Quality Improvement Plan (QIP)

Narrative for Health Care Organizations in Ontario

July 11, 2025

Ontario Health

OVERVIEW

HJ McFarland Memorial Home is undergoing a significant transformation, driven by a commitment to enhancing the Quality of Life for the Residents. Key improvements center on person-centered care, emphasizing individual's needs and preferences. This involves creating environments that feel more like home, with personalized care plans that respect residents' autonomy and dignity.

A core focus is on strengthening the workforce. This includes increased training and support for staff, enabling them to provide more compassionate and skilled care. HJ McFarland Memorial Home is seeing progress in creating healthier work environments, that in turn helps with the of Residents. Technological advancements are also playing a vital role, with innovations that improve monitoring, communication, and overall care delivery.

What HJ McFarland Memorial Home is most proud of is the shirt towards a holistic approach. This means addressing not just physical needs, but also emotional, social, and spiritual well-being. Activities that promote engagement, connection, and purpose are being integrated into daily life. HJ McFarland Memorial Home is also proud of the family involvement, and the drive to make Long-Term Care Home's a place of community. These changes are creating a more positive and enriching experience for the Residents, and that is the primary goal.

ACCESS AND FLOW

Nexsys ADC Cabinet: A Emergency Medication Cabinet was implemented recently to allow ease of use and quick access to medications for the registered staff when needed. These medications will be used in a variety of settings to support the residents. The cabinet also reorders itself when a medication is removed to allow the nurses to focus on other tasks related to resident care.

We received data from our Ontario Health atHome case coordinator about our admissions the time period is from January of 2023 to the end of March 66 admission, 34 have been from community, 29 from hospital and 3 from another LTCH. During this same time we have 1 discharged Resident back to the community. We have also had some 4A placements with 9 being from the community, 2 from the hospital and 1 from another LTCH.

EQUITY AND INDIGENOUS HEALTH

Increased education on Equity and Indigenous Health:

As a Municipality owned Long-Term Care Home, HJ McFarland is partnering with a newly developed committee, focused on Diversity, Equity, and Inclusion. Members of our team attend monthly meetings to assist with building policies, initiatives and future implementations that will not only affect the Home positively, but the Municipality as a hole. Our team networks between the Residents and staff at HJ McFarland and the other members of the committee to bring insight, perspective and a fresh outlook towards diversity, equity and inclusion.

Support from Home: Capturing any health information on assessments from HPG to promote an increase in positive health outcomes throughout journey at LTC.

Indigenous DOC - HJ McFarland recently hired a Director of Care with Indigenous background;Métis.They reside from Northwestern Ontario where the hospital they worked at utilized medical Indigenous practices with the surrounding Indigenous communities.

PATIENT/CLIENT/RESIDENT EXPERIENCE

Survey Feedback has improved since last year with more responses and we are currently working on the results we are going to focus on to improve our Home. We asked our Residents with a CPS score of 3 or lower to participate in the survey and sent it out to all family members/ friends for them to complete. We received 55 responses with 40 being our Residents at the Home and 15 being family members/friends. We have shared the results with the Family Council and asked for them to pick their top 5 that they would like us to improve upon. We will also being asking Residents Council to pick their top 5 results that they would like improvement on. This will provide us with a list of 5-10 items to create an action plan to improve our Home. This action plan will be shared with both the Resident and Family Council.

Specific, measurable, achievable, relevant, and time-bound (SMART) goals are developed based on the identified improvement areas. Progress towards these goals is regularly monitored and documented. Residents and family feedback is sought throughout the implementation process to ensure that changes are effective and responsive to their needs.

These surveys impact the improvement activities as they are assessed with follow-up surveys and ongoing feedback mechanisms such as phone calls, emails, in-person conferences, and events. This feedback loop ensures that the Home remains responsive to evolving needs and maintains a culture of continuous improvements, ultimately enhancing the quality of life for the Residents.

PROVIDER EXPERIENCE

Loyalist College, Loyola and other secondary education institutions provide us with placement students that gain direct experience working with Residents/Staff and families in our Home. This real world experience is invaluable in building skills like Resident care, communication and empathy. Students are supervised by experienced staff in the Home, they provide the students with feedback and mentorship that helps them grow professionally. 92% of our PSWs have taken the preceptor course offered by CLRI and this has made them excellent preceptors to students and new staff members.

We have received funding for the Living Classroom from the RIA and have partnered with Loyalist College. This partnership has been a great experience and has allowed us to strengthen our support systems. The partnership creates a potential career path for students who may be offered jobs at H.J. McFarland Memorial Home after graduation. This continuity benefits both the students and the Home. The Living Classroom allows students to have a practical, supportive learning environment which increases the students engagement and retention. The students feel more confident and capable after having spent time in a real world setting. Loyalist College and the Home have regular communication this ensures that the goals of the partnership align and that any challenges are addressed quickly. This fosters mutual understanding and a proactive approach to challenges. We have been encouraging the students to provide feedback so that we can improve the program for future cohorts. We have already expanded the Living Classroom program for the next cohort to include more students and increase the lab time at the Home. We have been asked to share our story with the RIA newsletter to extend to a broader

community, this will hopefully attract more students into the field of PSW.

