CONTINUOUS QUALITY IMPROVEMENT PLAN FOR THE BOB RUMBALL HOME FOR THE DEAF

2024-2025

DESIGNATED LEAD

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Administrator

QUALITY PRIORITIES FOR 2024/25

Bob Rumball Home for the Deaf is pleased to share our 2024/25 Continuous Quality Improvement Plan (CQIP).

The BRHD's principle, purpose and philosophy of care, as outlined in the BRHD's **Mission Statement**, is driven by the primary goal of providing quality care that is resident-directed and safe. [i]

The Bob Rumball Home for the Deaf further strengthens its devotion to excellence by adhering to the standards of the Ministry of Health and Long-term Care, committing to the Continuous Quality Improvement process, exhibiting the highest level of ethical and fiscal conduct, recognizing social and environmental responsibilities and providing fair and equitable treatment to all employees.

SUMMARY - QUALITY INITIATIVES FOR 2023/24

This past year has been extremely challenging for the Bob Rumball Home for the Deaf. We have seen changes in our leadership team; a new Administrator and Director of Care. As we chose to promote from within, there was a major focus for the Home's management team on the transition, along with the exchange of knowledge. Couple with the Health Human Resources (HHR) crisis we are currently facing challenges the Home has had to be reactive rather than proactive.

As a small Home, the challenge of 24-hour RN coverage often means pulling managers away from their work, to work the floor. Meeting the scheduling demands of an ever-fluctuating staffing compliment along with agency staffing has added greatly to our challenges. This situation has been exacerbated by the need for staff to know how to communicate in ASL. We have put in place free ASL classes which are mandatory for all staff.

These challenges have meant that we were not able to meet all of our targets for the change ideas we had planned for 2023- 2024. The Committee has determined that they will focus on these indicators for 2024-2025 along with some new indicators which are also a priority to the Home.

RESIDENT EXPERIENCE SURVEY

The BRHD's Annual Resident Experience Survey (RES) was distributed in November 2023. The survey was completed electronically through Surge Learning with the assistance of the Social Services Coordinator and the Nursing Administrative Assistant. There were 16 areas of concern

triggered from 2023. Triggers are defined by less than 80% of residents being satisfied with their experience with the care, services, programs and goods that are provided to them.

The results of the RES were posted on the bulletin boards located in the entrances to the two home areas and distributed to Resident's Council members. The results of the survey were brought forth in a meeting with the QIC on March 6th, 2024. At this meeting, the members were asked for feedback to assist the Home's Quality Improvement Committee (QIC) with ideas/strategies to improve the Home and the care, services, programs and goods residents receive. An action plan was developed and tasks were assigned to members of the QIC.

The Social Service Manager was invited to discuss the results of the RES at the Resident's Council meeting on March 13th, 2024. Feedback from residents was added to the action plan.

As of March 15th, 2024, the members of the QIC have started to implement the action items identified in the action plan. They include which were flagged they include: memos, newsletters, FAQ's, education, and PSW huddles.

The Social Services Manager has been invited to attend the April Resident's Council meeting to update members on the progress of the action plan.

QUALITY INITIATIVES FOR 2024/25

ISSUE # 1: Inappropriate transfers to Emergency Department (ED).

Quality Dimension: Decrease the number of unnecessary transfers to the Emergency Department.
Measure: Reduced ED visits.
Current Performance: The Home's current baseline is 17.72. Our target is to reduce this number to 15.00. We are still well below both the Provincial and local LHIN performance rates.
Source Information: Quality Improvement Plan-Health Quality Ontario (QIP) and ED tracking form, Point Click Care (PCC). Transfer to hospital/admission progress notes.
External Collaborators: LTC Diagnostic Strategy, NSM Palliative Care Network, STL Imaging, SilverFox Pharmacy, Nurse Practitioner Outreach Team, Specialized Geriatric Services, Pro-Resp.
Change Idea: Educate staff, families and residents on prevention of inappropriate transfers to ED.
Methods: Review of Best Practice Guidelines regarding reducing ED visits as well as utilizing the Pain/Palliative resource nurse. Discussion/education at the Annual Family Care Conference regarding Advanced Care Directives and prevention strategies for ED visits. Education huddles with frontline staff. On-line education for all frontline staff including agency staff. Identify trends and implement strategies accordingly. Add first and last resident checks at the beginning and end of shift to Point of Care (POC) task list. Utilize the LTC Diagnostic Strategy for non-urgent diagnostic work.
Process Measure
Audit the number of fall risk assessments reviewed per month by the quality team, audit on-line education, audit the POC tasks. Audit ED visits. Utilize the Plan, Do, Study, Act (PDSA) cycle.

