Access and Flow

Measure - Dimension: Efficient

Indicator #4	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.	P	Rate per 100 residents / LTC home residents	CIHI CCRS, CIHI NACRS / Oct 2021 - Sep 2022	23.53	0.20	To reduce the amount of unscheduled/unnecessary Emergency Room visits. To reduce load on the communities Emergency Room.	Jonathan De Witte, Collingwood General and Marine Hospital, On call MD list, Dr. Gandhi

Change Ideas

Change Idea #1 Ensure residents being sent to the Emergency room are either "scheduled" or "Unavoidable".

Methods	Process measures	Target for process measure	Comments
Staff to use their clinical judgment and Nursing skills to determine if residents presenting status can be managed in the LTC.	Decrease number of ER visits	Decrease in ER transfers and Visits that are deemed "Unnecessary"	Continuous education and skill development of nursing staff and utilize outside available resources, such as the Geriatric Mental Health team.

Change Idea #2 Prior to sending a resident to the ER, ensure all care that can be completed to remedy presenting status has been done, and documented prior to sending resident.

Methods	Process measures	Target for process measure	Comments
Call primary physician, or Nurse Practitioner. If after hours contact the On-call Doctor as per rotation.	Decrease in number of ER visits.	Decrease in transfers and visits to the ER that are deemed "Unnecessary"	On call rotation list is prepared by and delivered via fax from Collingwood General and Marine Hospital.

Change Idea #3	Ensure when sending a resident to the hospital, staff are aware of the residents "Advanced Care Directives", and staff have resident/SDM/POA consent.		
Methods	Process measures	Target for process measure	Comments
Prior to sending a resident to the hospital look up the ACD and get consent.	Decrease in ER transfers and visits	Decrease in transfers and visits to the ER that are deemed "Unnecessary"	

Change Idea #4	Work with placement Co Ordinator to ensure Bay Haven has the resources to properly care for new residents, and residents are appropriately placed.		
Methods	Process measures	Target for process measure	Comments
Identify resident who are at risk for unplanned/unscheduled ER visits such as uncontrolled behaviors, frail, medically unstable, or acutely ill at time of placement.	Decrease in unplanned/unscheduled ER visits of new residents.	Decrease in ER visits that are deemed "unnecessary".	DON/Delegate will look at care load and current residents status and take into consideration how new admission will impact the current resident flow.

Experience

Measure - Dimension: Patient-centred

Indicator #5	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?"	P	% / LTC home residents	In house data, NHCAHPS survey / Apr 2022 - Mar 2023	66.67	70.00	Residents should feel comfortable to voice their concerns and complaints, and staff should respond swiftly and effectively to resident and POA concerns and complaints.	

Change Ideas

Change Idea #1 Continue to work with Resident Council, and other resident committees (food, excursion etc.). This will create a safe place where residents feel comfortable to voice their questions, concerns and comments.

Methods	Process measures	Target for process measure	Comments
Continue to host/facilitate a safe place for residents to meet. Invite and encourage all residents to the council meetings. Encourage residents to participate. Allow residents to voice their concerns without interruption. Resident Council is facilitated by the Recreation Manager. The recreation team porters residents to the meeting and invites them. The meeting times are posted in the Monthly Recreation Calendar and on the daily calendar on the day of the meeting.	Percent of resident population who participates in the Resident Council meetings.	Continue participation in the Residents Council. Strive for 10% of the resident population to attend Council Meetings.	Total Surveys Initiated: 14 Total LTCH Beds: 59 Resident Council meetings occur monthly on the last Tuesday of each month. Opportunities for Zoom meetings with other homes and Resident's Council Association, where the president, or a representative from Residents Council can participate in.

Change Idea #2 Management be available to speak with Residents and POA about questions, concerns or comments.

Methods	Process measures	Target for process measure	Comments
When concerns or issues cannot be mediated by floor staff, or if resident or POA is not satisfied with the response, concerns and issues will be escalated to the department head.	Increase the number of residents or POA that respond positively to "how well do staff listen".	70% or more residents, or POA will respond positively to the question "How well do staff listen" on the 2023-2024 Resident satisfaction Survey.	Survey is currently sent out to family via e mail. Data is then collected by the QI Lead.

