QIP Narrative – Georgian Manor

May 2024

Overview

The County of Simcoe's Health and Emergency Services Division is committed to providing high quality, resident centered care and services that improve every resident's quality of life. It is our vision to work consistently within our Long-Term Care and Seniors Services (LTCSS) sites to create standards that ensure safe care and enhance the resident's quality of life.

Throughout all our quality improvement initiatives we strive to engage and collaborate with staff, residents, and their families to continuously improve our services while showing respect, dignity, and compassion in all that we do. Our ongoing commitment to quality is reflected in our mission "to provide effective, high quality, safe and efficient long-term care services in a home-like setting for the clients and families that we serve". The County of Simcoe's LTCSS quality improvement goals are aligned with the County of Simcoe's vision, mission, core values and strategic direction; as well as with the Long-Term Care and Seniors Services mission and core values, and demonstrate that we are committed to providing safe, high-quality resident centered care and services.

Georgian Manor's Quality Improvement Plan demonstrates our commitment to improve quality and outlines strategies for ensuring patient safety, delivering optimal care, and achieving high resident satisfaction. Our Quality Improvement Plan (QIP) for 2024-25 focuses on our objectives to provide high quality resident care and services that are safe, effective, and resident centered. It aligns with the provincial publicly reported priority issues and associated indicators for the long-term care sector identified by Ontario Health, Ministry of Health, and Ministry of Long-Term Care with input from partners as key determinants of resident safety and supporting the quality of care in Ontario. It serves as our roadmap and identifies opportunities to implement changes in practice to achieve better outcomes and meet resident expectations. Our QIP supports our strategic directions to achieve excellence, enable growth and build successful relationships with key stakeholders. It is aligned with our Long-Term Care Service Accountability Agreement (SAA), our balanced scorecard goals and with our accreditation body's required practices, standards, and recommendations.

The QIPs for 2024/25 will focus primarily on the following four (4) priority issues identified and will be used to measure the performance of the LTC Home:

1. **Access and flow**
   - Rate of potentially avoidable ED visits for long-term care residents *(number of resident ED visits is measured and tracked on our balanced scorecard)*
2. **Equity**
   - % of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and antiracism education *(staff education is measured and tracked through our education system)*
3. **Experience**
   - Do residents feel they can speak up without fear of consequences? / Do residents feel they have a voice and are listened to by staff? *(resident satisfaction is measured and tracked through our satisfaction surveys)*

4. **Safety**
   - % of long-term care residents not living with psychosis who were given antipsychotic medication *(Antipsychotics – number of antipsychotics prescribed in the absence of the associated diagnosis is measured and tracked on our balanced scorecard)*
   - % of long-term care residents who fell in the last 30 days *(total number of falls is measured and tracked on our balanced scorecard)*

The County of Simcoe's Quality Improvement Plan demonstrates our commitment to improve quality and outlines strategies for ensuring patient safety, delivering optimal care, and achieving high resident satisfaction. Our quality improvement efforts include the following:

1. To reduce falls.
2. To reduce the worsening of pressure ulcers.
3. To receive and utilize feedback regarding resident experience and quality of life
4. Early identification of Palliative Care needs through comprehensive and holistic assessment
5. To reduce worsening symptoms of depression
6. To reduce residents with pain
7. To reduce use of antipsychotics in the absence of psychosis

The Quality improvement metrics from our balanced scorecard include the following measurements to improve patient, resident, and family experience outcomes through inter-professional, high-quality care:

- Falls – Total number of falls
- Wounds – Number of Residents who had a pressure ulcer
- Resident satisfaction surveys – Overall, I am satisfied with the care and services provided in Home
- ED Visits – Number of Resident ED visits
- Depression – Residents with depression and worsening depression
- Pain – Residents in pain and with worsening pain
- Antipsychotics – Number of antipsychotics prescribed in the absence of the associated diagnosis

Our quality improvement success included enhancing the tracking of the balanced scorecard which has been in place since 2021 and continues to be improved on a regular basis to achieve improvements in the quality of care to our residents.

