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)	8.49	1.00	Our goal is to not send any of our resident to ER as we continue to work with our external partners such as our x-ray, u/s, lab, NPStat, tertiary health care and our physicians. We also work with our multidisciplinary team to treat in the home, or direct admit.	Westminster Xray and U/S Mobile Services, Lifelabs, NP Stat, Northumberland Hills Hospital, Peterborough Regional Health Centre, PASE

Change Ideas

Change Idea #1	Quarterly we report to our corporate office the # of ED visits occurred, DOC and multidisciplinary team discuss ED visits, as well each visit is reviewed during our monthly quality team meeting. Quarterly we review at our MAC/PAC meetings, and communicate with our registered staff the importance of assessment and utilizing our contracted providers to avoid ED visits. Our aim is to maintain or improve our % provincially and within our health region.

Methods	Process measures	Target for process measure	Comments
Data is collected and provided from Ontario Health. The data is shared with the home quarterly. This data is collected through CIHI data and applies to the resident in that quarter, whether they are admitted to the long term care home or hospital. The data transfers with the resident and may skew the data at times.	Quarterly we receive a data report from Ontario Health regarding ED transfers. Currently our % is 8.49% which decreased from 2023/2024 of 10.28. Our current practice will continue. Each resident who is transferred is discussed with the multidisciplinary team and QI team monthly to determine process, procedure and assessment of the resident. If resident is transferred and they did not meet requirements, discussions would take place with multidisciplinary team and through family care conferences with resident/POA/Family.	Our aim at Streamway Villa is to improve our current performance of 8.49%. The current performance in our health region is 22.6%.	Residents who had avoidable ER visits during data collection (CIHI and quarter) and were not admitted to our LTCH - the % and number of visits still counted towards our home %. This is a skewed data result not indicating true %.

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	All leadership employees will complete DEI education (mandatory) on SURGE eLearning in 2025. DEI Program roll out in 2025 to all employees at Streamway Villa with a focus on policies and procedures, engagement and events.	Ontario Health Team Northumberland

Change Ideas

Change Idea #1 Streamway Villa - Omni Quality Living includes in its strategic plan a DEI as a pillar to our organization. A new program with policy and procedures has been established for homes in early 2025. Our goal at Streamway Villa is to provide education and knowledge to all of our staff, residents, families, and visitors of our new program in the first half of 2025.

Methods	Process measures	Target for process measure	Comments
First step is education. At Streamway Villa new education for all leadership team members were introduced in our SURGE eLearning 2025. DEI is one of Omni Quality Living pillars. Our new program and policies have been rolled out in March 2025. All staff at Streamway Villa will engage in new education, events and programs to begin knowledge exchange, learnings and development.	Corporate Development with a DEI committee with partners from all homes and depts. continues to evolve. Streamway Villa's QI team will engage in discussions regarding DEI program and policy at the home level, as well as initiate events to engage staff in participating in our DEI program. The program will engage, staff, residents, families, visitors and volunteers.	Streamway Villa will continue to engage in discussions with our external partners such as the Ontario Health Team Northumberland, Community Care, Northumberland Hills Hospital, County of Northumberland, Town of Cobourg, and Alderville First Nations in continue our development of education sessions, programs, learning tools to engage all community partners in learning DEI and anti-racism education.	Ontario Health Team Northumberland is working closely will all partners in developing community programs and engagements around DEI programs. Currently, surveys and discussions have taken place with collaboration council, in which Streamway Villa has a seat at this table and leads in discussions with our DEI program roll out.

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	CB	99.40	99.40% is the % on our metrics Resident Satisfaction Survey for 2024-2025.	Metrics @ Work

Change Ideas

Change Idea #1 Metrics@Work and Streamway Villa with Omni Quality Living completed the annual Resident/family Experience Survey in November 2024 for 2024-2025. Survey was completed electronically with dedicated iPads to our residents and family members with our Life Enrichment Dept. as lead of the Initiative. Our goal is to increase our % of survey's completed from previous year, and to improve on our performance regarding "What number would you use to rate how well staff listen to you?"

Methods	Process measures	Target for process measure	Comments
Streamway Villa - Omni Quality Living will continue working with our external communicaty partner Metrics@Work in completing our annual surveys. As our population is dynamic, and ever changing it is imperative we utilize a quantitative method of gathering data to develop strong QIP's. Our goal for 2024-2025 is to continue to provide education with registered staff and frontline staff regarding communication, process and policy and procedure in caring for our vulnerable population.	Surveys will continue to be annual, and the Life Enrichment Dept. will continue to lead in this initiative. Communication of our results to our residents, families and staff are important to improve or maintain current outcomes.	Currently our 99.4% satisfaction is an indication that our current methods and focus on technology, engaging our families to participate and our dynamic group of residents that we are meeting our targets. We will continue to aim for 100% in this area for 2025-2026.	Total surveys completed in 2024-2024 = 33/59 56% Total surveys completed in 2024-2025 = 43/47 91%

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	CB	99.40	99.4% is the % on our metrics result of our Resident Satisfaction Survey.	Metrics @ Work

Change Ideas

Change Idea #1 Our change idea for 2025/2026 is to maintain or achieve 100% of survey's completed by providing improved methods of communication to our residents and families through resident/family councils, electronic newsletters and family emails. As well our Life Enrichment dept. will provide education, 1:1 Conversations with Life Enrichment team and residents/family participation for our 2025-2026 surveys.

