Trillium Health Partners
Better Together

A STRUCTURED QUALITY REVIEW OF RESIDENT CARE: CAMILLA CARE COMMUNITY December 15, 2020

1.0 PURPOSE OF THIS REPORT & WHAT IS INCLUDED

This Structured Quality Review ("the Review") was completed by Trillium Health Partners (THP) in cooperation with Sienna Senior Living ("Sienna"). It was carried out as a result of a high incidence of concerns related to abuse, neglect, incompetent care and resulting investigations at Camilla Care Community ("Camilla") identified over the course of the COVID-19 pandemic THP's role as temporary manager.

The purpose of this Review was to systematically check the quality of care received by each resident at Camilla between December 1, 2019 and May 31, 2020 (before THP began to temporarily manage the Home) in order to:

- Identify quality issues and/or discrepancies against recognized standards;
- Identify the causes or key contributors to these issues where possible; and
- Provide recommendations for continued corrective actions/plans to help ensure any issues are corrected and prevented.

The Review was conducted by an External Review Team that included a lead external reviewer as well as physicians and nurses from outside of Sienna. The External Review Team consisted of individuals who had experience in LTC and/or in completing medical/health care reviews. The external review team reported to THP, however a Working Group made up of senior leaders from LTC homes in the Region of Peel, Sienna, and THP was formed to provide input on the Review approach and to monitor progress.

This report summarizes the key findings from the 205 resident health records included in the Review and key witness interviews. Based on the findings, THP has made recommendations for improving the quality of care and safety of residents.

2.0 BACKGROUND

There are 626 Long-Term Care Homes (LTCHs) in Ontario that care for the frailest seniors in the province. To ensure that all homes operate effectively, efficiently, and safely, the government has set the minimum standards within the *Long-Term Care Homes Act, 2007* (*LTCHA*) and associated *Regulation 79/10*. These standards include home administration and operations; resident rights; care and services.

Camilla opened in 1970 and is owned and operated by a private, for-profit company, Sienna. Camilla is classified by the Ministry of Long Term Care (MTLC) as a "C bed" home and has four floors with a total of 236 beds (17 ward rooms, 79 semi-private rooms, 13 private rooms). Within the Home, staff from various departments provide both direct and indirect care to the residents at Camilla. There are also number of other speciality medical/clinical services that are offered to residents based on their needs.

During the first wave of the COVID-19 pandemic, Camilla had 186 residents and 68 staff test positive for the virus. Of those 186 residents, 74 died. On May 31, 2020, the government assigned THP as the temporary manager of Camilla. THP was responsible for protecting the health and safety of residents

and staff; and for helping ensure the Home was meeting the standards set out in legislation and regulations.

During the first few weeks of THP assuming management over Camilla in June 2020, several measures were put in place to protect resident safety, including additional clinical and leadership oversight roles, enhanced infection control measures and ongoing training for staff. In addition, THP clinical staff and physicians completed a medical and wellness assessment on each resident and updated individual care plans. At that time, a total of 17 unreported past (i.e. prior to May 31) Critical Incidents (CI) were also identified and reported to the MLTC. These included allegations of abuse, neglect, incompetent care, unexpected deaths, and failure to report respiratory outbreaks. Due to the increasing number and range of quality of care concerns and incidents that were being identified, in July 2020, THP decided to initiate the Review, with the support and cooperation of Sienna.

3.0 STRUCTURED QUALITY REVIEW KEY ACTIVITIES AND APPROACH

The key activities of the Review included:

- Examination of resident health records (paper and electronic) and any other documentation to identify any breaches of recognized professional or practice standards;
- Complete Key Witness interviews to understand the experience of staff and their perceptions of key contextual and contributory factors; and
- Where discrepancies compared to recognized professional or practice standards are found, identify themes, commonalities, and/or contributing factors.