Access and Flow

Access and flow of care in the right place at the right time is assessed through optimizing system capacity and timely access to care to improve the outcomes and experience of the care we provide for our residents. Our improvements to access and flow include continuing to work in partnership across care sectors on initiatives to avoid unnecessary hospitalizations and avoid visits to emergency departments through new models of care and by ensuring timely access to primary care providers. The quality improvement metric we are using to measure this priority

issue is rate of potentially avoidable ED visits for long-term care residents. The number of resident ED visits is measured and tracked on our balanced scorecard and reviewed monthly with our nursing and leadership teams.

The improvements we are working on to support resident access to care in the right place at the right time include educating LTC staff, residents, and families about the benefits of and approaches to preventing emergency department visits. We are also working on enhancing palliative care supports within the long-term care home with monthly palliative care meetings. We are also accessing and maximizing virtual and electronic solutions and working across the sector with digital health and project Amplify.

Equity and Indigenous Health

Ontario Health is committed to improved and equitable outcomes to reduce health inequities across the province, aligned with this priority our LTC Home has included planning and training for Equity, Inclusion, Diversity, and Antiracism for our staff. This year we are going to continue tracking resident satisfaction to evaluate health equity. In support of providing health equity and advancing awareness, mandatory equity training with Canadian Centre for Diversity and Inclusion (CCDI) on gender diversity was provided to all managers (#ITSTARTS with Diversity Ambassador Training). The opportunity for staff to take part in this training was also offered. The training sessions provide an overview and opportunity to raise awareness about multiculturalism and reducing racism and discrimination in our communities.

The quality improvement metric we are using to measure this priority issue is the percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and antiracism education. Staff education is measured and tracked through Human Resources.

The quality improvement initiatives we are working on that are driving equity and Indigenous health and Indigenous cultural safety initiatives include the Simcoe County Local Immigration Partnership in advancing diversity awareness in Simcoe County and providing Diversity Ambassador training sessions to gain valuable tools to lead the way in promoting inclusivity in the workplace and our communities.

Patient/Client/Resident Experience

In the past year we have experienced an increase in partnering and relations with residents. As a result of the pandemic one of the challenges we experienced was limited visiting. This challenge made us more aware of maintaining contact and we were able to do that through virtual methods. Our organization is acutely aware of social isolation and want to ensure that our residents do not feel socially isolated. As a result, we now have a better way of tracking family involvement and their connection to enhance the resident experience and to better track connection with the residents. An example is the Activity Pro Family Portal. We also became more aware of resident needs during this pandemic as families were not able to be as present physically. The ability to react appropriately was achieved through the home team taking a more active approach. We became more in tune with the resident's psychosocial needs during this

time. The improvements we are working on for patient/client/resident experience include the introduction of our social work program and year two of our expansion to program and support services department.

The quality improvement metrics we are using to measure the experience priority include the following questions: Do residents feel they can speak up without fear of consequences? Do residents feel they have a voice and are listened to by staff? Resident satisfaction is measured and tracked through our annual satisfaction surveys and the action plan from survey results.

Our quality improvement work will continue to focus on providing safe, high-quality resident centered care and services and include our learnings throughout the COVID-19 pandemic. Experience information from surveys, family and resident council committees or other feedback received about care experiences and quality of life will be incorporated into improvement activities through an action plan. Our annual satisfaction surveys for 2023 started on June 6th, 2023 and ended on August 18th 2023.

Summary of 2023 Satisfaction Survey Results – Georgian Manor: In 2023, detailed satisfaction surveys with residents and their families at Georgian Manor revealed high overall satisfaction, with 91% of residents and 94% of family members expressing contentment with the care and services provided. Outstanding findings included a 98% satisfaction rate for the cleanliness of public areas, and 96% satisfaction with the helpfulness of activity and program staff. Additionally, 96% of caregivers felt they were treated with courtesy and respect, and 92% of residents would recommend the home to others, reflecting strong general approval.

Areas for improvement were identified with staff responsiveness and the ability for residents and families to express their opinions. These areas were included in the QIP plan as 83% of residents felt staff listened to them, and 84% of families felt involved in care decisions, which are slightly lower compared to other satisfaction metrics. Feedback indicated occasional lapses in communication and attentiveness from staff, particularly during less supervised hours, and a need for more consistent engagement to ensure residents and families feel their opinions are valued.

