

Equity

Measure - Dimension: Equitable

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Equity, Diversity and Inclusion Framework	C	Number / N/a	In house data collection / 2024 2025	CB	CB	New initiative for ARH	

Change Ideas

Change Idea #1 1.Recruit EDI Specialist/Expert to lead ARH through this change journey.

Methods	Process measures	Target for process measure	Comments
1. Explore Regional recruitment specialist. 2. Progress will be monitored through a project schedule.	Number of early steps completed.	By the end of Q2 a specialist will be in place to support ARH.	

Change Idea #2 Develop year one action plan for EDI to support framework development

Methods	Process measures	Target for process measure	Comments
ARJH will work with EDI specialist	Plan completion	By the end of Q4 a multiyear action plan will be developed and approved.	

Safety

Measure - Dimension: Safe

Indicator #2	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 (Arnprior And District Nursing Home - The Grove)	O	% / LTC home residents	CIHI CCRS / July 2023– September 2023 (Q2 2023/24), with rolling 4-quarter average	21.84	19.48	Target is based on the expected outcomes of the increased visibility and monitoring by a multi-disciplinary approach of those residents identified as high risk for falling.	

Change Ideas

Change Idea #1 Increase resident corridor monitoring by staff to ensure better visibility of residents.

Methods	Process measures	Target for process measure	Comments
1) Installation of documenting kiosks in corridor 2) Adjust camera monitoring visual to only those areas relevant to each resident home area.	Number of kiosks installed by end of Q1 and camera monitoring system re-programmed.	1) two (2) kiosks installed per resident home area by end of Q1 2) camera monitoring system adjusted to only include high risk areas for each resident home area.	

Change Idea #2 Reintroducing Falling Star Program

Methods	Process measures	Target for process measure	Comments
1) Re-education of all team members in all departments on the program 2) Ensure all new hires are aware of the program and their role in the prevention of falls	1) Staff re-educated or educated on the Falling Star program 2) Orientation program will include the Falling Star program training	1) 80% of all staff provided training by Q2 2) 100% of all new hires are aware of the program by end of Q1	

Change Idea #3 Enhancing the current post falls huddles. Currently post fall huddles are not occurring consistently on the resident home areas and when they are completed the implementation of interventions to reduce the risk of falls is low. Communication is taking place to the Manager in charge however there is a lack of initiative to implement interventions on their own

Methods	Process measures	Target for process measure	Comments
1) Education of all registered staff on the process and requirement that post fall huddles take place after each fall. 2) Provide further training and education on interventions and how to implement them.	1) Registered staff will be re-trained on the use of the post falls huddle assessment in Point Click Care 2) Further training on interventions and corrective actions. 3) Audits to be completed monthly on compliance with post fall huddles occurring and interventions put in place.	1) 80% of registered staff educated on the post falls huddle assessment - completion and implementation of change of ideas. 2) 100% of post falls huddles take place after each fall incident by end of Q2 3) 100% of recommended interventions from post fall huddles implemented by end of Q3	

Measure - Dimension: Safe

Indicator #3	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. (Arnprior And District Nursing Home - The Grove)	C	% / Residents	In house data, InterRAI survey, NHCAPHS survey / October 1st 2023 to December 31st 2023	6.00	5.00	Q2 results were elevated based on several mitigating circumstances. Current trending is more in line with previous quarterly results. Working in collaboration with our hospital partner and enhancing the skills of our registered staff and PSW's will ensure better skin integrity management.	

Change Ideas

Change Idea #1 Build competency of Personal Support Workers (PSW) related to Skin Integrity management.

Methods	Process measures	Target for process measure	Comments
Training and development on Skin Integrity management.	1) The number of education sessions provided. 2) The percentage of PSW staff attending Skin Integrity management education	1) Monthly education sessions will take place for PSW's 2) 80% of all PSW staff will have completed Skin Integrity management education by end of Q2.	

Change Idea #2 Implementation of new Skin and Wound app on Point Click Care (PCC)

Methods	Process measures	Target for process measure	Comments
1) Training of the registered staff on the wound and skin application. 2) Training on the process for the implementation of the required interventions which includes proper referrals being completed; TARS update etc.	1) The percentage of staff completing the new training 2) Proper documentation and interventions implemented. 3) Number of referrals taking place on a monthly basis.	1) 80% of registered staff trained on the Skin and Wound App by end of Q2 2) 100% compliance in skin and wound assessments being completed by end of Q3 3) 100% of referrals being completed to Dietitian (stage 1) and to the ARH wound lead (stage 3) by end of Q3	

Change Idea #3 Identify several wound care champions at the home level to ensure timely assessment and interventions occur. The Champions would also provide training to build wound care assessment skills within the registered staff team members.