Change Idea #3 Staff to actively listen to Residents and POA

Methods	Process measures	Target for process measure	Comments
Staff will listen to Residents and POA, without interruption or judgment. Staff will encourage them to communicate any and all concerns. If staff cannot remedy the concern, then escalate to management. Complaints brought forward are to be documented in resident chart on PointClickCare (if necessary) and communicated to staff what corrective actions need to be taken. Management will complete a written record and archive complaints.	Number of complaints that are escalated to management without satisfactory resolution.	70% of concerns will be resolved "in house".	If residents and POA are not satisfied with suggested plan, or resolution they are encouraged to contact the MOLTCH. Telephone numbers and other communication are posted across from the nursing station on "Resident Information" bulletin board, or in the front foyer.

Measure - Dimension: Patient-centred

Indicator #6	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".	P	% / LTC home residents	In house data, interRAI survey / Apr 2022 - Mar 2023	100.00	100.00	Resident's and POA should never have fear of consequences when discussing matters with staff at Bay Haven.	

Change Ideas

Change Idea #1 Allow Residents and POA opportunities to bring forward questions, concerns and comments			
Methods	Process measures	Target for process measure	Comments
Ensure staff are available to receive and potentially solve resident, POA/SDM concerns. Staff will adopt a non-judgmental approach when discussing concerns and issues with Resident's and POA.	Number of Residents and POA who answer positively to "I can express my opinions without fear of consequences" on the Resident Satisfaction Survey.	100 percent of participants will answer positively to the question "I can express my opinions without fear of consequences".	Total Surveys Initiated: 14 Total LTCH Beds: 59 All staff have the ability to be the point of contact for a question or complaint. If the initial person cannot remedy the situation it is important to refer complaint to the appropriate person.

Change Idea #2 Staff are not to be judgmental or dismissive to any concerns, questions or comments made by a resident or POA.			
Methods	Process measures	Target for process measure	Comments
If staff are noted to be judgmental or dismissive to a resident or POA, disciplinary action will be taken as per Bay Havens Whistle Blowing policy and or up to termination.	Number of people who negatively answer to the question "I can express my opinions without fear of consequences"	0% of participants in the Resident Satisfaction Survey who answer negatively to the question "I can express my opinions without fear of consequences"	Any concerns with judgmental or dismissive responses will be brought forward to department heads and Human Resources. Staff to receive customer service and empathy training.

Change Idea #3 Provide an environment/atmosphere where Residents and POA feel safe to voice concerns, questions and comments. Regardless if the information is positive or negative.			
Methods	Process measures	Target for process measure	Comments
Actively listen to residents and POA, be non-judgmental and find a solutions to issues. If the concerns cannot be remedied, escalate to department heads, administrators, or other authorities. All staff should ensure that they are non-judgmental and respectful to the Resident, or POA.	Number of people who respond positively to the question "I can express my opinions without fear of consequences" on the Resident Satisfaction Survey.	0% of Residents or POA will answer negatively to the question "I can express my opinions without fear of consequences" on the Resident Satisfaction Survey.	

Measure - Dimension: Patient-centred

Indicator #7	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
The number of times "Family Council" was promoted/advertised to to families/SDM/POA.	C	Number / LTC home residents	In house data collection / April 2021-2022	2.00	5.00	Increase promotion of the "Family Council" to help encourgae Families/POA/SDM to join the "Family Council". Currently there are no members to create a family council. Target to have at least 2 members by year end.	

Change Ideas

Change Idea #1 Speak about Family Council at Admission Care Conferences

Methods	Process measures	Target for process measure	Comments
The Chair of the Admission Care Conference, will speak with Families/SDM/POA at Admission Care Conferences that occurs 6-8 weeks after admission to Bay Haven.	Number of promotions	Families/SDM/POA will be notified of "Family council" at the Admission Care Conference.	CRN (Clinical Resource Nurse) conducts the Admission Care Conferences.

Change Idea #2 Speak with Family/SDM/POA about Family Council at Annual Care Conference

Methods	Process measures	Target for process measure	Comments
The chairperson of the Annual Care Conferences will speak to the Families/SDM/POA during Annual Care Conference about Family Council This meeting occurs annually from date of admission.	Number of promotions.	Families/SDM/POA will be notified of Family Council at the Annual Care Conference.	Currently CNM (Clinical Nurse Manager) chairs the Annual Care Conferences.

