Quality Improvement Plan (QIP)

Narrative for Health Care Organizations in Ontario

June 20, 2025

Ontario Health

OVERVIEW

At Derbecker's Heritage House, our passion is people. Established in 1964, Derbecker's Heritage House is celebrating over 60 years of caring. We look forward to remaining a prominent and trusted operator of long-term care homes in Ontario for another 60 years as we embrace innovation and future growth.

Derbecker's Heritage House is dedicated to embedding quality throughout our culture and ensuring it is present in everything that we do. Our Quality program serves as the foundation that guides and directs our quality improvement initiatives to ensure that every resident who comes through our doors receives care that is timely, safe, appropriate, effective and responsive to each person's needs.

We have demonstrated our ongoing commitment to providing each resident with a care experience that is sustainable, quality driven and offers better value. We are a leader in providing evidenced based quality care that is routinely measured and evaluated and is reflective of industry leading best practices. We recognize our shared responsibility in providing health care services that are adaptable and sustainable. We share the provinces vision of having a sustainable universal health care system that is value based and is focused on preventing illness and improving results for all Ontarians and ultimately eliminates the need for hallway medicine and achieves better patient outcomes through more equitable access to quality care.

Our Quality Improvement Plan reflects the Annual Priorities selected provincially and includes quality improvement priorities identified within our home. Our 2025/26 Quality Improvement Plan further aligns with existing regional and provincial priorities.

Our Quality Improvement Plan also meets the requirements of the "Continuous Quality Improvement Initiative Report" as required under section 168 of O. Reg 246/22 of the Fixing Long-Term Care Act, 2021.

Additionally, our plan is strategically aligned with the provincial priorities of improving the health care experience through an integrated and patient-centered continuum of care and working with partners towards the achievement of an accountable, high performing health care system that also seeks to reduce disparities among different population groups.

ACCESS AND FLOW

Long-Term Care providers in Ontario have an important role to play in improving access and flow. Derbecker's Heritage House is committed to the following:

- Ensuring that all applications for admissions to our homes are reviewed promptly and responded to as per the requirements of the FLTCA.
- Ensuring that available beds are reported to Ontario Health at Home promptly and admissions scheduled as soon as possible.
- Leveraging Nurse Practitioner Led outreach.
- Continuing to reduce unnecessary transfers to Emergency Departments
- Partnering with local healthcare agencies to provide more facility-based services ex: X-Ray, Ultrasound, Lab Services.
- Working to leverage our use of technology as it pertains to communication with our external health care partners. We know transitions between long-term care, the community and hospitals can have the potential for medication and treatment errors which could cause harm. Our home use project "Amplify" to improve transitions of care by partnering clinical data systems between the LTC Home & Acute Care.
- Our home has adopted the "boomer process". The boomer process is a pharmacist led medication reconciliation system used for first time admissions.

Access & Flow is a complex system issue that impacts person centered care, resident safety, and resident quality of life. Residents entering long-term care today often have far more complex health care needs than they did just 10 years ago. Our resident populations continue to evolve. We are working to better manage these complex and specialized individuals in our settings with a goal of safely and efficiently managing their care needs in the home before sending them to another care setting (such as an Emergency Department) when they experience changes in their condition.

We regularly respond to changes in the health care needs of the population we serve through support of needed infrastructure and clinician support and training. We work to stay ahead of the curve to ensure that we can meet the varying and increasingly intense care needs of individuals requiring LTC in Ontario.

EQUITY AND INDIGENOUS HEALTH

Our commitment to achieving equitable outcomes and reducing health inequities remains unwavering. We firmly believe in fostering a diverse and inclusive environment where everyone feels safe, valued and respected. By implementing comprehensive strategies, we aim to reduce health inequities and foster a more inclusive environment for all.

As part of our home's strategy, we are dedicated to implementing anti-racism measures that promote inclusivity across all aspects of our organization. We recognize the importance of acknowledging and addressing the unique needs of indigenous peoples, people of color, members of the LGBTQ2S+ community and those living with disabilities.

We believe that actions speak louder than words. We are actively working towards creating a future where health disparities are minimized, and opportunities are equally accessible for everyone in our care.