We have partnered with Humber Learn and Earn and have had several staff members interested in the program. We have had two successful graduates and two more staff members going into the program April 1st. This is a great program as it provides opportunities for staff members in other departments who are interested in becoming PSWs to take a 22 week course with virtual and practical learning and apply it in the same Home that they already are familiar with. Our Home also volunteers to be a Home where the students can come to practice their skills while a faculty member from the College provides instruction.

We also have the CCPN and PSW ROS available in our Home and offer this as an incentive to new graduates coming to the Home. This is mutually beneficial, it provides the staff member with funds to assist with school costs and provides the Home with a staff member that has agreed to provide the Home with years of service.

SAFETY

To ensure high care standards and safety, we implement a structured approach with daily, weekly, and monthly activities, along with ongoing education and audits. Every shift starts with a detailed Daily Shift Report, documenting safety incidents, resident condition changes, and environmental hazards. Leadership reviews this report to address issues promptly.
Daily Management Meetings cover critical operational matters and safety concerns, while monthly meetings focus on long-term planning, safety protocols, and audit reviews. Weekly Whole Home Huddles involve all staff, addressing key safety issues and resident concerns. Daily Team Huddles within departments allow staff to address immediate care and safety concerns.
Each month, a Whole Home Health and Safety Audit reviews all areas, ensuring compliance with safety regulations and identifying hazards. Regular Nursing Audits evaluate care practices, safety protocols, infection control, and documentation standards. Our Nutritional Supervisor and Dietitian conduct audits to monitor nutritional safety and prevent malnutrition or choking hazards.
Education plays a key role in safety. We use Surge Learning to track staff training progress on safety protocols and best practices. The Behaviours Lead helps manage emerging resident behaviors, ensuring personalized care plans are in place.
By combining audits, education, leadership meetings, and continuous monitoring, we create a safe environment for both residents and staff.

PALLIATIVE CARE

At H.J. McFarland Memorial home we deliver best quality Palliative Care using multiple supports and resources which include but limited too:

1) External Partnerships/Care Partner Engagement: Utilizing Best Practice RNAO Coaches in the Palliative Care network to support building our Palliative Care program. Referrals to our Pain and Palliative Symptom Management Consultant when needed. Prince Edward County Hospice has provided assistance in our Palliative/EOL program, PEC Quilters Guild provided the quilt for our honour guard.

2) Education: Palliative Education to current and new staff about a variety of Palliative related topics from pain management(which medications to use and when), non-pharmacological interventions to support comfort and ways to support the family during this difficult period. This education is provided by Surge Learning and our Pain and Palliative Symptom Management Consultant.

3) Palliative Clinical Care Consultant: Involving a Palliative Clinical Care Consultant from the VON to help evolve and sharpen our current Palliative Care Program. We also have a Pain and Palliative Symptom Management Consultant from out of area that agreed to assist us until our region has a Pain and Palliative Symptom Management Consultant of their own. We can make referrals to them and they will meet with the Resident/Family to gain insight and provide us with other options that we might not have thought about.

4) Policy Revision: Ensuring our current Palliative Care Program related policies are up to date with the current best practices.

5) Palliative Care Committee: Meeting as a Palliative Care Committee monthly or as needed to discuss/review current Palliative Program and residents who may be currently palliative. This interdisciplinary committee has helped the Home improve Palliative and EOL for our residents. We have made palliative care carts for the Home that have aromatherapy, CD/radio player, hand masks, notebook, chicken soup for the soul books, chakra stones. These provide activities that are beneficial for the Resident and their families. We have also updated our honour guard through this committee, an honour guard is how we show our respect and say our goodbyes to the Resident for the last time. We play Amazing Grace (unless something else is requested), form two lines on either side of the Resident as they leave the Home for the last time. The quilt that we place over top of the Resident was made and donated by our Prince Edward County Quilters Guild. We also have started an evaluation survey that we send to families/friends around 6-8 weeks after the Resident has passed to gain insight into ways that we might improve our Palliative and EOL program.

POPULATION HEALTH MANAGEMENT

HJ McFarland Memorial Home continues to collaborate with other health services such as specialized diabetic foot care, eye-clinics, dentist and denturist to reduce unnecessary hospital readmissions and optimizes resources allocation. Partnerships with our rehabilitation clinics offer Residents access to physiotherapy and occupational therapy that assist with enhancing functional independence and quality of life.

Additionally, Providence Care is a valuable partner that HJ McFarland utilizes to support the ongoing transitions surrounding mental health that provides crucial support for Residents experiencing depression, anxiety, or dementia-related behavioral changes. Through BSO funding, our team performs Care Conferences that determine best plan of action to assist Residents and finding positive outcomes and solutions for care.

We have a dietician from the community that comes to the Home and works with our Nutritional Supervisor to develop personalized meal plans, catering to specific dietary needs and promoting healthy aging.

Community volunteers are extremely active in the Home, leading recreational activities, fostering a sense of belonging, and combating social isolation.

CONTACT INFORMATION/DESIGNATED LEAD

N/A

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 **April 1, 2025**

Dione Mills, Board Chair / Licensee or delegate

Dione Mills, Administrator /Executive Director

Dustin Brown, Quality Committee Chair or delegate

Hannah Hoskins, Other leadership as appropriate