Change Idea #3 Family Council advertisements will be placed in the newsletter once quarterly increase awareness.

Methods	Process measures	Target for process measure	Comments
Newsletter author will ensure at least once quarterly there is an advertisement/notice about the Family Council.	Number of promotions.	Families/SDM/POA will be notified of "Family Council" at least 4 times a year.	Recreation Manager provides information and Office Assistant arranges it into newsletter format.

Measure - Dimension: Patient-centred

Indicator #8	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
The number of people who respond negatively to the question "Were your concerns or complaints addressed promptly" on the Resident Satisfaction Survey.	C	Number / LTC home residents	In-house survey / 2022	15.00	10.00	It is important for staff to follow up with Patient/Family complaints. Together with the resident, or family member a solution can be agreed upon. Follow-up communication should be prompt, even if the solution may take some time to implement.	

Change Ideas

Change Idea #1 Ensure that all complaints, verbal or written are followed up by the most responsible person.

Methods	Process measures	Target for process measure	Comments
The staff member who first takes the complaint should attempt to solve the issue. If it is not within their scope, the concern will be forwarded to the next most responsible persons. (Example nursing concerns handled by nursing department, recreation concerns handled by recreation, etc.) All complaints and concerns should be followed up and documented.	To ensure concerns are followed up and solved promptly when possible.	Reduced negative responses to the question "was your complaint or concerns addressed promptly".	

Change Idea #2 Create a process in which staff can navigate the complaint process effectively, efficiently and consistently.

Methods	Process measures	Target for process measure	Comments
Complaint forms have been created, and are available on the server, to document complaints. Forms to be kept as documentation. This documentation process will be used to process complaints. This allows each staff member to be consistent with families and residents when attempting to remedy a concern or complaint.	Forms will be utilized to document the timeline as well as the concerns and solutions for all verbal and written complaints.	Decrease in persons who feel that their complaints are not being followed up.	Complaint forms have been created and distributed to all management and are available on the server.

Measure - Dimension: Patient-centred

Indicator #9	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
An increase in the overall Food Satisfaction as per the Resident Satisfaction Survey question "How would you rate the meals and snacks provided at Bay Haven?".	C	% / LTC home residents	In house data collection / 2023-2024	71.00	80.00	Residents should receive high quality, visually satisfactory, delicious meals, that satisfy them, while providing nutritional requirements.	

Change Ideas

Change Idea #1 Less complaints of food temperature discrepancies.

Methods	Process measures	Target for process measure	Comments
Ensure food is served at the appropriate temperatures as outlined by the Safe Food Handling Guidelines. Food will be held in the steam table to ensure food stays warm while serving. Staff to ensure lids remain on the steam table when not in use, food is stirred continuously and food is not to sit on the steam table for long periods of time. Residents who receive tray services, ensure lid covers the plate and it is taken to the rooms in the insulated cart.	Percent of residents who answer positively to the resident satisfaction survey question "Are the food and beverage served at the proper temperature?".	80% of resident will respond "yes" to the resident satisfaction question "Are the food and beverage served at the proper temperature?".	A new insulated cart and plate covers have been purchased to transport meals to residents room who require tray service.

Change Idea #2 More food varieties to be offered.

Methods	Process measures	Target for process measure	Comments
Input for the menus will continue to be provided by the Food Committee. Menus continue to rotate to keep menu fresh, and seasonal. Menu to include seasonal, fresh produce from local vendors. Residents will be given opportunity to provide feedback on meals.	Percent of residents who answer positively to the resident satisfaction survey question "Are the food and beverage served at the proper temperature?".	80% off residents will respond positively to the residents satisfaction survey question "Are the food and beverage served at the proper temperature?".	

Change Idea #3 Bay Haven will utilize high quality food options when preparing meals.

