# 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 / Oct 1, 2023, to Sep 30, 2024 (Q3 to the end of the following Q2) | 18.22 | 17.22 | Home Specific target as home below provincial 21.69 | |

# Change Ideas

**Change Idea #1**

Change Idea #1 Track and review/trend all emergency visits daily

**Methods**

RAI Leads to complete ED Tracking Sheet. ED transfer data and trends will be reviewed with clinical team: NMs, DON, Medical Director, and RAI Leads. The result will be reviewed in Nursing Practice and presented at Site CQI Committee meetings.

**Process Measures**

% of ED Transfers and trends reviewed by clinical team and interprofessional committees monthly

**Target for Process Measure**
100% of all ED transfers and trends will be reviewed

**Comments**

**Change Idea #2**
High risk care huddle will be held to discuss residents at risk, changes in health status, utilize external resources (i.e. NLOT/GMHOT).

**Methods**
Clinical team to continue interprofessional high risk huddles to review changes in health condition and to update care plans to include strategies to prevent future potential avoidable emergency visits

**Process Measures**
Number of scheduled high risk care huddle

**Target for Process Measure**
100% of scheduled high risk care plan reviews completed

**Comments**

# 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 | 86.25 | 100.00 | Home specific – SSLTC mandatory education | |

# Change Ideas

**Change Idea #1**

Provide education on Equity, Diversity, and Inclusion training for all full-time staff and managers.

**Methods**

Schedule all staff and remind managers to complete the mandatory *Let's Talk about Equity* training. Continue to promote mandatory training that supports Equity, Diversity, and Inclusion (EDI). Monitor completion rates.

**Process Measures**

% mandatory EDI training completion rate

**Target for Process Measure**

100% of staff complete EDI mandatory training *Let's Talk about Equity*

**Comments**

Total LTCH Beds: 228

# Experience

## Measure - Dimension: Patient-centred

| Indicator #3 | Type | Unit / Population | Source / Period | Current Performance | Target | Target Justification | External Collaborators |
|---|---|---|---|---|---|---|---|
| My issues, concerns or request for information are addressed. | C | % / Residents | In house data, NHCAHPS survey / Most recent consecutive 12-month period | 83.00 | 90.00 | Home specific target - Your Opinion Counts Survey | |

# Change Ideas

**Change Idea #1**

Review of all existing communication tools/paths available for residents to share issues, concerns and requests for information from all departments

**Methods**

All departments to gather all communication tools/paths and share findings. Committee will review findings. Processes to improve and streamline communication will be recommended based on findings.

**Process Measures**

% of departments who presented communication tools/paths

**Target for Process Measure**

100% of all departments will provide an overview of the tools/pathways available to residents to communicate.

**Comments**

**Change Idea #2**
Develop detailed survey for residents, families, and employees to voice opinion on current communication processes.

**Methods**
Create surveys specific to residents, families, and employees Allow survey to capture detailed perspective on current communication processes.

**Process Measures**

% of residents & families who completed the survey from Jan 20-Feb7, 2025 % of employees who completed the survey from Jan 20-Feb 7, 2025.

**Target for Process Measure**
20% of residents & families to complete survey from Jan 20-Feb7, 2025 80% of employees to complete survey from Jan 20-Feb 7, 2025.

**Comments**

**Change Idea #3**
Distribute the survey electronically or hard copy to all partners, collect and analyze the results

**Methods**
Department Leads will be identified and will communicate survey process with residents Leads will assist residents with CPS of 0-3 to complete survey. Leads will analyze results from surveys

**Process Measures**

% of surveys distributed % of surveys received

**Target for Process Measure**
100% of surveys distributed 20% minimum return rate

**Comments**

**Change Idea #4**
Engage Family Council and Residents' Council (per invitation) to complete 5 Why exercise to determine root cause of communication gaps.

**Methods**
Leads will engage Family Council and Residents' Council in the 5 why process to identify root causes. Action plans will be developed to enhance communication based on results.

**Process Measures**

% of planned meetings held to complete exercise

**Target for Process Measure**
100% of planned meeting will be held to complete 5 Why exercise.

**Comments**

**Change Idea #5**
Develop/implement strategies to improve the communication process

**Methods**
Identify what strategies will improve communication Review verbal, electronic, text and paper tools

**Process Measures**

% of recommended communication strategies tested/implemented

**Target for Process Measure**

Minimum 75% of strategies recommended will be tested/implemented

**Comments**

### Measure - Dimension: Patient-centred

| Indicator #4 | Type | Unit / Population | Source / Period | Current Performance | Target | Target Justification | External Collaborators |
|---|---|---|---|---|---|---|---|
| Personal laundry meets my needs | C | % / LTC home Residents | In-house survey / Most recent consecutive 12-month period | 86.00 | 88.00 | Home specific target – Your Opinion Counts Survey | |

## Change Ideas

**Change Idea #1**

Review areas of improvement by auditing/reviewing current practices compared to best practices/policies.

