Grove Park Home

2023 Quality Improvement Report

Program Evaluation Template

Program: Pharmacy

Date of Review: 2023

Policy/Standard Reference:

- See Silver Fox Pharmacies P&P Manual

Indicators/Methods Used to Monitor Program:

- Medication Incident reports
- Pharmacy provided reports and statistics
- Audits performed by Pharmacy and by GPH staff.

Participants and Positions:

Participants and Position		
Danie Cox	DOC	
Savita Dahliwal	SFP Pharmacist	
Jacalyn Krzak	Pharmacy Liaison	

State who participated and their position title.

Goals of the Program from Previous Year:

Goal & Plan	Date Achieved
Decrease of Medication Errors related to the use of the Writi Program	Not achieved in 2023-Increase Order sets are reviewed by MD/NP quarterly and PRN
To review/update/maintain current order sets to ensure the needs and rights of the residents are met.	
Transition to IMM with PCC to increase Medication Safety Technology	Achieved-Transition occurred in June 2023

State the goals that were set the previous year. Must be SMART Goals (Specific, Measurable, Achievable, Realistic, Time specific) and indicate if each goal was met.

Evaluation:

1. Based on established goals of the program, an analysis of the RAI-MDS indicators for this program and performance indicators from the Grove Park Home QI program, the resident outcomes related to the program have:

☐ Improved ■ Not Changed ☐ Not Met

Note: Include data that supports your evaluation (e.g. from department reports, CIHI reports or graphs from Board reports.

2. There are new best practices relating to this program (e.g. Best Practice Guidelines from the RNAO)

■ Yes ☐ No

Grove Park Home follows the Guidelines set in the Silver Fox P&P manual which is updated routinely by Silver Fox

Trends and Analysis: Medication Errors in 2023 as follows:

- Total 2023 medication errors = 129. In 2022 total = 49
- Omission errors = 62. These were largely r/t the Writi system with 43 occurring before we transitioned away from Writi and 18 occurring after the transition. This is up from 27 Omission errors in 2022.
- Transcription errors = 5. This is an increase from 4 transcription errors in 2022.
- Pharmacy errors = 17. This is increased from 1 in 2022. These errors are largely r/t the Writi system with 12/17 occurring prior to the transition away from Writi.
- Dosage errors = 22. This is an increase from 6 in 2022. These are largely r/t the Writi system as orders would often disappear from the system leading to missed dosage changes.
- Wrong Resident errors= 3. This number remains the same as 2022.
- Other errors = 20. This number is increased from 8 in 2022. The majority of these orders surround errors in the PMR's related to Writi. These errors slowly decreased after the Writi system was no longer in place.

Comments Related to Program:

- In 2023, GPH transitioned away from the Writi Program related to a noted increase in medication error related to the program. The program shut down operations shortly after we made this decision related to software issues.
- GPH returned to paper written orders after transitioning away from Writi, noting a substantial decrease in medication errors after this.
- GPH continues the "Drug of The Month Club" with the support of the Silver Fox Team to provide education on frequently used drugs and drug classes to all Registered Staff.
- Annual Medication Administration and P&P education occurred in July of 2023 for all registered staff.
- Transition to IMM occurred in June 2023 with education provided to all Registered staff.

AIM for Upcoming Year:

Change Ideas (will be reflected on the home's QIP) "What change can we make that will result in an improvement?"			
Planned Improvement Initiative (change idea)	**Methods and Process Measures "How will we know that the change resulted in an improvement?"**	**Goals for Change Ideas**	**Comments**
Increase in Night shift Registered staff	Audits of medication rooms, carts, Controlled substance count binders, glucometer calibration process.	*To note decrease in medication errors involving receiving medications *To see improvement in Pharmacy GPH audits. *Increased compliance with Glucometer calibration process.	The increase in registered staff on night shift will allow for more support through the night, allowing for increased focus on pharmacy processes that have not been prioritized in the past.
To decrease medication errors quarterly	Medication error trends are tracked by DOC and Nursing Administrative Assistant and decrease in med errors will be noted in this tracking.	*New process of Silver Fox emailing NP when families decline cost of med to decrease med errors r/t this. *DOC to implement 3 tiered warning system surrounding repeated medication errors.	NP and DOC work together to review each medication error, implementing interventions and providing education for each one.
To improve communication between pharmacy staff and Registered staff at GPH		DOC to provide on-going education to staff surrounding Silver Fox contact list and empower staff to reach out with questions and concerns.	
Planned Medication Safety Technology for 2024		Surveillance cameras planned for install in all medication rooms (Install date TBD)	Cameras will allow for review of situation when a medication error occurs or if a controlled substance is found missing

Program Evaluation Template

Program: Nursing and Personal Care

Date of Review: 2023

Policy/Standard Reference:

- See Nursing Manual

Indicators/Methods Used to Monitor Program:

- Stats of filled/unfilled shifts
- Family/staff/resident concerns
- Compliance with offered and mandatory education

Participants and Positions:

Participants and Position		
Danie Cox	DOC/Lead	
Charmaine Andreasen	ADOC	
Sara Pearson	ADOC	
Suzanne Briggs	Director of HR	

State who participated and their position title.

Goals of the Program from Previous Year:

Goal & Plan	Date Achieved
To improve Communication with all Nursing Staff	Ongoing
To continue decrease use of agency staff through recruitment and retention efforts	Ongoing

State the goals that were set the previous year. Must be SMART Goals (Specific, Measurable, Achievable, Realistic, Time specific) and indicate if each goal was met.

Evaluation:

1. Based on established goals of the program, an analysis of the RAI-MDS indicators for this program and performance indicators from the Grove Park Home QI program, the resident outcomes related to the program have:

☐ Improved ■ Not Changed ☐ Not Met

Note: Include data that supports your evaluation (e.g. from department reports, CIHI reports or graphs from Board reports.

2. There are new best practices relating to this program (e.g. Best Practice Guidelines from the RNAO)

■ Yes ☐ No

Grove Park Home continues to implement RNAO Best Practice Guidelines in all programs

Trends and Analysis:

- A meeting process was initiated in May 2023 in which the DOC and ADOC's hold "Huddle" meetings as follows:
  - with each unit twice weekly on day and evening shift
  - Mon-Fri with the Charge RN on days and evenings
  - Quarterly with Night shift staff
  - Quarterly and as needed RN meetings are held
  - DOC has a touch base with both Night shift Charge RN's every 8 weeks to ensure they feel part of the team.
  - DOC has a quarterly touch base with Nursing Administrative Assistant
  - DOC/ADOC's/Nursing Administrative Assistant Meet q Monday to review the past week and outline the upcoming week.
- Recruitment has been a focus in 2023 and will remain a goal in 2024. A decrease in the number of unfilled Nursing lines has been noted in 2023 with a significant decrease in Registered staff open lines. Attendance was addressed across the entire nursing department with initial attendance letter in the last quarter of 2023. Review to assess any improvement in attendance will occur post the first quarter of 2024.

Comments Related to Program:

AIM for Upcoming Year:

Change Ideas (will be reflected on the home's QIP) "What change can we make that will result in an improvement?"			
Planned Improvement Initiative (change idea)	**Methods and Process Measures "How will we know that the change resulted in an improvement?"**	**Goals for Change Ideas**	**Comments**
To continue focus on recruitment and retention of staff	-Measured by stats of unfilled shifts and unfilled lines		
To implement a process for regular performance reviews of all nursing staff.	-Stats of completed performance reviews	To have process in place to ensure an annual performance review is completed with each Nursing department employee	
To maintain current level of communication with staff	-A record of each huddle is documented by DOC/ADOC and kept in DOC office		

Note: A complete program evaluation must include review of the policy, procedure and forms used in the program. If a change is implemented, this must be reflected in all relevant program materials.

Program Evaluation

Program: Medical

Date of Review: 2023

Policy/Standard Reference:

Indicators/Methods Used to Monitor Program:

- Family survey feedback

Participants and Positions:

Participants and Position		
Danie Cox	DOC/Lead	
Dr Bruce McTurk	Medical Director	
Jennifer Riddell	RNEC- Nurse Practitioner	

State who participated and their position title.

Goals of the Program from Previous Year:

Goal & Plan	Date Achieved
To continue to facilitate the working relationship between MD and NP	Ongoing
To support communication between families and MD/NP	Ongoing
To have Medical Director and RNEC more involved in each program.	Ongoing

State the goals that were set the previous year. Must be SMART Goals (Specific, Measurable, Achievable, Realistic, Time specific) and indicate if each goal was met.

Evaluation:

1. Based on established goals of the program, an analysis of the RAI-MDS indicators for this program and performance indicators from the Grove Park Home QI program, the resident outcomes related to the program have:

☐ Improved ■ Not Changed ☐ Not Met

Note: Include data that supports your evaluation (e.g. from department reports, CIHI reports or graphs from Board reports.

2. There are new best practices relating to this program (e.g. Best Practice Guidelines from the RNAO)

☐ Yes ☐ No

Trends and Analysis:

- All feedback from Family Survey's remains positive. No complaints or concerns brought forward surrounding Medical care

Comments Related to Program:

- MD/NP have been attending an increased amount of meetings involving falls prevention, Responsive behaviors and staff meetings.
- Skin & Wound Policy updated in 2023 to ensure process for notifying medical team of wounds is in place.
- Communications between Pharmacy and Medical team have been improved to avoid future errors.

Tell a story about the program. Barriers, constraints, etc

AIM for Upcoming Year:

Change Ideas (will be reflected on the home's QIP) "What change can we make that will result in an improvement?"			
Planned Improvement Initiative (change idea)	**Methods and Process Measures** "How will we know that the change resulted in an improvement?"	**Goals for Change Ideas**	**Comments**
To facilitate communication between MD/NP and the RN team	Decrease in complaints from RN team	To finalize process of MD/NP list so that process is effective and efficient for all parties.	
Plan to move NP and MD into a shared office space in 2024 to strengthen working relationship and increase communication.	Move is planned for last week of February 2024		

Note: A complete program evaluation must include review of the policy, procedure and forms used in the program. If a change is implemented, this must be reflected in all relevant program materials.

Program Evaluation Template

Program: Critical Incidents

Date of Review: 2023

Policy/Standard Reference:

Enter the policy or standard relevant to the review (e.g. Inspection Protocol, LTCHA/Regulations …)

Indicators/Methods Used to Monitor Program:

- Resident Care Administrative Assistant tracks trends of CI's throughout the year

Participants and Positions:

Participants and Position		
Danie Cox	DOC	
Debbie Brown	Resident Care Administrative Assistant	

State who participated and their position title.

Goals of the Program from Previous Year:

Goal & Plan	Date Achieved
To see decrease in number of staff to resident abuse CI's in 2023	Remained equal

State the goals that were set the previous year. Must be SMART Goals (Specific, Measurable, Achievable, Realistic, Time specific) and indicate if each goal was met.

Evaluation:

1. Based on established goals of the program, an analysis of the RAI-MDS indicators for this program and performance indicators from the Grove Park Home QI program, the resident outcomes related to the program have:

☐ Improved ■ Not Changed ☐ Not Met

Note: Include data that supports your evaluation (e.g. from department reports, CIHI reports or graphs from Board reports.

2. There are new best practices relating to this program (e.g. Best Practice Guidelines from the RNAO)

■ Yes ☐ No

- GPH continues to implement RNAO's Best Practice Guidelines in all programs which lead to decrease in CI's.

Trends and Analysis:

- The total number of CI's in 2023 was 37. This is an increase from 21 in 2022.
- Staff to Res Abuse 2023= 4. After the "Abuse Awareness Day" providing education to all staff surrounding the types of abuse and duty to report, though the number of CI's involving staff to resident abuse remained the same in 2023 related to one repeat offender, the number of staff involved in Staff to resident abuse decreased in 2023.
- Res to Res Abuse in 2023= 7. This number was an increase from 2 in 2022 r/t increased admissions with physical behaviors in 2023..
- Fall with injury 2023 = 10. This is an increase from 6 in 2022 r/t to increased admissions with significant falls history and increased cognitive impairment than previous years.
- Outbreaks 2023= 8. This is an increase from 4 in 2022 r/t the way Public Health began managing outbreaks in 2023.
- Written c/o 2023 =5. This is an increase from 1 in 2022. Noted trend that families are less trusting of healthcare in 2023.
- Environmental Hazzard 2023= 2 (Both r/t hot water). This is an increase from 1 in 2022 (internet).
- Glucagon Use with transfer to hospital 2023 = 1. There were none in 2022.
- Unexpected Death 2023 = 0. This is a decrease from 2 in 2022.

Comments Related to Program:

- There was a larger number of CI's in 2023 as compared to previous years; however, a decrease in Abuse related CI's.
- The termination of some staff who had been implicated in abuse related CI's repeatedly over the past years contributed to this decrease.
- Related to the way Public Health manages Disease Outbreaks there was an increase in outbreaks in 2023 which contributed to the increase in number of CI's (Outbreak number was assigned to each unit involved in one Outbreak for a period of time, leading to increased reporting).

AIM for Upcoming Year:

Change Ideas (will be reflected on the home's QIP) "What change can we make that will result in an improvement?"			
Planned Improvement Initiative **(change idea)**	**Methods and Process Measures** **"How will we know that the change resulted in an improvement?"**	**Goals for Change Ideas**	**Comments**
To have a decrease in overall number of CI's in 2024	Monitoring of trends and analysis	*To ensure monthly review of CI's occurs with Management team *Continue to review Analysis & trends of	

		CI's at quarterly PAC meeting.	
To decrease the number of Falls with injury CI's.	Monitoring of falls statistics.	See Falls Prevention Program review.	

Note: A complete program evaluation must include review of the policy, procedure and forms used in the program. If a change is implemented, this must be reflected in all relevant program materials.

Program Evaluation Skin and Wound 2023

Program: Wound and Skin Program

Date of Review: December 2023

Policy/Standard Reference: Skin and Wound Care Policy NUR-05-05 (rewritten November 2023)

Enter the policy or standard relevant to the review (e.g. Inspection Protocol, LTCHA/Regulations ...)

Indicators/Methods Used to Monitor Program:

- CIHI Reports
- Decreased in number/severity/worsening of wounds
- Staff documentation/education

What indicators/methods are being used to monitor the program's performance (e.g. CIHI report ...)

Participants and Positions:

Participants and Position		
Allison Raymond – RPN	Registered Dieticians	Gaga Abbott
Jennifer Riddell – NP	Jodie Penfold / Sara Pearson – ADOC	
Danie Cox – DOC	Travis Durham – Dietary Manager	

State who participated and their position title.

Goals of the Program from Previous Year:

Goal	Date Achieved
Complete a skin-tear prevention in-service for PSW (will make as goal for 2024)	Not Completed (Training provided to staff as needed)
Continue to track internally and externally acquired pressure ulcers	Completed Monthly
Achieve indicator below 4% for facility - Has a stage 2 to 4 pressure ulcer	Not met Closest we've come in 4 years (4.4%)
Continued education for wound care team	Pressure Injury Prevention Day – Nov 16, 23 Pressure Injury Staging – Nov 16, 23
Implement the Bates Jenson Wound Assessment Tool on the units	October 11, 2023 Completed for Registered Staff
Ensure accuracy of Care Plans	Ongoing

State the goals that were set the previous year. Must be SMART Goals (Specific, Measurable, Achievable, Realistic, Time specific) and indicate if each goal was met.

Indicators for the year – Quarterly - Q4 (Jan-Mar), Q1 (Apr-June), Q2 (July-Sept)

Indicator Grove Park Home	Percentage Q4 2022	Percentage Q1 2023	Percentage Q2 2023
Has a stage 2 to 4 pressure ulcer	4.4%	5.1%	5.1%
Worsened stage 2 to 4 pressure ulcer	1.7%	2.2%	2.2%
Has a new stage 2 to 4 pressure ulcer	1.5%	1.8%	1.8%
Indicator Provincial – Ontario / Sector: Residential	Percentage Q4 2022	Percentage Q1 2023	Percentage Q2 2023
Has a stage 2 to 4 pressure ulcer	4.6%	4.6%	4.6%
Worsened stage 2 to 4 pressure ulcer	2.4%	2.4%	2.4%
Has a new stage 2 to 4 pressure ulcer	1.9%	1.9%	1.9%

Indicators for the year – Yearly 2019 - 2022

Indicator Grove Park Home	Percentage 2019 2019-2020	Percentage 2020 2020-2021	Percentage 2021 2021-2022	Percentage 2022 2022-2023
Has a stage 2 to 4 pressure ulcer	9.8%	5.5%	5.0%	4.4%
Worsened stage 2 to 4 pressure ulcer	5.7%	3.5%	2.8%	1.7%
Has a new stage 2 to 4 pressure ulcer	4.6%	2.7%	2.5%	1.5%
Indicator Provincial - Ontario Sector: Residential	Percentage 2019 2019-2020	Percentage 2020 2020-2021	Percentage 2021 2021-2022	Percentage 2022 2022-2023
Has a stage 2 to 4 pressure ulcer	4.8%	4.6%	4.6%	4.6%
Worsened stage 2 to 4 pressure ulcer	2.5%	2.5%	2.4%	2.4%
Has a new stage 2 to 4 pressure ulcer	2.0%	2.0%	1.9%	1.9%

Evaluation:

1. Based on established goals of the program, an analysis of the RAI-MDS indicators for this program and performance indicators from the Grove Park Home QI program, the resident outcomes related to the program have:

☒ Improved ☐ Not Changed ☐ Not Met

Note: Include data that supports your evaluation (e.g. from department reports, CIHI reports or graphs from Board reports.

2. There are new best practices relating to this program (e.g. BPG from the RNAO)

√ Yes ☐ No

- October 2019 launch of the BPG – Assessment and Management of Pressure Injuries for the Inter-professional Team. Implemented January 2020 with team meetings.

Trends and Analysis:

- 2022/2023 percentage indicators are lower than the provincial average for residential sectors.
- Policy was completely rewritten Fall 2023

- Maintained percentage of pressure injuries for 2022/2023 – quarter low of 4.4% – quarterly high of 5.1%.
- Multiple externally acquired pressure injuries were noted (on new admissions and return form hospitals) – all others were internally acquired – monthly tracking continues

Significant wounds that healed:

Pressure Injuries (Stage 3 or greater)

Externally acquired	Stage 4 PI	Coccyx	Closed
Internally acquired	Stage 3 PI	Coccyx	Closed
Externally acquired	Stage 3 PI	Coccyx	Closed
Externally acquired	Infected surgical incision to left hip		Closed

Other Wounds

Type 3 S/T – 5.5x2.5cm in size – externally acquired	Closed
Compound fracture to left D1 – internally acquired	Closed

Comments Related to Program:

- Photos are now being uploaded to misc. section of PCC routinely
- Continued to use offloading boots with good effect – all are out in place
- 60 wedges previously ordered are being implemented throughout the units for offloading
- Saw benefits of working with Triad – hydrophilic wound dressing of zinc, Vaseline and silicone – cost effective treatment practice
- Implemented NPWT on G. Profit – externally acquired stage 3 PI closed within 8 weeks.

