Baycrest

Baycrest Hospital and Apotex, Jewish Home for the Aged Long-Term Care Home
2024-2025 Quality Improvement Plan Narrative

Overview
Baycrest is an academic health sciences centre providing a continuum of care for older adults, within one campus. We are a global leader in geriatric residential living, healthcare, research, innovation and education, with a special focus on brain health and aging. Founded in 1918 as the Toronto Jewish Old Folks Home, Baycrest continues to embrace the long-standing tradition of all great Jewish healthcare institutions to improve the well-being of people in our local community and across the globe.

The Apotex, Jewish Home for the Aged (Apotex), is a 472-bed long-term care facility that provides a range of residential and specialized programs to meet each resident's needs and preferences. As a faith-based home, the principles of Judaism are woven into all that we do while considering each person as an individual, with unique needs and values. The Hospital specializes in the care of older adults, offering inpatient, ambulatory, day programs and outreach services. With 262 beds across nine inpatient units, we serve approximately 1,500 admitted seniors annually. Inpatient services include rehabilitation, mental health, behavioural neurology, complex continuing care, palliative care, and transitional care programs. Ambulatory services provide a wide array of home-based, virtual, and in-person health and social services to over 9,500 patients each year.

In the Apotex, we are incredibly proud of the improvements we've made over the past year, specifically as they relate to resident quality of life. In 2023, 90% of the resident survey items (interRAI Self-Report Resident Quality of Life) improved compared to the previous year. Through actively listening to our residents and families, therapeutic, cultural and spiritual programming evolved significantly. Some of the most notable results include:

- 63.8% of residents responding that they participate in meaningful activities[1] in 2023 compared to 48.6% the previous year;
- 64.8% of residents responding that they participate in religious activities that have meaning to them in 2023[1] compared to 50.5% the previous year; and,
- 68.6% of residents responding that they can easily go outdoors if they want[1] in 2023 compared to 48.6% the previous year.

We introduced new software to enable us to capture resident program interests, monitor their engagement and more nimbly make changes to recreation program offerings. Our beloved programs and common interest groups expanded and we continue to offer innovative programs such as Virtual Reality, Sharing Dance in partnership with the National Ballet School, cooking and language-based programs.

[1] always and most of the time

Similarly, the Hospital made significant progress over the past year, advancing a number of key quality initiatives in both the inpatient and ambulatory areas. We've chosen to highlight one of these many successes – the introduction of Central Navigation. The aim in 2023-2024 was to ensure that at least 80% of patients referred to the Ambulatory Mental Health program were contacted by a clinician within 14 days of referral (baseline 3.8%). This goal was exceeded and the current average wait time to first clinical contact across all services participating in Central Navigation is approximately eight days.

Central Navigation was re-designed by the people who receive and deliver care. Stories from three users' perspectives guided the redesign:

- As a Patient being referred to a clinic, and waiting for my appointment, I want accurate and correct information about what will happen next so that I feel my healthcare needs are going to be looked after.
- As a referring General Practitioner, I want a simple referral process with central intake so that I can spend more time seeing patients and less time filling in forms, finding services and dealing with referral rejections.
- As a receiving Specialist, I want to be certain that the requested assessment is not a duplication in service so that I can manage my patient load and all the work I do safely – for patients and myself.

Central Navigation not only exceeded the wait-time goal, it is also meeting these users' needs. In collaboration with partners in the Regional Geriatric Program, we are now considering the regional application of the Central Navigation concept.

As proud as we are with these and other accomplishments, we know there is no end to better. Our Quality Improvement Plan priorities for 2024-2025 are as follows.

Providing educational opportunities to advance capabilities related to equity, diversity and inclusion, Jewish Home for the Aged & Hospital
Over the coming year, educational opportunities related to various equity, diversity and inclusion topics will be provided. This will include the launch of the "we ask because we care" campaign which aims to support teams to use health equity information to provide inclusive care. Recognizing the importance of providing language concordant care to improve the experiences and outcomes of those we serve, we also aim to increase our use of interpreter services.

Addressing workplace violence, Apotex, Jewish Home for the Aged & Hospital
We know that experiencing violence in the workplace not only impacts those directly involved in incidents but it can also negatively impact the real and/or perceived safety of other patients and residents. Providing a respectful and safe environment for everyone who works, volunteers, learns, and receives care at Baycrest is an organizational priority and we remain committed to creating a workplace that encourages reporting of workplace violence incidents to inform ongoing prevention and safety initiatives.

