Royal Ottawa Place

Continuous Quality Improvement (CQI)

Annual Report

April 1st 2024 – March 31st 2025

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Royal Ottawa Place is a 64 bed Long Term Care Home which is a part of the Royal Ottawa Health Care Group. We function under the Fixing Long Term Care Homes Act and Regulations. Our home's mission is to support and enhance the quality of life for adults with a chronic stable severe mental illness, as well as those who could benefit from a mental health focused environment.

Our continuous quality initiatives are developed through resident, family and staff collaboration, implementation of best practices, evaluation of quality indicators and Ministry of long term care requirements.

Continuous quality improvement (CQI) is a team approach and it requires the skills, expertise and suggestions of all team members to help in the CQI process. Our resident and family councils are involved in collaboration with the home with the development, implementation and evaluation of quality initiatives. In addition, the quality aspect is embedded within the structure of all of our required programs and services in the home.

Overview of Royal Ottawa Place

- Average age is 68 years
- Most common primary diagnosis is Schizophrenia 34/64 residents have this diagnosis
- 84% of current residents have a severe mental health diagnosis at admission
- The current average length of stay for a Royal Ottawa Place resident is 3378 days (9.25 yrs)
- 62.5% of residents currently display responsive behaviours
- 14% (10) of residents have had a re-admission to hospital for a psychiatric reason in the past 10 years or since admission. 5 of these have had multiple admissions. All have a psychiatrist.
- 77 Individuals are on the waitlist -4 requesting basic accommodation. Most of the residents on the waitlist and in our home are on ODSP (Ontario disability support program) and they cannot afford a basic room
- ROP LTC continues to advocate for specialized mental health designation with The Province of Ontario for our program.

Demographics

Age in Years		Gender	Mobility
0-50	1 resident	34 Males	51 residents use a mobility device
51-60	13 residents'	30 Females	24 residents use lifts for transfer
61-70	26 residents		
71-80	17 residents		
81-90	5 residents		
91-100	2 residents		

# of Admissions in 2024 – 11 admissions
# of Discharges in 2024 – 11 discharges (9 deaths, 1 discharge to another facility and 1 discharge to home)

Primary Diagnosis

- Mental Health
  - Schizophrenia
  - Anxiety Disorder
  - Bipolar Affective disorder
  - Personality Disorder
  - Depression
- Developmental Delay/Intellectual Disability
- Diabetes
- Dementia
- Cerebral Palsy
- Acquired Brain Injury
- Parkinson's
- COPD

Staff and Services

- Nursing – RN, RPN, PSW
- Physical Therapy – PT, PTA
- Recreation Therapists/Recreation Therapy Assistants
- Music Therapy - Contract
- Dietary – Dietician, Aides
- Behavioural Supports Ontario (BSO) PSW, RPN and Behavioural Therapist
- Restorative Care
- Housekeeping/Laundry Services
- Maintenance program
- Occupational Therapy – contract
- Speech Language Pathology – referral with Home and Community Care
- IPAC team and LTC Infection Control RN lead
- Pharmacy – Contract
- Laboratory Services
- X-ray Services – Contract
- Dental Services – Contract
- Optometry Services - Contract
- Massage Therapy – Contract
- Hairdresser
- Volunteer Program
- Collaboration with Assertive Community Assessment Team (ACTT)
- Collaboration with Flexible Assertive Community Assessment Team – Dual Diagnosis (FACTT)

Medical Services

- Medical Director
- 2 Long Term Care Family Physicians
- Geriatric Psychiatry through BSO
- General Psychiatry referrals

Unique Challenges for Royal Ottawa Place LTC versus Other Long Term Care Homes

- Younger population- average age is 68 years
- 84% of current residents admitted have a severe mental illness diagnosis
- Higher proportion of Male residents
- High proportion of psychiatric diagnosis which do not score well on RAI classification which negatively impacts funding. Current Case Mix Index (CMI) is 1.1062 as of March 31 2025 Current funded Case Mix Index (CMI) is.9589
- No Mental Health Designation. There are challenges with providing services for very different populations. Continued advocacy with the Ministry to have mental health designation and increased funding.

SAFETY – keeping people safe in 2024/25

- Annual Non-crisis intervention training completed with all staff.
- Annual Safe Patient handling education and access to ergonomic occupation health staff for training.
- Access to ROHCG occupational health and safety team
- Evacu-sleds are on all beds
- Bariatric evacu-sleds for bariatric beds.
- Increased training and IPAC knowledge of all staff. Dedicated IPAC RN lead in the home. Access to ROHCG IPAC team and resources

This Years Successes

Accreditation Canada

We are accredited by Accreditation Canada with exemplary status.

RNAO Best Practice Spotlight Organization (BPSO)

- ROP LTC applied for the RNAO BPSO designation and was selected in 2023. In 2024/25 we continued to focus on the Quality improvement projects for the Best Practice Spotlight Organization. We have 56 staff that are trained as RNAO BPSO Champions. We have the highest percentage of staff (52%) in the BPSO program
- ROP endeavours to deliver resident care that reflects best practice. The areas we are focusing on are in areas of resident and family centered care, palliation and wound care.
- While we pride ourselves on our knowledge of mental illness and person centered care, we strive to enhance our knowledge on palliation and wound care to further meet our residents needs

RNAO BPSO and ROP LTC Initiatives

BPG Name	Rationale for selecting this BPG
Person and Family Centered Care	The Royal's new Strategic plan includes the innovating and shaping care to the client and family.
Palliative Approach to Care in the Last 12 Months of Life	To meet FLTCA regulations and meet a noted knowledge gap within the nursing department
Assessment and Management of Pressure Injuries for the Inter-professional Team	Nursing staff are predominantly psychiatric nurses requiring more skin and wound care. Increase in externally acquired wounds.