Staff	Date	Title	# of Staff Attended
Maple Staff	June 2023	NPWT Dressing Change Instructions - PowerPoint	1
Registered Staff	October 11, 2023	Bates Jensen Wound Assessment Tool Training	15
PSW	November 16, 2023 X2 session times	Staging of Pressure Injuries	22
All Staff	November 16, 2023 Throughout day	Pressure Injury Prevention Day	16 Multiple on-the-spot in-services

AIM for Upcoming Year:

Change Ideas (will be reflected on the home's QIP) "What change can we make that will result in an improvement?"			
Planned Improvement Initiative (change idea)	**Methods and Process Measures "How will we know that the change resulted in an improvement?"**	**Goals for Change Ideas**	**Comments**
Complete a skin-tear prevention in-service for PSW (ongoing request not completed)	Improvement in number of skin tears – improve skin integrity	Decreased skin tears	To be completed by Allison
Continue to track internally and externally acquired pressure ulcers	To see decreased in internally acquired pressure injuries	Decreased pressure injuries	To be completed monthly
Achieve indicator below 4% for facility - Has a stage 2 to 4 pressure ulcer	CIHI data collections	Continue with current changes and implementation projects	
Continued education for staff	Better knowledge gained to improve quality of care of wounds for residents	Continue to seek out online learning	
Assess completion rate of the Bates Jenson Wound Assessment Tool on the units	Routine data checks for collections to be completed	Accurate documentation of wounds	
Ensure accuracy of Care Plans	Quarterly reviews of skin and wound section of care plans to ensure up to date and accurate information	To be completed quarterly when RAI assessments completed	To be completed quarterly

Note: A complete program evaluation must include review of the policy, procedure and forms used in the program. If a change is implemented, this must be reflected in all relevant program materials.

Program Evaluation

Program: Falls Prevention

Date of Review: December 2023

Policy/Standard Reference: Falls Prevention Program – Policy # NUR-05-11

Enter the policy or standard relevant to the review (e.g. Inspection Protocol, LTCHA/Regulations ...)

Indicators/Methods Used to Monitor Program:

- CIHI Reports
- Decreased in number of falls /residents who fell / severity of falls / injury post fall
- Staff documentation / education

What indicators/methods are being used to monitor the program's performance (e.g. CIHI report ...)

Participants and Positions:

Participants and Position		
Allison Raymond – RPN	Jodie Penfold / Sara Pearson – ADOC	Danie Cox - DOC
Jennifer Riddell - NP	Camille Sposito – PTA	Registered Dieticians
Candice Godin – R/C	Alexandra MacPherson - PT	

State who participated and their position title.

Goals of the Program from Previous Year:

Goal	Date Completed
Review and update policy and procedure forms	Initiated – though not completed Has been added for goal for 2024
Decrease in falls rates	Rates vary monthly
Increase completion rate of post falls assessments	Completion rates vary monthly. Email was sent to agencies to distribute to their staff
Ensure accuracy of Care Plans	Ongoing – care plans are reviewed quarterly
Continue with monthly falls meeting	Goal Met – Monthly falls team meetings continue
Continue with obtaining monthly falls data – disseminate to all staff with email	Goal Met – falls data continues to be obtained monthly with emails sent out to all staff
Falls rate to be below provincial average	Continue to be higher than provincial average

State the goals that were set the previous year. Must be SMART and indicate if each goal was met.

Evaluation:

1. Based on established goals of the program, an analysis of the RAI-MDS indicators for this program and performance indicators from the Grove Park Home QI program, the resident outcomes related to the program have:

☐ Improved ☒ Not Changed ☐ Not Met

Note: Include data that supports your evaluation (e.g. from department reports, CIHI reports or graphs from Board reports.

There are new best practices relating to this program (e.g. Best Practice Guidelines from the RNAO)

☒ Yes ☐ No

- GPH has implemented the RNAO Best Practice Guideline of the Prevention of Falls and Fall Injuries in the Older Adult

Quarterly - Quality Indicator: Has fallen
Residential Sector

	Q3 2022 October - December	Q4 2022 January – March	Q1 2023 April – June	Q2 2023 July – September
Ontario Average	16.6%	16.5%	16.6%	16.6%
Grove Park Home	20.0%	19.2%	19.5%	21.5%

Yearly - Quality Indicator: Has fallen
Residential Sector

	2019 2019-2020	2020 2020-2021	2021 2021-2022	2022 2022-2023
Ontario Average	16.5%	16.7%	16.2%	16.5%
Grove Park Home	19.8%	21.6%	17.4%	19.2%

Monthly Statistics for the Year:

Month	Number of Falls	Number of Residents who Fell	Transfer to Hospital Post Fall	Hospital Admissions Post Fall
January	57	25	X1 suspected rib # X1 suspected hip #	1 – fractured rib
February	46	23	X1 suspected toe #	1 – fractured toe
March	69	29	X2 suspected hip #	1 – fractured R hip
April	78	30	X1 suspected hip # X1 suspected nose #	1 – fractured R hip 1 – fractured nasal bridge
May	72	28	-	-
June	69	33	X1 suspected femur # X1 suspected hip #	1 – fractured femur 1 – fractured R hip
July	43	28	X1 back/neck pain	-
August	50	26	X1 head laceration X1 suspected shoulder/hip #	1 – fractured R clavicle and R shoulder
September	59	30	X1 suspected hip #	1 – fractured L hip
October	69	29	X1 decreased LOC X1 decline in status	-
November	49	25	-	-
December	85	37	X1 concerns of compression # X1 left shoulder/arm concerns X1 suspected hip #	1 – fractured L hip

Trends and Analysis:

- Tied for highest falls rate September 2022 – December 2023 = 85 falls
- Increased in falls with injury noted (2022 = 6 fractures / 2023 = 11 fractures)
- Many falls continue at similar times
  - Nights after rounds (3-4am)
  - Days & evenings after meals and shift times

Education:

- Falls prevention month recognized
  - Fall prevention risk factors activity handed to all units – all units completed
    - Unit activity to identify ways to reduce risk factors from A to Z
    - All units completed, results were posted to the white board
    - Units received a treat box
  - Cards handed out "I'm stepped up to prevent falls and injuries by: _____"
    - Most units participated and placed their completed cards on the unit
  - Fall scenario
    - "Pandy Patterson" had a fall in the SCU
    - Staff were encouraged to attend the scene and record the numerous contributions that may have led to their fall as well as interventions that are available.
    - Poor attendance – 12 staff attended and completed the scenario

Comments Related to Program:

- Monthly Falls meeting continued routinely
- Varying completion in number of Post Fall Assessment being completed – audits continue monthly. Email was sent to S. Rosales to submit to the agencies for them to submit to their staff members to make aware of protocol.
- Found that staff were charting falls using 'post fall notes' instead of fall notes. Will continue to monitor. Unknown if ongoing concern and accuracy of monthly data.

Tell a story about the program. Barriers, constraints, etc

AIM for Upcoming Year:

Change Ideas (will be reflected on the home's QIP) "What change can we make that will result in an improvement?"			
Planned Improvement Initiative (change idea)	**Methods and Process Measures "How will we know that the change resulted in an improvement?"**	**Goals for Change Ideas**	**Comments**
Review and update policy	Ensure policy is up to date		To be completed by year end
Decrease in falls rates	CIHI data reports Monthly data reports	Monthly meetings with falls committee	

Increase completion rate of post falls assessments	Monthly audits being completed	Continue to discuss at monthly meetings	
Ensure accuracy of Care Plans	Quarterly reviews of care plans to ensure up to date and accurate information	To be completed quarterly by nursing staff	May need additional education to ensure accurate
Continue with monthly falls meeting	Ensure minutes are disseminated to all staff	No change	
Continue with obtaining monthly falls data – disseminate to all staff with email	Ensure data is emailed out to all staff to keep aware	No change	
Falls rate to be below provincial average	Obtain data from CIHI to monitor		
Participate in falls prevention month		Discuss ways to bring staff attention and awareness	

Note: A complete program evaluation must include review of the policy, procedure and forms used in the program. If a change is implemented, this must be reflected in all relevant program materials.

Program Evaluation Template

Program: Continence Program

Date of Review: December 2023

Policy/Standard Reference: Continence Care & Bowel Management

Enter the policy or standard relevant to the review (e.g. Inspection Protocol, LTCHA/Regulations ...)

Indicators/Methods Used to Monitor Program:

- CIHI Reports
- RAI data reports
- Staff documentation / education

What indicators/methods are being used to monitor the program's performance (e.g. CIHI report ...)

Participants and Positions:

Participants and Position		
Allison Raymond – RPN	Jodie Penfold / Sara Pearson - ADOC	Each unit has a PSW team lead – responsible for monitoring residents on their units.
Jennifer Riddell - NP	Registered Dieticians	
Danie Cox – DOC	Cheryl Buckle - Admin	

State who participated and their position title.

Goals of the Program from Previous Year:

Goal	Date Completed
Review and update policy, procedure, and forms	Partially completed Will make for goal for 2024
Decrease in worsened bladder continence by 1%	Goal Met Decreased (from 35.3% to 27.1%)
Decrease in worsened bowel continence by 1%	Goal Almost Met Decreased (from 35.3% to 34.5%)
Continue to monitor increased in urinary tract infections	Monitored by infection control routinely Increased rate from 3.7% to 4.7%

State the goals that were set the previous year. Must be SMART Goals (Specific, Measurable, Achievable, Realistic, Time specific) and indicate if each goal was met.

Evaluation:

1. Based on established goals of the program, an analysis of the RAI-MDS indicators for this program and performance indicators from the Grove Park Home QI program, the resident outcomes related to the program have:

☐ Improved ☒ Not Changed ☐ Not Met

Note: Include data that supports your evaluation (e.g. from department reports, CIHI reports or graphs from Board reports.

2. There are new best practices relating to this program (e.g. BPG from the RNAO)

☐ Yes ☒ No

GPH has chosen not to implement the guideline at this time.

CIHI Reports:

Grove Park Home – Quarterly Quality Indicators:

Indicator	Q2 – 2023 July – Sept	Q1 – 2023 Apr-June	Q4 – 2022 Jan-Mar	Q3 – 2022 Oct-Dec
Worsened bowel continence	35.5%	36.5%	34.5%	33.4%
Worsened bladder continence	27.6%	28.9%	27.1%	25.2%
Has Urinary Tract Infection	4.0%	3.9%	4.7%	5.4%
Improved bowel continence	20.5%	21.0%	21.4%	21.2%
Improved bladder continence	14.4%	13.6%	15.1%	15.6%

Ontario Resident Sector – Quarterly Quality Indicators:

Indicator	Q2 – 2023 July – Sept	Q1 – 2023 Apr-June	Q4 – 2022 Jan-Mar	Q3 – 2022 Oct-Dec
Worsened bowel continence	22.1%	22.0%	21.8%	21.5%
Worsened bladder continence	18.8%	18.6%	18.5%	18.5%
Has Urinary Tract Infection	3.9%	3.9%	3.9%	3.9%
Improved bowel continence	13.1%	13.2%	13.1%	13.0%
Improved bladder continence	7.9%	7.9%	7.8%	7.8%

Grove Park Home – Yearly Quality Indicators:

Indicator	2019 2019-2020	2020 2020-2021	2021 2021-2022	2022 2022-2023
Worsened bowel continence	32.9%	32.3%	35.3%	34.5%
Worsened bladder continence	25.8%	21.5%	35.3%	27.1%
Has Urinary Tract Infection	2.9%	5.5%	3.7%	4.7%
Improved bowel continence	22.1%	19.9%	21.0%	21.4%
Improved bladder continence	12.9%	14.4%	14.2%	15.1%

Ontario – Residential Sector – Yearly Quality Indicators;

Indicator	2019 2019-2020	2020 2020-2021	2021 2021-2022	2022 2022-2023
Worsened bowel continence	20.0%	19.9%	20.5%	21.8%
Worsened bladder continence	17.8%	17.9%	18.0%	18.5%
Has Urinary Tract Infection	3.7%	3.9%	3.9%	3.9%
Improved bowel continence	14.3%	13.8%	13.3%	13.1%
Improved bladder continence	8.1%	7.7%	7.9%	7.8%

Grove Park Home:

Indicator	Q4 2021 January – March	Q1 2022 April – June	Q2 2022 July – September
Number of residents on a scheduled toileting routine	48	51	49

Trends and Analysis:

- Implementing bowel routines has positively impacted bladder/bowel continence
- Monthly data continues to support the data that many falls are related to continence / incontinence / resident attempting to toilet themselves.
- New admissions continue to be assessed for toileting needs on admission.

Comments Related to Program:

- Tena Rep K. Burt assessed Maple resident (J. Calvert) to assess highly excoriated perineal region. Recommendation was to use Tena Ultra wipes and Cleansing cream.
  - Staff were vigilant on using this treatment though excoriation continued.
  - Swabs have been taken with orders written for multiple different treatment creams (and combinations) and medications have been trialed.
- We continued to struggle with multiple changes which have impacted our resident's ability to maintain continence including staffing shortages, multiple agency staff, isolation of residents in their room (new admissions/illness), significant increase in falls
- Remains significantly above provincial averages for worsened bladder and bowel continence
- Have sent emails out regarding the importance of not double briefing
- Continue to have staffing struggles with putting what product on residents
- Room audits have been completed with finding many (16 in one room) briefs in rooms

Tell a story about the program. Barriers, constraints, etc

AIM for Upcoming Year:

Change Ideas (will be reflected on the home's QIP) "What change can we make that will result in an improvement?"			
Planned Improvement Initiative (change idea)	**Methods and Process Measures "How will we know that the change resulted in an improvement?"**	**Goals for Change Ideas**	**Comments**
Review and update policy, procedure and forms	Ensure policy is up to date		To be completed by year end
Decrease in worsened bladder continence by 1%	CIHI data reports	Continue with routine toileting Implemented NR plans	
Decrease in worsened bowel continence by 1%	CIHI data reports	Continue with routine toileting Implemented NR plans	
Continue to monitor increased in urinary tract infections	CIHI data reports	Continue with routine toileting Implemented NR plans	

Note: A complete program evaluation must include review of the policy, procedure and forms used in the program. If a change is implemented, this must be reflected in all relevant program materials.

Program Evaluation Template

Program: Infection Prevention and Control

Date of Review: 2023

Policy/Standard Reference: IPAC P&P, FLTCA 2021.

Indicators/Methods Used to Monitor Program:

- IPAC audits including hand hygiene, donning and doffing PPE, Smoking area, outbreak staff cohorting, high touch surfaces, resident room cleaning, break rooms, and self-assessment audit tool.
    - Audits are completed on a monthly basis normally then completed weekly when in outbreak.
- Monthly symptom surveillance is completed by registered staff then submitted for review by IPAC Lead.
- Infection rates and spread through facility.
    - Outbreak report from SMDHU once outbreak has been declared over and they have reviewed outbreak outcomes.
- Vaccination rates- collected by IPAC Lead and reported to SMDHU and MOHLTC.
- Daily documentation review – helps identify changes in the moment.

Participants and Positions:

Participants and Position		
Jodie Penfold	Interim ADOC/IPAC Lead	January 2023- October 2023
Sara Pearson	ADOC/IPAC Lead	October 2023 - Present

Goals of the Program from Previous Year: 2023

Goal	Date Achieved
Increase compliance of COVID-19 Boosters in staff and residents.	Ongoing
Increase compliance of influenza rates of staff and residents.	Ongoing
Ensure isolation signage is cohesive throughout the building.	Ongoing
Improve staff knowledge and compliance in placing resident on isolation.	Ongoing
IPAC Lead to obtain further education and certification.	Ongoing

Evaluation:

1. Based on established goals of the program, an analysis of the RAI-MDS indicators for this program and performance indicators from the Grove Park Home QI program, the resident outcomes related to the program have:

    ■ Improved ☐ Not Changed ☐ Not Met

2. There are new best practices relating to this program (e.g. Best Practice Guidelines from the RNAO)

    ■ Yes ☐ No

Trends and Analysis: COVD-19 and Respiratory outbreaks continue to affect residents and staff at GPH however the severity is lessoning. Vaccine burnout is evident with staff and residents and families.

Comments Related to Program:

- IPAC Lead reviews documentation and life labs portal daily. This allows for prompt response to results and changes.
- Registered staff ensure that symptoms are recorded and immediate action is taken to reduce transmission and isolate residents and/or placing residents in cohorts as necessary
    - The IPAC Lead analyzes this data daily to detect the presence of infection and appropriate isolation protocols were followed
    - The IPAC Lead reviews this data monthly to detect trends for the purpose of reducing the incidence of infection and outbreaks at Grove Park Home
- The IPAC Lead will input immunization statuses and T.B. chest x-ray results in PCC for new admissions and residents who have received new immunizations
    - "Special Instructions" will be updated with isolation specifics accordingly for a quick reference for staff, and the 24 hour census will be updated by the night charge RN for all Grove Park Home's staff daily review
    - C&S/swab results will be reviewed, provided to the MD or NP for interpretation and/or treatment, and posted under Infection Control notes in PCC as needed
- Barriers to the program: Staff vaccine and Covid-19/pandemic burnout, various Covid-19 response measure changes, many outbreak definition changes, ongoing changes with response to COVID-19.

AIM for Upcoming Year:

Change Ideas (will be reflected on the home's QIP) "What change can we make that will result in an improvement?"			
Planned Improvement Initiative (change idea)	Methods and Process Measures "How will we know that the change resulted in an improvement?"	Goals for Change Ideas	Comments
Initiate PHO UTI program.	The amount of inappropriate urine specimens collected will decrease.	Initiate PHO UTI program. Educate both registered staff and PSWs on the program.	This will help with decreasing inappropriate specimen collections as well as unnecessary antibiotic treatment.
Continue to increase compliance with RSV immunization rates with residents.	Monitor staff vaccination statistics to assess if compliance percentage rates are	Continue to offer RSV vaccine in house. Provide education surrounding	

	increasing.	importance of vaccination. Provide communication to staff and resident's families re: same. Provide direction that SMDHU advises to residents and families regarding RSV vaccine.	
Continue to increase compliance with Influenza immunization rates with residents and staff.	Monitor staff vaccination statistics to assess if compliance percentage rates are increasing	Continue to offer Influenza vaccine in house. Provide education surrounding importance of vaccination. Provide communication to staff and resident's families re: same. Provide influenza clinics at GPH in the fall.	
Continue to increase compliance with COVID-19 booster immunizations with residents and staff.	Monitor staff vaccination statistics to assess if compliance percentage rates are increasing.	Continue to offer Covid-19 Booster in house. Provide education surrounding importance of vaccination. Provide communication to staff and resident's families re: same.	
IPAC Lead to obtain further education and certification	Long Term Care Certificate in Infection Prevention – LTC- CIP designation.	LTC CIP exam to be booked and written.	Recertification must be done every 5 years.

