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)	16.85	15.00	Rate of ED visits will decrease 2024/25 as compared to 2023/24 QIP.	

Change Ideas

Change Idea #1 Audit, review and track all ED transfers, identifying those considered avoidable based on conditions identified by HQO.

Methods	Process measures	Target for process measure	Comments
NP to review all ED transfers. Discuss results at the quarterly Medical Advisory committee meetings and with ADOC's/DOC and Charge RN's during rounds. Purpose is to identify any trends in ED visits and review all potentially avoidable ED visits with the team. NP to assist with assessments/treatment recommendations that can be provided in house to avoid unnecessary ED transfers.	Track and measure number of ED visits deemed potentially avoidable, according to the list of care-sensitive conditions identified.	100 percent of all ED visits will be tracked and analyzed for trends in order to improve Golden Plough Lodge's current processes and decrease total number of residents sent to ED.	Mobile diagnostic imaging accessibility has been affected in our region, due to the mobile providers own staffing shortages, and they are the only mobile service provider in our region.

Change Idea #2	Continue with early intervention, on admission, for residents and their SDM's, related to their desired plan of care for end of life. Continue to encourage and support residents and their SDM in choosing Advanced Health Directives and provide education on treatment options available in the home.		
Methods	Process measures	Target for process measure	Comments
Education and discussion at Admission and Annual Care Conferences regarding Advanced Directives and treatment options in the home.	Tracking and trending of ED visits quarterly.	Decrease avoidable ED transfers to be in line with Central East and Provincial data.	

Change Idea #3	Continued review and Implementation of RNAO BPG's for falls prevention, as falls are often a cause of ED transfers.		
Methods	Process measures	Target for process measure	Comments
Review and analysis of incidents in PCC Risk Management of ED transfers resulting from a fall.	The number of falls that result in injury requiring ED transfer.	100% of falls will be reviewed by the Medical Advisory Committee, quarterly, with falls prevention measures discussed with team, including PT, and prevention measures put in place.	

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	100.00	100% staff and completion 2024/25	

Change Ideas

Change Idea #1 All staff, including management, will complete the Surge training module titled "Diversity, Equity and Inclusion at Work" annually.

Methods	Process measures	Target for process measure	Comments
Surge training module titled "Diversity, Equity and Inclusion at Work" will be included in the annual mandatory Surge training modules, of which all staff at Golden Plough Lodge have access to.	Track education module completion rate annually in Surge.	100 percent of all Golden Plough Lodge staff and management will have successfully completed the Diversity, Equity and Inclusion at work learning module.	

Change Idea #2 Golden Plough Lodge LTC home will collaborate with Northumberland County to adopt County equity, diversity and inclusion policies and education.

Methods	Process measures	Target for process measure	Comments
Will have Golden Plough Lodge representation at Northumberland County equity, diversion and inclusion discussions and working group committees involved in developing equity, diversity and inclusion policies and education planning.	There will be Golden Plough Lodge representation at Northumberland County equity diversion and inclusion planning sessions and Golden Plough Lodge will adopt the County's policy and provide updated education to all staff as applicable.	Golden Plough Lodge will adopt the County's equity, diversity and inclusion policies and any education associated with the policies.	

Change Idea #3 Golden Plough Lodge will work with Community Partners when developing plans for further equity, diversion and inclusion education planning.

Methods	Process measures	Target for process measure	Comments
Working collaboratively with our community partners to identify areas of improvement and or gaps in current cultural competency and diversity plan.	Identify and connect with resources in our own community that could assist with collaborative efforts to enhance our current plan.	Collaboration will occur with at least one community partner.	

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	57.69	85.00	We have 151 residents, when at capacity. Goal is to have at least 50% complete the survey, which is approximately 75 completed surveys, to ensure reflective results of population. Of that goal of 75 respondents, goal is 85% positive responses.	

Change Ideas

Change Idea #1 Percentage of residents responding positively to "What number would you use to rate how well the staff listen to you".

Methods	Process measures	Target for process measure	Comments
Continue to encourage staff to take the time and listen to residents. Ongoing education for staff related to resident centered care and communication skills. Sharing of positive comments, thank you letters and kudos to staff when received.	Share survey results with staff to provide insight into the importance of active listening to residents and to improve quality of life for residents.	Number of positive survey results. Annual education completion by all staff.	Total Surveys Initiated: 52 Total LTCH Beds: 151

Change Idea #2 Higher percentage of participation in, and completion of, Resident and Family Survey.

Methods	Process measures	Target for process measure	Comments
Provide opportunity for discussion on importance and value of survey completion at regular Resident Council meetings.	Increase in total number of surveys completed.	50% of residents/and or POA's, will complete and submit survey.	

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	87.76	90.00	Goal is to have minimum 75 survey respondents, with 90% responding positively.	