ISSUE # 2: Resident perspective: What number between 0 -10 would you use to rate how well staff listen to you.

Quality Dimension: Resident Centered service excellence.
Measure: Resident experience, through the Resident Experience Survey where resident satisfaction was less than 80%.
Current Performance: 2023 survey indicated that 76.19% of residents were satisfied with the level of communication with staff.
Source Information: Resident Experience Survey, Individual feedback and input from Resident Council.
External Collaborators: Hire an ASL Instructor for teaching ASL to staff. SGS – How to communicate with different residents in different ways, GPA Program, NSM Hospice Palliative Care. Education on Customer Service, Alzheimer's Society. Deaf Blind-Services.
Change Idea: To improve the communication between staff and residents to a level where residents feel they are being heard, verbally and/or in ASL.
Methods: Training of staff including agency staff on the importance of having conversations with residents. Mandatory ASL classes have resumed, auditing attendance at ASL classes. Role play for education purposes. Observing dining room interactions .Teaching staff, small group discussions, body language, appropriate conversations with the elderly.
Process Measures: Resident satisfaction - asking for feedback on a quarterly basis as to how residents are feeling. (PDSA). Resident Council meetings, or on a one to one basis with the Social Service Worker. Observing staff and resident interactions. Number of complaints from families and residents; Annual Resident Experience survey (ARE).

ISSUE #3: Resident perspective: I can express my opinion without fear of consequences.

Quality Dimension: Resident Centered service excellence.
Measure: Resident experience, through the Resident Experience Survey where resident satisfaction is less than 80%.
Current Performance: 2023 survey indicates that 75% of residents indicated that they were comfortable expressing their opinion without fear of consequences. This is an increase of 5% over last year, this is a positive outcome.
Source Information: Resident Experience Survey, Individual feedback, Resident Council.
External Collaborators: ASL Instructor for teaching ASL to staff. SGS – How to communicate with different residents in different ways, GPA Program, NSM Hospice Palliative Care. Education on Customer Service, Alzheimer's Society. Deaf Blind-Services.
Change Idea: Educate staff on customer service. Make staff aware of residents feeling
Methods: Training of staff including agency staff on the importance of having conversations with residents. ASL classes, audit ASL classes. Role play for education purposes. Observing dining room interactions.. Annual Resident Experience surveys (ARE). Teaching staff through small group discussions, body language, appropriate conversations with the elderly. Education on Deaf Culture. Educating Deaf residents and staff on hearing perceptions.
Process Measures: Asking for feedback through our Social Service Worker. Observing staff and resident interaction, on-going training for staff. Educate residents on their rights to speak out. (PDSA).

Issue #4: Residents without psychosis who are given anti-psychotic medication in the seven days proceeding their resident assessment.

Quality Dimension: Decrease the number of residents without a psychosis diagnosis being given anti-psychotic medication.
Measure: Through CIHI-CCRS
Current Performance: The Home's current baseline is 18.89. Our target is reduce this number to 15.00.
Change Idea #1: IPAR – Pharmacists review all medications to determine why the resident is prescribed the current medication.
Methods: On admission receive detailed history from families or previous home/hospital. This information is added to the admission checklist for nurses to ask about resident history from POA/SDM if resident is taking anti-psychotic with no related diagnosis of psychosis.
Process Measure: Auditing through MDS quarterly.
Chang Idea #2: To use non-pharmaceutical approaches with identified residents with anti-psychotic usage without a diagnosis.
Method: Partnering with specialized Geriatric Services
Process Measure: Referrals and case consults to SGS.

