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 / October 1st 2022 to September 30th 2023 (Q3 to the end of the following Q2)	25.00	21.00	We were unsuccessful at decreasing our avoidable emergency department (ED) visits in the 2023-24 QIP. Therefore, we intend to reach the planned target in the 2024-25 cycle.	

Change Ideas

Change Idea #1 Initiate monthly emergency department (ED) transfer meetings with TOH Outreach NP.

Methods	Process measures	Target for process measure	Comments
QI Lead to facilitate monthly interdisciplinary meeting with NP, Directors of Nursing, and RAI coordinator to analyze each ED transfer case, from identification of change in status through to return to facility.	Ongoing log of reasons for transfers, including unit, sending physician, time of day, symptoms, returning diagnosis and analyze findings to look for patterns.	100% of ED transfers will be captured on the log and in monthly meetings resulting in identified patterns and targeted interventions to bring avoidable ED visits from 25 to 21 by the end of the 2024/25 QIP cycle.	This quality improvement initiative demonstrates our commitment to addressing Hillel Lodge's high number of avoidable ED visits by using resources available to us (Outreach NP) to analyze the data-driven root causes of ED transfers and implementing a targeted measurable education program to decrease avoidable ED transfers.

Change Idea #2 Utilize early detected significant weight loss or gain as a symptom of resident decline, necessitating a goals of care/palliative care discussion with the resident and/or POA.

Methods	Process measures	Target for process measure	Comments
Dietitian to monitor RAI-MDS for weight loss of and inform physician and nurse when the weight loss is significant, referring to a 5% weight loss or gain in one month. From here, the physician is expected to facilitate a discussion with the resident and/or POA to discuss the potential cause of weight loss, implications, investigations, and treatment, thereby increasing resident and/or POA knowledge of frailty and aging, and decreasing unnecessary ED visits that will not improve expected life span or quality of life.	At monthly multi-disciplinary rounds the dietitian will flag residents with a significant weight loss or gain for the team, and 100% of the time the registered dietitian will make a note in the doctor's book for assessment and documentation. Progress notes will be utilized to document that physicians are following up on the dietitian's findings by having conversations with residents and/or POAs 80% of the time to discuss treatment options and goals of care.	As a result of this process, by December 31, 2024, 80% of residents with significant weight loss will have an investigation to determine the cause of weight loss.	It is recognized that weight loss and weight gain are symptoms, not diagnoses. As such, there is no baseline to anchor this change idea in, but we expect identifying frailty and health decline early on will have a positive impact on avoidable ED visits.

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 employees at the leadership level require unconscious bias and diversity training to improve their performance and DEI knowledge.	

Change Ideas

Change Idea #1 Utilize the Learning Management System Hillel Lodge has in place to access DEI learning modules.

Methods	Process measures	Target for process measure	Comments
The training module that will be assigned will be determined by the Human Resources department. The module must meet the needs of the organization and adhere to the expectations of CARF, our accrediting body.	The number of staff that demonstrate uptake of DEI education documented by the end of the calendar year.	100% of the identified persons within the leadership team will successfully complete the assigned DEI training by December 31, 2024.	Requiring the leadership group to attend DEI training is a first step in our goal of providing DEI education broadly to all stakeholders.

Measure - Dimension: Equitable

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
10% of monthly life enrichment programming will be dedicated to the spiritual realm.	C	% / LTC home residents	In house data collection / April 1, 2024 to March 31, 2025.	3.00	10.00	We are a Jewish designated home and it is very important we meet the needs of our intended population by offering a variety of religious and cultural offerings. In addition, nearly 40% of residents are not Jewish, but also have spiritual need to be met. There are five wellness domains, and one-fifth of all programming needs to target the spiritual domain.	

Change Ideas

Change Idea #1 Meet the needs of diverse Jewish residents by offering both Ashkenazi and Sephardic cuisine by offering two Sephardic meals per four week menu rotation.

Methods	Process measures	Target for process measure	Comments
The Director of Food Services will incorporate Sephardic food into each seasonal meal schedule and it will be shared on the menu internally and externally.	Residents who identify as Sephardic on their spiritual care assessment will be surveyed to determine their satisfaction with the Sephardic meal choices on an ongoing basis. Meals will be adjusted based on feedback and residents will be resurveyed.	Sephardic residents will positively respond to the question “I am satisfied with the cultural food I am offered at Hillel Lodge" 60% of the time.	The majority of residents are Ashkenazi Jewish, and by default programming, food and celebration of holidays defaults to their traditions. The Sephardic tradition's cuisine differs from Ashkenazi. To create an equitable and inclusive environment, it is important to include foods from both Jewish groups.