3.1 Health Records Review

In order to create a standard approach to the health records review, a review tool was developed in consultation with the Working Group and the External Review Team. The tool focused on key aspects of quality of care in LTC as defined in the *LTCHA* in addition to being aligned to Health Quality Ontario's framework for measuring quality domains: effective, timely, resident-centred, safe, efficient and equitable. Several domains of care were reviewed including Resident Health Care Wishes; Acute Change in Condition (Mental or Physical); End of Life Care Management; Falls Prevention and Management; Diabetes Management; Skin and Wound Care; Management of Dementia with Responsive Behaviours; and Medication Management.

The health records review involved two stages:

- Stage 1: the nurse reviewers assessed the resident information in Point Click Care ("PCC"), Camilla's electronic health record, as this is where most resident care staff documented.
- Stage 2: the physician reviewers examined the information provided by the nurse reviewers; followed up on any issues identified; and reviewed the care provided by Camilla physicians. Paper health records were included in the physician review as they pertained to information related to the Camilla physicians' practice.

During the course of the Review, health records were flagged for additional consideration if any quality of care issues appeared to meet the legislative criteria for submitting a CI report to the MLTC. During the Review three resident health records were flagged for submission, however, upon further examination it was confirmed that CI submissions and investigations had already occurred. Thus, no additional action or notification respecting CIs was required.

3. 2 Key Witness Interviews

Two external consultants with expertise in studying teamwork, workplace environments and interdisciplinary collaboration conducted interviews in order to provide an opportunity for team members to share their work experiences before and during the pandemic as well as provide advice on what could be improved and acted upon. The interview guide used by the external consultants to conduct the interviews was modeled after the six domains required for effective interdisciplinary collaboration as listed in the *National Interdisciplinary Competency Framework*: Role Clarification; Team Functioning; Patient/Client/Family/Community-Centered Care; Collaborative Leadership; Interdisciplinary Communication and Interdisciplinary Conflict Resolution. Ten individuals, who represented a cross section of roles within Camilla (e.g. direct and indirect care staff, physicians, and leaders) were selected as key witnesses to interview.

4.0 OVERALL FINDINGS

Based on the health records review and key witness interviews ***24*** findings emerged, which are categorized below based on overarching themes.

4.1 Health Records Review

The findings below are a representation of the themes from the 205 resident health records reviewed. The findings are compiled into six themes measured against legislation; professional practice standards, including the College of Physicians and Surgeons of Ontario (CPSO) and College of Nurses of Ontario (CNO) practice standards; Sienna's policies and procedures; and best practices within the LTC sector.

4.1.1 Resident Care Processes

1. Existing policies and procedures do not provide sufficient direction for care providers and were not consistently followed.
2. Documentation by the nurses and physicians (with the exception of the Nurse Practitioners) was often inconsistent, illegible, inaccurate, incomplete, sparse and at times, completely missing.
3. The combination of an electronic health record and paper health record in addition to relying on provincial repositories for information makes it difficult to follow the complete resident care journey.
4. Plans of care, advanced care planning, care plans & health care wishes were documented inconsistently; were out of date; and did not involve the interdisciplinary team and residents/Substitute Decision Makers (SDM).

4.1.2. Acute Change in Resident Status

5. Of the reviewed residents, 66% of the documented acute resident changes in status were respiratory-related and, of those, 79% were COVID-19 infections. Other documented infections included bronchitis (10%) and urinary tract infections (10%).
6. The health care team did not consistently recognize an acute change in a resident's status, nor did they complete the required assessments to determine the need for intervention.
7. The healthcare team did not consistently respond appropriately to the signs and symptoms of a change in a resident's status.

4.1.3. Chronic Disease Management: Dementia with Responsive Behaviours & Diabetes

8. Management of chronic disease was not a regular part of the approach to medical care for two of the three attending physicians.
9. Regular investigation and monitoring of residents with diabetes did not occur consistently.
10. Consent for interventions and ongoing monitoring of residents who in particular were prescribed anti-psychotic medications did not occur regularly.

4.1.4. Interdisciplinary Programs: Falls Prevention & Management/Skin & Wound Care

11. Assessment results for falls prevention and management were not considered and did not inform subsequent treatment plans, monitoring and follow-up.
12. Delays of skin and wound assessments including escalation of any concerns to NPs/physicians may have led to delays in care planning and intervention.
13. For both programs, the lack of objective, descriptive and relevant information in the care plans and progress notes posed barriers to understanding the trajectory of a resident's care journey.

