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Scorecard Quarterly Report

Quarter 1

April 2024 – June 2024

# Strategic Planning 2021-2026: From Strategy to Action

August 2024

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# How to Use this Document

** Finance quadrant**

 ** Internal process**

** Learning & Growth**

 **Customer Quadrant**

** Externally Reported**

 **Quarterly reporting Annual Reporting**

* Trend Arrows refer to change in direction from the previous quarter.
* A red arrow means the indicator is trending in the opposite of desired direction
* A green arrow means the indicator is trending in the desired direction
* Not all indicators currently have defined targets

# Executive Summary

**Introduction**

The Shoreham scorecard reflects the majority of the quantitative performance indicators found in the management contract between Northwood and Shoreham Village (*refer to Appendix A: Shoreham Village Board of Directors – Management Contract Performance Measures*), plus additional quality of care and work life indicators. Additional qualitative indicators found in the management contract such as achieving accreditation status, finance reports, risk identification and mitigation are reported regularly i.e. Shoreham Village Board meetings, the CEO Monthly Report, and the Annual Community Report.

**How We’ve Done**

Shoreham experienced a number of successes in Q1 2024-25, as we worked towards our goal of providing safe and quality care/services to the people we serve. There has been a positive trend in many of our indicators when compared to Q4 2023-24. For those areas that we have had challenges, we continue to work towards making improvements.

For Q1 2024-25, areas we did well in include paid sick time. We were able to meet both the Nova Scotia and National targets with a rate of 12.65%, which was also an improvement over Q4 2023-24 at 13.2%. Hand Hygiene compliance also continues to exceed our internal target of 80% at 95% for this quarter. Although we are not meeting our internal target of 2% or less for Pressure Injury Prevalence, we have reported the lowest prevalence this quarter compared to Q1-Q4 in fiscal year 2023-24.

Areas for improvement this quarter includes the percent of residents with a restraint, although we did see a decrease this quarter compared to Q4 2023-24 (35%) at 31%. This is significantly higher than the national average – 5.7%. There is ongoing work in this area through the associated committee. All restraints are seat belts and are used to prevent falls and help with positioning for frail residents. We also continue to not meet our target for number of volunteers. The target is 158, and we have 108 active volunteers. Recruitment efforts continue.

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| Performance Summary: Q1 April 2024 – June 2024 |
| **Indicator** | **Rate** | **Target** | **Trend** | **Quadrant** | **Indicator** | **Rate** | **Target** | **Trend** | **Quadrant** |
| LTC Occupancy Rate | 98.9% |   99.2% | = |  | # of active volunteers | 108 |   158 | = |  |
| Paid Sick Hours per Employee (hrs.)  | 12.65 |  19.375-21.05 |  |  | % of Residents with a Restraint | 31% |  5.7% |  |  |
| WCB Hours of time loss per 100 employees | 125.3 | TBD |  |  | Pressure Injury Prevalence Rate | 3.37% |   2% |  |  |
| Incident rate per 1000 resident days | 10.6% | TBD  |  |  | **Externally Reported Indicators** |
| Resident Infection rate per 1000 resident days  | 3.24 |   3.0 |  |  | Hand Hygiene compliance | 95% | 80% |  |  |
| Net new CCAs | 2 | Maintain staffing levels |  |  |  |  |  |  |  |

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| --- | --- | --- | --- | --- |
| **98.9%** |  | **=** |  |  |
|  **Rate** | **Target** | **Trend** | **Reporting** | **Quadrant** |

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| Strengthening the Long Term Care Services We Provide: Occupancy Rate |

**Measurement:** The Occupancy Rate is the ratio of occupied beds to the total number of beds that are licensed to operate by SLTC under the *Homes for Special Care Act*.

**Key Points**

The Q1 occupancy rate for 2024-25 was 98.9% (0.7 average vacant beds per day), which is just below the targeted rate from SLTC. The Q1 rate is also slightly higher compared to the same period of 2023-24, which was 98.39%.

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| Be an employer of choice: Average Paid Sick Time per Employee |

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| **12.65**paid sick hours per employee |  |  |  |  |
| **Rate** | **Target** | **Trend** | **Reporting** | **Quadrant** |

**Measurement:** Paid sick time includes paid sick hours, paid family ill and paid preventative medical. The number of hours per employee used during periods of illness, without any loss of pay.

