# 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 | 31.91 | 18.00 | Currently highly above the provincial average, therefore need to lower as per historic performance. | |

## Change Ideas

Change Idea #1 Woodingford Lodge Tillsonburg is aiming to decrease the number of ED visits by ensuring staff communicate with the practitioners prior to sending a resident to the ED.

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| ED visits will continue to be tracked by the Coordinator of RAI each quarter. Details surrounding their visit are input into a spreadsheet to monitor characteristics of each ED visits. Quarterly ED visits are reviewed in real time at the PIC/PAC meetings. | 1) The number of resident's sent to the ED 2) The number of resident's sent to the ED that could have been prevented/managed within the facility. | 1) The number of residents sent to ED each quarter will decrease, as Woodingford Lodge Tillsonburg has historically had a low percentage. 2) The number seen here will be low or as close to the provincial average as possible. | |

# Theme II: Service Excellence

## 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?" | P | % / LTC home residents | In house data, NHCAHPS survey / Apr 2022 - Mar 2023 | 56.52 | 62.00 | 86% of those who completed the survey felt staff listened to them, with a score of 7 or higher. The goal for 2023-2024 is to increase the number of surveyed residents by 20% and increase the positive feedback by 5%, as Woodingford Lodge is currently working to maximize performance in this area. | |

## Change Ideas

Change Idea #1 Despite achieving high results Woodingford Lodge Tillsonburg knows initiates are imperative to maintaining this high standard.

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| 1) Continue to provide education on Resident's Bill of Rights and Person Centred Care 2) End of Life Questionnaire will continued to be completed by 100% of residents. | 1) Education to be provided in orientation and annually on Surge Learning. 2) Residents will have this process completed as part of their admission process. | 1) 100% of new hires will receive training in orientation and 100% of current staff will receive training annually on Surge 2) 100% of residents will have this survey completed and put into their care plan | Total Surveys Initiated: 23<br>Total LTCH Beds: 34 |

## 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". | P | % / LTC home residents | In house data, interRAI survey / Apr 2022 - Mar 2023 | 91.30 | 96.00 | 91% of those who completed the survey felt they could express their opinions without fear. The goal for 2023-2024 is to increase the number of surveyed residents by 20% and increase the positive feedback by 5%, as Woodingford Lodge Tillsonburg is currently trying to maximize performance in this area. | |

## Change Ideas

Change Idea #1 Despite achieving high results Woodingford Lodge Tillsonburg knows initiates are imperative to maintaining this high standard.

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| 1) Continue to provide education on Resident's Bill of Rights and Person Centred Care 2) Family Transition Program – working on strengthening this program and expanding it over 2023 3) Resident's Council anonymous suggestions & concerns | 1) Education to be provided in orientation and annually on Surge Learning. 2) Total number of residents/POA's/families participating in FTP vs admissions 3) Total number of anonymous suggestions/concerns vs those with follow up | 1) 100% of new hires will receive training in orientation and 100% of current staff will receive training annually on Surge 2) Increase the number of residents/POA's/families participating in FTP by 50% of their current participation rates 3) 100% suggestions & concerns will have follow up within a timely manner | Total Surveys Initiated: 23<br>Total LTCH Beds: 34 |

# Theme III: Safe and Effective Care

## Measure

**Dimension:** Effective

| Indicator #4 | Type | Unit / Population | Source / Period | Current Performance | Target | Target Justification | External Collaborators |
|---|---|---|---|---|---|---|---|
| Percentage of long-term care home residents who developed a stage 2 to 4 pressure ulcer or had a pressure ulcer that worsened to a stage 2, 3 or 4 | C | % / LTC home residents | CIHI CCRS / 2022 Quarter 2 | 8.90 | 4.00 | Tillsonburg is above the provincial average for wounds and worsening wound. Aim to improve services and approach provincial targets. | |

## Change Ideas

Change Idea #1 1.Skin and Wound Application implementation and continuous review 2. Wound rounds occurring monthly in all home areas 3. Dietician to be notified of all compromised skin integrity