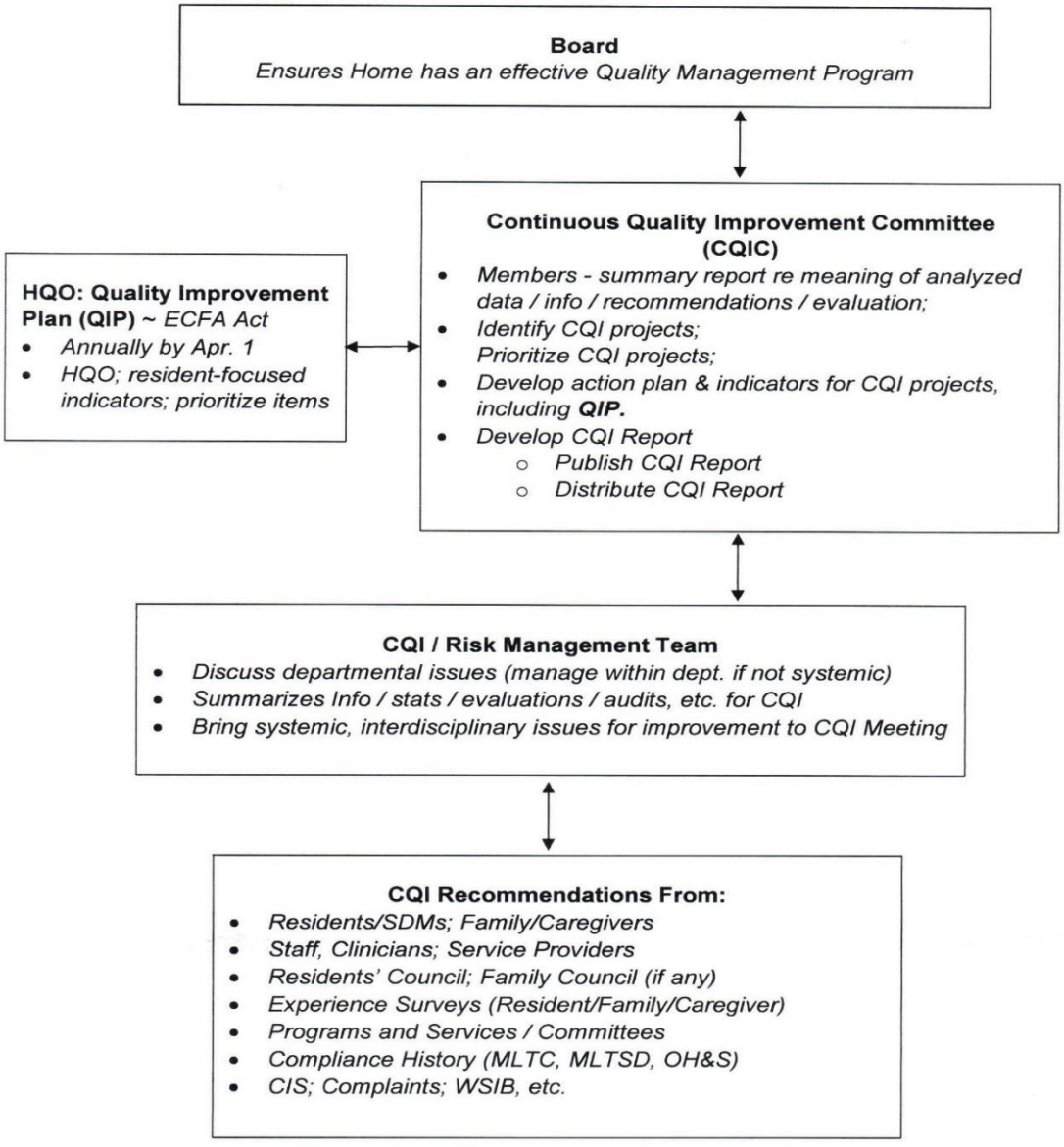
Issue #5: Due to the current system Deaf applicants are not considered a priority for admission to BRHD.

