Quality Improvement Plan (QIP)

# Narrative for Health Care Organizations in Ontario

March 4, 2025

Ontario Health

## OVERVIEW

Miramichi Lodge, located in the City of Pembroke, is a municipal (not-for-profit) long-term care home and home to 166 Residents. It is owned and operated by the County of Renfrew and City of Pembroke and has earned a reputation of providing high quality care to the frail and elderly since 1969. In January 2005, Residents and staff moved to our brand new, state-of-the-art facility located at 725 Pembroke Street West. Miramichi Lodge operates under the direction of the Director of Long Term Care in compliance with and the Ministry of Long-Term Care and the Fixing Long Term Care Act, 2019. Our Home governance is led by County Council with strategic and operational recommendations brought forth by the Director of Long Term Care through Health Committee. Our Management Team, led by the Director of Long Term Care provides guidance and sets the strategic vision for the Home with input from stakeholders. The Lodge is a non-smoking facility. Miramichi Lodge has an annual budget of approximately $22M, employs approximately 255 staff and relies on the assistance of volunteers who, together with our dedicated staff, enhance the quality of life of our Residents.
Miramichi Lodge has remained a workplace and Home of choice within
Renfrew County.
Accreditation Canada awarded a Four Year Accreditation with Exemplary Standing Award to Miramichi Lodge in 2023. This represents the
highest award granted by Accreditation Canada. The Accreditation process provides the Home with the opportunity to benchmark our programs and services to national standards and assists in our continuous quality improvements.
Miramachi Lodge utilizes an evidence-based best-practice approach with respect to service

delivery. Miramichi Lodge is pleased to share our 2025/2026 Quality
Improvement Plan (QIP) with our Residents, families, staff, volunteers, and community stakeholders. The annual QIP outlines the key actions we are committed to implementing to ensure continuous improvement of the care and services we deliver. As in previous years, these quality improvement initiatives are reflective of our broader organizational strategic plan, and are closely aligned with our Mission, Vision, and Values.

Mission Statement:
• With a person-centered approach, Miramichi Lodge is a safeand caring community to live and work.
Vision:
• Leading excellence in servicedelivery
Values:
• Honesty and Integrity
• Professionalism
• Client Service Orientation
• Focus on Results

It is important to note that this plan is only one of the many tools used by Miramichi Lodge to identify quality improvement priorities, and monitor system performance. Our commitment to the delivery of exceptional care, and enhancing quality of life for our Residents is
further evidenced by our ongoing quality improvement activities through our Continuous Quality Improvement (CQI) Committee. This QIP represents the top quality improvement priorities that have been committed to at all levels of the organization. The plan outlines new or revised performance targets, and new change ideas informed through reflection and evaluation of our quality improvement work in previous years.

## ACCESS AND FLOW

Miramichi Lodge has a full team of professionals who collaborate to ensure best possible Resident outcomes, as identified through Goals-of-Care meetings, on admissions, annually, and during high risk rounds. Our team consists of medical doctors, a FT Nurse Practitioner, a FT Physiotherapist, FT Registered Dietitian, and FT Social Worker. We work closely with other health care agencies to ensure the best care possible.

## EQUITY AND INDIGENOUS HEALTH

Our Primary services at Miramichi Lodge are provided to Residents 65 years of age or older. The Residents are mainly English speaking individuals from rural living, but we also have Residents who speak other dialects. Some
Residents also come from the Algonquin's of Pikwaknagan First Nation. Our primary Residents often have multiple comorbidities and are frail, elderly, cognitively impaired, developmentally challenged from a diverse socio-economic background.
To help meet these Resident's needs most staff are provided with education from the home. Education may be in: Cultural Competencies and Indigenous Cultural Safety Training, Gentle Persuasive Approach (GPA), Mental Health Disorders and Infection Prevention and Control. Inservices are
provided through internal/external stakeholders such as Regional Geriatric Mental
Health Team.
There are also numerous mandatory annual training sessions through SURGE
learning.
When sociodemographic needs are identified, the Home's social worker will help individuals navigate the system for available supports. Miramichi Lodge has a high functioning Resident Council where residents are able to speak freely and identify any issues there are experiencing and ask for support. Finally, we have resident care conferences which provide a forum for the interdisciplinary
team to identify and discuss any barriers residents may be facing while offering avenues of support to overcome these barriers.

## PATIENT/CLIENT/RESIDENT EXPERIENCE

Recognizing that the annual Quality Improvement Plan drives quality initiatives, the leadership team, front-line staff and support staff at Miramichi Lodge embrace a person-centered philosophy in the quality improvement process. Valuable feedback received through annual resident and family satisfaction surveys along with quarterly Resident and Family Council meetings drives both formal and informal quality improvement activities.
Miramichi Lodge enjoys a productive partnership with our active and engaged Resident Council and less formally, Residents enjoy the ability to connect directly with frontline staff or managers with concerns in the moment, allowing for timely resolution and improved CQI initiatives.
Resident and Family Councils are represented on the Continuous Quality Improvement
(CQI) Committee, as well as active participation in a variety of formal and informal working groups.