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| 1. Implemented March 2022. Continue to improve wound data 2. Nurse Practitioner to round with registered staff and dietician. 3. Dietician to be notified by referral process of all skin integrity issues to assist with preventative measures being put in place. | 1.100% of nursing staff feel comfortable using skin and wound application to ensure that information is accurate 2. All stage 2 or greater wounds being assessed monthly 100% of the time 4.Referral being sent to dietician 100% of the time that a new skin issue is identified | 1.To see nursing working at full scope and implementing treatments within their scope 2. To ensure timely treatment for residents identified as having altered skin integrity. 3.To see improvement in the stage 2-4 worsening wounds numbers based on strategies of early nursing interventions and early dietary consultation | 1.100% of the skin and wound application has been implemented. Further education to be provided to improve use of skin and wound application 2. Skin and Wound rounds have been started in Tillsonburg and will continue monthly. 3.Referral implemented on PCC New Goals for 2023-2024: 1.Implement Referral Process for NP and Dietician – fully implemented 2. Skin and Wound Application in PCC – Fully implement. 3. Decrease washable bed pads 4. Monthly high risk rounds with support of NP and dietician 5. Education – Tillsonburg has a registered staff trained with the skin and wound basic course 6. Dietician to be involved in all altered skin integrity. |

## Measure

**Dimension:** Effective

| Indicator #5 | Type | Unit / Population | Source / Period | Current Performance | Target | Target Justification | External Collaborators |
|---|---|---|---|---|---|---|---|
| Palliative - Increase volunteers available for Residents at End-of-Life (EOL) | C | Number / LTC home residents | In house data collection / 2023-2024 | CB | 5.00 | Woodingford Lodge has a group of volunteers, but none currently specific to EOL Support (Winter 2023) - Volunteers take time to recruit and train. | |

## Change Ideas

Change Idea #1 Increase the number of volunteers that are available to provide support at End Of Life for Woodingford Lodge Ingersoll Residents.

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| Supervisor of Recreation will work on recruiting more volunteers for EOL | Number of Volunteers Available | Will have 5 volunteers available for EOL support | |

## Measure

**Dimension:** Effective

| Indicator #6 | Type | Unit / Population | Source / Period | Current Performance | Target | Target Justification | External Collaborators |
|---|---|---|---|---|---|---|---|
| Palliative - Improve documentation at EOL | C | Number / Worker | In house data collection / 2023-2024 | CB | CB | No current standard or requirement for documentation at EOL (Summer 2023) - POC Tasks and Care Plan items are already created, communication just needs to be sent out to staff | |

## Change Ideas

| | |
|---|---|
| Change Idea #1 | Reg Staff to initiate TAR Items/POC Tasks for Residents receiving Palliative Care including: Palliative Oral Care and Turn/Reposition Schedule A Palliative Care focus in the Care Plan will be initiated at EOL which includes MD/NP Palliative Consultation; Nursing; Recreation; Physiotherapy; Spiritual An End of Life progress note will be completed each shift once a person is deemed EOL. |

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| Discuss new process at Registered Staff Meetings/Team Huddles and send out communication via email | 100% Residents at EOL will have these measures implemented | POC Tasks and Palliative Care Plans will be initiated | |

## Measure

**Dimension:** Effective

| Indicator #7 | Type | Unit / Population | Source / Period | Current Performance | Target | Target Justification | External Collaborators |
|---|---|---|---|---|---|---|---|
| Palliative - Improve communication at EOL | C | Number / Worker | In house data collection / 2023-2024 | CB | CB | Referrals to NP/Physician at EOL is not consistent (Summer 2023) - New process needs to be communicated to staff before implementation | |

## Change Ideas

Change Idea #1 Reg Staff to send referrals to NP and Dietician for all Residents with PPS =/<30% Reg Staff will initiate Palliative Consultation Note with AAR (Assessment, action and response) after reviewing Resident with NP/MD.

