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 / Oct 2021 - Sep 2022	11.39	10.00	Current perf. is below provincial average of 18.5 %. We will continue to improve avoidable ED visits by 12.20%.	ProResp, Mobile X-ray, Life Labs

Change Ideas

Change Idea #1 To establish functioning and effective lines of communication between the LTC facility and Emergency Department and/or the on call physician, all charge nurses will utilize the SBAR tool prior to ED transfers.

Methods	Process measures	Target for process measure	Comments
1. All registered staff will be educated on the SBAR communication tool to ensure adequate and precise information is shared with physicians and nurse practitioners prior to transfer.	The number of ED visits in comparison to The number of SBAR tools completed. The number of registered staff in comparison to staff trained on SBAR format.	80% of all ED transfers will have an SBAR completed. 100% of registered staff will be educated on the SBAR template by the end of June 2023.	

Change Idea #2 Create and educate staff on "quick reference sheet" to guide nursing team to reach out to external partners to utilize resources available in the home to prevent unnecessary ED transfers.

Methods	Process measures	Target for process measure	Comments
Nursing Leadership team will collect, analyze and review data during monthly meeting to validate the need for transfer, if available and appropriate resources were used and follow up with nursing team to educate as required.	Follow-ups with staff at registered meeting to review effectiveness of reference sheet and update as needed. Compare ED transfers data from month to month to see improvement.	100% of residents transferred to Emergency department will be reviewed monthly.	By Implementing quick reference sheet and addition of attending physician to support medical director in collaboration with nursing staff will help Golden Years to meet target goal of 12.20% improvement.

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 who responded positively to the statement: "Did we exceed your expectations?"	C	% / LTC home residents	In house data, interRAI survey / 2022 year end	90.48	95.00	To gauge residents overall inclusion/satisfaction with spiritual and religious services that have meaning to them.	Saint Clements Catholic Church, Grace Bible Church

Change Ideas

Change Idea #1 Our goal is to improve the overall spiritual and diverse religious needs of residents within the home.

Methods	Process measures	Target for process measure	Comments
1.The in house Spiritual leaders hours increased and reaching out to community church groups/members to identify and support diverse spiritual needs of residents based on their ethnic background and religious belief. 2.Identify residents with a specific religious/spiritual belief from demographic report in PCC, discuss with Resident/POA and personalize care plan to ensure everyone in resident's circle of care is aware and supports residents spiritual beliefs and needs.	Careplans will be reviewed and updated with resident specific religious activities/spiritual beliefs that add value and meaning to the residents life each month by the Recreation team and Chaplain.	To ensure all Care plans are reflective of residents spiritual/religious needs and beliefs as expressed by resident. Update residents care plan with specific religious activities/beliefs that adds value and meaning to residents life.	

Measure

Dimension: Patient-centred

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of Families who respond positively to "I would recommend this site/organization to others".	C	% / LTC home residents	In house data, interRAI survey / end of year 2022	100.00	100.00	To gauge and maintain resident and family overall satisfaction.	

Change Ideas

Change Idea #1 Our goal is to maintain overall excellent customer service, especially with regards to meal service and the overall resident dinning experience.

Methods	Process measures	Target for process measure	Comments
1.The DFS and leadership team will conduct meal audits once a week to gauge overall resident satisfaction during mealtime. The auditor will observe current routine, investigate requirements, communicate changes necessary, add information to dining room service plan and support staff ongoing.	The DFS will review mealtime audits monthly to gauge staff compliance with following policies and ministry requirements during mealtimes and to establish what education topics need to be implemented with frontline staff.	By June 30th 2023 80% of all staff will be trained and educated on new dinning room routine as per the policy/procedure guidance: Food, Nutrition and Hydration Inspection Guide (FLTCHA Data 2021), People Care policy 105010.00 and by Dec 31st 2023 100% of all staff will be trained and educated as per policy.	

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 / Jul - Sept 2022	25.43	20.80	Reduce our Antipsychotic usage without an appropriate Diagnosis to meet the provincial average.	community PRCs

Change Ideas

Change Idea #1 Psychiatry and Behavioural Neurosciences Specialist will review all antipsychotics and make changes accordingly.

