Access and Flow | Efficient | Priority Indicator

	Last Year		This Year	
Indicator #22 Rate of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents. (Cassellholme)	**27.27** Performance (2023/24)	**25.09** Target (2023/24)	**27.61** Performance (2024/25)	**6.50** Target (2024/25)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Home to monitor resident transfers to and from the ER/ED. Interventions in place to minimize transfers to the ER/ED that are avoidable (Dehydration).

Process measure

- To be reviewed with Clinical Management team and NP.

Target for process measure

- To reduce/minimize transfers to ER/ED by 2% ongoing through each fiscal quarter.

Lessons Learned

Did not meet goal of decrease in transfer to ER/ED. Information was collected and reviewed. Acuity of the resident was cause the increase of transfer.

Comment

Reviewed by Continuous Quality Improvement Committee

Access and Flow | Efficient | Custom Indicator

Indicator #26	Last Year		This Year	
Staff Orientation (Cassellholme)	**100**	**100**	**100**	**NA**
	Performance (2023/24)	**Target (2023/24)**	**Performance (2024/25)**	**Target (2024/25)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

Revitalizing Orientation Process

Process measure

- Checklist completed and signed off after departmental

Target for process measure

- Completion of all new hires to meet ministry standards

Lessons Learned

Implemented new ideas for orientation progress.
Streamlined and cut down on wasted time waiting for staff to present.

Comment

Reviewed by Continuous Quality Improvement Committee

	Last Year		This Year	
Indicator #27 Staff Training (Cassellholme)	**100** Performance (2023/24)	**100** Target (2023/24)	**100** Performance (2024/25)	**NA** Target (2024/25)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Staff Training Yearly for all employees

Process measure

- Report run of completion and email updates to remind staff to complete

Target for process measure

- To meet ministry standard

Lessons Learned

Goal Met
Allocation of time for staff explored to ensure completion

Comment

Reviewed by Continuous Quality Improvement Committee

Indicator #7	**Last Year**		**This Year**	
Emergency Plan (Cassellholme)	**X**	**100**	**100**	**NA**
	Performance (2023/24)	**Target (2023/24)**	**Performance (2024/25)**	**Target (2024/25)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

Emergency plan in place and it was reviewed by the home’s health and safety manager

Process measure

- Signed and updated policy

Target for process measure

- For 2023-24, the emergency plan will be reviewed and updated in greater detail than in past periods as the home will undergo physical layout changes due to redevelopment, which could result in the need for updated policies, procedures, floor plans and other important components of the emergency plan.

Lessons Learned

Fire Drills – Code Red - completed 3 times each month on each of the 3 shifts.
Horizontal Fire Drills – Code Green - trained as mock evacuations monthly. A debriefing is held immediately following the drill with all staff involved.
The Emergency Plan was reviewed/revised in May 2023 by Julie Pilkey, Ellen Whittaker, Lindsay Dyrda and several members of the Leadership Team
A Mock Evacuation was completed with the North Bay Fire Department on September 12, 2023
Reference Contacts – North Bay Police, North Bay Fire Department, North Bay Ambulance Services, were all contacted in person and received updated written letters on July 21, 2023
All staff completed their annual online training modules for 2023. Modules include Codes Black, Brown, Yellow, White, Green, Red, Orange, Grey, Purple, as well as Slings & Sliders and Fire Extinguishers
All staff, hired 5 years or longer, participated in the Slings & Sliders hands-on training in 2023, as well as completing the online training module.
All new hires attend Orientation that includes a Health & Safety Fire Tour of the Home, as well as in-class training. New staff also participate in the hands-on Slings & Sliders training. New hires must complete all online training modules prior to being cleared for the schedule.
An Annual Inspection of the Home was completed by the North Bay Fire Department on July 12, 2023

Comment

Reviewed by Continuous Quality Improvement Committee

Indicator #14 Nursing & PSW Staffing Plan (Cassellholme)	Last Year		This Year	
	100 **Performance (2023/24)**	**100** **Target (2023/24)**	**100** **Performance (2024/25)**	**NA** **Target (2024/25)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

Staffing plan in place and reviewed annually

Process measure

- Documented of review occurred.

