Continuous Quality Improvement Report
Hardy Terrace LTC

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DESIGNATED LEAD - Quality Improvement

Introduction to Hardy Terrace LTC

Hardy Terrace is situated on 13 acres of land in the town of Mt. Pleasant in the County of Brant. Hardy Terrace opened its doors in 1982 as a Nursing Home and Retirement Home under the name Brucefield Manor. In 1997, Brucefield Manor changed ownership and was renamed Hardy Terrace Nursing Home. In 2021, Hardy Terrace changed ownership again and is currently managed by UniversalCare Canada and operating as Hardy Terrace LTC Operating Ltd.

Hardy Terrace is a single floor facility with 2 designated Home Areas. The General Unit is a 69-bed unit. Accommodation on this unit include 13 Private Rooms, 14 Semi-private rooms, 7-four bed ward rooms. This Home Area has one Grande Dining Room, chapel, library, Wellness Room and 2 lounge spaces.

The Specialty Unit consists of 32 beds with accommodations of 20 Private Rooms and 6-two bed ward rooms. The unit is a secure unit with a designated dining room, Activity Room and lounge space. The space is conducive to residents with responsive behaviours.

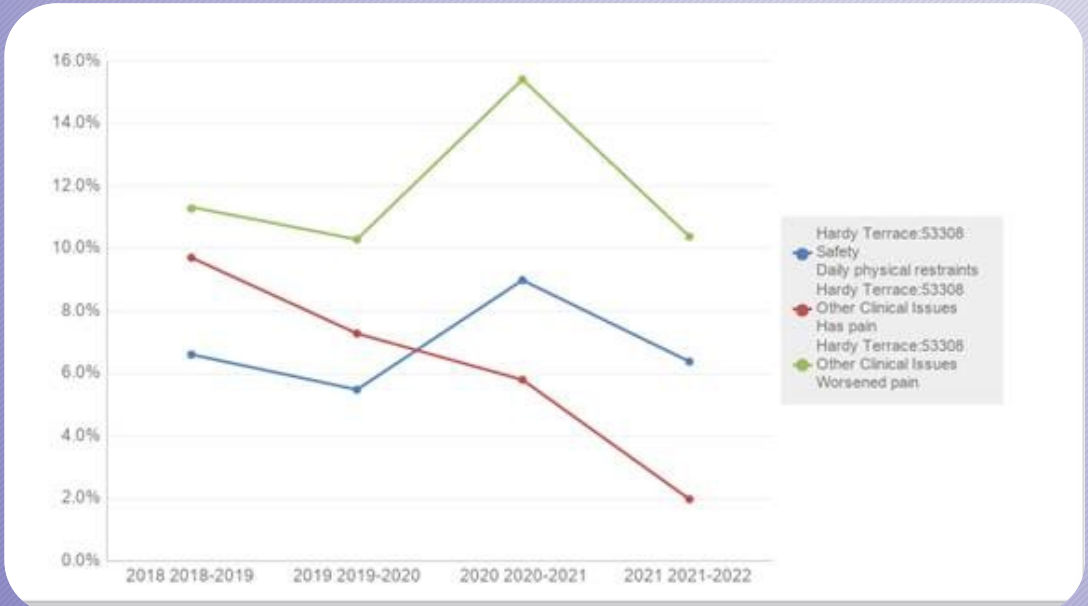
Quality Improvement Outcomes from 2022-23

