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)	10.84	10.00	1) Below the provincial Average 2) Maintain favourable outcomes and stay below target	NLOT NPs, BSO, PRCs, RNAO BP Consultant, MD

Change Ideas

Change Idea #1 1) To reduce unnecessary hospital transfers, through the use of NLOT Nurse practitioner; education to families; education to staff throught the use of SBAR, and physical assessment. 2) Build capacity and improve overall clinical assessment to Registered Staff; 3) Discussions about advance care planning on admission and care conferences

Methods	Process measures	Target for process measure	Comments
1) Education will be provided to registered staff on the continued use of increased clinical communication and support standardize communication between clinicians; 2) Discussion during admission about avoidable ED visits with the resident and family 3) MD communication with resident and family availability of in home resources 4) Educated family on the importance and relevance of advance care planning on admission and care conference	1) Number of registered staff educated on effective communication tool allowing measureable ED visits 2) Number of Registered Staff communication with clinicians based on good clinical judgement. 3) Number of MD communication with family 4) Number of care conferences with advance care planning discussion	1) 80% of Registered Staff effectively adverted an ED visit due to the utilization of clinical communication with clinicians 2) 80% of MD communication with family effectively adverted ED visit 3) 80% of family and residents were educated about advance care planning	

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	89.00	100.00	Through education, the Home expects to have an increase understanding of this criteria over the next 6 months	Surge Education, BSO, CERAH, Hospice Northwest Volunteers, on call chaplains, multidenominational volunteers

Change Ideas

Change Idea #1 1) To improve overall dialogue of diversity, inclusion, equity and anti-racism in the workplace including religion and spiritual preference 2) To increase diversity training through Surge education or live events; 3) To facilitate ongoing feedback or open door policy with the management team with diverse staff members 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)Add culture and divrsity in the quarterly quality meeting standing agenda	1) Number of staff education on Culture, Religion and Diversity; 2) number of new employee trained of Culture, Religion and Diversity; 3) number of culture and diversity events celebrated for the year 4) number of topics discussed at the quarterly CQI	1)100% of staff educated on different topics of Culture, Religion and Diversity 2) maintain the number of culture, religion and diversity events celebrated within the home 3) increase participation of topic discussion	Total LTCH Beds: 128

Experience

Measure - Dimension: Patient-centred

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of residents responding positively to: "What number would you use to rate how well the staff listen to you?"	O	% / LTC home residents	In house data, NHCAHPS survey / Most recent consecutive 12-month period	83.00	85.00	Target is based on corporate averages. We aim to do better than or in line with corporate average.	Surge Education with Live Events

Change Ideas

Change Idea #1	1)To increase our goal from 82.76% in 2023 to 85%. 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; 2) Customer Service annual re-education for staff; 3) To continue to provide new staff education regarding Resident Bill of Rights and Customer Service during on-boarding

Methods	Process measures	Target for process measure	Comments
1) Add Resident Bill of Rights to standing agenda for discussion by program Manager during Resident Council meeting. 2) Re-education and review to all staff on Resident Bill of Rights and Customer Service at department meetings by department managers. 3) Increase awareness during staff on-boarding with real live scenario as sample during the training.	1) Percentage of staff attendance during monthly departmental meetings; 2) Percentage of new staff on-boarding that attended the discussion	1) 100% of all department standing agendas will discuss Residents' Bill of Right , for review by December 2024. 2)100% of all staff will have education via department meetings/Surge on Resident Bill of Rights and Customer Service by December 2024. 3)100% of resident Council meeting will have Residents' Bill of Right at each monthly review by 100% of Standing Agenda for Resident Council by December 2024.	Total Surveys Initiated: 100 Total LTCH Beds: 128

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	12.95	12.00	Our aim is to continue to be below Corporate Average.	RNAO BP Coordinator, PT, NP

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	1) 100% of staff participation on Falls Weekly huddle in each unit; 2) 100% staff participation with RNAO Best Practice Coordinator; 3) 100% completion of Fall Program training	

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	X	17.30	Our aim is to continue to be below Corporate Average.	BSO, LHIN, Alzheimers Society of Ontario, MD, NP, PRC

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 that resulted in resident decrease or elimination of antipsychotic medication. 2) Number of PAC meetings held quarterly, where discussion and reviews on strategies have resulted in a decrease or elimination of antipsychotics"	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.	