Program Evaluation for 2023

Program: Palliative Care

Date of Review: Feb 13 2024

Policy/Standard Reference: Palliative Approach to Care Program NUR-05-06

Indicators/Methods Used to Monitor Program:

- Resident, Family & Staff feedback
- Improved quality of life for resident
- Palliative Care Plans
- Palliative Assessments-PPS, Frailty Scale, ESAS
- Pain Tracking-Abbey & OPQRST
- Pain/Palliative progress notes from PCC
- Feedback from Sue Martin-RN, CHPCN © Pain/Palliative/Symptoms Management Consultant
- NSMHPCN-LTC Palliative Care Project-Data Collection Tool
- Referrals to North Simcoe Muskoka Hospice Palliative Care Network
- Palliative Education
- Death of Location of choice

Participants and Positions:

Participants and Position		
Residents & Family	All residents & families who receive support	
Charmaine Andreasen	ADOC-Palliative Lead	
Charge RN/RPN	Registered Staff of the Building/Unit	
Dr. McTurk	Medical Director	
Jennifer Riddell	RNEC	
Sue Martin	NSMHPCN Pain/Palliative/Symptom Management Consultant RN	
Sherry Hubbard	NSMHPCN Palliative Consultant RN	
Unit Staff	Unit Meetings with the Palliative Care Lead Palliative Champions	The Pain/Palliative Team Lead meets with the Unit staff to assist them to identify who they feel is appropriate for an order for a "Palliative Approach to Care" order or requires more

		assessment of the resident's current pain

Goals of the Program from Previous Year:

Goal	Date Achieved
To provide more educational in-services as per staff 's identified needs	Ongoing
To establish Palliative Champions who can be a resource for staff	

Evaluation:

1. Based on established goals of the program, an analysis of the RAI-MDS indicators for this program and performance indicators from the Grove Park Home QI program, the resident outcomes related to the program have:

☐ X Improved ☐ Not Changed ☐ Not Met

Note: Include data that supports your evaluation (e.g. from department reports, CIHI reports or graphs from Board reports.

- Emergency Department Visits
- NSMHPCN-LTC Palliative Care Project-Data Collection Tool-which collects monthly data for 2023-Includes, total number of residents, number of palliative residents, number of residents transferred to hospital, number of residents who died at GPH, number of residents who died at hospital
- RAI Data

2. There are new best practices relating to this program (e.g. Best Practice Guidelines from the RNAO)

☐ Yes ☐ No X

Methods of Communication:

- Follow-up from families
- Internal Emails to staff to identify residents with a new/current palliative order
- Identifying Goals of Care
- Referrals to Registered Dietician
- Monthly List of Individuals who are currently a "Palliative Approach to Care" or "End-of-Life" posted in Tinkle Talk & emailed
- 24 Hour Census Form identifies Palliative Individuals
- ADOC/Behavioral Lead send a weekly summary of any resident who have received a new order for "Palliative Approach to Care" or "End of Life" made by the N/P-Jennifer Riddell & Dr. McTurk to all nursing staff and edit any abbreviations so all staff

understand the medication and the instructions for use & any additional interventions to provide comfort. The weekly list also includes residents who have died within the week.

Trends and Analysis:

Since 2020 and the pandemic of COVID Grove Park Home has required assistance with staffing from Agency staff. With the lack of consistency and continuity Grove Park Home has identified areas for improvement with communication, and training pertaining to the processes/policies of Grove Park Home. Grove Park Home has reached out the different agencies requesting them to consider providing routine staff to GPH to enhance the continuity of care for our residents and for our families to be able to recognize Agency staff. Grove Park Home has also implemented an "Agency" internal email and has also invited routine Agency staff to GPH in-services and mandatory training.

There was a decline in identifying residents who had an end of life order prior to their deaths for the months of August-October 2023. There were several admissions to GPH during this time and many residents had complex medical needs when they were admitted. As mentioned above another factor would be the use of Agency Staff who are not familiar with the resident's daily health status, to be able to distinguish a change.

Comments Related to Program:

- Monthly meetings with staff to identify those who are appropriate for a "Palliative Approach to Care" order or "End of Life"
- Staff have been advised to complete pain tracking under the assessment section in Point Click Care or POC (to be completed by PSW staff) to identify trends related to pain
- Families continue to be notified when there is a change in the current treatment plan to assist with pain or initiate a "Palliative Approach to Care" order. Family are encouraged to participate in the Care Planning
- Dr. McTurk and N/P-Jennifer Riddell is actively involved in updating families of changes with resident's current diagnoses and explaining the next steps towards palliation and goal planning

Goals Attained for 2023:

Change Ideas (will be reflected on the home's QIP) "What change can we make that will result in an improvement?"			
Planned Improvement Initiative (change idea)	**Methods and Process Measures "How will we know that the change resulted in an improvement?"**	**Goals for Change Ideas**	**Comments**

To ensure all staff receive training on the PPS Scale & Palliative Training as per MOLTC	Sue Martin-Palliative Consultant RN came to GPH for a 4 Week Palliative Program-Plan & Assess, Advance Care Planning, Symptom Management which all designations attended	To continue to utilize Sue's expertise within the facility to assist with ongoing staff education	Sue Martin-NSMHPCN Pain/Palliative/Symptom Management Consultant RN provided education to staff on the following dates: PPS Education-Jan 24/23-31 staff attended ESASr Education-Feb 7/23-33 staff attended Frailty Score Education-Feb 21/23-39 staff attended Palliative Approach/Pain Management-March 1/23-3 hr educational session for RPN Staff- 7 staff attended Early Identification & Prognostic Tool Education-March 7/23-36 staff attended Palliative Care Tools Training-for Registered Staff-March 8/23-11 staff attended Palliative Education for Registered ESAS review, Scenarios/Case Studies, Biase Exposure, Self-Awareness & Symptom Management-Sept 19th & 21st 2023
To add the frailty scale , CAM, PPS, ESAS in Point Click	By adding the assessments to PCC, all designations can	When Registered staff are approached by staff regarding the appropriateness of a	Added to Point Click Care on March 14, 2023

Care	view the results.	resident for a "Palliative Approach to Care" order they can review the assessments or complete a new one if required	
To have Sue Martin provide education to registered staff of who to complete the monthly assessments- PPS & ESAS for resident's who currently have an order for "Palliative Approach to Care" or "End of Life"	Staff to complete assessments- PPS & ESAS (if appropriate- resident can participate) to be completed monthly on each resident who currently has a "Palliative Approach to Care" or "End of Life" order	Change the Policy to include the expectation of monthly assessments	Palliative Care Tools Training-for Registered Staff-March 8/23-11 staff attended Palliative Education for Registered Staff-Utilizing the Palliative Tools in PCC-May 2/23-13 staff attended, July 6th-1 staff attended, July 12/23-2 staff attended
To teach registered staff how to complete a palliative assessment	Palliative assessments being completed for Dr. McTurk/N/P's review	Add a "drop down bar" for a Palliative Assessment to be able to quickly review changes as they take place and to be able to print off a report for prescribers/resident/families ADOC/Palliative Lead, Charmaine Andreasen will send an email with an example of what needs to be included to complete a palliative assessment when staff identify the resident as declining	Completed January 28, 2023
To teach staff how to add or update a resident specific Palliative Care Plan	ADOC/Palliative Lead, Charmaine Andreasen updated resident Care Plans for those residents who currently had an order for a "Palliative Approach to Care"	Palliative Lead/ADOC- Charmaine Andreasen will make a list of GPH Registered Staff and prepare a schedule to ensure all Registered staff have an opportunity to receive 1:1 training	Sue Martin- NSMHPCN Pain/Palliative/Symptom Management Consultant RN completed training with staff on May 9th, 10th, 24th 2023

	or "Palliative/End of Life". Sue Martin- Palliative Consultant RN will come and work 1:1 with registered staff to maintain/update the Palliative Care Plans		
<u>AIM for 2024:</u> To increase the number of residents who receive a "Palliative Approach to Care" order	Palliative Care Lead will collect monthly data pertaining to the number of residents who have a "Palliative Approach to Care" order To see an increase of 2%	Continue to mentor staff to complete PPS tool when they note a decline in the residents overall health	
To improve the number of residents who have an order for End-Of-Life prior to their death	Palliative Care Lead will collect monthly data pertaining to the number of residents who have an " End-of-Life" order To see an increase of 2%	A meeting took place with Sue Martin on January 29/24 with Palliative Lead/ADOC-Charmaine Andreasen, Dr. McTurk, Jennifer Riddell-N/P, Sue Martin-Pain/Palliative/Symptom Management Consultant to discuss when an order for a "Palliative Approach to Care " order and End-of-Life order should be initiated	
To utilize the Palliative Care	Palliative Lead/ADOC-	Return to monthly Unit Huddles which the Palliative	

Champions	Charmaine Andreasen will initiate a monthly Palliative Care meeting for 10 out of the 12 months of 2024	Care Champions can lead & collect data to support the decline the resident is experiencing	

- Policies and procedures reviewed January 13/2023-Revised made and approved by Executive Director-Paul Taylor

Program Evaluation for 2023

Program: Quality Improvement

Date of Review: Feb 20 2024

Policy/Standard Reference: Fixing Long-term Care Act 2021, Section Reg 165-169, Regulations O.Reg 246/22

Indicators/Methods Used to Monitor Program:

- Resident, Family & Staff feedback
- Improved quality of life for residents
- Best Practice Guidelines are followed
- Required education as per MOLTC are met annually

Participants and Positions:

Participants and Position		
GPH Staff	All Staff of Grove Park Home	
Charmaine Andreasen	Grove Park Home-ADOC/Educational Coordinator	
Suzanne Briggs	Director of Human Resources/Educational Director	
Debbie Brown	Administrative Assistant for Nursing	
Amanda Phillips	Grove Park Home PSW from Pine Unit	
Savita Dhaliwal	Consultant Pharmacist -Silver Fox Pharmacy	
Claire Campbell	Resident POA for	
	Grove Park Home-Resident from Aspen Unit	
Amy Randhawa	Consultant Pharmacist-Silver Fox Pharmacy	
Candice Godin	Grove Park Home Restorative Care Coordinator	
Ashley Allan	Royal Victoria IPAC Consultant	
Danie Cox	Grove Park Home-Director of	

	Care	
Paul Taylor	Grove Park Home-Executive Director	
Sandy Wolf	Grove Park Home-Director of Environmental Services	
Travis Durham	Grove Park Home-Director of Food & Nutrition & IT	
Cindy Rositt	Grove Park Home PSW from Pine Unit	
Sara Pearson	Grove Park Home-Assistant Director of Care/IPAC Nurse	
Dr. McTurk	Medical Director for Grove Park Home	
Kerry Guy	Grove Park Home-Director of Programs & Volunteers	
Jennifer Riddell	Grove Park Home Nurse Practitioner	
Karen Speed	Grove Park Home-RAI Coordinator	
Joanne Chandler	Grove Park Home-Dietician	
Joanne Swales	Grove Park Home Registered Nurse	
Stephanie Nelson	Grove Park Home Registered Practical Nurse on Maple Unit	
Jodie Penfold	Grove Park Home Registered Nurse	

Goals of the Program from Previous Year:

Goal	Date Achieved

			sessions for each staff member on November 30th or December 7th 2023 Managing Emotions-presented by Jennifer Bodera & Peter Dangerfield-Waypoint Mental Health-1 hour sessions for each staff member on November 16th or 22nd 2023
<u>Aim for 2024:</u> To improve the number of staff at Grove Park Home who are completing Surge Learning	An improvement of 5% of the total number of staff who complete their Surge Learning modules will take place	Each Department Director will follow-up with their staff semi- annually to ensure Surge Learning is being completed	An email was sent out on Feb 27/24 to each Director to inform them of what staff had not complete the required Surge Learning Modules to date and to request they follow-up with staff from their department
To provide more interactive educational opportunities	To provide a total of 2 interactive educational opportunities in 2024	Provide signup sheets for staff to sign and rotate staff so all staff may attend	
To be able to provide "Living with Dementia" to all GPH Nursing Staff	Have 40% of GPH Nursing Staff attend the "Living with Dementia" Day	Invite other LTC Homes to bring their staff to GPH to complete "Living with Dementia"	

To continue to identify gaps in our current practices and complete an Action Plan	Ongoing
We will continue to strive to return to our practices prior to COVID and return our sense of community among all stake holders at Grove Park Home.	Ongoing

Evaluation:

1. Based on established goals of the program, an analysis of the RAI-MDS indicators for this program and performance indicators from the Grove Park Home QI program, the resident outcomes related to the program have:

☐ X Improved ☐ Not Changed ☐ Not Met

Note: Include data that supports your evaluation (e.g. from department reports, CIHI reports or graphs from Board reports.

- Family Survey
- Resident Survey
- Staff Survey
- Minutes from QI Meetings

2. There are new best practices relating to this program (e.g. Best Practice Guidelines from the RNAO)

☐ Yes ☐ No X

Methods of Communication:

- Family Survey
- Resident Survey
- Staff Survey
- Sharing of Quality Improvement Minutes
- Town Hall Meetings
- Care Conferences
- Phone Blasts to family

Trends and Analysis:

Comments Related to Program:

We recognize the need to return to our best practices in our provision of care prior to the COVID pandemic. Related to poor staffing and a sudden decrease in continuity of staffing related to using Agency Staff many of our approaches to care which makes us unique at Grove Park home has ceased. However despite the pandemic of COVID following into 2023 Grove Park Home has continues to look for opportunities to identify gaps and make change to our

current practices to improve the lives of the residents who reside at Grove Park Home. We will continue to strive to return to our practices prior to COVID and return our sense of community among all stake holders at Grove Park Home.

During 2023:

- Additional members have been added to the Quality Improvement Team as per FLTCA requirements-improvement noted with having additional stake holders present
- Orientation check list has been expanded to include FLTCA recommendations
- Focus towards improving the current Palliative Care Program-additional education, implementing the PPS score upon admission and when a resident has an order for "Palliative Approach to Care" the PSS is to be completed quarterly
- Directors of Nursing developed a communication tool to address frequently areas of concern and a schedule for the Directors to meet with staff on a routine basis
- Communication and medication errors had increased therefore a change was made from Writi to IMM bar coding system provided by Silver Fox Pharmacy

AIM for Upcoming Year:

Change Ideas (will be reflected on the home's QIP) "What change can we make that will result in an improvement?"			
Planned Improvement Initiative (change idea)	**Methods and Process Measures "How will we know that the change resulted in an improvement?"**	**Goals for Change Ideas**	**Comments**
<u>Resident Satisfaction Survey indicates:</u> An overall score of 90.1% Lowest Score Satisfaction of Meals=73%	Resident Satisfaction Survey will measure improvement by 2% Travis-Director of Food Services will attend Resident Council Meetings on alternate months to gather resident feedback	A new menu was started with resident feedback Bring back virtual show plates	
<u>Staff Satisfaction Survey indicates:</u>			

A need for resident focused care to be expanded and return to care which was provided prior to the pandemic	Audits to be completed on a regular basis surrounding the quality of personal care provided Orientation to include training of treating work area as a resident home Feedback from staff survey in 2024-Goal will be to achieve 93.0% in 2024	"Back to the Basics" resident focused care Having PSW Leads on the Units to assist with new hires, ensuring they are well orientated to the Unit and GPH expectations for care Additional training regarding behaviors & person-centered care	
Pressures within the home & outside of Grove Park Home are becoming more difficult to not bring into work Improve what the families understanding of who and how to report concerns	Inquiries regarding mental wellness & job satisfaction Staff feedback & improved relationships between families & staff	Find additional resources to educate & support staff regarding various mental health barriers Education to families during the Care Conferences & family meetings regarding who to contact to discuss resident care	
<u>Family Satisfaction Survey indicates:</u> Return of large group gatherings & outings Re-opening of the café Return of volunteers & recruitment	Feedback from families & residents Review café sales from prior to COVID Retain current volunteers & recruit	Follow Public Health Requirements related to IPAC however return to previous practices with activities within the home	

activities	more	Celebrate the efforts made by the volunteers & have a recruitment day	

- Policies and procedures reviewed January 13/2023-Revised made and approved by Executive Director-Paul Taylor

Program Evaluation for 2023

Program: Pain

Date of Review: Feb 13 2024

Policy/Standard Reference: Pain NUR-05-03

Indicators/Methods Used to Monitor Program:

- Resident, Family & Staff feedback
- Improved quality of life for resident
- Pain Tracking-Abbey & OPQRST
- Pain progress notes from PCC
- Feedback from Sue Martin-RN, CHPCN © Pain/Palliative/Symptoms Management Consultant
- NSMHPCN-LTC Palliative Care Project-Data Collection Tool
- Referrals to North Simcoe Muskoka Hospice Palliative Care Network

Participants and Positions:

Participants and Position		
Residents & Family	All residents & families who receive support	
Charmaine Andreasen	ADOC-Palliative Lead	
Charge RN/RPN	Registered Staff of the Building/Unit	
Dr. McTurk	Medical Director	
Jennifer Riddell	RNEC	
Sue Martin	NSMHPCN Pain/Palliative/Symptom Management Consultant RN	
Sherry Hubbard	NSMHPCN Palliative Consultant RN	
Unit Staff	Unit Meetings with the Pain/Palliative Care Lead	The Pain Team Lead meets with the Unit staff to assist them to identify who they feel requires more assessment of the resident's current pain

Goals of the Program from Previous Year:

Goal	Date Achieved
To provide more educational in-services as per staff 's identified needs	Ongoing

Evaluation:

1. Based on established goals of the program, an analysis of the RAI-MDS indicators for this program and performance indicators from the Grove Park Home QI program, the resident outcomes related to the program have:

☐ X Improved ☐ Not Changed ☐ Not Met

Note: Include data that supports your evaluation (e.g. from department reports, CIHI reports or graphs from Board reports.

- Emergency Department Visits
- RAI Data
- Pain Tracking-Abbey & OPQRST

2. There are new best practices relating to this program (e.g. Best Practice Guidelines from the RNAO)

☐ Yes ☐ No X

Methods of Communication:

- Follow-up from families
- Internal Emails to staff to identify residents who are currently experiencing an increase in pain
- Referrals to Registered Dietician if a wound is the cause of pain-to promote additional interventions to promote wound healing
- ADOC/Pain Lead send a weekly summary of any medication changes related to increased pain management made by the N/P-Jennifer Riddell & Dr. McTurk to all nursing staff and edit any abbreviations so all staff understand the medication and the instructions for use.

Trends and Analysis:

Since 2020 and the pandemic of COVID Grove Park Home has required assistance with staffing from Agency staff. With the lack of consistency and continuity Grove Park Home has identified areas for improvement with communication, and training pertaining to the processes/policies of Grove Park Home. Grove Park Home has reached out the different agencies requesting them to consider providing routine staff to GPH to enhance the continuity of care for our residents and for our families to be able to recognize Agency staff. Grove Park Home has also

implemented an "Agency" internal email and has also invited routine Agency staff to GPH in-services and mandatory training.