We will work to achieve these goals through our ongoing efforts to develop and implement a comprehensive corporate program that focuses on cultural competence, diversity awareness, and anti-racism practices for all staff members. We look forward to engaging with our staff, residents and families to gain feedback on how we can improve our services. We their insights as invaluable as we work together towards a more inclusive future for all staff, residents and their families.

PATIENT/CLIENT/RESIDENT EXPERIENCE

Patient experience encompasses the range of interactions that patients have with the healthcare system, including their care from health plans, and from doctors, nurses, and staff in hospitals, physician practices, and other healthcare facilities. As an integral component of healthcare quality, patient experience includes several aspects of healthcare delivery that patients value highly when they seek and receive care, such as getting timely appointments, easy access to information, and good communication with health care providers.

Understanding patient experience is a key step in moving toward patient-centered care. By looking at various aspects of patient experience, one can assess the extent to which patients are receiving care that is respectful of and responsive to individual patient preferences, needs and values. Evaluating patient experience along with other components such as effectiveness and safety of care is essential to providing a complete picture of health care quality.

The voice of our residents and their families will continue to drive our Quality Improvement efforts forward. Our goal is to provide each resident with a care experience that is truly resident centered and reflective of everyone’s unique characteristics. It is our belief that our residents, families and caregivers benefit from the opportunity to provide meaningful input into the way that the care and delivery of services are provided in our home.

Our annual Resident /Family Survey is completed either electronically or in person with independent personnel.

The information received from this electronic survey has been invaluable and has provided the home with an accurate account of

our Resident and Families current experience. We consistently use the results to help guide change that will improve the resident experience in our home. We have openly shared the results and our plans of action with our residents, families and the public.

PROVIDER EXPERIENCE

Derbecker's Heritage House continues to actively recruit and retain qualified external candidates.

Derbecker's Heritage House partners with local colleges to provide student placement and preceptors to support student experiential learning. We currently have five trained preceptors available.

Through a partnership with Humber College our home was able to provide space for PSW students to take part in the lab skills training portion of their studies, the home then also supports the practicum placements while students complete the theoretical components of their studies on-line. This innovative approach to learning offers PSW students the opportunity to earn while they learn through a variety of financial incentives offered by the provincial government.

Staff appreciation week is one way our home celebrates the staff in fun ways with games, activities, prizes. Families and residents are often part of the fun and welcome the opportunity.

SAFETY

Derbecker's Heritage House has developed resident safety strategies that aim to prevent and reduce risks such as errors and harm that might occur during the provision of care. We believe that a cornerstone of resident safety is continuous improvement based on learning from errors and adverse events.

Resident safety is fundamental to delivering quality essential health services. There is clear consensus that quality health services should be effective, safe and person-centred. To realize the benefits of quality health care, health services must be timely, equitable, integrated and efficient.

Derbecker's Heritage House is committed to ensuring the successful implementation of resident safety strategies through the development and implementation of evidence-based policy and procedure, leadership capacity, data to drive safety improvements, skilled health care professionals and effective involvement of residents and their families in their care.

Data that we actively collect:

- Medication Errors
- Incidents of Resident Abuse and Neglect
- Health Care Setting Related Infections
- Falls
- Restraint Use
- Management of Continence
- Diabetes Management
- Skin and Wound
- Emergency Department Transfer
- Use of anti-psychotic medications
- Incidence of responsive behaviours
- Rates of infection (Covid 19, Influenza, RSV and others)

PALLIATIVE CARE

Palliative Care at Derbecker's Heritage House is designed to

provide comprehensive, individualized care for residents experiencing progressive and life-limiting chronic or terminal illnesses. This program is focused on enhancing the quality of life for those in need, with a holistic approach that addresses multiple facets of well-being, including:

Key Elements:

Resident-Centered Care

The care plan is tailored to meet the specific physical, social, emotional, psychological, and spiritual needs of each resident.
•We use additional assessments from the day of admission to create a resident specific culturally appropriate advanced care plan. This ensures that families or residents don't have to make difficult decisions at end of life.
•Ensures dignity, comfort, and respect for the resident, allowing them to experience a more fulfilling quality of life in their final stages.