**Key Points**

Shoreham is averaging 12.65 hours of sick time per employee in Q1 24-25, which is below both the NS and National targets. This is a decrease compared to Q4 23-24.

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| Be an employer of choice: WCB Hours of time loss per 100 employees |

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| **125.3**hrs./100 employees | **TBD** |  |  | **A seed growing out of a book  Description automatically generated** |
| **Rate** | **Target** | **Trend** | **Reporting** | **Quadrant** |

**Measurement**: Hours of time loss per 100 employees.

**Key Points**

Hours of time loss is 125.3 for Q1 24-25, which is a decrease compared to Q4 23-24. There is no data to report for Q1, Q2 as this is a new indicator for Shoreham.

WCB hrs. of time loss is impacted by injury rates, severity, duration and return to work processes.

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| Strengthening the Long Term Care Services We Provide: Resident Incident Rates  |

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| **10.6%**Incidents/ 1000 resident days | **TBD** |  |  |  |
|  **Rate** | **Target** | **Trend** | **Reporting** | **Quadrant** |

**Measurement:** [# of incidents (by category)/ # occupied bed days] \*1000

**Key Points**

The incident rate for Shoreham increased slightly from Q4 23-24 (10.41%) to Q1 24-25 (10.6%).

**Responsive Behaviors** There were 9 responsive behaviors this quarter compared to 6 last quarter. Of the 9 this quarter, 6 were physical aggression, 1 was verbal aggression and 2 were sexual non-aggression

**Falls:** We have had a decrease in falls this quarter. This could be due to having fall prevention strategies in place for residents who had been falling frequently. We had 36 falls this quarter and 51 falls last quarter. 6 falls were witnessed and 36 unwitnessed. 5 on A wing, 7 on B wing, 9 on C wing, 5 on D wing and 10 on E wing. All incidents continue to be reviewed on a regular basis by the Managers of Resident Care and the mobility team with prevention strategies added to the resident care plans.

**Medication Occurrences:** We had a slight increase in medication occurrences, this quarter there were 19 and in the last quarter there were 15. Of the 19, 3 were pharmacy errors, 4 were transcription and documentation errors, 2 were the wrong time, 1 was the wrong dose, and 9 were missed doses. Reminder to staff to double check medication porters and to take their time when administering medication.

**Other:** The other incidents consisted of 4 choking, 11 elopement, 2 injuries of unknown cause, 1 self-inflicted injury and 3 unknown.

The 3 unknown incidents consisted of a resident found halfway out of bed, a resident that had undone her seatbelt on her wheelchair and stood up, and a resident had reported she had gotten her fingers jammed in a door with no injury noted.

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| **3.24**Infections/ 1000 resident days |  |  |  |  |
| **Rate**  | **Target** | **Trend** | **Reporting** | **Quadrant** |

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| Strengthening the Long Term Care Services We Provide: Resident Infection Rates  |

**Measurement:** [# residents who are treated for an infection during the reporting period/ # of occupied bed days} \*1000

**Key Points:**

There was a total of 36 resident Covid swabs completed – all of which were negative except for 2 in June on B wing. There was two suspect outbreaks in June and one confirmed outbreak on B wing in June. Both were closed by the end of June. No RSV, Influenza or Gastrointestinal Infections.

Covid boosters continue to be offered to those who qualify, and focus is now on Pnemovax at the present time.

There were skin infections with only one being associated with a wound. Others were related to skin cellulitis.

There continues to be a high number of UTI’s. This has been higher than Q1 in 2023-24 however stable at the same rate as Q4 2023-24 at 14. These infections meet McGreer’s criteria and several of these are noted to be with residents with a predisposition for UTI’s or have a long history of same. There continues to be no common thread but through an investigation there are a number of contributing factors that may be involved:

* Multiple new staff with various levels of experience and training.
* In review on flow from time of identification of symptoms to orders for urine cultures, culture result, treatment prescribed and given as well as follow up post treatment for resolution, this is not consistent at all. This could lead to prolonged treatment with multiple antibiotics, prolonged symptoms in residents.

Plan of action:

 - Inform staff of trend.

 - Roll out PCC Infection control module as this may assist with communication flow

* Education for CCA staff re proper peri-care to ensure that best practice is being carried out
* Contact TENA rep for review of proper use of incontinent systems
* Work with NP, staff and IPAC to do a data review to see if there is a standard care path specifically focused on prevention of UTI in the LTC population and if none exists then work to create one that looks at the above noted factors as well as pushing fluids regularly as medically indicated, flagging those at high risk, and timely interventions.