Quality Dimension: Increase the number of Deaf residents that BRHD serves.
Measure: Number of Deaf residents currently residing at BRHD and the number of Deaf applicants on the waitlist
Current Performance: The current number of Deaf residents residing at BRHD is 15, our target is to have 30 Deaf residents served by BRHD.
Source Information: HPG wait list and Point Click Care
External Collaborators: Ontario Health, Advantage, local MPP, Minister of LTC, BRCCED.
Change Idea: Increase the number of Deaf residents served by BRHD.
Methods: Advocate for Deaf Rights as stated in the Supreme Court Decision
"Failure to provide sign language interpreters – who are, in fact, necessary for effective communication for the procurement of medical services – is a violation of equality rights under s. 15 (1)."
Process Measure: Number of Deaf residents and Deaf applicants on the waitlist.

Issue #6: BRHD needs to hire and schedule more direct care staff

Quality Dimension: Number of staff
Measure: Staffing reports, payroll reports, agency usage and scheduling reports
Current Performance: The Home's current baseline is 3 hours of direct care, our target is 3.6 hours of direct care.
Change Idea: Increase the number of staff working directly for BRHD in order to increase direct care hours to meet provincial targets as well as reduce agency staffing hours
Methods: Maximize opportunities offered through the various Ministry incentive programs for staffing. Build on community partnerships that offer PSW training and opportunities. Active recruitment through – signage, job fairs, advertising on our website, make use of Advantage job postings and job websites such as Indeed.
Process Measure: Quarterly staffing plan, payroll reports, agency usage and scheduling reports to be reviewed monthly with management.

Quality Management Plan



Model for Improvement: *Plan, Do, Study, Act*

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BRHD's Quality Management Plan

- The Quality Management Plan on the previous page is intended to provide an overview of the CQI process at BRHD.
- The arrows represent a flow of movement between the various boxes, including information related to the areas in need of improvement, and communication of the improvement outcomes.
- Process improvements will be prioritized, and may be "gradual" or "breakthrough" in nature.

The CQI Initiative

- The legislative requirements and many of the concerns and /or recommendations for improvement start with the residents, their SDMs / family/caregivers, and staff.
- As such, the explanation of the CQI Plan overview diagram will start with the Residents/SDMs and Family/Caregivers

Bob Rumball Home for the Deaf has developed Quality Improvement Plan (QIP's) since 2015, with the QIPs submitted to Health Quality Ontario (HQO) every April. Bob Rumball Home for the Deaf's QIP planning is ongoing, and includes an annual evaluation of the following factors to identify preliminary priorities:

- Progress achieved in recent years;
- Ongoing analysis of performance data over time available from the Canadian Institute for Health Information (CIHI); with areas indicating a decline in performance over time
- Resident, family and staff experience survey results;
- Emergent issues identified internally (trends in critical incidents) and/or externally;
- Input from residents, families, staff, leaders and external partners, including the MOLTC.
- Mandated provincial improvement priorities (e.g. HQO)

Final review of the Interim QIP is conducted by the Professional Advisory Committee, who endorses the plan for approval by the Board of Directors.

BOB RUMBALL HOME FOR THE DEAF'S APPROACH TO CQI (POLICIES, PROCEDURES AND PROTOCOLS)

Bob Rumball Home for the Deaf's nursing and administrative policies, combined with QI principles, provide a baseline for staff in providing quality care and service. Bob Rumball Home for the Deaf has adopted the following five principles to guide quality improvement activities.

Quality Improvement (QI) Principles [ii]

Quality improvement in healthcare is both achievable and absolutely necessary. By using the QI principles and starting small, BRHD can quicken the pace of QI in the home. In addition, BRHD can reduce wasteful spending while improving their processes by applying the following five guiding principles:

1. **<u>Facilitate acceptance/adoption through hands-on improvement projects</u>.**
   - QI theory & methodology is best learned through hands-on improvement work-applying it to the actual clinical/work environment.