Family Support

•The program recognizes the importance of family involvement and provides emotional and practical support to family members.
•Offers education and counseling for families to help them understand the process and how best to support their loved ones.

Holistic Approach

•Physical: Focus on pain management and symptom relief to ensure comfort.
•Social: Encourages social interaction, community, and relationships to maintain a sense of belonging and normalcy.
•Emotional and Psychological: Provides counseling and therapeutic interventions to manage anxiety, depression, and other mental health concerns associated with terminal illness.
•Spiritual: Offers spiritual care that is respectful of individual beliefs and preferences, fostering a sense of peace and purpose.

Quality of Life Enhancement

•The program is designed to enhance the overall quality of life for those with progressive conditions by focusing on comfort, dignity, and support, rather than aggressive medical interventions.

Minimizing Hospital Transfers

•One of the program's primary goals is to reduce unnecessary emergency department visits and hospital transfers for residents deemed palliative.
•Care is provided in a stable, familiar environment, reducing the stress and complications that can arise from hospital settings.

Benefits of the Program

•Individualized Care: A highly personalized care plan is created, ensuring that each resident's specific needs are addressed.
•Continuity of Care: The program works to avoid disruptions, maintaining consistent care without the need for frequent hospital visits.
•Comprehensive Support: Residents and their families receive support across all areas—physical, emotional, social, and

spiritual—creating a well-rounded care experience.
•Palliative and Comfort-Focused: The focus is on quality of life, ensuring that residents experience comfort and dignity during their time in the program.

This approach helps to provide a peaceful, supportive, and dignified end-of-life experience for residents while offering vital assistance to their families through the challenges of terminal illness.

POPULATION HEALTH MANAGEMENT

The Population Health Approach focuses on improving health status through action directed toward the health of an entire population, or sub-population, rather than individuals. It is increasingly recognized for its role in reducing healthcare demand and contributing to health system sustainability.

Core elements of the population health approach include focusing on health and wellness rather than illness, taking a population rather than individual orientation, understanding needs and solutions through community outreach, addressing health inequities and addressing the social determinants of health.

Population health management is where shared data is used to understand the care and support needs of the whole population so resources can be targeted and shared to those who need it. A population health approach will allow local communities to act and tailor their services to make better use of public resources. Organizations will work together using historical and current data about people's health to design new proactive models of care to improve the health and wellbeing of individuals now, and in the future to help reduce health inequalities across the country.

Ontario is working to build connected health care system centered around patients, families and caregivers. Known as "Ontario Health Teams" these regional teams will work to strengthen local services, making it easier for patients to navigate the system and transition between providers. Ontario Health Teams are an example of a population health approach. At present, there are 57 approved Ontario Health Teams, some are still in development.

Derbecker's Heritage House shares in the province's desire to improve Ontario's publicly funded health care system and deliver fully integrated care to achieve better outcomes, better experiences, and better value for all Ontarians, and we are ready to embark on this journey with providers and organizations in our geographic regions using a population health approach.

Achieving large-scale improvements such as a population health approach will require collaboration amongst partners and we are committed to working with those partners to improve health outcomes for the residents that we serve and further reduce disparities among different population groups.

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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 **March 28, 2025**

Pam Debecker, Board Chair / Licensee or delegate

Pam Derbecker, Administrator /Executive Director

Paula Leland, Quality Committee Chair or delegate

Other leadership as appropriate

Access and Flow

Measure - Dimension: Efficient

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Rate of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents.	O	Rate per 100 residents / LTC home residents	CIHI CCRS, CIHI NACRS / Oct 1, 2023, to Sep 30, 2024 (Q3 to the end of the following Q2)	15.46	13.46	Looking to achieve improvement that is realistic and sustainable.	