Methods	Process measures	Target for process measure	Comments
Food Service Supervisor (FSS) to order high quality products including in-season, quality produce. Cooks will report to FSS if food that arrives is not a quality item, to avoid re-ordering. FSS to report to vendors if quality is not up to standards.	Percent of residents who answer positively to the resident satisfaction survey question "does the food look appetizing and taste good?".	80% of residents will answer positively to the resident satisfaction survey question "does the food look appetizing and taste good?".	

Measure - Dimension: Patient-centred

Indicator #10	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Decrease in the percentage of residents who are on the "Fluid Watch List".	C	% / LTC home residents	POC/PCC Audits / 2023 -2024	81.00	75.00	Residents should remain hydrated and free of negative side effects of dehydration.	Registered Dietician

Change Ideas

Change Idea #1 If accepting offer/administer additional fluids at meal times.

Methods	Process measures	Target for process measure	Comments
Keep a water jug on the tables so staff can easily refill residents cups. Offer residents preferred fluids, this can be found in the resident preference binder in the dining room. When staff notice a cup is empty offer resident additional fluids. Offer tea/coffee at meals. Encourage residents to drink their fluids if they need redirection.	Reduce number of residents on the Fluid Watch List.	Less than 75% average of residents will be on the fluid watch list.	

Change Idea #2 If accepting, offer residents additional fluids during waking hours.			
Methods	Process measures	Target for process measure	Comments
Nourishment cart passes at scheduled intervals during the day, offer residents drinks at this time. If resident is awake in the night ask them if they would like a drink.	Reduce number of residents on the Fluid Watch List.	Less than 75% average of residents will be on the fluid watch list 2023-2024.	

Change Idea #3 Increase in accuracy in documentation surrounding fluid intake by residents in PointClickCare (PCC) and PointOfCare (POC).			
Methods	Process measures	Target for process measure	Comments
Provide education to staff what is a "fluid" and what needs to be documented. Cup sizes in milliliters are provided at documentation terminals to increase accuracy of documentation. Tally Sheets are provided for staff to mark fluid intake at point of care for later documentation after the meal to ensure accuracy.	Reduce the average number of residents on the fluid Watch list.	Less than 75% of resident average will be on the Fluid Watch list in 2023-2024.	

Safety

Measure - Dimension: Effective

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Number of residents/POA/SDM who negatively commented on the Resident Satisfaction Survey, or in person about residents hygiene or overall appearance.	C	Number / LTC home residents	In-house survey / 2021 -2022	3.00	2.00	Residents and families should find residents overall appearance and hygiene acceptable at all times. Resident teeth and hair should be brushed, resident should be dressed appropriately for the weather, and resident should be odor free.	

Change Ideas

Change Idea #1 Residents will show signs of improved oral care.

Methods	Process measures	Target for process measure	Comments
Teeth will be brushed at least 2 times daily. If resident refuses, staff will use proven strategies such as gentle approaches to care, Teepa Snow education, or reproach at another time. Continued refusals will be reported to the RN.	Less incidents of complaints about oral care.	Reduction of resident/family/PAO/SDM complaints about residents personal hygiene on the Resident Satisfaction Survey, and a reduction in "in person" complaints.	Utilizing an outsourced dental hygienist starting in 2022. Encourage participation in tooth protection pilot program.

Change Idea #2 Residents will be dressed appropriately for the season, with clothes that are in good repair.

Methods	Process measures	Target for process measure	Comments
Residents will wear seasonal appropriate clothing, provided by themselves, or their families. Staff will assist residents who need help getting dressed. For residents who dress themselves staff will ensure their clothing choices are appropriate. If resident needs new clothing, staff will reach out to the most responsible persons.	Less incidents of complaints of residents wearing soiled, damaged, or non-seasonal appropriate clothing.	Less than 2 complaints of poor hygiene on the resident satisfaction survey 2023-2024.	

Change Idea #3 Residents overall appearance will be satisfactory.

Methods	Process measures	Target for process measure	Comments
Residents hair will be brushed and aesthetically pleasing to resident. Residents finger nails will be trimmed to residents desired length, clean and well kept.	Less complaints about overall physical appearance.	Decrease of negative in-person comments, complaints on Resident Satisfaction Survey about residents overall appearance.	