Satisfaction Survey Action items: Previous surveys highlighted improvement areas of focus with continence care, residents being listened to by staff, residents can express their opinion without fear of consequences, and laundry services.

- In response to improvement opportunities to continence care staff completed education along with providing a toolkit (with or without catheterization) and reviewed algorithm of UTIs with staff to ensure appropriate identification of UTI and antibiotic stewardship. Reviews of individual toileting plans for residents that are high risk for falls was also completed, along with education on process for specimen collection.
- In response to improvement opportunities to foot care a new advanced foot care service was provided in our Long Term Care and Seniors Services in April 2023. In consultation with the Simcoe Muskoka District Health Unit following comprehensive review of our foot care practices, the decision to move forward with a new process aligned with the recent

changes implemented by Ontario Health to ensure compliance with the current Public Health recommendations on foot care services, and allow us to provide the highest standard of care for our residents.

- In an effort to ensure residents are being listened to by staff and that they can express their opinion without fear of consequences, staff were and continue to be provided with education in this regard including:
    - Gentle Persuasive Approaches (GPA) training is provided to staff to equip care providers with the knowledge, skills, and confidence to deliver person-centred dementia care. The number of staff who completed this training is 20.
    - Annual education for all staff is provided throughout the year that includes customer service, staff accountability, and communication modules. These modules give staff tools and methods following the Person Centred Care approach to ensure individual preferences and interests are included in their care plan, activities of daily living and recreation, as well as the practice of using 'person centred language'.
- In response to improvements to laundry services, the Laundry department has undergone a fulsome review and laundry hours have been realigned to better serve residents needs. In addition, a full revision of standard work processes used by laundry staff was completed to enable work to be conducted efficiently following best practice and reducing ergonomic strain. We are currently in the process of implementing the new laundry model that includes shift time changes and enhanced standard work.

The survey results were posted on the quality board and a detailed report, with both qualitative and quantitative results shared on November 21st, 2023, and all supervisors were provided with details to review with their staff. The survey results were presented on a high level with the QIP workplan at Family Council March 15th 2024 and at Residents Council on March 27th 2024. At these meetings, both Residents and Families were asked for possible improvements to the surveys with no suggestions or feedback provided by residents or families. The full presentation of survey results and action items was scheduled to occur during the Home Quality & Resident Safety Meeting and was postponed to June 7th 2024 due to a lack of participation from families and residents caused by an outbreak in the LTC Home.

Action Items from Surveys are blended into the Annual Priorities and Objectives that are tracked using our Project Scorecard. The Project Scorecard is available on Sharepoint enabling transparency as all staff can review priorities and objectives and their associated workplan items. Any key performance indicators are tracked and measured are included within our Balanced Scorecard and presented monthly to all levels of leadership, as well as quarterly at the Quality and Safety Committee.

For further details, see the reports on the website: https://simcoe.ca/ltc/homes/georgian/

Provider Experience

As a result of burnout and decreased staffing levels, our organization's Recruitment and Retention Committee is working to build schedules that meet staff needs and make

improvements to the County of Simcoe environment to make it a safe and desirable place to work. In addition, frontline staff are presented with information and included in discussions to identify opportunities for improvement.

The County of Simcoe is committed to working with its employees to promote a violence-free workplace that provides a safe work environment and takes all reasonable and practical measures to prevent violence and protect employees from acts of violence. Training is a critical part of the violence prevention policy/program. Providing appropriate training informs employees that The County of Simcoe will take threats seriously, encourages employees to report incidents and demonstrates the Corporation's commitment to deal with reported violent incidents and/or potential risks of violence. The County of Simcoe takes reasonable preventative measures to protect employees and others in County workplaces from workplace violence and ensure that workplace violence risk assessments are completed, reported, and communicated. Addressing violence and incivility in our organization, creates safer environments for our staff and improves our patient care.

The improvements we are working on for provider experience include Park Lane first aid reporting and dashboard available for incidents, the occupational health and safety nurse and corporate wellness committee.

