SHEPHERD VILLAGE
A Caring Christian Seniors' Community

Continuous Quality Improvement (CQI) Report 2024/2025

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DESIGNATED LEAD

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QUALITY PRIORITIES

Shepherd Lodge is happy to share our Continuous Quality Improvement Report. We embody quality in our Vision, Mission, and Values of the Organization.

SHEPHERD VILLAGE
A Caring Christian Seniors' Community

Vision

To be a continuum of care within a Christian community, where seniors find peace.

Mission

Recognizing our origins and shared common creed and values with the Pentecostal Assemblies of Canada, we meet the changing physical, spiritual and social needs of seniors through quality care and compassionate service.

Values

C **Compassionate Care**
We, as a team, are genuinely concerned about the well-being of those we serve.

A **Accountability**
We hold ourselves to a higher standard being responsible to our residents, co-workers, partners and our community.

R **Respect**
We treat everyone equally with integrity to earn their trust.

E **Excellence**
We are quality driven to exceed the expectations of those we serve.

Commission of Accreditation of Rehabilitation Facilities (CARF) Canada

In 2023, Shepherd Village was pleased to engage in the CARF Canada Accreditation Survey, of which we were issued a 3-year accreditation.

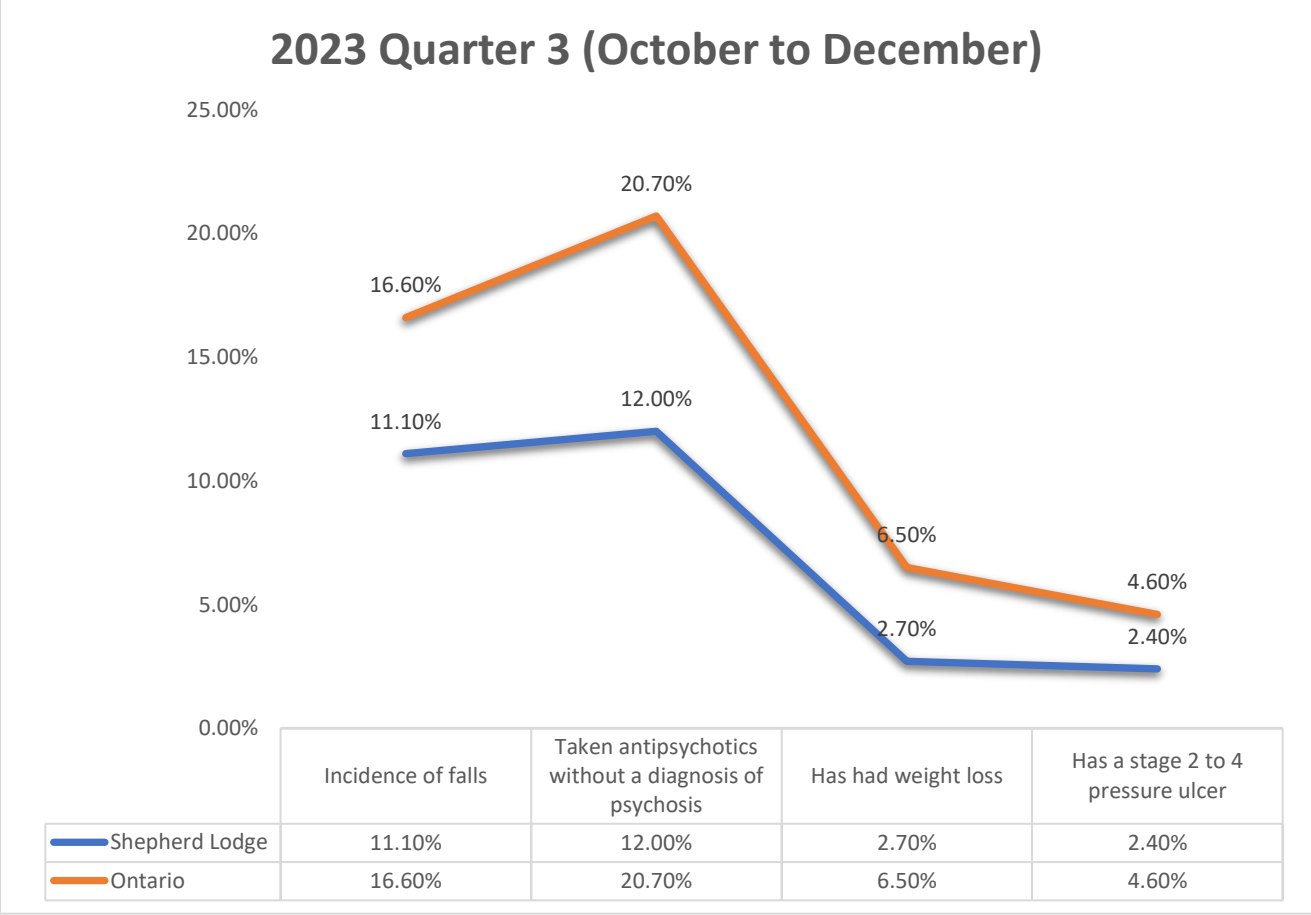
We are proud that no recommendations were given under the Person-Centred Long-Term Care Standards.