Comments Related to Program:

- Staff have been advised to complete pain tracking under the assessment section in Point Click Care or POC (to be completed by PSW staff) to identify trends related to pain
- Families continue to be notified when there is a change in the current treatment plan to assist with pain. Family are encouraged to participate in the Care Planning
- Dr. McTurk and N/P-Jennifer Riddell is actively involved in updating families of changes with resident's current diagnoses and explaining the next steps towards improving the pain the resident is experiencing

Goals Attained for 2023:

Change Ideas (will be reflected on the home's QIP) "What change can we make that will result in an improvement?"			
Planned Improvement Initiative (change idea)	**Methods and Process Measures "How will we know that the change resulted in an improvement?"**	**Goals for Change Ideas**	**Comments**
To ensure all staff receive training on the PPS Scale & Symptom Management	Sue Martin- Palliative Consultant RN came to GPH for a 4 Week Palliative Program- Plan & Assess, Advance Care Planning, Symptom Management which all designations attended	To continue to utilize Sue's expertise within the facility to assist with ongoing staff education	Sue Martin-NSMHPCN Pain/Palliative/Symptom Management Consultant RN provided education to staff on the following dates: Palliative Approach/Pain Management-March 1/23-3 hr educational session for RPN Staff- 7 staff attended ESAS review, Scenarios/Case Studies, Biase Exposure, Self-Awareness & Symptom Management-Sept 19th & 21st 2023
To teach staff how to add or update a	Sue Martin- Palliative Consultant RN will	Pain Lead/ADOC-Charmaine	Sue Martin- NSMHPCN Pain/Palliative/Symptom

resident specific Pain Care Plan	come and train 1:1 with registered staff to maintain/update the Pain Care Plans	Andreasen will make a list of GPH Registered Staff and prepare a schedule to ensure all Registered staff have an opportunity to receive 1:1 training	Management Consultant RN completed training with staff on May 9th, 10th, 24th 2023
<u>AIM for 2024:</u> Early identification of pain	Completed Abbey & OPQRST pain assessments Weekly pain tracking updates Follow-Up with residents regarding how their current pain level is A 2% reduction in pain that residents are experiencing	Return to Monthly meetings with staff to identify those who is experiencing an increase in pain Utilize pain tracking in "Point of Care" for PSW staff to complete for accuracy	

MANUAL **Nursing**	TITLE **Pain Management Program**		POLICY NUMBER NUR-05-03
CATEGORY **Resident Care**	**CROSS REFERENCE**		
	Department: Nursing	Resident Care	
CREATED Nov 2014	REVISED **May 2023**		PAGE 1 OF 7
LTC Act	**Section-** **NUR-05-03**	**Regulations**	

PURPOSE

The purpose of the Pain Management Program is to develop, implement, monitor and evaluate an interdisciplinary team approach to pain management that provides the resident with optimal comfort, dignity and quality of life. Specific goals include:

- To improve and maintain a resident's optimal functional level and quality of life;
- To optimally control pain for all residents;
- To reduce incidence of unmanaged pain;
- To ensure best practice interventions for residents with pain;
- To monitor and track trends related to pain management

The program focuses on communication and assessment methods for residents who are unable to communicate their pain or who are cognitively impaired, strategies to manage pain including non-pharmacologic interventions, equipment, supplies, devices and assistive aids, comfort care measures and monitoring of residents' responses to and the effectiveness of the pain management strategies. The program ensures team training, communication and effective care planning.

POLICY

Each resident must have a formal pain assessment on admission and be reassessed on readmission, quarterly and at significant condition changes. Resident experiencing pain must be treated using non-pharmacological and pharmacological methods to maximize function and promote quality of life.

All residents who have new pain or who have pain that is not relieved by initial interventions will receive a full assessment using the pain screening tools.

RAI MDS, assessment protocols and outputs will be reviewed in relation to pain and pain control with each new full assessment.

DEFINITION

Pain: An unpleasant subjective experience that can be communicated to others through self-report when possible and/or a set of pain-related behaviors; it is an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage.

Types of pain:

- Acute pain - is relatively brief that subsides as healing takes place
- Chronic pain - continues for a long period of time, generally is not curable, and can have episodes of exacerbation whereby certain activities or other conditions may cause the pain to reoccur

Categories of pain:

- Neuropathic pain - stimuli abnormally processed by the nervous system
- Nociceptive Pain- Normal processing of stimuli that damages normal tissues or has the potential to do so if prolonged; usually responsive to non-opioids and/or opioids.

RAI-MDS Definition:

Pain that is reported is unrelieved pain. If the resident does not have any pain due to pain management, then it is coded as "0" for no pain.

PROCEDURE

Pain Assessment & Management

Registered Nursing Staff

On Admission:

1. Collaborate with resident/Substitute Decision Maker to elicit a pain history and status. For example the resident:
    - states he/she has pain;
    - diagnosed with chronic painful disease;
    - has history of chronic unexpressed pain;
    - taking pain-related medication for >72 hours;
    - has distress related behaviors (e.g. changes in anxiety level) or facial grimace
    - Indicates that pain is present through family/staff/volunteer observation.
2. Screen residents within 24 hours of admission using:
    - If a resident arrives and we are not aware of their CPS score use your judgment. If they are able to make their own decisions related to care/financial and remain their

own POA then you may use the OPQRST scale. Otherwise please use the Abbey Pain Scale to determine their pain. Once an admission RAI/MDS is completed it may identify the resident would benefit from the OPQRST scale moving forward

- the Abbey Scale for residents who have a CPS score between 3-6.
- The OPQRST scale for residents who have a CPS score of 2 or less

3. Identify pain on the resident's care plan after 7 days of pain tracking is completed based on resident's assessed condition and the location, type and patterns of pain episodes, previous history of pain and what was used to manage pain in the past (both pharmacological and non-pharmacological interventions), contributing factors that may cause pain.
4. Obtain informed consent for the treatment interventions from the resident and/or the substitute decision-maker.

Ongoing:

5. Continue to screen the resident using the appropriate clinically appropriate (Abbey/OPQRST) for 7 days and thereafter including:
    - quarterly according to the RAI-MDS schedule;
    - when the resident exhibits a change in health status or pain is not relieved by initial interventions.
6. Screen resident daily for pain through conversation and observation
7. Complete the care plan within 21 days after admission and continue to update and adjust the care plan based on the RAI- MDS 2.0 assessment and daily assessments. The Pain, Cognitive Performance (CPS) and Communication (COM) outcome scales will inform three (3) questions.
    - Does the resident have pain (Pain Scale), its frequency (J2a) and Intensity (J2b)
    - Is the resident able to communicate the pain? (COM)
    - Is cognitive impairment affecting the ability to communicate? (CPS)
8. There is a strong relationship between pain and depression so the Depression Rating Scale, (DRS) may also be reviewed in the presence of pain.
9. Implement strategies to effectively manage pain including pharmacological and non-pharmacological interventions (e.g. positioning, distraction, relaxation, massage, heat and cold therapies.
8. Obtain informed consent for treatment when making changes to the care plan from the resident and/or Substitute Decision Maker (SDM).
9. Document the effectiveness of the interventions.
10. Monitor and evaluate the care plan at least quarterly and more frequently as required based on the resident's condition in collaboration with the interdisciplinary team. If the interventions have not been effective in managing pain, initiate alternative approaches and update as necessary.

11. Communicate to the team, the resident/SDM whenever there is a significant change to the care plan regarding pain prevention on an ongoing basis and annually at the care conference.

Personal Support Workers

1. Note behaviors in the non-verbal, cognitively impaired person such as:

    - flat affect;
    - decreased interaction;
    - decreased intake;
    - altered sleep pattern;
    - rocking;
    - negative vocalization;
    - frown or grimacing;
    - noisy breathing

and report to Registered staff

2. Participate with the interdisciplinary team in providing non-pharmacological interventions as directed (e.g. relaxation, music therapy, massage)

Interdisciplinary Team

1. Follow the interventions as outlined on the care plan.
2. Recognize and report resident verbalizations and behaviors indicative of discomfort/pain.
3. Report any decreases in any of the following; physical and social activity, energy, appetite, continence and sleeping patterns.
4. Share with team members resident interventions that are most effective for the resident.
5. Encourage maintenance/restorative/supportive care measures as supported through pain management approaches.
6. Support resident comfort and interests.

Pharmacist

1. Collaborate and communicate with the interdisciplinary team to ensure effective pharmacological pain management with minimum side effects.
2. Participate in Pharmacy and Therapeutic Committee meetings and review pain indicators.
3. Monitor when residents are taking prn medications and recommend drug regime options.

Restorative Care/Physiotherapist

1. Assess as appropriate for musculoskeletal and neurological conditions and contributing pain factors.
2. Develop, and implement therapeutic interventions for the assessed conditions.
3. Evaluate and advise the interdisciplinary team of the impact of pain on mobility and Activities of Daily Living status and recommend assistive mobility and adaptive aids.
4. Work with resident/ SDM re seating and mobility comfort.
5. Encourage resident independence as tolerated.
6. Work with external companies in relation to seating and mobility devices.
7. Work with resident and SDM to ensure that equipment remains in good condition.
8. Educate resident and SDM on approaches that supports pain management and resident comfort.

Physician/Nurse Practitioner

1. Review medications.
2. Obtain informed consent for the treatment from the resident and/or the substitute decision-maker.
3. Ensure that the selection of analgesics is individualized to the person, taking into account:
    - the type of pain (acute or chronic, nociceptive and/or neuropathic);
    - intensity of pain;
    - potential for analgesic toxicity (age, renal impairment, peptic ulcer disease, thrombocytopenia);
    - general condition of the resident;
    - concurrent medical conditions;
    - response to prior or present medications
    - considered one at a time and according to the WHO Analgesic Ladder to achieve optimum control that may be slowly titrated up.

Dietitian

1. Completes nutritional risk assessment
2. Suggests adequate fluid and diet intake to reduce the possibility of constipation

Resident/SDM

1. Provides an accurate history including strategies that have been effective in the past.
1. Works with staff for input into, support and evaluation of the plan of care.
2. Attends the interdisciplinary care conference.

Non-Pharmacological Pain Relief

Alternatives to medication for pain control can include referring to physio therapy or restorative care services, applying heat/cold or massaging affected area and relaxation and distraction techniques such as meditation, music therapy, conversation, audio books and Montessori techniques. The resident may also require psychological or social support.

Monitor and Evaluate

Registered Nursing Staff

1. Monitor resident according to the care plan.
2. Continually monitor resident verbalizations and behaviors indicative of discomfort/pain.
3. Evaluate to determine if pain strategies are effective. Are changes to the care plan required?

Evaluate Annually

Annually evaluate the effectiveness of the policy for managing pain and what changes and improvements are required in the program to improve and maintain a resident's optimal functional level and quality of life and to ensure compliance with the Long-Term Care Homes Act and Regulation. RAI MDS quality indicators will be compared to the provincial average at the Quality Improvement/Risk Management Committee.

Indicators:

- % of residents with pain
- % of residents with worsened pain

Staff Orientation and Training

Staff Orientation

Prior to assuming their job responsibilities, direct care staff must receive training on pain management including pain recognition of specific and non-specific signs of pain.

Training

Direct care staff must receive annual retraining on pain management including pain recognition of specific and non-specific signs of pain.

Documentation and Parties Responsible

The following table describes the various forms of documentation required and the parties responsible.

Documentation	Parties Responsible
Informed consent	Physician, Nurse Practitioner, Registered Staff
Written order	Physician, Nurse Practitioner
Pain Screening Tool (Abbey, PQRST)	Registered Nursing Staff
MDS-RAI 2.0	Registered Nursing staff
Care plan	Registered nursing staff, interdisciplinary team
Quarterly reassessment	Physician, Nurse Practitioner, Registered Nursing Staff, Pharmacist
Annual evaluation of the effectiveness of the policy and improvement introduced resulting from the evaluation	Administrator, Director of Nursing or Care, Registered Nursing Staff

Administrator_____ Date:_____

Paul Taylor

Program Evaluation for 2023

Program: Behavior Management

Date of Review: February 14, 2024

Policy/Standard Reference: Behavior Management NUR-05-04

Indicators/Methods Used to Monitor Program:

- Family & Staff feedback
- Improved quality of life for resident
- Behavioral Care Plans
- Bi-weekly "Risk Rounds" meetings with the Geriatric Mental Health Team
- DOS/Behavior Tracking & behavior progress notes from PCC
- Critical Incidents/GPH Incident Reports
- Referrals to GMH Team & Geriatric Medicine
- RAI Data
- Weekly GMH Schedule, including which residents are being followed and the GMH Team will be in the building

Participants and Positions:

Participants and Position		
Residents & Family	All residents & families who receive support	
Charmaine Andreasen	ADOC/Behavioral Lead	
Laura Downey	RN/Lead for GMH Team	
Sherri Conohan-Thayer	GMH Team RPN	
Amanda LeDuc	GMH Team CSW	
Dr. Daniel	GMH Team/Geriatric Medicine	
Dr. McTurk	Medical Director	
Jennifer Riddell	RNEC	
Unit Staff	Unit Meetings with the GMH Team	The GMH Team meets with the staff to assist them to identify who they feel they require additional support with

Goals of the Program from Previous Year:

Goal	Date Achieved
To have the GMH Team work directly with the Unit staff and complete Unit Huddles to better assist with prioritizing the needs of the residents living at Grove Park Home.	Ongoing

Evaluation:

1. Based on established goals of the program, an analysis of the RAI-MDS indicators for this program and performance indicators from the Grove Park Home QI program, the resident outcomes related to the program have:

☐ Improved ☐ X Not Changed ☐ Not Met

Note: Include data that supports your evaluation (e.g. from department reports, CIHI reports or graphs from Board reports.

- CIHI report
- Clinical Data related to number of residents who are being followed by the GMH Team monthly
- Feedback from families/residents/Staff/Medical Director
- Monthly tracking report from Health & Safety related to responsive individuals /Watch List

2. There are new best practices relating to this program (e.g. Best Practice Guidelines from the RNAO)

☐ Yes ☐ X No

Trends and Analysis:

Comments Related to Program:

- Related to COVID-19 and MOLTC expectations related to admission it continues to be identified that the residents coming into GPH are more complex. There has been several incidents where a resident was being followed in the community with a the Behavioural Support Team however Grove Park was not made aware by the family until there was an escalation in responsiveness and Grove Park Home is reaching out to the family to make them aware.
- The Geriatric Mental Health Team continues to support Grove Park Home. The process of their involvement remains consistent. The Geriatric Mental Health Team works directly with Unit staff to identify triggers/cues of escalation & approaches to care/interventions
- Since 2020 and the pandemic of COVID Grove Park Home has required assistance with staffing from Agency staff. With the lack of consistency and continuity Grove Park Home has identified areas for improvement with communication, and training pertaining to the processes/policies of Grove Park Home. Grove Park Home has reached out the different agencies requesting them to consider providing routine staff to GPH to enhance the continuity of care for our residents and for our families to be able to recognize Agency staff. Grove Park Home has also implemented an "Agency" internal email and has also invited routine Agency staff to GPH in-services and mandatory training.

Communication:

- ADOC/Behavioral Lead meets with the Geriatric Mental Health Team (GHM Team) on a bi-weekly basis to complete "Risk Rounds" to discuss the current interventions and approaches to cares which are currently being trialed.
- ADOC/Behavioral Lead updates the staff with changes in a progress notes in Point Click Care and then prints off the Action Plans and Behavioral Care Plans related to those currently being followed by & updated Behavioral Care Plan with staff's input

- ADOC/Behavioral Lead send a weekly summary of any medication changes related to behaviors/increased risk to resident made by the N/P-Jennifer Riddell & Dr. McTurk to all nursing staff and edit any abbreviations so all staff understand the medication and the instructions for use.

Goals Attained for 2023:

Change Ideas (will be reflected on the home's QIP) "What change can we make that will result in an improvement?"			
Planned Improvement Initiative (change idea)	**Methods and Process Measures "How will we know that the change resulted in an improvement?"**	**Goals for Change Ideas**	**Comments**
To improve communication within the facility related to "risk" of injury to self and others when providing care	A reduction of incident reports related to staff being injured by responsive residents.	ADOC participates in staff orientation to review responsive behaviors and why a resident require 2 staff to assist with care.	ADOC/Behavioral Lead participates in all orientation of staff. Orientation has been recorded to ensure all staff receive orientation even if ADOC is not present
To reduce the number of critical incidents of residents towards staff	Grove Park Home Joint & Occupational Health & Safety Monitoring Monthly Stats indicate Resident to Staff violence took place 135 times in 2023	Consider offering "GPA Training" as part of the orientation process	GPA was offered at GPH on October 24, 2023- 5 staff attended "Code White" is reviewed as part of the orientation of new staff/students during orientation by ADOC-Behavioral Lead PIECES-Learning & Developing Program was completed by Stephanie Nelson-RPN & Charmaine Andreasen-ADOC/Behavioral Lead-September 27th & October 18 2023
To provide awareness to identify the different types of Dementia and alternate disease processes which effect cognition	The education related to Dementia and Dementia Care will increase by 5%	Offer additional supports for strategies of how to maintain your personal safety A poster board has been made and it is showcasing the EPA Program which staff	Living with Dementia Journey –Oct 20th & 23rd , Nov 2nd, Dec 11th from 8:30-4:30pm Person Centered Culture-Oct 12th, 16th & 30th from 8:30-4:30pm

		can utilize for free support related to the emotions surrounding Dementia	Working Minds Leadership-Oct 4th-9-2pm Working Minds-Team Members-Oct 28th 9-2pm
		Increase educational opportunities "in house" for staff to be able to attend	"In house education" improved by 80%. Great feedback from staff. They enjoyed have educational opportunities which were bot offered through COVID outbreaks
		Have agency staff cover the Units as education is offered so the number of staff who may attend is increased	Agency Staff was booked for many of the educational opportunities so Grove Park Home staff could attend.
Improve Behavioural Care Plans for residents who are high risk and being followed by the Geriatric Mental Health Team. The GMH Care Plan to include up to date strategies as recommended by the GMH Team.	*Behavior Care Plans for individuals who are being followed by GMH Team will be in the front of the resident's chart *Behavioral Care Plans will be placed in the staff washroom for "Tinkle Talk"	*When sending an email out to registered staff related to new identified triggered and interventions, ask them to update the RCP	Once the Behavioral Care Plan is provided by the Geriatric Mental Health Team upon discharge form the Team. ADOC/Behavioral Lead updates the Resident Care Plan to include the identified triggers, causes of escalation, the approaches to care, recommended interventions. The goal remains for Unit RPN's to update the care plans to include the above however it currently is completed by the ADOC/Behavioral Lead related to lack of continuity and consistency of registered staff.