4.1.5. Medication Management

14. Medication administration occurred without a documented rationale for prescribing, effectiveness of medication and subsequent reassessment for ongoing use.
15. The reduction in frequency of medication reviews by pharmacists from quarterly to annually may have led to an increase in the simultaneous use of multiple medications per resident.
16. Medication orders were found without physician sign off, which is a violation of CPSO and Sienna standards.

4.1.6. End of Life Care

17. Symptoms, such as shortness of breath, anxiety and pain were not addressed consistently as part of the care plan (i.e. symptoms were assessed in only 67.5% of end of life residents).
18. Oral fluid intake was not consistently monitored as part of the care plan (i.e. only monitored in 54% of end of life residents).
19. Lack of reassessment by a NP/physician may have contributed to delays in stopping/starting interventions.

4.2 Key Witness Interviews

The key witness interview findings below are separated into three themes that provide context for the environment in which care was delivered as well as aspects of team functioning based on the *perceptions* and *experiences* from staff.

4.2.1Staff & Resident Connectedness

20. Staff feel a deep sense of connectedness to residents and their work.

4.2.2. Relationship with Management

21. Staff did not feel psychologically safe to raise questions and concerns with management and feared retribution.
22. Staff did not have confidence in management's ability to respond to the pandemic.

4.2.3 Communication & Team Functioning

23. There was limited engagement of staff for years prior to and during the pandemic which contributed to the lack of team cohesion across Camilla.

24. Increased staffing shortages contributed to the stress on the team and likely impacted the care provided during the pandemic.

5.0 RECOMMENDATIONS

The Review identified numerous opportunities for improving quality to ensure that care is more effective, timely, resident-centred, and safe. Identified gaps were observed throughout the study timeframe. There was a high degree of variability in care that was delivered and as a result established care standards were, for the most part, only partially met. This is similar to other observations and reviews that occurred at Camilla before and after THP had assumed the role of manager (e.g. THP's Initial Management Report, THP's Practice Review of Camilla and the MLTC September 29th Inspection Report).

Overall, it is not acceptable to meet standards some of the time or to only meet some parts of the standards. These gaps can lead to increased risks to resident safety, at a minimum, and in some cases irreversible harm as seen first-hand through the impact of the pandemic on residents.

In order to address the significant gaps in care that were noted through the Review, the right care environment needs to be created and sustained. The five recommendations below highlight steps to create a Home within which the right care is provided at the right time, every time.

5.1 Resident Care Standards & Processes

Sienna has up to date policies and procedures that direct staff in how to meet practice standards. These standards outline the expectations of how to deliver care for every resident, every time. The standards apply to all staff regardless of role and contribute to public protection.

5.1.1. Improve consistency in the utilization of standardized tools and processes such as the Pain Assessment tool; the BSO-DOS worksheet; Falls Assessment tool; and referrals to speciality services such as the Skin and Wound Care Nurse and Dietitian;

5.1.2. Ensure compliance with standards for medical practice through use of the Physician Chart Audit and Medical Advisor Appraisal policies, with feedback and follow-up on practice gaps; and

5.1.3. Consider reviewing and enhancing the configuration of the electronic health record (PCC) so that there is access to laboratory and diagnostic imaging results; there are more user prompts in PCC to support documentation expectations (e.g. documentation of multi-system assessment and escalation to physician/NP), paper charts are scanned and stored within PCC (or eliminated completely) and care tasks within the Point of Care (POC) module of PCC are configured in a way that is specific to the care that being delivered and intuitive to the user in order to increase documentation accuracy and efficiency.