BPSO RNAO BEST PRACTICE SPOTLIGHT ORGANIZATION

The Royal

Quality improvement program meetings are held regularly in the areas of:

- Skin and Wound
- Falls
- Continence (Bowel/Bladder)
- Pain
- Restraints
- Responsive Behaviours
- Infection Prevention and Control (IPAC)

2024/25 Quality Improvement Initiative – Resident Rounding

For the 2024/25 year we focused on resident rounding. This aligned with our RNAO BPSO project. Resident rounding has shown to greatly reduce falls, pain medication use, call bell use, increase continence, as well as increase resident satisfaction and staff job satisfaction.

Change Idea #1 Completion of Resident Care Rounds by PCA staff.

Methods	Process measures	Target for process measure
•Usage of the 6 P's questions checklist to be used by staff for resident rounding. The staff will ask residents within their groups on the following topics: • Possessions, personal, pain, position, protect, promise. • Each resident will have a resident rounding focus in their care plan, with unique questions that reflect the 6 P's, but are written with that residents needs/behaviors in mind.	•Staff charting on Point of Care that rounding is done each hour, except for meal times, or when staff are on break. •Audits of POC, interviews with residents and physical auditing of rounding being done. • Pre and post implementation survey with residents	100% by end of 2025, launch will occur in March/April after education and protocol development. Then mgmt. will expect to see at least 75% compliance within first 6 months and then 100% thereafter.

Evaluation: Following the resident surveys, it was found that PSW staff were not consistently completing resident rounding and the associated documentation. Discussions with staff revealed that timely electronic documentation was challenging. To address this, we switched to paper documentation placed in each resident's room. However, this approach presented some difficulties: certain residents were uncomfortable with having documentation on their doors or found the frequency of questions intrusive. In response, some residents' documentation was moved to the nurses' station, while others requested less intrusive interactions (i.e. visual safety checks of the residents by staff), which we have respected.

Change Idea #2 Development of protocol, educational sessions, POC rounding development in Point Click Care

Methods	Process measures	Target for process measure
Team will develop a protocol, and education champion sessions with education for staff	% staff, including PCA/RPN/RN/RT will receive education on rounding by April 30th 2024. New employees will receive this education during LTC orientation.	100% staff, including PCA/RPN/RN/RT will receive education on rounding by April 30th 2024. New employees will receive this education during LTC orientation.

Evaluation: All the LTC staff received training on the rounding by the required date. This education is now always included in new employee orientation.

Change Idea #3 Care Planning of rounding with unique interventions for each of the 6 p's to reflect the resident's unique needs.

Methods	Process measures	Target for process measure
Each resident will have a care plan focus of resident rounding with specific interventions that are personalized for that resident and tasked to the PCA so it shows on the Kardex	Number of residents with a unique Care Plan update	All 64 audit of care plans to be completed

Evaluation: All resident care plans and corresponding POC Kardex now include a dedicated focus on resident rounding, featuring personalized interventions tailored to the individual needs of each resident. These interventions are aligned with the 6 P's and are documented clearly for PCAs, ensuring visibility and accountability through the Kardex.

Change Idea #4. Evaluate and review the impact of the rounding on other outcome measures like Falls and Pain

Methods	Process measures	Target for process measure
The impact of resident rounding will be evaluated and reviewed on other contributing measures like falls and pain.	Review and report impact of rounding on other contributing measures like falls and pain on a regular basis	Report the impact rounding on measures for falls (incident reports) and pain (PointClickCare) will be reviewed every quarter.

Evaluation: By implementing resident rounding we have over the year reduced prevalence of falls and worsening of pain. Falls reduced from 14.1% to 9.4% while Pain started at 12.7 % in Q1 and went up to 17% in Q2. –Throughout the year we were able to reduce again from 17% to 12.7%. Utilizing regular resident rounding allows us to work with the resident and determine needs in a timely fashion. This proactive approach enables early identification and intervention, helping to prevent issues such as falls and unmanaged pain before they escalate, rather than responding only after problems arise.

Falls Prevalence Over Four Quarters (%)

Q1 |■■■■■■■■■■■■■■■■■■■■■■■■■■■■ 14.1%
Q2 |■■■■■■■■■■■■■■■■■■■■■■ 10.3%
Q3 |■■■■■■■■■■■■■■■■■■■■■■■■ 11.3%
Q4 |■■■■■■■■■■■■■■■■■■ 9.4%

Worsening Pain Over Four Quarters (%)

Q1 |■■■■■■■■■■■■■■■■■■ 12.7%
Q2 |■■ 17.0%
Q3 |■■■■■■■■■■■■■■■■■■■■■■■■ 13.5%
Q4 |■■■■■■■■■■■■■■■■■■ 12.7%

NEW 24/25 Quality Improvement Initiative

Measure: Reducing Rate of preventable Emergency Room Visits for residents with symptoms of delirium.