## PROVIDER EXPERIENCE

The health care provider experiences
across the sector have been relatively stable at Miramichi Lodge. Recruiting new staff to
meet increased direct care hours outlined in the FLTCA has been stable.
A variety of Ministry funding envelopes has
been utilized to support the recruitment of a full-time social worker,

a full-time physiotherapist and full-time a nurse practitioner. These recruitment efforts are also used to retain staff by improving the quality of care provided. These new employees will help to deliver care, share knowledge and encourage professional growth which will improve job satisfaction. The home has also revised schedules, reached out to internal and external stakeholders for input via rounding/unit meetings and encouraged collaboration with local unions. The Wellness Committee has also been re-established to engage employees in improving their workplace.

## SAFETY

Patient Safety is paramount at Miramichi Lodge. There is an active Joint Health and Safety Committee (JOHSC) consisting of employees and management who review employee incident reports monthly and ensure corrective actions are taken to mitigate risks to residents and employees. Safety huddles
take place in the moment with staff after each incident on resident home areas to ensure appropriate actions are taken. Risk Management assessments are completed and documented in Point Click Care (PCC) to ensure interventions are initiated and reviewed after an incident. Regular emergency code exercises are completed with staff
which include a debrief after the code exercise. Miramichi Lodge maintained regular resident care conferences throughout the pandemic and this has been an extremely effective method of obtaining critical feedback on safety concerns as well. Miramichi Lodge conducts regular High Risk Resident Rounds with all professional staff in attendance; review of all high risk areas(e.g. Falls, Wound Management, IPAC, Responsive Behaviors)is completed at each meeting and changes made the each Resident plan of care as required. Accreditation also
drives change for health and safety plans within the home ensuring best practice guidelines are reviewed an implement regularly.

## PALLIATIVE CARE

Miramichi Lodge prides itself in providing exceptional Palliative and End-of-Life Care to Residents in their own rooms, where they have lived since admission. FLTCA requires that each Resident careplan covers all aspects of care, including a palliative approach to care. At Miramichi Lodge, our care team meets with Residents/Families within six weeks of admission to start these conversations and develop a careplan that supports Resident rights and wishes going forward. The Home promotes a philosophy of Living Well Until Death which is person-centered and driven by the Resident in our care. At the time that End-of-Life symptoms present, family will be advised and further supported by staff. A family overnight suite is available for families who wish to remain close by during this very important time. Our active Palliative Care Committee meets regularly to review our program and have introduced such strategies as a post death survey for families who have received palliative care as well as an honour guard at time Resident passes.

## POPULATION HEALTH MANAGEMENT

Director of Long Term participates as member of Ottawa Valley Ontario Health Team (OVOHT) Steering Committee. As member of the OVOHT Long Term Care Network DLTC collaborates with participating Long Term Care Homes Leadership and various enabler group toward improved care access for seniors. Home Administrator / DOC is an active participant of Algonquin College / University of Ottawa Health Sciences Program Advisory Committee. This provides an opportunity for curriculum content input toward health care graduates meeting population health needs. Miramichi Lodge has embraced best practices with the RNAO Clinical Pathways and is implementing the Admission, Delirium, and Resident and Family Centered Care programs in conjunction with Point Click Care. This will further improve our standard of care and improve Resident outcomes.

## SIGN-OFF

It is recommended that the following individuals review and sign-off on your organization's Quality Improvement Plan (where applicable):

I have reviewed and approved our organization's Quality Improvement Plan on March 26, 2025.

Warden Peter Emon, County of Renfrew

Mike Blackmore, Administrator / Director of Long-Term Care

Nancy Lemire, Director of Care, Quality Committee Chair

Craig Kelley, Chief Administrative Officer

## CONTACT INFORMATION/DESIGNATED LEAD

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## Access and Flow

### Measure - Dimension: Efficient

| Indicator #1 | Type | Unit / Population | Source / Period | Current Performance | Target | Target Justification | External Collaborators |
|---|---|---|---|---|---|---|---|
| Potentially avoidable emergency department visits for long-term care residents | C | Rate per 100 / LTC home residents | Other / April 1-March 31 | 11.70 | 11.70 | Remain below the provincial target. | Bonnechere Manor, Pembroke Regional Hospital, Medical Team, Pharmacy |

**Change Ideas**

Change Idea #1 Further reductions to the number of potentially avoidable ED visits

