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)	27.36	26.00	To reduce ED visits in effort to meet provincial benchmarks.	

Change Ideas

Change Idea #1 Create and implement an SBAR transfer checklist for Registered Nurses.

Methods	Process measures	Target for process measure	Comments
The DOC and the NCC will create and implement an SBAR transfer checklist for Registered Nurses. The SBAR transfer checklist will be created in Q1 and then it will be brought to the monthly RN & RPN meeting for feedback. It will be implemented by Q2. The SBAR transfer checklist will be utilized by Registered Nurses to provide pertinent medical information to assist residents, SDM's, and MD's in determining the right treatment at the right place and at the right time. The CQI Co-ordinator will analyze, review, and report the data at the Continuous Quality Improvement meetings starting in Q2 of 2024.	# of SBAR transfer checklists utilized per month starting in July 2024.	100% of transfers sent to the ED will have the SBAR transfer checklist completed by the registered nurse on duty at the time of the ED transfer.	

Change Idea #2 Active collaboration with Medical Director, CEO, Director of Care, and Continuous Quality Improvement Co-ordinator to decrease the number of avoidable ED visits.

Methods	Process measures	Target for process measure	Comments
On a monthly basis the Continuous Quality Improvement Co-ordinator will collect data on resident's sent to the ED, analyze that data, and report the information to the Medical Director, the CEO, and the Director of Care.	# of residents sent to the ED whose visits were analyzed per month by the Medical Director, CEO, DOC, and the Nursing Coordinator.	100% of residents that are sent to the ED will be categorized for analysis and review.	

Change Idea #3 Improve awareness to residents and their SDM's on treatments that can be provided within the home.

Methods	Process measures	Target for process measure	Comments
The Direct Care Co-ordinator will inform residents and their SDM's about the treatments that can be provided to the residents within the home. The Direct Care Co-ordinator will also discuss with the residents and their SDM's the benefits of care delivered in the home environment at the "Move In" and annual multi-disciplinary care conferences.	# of residents/SDM's who received education on the treatments that can be provided within the home.	75% of residents or SDM's will be consulted by the end of Q3 2024 with the remainder of residents or SDM's consulted by the end of Q4 2025.	

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	The home will begin collecting baseline data as the home is not aware of its current performance.	

Change Ideas

Change Idea #1 Increase staff awareness on equity, diversity, inclusion, and anti-racism.

Methods	Process measures	Target for process measure	Comments
The CEO will arrange education on equity, diversity, inclusion, and anti-racism for staff starting in Q1. Attendance will be provided to the Administrative Coordinator who will track this information and enter it in the QIA tab that the home utilizes. The information will be reviewed and analyzed by the CQI committee at the CQI meetings that are held every 2 months.	# of staff who completed relevant equity, diversity, inclusion, and anti-racism education per month.	20% of the staff will have received education on equity, diversity, inclusion, and anti-racism by the end of Q1 2024, and 40% by the end of Q2 2024.	

Change Idea #2 Demonstrate our commitment to equity, inclusion, diversity and Anti-Racism.

Methods	Process measures	Target for process measure	Comments
Members of the Continuous Quality Improvement Committee will complete section 1 of Embracing Diversity: A Toolkit for Supporting Inclusion in Long-Term Care Homes. This assessment will help our home identify what we are doing well and how we can improve our equity, diversity, and inclusion practices. Members of the Continuous Quality Improvement Committee will then create and action plan based on the assessment results.	# of Continuous Quality Improvement committee members who have come together to complete Equity, Diversity, and Inclusion in LTC: Assessment and Planning Tool and the Action plan.	The Organization and Personal Reflection tool and the action plan will be completed by the end of Q2.	

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	73.81	79.00	Strive for 80th percentile.	

Change Ideas

Change Idea #1 The Resident and Family Satisfaction Survey will be reviewed and revised by Members of the Resident Council with the assistance of the lead of the CQI Committee.

Methods	Process measures	Target for process measure	Comments
The Lead of the CQI Committee will speak with members of the Resident Council in Q1 and arrange meetings around their schedules to review and revise the Resident and Family Satisfaction Survey. Meetings will be held in Q1 and part of Q2 of 2024. The members of the Resident Council will advise on how the survey will be carried out in the home.	# of meetings held with members of the resident council per month to review and make changes to the Resident and Family Satisfaction Survey.	The Resident and Family Satisfaction Survey will be completely reviewed and revised by Members of the Resident Council with assistance of the lead of the CQI Committee by August 30, 2024.	Total Surveys Initiated: 88 Total LTCH Beds: 90

Change Idea #2 Encourage residents to participate in monthly Residents' Council meetings to bring ideas or concerns forward.

Methods	Process measures	Target for process measure	Comments
Residents' Council will work in collaboration with the Manager of Recreation & Volunteers to create a Residents' Council brochure that will be included in the admission package. This will be completed by Q1 and will be added to the admission package by the Resident and Family Services Coordinator in Q1. The Manager of Recreation & Volunteers will also encourage residents to participate in Residents' Council when the Manager of Recreation & Volunteers meets the resident on "Move In" day. The Manager of Recreation & Volunteers will begin tracking the number of residents that were invited to participate in Residents' Council on a monthly basis. The Manager of Recreation & Volunteers will enter the data into the QIA tab that the home uses and this data will be analyzed and reviewed at the CQI Committee meetings that are held every 2 months.	# of residents invited to participate in Residents' Council meetings per month.	All new residents who move into Valley Manor will be invited to participate in monthly Residents' Council meetings.	

