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)	19.35	16.00	Our quality improvement program will improve the early identification, assessment, documentation and communication that changes in the resident health condition in our home. The goal is to improve care and reduce the frequency of potentially avoidable transfers to the ER.	

Change Ideas

Change Idea #1 Transfers to ED can be emotionally and physically challenging for residents, family and staff. We plan to implement additional quality improvements initiatives to reduce the frequency of transfers to the ED.

Methods	Process measures	Target for process measure	Comments
We will implement some tools available on the Ontario Health's website and some of the Interact Tools. We will adopt some basic types of tools. They will include quality improvement tools, communication tools, decision support tools, and advance care planning tools. We will purchase some of the Interact Tools for Change in condition/care, care paths guide, Stop and Watch early warning tools, SBAR communication form. We will implement tools to identify residents at high risk for an ED visit. We will identify the percentage of residents who had an ED visit in the previous month. We will identify the percentage of residents who had an ED visit in the previous month and had an accurate discharge record returned with the resident. We will identify the percentage of re-admitted resident to the home with the follow up care documented by the physician and the care plan updated accordingly. We will identify the number of residents who have an up to date care plan (including risk assessment and family and resident engagement).	Our process measure for this initiative will be calculated by taking the residents who had ER visits in the month, divided by the average number of resident in the home for the month. This measure will be a percentage.	We aim to reduce the rate of ED visits from our current rate of 19.35%, to 18% by October 31, 2024, and to 16% by February 28, 2025.	

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	CB	80.00	The recognition of trauma from residential schools and the COVID pandemic have highlighted the need for the redesign of models to address diversity, equity and inclusion in our health care system. We must be able to identify and then address the impact of inequity, diversity and anti-racism in our operations.	

Change Ideas

Change Idea #1 We need to identify clear accountability to ensure equity, diversity, inclusion and anti-racism in our operations. We need to collect data to support and justify decision making for equity, inclusion, diversity and anti-racism. Relevant education and ongoing training will start the process of recognition and fostering a culture focusing on equity, diversity, inclusion and anti-racism.

Methods	Process measures	Target for process measure	Comments
We will initiate a committee to support equity, diversity, inclusion and anti-racism. The committee will raise awareness of equity, diversity, inclusion and anti-racism throughout the home. We need to develop a program with a focus on addressing anti-indigenous racism and ensure that we prioritize our efforts to address equity, diversity, and inclusion in our framework and plan of operations.	The committee develop a mandate and meet monthly and as needed. We will update our education program to include relevant and ongoing training and education on equity, diversity and anti-racism. The education lead will provide the management team with data regarding the completion of the training quarterly. The education lead will present the data collected, based on department, total number of staff and total number who have collected the training.	We aim that 90% of our staff will have completed their relevant training by July 31, 2024. We also aim to ensure that 90% of agency staff working at the home will have completed the relevant training within 1 week of working at our home.	

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	CB	75.00	This is our residents's home and their voice must be heard. We need to capture the person's day to day experience of issues, including their care, autonomy, privacy, participation in activities, comfort, and safety. We will then use this data to drive quality improvement program.	

Change Ideas

Change Idea #1 We will regularly collect data to determine if our residents feel that their needs and concerns are being listened to. We will include this item as an agenda on our monthly Resident Council meeting to provide residents with an opportunity to raise awareness and discuss their need to feel free to openly discuss their concerns and if staff are listening to them. Based on the survey results, the management team will review and develop a plan to improve resident satisfaction as required.

Methods	Process measures	Target for process measure	Comments
We will have quarterly in-house surveys which ask all residents 'what number would they use to rate how well the staff listen to you'. This in-house survey will be managed by the activity department and distributed the first week of April, July, October and January. The activity department will submit the survey results to the administrator and the QI lead. The administrator will bring the survey results to the monthly team management meetings and to the quarterly medical advisory meetings.	We will total all the answers to the question and divide the total by the number of respondents. This will provide us with an average rating of how residents feel that staff listen to them.	We aim for a resident average rating of 6 on the July 2024 survey, an average rating of 7.2 for October 2024 and an average of 8.3 for January 2025 survey.	

Measure - Dimension: Patient-centred

Indicator #4	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	CB	80.00	This is our residents's home and they must feel safe. We need to capture the person's feelings with regard to feeling safe to discuss their opinion and needs. They have a right to make decision regarding their care, autonomy, privacy, participation in activities, comfort, and safety. Resident must feel safe to report their concerns. We will use this data to drive quality improvement program.	

Change Ideas

Change Idea #1	We will regularly collect data to determine if our residents feel that they can express their opinion without fear of consequences. We will include this item as an agenda on our monthly Resident Council meeting to provide residents with an opportunity to raise awareness and discuss their need to feel free to openly discuss their concerns. Based on the survey results, the management team will review and develop a plan to improve resident satisfaction as required.