Methods	Process measures	Target for process measure	Comments
Step 1: To ensure Antipsychotic medications usage is validated, the admission nurse and/or the BSO lead will conduct an in-depth review of medications upon admission and Quarterly with RAI MDS assessments. Step 2: BSO Lead will review every resident who is on an antipsychotic medication without a supporting Dx with psychogeriatric specialist reviewing medical history with the possibility to D/C and/or trial other interventions.	The BSO Team will review # of BSO referrals and the residents assessed by the psychogeriatric specialist quarterly.	100% of the new admissions on anti-psychotics will be assessed by the Psychiatry and Behavioural Neurosciences specialist physician within 3 months of admission.	Our Goal is to reduce usage of psychotropic medication by 18.20% and meet the provincial average.

Change Idea #2	Enhancing staff knowledge on trialing nonpharmacological interventions to minimize the usage of psychotropic medications by providing educational opportunities.		
Methods	Process measures	Target for process measure	Comments
Organizing the GPA training quarterly with the PRCC in the home to ensure all disciplines (Registered staff, PSWs, Dietary, Housekeeping) receives training to feel confident in approaching residents with responsive expressions. The BSO Team will update the monthly education board with the different responsive moods and expressions with appropriate interventions, interactive quizzes and games to enhance the learning experience of our Team.	The number of staff attending training courses as documented by educational sign in sheets.	75% of all staff to receive GPA Training by end of year.	Our Goal is to reduce usage of psychotropic medication by 18.20% and meet the provincial average.

Change Idea #3	Review quarterly RAI MDS assessments for all residents triggering the DRG01 QI for accuracy prior to submission to CIHI.		
Methods	Process measures	Target for process measure	Comments
Step 1: RAI Coordinator will review all residents individually based on the triggered QIs under PCC insights, to ensure accuracy of the coding. Step 2: Any resident without an appropriate Dx will be referred to the physician and the BSO Lead to follow up.	RAI coordinator will Audit each RAI assessment on a weekly basis.	100% of all residents on an antipsychotic medication will have an appropriate Dx recognized by CIHI by August 2023.	Our Goal is to reduce usage of psychotropic medication by 18.20% and meet the provincial average.

Measure

Dimension: Safe

Indicator #5	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
The percentage of residents whose care plan accurately captures the residents' expressed wishes for palliative and end-of-life care.	C	% / LTC home residents	CIHI CCRS / April 2023-March 2024	CB	CB	Identify resident decline and provide palliative care	Hospice Waterloo

Change Ideas

Change Idea #1 Additional section to care conference assessment to cover end of life wishes and will be updated in the CarePlan.

Methods	Process measures	Target for process measure	Comments
1.All plans of care will be updated ongoing with current CHESS score, Current PSI and current PPS, along with the residents Physical, Psychological, Emotional, Social, Cultural and spiritual needs. 2.Explanation of the palliative care options that are available, which may include, but are not limited to, early palliative care and end of life provided to SDM/POA.	Number of Care conference assessments and Care plans reviewed/completed with POAs and Family members per month by ADOC and leadership team.	50% of residents will have a palliative care conference section completed with plan of care updated by June 30th, 100% of residents will be complete by Dec 31st 2023.	

Change Idea #2 Increase in the number of residents who have experienced pain last quarter within the 7 day observation period as per the Quality indicator "Has pain PAIOX" 4 qtr avg. of 14.43% (August 2022) Updated pain scores were not documented throughout the 7 day observation period.

Methods	Process measures	Target for process measure	Comments
1.Education of staff -Code for the frequency the resident complains of, or shows evidence of pain (a), and code for the highest level of pain present in the last seven days (b). If the resident has no pain, code “0”, (No pain) Observation period with pain as a vital has been added to TAR to take pain level qshift for 7 days during Observation period 2.The DRQO will Monitor/Audit those residents who triggered the Has Pain indicator monthly for accuracy.	Quarterly all eligible residents will be on pain monitoring during a 7 day observation period and pain scores reviewed by DRQO for accuracy.	To have the QI Has pain 4 qtr avg. % under the provincial average by June 30th 2023 and to continue to maintain the % to be under provincial average through Dec 31st 2023.	