Improving resident social life, Apotex, Jewish Home for the Aged
The Resident Bill of Rights outlined in the *Fixing Long Term Care Act, 2021* states that "every resident has the right to form friendships and relationships and to participate in the life of the long-term care home."

Forming friendships and social connections is important to a resident's optimal quality of life. Feedback from our residents and families tells us that we can be doing more to provide residents with the opportunity to connect with other residents.

Ensuring appropriate antipsychotic prescribing, Apotex, Jewish Home for the Aged
Antipsychotic medications, often used to manage symptoms of psychosis, are also commonly and appropriately prescribed for seniors living in long-term care to manage severe behavioural and psychological symptoms of dementia. These residents may not have a diagnosis of psychosis and so the use of antipsychotic medication in this population can be considered "potentially inappropriate". Over the last year, our physicians and inter-professional staff including nursing, social work, recreation and behavior supports worked together to reduce the rate of potentially inappropriate antipsychotics by over 23%. Our goal this year is to build on this momentum and to ensure that antipsychotic medications are being used for the right symptoms, at the right dose and only for as long as needed.

Reducing potentially preventable visits from the long-term care home to the emergency department, Apotex, Jewish Home for the Aged
Although the Apotex's potentially preventable emergency department rate is lower than the Toronto region and the Province of Ontario, we know that a visit to the emergency department (ED) can cause additional healthcare risks, breakdowns in care coordination, and undue anxiety for residents and their families. We are steadfast in our goal to work with our residents, families, caregivers and staff to ensure any potentially preventable ED visits are avoided. Our goal is to maximize the use of clinical supports such as nurse-led outreach teams from our local hospitals and enhance palliative care supports within the home.

Improving pressure injury prevention and management, Inpatient Hospital
Patients with pressure injuries can experience pain, poor mobility, slower recovery, increased risk of infection and longer hospital stay. Hospital-acquired pressure injuries can be considered a 'never event' or an incident felt to be preventable with system-level interventions. The Hospital will build on the foundation built over the past several years, focusing on frequent repositioning and mobilization, ensuring patients deemed high risk for developing pressure injuries have tailored prevention strategies in place, and standardizing documentation.

Improving delirium prevention, identification and management, Inpatient Hospital
Delirium is a preventable patient harm and medical emergency that disproportionately affects older adults, with some studies suggesting that up to 30% of patients admitted to post-acute care develop delirium. Delirium has serious consequences for patients and their families and caregivers. As a geriatric-focused hospital, Baycrest aims to be a leader in the prevention and management of delirium. Areas of focus for the upcoming year include transitioning to the 4AT Rapid Clinical Test for Delirium screening method, standardizing the management of patients with confirmed delirium and ensuring consistent documentation of delirium diagnosis in the patient's health record.

Ensuring patients and their families are kept well-informed throughout their stay, Inpatient Hospital
In our efforts to ensure safe, high-quality and client- and family-centred care, we must ensure patients, families, and caregivers are supported and encouraged to be active partners in their care. One way to do

this is by providing comprehensive information and education on admission and throughout a patient's admission to hospital. Over the coming year, efforts will focus on understanding each patient's information needs, their preferred methods of receiving information, and meeting those needs and preferences through change ideas such exploring patient and family participation in interprofessional rounds.

Access and Flow

As a large organization with a broad range of programs and offerings tailored to serve older adults, Baycrest plays an important role in ensuring people can access the care they need, when and where they need it. Below we have profiled just some of our contributions to this growing system challenge. In addition to the initiatives below, Baycrest is an active and committed partner to two Ontario Health Teams – the North Toronto Ontario Health Team and North York Toronto Health Partners which both feature ALC on their collaborative Quality Improvement Plans.

The Apotex is grateful to be collaborating with the Sunnybrook Nurse Led Outreach Team (NLOT), a team of specialized registered nurses that provide emergency mobile nursing services to residents living in the Apotex. Through capacity building and prevention, the NLOT team works collaboratively with point of care staff in the Apotex to identify acute change of status, provide consultation to avoid unnecessary emergency transfers, support end of life care planning and provide any follow-up to enhance the continuity of care should an emergency or hospital visit be necessary. In addition, the Apotex team continues to participate in LTC+, a virtual care program that connects us directly to partners in acute care including general internal medicine, specialist care and community resources to avoid unnecessary hospital transfers and deliver the most effective care in the resident's home.