Methods	Process measures	Target for process measure	Comments
Streamway Villa will continue to work with our corporate office and our external partner Metrics@Work for the 2025-2026 survey. As with previous years, this year we will include in person education with our residents and families prior to the survey. Our success this past year contributed to early discussions with resident and families and what the survey means.	Continue with annual surveys in collaboration with Metrics@Work. New to this year's QIP our QI team would like to develop an information Video/Vimeo for our residents and families to engage them in completing the satisfaction surveys.	Our aim at Streamway Villa is to maintain our 99.4% and strive for 100% of residents responding positively to: " Percentage of residents who responded positively to the statement: I can express my opinion without fear of consequences."	

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	12.74	9.00	Current performance in the home will always be dynamic as population changes occur during a quarter. Our focus for 2025/2026 will be on our high risk frequent fallers, and how we can improve our falls prevention program.	Achieva Health Care

Change Ideas

Change Idea #1 Our goal for 2025/2026 is to improve communication with our registered staff and physiotherapy team in regards to our electronic referral process. Our focus will be our high risk residents with multiple falls per month. We will observe and gather data from process and policies. Part of this process will include ethical questions for our registered staff- Professional vs Personal Opinions Focus on the High Risk Frequent Fallers.

Methods	Process measures	Target for process measure	Comments
We will continue to use our LEAN methods with our current Falls Prevention Program and our Policies and Procedures. One change idea is to create an inventory Lists Team Approach Documentation/Interventions Care Plans	As our population changes and medical stability changes with our residents, we have observed some new patterns regarding high risk frequent fallers. This year we want to establish clear outcomes, communication and assessment and engage our registered staff and frontline staff in recognizing patterns. We will continue to use our data, and utlize our PT and QI team to	Our aim is to improve our % of falls to 9% through each quarter of 2025/2026 by changing our current method to our new method using PDSA analysis.	Work with corporate and clinical to make changes in referral processes in PCC to ensure clear communication and process to ensure programs are meeting compliance.

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	15.67	15.00	We have improved and have almost reached our goal to meet international standards regarding antipsychotic use in long term care.	CareRx, Behaviour Supports Ontario, PASE

Change Ideas

Change Idea #1	Our goal is to education our staff in our new procedures, policies and processes that align with Behaviour Supports Ontario. Although we current do use all documents required, our goal is to provide further education and follow up regarding these processes. DOS- incomplete, why are they on, completed not communicated

Methods	Process measures	Target for process measure	Comments
Our Registered staff will lead the process by ensuring staff initiate DOS and complete DOS in a timely fashion, providing the RN who completes the analysis is done efficiently. In conjunction with DOS, Registered staff will utilize CareRx documentation regarding monitoring of antipsychotic medications with a change, a new order or a discontinuation of a medication. All observations will be documented and all processes will be reviewed in our monthly nursing practice meeting, QI meeting and quarterly at our MAC/PAC meetings. Currently 47/47 residents and 15.67% of our residents take antipsychotics without a diagnosis. This is a significant improvement from last years QIP. We remain below provincial averages. As previous mentioned, our population is every changing and dynamic therefore numbers and % will vary. Our aim is to make improvements in our current processes and be proactive on admissions and reviewed each month as a multidisciplinary team to maintain or improve our current performance.	Utilizing CareRx assessment documents for medications Utilizing our CareRx Consultant for medication reviews on admission, quarterly or with a change in medication Education of new processes and alignment with BSO and Think Research PDSA cycles with our QI RN and reviewed at monthly QI meetings to reach our goals in 2025/2026.	85% of our current population has a diagnosis of dementia, and 48.9% of our current population are currently managed and monitored through our BSO program. Our target is to maintain below provincial targets and maintain our current targets with our BSO program.	Engage in discussion with our corporate clinical team to add on PCC Dashboard - PCC Electronic version of DOS vs Paper Medication Reviews. Currently, our RPN BSO position has remained vacant for 3 years. We have ensured our home has a sustainable program not relying on one staff member. This has been effective, as all Registered staff are trained and educated with PIECES, UFirst and GPA. We currently now have a QI RN who will complete observations, data analysis and PDSA cycles to ensure our program remains sustainable, as well as keeping our current performance.