Safety

The mission of the LTC home is to provide effective, high quality, safe and efficient long-term care services in a home-like setting for the clients and families that we serve. Resident Care Conferences are held to ensure resident safety. The care team reviews each resident's individual care requirements within six (6) weeks of admission, on an annual basis and as needed to evaluate care and programming. Residents and/or their Power of Attorney (POA) are invited to participate in this process to discuss any problems or concerns they have and review the care plan. Families are invited to attend at the discretion and consent of the competent resident. The object is to provide optimal quality of life for each resident. Additional meetings are regularly held to ensure resident safety, which include the Joint Health and Safety committee (with front line staff, maintenance, program health and safety supervisor) and Home Quality and Resident Safety meetings (with management, staff, residents, and families).

The quality improvement metrics we are using to measure this priority issue are the percentage of long-term care residents not living with psychosis who were given antipsychotic medication. The number of antipsychotics prescribed in the absence of the associated diagnosis is measured and tracked on our balanced scorecard. The second metric we are using to measure this priority issue is the percentage of long-term care residents who fell in the last 30 days. The total number of falls is measured and tracked on our balanced scorecard.

Population Health Approach

Population health-based approaches involve a focus to include taking the initiative in meeting the needs of an entire population. This includes providing proactive services to promote health,

prevent disease, and help our residents live well with their conditions in every interaction with the health system.

The initiatives we are working on to support population health-based approaches for our residents include offering Respiratory Syncytial Virus (RSV) vaccinations and investing in diagnostic equipment. In addition, partnering with Ontario Telemedicine Network (OTN), Behaviour Supports Ontario (BSO) and the Alzheimer's society for use as a source of information and training. We are also working as a coordinated team with Ontario Health Teams (OHT) to provide a new way of organizing and delivering care that is more connected to patients in their local communities (South Georgian Bay, Barrie, and Area, and Couchiching).

Contact Information

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QIP Narrative – Georgian Manor

May 2024

Designated Lead

LTC Home	**Georgian Manor**
Administrator	Debbie Arbour
Project Coordinator	Shanique Barrett
Decision Support Coordinator	Olga Belanovskaya

Abbreviations

Abbreviation	Description
BSO	Behaviour Supports Ontario
CCDI	Canadian Centre for Diversity and Inclusion
ED	Emergency Department
LTC	Long Term Care
LTCSS	Long Term Care and Seniors Services
OHT	Ontario Health Teams
OTN	Ontario Telemedicine Network
PCC	Point Click Care
POA	Power of Attorney
QIP	Quality Improvement Plan
RSV	Respiratory Syncytial Virus
SAA	Service Accountability Agreement

Sign-off

I have reviewed and approved our organization's Quality Improvement Plan (QIP):

Basil Clarke	Warden COS	
Jonathan Magill	County Clerk	
Jane Sinclair	General Manager Health & Emergency Services	
Debbie Arbour	Administrator Georgian Manor	

2024/25 Quality Improvement Plan for Ontario Long Term Care Homes
"Improvement Targets and Initiatives"

Georgian Manor Home For The Aged 101 THOMPSONS ROAD, Penetanguishene , ON, L9M0V3

M = Mandatory (all cells must be completed) P = Priority (complete ONLY the comments cell if you are not working on this indicator) O= Optional (do not select if you are not working on this indicator) C = Custom (add any other indicators you are working on)