Target for process measure

- provide for a staffing mix that is consistent with residents' assessed care and safety needs; set out the organization and scheduling of staff shifts; promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection.

Lessons Learned

Reviewed October 2023 and March 2024

Comment

Reviewed by Continuous Quality Improvement Committee

Equity | Equitable | Custom Indicator

	Last Year		This Year	
Indicator #21 Physical Examination (Cassellholme)	**CB**	**CB**	**CB**	**NA**
	Performance (2023/24)	Target (2023/24)	Performance (2024/25)	Target (2024/25)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Physician to conduct a physical examination

Process measure

- Ensure completion with chart audit

Target for process measure

- Meet Ministry standards

Lessons Learned

Physical Examinations changed to electronic within Point Click Care.

Comment

Reviewed by Continuous Quality Improvement Committee

Experience | Patient-centred | Custom Indicator

	Last Year		This Year	
Indicator #1 Activities (Cassellholme)	**95** **Performance (2023/24)**	**97** **Target (2023/24)**	**94.40** **Performance (2024/25)**	**NA** **Target (2024/25)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

Maintain 3 quality contacts with residents per week

Process measure

- Manager of Activities runs weekly report and sends notices to staff where needed

Target for process measure

- 97% on satisfaction survey

Lessons Learned

The goal was implemeted, but not met.
3 quality contacts not met every week. Not met due to hospitalization, sleeping, outbreaks
Review 3 times per week in the department

Change Idea #2 ☑ Implemented ☐ Not Implemented

Increase enrollment in family activity portal

Process measure

- enrollment in activity pro

Target for process measure

- Current enrollment is 8% of resident families to improve to 15% of families enrolled

Lessons Learned

Met goal
15%
Achieved by placing activity pro invitations in admission handbook

Comment

Reviewed by Continuous Quality Improvement Committee

Indicator #4

Dietary (Cassellholme)

	Last Year		This Year	
	85	**90**	**90.30**	**NA**
	Performance (2023/24)	Target (2023/24)	Performance (2024/25)	Target (2024/25)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Improve on food temperature.

Process measure

- Conduct staff Observations in the dining room to ensure food is still hot.

Target for process measure

- 90% resident satisfaction on resident surveys.

Lessons Learned

Change idea and increased education implemented. Did meet our 90% goal with resident satisfaction survey results.

Comment

Reviewed by Continuous Quality Improvement Committee

Indicator #10

Housekeeping (Cassellholme)

	Last Year		This Year	
	89	**90**	**95**	**NA**
	Performance (2023/24)	Target (2023/24)	Performance (2024/25)	Target (2024/25)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Improve room cleanliness of resident areas- dining rooms, front entrance, stairwells, flooring etc...

Process measure

- conduct complete clean audits and resident satisfaction survey.

Target for process measure

- 90% satisfaction on cleanliness on resident satisfaction survey.

Lessons Learned

More staff hours implemented
Did meet our 90% goal exceeding to 95% Staff concentrated more on surface cleaning to prevent the spread of infection, staff project work added

Comment

Reviewed by Continuous Quality Improvement Committee

Indicator #12
Laundry (Cassellholme)

Last Year		This Year	
89	**90**	**90.40**	**NA**
Performance (2023/24)	**Target (2023/24)**	**Performance (2024/25)**	**Target (2024/25)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

Reduce the turnaround time for personal clothing to 48 hours

Process measure

- Audit personal clothing soiled areas to see amount of clothing bags in area and resident satisfaction survey.

Target for process measure

- 90% on resident satisfaction survey.

Lessons Learned

Change idea adding hours implemented
Did meet our goal of 90% - the soiled areas need to be audited more frequently in order to exceed the goal.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Items being placed in wrong closets/ items not folded neatly.