Great Place to Work® Canada

Many business leaders, research institutions, and the public rely on the Great Place To Work® Canada Trust Model© as the definitive standard for a great workplace. Shepherd Village has adopted this methodology and is proud that our staff voted us as a Great Place to Work!

Canadian Institute for Health Information (CIHI)

There are several areas in which Shepherd Lodge continues to do better than the provincial average. Some of these areas include:



	Incidence of falls	Taken antipsychotics without a diagnosis of psychosis	Has had weight loss	Has a stage 2 to 4 pressure ulcer
Shepherd Lodge	11.10%	12.00%	2.70%	2.40%
Ontario	16.60%	20.70%	6.50%	4.60%

OUR APPROACH TO CQI (Policies and Procedures)

Our Quality Improvement Manual, which consists of policies and procedures, guides us in determining when to utilize a DMAIC process for improvement. An interdisciplinary team, including family and resident representatives, will work through the priority projects using this model:

DMAIC Quality Improvement Cycle

DMAIC (Define, Measure, Analyze, Improve, and Control) is a quality Improvement Cycle used by the Residents First Initiative (HQO). This model has five phases. This model is available for the team(s) to use as part of the quality improvement or initiative.

1. **Define:** Identify a situation or problem
    - Seek to understand a process.
2. **Measure: Review or collect baseline data**
    - Collect baseline data to verify what the problem is and allow us to compare before and after the change.
3. **Analyze – The current problem.**
    - What story does it tell us about the system?
4. **Improve**
    - The team starts developing change ideas and starts implementing these changes.
5. **Control**
    - The team creates an action plan to sustain the changes that have been made with clear lines of accountability

PROCESS TO DETERMINE PRIORITY AREAS

When looking at the possible opportunities for improvement, we review the following data:

- Resident and Family experience surveys
- Staff satisfaction and engagement surveys
- Resident & Family Council feedback
- Canadian Institute for Health Information data
- Internal key performance indicators
- Internal and external audit/inspection outcomes
- Program evaluation outcomes

The interdisciplinary team meets several times a year to review data and feedback from our stakeholders to determine the improvement priorities. We also refer to resources such as Health Quality Ontario for our quality improvement journey.

The Board Quality Committee also provides input into the annual plan.

MONITORING AND MEASURING PROGRESS

A key component of the sustainability plan is the collection and monitoring of the key project measures over time. Analysis of the outcome measure(s) will be used to identify if the Home is achieving the desired outcomes or not. If not achieving the 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 compliance, etc.

COMMUNICATION OF INITIATIVES

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

- Posting on home area quality boards in common areas
- Publishing stories and results on the website, on social media, or via a newsletter
- Direct email to staff, families, and other stakeholders
- One-to-one communication with residents and families
- Presentations at staff meetings, town hall meetings, and Resident and Family Council meetings
- Presentation through the family education programs at Shepherd Lodge
- Home area staff huddles

PRIORITY AREA OUTCOMES FOR 2022/2023

Improve worsened mood from symptoms of depression	➢ Utilized the Geriatric Depression Scale (GDS) screening test ➢ Updated BSO (Behavioural Support Ontario) weekly activities based on residents' interests and hobbies. ➢ Enhanced the sensory room	Overall, the incidence of residents who had worsened mood from depression has improved from 23.7% in 2022 Q3 to 9.5% in 2023 Q3. The provincial average in 2023 Q3 was 20.7%
Transition from Advanced Directives to Goals of Care and the Prevention of Error-based Transfers (PoET Project)	➢ (New) Goals of Care were discussed upon move-in, when there is a significant change in health condition, upon request by resident or family, at annual care conferences, and during the end-of-life.	We successfully transitioned 90% of our residents from Advance Directives to Goals of Care Conversations.