Measure - Dimension: Patient-centred

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences".	O	% / LTC home residents	In house data, interRAI survey / Most recent consecutive 12-month period	40.91	60.00	Higher is better.	

Change Ideas

Change Idea #1 Consult residents/families on how they interpret the statement, "I can express my opinion without fear of consequences".

Methods	Process measures	Target for process measure	Comments
The Manager of Recreation & Volunteers will engage Resident Council and Activation staff to collect feedback at the Resident Council meetings, at the "Move In" Multi-disciplinary Care conferences and annual Multi-disciplinary Care conferences. Provide 1:1 discussion on their interpretation of the embed question for data collection within the LTC Resident Experience Survey. The Manager of Recreation & Volunteers will collect, analyze, and share the information at the Continuous Quality Improvement Committee meetings that are held every 2 months.	# of residents/families consulted per month on how they interpret the statement, "I can express my opinion without fear of consequences".	75% of residents or SDM's will be consulted by the end of Q3 2024 with the remainder of residents or SDM's consulted by the end of Q4 2025.	Total Surveys Initiated: 88 Total LTCH Beds: 90

Change Idea #2 Improve the experience of the residents and families by encouraging an open door approach.

Methods	Process measures	Target for process measure	Comments
The CEO, DOC, Manager of Support Services, Manager of Recreation & Volunteers, Resident and Family Services Coordinator, and the Nursing Coordinator will address any requests or concerns brought forward by residents and family members within 10 days. This indicator will be tracked on a monthly basis by these senior leadership members and it will be reported on and analyzed every 2 months at the Continuous Quality Improvement Committee meetings.	# of requests or concerns brought forward by residents or family members that were addressed per month.	100% of concerns brought forward will be addressed within 10 days.	

Safety

Measure - Dimension: Safe

Indicator #5	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	20.27	19.20	Work towards the provincial benchmark.	

Change Ideas

Change Idea #1	Implement routine use of Falls Recording and Tracking tool, analyze data and perform trend analysis in effort to decrease incidence, risk, and severity of falls.		
Methods	Process measures	Target for process measure	Comments
The PTA collects the information monthly and enters it into the Falls recording and Tracking tool. The Direct Care Coordinator who leads the Fall Prevention and Management program and the Restorative Care Coordinator will review and analyze the data and perform trend analysis on a monthly basis. The Direct Care Coordinator will provide a a summary of the monthly analysis and report on trends at the monthly RN & RPN and the monthly PSW meetings. The Direct Care Coordinator will also present a summary of the analysis with the Continuous Quality Improvement Committee every 2 months for input and feedback for additional program improvements.	# of falls reviewed and analyzed per month by the Direct Care Coordinator and the Restorative Care Coordinator.	Starting in Q1 100% of falls that have been recorded in the Falls Recording and Tracking tool will be analyzed and reviewed by the Direct Care Coordinator and the Restorative Care Coordinator.	

Change Idea #2	To review and revise the homes Falls Prevention and Management program to ensure most current evidence informed practices are reflected. Audit current organizational practices to assess the quality of the homes falls prevention and management program to determine the areas requiring quality improvement(s).

Methods	Process measures	Target for process measure	Comments
The Direct Care Coordinator and the Restorative Care Coordinator will plan meetings for Q1 to review and revise the homes Falls Prevention and Management program. Recommendations for changes in the program will be made in red and brought forward to the Continuous Quality Improvement Committee by the Direct Care Coordinator and the Restorative Care Coordinator for review and approval. In Q2 the changes will be brought forward to the monthly nursing meetings by the Direct Care Coordinator and the Restorative Care Coordinator. Audits will be created by the Direct Care Coordinator and the Restorative Care Coordinator and they will implemented in Q2 to ensure current organizational practices. Completed audits will be reviewed and analyzed by the Direct Care Coordinator and the Restorative Care Coordinator, and then brought forward to the Continuous Quality Improvement Committee every 2 months for review. Areas for improvements will be discussed at the Continuous Quality Improvement meetings as well as successes.	# of fall prevention audits performed per month by the Direct Care Coordinator and the Restorative Care Coordinator.	By the end of Q3 the Direct Care Coordinator and the Restorative Care Coordinator will have audited 66% of the residents to ensure fall prevention interventions are in place and are current, and by the end of Q4 100% of residents will have had audits completed.	

Change Idea #3	To ensure residents who move into Valley Manor are assessed to identify potential for nursing restorative services in effort to reduce their risk for falls.		
Methods	Process measures	Target for process measure	Comments
Within 24 hours of moving in the Restorative Care Coordinator will assess each resident to determine the need for interventions, potential to improve or maintain his/her functional level, and to prevent deterioration. The Restorative Care Coordinator will collect information from all available sources including the resident and his/her SDM and evaluate the information in order to develop a plan of care. The Restorative Care Coordinator will document the assessment findings in the resident's progress notes under the Nursing Restorative Therapy template. On a monthly basis the Restorative Care Coordinator will collect the data and enter it into the QIA tab of Point Click Care. The Restorative Care Coordinator will then review the data with the Continuous Quality Improvement Committee every 2 months.	# of residents who moved into Valley Manor and were assessed for Nursing Rehabilitation Programs and admitted into Nursing Rehabilitation Programs per month.	100% of all new residents who move into Valley Manor from May 1,2024 - March 31, 2025 will be assessed to identify potential for nursing restorative services.	