To provide resident focused education which staff identify as a need	Staff participation and feedback after the education is provided. Has the stress/anxiety associated with the need been reduced	There has been in-services within the facility which are resident specific to assist staff to better understand the disease processes & how it effects the quality of life for our residents.	U-First Course was provided on September 18, 2023-4 staff attended "Code White" was reviewed by ADOC/Behavioral Lead on each Unit in the month of November 2023-56 staff attended Frontline Wellness Program-Self Care-presented by Jennifer Bodera & Peter Dangerfield-Waypoint Mental Health-1 hour sessions for each staff member on November 30th or December 7th 2023 Managing Emotions-presented by Jennifer Bodera & Peter Dangerfield-Waypoint Mental Health-1 hour sessions for each staff member on November 16th or 22nd 2023
<u>AIM for 2024:</u> To reduce the number of critical incidents of residents towards staff	Grove Park Home Joint & Occupational Health & Safety Monitoring Monthly Stats	Decrease the number of incident reports by 2% in the next year	
To reduce "staff burnout"	Annual Staff Survey Tracking completed by ADOC/Behavioural Lead regarding the number of referrals received & family/staff feedback	Provide PSW Behavioral Sup[port Leads to float to each Unit to provide additional support Staff survey to indicate an improvement of staff	In February of 2024 3 staff-2 full-time and 1 part-time casual was hired for this role and additional education asper recommendation of the Geriatric Mental Health Team

		satisfaction/safety within the home by 2%	
To reduce the number of residents who require 1:1 related to additional support in the Units	A reduction is stress caused to residents requiring more 1:1 time with staff Review hours accumulated to provide 1:1 staffing	Decrease the use of 1:1 by 2%	

- Policies and procedures reviewed January 13/2023-Revised made and approved by Executive Director-Paul Taylor

Program Evaluation for 2023

Program: Staff Education

Date of Review: Feb 20 2024

Policy/Standard Reference:

Indicators/Methods Used to Monitor Program:

- Resident, Family & Staff feedback
- Improved quality of life for residents
- Best Practice Guidelines are followed
- Required education as per MOLTC are met annually

Participants and Positions:

Participants and Position		
GPH Staff	All Staff of Grove Park Home	
Charmaine Andreasen	ADOC-Educational Coordinator	
Suzanne Briggs	Director of Human Resources/Educational Director	
Sue Martin	NSMHPCN Pain/Palliative/Symptom Management Consultant RN	
Jennifer Bodera & Peter Dangerfield	Waypoint Mental Health Support Educators	
Jacalyn Krzak	Pharmacy Liaison/RPN-Silver Fox Pharmacy	
Greg Fillier	Tena Representative	
Allison Raymond	Grove Park Home-RPN/Wound Care Nurse	
Candice Godin Ashley	Grove Park Home Restorative Care Coordinator Royal Victoria IPAC Consultant	

Goals of the Program from Previous Year:

Goal	Date Achieved
To provide more educational in-services "in house" as per staff 's identified needs	Ongoing

Evaluation:

1. Based on established goals of the program, an analysis of the RAI-MDS indicators for this program and performance indicators from the Grove Park Home QI program, the resident outcomes related to the program have:

☐ X Improved ☐ Not Changed ☐ Not Met

Note: Include data that supports your evaluation (e.g. from department reports, CIHI reports or graphs from Board reports.

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2. There are new best practices relating to this program (e.g. Best Practice Guidelines from the RNAO)

☐ Yes ☐ No X

Methods of Communication:

- Surge Learning send staff a reminder of what is due to the staff's personal email as this is their personal preference
- Each Department Director is responsible for sending out reminders to staff who are behind on Surge Learning semi-annually & provide follow-up to staff who continue to not complete their Surge Learning on time. This will be included as a topic for performance appraisals.
- There is a Computer Room for staff to complete their required education at GPH if they do not have a computer at home to utilize
- When Performance Evaluations are completed, it is noted if the required educational modules have been completed on time or if the staff need to have a specific time/date to have the education completed by

Trends and Analysis:

Since 2020 and the pandemic of COVID Grove Park Home has had a decline in the completion of Surge Learning from previous years. Grove Park Home has required assistance with staffing from Agency staff. Grove Park Home does not have the number of registered staff that was employees by Grove Park Home prior to COVID. Unfortunately with the use of Agency staff it places is increased responsibility on Grove Park Home staff. The workload continues to be increasing related to the number of COVID outbreaks Grove Park Home has experienced and the complexity of the new residents being admitted to Grove Park Home. Staff "burnout" was also obvious; staff struggled to complete their roles and responsibilities at times related to workload and a decrease in continuity of staff. Grove Park Home staff was consistently orientating Agency staff to Grove Park Home.

2020 72% staff completed Surge Learning Modules
2021 60%
2022 51%
2023 37%

Although the percentage of staff who had completed Surge Learning decreased the number of staff who completed additional education outside of Surge Learning increased by 60 %
Effort was made to offer education to staff on all shifts and was scheduled as per staff requests for their time preference to ensure there was an increase in the number of staff participating in hands on or in personal training. For the first time since the pandemic started staff were able to complete education in person and outside of Grove Park Home. In the previous 2 years education was provided through Zoom/on-line and the education resources was limited.

*See attached 2023 Event Calendar which includes all dates for Surge Learning and additional education opportunities.

Comments Related to Program:

- Grove Park Home will continue to place the need for staff education as a priority to ensure the safety and quality of life for the residents living at Grove Park Home.

Goals attained for 2023:

Change Ideas (will be reflected on the home's QIP) "What change can we make that will result in an improvement?"			
Planned Improvement Initiative (change idea)	**Methods and Process Measures "How will we know that the change resulted in an improvement?"**	**Goals for Change Ideas**	**Comments**
To ensure all staff receive training on the PPS Scale & Palliative Training as per MOLTC	Sue Martin-Palliative Consultant RN came to GPH for a 4 Week Palliative Program-Plan & Assess, Advance Care Planning, Symptom Management which all designations attended	To continue to utilize Sue's expertise within the facility to assist with ongoing staff education	PPS Education-Jan 24/23-31 staff attended ESASr Education-Feb 7/23-33 staff attended Frailty Score Education-Feb 21/23-39 staff attended Palliative

			Approach/Pain Management- March 1/23-3 hr educational session for RPN Staff- 7 staff attended Early Identification & Prognostic Tool Education-March 7/23-36 staff attended Palliative Care Tools Training-for Registered Staff- March 8/23-11 staff attended Palliative Education for Registered ESAS review, Scenarios/Case Studies, Biase Exposure, Self-Awareness & Symptom Management-Sept 19th & 21st 2023
To have Sue Martin provide education to registered staff of who to complete the monthly assessments-PPS & ESAS for resident's who currently have an order for "Palliative Approach to Care" or "Palliative"	Moving forward the expectation will be for staff to complete the assessments & a revision to the current protocol will be made to include the assessments- PPS & ESAS to be completed monthly on each resident who currently has a "Palliative Approach	Change the Policy to include the expectation of monthly assessments	Palliative Care Tools Training-for Registered Staff- March 8/23-11 staff attended Palliative Education for Registered Staff- Utilizing the Palliative Tools in PCC-May 2/23-13 staff attended, July 6th-1 staff attended, July 12/23-2 staff attended

	to Care" or "Palliative" order		
To teach registered staff how to complete a Palliative Assessment	ADOC/Palliative Lead, Charmaine Andreasen will send an email with an example of what needs to be included to complete a palliative assessment when staff identify the resident as declining	Add a "drop down bar" for a Palliative Assessment to be able to quickly review changes as they take place and to be able to print off a report for prescribers/resident/families	January 28, 2023
To teach staff how to add or update a resident specific Palliative Care Plan	ADOC/Palliative Lead, Charmaine Andreasen updated resident Care Plans for Palliation for those residents who currently had an order for a "Palliative Approach to Care" or "Palliative/End of Life". Sue Martin-Palliative Consultant RN will come and work 1:1 with registered staff to maintain/update	Palliative Lead/ADOC-Charmaine Andreasen will make a list of GPH Registered Staff and prepare a schedule to ensure all Registered staff have an opportunity to receive 1:1 training	May 9th, 10th, 24th 2023 GPA was offered at GPH on October 24, 2023- 5 staff attended "Code White" is reviewed as part of the orientation of new staff/students during orientation

			by ADOC-Behavioral Lead PIECES-Learning & Developing Program was completed by Stephanie Nelson-RPN & Charmaine Andreasen-ADOC/Behavioral Lead-September 27th & October 18 2023 Living with Dementia Journey – Oct 20th & 23rd , Nov 2nd, Dec 11th from 8:30-4:30pm Person Centered Culture-Oct 12th, 16th & 30th from 8:30-4:30pm U-First Course was provided on September 18, 2023-4 staff attended "Code White" was reviewed by ADOC/Behavioral Lead on each Unit in the month of November 2023-56 staff attended Frontline Wellness Program-Self Care-presented by Jennifer Bodera & Peter Dangerfield-Waypoint Mental Health-1 hour

			sessions for each staff member on November 30th or December 7th 2023 Managing Emotions-presented by Jennifer Bodera & Peter Dangerfield-Waypoint Mental Health-1 hour sessions for each staff member on November 16th or 22nd 2023
<u>Aim for 2024:</u>			
To improve the number of staff at Grove Park Home who are completing Surge Learning	An improvement of 5% of the total number of staff who complete their Surge Learning modules will take place	Each Department Director will follow-up with their staff semi- annually to ensure Surge Learning is being completed	An email was sent out on Feb 27/24 to each Director to inform them of what staff had not complete the required Surge Learning Modules to date and to request they follow-up with staff from their department
To provide more interactive educational opportunities	To provide a total of 2 interactive educational opportunities in 2024	Provide signup sheets for staff to sign and rotate staff so all staff may attend	
To be able to provide "Living with Dementia" to all GPH Nursing Staff	Have 40% of GPH Nursing Staff attend the "Living with Dementia" Day	Invite other LTC Homes to bring their staff to GPH to complete "Living with Dementia"	

- Policies and procedures reviewed January 13/2023-Revised made and approved by Executive Director-Paul Taylor

Program Evaluation

Program: Restraints/ PASDs

Date of Review: February 16th, 2024

Policy/Standard Reference: Least Restraints/ PASD Policy

Indicators/Methods Used to Monitor Program: The number of Restraints/ PASDs used in the home, Quarterly/ PRN meetings, RAI/ RAPS, Provincial bench marking, QI team meetings, Bedrail Assessment Tool (PCC).

Participants and Positions:

Participants and Position		
Candice Godin	Restraint Team Lead	Restorative Care
Danie Cox	Committee Member	Director of Care
Charmaine Andreasen	Committee Member	Assistant Director of Care
Jodie Penfold	Committee Member	Assistant Director of Care

Goals of the Program from Previous Year: **2023**

Goal	Date Achieved
Provide resident/ families with the necessary education when request for restraint is proposed.	On an as needed basis
Staff education through Surge Learning (Restraints/ PASDs)	Yearly
Ensure bed safety for all residents throughout the home.	Ongoing throughout 2023
Review of the current Restraint use.	Ongoing throughout 2023
Review of the current PASD use.	Ongoing throughout 2023
Assessment and Implementation use of Transfer Rails where appropriate	Ongoing throughout 2023
Incorporate new Transfer Rail assessment tool	Not completed – deferred.

Evaluation:

1. Based on established goals of the program, an analysis of the RAI-MDS indicators for this program and performance indicators from the Grove Park Home QI program, the resident outcomes related to the program have:

☐ Improved ☒ Not Changed ☐ Not Met

Note: Include data that supports your evaluation (e.g. from department reports, CIHI reports or graphs from Board reports.

2. There are new best practices relating to this program (e.g. Best Practice Guidelines from the RNAO)

☐ Yes [x] No

Trends and Analysis: GPH continues to work toward non-use/ minimal use of Restraints in order to reduce entrapment risks and comply with government standards, regulations and recommendations. All restraint implementation was driven by family demand in an attempt to reduce risk for resident falls (despite all other fall prevention interventions being in place).

Comments Related to Program: GPH continues to embrace government regulations and utilize minimalistic/ less invasive interventions that may pose entrapment risks to the residents of GPH.

AIM for Upcoming Year:

Change Ideas (will be reflected on the home's QIP) "What change can we make that will result in an improvement?"			
Planned Improvement Initiative (change idea)	**Methods and Process Measures "How will we know that the change resulted in an improvement?"**	**Goals for Change Ideas**	**Comments**
Implementation of Transfer Rails	Assess the need for use – provide intervention	Provide transfer rails to res' that require for transfer only to promote independence.	Implement as needed.
Incorporate new bedrail assessment tool	Adopt a tool that measures the ability for a resident to use transfer rail.	Introduce a new tool to determine a res' need for a Transfer Rail with pre-generated guidelines/ approval for use.	Goal to be completed by end of 2024.
Educate Staff and Family	Email, newsletters, surge learning, 1-1 education on admission.	Increased awareness	Ongoing

2023
Programs Department Annual Review

Created by: Kerry Guy,

Director of Resident & Family Services

PROGRAM OVERVIEW

The primary purpose of the Programs Department is to assist the residents of Grove Park Home to lead meaningful lives by designing and promoting programs, with collaboration from Life Enrichment, Restorative Care, Physiotherapy, Chaplain/Spiritual Services & Volunteers. Programs will stimulate mental and physical activity, maintain spiritual beliefs, and encourage the enjoyment of social and emotional relationships.

Within this Department, we have a had a few changes in 2023. One of which was a title change. The Director of Programs and Volunteer Services is now known as the Director of Resident & Family Services. This position was modified to include the following, rresponsible and accountable for providing a smooth transition for resident admission and continued placement, ensures and provides support to residents and families before, during and following the Admission Process, while acting as a resident advocate.

For 2024, the Director of Resident and Family Services, with help from, the Director of Nursing Care, would like to improve on and better manage the Health Partner Gateway (HPG). The Home has also been working on "tweaking" and improving the admission process. With the admission being a vital aspect of the Home, we would like to make it the best it can be to support the new residents moving in, as well as their families.

Life Enrichment/Activities

The Life Enrichment/Activity staff are accountable for the provision of a range of recreational, therapeutic, leisure programming. These programs must be of high quality, evidenced based, and provided in a manner that is consistent with Grove Park Home's Vision and Mission Statements, the Long-Term Care Guidelines and other applicable regulations and guidelines. Karen Dixon is the Coordinator of Activities and works closely with the Director of Resident and Family Services.

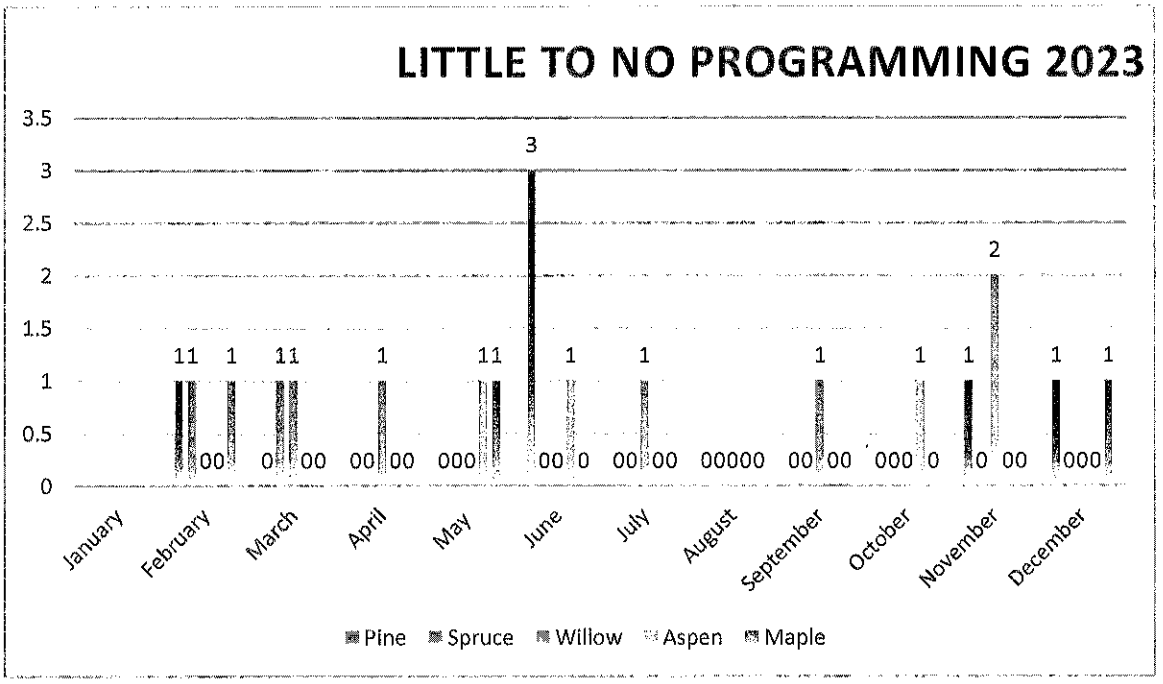
2023 Life Enrichment Quality Initiatives:

- A role was developed for an Activity Coordinator. This position will plan and manage the day-to day "on the floor" programs and work closely with the Director of Resident and Family Services. The Director will still be the responsible person for the Department and will oversee the Coordinator.
- Although Virtual visiting is not required as much, since the pandemic, our department will continue to offer for family unable to visit or for those who live far away.
- Continued to post regularly to Social media/Facebook
- Continued to increase communication with families. We now use the Grove Park Home channel for added communication.
- Increased our special themed days and holidays that we celebrate/discuss.
- Continued support of the link garden program
- Ongoing collaboration with local schools in the area for placement learning opportunities.
- Continued increasing resident outings, introducing new ideas, when possible.
- Continued to revise policies, orientation process, etc... in the Department Manual

- We reintroduced varied programs while always stive to introduce new and innovative programs for our residents.
- A television was purchased for the Maple Activity room for LE to utilize for programming needs.
- Planned/organized a Diversity/Special Event and Holiday Schedule for the Life Enrichment Team. (this project continues to evolve)
- Google HUB nests were purchased for the 3 remining floors that didn't already have. These HUBS are used by the LE team on the floors for music, trivia, etc...
- In 2023 we were happy to invite the different religious denominations back into the Home to provide services for our residents. Prior to Volunteers returning for this type of thing, LE staff were able to meet religious needs through spiritual programming.
- The cafe was reopened. Is is a big part of programming for our Residents as it provides a space for residents a to join with co-residents and family members.
- We introduced a painting program, Painting with Olivia. This is a paid program, through programs department. We have had many positive comments from resident and families about this program. We plan to have Olivia continue with us bi-monthly.
-

2024 Goals for Quality Improvement

- Host a Canada Summer jobs student program
- Ongoing collaboration with local schools in the area for placement learning opportunities.
- Complete the Courtyard project. This will be another added space for our residents, families and staff to be able to gather. This space will also be used for programming.
- Have our own means of transportation. Ie. Accessible bus
- Continue increasing resident outings, introducing new ideas, when possible.
- Continue to revise policies, orientation process, etc... in the Department Manual
- Strive to introduce new and innovative programs for our residents.
- Continue to develop and work on the Diversity/Special Event/Holiday schedule/calendar. This project is underway, we are ever evolving and trying to be as inclusive as possible with programming and celebrating special events/holidays with in the Home.
- The LE/Activity Department would like to increase our special events on weekends and provide the opportunity bi-monthly to quarterly.
- New Ipads will be purchased for the department.
- We hope to be able to purchase the Mobile Obie Interactive Projector. There are 60 games included, they come with different levels of difficulty to fit the needs of seniors of all stages of cognitive impairment as well as fully independent seniors.