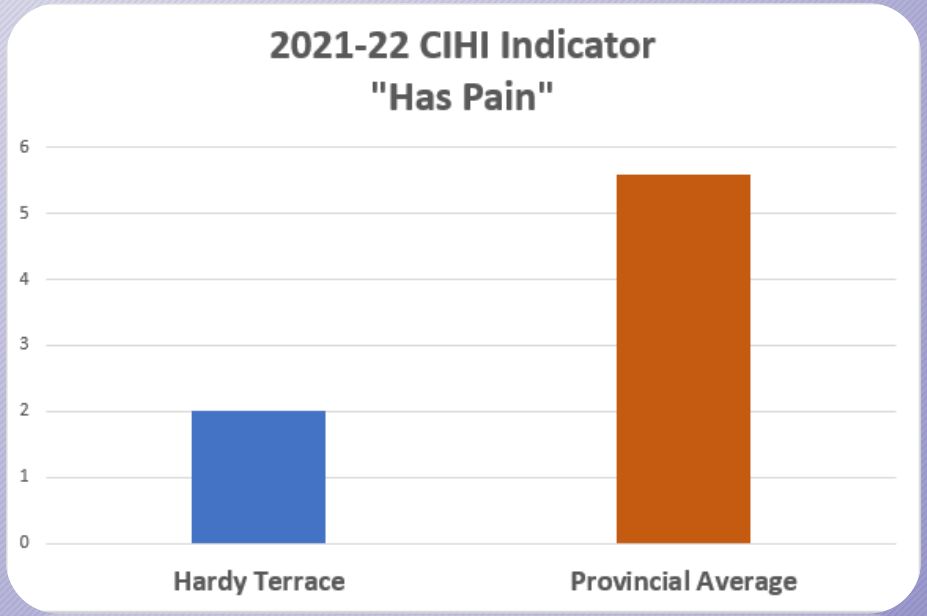
Quality Indicator	Performance Identified in 2022	Current Performance Indicator
Physical Restraints	9.0%	6.4%
Has Pain	5.8%	2.0%
Worsened Pain	15.4%	10.4%

High-Level overview of successes and objectives achieved in 2022:

- Implemented RNAO's "Alternative Approaches to the Use of Restraints" Best Practice Guideline in decreasing the use of physical restraints.
- Implemented RNAO's "Assessment and Management of Pain Best Practice Guideline". Since the implementation of the BPG, there has been an improvement in overall screening and assessment for pain management and have effectively decreased the indicator.

Quality Improvement Outcomes from 2022-23





QUALITY PRIORITIES FOR 2023/24

Hardy Terrace LTC is pleased to share its 2023/24 Continuous Quality Improvement Plan Report. Hardy Terrace LTC is committed to quality improvement and is reflected in our mission and strategic plan. We are continuing the implementation of the Person and Family Centred Care Best Practice Guideline ensuring residents and their families are supported to achieve their personal goals for their health and quality of life. We are implementing the Palliative Approach to Care and End-of-Life Care Best Practice Guidelines concentrating on improving or sustaining comfort and quality of life for the residents and their families facing a life-limiting illness. Our Palliative care approach encompasses holistic services that meets the physical, emotional, social, cultural, spiritual and psychological needs of the resident and their family members.

Meeting the requirements of the Fixing Long Term Care Act 2021 and Ontario Regulations 246/22, respecting Residents' Bill of Rights, maintaining an environment that supports evidence based practices and innovation remain high priorities for Hardy Terrace LTC . Our Continuous Quality Improvement Plan is a roadmap to integrating excellent care, collaboration and enhanced quality of life for residents in our Home.

The high-level priorities for Hardy Terrace LTC 2023 Continuous Quality Improvement are enhancing care outcomes and empowering frontline staff with knowledge and skill by implementing best practice guidelines as a Pre-designate Best Practice Spotlight Organization, supporting innovation in data integration, and maintaining Resident and Family Satisfaction :

- Achieving Excellence in Quality of Life for residents in our Home
- Achieving Resident's Comfort
- Supporting Resident's Transition in our Home
- Meeting Resident's needs, wishes
- Supporting Point of Care Decision Making
- Enhancing screening, assessment and prevention of risk
- Data Integration
- Maintaining Residents' and Staff Satisfaction