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| Discuss new process at Registered Staff Meetings/Team Huddles and send out communication via email | 100% Residents at EOL will have these measures implemented | 100% Residents at EOL will have these measures implemented | |

## Measure

**Dimension:** Effective

| Indicator #8 | Type | Unit / Population | Source / Period | Current Performance | Target | Target Justification | External Collaborators |
|---|---|---|---|---|---|---|---|
| Palliative - Review EOL Questionnaires annually | C | % / LTC home residents | In house data collection / 2023-2024 | 100.00 | 100.00 | EOL questionnaire has been implemented as a way for all residents to inform their care and have their wishes at EOL respected. Determine with working group ideal time in resident's stay to address EOL and complete questionnaire and a process for reviewing annually to ensure resident's wishes are accurate and up-to-date. (Winter 2023) - Working group needs to meet and determine best process for annual review. | |

## Change Ideas

Change Idea #1 Implement a review cycle to ensure that all end of life questionnaires are reviewed annually with Resident's and/or their Power of Attorney.

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| Implement review cycle. | 100% EOL Questionnaires reviewed annually | 100% EOL Questionnaires reviewed annually | |

## Measure

**Dimension:** Effective

| Indicator #9 | Type | Unit / Population | Source / Period | Current Performance | Target | Target Justification | External Collaborators |
|---|---|---|---|---|---|---|---|
| Palliative - CLRI Palliative Care Initiative continued engagement in goals of project. | C | % / Worker | In house data collection / 2023-2024 | CB | CB | Participation in Initiative began in 2021 and will continue into 2024. Initiative participation has identified QIPs that team is to support which will be identified here (Spring 2024) - It will take time to set up working group with CLRI and determine best course of action. | |

## Change Ideas

Change Idea #1 Increase multidisciplinary team knowledge on Palliative Care to create a support team for residents and families at EOL. With end goal being formal support at EOL is added as an expansion of the already existing Family Transition Program which focuses on supporting residents and families on admission to LTC.

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| Educate team members on Palliative Care and Family Communication Working group to meet with Family Transition Program to develop plan for support of families and residents at EOL based on principles and values of program. Working group to work with educated team members to implement plan. Working group to work with CLRI group to create a family and resident survey for EOL care and implement survey to identify opportunities for further improvement in program | Metric #1: Develop and implement plan for support of residents and families at EOL Metric #2: % of residents/families supported/month Metric #3: Create and implement EOL care survey with CLRI Metric #4: % of surveys completed/month | Metric #1 Goal: Summer 2022 Metric #2 Goal: 80% or greater Metric #3 Goal: Summer 2022 Metric #4: 80% or greater | |

## Measure

**Dimension:** Effective

| Indicator #10 | Type | Unit / Population | Source / Period | Current Performance | Target | Target Justification | External Collaborators |
|---|---|---|---|---|---|---|---|
| Percentage of long-term care home residents who experienced moderate pain daily or any severe pain during the 7 days prior to their most recent resident assessment | C | % / LTC home residents | CIHI CCRS / 2022 Quarter 2 | 13.60 | 5.00 | Decrease the amount of residents who have pain by developing criteria for screening and enhancing the follow up process in the event pain is new and/or worsening.<br><br>Justification: Currently percentages are well above provincial average therefore a goal of increasing follow up interventions in the event of new and/or worsening pain seems sufficient | |

## Change Ideas

| | |
|---|---|
| Change Idea #1 | Currently Woodingford Lodge Tillsonburg's screening times are not ideal at capturing accurate pain levels. With the adjustment of these times and the prompt and proper follow up it is the expectation we can capture unmanaged pain and implement strategies and/or orders to alleviate or improve the level of pain |

