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)	23.44	20.00	Improve performance to provincial average (20.3 %)	

Change Ideas

Change Idea #1 Partnership with and utilization of the Nurse Led Outreach Team (NLOT) through Norfolk General Hospital

Methods	Process measures	Target for process measure	Comments
NLOT is consulted in the following circumstances: 1. Residents being considered for transfer to the ED 2. Residents actually transferred to the ED 3. Residents with changing health conditions indicating ED transfer is probable 4. Residents and/or POAs requesting transfer to the ED	Number of NLOT consults per month Number of ED transfers per month Number of NLOT consults outside of NLOT working hours	100% of actual ED transfers had an NLOT consult prior to transfer	Constraints include NLOT availability

Change Idea #2 All cases of resident transfers to the ED are reviewed monthly by the interdisciplinary team			
Methods	Process measures	Target for process measure	Comments
Following monthly care conferences the interdisciplinary team will review all cases of resident transfers to the ED for the preceding month.	RAI Coordinator tracks all monthly resident ED transfers and all monthly NLOT consults. The RAI Coordinator provides a monthly schedule of cases to be reviewed at the interdisciplinary care conference	100% of resident transfers to the ED are reviewed by the interdisciplinary team	

Change Idea #3 All Residents with Advance Directives Levels 1,2,3,4 will receive information and education on the NGH NLOT Team and consultation process			
Methods	Process measures	Target for process measure	Comments
Establish standardized process for NLOT information and education with residents and POAs Review NLOT at all post admission and annual care conferences Review NLOT with all new admissions during the admission process	Distribution of NLOT brochures Follow up education with Residents and POAs Care Conference discussion/action item	100% of Residents/POAs with Advance Directives Levels 1,2,3,4 are provided education on NLOT 100% of Residents/POAs are aware that NLOT will be consulted when ED transfer is being considered 100% of care plans containing Advance Directives Levels 1,2,3,4 contain the NLOT consultation intervention 100% of care conferences included NLOT discussion.	Constraining factor - Resident/POA refusal

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	2.50	100.00	Part of new Strategic Plan and in alignment with our mission, vision, values and person-centered philosophy of care	Norfolk General Hospital, BBNOHT

Change Ideas

Change Idea #1 Utilize current and available DEI courses on LMS platform - Surge Learning

Methods	Process measures	Target for process measure	Comments
Assign the following Surge Learning courses to all NHNH staff: 1. DEI 2. Understanding Gender and Pronouns in Healthcare 3. Blindspot	% of staff completing mandatory assigned courses in Surge Learning - monthly progress audit	100% staff completion of all assigned equity, diversity, inclusion, and anti-racism courses in Surge Learning by March 31, 2026	Total LTCH Beds: 52

Change Idea #2 In partnership with Norfolk General Hospital through the IDEA initiative, identify new and/or emerging best practices and care supports for Residents of NHNH

Methods	Process measures	Target for process measure	Comments
Develop a small team of NHNH IDEA champions	NHNH IDEA champions completion of IDEA training. NHNH IDEA champions partnership and collaboration with NGH IDEA champions. Visual representations in the Home i.e. posters, infographics reinforcing IDEA initiative	4-6 NHNH staff identified as IDEA champions	

Experience

Measure - Dimension: Patient-centred

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of Residents responding YES to the statement: "Nursing Staff have discussed my end of life wishes with me"	C	% / Residents	In-house survey / April1, 2025 - March 31, 2026	CB	100.00	NHNH is planning improvements to its palliative care program. One of these goals is enhancing resident knowledge and understanding of palliative care.	

Change Ideas

Change Idea #1 Develop an NHNH palliative care team

Methods	Process measures	Target for process measure	Comments
Team membership - Registered Staff, PSW Staff, Family member(s), Resident (s) if willing, and Social Worker (ad hoc)	NHNH palliative care team membership is formed Terms of Reference are complete	First meeting in July 2025	Dr. Martin-Godelie great resource

Change Idea #2 Palliative Care Team surveys residents regarding measure/indicator: % of Residents responding yes to the statement: "nursing staff have discussed my end of life wishes with me"

Methods	Process measures	Target for process measure	Comments
In house survey	percentage of surveys completed	100% of residents/POAs respond to survey	

Change Idea #3 Survey Results are used to develop targeted improvements to palliative care processes at NHNH

Methods	Process measures	Target for process measure	Comments
Palliative Care Team analyzes survey results Palliative Care Team develops recommendations based on survey results	# of proposed improvements to palliative care program at NHNH Proposed improvements are presented and reviewed by the NHNH Quality Committee	100% of proposed improvements to palliative care program at NHNH are reviewed by the Quality Committee	