Change Idea #2	Offer an increased variety of recreation/religious/cultural non-shul programming that allows residents more choice in how engage in their Jewish cultural and traditions.		
Methods	Process measures	Target for process measure	Comments
Pre-scheduled programming will be included in Welbi, our recreation platform, from which data can be analyzed regarding the types of programs and the percentage of Jewish religious/cultural programming. Residents will be engaged in program planning meetings to determine Jewish programming they would like to see.	Use Program Planning Meetings to determine exactly what kind of Jewish programming residents are looking for. Assess the participation of residents in the returning Jewish programming using attendance tracking on Welbi. Ongoing tracking with Welbi and Program Planning Meetings to determine if resident needs are being met.	Implementation of programs requested at Program Planning Meetings. Attendance of a minimum of one resident at program (if programs have no attendance after three sessions, the program will be altered or removed).	Current programming other than Sabbath and High Holiday synagogue services are limited and do not meet the needs of many Jewish residents. Non-service Jewish programming may include public speakers and education, Holiday celebrations (i.e. - Passover Seder), Sabbath activities (i.e. - Oneg Shabbot, Shabbot dinners), memorial days (i.e. - Holocaust Remembrance Day), and cooking programs.

Change Idea #3	Increase the number of non-Jewish religious and spiritual programs at Hillel Lodge.		
Methods	Process measures	Target for process measure	Comments
The Life Enrichment Manager will complete spiritual care assessments of all residents and document the findings in Welbi. Using Welbi insights and findings from the resident survey, gaps in resident spiritual care will be identified and programming can be initiated. Programming will need to be delivered by in-house staff and using external clergy or pastoral volunteers.	All residents will have a spiritual care assessment completed within two weeks of admission. In-house programming will be developed and added to the recreation calendar to meet these needs. Using internal resources and external volunteers, religious programming and holidays will have formal programs tied to the spiritual domain.	First quarter: 5% of recreation programming will be dedicated to the spiritual realm, and of this one program per week will be non-Jewish religion/faith. Second quarter: 10% of programming will be dedicated to the spiritual realm, including two programs per week that are non-Jewish religion/faith.	40% of Hillel Lodge residents identify as religions other than Jewish, and it is critical we offer them appropriate religious and culturally sensitive care. Recruitment of pastoral volunteers and clergy will occur through creative means including connecting with local faith communities, job postings for pastoral volunteers, and networking with local post-secondary institutions.

Experience

Measure - Dimension: Patient-centred

Indicator #4	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	75.00	Our survey does not allow us to input results in the format required in this change goal. Therefore, we are unable to calculate the performance of this indicator for the purposes of our QIP. Furthermore, this question is not available on the InterRAI QOL survey. In lieu, we are using the question "Staff respect what I like and dislike." Our current performance of residents who answered this positively with, "most of the time" or "always" was 69.4%. We intend to use our change ideas to improve this to 75%.	

Change Ideas

Change Idea #1	Improve the number of residents who respond positively to the question, "Staff respect what I like and dislike" "most of the time" or "always" from 69.4%.		
Methods	Process measures	Target for process measure	Comments
Ask this question on the annual resident satisfaction survey.	% of residents who respond with "most of the time" or "always" to this question on the survey.	75% of residents feel that staff listen to them "most of the time" or "always."	Last year, the resident survey was completed with only 38 residents. We succeeded in last year's change ideas, but there are opportunities to go further in our person-centredness and ensuring residents are heard and their ideas are responded to and built into improvements.

Change Idea #2	Ensure that residents are consistently asked for feedback on this specific topic.		
Methods	Process measures	Target for process measure	Comments
Receive and document feedback and suggestions from residents at formal regularly scheduled meetings including Program Planning Meetings, Food Committee Meetings, Resident Council, and Resident Town Halls.	Follow up at next meeting to ensure Hillel Lodge has addressed the issue, including documented evidence how we did so (i.e. - training, Surge learning, etc. documentation (training, inservice, etc.).	Collecting baseline.	Given we do not have the opportunity to add the indicator question, we will continue using "staff respect what I like and dislike" as our indicator for how well listened to residents feel.

Change Idea #3	Ask residents where they want to sit in the dining room.		
Methods	Process measures	Target for process measure	Comments
Residents will be asked at their care conferences if they are satisfied with their seating arrangement and if not, the nursing staff will work to find a more suitable arrangement. As part of the pleasurable dining rollout, this question will be added to the quarterly pleasurable dining survey.	Residents will be asked if they are content with their seating arrangement 100% of the time at their initial care conference and it will be documented as a progress note.	90% of the time, when residents are not satisfied, their seating plan will be rectified within 3 weeks.	We expect that asking residents where they want to sit and ensuring they are sitting with compatible tablemates of their choosing will improve how well residents feel they listen, especially if we are responsive to their suggestions and requests.

Measure - Dimension: Patient-centred

Indicator #5	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	76.32	78.00	Although we are performing well with respect to this indicator, we hope to improve residents' comfort with expressing their opinions by use of a suggestions box, and by improving the percentage of residents who feel the staff know their likes and dislikes.	

Change Ideas

Change Idea #1 Ensure that residents are consistently asked for feedback on this specific issue.

Methods	Process measures	Target for process measure	Comments
Ask this question on our Resident Satisfaction Survey.	% of resident who respond with 'agree' (or 'most of the time') or 'strongly agree' ('always') to this question in the 2023 survey.	76.32% threshold of those agreeing or strongly agreeing with this statement.	Total Surveys Initiated: 38 Total LTCH Beds: 121 We are comfortable with this target as it is aligned with the median average of all homes who use the InterRAI QOL survey, which is 76%.

