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

Country Village Health Care Centre 440 COUNTY ROAD 8 , R.R. #2, South Woodslee , ON, N0R1V0

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
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)															
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)	51093*	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.		1)To reduce unnecessary hospital transfers	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	Utilize Nurse Practitioner, other stake holders such as CareRx
											2)Support early recognition of residents at risk for ED visits by providing preventive care and early treatment for common	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	
											3)Implement tracking tool for ED Transfers	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	
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	51093*	CB	80.00	Through education, the Home expects to have an increase understanding of this criteria over the next 6 months		1)To improve overall dialogue of diversity, inclusion, equity and anti-racism in the workplace	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	
											2)To increase diversity training through Surge education or live events	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	
											3)To facilitate ongoing feedback or open door policy with the management team	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	
											4)To improve the Home's discussions on Cultural Diversity	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	Patient-centred	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	51093*	91.94	96.00	To improve by 5% from previous Satisfaction Survey		1)To increase to 96% by engaging residents in meaningful conversations, and care conferences, that allow them to express their	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	
											2)Review "Resident's Bill of Rights" more frequently at monthly department meetings. With a focus on Resident Rights #29. "Every	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	
											3)An additional process to submit feedback and ideas to leadership team	Implementation of a Resident and Family Feedback box	Number of feedback submissions received	100% of feedback submissions reviewed by Leadership Team for process	
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	51093*	20.37	15.00	Target is based on corporate averages. We aim to do better than or in line with corporate average.		1)To facilitate a Weekly Fall Huddles on each unit	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	
											2)To collaborate with external resources of ideas to help prevent further resident increase of falls or injury related to falls	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	
											3)To improve overall knowledge and understanding of Falls Program	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.	
											4)Improve tracking of Falls within the Home to identify trends to prevent falls	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.	
		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	51093*	18.27	17.30	Target is based on corporate averages. We aim to do better than or in line with corporate average.		1)The MD, NP, BSO (including Psychogeriatric Team), with nursing staff will meet monthly to review all new admissions	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	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	100% of Residents receiving an antipsychotic will be reviewed quarterly and	
											2)Residents who are prescribed antipsychotics for the purpose of reducing agitations and or aggression will have	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	Number of antipsychotics reduced as a result monthly	100% of residents who are prescribed antipsychotic medications will	
											3)Implement behavior monitoring upon admission with data observation system (DOS) and BSO to review and document the	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	