CONTINUOUS QUALITY IMPROVEMENT – REPORT 2023-2024

Golden Manor

DESIGNATED LEAD

Amy Beaven

Quality, Risk, and Resident Experience Coordinator

QUALITY PRIORITIES FOR 2023-2024

The Golden Manor is pleased to share its 2023-2024 Integrated Quality, Safety, and Risk Management Plan. At the Golden Manor, we are committed to delivering safe, resident-centred services of the highest quality. To guide us in this endeavor, we have developed the 2022-2023 Integrated Quality, Safety and Risk Management Plan, which combines the respective work plans for Resident Safety, Quality, Risk Management and Continuous Improvement. This plan considers the types of services delivered by the organization, it is inclusive of resident and family needs, and it details the key quality, safety and risk management strategies that we undertake.

At the Golden Manor, we envision excellence in culturally-appropriate resident-and-family-centred care delivered by a talented workforce. This approach is reflected in our vision "Golden Manor Home for the Aged will be the leading Community of Care for the overall well-being and diversity of individuals and cultures in our community." Our vision signifies the importance of meeting the physical, psychological, social, spiritual and cultural needs of residents while providing the highest quality care. We acknowledge that a resident's well-being and quality of life depend on integration and collaboration between an ecosystem of people.

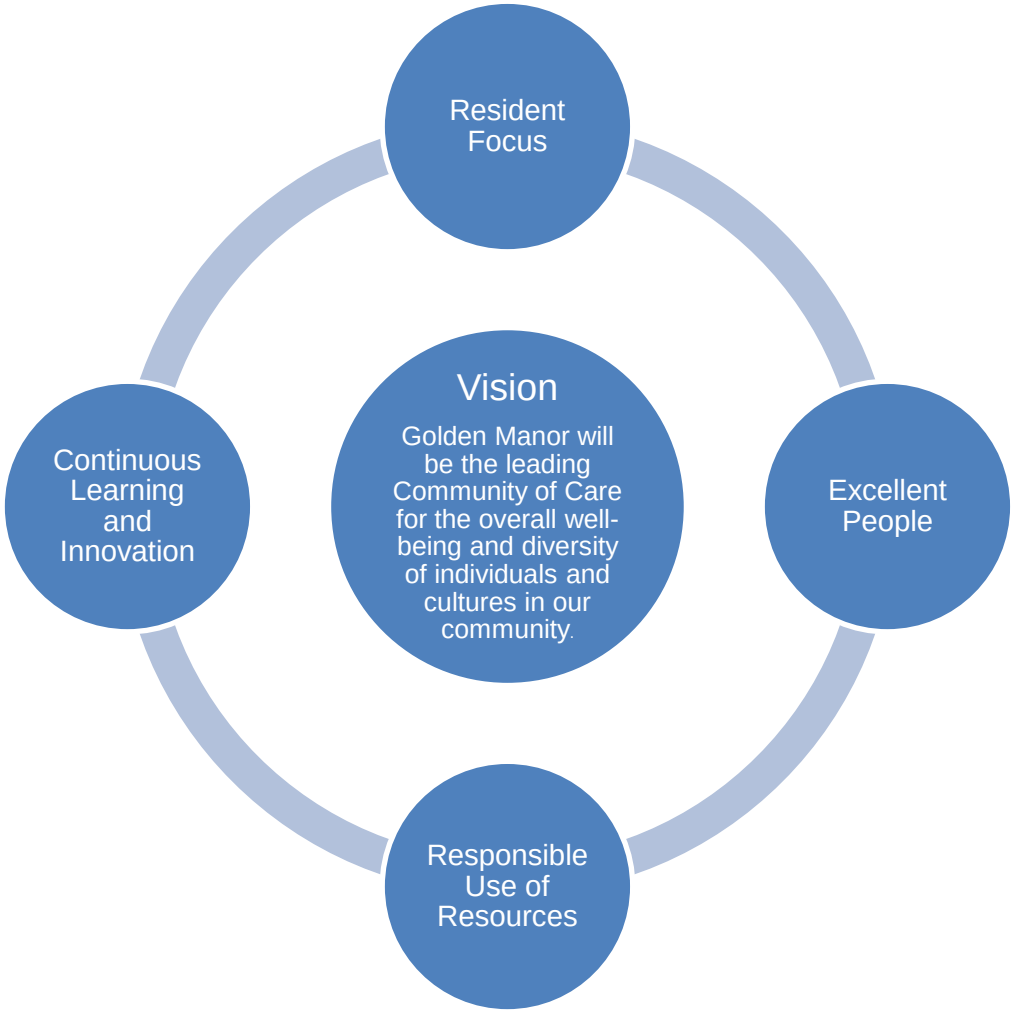
Early in 2020, the Golden Manor set out to update and develop a strategic plan which would identify our priorities and guide our activities over the period of 2020-2024. We are committed to ensure that we remain focused on and committed to maintaining and sustaining a heathy environment for our residents to live and for our staff to work, while we plan for the redevelopment of the Golden Manor. The four strategic priorities identified outline our objectives and priorities for 2020 - 2024. These priorities are:
STRATEGIC PRIORITY # 1: To ensure that Golden Manor is an exceptional place for our residents to live.
STRATEGIC PRIORITY # 2: To ensure that Golden Manor is an exceptional place for our staff to work.
STRATEGIC PRIORITY # 3: To ensure that our physical assets meet the needs of our residents, families and staff and that we remain financially sustainable.
STRATEGIC PRIORITY # 4: To sustain our ability to change and improve.

Objectives for Quality Improvement, Resident Safety, and Risk Management flow from this framework. These objectives are linked to performance metrics and are evaluated on an

ongoing basis. Each program and department in the Golden Manor develop an Integrated Quality, Safety, and Risk Management Plan that identifies outcomes, activities and objectives. An overarching priority for all plans is person-centred care, ensuring all plans set at least one outcome that prioritizes excellence in resident and family-centred care.

QUALITY OBJECTIVES FOR 2023/24

Accountability Framework System
Appendix A



RESIDENT FOCUS

STRATEGIC PRIORITY # 1: To ensure that Golden Manor is an exceptional place for our residents to live.

- We are targeting to increase the percentage of residents responding positively to: "What number would you use to rate how well the staff listen to you?" by 22.15% from 61.4% to 75% by focusing on key aspects of daily life (meals) and embedding resident-centred care values.
- We are targeting to increase the percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences". by 10.52% from 85.96% to 90% by engaging with residents through Residents' Council and Food Council.
- We are targeting to remain below Ontario and NELHIN averages while continuing to implement actions to further reduce ED visits from a rate of 15.43 to 13.5 by focusing on the falls and advance care planning programs.
- We are targeting to reduce percentage of resident falls resulting in injury per quarter from 19.5% to 18.3% by focusing on risk mitigation strategies.

- We are targeting to maintain our current performance below the NELHIN average of percentage of resident with a worsened pressure injury at 2.3% through standardized treatment protocols and use of technology.
- We are targeting to reduce the percentage of residents on antipsychotics without a diagnosis of psychosis from 29.82% to 27.30% to reach the NELHIN average by standardizing the antipsychotic monitoring program.
- Reduce number of outbreaks annually by 50% from 9 to 4 by improving hand hygiene and high touch cleaning compliance.

EXCELLENT PEOPLE

STRATEGIC PRIORITY # 2: To ensure that Golden Manor is an exceptional place for our staff to work.

- Increase staff retention and improve net loss of staff by 25% from 35 to 28 through engagement feedback and employee recognition.

RESPONSIBLE USE OF RESOURCES

STRATEGIC PRIORITY # 3: To ensure that our physical assets meet the needs of our residents, families and staff and that we remain financially sustainable.

- Meet redevelopment timelines while ensuring innovative detailed design is maintained within budget.
- Reduce municipal contribution as % of total costs from 22% by maximizing use of funding envelopes and monitoring budget.

CONTINUOUS LEARNING & INNOVATION

STRATEGIC PRIORITY # 4: To sustain our ability to change and improve.

- We target to increase the percentage of residents that have had an ACP meeting and ACP section added to their care plan from 22% to 50% through standardized processes and early identification.
- We are targeting to reduce the percentage of resident participating in less than 3 activities per month by 12% from 26% to 23% through engagement with residents and standardization of processes.

IQSRM PLANNING CYCLE AND PRIORITY SETTING PROCESS

The Golden Manor develops Integrated Quality, Safety, and Risk Management Plans annually in January and February for the fiscal year in line with QIPs submitted to Health Quality Ontario (HQO) every April (Appendix B & C). The Golden Manor evaluates a number of factors and data (see issue identification) to identify priorities.

This is an integral process with multiple touchpoints of engagement with different stakeholder groups as change ideas are identified and confirmed. Final review of the plans is completed by the Integrated Quality, Safety, and Risk Committee and leadership team (Appendix D).

APPROACH TO CQI (POLICIES, PROCEDURES AND PROTOCOLS)

The Golden Manor administrative policies, combined with Best Practice Guidelines and Accreditation standards, provide a baseline for staff in providing quality care and service. The Golden Manor has adopted IDEAS Foundational Program for Quality Improvement to guide quality improvement activity. City of Timmins and Golden Manor staff have also been trained in a Continuous Improvement Program, the Continuous Improvement (CI) process is designed to improve process throughout the Corporation of the City of Timmins'

ecosystem. Interprofessional quality improvement teams, including resident and family advisors, work through the following phases of the CI process.

1. **Issue Identification**

   Analysis of the following factors help to identify potential areas of improvement:
   - progress achieved in recent years;
   - performance data 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;
   - resident, family and staff experience survey results;
   - emergent issues identified internally (trends in critical incidents) and/or externally;
   - input from residents, families, staff, leaders and external partners, including the MOLTC;
   - mandated provincial improvement priorities (e.g. HQO) and;
   - RNAO Best Practice Guidelines and Gap Analysis.

