Access and Flow

Measure - Dimension: Efficient

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Rate of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents.	O	Rate per 100 residents / LTC home residents	CIHI CCRS, CIHI NACRS / October 1st 2022 to September 30th 2023 (Q3 to the end of the following Q2)	32.81	21.00	1) To meet the provincial Average 2) Through implementation of our change ideas, the home expects an improvement over the next 6 months.	

Change Ideas

Change Idea #1 To reduce unnecessary hospital transfers

Methods	Process measures	Target for process measure	Comments
Education will be provided to registered staff on the continued use of SBAR tool and support standardize communication between clinicians	Number of communication process used in the SBAR format, between clinicians per month	80% of communication between physicians, NP and registered staff will occur in SBAR Format by September 2024	Utilize Nurse Practitioner, other stake holders such as CareRx Pharmacy, DOC/ADOC and MD to provide education to registered staff on topics

Change Idea #2	Support early recognition of residents at risk for ED visits by providing preventive care and early treatment for common conditions leading potentially avoidable ED visits.		
Methods	Process measures	Target for process measure	Comments
The home's attending NP will review and collaborate with the registered staff on residents who are at high risk for transfer to ED, based on clinical and psychological	The number of ER transfers averted monthly. Number of transfers to ED who returned within 24 hours	Decrease by 10% until goal is achieved by reviewing all process measures in a quarterly basis	

Change Idea #3	Implement tracking tool for ED Transfers		
Methods	Process measures	Target for process measure	Comments
Track internal hospital transfers and analyze each transfer status and discuss at weekday risk management meetings	Number of avoidable ED visits and number of risk management meeting held	50% reduction of ED visits by December 31, 2024. 100% of risk management meetings to include ED transfers	

Equity

Measure - Dimension: Equitable

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education	O	% / Staff	Local data collection / Most recent consecutive 12-month period	CB	80.00	Through education, the Home expects to have an increase understanding of this criteria over the next 6 months	

Change Ideas

Change Idea #1 To improve overall dialogue of diversity, inclusion, equity and anti-racism in the workplace

Methods	Process measures	Target for process measure	Comments
Training and/or education through Surge education or live events	Number of staff education on Culture and Diversity	80-100% staff education on Culture and Diversity	

Change Idea #2 To increase diversity training through Surge education or live events

Methods	Process measures	Target for process measure	Comments
Introduce diversity and inclusion as part of the new employee onboarding process	Number of new employee trained of Culture and Diversity	100% number of new employee trained of Culture and Diversity	

Change Idea #3 To facilitate ongoing feedback or open door policy with the management team			
Methods	Process measures	Target for process measure	Comments
Celebrate culture and diversity events through the use of the CLRI Diversity and Inclusion Calendar	Number of events held in the Home related to Culture and Diversity	at least 4 events held in the Home by December 2024	

Change Idea #4 To improve the Home's discussions on Cultural Diversity			
Methods	Process measures	Target for process measure	Comments
Include Culture and Diversity as part of the standing Agenda Item at CQI meetings	Number of CQI Meetings that discuss Culture and Diversity	00% of CQI Meetings will include Culture and Diversity	

Experience

Measure - Dimension: Patient-centred

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences".	O	% / LTC home residents	In house data, interRAI survey / Most recent consecutive 12-month period	91.94	96.00	To improve by 5% from previous Satisfaction Survey	

Change Ideas

Change Idea #1 To increase to 96% by engaging residents in meaningful conversations, and care conferences, that allow them to express their opinions

Methods	Process measures	Target for process measure	Comments
Add resident right #29 to standing agenda for discussion on monthly basis by Program Manager during Resident Council meeting	Number of Resident Council agendas will have Residents' Bill of Right #29 added	100% of Resident council meetings will include Resident' Bill of Rights #29	Total Surveys Initiated: 62 Total LTCH Beds: 104

Change Idea #2 Review "Resident's Bill of Rights" more frequently at monthly department meetings. With a focus on Resident Rights #29. "Every resident has the right to raise concerns or recommend changes in policies and services on behalf of themself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else"

Methods	Process measures	Target for process measure	Comments
Review Resident's Bill of Rights #29 at departmental meetings	Number of Departmental Meetings that include Resident Bill of Rights #29	100% of all Departmental Meetings will include Resident Bill of Rights #29	

Change Idea #3 An additional process to submit feedback and ideas to leadership team

Methods	Process measures	Target for process measure	Comments
Implementation of a Resident and Family Feedback box	Number of feedback submissions received	100% of feedback submissions reviewed by Leadership Team for process improvement	

Safety

Measure - Dimension: Safe

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of LTC home residents who fell in the 30 days leading up to their assessment	O	% / LTC home residents	CIHI CCRS / July 2023– September 2023 (Q2 2023/24), with rolling 4-quarter average	20.37	15.00	Target is based on corporate averages. We aim to do better than or in line with corporate average.	

