Access and Flow | Efficient | Priority Indicator

Indicator #3	Last Year Performance (2023/24)	Last Year Target (2023/24)	This Year Performance (2024/25)	This Year Target (2024/25)
Rate of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents. (Spruce Lodge Home For The Aged)	11.59	10	14.18	NA

Change Idea #1 ☑ Implemented ☐ Not Implemented

To implement the use of a bladder scanner within the home to enhance the assessment skills of the registered staff related to

Process measure

- Number of registered staff educated on proper use of bladder scanner and how to interpret results. Number of residents transferred to ER who were identified as having urine retention.

Target for process measure

- 80% of registered staff will be educated on the proper use of the bladder scanner by June 30, 2023.

Lessons Learned

85% of registered staff have been educated on the proper use of the bladder scanner. The scanner has been successful in identifying if a resident requires an indwelling catheter for urinary retention rather than inserting the catheter and increasing the resident's risk of infection. Of the 39 residents who were transferred to hospital April,2023 -February,2024, one resident was diagnosed with Urinary Retention. Unfortunately, the bladder scanner has not been functioning as it was designed to and is being sent back to the manufacturer for warranty repair. The team is missing the use of this valuable assessment tool.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Residents to identify Substitute Decision Maker and or Power of Attorney for care to ensure the home is reviewing plan of care as well as values of care with the correct person according to resident wishes.

Process measure

- Number of residents who do not have a POA for Care identified. Number of residents who are not capable to identify and POA for Care if one has not already been appointed.

Target for process measure

- 95% of residents will have POA for care form on their resident file by September 2023. 100% of residents will supply the home with their POA for care at time of admission by December 2023.

Lessons Learned

The home has implemented an Admission Assessment through the RNAO Clinical Pathways project. Part of revising the admission process has been focused on gathering information from the resident on who is important to them including, identifying if POA has been identified. Education for the registered staff was been held in February and March of 2024 with an education session booked for families and residents in April of 2024 to review substitute decision maker hierarchy, how to make a decision on behalf of a resident as an SDM or POA for care and to introduce the homes new Goals of Care and Palliative philosophy. To date, 13% of residents do not have a POA for Care identified but do have an appointed SDM. 6% of these residents have been living at Spruce Lodge for over 2 years.

Change Idea #3 ☑ Implemented ☐ Not Implemented

To align the resident's values of care with their plan of care including palliative plan of care.

Process measure

- 80% of registered staff to complete education related to consent to treatment 50% of residents and families will attend an education session on plan of care and consent to treatment by December 2023.

Target for process measure

- 100% of new admissions will have palliative goals of care identified on plan of care by September 2023. 75% of current residents will have palliative goals of care identified on plan of care by December 2023.

Lessons Learned

Palliative Goals of care were introduced in May of 2023. Registered staff were educated on the importance of goals of care and using this information to develop individualized plans of care that respect the resident's values. Education for families has occurred on a 1:1 basis and a large session will occur in April of 2024. The palliative program continues to evolve and will focus on further education on the definition of palliative care and end of life care. This change initiative will continue in 2024-2025.

Experience | Patient-centred | Priority Indicator

	Last Year		This Year	
Indicator #2 Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences". (Spruce Lodge Home For The Aged)	**97.96** Performance (2023/24)	**98** Target (2023/24)	**CB** Performance (2024/25)	**CB** Target (2024/25)

Change Idea #1 ☑ Implemented ☐ Not Implemented

To implement the program Welbi to provide each resident with a personalized activity experience using our recommendation engine.

Process measure

- The number of residents who have life stories completed and posted through Welbi. The number of annual care conferences that staff are able to report on the residents engagement in programming throughout the home. The number of monthly calendars designed using Welbi.

Target for process measure

- 100% of Activity staff to be trained on the use of Welbi by June 2023. 30 % of residents to have data inputted into Welbi by June 2023 and 100% of resident by December 2023 85% of residents who agree will have life stories posted at entrance to room by March 2024.

