Theme I: Timely and Efficient Transitions

Measure

Dimension: Efficient

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Number 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	21.78	18.50	To meet provincial average of 18.5%. There is a continuing discussion with Residents/SDMs regarding the goals of care,and the options in terms of services that the hospital and the nursing home can provide. While the options of care provided at the nursing home level are discussed, it is a right of each Resident/SDM to seek care at the ER department that must be respected. In addition, the ER transfers, in the absence of external outpatient speciality care for mental health issues and crisis situations, may be the only way to provide Residents with a care that they need.	LTC- CARES, Outreach program - Psychiatry - when available

Change Ideas

Change Idea #1 In-House Nurse Practitioner(NP) involvement in discussion with the Residents/SDMs regarding goals of care during the Innitial and Annual Family Conferences.

Methods	Process measures	Target for process measure	Comments
Initial/Annual Family conferences will be attended by NP.The data will be collected by NP on a quartely basis, and evaluated during the quarterly Medical Advisory and QI meetings.	Total number of the Initial/Annual Family conferences. Number/Percentage of the Initial/Annual Family conferences attended by NP.	At least 90% of Residents will have their Initial/Annual Family conference attended by NP on an ongoing basis.	Full time in-house NP position as of January 2023.

Change Idea #2	In-House Nurse Practitioner (NP) ability to provide timely physical assessments and follow-up of chronic and acute cases.		
Methods	Process measures	Target for process measure	Comments
Registered Staff will report any changes in Resident's condition to NP. NP will conduct the assessment. NP along with Resident/SDM, and with input from MD and/or Registered Staff will faciliate the transfer to ER department as necessary. NP will collect data related to a number of Resident's transfers to the ER department, including the reason.. The data will be collected by NP on a quartely basis, and evaluated during the quarterly Medical Advisory and QI meetings.	Total number (with reason) of Residents who were transferred to the ER department. Number of not admitted Residents who were transferred to the ER department. Percentage of not admitted Residents who were transferred to ER department.	Decrease in percentage of ER transfers from 21.78% to 18,5% by December 31, 2023	Full time in-house NP position as of January 2023.

Change Idea #3	Building liason with other Health Care settings/Practitioners to ensure proper and timely access to outpatient speciality care, such as mental health services.		
Methods	Process measures	Target for process measure	Comments
NP, DOC and Registered Staff are/will identify need of seeking community based support services for Residents with complex medical conditions and mental health conditions - example, access to the Psychiatry services. The data related to Residents accessing the services as needed, will be collected by NP on a quartely basis, and evaluated during the quarterly Medical Advisory and QI meetings.	Total number of Residents who were identified at need to have an access to the community based support services, exampe mental health,who were declined/ not able to access these services.	No specific target. Access to the services depends on the availability of the services for the residents living in the nursing home.	It is our experience that, once a Resident is placed in a nursing home, the access to the community based speciality clinics (for example Shizophremia clinic) is no longer available.Presently, there is no Outreach Psychiatry program present for the Residents living in the nursing homes. Recently, a transfer to the ER was necessary for a Resident who needed an adjustment in medication done by a Psychiatrist.

Theme III: Safe and Effective Care

Measure

Dimension: Safe

Indicator #2	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	32.61	25.00	To approach provincial average.	LTC -CARES, Outreach program - Psychiatry - when available

Change Ideas

Change Idea #1 In-House Nurse Practitioner(NP) involvement in reviewing need of antipsychotic medication usage.

Methods	Process measures	Target for process measure	Comments
NP will meet with Pharmacist and Registered Staff to review usage of the antipsychotic medications for all Residents. NP will collect data related to antypsychtic medication usage. This data will be evaluated on a quarterly basis during the Medical Advisory and QI meetings.	Total number of Residents on antipsychotic medication - with reason. Number of residents for whom the antipsychotic medication was decreased. Number of residents for whom the antipsychotic medication was discontinued.	Decrease in the antipsychotic medication usage from 32.61% to 25% by December 31, 2023	Full time in-house NP position as of January 2023.

Change Idea #2 Nurse Practitioner (NP) will review antipsychotic medicatioon usage during the Querterly Drug Review (QDR).

Methods	Process measures	Target for process measure	Comments
NP will participate in QDRs. The data will be collected by NP on a quartely basis, and evaluated during the quarterly Medical Advisory and QI meetings.	Total number of QDRs. Number of Residents for whom the antipsychtic medication was decreased during QDR. Number of Residents for whom the antipsychtic medication was discontinued during QDR.	At least 90 % of QDRs will be reviewed by NP on an ongoing basis.	Full time in-house NP position as of January 2023.

Change Idea #3	Building liason with other Health Care settings/Practitioners to ensure proper and timely access to outpatient speciality care, such as mental health services.		
Methods	Process measures	Target for process measure	Comments
NP, DOC and Registered Staff are/will identify the need of seeking community based support services for Residents with complex medical conditions and mental health conditions - example, access to the Psychiatry services. The data related to Residents accessing the services as needed, will be collected by NP on a quartely basis, and evaluated during the quarterly Medical Advisory and QI meetings.	Total number of Residents who were identified at need to have access to the community based support services, example mental health,who were declined/ not able to access these services.	No specific target. Access to the services depends on the availability of the services for the residents living in the nursing home.	It is our experience that, once a Resident is placed in a nursing home, the access to the community based speciality clinics (for example Shizophremia clinic) is no longer available.Presently, there is no Outreach Psychiatry program present for the Residents living in the nursing homes. Recently, a transfer to the ER was necessary for a Reident who needed an adjustment in medication done by a Psychiatrist.