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| Develop a definition for unmanaged pain Develop criteria for unmanaged pain to require a comprehensive pain assessment | 1) Refer to NP when residents have a pain score of 2 or 3 on their RAI Assessment 2) Comprehensive pain assessments completed on residents who have unmanaged pain that meet the criteria for the assessment 3) Ensure follow-up is completed post comprehensive pain assessment | 1) Resident's with pain scores of 2 or 3 will have a decrease in their score on their next assessment 2) Residents with incidents of unmanaged pain will have a comprehensive pain assessment completed 3) Education to staff regarding indications of pain and sequences of interventions to be put in place for those experiencing pain | Pain assessment has been implemented into the eMAR during all the resident's observation period. The PAINAD can be skewed depending on staff member documenting. Difficult to assess location or intensity of pain in those who are severely cognitively impaired. New Goals for 2023/2024: Connect with Pain & Symptom Management Group to have a pain consultant available on site to support those resident's experiencing unmanaged pain |

## Measure

**Dimension:** Effective

| Indicator #11 | Type | Unit / Population | Source / Period | Current Performance | Target | Target Justification | External Collaborators |
|---|---|---|---|---|---|---|---|
| Continence: Decrease the percentage of residents with an indwelling catheters. | C | % / LTC home residents | CIHI CCRS / 2022 Quarter 2 | 6.80 | 1.80 | Historically Woodingford Lodge Tillsonburg has not been below the provincial average. From last year the numbers have decreased significantly however remain above the provincial average. | |

## Change Ideas

Change Idea #1 Woodingford Lodge Tillsonburg needs to look at factors that may increase the need for residents to have indwelling catheters. Consequently Woodingford Lodge Tillsonburg will look at any factors that are modifiable keeping the goal of a 5 % overall decrease in this number for 2023.

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| In order to reduce this number further the registered team members in partnership with the NP will review all residents with a new or existing indwelling catheter for clinical trials for removal throughout the year. | 1) Number of residents requiring an indwelling catheter. 2) For those residents complete a bladder scan at designated times of the day. | 1) 100% of residents with indwelling catheters to be assessed for possible removal in 2023. 2) All newly admitted residents with indwelling catheters be assessed for possible removal in 2023. | -It has been observed that there is a significantly higher prevalence of UTIs in those residents requiring indwelling catheters. -Although Tillsonburg has lower percentage of residents with UTIs the majority of these infections occur in residents with indwelling catheters. |

## Measure

**Dimension:** Effective

| Indicator #12 | Type | Unit / Population | Source / Period | Current Performance | Target | Target Justification | External Collaborators |
|---|---|---|---|---|---|---|---|
| Continence - Decrease the percentage of residents with worsened bowel incontinence. | C | % / LTC home residents | CIHI CCRS / 2022 Quarter 2 | 25.70 | 24.00 | This is an indicator that Woodingford Lodge Tillsonburg has historically been above the provincial average on. From one year ago Woodingford Lodge Tillsonburg has made a slight decrease 0.8% for this indicator. | |

## Change Ideas

Change Idea #1 To affect change in this indicator Woodingford Lodge Tillsonburg will need to determine factors contributing to fecal incontinence in the residents.

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| Monitoring of the residents requiring PRN laxative use on a monthly basis for both units will occur. | 1) Identify those residents requiring PRN laxative use on a monthly basis. 2) For those residents review the routine laxative regime with the NP and fluid intake levels with the RD for possible adjustment. | 1)100% of residents requiring PRN laxative use to be reviewed by DOC/SCR of the unit in partnership with the NP. | There is a need to determine the co relation between PRN laxative use and any increase in bowel incontinence. To decrease this condition for our residents will lead to a decrease in anxiety/responsive behaviors and improve skin integrity. |

## Measure

**Dimension:** Safe

| Indicator #13 | 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 | 8.33 | 8.00 | Woodingford Lodge Tillsonburg is below the provincial benchmark therefore reduction or maintenance is the goal. | |

## Change Ideas

Change Idea #1 Antipsychotic Reviews will be completed by BSO RPNs using the Antipsychotic Review Assessment Tool on a quarterly basis. This will be reviewed quarterly by the NP, and Pharmacy for further review with family and resident at annual care conferences. BSO RPNs and Pharmacy will examine our resident's diagnoses and medications as well prior to annual care conferences to decrease inappropriate medication usage. Admissions and Transitions will have increased supports to decrease the need for antipsychotic use on admission for responsive behaviours due to change in environment.

