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)	17.57	14.00	Our goal is to reduce avoidable emergency department visits by 20% over the next year.	

Change Ideas

Change Idea #1	Reduce (avoidable) repeat visits by the same Resident to the emergency department for unresolved/ongoing symptoms through increased nursing and medical surveillance and intervention in follow up to the previous ED/hospital visit.		
Methods	Process measures	Target for process measure	Comments
Purchase of diagnostic equipment funding approved items (doppler, IV equipment). The staff educator in collaboration with the nursing manager and equipment provider will support registered staff in the utilization of the new diagnostic equipment to better identify and treat issues that may have otherwise resulted in a transfer to the emergency department. Implementation of updated shift report and education for registered staff on opportunities for improved transition between shifts to support improved care outcomes for residents.	Track the number of staff trained to use new diagnostic equipment. Track the number of potential issues identified utilizing the new diagnostic equipment Track the ongoing use of daily report sheets and shift hand offs.	Reduce the number of Residents who returned to the hospital/ED within 30 days of a previous visit/admission, to less than 2 per month by Dec 2024.	Readmission to a care facility can be stressful for both Residents and the SDMs particularly when there are concurrent stays within a short period of time. This also increases the burden on caregiving staff and physicians. Early recognition of high risk conditions will prompt additional nursing and medical interventions, which may decrease the number of repeat visits to the Emergency department.

Change Idea #2	All registered staff will understand how to utilize the Clinical Data Exchange on Point Click Care for admissions, transfers and discharges.		
Methods	Process measures	Target for process measure	Comments
Education will be provided to all registered staff during orientation and will be incorporated into the orientation package. A nursing manager will meet with all nurses prior to independent work on the floor to ensure they have an understanding of how to utilize this program. Managers will utilize this system to track unplanned Emergency Department visits and hospital admissions. Data will be presented at the CQI meetings for analysis and action planning.	We will track the number of Admissions, Discharges and Transfers being completed by registered staff compared to the orientation provided. The percentage of staff trained on the use of the clinical data exchange.	100% of hospital transfers will be captured utilizing the Clinical Data Exchange by Dec. 2024; 100 % of registered staff will understand and implement data for all unplanned ED visits.	Utilizing the Clinical Data Exchange accurately tracks hospital visits and it enhances the flow of resident health information to both parties thereby providing the nurses with the information necessary to provide optimal resident care, which in turn may decrease repeat Emergency Department visits.

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	CB	All staff at Bobier Villa are provided annual education on Workplace Harassment and Discrimination as well being provided with annual education on Civility and Respect in the Workplace. We will continue to provide training at the time of orientation and annually to all staff including management.	

Change Ideas

Change Idea #1	Elgin County will build on the Respect Lives Here project; education will be provided to all staff to support civil respectful interactions within the workplace.		
Methods	Process measures	Target for process measure	Comments
Utilize the Civil Respectful Wokplace training package developed in consultation with external provider. Post reminders in the Home for all staff. Posters to include reminders of what equity entails: providing every person with fair and equal treatment, while at the same time, striving to identify and eliminate barriers that prevent full participation. Continue with annual review of policies to ensure justice and fairness within the policies, procedures, practices, and the distribution of resources.	Number of staff who engaged in civil disrespect after having received Respect Lives Here education.	100% of staff will receive education and will follow the process; zero incidents of civil disrespect in the workplace.	

Change Idea #2	Introduction of RNAO Developing and Sustaining Nursing Leadership.		
Methods	Process measures	Target for process measure	Comments
Gap analysis scheduled for April 2024. Implementation plan will be created. All departments will participate in this best practice guideline. Part of this will include a staff satisfaction pre and post survey.	The creation and implementation/action plan will include pre and post staff survey evaluations and will be incorporated into the implementation plan.	Implementation plan to be developed by May 2024. Surveys will be developed and handed out by June 2024 and results reviewed by August 2024. Implementation plan reviewed and updated monthly beginning in July 2024.	When management staff and nursing leaders are knowledgeable and confident in their roles as leaders/supervisors they are better equipped to recognize and intervene in order to avoid any potentially escalating conflict amongst staff, thus preventing incidents of civil disrespect.

Change Idea #3 Development and implementation of Diversity, Equity and Inclusion policy specific to long-term care home resident care and services.

Methods	Process measures	Target for process measure	Comments
Conduct gap analysis and include staff, resident and family councils. Develop policy. Complete education. Include DEI as a standing agenda item on resident and family council meeting agenda and annual satisfaction survey.	Conduct pre and post policy survey specific to DEI for residents; # of surveys completed; # of DEI concerns identified within the survey; # of concerns brought forward separate to the survey; # of strategies implemented for resident care needs in support of DEI	Survey to be developed and implemented by the end of spring 2024; policy developed and implemented by end of summer 2024; post survey questions will be implemented into the annual satisfaction survey for the fall 2024 survey	While the corporation has DEI related policy and procedures, they do not fully incorporate the LTCH resident DEI related care and services. As such, the development of LTC specific policies will further enhance the DEI needs of residents in 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	100.00	100.00	In 2022 8% of survey respondents were dissatisfied with how well staff listen to them. In response we introduced the BPG Person and Family Centered Care and made some significant changes. Those changes contributed to the 2023 results of 0% of respondents expressing dissatisfaction. We will continue our work along this line by addressing related areas of concerns.	

Change Ideas

Change Idea #1 Improve satisfaction of the Resident/SDM as it relates to how they participate in their plan of care.