QUALITY OBJECTIVES FOR 2022/23

1. Achieving Excellence in Quality of Life for residents in our Home through the implementation of Person and Family Centered Care (PFCC) and Alternative to Restraints Best Practice Guideline and the Palliative Approach to Care Guideline
2. Achieving Resident's Comfort through the implementation of Pain Assessment and management Best Practice Guideline and the End-of-Life Care Guideline
3. Supporting Resident's Transition in our Home prior to admission through the process of pre-admission conference and on the day of admission through the implementation of the Admission and 24 Hours Assessment and Plan of Care Clinical Pathway
4. Meeting Resident's needs, wishes through the implementation of Clinical Pathways (Person and Family Centred Care and Pain Assessment and Management) and integration of goals of care discussions during resident care conferences
5. Data Integration through the implementation of AMPLIFI for the continuous updating of resident's information in both hospital and LTC Home record with transition exchanges
6. Supporting screening, assessment, prevention of risk and point of care decision making through the implementation of Assessment Tools and Clinical Pathways that integrate with Plan of Care though Nursing Advantage Canada electronic platform for residents' assessment
7. Maintaining Resident and Staff Satisfaction through Response and Action

QIP PLANNING CYCLE AND PRIORITY SETTING PROCESS

Hardy Terrace LTC has developed an annual planning cycle for their Continuous Quality Improvement Report and Quality Improvement Plan (QIP).

Quality Improvement planning includes an evaluation of the following factors to identify preliminary priorities:

- Progress achieved in past year based on previous QIP;
- Ongoing analysis of performance data over time available from the Canadian Institute for Health Information (CIHI); with areas indicating a decline in performance over time and/or where benchmarking against self-identified peer organizations suggests improvement required
- MDS Indicators Raw Data Reports available in Point Click Care
- Resident, family and staff experience survey results;
- Identified priorities through program evaluations and recommendations from the homes continuous quality improvement committee
- Results of care and service audits
- Emergent issues identified internally (trends in critical incidents) and/or externally;
- Input from residents, families, staff, leaders and external partners.
- Mandated provincial improvement priorities (e.g., HQO)
- Acts and Regulations for Long Term Care Homes, other applicable legislations and best practice guidelines

- Priorities are discussed within different committees and councils by interprofessional and interdisciplinary team members.
- These committees and councils include the Leadership Team, Resident Councils, Family Council, CQI Council and the Board of Directors Committee, such as Quality Care Committee. The process is interactive and engages different stakeholder groups.
- QIP targets and practice change ideas are identified and confirmed by the Owner.

HARDY TERRACE'S APPROACH TO CQI (POLICIES, PROCEDURES AND PROTOCOLS)

- Hardy Terrace LTC's Policies and Procedures, electronic documentation platform setup and practice standards, provide a baseline for staff in providing quality care and services, while maintaining safety. Hardy Terrace LTC has adopted the Model for Improvement to guide quality improvement activities. Interprofessional quality improvement teams, including resident and family advisors, work through the phases of the model to:

1. Complete Trends Analysis

- Teams use various QI methodologies to understand some of the root causes of the problem and identify opportunities for improvement. This work can include process mapping, 5 whys, fishbone, Plan-Do-Study-Act (PDSA) cycles, etc. Also included in this work, is an analysis of relevant data and completion of a gap analysis against relevant Best Practice Guidelines.

2. Set Improvement Aims

- Once there is a better understanding of the current system or practice challenges, the aim is expressed and documented. The aim includes information regarding the actual indicator target for improvement, the resident and family experience and satisfaction of outcomes, staff adherence to practice change and work satisfaction and, use of resources. This aim will be used to evaluate the impact of the change ideas through implementation and sustainability. Aim Statements are Specific Measurable, Attainable, Relevant, Timeline-Bound.

- The aim statement includes the following parameters - "How much" (amount of improvement – e.g., 30%), "by when" (a month and year), "as measured by" (indicator or a general description of the indicator) and/or "target population" (e.g., residents, residents in specific area, etc.)

