THE ROYAL

Royal Ottawa Health Care Group

Royal Ottawa Place

Continuous Quality Improvement
Annual Report

April 1, 2025 – March 31, 2026

Submitted by: Melissa Laroche – Interim Administrator and Director of Care (CQI Lead)

Prepared by: ROP Continuous Quality Improvement Committee

RNAO BPSO Designate 2026

Executive Summary

Royal Ottawa Place (ROP) is a 64-bed Long-Term Care Home within the Royal Ottawa Health Care Group, operating under Ontario's Fixing Long-Term Care Homes Act. Our mission is to support and enhance quality of life for adults with chronic stable severe mental illness and those who benefit from a mental health-focused environment.

This report presents CQI outcomes for April 1, 2025 – March 31, 2026, covering our annual Quality Improvement Committee objectives, key clinical programs, and our path forward.

★ 2025/26 Highlights at a Glance

- RNAO BPSO Pre-Designation completed after 3 years; ceremony recognition in May 2026
- 75–85.7% reduction in avoidable ED transfers for delirium (Q1 & Q2)
- Emergency Restraint use reduced from 4.7% → 1.5% (sustained Q2–Q4)
- 97–100% hand hygiene compliance achieved (Q1); recovered to 91–95% by year-end
- 47 student placements (39 PCA + 8 RPN) welcomed

Organizational Overview

About Royal Ottawa Place

Royal Ottawa Place is a specialized 64-bed Long-Term Care Home committed to mental health-focused, person-centered care. CQI is a team approach embedded across all programs and services, driven by collaboration with residents, families, and all care team members.

Resident Demographics

Characteristic	Detail
Total Beds	64
Average Age	69 years
Average Length of Stay	2,389 days (6.6 years)
Severe Mental Health Diagnosis at Admission	56% of residents
Dementia Diagnosis at Admission	17% of residents
Residents with a Psychiatrist	45%
Residents Displaying Responsive Behaviours	62.5%
Most Common Primary Diagnosis	Schizophrenia (27/64 residents)
Current Case Mix Index (CMI)	1.6 (as of March 31, 2026)

Age Distribution & Mobility

Age Range	# Residents	Mobility Detail	# Residents
0–50	1	Use a Mobility Device	50
51–60	13	Require Lifts for Transfer	22
61–70	20		
71–80	23		
81–90	4		
91–100	2		

Admissions & Discharges (2025/26)

Category	Count	Notes
Total Admissions	13	April 1, 2025 – March 31, 2026
Total Discharges	13	

Primary Diagnoses

Residents present with complex, overlapping diagnoses including:

- Mental Health: Schizophrenia, Schizoaffective Disorder, Bipolar Affective Disorder, Anxiety Disorder, Personality Disorder, Depression
- Neurological: Traumatic Brain Injury, Acquired Brain Injury, Dementia, Cerebral Palsy, Parkinson’s
- Other: Developmental Delay/Intellectual Disability, Diabetes, COPD

Unique Challenges

- Younger average population (age 69) compared to typical LTC homes
- High proportion of male residents
- 56% admitted with severe mental illness
- No formal Mental Health Designation — ongoing provincial advocacy underway
- CMI of 1.6 reflects high clinical complexity

Staffing & Services

Clinical & Allied Health Team

- Nursing: RN, RPN, PCA
- Physical Therapy: PT, PTA; Occupational Therapy (contract)
- Recreation Therapy & Assistants; Music Therapy (contract)
- Dietary: Dietician, Dietary Aides
- Behavioural Supports Ontario (BSO): PSW and Behavioural Therapist
- IPAC Team: Dedicated LTC Infection Control RN Lead + ROHCG IPAC support
- Speech Language Pathology (via Home and Community Care referral)
- Restorative Care; Volunteer Program