Safety

Measure - Dimension: Safe

Indicator #4	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 1 to Sep 30, 2024 (Q2), as target quarter of rolling 4-quarter average	24.65	20.00	Provincial Value - 19.65%	Behavioural Supports Ontario, Roulston's Pharmacy

Change Ideas

Change Idea #1 Implementation of an antipsychotic medication review tool

Methods	Process measures	Target for process measure	Comments
Leverage pharmacy partners in identification, implementation, and tracking of tool use Engage Medical Director in use of tool	Standard process is used to identify Residents appropriate for tool use Antipsychotic review tool is consistently used	Tool is used at every identified opportunity Tool demonstrates effectiveness toward goal of reducing antipsychotic use where applicable	

Change Idea #2 Increase staff education and training in GPA & Teepa Snow positive approach to care			
Methods	Process measures	Target for process measure	Comments
Resume Alzheimer Society GPA Training in-house at NHNH / NGH Send maximum staff allotment to local Teepa Snow education sessions Utilize Behavioural Supports Ontario staff expertise	Maximize BSO consults on residents taking antipsychotic medications Percentage of staff with current GPA training Percentage of staff with current Teepa Snow training	BSO will consult on all residents with new or changing antipsychotic medications Increase staff certification in GPA training by 10% 100% utilization of all Teepa Snow training seats offered to NHNH this fiscal year	

Change Idea #3 Improve indication of use of antipsychotic medications			
Methods	Process measures	Target for process measure	Comments
Behavioural Support Staff review residents on antipsychotic drugs without a diagnosis quarterly BSO, Nursing, and Physician collaborate on recommendations and possible alternatives quarterly New Admissions to NHNH with existing antipsychotic medication(s) are tracked and reported	Quarterly reports are sent to BSO staff for review and feedback Number of residents taking antipsychotic medications without a diagnosis % of residents taking antipsychotics with indication of use documented	100% of Residents taking antipsychotic medications without a diagnosis are reviewed by BSO 100% of Residents taking antipsychotic medications have a documented indication of use	

Measure - Dimension: Safe

Indicator #5	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of long-term care home residents in daily physical restraints over the last 7 days	C	% / LTC home residents	CIHI CCRS / April 1st 2025 - March 31st, 2026	6.80	4.00	Provincial Average currently 2.2%. Bests Practice Guidelines clearly outline, and the Fixing Long Term Care Homes Act clearly requires all LTC Homes to: 1. Minimize the use of restraints 2. Explore and implement restraint alternatives	

Change Ideas

Change Idea #1 Resident & Family Education on restraint minimization and restraint alternatives in LTC

Methods	Process measures	Target for process measure	Comments
Develop Resident and Family education brochure including information from the FLTCHA and the RNAO BPG for LTC on why LTC Homes are committed to minimizing restraints	1. Percentage of Residents and Families who received the educational brochure 2. Brochure and Restraint use in LTC is reviewed at Resident Council and Family Council 3. Brochure is reviewed with all new admissions to NHNH and at all care conferences where applicable	100 % of Residents/POAs and family members receive education brochure. 100% of care conferences include discussion on restraints where applicable, in addition to restraint best practices and restraint alternatives. 100% of all new admissions include brochure dissemination and restraints discussion	Important to clearly distinguish between Restraints and PASDs

Change Idea #2 Staff Education on Restraint minimization and restraint alternatives in LTC

Methods	Process measures	Target for process measure	Comments
Multimodal Education approach: Education Boards Staff Meetings Huddles Nursing Week Displays Memos Surge Learning Restraints Minimization Education	% of staff completion of surge learning education % of daily huddles with restraint focus # of weeks of education boards on display with restraint focus % positive feedback on Nursing Week Displays with restraint focus memo sign-off completion rates	100% staff completion of Surge Learning Restraint Minimization education by August 1st, 2025 100% of staff meetings will include Restraints as a standing agenda item Nursing Week will include education boards on Restraint minimization 100% of staff will sign off on memos pertaining to restraints	Countermeasure to this initiative will be our Resident Fall rates and fall with injury rates

Change Idea #3 Policy, Protocol, Assessment and Documentation Review

Methods	Process measures	Target for process measure	Comments
Interdisciplinary Team review and analysis of all current NHNH policies, protocols, assessments, and documentation relative to restraints and PASDs	Inventory identified and compiled Interdisciplinary Team review of all relevant documents is complete All policies, protocols, assessments and documents are updated to reflect best practices and alignment with the FLTCHA. Point Click Care functionality is maximized to support this change initiative	100% of policies, protocols, assessments and documentation reflect best practices 100% of policies, protocols, assessments and documentation support and align with the FLTCHA Point 100% Click Care assessments and documentation reflect best practices	Ongoing implementation of the RNAO Clinical Pathways should assist with this change initiative over time.