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| Implement an Antipsychotic Medication Review policy. NP and Pharmacy member will attend annual care conferences after reviewing BSO RPN antipsychotic assessment tools. | 1) % residents receiving antipsychotic medications without diagnosis 2) % residents receiving antipsychotic medications total 3) # gradual dose reductions generated from antipsychotic reviews quarterly by NP/BSO RPNs, and annually by BSO RPNs/Pharmacy | 1) Tillsonburg –maintain below the provincial benchmark (2023) 2) Dose Reductions: Tillsonburg- max 4/month | - 100% of reviews for antipsychotic use were completed. - Due to change in staff within BSO team, staff education was a challenge, but the BSO team will look at providing staff education for 2023-2024, with the support of Pharmacy. Goals for 2023/2024: 1) maintain number below provincial benchmark 2) Improve the monitoring of those residents using Antipsychotic 3) GDR or change of antipsychotic medications for those without an appropriate diagnosis for usage 4)increase education on antipsychotic uses and the benefits of non-pharm approaches |

## Measure

**Dimension:** Safe

| Indicator #14 | Type | Unit / Population | Source / Period | Current Performance | Target | Target Justification | External Collaborators |
|---|---|---|---|---|---|---|---|
| Decrease the number of residents with worsened behaviours. | C | % / LTC home residents | CIHI CCRS / 2022 Quarter 2 | 15.40 | 12.40 | 1)Improve worsened behavioural symptoms by 3% - Historically Woodingford Lodge Tillsonburg has been above the provincial average for worsened behavioural symptoms.<br><br>2)Maintain our positive averages for improved behavioural symptoms - Embedded BSO team works collaboratively with the medical team and external hospital resources<br><br>3)Improve educations and training on non-pharm approaches to care - With Covid restrictions, there has been a decrease with in-person training | |

## Change Ideas

Change Idea #1 1) Providing options for the admission process, to enable the family and caregiver to better support their loved one moving in on move-in day (ex. alternate day to complete paperwork) 2)All staff in WFL trained in GPA, beginning with frontline care providers

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| 1) Collaboration with transitions, admissions, Caregivers, external supports prior to admission | 1)Number of admissions supported into WFL with a diagnosis of dementia and/or a history of responsive behaviours are reviewed prior to admission, supported with the transition on move-in day, and supported by Transitions and BSO Team 2)Number of staff GPA trained | 1) 100% of transitions into the home are reviewed and supported with caregiver obtaining background personhood information prior to moving in 3) 100% of frontline staff trained in GPA | This is a new QIP, however the admissions into WFL have been altered to better support these potential difficult admissions into the home, in collaboration with the family/caregiver, and existing community supports, which has assisted with improving supports and communications of potential responsive behaviours |

## Measure

**Dimension:** Safe

| Indicator #15 | Type | Unit / Population | Source / Period | Current Performance | Target | Target Justification | External Collaborators |
|---|---|---|---|---|---|---|---|
| Decrease Percentage of residents who have fallen and Increase staff knowledge re Curbell alarms/ set up and reduce falls risk and improve Resident safety. | C | % / LTC home residents | CIHI CCRS / 2022 Quarter 2 | 25.00 | 20.00 | Provincial target 15.2%, therefore need to decrease Tillsonburg's amount of falls. | |

## Change Ideas

Change Idea #1 Review SURGE learning modules and ensure the best videos for falls prevention/ falls harm reduction strategies are used. Educate staff re: CURBELL ALARMS (how to set up properly) Wall mounted curbell boxes, to reduce falls risk and improve Resident safety.