**Methods**

Identified current laundry issues by utilizing: Environmental course theories specifically Public Health Provincial Infectious Diseases Advising Committee (PIDAC) Course Module on Processing Personal Laundry Course Module on Processing Personal Laundry SSLTC Laundry Program Policy LS-0105-00.

**Process Measures**

% compliance with Best Practices for Environment Cleaning for Laundry Services (PIDAC)

**Target for Process Measure**

100% compliance with Best Practices for Environment Cleaning for Laundry Services (PIDAC)

**Comments**

**Change Idea #2**

Meet with Residents' Council to understand their concerns and issues with our current laundry procedures.

**Methods**

Discussion with Residents' Council

**Process Measures**

% of laundry issues resolved

**Target for Process Measure**

100% of laundry issues to be resolved

**Comments**

**Change Idea #3**

Provide Education sessions on laundry standardized process.

**Methods**

Improving laundry operational efficiency: Education sessions regarding the standardized process for laundry processing will be in place. Closet organization and maintenance will lead to a positive laundry experience with our residents. • Request for Ecotex to provide 2 Education Sessions throughout 2025 to all staff disciplines. Resident Council Tour of the laundry facilities in March 2025

**Process Measures**

% of staff who attend education

**Target for Process Measure**

100% monthly completion

**Comments**

**Change Idea #4**

Audit Compliance with laundry standards

**Methods**

Ensuring compliance: Our internal audits will drive our continuous quality improvements. Accountability measures will be in place through daily audits and weekly rounds completed by the team to uphold standards (Laundry service workers, Housekeeping, IPAC Manager, AA, RSA). Team Accountability to meet our regulatory standards (Public Health) and SSLTC Policies

**Process Measures**

% compliance with standards

**Target for Process Measure**

100% compliance with standards

**Comments**

# Safety

## Measure - Dimension: Safe

| Indicator #5 | 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 1 to Sep 30, 2024 (Q2), as target quarter of rolling 4-quarter average | 5.21 | 5.21 | Sustain as home is below provincial. | |

# Change Ideas

**Change Idea #1**

Fall incidents/risk management report will be reviewed and analyzed

**Methods**

Clinical team to complete monthly review of falls data and trends. To communicate and review this report in Nursing Practice and Site Quality committee meetings.

**Process Measures**

% of fall incidents reviewed and included in the trending analysis

**Target for Process Measure**

100% of fall incidents reviewed

**Comments**

FH QI for fall prevention and management has been below provincial and divisional benchmark. The clinical program has been stable and shown improvement in 2024.

**Change Idea #2**

Fall related Critical Incidents will be analyzed and clinical huddle conducted with care team to prevent falls and injury

**Methods**

Nurse Managers to analyze each fall related CI, to have interprofessional care plan huddles to review changes in health condition and to update care plans to include strategies to prevent future incident

**Process Measures**

% of CIs reviewed, analyzed and care plan updated

**Target for Process Measure**

100% of fall related CIs reviewed and analyzed

**Comments**

### Measure - Dimension: Safe

| Indicator #6 | 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 1 to Sep 30, 2024 (Q2), as target quarter of rolling 4-quarter average | 5.85 | 5.85 | Sustain home is below provincial average 19.65. | |

## Change Ideas

**Change Idea #1**

New admissions on antipsychotic medications will be reviewed by BSO Lead and medication reconciliation process

**Methods**

Behavioral support Lead to review all new admissions with anti-psychotics prescribed, to assist in the identification of non-pharmacological approaches to address responsive behaviors

**Process Measures**

% of new admissions reviewed to identify inappropriate antipsychotic use

**Target for Process Measure**

100% of new admissions are reviewed

**Comments**

FH QI for potential inappropriate antipsychotic use has been below provincial and divisional benchmark. The clinical program has been stable and shown improvement in 2024

**Change Idea #2**

CIHI QI data on inappropriate antipsychotic use will be reviewed by interdisciplinary team meetings

**Methods**

Quarterly review of CIHI QI data on inappropriate anti-psychotics use in collaboration with interdisciplinary team (RAI, BSO, Clinical Leads, NM, DON, NP and Physician) Site Quality committee meetings and in Nursing Practice Meetings

**Process Measures**

% of residents on anti-psychotics and CIHI QI report reviewed quarterly by home inter-professional team and BSO Lead

**Target for Process Measure**

100% of CIHI QI reports reviewed

**Comments**