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	22.13	15.00	Our goal is to reduce the number of unnecessary ED visits through the utilization of communication tools and improved communication methods between the nursing staff, Residents, SDM and the physician while recognizing that this indicator can be influenced by SDM and Physicians decisions outside of staff/Home control.	

Change Ideas

Change Idea #1 Provide refresher education to all staff for Comfort Care Rounds and then implement Comfort Care Rounds on all Residents who have been identified as a very high risk for falls and for Residents with a precarious health condition.

Methods	Process measures	Target for process measure	Comments
SURGE learning education. Manager of Resident Care (MRC) and Resident Care Coordinator (RCC) to discuss and review Comfort Care rounds with staff at weekly huddles. A member of the fall team will set up comfort care rounds after assessing the Resident.	Tracking on 24hr log. Care conferences will indicate Comfort care rounds discussion with family. Progress notes will reflect consideration of comfort care rounds.	100% of staff will have been provided a refresher course by Dec 2022. 100% of Residents identified as a very high risk for falls will be assessed and considered for Comfort Care Rounds by a fall team member.	It takes time to build trust so it is important for staff to be consistent when conducting comfort care 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/or treatment received, admission to hospital and where it may have been a preventable transfer.

Methods	Process measures	Target for process measure	Comments
MRC or RCC will complete a tracking sheet on every Resident transferred to the ED. This information will be discussed at weekly unit meetings and at monthly CQI meetings to determine whether the transfer was preventable through treatment at the Home.	ER tacking sheets	100% of ED visits will be tracked and analyzed by the CQI team on a monthly basis.	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, SDMs, or even physicians.

Change Idea #3	MRC will meet with the staff on each unit on a weekly basis to determine which Resident would benefit from additional monitoring or interventions. Discussion will take place to promote safe mobility, to identify sensory impairments requiring interventions, to discuss pain and palliative care management and for other precarious health conditions that may lead to a preventable ED visit.

Methods	Process measures	Target for process measure	Comments
A log of high risk residents will be maintained by the Registered staff on the unit.	Staff will review, with MRC, on a weekly basis, all Residents with a frail or precarious health condition. To be reviewed by the CQI team monthly.	By Dec 2022 100% of Residents will have been reviewed for potential ED transfer.	

Theme II: Service Excellence

Measure

Dimension: Patient-centred

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Resident Care Experience: All staff will wear name tags and staff on duty will be publicly posted.	C	% / LTC home residents	In-house survey / Jan - Dec 2022	53.00	75.00	Goal is to ensure that all staff, at all times are wearing name tags and that they introduce themselves to the Resident when providing care, interacting with, or answering call bells. This aligns with legislation and the RNAO BPG for Person and Family Centered Care. Survey indicates 53% excellence rating and a 47% satisfied rating; goal is to increase to 100% excellency rating. The gap analysis for PFCC indicates that staff do not always wear name tags nor introduce themselves.	RNAO

Change Ideas

Change Idea #1 Residents, SDM and visitors will be able to identify staff by their colour coded name tag.

Methods	Process measures	Target for process measure	Comments
Signage will be posted by the time clock, in the change rooms and in the nursing stations to remind staff to wear their name tags. MRC or RCC will conduct 2x/week random name tag audit. Visitor Attendant will remind staff when screening staff in for their shift.	Audits will reveal whether staff are wearing their name tags. Resident satisfaction survey will identify whether this has improved.	By Dec 2022 100% of staff will be wearing their 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 a pin type of name tag.

Change Idea #2 Residents and visitors will know which staff is on active duty in each Resident Home Area.

Methods	Process measures	Target for process measure	Comments
A white board will be displayed outside of each nursing station (on each unit.) Registered staff will keep the board up to date with the names of the staff who are working on each shift. A coloured patch corresponding to the coloured departmental name tags will be placed beside the staff names so that residents and visitors can identify the staff by the colour name tags that they are wearing.	Managers will check daily while conducting their rounds, to ensure that the board contains up to date information. Positive results will be reflected in the Resident Satisfaction survey.	By Dec 2022 each unit will have a white board posted and it will contain current staffing information.	

