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)	X	0.00	We have a low number of ED visits and continue to strive to maintain a low number of ED visits.	

Change Ideas

Change Idea #1 Continue to source out a new community partner with portable x-ray and U/S services.

Methods	Process measures	Target for process measure	Comments
The Director of care will continue to reach out at least monthly to local community resources to locate a mobile x-ray service. We are currently awaiting approval for services to commence with MLTC Portable x-ray service.	Continue to source out a new community partner with portable x-ray and U/S services to reduce ER visits.	The home will have a portable x-ray and u/s service within the next quarter.	The challenge is the rural location of our home. Our Medical director is assisting the home to achieve the goal to reduce ED visits providing the home with support and education. We also have a couple residents who request to go to ER regardless of reason and or support available in the home. We will continue to educate residents and families as to how we are able to support in house with variety of services from our NP and Medical Director.

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	66.18	100.00	The home feels passionately about Equity, diversity, inclusion and antiracism education and will strive for 100% compliance.	

Change Ideas

Change Idea #1 1)Omni continues to enhance their current EDI program and will be rolled out throughout the corporation. At this time, we will continue with mandatory Annual Surge learning courses. Current courses in Surge are as follows: Cultural Competence and Indigenous Cultural Safety - 4 Part series, Accenture Inclusion and The Power of Diversity Accenture -Accessibility Standards and AODA (1) AODA 2017, Blinds Spots Challenge Assumptions, and Understanding Gender and Pronouns in Healthcare-all 100% Completion Rate. The leadership team completed training at our annual FORUM around resiliency and EDI presented by Rick Gourlie, Doneath Stewart and Patsy Morrow in the Fall of 2024. We also post monthly diversity calendar from the CLRI for all the residents, families and staff to view. Omni has also developed a road map that aligns with the strategic plan as well as 6 step process that will initiate and maintain momentum in the implementation of a framework to support Diversity, Equity and Inclusion. Our home is in the process of establishing a Diversity, Equity and Inclusion Committee that will be responsible for promoting the success of DEI strategies in the Home.

Methods	Process measures	Target for process measure	Comments
All staff will complete Mandatory Surge Learning on hire and completed monthly as per annual schedule thereafter. Routine huddles to communicate DEI to promote discussion and encourage an inclusive atmosphere in the home. Schedule regular training programs/meetings focused on DEI principles to increase awareness, reduce biases, and promote understanding of diverse cultures and perspectives within the workplace.	All managers to monitor Surge stats and completion rates. If we find that employees have not completed required surge within the timelines then letters are sent out with our expectations for completion and further action steps will be taken if continued non-compliance with completion.	100% compliance with Surge completed regarding relevant equity, diversity, inclusion, and anti-racism education annually.	Total LTCH Beds: 34 Total LTCH Beds: 34 We continue to work with resident and family council and staff to promote all aspects regarding equity, diversity, inclusion, and anti-racism education and share the DEI program as becomes available. We plan to have a stronger focus on in house hosted cultural events.

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	91.18	100.00	Current Performance is 91.1% with target of 100%. Kentwood feels we can continue to meet our target with continued education to all staff which is provided upon hire, again as a refresher throughout each year with mandatory surge learning. We also have had outside community partners join us on site for in person education focusing on staff/ resident communication techniques.	

Change Ideas

Change Idea #1	Kentwood continues to utilize the resident satisfaction survey with OMNI's partnership with Metrics at Work and this will continue into 2025/26 Metrix at work is a leading provider of organizational measurement and consulting. Resident council also have input on developing the resident satisfaction survey questions each year. We are going to encourage residents to join their annual care conference with their loved ones so that the individual resident can voice and questions and or concerns and allow the multi-disciplinary to listen and create action plan for improvement.

Methods	Process measures	Target for process measure	Comments
Quantitative and qualitative survey designed by Metrics at work to ensure that all residents and families are aware that by completing the surveys they have input in the culture of the home without fear of consequences. This survey topics will be discussed monthly at residents council to ensure the residents feel comfortable and are aware of who and where they can openly report any of their concerns at any time. Our homes has an open-door concept regarding any concerns with the confidence in knowing that their concerns will be taken seriously. Residents are encouraged that if they have brought up a concern and feel any fearful or distressed in any way due to voicing their concern that they seek out the administrator to report this immediately so that it can be addressed.	Completing the Surveys via computer/tablet, an electronic qualitative and quantitative survey, ensure tablets and computers available with staff to assist residents with inputting the data for more accurate results. Resident population year to year will affect the survey results due to dementia with confusion. Families are encouraged to assist and add input when willing and able. Finalized results are then discussed at resident and family council meetings. Any flagged result below 80% will have a required action plan that will also be reviewed at both council meetings. We will work with our Resident and family councils and encourage input within the action plan for improvement.	The information received from this electronic survey has provided the home with an accurate account of our resident/ family current experience. We believe that this information will allow us to reflect and act upon our residents and families current experience as well we develop an action plan with those results being openly discussed with all parties involved. 100% Percentage of residents who responded positively to the statement: What number would you use to rate how well the staff listen to you. Our home scored 91.1% in this category out of 28 surveys completed. In light of our smaller resident population we find that this has an effect on our percentage's.	Total Surveys Initiated: 34 Total LTCH Beds: 34 Total Surveys Initiated: 28 Total LTCH Beds: 34 Kentwood remains at 82% participation with answering the survey in this category. The information gathered from the surveys allows the home to act upon any family or resident complaint. The concern and complaint log is filled out/ completed and response/ answer/ action plan provided to the family within 10 days.

