Equity

Measure - Dimension: Equitable

Indicator #1	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	CB	As this is a new indicator for the home, we will be collecting information to develop baseline tracking.	

Change Ideas

Change Idea #1 To develop an interdepartmental working group who will analyze our current practices related to Equity, Diversity and Inclusion and recommend enhancements to support the people the home serves- residents, families and staff.

Methods	Process measures	Target for process measure	Comments
To invite team members to participate in the EQUITY, DIVERSITY AND INCLUSION IN LTC: ASSESSMENT AND PLANNING TOOL (provided through CLRI). Once tool has been completed, to prioritize 4 items that would have the biggest impact on those we serve- submit action plan to Resident Council/Family Council and Quality Circle for implementation.	Number of team members involved in the toolkit implementation. Number of areas identified for improvement. Number of change items implemented.	The home will complete EQUITY, DIVERSITY AND INCLUSION IN LTC: ASSESSMENT AND PLANNING TOOL by September 30, 2024 with an action plan developed by December 1, 2024.	

Change Idea #2 To promote awareness of equity, diversity and inclusion throughout Spruce Lodge by educating team members on definitions associated with EDI.

Methods	Process measures	Target for process measure	Comments
To post a definition a month throughout the home area with examples to increase awareness to all persons. To identify cultural events that can be celebrated each month and educate persons served on this event to increase awareness.	Number of monthly education memos/signs used to educate team members, residents and families each month. Number of complaints related to equity, diversity and inclusion including anti-racism received from residents, family members or team members each month.	Six memos/posters related to Equity, Diversity and Inclusion will be posted throughout home and used in newsletters by January 31, 2025.	

Experience

Measure - Dimension: Patient-centred

Indicator #2	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	90.00	The home has set a baseline target. This question has been asked previously on resident engagement surveys however not using this exact wording.	

Change Ideas

Change Idea #1 To enhance our pain program to include the Clinical Pathway Pain to improve the quality of life of our residents related to comfort.

Methods	Process measures	Target for process measure	Comments
Registered staff to be trained on the Clinical Pathway related to pain including RNAO best practice guidelines and legislation related to Fixing Long Term Care Act.	The number of residents with Clinical Pain Pathway Assessments completed The number of residents who have a pain plan of care developed	75% of residents will respond positively to the question " Are staff attentive to your pain?" when asked at care conference.	

Change Idea #2 To implement Synergy Tech Suite which will provide residents the ability to chose food preferences at time of service versus having to decide in advance to enhance quality of life of the residents.

Methods	Process measures	Target for process measure	Comments
To install hardware required for the Synergy program. To educate team members on how to approach resident at point of service with use of show plates/photos of meal to have resident make meal choice. To inform residents and families of change in process and benefits to resident in promoting food choices. Education to dietary staff on numbers of meals that will need to be produced to ensure appropriate quantities of both choices available at meals.	Number of staff education on new process related to Synergy Tech Suite. Number of staff educated on resident choice at time of meal service. Number of resident concerns received related to meal service post the implementation of Synergy Tech Service.	50% of staff trained on new process of meal service utilizing Synergy Tech Service by September 30, 2024 and 75 % of staff trained by December 31, 2024.	

Change Idea #3 To investigate the implementation of an Emotion Focused Care approaches in our memory care cottages.

Methods	Process measures	Target for process measure	Comments
To visit or interview staff at a home that has implemented a Person Centred Care approach such as DementiAbility, a home that has successfully implemented the Butterfly Approach using the Meaningful Care Matters program, as well as a home that has implemented the Eden Approach to decide what philosophy is closest to Spruce Lodge Mission and Values. To develop a project plan for the implementation of an emotion focused care approach including budget impacts of increased staffing levels as well as enhancements to the appearance of the home areas.	Number of education sessions attended by the team related to emotion focused care approaches. Number of homes toured/staff interviewed that have implemented emotion focused care approaches. Number of staff who have volunteered to be involved in the implementation of an emotion focused care approach.	Two home tours/interviews to be completed by December 31, 2024 for information gathering on different emotion focused care approaches to guide the team in deciding which philosophy matches SL mission.	

Measure - Dimension: Patient-centred

Indicator #3	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	CB		

Change Ideas

Change Idea #1			
Methods	Process measures	Target for process measure	Comments
			We are prioritizing other areas of focus

Safety

Measure - Dimension: Safe

Indicator #4	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 2023– September 2023 (Q2 2023/24), with rolling 4-quarter average	30.24	27.00	Percentage Improvements. This goal is a long term goal and our priority is to continue to decrease this rate year over year.	

Change Ideas

Change Idea #1 To implement the Clinical Pathway for Falls as well as the Post Falls Assessment which will include a team huddle post each fall to enhance the home's approach to prevention of resident falls and preventing injury from falls.

Methods	Process measures	Target for process measure	Comments
Education to direct care staff on the value of the Clinical Pathway- assessments are validated and meet the Fixing Long Term Care Act as well as being Person Centred. Education to residents and family members on the new pathways including goal to include resident in developing plan of care related to falls interventions.	Number of resident falls each month. Number of resident falls assessments completed using the N-Can Adv. Falls pathway monthly. Number of residents who experienced an injury post a fall. Number of residents transferred to ER for assessment post fall. Number of residents who have a falls plan of care.	95% of all residents who experience a fall will be assessed utilizing the N-Can Adv Falls Clinical Pathway by July 31, 2024.	

Change Idea #2	To implement a hydration program to improve the fluid intake of residents who are not meeting their recommended fluid intake. Residents at risk for dehydration are at a higher risk for falls.		
Methods	Process measures	Target for process measure	Comments
Education to direct staff on the importance of implementing a hydration program and the impact all team members have. Education to direct care staff on how to calculate fluid intake at meals times as well as through snack pass and other times when a resident consumes fluid.	Number of hydration documentation audits completed monthly. Number of residents each day not meeting their recommended fluid intake. Number of days when look back report not completed. Number of staff trained on the importance of hydration, accuracy of documentation and how to complete look back reports.	75% of staff will be trained by December 31, 2024 on the importance of hydration related to resident health. 60% of residents will be meeting their recommended fluid intake by March, 2025.	

Change Idea #3	To revise and implement new bowel protocol to improve resident quality of life related to bowel care. Constipation raises a resident's risk for falls.		
Methods	Process measures	Target for process measure	Comments
Physicians with input from registered staff, RD and consultant pharmacist to revise bowel protocol as a a part of updating medical directives. Bowel Program to be updated to include enhancements of a new hydration program as well as incorporating dietary changes to promote bowel health in the residents. Education to front line staff on the importance of promoting a regular pattern for bowels for residents. Implement the use of the Bristol Stool Chart to standardize documentation of BM's.	Number of staff educated on the importance of routine bowel movements and priority to prevent constipation. Number of PRN laxatives required monthly and number of residents who required PRN laxatives two or more times in a month. Number of residents who required the use of an enema to manage constipation each month.	50% of residents will have new bowel regime implemented by September 30th, 2024 with 75% of residents will have a new bowel regime implemented by December 31, 2024.	