Recognizing the alternative level of care (ALC) challenge across the province, Ontario Health has identified related targets. In the Hospital we have been working diligently to meet occupancy targets of 95% or greater across our rehabilitation and complex continuing care programs and have consistently met this requirement. Moving into 2024/2025, we will continue to work to improve our ALC throughput and case count indicators. Guided by ALC leading practices published by Ontario Health as well as the Senior Friendly Care framework, Baycrest's rehabilitation program is engaged in active quality improvement work to ensure safe, effective and timely transitions. Through current and future state mapping of the process from admission to discharge, the team is focused on establishing protocols to identify patients at risk for complex discharge and introducing interventions in collaboration with community partners to support patents and families through the discharge process. Further aligned with our ALC and Senior Friendly Care efforts, the Hospital is emphasizing frequent patient mobilization in order to prevent deconditioning and other complications across all of our inpatient programs.

The Virtual Behavioural Medicine (VBM) Program is a collaboration between the Sam and Ida Ross Memory Clinic at the Pamela and Paul Austin Centre for Neurology and Behavioural Support at Baycrest, and the Toronto Central Behavioural Support for Seniors Program. The VBM Program team of specialists provide a rapid response where and when they are needed. They work in close collaboration with care teams and specialized geriatric services in acute care hospitals and long-term care homes and with family members in the community to help them develop and implement care plans, access behavioural and social supports and provide follow-up to support in the management of challenging dementia-related

responsive behaviours, such as physical and verbal aggression, agitation, hallucinations and paranoia. This novel approach has been shown to reduce the need for admission to specialized behavioural units.

Equity and Indigenous Health

Over the coming year, Baycrest will expand equity, diversity, and inclusion curriculum offerings. We are also committed to increasing our collection of health equity data with the ultimate aim of using this information to tailor programs and services to meet the needs of the people we serve. The "we ask because we care" campaign will support an improved understanding of how to use health equity information at the point of care.

Recognizing that patients with limited English proficiency experience more frequent adverse events, disproportionately worse health outcomes and poorer experiences, we've included a focus on language concordant care in our 2024-2025 QIP. Language concordant care has been shown to enhance trust between patients/residents and providers, improve health outcomes, and advance health equity for diverse populations.

Patient/Client/Resident Experience

Apotex, Jewish Home for the Aged

There are numerous ways that the Apotex incorporates experience information into improvement activities. We have a number of active councils/committees focused on improving the resident and family experience, specifically the Resident Advisory Council, Family Advisory Council and Food Committee. All three forums encourage active collaboration and idea generation. Apotex leadership also routinely seeks feedback through formal surveys, specifically using the interRAI Resident and Family Quality of Life surveys which generate over 200 responses annually. Results from the surveys are shared with resident and family councils as well as with staff to help inform change. Results are also included on our website and posted across the home for residents, families, visitors and staff to review.

Over the last year, the feedback we received helped us improve our activity offerings, outing locations, menu items and furniture selection. For example, Resident Advisory Council input contributed to prioritizing equipment purchases and residents participated in the working group to help select our new vendor for our lifts. Resident council was also instrumental in contributing their lived experiences to the ongoing person-centred care, responsive behavior and cognitive impairment training sessions delivered to staff throughout the home. Residents and families, both through councils and individually, also contribute to discussions related to spiritual and cultural programming and on the Food Committee, contributed to a new recipe for chicken soup which the residents now thoroughly enjoy. A breakfast club was recently introduced as well over the last year based directly on resident feedback. We also worked very hard to respond to feedback from family council that they are not always kept informed about programs offered throughout the home and introduced a few new strategies to make this information readily available. Compared to 2022 when just over 50% of families responded that they are aware of programs offered to residents, over 77% of families responded favorably to this question in 2023.

Baycrest Hospital

Baycrest is grateful to the Client Family Partner Panel (CFPP). Client Family Partners are integral members of interprofessional working groups and committees responsible for quality improvement efforts in the hospital. Their input and guidance inform the selection of our quality priorities and associated change ideas and their expertise and lived experiences provide crucial guidance as initiatives are executed and evaluated. The Hospital also makes a concerted effort to engage patients currently receiving care at Baycrest when identifying opportunities for improvement and piloting change ideas. This is accomplished through our experience surveying as well as through one-to-one discussions with admitted patients and families to gather input on targeted initiatives.

