acres
Caitlin Demers
Increasing Access to End of Life Care

Project Description
Bendale Acres is directly-operated by the City of Toronto, providing individualized care to each of its 302 residents within a safe and friendly long-term care environment.
Guided by the CARE values – Compassion | Accountability | Respect | Excellence, the team is committed to improving quality of life and support for healthy aging.

As part of the LTC QI Healthcare Excellence Canada project, Bendale Acres focused on improving care plans to reflect person-centred care planning for residents at End of Life (EOL). The goal is to decrease the number of residents passing away without being identified as requiring end of life care, and to decrease the number of residents who pass away without an end of life conference. Resulting in improving resident and family end of life experience, enhancing resident and family engagement in discussions/care planning upon admission, improving staff relationships with resident and families and increasing staff comfort level with having sensitive conversations regarding end of life care.

The team has suggested several strategies to improve end of life care such as:
Champions/master trainers attended resident-centered care planning education session

- Education for staff to prepare them to start having conversations with resident and families regarding end of life wishes, as early as at the time of admission
- Consistently identifying changes in resident condition which leads to the engagement of timely care planning
- Engaging inter-professional team, family and resident once identified through PPS score of 20% that an end of life conference should be held.

To date, a survey has been administered to family members (past and present) to gain feedback on receptiveness to end of life conversations occurring within 6 weeks of admission, and a care conference template is being redeveloped to include end of life care conversations at admission and beyond.

Bethany Care Society

Author Lesley MacKinnon

What challenge did you work to improve?

Address staff burnout attributed to working in long term care settings during a global pandemic by examining staff resiliency, establishing a shared language and introduction of resources that address psychological safety risks.

What did you implement?

Measurement of psychological safety factors attributable to staff burnout using the Guarding Minds at Work survey tool to both identify opportunities to advance psychological safety in the workplace and measure impacts of interventions following changes and improvements.

What happened?

Increased frontline team understanding of psychological safety in the workplace across 10 long term care sites with a shared language in identifying and implementing changes focused on improving staff resiliency. Increased capacity for frontline led process improvement through development and management of project interventions.

What are you most proud of?

Increased frontline team comfort and confidence in identifying and effectively addressing workplace factors impacting staff resiliency such as civility, respect, recognition and work life balance; both through process improvement and integration of formally trained mental health first aide teams

Poster Presentation Overview

Bethany Care Society
Steve Friesen, Executive Director, Research & Innovation and Lesley MacKinnon, Manager, Safety
Guarding Minds @ Work – Building Staff Resiliency

Project Description
Addressing staff burnout attributed to working in a long-term care setting during a global pandemic by examining staff resiliency, establishing a shared language and introduction of resources that address psychological safety risks.

TORONTO
Seniors Services and Long-Term Care

Carefree Lodge

Person-Centred Falls Care Plans

What challenge did you work to improve?

- The percentage of care plans with person-centered strategies related to falls from the initial audit result of 15% to 100% by December 2022

What did you implement?

- Blind audit by staff of person-centered care plans
- Care plan review and risk management process
- Identified Champions to train staff on creating person-centered strategies
- Developed care planning questions involving resident and family

What happened?

- Improvement in number of falls care plans with person-centered strategies from 15% to 100%
- Inter-professional care plan review and risk management process led by registered staff
- Incremental decrease in the number of falls with injury per month
- Increased satisfaction (staff and family)

What are you most proud of?

- Success rate of blind audits implementation amongst the care team
- Inter-professional collaboration for the review of falls care plans and risk management completion led by registered staff

Carefree Lodge Quality Improvement Team

Poster Presentation Overview

Carefree Lodge
Melissa Giraldo
Person-Centred Falls Care Plans

Project Description
Carefree Lodge is directly-operated by the City of Toronto, providing individualized care to 127 residents within a safe and friendly long-term care environment. Guided by the CARE values – Compassion | Accountability | Respect | Excellence, the team is committed to improving quality of life and support for healthy aging.

As part of the LTC QI Healthcare Excellence Canada project, Carefree Lodge focused on improving the percentage of care plans with person-centred strategies and a focus on falls prevention. The team introduced several processes and strategies to improve outcomes including:
Blind audit by staff introduced to measure if care plans were person-centered

- Care plan review and risk management process led by Registered Staff
- Champions were trained to support the introduction of person-centered care planning
- Development of care planning questions for residents and families.

The strategies implemented have resulted in the establishment of an inter-professional care plan review process, increased leadership by registered staff in the care planning process, improved risk management and care plan auditing process, enhanced education for developing person-centred care plan strategies, and engagement of family and resident in the development of personalized care plans upon admission.

To date, there has been improvement in the number of falls care plans with person- centred strategies, increased satisfaction (staff experience and family expectations), increased resident quality of life, improved staff education of person-centred strategies, and an incremental decrease in the number of falls, with injury, per month.

Patient attendant team leaders in 17 of the CIUSSS Centre-Sud de l'Île de Montréal's CHSLDs

Joane JOSAPHAT-DOUYON and Pascale DUNLOP

What problem were you trying to solve?

DUAL PROBLEM

1. Support the rapid integration of patient attendants on scholarship and ensure high-quality care.
2. Relieve the burden on nursing assistants to the immediate supervisor and head nurses after the first wave of COVID.

What steps did you take?

A SINGLE SOLUTION

Relied on **patient attendant team leaders** to harmonize assisted care practices. Planned and supervised the work of patient attendants through training sessions, coaching and mentoring, and provide support to nurses.

85 patient attendant team leaders on duty, day, evening and night

What happened?

- Identified patient attendant champions (day/evening/night), supported the accelerated training of patient attendants on scholarship
- Expanded the role: onboarding, integration, and ongoing training of new employees
- Updated the competencies and skills of all patient attendants
- Had the project evaluated by a researcher, audits and consolidation

What are you most proud of?

- Improved the quality of care and services for the clientele
- Achieved recognition for the role of patient attendant
- Built a patient attendant community of practice
- Provided concrete assistance to the nurses and the team on a daily basis

Poster Presentation Overview

CIUSSS du Centre-Sud-de-l'Île-de-Montréal (Integrated Health and Social Services University Network for South-Central Montreal)
Joane Josaphat-Douyon, Director, supportive housing unit at CHSLD St-Henri (residential and long-term care centre)
PSW project for team leaders at CHSLDs in the CIUSSS du Centre-Sud-de-l'Île-de-Montréal

Description of project/poster
Building a PSW community of practice by standardizing basic care practices via PSW team leaders at the 17 CHSLDs in the CIUSSS du Centre-Sud-de-l'Île-de-Montréal.

Additional Poster Representatives: Pascale Dunlop

Toronto Seniors Services and Long-Term Care

Castleview Wychwood Towers

Care Planning and Falls Reduction

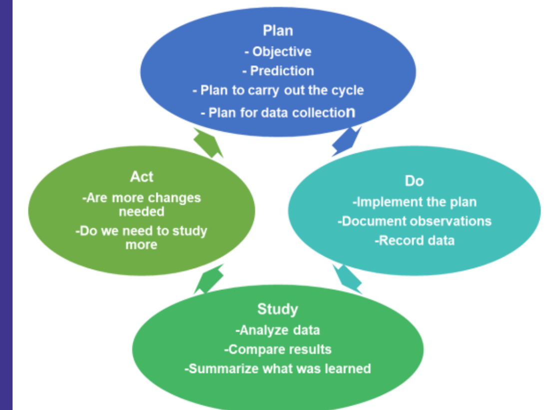
What challenge did you work to improve?

- Reducing the number of resident falls across the home areas from the current baseline average of 72 falls per month by 30% to 51 falls per month by December 2022
- Improving communication and implementation of falls strategies using an inter-professional approach.

What did you implement?