Target – Aiming to reduce overall annual percentage of avoidable ED visits by 5% from year 2024/25 to year 2025/26

External Collaborators: Nurse Led outreach team (NLOT), Behavioural Supports Ontario (BSO)

Change ideas:

1. Increase utilization of Nurse practitioner from NLOT
    - Method 1: Develop and algorithm for a nursing referral pathway to involving the NP Process Measure: Number of referrals to NP for in the month Target: 100% of nurses will contact the NP for assessment of a resident prior to sending out a resident for a symptom of delirium – (during NP working hours) This to be completed Monthly.
    - Method 2: Monthly meeting with NP and LTC team to review all ED transfers in the previous month and evaluate for appropriateness and make corrective action plans if necessary. Target: meeting will occur each month.

2. Increase early interventions of delirium
    - Method 1: Provide and train nursing staff on early interventions and warning signs . Target: 80% of nursing staff to complete training by end of Q1
    - Method 2: increase utilization of resident rounding to target early interventions ie: anticipating resident needs, offering fluid, adherence of toileting schedules Target. 80% of staff to document on rounding by end of Q1

- Method 3: Add to unit shift to shift report and discuss in unit huddles any resident changes from baseline for immediate follow up. Target: 100% of resident who are sent to ER for delirium in that month will have been identified in unit huddles prior.

3. Investigate Best Practice tools for early intervention.
    - Method: research early intervention tools including but not limited to the Preview ED tool and the CAM (confusion assessment method for delirium) Target: Tools will be investigated by end of Q2 to determine if feasible for our setting.

Skin & Wound Program

Objective:
Improve skin integrity by reducing pressure injuries throughout the 24/25 year.

Interventions Implemented – How we improved and why:

- Collaborated with the interdisciplinary team, residents, and families to address skin breakdown and implement preventive care.
- Monthly Skin and Wound interdisciplinary team meetings to review all cases of resident skin breakdown and update care interventions.
- Increased direct care staffing by adding dedicated hours for skin and wound care and staff education, led by a trained skin care champion RPN who dedicates one day per week to this initiative.
- Implemented a skin and wound assessment app integrated with Point Click Care (PCC) for real-time documentation accessible to all team members, supported by two dedicated wound care iPads.
- Used an artificial "butt" model for hands-on staff training in skin and wound care techniques.
- Provided dietary interventions targeted at improving skin healing and integrity.
- Ensured residents at risk for pressure injuries were maintained on individualized positioning schedules.
- Purchased additional positioning devices, funded through equipment and training grants, to enhance resident comfort and pressure relief.
- Acquired advanced wound care technologies, including wound care light and ultrasound, to support healing.
- Utilized Health Industry Network (HIN) wound care products for residents with complex wound care needs.

Outcome:
Throughout the year, ROP successfully maintained rates of pressure injuries at or below target levels. The only exception occurred in the last quarter, when a new admission arrived with five significant pressure injuries already present. This admission temporarily impacted the overall pressure injury statistics but was not attributable to in-house care.

Analysis:

- The proactive, multidisciplinary approach ensured early identification and consistent management of residents at risk.
- Enhanced staff education and the dedicated skin care champion improved wound prevention and treatment practices.
- Use of technology for wound documentation improved communication and care coordination among team members.
- Dietary and positioning interventions, combined with specialized equipment, provided comprehensive support to maintain skin integrity.
- The increase in pressure injuries in Q4 was linked to external factors related to the new admission rather than lapses in internal care protocols.

Conclusion:
ROP met its goal of reducing and maintaining low levels of in-house acquired pressure injuries over the 24/25 year.

Continued adherence to the established interventions and ongoing monitoring remain essential. Special attention and tailored care plans are necessary for new admissions with pre-existing wounds to prevent further deterioration.

Prevalence of stage 1-4 pressure injuries

Q1	Q2	Q3	Q4
4.70%	1.70%	4.80%	10.90%

MDS Threshold
2.4-7.7%

Responsibility: Interdisciplinary skin and wound committee

Fall Program

Objective:
Reduce the incidence of resident falls and minimize significant injuries resulting from falls.

Interventions Implemented -How we improved and why:

- Conducted thorough identification of areas and causes of resident falls to target prevention efforts.
- Installed fall mats in resident rooms to reduce injury risk from falls.
- Ensured beds for at-risk residents are placed in the lowest position to minimize fall impact.
- Introduced new beds in 2023 equipped with night lights, call bell systems integrated into headboards for easy access, and embedded bed alarms when necessary.
- Performed comprehensive pre- and post-fall assessments, with fall huddles held and documented following each fall incident to review and adjust care plans promptly.

Outcome:
The combination of these interventions contributed to a notable reduction in resident fall rates, decreasing from 14.1% at the start of the year to 9.4% by year-end.

Analysis:

- Identifying fall hotspots and causes allowed targeted environmental and procedural adjustments, effectively mitigating common fall risks.
- Fall mats and beds positioned at the lowest level physically reduced injury severity when falls occurred.
- The introduction of advanced beds with night lighting and accessible call bell systems likely enhanced resident safety and response times during night-time mobility.
- Bed alarms provided additional monitoring for high-risk residents, alerting staff to early signs of movement and potential falls.
- Regular fall assessments and multidisciplinary huddles ensured timely review and adaptation of care strategies, contributing to ongoing fall prevention.