APPROACH TO CQI (POLICIES, PROCEDURES AND PROTOCOLS CON'D)

3. Developing and Testing Practice Change(s)

- As a principal, Hardy Terrace LTC will identify practice changes to implement current evidence based recommendations established by the published best practice guideline(s)
- With the completion of the gap analysis, and program evaluation as required, areas for improvement are identified by various teams that will move Hardy Terrace LTC towards meeting its aim statement (s).
- Hardy Terrace LTC will monitor and track outcomes of practice changes through observation, auditing and data collection

4. Implementation, Dissemination, Sustainability

- Improvement teams consider the following factors when developing implementation of practice change plan:

➢ Outstanding work to be completed prior to implementation (e.g., final revisions to change ideas, embedding changes into existing workflow, updating relevant Policies and Procedures, work flow charts, documentation systems etc.)

➢ Education required to support implementation, including key staff resources (e.g., Best Practice Champions, Best Practice Liaisons and Co-liaisons).

➢ Communication required to various stakeholders, before during and after implementation

➢ Approach for spread across Hardy Terrace LTC , (to residents, families, staff)

➢ Dissemination at monthly Best Practice Change meetings, conferences, webinars, Best Practice Symposium, etc.)

Measures includes the following types:

Outcome Measures:

- Measures what the team is trying to achieve (the aim)

Process Measures:

- Measures key activities, tasks, processes implemented to achieve aim

Structure Measures:

- Measures systems, and processes to provide high-quality care.

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

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

At An Organizational Level

- Hardy Terrace LTC is using different reports to monitor and measure progress on strategic aims such as reports and Quality Improvement modules, best practice indicators based on guideline and clinical pathway implementation, and different analysis tools available within different programs.
- Communication strategies are tailored to the specific improvement initiative. These include, but are not limited to:

- Posting on unit Continuous Quality Improvement and Best Practice Boards, in common areas and in staff lounges
- Publishing stories and results via the newsletter, presenting at practice change webinars, social media
- Direct email to staff and families and other stakeholders
- Handouts and one: one communication with residents, families and staff
- Presentations at staff meetings, Resident Councils, Social Media Page
- Change of shift reports
- Use of Best Practice Champions to communicate directly with peers

Resident and Family Satisfaction Survey

- Resident and Family Satisfaction Surveys are provided to Residents and their family members each year in August.
- The results of the satisfaction surveys are communicated to the residents and their families, the Residents Council and Family Council and members of the staff of the home
- Hardy Terrace LTC completes a review of all the responses and establishes goals on the CQI action plan for any areas identified as needing improvement in collaboration with residents and their families, Residents Council, Family Council, CQI committee members and staff members of the home

Hardy Terrace LTC 2022 Resident & Family Satisfaction Survey

2022 Resident and Family Satisfaction Surveys was completed in September

Summary of Areas home is performing well:

- 100% Satisfaction to the question to “Staff are professional and respectful at all times.”
- 100% Satisfaction to the question “Cultural beliefs and practices are respected and encouraged.”
- 100% Satisfaction to the question “Do you feel at home here?”
- 100% Satisfaction to the question “How well do you feel the staff listen to you?”
- 100% Satisfaction to the question “I can express my opinion without fear of consequence.”

Summary of Areas for Improvement identified on 2022 Survey listed below:

- Satisfaction with appearance of meals
- Satisfaction with variety snacks
- Satisfaction with overall dining experience

Hardy Terrace LTC Quality Improvement Priority Indicators

1. Nutrition and Hydration Program

Indicator	Target Performance
Appearance of Meals	90%
Variety of Snacks	90%
Overall Dining Room Experience	95%

2. Least Restraint Program

Indicator	Target Performance
Has physical restraints	0%
Antipsychotic usage without a diagnosis	20%

3. Palliative and End-of-Life Care

Indicator	Target Performance
Number of residents identified under palliative care with resident specific care plans based on goals of care discussions regarding palliative care measures	100%
Percentage of palliative care residents that have had an interdisciplinary assessment of their holistic palliative care needs	100%
Number of Palliative Care Champions	12

