Experience | Patient-centred | Custom Indicator

	Last Year		This Year	
Indicator #1 Percentage of capable residents involved in plan of care and make the care decision (Yee Hong Centre - Mississauga)	**41** Performance (2023/24)	**70** Target (2023/24)	**69** Performance (2024/25)	**NA** Target (2024/25)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Arrange training and education on updating care plans for the inter-professional team, including nurses and personal support workers (PSWs).

Process measure

- The percentage of staff who will receive training.

Target for process measure

- 100% of full time Inter-professional staff received training on updating care plans by December 31, 2023.

Lessons Learned

- Trained 100% of full-time Interprofessional staff on updating care plans.
- Arranged multiple training sessions to increase staff accessibility.
- Delivered multiple training delivery methods, such as hands-on demonstrations to promote staff engagement.
- Translated training materials to Chinese for staff to easily understand.
- Provided refresher training for existing staff to maintain sustainability.
- Plan to provide a training handout for future sessions.
- Will incorporate the training materials into the new nursing staff orientation.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Involve capable residents (Cognitive Performance Scale (CPS) score is from 0 or 2) in developing and modifying the care plan.

Process measure

- The percentage of capable residents will be involved in developing and modifying the care plan quarterly.

Target for process measure

- 100% of capable residents involved in developing and modifying care plan by December 31, 2023.

Lessons Learned

• Involved 100% of capable residents in developing and modifying care plans and upon any condition changes.
• Maintained clear communication using effective communication tools, such as the Communication Log Sheet, between the teams and residents for updating the care plan.
• Pre-scheduled timeline for staff updating care plan with capable residents. For instance, RN/RPN used the MDS schedule as the timeline for updating the care plan.
• Modified care plan proactively with capable residents when their condition changes.
• Plan to update the Cognitive Performance Scale (CPS) scores in a timely manner to maintain accuracy on cognitive assessment.
• Will identify cognitive level changes early when residents' health conditions change.

Change Idea #3 ☑ Implemented ☐ Not Implemented

Seek feedback and suggestions from capable residents about their care plan and care needs, and share the feedback with Inter-professional team as appropriate.

Process measure

- 1. The percentage of capable residents who will provide feedback and suggestions on their care plan. 2. The percentage of residents' feedback and suggestions about the care plan will be shared with the team as appropriate. 3. The percentage of care plans which will be updated based on the feedback from residents.

Target for process measure

- 1. 100% of capable residents who provided feedback and suggestions on their care plan. 2. 100% of residents' feedback and suggestions about the care plan were shared with the team. 3. 100% of care plans were updated based on the capable residents' feedback. All by December 31, 2023.

Lessons Learned

- Received 100% of capable residents who provided feedback.
- Shared feedback openly with the team.
- Updated care plan based on the feedback and suggestions.
- Dedicated time for staff to encourage residents to provide feedback.
- Provided training to residents during the annual resident orientation. All capable residents were actively engaged in the discussion of care plan training sessions to enhance their understanding.
- Maintained strong relationships with residents to facilitate open communication.
- Completed documentation to enhance team communication, including the care plan updates.
- Plan future interventions to obtain more feedback from residents who have borderline cognitive levels.
- Continue to improve documentation in a timely manner.

Safety | Effective | Custom Indicator

	Last Year		This Year	
Indicator #2 Percentage of newly admitted residents and families who respond positively to care transition experiences to long-term care. (Yee Hong Centre - Mississauga)	**CB** **Performance (2023/24)**	**CB** **Target (2023/24)**	**70** **Performance (2024/25)**	**NA** **Target (2024/25)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

Identify the newly admitted residents' care needs and challenges prior to admission.

Process measure

- 1. The percentage of "Pre-Admission Review Forms" will be completed with identified care challenges for newly admitted residents. 2. The percentage of care challenges which will be shared with the Inter-professional team as appropriate. 3. The percentage of newly admitted residents' proactive measures will be prepared.

Target for process measure

- 1. 100% completed "Pre-Admission Review Forms" with identified care challenges for newly admitted residents. 2. 100% of care challenges shared with the Inter-professional team as appropriate. 3. 100% of newly admitted residents' proactive measures prepared. All by December 31, 2023.

Lessons Learned

- Completed 100% “Pre-Admission Review Forms" with identified care challenges for newly admitted residents.
- Revised the "Pre-Admission Review Forms" to incorporate staff feedback.
- Applied the following approaches proactively to prepare for new admission:
- Utilized the “Pre-Admission Review Forms" to prescreen upcoming new residents and outline their care challenges.
- Communicated the care challenges with the care team.
- Developed strategies to mitigate care issues.
- Standardized a new admission process.
- Adopted effective communication tools, such as a new “Pre-Admission Review Forms.”
- Seek and clarify clinical information from external partners to ensure up to date new admission clinical status.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Provide residents' care in a holistic and Inter-professional team approach during new admission.

Process measure

- 1. The percentage of "Pre-Admission Review Form" will be shared with the staff during the shift report for the first 3 days of admission. 2. The percentage of new admission assessments and care plans will be completed by the Inter-professional team. 3. The percentage of discussions on care challenges held in collaboration with newly admitted residents and families.

Target for process measure

- 1. 100% of the "Pre-Admission Review Form" were shared with the staff during the shift report for the first 3 days of admission. 2. 100% of new admission assessments and care plans were completed by the Inter-professional team. 3. 100% of discussions on care challenges were held with newly admitted residents and families. All by December 31, 2023.

Lessons Learned

• Shared the "Pre-Admission Review Forms" with the staff during the shift report for the first three days of admission.
• Completed new admission assessments and care plans by the Interprofessional team.
• Implemented care plan interventions and strategies in a holistic and Interprofessional team approach.
• Discussed care challenges with newly admitted residents and families.
• Collaborated with the family members to develop care plan interventions and strategies to mitigate the care challenges.
• Received support from family members.
• Continue to remind staff to share residents' admission information thoroughly with the team every shift for the first three days of new admission.

Change Idea #3 ☑ Implemented ☐ Not Implemented

Evaluate care transition experiences of newly admitted residents and families after 4 to 6 weeks during the care conference.

Process measure

• The percentage of newly admitted residents and families will share their care transition experiences during the admission care conference.

Target for process measure

• 100% of newly admitted residents and families shared their care transition experiences by December 31, 2023.

Lessons Learned

• 100% of newly admitted residents and families shared their care transition experiences during the new admission care conferences.
• Maintained a trusting therapeutic relationship with residents and their family members to facilitate open communication.
• Continue to encourage newly admitted residents and families to share their care transition experiences.