Process measure

- Resident Satisfaction survey

Target for process measure

- 90% on Satisfaction Survey

Lessons Learned

Negative Comments in survey related to items put away

Comment

Reviewed by Continuous Quality Improvement Committee

	Last Year		This Year	
Indicator #28 Volunteer Program (Cassellholme)	**100** **Performance (2023/24)**	**100** **Target (2023/24)**	**100** **Performance (2024/25)**	**NA** **Target (2024/25)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

Orientation for new volunteers

Process measure

- All new volunteers completed general orientation check sheet

Target for process measure

- 100% complete general orientation

Lessons Learned

Every licensee of a long-term care home shall ensure that there is an organized volunteer program for the home that encourages and supports the participation of volunteers in the lives and activities of residents. The volunteer program must include measures to encourage and support the participation of volunteers as may be further provided for in the regulations. Therefore Volunteer orientation focuses solely on areas that volunteers will be directly involved with the resident in. Thus our orientation program for volunteers is distinctly different that the orientation provided for clinical staff members.

Comment

Reviewed by Continuous Quality Improvement Committee

Indicator #2

Care Conference (Cassellholme)

	Last Year		This Year	
	CB	**100**	**100**	**NA**
	Performance (2023/24)	Target (2023/24)	Performance (2024/25)	Target (2024/25)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Complete an initial care conference within 6 weeks, and an annual care conference for every resident

Process measure

- Review Monthly number of residents completed

Target for process measure

- 100% of residents have completed a care conference within 6 weeks, and/or an annual care conference by April 2024.

Lessons Learned

All Care Conferences Completed for 2023

Comment

Reviewed by Continuous Quality Improvement Committee

Indicator #6

Dietary - Weight Review (Cassellholme)

Last Year		This Year	
100	**100**	**100**	**NA**
Performance (2023/24)	Target (2023/24)	Performance (2024/25)	Target (2024/25)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Weights of all residents reviewed Monthly

Process measure

- Monthly report sent to NFS and Clinical team

Target for process measure

- Meet ministry standard

Lessons Learned

Dietician completed weight audit on a monthly basis

Comment

Reviewed by Continuous Quality Improvement Committee

	Last Year		This Year	
Indicator #5 Dietary - Menu Planning (Cassellholme)	**85** Performance (2023/24)	**90** Target (2023/24)	**90.30** Performance (2024/25)	**NA** Target (2024/25)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Improve Spring and summer/Fall and Winter menu by removing some items that residents do not like (carrot and raisin salad). Changing some cold pates into sandwiches. Add in bagels.

Process measure

- Resident satisfaction survey, following up with residents in the dining rooms. Trial bagels

Target for process measure

- 90% satisfaction on survey.

Lessons Learned

Did meet our goal of 90%.
Bagels were trialed and have been implemented on the Fall/Winter menu on a permanent basis.

Comment

Reviewed by Continuous Quality Improvement Committee

Experience | Patient-centred | Priority Indicator

Indicator #18	Last Year		This Year	
Percentage of residents responding positively to: "What number would you use to rate how well the staff listen to you?" (Cassellholme)	**87.34**	**90**	**84.21**	**90**
	Performance (2023/24)	Target (2023/24)	Performance (2024/25)	Target (2024/25)

Change Idea #1 ☐ Implemented ☑ Not Implemented

Care Conference Follow up Audit

Process measure

- Resident and Family Navigator Weekly review and close when follow up completed. Follow up when not completed.

Target for process measure

- 100% of care conference follow up completed by staff 1 week after care conference have been done.