- Provide education to RN's to assign the care plan falls interventions to Point of Care (POC) for PSW's
- Provide education to RN/RPN's on completion of Morse Falls Risk Assessment on all residents as per policy
- Develop process and provide education to PSW's on falls interventions and how to view in POC.

Care Planning and Falls Reductions



What happened?

- RN's were educated on pushing falls intervention strategies from PCC to the PSW POC Kardex
- PSW's were educated on reviewing falls intervention strategies in their POC Kardex
- Monthly reports are produced from PCC regarding number of falls and number of residents who have fallen.
- RN's and RPN's were educated on resident-centered care plans.

What are you most proud of?

- Identifying a process gap between care planning and POC tasks
- Kaizen falls prevention event held for inter-professional team members including PSW, RN, RPNs, PT, OT, therapy assistants, social work, food and nutrition etc.
- The event led to multiple changes including effective processes to communicate changes in falls strategies for residents, to PSWs.

Poster Presentation Overview

Castleview Wychwood Towers
Helen Lampi
Falls Reduction

Project Description
Castleview Wychwood Towers is directly-operated by the City of Toronto, providing individualized care to each of its 456 residents within a safe and friendly long-term care environment. Guided by the CARE values – Compassion | Accountability | Respect | Excellence, the team is committed to improving quality of life and support for healthy aging

As part of the LTC QI Healthcare Excellence Canada project, Castleview Wychwood Towers focused on improving the percentage of care plans with person-centred strategies, with a focus on falls prevention. The team held a Kaizen event in June 2022 where the project team members presented several processes and strategies to improve outcomes including:

- Ongoing auditing and education for RN’s on assigning the care plan falls interventions to Point of Care (POC) for PSW’s
- Ongoing education for RN/RPN’s on completion of Morse Falls Risk Assessment on all residents
- Developed process and provided education to PSW’s on falls interventions and how to view in POC.
- Champions/master trainers attended resident-centered care planning education session
- Resident-centered care plan education session focused on auditing, care plan and Kardex development.

To date, several education sessions have been held for RN's, RPN's and PSW's sharing the falls reduction strategies, and resident-centered care planning. Monthly outcome reports are being reviewed for the number of falls and number of residents who have fallen, and ten inter-professional team members have participated in person- centred care planning education and will be care planning champions for each of the resident home areas.

CIUSSS du Nord-de-l'Île-de-Montréal

CHSLD Saint-Joseph-de-la-Providence

Stéphanie Larose

What problem were you trying to solve?

Often, people who need to be placed in a CHSLD are unable to physically visit the facility in advance. This makes it difficult for them to make an informed decision.

What steps did you take?

CHSLD description sheets, virtual tours, and Q&A sections were made available to the public online at all times. A comprehensive communication plan was carried out to let internal and external partners know about these decision-making tools.

What happened?

A working committee formed of representatives from across the senior care continuum joined forces with the communications department to review existing tools and procedures and carry out a project to improve and increase access to care.

What are you most proud of?

People experiencing a loss of autonomy (regardless of the level) can now take part in decisions about where they will live. The members of the future resident's entourage can also access information remotely, when it's convenient for them.

Sheets

Web

Video

Poster Presentation Overview

CHSLD Saint-Joseph-de-la-Providence
Stéphanie G. Larose, RN, BSc, DESS, site coordinator, residential management and Chantale Denoncourt, clinical operations specialist
Residential and long-term care centre virtual preadmission visits: A new approach to choosing a residential and long-term care centre

Description of project/poster

Seniors and their loved ones are faced with major life changes once they realize that the senior needs residential care. This senior in need of care is on the verge of experiencing loss after loss of their home, their independence, their daily routine, their surroundings and often, their friends and family. When they join a care centre, it becomes their new home—but often also their last home. All of this is in play as they seek residential care. During the pandemic, the divide between residents and their future home only deepened as visits from loved ones were prohibited for months at a time.

Seniors with decreasing independence who are considering a new living environment often struggle with physical impairments that make visiting a residential and long-term care centre more difficult. Although more and more residential care applications come from people living at home, many come from patients at the end of a hospital stay.

Best practices to ensure seniors are treated well include making person-centred decisions, consulting seniors systematically on any issues that could impact them and not making assumptions about their wishes or preferences. Self-determination is an individual's ability to act and make decisions on their own, based on their own wishes. Seniors are the ones who should decide, to the best of their knowledge, which residence they'd prefer to live in, how they'd like to live and the care and services they'd like to receive. Virtual preadmission visits play an important role in seniors' ability to determine what they want for themselves.

Preadmission visits are part of the continuum of care and services available to seniors. They serve as the first point of contact for future residents and their loved ones with residential and long-term care centres. Until recently, preadmission visits were handled by a professional and differed from one residential and long-term care centre to the next. A working group at our CIUSSS examined how visits could be standardized. To do this, the CIUSSS website was expanded.

The website now includes virtual visits of our care centres, fact sheets on the specifics of each centre and a Q&A section. Future residents and their families will be able to virtually visit our centres from wherever they want, whenever they want. The project includes a communications plan for internal and external partners.

Toronto
Seniors Services and Long-Term Care

Cummer Lodge

Emergency Department Visits at End of Life

What challenge did you work to improve?

- To decrease or maintain the number of potentially inappropriate end of life emergency department (ED) visits by November 2022, where end of life (EOL) is defined as death within 1 month of ED transfer

What did you implement?

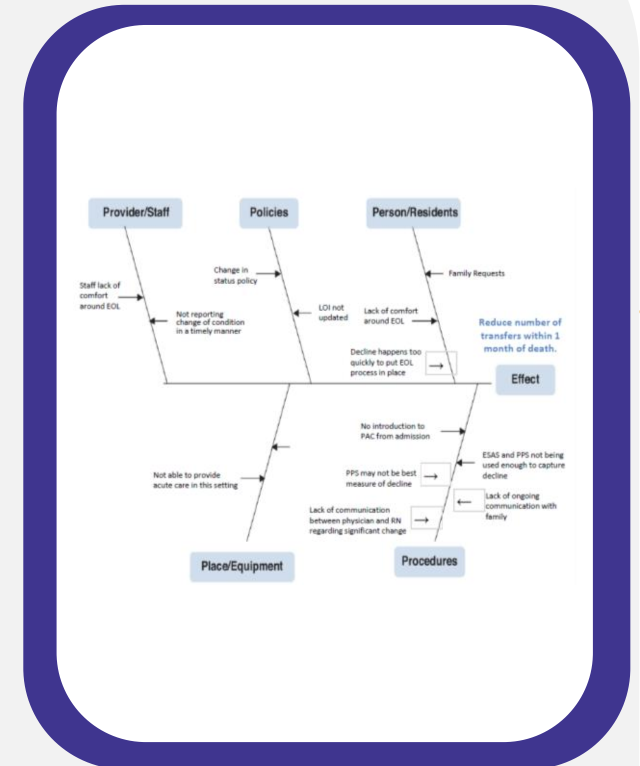
- Develop a training program to educate staff on a palliative approach to care
- Develop a resource document that introduces staff to the palliative approach to care at Cummer Lodge
- Develop a process for introducing and discussing the resource document during the admission process

What happened?

- Admission Care Conference letter prepared for Family Council review
- The 'Palliative Approach to Care at Cummer Lodge' education module has been finalized
- Change ideas will be tested on one resident home area (2 North) in Fall/Winter 2022

What are you most proud of?

- The team adopted a co-creation healthcare approach to the QI project, engaging in an equal partnership with Family Council members who established expectations and priorities for the change ideas and participated in collaborative decision making around what the final product would look like



Poster Presentation Overview

Cummer Lodge
Adriana Caggiano
Emergency Department Visits at the End of Life

Project Description
Cummer Lodge is directly-operated by the City of Toronto, providing individualized care to each of its 391 residents within a safe and friendly long-term care environment. Guided by the CARE values – Compassion | Accountability | Respect | Excellence, the team is committed to improving quality of life and support for healthy aging.

