Theme I: Timely and Efficient Transitions

Measure

Dimension: Efficient

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Number of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents.	P	Rate per 100 residents / LTC home residents	CIHI CCRS, CIHI NACRS / October 2020 - September 2021	15.07	14.00	Although this indicator can be influenced by families' and physicians' decisions outside of staff/Home control we continue to strive for improvement. Our goal is to reduce unnecessary ED visits through the utilization of communication tools and improved communication between nursing staff, physicians, families and Residents.	

Change Ideas

Change Idea #1 Provide refresher education to all staff for Comfort Care Rounds and then implement comfort rounds on Residents identified as being high risk for falls and/or Residents with a precarious health condition.

Methods	Process measures	Target for process measure	Comments
SURGE Learning education for all staff. Manager of Resident Care (MRC) will review at weekly huddles. Fall team will initiate comfort care rounds after assessing the resident.	Tracking on 24hr log. Conferences will document discussion/goals of care with family. Fall team will document and relay at monthly CQI meetings.	100% of staff will have been provided a refresher on Comfort Care Rounds by Dec 2022. All high risk Residents will be assessed and considered for comfort rounds	It requires staff consistency to build trust when performing comfort rounds.

Change Idea #2 Track and analyze each ED visit by utilizing a formalized tracking system that specifies reason for transfer, diagnosis, who sent the Resident, order and/or treatment received, admission to hospital, preventable transfer.

Methods	Process measures	Target for process measure	Comments
MRC to complete tracking sheet on every Resident transferred to the ED. This information will be discussed at monthly CQI meetings to determine whether the transfer could have been prevented and if so then how to prevent another unnecessary transfer.	Tracking sheets.	100% of ED visits will be tracked and analyzed by CQI team at monthly meetings	By utilizing a formal detailed ED tracking system the team will be better equipped to determine whether future changes are required or whether additional education is required for staff, Residents, SDM or even MDs.

Change Idea #3	MRC will meet with the staff on each unit on a weekly basis to determine which Residents may benefit from additional monitoring or interventions. Discussion will take place to promote safe mobility in Residents at high risk for falls, to identify sensory impairments requiring interventions, to discuss pain and palliative care management and for other precarious health conditions that may lead to a potential ED visit.		
Methods	**Process measures**	**Target for process measure**	**Comments**
A log of high risk Residents will be maintained	Staff will review identified Residents with frail or fluctuating health conditions on a weekly basis.	Within 3 months 100% of Residents will be reviewed for potential risk of conditions requiring ED transfer.	Early detection promotes early prevention of declining health and implementation of applicable/appropriate interventions

Theme II: Service Excellence

Measure

Dimension: Patient-centred

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of Residents responding positively to the question "Do staff intentionally start with what matters most to you when delivering care?"	C	% / LTC home residents	In house data collection / June 2022-Dec 2022	92.00	100.00	The goal is to have 100% of residents satisfied that their care provision is delivered in accordance to Resident preference versus an approach as decided by staff. This aligns with the RNAO Best Practice Guideline of Person and Family Centered Care.	RNAO

Change Ideas

Change Idea #1 Care Plans to detail Resident Centered language, as directed by Resident/Family.

Methods	Process measures	Target for process measure	Comments
Care provision will be discussed in detail with Resident and SDM upon admission, during admission conference, during annual care conference, with any change in status and any time that a Resident requests a change in routine. Details of the order of care provision will be documented in the individual care plan in collaboration with Resident/SDM. Changes will not be made without consulting Resident and/or SDM. Resident Centered Care language will be used.	Annual Resident satisfaction survey	By Dec 2022 100% of care plans will reflect individual care provision including the order of care provision if indicated.	

Change Idea #2 Five Things About Me pamphlet will be filled out on the day of admission by the registered staff and/or BSO team. This will be reviewed and updated at the admission care conference. It will be posted on the bulletin board in the Residents room.

Methods	Process measures	Target for process measure	Comments
Chart audits and care conference audits will be used to track the use of these pamphlets. The Resident satisfaction survey will indicate the success of them.	Number of completed pamphlets will equal the number of admissions within a 2 month period.	100% of new admission Residents will have a completed pamphlet by Dec 2022	This pamphlet will flag, for the staff, information that the Resident holds in high regard. The intention is to remind staff of what's important to the Resident allowing for optimal care provision and an enhanced therapeutic relationship.