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| Educate staff on new RNAO Clinical Pathways for Resident admissions and delirium assessments. Admission care conferences and goals-of-care meetings are held within six weeks of transition to LTC. | In collaboration with the Resident and their SDM, interdisciplinary care team ensures accurate documentation that defines goals of care specific to palliation and the threshold for acute care transfer. | Indicator data is reviewed at quarterly Professional Advisory Committee meetings. NP will provide ongoing training & support to RNs/RPNs. All new admissions will have admission and delirium assessment completed through the RNAO Clinical Pathways programs. | NP and medical staff now utilizing a portable ultrasound machine which will aid in bedside diagnosis and eliminate need for transfer to hospital for chest infections, constipation, etc. NP will review quarterly stats on transfer to hospital and flag any unnecessary transfers for review with nursing staff. |

## Safety

### Measure - Dimension: Safe

| Indicator #2 | Type | Unit / Population | Source / Period | Current Performance | Target | Target Justification | External Collaborators |
|---|---|---|---|---|---|---|---|
| Percentage of LTC home residents who fell in the 30 days leading up to their assessment | O | % / LTC home residents | CIHI CCRS / July 1 to Sep 30, 2024 (Q2), as target quarter of rolling 4-quarter average | 20.36 | 12.00 | Strive for provincial benchmark of 16.5% | Bonnechere Manor, Medical Staff, Pharmacy. |

#### Change Ideas

Change Idea #1 Home is now reviewing each Resident fall regularly through interprofessional High Risk Rounds meetings.

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| Each Resident fall will be reviewed and documented in a fall's tracking tool. Gap analysis completed using this tool. | Nurses will review careplan interventions at High Risk Rounds and update as necessary. All disciplines (SW, PT, RD, NP) will complete assessments to rule out potential causes for falls. Falls huddles will occur on the Resident Home Areas with goals of discussing falls prevention in the moment and at frontline. Education also provided to Resident/Family during care conferences regarding history of falls and interventions in place. | Decrease in number of Resident falls. | Common trend to have one resident with several falls which is also a consideration when reviewing stats. In addition, some Residents/Families wish to live at risk and refuse fall prevention strategies home has offered; such wishes are part of careplan. |

## Measure - Dimension: Safe

| Indicator #3 | Type | Unit / Population | Source / Period | Current Performance | Target | Target Justification | External Collaborators |
|---|---|---|---|---|---|---|---|
| Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment | O | % / LTC home residents | CIHI CCRS / July 1 to Sep 30, 2024 (Q2), as target quarter of rolling 4-quarter average | 16.97 | 14.00 | Home will continue to work on de-prescribing initiatives in an effort to decrease antipsychotic usage. | Medical team and Geriatric Mental Health, Pharmacy |

### Change Ideas

Change Idea #1 Percentage of Residents without psychosis who were given antipsychotic medications

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| De-prescribing initiatives were introduced in 2023 and continue to be followed. Medical staff and NP complete thorough three month medication reviews and make changes where able. Home embarking is Assessment for Delirium clinical pathway through RNAO during this reporting period which will decrease need for antipsychotic meds by taking a more proactive approach to addressing deliriums. | Quarterly drug utilization reports provided by Pharmacy; antipsychotic use strategies analyzed at quarterly Professional Advisory Committee meetings. | 100% of residents will continue to have quarterly drug reviews to ensure appropriate use and reassessment of antipsychotics occurs. | New admissions from acute care and retirement home often have antipsychotics as behaviour management strategies. Our home refers to Geriatric Mental Health after BSO strategies have been exhausted; typically results in addition of antipsychotic medications as last resort to manage residents in the Home. |

## Measure - Dimension: Safe

| Indicator #4 | Type | Unit / Population | Source / Period | Current Performance | Target | Target Justification | External Collaborators |
|---|---|---|---|---|---|---|---|
| Percentage of long-term care home residents who developed a stage 2 to 4 pressure ulcer or had a pressure ulcer that worsened to a stage 2, 3 or 4 | C | % / Residents | In house data collection / July1-Sept 30, 2024 | 4.10 | 2.30 | A reduction in worsening pressure ulcers will be evidenced quarterly | |

### Change Ideas

Change Idea #1 Reduction in number of worsening pressure ulcers quarterly.

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| All Resident wounds/ulcers are reviewed at regular High Risk Rounds. RN/RPN assesses wounds at Stage 1&2, NP assesses wounds at Stage 3+ Education to frontline staff occurs daily related to skin care and standards of nursing practice being reviewed to ensure Home's staff are going above and beyond to prevent and treat wounds. | All RNs have training on Skin & Wound program and closely monitor progress closely in Point Click Care. Expand preventative skin integrity education to PSW staff. | 75% of RPNs will receive training on Skin and Wound app per NP and RCCs; emphasis on accurate documentation, utilizing most effective wound care products, and expanding photographic documentation. Frontline PSWs educated on best practice related to skin care such as removal of soaker pads, removal of transfer slings post transfer, NP education at the bedside. | Statistics will be formally reviewed at quarterly Quality Improvement meetings and Professional Advisory meetings. ML will be formalizing Skin & Wound Clinical Pathways through RNAO in this reporting period. |