Provider Experience

Apotex, Jewish Home for the Aged

Across the healthcare sector, the impact of inadequate health human resources has yet again become a focal point. Many efforts have gone into supporting more individuals to go into the personal support worker (PSW) programs that are fully funded by the government. In addition, there are grants being offered to healthcare workers who are looking to upgrade. Specifically, PSWs who are looking to become registered practical nurses (RPN), and also for RPNs who aspire to become registered nurses (RN). These challenging times have also spurred improvements to the Internationally Trained Nurse program by making it a seamless process for them to become licensed to practice in the Province of Ontario. Despite these efforts to bring in additional health human resources, we continue to experience difficulty in attracting new talent mostly in part-time and casual positions. This highlighted the need to focus on our current staff, in terms of our retention, engagement and recognition efforts. Here are some objectives in progress:

1. Comprehensive review of employee engagement survey results. This included sharing and validating results with staff through transparent discussions about the survey questions and hosting staff town hall events across different shifts to provide opportunities for staff to be involved in developing actions to address the gaps noted in the employee engagement survey results.
2. Conducting weekly and/or monthly floor/department huddles to solicit input from team members.
3. Continued use of performance boards to highlight quality improvement initiatives and engage direct care staff in improvement activities.
4. Ongoing coordination and roll-out of morale-boosting activities throughout the home through the "Apotex Fun Squad". Over the past year, we successfully hosted a number of Apotex-wide events such as neighbourhood decoration contests, scavenger hunts, Slushie tropical day, tea and cookies, and orange shirt day to name a few. This has been a good way for Apotex leaders to engage with staff in a relaxed atmosphere. Furthermore, we now have family council support for our Fun Squad events.

There are other opportunities being explored to improve workplace culture such as creating a new safety culture action plan, schedule optimization and attendance management as well as expanding social events for staff.

Baycrest Hospital

Pressures on health human resources reached unprecedented levels during the COVID-19 pandemic and, although there has been progress, Baycrest remains focused on improving the experiences of our most valuable asset, the people who choose to work and volunteer at Baycrest. To achieve this, we must create an environment where individuals feel both physically and psychologically safe. In this space, people are acknowledged, respected and valued for their contributions and innovative ideas and they are working to their full scope. Below we have highlighted some of the recent efforts to optimize the experiences of providers in the Hospital.

In their efforts to stabilize health human resources, Ontario Health has provided funding opportunities for Clinical Externs and new Graduate Nurses. A Clinical Extern is a nursing student who is between their first and final year of school to become an RPN or RN and recruited to work as an unregulated health care provider under the supervision of registered staff. Introducing Clinical Externs has proven to be valuable for the Hospital, as the role supports care needs such as patient feeding, assistance with activities of daily living and the provision of companionship for our geriatric patient population. One of the first Clinical Externs successfully graduated from their degree in 2023, and has since joined Baycrest working as an RN on the Palliative Care Unit.

The Nursing Graduate Guarantee program supports an extended 12-week orientation to newly graduated nurses at the organization which commits to providing full time employment. For nurses who completed formal training over the course of the pandemic and had limited opportunities for patient care experiences, this gradual and supported entry to practice has proven to be a valuable experience. Baycrest Hospital has also taken advantage of new funding to introduce two new interim practice roles, the Clinical Scholar and Clinical Extern Leader. These roles are essential in providing unit-level support to both Clinical Externs and novice nurses; contributing to their learning experience and working to support their transition to practice on inpatient units.

One area of focus across the organization has been ensuring people are working to full scope and in productive environments. The Nursing Scope of Practice Refresh was developed by the Professional Practice team with the aim of enhancing nursing expertise as well as patient experiences and outcomes. The Scope of Practice Refresh provides all registered nurses and registered practical nurses with hands on, problem-based learning to enhance practice related to topics such as pain, pressure injuries and head to toe assessment.

Through the introduction of Ontario Health Team care models such as Neighbourhood Care Teams and the improved integration of Baycrest programs achieved through Central Navigation, point-of-care staff are finding the opportunity to contribute to collaborative care models highly engaging. Clinicians report that they are meeting more patients who need their specialized skills; they notice that care is less fragmented and they are not repeating or redoing work of others in other sectors; and, they enjoy the feeling of being part of a team. Productivity seems to be increasing as well. The same staff are seeing more patients, or completing more visits.

Safety

At Baycrest, we aim to create a work environment where staff, physicians, and learners are encouraged to proactively speak-up about safety matters. We work collaboratively not only to collect information related to safety incidents, but also to share lessons learned and take advantage of opportunities for system-level improvement. As testimony of this approach, during care conferences we discuss safety with residents, their families and care teams as a strategy to reduce preventable harm.