Contract & External Services

- Pharmacy, Laboratory, X-ray, Dental, Optometry, Massage Therapy, Hairdresser
- Collaboration with ACTT (Assertive Community Assessment Team)
- Collaboration with FACTT – Flexible Assertive Community Assessment Team – Dual Diagnosis

Medical Services

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

Safety

Key Safety Initiatives 2025/26

- Annual Non-Crisis Intervention (NCI) training completed with all staff
- Annual Safe Patient Handling education; access to ergonomic occupational health staff
- Evacu-sleds installed on all beds.
- Joint Occupational Health & Safety Committee conducting regular risk assessments
- Client Safety Incident Feedback (CSIF) reporting including near-miss incidents
- Point-of-care risk assessment and “Do Not Walk By” program
- Access to The Royal’s occupational health and safety team
- Dedicated IPAC RN lead; full access to ROHCG IPAC team and resources
- Quality Reviews completed for all critical incidents

2025/26 Achievements

RNAO Best Practice Spotlight Organization (BPSO)

- Selected for RNAO BPSO designation in 2023; three-year pre-designation completed in 2025/26
- **56 staff** trained as RNAO BPSO Champions — the highest staff participation rate (52%) in the program
- Three active Best Practice Guidelines (BPGs): Resident & Family-Centered Care, Palliation, and Wound Care
- Formal BPSO recognition at the annual RNAO ceremony in **May 2026**
- A fourth BPG — **Transitions in Care** — will be added in late 2026/early 20

Quality Improvement Committees

Interdisciplinary QI meetings are held regularly across all clinical program areas:

- Skin & Wound Care
- Fall Prevention and Management
- Continence Care and Bowel Management Program
- Pain Management
- Restraints Minimizations
- Responsive Behaviours
- Infection Prevention and Control (IPAC)

2025/26 Quality Improvement Project: Reducing Avoidable ED Visits

Overview

Objective: Reduce the overall annual percentage of avoidable emergency department (ED) visits for residents presenting with symptoms of delirium.

Target: 5% reduction in avoidable ED visits compared to 2024/25.

External Collaborators: Nurse-Led Outreach Team (NLOT), Behavioural Supports Ontario (BSO)

Strategies Implemented

1. NP Utilization – Standardized Referral Algorithm

- Developed a nursing referral algorithm directing staff to involve the Nurse Practitioner (NP) before any delirium-related ER transfer
- Trained all registered nursing staff on the algorithm; posted in medication rooms and RN offices
- Target: 100% of nurses contact NP prior to transfer (during NP hours)
- Monthly interdisciplinary team meetings to review all ER transfers and appropriateness

2. Early Delirium Screening and Intervention

- Targeted training for nursing staff on warning signs and early intervention techniques
- Structured resident rounding every two hours to proactively identify changes
- Unit shift reports and huddles updated to include early baseline-change prompts

3. Best Practice Tool Investigation

- Reviewed tools including PreviewED and CAM (Confusion Assessment Method)
- Feasibility assessment completed by end of Q2

Quarterly Results

Quarter	Delirium-Related Cases	Managed On-Site	ED Transfers	Avoidance Rate
Q1 (Apr–Jun 2025)	32	24	8 (25%)	75%
Q2 (Jul–Sep 2025)	7	6	1 (14.3%)	85.7%
Q3 (Oct–Dec 2025)	6	4	2 (33%)	67%
Q4 (Jan–Mar 2026)	7	1	6	14% (challenged by complexity)

Key Findings

- **Q1–Q2 saw exceptional results** — 75–86% avoidance rates — driven by early adoption of the referral algorithm and enhanced staff education
- Q3 performance remained strong at 67%, sustained through ongoing rounding and huddle protocols
- **Q4 was impacted** by family-driven transfer decisions, rapid clinical deterioration, and repeat hospital presentations — not reflective of protocol failures
- Bowel/bladder management, infection protocols, and psychiatric monitoring were consistently identified as key delirium triggers
- A catheterization education program through NLOT was initiated in Q4 for future risk reduction

Clinical Quality Programs

Skin & Wound Care Program

Objective: Improve skin integrity and reduce pressure injuries across 2025/26.

