Access and Flow | Efficient | Priority Indicator

Indicator #7	Last Year Performance (2023/24)	Last Year Target (2023/24)	This Year Performance (2024/25)	This Year Target (2024/25)
Rate of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents. (St. Joseph's At Fleming)	21.51	20	22.70	21

Change Idea #1 ☐ Implemented ☑ Not Implemented

#1 Support early recognition of residents at risk for ED visits

Process measure

- Percentage of residents at high risk for an ED visit who had a change in condition documented within 24 hours prior to ED visit. (High risk residents are defined as those admitted to the LTC home within the last 30 days; re-admitted to the LTC home from an ED visit or hospitalization within the last 30 days; those who have experienced a change in medication, change in treatment plan or significant change in condition (as per RAI MDS) within the previous 7 days); percentage of staff educated.

Target for process measure

- 100% of registered staff receive education on risk factors for avoidable ED visits;

Lessons Learned

Additional education for Registered Staff being developed. Best method for dissemination under consideration.

Change Idea #2 ☐ Implemented ☑ Not Implemented

2) Include information on the benefits of in-house treatments where possible at Admission and Annual Care Conferences. Review of RAI MDS Outcome measures at care conferences to provide a clear picture to families regarding resident conditions and included resident and family in planning for health care decisions.

Process measure

- The number of Care Conferences conducted with assistance of current MDS data.

Target for process measure

- 100% of Care Conferences have current MDS outcome measures available for discussion prior to conference.

Lessons Learned

Preparation and inclusion of this information for the care conferences has not been possible due to workload issues.

Change Idea #3 ☐ Implemented ☑ Not Implemented

Trail the STOP AND WATCH EARLY WARNING TOOL on a Resident Home Area to try to reduce avoidable transfers.

Process measure

- The number of resident transfers to hospital diagnosed with sensitive conditions.

Target for process measure

- The numbers of resident transfers will decrease by 1% by the end of 2023/24

Lessons Learned

Tool not implemented this year - deferred due to education resources.

Comment

Deferrals of transfers to Emergency Department remain a priority. Discussions at Health Advisory Committee for implementation of transfer tool and staff education under consideration.

Experience | Patient-centred | Priority Indicator

	Last Year		This Year	
Indicator #2	**CB**	**98**	**92.19**	**95**
Percentage of residents responding positively to: "What number would you use to rate how well the staff listen to you?" (St. Joseph's At Fleming)	**Performance (2023/24)**	**Target (2023/24)**	**Performance (2024/25)**	**Target (2024/25)**

Change Idea #1 ☐ Implemented ☑ Not Implemented

Improve the number of residents who feel staff listen to them.

Process measure

- Track numbers of staff educated on active listening techniques and provide tips on how to action requests/concerns

Target for process measure

- 80% of active staff will receive education during the next year on active listening techniques and processes.

Lessons Learned

Competing education priorities derailed this initiative.

Comment

Resident/Family survey results showed 90% of respondents felt staff listened well Most of the Time or Always. 6% indicated Sometimes; 2% stated Rarely/Never; 2% didn't know.

	Last Year		This Year	
Indicator #5 Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences". (St. Joseph's At Fleming)	**75.90** **Performance (2023/24)**	**100** **Target (2023/24)**	**28.79** **Performance (2024/25)**	**NA** **Target (2024/25)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

Strengthen resident and family relations process through open communication between Resident and Family Councils.

Process measure

- Number of residents and families with a positive response to the survey question.

Target for process measure

- 98% of residents answer Most or Always to the Survey question

Lessons Learned

Resident/family survey included this question. Survey return remains low.

Comment

89% of respondents replied Most of the time/Always to the question; 3% indicated Sometimes; 2% indicated Rarely/Never. [Calculations shown as Current Performance do not reflect performance as calculated based on total surveys returned and coded]

Safety | Safe | Priority Indicator

Indicator #1	Last Year		This Year	
Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment (St. Joseph's At Fleming)	**16.97** Performance (2023/24)	**15.50** Target (2023/24)	**24.58** Performance (2024/25)	**NA** Target (2024/25)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Maintain or reduce current performance related to identification of residents receiving anti-psychotic medications in absence of psychosis.

