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)	15.31	10.00	Achieve a target of 10% or lower should be attainable by providing registered staff education to keep residents in the home. We will also provide additional education to Power of Attorneys about the services and comfort measure we provide. We will ask for our Medical Director, Physicians, and Nurse Practitioner to provide education to POAs.	Campbellford Memorial Hospital, Peterborough Regional Health Centre

Change Ideas

Change Idea #1 Decrease and improve on the current number of ED visits for modified list of ambulatory case-sensitive conditions. Utilize resident's physician or on-call physician if a resident is required to be sent to ED. Utilize our Nurse Practitioner to assist with specialized care.

Methods	Process measures	Target for process measure	Comments
Data is provided by Ontario Health atHome. Utilize the data for efficiency. Utilize Physicians and NP to train and educate registered staff to perform duties within their scope based on the needs of the home. Utilize Physicians and NP to provide POA education.	Daily review of ED visits in a multidisciplinary forum. Monthly and Quarterly review of the number of ED visits for modified list of ambulatory care-sensitive conditions.	Achieve a goal of under 10% per 100 residents.	Current performance data may be inaccurate and should be interpreted with caution.

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	99.19	100.00	Education that was provided to staff was 99.2% complete by all staff. Our target is 100% performance and believe this is achievable.	Develop Consulting, Surge Learning Inc., Energize Me

Change Ideas

Change Idea #1 Omni Quality Living continues to be a strategic focus for the company and demonstrates passionate dedication to developing and enhancing our DEI program for all Omni homes. Pleasant Meadow Manor will encourage staff to participate in relevant equity, diversity, inclusion, and anti-racism education and bring ideas and feedback forward. Empower staff to bring forward any concerns they may have with our current DEI and anti-racism culture in the home. Develop a DEI topic specific plan that would be updated quarterly.

Methods	Process measures	Target for process measure	Comments
Provide new DEI and anti-racism annual education and encourage staff completion. Post DEI and anti-racism calendar in the home and promote awareness of dates. Promote an DEI and anti-racism culture in the home. Monitor the DEI topic specific plan quarterly. Discuss any DEI and anti-racism concerns at a daily multidisciplinary report.	DEI survey completed in the home. Completion of DEI education on Surge Learning for 2025.	Our goal would be for our home to score 90% on feeling satisfied with our current DEI and anti-racism culture in the home. Our goal would also be to have 100% participation in the home for completing education completion.	Total LTCH Beds: 96 Current performance data may be inaccurate and should be interpreted with caution.

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	93.10	100.00	Resident Experience Survey was 90%. Target of 100% is what we strive to achieve. The absolute target is 100%.	Metrics@Work

Change Ideas

Change Idea #1 Encourage residents to participate in the home's Resident Council to bring ideas or concerns forward. Provide assistance to residents on the use of the devices in which to complete the Resident Experience Survey. Empower staff to bring any resident idea or concern forward so that managers and staff can collaborate towards a resolution for the resident. Present resolution to the resident which had the idea or concern.

Methods	Process measures	Target for process measure	Comments
Annual Resident Experience Survey, quarterly Quality Improvement meeting, monthly Resident Council meeting, daily multidisciplinary meeting. Gentle Persuasive Approach training along with Dementia training through Ontario Health in our home.	Metrics@Work 2025 survey results for the question: "What number would you use to rate how well staff listen to you?"	Our goal is to improve from NUMBER% in 2024 to 100% in 2025.	Total Surveys Initiated: 58 Total LTCH Beds: 85 Current performance data may be inaccurate and should be interpreted with caution.

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	87.93	100.00	Resident Experience Survey was NUMBER%. Target of 100% is what we strive to achieve. The absolute target is 100%.	Metrics@Work

Change Ideas

Change Idea #1 Encourage residents to participate in the home's Resident Council to bring ideas or concerns forward. Provide assistance to residents on the use of the devices in which to complete the Resident Experience Survey. Empower staff to bring any resident idea or concern forward so that managers and staff can collaborate towards a resolution for the resident. Present resolution to the resident which had the idea or concern. Education and communicate to staff our change ideas and to maintain professionalism and display a high level of customer service standard.

Methods	Process measures	Target for process measure	Comments
Annual Resident Experience Survey, quarterly Quality Improvement meeting, monthly Resident Council meeting, daily multidisciplinary meeting. Gentle Persuasive Approach training along with Dementia training through Ontario Health in our home.	Metrics@Work 2025 survey results for the question: "I can express my opinion without fear of consequences."	Our goal is to improve from 82% in 2024 to 100% in 2025.	Total Surveys Initiated: 58 Total LTCH Beds: 85 Current performance data may be inaccurate and should be interpreted with caution.