Change Ideas

Change Idea #1 Education for residents on Resident Rights under current legislation.

Methods	Process measures	Target for process measure	Comments
Provide education on Resident Rights and importance of survey participation/completion to ensure resident voices are heard and quality improvements initiated based on survey results.	Number of education sessions completed at Resident Council meetings. Increased number of completed surveys. Increased number of positive survey responses.	Goal is to be at or above 90% of positive responses by Residents on the Resident Satisfaction Survey. Minimum of 4 education sessions per calendar year provided at Resident Council.	Total Surveys Initiated: 49 Total LTCH Beds: 151

Change Idea #2 Increase the positive responses on Resident Satisfaction Survey to the statement "I can express my opinion without fear of consequences".

Methods	Process measures	Target for process measure	Comments
Education to all staff on Resident Bill of Rights at annual education sessions as well as during onboarding of new staff. Review of Resident Satisfaction Survey at Resident Council, prior to completion deadline, to encourage an increase in completed surveys.	Increase in positive responses to the statement "I can express my opinion without fear of consequences", on the Resident Satisfaction Survey.	Goal is to be at or above 90% positive resident responses. Goal is to be at or above 50% resident/POA participation in survey completion.	

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	19.93	15.54	Target performance is based on Provincial rate. Relative target is reflective of Provincial rate and our homes previous years data.	

Change Ideas

Change Idea #1 Falls will be reduced to reflect Provincial average of 15.54% annually.

Methods	Process measures	Target for process measure	Comments
Implementation of RNAO Best Practice Guidelines for Falls Prevention. Review of all falls in PCC Risk Management, to analyze data and track/observe for preventable trends.	Percentage of falls annually.	Percentage of falls will decrease to 15.54%.	

Change Idea #2 Regular review and analysis of internal falls data collected from PCC Risk Management.

Methods	Process measures	Target for process measure	Comments
Continue with regular Falls Committee meetings quarterly, and as needed, to analyze falls data. Including identifying which home areas have highest falls rates, what time of day are most falls occurring and those residents who have most falls.	Percentage of falls.	Incidence of falls in the home will decrease to fall in line with the provincial average.	PT currently conducts quarterly reviews and presents data at quarterly Medical Advisory Commitee meetings.

Change Idea #3 Update Falls Prevention Program and associated policies/procedures.

Methods	Process measures	Target for process measure	Comments
Annual program reviews and annual policy reviews/updates completed, to ensure are reflective of RNAO BPG's.	Falls Prevention Program review and associated policies are updated with most current data.	Falls Prevention Program review completed by March 31, 2025. Associated policies are reviewed/updated by March 31, 2025.	Program reviews, and policy updates will remain part or Golden Plough Lodge's annual review processes.

Measure - Dimension: Safe

Indicator #6	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	O	% / LTC home residents	CIHI CCRS / July 2023– September 2023 (Q2 2023/24), with rolling 4-quarter average	3.51	3.51	Currently our home is well below the provincial average for percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment. This is reflective of the efforts of our Medical Directors in making this a priority quality improvement area for 2023/24. The Medical Directors will continue to focus on this priority indicator for 2024/25.	

Change Ideas

Change Idea #1 Golden Plough Lodge will maintain the low percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment, to remain below the provincial average and aim to be at or below the homes average in 2023/24.

Methods	Process measures	Target for process measure	Comments
The Medical Directors will continue with regular chart audits and medication reviews for all residents of Golden Plough Lodge. Review of diagnosis and medications will also continue to take place during admission and annual care conferences.	Percentage of residents without a diagnosis of psychosis, who are currently receiving antipsychotic medications will remain below the provincial average.	Remain below provincial average and aim to remain at or below the homes current average.	The Medical Directors will continue to focus on this priority quality improvement area for 2024/25.

Change Idea #2	Continued identification of residents who were prescribed antipsychotic medication without an appropriate diagnosis of psychosis and deprescribe where appropriate.		
Methods	Process measures	Target for process measure	Comments
Pharmacy will continue to conduct quarterly reviews and provide reductio suggestions to the physicians.	Number of residents on antipsychotic medication without a diagnosis will remain at par or below the homes average in 2023/24.	100% of residents on antipsychotic medications will be reviewed.	

Change Idea #3	Staff will continue to be encouraged to trial all non-pharmacological interventions before administering PRN medications for responsive behaviours.		
Methods	Process measures	Target for process measure	Comments
Refer to BSO, who will work with staff, to identify triggers and develop interventions including GPA, sensory stimulation, resident specific programming, Snoezelen room.	Percentage of residents with responsive behaviours that have non-pharmacological interventions in care plan.	100% of residents with responsive behaviours will have non-pharmacological interventions in care plan.	BSO is actively maintaining intervention folders in each resident home area.