As part of the LTC QI Healthcare Excellence Canada project, Cummer Lodge focused on decreasing or maintaining the number of potentially inappropriate emergency department (ED) visits occurring at end of life (EOL), where EOL is defined as death within 1 month of ED transfer. The team introduced several processes and strategies to support positive outcomes including:

- Enhancing consistent support and care provided by Cummer Lodge staff
- Reflecting resident's goals and choices at end of life(EOL) in person-centered care plan
- Developing resources and making them available for families to support EOL care, and to increase their confidence in the care team's ability to provide EOL care without transfers to hospital
- Creating an environment where staff are confident in providing EOL care for residents
- Providing training for staff to support resident's goals and choices, minimizing discomfort and promoting quality of life, enabling residents to die in a dignified, respectful manner, as free from pain and distress as possible
- Reducing the number of potentially inappropriate ED visits at end of life, saving hospital capacity for more urgent cases.

The team continues to enhance many of the strategies in partnership with staff, residents and families, such as the training program to educate staff on palliative and end of life care, resource documents that introduces staff to these approaches, and developing a process and letter for introducing and discussing Palliative Care and End of Life upon or near the time of admission.

Currently, the admission care conference letter is being reviewed by Family Council, the Palliative Approach to Care at Cummer Lodge' education module has been finalized, and the home is planning to trial their change ideas on one home area in Winter 2022/2023.

Reducing Falls and Restraint Use At Evergreen Baptist Care

Barbara Blois, Sanchit Garg, Fran Jenkins, Julia Pereira, Susan Thayer, Janice Wallace

EVERGREEN

A BAPTIST HOUSING COMMUNITY

What challenge did you work to improve?

There is overwhelming evidence that restraints contribute to falls, with increased severity of injury. In spring 2022, we observed a high number of monthly falls **and** high physical restraint use at Evergreen. Our goal was to reduce the number of falls without injury by 30% and falls with injury by 50% while reducing or eliminating the use of restraints.

What did you implement?

Implemented Evidenced Based Tool

We implemented the Vicky Scott Falls Risk Assessment – a Baptist Housing and provincial standard

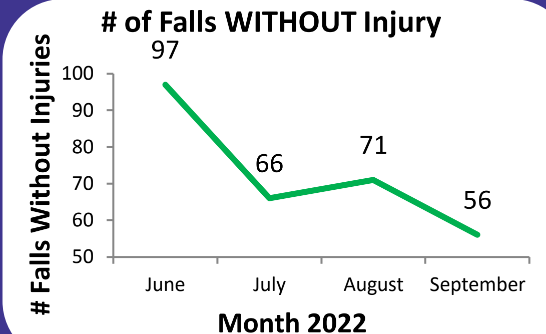
Helping those at Highest Risk!

We identified high risk residents and prioritized them for Fall prevention review

Enhance Resources

We maximized appropriate use of fall prevention equipment like hip protectors and fall mats

"You can't manage what you can't measure"-- W. Edward Deming



What happened?

We achieved a 44% reduction in falls without injuries (from 97 in June to 56 in September). We also reduced the use of physical restraints by 28%.

We continue to work on reducing falls with injuries. There was some improvement noted over three months, where we had a greater than 50% reduction, but we couldn't sustain it.

What are you most proud of?

We are proud of our resident families and team members, who were all highly involved in this initiative. Their continuous efforts, active participation, and willingness to contribute to the quality of care and lives of our residents made this initiative a huge success!!

Poster Presentation Overview

Evergreen Baptist Care Home (1 of 2)
Sanchit Garg, Clinical Quality Assurance Specialist
Reducing Falls and Restraint Use at Evergreen Baptist Care

Evergreen Baptist Home's Fall Prevention and Least Restraints Quality Initiative has been possible thanks to funding from Healthcare Excellence Canada

Goals

- Reduce the number of falls without injury by 30%, from 72 per month to 50 per month at Evergreen Baptist Care by October 2022.
- Reduce the number of falls with injury by 50%, from 6 per month to 3 per month at Evergreen Baptist Care by October 2022.

The following interventions are implemented to achieve our project aim:

1. Implement Fall Risk Assessment V. Scott (PCC) as per Baptist Housing and Provincial standards.
    - Complete electronic Fall Risk Assessment for all residents at admission, change in status and post fall. Assessment scores reflect levels of fall risk
    - Ensure Care Plans are updated based on outcomes of risk assessments, and following nursing assessments
    - Ensure that each intervention is implemented to ensure safety and injury reduction for all residents that are determined a high falls risk

2. Identify High Risk Residents and prioritize for fall prevention review
    - High risk for falls (VS score greater than 12) and persons with multiple falls will have an inter-disciplinary review to conduct more in-depth analysis of trends and contributing factors. Team will optimize and implement resident-centered fall and injury prevention strategies, while maximizing resident freedom of movement.

3. Maximize appropriate use of fall prevention equipment
    - Where appropriate, trial use bed sensors, chair sensors, fall mats
    - Communicate equipment use on resident care plan
    - Continue to promote and enhance the use of hip protectors
    - Maximizing equipment use with greater Rehab/Therapy involvement

Current Outcomes
Our teams were actively tracking data throughout the project to ensure that all the planned interventions are in place and that the project is completed in a timely manner.

Implement Fall Risk Assessment – V. Scott
A learning module was created, posted on our online platform and assigned to all team, and ALL residents have a *Vicky Scott* Fall Risk Assessment completed as of October 2022.

Evergreen Baptist Care Home (2 of 2)

Identify High Risk Residents and Prioritize for all prevention review
June rate of 30% of Falls Without Injury occurring from persons who have had multiple falls, down to 15% as of September 2022.

Maximizing appropriate Use of Falls Prevention Equipment
We purchased 40 falls mats and 30 wheelchair/bed alarm monitors which are all now in use. Enhanced Therapy involvement and assessment supported the additional purchase of 10 wheelchair/bed alarms, 40 chair sensors, 10 bed sensors, 300 call-bell clips and extension cords for call-bells. An innovative cord management methodology was implemented.

Note: 70 new beds were purchased. Additional Therapy assessment and education was provided.

Least Restraints Status
Evergreen, as part of their Fall and Injury Prevention initiatives, are also undergoing this least restraint initiative. There is a higher number of physical restraints in place in these communities, mostly through the use of side rails and wheelchair seat belts.

The most common reason given for using a physical restraint is to prevent falls, despite the overwhelming evidence that restraints contribute to falls, with increased severity of injury.

Persons with dementia do not see side rails or seat belts but will make attempts to climb over rails and or get up with seat belt in place, which can cause more serious injury. The therapy team is engaged in supporting individualized assessment and offering alternative strategies. Side rails are not only a restraint but pose entrapment risk. Strategies like sensor alarms to alert when a resident is getting up, as well as transfer poles, are being explored based on the resident's functional abilities.

Using Minimum Data Set (MDS) quarterly reporting, our percent of Residents in Daily Physical Restraints is 13.7% from January to March, 2022.
We are aiming to reduce use of restraints to meet the provincial target of 6.4. Unfortunately, current RAI-MDS data does not capture the results of our recent efforts. We expect future quarters to show this reduction.

In real time reporting, based on manual auditing data, we have had a 28% reduction of side rail and/or seat belt restraint.

Overall QI Project Results
- We ACHIEVED a 44% reduction in number of falls without injury (97 in a month down to 56 per month)
- We continue to work on reducing our falls with injuries. There was some improvement noted over 3 months where there was greater than 50% reduction but so far, we were not able to maintain.

Additional Wellness Outcomes
Team Members are highly engaged. Resident family were very supportive at the Resident Quality Safety Fair. Skills Fair Education for Team included enhanced strategies for Muscular Skeletal Injury Prevention and Safe Resident Handling (assisted resident transfers). All team were given *Pre-Standing Safety Checklist* cards and *Point of Care Assessment* cards for their lanyards as practice reminders.