Conclusion:
The integrated fall prevention strategies implemented throughout the year have successfully reduced resident falls and associated injuries. Continuing these practices, along with ongoing staff education and environmental safety audits, will be crucial to maintaining and further improving resident safety.
Responsibility: Interdisciplinary Falls Committee

Prevalence of falls

Q1	Q2	Q3	Q4
14.10%	10.30%	11.30%	9.40%

MDS Threshold
5.8-16%

Continence Care and Bowel Management Program

Objective:
Ensure all residents' continence is regularly reviewed, apply interventions to prevent worsening incontinence, constipation, maintain residents with incontinence on toileting schedules, reduce urinary tract infections, and identify residents demonstrating improved bowel and bladder continence.

Interventions Implemented - How we improved and why:

- Established toileting schedules for residents who require assistance to support regular bladder emptying and reduce incontinence episodes and constipation.
- Monitored and encouraged adequate fluid intake among residents to promote urinary tract health and prevent constipation.
- Collaborated with independent residents to improve peri care hygiene, reducing the risk of infection and skin breakdown.
- Implemented a formal resident rounding program to ensure residents are clean/ dry and comfortable.
- Implemented Individual resident bins in each resident room tailored with individualized resident products.
- During quarterly meetings the team reviews of each resident and notes if they have declined with bladder/bowel continence, type and frequency of incontinence, contributing factors, potential to restore, toileting schedules, when their continence assessment was done last, continence products, dietary/ pharmacological/ non-pharmacological.

Prevalence of urinary tract infections

Q1	Q2	Q3	Q4
7.80%	1.70%	6.50%	3.10%

MDS Threshold
2.5-8.8%

Prevalence of Bowel worsening/improvement
Q1 April 1 to June 30, 2024
Percent of Residents who's Bowel Continence Worsened: 18.9%
Percent of Residents who's Bowel Continence Improved: 15.8%

Q2 July 1 to September 30, 2024
Percent of Residents who's Bowel Continence Worsened: 21.2%
Percent of Residents who's Bowel Continence Improved: 8.1%

Q3 October 1 to December 31, 2024
Percent of Residents who's Bowel Continence Worsened: 23.5%
Percent of Residents who's Bowel Continence Improved: 18.9%

Q4 January 1 to March 19, 2025 *March 19th marks the end of MDS and transition to RAI
Percent of Residents who's Bowel Continence Worsened: 9.4%
Percent of Residents who's Bowel Continence Improved: 13.9%

Outcome:
Over the course of the year, the continence management interventions have resulted in a significant reduction in the incidence of urinary track infections among residents, from 7.8% at the beginning of the year to 3.1% by year-end. Bowel patterns initially increased the first 3 quarters of the year but after identifying this and implementing interventions we decreased from Q1 of worsening bowel continence of 18.9% to ending at Q4 with 9.4%. The ROP will be incorporating the RNAO's BPG 'A Proactive Approach to Bladder and Bowel Management' this upcoming year. This will include completion of a gap analysis by the interdisciplinary team to identify gaps in practice and development of an implementation plan over 2025/26.

Analysis:

- Implementing toileting schedules helped maintain bladder regularity and decreased episodes of incontinence, a key risk factor for UTIs.
- Encouraging proper hydration supported flushing of the urinary tract, reducing bacterial growth and infection risk and improved bowel health reducing constipation.
- Improving peri care hygiene in independent residents minimized potential sources of bacterial contamination.
- Conduct gap analysis of current bowel program related to best practice, identify gaps and formulate implementation plan and ongoing evaluation and program sustainment.
- Identified barriers are resident behaviours, lack of motivation, cognitive symptoms affecting thinking, non-compliance with meds/hygiene/care.
- The combined effect of these focused interventions contributed to a safer and healthier environment for residents, effectively lowering the incidence of UTIs and instances of constipation.

Conclusion:
The targeted continence care interventions have effectively improved bladder continence outcomes among residents. Ongoing monitoring and continued application of these strategies are recommended to sustain and further this positive trend. Current state bowel trends and metrics are being reviewed in order to set future benchmarks.

Responsibility: Interdisciplinary continence committee

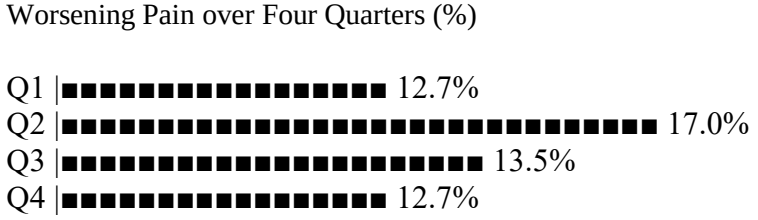
Pain Program

Objective:
Reduce resident pain and ensure effective pain control and treatment throughout the year.

Interventions Implemented - How we improved and why:

- Conducted quarterly interdisciplinary pain management meetings to discuss and evaluate residents experiencing pain.
- Reviewed pain medications, including scheduled and PRN (as needed) usage, to optimize pain relief strategies.
- Assessed response to physiotherapy, restorative nursing, and other nursing interventions for pain management.
- Paid special attention to residents with chronic pain and those with a history of medication-seeking behaviors.
- Identified pain in residents unable to vocalize symptoms through careful observation and assessment.
- Provided targeted physical therapy interventions to residents with identified pain issues.

Outcome:
Pain prevalence increased from 12.7% in Q1 to 17% in Q2, likely reflecting improved identification and documentation of pain during that period. However, through focused interventions and regular rounding, the pain rate was successfully reduced back to 12.7% by year-end.