2. **Define quality** (as per objectives) and **get agreement**.

3. **Measure for *improvement*, not accountability.**
   - An improvement **measure collects data to measure system (not people) performance**, so a process can be improved. *[prevention over correction]*

4. **Use a quality improvement framework and PDSA (Plan-Do-Study-Act) cycles**.[iii]
   - The "**Model for Improvement**" framework proposes that an improvement team should ask three fundamental questions:
     - What are we trying to accomplish? *(goal / **aim**)*
     - How will we know that a change is an improvement? *(**measure**)*
     - What changes can we make that will result in improvement? *(**intervention/ change**)*
       ***This question leads to PDSA cycle. The PDSA cycle** tests small scale changes, or interventions, to measure their effect on outcomes*

   PDSA Cycles ~ Plan-Do-Study-Act Cycles – backbone of QI in healthcare [iv]
   - ***Plan*** ~ Establish the objective, determine what questions need to be asked and what predictions need to be made, and then plan to carry out the cycle.
   - ***Do*** ~ Carry out the plan, document problems and unexpected observations, and begin data analysis
   - ***Study*** ~ Complete the data analysis, compare the data to the predictions, and then summarize learnings.
   - ***Act*** ~ Determine what changes will be made and what the next cycle will be.

   The PDSA Cycle - YouTube; Whiteboard: The PDSA Cycle (Part 2) - YouTube
   ***Note:** Refer also to the PDSA description of the Steps in Policy QI-A-02.*

   - An improvement project usually involves several PDSA cycles. After each cycle, the improvement team assesses the success of the associated intervention. At some point, the intervention is adopted or abandoned, which indicates the end of PDSA cycles for that intervention. Then the team can move to the next intervention. Reaching global aim indicates completion of the overall QI project.

5. **Learn from variation in data.**
   - **Intended and unintended variation** in data
     - Intended variation is purposely deciding to do something a different way (A rationale exists for the decision.)
     - If the variation is not thoughtful or it's out of habit or convenience, then it's unintended.
   - **Common cause and special cause variation**
     - Common causes are an inherent part of a system or process that impact all people and outcomes.
     - Special causes arise from specific circumstances which may impact only a subset of people or outcomes.

Studying common cause and special cause variation is a cornerstone of improvement because it shows why the variation occurred and suggests the most effective approach to address it.

PROCESS TO MONITOR AND MEASURE PROGRESS, IDENTIFY AND IMPLEMENT ADJUSTMENTS AND COMMUNICATE OUTCOMES

A key component of the sustainability plan is the collection and monitoring of the key project measures over time. Run charts and Statistical Control charts, with established rules for interpretation, are essential to understanding if there has been an improvement or deterioration in performance. Analysis of the Outcome measure(s) will be used to identify if the Home is achieving the desired outcomes. If not achieving desired outcomes, the team can review the Process measure(s) over time to either confirm compliance with key change ideas or identify gaps in compliance that need to be addressed. Based on the results of this analysis, the team may consider alternative change ideas, provide coaching to staff to enhance compliance, engage with staff to better understand gaps in compliance, etc.

Operational indicators.

Communication strategies are tailored to the specific improvement initiative. These include, but are not limited to:

- Posting at Care Centre, in common areas and in staff lounges
- Publishing stories and results on the website, on social media
- Direct email to staff and families and other stakeholders
- Handouts and one: one communication with residents
- Presentations at staff meetings, town halls, Resident Councils, Family Council
- Huddles at change of shift
- Use of Champions to communicate directly with peers

[i] FLTCA s.4.(1) (b).

[ii] Quality Improvement in Healthcare: 5 Guiding Principles (healthcatalyst.com)

[iii] Model For Improvement Clip 1 - YouTube

[iv] Quality Improvement in Healthcare: 5 Guiding Principles (healthcatalyst.com)