Practice Changes/ Action Items to Support Quality Improvement

1. **Clinical Pathway Implementation:**
   - 24 Hours Assessment and Plan of Care
   - PFCC
   - Risk for Delirium
   - Pain Assessment and Management
   - Feedback provided to RNAO and Point Click Care

2. **Data Integration (AMPLIFI Project)**
   - Match of resident electronic health records between Hardy Terrace LTC and hospital software systems

3. **Safety and Technology:**
   - Skin and Wound App.
   - Practitioner Engagement and Secure Conversation App.
   - Automated Dispensing Cabinets (ADC) use
   - Infection Control Program Implementation

4. **Improved Staff Experience:**
   - Supporting Point of Care Decision Making: Clinical Pathways, electronic Infection Control Program, ADC, electronic Skin and Wound Program
   - Satisfaction Survey and Outcome

5. Residents Satisfaction Survey:
   - Satisfaction Survey and Outcome
   - Residents' Council Feedback
   - Actions for improvement

Hardy Terrace LTC Continuous Quality Improvement Action Plan

Year: 2023

Instructions: Complete Continuous Quality Improvement Action Plan as a part of the CQI Report annually. Create action plan for targeted quality improvement initiatives identifed during review of Resident & Family Satisfaction surveys from year previous, CQI Audits and Program Evaluations.

The following items need to be addressed each year in this action plan: QI Indicators (I.E. Skin, ED Transfers, Fall Prevention); Innovation (I.E. MST, PE/SC, Epic PCC integration); Resident/Family Survey action items; BPSO Indicators (i.e. Pain assessment and management, restraints, PFCC); CQI Audits action items and Program Evaluation action items

Item Number	Quality Improvement Indicator	Current Performance	Target Performance	SMART Goal & Quadruple Aim (1. Resident Experience, 2. Outcomes, 3. Care Team Experience, 4. Effective Resource Utiliziation)	Practice Change Idea	Action Items	Target Completion Date	Responsible Person	Date Action was Taken	Outcomes of Actions Completed	Role of Resident/ Family Council in Actions Taken	Role of CQI Committee in Actions Taken	Description of how and when that actions taken were communication to: 1) Residents 2) Families 3) Resident's Council 4) Family Council (if any) 5) Staff of the Home
1	Resident/Family Satisfaction with appearance of Meals	78%	83%	To improve resident and family satisfaction with regards to the appearance of meals from 78% to 83% by December 2023 Aim Statement - By providing nutritious, appealing, and enjoyable meals, we strive to create an environment where residents feel comfortable and supported during meals.	Education to frontline dietary staff on food presentation	Create education sessions on how to prepare and present meals to engage residents in their meals and improve residents appetite	2023-07-31	Nutrition Manager					
						Create audit schedule to inspect appearance of meals	2023-06-30	Nutrition Manager					
					Regular Communication with Resident and Families regarding the appearance of meals	Host monthly information sharing sessions with residents and family to discuss meal appearance, variety and overall dining experience. Identify any area of improvement then develop plan to improve with residents and family members.	2023-04-30	Programs Manager and Nutrition Manager	26-Apr	Ongoing	Feedback documented in Resident/ Food Council minutes and in Action Update	Summary of items are identified for re-evaluation and further action to be taken	Communication of improvements, practice change, education, and updates at relevant committees Resident Council updates Resident Council minutes dissemination Relevant committees Relevant boards
2	Resident/Family Satisfaction with Variety of Snacks	70%	83%	To improve resident and family satisfaction with variety of snacks from 70% to 83% by December 2023 Aim Statement - In order to provide the residents with the nutrition and hydration they need, it is essential to ensure that they are adequately hydrated throughout the day with beverages and snacks.	Regular Communication with Resident and Families regarding variety of snacks	Host monthly information sharing sessions with residents and family to discuss meal appearance, variety and overall dining experience. Identify any area of improvement then develop plan to improve with residents and family members.	2023-04-30	Programs Manager and Nutrition Manager	26-Apr	Ongoing	Feedback documented in Resident/ Food Council minutes and in Action Update	Summary of items are identified for re-evaluation and further action to be taken	Communication of improvements, practice change, education and updates at relevant committees Resident Council updates Resident Council minutes dissemination Relevant committees Relevant boards
					Explore available snack options	Create list of available snack options for each diet type and texture from nutrition vendor and local vendors	2023-07-31	Nutrition Manager					Communication of improvements, practice change, education, and updates at relevant committees Resident Council updates Resident Council minutes dissemination Relevant committees Relevant boards
3	Resident/Family Satisfaction with Overall Dining Room Experience	78%	83%	To improve resident and family satisfaction with overall dining experience from 78% to 83% by December 2023 Aim Statement - Implement a comprehensive quality improvement program which includes improving the quality and variety of food, providing better customer service, and increasing the efficiency of the dining process.	Recruitment and Retention of Dietary Aids and Cooks	Create job postings to fill current vacancies in Dietary Department	2023-07-31	Nutrition Manager		Ongoing		Update at the Quarterly CQI Committee Meeting	Communication of improvements, practice change, education dates, and updates at relevant committees
						Attend local job fairs to bring awareness to vacanies within the Dietary Department at Hardy Terrace	2023-09-30	Programs Manager					