Analysis:

- The initial increase in reported pain may be attributed to heightened awareness and better identification of pain, especially in residents unable to communicate effectively.
- Regular interdisciplinary review allowed for timely adjustments in pain management plans, including medication and therapy interventions.
- Enhanced monitoring of PRN medication use ensured residents received appropriate pain relief when needed without overuse.
- Physical therapy and restorative nursing interventions contributed to reducing pain through non-pharmacological means.
- The combination of multidisciplinary approaches and continuous reassessment helped bring the pain prevalence back to baseline levels by year-end.

Conclusion:
The comprehensive pain management program, supported by quarterly interdisciplinary meetings and targeted interventions, effectively controlled worsening pain among residents over the year. Ongoing vigilance and individualized care remain essential to maintaining optimal pain management outcomes.

Responsibility: Interdisciplinary pain committee

Restraint Program

Objective:
Promote the use of the least restraints possible with residents to enhance their safety and quality of life.

Interventions Implemented - How we improved and why:

- Provided education to residents and their families about the philosophy and benefits of least restraint use during admission and annual care conference.
- Utilized Personalized Assisted Safety Devices (PASDs) where appropriate to support residents' independence and safety.
- Conducted thorough restraint assessments to ensure restraints were used only when absolutely necessary.
- Regularly compared restraint usage data with fall incidents to monitor and balance safety risks.
- Implemented wander guards for residents at risk of wandering, as an alternative to physical restraints.

Outcome:
We successfully reduced the use of restraints among residents from 7.8% to 4.7% over the evaluation period.

Analysis:

- Education efforts helped increase awareness and acceptance of least restraint practices among residents and families, supporting a culture shift toward restraint minimization.
- PASDs and wander guards provided effective, less restrictive alternatives to physical restraints, allowing residents more freedom while maintaining safety.
- Regular assessments ensured restraints were only applied when clinically justified, preventing unnecessary use.
- Cross-referencing restraint and fall data facilitated a balanced approach to resident safety, minimizing both restraint use and fall risk.
- The coordinated multidisciplinary efforts contributed to a significant reduction in restraint prevalence.

Conclusion:
The strategic focus on education, alternative safety devices, and careful assessment effectively reduced restraint use

from 7.8% to 4.7%. Continued commitment to least restraint principles and ongoing monitoring are recommended to sustain this positive trend.

Prevalence of daily physical restraints

Q1	Q2	Q3	Q4
7.80%	6.90%	4.80%	4.70%

MDS Threshold
1.5-
6.9%

Responsibility: Interdisciplinary Restraint Committee

Responsive Behaviours

Objective: Reduce resident responsive behaviours.

Evaluation:

In 2024, we strengthened our behavioural health support through key staffing enhancements. By utilizing Allied Health supplemental funding, we were able to expand the hours of our Behaviour Therapist position, ultimately establishing a full-time Behaviour Therapist role. Additionally, with support from Behavioural Supports Ontario (BSO), we secured funding for 1.6 full-time equivalent (FTE) Behavioural Support Personal Support Workers (PSWs).

We continue to benefit from the ongoing involvement of a BSO psychiatrist and nurse, who provide psychiatric care for residents aged 65 and older who do not have an existing psychiatrist. These combined resources have greatly enhanced our capacity to manage and support residents with responsive behaviours.

Throughout the year, these efforts contributed to a notable reduction in resident responsive behaviours, reflecting the effectiveness of a proactive, person-centered approach.

Interventions Implemented - How we improved and why:

- Identified individual resident behaviours and specific triggers through regular assessment and observation.
- Collaborated with residents, families, and staff to develop personalized strategies aimed at reducing responsive behaviours, supported by monthly Responsive Behaviour meetings on both floors.
- Ensured timely identification of resident support needs and connected them with appropriate internal and external resources.
- Monitored and addressed any safety concerns related to responsive behaviours.
- Developed and implemented individualized routines and interventions proven to reduce responsive behaviours over time.

Conclusion:
The combination of enhanced behavioural staffing, targeted interventions, and a strong interdisciplinary approach has resulted in a successful year in reducing resident responsive behaviours by 30.7% . Continued focus on early identification, staff education, and person-centered care will be essential in maintaining and building on these positive outcomes.

Responsibility: Interdisciplinary Responsive behaviour team.

YEAR IN REVIEW

2024/2025

Behavioural Recording of ROP Resident

Month	*Second Floor Recordings*	*Third Floor Recordings*
April	52	34
May	64	48
June	82	41
July	57	38
August	53	34
September	45	30
October	78	48
November	82	35
December	81	22
January	59	28
February	63	21
March	76	24
Total	*792*	*403*

Second Floor

This Year: 792 behavioural recordings

Last Year: 947 behavioural recordings

16.4% decrease in second floor behaviours since last year.