Change Ideas

Change Idea #1 1)Decrease number of ED visits

Methods	Process measures	Target for process measure	Comments
1. Continue to review stats with Registered Staff at regular staff meetings 2. Discussion regarding Advanced Care wishes at 6 week care conference. 3. Registered staff to use SBAR when reviewing resident status with MD.	1. Review with on call MD the residents status. testing and medication may be ordered to avoid a transfer. 2. Review findings and advanced care wishes with POA for care as they may opt for hospital transfer. 3. Education of the registered staff and families in order to reduce transfers to ED. NLOT to provide Registered staff education. 4. DOC to review previous month data with physician monthly.	Review the quarterly statistics from the SWLHIN. Target to have 13 or less ED visits	

Equity

Measure - Dimension: Equitable

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education	O	% / Staff	Local data collection / Most recent consecutive 12-month period	5.17	100.00	In 2024 all management staff were educated on the principles of DEI. In 2025 all management and staff will be educated.	

Change Ideas

Change Idea #1 To ensure that all staff and management are trained in DEI and anti-racism in 2025.

Methods	Process measures	Target for process measure	Comments
Equity, Diversity, Inclusion and Anti-racism education to be added to Surge for all staff.	Monitor Surge for staff completion of required education.	100% completion	Total LTCH Beds: 72

Experience

Measure - Dimension: Patient-centred

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences".	O	% / LTC home residents	In house data, interRAI survey / Most recent consecutive 12-month period	97.14	100.00	Internal Goal	

Change Ideas

Change Idea #1 1)Engage the Residents and have them participate giving input into routines ie likes and dislikes. Get them more involved with organizational practices and day to day operations

Methods	Process measures	Target for process measure	Comments
Invite Residents to participate in quarterly Quality meetings with staff. Continue to allocate time during residents council for residents to express any concerns they may have. f/u with the appropriate actions to address concerns.	Continue with current practice of Recreation manager to track number of concerns as well as administrator tracking number of written complaints from residents and family.	90% response rate	Total Surveys Initiated: 35 Total LTCH Beds: 72

Change Idea #2 All staff to receive education on approach, body language, respect and "can do" attitude when caring for their residents.

Methods	Process measures	Target for process measure	Comments
Quality improvement plan will be discussed at general staff meetings monthly, including # of client concerns and resident/family concerns outcomes and follow up. Utilize Surge learning to circulate meeting minutes for those unable to attend the meetings.	Recreation manager, DOC and Administrator track number of verbal and written complaints and what follow up has been completed.	90% response rate	

Safety

Measure - Dimension: Safe

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of LTC home residents who fell in the 30 days leading up to their assessment	O	% / LTC home residents	CIHI CCRS / July 1 to Sep 30, 2024 (Q2), as target quarter of rolling 4-quarter average	22.56	21.40	Internal Goal	

Change Ideas

Change Idea #1 1. Compare falls data pre and post implementation of iPad and evaluate, Reg staff are monitoring positioning of staff (close to residents at risk) when charting each shift

Methods	Process measures	Target for process measure	Comments
1.Track occurrence of post fall huddles to ensure compliance 2. Falls lead will facilitate care plan review and discuss with falls prevention team, ensuring that residents within in the parameters are followed as per improvement initiative.	1.Compare numbers of post fall huddles to actual falls to ensure all are complete. Audit assigned to specific registered staff. 2. Falls lead will co-ordinate review with falls team after month end audit 3. Review residents who have fallen 3 or more times during the month and review care plan with interdisciplinary approach	Utilize data from PCC insights to monitor change.	

Measure - Dimension: Safe

Indicator #5	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment	O	% / LTC home residents	CIHI CCRS / July 1 to Sep 30, 2024 (Q2), as target quarter of rolling 4-quarter average	14.78	14.00	Internal goal	

Change Ideas

Change Idea #1 1)Quarterly Medication review of residents who are receiving antipsychotic medication and reason for use with goal to possible reduction.

Methods	Process measures	Target for process measure	Comments
Internal BSO team will prepare a quarterly summary and recent 5 day DOS prior to Quarterly medication review with in put from consultant pharmacist for physician review.	1. Registered staff should review medications and MDS to ensure accuracy of coding. 2. Review any current medications for possible reduction. 3. Review of PRN medication use with view to reduction or discontinuation. 4. Physician, pharmacist and BSO lead to review information with view to antipsychotic reduction	To decrease use of antipsychotics for residents without a diagnosis to annually.	