Theme III: Safe and Effective Care

Measure **Dimension:** Safe

Indicator #3	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	28.57	20.00	EM is higher than the provincial average and higher than our 2 sister homes. Antipsychotics comes with side effects such as sedation, higher risk of falls, struggles to communicate or sleeping for large periods of time during the day; however, without the use of medications some residents are at risk of suffering from the effects of their health condition or others are put at risk because of responsive behaviors. We will strive to achieve a balance; lower the inappropriate use of antipsychotics while recognizing and documenting the need for antipsychotic use in other residents.	CareRx Pharmacy, External BSO

Change Ideas

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

Methods	Process measures	Target for process measure	Comments
Utilize CareRx Drug Utilization Report (DUR) and review stats at monthly CQI meetings. Submit results to physician for medication review and order adjustment.	Monthly DUR reports. Physician chart orders. Quarterly review. MDS/RAI stats.	100% of Residents taking an antipsychotic will have a supporting diagnosis by Dec 2022	Ensuring that orders are appropriately written will decrease the inappropriate use of anti-psychotics and improve documentation transfer when conducting the quarterly RAI.

Change Idea #2	Education for all Registered Staff who complete RAI/MDS coding and raps that includes the following: ensuring that the Medical diagnosis aligns with the MDS data sheet in PCC and that the care plans reflect this.

Methods	Process measures	Target for process measure	Comments
Education on SURGE. Discussion at CQI meetings to determine the most effective means of educating staff to ensure the highest retention of knowledge. MRC to discuss with staff at weekly huddles.	Tracking list of educational in services. Surge reports.	100% of all registered staff who complete MDS coding/raps will receive education about how and where to document a diagnosis of psychosis.	Assess staff understanding of how and what information to document will enhance accuracy in understanding the need for antipsychotics in residents with (psychotic) responsive behaviors.

Change Idea #3	Upon admission and at the admission care conference: if the Resident is taking a prescribed antipsychotic medication a discussion will take place with the Resident and/or Substitute Decision Makers about the Residents historical use of antipsychotics. Questions about the use of alternative methods for managing responsive behaviors will be asked.

Methods	Process measures	Target for process measure	Comments
Registered staff will gather information about the Resident's historical use of antipsychotic medication; when were they started? why? Improvements since starting? Side effects? Staff will document this information in progress notes and collaborate with the physician and pharmacy to review the medication history and if appropriate, to discuss alternative medications with resident and/or SDM.	Progress notes to reflect these discussions.	By Dec 2022, 50% of Residence who are admitted on an antipsychotic will have admission progress notes that attest to active discussions between the registered staff and Resident (and/or SDM) regarding the use of antipsychotic medications and alternatives tried in the past.	Upon admission, enhanced communication and documentation, knowledge and understanding of the use of antipsychotics may result in lower expectations to utilize these medications as a first choice in managing non-psychotic responsive behaviors.

Change Idea #4	Education to frontline staff who document in Point Click Care (PCC); defining and recognizing delusional disorder behaviors in order to document accurately.

Methods	Process measures	Target for process measure	Comments
Education regarding delusions and hallucinations will be posted on SURGE for all frontline staff. Individual education will be offered to staff who may require further information.	SURGE reports will indicate who has completed the education and will include an area for staff to request further information. This will be tracked monthly by the education and QI Co-Ordinator.	100% of frontline staff will have reviewed and have an understanding of what constitutes delusional behavior.	

Change Idea #5 An admission assessment form will be developed for assessing Residents who are admitted on an antipsychotic medication.

Methods	Process measures	Target for process measure	Comments
The CQI team will develop an assessment form for collecting information about the historical use of antipsychotic medications.	Form to be developed for collecting data.	By Dec 2022 the CQI team will have created a form for gathering information on the Residents historical use of antipsychotics.	This form will direct the registered staff during the admission assessment so that information is not forgotten. The goal is to begin utilizing and testing the benefit of this form in 2023.