CONTINUOUS QUALITY IMPROVEMENT

2024

CQI Designated Lead: Mary Buhion, Director of Care

Downsview Long Term Care Centre is committed to continuous quality improvements. Our processes support a culture of constant improvement firmly grounded in the home's overall mission: to serve our residents by providing care in a home away from home. In addition, our processes are anchored on our core values of professionalism, empowerment, accountability, community, and empathy and comply with the requirements stipulated in the Fixing Long-Term Care Act, 2021 (FLTCA) and Ontario Regulation 246/22. . For over four (4) years, we have seen a considerable shift in our operations driven by changes in legislation and our core focus on providing safe and exceptional care to our residents

As a backgrounder, the Continuous Quality Improvement Committee comprises the Administrator, Medical Director, Registered Dietitian, Pharmacy Consultant, registered nurse, a PSW, Resident Council president, program leads, and the Director of Care (Committee Chair).

To build trust, promote transparency, and increase ownership of the program's outcomes, our goal is to invite the Resident Council President and family members to our quarterly meetings. :

1. **CRITICAL INCIDENTS**

   Program Lead: Mary Buhion, RN

   Goal Statement: To reduce the number of critical incidents (CI) related to alleged abuse (staff-to-resident and resident-to-resident) and neglect by 10% in a calendar year compared to the previous year.

2. **REDUCTION OF EMERGENCY DEPARTMENT (ED) VISITS**

   Program Leads: Mary Buhion and Clinical Nurse Managers

   Goal Statement for 2024: To reduce the ED visit rate (by 100 residents) from 8.52 in 2023 down to 7.52 in 2024

   Indicator: The number of emergency visits including both ED visits and ED visits resulting in admission or death.

Unit of measurement: Rate per 100 residents

Evaluation: The program will be evaluated by the end of the year.

Change Ideas:

- Advocated for Downsview residents that accompaniment fee (escort) will be funded by the Ministry. The advocacy was coursed through HRH. HRH already sent the request on behalf of Downsview for the accompaniment fees' funding. Awaiting outcome.
- Continue with collaboration with HRH LTC Plus program, i.e. for the specialty appointments and diagnostic services
- Escalating changes in health condition with the MRPs or NLOT.
- Timely detection of infection
- Work closely with Mt. Sinai's Temmy Latner Palliative Care Services (c/o Dr. Goldman)
- Understanding Advance Care Directives that impacts ED utilization
- Leveraging virtual visits
- Providing access to supplies and equipment such as bladder scanner, INR machine)
- RNs and RPNs received 3 full day sessions on IV Therapy
- Making use of the services of the Medical Care Privileges of the Medical Director

3. SKIN AND WOUND PROGRAM

Program Lead: Araceli Balaoeg, RN

Goal Statement: To reduce internally acquired pressure ulcer by 3% every quarter

Indicator: Number of residents with new pressure ulcers compared to the previous quarterly assessment.

Goal Statement # 2 for CY Q1 2024. To reduce the percentage of residents with internally acquired pressure ulcers every quarter by 5%:

Indicator: The number of residents with new internally acquired pressure ulcers (Stages 1, 2, 3, 4, unstageable and Deep Tissue Injury).

Evaluation: Please refer to Table 2 for the data

4. RESPONSIVE BEHAVIOUR

Program Lead: Christian Daguio, RPN

Goal Statement: To increase the number of residents to 6 residents who will be included in the antipsychotic reduction program in a year.

Indicator: The number of residents who are taking antipsychotic medications.

Change Ideas:

- Continue to collaborate with MDs and Pharmacy Consultants in identifying residents who will benefit from the program.
- Will be adopting and implementing the Toronto Central BSO behavioural Pathway into the Home's Behavioural Policy. Timeline: CY Q2.

5. FALL PREVENTION AND MANAGEMENT

Program Lead: Lidia Jodoin, RN

Goal Statement # 1: To reduce the percentage of falls for newly admitted residents by 5% quarterly

Indicator: Number of newly admitted residents who have a fall.:

Evaluation: The goal will be evaluated each quarter.

Table 3:

Goal Statement #2: To reduce the fracture rate for 2024 from the previous year (2023)

Indicator: Fracture Rate (based on census) in 2024 compared to fracture rate in 2023

Evaluation: The goal will be evaluated at the end of the year

Change Ideas and Tracking of Progress:

- Medication reviews (consultation with physician and pharmacist) on admission, every quarter and as needed to assess and address risk factors for falls
- Include fall risk status during shift report, especially for new residents
- Collaboration with interdisciplinary teams from other departments
- Utilization of evidence-based practices implemented to reduce falls and prevent injuries such as hip protectors, mats on the floor, bed/chair alarms
- Interdisciplinary fall huddles with residents who had three or more falls.
- Utilization of Fracture Order Set on admission and re-assessment as needed
- Nursing staff to familiarize and know the policy and front-line staff to be familiar with residents' plan of care
- Vision consults
- Identification of frequent fallers/high risk for falls residents with the use of visual cues (falling star)
- Use of mechanical lift for transfers' post-fall
- Assessing residents on admission with the use of falls risk assessment and falls risk Morse scale
- Include family's input
- Staff to assess new admissions for falls risk (using falls risk assessment) and also implement fall interventions during the shift of resident's admission with the input and recommendations of the physiotherapist

6. RESTRAINT MINIMIZATION

Program Lead: Lidia Jodoin, RN

Goal: To maintain the current number of restraints (3 residents) in-house throughout the year 2024

Indicator: Number of residents using restraints used throughout the home.