As per our RAI/MDS coding, residents reviewed per quarter could be coded as "little to no" programming. Keeping in mind that this is coded on a 7-day observation period throughout the quarter. As a multidisciplinary team, the programs department, (Life enrichment, Restorative Care and Physiotherapy), sit and discuss residents that have been flagged as "little to no" programming, review their overall support level and then put interventions in place to attempt to increase resident participation, whether it be 1:1 or group programming, or support the resident however possible. **Trends:** There is trending that occurs with the same residents coding as little to no programming. After our team has attempted interventions with no effect, we respect the individual's choices with their day-to-day involvement within the facility. When coding (RAI MDS) for "little to no" during an outbreak, please note, we take into consideration 1:1 visiting, 1:1 restorative exercise, 1:1 physiotherapy, virtual visits/phone calls with family and visits with family.

Restorative Care

The Restorative Care department is accountable for the provision of a range of restorative, rehabilitative and activation programming. These programs must be of high quality, evidenced based, and provided in a manner that is consistent with Grove Park Home's Vision and Mission Statements, the Long-Term Care Standards and other applicable regulations and guidelines. Candice Godin is the Restorative Care Coordinator and works closely with the Director of Resident & Family Services.
The Restorative Care department works closely with Physiotherapy and Nursing Rehab which collectively, as a Rehab team, work to make sure residents are receiving the Therapy they need. The idea is that if residents are not seen by physiotherapy or discharged, for any reason other than death, restorative care will pick up that resident in their programming. Restorative Care programs consist of range of motion, exercise class, balance, hand therapy, x n' flex, bike, sit and dance and individualized 1:1 programs. Our restorative care department also manages all of the assistive devices, wheelchairs, walkers, dining assists and restraints for the building.

2023 Restorative Care Quality Initiatives:

- Continued to increase communication with the rehab team through quarterly meetings
- Continued with safety measures, ie. Infection Control, resident masking, put in place to allow residents to have opportunities to benefit their health mobility, well-being and physical abilities.
- Implement a new Transfer Rail Assessment Tool (deferred from 2022)
- Increased the number of staff hours on the floor for 1:1 therapy.
- Increased the number of residents that use the bike in the Rehab Centre.
- The Restorative Care Coordinator took more of a role in the planning and implementation of Nursing Rehab programs. Nursing Rehab works closely with the RC Coordinator to help target specific areas of residents needs, while working together to provide a cohesive environment to, in turn, give the best care for our residents.
- Grove Park Home made a change in their service provider for mobility aids and repair services. The new company is called Align.

Goals for Restorative Care 2024:

- Implement a new Transfer Rail Assessment Tool (deferred from 2023)
- Continue with safety measures, ie. Infection Control
- Continue to introduce new and innovative programming ie. Drumming exercise, the use of technology, etc...
- Continue to work closely with Physiotherapy to be sure all Residents are receiving therapy
- Continue to look for a new volunteer to run a seated yoga or tai chi program.
- Develop and add a Mobility Assessment to PCC.
- Reimplement the Time Hortons' Walk and overall increase outdoor walking programs.
- Research the possible thought of a Swimming program (off-site)
- Increased wheelchair cleaning clinics from 2-4
- Purchase new transport wheelchairs for the Home
- Purchase another bike for the Rehab Centre
- Implement the "new portal" through ALIGN – mobility and aids services

Volunteer Services

The primary purpose of Volunteer Services is to extend and enrich the quality of life for the residents and services of the Home through the utilization of volunteers

Total Active 2023	New	Discharged	Total Hours 2023
30	12 new applications 6 new volunteers	3	2156

2023 Volunteer Services Quality Initiatives:

- Our Volunteers returned to Home is many different aspects.
- Our café re-opened so our Volunteers have been brainstorming to figure out ways to increase business.
- **Recruitment – ongoing.**
- Nikki Latour is now the Volunteer Coordinator; this role was modified in late 2023. Kerry Guy, Director of Resident and Family Services, will continue to oversee the program.
- The Volunteer Coordinator was able to attend a workshop, presented by Traycon, "Volunteer Management, Recruitment, Retention and Recognition". This workshop was useful and was able to give great insight for recruitment and retention of volunteers.
- We celebrated Volunteer Appreciation through our newsletter/email.
- Improve tracking and monitoring volunteer retention. We need to use a new program as existing has retired. (pending)
- Look at some different options for celebrating Volunteer Appreciation week.

Looking ahead to 2024 with Volunteers:

- **Recruitment** continues to be our top priority for 2024. We lost so many volunteers throughout the pandemic and we are excited to recruit and grow our volunteer base.
- Develop a new Volunteer brochure (pending)
- Improve tracking and monitoring volunteer retention. We need to use a new program as the old program was retired. (pending)
- Seek out a volunteer to run a Yoga program within the Restorative Care department.
- Re-start our volunteer meetings quarterly.
- Look at some different educational opportunities for the Volunteers to take part in.
- Continue to email a "Volunteer Newsletter" bi-monthly to all active volunteers
- Our volunteers are the main reason we are able to have a café. The volunteers have started to introduce "special menus" days to, hopefully, increase the business.

Physiotherapy Services

The Physiotherapist acts as the primary agent in identifying and improving Resident movement and function. The Physiotherapist must decide on the appropriate course of

patient care, based on the patient's physical difficulties, due to illness, injury, disability or ageing. The Physiotherapist promotes resident health and well-being and quality of life.

2023 Physiotherapy	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
Active	47	47	47	40	44	43	39	44	43	44	47	48
Discharged	4	3	7	1	4	5	0	4	3	0	4	4
Added/Admission	4	3	0	5	3	1	5	3	4	3	5	4
Total # on Physio Program	47	47	40	44	43	39	44	43	44	47	48	48

In 2023 our Physiotherapy Department worked closely with the Restorative Care Department and increased the amount of resident on PT program. The Physio Gym Program has been beneficial and a positive change for the department. In 2024, we would like to look at increasing the hours of the PTA, with adding a part-time role. The department continues to offer student placement opportunities.

Chaplain Services

The Chaplain works collaboratively with all departments within Grove Park Home. The programs provided by the Chaplain will be done in a manner that reflects Grove Park Home's Vision and Mission statements, the Long-Term Homes Act and the legislated regulations.

The Bible study program continues to be held on a weekly basis and Claude Cox, our chaplain, is available to visit with our residents when in the building. Claude offers a great support to residents, staff, volunteers and family when needed. Unfortunately, Claude retired in the summer of 2023. Although still volunteers for a bible study program 1-2 x/month.

Grove Park also continues to offer religious programs monthly from many different denominations.

2023 Spiritual Service Initiatives:

- In 2023, there were two Celebration of Life Services. Due to covid, these celebrations had to be done a little differently. We recorded a Celebration of Life and sent the information to the families of lost loved ones to be able to watch if they wished to.
- Re-start our Pastoral Care meetings with Resident input. We aim to have a meeting quarterly.
- Continue with in-person bible study programs weekly.

2024 Spiritual Service Goals:

- Continue Pastoral Care meetings with Resident input. We aim to have a meeting quarterly. (deferred from 2022). We have used our Resident Council meetings to give opportunity for our residents to voice concerns or give suggestions around

spiritual/religious programming.
- Continue Bible Study Programs. Held in the Auditorium for all to join. Activity staff will have a "spiritual based program" on every week and continue to have a Hymn Sing every Sunday.
- Continue with the Celebration of Life, brainstorm on different ways to run the program.

Resident Council

The Director of Programs and Volunteer Services acts as the liaison with Residents' Council; answer questions, provide information on current concerns, typing and distribution of minutes. The staff do not have voting rights. This position must receive permission annually by Resident Council to attend meetings.
It is policy of the Home to welcome participation of Residents, families and/or representatives in the affairs of the Home by participating in a Resident Council.

2023 Resident Council and Projects that Council was involved in:

-Retirement gifts
-Honey – funded and fundraising for their council
-Donation to the BPSO for Welcome baskets for new admissions
-Christmas events including:
-Staff Children's Christmas.
-Gift Card fundraiser
-Staff gifts – every staff member received a Christmas gift.
-Donation towards our "staff in need" baskets
- Grove Park celebrated Resident Council Week. We used this week to promote awareness for the Council. We had a special day all week long.
-Throughout 2023 we were able to continue with our routinely scheduled Resident Council Meetings. We did our very best to keep our residents informed as to what was happening in the community and the Home. We continued to meet monthly together as a Home and not cohorted to the floors.
-Developed a new Resident Council Information brochure to be delivered with new admissions welcome blanket. This will encourage residents to become a part of the Council. (deferred from 2022)

2024 Resident Council Goals

-In 2021, the Fixing of Long-Term Care Act was issued. What this will mean for Residents' Council is that they will have an increased amount of collaboration and communication with the overall goings on of the Home.
-Develop a new Resident Council Information brochure to be delivered with new admissions welcome blanket. This will encourage residents to become a part of the Council. (deferred from 2023).
-Every resident in the Home will receive a new brochure and a new Resident Right booklet in 2024.
-Continue with our regular scheduled Resident Council Meetings, monthly.
- Collaborate with the Council on Ipac strategies, policies, codes or drills in the Home, incidents and any redevelopment news.
-Continue to have a hand in special projects/fundraising in the Home.

Family Council

The Director Resident & Family Services acts as the staff assist to the Family Council. Family Council meets monthly to discuss ways of improving the quality of life of their loved ones.

2023/2024 Family Council:

- We hope to get our Family Council back up and running.
- Collaborate with the Council on Ipac strategies, policies, codes or drills in the Home, incidents and any redevelopment news.
- Information about the Family Council is posted on the Family Council Board with details on "what it is" and how to become involved. There has also been numerous "groupcast" emails sent to the families to remind them of the Council and to contact the Director of Resident & Family Services if they are interested.
- Survey results, Family Survey and Resident Survey, are posted on the Family Council Board. This board is able to be seen by all visitors coming into the Home.

The goal for 2024 was to get back on track and have our Council meet once again. Due to the pandemic, the Family Council is starting fresh and looking for interest. Recruitment was the number one priority for 2023 and will remain for 2024. With the Fixing of Long-term Care Act, Family Council will be playing a larger role with the regular goings on of the Home.

Resident Support Aides & Support Positions in 2023

RSA's

- In 2020 Grove Park Home adopted the idea of Resident Support Aides to the units. With the challenge of the PSW shortage, sector wide, the RSA's are here to offer support to the PSW's with a few tasks such as assisting in the dining room (feeding support), garbage's, linens, stocking care carts, tea cart assistance and making of beds. The RSA works between the PSW's and Programming staff to then offer support to the residents through 1:1 programming, virtual visits with families and assisting the Program staff with programs on the unit. We continued to have support during 2023. Looking ahead to 2024, we are sad to announce that our RSA positions will come to an end.

Other Support Staff

-Grove Park Home added hours to the front office in 2023. The front office support staff will assist with the nursing schedule, call-ins, front door and visitor monitoring and other tasks assigned. This position has been very beneficial for, not only, the assistance it provides the RN for staffing purposes but for an overall improvement of security for the home.

Social Worker

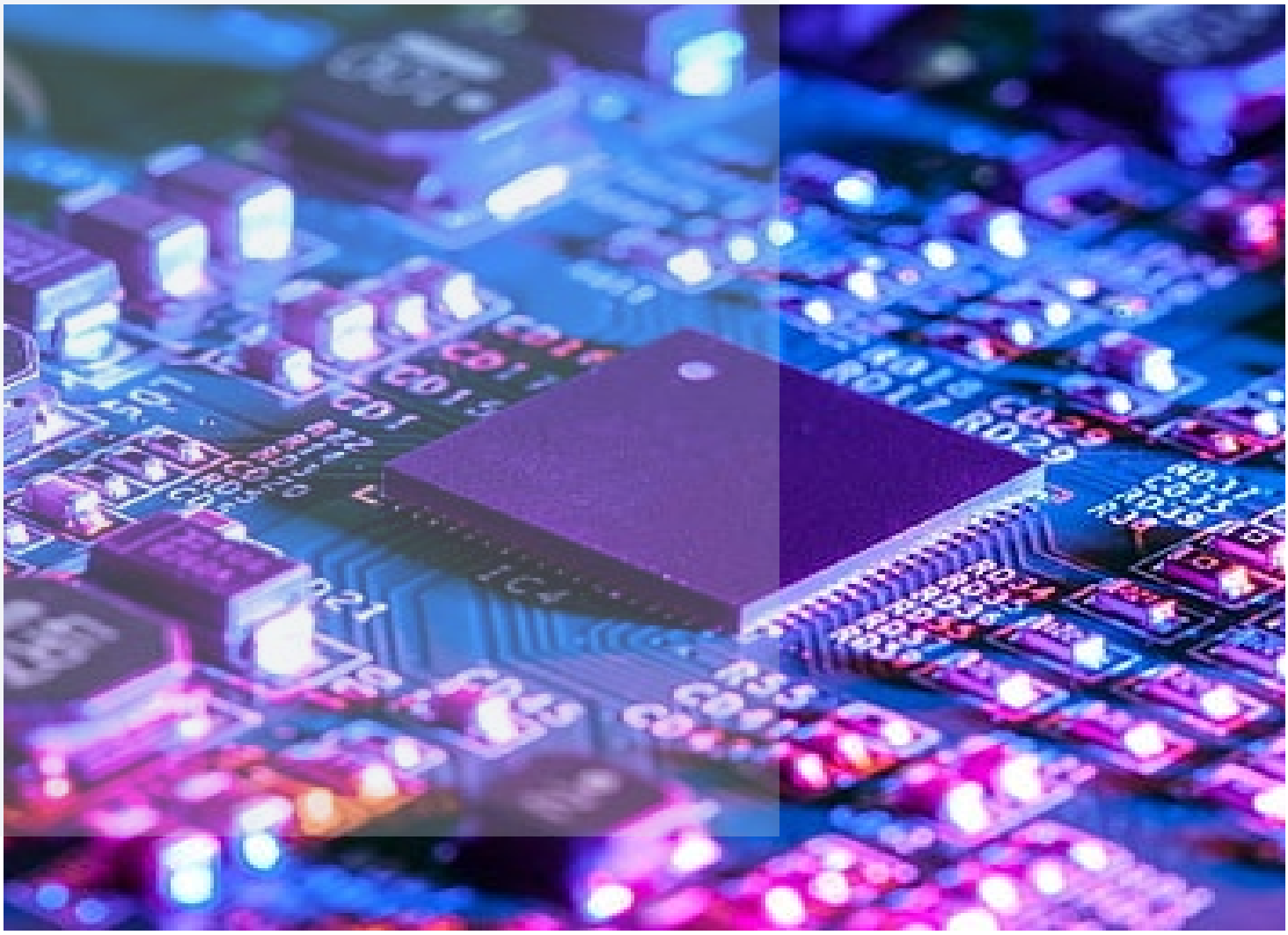
We are pleased to announce that we have added a Social Worker to our care team at Grove Park Home, Alexandra Lang MSW, RSW. *Social Work services are available to residents and families on a referral basis.*

Reasons for referral to social work include, but are not limited to, the following concerns with residents or family members:

- Adjustment/transition challenges
- Bereavement/grief/loss
- Interpersonal issues (e.g. conflict, intimacy, role transitions, etc.)
- Crisis support
- Mental health concerns
- Substance use and addictions concerns
- Resource and community support referrals
- Resident legal or financial matters (POA, wills, etc.)
- End of life care concerns, coping and support
- Support around residents presenting with BPSD

2023 INFORMATION TECHNOLOGY

ANNUAL REVIEW



TRAVIS DURHAM | DIRECTOR OF DIETARY SERVICES &
INFORMATION TECHNOLOGY | FEBRUARY 15, 2024

CONTENTS

POLICY STATEMENT

At Grove Park Home, we recognize the pivotal role Information Technology (IT) plays in supporting our mission to provide exceptional care and services to our residents. We are dedicated to upholding a secure, efficient, and reliable IT infrastructure that aligns with industry best practices and regulatory requirements. This policy statement articulates our guiding principles and expectations governing the management and use of IT resources within our organization, with a focused emphasis on the following key areas:

1. **Hardware and Software Procurement:**
    - The IT department shall oversee the procurement process for hardware and software, ensuring alignment with organizational needs, budgetary considerations, and technical requirements.
    - All acquisitions will undergo comprehensive assessment, including evaluations of compatibility, performance, reliability, and vendor reputation.
    - Purchases must adhere to established procurement protocols, encompassing vendor selection, competitive bidding, and contractual negotiations.
2. **Security:**
    - Security is paramount across all IT endeavors. The IT department will establish and maintain robust measures to safeguard our systems, data, and network from unauthorized access, breaches, and cyber threats.
    - Regular risk assessments, access controls, encryption protocols, and employee training initiatives will be employed to foster a culture of cybersecurity awareness.

    - Continuous monitoring and auditing of systems will be conducted to promptly address any identified security vulnerabilities or incidents.
3. **Communication and Life Safety Systems:**
    - The IT department is entrusted with managing and maintaining communication and life safety systems, including voice communication, emergency notification, and surveillance systems.
    - These systems shall be upheld to ensure operational efficacy, reliability, and compliance with relevant regulatory standards and emergency response protocols.
    - Routine testing, maintenance, and upgrades will be executed to optimize the functionality and reliability of communication and life safety systems.
4. **Data Management:**
    - Upholding the privacy and confidentiality of resident and employee information is of paramount importance. The IT department shall oversee the management of data assets, encompassing collection, storage, transmission, and disposal, in adherence to pertinent laws and regulations.
    - Stringent data management policies and procedures will be implemented to ensure secure handling and access limited to authorized personnel based on necessity.
    - Regular audits and assessments will be conducted to monitor compliance with data management protocols and identify areas for enhancement.
5. **User Training and Awareness:**
    - Ongoing training programs will be developed and implemented by the IT department to educate employees on IT policies, procedures, and best practices.
    - Training initiatives will cover topics such as cybersecurity awareness, data privacy, acceptable use of IT resources, and emergency response protocols.

- Regular communication and awareness campaigns will reinforce training messages, fostering a culture of IT security and compliance among all staff members.

6. **Incident Response and Escalation:**
   - Clear procedures for incident reporting, escalation, and response will be established by the IT department to address security breaches, system failures, and other IT-related incidents.
   - Employees will be provided with guidance on recognizing and promptly reporting security incidents, with designated points of contact and communication channels.
   - Documented incident response plans, delineating roles, responsibilities, and escalation procedures, will ensure a coordinated and effective response to IT incidents.
7. **Vendor Management:**
   - The IT department will maintain relationships with technology vendors and service providers to ensure timely delivery of products, services, and support.
   - Vendor contracts and service level agreements will be scrutinized and negotiated to align with organizational requirements, including performance expectations, support provisions, and data protection commitments.
   - Continuous monitoring of vendor performance and compliance will be conducted, addressing any discrepancies through established escalation procedures.
8. **Continual Improvement:**
   - Engaging in continual improvement initiatives will be a priority for the IT department to enhance the effectiveness, efficiency, and reliability of IT services and infrastructure.
   - Stakeholder feedback mechanisms will be instituted to identify areas for improvement and innovation, including input from residents, families, and staff.
   - Regular performance reviews, benchmarking exercises, and technology assessments will be conducted to evaluate the impact of IT investments and identify opportunities for optimization and enhancement.
9. **Documentation and Knowledge Management:**
   - The IT department shall maintain comprehensive documentation of IT systems, configurations, procedures, and troubleshooting guides to facilitate knowledge sharing and operational continuity.
   - Documentation will be regularly updated and accessible to authorized personnel to ensure accurate and up-to-date information is available for IT support and maintenance activities.
   - Knowledge transfer sessions will be conducted to disseminate critical information and expertise among IT staff members, fostering collaboration and skill development within the team.