5.2 Education and Training

While resident care standards outline which and how staff are supposed to provide care within their scopes of practice and roles, education and training are great tools to increase staff's knowledge, skill and judgment. The following is recommended with respect to education and training:

5.2.1. Education plans should be developed based on individual competency evaluation and the training should be interactive, when possible, to assess understanding and competency across a diverse employee group;

5.2.2. Orientation and onboarding curriculum for resident care staff should be reviewed and updated in alignment with the recommendation above; and

5.2.3. Key topics for education and training should include how to recognize and act upon a change in a resident's status; expectations on pain assessment and documentation; preventative measures for reducing the risk of falls and pressure injuries; the Behavioural Supports Ontario clinical pathway; approaches to tapering of antipsychotics for residents with dementia; end of life care management and the management of hypo- and hyper-glycemia for residents with diabetes.

5.3 Team Functioning

Team functioning, including how to effectively communicate as a team and demonstrates accountability are key factors in achieving safe reliable resident care. As such, a number of recommendations related to improving team functioning and communication are listed below:

5.3.1. Strengthen the communication structures within the team and across all care areas to ensure dissemination of information to all team members [e.g. standard interdisciplinary huddles with checklists to guide the discussion; use of existing standardized communication tools (e.g. SBAR) and/or standardized documentation formats for progress notes (e.g. SOAP) for effective information sharing];

5.3.2. Develop/reinforce standard work/job routines for all team members (including management roles) to outline accountabilities; and

5.3.3. Clearly define escalation and communication pathways at the local Home level and beyond.

5.4 Culture of Resident Safety & Just Culture Approach

Build and reinforce a culture of reporting and transparency in all aspects of management in the Home by implementing the following:

5.4.1. Leverage current supports available to team members to create an environment of psychological safety and a supportive team culture, which will lead to a more supportive culture and improved staff resiliency (e.g. Whistleblower Hotline; Risk Management reporting system; Employee Assistance Program; confidential mailboxes outside managers' offices);

5.4.2. Complete formal safety incident reviews using a standardized framework (e.g. Canadian Incident Analysis Framework) and follow-up with relevant team members on opportunities and learnings; and

5.4.3. Per the Institute for Healthcare Improvement, implement regular leadership walkabouts to focus on safety and provide opportunities for team members to escalate concerns regarding resident safety.

5.5 Monitoring of Performance

Measuring performance is a key aspect of creating and reinforcing a culture of continuous quality improvement and accountability. Camilla has a number of key performance indicators (KPIs) that have historically been measured, monitored and reported to Health Quality Ontario; however most tools for monitoring performance are oriented to demonstrating compliance versus continuous quality improvement. It is therefore recommended that Camilla:

5.5.1. Continue to utilize current KPIs and develop additional process metrics and quality oriented tools to measure progress;

5.5.2. Through the local and corporate leadership structures, monitor the on-going competency of staff/physicians on various aspects of practice (both individually and as a group) and provide feedback to staff/physicians on areas of opportunities on a regular basis within the context of coaching and mentorship; and

5.5.3. Share and discuss quality of care results and formal resident safety incident reviews with all staff/physicians regularly to promote continuous learning; and implement recognition programs for staff and physicians for achieving quality outcomes as reinforcement for progress and success.

6.0 NEXT STEPS

The findings from the Review are significant and concerning. Many of these issues pre-dated COVID-19 and likely contributed to the impact on resident safety during the pandemic. THP has already taken the first step to implement a number of these recommendations during its management term and strongly recommends Sienna to proceed with the remaining set after Camilla is transitioned back under their oversight (See Appendix A for details).

The goal is that the information contained in the Review highlights a number of different opportunities to ensure that not only residents at Camilla but all residents in LTC actually receive the care they deserve. The interim report of Ontario's Long-Term Care COVID-19 is an important step towards change and improvement.

Fundamentally, the right care environment needs to be created in each LTCH. This will only happen by having collaborative, skilled leaders in the Home, holding staff and physicians accountable to practice standards; offering continuous education and training; fostering interdisciplinary collaboration, and monitoring performance at all levels through a quality of care lens versus a lens of compliance. It is critical that this environment be created within a culture that supports reporting, transparency and accountability

Hopefully, the learnings that have come as a result of COVID-19's impact on LTC, in combination with reports such as this and similar ones, will serve as a catalyst for necessary transformation within the LTC sector. Only though significant transformation will Ontario build a LTC system that truly serves for the residents within its care, a system we can be proud of—now and in the future.