Lessons Learned

The Welbi program has been successfully implemented throughout the home and the Activity Team has been using the system to develop the monthly activity calendars which provide information on the daily events occurring throughout the home. This process has been fully implemented since May 2023. Team members are able to provide information at care conferences or when requested on what events the resident has been attending and their level of participation. This has been a valuable tool to provide evidence of all of the programs a resident participates in when at times, they may tell their family they have not done anything. We were not successful in implementing the life story- the home delayed the implementation of this project due to the implementation of the Resident and Person Centered Care assessment as well as BSO My Personhood to be uploaded to PCC. The team has met and has decided to use the BSO My Personhood template to compile a life story for the resident that can be posted at the bedside with resident consent. This change idea will continue the into 2024-2025.

Change Idea #2 ☑ Implemented ☐ Not Implemented

To align the admission process to be person centred using validated assessment tools.

Process measure

- Number of residents admitted from July, 2023-March 2024. Number of admissions assessments completed in this time frame using RNAO admission assessment tool. Number of admission assessments completed within 24 hours with kardex posted for staff.

Target for process measure

- 80% of residents admitted from July 2023-March 2024 will have their admission assessment and 24 hour care plan finalized within 24 hours of admission. 100 % of residents admitted after September 2023 will be admitted to the home utilizing the admission assessment tool.

Lessons Learned

Thirty-three residents have been admitted to the home from April 27th,2023 when we implemented the RNAO Clinical Pathways. All new admissions were assessed using the updated Admission pathway which guides the staff to develop the plan of care while completing the assessment. The plan of care is posted within 4 hours of admission for staff to have access to as well as a structured progress note that describes resident's likes, dislikes, goals related to care and interventions to provide care. The home has been able to schedule a dedicated RPN to complete all of the admissions, which has also supported this change idea as it has promoted consistency. We have set the goal to increase the number of staff welcoming a resident to the home to build capacity within our staff over 2024.

Change Idea #3 ☑ Implemented ☐ Not Implemented

To align the on boarding process for new staff to meeting the Fixing Long Term Care Act, Employment Standards Act, Spruce Lodge policies and BPG Person Centred Care.

Process measure

- Number of employees who have commenced employment from July 1st, 2023 to March 31, 2024. Number of new hires who remain at the home on March 31, 2024. Number of exit surveys completed.

Target for process measure

- 95% of new staff to be onboarded using the new process by December 2023.

Lessons Learned

The onboarding program has been revised to ensure we are meeting the Fixing Long Term Care Act, Employment Standards, Health and Safety standards, other regulatory standards as well as the home's Mission and Values and home specific standards. The new process is to roll out effective April 2025. The home has been successful in recruiting new team members and have decreased agency use in the home in 2023 compared to 2022. In person mandatory education occurred in the fall of 2023 and in person education related to nutrition services was also held in 2023. The home is currently in the process of updating all orientation checklists and job routines to ensure current and inclusive of all aspects of the position to better prepare a new team member. The home will be working with our scheduling team to limit the number of areas in the home that a new employee works to allow the employee time to get to know routines and policies as well as the residents in that area before being moved to a new home area. The need for this process change was identified as well through resident, family and staff survey responses in 2023. From April-December,2023, 103 persons joined the Spruce Lodge team with 56 of the team members remaining. We will continue to evaluate this number to evaluate if the process change of our orientation program will decrease the number of staff who leave the home in the same year. We have also implemented an online exit survey to receive feedback from the employee leaving, should they choose to complete it. This was rolled out in February,2024 with only three responses to date, however the information received is valuable in evaluating our programs.

Change Idea #4 ☑ Implemented ☐ Not Implemented

Residents to be offered a variety of snacks, including fresh fruit, that they enjoy and consume.

Process measure

- Number of audits of snack pass to observe snack being distributed. Number of audits to track food wasted post snack pass, what food is being consumed. Number of focus audits with residents at Food Committee to review snack pass Number of dietary staff and nursing staff trained with new snack process

Target for process measure

- 90% of residents will be satisfied with the choices being offered at snack on Quality of Life survey completed in November/December 2023.