AIM		Measure									Change				
Issue	Quality dimension	Measure/Indicator	Type	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	External Collaborators	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments (Staff Members Responsible for Action Plan)
Access and Flow	Efficient	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 / October 1st 2022 to September 30th 2023 (Q3 to the end of the following Q2)	51859*	26.2	23.58	To decrease the # of ED visits by 10%		Continue to track monthly to evaluate trends	Balanced scorecard	Monthly balanced scorecard and quality reports	# of hospitalizations	**Planned Improvement Initiative - Responsible Lead:** Director of Resident Care - Sherri Lotton, Christina Bath Decision Support Coordinator - Olga Belanovskaya Administrator - Debbie Arbour Quality Lead - Shanique Barrett **Meetings:** The QIP planned improvement initiative for this metric is reviewed at the Home Quality & Resident Safety meetings, Resident Council, Family Council, Required Program meetings, Nursing Steering Committee meetings, and Leadership meetings.
											Educate LTC staff, residents and families about the benefits of and approaches to preventing emergency department visits	Emergency Department Visit Toolkit for Long-term Care Facilities	Staff, residents, family education counts	% of staff, residents, family trained	**Planned Improvement Initiative - Responsible Lead:** Director of Resident Care - Sherri Lotton, Christina Bath Administrator - Debbie Arbour Quality Lead - Shanique Barrett **Meetings:** The QIP planned improvement initiative for this metric is reviewed at the Home Quality & Resident Safety meetings, Resident Council, Family Council, Required Program meetings, and Nursing Steering Committee meetings.
											Enhance palliative care supports within the long-term care home	Palliative Care Required Program Evaluation	Monthly Palliative Care Meetings	# of palliative care residents	**Planned Improvement Initiative - Responsible Lead:** Director of Resident Care - Sherri Lotton, Christina Bath Administrator - Debbie Arbour Quality Lead - Shanique Barrett **Meetings:** The QIP planned improvement initiative for this metric is reviewed at the Home Quality & Resident Safety meetings, Resident Council, Family Council, Required Program meetings, Palliative Care meetings and Nursing Steering Committee meetings.
Equity	Equitable	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	51859*	48%	50%	To increase the # of staff completing relevant equity, diversity, inclusion, and anti-racism education		Ensuring education for all staff	Canadian Centre for Diversity and Inclusion (CCDI)	Staff education counts	% of staff trained	**Planned Improvement Initiative - Responsible Lead:** Human Resources - Karen Upshaw Quality Lead - Shanique Barrett **Meetings:** The QIP planned improvement initiative for this metric is reviewed at the Home Quality & Resident Safety meetings, Resident Council, and Family Council.
Experience	Patient-centred	Percentage of residents responding positively to: "What number would you use to rate how well the staff listen to you?"	O	% / LTC home residents	In house data, NHCAHPS survey / Most recent consecutive 12-month period	51859*	83%	85%	Based on previous survey question baseline data we are aiming to maintain 83% or greater performance of overall satisfaction		Continue best practice and evaluation of satisfaction survey results	2023 Annual satisfaction survey (start date: June 6, 2023 / End date: August 18, 2023)	Annual satisfaction survey; How you were treated (staff listen to me), Personal needs and other services, Overall I am satisfied with the care and services provided at the home	% of residents responding to survey question	**Planned Improvement Initiative - Responsible Lead:** Decision Support Coordinator - Olga Belanovskaya Administrator - Debbie Arbour Quality Lead - Shanique Barrett **Meetings:** The QIP planned improvement initiative for this metric is reviewed at the Home Quality & Resident Safety meetings, Resident Council, and Family Council, and Leadership meetings.
											Learn about and practice active listening towards residents	Active Listening education and resources	Staff education counts	% of staff trained	**Planned Improvement Initiative - Responsible Lead:** Decision Support Coordinator - Olga Belanovskaya Administrator - Debbie Arbour Quality Lead - Shanique Barrett **Meetings:** The QIP planned improvement initiative for this metric is reviewed at the Home Quality & Resident Safety meetings, Resident Council, and Family Council, and Leadership meetings.
		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	51859*	93%	95%	Based on previous survey question baseline data we are aiming to maintain 93% or greater performance of overall satisfaction		Continue best practice and evaluation of satisfaction survey results	2023 Annual satisfaction survey (start date: June 6, 2023 / End date: August 18, 2023)	Annual satisfaction survey; How you were treated (I feel safe and secure), Personal needs and other services, Overall I am satisfied with the care and services provided at the home	% of residents responding to survey question	**Planned Improvement Initiative - Responsible Lead:** Decision Support Coordinator - Olga Belanovskaya Administrator - Debbie Arbour Quality Lead - Shanique Barrett **Meetings:** The QIP planned improvement initiative for this metric is reviewed at the Home Quality & Resident Safety meetings, Resident Council, and Family Council, and Leadership meetings.
											Support residents' councils and work with them to make improvements in the home	2023 Annual satisfaction survey (start date: June 6, 2023 / End date: August 18, 2023)	Family and Residents Council	# of improvements	**Planned Improvement Initiative - Responsible Lead:** Decision Support Coordinator - Olga Belanovskaya Administrator - Debbie Arbour Quality Lead - Shanique Barrett **Meetings:** The QIP planned improvement initiative for this metric is reviewed at the Home Quality & Resident Safety meetings, Resident Council, and Family Council, and Leadership meetings.
Safety	Safe	Percentage of LTC home residents who fell in the 30 days leading up to their assessment	O	% / LTC home residents	CIHI CCRS / July 2023–September 2023 (Q2 2023/24), with rolling 4-quarter average	51859*	12.55	11.92	To decrease the # of falls by 5%		Auditing plan for fall prevention strategies matching care plan and environment	Falls Management Required Program Evaluation	Creation of plan and audit tool	# of audits	**Planned Improvement Initiative - Responsible Lead:** Director of Resident Care - Sherri Lotton, Christina Bath Administrator - Debbie Arbour Quality Lead - Shanique Barrett **Meetings:** The QIP planned improvement initiative for this metric is reviewed at the Home Quality & Resident Safety meetings, Required Program meetings, and Nursing Steering Committee meetings.