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| SURGE learning modules and ensure appropriate annual and onboarding education modules assigned to PSWs, RPNs and RNs. Education to all staff through huddles/ SURGE learning (Curbell) | All staff have an understanding of how to set up a curbell alarm for bed or chair. | Staff will complete annual surge modules related to falls and curbell alarm set up/use. Wall mounted curbell boxes, to reduce falls risk and improve Resident safety by eliminating a longer cord and lengthen the life of the Curbell monitors by ensuring they are not dropped or knocked off the bed. The mount keeps the monitors in a consistent place so that staff do not have to search for the monitor to shut it off and ensures it is easily audible when sounding. | Tillsonburg has mounted clips on each wall with a 1 foot cord that goes to the call receptacle to the Curbell monitor. 12/34 Residents in Tillsonburg have safety monitors in place. Cords cost $18 each, wall clips are $20 each. Cardinal Health is willing to do a Train-the-Trainer on use of safety monitors. This has been completed in Tillsonburg. Continue to have the curbell alarms set up and purchased for the Tillsonburg location. Ensure that all staff will have education on how to properly set up or reset a curbell. |

## Measure

**Dimension:** Safe

| Indicator #16 | Type | Unit / Population | Source / Period | Current Performance | Target | Target Justification | External Collaborators |
|---|---|---|---|---|---|---|---|
| IPAC - Increase the number of staff that are current and up-to-date with fit testing | C | Number / Worker | In house data collection / 2023-2024 | 67.00 | 100.00 | Fit testing takes place at orientation by county H & S rep (Winter 2023).<br><br>There are a number of employees are currently approaching 2 years from last fit test or not fit to a respirator (Fall 2023).<br><br>Justification: WFL will follow County Respiratory Protection Program Policy as well as Ministry regulations and IPAC standards | |

## Change Ideas

Change Idea #1 Create a sustainable program with dedicated and trained staff to complete fit testing over a regular and predictable schedule.

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| Use Ministry referred agency to up-date staff from all 3 sites Train and educate current IPAC staff through surge learning modules, train-the trainer method and external programs/courses Recruit staff to participate in fit testing from JHSC, front line, all three shifts and all three sites and offer training Reach out to internal stakeholders to explore partnership and human resources sharing (EMS) | Metric 1: Staff are trained and available as needed to complete the fit testing Metric 2: Regular schedule set covering all 3 shifts and all 3 sites Metric 3: Staff are current with their fit testing by end of 2023 | Goal 1: Sustainable program established which enhances respiratory protection of WFL staff and reduces exposures to occupational hazards Goal 2: Quarterly schedule Goal 3: 55 % of active employees | Successfully fit tested 10 employees between January 10-18, 2023 using Ministry appointed company 67 % of staff are up-to-date (March 17, 2023) |

## Measure

**Dimension:** Safe

| Indicator #17 | Type | Unit / Population | Source / Period | Current Performance | Target | Target Justification | External Collaborators |
|---|---|---|---|---|---|---|---|
| IPAC - Ensure all staff are familiar with and practice 4 moments of hand hygiene. | C | % / LTC home residents | CIHI CCRS / 2023-2024 | 100.00 | 100.00 | Four moments of hand hygiene are reviewed at all staff orientation and once per year with surge learning modules<br><br>ABHR and dedicated handwashing sinks are located throughout the facility<br><br>Signage on the steps for performing hand hygiene are located at dispensers<br><br>Hand hygiene audits have been introduced with themes identified, including less than 15 second rubs, gloves used beyond original task and missed opportunities prior to medication administration<br><br>Justification: Hand hygiene (hand cleaning) is the single most important strategy for preventing the spread of disease causing organisms and is a core element of resident safety to prevent healthcare associated infections. | |

## Change Ideas

Change Idea #1 Create a sustainable hand hygiene auditing program with dedicated and trained staff to complete over a regular and predictable schedule