   Potential areas of improvement are reviewed by the ecosystem – those with interest or involvement in the process. Priorities are presented and discussed at various forums to validate the approach and identify additional priorities that may have been missed. These forums include the broader leadership team, Residents' Council, Family Council, and the Integrated Quality, Safety, and Risk Committee.

2. **Define the Project and Set Improvement Aims**
   Once teams have a better understanding of the current system they aim to improve as well as an understanding of what is important to the resident, the project is clearly defined using a project charter and an overall improvement aim is identified. This aim will be used to evaluate the impact of the change ideas through implementation and sustainability.

   At the Golden Manor, improvement teams develop aim statements that are Specific, Measurable, Attainable, Relevant, Time-Bound (SMART). A good aim statement includes the following parameters - "How much" (amount of improvement – e.g. 30%), "by when" (a month and year), "as measured by" (a big dot indicator or a general description of the indicator) and/or "target population" (e.g. all Golden Manor residents, residents in specific area, etc.)

3. **Understand the Process**
   Vital to process improvement is mapping and analyzing the current process. The team will draft Process Flow Diagrams with those directly involved in carrying out the process.

4. **Investigate Cause**
   Teams use various methodologies to understand some of the root causes of the problem and identify opportunities for improvement. This work can include Red, Blue, Green Analysis; Fishbone or Tree diagrams; 5 whys; etc. Also included in this work, is an analysis of relevant data and completion of a gap analysis against relevant Best Practice Guidelines to validate potential causes.

5. **Create, Pilot and Implement Solutions**
   With a better understanding of the current system, improvement teams identify various change ideas that will move the Golden Manor towards meeting its aim statement. During this phase, teams will prioritize alignment with best practices when designing preliminary change ideas for testing.

Plan-Do-Study-Act (PDSA) cycles are used to test change ideas through small tests of change. PDSAs provide an opportunity for teams to iteratively refine their change ideas and build confidence in the solution prior to implementation. Change ideas typically undergo several PDSA cycles before implementation.

Once alignment is reached for a solution set detailed design is required to ensure sustainability and consistency.

6. **Sustain, Reflect and Improve**
   Improvement teams use process controls to ensure sustainability in improvements. These process controls include: policies and procedures, education required to support implementation, forms and checklists, audits, communication, etc.

   Teams ensure that objectives have a clear process target (measure) and supporting plan to achieve this measure. Teams review this measures to determine if the changes implemented resulted in improvement.

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. Analysis and updates are provided quarterly using the Integrated Quality, Safety, and Risk Management Plans, including run charts. Analysis of the indicators 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 actions to determine if change ideas are effective or if other gaps 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.

At an organizational level, the Golden Manor has adopted a Balanced Scorecard to monitor and measure progress on strategic aims.

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

- Posting on unit quality boards,
- Publishing stories and results on the website, on social media or via the newsletter
- Direct email to staff and families and other stakeholders
- Handouts and 1:1 communication with residents
- Presentations at staff meetings, Residents' Council, Family Council
- Huddles at change of shift

RESIDENT EXPERIENCE SURVEY

2022-2023 Surveys

The resident experience survey for 2022-2023 was administered through February 2023. A staff member assisted residents in completing the survey. At the end of the survey period, 67 residents completed the survey.

Survey Results are available in Appendix E. Following an analysis of the survey results, the areas of environment, bathing flexibility, and staff resident bonding were identified to

be most important areas of improvement for the residents along with resident voices and engagement.

Communication of results and discussion of next steps was completed with various stakeholder groups. Please refer to the table below for an overview of the stakeholder groups that have reviewed the results at a high-level and discussed actions. All communication provided by the Quality, Risk, and Resident Experience Coordinator, unless otherwise noted.

Date	Meeting	Content
February 8, 2023	Integrated Quality, Safety, Risk Committee	Reviewed survey results and discussed improvement opportunities.
April 17, 2023	Residents' Council	Reviewed survey results and identified priorities.
April 17, 2023	Integrated Quality, Safety, Risk Committee	Reviewed survey results and goals.
May 26, 2023	Organizational leadership and clinical leads	Reviewed survey results and next steps in terms of IQSRM planning.
June 22, 2023	Family Council	Reviewed survey results and discussed next steps.

2023-2024 Surveys

The resident experience survey for 2023-2024 will be conducted in winter 2024 with residents and families.

IMPROVEMENTS TO CARE, SERVICES, PROGRAMS AND GOODS AT GOLDEN MANOR (2022-2023)

Care/Services

- Introduction of Recreation Therapist
- Introduction of IPAC RPN
- Food Council established
- Change over to new skin products and incontinence products with
- New technology for medication management and skin and wound program preparation work
- Addition of members to IQSRC (October 2022 see Appendix D IQSRC Terms of Reference)
- Ongoing implementation of QIP and presentation of Annual Report to IQSRC (April 2023 see Appendix F Annual Quality Committee Report Presentation)
- Advance Care Planning meetings established
- Continuous improvement project continued for palliative program
- Involvement at job fairs and continued partnership with local colleges

- Short stay/respite bed re-opened
- Received $160 167 from Local Priorities Fund for dialysis unit, advanced wound care, and behavioural supports
- Ongoing GPA, Dementiability, Positive Approach training

Programming

- Donation of VR equipment for resident activities
- Continuous improvement project initiated for resident recreation
- Reintroduced external outings
- Reintroduced resident BBQ in auditorium
- Planning of special meals for residents with Food Council
- Reintroduced home-wide events

Goods/Facility

- Continued work on Golden Manor redevelopment project
- Addition and improved security system installed
- Extensive upgrades and repairs to lifts and improved lift repair process
- Upgrades to kitchen equipment
- Updated fire suppression systems
- New care carts introduced
- HVAC updates
- Maintenance training to increase competencies

Resident and Family Engagement and Partnering (Role of Residents' and Family Councils and Integrated Quality, Safety, and Risk Committee)

The Golden Manor has three active councils focused on resident and family experience: Residents' Council, Family Council, and Food Council. These councils are a valuable forum for ongoing collaboration and engagement. The home routinely seeks involvement and feedback from the councils regarding proposed projects, quality improvement initiatives, and strategic planning.

The Golden Manor has highly engaged Family and Residents' Councils that meet monthly.

1. We have regularly sought their input throughout the implementation of key improvement ideas for the CI palliative process including: Advance Care Plan meeting process, hospice/end-of-life resources, education/information packages.
2. We have been reviewing the resident satisfaction survey results with Residents' and Family Council to garner their feedback and assist in creating actions plans.
3. We have consulted both groups during recent product changes including having members from Family Council meet with representatives from the company providing our new incontinence products.

In 2022, we added membership of a Family Council and Residents' Council member to the IQSRC to increase their engagement at this meeting. We also provide regular updates from IQSRC to these councils as a whole.

A Food Council has been established with high engagement from residents throughout the home along with staff and family. The mandate of Food Council is:

- To assist with the development, review and revisions of the menu twice annually.

- To participate in the development and review of quality assurance audits, processes and materials for the Dietary Department.
- To review monthly audit reports and develop plans for improvement.
- To test new food and menu items for acceptability.
- To participate in presentations by food manufactures (as appropriate and available).
- To assist in visioning and preparation for Special Events (including celebrating holidays or cultural events).

Approach to Communication

Communication about improvements to care, facilities and programming varies based on the nature of the change. Communication methods include, but are not limited to, the following:

- Verbal reports and written reports to Residents' Council, Family Council, and Food Council
- Verbal reports and written reports to departmental meetings
- Written communication via email to resident and family distribution list
- Written communication via staff memos and City of Timmins Newsletters
- Written communication via TV in lobby and signage posted across home
- Written communication on website and through social media channels