Toronto Seniors Services and Long-Term Care

Fudger House

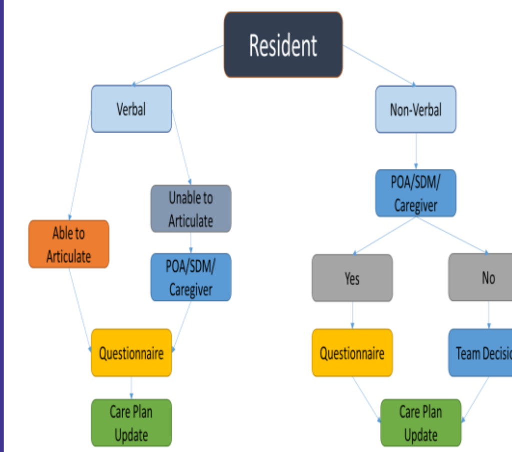
Person-Centred Care Planning

What challenge did you work to improve?

- Care plans to reflect resident preferences from 32% in May 2022, to 100% by November 2022.
- Person-centred care planning will focus on resident preferences such as dressing, grooming, bed time and shower/tub bath

What did you implement?

- Review care plans to determine which did not indicate likes/preferences
- Interview eligible residents/family/POA to obtain their preferences
- Add specific questions in admission interview to collect personal preferences
- Review preferences during initial/annual care conference



What happened?

- Care plan coaches participated in a person-centred care planning education in September 2022
- Updating care plans to reflect refreshed resident preferences

What are you most proud of?

- Active participation of team members in enhancing care plans.
- Better knowledge and understanding of person-centred care.
- Collaborative efforts of multidisciplinary team towards exemplary care delivery through care planning.

Poster Presentation Overview

Fudger House
Wei Wang
Person-Centred Care Planning

Project Description
Fudger House is directly-operated by the City of Toronto, providing individualized care to each of its 250 residents within a safe and friendly long-term care environment. Guided by the CARE values – Compassion | Accountability | Respect | Excellence, the team is committed to improving quality of life and support for healthy aging.

As part of the LTC QI Healthcare Excellence Canada project, Fudger House focused on improving care plans to reflect person-centred care planning with a focus on resident preferences including dressing, grooming, bed time, and shower/tub bath. The person- centred strategies will improve resident experience of care and well-being, enhance resident and family engagement in the development of their plan of care, and improve staff job satisfaction. The team introduced several processes and strategies including:

- Resident centered care planning audit tool
- Inter-professional care plan auditing process to determine if likes/preferences are indicated
- Developing a Decision Making Tree to support resident-centered care planning
- Updating care plans with residents/family/POA to obtain their preferences.

The team continues to implement other strategies including:

- Adding specific questions to admission interviews to collect personal preferences
- Reviewing preferences during Initial/Annual Care Conference.

The strategies implemented have resulted in 11 care plan coaches attending a full day person-centred care planning education, and a schedule is being developed to update residents' preferences and to update care plans. Future plans include adding 'All About Me' questionnaire in the package for new admissions, a monthly audit for completion of the questionnaire for new admissions, review of resident preferences during the annual care conference, and to integrate these revised processes into day-to-day operations.

Isabel and Arthur Meighen Manor

Monica Klein-Nouri

What challenge did you work to improve?

Most significant challenge

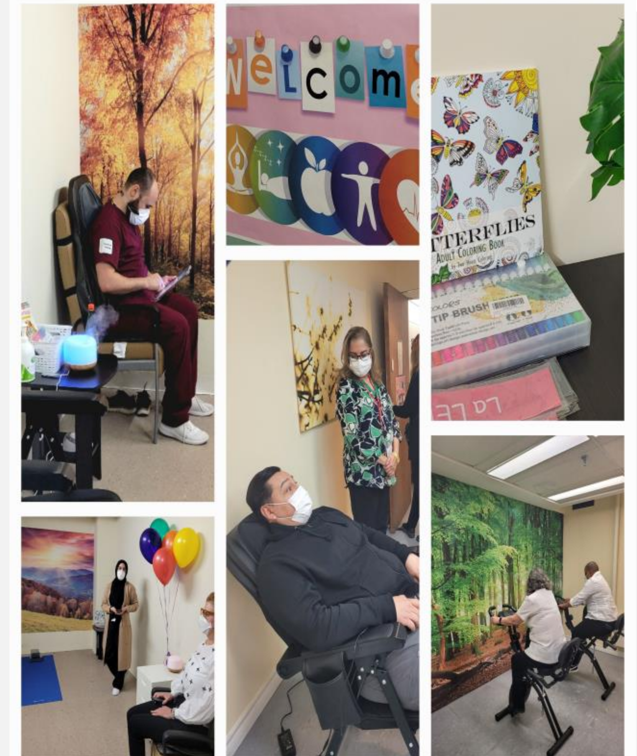
- Convincing staff to accept the concept of wellness and self-care applied
- Accepting that it is ok to stop and rest/take care of themselves.

What did you implement?

Funding from HCE

- Repurpose and create Staff Wellness Rooms
- Purchased massage chairs, yoga equipment, exercise bikes, sound and aromatherapy, relaxing murals, and free wellness resources.

Leadership role model approach- walk the talk- persuading staff to benefit from Staff Wellness Rooms



What happened?

Positive: We received additional donations from family members and were able to repurpose 3 additional rooms into Staff Wellness Rooms, one room on each floor to promote easy access

Negative: We had a challenging time convincing staff to use them mainly due to a misunderstood sense of guilt

What are you most proud of?

- **Starting the discussion** about the importance of self-care in healthcare staff and how to incorporate it into daily routines
- **Self-initiative and engagement** of staff during the summer to participate in weekly 15 min Zumba class in the garden

Poster Presentation Overview

Isabel and Arthur Meighen Manor LTC home
Monica Klein-Nouri, Executive Director
Staff Wellness Rooms

Description of project/poster
Our project tackled a subject not too often addressed in the LTC sector: the wellness of those who devote themselves to the well-being of the most vulnerable, our elders. As professional caregivers, they always focus on others, and they are never a priority or concern for their employers, Ministry or even themselves.

The recent pandemic did not spare Meighen's healthcare workers, as the Homme was one of the first victims of the first wave of the pandemic, which claimed its share of residents and staff. The trauma of these tragic events affected all staff without discrimination, with PTSD symptoms, chronic fatigue, and misplaced feelings of guilt at the top of the list.

Our goal was to spread the message that staff physical and mental health is as important as the health of residents and their families. Working short-staffed, overtime and with no vacations, in addition to the continuous negative media on LTC Homes and its staff, was a recipe for disaster. We had to help staff recover and understand the respect and appreciation we all held for their work and resilience. We understood that this is possible just by raising awareness about the importance of self-care and own wellness.

When the HEC funding became available, there was no doubt in our leadership team about which project to use it for. We decided to create Staff Wellness Rooms and could repurpose 4 rooms and transform them to provide easy access on each floor. Our employees, from any department, could go there for a shorter or a longer time to have a recovery break using the massage chair, the exercise bike, meditating or having a yoga session, aromatherapy or listening to calming sounds, away from the fast-paced daily work. They were also offered a multitude of free wellness resources, all gathered in a magazine, Care+, put together by our partners at the Wellness Hub.

It was initially surprising to see staff not taking advantage of these spaces designed just for them. Some misunderstood the purpose, thinking they were for residents, not for them, so we identified their purpose clearly on the doors, but the uptake was still minimal. The challenge encountered was convincing staff to use them. Specifically convincing them not to feel guilty about doing something for themselves due to a misunderstood sense of guilt covered by the response, "I do not have time for this."