Evaluation: The goal will be evaluated at the end of the calendar year.

Change Ideas and Tracking of Progress:

- Track residents who have Restraint/PASD usage per unit.
- Quarterly and PRN assessments to be completed by the registered staff on the usage of restraint/PASD.
- Interdisciplinary meetings to discuss the potential of removal/trial removal of restraints/PASD.
- Alternatives to restraints used and documented
- Use of alternative devices where possible and document the effectiveness.
- Input from family regarding restraint use/removal of restraint

7. REDUCTION OF MEDICATION ERROR

Program Lead: Helen Filoteo, RN

Goal: To reduce the percentage of Medication Errors by 10% on an annual basis

Indicator: Number of medication errors reported by registered nursing staff.

Evaluation: The goal will be evaluated by the end of the calendar year.

The most common errors identified are the following:

- Medication was given to the wrong resident.
- Orders not carried out accordingly resulted in:
  - Wrong transcription
  - Not all orders were transcribed in eMAR
- Med errors r/t Med Reconciliation

Strategies/Interventions:

- We cultivate a culture of safety. RNs/RPNs are encouraged to report medication errors to identify gaps.
- Follow all error reporting guidelines as noted
- Ongoing education to staff re: Med Rec, Safety Administration
- Ensure all registered staff members are properly trained to give medications to residents
- Follow all medication administration guidelines
- Consider using a drug guide

Tracking of Progress:

- Thoroughly check procedures regularly
- Track the number of registered nursing staff who have taken the Medication Reconciliation and Medication Safety Administration
- Learn proper medication administration guidelines
- Learning the lessons from medication errors

8. MANAGING URINARY TRACT INFECTIONS

Program Lead: Roland Madrona, RPN

Goal: To reduce the percentage of residents with urinary tract infection to 5% every quarter

Indicators:

1) Number of resident urinary tract infections associated with non-cath UTI, CAUTI, UTI-prolapse, UTI-BPH.
2) Surveillance, diagnosis (BPH, prolapsed, behavior), Treatment without a diagnosis.
3) No. of residents taking antibiotics with asymptomatic bacteriuria in the presence of bacteria in the urine without the symptoms of urinary tract infection

Evaluation: The goal will be evaluated every three months.

Change Ideas and Tracking of Progress:

- Prevention: Re-education of staff on personal care, usage of own equipment like (basin) the use of incontinent products (c/o continence lead), identifying resident's needs for toileting, and ongoing coaching if needed.
- Proper assessment. Staff is to monitor and look out for clinical signs and symptoms of a UTI are acute dysuria or two or more of fever, new flank pain or suprapubic pain or tenderness, new or increased urinary frequency/urgency, and gross hematuria.
- NLOT did educational sessions on physical assessment and documentation in January 2023.

Challenge and Barrier: Staffing and time constraints when providing education

9. VACCINATION

Program Lead: Roland Madrona, RPN

Goal: To increase the COVID-19 and Influenza vaccination percentage by 85% by the end of 2024.

Evaluation. The goal will be evaluated at the end of the calendar year**.** a Vaccination.

10. WEIGHT MANAGEMENT

Program Leads: Usoshi Bose, RD and Julie Mendis, FSS

Goal: To reduce the occurrence of Weight Variance by 2% annually**.**

Definition of Term: Weight variance is a weight change that can be unplanned weight loss and unexplained weight gain that requires evaluation for possible secondary causes if any of the loss or gain cannot be linked to intended modifications in diet or activity.

Erroneous weight variances can lead to:

- Unnecessary weight referrals
- Inaccurate assessment by RD
- Possible medication errors.

Indicator # 1: Number of weight variances attributed to incorrect entry.

Indicator # 2: Number of weight variances attributed to inconsistent weighing methods.

Challenges/barriers:

- Staff continuously use multiple weighing methods for weight entry.
- Weight scales used do not apply to the resident.
- No reweight is mentioned in the documentation of weight variance in the progress notes.
- No reweigh was done for a weight difference of 2.0 kg.(Dieticians of Canada, 2019)
- Inaccurate wheelchair weight and the weight of wheelchairs are not deducted from the weight obtained at the time of weighing a resident
- Multiple entries in a given month
- Staff to refer to the previous month's weight before encoding the weight entries

Change Ideas:

- On-going in-service/re-education for PSW and charge-nurse
- Ongoing auditing of weight entries every month
- Purchase a new weighing scale.