7.0 ACKNOWLEDGEMENTS

A special thank you to the residents, families and staff members who agreed to participate in the Structured Quality Review. Without their participation, including in-person interviews, it would not have been possible to examine the quality of care provided to residents at Camilla Care Community between December 2019 and May 2020 and subsequently to identify the above areas for improvement.

To provide an objective and meaningful review requires vast expertise and individuals who are committed to the care of seniors in long-term care. Within that context, in addition to the residents, families and staff, we would like to acknowledge the contributions of key members below who contributed to the review.

Thank you to the following external experts for their involvement in guiding, shaping and conducting the review and key interviews:

- *Dr. Brad Birmingham, External Physician Reviewer

- *Lawna Brotherston, External Nurse Reviewer
- *Dr. Susan Deering, External Physician Reviewer
- Susan Griffin Thomas, Interim Director, Long Term Care Health Services, Regional Municipality of Peel
- *Myra Kreick, External Nurse Reviewer
- **Pamela Hudak, Mediator/Principal, The Alternative Dispute Resolution Practice Inc.
- Stephanie Joyce, VP, Patient Care Services & Health System Integration, THP
- Dr. Andrea Moser, Chief Medical Officer, Sienna Senior Living
- Tracy Richardson, Interim Executive Director, Camilla Care Community, Sienna Senior Living
- **Lynne Sinclair, Educational Consultant and Assistant Professor, Department of Physical Therapy, University of Toronto
- *Katherine Smith, External Nurse Reviewer
- *Dr. Evelyn Williams, External Lead Reviewer

**denotes members of the External Review Team; **denotes facilitators for Key Witness Interviews*

Thank you to the following members from Sienna for their cooperation and collaboration:

- Dr. Andrea Moser, Chief Medical Officer, Sienna Senior Living
- Tracy Richardson, Interim Executive Director, Camilla Care Community, Sienna Senior Living
- Philippa Welch, Vice President (VP), Clinical Operations, Sienna Senior Living

Thank you to the following members of THP for their support in guiding the overall Review and the team of external reviewers:

- Stephanie Joyce, VP, Patient Care Services & Health System Integration, THP
- Madeline Timlin, Project Manager, THP
- Andrea Thompson, Director, Patient Care Services, THP
- Dr. Tamara Wallington, Interim Medical Director, Camilla Care Community & Program Chief/Medical Director, Primary Care, Rehab, CCC, Palliative Care & Seniors' Services, THP

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APPENDIX A- Summary of Findings, Recommendations & Actions Taken

FINDINGS	RECOMMENDATION	ACTIONS TO DATE
Finding No. 1: Existing policies and procedures do not provide sufficient direction for care providers and were not consistently followed at Camilla.	***5.1 Resident Care Standards & Processes*** **5.1.1.** Improve consistency in the utilization of standardized tools and processes such as the Pain Assessment tool; the BSO-DOS worksheet; Falls Assessment tool; and referrals to speciality services such as the Skin and Wound Care Nurse and Dietitian.	• Developed COVID Wave 2 Plan and Emergency Preparedness Evacuation Plan (e.g. Code Green) in alignment with Sienna's corporate materials that details local level procedures. • Developed new clinical forms (unit shift report, supervisor shift report, daily resident assignment, code status and allergies list) and resource binders relating to Interdisciplinary programs.
Finding No. 2: Documentation by the nurses and physicians (with the exception of the Nurse Practitioners) was inconsistent, illegible, inaccurate, incomplete, sparse and at times, completely missing**.**	***5.1 Resident Care Standards & Processes*** **5.1.3** Consider reviewing and enhancing the configuration of the electronic health record so that there are more user prompts in PCC to support documentation expectations (e.g. documentation of multi-system assessment and escalation to physician/NP) and care tasks within PCC are configured in a way that is specific to the care that being delivered and intuitive to the user in order to increase documentation accuracy and efficiency. ***5.2 Education and Training*** **5.2.3** Key topics for education and training should include expectations on documentation. ***5.5 Monitoring of Performance*** **5.5.2** Through the local and corporate leadership structures, monitor the on-going competency of staff/physicians and provide feedback on a regular basis.	• Provided 128 nursing team members with in-service class room education where the importance of documentation for resident care was highlighted. • Provided at the elbow support to all team members to reinforce education and best practice.