Lessons Learned

Did meet 100% goal.
Did improve from following year
audit was initiated and completed. NOt 100% of the time

	Last Year		This Year	
Indicator #19 Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences". (Cassellholme)	**96.20** **Performance (2023/24)**	**98** **Target (2023/24)**	**95.79** **Performance (2024/25)**	**98** **Target (2024/25)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

Monthly Orientation for Families

Process measure

- RFN report to DOC Monthly of Completion

Target for process measure

- 1 orientation per month

Lessons Learned

Orientation to families completed. Invitation process changed to letter to each individual rather than general email to all

Safety | Safe | Custom Indicator

	Last Year		This Year	
Indicator #25 Restraint (Cassellholme)	**9.80** Performance (2023/24)	**7** Target (2023/24)	**9.10** Performance (2024/25)	**NA** Target (2024/25)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Decrease restraint usage by multidisciplinary group reviewing residents using restraints

Process measure

- Evaluated by ongoing utilization of RAI-MDS. Documented restraints in care plan.

Target for process measure

- Decrease to closer to provincial average or better

Lessons Learned

Monthly review on units
fluctuates with resident population
Did not meet goal but did see a decline

Comment

Reviewed by Continuous Quality Improvement Committee

	Last Year		This Year	
Indicator #8 Falls (Cassellholme)	**18.60**	**15.60**	**21.80**	**NA**
	Performance (2023/24)	**Target (2023/24)**	**Performance (2024/25)**	**Target (2024/25)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

The Falls Committee will be working in collaboration with all quality programs in the Home.

Process measure

- Continuous review of action plans as well as quality indicators ongoing through each quarter

Target for process measure

- CIHI statistic for "Has Fallen" will improve from 18.6%, closer to 15.6 or better ongoing through the fiscal year.

Lessons Learned

-Bedside logos were redesign to include indication of fall risk, this provides quick reference access to interdisciplinary team members at the bedside;
-All staff completed related training on Safety 24/7 platform, 100% completion;
-Interdisciplinary team (including physician, pharmacy among others) reviewed medications quarterly with a goal of reviewing medications that could increase a residents' risk of falls;
-Fall reduction equipment continue to be purchased throughout the year as required (hip protectors, high low beds, fall mast, seatbelts, bed and chair alarms, raised toilet seats with handrails, hand rails for toilets);
-Monthly stats were compiled/evaluated for trend monitoring. This was also a useful tool for evaluating opportunities to reduce individual falls, and to enhance fall preventions strategies within the program;
-Embedded physio program continued to provide services to residents including walking and strength balance programming. Physio completed annual and admission assessments on all residents as well as quarterly assessments on residents in the physio program;
-Communication: emails were sent out to all interdisciplinary team members involved in the program alerting them that a resident has fallen;
-Risk assessments and post fall incident report information gatherings were completed as per policy;
-Weekly Interdisciplinary Team meetings were established and chaired by our Nurse Practitioner
-Cassellholme on boarded a Nurse Practitioner. She has provided valuable input and assessments which has enhance the overall care the residents receive.
-A new medical Director/attending physician and three additional attending physicians have joined our team. This addition has enriched the medical services to our residents ultimately improving safety and reducing risk of falls.

Comment

Reviewed by Falls Committee

	Last Year		This Year	
Indicator #29 Wound Care (Cassellholme)	**4.40** Performance (2023/24)	**4** Target (2023/24)	**3.90** Performance (2024/25)	**NA** Target (2024/25)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Assessing skin changes amongst palliative residents at the end of life by initiate a standardized system and language. Providing pressure management surfaces for all residents with wounds. Standardized educational programs for the prevention of pressure ulcers.

Process measure

- Ongoing review through quality meetings, evaluation of Homes processes and quality indicators.

Target for process measure

- Notable improvement in wound statistics ongoing through each subsequent quarter. Optimally, indicator to reflect closer to the provincial average of better

Lessons Learned

Q1-Q2 2023-2024 worsened pressure ulcers decreased 4.5% to 3.9%
Wound care schedule added to huddle boards
Procedure developed with RFN regarding notification if pressure relief surface required on admission
Training and re training of the wound app ongoing for registered staff

Comment

Reviewed by Wound Committee

Indicator #3 Continence Care (Cassellholme)	Last Year		This Year	
	14	**14**	**12.90**	**NA**
	Performance (2023/24)	**Target (2023/24)**	**Performance (2024/25)**	**Target (2024/25)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

Tena representative and Continence champions to ensure teaching and learning is ongoing.

