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)	18.72	16.72	1) At/Below the provincial Average; 2) Through implementation of our change ideas, the home expects an	

Change Ideas

Change Idea #1	1) To reduce unnecessary hospital transfers, through the use of on-site Nurse practitioner; education to families; education to staff; Use of SBAR, Root cause analysis of transfers. Registered in charge nurse to communicate to physician and NP, a comprehensive resident assessment, to obtain direction prior to initiating an ER transfer; 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. Discussion with residents and families, about role of NP's in LTC. re-education of registered staff, regarding assessment skills, and become part of standing nurse practice monthly meetings review; 3) Build capacity and improve overall clinical assessment to Registered Staff; 4) Discussions about advance care planning on care conferences

Methods	Process measures	Target for process measure	Comments

1) Education will be provided to registered staff on the continued use of SBAR tool and support standardize communication between clinicians; 2) Educate residents and families about the benefits of and approaches to preventing ED visits. 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; 3) Conduct needs assessment from Registered Staff to identify clinical skills and assessment that will enhance their daily practice. 4) Nurse Practitioner on site will provide education theoretically and at bedside. 5) SBAR documentation will be used for clinical charting and NP will provide refresher education to registered staff. 6) Implement internal hospital tracking tool and analyze each transferstatus. ED transfer audit will be completed and reviewed monthly by nursing leadership (DOC, ADOC). Reports will be reviewed at quarterly PAC meetings; 7) Education to the interdisciplinary team related to "my wishes" to include resident's wishes related to CPR, Active management and hospital transfers. 8) Education and utilization of Palliative Performance Score (PPS) to determine disease progression	1) Number of communication process used in the SBAR format, between clinicians per month; 2) The number of residents whose transfers were a result of family or resident request. Number of staff who demonstrated education application via documentation quarterly. Thenumber of ER transfers averted monthly. Number of transfers to ED who returned within 24 hours; 3) based on needs assessment. 4) Improved confidence and decision making from Registered staff related to clinical assessment. 5) Increased SBAR documentation and improved communication within clinical team 6) Number of avoidable ED visits	1) 80% of communication between physicians, NP and registered staff will occur in SBAR Format by Sept 2024 2) Decrease by 0.5% until goal is achieved by reviewing all process measures in a quarterly basis; 3) 2% reduction of ED visits by December 31st 2024.	Utilize Nurse Practitioner, other stake holders such as Medigas, CareRx Pharmacy ands MDs to provide education to registered staff on topics

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	38.37	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 1) To improve overall dialogue of diversity, inclusion, equity and anti-racism in the workplace; 2) To increase diversity training through Surge education or live events; 3) To facilitate ongoing feedback or open door policy with the management team; 4) To include Cultural Diversity as part of CQI meetings

Methods	Process measures	Target for process measure	Comments
1) Training and/or education through Surge education or live events; 2) Introduce diversity and inclusion as part of the new employee onboarding process; 3) Celebrate culture and diversity events; 4) Monthly quality meeting standing agenda	1) Number of staff education on Culture and Diversity; 2) number of new employee trained of Culture and Diversity;	80-100% of staff educated on topics of Culture and Diversity	Total LTCH Beds: 157

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	76.43	78.43	Target is based on corporate averages. We aim to do better than or in line with corporate average.	

Change Ideas

Change Idea #1	1) To increase our goal from 76.4% (as compared to previous year %) to 78.5%. Engaging residents in meaningful conversations, and care conferences, that allow them to express their opinions. Review "Resident's Bill of Rights" more frequently, at residents' Council meetings monthly. 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
1) Number of meetings held monthly by interdisciplinary team. Number of antipsychotics reduced as a result monthly. Number of PAC meetings held quarterly, where discussion and reviews on strategies have resulted in a decrease of antipsychotics; 2) 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.	1) Number of meetings held monthly by interdisciplinary team. Number of antipsychotics reduced as a result monthly. Number of PAC meetings held quarterly, where discussion and reviews on strategies have resulted in a decrease of antipsychotics; 2) Number of residents prescribed antipsychotics medications over the number of residents who have received a medication review in the last quarter.	1) 100% of newly admitted residents will have been reviewed for the appropriateness of antipsychotics use; 2) 100% of residents who are prescribed antipsychotic medications will receive a 3 month review to determine potential for reduction in dosage or discontinuing antipsychotics.	Total Surveys Initiated: 157 Total LTCH Beds: 157

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	17.57	15.57	Target is based on corporate averages. We aim to do better than or in line with corporate average	

Change Ideas

Change Idea #1	1) To facilitate a Weekly Fall Huddles on each unit; 2) to improve overall knowledge and understanding of Falls Program; 3) 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
1) Complete a weekly meeting with unit staff regarding ideas to help prevent risk of falls or injury related to falls; 2) To increase participation with RNAO Best Practice Coordinators navigate falls processes; 3) To increase training and/or education of Falls program;	1) Number of weekly meeting in each unit; 2) number of staff participants on the weekly falls meeting; 3) increase staff participation with RNAO Coordinators	100% of staff participation on Falls Weekly huddle in each unit	

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	16.79	14.79	Target is based on corporate averages. We aim to do better than or in line with corporate average.	

Change Ideas

Change Idea #1	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; 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
1) Number of meetings held monthly by interdisciplinary team. Number of antipsychotics reduced as a result monthly. Number of PAC meetings held quarterly, where discussion and reviews on strategies have resulted in a decrease of antipsychotics; 2) 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.	1) Number of meetings held monthly by interdisciplinary team. Number of antipsychotics reduced as a result monthly. Number of PAC meetings held quarterly, where discussion and reviews on strategies have resulted in a decrease of antipsychotics; 2) Number of residents prescribed antipsychotics medications over the number of residents who have received a medication review in the last quarter.	1) 100% of newly admitted residents will have been reviewed for the appropriateness of antipsychotics use; 2) 100% of residents who are prescribed antipsychotic medications will receive a 3 month review to determine potential for reduction in dosage or discontinuing antipsychotics.	