Key Interventions

- Dedicated skin care champion RPN (one day/week) added to support direct wound care and education
- Skin and wound line listings brought to daily huddles for faster identification and response
- Wound assessment app upgraded to ChartPic — offline documentation, multi-wound tracking, expanded menus
- Two dedicated wound care iPads for real-time documentation integrated with Point Click Care
- New “Alerts” in point-of-care documentation for early flagging of new skin conditions
- HIN wound care products utilized for complex cases; dietary interventions and individualized positioning schedules
- Hands-on staff training using an artificial skin model

Outcomes by Quarter

Quarter	Total Prevalence	Internally Acquired
Q1 (Apr–Jun 2025)	6.25%	3.12%
Q2 (Jul–Sep 2025)	4.68%	3.12%
Q3 (Oct–Dec 2025)	10.9%	7.8%
Q4 (Jan–Mar 2026)	10.9%	4.68%

Notable Q3 increase is attributed to seasonal factors (residents remaining indoors), increased resident complexity, and more thorough tracking (including Stage 1 injuries). Q4 improvement in internally acquired injuries reflects intervention effectiveness.

A key success: one resident’s potential amputation was avoided through early interdisciplinary collaboration and timely referral.

Fall Prevention and Management Program

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

Key Interventions

- Fall mats installed in resident rooms; at-risk beds maintained at lowest position
- Advanced beds (2023) with integrated night lights, accessible call bells, and embedded alarms
- Pre- and post-fall assessments with documented fall huddles within 24 hours
- Monthly interdisciplinary fall review meetings
- Targeted identification of fall "hotspots" for environmental adjustments

Fall Prevalence by Quarter

Quarter	Fall Prevalence Rate
Q1 (Apr–Jun 2025)	14.1%
Q2 (Jul–Sep 2025)	34.0%
Q3 (Oct–Dec 2025)	29.6%
Q4 (Jan–Mar 2026)	29.6%

Q2 spike linked to unassisted self-transfers, medication adjustments, and increased agitation. Q3/Q4 stabilization reflects impact of enhanced environmental supports, call bell access, and consistent post-fall huddles.

Planned Actions

- Physiotherapy referrals for residents with unassisted self-transfer history
- Individualized transfer strategies and strengthening programs embedded in care plans
- Achieve ≥95% compliance with care plan updates within 24–48 hours post-fall
- Audit compliance with huddle-identified interventions at monthly fall meetings

Continence Care & Bowel Management Program

Objective: Prevent worsening incontinence and constipation, maintain toileting schedules, reduce UTIs, and identify residents showing improvement.

Key Interventions

- Individualized toileting schedules for residents requiring assistance
- Formal resident rounding program to ensure comfort and continence
- Individual resident supply bins tailored to each resident's needs
- Hydration monitoring and peri-care hygiene collaboration
- Quarterly interdisciplinary review of continence status for every resident

Continence Outcomes by Quarter

Indicator	Q2 (Jul–Sep)	Q3 (Oct–Dec)	Q4 (Jan–Mar)
Improved Bladder Continence	7.8%	7.8%	4.7%
Declined Bladder Continence	7.8%	12.5%	12.5%
Improved Bowel Continence	12.5%	11.0%	7.8%
Declined Bowel Continence	9.3%	7.8%	17.0%

Q1 excluded due to incomplete data during RAI transition. Q4 decline in both bladder and bowel continence signals a need for targeted intervention. A bowel continence quality improvement plan is planned for 2026/27.