By adhering to these principles and guidelines, we reaffirm our commitment to leveraging technology to enhance the quality of care and services provided to our residents, while safeguarding the security, privacy, and integrity of our IT infrastructure and data assets.

2023 ACTIVITY

May

- Conducted a full audit of the shared folders on the U: drive, and ensured user security settings were in place.

June

- Reprogrammed with the PCC the capabilities of routine back-up of the EMAR system to our shared drive, for disaster access.

July

- Purchased a Chromebook device to trial use and friendliness to staff in comparison to the business devices we normally use.
- Replaced the network switch serving the Pine home area due to equipment malfunction.
- Had the penthouse wired to the network with an IP address assigned to manage the new boiler system.
- Topped up PowerEdge support timebank for $10,000

August

- Cleaned out the Exchange server of old mailboxes, granting more available space for storage.

September

- With the arrival of a new Social Worker and the need for a upgraded device. Both the RN Office and the Social Worker office were equipped with laptops for day-to-day activity.
- Ended the use of the Writi prescriber software, returning to faxing pharmacy orders.
- Upgrading the LifeLabs access certificate to all necessary users devices.

October

- Conducted an audit of wireless devices, reprogrammed the main WIFI password to knock off unauthorized devices from the business network.

November

- Upgraded the Sonifi Ucrypt device to a new high-definition device. This device allowed us to upgrade the picture quality for all TV channels serving our residents.
- Upgraded Microsoft Exchange certificate to allow for Chrome and Edge access to Outlook.

December

- Engaged with Project Amplifi to have Grove Park Home join with hospitals in the area to share resident information while in hospital. Preliminary work only.

Throughout the year

- Improving wireless access in underserved areas. The Executive Directors office, as well as various points on the resident home areas and the Staff Room had received wireless access points to improve connectivity.
- Maintain/troubleshoot resident connectivity issues.
- Act as a help desk and remote support for any issues arising related to user access.
- Ongoing improvements to workstations, printers, telephone devices.

2024 PLANNING

- Review strategic plan and update for 2025-2028.
- Prepare for CARF Accreditation
- Conduct a full assessment of network security
- Upgrade SonicWall Firewall device toa T2-370 with 2-year service plan $1999.00
- Upgrade Datto device to 1TB support for $999.00 with $649/month service
- Add Wanderguard protection to the Maple exit to the Aspen link.
- Introduce Microsoft 365 to replace Office and Exchange
- Provide laptop to new Resident Support Leads position
- Replace the video conferencing laptop in the Centre of Excellence
- Upgrading the audio/visual equipment in the Auditorium
- Adding a video conferencing cart for the organization.
- Improving wireless connectivity by upgrading/adding new wireless access points
- Adding five cameras to the surveillance system to oversee medication rooms
- Upgrade six laptops and six desktop computers
- Upgrade telephone system prior to/and as part of capital redevelopment.

REDEVELOPMENT PLANNING

In capital redevelopment planning, IT at Grove Park Home oversees the integration of essential technology systems, including nurse call, telephone, door control, elopement control, cable television, and internet access. Our responsibilities include ensuring seamless deployment, optimizing functionality, and prioritizing resident safety and operational efficiency.

Rogers Cable – auditing existing infrastructure, determining locations of coaxial outputs in the redeveloped home areas.

Chubb Security – removing existing cameras and infrastructure in the redeveloped home areas and then having them re-installed after construction.

Aatel Communications – upgrading telephone system, wireless phone system, door controls (in construction areas), elopement monitoring system, and nurse call system for entire facility.

2023 Health & Safety Program Review

Travis Durham
Management Chair, Joint Health & Safety Committee
February 9, 2024

Health & Safety Policy

The Board of Directors and the Management Personnel of Grove Park Home are vitally interested in the health and safety of its employees. Protection of all from injury or occupational disease is a major continuing objective.

As an employer, Grove Park Home will make every reasonable effort to provide a safe, healthy work environment. Providing employees with the information, training, tools, procedures, and support required to do their job safely and without harming other employees' health. Legislative requirements will serve as minimum acceptable standards for Grove Park Home.

Managers and supervisors are accountable for the health and safety of employees under their supervision. Managers and supervisors are responsible to ensure that instruments, machinery, and equipment are safe and that employees work in compliance with established safe work practices and procedures. Employees must receive adequate training in their specific work tasks to protect their health and safety before commencement of their job.

Employees are accountable for maintaining or taking positive steps to achieve a state of health that is consistent with the demands of his/her occupation. They are also accountable for performing work safely and for identifying, communicating and where appropriate correcting workplace hazards in order to protect themselves and their co-workers from harm. Every employee, sub-contractor and worker of sub-contractor must protect his or her own health and safety by following the law, and Grove Park Home's safe work practices and procedures.

Employees will be involved in decisions, which will have an impact on their health and safety, both individually and through their employee representative groups.

Health and safety will be measured and evaluated in a meaningful way. With an objective of continuously improving performance.

Contents

Health & Safety Audit Results

Committee Members conducted an audit on the Grove Park Home Health & Safety Program, scoring 94%, a decrease from the 2023 score of 97% overall

The areas requiring further development or Committee Member competence are as follows:

Reporting, Recording and Investigating Incidents:
-Do all staff report incidents to their managers / supervisors as soon as possible? At times not all injuries are captured. *Repeat item.

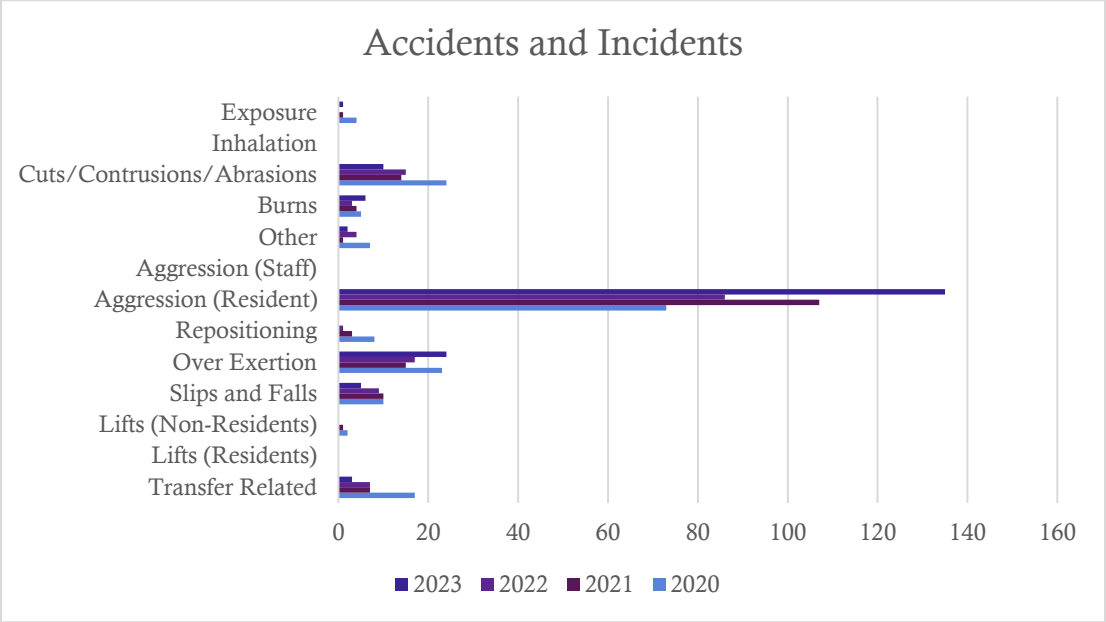
Inspections:
Does the committee carry out regular inspections? This has been an issue for 2023.

Occupational Health Services:
Do all staff returning from sick leave or compensation report to their manager? This does not always happen.

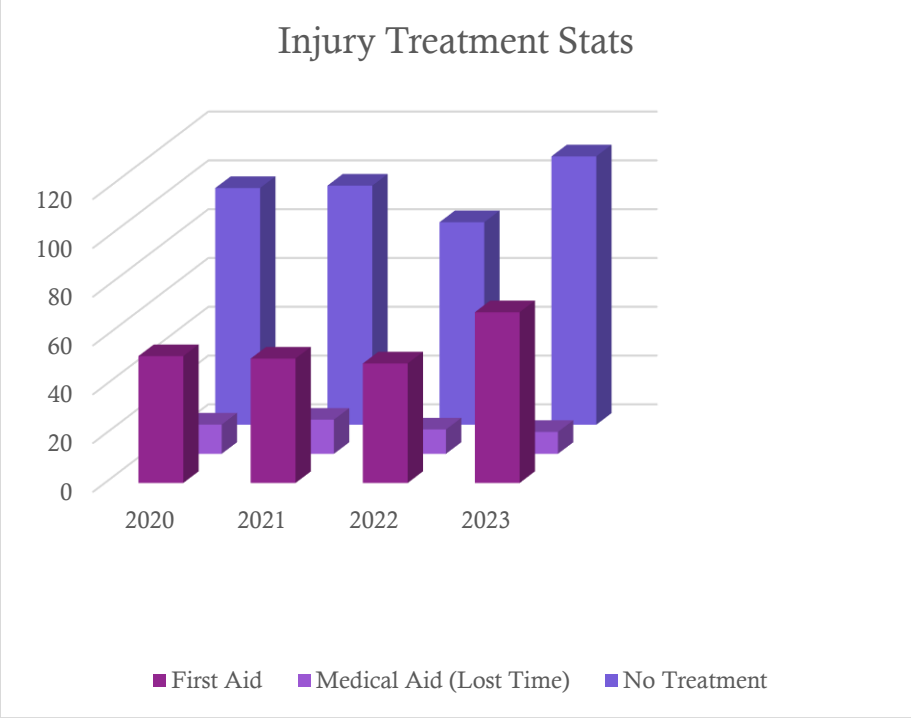
Visitor Safety:
-Is visitor safety part of the orientation program for new staff as well as the continuing education of experienced staff? No. *Repeat item, more staff training required.

Committee Members participating in the annual review: Candice Godin, Edward Larsen, Suzanne Briggs, Christina Flynn, Kari Abrams, Clinton Simmons, Sandy Wolf & Travis Durham

Review of 2023 Accident & Incident Statistics



In comparison from 2020 to 2023; incidences have decreased from 173 to 142. The biggest contributor to the incidents continues to be Resident-to-Staff Aggression.



A thorough review of the incident and accidents is available of the H&S shared folder.

2023 Committee Activity

In 2023 the Joint Health & Safety Committee (JHSC) continued to commit to ensuring staff were protected and prepared to respond to the COVID-19 pandemic.

- The Ministry of Labour, Immigration, Training and Skills Development (MLITSD) were on-site and remote for numerous follow-ups to ensure COVID-19 policies and procedures were in place. There were numerous infectious disease outbreaks during the 2023 year.
- Candice Godin was responsible for ensuring mask fit testing of disposable respirators was kept up-to-date for all staff.
- Candice Godin participated and was certified in the Ergo Inc. Office Ergonomics Evaluator Series.
- The committee was influential in ensuring PPE stock was upheld and sourced regularly.
- The Committee continued the work towards decreasing incidents resulting from Resident-to-Staff Aggression. This was done by expediting behavourial supports to address certain residents, as well as developing a 'Residents to Watch' list for all staff when approaching those residents with known aggression.
- Ongoing COVID-19 awareness, precautions and preparation during the pandemic
- Regular disposable and reusable mask fit testing as PPE supply becomes available
- Maintaining reasonable supply of PPE for future pandemic and/or outbreak situations
- Working with IPAC lead to ensure pandemic policies are developed and up-to-date
- Throughout the year, Candice Godin continued to sit as a committee member during the COVID-19 Situation Meetings to review JHSC concerns with Leadership.
- New members were recruited to the JHSC to ensure all areas were represented by Worker members. That includes: Clinton Simmons (Environmental), Celeste Godin (Dietary) and Kari Abrams (Nursing)
- Mechanical and ceiling lift training provided to coincide with new equipment arrivals
- Review and update of the Workplace Violence, Bullying and Harassment policy.
- Audit of PPE in areas where chemicals are stored/handled and other risk areas throughout the building.

2023 MLITSD Inspections

February 1st, 2023 – Inspection in Response to a Notice of Occupational Illness. This was in relation to the COVID Outbreak at the time. Findings included:

- Several bottles of hand sanitizer were noted to be expired during the inspection.

The above orders were rectified at time of inspection.

May 29th, 2023 – Proactive Inspection Regarding Compliance with OHSA and Applicable Regulations. Findings included:

- Workplace Violence and Harassment Policy not reviewed annually as required.
- Shelving in the main kitchen not anchored to the walls or ceiling, which could result in tipping/crushing.
- Receptacle was installed below a water source at the laundry room eyewash station.
- Eyewash station in the main kitchen was not in good repair and was inoperable.
- Ladder found leaning against the wall in the receiving area, and was not mounted to ensure it wouldn't fall onto anyone.
- Metal shelf in the Pine housekeeping closet was not secure and had heavy chemicals stored above eye level.
- Chemicals in a pest sprayer device were not known, ensuring that workplace labels are utilized.
- Shelves in the basement housekeeping storage room were not anchored together, to the wall or the ceiling, which could result in tripping/crushing.
- Extension cord in the maintenance workshop was damaged.

The above orders were either rectified at time of inspection or by the due date of June 29th, 2023.

August 22nd, 2023 – Investigation Regarding Notice of Occupational Illness Reported to the MLITSD. This was in relation to the COVID Outbreak at the time. No findings during this visit.

October 17th, 2023 – Investigation Regarding Notice of Occupational Illness Reported to the MLITSD. This was in relation to the COVID Outbreak at the time. Findings included:

- N95 respirators in the isolation carts may be exposed to infectious disease when stored, change the method of storage.

The above orders were rectified at time of inspection.

December 14th, 2023 – Inspection to Audit Compliance with a Focus on Musculoskeletal Disorder Prevention. Findings included:

- The organization was missing a comprehensive policy on materials handling.
- Mechanical lift pre-start up daily audits were incomplete multiple days leading up to visit.

The above orders were rectified by the due date of January 26th, 2024.

2024 Committee Planning

Following the results of the annual program audit and some of the trends in the sector, the JHSC plans the following key areas to focus on in 2024

- Any MLITSD driven trends or legislative changes
- Ongoing improvements to communicating known hazards and know aggressive residents to front line staff
- Ongoing IPAC awareness, precautions and preparation during COVID-19, RSV and Influenza seasons.
- Regular disposable and reusable mask fit testing as PPE supply becomes available
- Maintaining reasonable supply of PPE for future pandemic and/or outbreak situations
- Ensure monthly inspections are completed as per inspection schedule
- Prepare for a safe work environment during the planned redevelopment construction project
- Prepare for 'Slips, Trips and Falls' blitz planned by the MLITSD.
- Hold a Health and Safety Awareness training day, focusing on workplace violence and harassment, safe lifting, electrical safety and vertical evacuations.
- Ongoing respirator mask fit testing to take place throughout the year to ensure all staff are up-to-date.

2023 Dietary Services Program Review

Travis Durham
Director of Dietary Services & Information Technology
January 2024

Statement of Purpose

The Dietary Services Department at Grove Park Home is to improve and preserve the quality of life of the elderly. We accomplish this by providing a home-like atmosphere, high quality of service and food, and meeting everyone's nutritional needs.

The department is self-operated, and food is prepared in a conventional manner. Receiving, storing, preparing and serving food is carried out in a manner that is consistent with public health practices, applicable standards and institutional food production methods. There is an extensive Quality Assurance (HACCP) program in place to assure all sanitation standards are met throughout the food storage, preparation, cooking and serving of meals. Food preparation takes place according to standardized recipes and production worksheets. Food is prepared fresh every day, in quantities appropriate for consumption.

Grove Park Home encourages resident participation in menu planning. There is a 21-day cycle menu. This meets all nutritional criteria and provides appropriate choices for all diet variations. The menu is planned by the Director of Dietary Services & Information Technology and is approved in writing by the Consulting Registered Dietitian(s). The menu is presented to the Resident Council for consultation and approval prior to implementation.

Meals are a highlight of the resident's day, and as such comprise an important aspect of the resident's quality of life. This is especially true on holidays and special occasions. We work to provide special meals and celebrate special occasions with food because we believe that providing special acknowledgment of special occasions improves overall well-being, stimulates appetite, and increases resident satisfaction.

In this way, we take the utmost care in contributing to the implementation of the Vision of Grove Park Home to continuously provide the finest care for every resident. As well, the Mission statement for staff of Grove Park Home to provide continuous high-quality care in a secure environment with family and community support is realized within the parameters of nutritional care provided by the Director of Dietary Services & Information Technology and the Consulting Dietitian(s).

Organizational Liaison:

The quality of service is enhanced through liaison with the Dietary Services Department in other Long-term care facilities, the Canadian Society of Nutrition Management, Advantage Ontario, Dietitians of Canada and the College of Dietitians.

Human Resources/Education:

The Dietary Services Department recognizes its staff as its most valuable resource and, as such is committed to providing opportunities for professional and personal growth. Attendance at educational programs offered within and outside the home is encouraged. In-servicing and departmental meetings are held regularly throughout the year for front-line staff.

Management Approach:

Staff are offered the opportunity to participate in the decisions that will directly affect their job and their work environment. Department Management integrates Quality Assurance, Risk Management, and Continuous Quality Improvement programs.

Contents

Nutrition & Hydration Program Audit Results

Clinicians of the Dietary Services team conducted an audit of the Nutrition & Hydration program in December 2023.

The areas requiring further development are as follows:

Major Asset Replacements

A number of major assets in the serveries and kitchen are requiring replacement. Capital requests have been made for the 2024 year.

Redevelopment Preparation

Redevelopment of the Maple and Aspen home areas may start in 2024. With that being said, design, layout, equipment and electrical requirements will be assessed to ensure that the new servery and dining areas are appropriate to meet the needs of future residents.

IDDSI Implementation

Grove Park Home has slowly introduced the IDDSI terminology for fluid consistencies. Plans for incorporating the soft-bite sized therapeutic texture to be implemented. This will allow safer texture for those who do not yet qualify to be minced texture.

Fluid Intake Referrals

Grove Park Home has been working to improve fluid intake of all residents. Further in-servicing required for nursing to ensure that the residents are meeting fluid requirements, and that the RDs are included when fluid requirements are not being met.

Meal Service Responsibilities

All disciplines play a role in meal service. In 2024 we plan to outline those roles, and provide all staff with clear direction to ensure a safe and pleasurable dining experience for all residents.