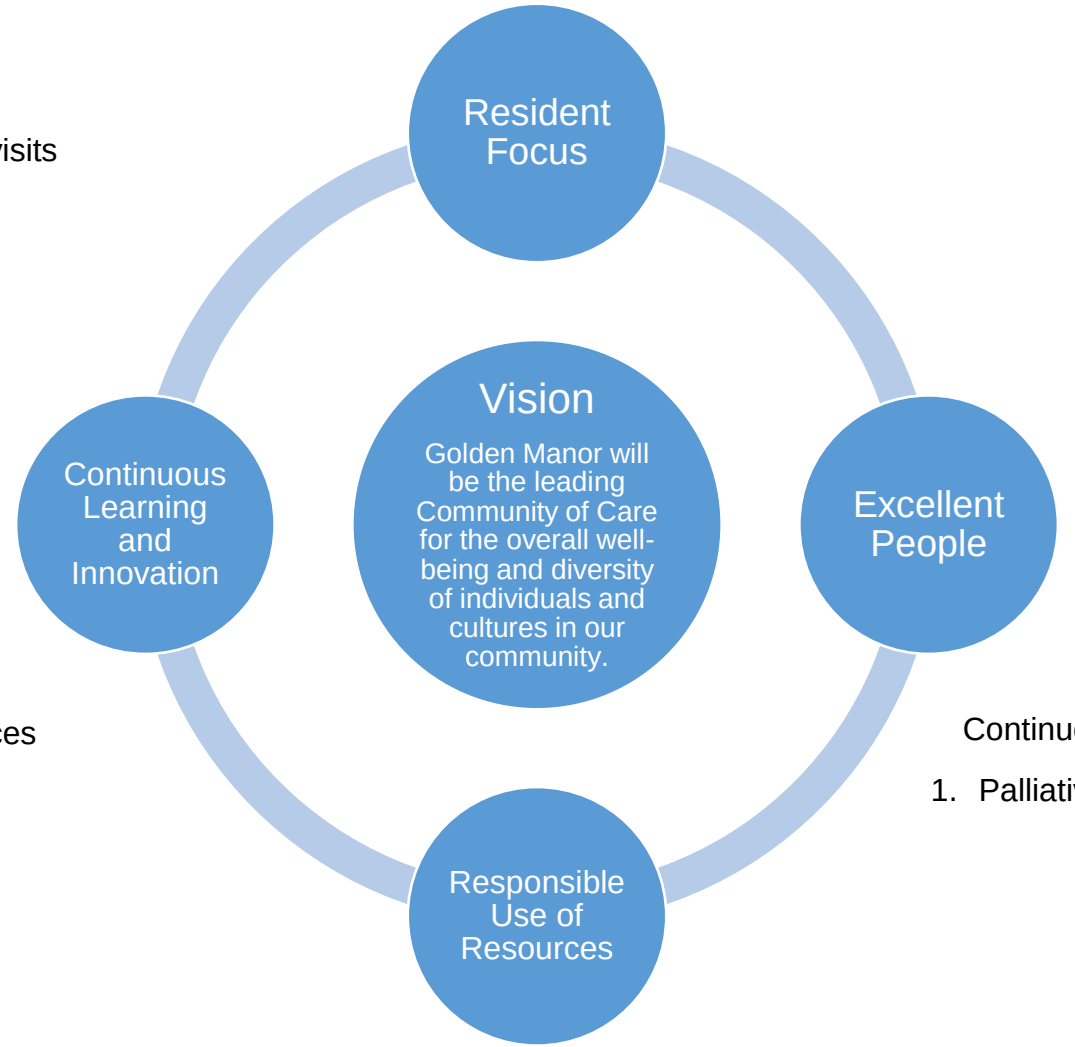
Appendix A: IQSRM Accountability Framework
Appendix B: IQSRM Required Plans & Schedule
Appendix C: IQSRM Plan Template
Appendix D: IQSRC TOR
Appendix E: Survey Results
Appendix F: Annual Quality Committee Report Presentation

Golden Manor | Integrated Quality, Safety and Risk Management Plan 2023-2024

Accountability Framework

Resident Focus

1. Resident satisfaction
2. Emergency department visits
3. Falls
4. Pressure injuries
5. Safety incidents
6. Weight loss
7. Pain management
8. Transitions of care
9. Medication management (incidents, antipsychotic usage)
10. Outbreaks



Excellent People

1. Staff retention
2. Staff engagement
3. Staff Recognition

Responsible Use of Resources

1. Redevelopment
2. Municipal Contribution
3. Funding envelopes
4. Budgeting

Continuous Learning and Innovation

1. Palliative/End-of-life care (Advance Care Planning)
2. Resident Recreation
3. Education and Training

Appendix A: Department and Program Overview

Department/Program	Responsibility	Subcommittee	IQSRC Meeting	IQSRM Plan Reviewed & Approved	Quarterly Update Complete			
					Q1	Q2	Q3	Q4
Financial management	Administrator	Budget Meeting (quarterly)	Annual					
Health and safety	Quality Coordinator	Joint Health and Safety Committee (monthly)	Annual					
Human resources	Administrator		Annual					
Resident safety/incident management	Quality coordinator		Annual					
Care plans and care transitions	Health Informatics Nurse	Care Plan Meeting (monthly)	Q1 (Apr-Jun)					
Continence care and bowel management	Assistant Director of Care		Q1 (Apr-Jun)					
Nutrition and hydration	Dietitian		Q1 (Apr-Jun)					
Oral care*	Assistant Director of Care		Q1 (Apr-Jun)					
Pain management	Nurse Practitioner		Q1 (Apr-Jun)					
Palliative	Nurse Practitioner		Q1 (Apr-Jun)					
Skin and wound	Director of Care	Skin and Wound Meeting (bi-weekly)	Q1 (Apr-Jun)					
Dietary services	Dietitian	Food Council	Q2 (Jul-Sep)					

Department/Program	Responsibility	Subcommittee	IQSRC Meeting	IQSRM Plan Reviewed & Approved	Quarterly Update Complete			
					Q1	Q2	Q3	Q4
Housekeeping and maintenance	Facilities Supervisor		Q2 (Jul-Sep)					
Infection control	Infection Control Coordinator	Infection Control Practice Committee (quarterly)	Q2 (Jul-Sep)					
Resident experience/ Resident-centred care/ complaints	Quality Coordinator		Q3 (Oct-Dec)					
Resident recreation	Resident Services Supervisor		Q3 (Oct-Dec)					
BSO	BSO lead		Q3 (Oct-Dec)					
Delirium, dementia, depression*	BSO lead		Q3 (Oct-Dec)					
Pharmacy and therapeutics	Director of Care	Pharmacy and Therapeutics Committee (quarterly)	Q3 (Oct-Dec)					
Suicide prevention*	BSO lead		Q3 (Oct-Dec)					
ED visits	Nurse Practitioner		Q4 (Jan-Mar)					
Falls prevention	Assistant Director of Care	Falls Prevention Committee (bi-monthly)	Q4 (Jan-Mar)					
Minimizing restraints	Assistant Director of Care		Q4 (Jan-Mar)					
Resident handling*	Assistant Director of Care		Q4 (Jan-Mar)					
Restorative Care (physio & nursing rehab)	Health Informatics Nurse	Mobility Rounds (bi-weekly)	Q4 (Jan-Mar)					

*Not required

QUARTER	MONTH	MEETING	MEETING TOPICS	REPORTS DUE	CIHI REPORTS UPDATED
Q1	**Apr**	Annual	• Annual Report/QIP – Financial management, redevelopment, CI, human resources, health & safety, resident safety	IQSRM plan: Q4 update	
	May	Q4 (Jan-Mar)	• Restorative care, falls, minimizing restraints, resident handling		
	Jun			Continuous quality improvement initiative report	Q4 (Jun 14-21)
Q2	**Jul**			IQSRM plan: Q1 update	
	Aug	Q1 (Apr-Jun)	• Oral care, skin & wound, continence care & bowel management, pain management, palliative, nutrition & hydration, care plans		
	Sep				Q1 (Sep 14-21)
Q3	**Oct**			IQSRM plan: Q2 update	
	Nov	Q2 (Jul-Sep)	• Dietary services, infection control, housekeeping, maintenance		
	Dec				Q2 (Dec 14-21)
Q4	**Jan**			IQSRM plan: Q3 update	
	Feb	Q3 (Oct-Dec)	• BSO, resident recreation, 3Ds, suicide prevention, pharmacy & therapeutics, resident experience, ED visits		
	Mar			IQSRM plan QIP Annual Report	Q3 (Mar 14-21)

Golden Manor | Integrated Quality, Safety and Risk Management Plan 2023-2024

CI VISION: Recognized as the "Home of Choice" by delivering resident-centered care and demonstrating value and appreciation of our employees.

Department/Program:
Report prepared by:
Date prepared:

Operational Plan

Aim (Strategic Priority)

☒	STRATEGIC PRIORITY #1: TO ENSURE THAT GOLDEN MANOR IS AN EXCEPTIONAL PLACE FOR OUR RESIDENTS TO LIVE
☐	STRATEGIC PRIORITY #2: TO ENSURE THAT GOLDEN MANOR IS AN EXCEPTIONAL PLACE FOR OUR STAFF TO WORK
☐	STRATEGIC PRIORITY #3: TO ENSURE THAT OUR PHYSICAL ASSETS MEET THE NEEDS OF OUR RESIDENTS, FAMILIES AND STAFF AND THAT WE REMAIN FINANCIALLY VIABLE
☐	STRATEGIC PRIORITY #4: TO SUSTAIN OUR ABILITY TO CHANGE AND IMPROVE

Measure

Indicator #1	Current Performance	Target	Target Justification

Planned Improvement Initiatives (Change Ideas)

Change Idea #1:		
Methods	Process Measures	Target for Process Measures

Change Idea #2:		
Methods	Process Measures	Target for Process Measures

Quarterly Progress Report

Measure

#	Indicator	2022-2023 Performance	Target	Reporting Frequency	Q1 2023 (Apr-Jun 2023)	Q2 2023 (Jul-Sep 2022)	Q3 2023 (Oct-Dec 2023)	Q4 2023 (Jan-Mar 2024)

Planned Improvement Initiatives (Change Ideas)

Q1 2023 (Apr – Jun 2023)	
Date updated:	Updated by:

Indicator #			
Change Idea #1:			
☐Implemented		☐Not Implemented	
Methods	Process Measures	Target for Process Measures	Current Performance
Lessons Learned:			
Change Idea #2:			
☐Implemented		☐Not Implemented	
Methods	Process Measures	Target for Process Measures	Current Performance
Lessons Learned:			

Comment:

Results:

Q2 2023 (Jul – Sep 2023)	
Date updated:	Updated by:

Indicator #			
Change Idea #1:			
☐Implemented		☐Not Implemented	
Methods	Process Measures	Target for Process Measures	Current Performance
Lessons Learned:			
Change Idea #2:			
☐Implemented		☐Not Implemented	
Methods	Process Measures	Target for Process Measures	Current Performance
Lessons Learned:			

Comment:

Results:

Q3 2023 (Oct – Dec 2023)	
Date updated:	Updated by:

Indicator #

Change Idea #1:			
☐Implemented		☐Not Implemented	
Methods	Process Measures	Target for Process Measures	Current Performance
Lessons Learned:			
Change Idea #2:			
☐Implemented		☐Not Implemented	
Methods	Process Measures	Target for Process Measures	Current Performance
Lessons Learned:			

Comment:

Results:

Q4 2023 (Jan – Mar 2024)	
Date updated:	Updated by:

Indicator #			
Change Idea #1:			
☐Implemented		☐Not Implemented	
Methods	Process Measures	Target for Process Measures	Current Performance
Lessons Learned:			

Change Idea #2:			
☐Implemented		☐Not Implemented	
Methods	Process Measures	Target for Process Measures	Current Performance
Lessons Learned:			

Comment:

Results:

The Corporation of the City of Timmins

Policies and Procedures

Integrated Quality, Safety and Risk Committee

Terms of Reference

OBJECTIVE

To provide Terms of Reference to govern the Integrated Quality, Safety and Risk (IQSR) Committee.