Lessons Learned

Fresh fruit is being offered at snack pass as per the request of residents at Food Committee. The Food Committee has met five times over the past year with feedback obtained from the residents regarding likes and dislikes and what choices they would like to see offered. An average of three snack audits occur each month with positive comments. Residents responded that 95% say they receive help with their meals and snacks; unchanged from 2022. 93% receive food and drinks that I like versus 88% in 2022. 85% say the quality of food is good which is a new question for 2023 so not able to compare results to the previous year.

Safety | Safe | Priority Indicator

	Last Year		This Year	
Indicator #1 Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment (Spruce Lodge Home For The Aged)	**29.32** **Performance (2023/24)**	**27** **Target (2023/24)**	**29.46** **Performance (2024/25)**	**NA** **Target (2024/25)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

To implement the RNAO clinical pathway Delirium Assessment to identify residents experiencing delirium or at risk to experience delirium.

Process measure

- Number of Delirium assessments completed on admission. Number of delirium assessments completed with change in status. Number of residents referred to MD post delirium assessment for further intervention. Number of residents with a delirium plan of care.

Target for process measure

- 100% of residents identified as being at high risk for delirium will have a plan of care initiated with resident specific interventions by December, 2023. 100% of all new admissions will have a delirium screen completed by December 2023.

Lessons Learned

The home implemented the RNAO Delirium assessment with a go live date in April 26, 2023. As of February 28, 2024, 187 assessments have been completed on 136 residents. 33 residents have had an admission delirium screen completed in the first 24 hours of moving into the home. All current residents have a plan of care related to risk for delirium or a delirium focused plan of care. 30% of the assessments were completed post an alert in a change in status triggered from the PSW staff. 58% of the assessments were completed as a baseline and to develop a plan of care for residents. 6% of the assessments were completed based on a change in health status or an onset of symptoms. The Delirium Clinical Pathway has provided the team with a tool for early identification of a change in condition with the goal to prevent a delirium from occurring, which we know are life altering in our senior population.

Change Idea #2 ☑ Implemented ☐ Not Implemented

To implement RNAO Person Centred Care Best Practice program with support from project team leading the nursing advantage program.

Process measure

- Number of information posters/ memos posted, shared throughout the implementation period. Number of staff educated on Person Centred Care at mandatory education. Number of code whites that have occured.

Target for process measure

- 75% of staff will be trained on person centred care by December 2023.

Lessons Learned

88% of all staff were trained on Person Centred care and Person Centred Language. Word Swap posters and BSO My Personhood information has been posted throughout the home as well as information shared through staff newsletters. The home is slowly transitioning to Person Centred Language in Care Plans and focus is to continue to transition policies, resident agreements, handbooks, brochures to Person Centred Language. This change idea will continue through 2024-2025.

Change Idea #3 ☑ Implemented ☐ Not Implemented

To participate in GPA bathing program education as a way to decrease the number of antipsychotic medications usage as 31 residents (32.8% raw data Q2, 2022 CIHI) currently have an order for a PRN antipsychotic with out a diagnosis of psychosis.

Process measure

- Number of staff who have completed the training by December 2023. Number of residents who have an individualized plan of care interventions related to bathing/behaviours.

Target for process measure

- To decrease the number of residents utilizing antipsychotic medications without a diagnosis of psychosis to 25% by March 2023.

Lessons Learned

BSO staff have worked alongside team members to provide 1:1 mentoring to support the front line staff in being able to provide care to residents in a dignified manner, decreasing the number of episodes that a resident refuses a bath. Ten residents have been supported by BSO and staff knowledge and comfort with providing care has increased due to this support. Current CIHI quality indicator raw data for Q2, 2023- residents who have an order for a PRN antipsychotic without a diagnosis is 29.5% which is an improvement from our 2022 results. We continue to review residents who require antipsychotic medications prior to bathing to see what other interventions can be used to be successful in providing the resident with bathing support without the use of medications.