Access and Flow | Efficient | Priority Indicator

Indicator #4

Rate of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents. (Golden Years)

Last Year		This Year	
11.39	**10**	**18.92**	**NA**
Performance (2023/24)	**Target (2023/24)**	**Performance (2024/25)**	**Target (2024/25)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

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.

Process measure

- 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.

Target for process measure

- 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.

Lessons Learned

Review of the SBAR tool was done with nurses by the NLOT nurse at the end of last year. Nurses were encouraged to always ensure the use of the SBAR tool when communicating with the physician. The use of SBAR tool was discussed at monthly registered staff meeting and at huddle. Its use has markedly improved.
The issue of communication was discussed at the Cambridge Collaborating Care Committee (CCCC) meeting and it was agreed that moving forward,

Challenge is communication and this is what is being implemented to address this challenge.
- Communication between the homes interdisciplinary team and the hospital team; create active directory/extension numbers
- Provide better communication - collaboration/discussion on what is best for the resident at that moment
- Start bringing communication of physician hand-off to the hospitalist meeting and internal medicine meeting when patients are being discharged back, when warranted.

- CMH staff schedules – establishing what times are best to contact nursing staff

Change Idea #2 ☑ **Implemented** ☐ **Not Implemented**

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.

Process measure

- 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.

Target for process measure

- 100% of residents transferred to Emergency department will be reviewed monthly.

Lessons Learned

Success
Implementation of Amplify – this platform will be helpful as we continue to build improved and helpful communication between the ED department and the long term care. This platform ensures continuation of care after discharge.
Quick reference sheet for external partners

Our nurses are familiar with external partners and reach out to them for support. Launchpad has been implemented at Golden years for quick access of online lab results which can be helpful in early care implementation.
Challenge – Life labs – e.g faulty ECG machine increasing wait time for ECGs
STL – sometimes not able to come in for several days, unfortunately, a resident may require an ED transfer for assessment is such instances.
Skin and wound care – without a nurse practitioner, frontline education for glue of a skin tear, we have to send a resident to the hospital if they require skin glue/sutures after a laceration.

Experience | Patient-centred | Custom Indicator

	Last Year		This Year	
Indicator #3	**90.48**	**95**	**100**	**NA**
Percentage of Residents who responded positively to the statement: "Did we exceed your expectations?" (Golden Years)	**Performance (2023/24)**	**Target (2023/24)**	**Performance (2024/25)**	**Target (2024/25)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

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

Process measure

- 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.

Target for process measure

- 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.

Lessons Learned

We have successfully completed the task of reviewing and updating care plans with resident-specific religious activities and spiritual beliefs. This monthly review was conducted by the Recreation team and the Chaplain to ensure that residents' lives are enriched with meaningful religious and spiritual practices.

My person hood summaries, personal leisure profiles and All about me, are resident centered information tools that are resident specific and filled out by collaborating with residents and families upon admission and ongoing.

	Last Year		This Year	
Indicator #1	**100**	**100**	**100**	**NA**
Percentage of Families who respond positively to "I would recommend this site/organization to others". (Golden Years)	**Performance (2023/24)**	**Target (2023/24)**	**Performance (2024/25)**	**Target (2024/25)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

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

Process measure

- 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.

Target for process measure

- 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.

Lessons Learned

We have completed the task of reviewing mealtime audits on a monthly basis. This review was conducted to assess staff adherence to policies and ministry requirements during mealtimes. The purpose of the review was also to identify any educational topics that need to be addressed with frontline staff.
This plan was implemented and successful

We continue with monthly resident food council meetings.
Seasonal meal planning is ongoing.

Safety | Safe | Custom Indicator

Indicator #5	Last Year		This Year	
The percentage of residents whose care plan accurately captures the residents' expressed wishes for palliative and end-of-life care. (Golden Years)	**CB** Performance (2023/24)	**CB** Target (2023/24)	**NA** Performance (2024/25)	**NA** Target (2024/25)

Change Idea #1 ☑ Implemented ☐ Not Implemented

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

Process measure

- Number of Care conference assessments and Care plans reviewed/completed with POAs and Family members per month by ADOC and leadership team.

Target for process measure

- 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.

Lessons Learned

The lessons learned include recognizing the importance of incorporating end-of-life wishes into care conferences and updating the CarePlan accordingly. Additionally, the challenge of incomplete pain score documentation has prompted the implementation of quarterly pain monitoring for all eligible residents. The ADOC and leadership team are committed to conducting a specified number of care conference assessments and care plan reviews with POAs and family members monthly. These measures reflect a positive approach towards improving resident care and communication with families.

Change Idea #2 ☑ Implemented ☐ Not Implemented

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.

Process measure

- Quarterly all eligible residents will be on pain monitoring during a 7 day observation period and pain scores reviewed by DRQO for accuracy.

Target for process measure

- 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.

Lessons Learned

Success current percentage below provincial avgs. 5.5%

Safety | Safe | Priority Indicator

	Last Year		This Year	
Indicator #2 Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment (Golden Years)	**25.43** Performance (2023/24)	**20.80** Target (2023/24)	**11.59** Performance (2024/25)	**NA** Target (2024/25)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Psychiatry and Behavioural Neurosciences Specialist will review all antipsychotics and make changes accordingly.

Process measure

- The BSO Team will review # of BSO referrals and the residents assessed by the psychogeriatric specialist quarterly.

Target for process measure

- 100% of the new admissions on anti-psychotics will be assessed by the Psychiatry and Behavioural Neurosciences specialist physician within 3 months of admission.

Lessons Learned

The BSO Team in house complete rounds every 5-6 weeks with our in house psychogeriatric specialist assessing all residents on Antipsychotic medications.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Review quarterly RAI MDS assessments for all residents triggering the DRG01 QI for accuracy prior to submission to CIHI.

Process measure

- RAI coordinator will Audit each RAI assessment on a weekly basis.

Target for process measure

- 100% of all residents on an antipsychotic medication will have an appropriate Dx recognized by CIHI by August 2023.

Lessons Learned

Ongoing and ensures accurate Documentation within the RAI MDS assessment to reflect appropriate quality indicators with regards to DRG01

Change Idea #3 ☑ Implemented ☐ Not Implemented

Enhancing staff knowledge on trialing nonpharmacological interventions to minimize the usage of psychotropic medications by providing educational opportunities.

Process measure

- The number of staff attending training courses as documented by educational sign in sheets.

Target for process measure

- 75% of all staff to receive GPA Training by end of year.

Lessons Learned

At the time of implementation process and ongoing all staff attend and are encouraged to attend educational opportunities such as BSO EDU, PIECES, U-First, BSO foundations course to better understand and implement nonpharmalogical interventions