**Apotex, Jewish Home for the Aged 2023/24 Workplan**

**Percentage of residents who respond positively (most of the time and always) to the following statement: *“I participate in meaningful activities”***

|  |  |
| --- | --- |
| **2023-24 Target** | **Target Justification** |
| 55.6% | From 2015-2022, our median performance was at 37%. Through focused efforts, there has been an improvement from 40% in 2021 to 52% in 2022. Based on ongoing feedback received from residents and families that this is still a critical area for improvement and reflecting the great improvements made over the past year, the Apotex is aiming to meet the external benchmark (perform better than 80% of LTC homes based on interRAI international benchmarking) in 2023. |

| **Change idea** | **Methods** | **Process measure** | **Target** |
| --- | --- | --- | --- |
| Better identify and integrate ‘what matters most’ to residents into recreational programming through the introduction of new recreational software (ActivityPro) and alignment with SQLI Quality Improvement Project.[[1]](#footnote-1) | Monitor ActivityPro implementation milestones and SQLI improvement project deliverables | Roll out of the software complete; SQLI project milestones on track | ActivityPro implemented by end of Q1 and SQLI charter presented in May |
| Introduce more visitor/caregiver inclusive weekend activities/ programming and improve how these offerings are communicated to residents and families | 1. Monitor calendars 2. Monitor resident and family survey results | 1. Number of programs offered on the weekend 2. Percentage of residents who respond positively that they have meaningful things to do on weekends; % of families who respond positively that they are aware of the programs offered to residents. | 1. At least 1 home wide program offered every Saturday and Sunday. 2. At least 45% of residents respond positively that they have meaningful things to do on weekends and at least 65% of families respond that they are aware of the program offered to residents by the end of 2023.[[2]](#footnote-2) |
| Based on the cultural needs assessment conducted in 2022, introduce new spiritual, religious and/or cultural programming such as, but not limited to: heritage month programs & spiritual care guest lectures, increased 1:1 spiritual care visits, more involvement of residents in synagogue services/Torah study/Shabbat | Monitor resident quality of life survey results | % of residents who respond positively that they participate in religious activities that have meaning to them | At least 56% by the end of 2023.[[3]](#footnote-3) |
| Increase opportunities for meaningful social connection between residents with common interests through the introduction of new programming such as community drumming circles, new admissions social group, language-based groups and social support groups. Continue to capture resident profiles through the “About Me” forms. | Monitor resident quality of life survey results and audit About Me forms for new admissions | 1. % of residents who respond positively that have opportunities to spend time with like-minded residents 2. % of About Me forms completed for new admissions | 1. At least 40% in 2023. [[4]](#footnote-4) 2. At least 75% of new admissions have About Me forms completed |
| Introduce formal outdoor programming “Project Go Outside (Project G-O)” to provide residents with more structured opportunities to go outdoors. Deliver programs. | Monitor resident quality of life survey results | % of residents who respond positively that they can easily go outdoors if thy want | At least 55% in 2023.[[5]](#footnote-5) |

**Percentage of long-term care residents without psychosis (delusions, hallucinations, schizophrenia, Huntington’s chorea) who were given antipsychotic medication on one more day in the week before their Resident Assessment Instrument (RAI-MDS)**

|  |  |
| --- | --- |
| **2023-24 Target** | **Target Justification** |
| 21.3% | Apotex performance has been declining and has been higher (worse) than Ontario average since FY21/22. The recommended target is to achieve performance at the Ontario average. This translates to a reduction in the number of residents triggering this indicator of 2 (net) per quarter. The focus will be on the four or five units with higher rates of antipsychotic use, with a similar target of each reducing the number of residents triggering by 2 each quarter. |

|  |  |  |  |
| --- | --- | --- | --- |
| **Change idea** | **Methods** | **Process measure** | **Target** |
| Introduce interdisciplinary huddles on units with higher rates for a targeted review and plan for residents who may be good candidates for dose reduction or discontinuation. | Track number of huddles that have occurred during the quarter and the number of residents for dose reduction/discontinuation | Number of residents with dose discontinued or reduced | 2 residents on each targeted unit for dose reduction |
| Observation of dosing: identify all newly admitted residents with an antipsychotic and track doses increased, decreased and discontinued | Through quarterly medication reviews, track residents admitted with antipsychotic; those with doses increased; those with doses decreased and those with doses discontinued | Percent of data captured each quarter | Increase in the % of residents with dose discontinued and reduced |
| Identify residents that are prescribed PRN (as needed) antipsychotics without a scheduled order. | Audit all PRN medication that have been removed based on administration schedule | Number of residents with PRNs | Collecting baseline |
| Increase “social prescribing” – leverage resources through Behavior Supports Ontario (BSO) and guidelines from the Canadian Coalition of Seniors Mental Health to introduce non-pharmacological approaches to behavior management for identified residents. Leverage expertise of recreation and music therapy. | Track BSO referrals received on residents who are receiving dose reductions and capture the # of residents with therapies introduced. | Audit targeted residents that have received identified therapy. Audit plan of care with approved interventions | 100% of targeted residents will have new interventions trialed based on referrals |
| Improve documentation of residents at end of life. Identify all residents with a PSI (Personal Severity Index 0-18) score of 10 or greater. | Run monthly reports of residents whose PSI (personal severity index) is >9 and share with the most responsible physicians. Document end of life where appropriate. | Percent of residents identified > 10 | Collecting baseline |

1. *SQLI Members will collectively be working on an improvement project to improve resident quality of life by implementing the “What matters most” component from the IHI Age-Friendly Health System 4Ms Framework* [↑](#footnote-ref-1)
2. *2022 performance from resident survey was 41%; top 20th percentile is 47%. 2022 performance from family survey was 60%. There is no benchmark yet.*  [↑](#footnote-ref-2)
3. *2022 performance was 50%; bottom 20th percentile is 56%* [↑](#footnote-ref-3)
4. *2022 performance was 33%, a decrease from 2021. Bottom 20th percentile is 36%* [↑](#footnote-ref-4)
5. *2022 performance was 48% Bottom 20th percentile is 53%* [↑](#footnote-ref-5)