Methods	Process measures	Target for process measure	Comments
Ensure Resident/SDM understanding of the purpose and intent of the plan of care through improved communication and education of residents and families. During care conferences (admission and annual) staff will start the conference by reviewing the purpose and intent of the plan of care, how this impacts the resident and how we seek participation from the resident and substitute decision makers in its development. A tip sheet with speaking points will be developed for staff to review at care conferences to ensure the information is shared. The home will develop, in collaboration with Resident and Family Council, a hand out on the plan of care including; how it is developed, its intent and purpose, who participates and how often which will be provided to new residents and families on admission.	Number of residents who respond positively to the survey question "I participate in my plan of care."	100% participation and satisfaction by Nov 2024, 0% uncertainty.	Total Surveys Initiated: 18 Total LTCH Beds: 56 Benchmarking against a 2023 11% dissatisfaction rate and 11% uncertainty rate

Change Idea #2 Review and update the resident and family satisfaction surveys to ensure questions are better understood by those completing the survey

Methods	Process measures	Target for process measure	Comments
Simplify the survey by eliminating multi-tiered questions. In order to understand the level of dissatisfaction we will divide the following question into 3 separate questions: "staff wear a name tag, introduce themselves, and explain their roles". The Home will continue to conduct name tag audits and to remind staff to wear their name tags. We will continue to address name tags and role explanations in the orientation training.	Track the number of positive responses to the satisfaction survey questions.	100% satisfaction 100% audits reflect name tags are worn	Benchmarked against our 2022 survey which indicated a 9% dissatisfaction rate we showed improvement in 2023 with a 0% dissatisfaction rate. We are addressing this because there was a comment stating "not all staff wear name tags."

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	12.86	10.00	This ties into our program evaluation.	

Change Ideas

Change Idea #1	Resident self transfers was identified as a major contributor of resident falls, while many residents fell when self transfering without staff assistance. We will be working to improve our lift and transfer program with the intent of an increase awareness of residents ability to self transfer and when they need assistance.

Methods	Process measures	Target for process measure	Comments
The development and implementation of a new transfer assessment which will be located within point click care for easy use will be completed in April 2024. New transfer assessment will be implemented in June 2024. Lift and transfer 'Trainer' training will take place for registered staff in April of 2024. All residents will receive the new transfer assessment on admission, quarterly and with any change in status that impacts mobility.	Number of staff who received hands on lift and transfer training. Audit of residents transfer assessments to ensure completed on admission, quarterly and with a change in status.	By Dec 2024 less than 5 residents per month will fall.	

Change Idea #2 Decrease the number of falls with injury; defined by level 2+ harm category.

Methods	Process measures	Target for process measure	Comments
Analysis of the post falls to identify trends and adjust routines where applicable at fall committee meetings and CQI meetings. Continue to review monthly fall audits with a consideration on adding additional interventions. Consider comfort rounds for any resident with repeat falls	# of falls with injury (level 2 or higher)	Monthly falls with injury will be less than 1 per month and maintained for 3 consecutive months by Dec 2024	

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	X	5.00	Bobier Villa is consistently well below the provincial average. Our goal is to maintain a less than 5% rate so we will address this in the 2024-2025 QIP	

Change Ideas

Change Idea #1	Implement collaborative regular meetings between the consultant pharmacist and the BSO team to review all residents on antipsychotic medications without a supporting diagnosis.		
Methods	Process measures	Target for process measure	Comments
Development of list of all residents who are using antipsychotics without a supporting diagnosis. Invite consultant pharmacist to attend BSO meetings on a quarterly basis to review medications. Complete review of residents and their associated behaviours and the need for medications. Work with consultant pharmacist and BSO staff to liaison with prescribing physician to provide recommendations for residents quarterly medication reviews, to support their behavioural needs while minimizing the use of antipsychotics. BSO team to support any resident who is discontinuing use of antipsychotic medication.	Number of residents using antipsychotic medication without an indication for use or a supporting diagnosis. Number of meetings between BSO team and consultant pharmacist. Number of residents on antipsychotic medications without a supporting diagnosis that are being supported by BSO	By Dec 2024 100% of residents using antipsychotic medications without a supporting diagnosis will be reviewed by the BSO team in collaboration with the consultant pharmacist to ensure behavioural care plans are in plan and medication aligns with the residents behavioural needs.	We recognize that the use of antipsychotic medication has a risk of side effects, however, antipsychotic medications are also effective at improving the quality of life for people with responsive behaviors so our goal is to ensure that an indication for use is supported by a medical diagnosis and that antipsychotic medications are used in conjunction with alternative forms of treatment.

Change Idea #2	Improvements to the internal BSO team structure by supporting regular team meetings and providing ongoing education and support for documentation in relation to BSO assessments, evaluations and plans of care.		
Methods	Process measures	Target for process measure	Comments
Schedule routine meetings: every 2 months with the BSO team. Educational webinars offered as staffing is available. Work with scheduling staff to ensure that each BSO team member is able to attend at least 2 educational sessions per year. Review of health records to ensure that BSO referrals are complete and that documentation reflects the work of the BSO team.	# of BSO meetings # of educational sessions each BSO member attends; documentation audits reflect completeness r/t BSO involvement	By Jan. 2025 each BSO member will have attended at minimum 2 BSO meetings. By Dec 2024 minutes will reflect 4 internal BSO meetings with 75% attendance; improved documentation for BSO clients.	