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	15.09	12.50	The provincial average in Q3 2024 was 15.63%. Our goal is to be at 12.5%, below the provincial average from last quarter. This would be a decrease in percentage of LTC home residents who fell in the 30 days leading up to their assessment by approximately 2.5%%.	Ontario Health Team East, Achieva Health, CE Ontario Health atHome

Change Ideas

Change Idea #1	Provide direction to all nursing staff of new resident's assistive devices for mobility upon admission. Provide education to all nursing staff on accurate documentation and reporting on mobility and post fall requirements. Post fall huddles, and daily QI huddles occur to keep clear and open communication between shifts, to target and observe high risk fallers, and to increase supports such as programming (fun and fitness) or our PT program such as our walking program and strength programs. Follow policy and procedure regarding quarterly assessment and care plan review.

Methods	Process measures	Target for process measure	Comments
Data collected and reviewed in the home each month by the Falls team and Quality Improvement team. Residents with falls are tracked daily by multidisciplinary team report.	Our resident population in QI Q4 2023 - Q3 2024 had a percentage of 15.09% of has fallen. Our goal is to below 12.5%. We have recently admitted 32 residents into new beds between September 2024 - February 2025. Many of these residents could be at high risk for falls upon admission to our home. Measures will be daily multidisciplinary report, monthly falls team meeting and monthly Quality Improvement team meetings.	Our goal is to be at less than 12.5% of resident who have fallen in the 30 days leading up to their assessment in each quarter of 2024.	Current performance data may be inaccurate and should be interpreted with caution.

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	33.51	20.00	The provincial average in QI Q3 2024 was 20.4%. Our goal is to be below the provincial average and achieve less than 20%, which will be a decline of approximately 14%. 32 new residents have been admitted to the home from September 2024 - February 2025 due to the completion of a redevelopment project. It is common for new admissions to be receiving antipsychotic medication without a diagnosis of psychoses that are admitted from an acute care setting. We believe that we will be able to significantly decrease this performance.	Ontario Health at Home Central East, Peterborough PASE, BSO Program, Ontario Health East

Change Ideas

Change Idea #1	#1) Provide education to all nursing staff on the completion of DOS documentation and review by registered staff. Provide education to all nursing staff on the importance of accurate documentation, reporting, and communication of resident behaviors and successful interventions. Follow policy and procedure regarding quarterly assessment and review. Review resident diagnosis of resident's were were given antipsychotic medication with the physicians of the home.

Methods	Process measures	Target for process measure	Comments
Data collected in the home each month by the Quality Improvement Team and reviewed. BSO Team Lead submission of metrics to BSO Ontario.	Quality Improvement Team meeting each month and quarterly meeting each quarter. Daily review of antipsychotic medication changes at multidisciplinary team meeting.	Our target will be less than 20% of residents without psychosis who are given antipsychotic medication in their look back period for assessment.	Current performance data may be inaccurate and should be interpreted with caution.

Measure - Dimension: Safe

Indicator #7	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Infection Prevention and Control - Hand Hygiene Compliance	C	% / Staff	In-home audit / January - December 2024	88.20	95.00	Our home has increased HH training and auditing in the home in Q4 2024. There has been an increase in performance in Q4 2024. We believe with consistent education along with auditing paired with correcting staff on potential missed opportunities there will continue to be improvement and we can achieve 95% compliance.	Health Connex, Peterborough IPAC Hub, Peterborough Public Health Unit

Change Ideas

Change Idea #1	Ensuring 100% staff compliance on annual education on Surge Learning on the four moments of hand hygiene. Provide in person education with return demonstration on the four moments of hand hygiene using both ABHR and soap and water. Provide the education and return demonstration in September prior to the fall and winter months. Respiratory viruses tends to increase in the fall and winter months. Utilize Peterborough IPAC Hub as an educational resource for staff on a quarterly basis. Assign all managers to complete hand hygiene audits each day, on a rotating basis to maintain consistency in the auditing and coaching process.

Methods	Process measures	Target for process measure	Comments
Data collected using Health Connex application.	Analyze hand hygiene compliance on the monthly basis in the IPAC committee monthly meeting.	Our target will be 95% for the calendar year, including achieving 95% compliance on a monthly basis.	Current performance data may be inaccurate and should be interpreted with caution.