MANDATE

The Golden Manor shall comply with the Fixing Long-Term Care Act (2021), O. Reg. 246/22, Excellent Care for All Act (2010), expectations outlined in the MOLTC Quality Improvement Inspection Protocol and Accreditation Canada Standards and Required Organizational Practices.

In reporting to the Golden Manor Committee of Management, the Integrated Quality, Safety and Risk Management Committee shall ensure that the Golden Manor has clearly defined and coordinated quality improvement, safety and risk management systems in place that continually monitor, evaluate and improve the quality and safety of care and services for residents, provides an avenue for resident/family compliments and complaints, as well as ensure a safe environment for staff, physicians, volunteers and visitors.

DUTIES AND RESPONSIBILITIES

1. Promote a culture of safety, quality care and continuous improvement that aligns with Golden Manor's vision, mission, values and strategic priorities.

2. Ensure that there is a process to bring an issue to the attention of the IQSR Committee.

3. Monitor a review process to solicit and document feedback on concerns, issues, suggestions, *(e.g. feedback and concerns from Resident Advisory Council, Family Council)* and to ensure proper follow-up to address concerns and suggestions.

4. Ensure that there is a process to communicate quality improvement, safety and risk management results to both internal and external stakeholders (i.e. residents and families, staff, Resident Advisory Council, Family Council, Committee of Management, etc.), as well as a process to engage stakeholders in developing improvement plans when appropriate.

5. Review the results of the annual Resident Satisfaction Survey and ensure that there is a process to, based on the results, take action to improve the home, care, services and programs accordingly, and to ensure there is a process to communicate the documented results of the survey and actions taken to residents and families.

6. Monitor, assess and report to the Committee of Management on quality and safety issues along with residents' quality of life , and the overall quality of care and services provided by the Golden Manor, which includes resident and family experience, and safety and risk management initiatives that are consistent with recognized standards and the organization's strategic goals, with reference to appropriate data including:
    - Performance indicators and benchmarks used to measure quality of care, programs and services;
    - Performance indicators and benchmarks used to measure safety and risk management;
    - Performance indicators and benchmarks used to measure resident/family compliments and complaints;
    - Performance indicators and benchmarks related to the Quality Improvement Plan;
    - Publicly reported resident safety indicators and benchmarks;
    - Performance indicators and issues related to accommodation services and the physical facility;
    - Reports received that identify and make recommendations with respect to systemic or recurring quality of care and safety issues *(e.g. quarterly reports from the Joint Health and Safety Committee on workplace violence; quarterly reports on healthcare-associated infections and recommendations from outbreak reviews)*;
    - Reports identifying initiatives to improve resident/family experiences;
    - Reports from external agencies on issues that relate to quality, safety and risk (e.g. Compliance reports from the Ministry of Health and Long Term Care); and
    - Critical incidents and adverse effects, risk management issues and trends.

7. Provide the Committee of Management with reports on resident safety that include recommended actions arising out of resident safety incident analysis, as well as improvements that were made.

8. Provide support and receive reports from Continuous Improvement teams at the Golden Manor.

9. Make recommendations to the responsible body regarding quality, safety and risk improvement initiatives and policies.

10. Monitor and review progress related to the Accreditation process; Ensure the facility meets standards as outlined by the Accreditation Canada and is prepared for Accreditation surveys

11. Oversee the preparation of annual Quality Improvement Plan.

12. Oversee the development of an Integrated Quality, Safety and Risk Management Plan.

13. Oversee the development of a Balanced Scorecard to monitor progress with respect to the operationalization of strategic priorities.

14. To coordinate and support the implementation of the continuous quality improvement initiative, including but not limited to, preparation of the report on the continuous quality improvement initiative.

15. Review annually the IQSR Committee Terms of Reference

16. Review annually the quality improvement and utilization review system, including its goals, objectives, policies, procedures, protocols and process to identify improvement initiatives.

MEMBERSHIP

The committee's membership shall include, but is not limited to:

- The Administrator
- The Medical Director
- Director of Care
- Assistance Director of Care
- Every designated nursing program lead
- Health Informatics Nurse
- Nurse Practitioner
- Clinical and Administrative Dietitian
- Nutrition Coordinator
- Facilities Supervisor
- Housekeeping and Laundry Lead
- Maintenance Lead
- Infection Control and Employee Wellness Coordinator
- Infection Prevention and Control Nurse
- CareRx Pharmacist
- Charge RN
- PSW
- The Quality, Risk and Resident Experience Coordinator *(Chair of the Committee)*
- One member of the home's Residents' Council
- One member of the home's Family Council

FREQUENCY OF MEETINGS

The committee will meet at least quarterly, and at call of the Chair.

ACCOUNTABILITY

The IQSR Committee is accountable to the Golden Manor Committee of Management.

REFERENCES

- Excellent Care for All Act *(2010)*
- Fixing Long-Term Care Act (2021)
- O.Reg. 246/22
- MOLTC Quality Improvement Inspection Protocol
- Accreditation Canada Standards and Required Organizational Practices

SUMMARY INFORMATION

Issue Date: April 2019

Last Revision Date: October 2, 2022

Next Revision Date: October 2, 2023

RESIDENT SURVEY REPORT 2022-2023

Golden Manor

DESIGNATED LEAD

Amy Beaven

Quality, Risk and Resident Experience Coordinator

RESIDENT SURVEY METHODOLOGY

Number of residents surveyed: 57

RESIDENT SURVEY RESULTS

FOOD & MEALS

QUESTION	% POSITIVE RESPONSES			
	2019-2020	2020-2021	2021-2022	2022-2023
I enjoy the foods I am served			78.0%	77.2%
The food tastes good			76.3%	78.9%
The food looks good			81.0%	73.7%
Hot foods are served hot enough			69.5%	64.9%
Cold foods are served cold enough			84.5%	87.7%
I am getting enough to eat			93.2%	87.7%
I eat most of the food I receive at each meal			83.1%	78.9%
I am given enough time to finish my meal			94.9%	94.7%
If I do not like the meal, I am offered another choice			81.5%	68.4%
I receive adequate help at mealtimes			74.6%	38.2%
I enjoy eating with my tablemates			91.4%	78.9%
My table setting is clean and neat			100.0%	96.5%
My suggestions about meal service are dealt with to my satisfaction			92.0%	73.7%
My personal, cultural or religious food preferences are met			96.0%	41.1%
Those who serve my meals pleasant and friendly			96.6%	91.2%

FALLS

QUESTION	% POSITIVE RESPONSES			
	2019-2020	2020-2021	2021-2022	2022-2023
The staff ensured I maintained my dignity while assisting me after the fall.	--	--	100.0%	100.0%
I felt a plan was put into place to help prevent me from falling again or injuring myself if I fell.	--	--	100.0%	100.0%

ADMISSION

QUESTION	% POSITIVE RESPONSES			
	2019-2020	2020-2021	2021-2022	2022-2023
I felt welcomed by staff when I first moved in	--	--	96.3%	94.9%
I got clear, accurate information during the admission process	--	--	88.5%	97.4%
The admission process took a reasonable amount of time	--	--	92.5%	87.2%
I was satisfied with the overall admission process	--	--	92.5%	97.4%

CARE PLAN & PLAN OF CARE

QUESTION	% POSITIVE RESPONSES			
	2019-2020	2020-2021	2021-2022	2022-2023
The information in my plan of care meets my needs	--	--	--	100.0%
I am able to provide feedback on my plan of care	--	--	--	95.5%

ENVIRONMENT

QUESTION	% POSITIVE RESPONSES			
	2019-2020	2020-2021	2021-2022	2022-2023
I feel the home is clean	--	--	98.3%	98.2%
The temperature here is comfortable	--	--	81.7%	60.7%

PRIVACY

QUESTION	% POSITIVE RESPONSES			
	2019-2020	2020-2021	2021-2022	2022-2023
A1. I can be alone when I wish.	87.3%	91.8%	83.1%	93.0%
A2. My privacy is respected when people take care of me.	83.1%	95.1%	89.8%	96.5%

FOOD & MEALS 2.0

QUESTION	% POSITIVE RESPONSES			
	2019-2020	2020-2021	2021-2022	2022-2023
B1. I get my favourite foods here.	69.4%	73.8%	67.2%	--
B2. I can eat when I want.	68.1%	83.6%	61.0%	--
B3. I have enough variety in my meals.	90.3%	83.6%	84.7%	--
B4. I enjoy mealtimes.	86.1%	90.9%	88.1%	--
B5. Food is the right temperature when I get to eat it.	69.4%	87.3%	81.0%	--

SAFETY & SECURITY

QUESTION	% POSITIVE RESPONSES			
	2019-2020	2020-2021	2021-2022	2022-2023
C1. If I need help right away, I can get it.	90.3%	90.3%	88.1%	83.9%
C2. I feel my possessions are secure.	91.7%	96.8%	95.0%	50.9%
C3. I feel safe when I am alone.	91.7%	96.8%	93.3%	83.9%

