Access and Flow | Efficient | Optional Indicator

	Last Year		This Year		
Indicator #5 Rate of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents. (Bobier Villa)	**17.57**	**14**	**16.67**	**5.12%**	**15**
	Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

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.

Process measure

- 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.

Target for process measure

- 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.

Lessons Learned

Registered staff completed IV pump training via in person and in surge learning. New daily report sheets were implemented to assist in improved staff hand offs.

Change Idea #2 ☑ Implemented ☐ Not Implemented

All registered staff will understand how to utilize the Clinical Data Exchange on Point Click Care for admissions, transfers and discharges.

Process measure

- 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.

Target for process measure

- 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.

Lessons Learned

All registered staff were provided training, however, ongoing audits and follow up are required to ensure timely completion.

Comment

With the implementation of RNAO Clinical Pathways we anticipate increased screening and follow ups to avoid ED visits.

Equity | Equitable | Optional Indicator

	Last Year		This Year		
Indicator #4 Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education (Bobier Villa)	**CB**	**CB**	**95.65**	**--**	**100**
	Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☐ Implemented ☑ Not Implemented

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.

Process measure

- Number of staff who engaged in civil disrespect after having received Respect Lives Here education.

Target for process measure

- 100% of staff will receive education and will follow the process; zero incidents of civil disrespect in the workplace.

Lessons Learned

Education building on the respect lives here project was not implemented through to front line staff in 2024. However, the Homes management team did receive "Manager as a Coach Training" to better support civil and respectful workplace practices within the Homes.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Introduction of RNAO Developing and Sustaining Nursing Leadership.

Process measure

- The creation and implementation/action plan will include pre and post staff survey evaluations and will be incorporated into the implementation plan.

Target for process measure

- 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.

Lessons Learned

Lesson learned was an increase awareness of whom would be participating in the survey and providing feedback. The importance of creating a safe space for front line staff to share opinions and thoughts.

Change Idea #3 ☐ Implemented ☑ Not Implemented

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

Process measure

- 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

Target for process measure

- 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

Lessons Learned

This change idea will be carried into next years QIP

Comment

Embracing diveristy tool kit from CLRI will be utilized in 2025 to develop and implement policy and provide education to staff based on gaps identified.

Experience | Patient-centred | Optional Indicator

	Last Year		This Year		
Indicator #3 Percentage of residents responding positively to: "What number would you use to rate how well the staff listen to you?" (Bobier Villa)	**100.00** Performance (2024/25)	**100** Target (2024/25)	**94.95** Performance (2025/26)	**-5.05%** Percentage Improvement (2025/26)	**NA** Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

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

Process measure

- Number of residents who respond positively to the survey question "I participate in my plan of care."

Target for process measure

- 100% participation and satisfaction by Nov 2024, 0% uncertainty.

Lessons Learned

Informational pamphlet was developed describing the role of the resident and family in development of the plan of care. Pamphlet to be given out on admission and reviewed during care conferences.

Change Idea #2 ☑ Implemented ☐ Not Implemented

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

Process measure

- Track the number of positive responses to the satisfaction survey questions.

Target for process measure

- 100% satisfaction 100% audits reflect name tags are worn

Lessons Learned

Questions revised and updated. Reviewed with resident and family council to ensure a better understanding of the questions.

Comment

There was a very slight decrease in this indicator but overall very positive results. The Home is continuing to implement RNAO best practice guidelines - continuing focus on the BPG related to developing and sustaining leadership which will support resident outcomes in this area.

Safety | Safe | Optional Indicator

Indicator #2	Last Year		This Year		
Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment (Bobier Villa)	X	5	X	--	0
	Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☐ Implemented ☑ Not Implemented

Implement collaborative regular meetings between the consultant pharmacist and the BSO team to review all residents on antipsychotic medications without a supporting diagnosis.

Process measure

- 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

Target for process measure

- 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.

Lessons Learned

The Home transitioned to a new pharmacy in 2024 and has seen significant improvement in this indicator. While this change idea of the consultant pharmacist involvement with BSO team meetings was not fully implemented, discussions and work regarding antipsychotic medications occurred through Professional Advisory Committee meetings and quarterly medication reviews.

Change Idea #2 ☑ Implemented ☐ Not Implemented

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.

Process measure

- # of BSO meetings # of educational sessions each BSO member attends; documentation audits reflect completeness r/t BSO involvement

Target for process measure

- 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.

Lessons Learned

The home was able to recruit and onboard BSO staff which helped ensure this change idea was met. BSO meetings and attendance goals were met and documented in meeting minutes.

Comment

The home exceeded the target and has seen significant work in this indicator. The implementation of the RNAO clinical pathways project work will support this work.

Indicator #1

Percentage of LTC home residents who fell in the 30 days leading up to their assessment (Bobier Villa)

Last Year		This Year		
12.86	**10**	**9.52**	**25.97%**	**8**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

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.

Process measure

- 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.

Target for process measure

- By Dec 2024 less than 5 residents per month will fall.

Lessons Learned

Increasing number of staff who are lift trainers, including Registered Staff. Nursing staff completed hands on lift and transfer training
Implemented a new lift/transfer assessment in October 2024

Change Idea #2 ☑ Implemented ☐ Not Implemented

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

Process measure

- # of falls with injury (level 2 or higher)

Target for process measure

- Monthly falls with injury will be less than 1 per month and maintained for 3 consecutive months by Dec 2024

Lessons Learned

2023= 16%
2024= 14%

Comment

Adjustment were made to PSW shifts to ensure PSW staff member always able to be on the unit during shift change as this was identified as a time falls occurred. The lift/transfer assessment helps ensure registered staff can assess transfer ability more accurately.