						Conduct job interviews and extend offers in a timely manner when appropriate	2023-07-31	Nutrition Manager/ Interview Committee		Ongoing		Update at the Quarterly CQI Committee meetings	
						Conduct annual performace appraisal and include discussions on professional growth and how the home could support employees with their career goals.	2023-07-01	All Managers					
					Have at least 1 themed meal experience monthly	Coordinate: present available themes to the residents. Programs department and Food Service Depatment to plan and organize.	2023-04-30	Programs Manager and Nutrition Manager	18-Apr-23	successful event that we will continue monthly.	Feedback documented in Resident/ Food Council minutes and in Action Update	Update at the Quarterly CQI Committee meetings	
					Have a resident choice meal once a month	Have resident participate and discuss the plan to Food Service and Programs Department .	2023-04-30	Nutrition Manager	26-Apr-23	Ongoing	Feedback documented in Resident/ Food Council minutes and in Action Update	Update at the Quarterly CQI Committee meetings	
4	Has Physical Restraint	6.40%	0%	To reduce the use of physical restraints from 6.4% to 0% by December 2023 Aim Statement - To strengthen implementation of evidence-based practices and interventions that are designed to reduce the use of restraints, such as Alternative Approaches to Restraint Use, it can create an environment where physical restraints are no longer necessary resulting to improved resident safety, respect for patient dignity, and a better overall quality of care.	Continue to implement recommendations from the Promoting Safety: Alternative Approaches to Restraint Use Best Practice Guideline	Complete Gap analysis with Least Restraint program evaluation from 2022 to identify any additional recommendations that could be implemented further	2023-03-31	Program Lead	31-Mar-23	Currently physical restraint free	Communication on relevant boards	Update at the Quarterly CQI Committee meetings, Summary of items are identified for re-evaluation and further action to be taken	
						Identify list of residents that currently use restraints, identify alternative approaches that may be utilized in place of the physical restraint. Collaborate with care team including resident/SDM to identify and trial alternatives	2023-03-31	Program Lead	31-Mar-23	Currently physical restraint free	Communication on relevant boards	Audits summary presented and discussed for further evaluation or corrective action as needed Collaboration with Resident/Family	
						Promote a restraint free home for any new or prospective residents. Provide education to prospective residents and their families on the risks associated with restraint use and the alternatives that are available	2023-06-30	DOC, ADOC, Program Lead and Clinical Resource Nurse (CRN)	30-Apr-23	Ongoing	Communication on relevant boards and care conference	Audits summary presented and discussed for further evaluation or corrective action as needed Collaboration with Resident/Family	