Measure - Dimension: Effective

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percent of family members that are aware of the Palliative Care Program, as per the answers to the resident satisfaction survey question " Are you aware of Bay Haven's Palliative and End of Life program?".	C	% / LTC home residents	In-house survey / 2022 -2023	71.00	80.00	It is essential that residents and Families/POA/SDM are aware of the program, so they can make informed decisions about their end of life care. It is important that Bay Haven clearly outline the services we can provide.	

Change Ideas

Change Idea #1	Make residents and families/SDM/POA aware of the Palliative and End of Life programs at Bay Haven during Admission, Admission Care Conferences and Annual Care Conferences.		
Methods	Process measures	Target for process measure	Comments
Inform families about the program during admission when the Advanced Care Directives are being signed. Review at the Admission Care Conference (6-8 weeks after admission) if they would like to continue with the current plan. Annually at the conferences review Advanced Care Directives and ensure Plan of Care still aligns with the wishes of the resident.	Ensure families and residents are aware of End of Life services.	By April 2024, as per the resident satisfaction survey question 80% of survey takers will response "yes" to "Are you aware of Bay Haven's palliative and end of life program?".	

Change Idea #2	Provide education to families about Bay Havens Palliative and End of life Program.		
Methods	Process measures	Target for process measure	Comments
A Palliative and End of Life Program pamphlet will be placed at the entrance of the home, for families to take home. The program policy and procedure is also posted at the front entrance information board.	Increase family members awareness of available End of Life and Palliative Care services.	By 2023-2024 as per the resident satisfaction survey 80% of residents, families/POA/SDM will answer "yes" to the question "Are you aware of Bay Haven's Palliative and End of Life Program".	Information has been posted at front entrance. Will ensure information is kept up to date.

Measure - Dimension: Effective

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percent of residents who begin their "Symptom Relief Kit" (SRK) at least 48 hours prior to their death.	C	% / LTC home residents	EMR/Chart Review / 2023-2024	CB	75.00	To ensure residents receive high, quality, resident focused care at end of life. This includes symptom management, the use of pharmalogical and non-pharmalogical interventions.	Medisystem Pharmacy, North Simcoe Muskoka Hospice Palliative Care Network, Dr. Gandhi, Jonathan DeWitte (NP)

Change Ideas

Change Idea #1 Ensure residents who need symptom management receive the orders from clinician in a timely manner prior to death.

Methods	Process measures	Target for process measure	Comments
Nurses and front line staff to evaluate need for symptom management. Front line staff to communicate to Nursing team who will communicate with clinicians and describe signs and symptoms and their clinical judgment to request the SRK. Residents Palliative Performance scale is discussed at MRCC meetings and during Annual Conferences.	Staff will identify and communicate the need of symptom management with clinicians when clinical judgment dictates that it is time for symptom management.	Upon reviewing medication administration records, it will be noted that at least 75% of residents received orders for SRK at least 48 hours prior to their death, or upon first signs and symptom's.	Staff will utilize "Doctors" and "NP" boards, telephone, in person or PS Suits messaging system to communicate confidentially with the clinicians.

Change Idea #2 The clinician to give orders for the SRK, if deemed clinically necessary when asked by staff either by phone, verbally, fax or PS Suites.

Methods	Process measures	Target for process measure	Comments
When staff provide updates on residents status including Palliative Performance Scale (PPS) clinicians will assess residents overall state and use their clinical judgment to decide if a SRK is necessary. If deemed necessary clinician will provide the order.	Number of residents who receive symptom management orders at least 48 hours prior to death.	Clinicians will write orders for SRK in at least 75% of residents, more than 48 hours prior to their death.	

Change Idea #3 The pharmacy will ensure that frequently used medications in the SRK (Symptom Relief Kit) are stocked at Bay Haven, for quick dispensing and administration for symptom management.

Methods	Process measures	Target for process measure	Comments
Pharmacy will ensure that commonly used medication are stocked in the Emergency Medication Dispensing Unit for afterhours use. Upon receiving the order for SRK, pharmacy will process and dispense medications as soon as they are able, if unable, or medication runs out in the dispensing machine, emergency after hours pharmacy will dispense the medications.	Medications from the SRK will be made available to staff when it is needed to administer.	Medications that are ordered by clinician for the SRK that are not available immediately should be delivered within 12 hours or less. Medications that are not deemed "necessary" medication on the SRK will be delivered within 24 hours.	