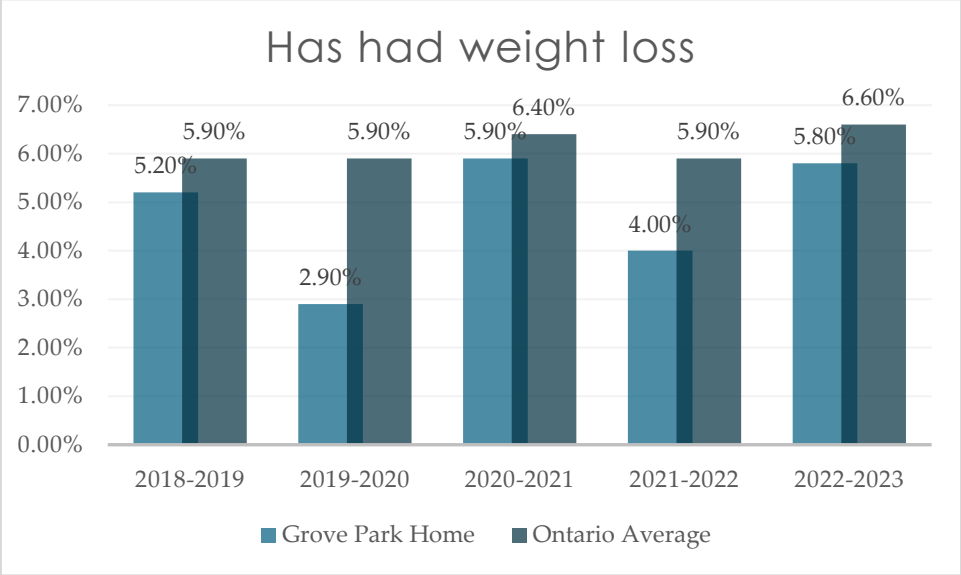
Dietary Services clinical team participating in the annual review: Travis Durham, CNM, Bahaar Hundal, NM, Kristy Clement, RD & Joanne Chantler, RD.

2023 Performance Indicator Review

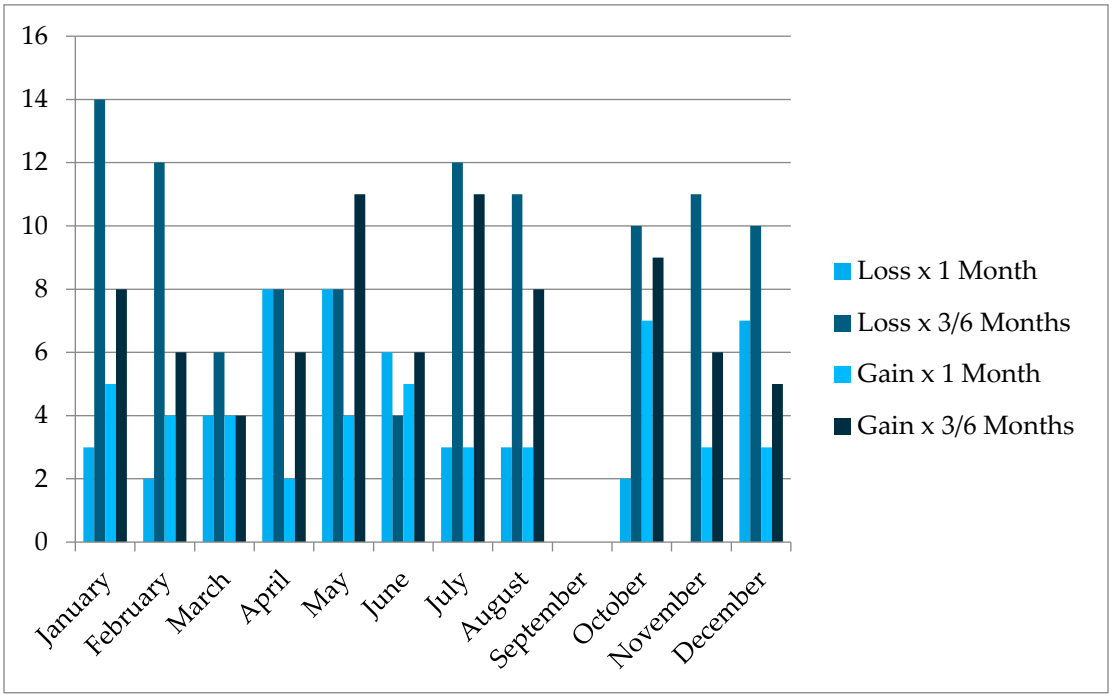
The 2023 indicators remained somewhat status quo month-to-month in 2023. Presented first will be a summary from January to December of the average, the minimum and the maximum of each indicator.

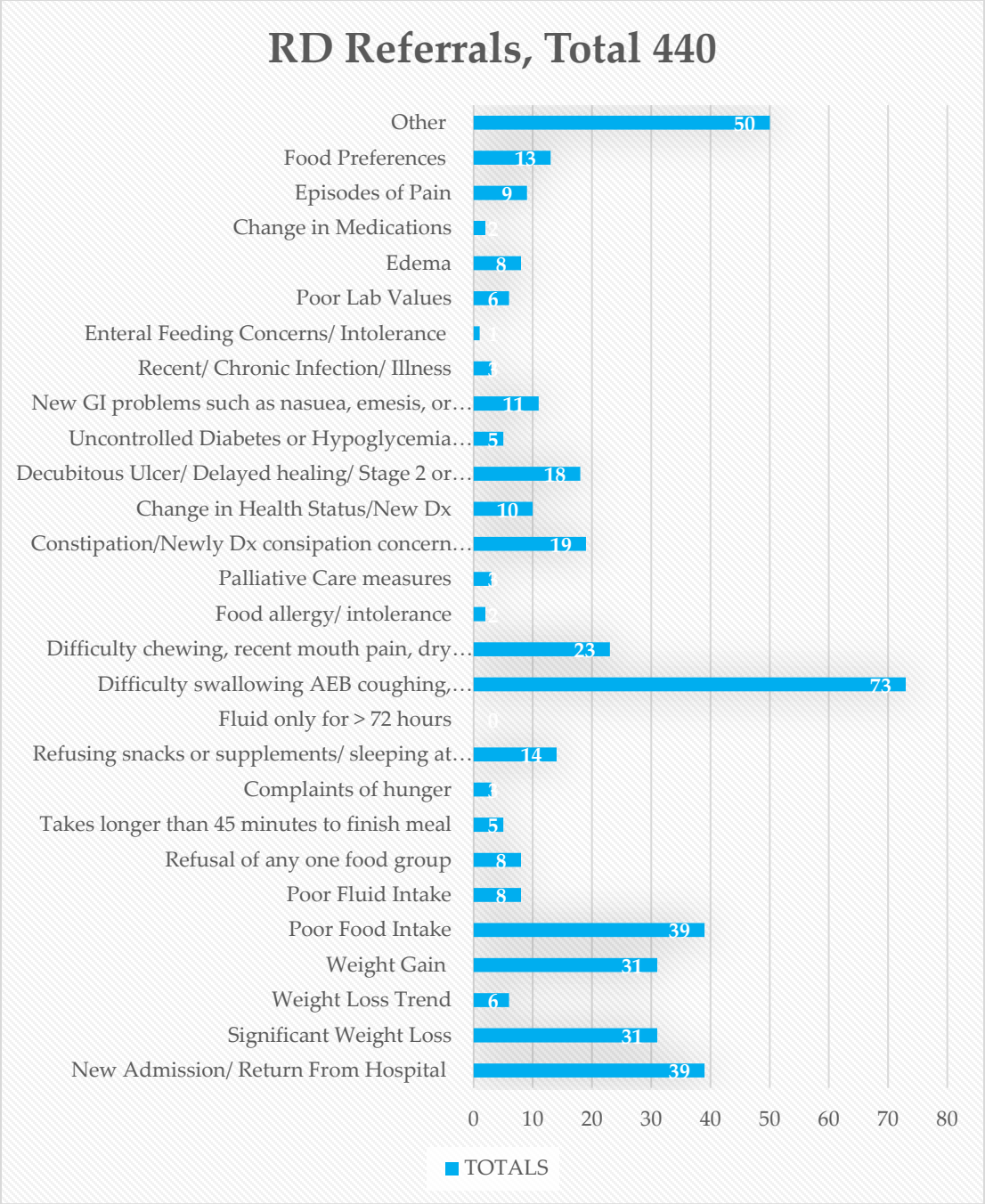
INDICATOR	AVG	MIN	MAX
# of Residents on Regular diet	79.5	79	80
# of Residents on Minced texture	22.5	21	24
# of Residents on Pureed texture	26	24	28
# of Residents on a Diabetic diet	22	20	24
# of Residents on Renal diet	0	0	0
# of Residents on Lactose Reduced diet	6.5	6	7
# of Residents on Gluten Restricted diet	0	0	0
# of Residents on Low Fat/Reducing diet	0	0	0
# of Residents on High Calories / High Protein diet	25.5	21	30
# of Residents on nutritional supplements	10	10	10
# of Residents on enteral feeding	1	1	1
# of Residents at HIGH nutritional risk	106	101	111
# of Residents at MODERATE nutritional risk	33.5	32	35
# of Residents at LOW nutritional risk	0	0	0
# of Residents on Anti-Reflux diet	0.5	0	1
# of Residents on Individual diet plans	0	0	0

Comparison of weight loss quality indicator in comparison to the Ontario average shows that Grove Park Home has maintained a weight loss level below the Ontario average.

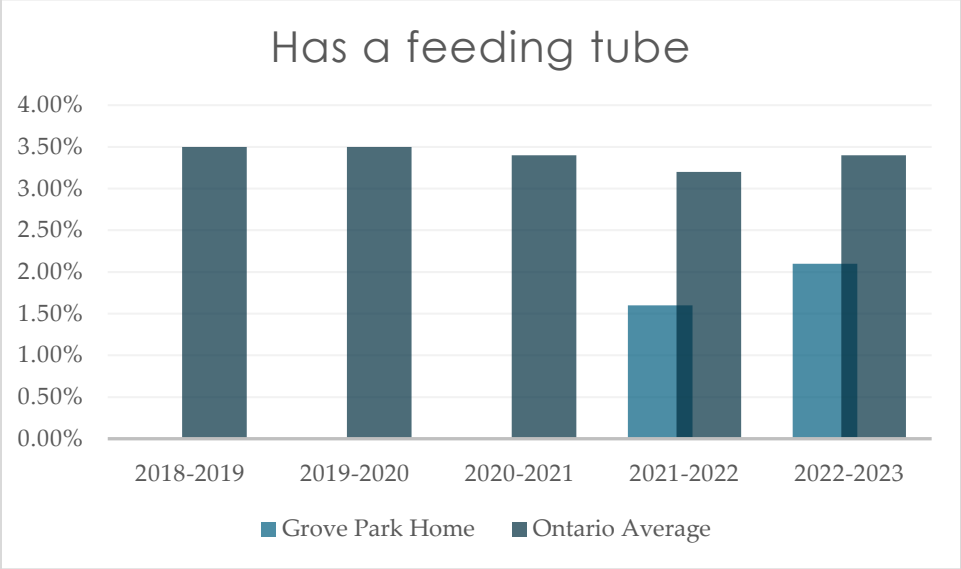


Internal Weight Change Report Based on Monthly Referrals




RD Referrals, Total 440
Other
Food Preferences
Episodes of Pain
Change in Medications
Edema
Poor Lab Values
Enteral Feeding Concerns/ Intolerance
Recent/ Chronic Infection/ Illness
New GI problems such as nasuea, emesis, or…
Uncontrolled Diabetes or Hypoglycemia…
Decubitous Ulcer/ Delayed healing/ Stage 2 or…
Change in Health Status/New Dx
Constipation/Newly Dx consipation concern…
Palliative Care measures
Food allergy/ intolerance
Difficulty chewing, recent mouth pain, dry…
Difficulty swallowing AEB coughing,…
Fluid only for > 72 hours
Refusing snacks or supplements/ sleeping at…
Complaints of hunger
Takes longer than 45 minutes to finish meal
Refusal of any one food group
Poor Fluid Intake
Poor Food Intake
Weight Gain
Weight Loss Trend
Significant Weight Loss
New Admission/ Return From Hospital
50
13
9
8
6
11
5
18
10
19
23
73
14
5
8
8
39
31
6
31
39
0
10
20
30
40
50
60
70
80
TOTALS

Comparison of feeding tub indicator in comparison to the Ontario average shows that Grove Park Home has maintained residents on feeding tubes below the Ontario average.



2023 Quality Improvement Initiatives

2023 was a unique year for the Dietary Services department. A number of construction projects in the department were necessary due to equipment malfunctions and flooding. Below is a sample of the work that was completed;

Equipment & Dining Room Enhancements

-replaced the steam table in the Maple servery, removing the counter and providing the servery with space to park the mobile steam wells
-replaced the dishwasher in the Maple servery
-replaced the cracked countertop in the Pine servery
-full floor replacement in the main kitchen, Aspen dining room and the Birch hallway outside the Aspen dining room
-removal of the glass wall between the Aspen dining room and the Birch hallways
-replaced hot water boosters in the main kitchen dishmachine and the Willow dishmachine
-replaced the dishwasher in the Spruce servery

Education

-mentored students from the Georgian College Food Nutrition Management program and the Northern Ontario School of Medicine Dietetic Internship Program
-participate on the Ontario Seniors Nutrition & Advisory Committee (OSNAC) and the Food and Nutrition Advisory Team (FNAT) working group
-regular safe food handling certification for all front line staff
-hosted Barrie North and Eastview co-op students to complete their work terms in food production

Resident Meal Satisfaction

-introduce a new menu in September 2023
-regular participation in the Resident Council meetings, as well as the Quality Improvement Committee. This allows the Diet team to hear resident concerns with food quality and nutrition care, and act upon them
-reintroduce the iPad dining selection photos to help residents with making choices at meal times

-introduced new initiatives for nutritional supplements as manufacturers have been making significant adjustments; bringing in Magic Cups for dysphagia supplements, and started using Boost Plus and Boost Powder (with the retirement of Boost 1.5 and Carnation Instant Breakfast)

Food Improvements

-continuously improve upon the current honey and gardening programs in order to ensure sustainability
-ongoing relationship with a new beekeeping partner
-ongoing purchasing of fresh local foods to enhance the menu
-continuation of the Country Fair meal in September, holding a pig roast in 2023

Policy Changes

-created a policy for fluid intake tracking
-development of a meal time responsibilities policy to outline each role in dining
-made adjustments to the staffing policies as per new regulations under the Fixing Long Term Care Act.
-made updates to the visitor meal policy as post-pandemic flexibilities allow

Human Resources

-continued to seek new initiatives to keep staff engaged in the workplace
-recruited new Dietary Supervisors (turnover high in 2023)
-made staffing plans for the purposes of preparing for redevelopment
-created a 45-minute educational video regarding meal service to be used for general orientation and staff training

Resident Satisfaction Survey Results

The 2023 Resident Satisfaction Survey resulted in a score of 73% satisfaction under the category 'Overall Satisfaction with Meals'. Some of the comments made by residents under this question were:

- *could be better*
- *chicken and fish usually pretty good*
- *dessert is always good*
- *breakfast always good*
- *lunch and dinner could use improvement*
- *very satisfied*
- *too many fancy dishes, old people like meat and potatoes*
- *need more variety*
- *would like margarine on table*
- *not consistent - good and bad meals*

The Action Plan is as follows:

New menu created with resident input, will review for follow up when in place	Director of Dietary Services and Information Technology	September 2023
Continue to attend Resident Leadership Team meetings monthly to gather feedback from the resident representatives.	Director of Dietary Services and Information Technology	On-going
Re-introduce ipads to be used for visual of meal options to be served	Director of Dietary Services and Information Technology	September 2023

Family Satisfaction Survey Results

The 2023 Family Satisfaction Survey resulted in a score of 81% satisfaction under the category 'Meal Service (Pleasurable Dining) and 85% satisfaction under the category 'Nutritional Content of Meals'. The areas requiring improvement and the action plan is as follows:

Identified areas for improvement	**Action Plan**	**Date**
• Would like "home cooked" meals added to the menu • Allowing residents the full hour for meal service • Have drinks available before meal service	• Outdoor gardens are being utilized again this year, vegetables from this garden are used in recipes being served	Seasonal
	• Purchases of local produce will be increased this year	Seasonal
	• New resident menu has been developed with resident input	September 2023
	• Staff to be reminded of pleasurable dining policy, allowing residents a full hour to enjoy their meal and to not feel rushed	On-going
	• Staff are to be reminded to pour drink preference for resident at time of seating (not beforehand causing coffee/tea to be cold)	On-going

2024 Improvement Initiatives

In order to build on the Resident focused initiatives of 2023, the following projects and enhancements are planned for 2024:

Equipment

-replace dishwasher in the Pine or Willow dining room
-continue to plan for the capital redevelopment of Maple and Aspen home areas
-replace convection ovens in the main kitchen
-replace one of the food processors in the main kitchen
-replace the main kitchen dishwasher

Dining Room Enhancements

-on Willow, add blinds to the windows and make repairs to the floors near the windows
-on Willow replace two dining tables with therapeutic tables
-upgrade one of the food transport carts
-replace steamtables in the Aspen and Pine dining rooms
-refresh the plateware and drinkware being used in the dining rooms

Education

-mentor students from the Georgian College Food Nutrition Management program, Northern Ontario School of Medicine Dietetic Internship Program
-regular testing of safe food handling for all front-line dietary staff
-host high school co-op students for food production roles

Resident Meal Satisfaction

-introduce a menu changeover in the 2nd quarter of 2024
-continue to build special event meals to coincide with popular holidays
-continue to participate in the Quality Improvement Committee and work on increasing resident meal satisfaction

Food Improvements

-improve upon the current honey and gardening programs in order to ensure sustainability

-ongoing purchasing of fresh local foods to enhance the menu

Policy Changes

-implementation of IDDSI soft-bite size therapeutic texture

-Make adjustments to policies as per new regulations under the Fixing Long Term Care Act.

Human Resources

-ongoing recruitment of staff to while navigating the health human resources crisis in long-term care

-managing operational changes as a result of closing Maple and Aspen home areas during redevelopment

Third-Party Interaction

In 2023 the Dietary Services department had numerous interactions with various regulatory and accrediting bodies.

Simcoe Muskoka District Health Unit had visited on three occasions in 2023 to conduct Food Premises Act inspection; March 1, July 12 and November 9. Findings from these visits were minimal to nil, with the most serious of those being:

- ensuring temperatures of dishmachines are well documented
- replace cracking countertop in the Pine servery
- ensuring automated handwash sinks, paper towel dispensers and soap dispensers are functioning in food prep areas.

Ministry of Long-Term Care compliance inspectors visited throughout 2023. No findings related to Dietary during the various inspections. 2023 did not have a Proactive Inspection

Canadian Food Inspection Agency inspectors did not visit the home in 2023. No areas of non-compliance.