5	Antipsychotic Usage without diagnosis	24.50%	20.00%	To reduce the use of antipsychotics without a diagnosis from 24.5 % to 20.0% by December 2023. Aim Statement - Working with other providers and external partners allows us to better understand the needs of our residents and develop solutions that don't solely rely on pharmaceuticals to meet those needs, while including alternative therapies from valid sources in the plan of care.	Explore partners and other services that could start non pharmocological interventions	CRN to collaborate with partners about implementing non pharmacological interventions and apply to atleast 1 resident per month.	2023-09-30	CRN, SW and BSO Team					
6	% of palliative care residents that have had an interdisciplinary assessment of their holistic palliative care needs	New Indicator	100%	Goal - To increase the percentage of residents that have had an interdisciplinary assessment of their palliative care needs (when appropriate) Aim Statement - To improve the residents, family and staff experience by establishing therapeutic and collaborative partnerships that identify the physical, psychological, social, spiritual (existential) and practical requirements of the resident and their family members facing a life limiting illness. Completing a holistic assessment in partnership with the resident and their loved ones can support the development of a plan of care that has been co-designed to encompass the residents values, wishes, beliefs, preferences and expectations. Establishing care and services that are tailored to the resident and the family members needs will enhance residents quality of life and comfort.	1) Education for staff regarding how to conduct a holistic assessment of the residents palliative care needs using the "Palliative Care Assessment" UDA in PCC	1) Develop education session and training materials to educate staff on the use of the Palliative Care Assessment UDA and how to collect this information, how to initiate referrals for palliative care needs when required and how to build a resident specific and holistic plan of care tailored to the residents palliative care needs	2023-04-30	DOC, ADOC, Program Lead and Clinical Resource Nurse (CRN)	17-Apr-23	Ongoing	Communciation included with Care Conference and newsletter	Update at the Quarterly CQI Committee meetings, Summary of items are identified for re-evaluation and further action to be taken	
						2) Schedule and implement training sessions for staff on palliative care, assessment, interventions, referrals and care planning.	2023-04-30	DOC, ADOC, Program Lead and Clinical Resource Nurse (CRN)	18-Apr-23	Ongoing	Communciation included with Care Conference and newsletter	Update at the Quarterly CQI Committee meetings, Summary of items are identified for re-evaluation and further action to be taken	
					2) Establish an audit process to audit the completion and quality of palliative care assessments	1) Create an audit schedule indicating the responsible person (s) for completion of audits and number of audits to be completed each month	2023-07-24	DOC, ADOC, Program Lead and Clinical Resource Nurse (CRN)					
						2) Conduct monthly audits of Palliative Care UDAs. Follow up to be completed as required	2023-08-31	DOC, ADOC, Program Lead and Clinical Resource Nurse (CRN)					Communication of improvements, practice change, educations, and updates at relevant committees