What did we do? We took the "walk-the-talk" approach. Have one staff member come and talk about their day while sitting in the massage chair. Once they experienced it, they were more likely to use it again and share their experience with others. In time we observed PSWs choosing to complete their documentation while sitting in the Wellness Rooms, listening to relaxing music or getting a back massage. There is still a long road until every staff member reaches this stage of placing personal well-being at the same level of importance as the well-being of residents or their loved ones. However, we are proud to have started the conversation about personal wellness and its importance in caregivers' professional and personal lives, discovering new approaches and ways of incorporating them into daily routines. An unexpected consequence of this program was creating a weekly Zumba class in the garden during the summer when staff will join for 15 minutes of light and fun physical activity. We are at the beginning of this journey, but we are confident that more is to come if we continue to make the well-being of our staff a priority.

Additional Poster Representatives: Nazila Afghani, Director of Care; Tessa Jankie, Assistant Director of Care; Jodyanne Pacay, Quality Improvement Coordinator

Toronto Seniors Services and Long-Term Care

Kipling Acres

Enhanced Person-Centred Care Planning

What challenge did you work to improve?

- Enhance person-centred care planning with a focus on high risk areas related to falls and impaired skin integrity.

What did you implement?

- Ongoing training - person-centred care planning and Point Click Care (PCC)/Point of Care (POC).
- New resident-centred care plan audit tool
- New skin and wound protocol
- Head-to-toe assessment tool in POC for PSWs
- Increased utilization of POC Alerts
- Refinement of admission care plan development

What happened?

- Significant reduction in falls with injury from 11 to zero
- Number of falls were also reduced
- Innovative approaches increased resident and family engagement
- Improved skin care outcomes

What are you most proud of?

- Falls have been an area for risk and it is very satisfying to see a reduction in falls and falls with injury
- New skin and wound communication and documentation protocols implemented in PCC/POC

Poster Presentation Overview

Kipling Acres
Jacqueline Cornwall
Enhanced Person-Centred Care Planning

Project Description
Kipling Acres is directly-operated by the City of Toronto, providing individualized care to each of its 337 residents within a safe and friendly long-term care environment. Guided by the CARE values – Compassion | Accountability | Respect | Excellence, the team is committed to improving quality of life and support for healthy aging.

As part of the LTC QI Healthcare Excellence Canada project, Kipling Acres focused on enhancing person-centred care planning in high risk areas of falls and impaired skin integrity.

The team introduced several processes and strategies to improve outcomes including:

- Stronger engagement of residents and family in care planning development through innovative approaches and understanding care needs
- Champions/master trainers attended resident-centered care planning education session to support the initiatives
- Staff training on resident-centred care planning, and targeted education such as RAI-MDS, PointClickCare (PCC) and Point of Care (POC)
- Enhanced resident centered care planning processes which identify high risk areas such as falls and skin integrity
- Ongoing monitoring/auditing of the care plan and kardex using new auditing tool.

The strategies implemented have resulted in the creation of person-centred falls care plans, and overall falls reduction and reduction of falls resulting in significant injury. In addition, there has been increased recognition of early stage pressure ulcers, and improved skin and wound treatment using resident-centred interventions.

TORONTO
Seniors Services and Long-Term Care

Lakeshore Lodge

Integrated Person-Centred Care Plans

What challenge did you work to improve?

- Increase the percentage of person-centred care plans that are integrated and are less than 6 pages from 25% to 80% by November 2022

What did you implement?

- Engagement of resident and family in the development of initial care plans, and obtain background information prior to admission.
- Develop an innovative approach to care planning that supports caregivers
- Identify champions/master trainers for care planning education and ongoing support
- Develop a schedule for monthly care planning and Kardex audits

Person-Centred Care Education

What happened?

- Champions/master trainers completed person-centred care planning education modules
- Improved communication between disciplines resulting in collaborative interventions to address resident needs
- Shorter care plans – clear, more succinct

What are you most proud of?

- Increased staff engagement in updating the care plans
- Care plans are more reflective of person-centred care philosophy
- Care plans are clear and concise and accurately describe resident needs/preferences and strategies

Poster Presentation Overview

Lakeshore Lodge
Rhonda Bell
Integrated Person-Centred Care Plans

Project Description
Lakeshore Lodge is directly-operated by the City of Toronto, providing individualized care to each of its 150 residents within a safe and friendly long-term care environment. Guided by the CARE values – Compassion | Accountability | Respect | Excellence, the team is committed to improving quality of life and support for healthy aging.

As part of the LTC QI Healthcare Excellence Canada project, Lakeshore Lodge focused on improving the percentage of person-centred care plans that are integrated and less than 6 pages in length.

The team introduced several processes and strategies to improve outcomes including:

- Creating care plans that are resident-centered, dynamic and useful
- Improving communication between disciplines
- Resident and family involvement in creating care plans
- Supporting residents and families in their care needs
- Improving resident outcome scores.

The strategies implemented have resulted in over 30 staff attending person-centred care planning education, improved communication between disciplines resulting in collaborative interventions to address resident needs, and overall care plans that are clear, and more succinct. Progress will continue with ongoing education, involvement of resident and family in development of care plans, review of care plans, and continuation of plan of care and kardex audits.

Malton Village Long Term Care

Authors: Dwayne Green, Shilu Joshi, Lori Bourdeau, Amandeep Singh, and Carmen Hung

What challenge did you work to improve?

- To promote a continuous improvement culture in everyday work
- To strengthen staff engagement on the new concept

What did you implement?

- Implemented an "Idea Board" on the 2nd floor at Malton Village Long Term Care to enable staff to post and discuss ideas to improve daily work
- This board will help promote team collaboration to find solutions together

What happened?

- Completed kick off meeting and started facilitator training
- Conducted in-person soft launch of the Idea Board for 2nd floor staff, led by LTC Administrator
- Received positive feedback, as staff were excited to know their ideas will be heard and solutions discussed together

What are you most proud of?

- Staff were excited for the launch of the Idea Board and were eager get started
- Cultivated teamwork and team engagement with involvement from multiple disciplines (e.g., Activation, Nursing, Dietary, etc.)

Poster Presentation Overview

Malton Village Long Term Care Centre (1 of 2)
Dwayne Green, Administrator dwayne.green@peelregion.ca
Daily Continuous Improvement Program (CIP)

Poster Representatives: Shilu Joshi, RN – Project Lead, Harinder Saran, Director of Care, Lori Bourdeau, Education Specialist, Carmen Hung, Advisor, Health Planning and Performance

History and General Overview
Daily CIP implementation was initiated across Region of Peel Long Term Care (LTC) Centres starting in 2018. The concept of Daily CIP was adapted from the program created in the acute care setting and is being used in Ontario at SickKids Hospital. Our initial project implementation was supported by the Value Collaborative.

The purpose of Daily CIP is to create an interdisciplinary approach to Quality Improvement by engaging employees at every level of the organization. It is accomplished using Quality Improvement Methodologies such as Muda, the 5Whys, Fishbone diagrams, and PDSA cycles; to identify, analyze and improve process issues identified by the staff who are doing the work.

The Region invested in identifying and training Home level Daily CIP Champions that included the Centre Leadership Team, RAI coordinators and key members of the divisional Practice Innovation and Education (PIE) Team to be Greenbelt Trained to be able to support any larger projects that required a PDSA cycle that are identified using our huddle board approach.

Additional recruitment wad done to find Daily CIP Facilitators among the front line staff from all departments. They were provided with additional training on Quality improvement and the basics of how to lead a huddle.

So, What exactly is a Huddle Board?
The Huddle Boards are actual wipe-erase boards set up in a physical location in the Centre for staff to gather, identify process issues and discuss quality improvement.