Third Floor

This Year: 403 behavioural recordings

Last Year: 778 behavioural recordings

48.2% decrease in third floor behaviours since last year

A COMPARISON

2023/2024 - 2024/2025

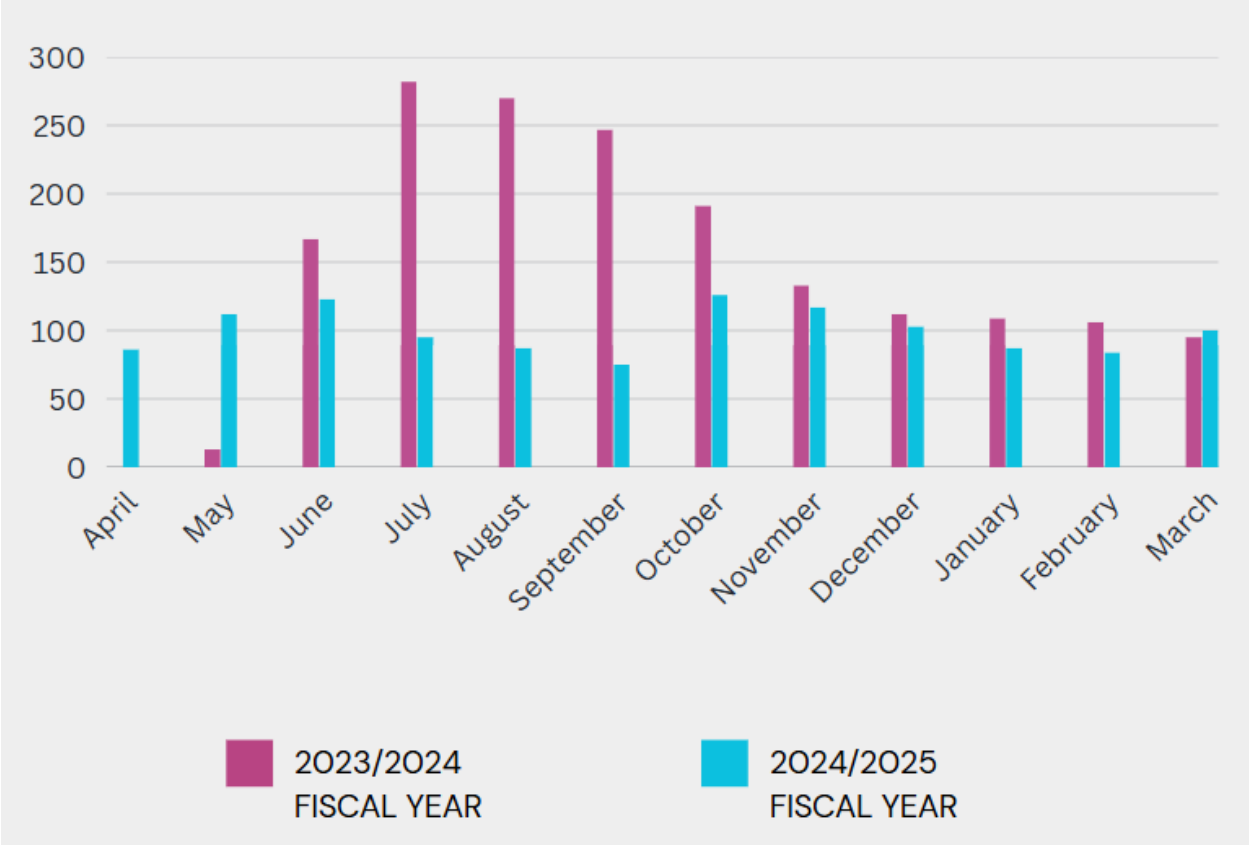
Behavioural Recording of ROP Residents

Month	*Total Recordings Last Year (2/3 floors)*	*Total Recordings This Year (2/3 floors)*
April	0	86
May	13	112
June	167	123
July	282	95
August	270	87
September	247	75
October	191	126
November	133	117
December	112	103

January	109	87
February	106	84
March	95	100
Total	*1725*	*1195*

Total number of behavioural recordings for both floors *this year*: 1195
Total number of behavioural recordings for both floors *last year:* 1725

30.7% overall decrease in total behaviours since last year.



Invention Prevention and Control (IPAC)

Objective:
Ensure Royal Ottawa Place (ROP) is a leader in Infection Prevention and Control (IPAC) and fully compliant with all IPAC requirements set by the Ministry of Long-Term Care (MOLTC) and Ottawa Public Health (OPH).

Evaluation:

In 2024, Royal Ottawa Place demonstrated strong leadership in infection prevention and control, achieving full compliance with all regulatory standards while proactively adapting to changing public health needs.

Key Outcomes & Highlights:

- **Outbreaks:** ROP had 1 July 2024 Covid outbreak and 1 influenza outbreak in March 2025**.** The covid -19 outbreak was a facility wide outbreak and the influenza outbreak was limited to 3rd floor only. In both instances we were able to quickly resolve these outbreaks, underscoring the effectiveness of our preventive protocols and rapid response strategies.

- **Regulatory Compliance:** Two OPH IPAC audits were completed in 2024/25 with no concerns identified, reflecting our continued commitment to excellence and regulatory alignment.
- **Enhanced Infrastructure:** Additional IPAC supplies were acquired, including isolation carts and dedicated isolation garbage containers, further strengthening our outbreak preparedness and daily infection control practices.
- **Masking Strategy:** In alignment with the region's risk level and the Point of Care Risk Assessment (POCRA) framework, the home transitioned out of mandatory masking in summer 2024. However, in response to rising respiratory virus activity in the fall, universal masking was reinstated proactively.
- **Ongoing Collaboration:** ROP's IPAC team worked closely with the ROHCG IPAC department to ensure consistent implementation of best practices, up-to-date policies, and a unified approach across the organization.
- **Vaccination Policy:** ROP maintained its policy requiring all staff, visitors, and volunteers to have a minimum of two COVID-19 vaccinations to enter the home, supporting resident safety and community protection.
- **Education & Training:** Comprehensive IPAC training was delivered to all staff, volunteers, residents, and families to reinforce best practices in hygiene, PPE use, and infection control protocols.
- **Committee Oversight:** The IPAC Committee met quarterly to review and act on key indicators including monthly hand hygiene compliance, disease surveillance, reprocessing of medical devices, and IPAC practices across departments including nursing, dietary, and environmental services.

