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)		20.83	To decrease the number of annual transfers to the ED by continuously improving quality of care and maximizing engagement of stakeholders.	

Change Ideas

Change Idea #1 Educate LTC staff, residents and families about advanced directives specifically regarding ED transfer to ensure every resident has a documented advance care directive plan.

Methods	Process measures	Target for process measure	Comments
The clinical team led by Nurse practitioners will provide education to the staff on how to initiate advance care directive conversations to ensure every resident has a documented advance care directive.	Percentage of residents with a completed advance care directive plan that includes ED transfer discussion.	100% of residents will have a documented advance care directive with ED transfer discussion by March 31, 2025.	Advance care planning and advanced directives have been shown to decrease the rate of ED transfers for long-term care residents.

Change Idea #2	Enhance specialized palliative care knowledge and skills in the home, by creating a Palliative Care Program to decrease the number of palliative residents transfer to the ED.		
Methods	Process measures	Target for process measure	Comments
Develop and establish a framework for a Palliative Care Program in the home, which includes staff education and roll out of the program.	Number of residents with an individualized care plan that includes a specific goal of care to determine eligibility to enroll in the Palliative Care Program.	100% of residents in the home will have a documented goal in the care plan. Less than 10% of residents in the Palliative Care Program would have a transfer to ED.	

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		75.00	Develop a strategy for building strong diversity, equity and inclusion, through partnerships, and ensure it is embedded into everything we do	

Change Ideas

Change Idea #1 All staff across the organization including health service providers are expected to participate in an annual EID-AR education.

Methods	Process measures	Target for process measure	Comments
Implement an EID-AR educational module on the SURGE Learning platform to provide additional opportunities for education and awareness to all staff by July 2024	Number of staff and board members that have completed EID-AR education module.	75% of all employees and Board members will complete training by March 2025.	

Change Idea #2 Equity, Inclusion, Diversity and Anti-Racism resources available to support equity planning and raising awareness within the Home.

Methods	Process measures	Target for process measure	Comments
Engagement and collaboration with the department leads to provide targeted education sessions to all staff. Increase awareness by providing access to resources, and tools to promote equity, diversity and inclusion in the Home.	Create and deliver, at a minimum two culturally specific programs during 2024. Department leads to provide education regarding EID-AR during orientation, and as needed to continuously promote diversity and equity into the operations of the Home.	75% of staff to have completed education courses by the end of March 2025.	

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		60.00	Enhancing resident quality of life and satisfaction through the provision of resident centered care. We believe in creating an environment where everyone feels heard and work towards positive outcomes while promoting transparency and openness.	

Change Ideas

Change Idea #1 The home will implement a Let's Connect Program, to gather residents feedback related to care, services and experience in the Home.

Methods	Process measures	Target for process measure	Comments
ADOC will collect on a weekly basis the feedback cards received from families and residents and promote participation through weekly rounds on residents. The feedback will be analyzed, and the team will develop action plans.	Number of feedback cards received on a weekly basis that have a completed action plan.	90% of residents feedback cards have an implemented action plan within 30 days of feedback received.	

Change Idea #2 Promote the PCH Social Model of Care in enhancing the health and quality of life of our residents by developing an annual resident satisfaction survey.

Methods	Process measures	Target for process measure	Comments
The ED will lead and support the development and rollout of an annual Resident Satisfaction survey by December 2024. It is expected that all staff will promote and support the annual resident satisfaction survey.	# of completed responses to the resident satisfaction survey with a minimum of 50% of the residents participating in the survey.	60% of completed responses will indicate that residents feel that they are listened to by staff.	

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		20.00	To increase resident safety in the home by implementing a Falls Prevention Program.	

Change Ideas

Change Idea #1 Implement Falls Prevention Program and frontline staff education on falls prevention strategies.

Methods	Process measures	Target for process measure	Comments
Create a falls prevention committee with terms of reference by July 2024 led by the Director of Care. Upon establishing the committee the team will collect, analyze, and review falls indicators at the Monthly Quality Committee meeting with the goal of identifying trends and establishing preventive interventions. The Falls Committee will also lead the education of frontline staff in falls prevention strategies.	Number of fall incidents with a risk assessment that was reviewed and evaluated on a monthly basis by the fall prevention committee.	100% of residents identified as high-risk fallers will have an individualized care plan and interventions in place. 100% of fall incidents will be reviewed and evaluated by the falls prevention committed every month.	

Change Idea #2 Implement weekly falls rounds for those residents identified as high risk for falls.

Methods	Process measures	Target for process measure	Comments
Falls lead and a falls champion will conduct bi-weekly rounding to visit all of the residents on the falls program. Falls lead will evaluate the effectiveness of current initiatives in place with the team on a biweekly basis. Develop inventory tracking tool or process to monitor supply of falls program supplies (including sensor alarms, hip protectors, SAKA pole, floor mats, non-skid socks, non skid strips) and audit inventory on a regular basis.	Number of bi-weekly rounding completed by the team. Number of supplies in use with residents enrolled on the falls prevention program.	10% reduction in falls by March 2025.	

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		21.00	Identify residents with antipsychotic medication without a diagnosis of psychosis and provide an interdisciplinary assessment and appropriate interventions to best meet the needs of the residents and improve quality of a life.	

Change Ideas

Change Idea #1 Review antipsychotic medication utilization on all new admissions and existing residents on a quarterly basis.

Methods	Process measures	Target for process measure	Comments
Admissions team will review each application prior to admission to identify residents with a use of antipsychotic medication without diagnosis and flag to the clinical team to address during the admission process. The clinical team will ensure that medication review for every resident is completed on a quarterly basis in collaboration with the physicians group.	Number of new admissions where the Admission Coordinator identify residents on antipsychotic medication without diagnosis. Number of existing residents on antipsychotic medication without a diagnosis.	Decrease in the use of antipsychotic in residents without a diagnosis by 20% by end of March 2025.	