Change Idea #2 Provide opportunities for residents to share opinions and comments.

Methods	Process measures	Target for process measure	Comments
Hillel Lodge will install a suggestion box near reception for residents to leave comments.	The suggestion box will be checked weekly. Suggestions and comments will be forwarded to the most responsible person for action, results will be reported to Resident Council at the town halls, and documented in meeting minutes.	100% of the time, suggestions will be reported at resident council townhall. 75% of the time, suggestions will be implemented.	We recognize that not suggestions are able to be implemented. Therefore, we intend to share all suggestions at the town halls, including explanations as to why some suggestions cannot be implemented.

Safety

Measure - Dimension: Safe

Indicator #6	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	15.17	12.00	Falls have been an ongoing priority for Hillel Lodge. We have made great strides in addressing falls by facilitating falls huddles and informally consulting the BSO. By formalizing our processes and reviewing falls from a holistic perspective, we believe it is a reasonable goal to decrease falls by 20.90% by the end of the 2024/25 cycle.	

Change Ideas

Change Idea #1 For residents who have two or more falls within a two week period, Dementia Observational System (DOS) tracking will be implemented for 7 days.

Methods	Process measures	Target for process measure	Comments
The post-falls huddle outcome will include a BSO referral and DOS assessment when it is the resident's second fall in two weeks. The 7 days of DOS monitoring will be analyzed by the BSO to look for patterns in falls, and they will make recommendations.	Number of residents who meet criteria for a BSO referral/DOS will have one initiated. BSO interventions implemented at conclusion of DOS. BSO recommendations documented in PointClickCare.	100% of residents who have had falls within the last two weeks will have DOS charting complete. 100% of residents will have a completed referral, progress note, and interventions, charted by BSO in PointClickCare.	We have been informally noting patterns in our residents who fall frequently, such as needing to use the washroom in the middle of the night or waking up hungry. Formalizing our data collection will allow us to implement specific tailored interventions and measure their success in reducing falls.

Change Idea #2 Refer all residents who have fallen two times in the last two weeks to the restorative nursing team for assessment and intervention.			
Methods	Process measures	Target for process measure	Comments
After a resident has two falls in the last two weeks, the registered staff will complete a formal referral to the nursing restorative program.	Residents who have fallen twice in a two week period will be measured against referrals to restorative nursing. Frequently falling residents who are added to the nursing restorative program will begin having quarterly RAI-MDS assessments complete and their gains can be measured against their last quarterlies.	100% of residents who have fallen two times in the last two weeks to the restorative nursing team for assessment and intervention, and 90% of residents will be given the opportunity to participate in restorative nursing, regardless of cognitive ability.	Informally, we have witnessed great success with our nursing rehab program in reducing the number of falls residents are having. By creating a formal process where all residents who fall frequently are assessed by the restorative nursing team, residents who may not normally be considered for nursing rehab will have the opportunity to participate in the restorative program.
Change Idea #3 Reinstate referrals to NP for all residents who fall.			
Methods	Process measures	Target for process measure	Comments
All residents who fell in the past were automatically referred to the Outreach NP for assessment. This practice fell away and as a consequence, the NP is unaware of residents who fall.	Develop a referral form for registered staff to use with NP. Use of referral tool so that NP can assess all residents with falls. Audit number of falls against NP referrals.	100% of residents who have falls will be referred to the Outreach NP for assessment.	All residents who fell in the past were automatically referred to the Outreach NP for assessment. This practice fell away and as a consequence, the NP is unaware of residents who fall. We intend to use this change idea as an opportunity to reinvolve our Outreach NP in the falls program.

Measure - Dimension: Safe

Indicator #7	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 2023– September 2023 (Q2 2023/24), with rolling 4-quarter average	6.00	5.80	Despite a perceived increase in anti-psychotic use that we attribute to more accurate reporting, Hillel Lodge performs well below the provincial average with resident to anti-psychotic use. Our goal is to further reduce our antipsychotic use by a relative target of 3.33%.	

Change Ideas

Change Idea #1 Verify the data on the number of residents prescribed antipsychotics, including new starts, PRNs, and administration rates.

Methods	Process measures	Target for process measure	Comments
At the quarterly medication review/audit meeting, the QI Lead, pharmacist, and Directors of Nursing will review residents who are prescribed antipsychotics and the reasons for the prescription. From here, residents who are found to be on antipsychotics without psychosis will be reviewed with the physician, reviewed with the ROH, started on DOS, deprescribed and initiate a new DOS.	Quarterly, all residents who are prescribed antipsychotics will be reviewed and assessed for their ability to be deprescribed antipsychotics. Implementation of DOS before and after deprescribing to track behaviours and adjust non-pharmacological interventions as needed. This will be reported at the following quarter's meeting.	The discussion about residents and plan of care will be accurately recorded in PointClickCare, our electronic health record and Hillel Lodge will maintain its use of antipsychotics in residents without psychosis at 6.0%.	We learned that up until spring 2023, the number of residents with symptoms or diagnoses necessitating the use of antipsychotics were overreported. This change idea provides us with an opportunity to review resident diagnoses and prescribing.