The basic process is as follows:

- Any employee at the Centre has an idea for improvement and fills out an improvement ticket that identifies the issue and includes the employee's ideas on how we can improve
- This idea is shared at a regularly scheduled team huddle led by staff identified and trained in Daily CIP Huddle Board Facilitation
- The multidisciplinary group of staff huddled will elaborate on the issue, add more information and then decide using an Impact-Priority matrix on how to proceed
- A lead, co-lead are selected for the ticket and next steps are identified for ideas that are going to be implemented
- The team continues to review, analyze, and progress the idea, project or process at future huddles until it is implemented and adopted operationally.

Malton Village Long Term Care Centre (2 of 2)

Malton Village Project 2022

The initial roll out of Daily CIP huddle boards was delayed at Malton Village due to the global COVID-19 pandemic. With all of the challenges brought on by the pandemic, it was decided to restart this project with a new lens and learn from process issues identified at the other Centres who had already launched the boards.

Huddle Board name was changed to IDEA Board to better identify the purpose of the board and to differentiate it from the word “huddles” that are used clinically e.g. Falls Huddle/Behaviours Huddle.

A more detailed Facilitator Training was developed as it was discovered that the facilitator training that was previously delivered at the other centres did not provide sufficient skills in how to lead a conversation and deal with group dynamics. It was also lacking in training on how to use specific quality improvement methodology's such as a fishbone diagram, the 5 Whys, or developing a problem statement. The new facilitator training sets the front line facilitators up for success by providing ample opportunities for doing mock huddles and allowing the facilitators to practice their skills after being trained in how to facilitate and how to utilize specific quality improvement tools.

Additional info

There are several components to Daily CIP, The four main areas LTC focused on are:

Quality Scorecards

- RAI Scorecards
- RNAO scorecards

Status Sheets

- Communication tools from all levels
- Align with our Service plan outcomes
- Goal is to predict issues/problems and be proactive in resolving
- Should be updated to reflect operational needs and align at all levels
- Is like a highway of information flowing back and forth to and from all levels

PDSA’s

- Quality projects
- Identified at the huddle board, and prioritized by the team as having a high positive impact on a service outcome
- Improvements that require additional time and resources
- Led by Green belt trained staff

Huddle Boards

Responsive Group LTC Homes

Sandy Croley, Director of Programs & Rehabilitation, Responsive Management Inc. Julienne Latham, Nurse Consultant, Responsive Health Management

What challenge did you work to improve?

Making Every Moment Matter™ and taking resident's quality of life in LTC to a new level! Creating a "new normal" …..daily life in LTC is marked by long-held schedules (of what happens and when), a focus on tasks performed by team members to and for residents. Resident quality of life has fallen 'second' to this norm and, "satisfaction surveys" aside, operators have had few tools, methods and metrics to measure & advance it.

What did you implement?

QUIS - a research validated observational tool – Quality of Interactions Schedule – adapted for congregate care settings by Meaningful Care Matters (or MCM), a UK based consultancy – best known for its emotion-based person-centered Butterfly culture transformation approach. QUIS measures the quality of interactions between people giving and receiving care and provides a suite of actionable interventions to change each moment…what residents see, feel and hear….

What happened?

We introduced QUIS to all 19 of our LTC homes: over two-days MCM trained 200 home team members on how to use it. Our team members then conducted over 700 hours of observations at three different time intervals. We measured the quality of interactions through the first 400 hours of observations, empowered home teams to select and implement interventions of their choice in between observations and measured outcomes. And we have a sustainability plan to carry us forward.

What are you most proud of?

Our team members for embracing a BIG initiative amid the enduring pandemic and driving tangible change… for the many moments changed and for the many more to come….for shedding uniforms, for changing language, for changing the moment, for exploring resident life stories, likes and preferences, bringing the outdoors in and placing themselves in the residents' shoes, Making Every Moment Matter™. Thank You Thank You Thank You

Poster Presentation Overview

Initiative conducted at 19 LTC homes in ON managed by Responsive (1 of 2)
Sandy Croley, Director of Recreation & Rehabilitation
See it, Feel it, Hear it ~ QUIS Improving Quality of Life in LTC

Project Description
In 2022 HEC funding allowed us to take an important step forward in our journey of person-centeredness journey advancing our purpose of Making Every Moment Matter

Too often in the past – and in our present – daily life in LTC is marked by long-held schedules (of what happens and when), a focus on tasks performed by team members to and for residents - in environments that unwittingly continue to look, feel, smell and sound institutional.

Resident quality of life has fallen ‘second’ to this norm and, “satisfaction or engagement surveys” aside, we as operators have had few tools, methods and metrics to measure and advance it.

“Suppose we STOPPED. for only 5 minutes and looked around. We can be the change if we can see it.”

QUIS is a research validated observational tool – Quality of Interactions Schedule – developed by Rachel Dean and Roger Proudfoot in 1993 that allows us to do so.

Meaningful Care Matters (or MCM), a UK based consultancy – best known for its emotion-based person-centered Butterfly culture transformation approach – has developed and retains the intellectual property rights to QUIS.

QUIS measures the quality of interactions between people giving and receiving care through the use of observations: team members (or third parties) taking time out of their day to observe interactions between people and categorize them into 5 levels – from the lowest quality level, described as “controlling restrictive care”, to the next level of “controlling protective care”, the next – described as “neutral care”, to a level described as “positive care” up to the highest quality of interactions, described as “meaningful engagement”.

A fulsome criteria list is provided for each level.

Initiative conducted at 19 LTC homes in ON managed by Responsive (2 of 2)

QUIS uses a two step approach to improve the quality of interactions;

Step 1: Is to Observe & Score
Step 2: Is a Call to Action

QUIS teaches us to stop and witness and put ourselves in the place of the resident….listen, look, see, feel from the resident perspective……and we need this "time-out" and this bird's eye view to measure and evaluate the level of engagement….

Scores from each 60-minute observation period are tallied and reflect the quality of lived interactions – as witnessed at that time.

QUIS then calls for action…. and has a menu of 15 intuitive intervention areas to choose from…each home team decides which interventions to focus on – for the next period of time - to change the lived environment and what it looks, feels and sounds like… the team drives the change, models the change and thereby creates the "new, improved, normal"….

QUIS requires the investment of time and training of staff & leaders - together - to yield its outcomes….

We started our journey at each home w/ training of 12 people (frontline, Leadership and support people) for 2 days on QUIS, followed by ongoing monthly calls, time invested to perform observations and time invested deciding and implementing required interventions.

Overall we spent close to 700 hours observing & evaluating / scoring the quality of interactions ….almost 40 hours of observations per home throughout 2022….without counting the time to then "act" and change way of engaging in the moment…

As a result of the initiative, we were able to improve QUIS scores: with 91% of communities moving up a level, a 10% decrease in negative controlling and restrictive care and a 10% increase in positive and meaningful engagement. In addition, after the initial training 100% of team members reported an improved understanding of what quality of life means for people living in their care setting; 92.86% of team members reported an improved knowledge of care practices that contribute to and detract from quality of life for people they support, and how to use QUIS and finally 96.43% felt more confident in improving the quality of care provided.

We learned that QUIS is a BIG undertaking - but so worthwhile! Going forward we have a sustainability plan that sees QUIS as an integral part of each home's quality improvement plan.

Additional Poster Representatives: Julienne Latham, Nurse Consultant, Responsive Health Management, Uyen Thuy Nguyen, Canada Support Manager, Meaningful Care Matters

Schlegel Villages

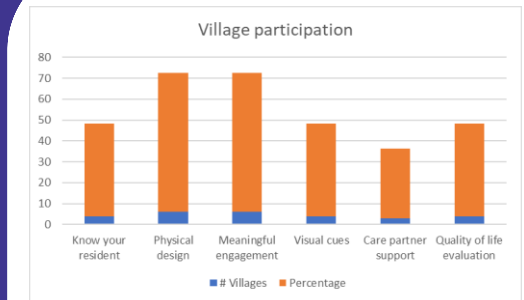
Heather Luth, Director of Dementia Services & Knowledge Integration; Lora Bruyn Martin, Innovation Specialist

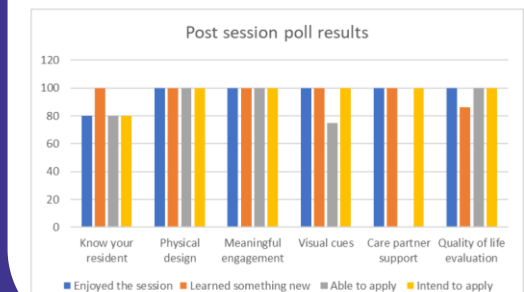
What challenge did you work to improve?