FINDINGS	RECOMMENDATION	ACTIONS TO DATE
Finding No. 3: The combination of an electronic health record and paper health record in addition to relying on provincial repositories for information makes it difficult to follow the complete resident care journey.	***5.1 Resident Care Standards & Processes*** **5.1.3** Consider reviewing and enhancing the configuration of the electronic health record so that there is access to laboratory and diagnostic imaging results within PCC and paper charts are scanned and stored within PCC (or eliminated completely).	• No actions completed at this time.
Finding No. 4: Plans of care, advanced care planning, care plans & health care wishes were documented inconsistently; were out of date; and did not involve the interdisciplinary team and residents/Substitute Decision Makers (SDM).	***5.1 Resident Care Standards & Processes*** **5.1.2** Ensure compliance with standards through the use of auditing tools. ***5.3 Team Functioning*** **5.3.2** Develop/reinforce standard work/job routines for all team members (including management roles) to outline accountabilities. ***5.5 Monitoring of Performance*** 5**.5.1** Continue to utilize current KPIs and develop additional process metrics and quality oriented tools to measure progress.	• Rescheduled postponed Annual Care Conferences in order to update residents' plans of care, advanced care plan and health care wishes. All SDM's (unless PGT/SDM chooses not to) and interdisciplinary team members are expected to participate. • Through in-service classroom education on assessments and escalation it was highlighted as an expectation that care plans need to be updated when there is a change in resident status.
Finding No. 5: Of the reviewed residents, 66% of the documented acute resident changes in status were respiratory-related and, of those, 79% were COVID-19 infections. Other documented infections included bronchitis (10%) and urinary tract infections (10%).	***5.2 Education and Training*** **5.2.3** Key topics for education and training should include how to recognize and act upon a change in resident status.	• No actions completed at this time.
Finding No. 6: The health care team consistently did not recognize an acute change in a resident's status, nor did they complete the required assessments to determine the need for intervention.	***5.2 Education and Training*** **5.2.3** Key topics for education and training should include how to recognize and act upon a change in resident.	• Provided nursing team members with in-service education and onsite clinical supervisory support to assist them with recognizing when a change in status occurs.

FINDINGS	RECOMMENDATION	ACTIONS TO DATE
	5.2.2 Orientation and onboarding curriculum for resident care staff should be reviewed and updated in alignment with the recommendation above.	
Finding No. 7: The healthcare team consistently did not respond appropriately to the signs and symptoms of a change in a resident's status.	***5.2 Education and Training*** **5.2.3** Key topics for education and training should include how to recognize and act upon a change in resident. ***5.3 Team Functioning*** **5.3.3** Clearly define escalation and communication pathways at the local Home level and beyond. ***5.4 Culture of Resident Safety & Just Culture Approach*** **5.4.2** Complete formal safety incident reviews using a standardized framework (e.g. Canadian Incident Analysis Framework) and follow-up with relevant team members on opportunities and learnings. **5.4.3** Implement regular Institute for Healthcare Improvement leadership walkabouts to focus on safety and provide opportunities for team members to escalate concerns regarding resident safety regularly.	• See above re: education training provided to nursing team members.
Finding No. 8: Management of chronic disease was not a regular part of the approach to medical care for two of the three attending physicians at Camilla.	***5.1 Resident Care Standards & Processes*** **5.1.2** Ensure compliance with standards through the use of auditing tools. **5.1.3** Improve consistency in the utilization of standardized tools and processes	• No actions completed at this time.
Finding No. 9: Regular investigation and monitoring of residents with diabetes did not occur consistently.	***5.2 Education and Training*** **5.2.3** Key topics for education and training should include management of hypo- and hyper-glycemia for residents with diabetes. ***5.5 Monitoring of Performance*** **5.5.1** Continue to utilize current KPIs and develop additional process metrics and quality oriented tools to measure progress.	• Provided in-service education to nursing team members to review management of hypo- and hyper-glycemia for residents with diabetes. • Provided specific education relating to diabetes medication through online modules.