Reduce the # of new internally acquired pressure injuries.	➢ (New) Successfully collaborated with the Nurse Lead Outreach Team (NLOT) from Scarborough Health Network to address complex wounds ➢ Our skin and wound specialist from Medline Canada provided education and training on the following: • Skin care • Skin health, wound assessment and documentation	An improvement has been made of an average of 13 to 7.6 internally acquired pressure injuries per month. We will continue to focus on this improvement initiative.
Improve the positive response to "I can express my opinion without fear of consequence.	➢ (New)The BSO team provided training on the NODD practice. Staff are to provide their **n**ame, **o**ccupation, and **d**uty, including asking residents if they need anything else before **d**eparture. ➢ (New) Initiated the Circle of Care Forum which is led by the ADOC to provide operational updates, answer questions, and follow up/questions raised by residents.	The positive response to this question remains unchanged from 2022 to 2023 at 73%. This will remain a priority for 2024-2025.
Strengthen Privacy in the home	➢ Provided retraining to all staff ➢ Hired a Privacy Consultant to identify areas for improvement	The privacy officer provided refresher training on privacy legislation and practices. An audit was performed by the consultant and the team has created an action plan for all identified areas for improvement.
Enhance the process to raise concerns.	➢ Upon move-in, the social services staff review the resident and family handbook, including the internal complaints process and whistleblowing policy.	The positive response to this question has improved from 76% in 2022 to 81% in 2023.

Improve resident's involvement in their care decisions.	➢ Reviewed resident's bill of rights. ➢ Implemented the meet and greet upon move-in, where residents and families meet the interdisciplinary team	The positive response to this question has improved from 87% in 2022 to 95% in 2023.
Improve pleasurable mealtime experience	➢ Focused group discussion around pleasurable mealtime on seating and environment in the dining room ➢ Decorations and centerpieces for Holidays and events ➢ Introduce a café cultural lunch program	Overall satisfaction has improved compared to the previous year and will continue to be a priority in 2024-2025.
Improve the quality of food and drink	➢ Increased availability of the condiment caddy in the dining room ➢ Improved garnishing of plated meals ➢ Introduced a dinner roll maker in the kitchen, which makes fresh homemade dinner rolls	Overall satisfaction with food quality and drink improved from 72% in 2022 to 78% in 2023.
Improve evening programming	➢ Hire two more full-time staff for evening and weekend programming. ➢ Ask families to participate in more outings and events in the home. ➢ Offer more large group evening and weekend programs and events.	Overall, residents' participation in evening programming has increased. In addition, there is more family involvement in activities, events, and outings.
Improve personal clothing management	➢ Revise the clothing inventory process upon move-in.	Revised Personal Clothing Inventory process is in place and utilized upon move-in.

Improve providing of general health updates	➢ Re-establish and roll out a schedule for registered staff to update families ➢ Reinforce utilization of portable phones	Providing families with general health updates is a standing agenda discussed during the registered staff meetings. A portable phone audit was completed, identified areas for improvement were addressed, and additional training took place.

RESIDENT AND FAMILY EXPERIENCE SURVEY

At Shepherd Lodge, the Resident Council (RC) Lead and the Family Council (FC) Chair are active members of the Quality Team. This interdisciplinary team is responsible for identifying and supporting opportunities for improvement for Shepherd Lodge. The Resident and Family Experience Survey results and the action plans are reviewed for input at the Quality Team meeting by the interdisciplinary members including the registered staff and PSW representative.

Summary of the 2023 Resident and Family Experience Survey

Action	Date
Date draft survey taken to council for input	RC - September 12, 2023 FC - August 18, 2023
Distribution start date	RC - October 4, 2023 FC - October 6, 2023
Date the results shared and input for action with the council	RC - March 12, 2024 FC - February 8, 2024
Date the survey results shared with the staff at the town hall	February 15, 2024

The Director of Client Care Services shared the results with both Councils via presentation format and highlighted the following outcomes of the survey:

- 98% (92) response rate from Residents
- 30% (73) response rate from Families
- 90% of respondents said that overall, they are satisfied with Shepherd Lodge
- 86% of respondents said they would recommend Shepherd Lodge

Top 3 areas Shepherd Lodge is doing well:

- Staff treat me with respect
- May daily health care needs are met
- The home is free from odors

Areas to improve:

- Weekend programing
- Variety and quality of food
- Staff listening skills

Shepherd Lodge creates an action plan each year with input from the Family and Resident Councils.

PRIORITY AREAS FOR 2024/2025

The high-level priorities include:

1. Reduce the number of avoidable ED (Emergency Department) transfers from 17.55% to 17%
2. Improve the resident-centred experience by responding positively to the statement “I can express my opinion without fear of consequences” from 73% to 75%.
3. Reduce the number of internally acquired pressure injuries from an average of 7.6 to 7 per month
4. Improve staff listening skills
5. Improve resident participation in weekend programming
6. Improve the variety and quality of food
7. Provide training to staff on diversity, equity and inclusion.