COMFORT

QUESTION	% POSITIVE RESPONSES			
	2019-2020	2020-2021	2021-2022	2022-2023
D1. I get the services I need.	95.7%	93.1%	96.6%	100.0%
D2. I would recommend this site or organization to others.	91.3%	91.4%	94.7%	94.7%
D3. This place feels like home to me.	58.6%	62.1%	73.3%	78.9%
D4. I can easily go outdoors if I want.	71.8%	82.5%	68.3%	94.7%
D5. I am bothered by the noise here.	64.8%	81.4%	90.0%	61.4%

DAILY DECISIONS/AUTONOMY

QUESTION	% POSITIVE RESPONSES			
	2019-2020	2020-2021	2021-2022	2022-2023
E1. I can have a bath or shower as often as I want.	74.3%	78.7%	43.3%	49.1%
E2. I decide when to get up.	76.1%	88.7%	68.3%	100.0%
E3. I decide when to go to bed.	88.7%	93.5%	75.0%	100.0%
E4. I can go where I want on the "spur of the moment".	80.6%	83.6%	61.0%	91.1%
E5. I control who comes into my room.	83.3%	90.2%	71.2%	94.7%
E6. I decide which clothes to wear.	95.8%	96.8%	85.0%	100.0%
E7. I decide how to spend my time.	98.6%	96.8%	98.3%	100.0%

RESPECT BY STAFF

QUESTION	% POSITIVE RESPONSES			
	2019-2020	2020-2021	2021-2022	2022-2023
F1. I am treated with respect by staff	98.6%	95.2%	93.2%	96.5%
F2. Staff pay attention to me.	97.2%	93.5%	94.9%	94.7%
F3. I can express my opinion without fear of consequences.	90.3%	95.2%	86.0%	86.0%
F4. Staff respect what I like and what I dislike.	95.8%	95.2%	87.7%	89.5%

STAFF RESPONSIVENESS

QUESTION	% POSITIVE RESPONSES			
	2019-2020	2020-2021	2021-2022	2022-2023
G1. The care and support I get help me live my life the way I want.	90.23%	95.1%	94.8%	100.0%
G2. Staff respond quickly when I ask for assistance.	91.7%	87.1%	74.6%	73.7%
G3. Golden Manor staff respond to my suggestions.	81.4%	87.7%	74.5%	59.3%
G4. I get the health services I need.	97.22%	93.3%	98.2%	100.0%
G5. Staff have enough time for me.	90.3%	83.9%	86.4%	89.3%
G6. Staff know what they are doing.	98.6%	93.5%	89.3%	94.7%
G7. My services are delivered when I want them.	95.8%	93.5%	78.6%	89.5%

STAFF-RESIDENT BONDING

QUESTION	% POSITIVE RESPONSES			
	2019-2020	2020-2021	2021-2022	2022-2023
H1. Some of the staff know the story of my life.	59.2%	61.3%	46.6%	42.9%
H2. I consider a staff member my friend.	87.3%	57.4%	67.8%	64.9%
H3. I have a special relationship with a staff member.	66.7%	41.9%	59.6%	52.6%
H4. Staff take the time to have a friendly conversation with me.	88.7%	83.9%	69.5%	94.6%
H5. Staff ask how my needs can be met.	88.9%	85.2%	70.2%	94.7%
H6. I have the same nurse assistant on most weekdays.	54.2%	88.7%	20.7%	53.6%

ACTIVITIES

QUESTION	% POSITIVE RESPONSES			
	2019-2020	2020-2021	2021-2022	2022-2023
I1. I have enjoyable things to do here on weekends.	70.4%	58.3%	46.4%	78.9%
I2. I have enjoyable things to do here in the evenings.	77.5%	63.9%	44.6%	75.4%
I3. I participate in meaningful activities.	60.0%	68.9%	41.1%	70.2%
I4. If I want, I can participate in religious activities that have meaning to me.	77.1%	76.8%	45.1%	61.4%
I5. I have opportunities to spend time with other like-minded residents.	85.7%	74.2%	68.4%	87.7%
I6. I have the opportunity to explore new skills and interests.	80.0%	61.3%	50.9%	92.9%
I7. The activity calendar is easy to read and understand	--	--	--	73.7%
I8. I feel rejuvenated after participating in activities	--	--	--	82.5%
I9. I get excited to participate in group activities	--	--	--	82.5%
I10. I participate in activities simply because I enjoy them	--	--	--	84.2%

PERSONAL RELATIONSHIPS

QUESTION	% POSITIVE RESPONSES			
	2019-2020	2020-2021	2021-2022	2022-2023
J1. Another resident here is my close friend.	62.0%	57.6%	56.7%	70.2%
J2. People ask me for my help or advice.	40.3%	28.8%	35.7%	24.6%
J3. I have opportunities for affection or romance.	16.7%	21.1%	1.8%	12.5%
J4. It is easy to make friends here.	68.1%	69.5%	69.5%	71.9%
J5. I have people who want to do things together with me.	52.8%	45.6%	48.3%	64.9%

COMMUNICATION

QUESTION	% POSITIVE RESPONSES			
	2019-2020	2020-2021	2021-2022	2022-2023
What number would you use to rate how well staff listen to you?	29.31%	42.9%	56.7%	61.4%
What number would you use to rate how respectful the staff are to you?	--	--	71.7%	61.4%
What number would you use to rate how well the staff explain things in a way that is easy to understand?	--	--	53.3%	45.6%
What number would you use to rate the communication you receive from the home?	--	--	66.7%	29.8%
What number would you use to rate how the home involved you in engagement or improvement activities?	--	--	34.5%	45.6%

Integrated Quality, Safety, and Risk Committee

Annual Meeting

Welcome

- Land Acknowledgement and Overview of IQSRC

Land Acknowledgement

Wachay | *Hello* | *Bonjour*

The Golden Manor and City of Timmins acknowledge that we are located on the traditional Lands of Mattagami First Nation, Flying Post First Nation, and Matachewan First Nation, home to many Ojibway, Cree, Oji-Cree, Algonquin and Métis people. We also acknowledge that we are situated in Treaty 9 territory (also known as the James Bay Treaty), which is steeped in the rich Indigenous history of many First Nations, Metis and Inuit People. We are grateful to have the opportunity to work, live, and provide care in this territory.

We recognize all Indigenous Peoples as contemporary stewards of the lands and waters and as vital contributors to our community. It is with the utmost respect for the ties to the past, present, and future, that our organization recognizes its current relationships with Indigenous Peoples and with all members of our community we have had the privilege of servicing.

Guided by and in spirit of Truth and Reconciliation, our work in and building strong and thriving relationships with Indigenous Peoples, does not start and end with this acknowledgement. This is just one important action we recognize together, year-round to ensure that everyone has access to equitable and exemplary care.

What is IQSRC?

- To ensure that the Golden Manor has clearly defined and coordinated quality improvement, safety and risk management systems in place that continually **monitor, evaluate and improve** the quality and safety of care and services for residents, as well as ensure a safe environment for staff, physicians, volunteers and visitors.

Agenda

1.0. Welcome and Land Acknowledgement
2.0. Receipt of Agenda
3.0. Receipt of Minutes
4.0. Standing Items – Annual Meeting
    4.1. Strategic Priorities
    4.2. Human Resources
    4.3. Financial Overview
    4.4. Infection Prevention & Control
    4.5. Health & Safety
    4.6. Quality Improvement Plan
    4.7. Accreditation
    4.8. Continuous Improvement
5.0. Adjournment

4.1. Strategic Priorities

1. To ensure that the Golden Manor is an exceptional place to live

- Plan for and design a new LTC building that will be responsive to the needs of our residents, families, staff and volunteers.
- Plan for the conversion of the existing facility into a Campus of Care

4.1. Strategic Priorities

2. To ensure that the Golden Manor is an exception place to work.

- Establish Golden Manor as the Employer of Choice because of our inspired teamwork and healthy and safe workplace.
- Identify and pilot new pathways and models of care to recruit and retain more staff for the Golden Manor.

4.1. Strategic Priorities

3. To ensure that our physical assets meet the needs of our residents, families and staff and that we remain financially sustainable

- Optimize the delivery of services through effective financial management and creative leadership.
- Design our new facility to be safe, environmentally friendly and efficient to operate.

4.1. Strategic Priorities

4. To sustain our ability to change and improve

- Expand and enhance relationships with community partners and stakeholders.
- Plan for the future while maintaining and improving our Home for our residents of today.