The importance of reporting safety incidents is continuously shared with staff, starting at new hire orientation sessions and sustained through day-to-day interactions such as unit huddles. After a safety incident occurs, we initiate a review process. The process details, and the stakeholders involved in the review, depend on the level of harm initially assigned in the report. For instance, when a resident or patient safety incident with a level of harm of "severe" or "critical" happens, the most appropriate clinical and operational leaders receive a notification to enable timely actions and ensure the safety of both the affected resident or patient and the staff involved. The safety team completes chart reviews, interviews involved staff/physicians and subject matter experts, while also reviewing relevant policies, care standards and literature. Throughout the incident review process, the team is mindful of the second victim phenomenon.

We develop recommendations aimed at eliminating or reducing the likelihood and impact of recurrences. Staff and physicians provide feedback and play an active role in the implementation and sustainability of these recommendations and the affected resident or patient is informed of actions to close the loop on the disclosure process. In addition, the Apotex and Hospital Quality Committees and the Quality & Safety Committee of the Board follow-up on post-incident recommendations to keep track of improvements, challenges, changes or any other action needed.

Despite our efforts above, Safety Culture Survey results reveal an opportunity to ensure we are creating a just culture. An area of focus for the upcoming year is to address opportunities revealed through the Patient Safety Culture Survey.

Population Health

Baycrest remains a committed partner involved in two Ontario Health Teams (OHTs) and we are proud of our contributions to advance the initiatives profiled in the collaborative Quality Improvement Plan (cQIP) for North York Toronto Health Partners and the North Toronto OHT. One such initiative is profiled below and demonstrates Baycrest's commitment to working with system partners to advance population health and equity-based approaches to care for the communities we serve.

In collaboration with North Toronto OHT partners, we have undertaken an analysis to better understand the primary care needs of our local community. Primary care is the foundation of a strong healthcare system and plays a critical role in improving population health and coordinating care across the continuum. Utilizing data from Ontario Community Health Profiles Partnership, we have identified that North Toronto has a shortage of 63 primary care physicians and 327 interprofessional health providers (full-time equivalents). In response, the North Toronto OHT has developed a three-pronged strategy with the goal of ensuring all North Toronto residents have access to team-based primary care. This will be achieved by creating Integrated Health Hubs; expanding capacity and access to interprofessional team

supports for local primary care physicians; and, developing Neighbourhood Care Teams to spread integrated, collaborative care models across Toronto Seniors Housing Corporation buildings in North Toronto.

To implement the strategy, we examined neighborhood-level data and sought feedback from community members to identify and prioritize the creation of two Integrated Health Hubs in North Toronto and South-Eglinton Davisville (two neighborhoods formerly known as Mount Pleasant West) and Englemount Lawrence; these neighbourhoods have elevated unmet health and social care needs. The North Toronto OHT is committed to using population health management and equity approaches to address identified healthcare gaps and improve health outcomes across the communities we serve.

Executive Compensation

Baycrest has a long history of utilizing a performance management framework and performance-based compensation strategy for the Senior Executive Team. Each year, the Board and Senior Executive Team reflect on the performance of the organization and consider what incentives will best support accountability and continuous improvement. This strategy involves the creation of team (40%) and individual (60%) based goals, which include both process, and outcome measures to ensure a balanced approach to performance that adequately reflects the organization's values, strategic priorities and annual objectives. In accordance with the requirements of the *Excellent Care for All Act, 2010*, Senior Executive Team compensation is linked to performance on selected QIP indicators.

Executives who have 40% of their performance/at risk compensation linked to achieving team goals, including the identified QIP indicators, are as follows:

- President and Chief Executive Officer, Baycrest Hospital
- Vice President, Inpatient Services, Clinical Support and Chief Nursing Executive
- Vice President, Long-Term Care, Ambulatory and Chief Heritage Officer
- Vice President, Medical Services & Chief of Staff
- Vice President, eHealth and Chief Information and Privacy Officer
- Vice President, Finance and Chief Financial Officer
- Vice President, Human Resources and Chief Human Resource Officer

Overall, executive performance/at risk compensation is linked to achieving improvements from the previous year's performance in the majority of QIP indicators and other team goals. In accordance with the overall pay for performance/at risk compensation approach at Baycrest, payment is made in the first quarter of the following fiscal year, in order to allow appropriate time to fully evaluate achievement of performance goals.

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