FINDINGS	RECOMMENDATION	ACTIONS TO DATE
Finding No. 10: Diet modifications for residents with Type 2 diabetes did not occur consistently and were not updated at a reasonable frequency, which could have contributed to earlier reliance on medication to manage blood glucose.	***5.1 Resident Care Standards & Processes*** **5.1.1** Improve consistency in the utilization of standardized tools and processes such as referrals to speciality services e.g. Dietitian. ***5.2 Education and Training*** **5.2.3** Key topics for education and training should include management of hypo- and hyper-glycemia for residents with diabetes. ***5.3 Team Functioning*** **5.3.2** Develop/reinforce standard work/job routines for all team members (including management roles) to outline accountabilities.	• See above re: education training provided to nursing team members.
Finding No. 11: Assessment results for falls prevention and management were not considered and did not inform subsequent treatment plans, monitoring and follow-up.	***5.1 Resident Care Standards & Processes*** **5.1.1** Improve consistency in the utilization of standardized tools and processes such as the Falls Assessment tool. ***5.3 Team Functioning*** **5.3.2** Develop/reinforce standard work/job routines for all team members (including management roles) to outline accountabilities.	• Created resources binders available on home areas to assist with identification of relevant policies and procedures that relate to falls management.
Finding No. 12: Delays of skin and wound assessments including escalation of any concerns to NPs/physicians may have led to delays in care planning and intervention.	***5.1 Resident Care Standards & Processes*** **5.1.1** Improve consistency in the utilization of standardized tools and processes such as referrals to speciality services such as the Skin and Wound Care Nurse. ***5.3 Team Functioning*** **5.3.1** Strengthen the communication structures by using existing standardized communication tools for effective information sharing.	• Provided nursing team members with in-service education and onsite clinical supervisory support for them to understand the importance of head to toe assessments (Skin & Wound) and when concerns need to be escalated.
Finding No. 13: For both programs, the lack of objective, descriptive and relevant information in the care plans and progress notes posed barriers to	***5.2 Education and Training*** **5.2.3** Key topics for education and training should include preventative measures for reducing the risk of falls and pressure injuries.	• See above for completed actions.

FINDINGS	RECOMMENDATION	ACTIONS TO DATE
understanding the trajectory of a resident's care journey.	***5.4 Culture of Resident Safety & Just Culture Approach*** **5.4.2** Complete formal safety incident reviews using a standardized framework (e.g. Canadian Incident Analysis Framework) and follow-up with relevant team members on opportunities and learnings. ***5.5 Monitoring of Performance*** **5.5.1** Continue to utilize current KPIs and develop additional process metrics and quality oriented tools to measure progress **5.5.2** Provide feedback to staff/physicians on areas of opportunities on a regular basis within the context of coaching and mentorship.	
Finding No. 14: Medications administration occurred without a documented rationale for prescribing, effectiveness of medication and subsequent reassessment for ongoing use.	***5.1 Resident Care Standards & Processes*** **5.1.1** Improve consistency in the utilization of standardized processes ***5.2 Education and Training*** **5.2.3** Key topics for education and training should include how to recognize and act upon a change in resident and approach to tapering of antipsychotics for residents with dementia	• No actions completed at this time.
Finding No. 15: The reduction in frequency of medication reviews by Pharmacists from quarterly to annually may have led to an increase in the simultaneous use of multiple medications per resident.	***5.1 Resident Care Standards & Processes*** **5.1.1** Improve consistency in the utilization of standardized processes	• No actions completed at this time.
Fining No. 16: Medication orders were found without physician sign off, which is a violation of CPSO and Sienna standards.	***5.1 Resident Care Standards & Processes*** **5.1.2** Ensure compliance with standards for medical practice through use of the Physician Chart Audit and Medical Advisor Appraisal policies, with feedback and follow-up on practice gaps ***5.5 Monitoring of Performance***	• It is now an expectation for Camilla physicians to be regularly on-site to (even during an outbreak) and therefore able to sign off medication orders honoring CPSO and Sienna standards.