Measure - Dimension: Safe

Indicator #11	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	P	% / LTC home residents	CIHI CCRS / Jul - Sept 2022	31.31	19.00	To reduce the amount of residents who are taking antipsychotic medications without a diagnosis of psychosis. 19% is provincial average and the average for the LHIN that Bay Haven is part of.	Medisystem Pharmacy, Dr. Gandhi

Change Ideas

Change Idea #1 To reduce antipsychotic use that is not given without a corresponding diagnosis.			
Methods	Process measures	Target for process measure	Comments
When clinicians are ordering antipsychotic medications review diagnosis list, and determine if there is a diagnosis. If there is not, review with the clinician if a diagnosis is appropriate.	Number of residents who are receiving antipsychotic medications without a corresponding diagnosis.	The number of residents who receive antipsychotic medication without a corresponding diagnosis will be decreased by 50% through the following year.	Medication reviews and collaboration have already begun.

Change Idea #2 Review use of antipsychotic medications through the use of PointClickCare's QIA tab.			
Methods	Process measures	Target for process measure	Comments
Information is sent via secured email from the pharmacy about residents who are on an antipsychotic (both routine and PRN) and those without a corresponding diagnosis. Double check data, and reach out to clinicians in regards to residents, who do not have diagnosis, Assess if a diagnosis is warranted, or if the medication is necessary.	Reduce the number of residents using antipsychotic medication who do not have a corresponding diagnosis.	The CRN will review the residents antipsychotic use, utilizing the email from pharmacy as well as PCC QIA tab, monthly.	

Change Idea #3 Medication reviews for residents on antipsychotic medications.			
Methods	Process measures	Target for process measure	Comments
When pharmacist completes medication review, residents who are on an antipsychotic, suggestions will be forwarded to most responsible clinician.	Reduce the number of resident who receive antipsychotic medications without a corresponding diagnosis.	Medication reviews will occur annually, and as needed if there is a significant change, or concern.	This has already started to occur.

Measure - Dimension: Safe

Indicator #12	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of Bay Haven LTC residents who have had a fall in the past year.	C	% / All patients	HQO public reporting website / 2020-2021	20.80	15.80	This is a 5% decrease, it is noted that 2019-2020 Bay Havens percent was 9%. However due to the new population index this previous percentage is not attainable.	

Change Ideas

Change Idea #1 To complete Purposeful Rounding of residents, to decrease the incidents of falls and fall related injuries.

Methods	Process measures	Target for process measure	Comments
PSW, and frontline workers will preform purposeful rounding. They will check that residents needs are being met (pain, personal needs (hunger, thirst, toileting), positioning, and personal items are in reach) If needs are not being met ensure staff can meet these needs, or find a member of staff who can meet the needs of the resident. Residents will be checked at least every 2 hours, or more often as needed.	To reduce the percentage of resident who have fallen.	The percent of residents who have fallen will reduce by 5% through the next year.	

Change Idea #2 Fall and Prevention Program: Review, Implement, Audit, and Evaluate.			
Methods	Process measures	Target for process measure	Comments
Including in the program is comfort rounds, "Falling Star Program", 72 hour fall risk assessment, alarms for chair and beds etc. Will utilize program and different aspects of the program, for residents who meet criteria.	To reduce the number of residents who have fallen.	The percentage of resident who have fallen will decrease by 5% over the next year.	

Change Idea #3 Falls and Fall prevention committee			
Methods	Process measures	Target for process measure	Comments
Committee will meet quarterly and review program, provide education and review high risk residents and identify strategies to implement to decrease falls and promote reduction on fall related injuries.	To reduce the percent of residents who fall at Bay Haven.	The percentage of resident who have had a fall in Bay Haven will decrease by 5% per the next year.	Committee is already established, will continue with committee in 2023-2024.

Measure - Dimension: Safe

Indicator #13	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Number of emergency planning exercises completed during the year.	C	Number / Health providers in the entire facility	In house data collection / April 2023-March 2024	12.00	12.00	As per fixing Long term Care Act 2021, 12 emergency exercises must be completed over the year to ensure resident safety and staff compliance.	