Pain Management Program

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

Key Interventions

- Quarterly interdisciplinary pain management reviews
- Medication auditing: scheduled and PRN usage reviewed and optimized
- Non-pharmacological approaches: physiotherapy, restorative nursing, targeted physical therapy
- Structured tools and clinical judgment applied for non-verbal/behavioural pain indicators

Pain Prevalence by Quarter

Quarter	Pain Prevalence	Note
Q1 (Apr–Jun 2025)	N/A	RAI transition / PCC technical issues
Q2 (Jul–Sep 2025)	12.5%	Baseline
Q3 (Oct–Dec 2025)	20.3%	Likely reflects improved identification
Q4 (Jan–Mar 2026)	17.2%	Reduction following targeted management

Q4 improvement is encouraging, though pain remains an ongoing clinical concern in this population. Continued interdisciplinary review and non-verbal pain assessment are essential.

Restraint Minimization Program

Objective: Promote the least restrictive environment possible, as a last resort, enhancing resident safety and quality of life.

Key Interventions

- Resident and family education on least restraint philosophy during admission and annual care conferences
- Personalized Assisted Safety Devices (PASDs) and wander guards used as restraint alternatives
- Rigorous restraint assessments ensuring use only when clinically justified
- Cross-referencing restraint use with fall data to maintain a balanced safety approach

Restraint Use by Quarter

Quarter	Residents with occurrence of Physical Restraints
Q1 (Apr–Jun 2025)	4.7%
Q2 (Jul–Sep 2025)	1.5%
Q3 (Oct–Dec 2025)	1.5%
Q4 (Jan–Mar 2026)	1.5%

Key Result

- Restraint use reduced from 4.7% to 1.5% — and sustained at 1.5% for three consecutive quarters.
- This reflects a meaningful and sustainable culture shift toward restraint minimization across the interdisciplinary team.

Responsive Behaviours Program

Objective: Support residents with responsive behaviours, reduce incidence, and build team capacity using person-centered, non-pharmacological strategies.

Context for 2025/26 Increase

ROP experienced a significant increase in responsive behaviours this year, driven by several converging factors:

- Residents developed severe psychosis.
- Overall decline in physical and mental health among some existing residents
- Multiple new admissions with complex mental health diagnoses and high behavioural support needs

Interventions Implemented

- 25 behavioural referrals received; 15 individual behavioural mapping tracking sheets completed using BSO-DOS
- 17 Code White responses and 13 Constant Therapeutic Engagement (1:1) placements to address acute safety needs
- 1 resident referred to Geriatric Psychiatry; 1 to acute care psychiatry services
- 10 residents discharged from behavioural support upon demonstrating stability
- BSO education delivered: 8 BSO-DOS sessions, 1 full-day GPA training, 2 responsive behaviour sessions, 5 Leisure Education sessions, bi-weekly meetings
- Person-centered strategies: individualized routines, one-on-one companion time, preference-based programming

Behavioural Recording — Year in Review

Month	2nd Floor	3rd Floor	Combined Total
April 2025	76	71	147
May 2025	63	62	125
June 2025	74	57	131
July 2025	70	54	124
August 2025	75	32	107
September 2025	60	35	95
October 2025	73	39	112
November 2025	101	64	165
December 2025	62	44	106
January 2026	75	57	132
February 2026	63	43	106
March 2026	83	69	152
TOTAL	875	627	1,502

Year-Over-Year Comparison

Floor	2024/25	2025/26	Year-Over-Year Change
Second Floor	792	875	+10.5% increase
Third Floor	403	627	+55.6% increase
BOTH FLOORS	1,195	1,502	+25.7% overall increase

2026 Quality Improvement Plans for BSO

- **GPA Training for All Staff:** Mandatory Gentle Persuasive Approaches training to build non-pharmacological behaviour management skills across the entire team
- **Increased BSO Presence:** Regular on-unit observations during hygiene care, showers, medications, mealtimes, and recreational programming to support consistent intervention implementation
- **BSO Binder Education:** In-depth review of BSO binder contents to reinforce knowledge and compliance with behaviour management expectations

Infection Prevention & Control (IPAC)

Objective: Maintain leadership in IPAC and ensure full compliance with all MOLTC and Ottawa Public Health (OPH) requirements.