Change Ideas

Change Idea #1 To facilitate a Weekly Fall Huddles on each unit

Methods	Process measures	Target for process measure	Comments
Complete a weekly meeting with unit staff regarding ideas to help prevent risk of falls or injury related to falls	Number of weekly meeting on each unit	80% of nursing staff participation on Falls Weekly huddle in each unit	

Change Idea #2 To collaborate with external resources of ideas to help prevent further resident increase of falls or injury related to falls

Methods	Process measures	Target for process measure	Comments
To increase participation with RNAO Best Practice Coordinators to navigate falls processes	Number of staff participants with RNAO Best Practice for Falls	100% of staff participate in RNAO Best Practice for Falls	

Change Idea #3 To improve overall knowledge and understanding of Falls Program			
Methods	Process measures	Target for process measure	Comments
To increase training and/or education of Falls program and Falls prevention to staff	Number of staff educated on the Falls Management Program and Fall Prevention equipment.	100% of staff educated on Falls Management Program and Falls Equipment.	

Change Idea #4 Improve tracking of Falls within the Home to identify trends to prevent falls			
Methods	Process measures	Target for process measure	Comments
Enhanced utilization of Falls tracking system and communication of trends identified to Nursing staff on a quarterly basis	Number of quarterly CQI Meetings that review falls tracker data to identify trends and analysis	100% of quarterly CQI Meetings will address trends and analysis of falls in the Home.	

Measure - Dimension: Safe

Indicator #5	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment	O	% / LTC home residents	CIHI CCRS / July 2023–September 2023 (Q2 2023/24), with rolling 4-quarter average	18.27	17.30	Target is based on corporate averages. We aim to do better than or in line with corporate average.	

Change Ideas

Change Idea #1	The MD, NP, BSO (including Psychogeriatric Team), with nursing staff will meet monthly to review all new admissions for diagnosis and medications related to inappropriate prescribing of antipsychotics. This is also part of PAC quarterly meeting agenda, which also includes the pharmacy for further analysis and improvement strategies

Methods	Process measures	Target for process measure	Comments
Nursing team will ensure that residents who receive antipsychotics are reviewed quarterly and as needed, by the physician and appropriate team members. this will be included in team meetings routinely, occurring, as a means to access responsive behaviours and the use of antipsychotics.	Number of Monthly quality meetings that review Residents prescribed antipsychotics and potential for de-prescribing. PAC meetings held that review Residents have been appropriately prescribed antipsychotics and Number of Residents that have been de-prescribed successfully	100% of Residents receiving an antipsychotic will be reviewed quarterly and reviewed at PAC Meeting.	

Change Idea #2	Residents who are prescribed antipsychotics for the purpose of reducing agitations and or aggression will have received medication reviews quarterly and as appropriate, in collaboration with their care team; that being, physician, pharmacist, NP, nurse etc., to consider dosage reduction or discontinuation.

Methods	Process measures	Target for process measure	Comments
BSO lead and nursing team will ensure that residents who receive antipsychotics are reviewed quarterly and as needed, by the physician and appropriate team members. this will be included in team meetings routinely, occurring, as a means to access responsive behaviours and the use of antipsychotics use.	Number of antipsychotics reduced as a result monthly	100% of residents who are prescribed antipsychotic medications will receive a 3 month review to determine potential for reduction in dosage or discontinuing antipsychotics.	

Change Idea #3	Implement behavior monitoring upon admission with data observation system (DOS) and BSO to review and document the findings for NP and MD to follow-up

Methods	Process measures	Target for process measure	Comments
PSWs to completed behavioural DOS tracking and BSO Lead to review and document findings to NP and MD for follow-up and safe reduction or eliminating of antipsychotics as deemed appropriate.	Number of behavioural DOS completed upon admission and BSO Lead reviews findings with NP and MD	100% of new admissions will have a DOS tool completed and reviewed by the BSO, NP, and MD	