											Ensuring education for all staff on lift and training policy	Falls Management Required Program Evaluation	Staff education counts	% of staff trained	**Planned Improvement Initiative - Responsible Lead:** Director of Resident Care - Sherri Lotton, Christina Bath Administrator - Debbie Arbour Quality Lead - Shanique Barrett **Meetings:** The QIP planned improvement initiative for this metric is reviewed at the Home Quality & Resident Safety meetings, Required Program meetings, and Nursing Steering Committee meetings.
											Bed entrapment audits	Falls Management Required Program Evaluation	Entrapment audit results	# of audits	**Planned Improvement Initiative - Responsible Lead:** Director of Resident Care - Sherri Lotton, Christina Bath Administrator - Debbie Arbour Quality Lead - Shanique Barrett **Meetings:** The QIP planned improvement initiative for this metric is reviewed at the Home Quality & Resident Safety meetings, Required Program meetings, and Nursing Steering Committee meetings.
											Post fall assessment evaluation (evidence based) and process standardization (post fall huddles)	Falls Management Required Program Evaluation	Post fall assessment tool	# of post fall assessments # of post fall huddles	**Planned Improvement Initiative - Responsible Lead:** Director of Resident Care - Sherri Lotton, Christina Bath Administrator - Debbie Arbour Quality Lead - Shanique Barrett **Meetings:** The QIP planned improvement initiative for this metric is reviewed at the Home Quality & Resident Safety meetings, Required Program meetings, and Nursing Steering Committee meetings.
		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 2023–September 2023 (Q2 2023/24), with rolling 4-quarter average	51859*	22.43	20.19	To decrease the # of residents using antipsychotics with the absence of psychosis by 10%		Continued evaluation to ensure best practice is followed and continued resident assessments to ensure antipsychotics are prescribed appropriately	Balanced scorecard	Monthly balanced scorecard and quality reports, PCC	# of antipsychotics prescribed in the absence of the associated diagnosis	**Planned Improvement Initiative - Responsible Lead:** Director of Resident Care - Sherri Lotton, Christina Bath Decision Support Coordinator - Olga Belanovskaya Administrator - Debbie Arbour Quality Lead - Shanique Barrett **Meetings:** The QIP planned improvement initiative for this metric is reviewed at the Home Quality & Resident Safety meetings, Resident Council, Family Council, Required Program meetings, Nursing Steering Committee meetings, and Leadership meetings.
											Review the quality standard Behavioural Symptoms of Dementia	Ontario Health Quality Standards (behavioural symptoms of dementia)	Review and gap analysis	# of antipsychotics prescribed in the absence of the associated diagnosis	**Planned Improvement Initiative - Responsible Lead:** Director of Resident Care - Sherri Lotton, Christina Bath Administrator - Debbie Arbour Quality Lead - Shanique Barrett **Meetings:** The QIP planned improvement initiative for this metric is reviewed at the Home Quality & Resident Safety meetings, Required Program meetings, and Nursing Steering Committee meetings.