4.2. Human Resources

Workforce (as of December 2022)

238 employees

120.7 Full time equivalents

Recruitment and Retention		
Area of Work	**# staff hired 2022**	**# staff left (retirement, resignation) 2022**
Administration	2	5
Dietary	2	6
Housekeeping	3	6
Maintenance	2	4
Personal Support Workers	19	29
Resident Support/Activities	2	11
Registered Practical Nurse (RPN)	2	3
Registered Nurse	0	1
Resident Support Associate (RSA)	1	3
TOTAL	33	68

4.3. Financial Overview

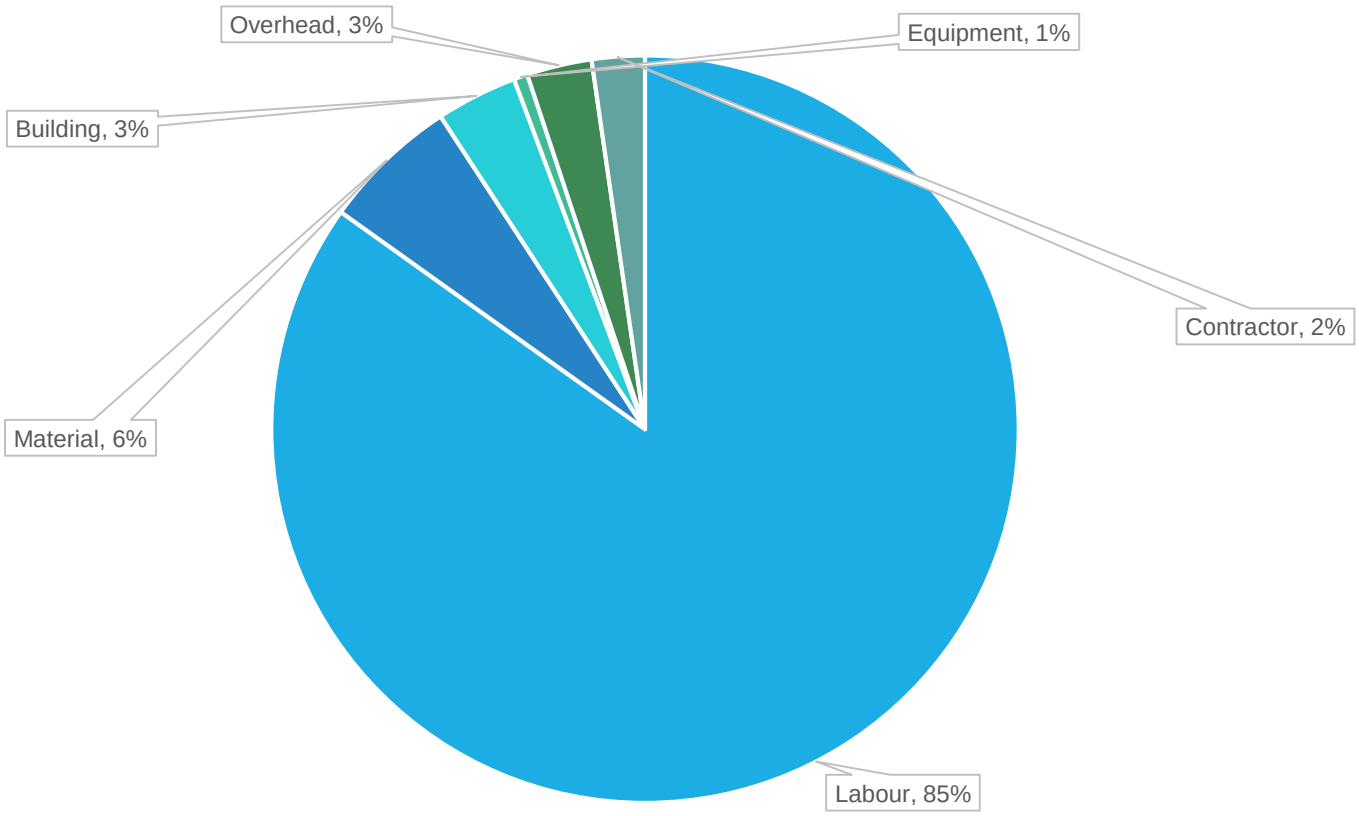
Overview Of Revenue, Expenses, Municipal Contribution					
	2018	**2019**	**2020 ***	**2021 ***	**2022 ****
Operating Revenue	(12,443,000)	(12,946,393)	(14,710,791)	(15,162,888)	(12,717,431)
Operating Expense	15,381,481	15,608,053	16,797,170	17,509,650	16,280,795
Total Operating Costs (A)	2,938,481	2,661,660	2,086,379	2,346,762	3,503,614
Capital Revenue	(446,508)	(161,508)	(190,633)	(409,767)	(112,837)
Capital Expense	593,868	368,822	593,465	2,281,268	190,000
Total Capital Costs (B)	147,360	207,314	402,832	1,871,501	77,163
Total Annual Cost to Municipality (A + B)	3,085,841	2,868,974	2,489,211	4,218,263	3,580,777
% Municipal Contribution to operating costs	19%	17%	12%	13%	21%
Municipal Contribution as % of Total Costs	19%	18%	14%	21%	22%

* Increased Revenue from additional COVID funding envelopes to offset costs of additional precautions and requirements

** Values for 2022 are the budgeted, not actual values. Actual values not available at the time of report.

4.3. Financial Overview

2022 Operating Budget by Cost Segment



4.3. Financial Overview

Additional COVID Funding Envelopes

- Throughout the pandemic the Ministry of Long-Term care made available additional funds to assist homes in meeting COVID requirements.

Funding Envelope	Eligible Expenses/Conditions
Covid-19 Prevention and Containment Funding	Expense must be incremental and to support activities such as active screening, point of care testing, additional staff, virtual care support and services, vaccine administration
IPAC Minor Capital	Capital Expenditures to support renovations for social distancing, furnishings/small equipment, repairs or assessment of building, water or HVAC systems that would enhance IPAC measures
IPAC Personnel	Salary and wages for IPAC professionals. Costs associated with and direct supports to enable delivery of IPAC services

4.4. Infection Prevention & Control

OUTBREAK TABLE			
Dates of Outbreak	**Type of Outbreak**	**Area Affected**	**# of Residents/Staff Affected**
Dec 21/21 to Jan 13/22	Gastro	West 2	22 residents 6 staff
Jan 2022	COVID-19	West 1	Investigation only
Feb 12/22 to Mar 3/22	Seasonal Coronavirus	East 3	9 residents 6 staff
Feb 22/22 to Mar 23/22	COVID-19	East 2	9 residents 1 staff
Apr 18/22 to May 17/22	COVID-19	East 3	16 residents 4 staff
Jun 26/22 to Aug 9/22	COVID-19	East 1, West 1, West 2, Special Care	95 residents 42 staff
Sep 19/22 to 25/22	Rhinovirus	West 2	2 residents
Oct 9/22 to 27/22	COVID-19	East 2	3 residents
Nov 8/22 to Dec 12/22	COVID-19	East 2 East 3	9 residents

4.4. Infection Prevention & Control

VACCINATION RATES			
	COVID primary	COVID Booster	Flu
Staff	100%	35%	92%
Residents	100%	98%	98%

4.4. Infection Prevention & Control

HAND HYGIENE COMPLIANCE	
RATES	**COMMENTS**
60 to 70% compliance before contact	Handwashing is proven to decrease the spread of disease. Improved compliance remains to be an ongoing quality improvement initiative with the initial goal being an 85% compliance rate before contact with residents and their environments. This initiative involves: • Staff and resident education • Increased auditing • On-the-spot feedback/coaching • Increased awareness of importance through targeted activities

4.4. Infection Prevention & Control

Other important IPAC Highlights

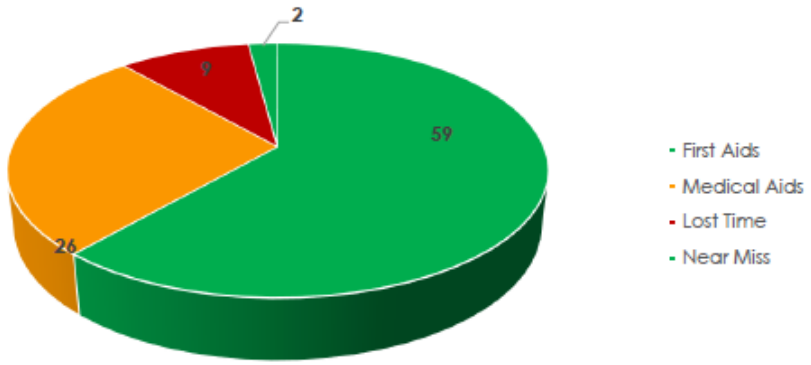
- Jozie Lyrette, RPN, joined the IPAC team
- Antibiotic resistance continues to be a growing concern
  - MRSA
  - ESBL
  - CPE (this one requires close environmental testing and monitoring)
- On average, 500 point of care tests for COVID-19 were performed each week throughout 2022
- Other precautions that remained throughout the year were:
  - Active, asymptomatic screening
  - Social distancing
  - Masking
  - Enhanced resident surveillance for illness

IPAC Goals for 2023

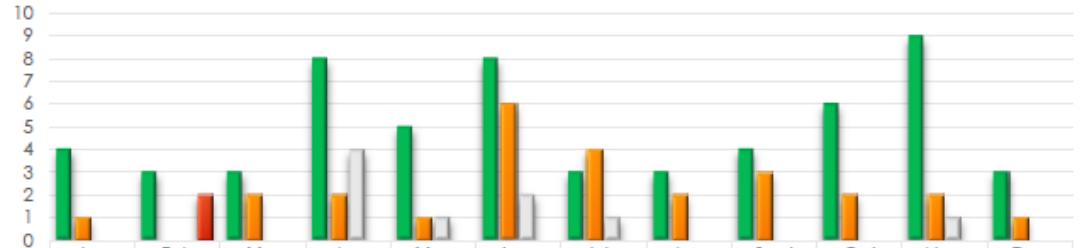
- Improve hand hygiene compliance rates (target is 85% by end of 2023)
- Less outbreaks
- Focus on education for front line staff, residents and families.