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| Ensure staff are up-to-date with the IPAC components of surge learning specific to hand hygiene Ensure all staff have access to and are familiar with the hand hygiene policy Ensure there is access to ABHR at point of care and dedicated hand washing sinks when hands are visibly soiled Train and educate staff to perform hand hygiene audits, have a regular schedule and share trends | Metric 1: Review surge learning records with education supervisor yearly (November) to determine if staff are missing components of their learning requirements Metric 2: Staff receive a copy of the policy and are expected to have read Metric 3: ABHR placement, exp. dates and accessibility to sinks are audited using COVID-19 self- assessment tool Metric 4: Each home unit will perform weekly audits that are multidisciplinary | Goal 1: 85 % of staff have completed surge learning with outstanding modules being completed within 30 days of review Goal 2: 85 % of all staff Goal 3: ABHR is available 100 % of time at point of care Goal 4: 4 moments of hand hygiene are practiced by all staff 85 % of the time | |

## Measure

**Dimension:** Safe

| Indicator #18 | Type | Unit / Population | Source / Period | Current Performance | Target | Target Justification | External Collaborators |
|---|---|---|---|---|---|---|---|
| IPAC - Ensure resident room set up for Additional Precautions (AP) has the correct signage and equipment | C | Number / LTC home residents | In house data collection / 2023-2024 | CB | 100.00 | Signage alerting staff, visitors and residents to the precautions required to protect oneself and others while providing direct care or interacting with residents environment has been incorrect, outdated, missing steps or remains in place after precautions are removed.<br><br>Variety of equipment options for garbage, laundry and PPE set up.<br><br>Placement of equipment varies room to room, among home areas and sites.<br><br>Justification: Effective Routine | |

Practices and Additional Precautions reduce the risk of transmission of microorganisms in health care settings.

Signage is cautionary, provides reminders and reviews steps required at time of entry to a residents room and is an important component of outbreak preparedness and management required by the Ministry and defined in the FLTCA, 2021.

Provincial Infectious Diseases Advisory Committee (PIDAC) and Accreditation Canada promote best practices and auditing tools for AP to assist health care organizations in improving quality of care, as well as resident safety

## Change Ideas

Change Idea #1 Create an accessible and no fail process for staff to set up a room for the necessary additional precautions when residents are at risk of transmitting disease. Create an opportunity for educating, auditing and feedback.

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| Create ready to use packages with complete signage requirements for the additional precautions most often used in LTC. Ensure an up-to-date picture is available of room set up for each AP and located where equipment and signage is stored. Ensure additional precautions module is added to surge learning for staff yearly re-fresher Ensure staff have opportunities to receive feedback on trends observed and follow best practices | Metric 1: Complete packages for AP are accessible to staff at the onset of precautions being put into place and photo of set up is with equipment Metric 2: Review surge learning records with education supervisor yearly (November) to determine if staff are missing components of their learning requirements Metric 3: Resident rooms with AP's are audited using COVID-19 self assessment tool q 2 wks and when initiated | Goal 1: Packages are ready-to-go with outbreak equipment as per bi-weekly audit with COVID self- assessment tool Goal 2: 85 % of staff have completed surge learning with outstanding modules being completed within 30 days of review Goal 3: 95 % of rooms have correct signage, equipment and timely removal when dc'd | Tillsonburg signage is in bins within managers office and equipment is in pandemic room |

## Measure

**Dimension:** Safe

| Indicator #19 | Type | Unit / Population | Source / Period | Current Performance | Target | Target Justification | External Collaborators |
|---|---|---|---|---|---|---|---|
| IPAC - Ensure the infection and control lead designated under the FLTCA, 2021 works regularly in that position on site at the home | C | Hours / Worker | In house data collection / 2023-2024 | CB | 17.50 | IPAC RPN works 40 hours/week dividing time between 3 WFL sites<br><br>IPAC supervisor works 35 hours/week as the IPAC lead for Woodstock site, dividing time between 3 WFL sites<br><br>With a two team member approach, there is no one person dedicated to work regularly in each home as the IPAC lead that meets the required hours legislated<br><br>Justification: Each licensee of a long-term care home is required to meet the legislated IPAC lead hours.<br><br>In a home with 69 or fewer beds, at least 17.5 hours per week is required; in a home with more than 69 beds but fewer than 200 beds, at least 26.25 hours per week is required. | |