Conclusion:
Royal Ottawa Place continues to excel in infection prevention and control through a proactive, evidence-based, and collaborative approach. The home remains fully compliant with all provincial and public health standards and serves as a strong example of IPAC excellence within the long-term care sector. We continue to complete IPAC audits and provide regular and on the spot training to residents, staff, volunteers, contractors and visitors.

Responsibility: IPAC interdisciplinary committee

Collaboration with Resident and Family Councils.

In 2024/25 year we had 2 resident councils and 1 family council.

There is a resident council on both the 2nd floor and 3rd floor. During 2024, the resident councils of both floors determined that they wanted to continue with having separate councils – 1 on each floor. Both of these councils have voted that the structure of their councils are with co-leaders, sharing the responsibility of leadership. Resident council meets every 2 months. Resident council invites staff each meeting to work collaboratively with them. Resident council has a staff assistant who assists the council with typing the agenda and minutes.

In 2024, the resident annual survey was completed in October 2024. Residents who had a cognitive performance score (CPS) of 1-3 were offered the survey. Those residents with a CPS score of 4-6 have cognitive deficits and are not able to complete the survey independently. For these residents, the survey was sent to the resident's substitute decision maker or power of attorney.

Overview of 2024 Resident Satisfaction Survey Results
Results Received: October 23, 2024

General

- 43 residents were offered the survey, 36 out of 43 completed the survey (84%).
- 20 family members/POAs (Power of Attorney) were sent the survey on behalf of a resident based on their Cognitive Performance Score (CPS). A CPS of 4, 5, or 6 means the resident has a severe cognitive impairment and would not be able to understand or complete the survey themselves. We will also send to families/POAs if a resident requests us to. 4 out of 20 families completed the survey.
- 47.5% from second floor and 52.5% from third floor completed the survey.

Top Positive Results

- 97.5% of residents/respondents feel that they are informed of activities within the home.

- 85% say they participate in activities within the home.
- 85% feel the activities available are of interest to them.
- 75% feel the therapy programs at ROP help them to be as independent as possible.
- 79.5% feel activities help improve their mood (15% do not attend programs so selected N/A).
- 85% are satisfied with the care that their Attending Physicians provide them.
- 97.5% feel they are treated with respect in the home. 11.5% increase from 2023!
- 100% feel their personal and physical privacy is respected in the home. 14% increase from 2023!
- 95% feel that the unit provides a safe environment.
- 95% feel the home is well maintained.
- 100% feel their room is clean and tidy.
- 92.5% feel the staff are friendly and helpful during meal service.
- 90% rated the care they are receiving as good or very good (top two levels). 12% increase from 2023!
- 90% say they would recommend ROP to families and friends. 12% increase from 2023!

Resident Satisfaction Evaluation Report

1. Noise Levels in the Home

Finding:

- 55% of residents reported being bothered by persistent noises in the home.
- This represents a notable decrease from 71% in 2023, indicating progress.

Details:

- Noises include yelling and screaming associated with responsive behaviours, as well as the call bell system during meals and programming.

Implementation:

- Short-term (Jan 2025):
    - Encourage residents affected by noise to participate in the "Coping Skills" group led by Recreation Therapists (RTs).
    - Provide individualized invitations to residents who've reported concern.
- Mid-term (Feb 2025):
    - Follow-up on call bell noise: Continue working with the call bell company to remove/minimize audible alerts from dining areas and implement scrolls for visual notifications.
    - Pilot test scroll systems in one dining area before full implementation.

Follow-Up Actions:

- July 2025: Evaluate feedback from participants in the Coping Skills group.
- July 2025: Assess effectiveness of scroll system and finalize full rollout.

2. Food Variety and Satisfaction

Finding:

- 22.5% of residents are dissatisfied with the variety of food offered, improved from 31% in 2023.

Details:

- Concerns are more focused on food texture related to dietary restrictions, rather than menu choices.
- Menus are resident-driven through a Food Committee.

Implementation Suggestions:

- Ongoing:
    - Continue supporting the Food Committee and reinforce resident involvement.
    - Educate residents about their dietary options, including the waiver process for non-recommended diets.
    - Hold education sessions as needed with the Dietitian (Rachelle) to discuss texture-modified diets, risks, and waiver options.

- Short-term (Dec 2024):
    - Solicit feedback on menu variety separate from texture concerns to clarify future changes in food committee every other month.

Follow-Up Actions:

- July, 2025: Review food satisfaction trends with dietician and nutrition supervisor.
- August, 2025**:** Survey residents again to determine if perception of food variety improves.

3. Morning Care and Meal Service Experience

Finding:

- Residents report feeling rushed during morning care and meal service, especially at breakfast.

Implementation Suggestions:

- Immediate Implementation (Nov 2024):
    - Eliminate routine showers before breakfast.
    - Shift PCA workload to support more relaxed and personable morning care routines.
- Short-term (Nov 2024- Feb 2025):
    - Monitor staff and resident feedback regarding new morning routine structure.
    - Provide additional training or support to PCAs as needed during transition.