Measure

Dimension: Patient-centred

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Resident Care experience; All staff will wear name tags	C	% / LTC home residents	In-house survey / June 2022-Dec 2022	78.00	100.00	Goal is to ensure that all staff, at all times are wearing name tags and introduce themselves to the Resident when providing care, interacting with residents or answering call bells. This aligns with not only legislation but with the best practise guideline for Person and Family Centered Care.	

Change Ideas

Change Idea #1 Resident and Visitors will know who is on duty and will be able to identify staff by their name tags which are colour coded according to departments.

Methods	Process measures	Target for process measure	Comments
Posting signage to remind staff to wear their name tags. 'Cheat sheet' requested by SDM and Residents for corresponding colours of the name tags. We will hand these out during the admission. Managers will conduct audits 2x/week and will remind staff at daily huddles. Visitor Attendant/screener at the front door will remind staff to wear their name tags upon arrival to the Home during screening process.	Audits will reveal whether staff are wearing their name tags. Resident satisfaction survey will identify whether this has improved since conducting audits, daily reminders and posting signage.	By Dec 2022 100% of staff will be wearing name tags 100% of the time.	Name tags sometimes become dislodged when providing Resident care or when donning or doffing gowns. If that is identified as a problem then we will offer traditional pin type name tags.

Theme III: Safe and Effective Care

Measure Dimension: Safe

Indicator #4	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	P	% / LTC home residents	CIHI CCRS / July - September 2021	7.14	6.00	BV is below the provincial benchmark, however, we have chosen to continue to focus on reducing the use antipsychotics in Residents without a diagnosis, to ensure optimal care provision. There continues to be some challenges in the Homes' understanding of MDS documentation as it relates to the use of antipsychotics.	External BSO, CareRx Pharmacy

Change Ideas

Change Idea #1 Auditing of all physician orders for all Residents taking an anti-psychotic medication (both atypical and typical) with the focus on ensuring all orders have a supporting diagnosis.

Methods	Process measures	Target for process measure	Comments
Pull all stats utilizing the Pharmacy (CareRx) Drug Utilization Reports (DUR) report every month and present stats at CQI meeting. Submit results to physician for order adjustment as applicable.	Monthly DUR pharmacy reports. Physician orders on individual charts.	100% of our Residents will have a supporting diagnosis when taking any anti-psychotic medication by the end of Dec 2022.	Ensuring physician orders are appropriately written decrease the inappropriate use of anti-psychotics.

Change Idea #2 Education to Register staff who complete MDS coding; ensure medical diagnosis aligns with MDS data sheet in PCC and that care plans reflect this. Education to all front line staff defining delusional disorder or delusional responsive behaviors.

Methods	Process measures	Target for process measure	Comments
Auditing of individual charts. Utilize SURGE. Discuss at monthly CQI meetings to determine the most effective means of educating staff to ensure highest retention of knowledge. Discuss at monthly staff meetings and seek staff input on education methods.	Tracking list of educational in services and SURGE learning.	100% of frontline registered staff will receive education on MDS coding by Dec 2022.	Assessing staff understanding of how and what information to document will enhance accuracy in understanding of the need for antipsychotic medication in Residents with delusional responsive behaviors.

Change Idea #3 Education to Substitute Decision Makers and Residents about alternative methods for managing responsive behaviors.

Methods	Process measures	Target for process measure	Comments
Discussions with Resident and SDM upon admission, at admission care conference, at annual care conferences and any time a medication has been changed or adjusted. Share with SDM the availability of courses such as online Teepa Snow or GPA or in services through the Alzheimer Society or CMH. Share nursing knowledge about alternatives to medication. Refer to BSO PRN.	Progress notes reflective of these discussions.	50% of audited admission progress notes and conference notes, will attest to active discussion between either the MD or register staff and Res/SDM regarding alternative means of managing responsive behaviors. Goal date is end of year	Enhanced communication, knowledge and understanding of the use of anti-psychotic medications will result in a lower expectation to use those medications as a first choice in managing responsive behaviors.