FINDINGS	RECOMMENDATION	ACTIONS TO DATE
	5.5.2 Through the local and corporate leadership structures, monitor the on-going competency on various aspects of practice and provide feedback on areas of opportunities on a regular basis	
Finding No. 17: Symptoms such as shortness of breath, anxiety and pain were not addressed consistently as part of the care plan (i.e. symptoms were assessed in only 67.5% of end of life residents	***5.1 Resident Care Standards & Processes*** **5.1.1** Improve consistency in the utilization of standardized tools and processes such as the Pain Assessment tool ***5.2 Education and Training*** **5.2.3** Key topics for education and training should include End of Life management including expectations on pain assessment	• No actions completed at this time.
Finding No. 18: Oral fluid intake was not consistently monitored as part of the care plan (i.e. only monitored in 54% of end of life residents).	***5.2 Education and Training*** **5.2.3** Key topics for education and training should include end of life management	• No actions completed at this time.
Finding No. 19: Lack of reassessment by a NP/physician may have contributed to delays in stopping/starting interventions.	***5.1 Resident Care Standards & Processes*** **5.1.1** Improve consistency in the utilization of standardized tools and processes ***5.3 Team Functioning*** **5.3.2** Develop/reinforce standard work/job routines for all team members (including management roles) to outline accountabilities.	• It is now an expectations for Camilla physicians to be regularly on-site to (even during an outbreak) in order to re-assess residents in a timely manner.
Finding No. 20: Staff feel a deep sense of connectedness to residents and their work.	***No recommendations required.***	• Continued to build on staff's deep sense of connectedness to residents in order to foster a culture of Resident Safety and Just Culture Approach
Finding No. 21: Staff did not feel psychologically safe to raise questions and concerns with management and feared retribution.	***5.4 Culture of Resident Safety & Just Culture Approach*** **5.4.1** Leverage current supports available to team members to create an environment of psychological safety and a supportive team culture leading to exceptional experiences and improved staff resiliency (e.g. Whistleblower Hotline; Risk Management	• Continued to build on current supports available to team members to foster an open and transparent environment where staff escalations and questions are welcomed/addressed.

FINDINGS	RECOMMENDATION	ACTIONS TO DATE
	reporting system; Employee Assistance Program; confidential mailboxes outside managers' offices). ***5.5 Monitoring of Performance*** **5.5.3** Promote continuous learning and consider recognition programs for staff and physicians for achieving quality outcomes as reinforcement for progress and success.	
Finding No. 22: Staff did not have confidence in management's ability to respond to the pandemic.	***5.3 Team Functioning*** **5.3.2** Develop/reinforce standard work/job routines for all team members (including management roles) to outline accountabilities. **5.3.3** Clearly define escalation and communication pathways at the local Home level and beyond.	• Developed COVID Wave 2 preparedness plan that includes standard work for all team members (including management roles) for prevention, management, and recovery. Clear accountabilities, defined escalation and communication pathways are all detailed at the local level. •
Finding No. 23: There was limited engagement of staff for years prior to and during the pandemic which contributed to the lack of team cohesion across Camilla.	***5.3 Team Functioning*** **5.3.1** Strengthen the communication structures within the team and across all care areas to ensure dissemination of information to all team members.	• Strengthened the communication structures at Camilla and information dissemination through daily management meetings, huddles, memos and bi-weekly Staff Town Halls.
Finding No. 24: Increased staffing shortages contributed to the stress on the team and likely impacted the care provided during the pandemic.	Detailed recommendations related to monitoring of staffing levels and backfilling vacancies are provided in THP's Final Management Report.	• Developed new master staffing schedule and identified vacancies that are being filled in order to ensure continued staffing to meet care needs for residents. • Reviewed *Leave of* Absence (LOA) list and facilitated the return to work for staff.