Process measure

- Percentage of residents receiving anti-psychotic medications on a monthly basis will remain below provincial benchmark.

Target for process measure

- Percentage of anti-psychotics given on a monthly basis will be reduced by 2% over the next year.

Lessons Learned

Challenges related to clinical capacity to evaluate need for on-going antipsychotic medications. Recruitment of new NP was successful in fall of 2023. Will continue to work toward appropriate adjustments.

Comment

Physicians/NP will direct the reduction of these medications where appropriate. Increased numbers of residents with BPSD being admitted to the Home. Require pharmaceutical intervention, but do not necessarily demonstrate delusions/hallucinations during assessment periods.

Safety | Safe | Custom Indicator

Indicator #4

Percentage of residents who fell during the 30 days preceding their resident assessment. (St. Joseph's At Fleming)

Last Year		This Year	
26	**20**	**29.80**	**NA**
Performance (2023/24)	**Target (2023/24)**	**Performance (2024/25)**	**Target (2024/25)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

Continued monthly review of resident falls with a focus on residents at High Risk for falls.

Process measure

- Residents who have fallen will be reviewed by the reviewed by the registered staff for the need for additional measures/interventions to prevent further falls.

Target for process measure

- 100% of High Risk residents with falls will be reviewed

Lessons Learned

Registered Nurses are notified of all falls. Residents continue to be monitored 48 hours post fall and adjustments are made to the Plan of Care as indicated.

Comment

Regeneration of the falls committee under way. Membership on the falls committee has changed due to staff movement. New committee membership recruitment is underway.

	Last Year		This Year	
Indicator #6 Percentage of residents who were physically restrained every day during the 7 days preceding their resident assessment (St. Joseph's At Fleming)	**5.50** Performance (2023/24)	**5** Target (2023/24)	**4.90** Performance (2024/25)	**NA** Target (2024/25)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Continue monthly review of all residents who are restrained by seatbelt and tilt chairs by the Restraint Reduction Committee.

Process measure

- All MDS Submissions indicating the presence of Daily Restraints will be reviewed for accuracy by the Manager of Quality & Risk who is responsible for Data Submission.

Target for process measure

- 100% of assessments reviewed

Lessons Learned

all submissions are reviewed. Seatbelt usage remains high and perception is that residents are safer with the seatbelt than being allowed to ambulate independently.

Comment

On-going challenges related to POA/family request to have seatbelts in place for residents using wheelchairs.

	Last Year		This Year	
Indicator #3 Percentage of Residents who experienced Weight Loss in the 30 days prior to their MDS assessment. (St. Joseph's At Fleming)	**8.20** **Performance (2023/24)**	**6.90** **Target (2023/24)**	**7.20** **Performance (2024/25)**	**NA** **Target (2024/25)**

Change Idea #1 ☐ Implemented ☑ Not Implemented

Residents will not experience unexplained weight loss.

Process measure

- Number of staff trained in obtaining and confirming monthly weights

Target for process measure

- 100% of Bath aides will have targeted education regarding importance of accurate weights, and how to confirm weights being obtained.

Lessons Learned

Tracking numbers of individuals trained was not feasible. All staff are educated on the need for accurate weights during orientation and reminded monthly to complete this task.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Registered Staff will review monthly weights with dietician to identify residents at risk for failure to thrive

Process measure

- 100% resident weights will be reviewed for weight loss in comparison to previous month value.

Target for process measure

- 100% of residents experiencing weight loss will be identified for increased observations related to change in food and liquid intake.

Lessons Learned

On-going monitoring by Registered Dietician continues with interventions as indicated.
Recent CIHI data review indicates an improvement in this indicator. Trends will continue to be reviewed, but not addressed in the upcoming QIP for 2024-25.

Comment

Heightened need for accurate tracking of weights and intake of food fluids being communicated during staff meetings, monthly communication verbally and by email. Ongoing initiative.