Change Ideas

Change Idea #1 Complete an Emergency Exercise monthly, to ensure yearly completion goal.			
Methods	Process measures	Target for process measure	Comments
Administrator to create and distribute Emergency Exercise to appropriate staff. Staff to review and suggests any changes where necessary and return to administrator in a timely manner.	To ensure all the Emergency Exercise are completed in the year.	12 Emergency Exercises will be completed in the year.	

Change Idea #2 Prior to the end of the year, ensure that all 12 Emergency Exercises have been completed.			
Methods	Process measures	Target for process measure	Comments
At the end of the year, audit the Emergency Exercises and ensure that 12 have been completed. Ensure that exercises are completed and recommendations have been completed.	Number of Emergency Exercises completed in one year.	12 Emergency Exercises to be completed yearly as per the Fixing Long Term Care Act 2021.	

Change Idea #3 Allow for transparency of the results of the Emergency Exercises.			
Methods	Process measures	Target for process measure	Comments
Administrator will share findings with the Health and Safety Committee and report regularly to Residents Council.	Reports will be posted on the Health and Safety Bulletin Board.	Resident Council and the Health and Safety Committee will be given the results the Emergency Plans.	

Measure - Dimension: Safe

Indicator #14	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Number of IPAC audits that are completed internally, annually.	C	Number / Health providers in the entire facility	In-home audit / March 2023-April 2024	25.00	25.00	As per the Ministry of Health and Long Term Care, complete 25 IPAC audits.	

Change Ideas

Change Idea #1 Schedule the audits at regular intervals.

Methods	Process measures	Target for process measure	Comments
IPAC audits to be completed bi-weekly, unless home is in outbreak where audits will be completed weekly.	Number of IPAC related audits completed annually.	Minimum 25 IPAC related audits will be completed annually.	Audits can be completed by the IPAC lead, or any designated staff member who has received training.

Change Idea #2 Appoint an IPAC lead to oversee the IPAC program.

Methods	Process measures	Target for process measure	Comments
IPAC lead will oversee the IPAC program and ensure audits are being completed on schedule and as needed.	Number of IPAC related audits completed annually.	Minimum 25 IPAC related audits will be completed annually as per the recommendations of the Ministry of Health and Long Term Care.	

Change Idea #3 Ensure that scores of IPAC audits are over 80%

Methods	Process measures	Target for process measure	Comments
When completing the IPAC audit staff will report any discrepancies to the IPAC Lead, the IPAC lead will correct any gaps. Corrections can include changing layouts of PPE caddies, ordering supplies, or providing education to staff or residents. After corrections have been made another audit will be completed to ensure compliance.	Number of audits with a score over 80%.	All audits in the 2023-2024 will score over 80%.	

Measure - Dimension: Safe

Indicator #15	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Number of days where there is not a full complement of staff.	C	Days / Health providers in the entire facility	Other / March 2022-April 2023	229.00	175.00	To reduce the number of days we are short staffed to under 50%. Being fully staffed ensures residents receive high quality, resident focused care.	

Change Ideas

Change Idea #1 To retain students who have conducted their placements at Bay Haven.			
Methods	Process measures	Target for process measure	Comments
Ensure Bay Haven provides a welcoming and inviting place to work. If the students performance aligns with Bay Havens mission, vision and values offer a position of employment, if one is available.	More students will be retained by Bay Haven and become a permanent member of staff.	5% of students will retain a position at Bay Haven.	

Change Idea #2 Implement a staff retention/recruitment committee.			
Methods	Process measures	Target for process measure	Comments
A Multidisciplinary Committee will meet to create ideas/incentives to retain current staff at Bay Haven. Committee will meet as needed.	Staff will be retained and there will be a reduction of staff turn-over. More staff will be hired and there will be less available lines open.	There will be a decrease in staff turn over over the next year.	

Change Idea #3 Utilize agency staff.			
Methods	Process measures	Target for process measure	Comments
When there is a gap in the schedule and all of Bay Havens staff have been asked to complete the shift. Bay Haven will then reach out to agency partners to fill the shift.	Less incidents of working short staffed.	There will be less than 50% of days where staff need to work short over the next year.	