Process measure

- Ongoing review of discussion and actions items that are generated by the quality group during quarterly meetings.

Target for process measure

- To continue to maintain or improve current stats related to continence care, as evaluated by the RAI-MDS and reflected by CIHI.

Lessons Learned

Implemented and met the goal.
Tena Representative education with continence to staff members.

Comment

Reviewed by Continuous Quality Improvement Committee

Indicator #15 Pain (Cassellholme)	Last Year		This Year	
	13.30 Performance (2023/24)	**11** Target (2023/24)	**15.20** Performance (2024/25)	**NA** Target (2024/25)

Change Idea #1 ☑ Implemented ☐ Not Implemented

The Pain Committee is to meet with all members of the quality team on a quarterly basis at minimum.

Process measure

- Evaluated on an at minimum quarterly basis through quality meetings. Action plans to be reviewed on a regular basis

Target for process measure

- Notable improvement in pain control moving through each subsequent quarter.

Lessons Learned

Pain Committee did meet throughout the year. Pain numbers did rise and GAP analysis

Comment

Reviewed by Pain Committee

Indicator #16 Palliative (Cassellholme)	Last Year		This Year	
	CB	**CB**	**CB**	**NA**
	Performance (2023/24)	**Target (2023/24)**	**Performance (2024/25)**	**Target (2024/25)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

Education of all staff in the Palliative Program along with a mentoring of newer staff with Cassellholme palliative champions

Process measure

- Goals, interventions and actions to be carried out by committee staff/delegates.

Target for process measure

- To be re-evaluated quarterly at a minimum.

Lessons Learned

Our goal was to offer all of our staff a palliation in service and on going support through end of life education and dialogue. We did meet this goal and the few staff that did not receive can access on health and safety 24/7

Comment

Reviewed by Palliative Committee

	Last Year		This Year	
Indicator #24 Restorative (Cassellholme)	**CB** **Performance (2023/24)**	**CB** **Target (2023/24)**	**18** **Performance (2024/25)**	**NA** **Target (2024/25)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

To maximize the number of residents that receive nursing rehab, as appropriate.

Process measure

- TO be evaluated ongoing utilizing the RAI-MDS, Weekly reporting to the RAI Coordinator and ongoing discussion with physiotherapy at least monthly. Continuous review of residents that remain or are added to the nursing rehab caseload by the restorative nurse.

Target for process measure

- To be reviewed at least weekly and ongoing through each quarter.

Lessons Learned

18% of total resident of Home currently receive nursing restorative services (1/16/2024) Changes in department structure initiated to maximize nursing restorative time on units. Ongoing education to staff provided by NRC. Ongoing communication with physiotherapy to maximize services offered. Increase in the utilization of nursing restorative services noted in the past few months. To continue with current plan; ongoing at this time.

Comment

Current plan effective in maximizing services at this time. Ongoing assessment of residents that may benefit from nursing restorative.

Indicator #23

Responsive Behaviours (Cassellholme)

	Last Year		This Year	
	13.50	**13**	**15.90**	**NA**
	Performance (2023/24)	Target (2023/24)	Performance (2024/25)	Target (2024/25)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Recognizing behavioral symptoms of delirium and BPSD

Process measure

- Ongoing evaluation of goals and targets through quality meetings and QI. Notable improvement in the QI's r/t to behavioral symptoms "Worsened Behaviors" and "Improved Behaviors".