Schlegel Villages is implementing a comprehensive dementia program. We have observed a disconnect for team members between understanding the theory behind resident-centered care for those living with dementia and how this translates into practice. We wanted to provide them with tools and problem solving skills to empower them to adopt resident centered care strategies in daily interactions and care moments.

What did you implement?

Schlegel Villages piloted the Project ECHO™ (Extension for Community Healthcare Outcomes) Community of Practice model focusing on evidence-based and resident-centered strategies to care for residents living with dementia. The ECHO™ model pairs an education session with an actual case-study to empower participants to teach and learn together from their shared experiences.





What happened?

We held six ECHO ™ sessions on the following topics:

1. Knowing your resident
2. Physical design of your spaces
3. Meaningful engagement
4. Visual cues during Mealtimes
5. Care partner support
6. Quality of life evaluation

Overall participants enjoyed the sessions, learned something new and said they intend to apply what they learned. The case study learning was preferred over the didactic.

What are you most proud of?

As the series progressed, team members' recommendations for case studies became more holistic, with practical suggestions that reflected an increased awareness of the resident as a person, not just a diagnosis or challenge.

Teams were confident to try strategies shared with them and reported positive results!

Poster Presentation Overview

Schlegel Villages (1 of 2)
Heather Luth, Director of Dementia Services & Knowledge Integration and Lora Bruyn Martin, Innovation Specialist
Enabling the adoption of resident-centered care using Project ECHO™

Project Description
Schlegel Villages is implementing a comprehensive evidence-based dementia program called LIVING In My Today (LIMT). LIMT is both a philosophy and program outlining specific best practices to support the well-being of residents living with dementia within our villages. It focuses on five pillars, identified by our early working group as the key areas that impact the day-to-day lived experience of residents with dementia. Each pillar is strengthened by its connection to supporting the seven domains of well-being, and a strengths-based belief that people living with dementia are capable and resourceful.

1. Supportive Approaches to Care
2. Meaningful and Active Engagement
3. Enjoyable Mealtimes
4. Empowered Care Partners
5. Thoughtful Design

LIMT training and materials are gradually being introduced within our villages, and challenge some long-standing habits and ways of providing care. Changing the mindset and practices of team members isn't as simple as offering new training and a couple checklists. We recognize the best learning occurs when team members are able to connect theory to their everyday experience. With multiple villages, we were interested in creating an opportunity for team members not only to learn about LIMT, but to also be given opportunities to apply this to their own, real-life interactions and challenges with residents living with dementia.

The Project ECHO™ model is a community of practice pairing didactic education with case- based learning, empowering participants to teach and learn together from their shared experiences. It adopts a hub and spoke model which is well-suited to our organization which has multiple sites.

As an organization, we embarked on a 6-month pilot using the Project ECHO™ approach to support the implementation of our LIMT program. Our hub included a facilitator, administrator, evaluator and selected "experts" on the topic of each ECHO™ session, while our participating villages represented the individual spokes. The case study presented at each session was provided by a single village and was selected because it was directly related to the topic of focus.

Schlegel Villages (2 of 2)

We held six ECHO ™ sessions on topics that aligned with the LIMT program pillars:
1. Knowing your resident
2. Physical design of your spaces
3. Meaningful engagement
4. Visual cues during Mealtimes
5. Care partner support
6. Quality of life evaluation

During each 1.5-hour ECHO™ session, an “expert” provided 15-20 minutes of didactic education related to the selected topic. This was followed by the presentation of the selected case study by a village team representative. The entire group (hub and spokes) were able to ask clarifying questions before each individual in the hub and each village team spent 10 minutes reviewing the case study, referencing the didactic knowledge sharing, and developing recommendations. The remainder of the session was dedicated to hub members and village teams sharing their thoughts and recommendations related to the case study.

The recommendations were documented by a hub member and distributed to all participants following the session. Starting with session 3, we dedicated 5 minutes at the beginning of each session to allow the village that presented the case study during the previous session to report back on whether they implemented any of the recommendations and the resulting outcomes.

The evaluation of the LIMT Project ECHO™ pilot showed participants enjoyed the sessions overall, with the sessions on physical design and meaningful engagement being the most well-received. At least 80% of participants indicated they learned something new and intend to apply what they learned in every session. Qualitative data from post-session surveys suggested participants learned more from analyzing and discussing the case studies compared to the didactic education.

As the series of ECHO sessions progressed, we noted team members’ case study observations and recommendations became more holistic, with practical suggestions that reflected an increased awareness of the resident as a person, not just a diagnosis or challenge. Finally, in terms of outcomes, village teams reported implementing strategies recommended by ECHO participants and observing positive results.

Schlegel Villages has completed the 6-session pilot and plans to continue offering regular LIMT Project ECHO™ sessions. Some modifications will be made to improve the experience for hub members and village team members. In particular, we will focus on improving the case study development experience and the sharing of recommendations with all participants. From an evaluation perspective, we plan to make changes that will allow us to collect more and better feedback from participants.

Additional Poster Representatives: Lyndi Dougherty, Project ECHO™ Administrator, Dr. Allen Power, Schlegel Chair in Aging and Dementia Innovation

TORONTO
Seniors Services and Long-Term Care

Seven Oaks

Person-Centred Care Plans

What challenge did you work to improve?

- Increase the percentage of care plans that accurately reflect the abilities and needs of our newly admitted residents as evidence by increase in care plan audit results from 70% to 90% by October 2022

What did you implement?

- Implement a person-centred auditing tool
- Develop a person-centred care planning process
- Update care planning library to reflect an interdisciplinary approach
- Implement "getting to know me" information during the first week of admission

Seven Oaks QI Team

What happened?

- Director, Resident Care & Services developed and delivered person-centred care planning education modules
- "Getting to know me" form given to families and/or residents to complete on admission day with the Social Worker and posted in the residents' room

What are you most proud of?

- Positive engagement of residents and families in the development of the initial care plan through the "getting to know me" form.
- Increased involvement of various interdisciplinary team members that collaborated with residents and families to identify strengths, deficits and intricate resident needs.

Poster Presentation Overview

Seven Oaks
Michele Rodway and Anusha Gunalingham
Person-Centred Care Plans

Project Description:
Seven Oaks is directly-operated by the City of Toronto, providing individualized care to each of its 249 residents within a safe and friendly long-term care environment. Guided by the CARE values – Compassion | Accountability | Respect | Excellence, the team is committed to improving quality of life and support for healthy aging.

As part of the LTC QI Healthcare Excellence Canada project, Seven Oaks focused on improving the percentage of care plans that accurately reflect the abilities and needs of newly admitted residents. Care plans are to reflect personalized preferences, abilities, and care support needs, thereby creating a positive work environment for staff and enhanced life experience for residents and their loved ones.

The team introduced several processes and strategies to improve outcomes including:

- Implementing person-centred auditing tool
- Developing person-centred care planning process
- Developing education modules to support new care planning
- Auditing knowledge and care plans
- Updating care planning library in Point Click Care (PCC) to reflect inter- professional approach
- Implementing "Getting to know me" information during the first week of admission.

The strategies implemented have resulted in 10 staff becoming champion/master trainers receiving person-centred care planning education, and a 'Getting to Know Me' form provided to families and/or residents to complete on admission, and then posted in the resident's room.