7	Number of residents identified under palliative care with resident specific care plans based on goals of care discussions regarding palliative care measures	New Indicator	100%	Goal - To increase the percentage of residents identified under palliative care with resident specific care plans based on goals of care discussions regarding palliative care measures Aim Statement -To improve the residents, family and staff experience by establishing therapeutic and collaborative partnerships that identify the physical, psychological, social, spiritual (existential) and practical requirements of the resident and their family members facing a life limiting illness. Completing a holistic assessment in partnership with the resident and their loved ones can support the development of a plan of care that has been co-designed to encompass the residents values, wishes, beliefs, preferences and expectations. Establishing care and services that are tailored to the resident and the family members needs will enhance residents quality of life and comfort.	1)Educate Registered Staff on goals of care discussions related to palliative care and/or end-of-life in collaboration and partnership with the resident, SDM(s) and interprofessional team	1) Develop education session and training materials to educate registered staff on goals of care discussions related to palliative care and/or end-of-life needs in collaboration and partnership with the resident, SDM(S) and interprofessional team, how to initiate referrals for palliative care or end-of-life needs when required and how to build a resident specific and holistic plan of care tailored to the residents palliative care needs	2023-04-30	DOC, ADOC, Program Lead and Clinical Resource Nurse (CRN)	30-Apr-23	Ongoing	Communciation included with Care Conference and admission package	Update at the Quarterly CQI Committee meetings, Summary of items are identified for re-evaluation and further action to be taken	Communication of improvements, practice change, educations, and updates at relevant committees
						2) Schedule and implement training sessions for registered staff on goals of care discussions, referrals and resident specific care planning based on goals of care discussions.	2023-04-30	DOC, ADOC, Program Lead and Clinical Resource Nurse (CRN)	30-Apr-23	Ongoing	Communciation included with Care Conference and admission package	Update at the Quarterly CQI Committee meetings, Summary of items are identified for re-evaluation and further action to be taken	Relevant committees and Relevant boards
					2) Establish an audit process to audit the completion and quality of palliative care plans based on goals of care discussions	1) Create an audit schedule indicating the responsible person (s) for completion of audits and number of audits to be completed each month	2023-04-30	DOC, ADOC, Program Lead and Clinical Resource Nurse (CRN)	30-Apr-23	Ongoing	Communciation included with Care Conference	Update at the Quarterly CQI Committee meetings, Summary of items are identified for re-evaluation and further action to be taken	Communication of improvements, practice change, educations, and updates at relevant committees
						2) Conduct monthly audits of Palliative Care Plans. Follow up to be completed as required	2023-05-31	DOC, ADOC, Program Lead and Clinical Resource Nurse (CRN)	30-Apr-23	Ongoing	Communciation included with Care Conference	Update at the Quarterly CQI Committee meetings, Summary of items are identified for re-evaluation and further action to be taken	Relevant commitees
8	Number of palliative champions within the home	8 Staff	12 Staff	Goal - To increase the number of palliative care champions within our home from 8 staff to 12 staff by September 2023. Our aim is to improve the experience of our residents, families, and staff by enhancing the knowledge and skills of our frontline staff regarding palliative care and end-of-life care. Residents, their families, and caregivers will benefit from supportive palliative care champions who will promote a Model to Guide Hospice Palliative Care. Palliative Care champions will promote effective communication, and effective group functioning amongst the entire healthcare team with regards to assessment, information sharing, decision making, care planning, care delivery and confirmation. In order to support the best possible quality of life and outcomes for residents, it is essential that they receive the right type of care, from the right provider, and in the way they prefer.	1) Canvas the employees on all three shifts to identify staff members that would like to become a Palliative Care Champion and participate in the Palliative Care Committee	Post internally the opportunity for staff to become Palliative Care Champions and be provided the opportunity to have additional training and education regarding palliative care and end-of-life care	2023-04-30	DOC, ADOC, Program Lead and Clinical Resource Nurse (CRN)	April 30,2023	Ongoing	Communciation included with Care Conference	Update at the Quarterly CQI Committee meetings, Summary of items are identified for re-evaluation and further action to be taken	Relevant committees and Relevant boards
						2) Choose staff members to be palliative care champions. Ensure all 3 shifts have 2 ore more champions to support the implementation of the palliative care and end-of-life care best practice guidelines. Register the selected champions for the fundamentals of palliative care, for registered staff register them for the enhanced fundamentals course through the OHT West Pain and Symptom Management Consultant	2023-08-31	DOC, ADOC, Program Lead and Clinical Resource Nurse (CRN)					Communication of improvements, practice change, education dates, and updates at relevant committees

Dates Action Plan and Outcomes communicated to Residents:March 29, 2023, will review updated sections by August 31, 2023
Dates Action Plan and Outcomes communicated to Family Members: August 31, 2023
Dates Action Plan and Outcomes communicated to Staff: March 31, 2023, update ugut 31, 2023
Dates Action Plan and Outcomes communicated to Residents Council: March 29, 2023, update July 31
Dates Action Plan and Outcomes communicated to Family Council: September 30, 2023