Follow-Up Actions:

- Ongoing: Conduct informal check-ins with staff and residents to gather early feedback.
    - In the January 2025 Resident Council meetings, residents from both the second and third floors reported noticeable improvements in their morning care routines and meal service. They shared that staff appeared more relaxed and attentive, which positively impacted the overall dining room atmosphere and enhanced the quality of resident care.
- August 2025: Formal review of care routines and any changes in resident satisfaction scores related to morning care.

Summary of Trends (2023 vs 2024)

Category	2023 (%)	2025 (%)	Change
Noise Disturbance	71%	55%	↓ 16%
Food Dissatisfaction	31%	22.5%	↓ 8.5%

FAMILY COUNCIL

In 2024, Family Council continued to meet quarterly via Zoom, a format the council unanimously chose to maintain due to its accessibility and convenience. The use of virtual meetings has significantly increased participation, with family members joining from across the globe. This broader engagement has strengthened our collaborative approach, allowing for open communication and shared decision-making between the home and families.

We are proud to work alongside an active and committed Family Council, led in 2024 by President Gordon Reynen, the brother of a resident living on the 3rd floor. Gordon's leadership and insight have been instrumental in fostering a positive, inclusive environment where families feel heard and involved in the care community.

TRAINING in 2024

In addition to mandatory annual training modules for all staff in 2024 we utilized the MLTC professional growth funding to train staff in the following areas:

- Trained RPN in Wound Care Canada program
- Trained RN in IPAC certification.

- CPR training.
- GPA training for RPN's
- Trained 39 champions with the RNAO BPSO training.
- Behaviour support training for 3 BSO staff
- Restorative Training
- PSW training day
- Added additional training days to new employee orientation.
- Registered staff training day
- NCI training for all staff
- Advantage Ontario Conference

Additional Direct Care Staffing added 2024/25

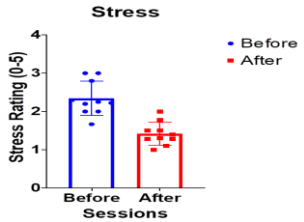
In 2024/25 year we received additional funding from the ministry and BSO to add additional direct care staff. We added:

- 2.1 FTE RPN to have a 1:16 ratio for days and evening shift.
- 0.4 FTE RPN palliative care and person centered care BPSO nurse
- 0.4 FTE Restorative care PSW
- 0.4 FTE Behaviour Therapist
- 0.9 FTE Behaviour Support PSW
- 0.6 FTE Recreation Therapist Assistant
- 0.2 FTE Occupational Therapist contract
- 0.2 FTE Music Therapist contract
- 4-8pm PSW shift daily on each unit

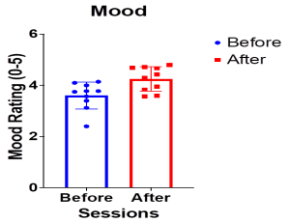
RESEARCH PROJECT

In 2024/25 year Royal Ottawa Place Recreation Therapy department and the psychology department of the ROHCG were involved in a trishaw research program evaluating the effects of trishaw bike rides on mood and responsive behaviours. 12 residents were involved in the research project during the 2024/25 year. RAI-MDS data was used to measure long term behaviours.

- No differences were observed here but there was too much variability with our population (different levels of functionality, cognition, mental/neurological illnesses) which most likely affected the comparison
- No difference in the agitation most likely due to the small sample size
- Current results for mood and stress indicate the trishaw program has a more immediate effect on improvement. It is trending towards a positive impact.
- Log results (these included the pre- and post- interview questionnaires for agitation, mood, and stress levels)
- We don't see long-term effects however this could be do to several factors including the appropriateness of the measures used during the interviews and delays in measurements
- Focus groups indicated that the majority of residents loved the bike rides, made them happier afterwards, bike seat was bit uncomfortable for some, most feel that if they had just gone outside instead of on the bike it wouldn't have been the same, less stressed, liked people sitting with them, the company.



Stress decreased immediately following session



Mood increased immediately following session

STUDENT PREP PROGRAM

In 2024 Royal Ottawa Place re-enrolled in the LTC PREP program. We have a PSW supervisor to both supervise the PSW's and run the LTC Prep Program. In 2024 we had 36 PSW students and 16 RPN students complete their consolidation in the program this is a significant increase from the previous year

Quality Projects Completed 2024/25

In consultation with staff, resident and family councils we completed a number of quality improvement projects in the home including:

- Development of accessible door widening to the courtyard area for bariatric residents
- New furniture in resident rooms – bedside tables and dressers.
- New flooring in hallways of 2nd and 3rd floor
- 2 new programs on point click care documentation IPAC and FAX
- New resident computer in the lounge area.
- New accessible ramp for emergencies out of courtyard.
- New JUBO vital cart for each floor that automatically uploads to Point click care for increased accuracy.
- BSO equipment – new iPad and noise cancelling earphones.
- Installed scroll system in dining room on 2nd and 3rd floor.

Safety Elements:

1. We have a Joint occupational health and safety committee. This committee reviews and analyses staff safety data and conducts risk assessments.
2. Client Safety Incident Feedback (CSIF) reporting for resident and staff incident review. Near miss incidents are also reported.
3. Recognition of hazards. Point of care risk assessment is completed by staff and Do not walk by program.
4. Quality Reviews for critical incidents are completed.