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)	18.18	16.00	Home specific target, Provincial average currently at 20.83%.	NLOT

Change Ideas

Change Idea #1 RAI Leads and interprofessional team to review list of residents transferred to ER – assess if it was avoidable

Methods	Process measures	Target for process measure	Comments
Track all residents sent to hospital using divisional tracking tool.	% of on site tracking of ED visits and data analysis based on return diagnosis and procedures performed in the hospital.	100% of residents sent to hospital tracked and assessed if transfer was avoidable	

Change Idea #2 Consultation prior to emergency room visit.			
Methods	Process measures	Target for process measure	Comments
Application of SBAR (to improve communication) to use when communicating with MDs and indicate why an emergency transfer is needed. Registered nurse to consult with the NM, Physician or NP [as possible] prior to sending a resident to ED in order to be proactive in minimizing avoidable transfers.	% of registered full time staff who completed education of SBAR.	100% of full time staff completed SBAR education	

Change Idea #3 Engage families and residents in discussing treatments options, early recognition of change in health status and initiation of end of life discussions.			
Methods	Process measures	Target for process measure	Comments
Collaborate with MD/NP/NLOT to provide in-home services/options regarding on site care to avoid hospitalizations.	% of resident in-home services/options on Palliative Care/EOL (Level 1 and 2 interventions) provided	Collecting baseline data	

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	44.35	100.00	Divisional target	

Change Ideas

Change Idea #1 Continue with Equity, Diversity and Inclusion training for all staff

Methods	Process measures	Target for process measure	Comments
Schedule staff who have not previously completed the training to complete it. Will continue to promote corporate workshop which support EDI	% completion rate	100% of managers and staff trained.	Total LTCH Beds: 150

Experience

Measure - Dimension: Patient-centred

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of resident expressing a high satisfaction with programming.	C	% / Residents	In-house survey / 2024	85.00	90.00	Home specific target	

Change Ideas

Change Idea #1 Review current programming using the SIPPS (Social Intellectual, Physical, Psychological and Spiritual) model and identify gaps in domains.

Methods	Process measures	Target for process measure	Comments
Create an excel spreadsheet capturing the unit based programs divided into the 5 domains according to the SIPPS model. Review the data collected over the course of 2 months	% of calendar compliant with 5 domains	100% calendar compliant	

Change Idea #2 Ensure the full time and part time RSA positions are filled to support evening and weekend programming.

Methods	Process measures	Target for process measure	Comments
Ongoing recruitment, filling vacancies with temp assignments. Scheduling evening and weekend programming	% of weekend/evening coverage	100% weekend/evening coverage	

Change Idea #3 Seeking consultations on current programs post program/event with participating residents.

Methods	Process measures	Target for process measure	Comments
Develop a tracking tool to collect feedback immediately following the program or event.	% of RSA who sought feedback	100% RSA's sought feedback	

Change Idea #4 Each program will have a completed program protocol and program evaluation.

Methods	Process measures	Target for process measure	Comments
Programs protocols will be completed for each program and evaluated by the end of the year.	% of Programming Evaluations completed	100% of Programming Evaluations completed	

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	8.15	7.50	Home specific target, Provincial average currently at 15.6%.	Achieva, PT, OT, PTA

Change Ideas

Change Idea #1 Maintain accurate tracking system and analyze trends.

Methods	Process measures	Target for process measure	Comments
NM to review reports daily and review/update tracking tool.	% of fall incident reports completed	100% fall reports completed	

Change Idea #2 PT recommendations/assessments will be followed up by Falls program rounds and care plan review/update with staff will be completed within 5 working days.

Methods	Process measures	Target for process measure	Comments
PT assessments and post fall huddles are utilized in post fall program rounds.	% of fall huddles completed	100% of fall huddles completed	

Change Idea #3 Organize education with pharmacist consultant regarding the impact of medication on falls.

Methods	Process measures	Target for process measure	Comments
Scheduling full time staff to attend sessions using adult learning principles.	% of full time registered staff trained	100% of full time staff trained	

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	27.55	17.00	Home specific target, Provincial average currently at 20.4%.	CAMH, Baycrest Hospital (North York), TRI, PRC

Change Ideas

Change Idea #1 Quarterly review of antipsychotic medication use by BSO lead and documentation in progress notes.

Methods	Process measures	Target for process measure	Comments
Quarterly meeting with unit staff to review the reason for antipsychotic medication use and its effectiveness.	% of antipsychotic medication plans reviewed for residents who do not have signs of psychosis	100% of antipsychotic medication plans reviewed	

Change Idea #2 Auditing MDS coding for accuracy.

Methods	Process measures	Target for process measure	Comments
RAI lead to audit weekly.	% of RAI MDS coded accurately	100% of RAI MDS codes accurate	

Change Idea #3 Consultation with external partners - CAMH, Baycrest, TRI, PRC to decrease Incidents/Form 1

Methods	Process measures	Target for process measure	Comments
BSO lead will liase with all external partners.	% of resident incident/ Form 1	0% resident incident/ Form 1	

Change Idea #4 BSO lead to participate in assessments, care planning and providing updates. To decrease incidents/complaints

Methods	Process measures	Target for process measure	Comments
Referral based assessments.	% of resident incidents/Form 1/complaints	0% resident incidents/Form 1/complaints related to behavioral issues.	

Measure - Dimension: Safe

Indicator #6	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Reduce percentage rate of residents with UTI and appropriate use of antibiotics	C	% / Residents	CIHI CCRS / July 2023– September 2023 (Q2 2023/24), with rolling 4-quarter average	3.50	3.00	Above divisional and provincial average	

Change Ideas

Change Idea #1 Review resident symptoms, document and refer to Public Health Ontario (PHO) Urinary Tract Infection (UTI) algorithm for interventions.

Methods	Process measures	Target for process measure	Comments
Implementation of evidenced based PHO UTI program.	% of lab confirmed UTIs treated with antibiotic compared to algorithm.	100% UTI's treated with antibiotic	

Change Idea #2 Provide information and education to residents, families/Power of Attorney (POA) and staff.			
Methods	Process measures	Target for process measure	Comments
• Staff will be booked to attend PHO education sessions. • Information to be communicated at Resident and Family Council and through newsletter. • Create communication form combining SBAR and PHO UTI algoritham for unit RN/RPN to use when calling MD to consult/ report urine lab result.	% of trained full time registered staff (all shifts) who completed the education by end of June 2024.	100% of full time staff education completed by end of June 2024	

Change Idea #3 Provide ongoing coaching and support to ensure compliance with the newly implemented practices.			
Methods	Process measures	Target for process measure	Comments
Immediate rounds will be done on each unit to ensure compliance with program [ongoing coaching tool be provided by IPAC/Nurse Manager].	% of scheduled rounds completed	100% of rounds completed	