Methods	Process measures	Target for process measure	Comments
1) Identify 3 skin and wound champions. 2) provide education and training to the champions. 3) develop an educational training plan for registered staff.	1) the number of skin and wound champions identified. 2) training completed to the champions by target date 3) number of educational sessions taking place 4) number of registered team members attending educational sessions.	1) Three (3) skin and wound champions identified by end of Q1. 2) 100% of skin and wound champions trained by end of Q2. 3) Monthly educational sessions taking place for registered team members on skin integrity management. 4) 80% of registered team members have attended skin integrity management training by end of Q4.	

Measure - Dimension: Safe

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Prevalence of pressure ulcers (all stages, unstageable and deep tissue). Include adult acute and CCC patients.	C	Rate per total number of discharged patients / All inpatients	In house data collection / April 1, 2024 - March 31, 2025	CB	CB	New Program. Prevalence rate may change as staff receive education in staging and as consults go to wound care nurse with specific expertise in staging. Rate of stage II and above 0 in current ands previous year.	

Change Ideas

Change Idea #1 Develop a Wound Care Program that is current and in alignment with best practice.

Methods	Process measures	Target for process measure	Comments
<p>1. Implementation and standardizing of the wound care nurse role. 2. Evaluation of wound care awareness levels. 3. Review policies and procedures related to Skin Integrity and Wound Care Program. 4. Collaborate with external partners to establish alignment with external best practices hospital. 5. Audit admission procedures and discharge/admission procedures related to wound care assessments when patients are discharged from acute care to CCC (including education of patients and families, using standardized risk assessment tool, incorporating risk level into care planning).6. PUP study one day prevalence.</p>	<p>The number of policies, procedure and program audits and revisions completed.</p>	<p>By the end of Q1 we will have 100% completion of: 1. Wound Care Nurse in-place and electronic referral process developed and live. 2. Collect baseline data Nurses' self-rating of their knowledge about which dressings and topical treatment. 3. Collect baseline data related use of assessment screens and patient plan of care based on Braeden/level of risk. 4. Collect patient experience and feedback 5. Review and revise policies and procedures related to Skin Integrity and Wound Care Program. 6. Collaboration with external partners 7. Review admission procedures and discharge/admission procedures related to wound care assessments when patients are discharged from acute care to CCC. 8. PUP study completed.</p>	

Change Idea #2 Develop and provide educational tools and materials necessary to promote the ideals of best practice.

Methods	Process measures	Target for process measure	Comments
1. Nurses, allied health, and physicians participate in education that targets wound prevention and care. 2. The hospital will track the frequency of educational programming and staff participation 3. A supplemental resources/toolkit will be developed to support staff when wound care SME not available. 4. Empower patients and families to understand how their involvement in patient care can help support wound care management.	1. The number of education sessions provided 2. The percentage of applicable staff trained on the new program/revisions. 3. The number of supplemental resources developed.	1 Revised program education developed by end of Q1 2. 60% of all applicable staff (nursing, allied health) will have completed wound care education by end of Q2 and 80% will have completed wound care education by end of Q3. 3. One (1) group physician education session offered by end of Q2. 3. One supplemental resource developed and deployed by the end of Q3. 4. By the end of Q3 at least 66% of applicable chart reviews will have incorporated risk level into care planning based on our standardized risk assessment tools Braden (acute patients) or PURS (CCC) 4. Through leader rounding, 70% (end of Q3)of patients and families and 75% (end of Q4) will rate the information they receive from staff related to wound care management as very good or excellent.	

Change Idea #3 Introduce weekly multidisciplinary high risk rounds that target PREVENTION STRATEGIES and identify factors and co-factors that affect high risk patients and ensure high risk patients are evaluated regularly for their risk of developing pressure ulcers. Patients and families are included in the high risk rounds discussion.

Methods	Process measures	Target for process measure	Comments
Wound Care specialist will run a report from EMR and conduct walk rounds (as part of high risk rounds) on a weekly basis. Wound care nurse will attend weekly unit rounds.	Number of hospital patients discussed at weekly rounds	By the end of Q4, 75% of patients who flag as high risk on standardized tools will be discussed at weekly rounds.	