2025/26 Outcomes & Highlights

IPAC Area	Outcome
Outbreaks	1 influenza outbreak (Mar 6–20, 2025 — 3rd floor only); 1 COVID-19 outbreak (Apr 3–18, 2025 — 2nd floor only). Both resolved quickly.
Regulatory Compliance	Full compliance maintained. Prompt PHU notification on all reportable diseases. No concerns identified.
Hand Hygiene Compliance	97–100% (Q1); declined to 54% Moment 1 in November; recovered to 91–95% by Feb–Mar 2026
Masking Strategy	Universal masking reinstated fall 2025; transitioned out March 26, 2026
COVID Vaccination – Residents	84% vaccinated (54/64 eligible); 10 refusals
Influenza Vaccination – Residents	47 vaccinated; 15 declined; 2 vaccinated externally
Staff Education	74 staff attended IPAC education sessions + annual mandatory training completed
Mock Outbreak Drill	Influenza mock outbreak conducted — 24 staff participated
Infrastructure	Additional IPAC supplies acquired; dedicated vital sign kits for isolation carts

The IPAC Committee met quarterly to review hand hygiene compliance, disease surveillance, medical device reprocessing, and cross-departmental IPAC practices. ROP continues to work closely with the ROHCG IPAC department for consistent implementation of best practices.

Resident & Family Collaboration

Resident Councils

- Two active resident councils (one per floor) meeting every two months
- Both councils opted for a co-leader model; staff assistant supports agenda and minutes
- Resident councils invite staff to each meeting to enable direct collaboration

The 2025 Annual Resident Satisfaction Survey was completed by the Recreation Therapy Assistant to support relationship-building with residents. Survey completion rate was significantly lower than previous years due to communication challenges and winter timing. Both resident and family councils agreed the results did not reflect the home's true quality, and a repeat survey will be conducted by June 30, 2026.

- Survey will include all residents with a CPS score of 1–3
- For residents with a CPS score of 4–6, the survey will be sent to their Power of Attorney (POA)

Family Council

- Quarterly meetings held via Microsoft Teams (transitioned from Zoom following Outlook migration)
- Virtual format has significantly increased participation, including members joining from internationally
- 2025/26 New Family Council President: recognized for his inclusive leadership in strengthening family-home communication

Education & Training

Staff Training 2025/26

In addition to mandatory annual training modules, MLTC Professional Growth Funding was utilized to deliver:

- Wound Care Canada programs – RPN trained
- Skin and wound training for PCA and registered staff
- CPR training
- Restorative Care training
- Expanded new employee orientation (additional training days)
- Registered staff mental health and physical exam training day
- NCI (Non-Crisis Intervention) training for all staff
- InterRAI education for PCA, registered nursing staff, and allied staff (dietary, recreation, physio)

Student Placement Program

Lead: Brooke Meredith, Clinical Support Supervisor

ROP re-enrolled in the LTC Prep Program and continued participation in the Next Phase PSW Investment Program through Ontario Health. In 2025/26:

- **39 PCA students** welcomed for consolidation placements
- **8 RPN students** welcomed for Level 1 and Level 2 clinical placements
- The Clinical Support Supervisor provided mentorship, operational support, and program oversight

Quality Projects Completed 2025/26

Infrastructure & Accessibility

- **Courtyard Door:** Completed to enhance resident access to outdoor space
- **Sidewalk Entrance Accessibility:** Completed to improve wheelchair access to the facility

Looking Ahead: 2026/27 Priorities

- Implement bowel continence as a dedicated Quality Improvement project.
- Add RNAO BPG — Transitions in Care — as the fourth Best Practice Guideline.
- Expand GPA training to all staff.
- Redo 2025/26 resident satisfaction survey (by June 30, 2026).
- Continue provincial advocacy for a formal Mental Health Designation.
- Sustain and expand catheterization education program through NLOT.