Methods	Process measures	Target for process measure	Comments
We will have quarterly in-house surveys which ask all resident 'do you feel that you can express your opinion without fear of consequences'. This in-house survey will be managed by the activity department and distributed the first week of April, July, October and January. The activity department will submit the survey results to the administrator and the QI lead. The administrator will bring the survey results to the monthly team management meetings and to the quarterly medical advisory meetings.	We will total all the answers to the question and divide the total by the number of respondents. This will provide us with an average rating of how residents feel that staff listen to them.	We aim for a resident average rating of 6 on the July 2024 survey, an average rating of 7.2 for October 2024 and an average of 8.3 for January 2025 survey.	

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 2023– September 2023 (Q2 2023/24), with rolling 4-quarter average	14.52	12.00	Falls often have serious consequences for residents in long term care.Fall-related injuries negatively affect the resident's quality of life and activities of daily living. Resident who fall without injury, will develop a fear of falling and then restrict their own activity due to a fear of falling. Our home has a fall programs in place, but we recognize that there is room for improvement. We need to ensure that we have a systematic process of assessment, intervention and monitoring that results in minimizing fall risk.	

Change Ideas

Change Idea #1	We need to clearly identify residents who are at the greatest risk for falls. In addition to our current interventions in plan, we will screen for visual acuity, screen for osteoporosis and complete a revised med review. We need to collect data to identify at highest risk. We will review residents who have had a fall in the previous month at our weekly falls/restraint meetings. Provide family with findings regarding the causes of past falls in education materials for distribution to residents and families. Relevant education and ongoing training will provided to all staff on the new reviews.

Methods	Process measures	Target for process measure	Comments
We will update our fall risk assessment, fall report and the post fall assessment and incorporate other factors. This will be completed by the nursing department. Current fall risk assessment ratings will be discussed at the weekly falls'restraints meetings. Residents at high risk for falls will be visually identified, easily recognized by staff. This process to be determined. Listing of resident who have fallen in the previous month will be reviewed at the weekly falls/restraint committee meeting. Referral will be made as needed.	We will total the number fall risk rating and divide the total by the number of residents. This will provide us with an average fall risk for residents.	We aim for a declining fall risk assessment by March 2025. Our current FRAT risk assessment is 14.12, indicating a moderate risk for falls. We aim to lower it to 13.5 by July 2024, 13.0 by October 2024 and to 12.5 by January 2025.	

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 2023– September 2023 (Q2 2023/24), with rolling 4-quarter average	24.49	18.00	In long term care, anti-psychotics are mainly used to manage psychosis, in residents with schizophrenia and bipolar disorders. In those residents, anti-psychotic drug use will improve their quality of life and reduce anxiety and reduce their risks. Anti-psychotic may be used to manage behaviours of residents with dementia. This use raises concerns regarding their safety and quality of cof care. The use of anti-psychotic medication may bring more risks than benefits.	

Change Ideas

Change Idea #1	We need to carefully monitor and manage the use of anti-psychotics. MD will assess each resident taking an anti-psychotics at least quarterly to assess the need and ensure that they have a corresponding diagnosis. A progress note will be completed by MD. All resident taking an anti-psychotic will have a geriatric assessment to ensure that it is recommended and that they meet the criteria for the anti-psychotic. Perhaps a more appropriate alternative medication could be used.

Methods	Process measures	Target for process measure	Comments
A list of resident receiving anti-psychotic medication without having been diagnosed with psychosis, will be forwarded to the physicains monthly for review. A standardized progress note for review of antipsychotic medication use will be created for use by the MD and as needed. It will included if a geriatric assessment/reassessment is needed. The use of anti-psychotics without diagnosis will be reviewed at our quarterly Medical Advisory meetings. Our physicians and pharmacy will continue to work together to ensure appropriate use of these medications. We will encourage our physician to log into 'My Practice - long term care' to view their prescribing patterns in relation to peers across the province. Networking and education opportunities will become a priority. We will schedule monthly teleconferences on this indicator. We will provide additional training to residents and substitute decision makers on their proper use. We will consult with the Behavioral Supports Ontario (BSO) team to consider some non-pharmacological interventions.	Our process measure for this initiative will be calculated by taking the residents who are received an anti-psychotic medication in the month (without a diagnosis of psychosis) , divided by the average number of resident in the home for the month. Residents with a diagnosis of schizophrenia, Huntington's chorea, delusions and hallucinations and residents who are at or near end-of life will be excluded. This measure will be a percentage.	We aim for a declining percentage by March 2025. Our current percentage of resident receiving an anti-psychotic medication without a diagnosis of psychosis is 24.49%. We aim to lower it to 22.5% by July 2024, 20.0% by October 2024 and to 18.0% by January 2025.	