4.5. Health & Safety

INCIDENT SUMMARY

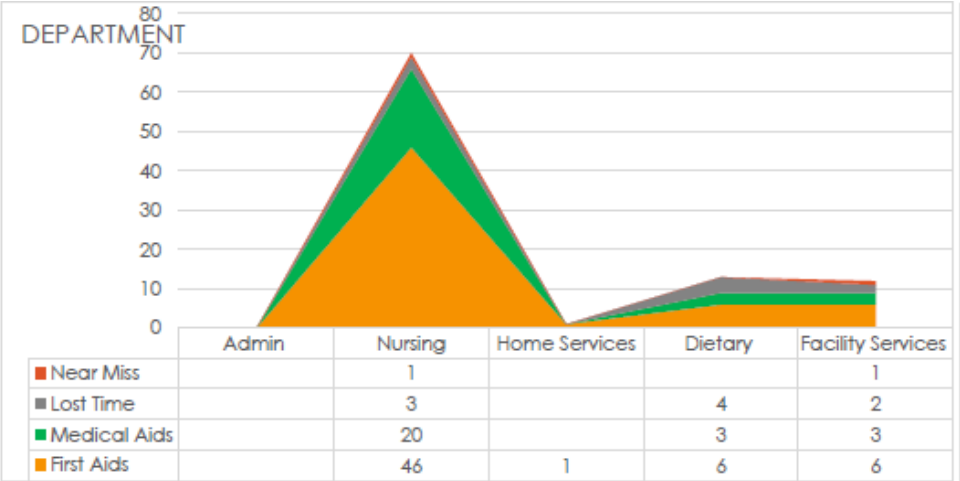


MONTHLY
INCIDENT TREND

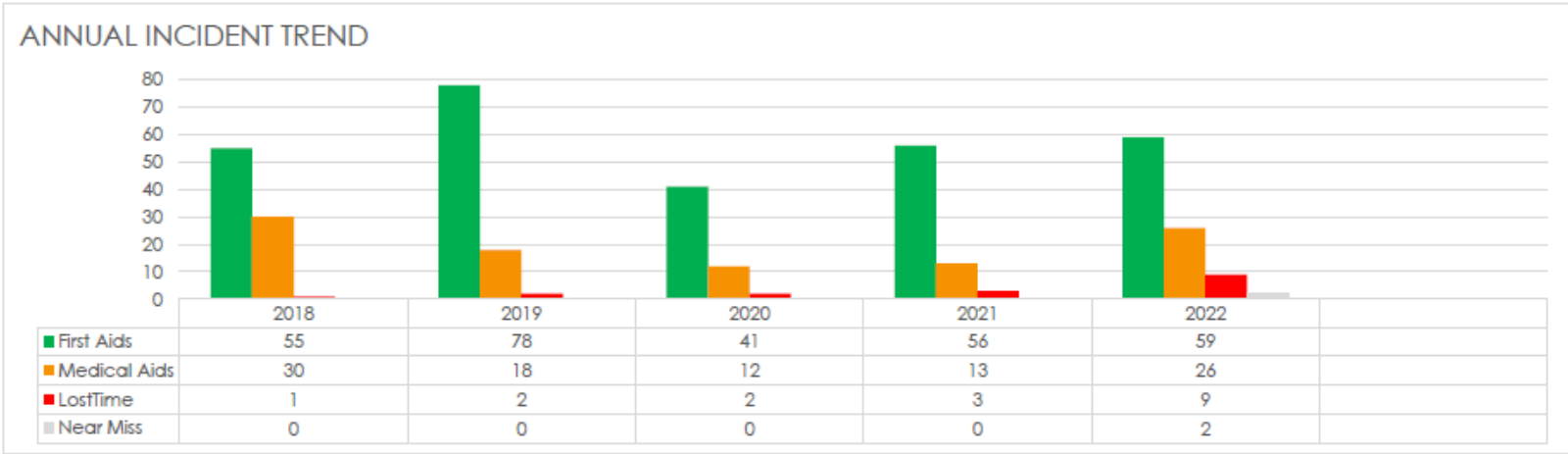


	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
First Aids	4	3	3	8	5	8	3	3	4	6	9	3
Medical Aids	1		2	2	1	6	4	2	3	2	2	1
Lost Time				4	1	2	1				1	
Near Miss		2										

4.5. Health & Safety



	Admin	Nursing	Home Services	Dietary	Facility Services
Near Miss		1			1
Lost Time		3		4	2
Medical Aids		20		3	3
First Aids		46	1	6	6



	2018	2019	2020	2021	2022
First Aids	55	78	41	56	59
Medical Aids	30	18	12	13	26
LostTime	1	2	2	3	9
Near Miss	0	0	0	0	2

4.6. Quality Improvement Plan

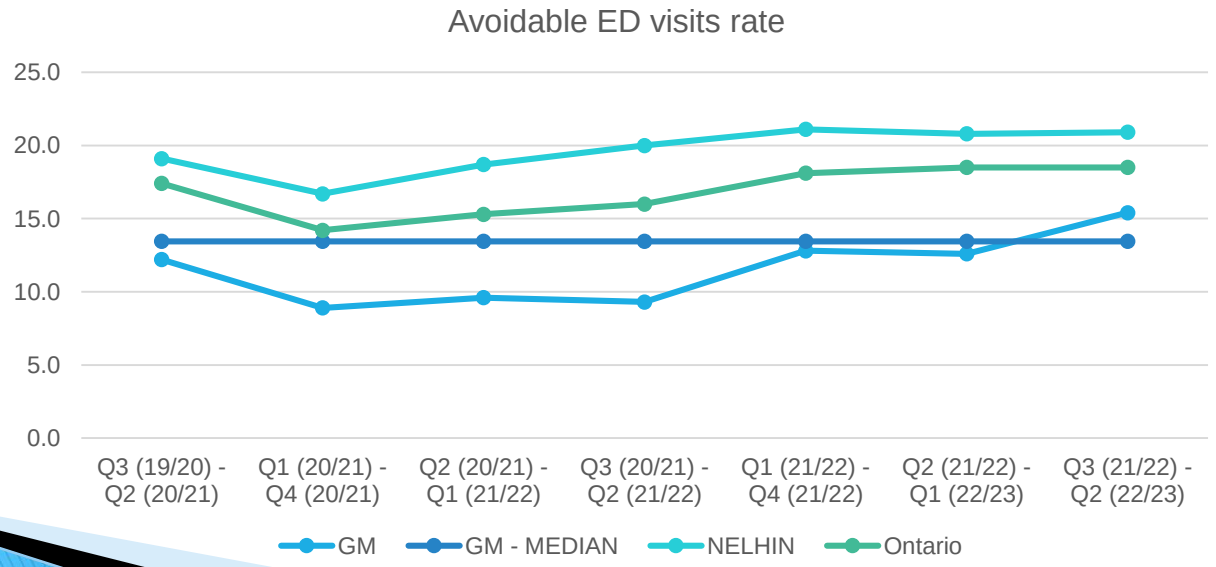
- Annually, organizations in the health care sector complete a Quality Improvement Plan (QIP) to outline how they will improve the quality of care they provide and demonstrate their commitment to quality improvement.
- The QIP includes:
  - The Progress Report: reflection of improvements
  - The Workplan: identifies indicators and quality improvement targets
  - The Narrative: executive summary of the QIP context
- Submitted to Health Quality Ontario

4.6. Quality Improvement Plan

Theme I: Timely and Efficient Transitions

- Indicator: Percentage of potentially avoidable emergency department visits for long term care residents
- Target:

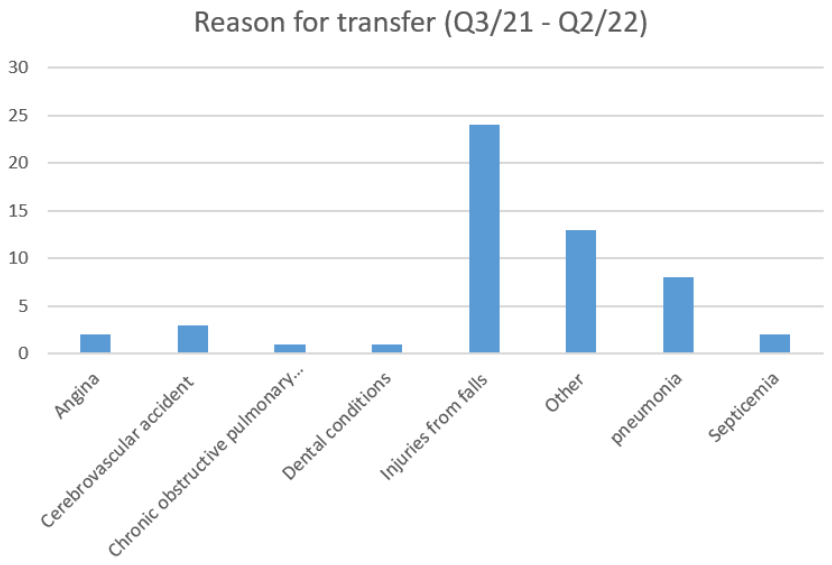
Last Year		This Year	
9.29	9	15.43	13.50
Performance (2022/23)	Target (2022/23)	Performance (2023/24)	Target (2023/24)



4.6. Quality Improvement Plan

Theme I: Timely and Efficient Transitions

- Change Ideas:
  - Falls prevention
  - Goals of care
- Lessons Learned:
  - NP and MD consultation promote early recognition, assessment and GOC discussions
  - Injuries from falls → 44% of ED

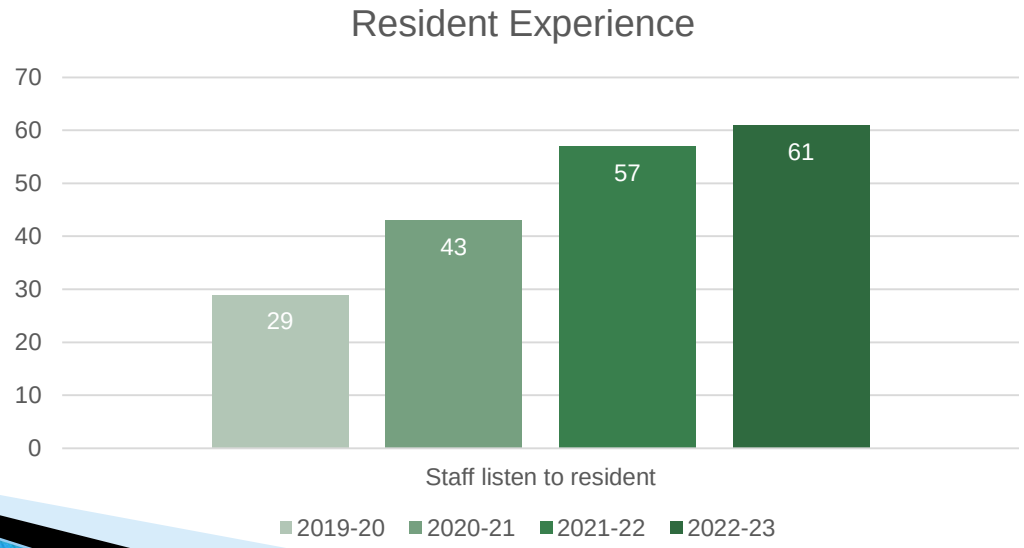


4.6. Quality Improvement Plan

Theme II: Service Excellence

- Indicator: Percentage of residents responding positively to: “What number would you use to rate how well the staff listen to you?”
- Target:

Last Year		This Year	
56.67	75	61.40	75
Performance (2022/23)	Target (2022/23)	Performance (2023/24)	Target (2023/24)



4.6. Quality Improvement Plan

Theme II: Service Excellence

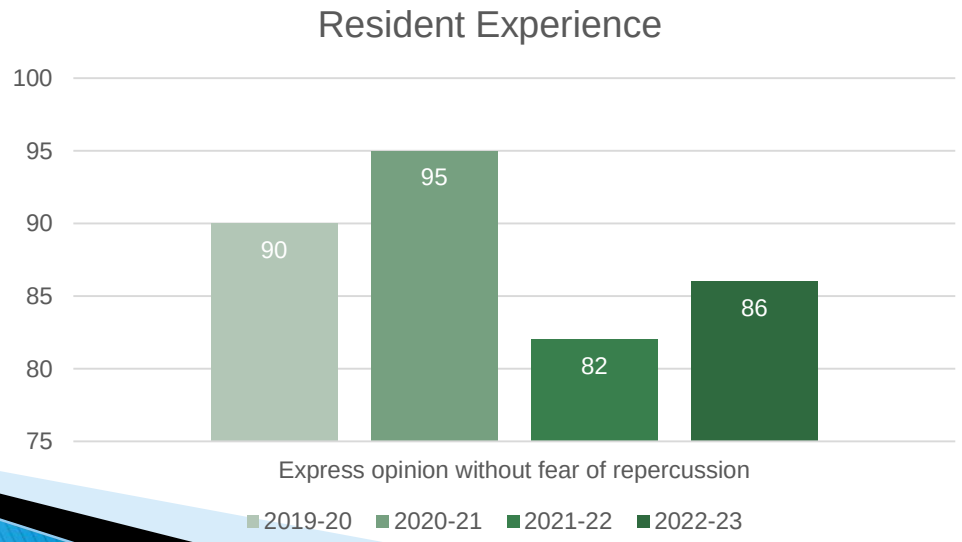
- Change Ideas:
  - Improve key aspects of daily life that bring residents enjoyment, such as mealtimes
  - Resident-centred care: empowerment, communication, and shared decision-making
- Lessons Learned:
  - Continue focus on resident-centred care
    - cultivating mutual respect and showing empathy, active listening, and creating relationships and empowering partnerships

4.6. Quality Improvement Plan

Theme II: Service Excellence

- Indicator: Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences".
- Target:

Last Year		This Year	
81.67	95	85.96	90
Performance (2022/23)	Target (2022/23)	Performance (2023/24)	Target (2023/24)



4.6. Quality Improvement Plan

Theme II: Service Excellence

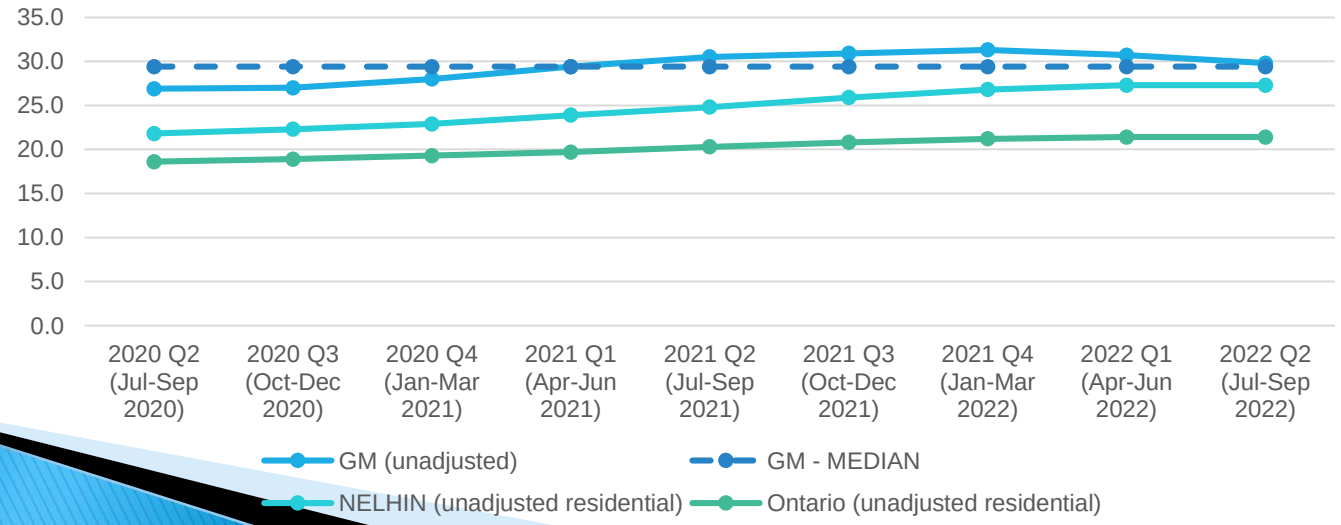
- Change Ideas:
  - Support Residents' Council
    - Food Council engagement
    - Residents' Council engagement
- Lessons Learned:
  - Embed PCL
  - Opportunity to work with engaged Residents' Council

4.6. Quality Improvement Plan

Theme III: Safe and Effective Care

- Indicator: Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment
- Target:

Last Year		This Year	
30.51	25.90	29.82	27.30
Performance (2022/23)	Target (2022/23)	Performance (2023/24)	Target (2023/24)



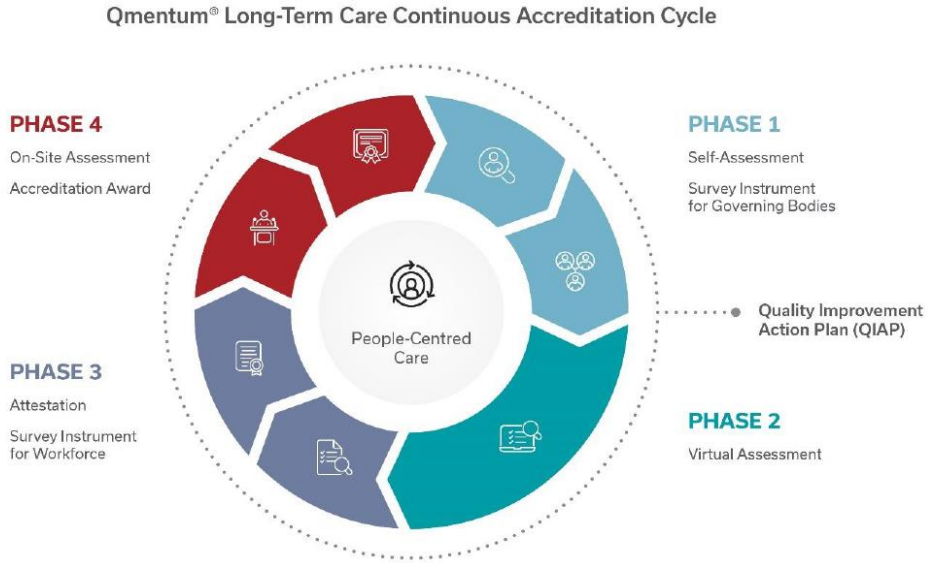
4.6. Quality Improvement Plan

Theme III: Safe and Effective Care

- Change Ideas:
  - Improve medication review process
- Lessons Learned:
  - Verification of data
  - Focus on antipsychotic monitoring program with interdisciplinary approach

4.7. Accreditation Journey

- In November 2021, we received our Accreditation Report. The Golden Manor was Accredited with Exemplary Standing.
- Accreditation Canada has launched the new Qmentum Long-Term Care Continuous Accreditation Cycle program.



4.8. Continuous Improvement Projects

Golden Manor CI Vision: To be recognized as the “Home of Choice” by delivering resident-centered care and demonstrating value and appreciation of our employees.

Project	Key Improvements	Completion Date
Resident Admissions	• Process standardization • Digitization • Role clarity	January 2022
Employee Onboarding	• Process standardization	March 2021
Palliative Care	• Best practice guidelines • Process standardization	
Resident Recreation	TBD	TBD
Staff Scheduling	TBD	TBD

5.0. Adjournment

- 2023-2024 Meeting Schedule
  - May 2023: Q4 2022 (Jan-Mar)
    - Restorative care, falls, minimizing restraints, resident handling
  - Aug 2023: Q1 2023 (Apr-Jun)
    - Oral care, skin & wound, continence care & bowel management, pain management, palliative, nutrition & hydration, care plans
  - Nov 2023: Q2 2023 (Jul-Sep)
    - Dietary services, infection control, housekeeping, maintenance
  - Feb 2024: Q3 2023 (Oct-Dec)
    - BSO, resident recreation, 3Ds, suicide prevention, pharmacy & therapeutics, resident experience, ED visits
  - Apr 2023: Annual
  - May 2023: Q4 2023 (Jan-Mar)