## Change Ideas

| Change Idea #1 | Tillsonburg site requires a dedicated IPAC lead who has the education and experience in IPAC practices as per FLTCA and can provide on site IPAC support for a minimum of 17.5 hours/week | | |
|---|---|---|---|
| Methods | Process measures | Target for process measure | Comments |
| Recruit internally through an EOI process for staff members with an interest, experience and education in IPAC FLTCH, 2021, IPAC Standards and Accreditation Canada legislate and guide this requirement. | Metric 1: Recruitment process to be initiated. Metric 2: Successful candidate to be provided education, orientation and training for the role to support best practices in the home. Metric 3: Support the preparation to certify with the Certification Board of Infection Control and Epidemiology (CIC) within 3 years of the act coming into force | Goal 1: Process initiated in March and completed in April 2023 Goal 2: Provide access to IPAC education through an accredited education institution meeting IPAC requirements Goal 3: Encourage mentoring opportunities, communities of practice to learn and share, offer tools required to prep for the exam | Ensure that Tillsonburg has the required number of IPAC hours each week. WFL IPAC program to: cover the cost of the exam once successfully completed |

## Measure

**Dimension:** Safe

| Indicator #20 | Type | Unit / Population | Source / Period | Current Performance | Target | Target Justification | External Collaborators |
|---|---|---|---|---|---|---|---|

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| IPAC - Ensure that the training for staff in infection prevention and control (IPAC) at orientation and yearly cover the topics required by the FLTCA, 2021. | C | Number / Worker | In house data collection / 2023-2024 | CB | 100.00 | IPAC modules for nursing and hours paid for training…22:33 hr/min<br><br>IPAC modules for non-nursing and hours paid for training…22:33 hr/min<br><br>Topics not covered: what to do if experiencing symptoms of infectious disease and handling and disposing of biological waste including used PPE.<br><br>Retiring surge module, IPAC 101 that covers modes of infection transmission, signs and symptoms and cleaning and disinfecting practices needs to be replaced<br><br>Recommended by standards is PHO core competencies up to 2:00:00 on surge<br><br>Justification: Ensure that the training for staff in IPAC at orientation and yearly re-training include the topics: hand hygiene, modes of infection transmission, signs and symptoms of infectious diseases, respiratory etiquette, what to do if experiencing symptoms of infectious disease, cleaning and disinfection practices, use of personal protective equipment including appropriate donning and doffing, and handling and disposing of biological waste including used PPE. |

## Change Ideas

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| Change Idea #1 | Ensure the surge learning modules required to provide staff education and re-training are up-to-date and meet the requirements of Act and best practices offered by Accreditation Canada. Ensure there is auditing of completion of surge learning modules. Ensure there is opportunity for learners to evaluate their learning and provide feedback once modules are completed. Ensure staff know where to find policies to support IPAC and practices. |

| Methods | Process measures | Target for process measure | Comments |
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| Update the slides covered in orientation curriculum to meet legislation and current and best IPAC practices. Ensure that hours provided to all staff for IPAC meet the requirements. Ensure staff are completing the surge modules on an annual basis. Ensure staff understand and follow IPAC best practices. | Metric 1: All staff at orientation are offered the required training topics as outlined, in person and surge learning Metric 2: All staff are offered yearly re-training on the required topics as outlined, in person and or surge learning Metric 3: Review surge learning records yearly (November) to determine if staff are missing components of their learning requirements Metric 4: IPAC audits and feedback to be used to determined knowledge gaps | Goal 1: 100 % of topics covered at orientation meet FLTCA requirements and re-evaluated yearly. Goal 2: 100 % of staff are offered core competencies modules Goal 3: 85 % of staff complete the training within the year Goal 4: 85 % of audits demonstrate competency with feedback/ re-training offered prn | February, IPAC lead and IPAC RPN provided in- class support at orientation to cover topics of hand hygiene, modes of transmission, donning and doffing, and PCRA. Enhanced slides for orientation of new staff: 4 moments of hand hygiene, respiratory etiquette, what to do if experiencing symptoms, cleaning and disinfecting practices. |