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 / Oct 1, 2023, to Sep 30, 2024 (Q3 to the end of the following Q2)	24.68	21.70	Reduced unneccessary transfers to hospital is better for both Quality of life for each resident, and reduced burden on the ER.	

Change Ideas

Change Idea #1 Initiation of quarterly ED visit analysis.

Methods	Process measures	Target for process measure	Comments
Medical director will provide a quarterly analysis report to identify appropriateness of ED transfers. Inappropriate transfers will be analyzed to determine gaps for what education would be needed to help prevent future inappropriate transfers, such as review of in-home available resources and clinical resident assessments.	Monthly audits of ED visits entry of QIa into PCC. Quarterly PAC Meeting review of trends and Quality meetings semi annually	Avoidable ED visits to meet provincial average (Current provincial average 21.7) by Sept 2025	

Change Idea #2 Education of Newly initiated medical directives to prevent unnecessary ED transfer

Methods	Process measures	Target for process measure	Comments
24hr report review by Leadership member to determine necessity of ED transfer and initiate 1:1 discussion with staff on how the ED transfer could have been prevented. Develop education on how to best utilize medical directives in relation to hospital transfer, to present at monthly registered staff meeting by RAI department in collaboration with clinical support nurse.	Education to be tracked and data presented at quarterly PAC meeting. Review of LTC QIP indicator report quarterly.	Target to meet provicial average of 21.7%	

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	100.00	100.00	Prioritizing Diversity, Equity and Inclusion practice aims to support culturally appropriate care and meaningful growth in long-term care while helping to foster an Inclusive workplace. Encouraging diversity can lead to increased innovation and Collaborative work environment.	

Change Ideas

Change Idea #1 To gain deeper understanding, DEI Leads will complete education program " Creating a Culture of Belonging: From Awareness to Action" which will provide tools and knowledge needed to foster a more inclusive and affirming environment for residents, care partners/care givers, and fellow team members.

Methods	Process measures	Target for process measure	Comments
Virtual education to be attended by all the DEI Leads.	The number of DEI Leads completed training on Creating Culture of Belonging: From Awareness to Action training.	100% of DEI leads will complete the training by the end of 2025, with ultimate goal to create and share the education with staff.	Total LTCH Beds: 160

Change Idea #2 Share information on equity, diversity, inclusion and anti-racism topics with residents by scheduling information sessions.

Methods	Process measures	Target for process measure	Comments
DEI lead to attend resident council meetings by invitation to discuss equity, diversity, inclusion and anti-racism topics. Information will be also shared in monthly newsletters.	The number of information sessions offered/completed at the resident and family council meetings. Number of time the information was shared via monthly newsletters.	All members of resident and family council will at least attend one session in 2025. Quarterly newsletters will contain information about equity, diversity, inclusion and anti-racism topics.	

Experience

Measure - Dimension: Patient-centred

Indicator #3	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	CB	95.00	90% of Hilltop Residents report they can express themselves without fear of consequences. The higher the score the better.	

Change Ideas

Change Idea #1 Developement process to early identify Residents that are High risk of being reluctant to express their opinions due to fear of consequences

Methods	Process measures	Target for process measure	Comments
1-Early Identification of res. fears with RFC on admission day - Supported by Social Work Dept 2-Admission and Annual Care Conference to help identify risk of fear sharing opinions with Resident/Family/SDM involvment-supported by DRC/ADOC 3-Admission Assessments which may help to identify resident's willingness to share information vs fear of sharing supported by Clinical Admission support Nurse. 4-BSO Involvement from day of admission and throughout stay as identification of possible fear issues identified.	Review of Resident Quality of Life Survey Results as they are completed quarterly Shared with PAC and Quality Commitee Review quarterly DRS Scores for identification of mood/fear concerns that may impact resident expressing themselves quarterly	By Sept 2025, Quality of life survery results with be reviewed, analyzed and at least 95% of Residents will reply positively to " I can express my opinion without fear of consequences"	

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 following statement " This place feels like home"	C	% / Adult long stay home care clients	In-house survey / Dec/23-Nov/24	62.29	80.00	The higher the better outcome for this Quality of Life Survey response.	

Change Ideas

Change Idea #1 Enhanced Artwork throughout the home.

Methods	Process measures	Target for process measure	Comments
1-Sensory Scape to be installed on Dementia secure unit for visual enhancement - Supported by Leadership/ED/DOC 2-Initiation of Themed Meals for Hallmark Holidays-with themed place mats and table decor-Supported by Dietary Department 3-Allocation of budgeting for warm welcoming decorations for all holidays-Recreation dept	Review quarterly Depression Rating Scores that may indicate res. mood and satisfaction in their home. Review of Quality Indicators with Professional Advisory Committee for identification of Risk Quality Indicators. Quality Meeting every 6 months to review opportunities and success'. Family and Resident Council meet monthly to identify home opportunities and success'	By November 2025 80% of Residents will respond positively to " This place feels like home"	

Change Idea #2 Increased Dietary Satisfaction

Methods	Process measures	Target for process measure	Comments
1-Initiation of Homemade baking within the Dietary Department 2-Enhanced baking program- Hiring a Baker to work within the Rec department 3- Initiation of New Technical Software in the Dietary dept which will help to improve accuracy of service at meals. 4- Goal to purchase more adaptive dining tables to support pleasurable and comfortable dining.	Review quarterly Depression Rating Scores that may indicate resident's mood and satisfaction in their home. Review of Quality Indicators with Professional Advisory Committee for identification of Risk Quality Indicators quarterly. Quality Meeting every 6 months to review opportunities and success'. Family and Resident Council meet monthly to identify home opportunities and success'.	By November 2025 80% of Residents will respond positively to " This place feels like home"	

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 1 to Sep 30, 2024 (Q2), as target quarter of rolling 4-quarter average	19.82	15.40	Would like to meet target goal of Provicial Average of 15.40%	

Change Ideas

Change Idea #1	Education of Registered staff on Falls Risk Prevention strategies, and tools that would most benefit a Resident based on the outcome of the Post Fall Assessment		
Methods	Process measures	Target for process measure	Comments
Falls lead to develop education based on best practice guidelines from RNAO around the post falls assessment, prevention strategies and careplan. DRC's review monthly falls and analyze data during monthly falls meeting in collaboration with physio, can be tracked through monthly minutes. At this monthly review we will ensure the falls algorithm is being followed. Track % of resident fell with no careplan update and compare monthly. Annual falls prevention education done through surge and % of staff completed the education. Initiating falls strategy education provided by nursing led outreach team, staff attendance collected.	Monthly audits of Falls QI in the home and entry into PCC PAC Meeting review of Falls trends Quality meetings with review of Falls programs and 6 month QI presentation	By Sept 2025 Percentage of Residents who Fell in the last 30 days will meet Provincial Average of 15.40%	