ST. PATRICK’S HOME OF OTTAWA

Authors: Monique Patterson, VP of Nursing and Beth Ciavaglia, Quality and Risk Coordinator

What challenge did you work to improve?

The Challenge that we worked to improve was to ensure Care Plans were in first person language, with the goal of improving staff understanding of each resident as a person.

What did you implement?

We implemented person-directed language to the Responsive Behaviour Focuses of the electronic Care Plan Library. This is known as “I” Care plans.

What happened?

The team comprised of frontline staff- PSWs, RPNs, REC, HSK, Resident, Family Member, RN, VP of Nursing, RAI Coordinator, Quality and Risk Coordinator. We met and set a plan on how to review the focuses and ideas on how the language should change to reflect the care from the resident perspective. The frontline staff, in particular the PSWs, worked on the library for the teams review. Once that review was done, the library changes were initiated.

What are you most proud of?

We are most proud of how excited the team was to make these changes and how they worked together to complete the project. The team members were able to demonstrate other skills than their usual roles and they did a fabulous job!

Poster Presentation Overview

St. Patrick's Home of Ottawa
Beth Ciavaglia and Monique Patterson
An i-Care plan Implementation: A Big Step on our Person-Directed Journey An i-Care plan Implementation: A Big Step on our Person-Directed Journey

Project Description
The project entailed a muti-disciplinary group undertaking. We were able to complete a massive re-write of the care plan library to first person language. Teams transitioned the library under existing focuses, updating, and adding new phrases as needed. We are in the process of entering the new phrases into the electronic chart.

TORONTO
Seniors Services and Long-Term Care

True Davidson Acres

Reducing the Number of Preventable Emergency Department Visits

What challenge did you work to improve?

- To reduce emergency department visits from 14.8% to 7.4% by November 2022

What did you implement?

- Consistent communication protocol (SBAR)
- List of common symptoms/diagnosis that result in hospital transfers
- Guidelines of what treatments can be performed in the long-term care home
- Monthly inter-professional review and discussion of future prevention strategies for residents sent out and returned same day

What happened?

- Reduction in number of residents sent for ED visit
- Increased treatment options provided within the LTC setting, to avoid hospital
- Enhanced nursing scope of practice
- Improved care plans with new interventions minimizing risk of ED transfer

What are you most proud of?

- Reducing number of unnecessary ED visits for the residents and minimize the stress for family members.
- Implementing new interventions and strategies within the home to increase the level of care that can be provided in LTC setting.

True Davidson Acres Quality Improvement Team

Poster Presentation Overview

True Davidson Acres
Kobo Tang
Reducing the Number of Preventable Emergency Department (ED) Visits

Project Description
True Davidson Acres is directly-operated by the City of Toronto, providing individualized care to each of its 187 residents within a safe and friendly long-term care environment. Guided by the CARE values – Compassion | Accountability | Respect | Excellence, the tem is committed to improving quality of life and support for healthy aging.

As part of the LTC QI Healthcare Excellence Canada project, True Davidson Acres focused on reducing the number of potentially avoidable Emergency Department (ED) visits.

The team introduced several processes and strategies to improve outcomes including:

- Implementing consistent communication protocol (SBAR) with physicians prior to transfer
- Creating a list of common symptoms/diagnosis that currently result in hospital transfers, and guidelines for what can be performed in the LTC home prior to sending a resident to hospital
- On a monthly basis, review all the residents that were sent out and came back on the same day (ED visit only) and discuss with the inter-professional team options to prevent similar cases from happening again
- Designating two individuals (Nurse Practitioner and/or Clinical Lead) to be called prior to sending resident out to non-emergency hospital visit.

The strategies implemented have resulted in increased nursing staff capacity to provide care to maintain IV and CADD pump on site, enhancing nursing knowledge and assessment skills, improving care plans with new interventions to minimize risk of hospital transfer, and overall reducing residents being sent to ED.

TORONTO
Seniors Services and Long-Term Care

Wesburn Manor

Falls Prevention and Integrated Care Planning

What challenge did you work to improve?

- Reduce fall incidents, with or without significant injuries, by 10% by December 2022

What did you implement?

- Introduced 2RaceWithMe technology to support residents with physical strengthening
- Implemented various resident activities to reduce agitation, anxiety, restlessness, boredom etc. which can contribute to falls
- Implement fall prevention interventions for high risk residents at admission

What are you most proud of?

- We received numerous positive comments from residents about the 2RaceWithMe exercise machine
- Improved inter-professional collaboration and integrated care plans for fall prevention

What happened?

- Decreased total number of falls
- Improved inter-professional collaboration
- Enhanced person-centred care planning – staff attended care planning education sessions

2RaceWithMe Technology

Poster Presentation Overview

Wesburn Manor
Barbara Fidera
Fall Prevention & Integrated Care Planning

Project Description
Wesburn Manor is directly-operated by the City of Toronto, providing individualized care to 192 residents within a safe and friendly long-term care environment. The home is guided by the CARE values – Compassion | Accountability | Respect | Excellence, the team is committed to improving quality of life and support for healthy aging.

As part of the LTC QI Healthcare Excellence Canada project, Wesburn Manor focused on reducing incidents of resident falls, both with or without significant injuries. The team introduced several strategies to successfully reduce falls, including enhancing inter- professional collaboration in the falls prevention care planning, incorporating interventions consistent with resident needs, preferences and condition, implementing falls prevention interventions for high fall risk residents at time of admission, and the introduction of 2RaceWithMe exercise program.

With these strategies, Wesburn Manor has been able to support residents and maximize their abilities, capabilities and improve their quality of life, by providing sufficient time for resident engagement with the outcome of improving the residents' quality of care.

Overall, there is a decrease in the total number of resident falls, improvements to inter- professional collaboration, and focus on person-centred care planning.

Expanding Recreation Services to Counter Weekend Boredom

Umair Kharral

What challenge did you work to improve?

There were no recreation activities for residents on weekends at Yorkton & District Nursing Home. Residents expressed that they were bored and needing something to do.

What did you implement?

We implemented weekend recreation, and introduced two 8-hour shifts into the weekend rotation on a temporary basis.

Programming was developed for the weekend that was different from the regular Monday-Friday programming to attract residents to the new programming.

What happened?

The resident engagement in recreation programming increased. Residents looked forward to the new recreation activities, and that there was something occurring over the weekend.

Found the most success on our memory care neighbourhood.

Overall feedback from staff was also positive.

What are you most proud of?

I'm proud of leading the change management with the team and engaging them in trying something new.

The feedback we received was very positive, and we are interested in working to see how we can expand our programming in the future to include weekend recreation.

Poster Presentation Overview

Yorkton & District Nursing Home
Umair Kharral, Clinical Manager
Expanding Recreation Services to Counter Weekend Boredom

Project Description
Yorkton & District Nursing Home is a 227-bed Long-term care home in Yorkton, Saskatchewan, which is compromised of five neighbourhoods and residents with varying level of abilities and ages. There was no evening or weekend recreation offered at the nursing home. Some of our residents had expressed that they were bored and had nothing to do on weekends.

We utilized the Healthcare Excellence funding to implement weekend recreation and introduced two 8-hour shifts into the weekend rotation on temporary basis. Our weekend programming was different from weekday programming to generate some excitement among our residents. We had good weather and it was the perfect time to go out for outings, spend time in the patio, and play summer games.

We had noticed that our residents' engagement had increased, and they were always looking forward to the new activities. We had also heard positive feedback from our families and staff.

Based on this trial, we are exploring the possibility of expanding our recreation programming to include weekends.

Additional Poster Representatives:
Danielle Bellamy – Executive Sponsor and Director, Continuing Care
Karen Delong – Recreation Coordinator
Maisy Wheeler – Recreation Worker
Allison Link – Recreation Worker
Sarah Nelson – Recreation Worker
Darlene Schlechter – Recreation Worker