Target for process measure

- Reduce responsive behaviors

Lessons Learned

Delrium assessment tools are being used more frequently when there is a change in behaviour and delrium is suspected.
Symptoms of delrium quality indicators show a 1.10% increase. This suggests that delrium is being recognized and identified in the home therefore increasing the numbers reported. (percentages only evaluated to Q3)

Comment

Reviewed by Responsive Behaviors Committee

Indicator #11
Infection Control (Cassellholme)

Last Year		This Year	
CB	**CB**	**2434**	**NA**
Performance (2023/24)	**Target (2023/24)**	**Performance (2024/25)**	**Target (2024/25)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

Increase the number of staff hand hygiene observations to at least 2400 annually

Process measure

- Data collected and measured on the online app

Target for process measure

- In collaboration with Public Health

Lessons Learned

2434 Hand hygiene observations completed by numerous staff

Change Idea #2 ☑ Implemented ☐ Not Implemented

Continue Housekeeping IPAC audit with a goal of 2 per month (24 observations annually)

Process measure

- No process measure entered

Target for process measure

- No target entered

Lessons Learned

The audits were done, however only 8 were done and they were done in the first half of the year.

Change Idea #3 ☑ Implemented ☐ Not Implemented

- Continue the IPAC Self-Assessment audit, including the unit managers/delegate biweekly and weekly when in outbreak.

Process measure

- No process measure entered

Target for process measure

- No target entered

Lessons Learned

This requirement changed to 2 times per year and weekly when in outbreak. 25 audits were done in 2023, therefore the goal was met.

Change Idea #4 ☑ Implemented ☐ Not Implemented

- Begin to include the Construction/Renovation IPAC Risk assessment for internal dust-generating renovations, including carpet removal and counter replacement.

Process measure

- No process measure entered

Target for process measure

- No target entered

Lessons Learned

This goal was partially met; the carpet replacement procedure was developed and has been followed.

Comment

Reviewed by Infection Control Committee

Safety | Safe | Priority Indicator

Indicator #17	Last Year		This Year	
Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment (Cassellholme)	**27.56** Performance (2023/24)	**21** Target (2023/24)	**27.93** Performance (2024/25)	**NA** Target (2024/25)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Weekly 3 Month Drug Reviews reinstated post pandemic

Process measure

- Utilization of Point Click Care

Target for process measure

- All current resident of the long term care home have a drug review completed every 3 months.

Lessons Learned

Meetings were reintroduced, but the goal to decrease was not met.
Last 3 months of the year has been decreasing

Comment

Reviewed by Continuous Quality Improvement Committee

Safety | Effective | Custom Indicator

	Last Year		This Year	
Indicator #9 Heat Related Illness Prevent and Management (Cassellholme)	**100** Performance (2023/24)	**100** Target (2023/24)	**100** Performance (2024/25)	**NA** Target (2024/25)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Spring Completion of Heat Assessment of all current residents June, July, August New Admissions

Process measure

- DOC or Delegate run report to ensure completion

Target for process measure

- Meet Ministry Standards

Lessons Learned

Completed May 2023

Comment

Reviewed by Continuous Quality Improvement Committee

	Last Year		This Year	
Indicator #13 Maintenance - Boilers (Cassellholme)	**100**	**100**	**100**	**NA**
	Performance (2023/24)	**Target (2023/24)**	**Performance (2024/25)**	**Target (2024/25)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

hot water boilers and hot water holding tanks are serviced

Process measure

- Manager to ensure completion and documentation is kept of the service;

Target for process measure

- to meet ministry standards

Lessons Learned

Visits from Honeywell Documented by Maintenance Department

Comment

Reviewed by Continuous Quality Improvement Committee

Indicator #20

Pharmacy - Destruction (Cassellholme)

	Last Year		This Year	
	100	**100**	**100**	**NA**
	Performance (2023/24)	Target (2023/24)	Performance (2024/25)	Target (2024/25)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Bi - Monthly Destruction of Narcotics

Process measure

- in Collaboration with Care Rx

Target for process measure

- To Meet Ministry Standards

Lessons Learned

Goal Met to meet ministry standards

Comment

Reviewed by Continuous Quality Improvement Committee