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	88.24	100.00	Current Performance is 89.3%. We strive to reach this target at 100% as we feel we provide continuous opportunity for residents to safely expression their opinion.	

Change Ideas

Change Idea #1 Kentwood Park continues to utilize the resident satisfaction survey with OMNI's partnership with Metrics at work and this will continue intro 2025/26. Metrics at work is a leading provider of organizational measurement and consulting.

Methods	Process measures	Target for process measure	Comments
Quantitative and qualitative survey designed by Metrix at work to ensure that all residents and families are aware that by completing the surveys they have input in the culture of the home without fear of consequences. This survey topic will be discussed at residents' council meetings to ensure the residents feel comfortable and know how, who and where they can openly report any of their concerns at any time. Our home has an open-door concept regarding any concerns with the confidence in knowing that their concerns will be taken seriously. Residents are encouraged that if they have brought up a concern and feel any fear or are distressed in any way due to voicing their concern that they seek out the administrator or other manager they feel comfortable with to report this immediately.	Completing the Surveys via computer/ tablet, an electronic qualitative and quantitative survey, ensure tablets and computers available with staff to assist residents with inputting the data for more accurate results. Resident population year to year will affect the survey results due to dementia with confusion. Families are encouraged to assist and add input. Finalized results are then discussed at resident monthly and family quarterly meetings and any flagged result below 80% will have a required action plan that will also be reviewed at both resident and family council meetings and our resident and family input is strongly encouraged.	The information received from this electronic survey has provided the home with an accurate account of our resident/ family current experience. We believe that this information will allow us to reflect and act upon our residents and families current experience as well as develop an action plan with those results being openly discussed with all parties involved. 100% Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences. Our home scored 89.3% in this category after completing 28 surveys. In light of our smaller resident population we find that this has an effect on our percentage's.	Total Surveys Initiated: 34 Total LTCH Beds: 34 Total Surveys Initiated: 28 Total LTCH Beds: 34 Kentwood was successful this year with 82% Survey completion with families and residents. Kentwood would like to thank all the residents who participated as well to the families for assisting the home in completing this survey and supporting their loved ones who were unable to answer due to diagnosis dementia with confusion.

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	X	4.00	Current performance was 4.79%. The home will continue to strive to attain this goal over the next quarter.	

Change Ideas

Change Idea #1 1) Utilize and improved RISK management falls report on PCC. It includes a more streamlined assessment tool which provides risk management analysis on all falls.

Methods	Process measures	Target for process measure	Comments
All staff training on PCC assessments, Surge education for all staff around falls prevention and Post fall Policy.	DOC and Admin will review Surge learning stats and orientation package completion. Falls policy attached on back of registered staff report sheet to improve completion per policy and continued education provided at Nursing practice meeting, falls prevention meeting.	100% staff trained on orientation and as required on Post falls Policy. 100% compliance with falls prevention education on surge learning completed annually.	LTC population affects the rate of falls, the home's goal is to decrease this risk.

Change Idea #2 Utilization of falls prevention funding for equipment.

Methods	Process measures	Target for process measure	Comments
Falls reports reviewed monthly, quarterly and PRN. PT will assess interventions/ equipment in place for resident falls prevention. DOC will review falls prevention budget and equipment allowance and ensure the home has a variety of equipment to promote safety ie: HILO beds, personal alarms, and fall matts.	DOC will submit invoices and review budget monthly. DOC will review falls rates monthly and discuss at monthly nursing practice meeting.	Increased utilization of falls prevention equipment will decrease falls by 5% (10% to 5%) over the next quarter.	At Kentwood Park we will strive to maintain a goal to further decrease maintain a low number of falls.

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 1 to Sep 30, 2024 (Q2), as target quarter of rolling 4-quarter average	27.27	20.00	Kentwood Park has been at 8residents of 18 assessments = 27.03% in the rolling quarter and we feel we can continue to achieve this goal or improve.	

Change Ideas

Change Idea #1 Improve communication with community partners, and discharge planners at Hospital. We will try to complete in person and onsite hospital visits from DOC/ED. We also work towards obtaining a more thorough review of medication list on admissions of the why's, when, how long.

Methods	Process measures	Target for process measure	Comments
BOOMR program continues at the home to assist with process of medication review by Pharmacy CareRx with Medical director discussion to review current medications. Improved communication with community partners and HCCSS to gain access to past assessments, med reviews and orders put in place. MD has reviewed and tried to decrease, once antipsychotic decreased, it is evident that resident required to have it.	Monitor antipsychotic usage with monthly Quality meeting and quarterly MDS assessment, pull report to determine if usage decreased. Antipsychotic monitoring tool in place when attempting to decrease usage. Discuss results at monthly QI meeting. MD to review quarterly and PRN for other effective interventions. CareRx to review annually and PRN.	100% of resident's medications will be reviewed on a quarterly bases by MD and annual by Pharmacy consultant.	Challenge in the home is that the BOOMR system requires 48hrs to effectively complete. Second Challenge in the home is residents who are moving into the home on antipsychotics and no family MD to gain any previous history.