Further investigations into data to include: those treated with indwelling catheters versus without, those with medical conditions that predispose to UTI’s, those using incontinent systems versus those who do not and how many residents with multiple infections and type if bacteria if isolated. This is the area currently which is being focused on.

A potential SBAR is being developed for all Urine collections and treatment for UTI’s to further examine potential areas for improvement. Work has been done with the lab to improve turnaround times for reporting of lab results so this will also benefit the residents.

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| **3.37%** |  |  |  |  |
| **Rate** | **Target** | **Trend** | **Reporting** | **Quadrant** |

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| Strengthening the Long Term Care Services We Provide: Pressure Injury Prevalence |

**Measurement**: Point Prevalence = [number of pressure injuries / # residents that day] x100

**Key Points**:

The Provincial Wound Care Program, overseen by Health Association of NS (HANS) collects data monthly through a submission to the Seniors & Long-Term Care (SLTC). Shoreham data is submitted on the pressure injuries (PIs) in the facility on a given date, the last day of the month. For Q1 24-25, it was reported at the end of June, which is 3.37%. This data captures pressure injuries and does not include other wounds i.e. skin tears, diabetic wounds.

In the last quarter Shoreham had 1 new facility acquired wound. The remaining wounds were acquired while in acute care or were existing wounds. The wound care team has regular monthly meetings. Shoreham also has regular check-ins with the wound consultant from the western zone wound program.

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| Strengthening the Long Term Care Services We Provide: % of Residents with a Physical Restraint |

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| **31%** |  |  |  |  |
| **Rate** | **Target** | **Trend** | **Reporting** | **Quadrant** |

**Measurement**: [# of residents with a physical restraint/ total # of residents] x 100

 **Key Points:**

There was a slight decrease in the % of resident physical restraints in Q1 24-25 at 31% compared to Q4 23-24, which was 35%. Seat belts are the restraint being used, and it is primarily related to positioning to reduce the risk of falls.

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| **2**net new CCAs |  |  |  |  |
| **Rate** | **Target** | **Trend** | **Reporting** | **Quadrant** |

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| Be a recruitment magnet: Recruitment of CCAs/PCWs |

**Measurement**: # of new hires minus the # of terminations during the quarter = net growth. The current target is to maintain staffing levels during the 2024-25 fiscal year.

**Key Points**

There was a total of 6 CCA new hires during this quarter with a loss of 4 CCAs. Of the 4 CCAs lost, 3 were casual. With our vacancies decreasing, we no longer have extra shifts to offer casuals as we used to. Casuals were accustomed to providing availability and taking shifts, but with this change, they are not getting as many shifts as before.

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| **108** |  | = |  | **A blue circular arrow with a white background  Description automatically generated** |
| **Rate** | **Target** | **Trend** | **Reporting** | **Quadrant** |

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| Be a recruitment magnet: Number of Active Volunteers |

**Measurement:** the total number of volunteers based on those recruited and deactivated during the quarter.

**Key Points:**

The number of active volunteers has remained the same this quarter compared to Q4 23-24 at 108.

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| Strengthening the Long Term Care Services We Provide: Hand Hygiene Compliance (%) |

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| --- | --- | --- | --- | --- |
| **95%** |  |  |  |  |
| **Opportunities Met** | **Target** | **Trend** | **Reporting** | **Quadrant** |

**Measurement:** # of opportunities for hand hygiene met/ total # of opportunities observed. Random hand hygiene audits are completed on a quarterly basis with the goal to observe 10% of staff including regular, part time and casual staff.

**Key Points:**

Compliance has declined slightly this quarter to 95% from 98%; however, well within the expected range. There will be an increased push in Q2 as we are now heading back into respiratory season and the start of school, which can be challenging.

There has been a decrease in audits this quarter. There has been a significant change in staff and residents which may account for this. Regular reminders for hand hygiene and mask usage have been completed. The importance has also been discussed at the Resident Council.

There are increased reminders for offering hand hygiene to residents in the dining area as well.

Areas to note:

Handling of clean linen is our primary area of focus. This can be a result of facility space issues and multiple new staff and lack of staff. Multiple reminders continue to go out. This is an ongoing area of focus. This may be in part related to our facility structure given things can be cramped. We continue to hire new staff and regular reminders go out. Staff doing hand hygiene observations are also coached at the point of the assessment if opportunities are missed to allow for point-in-time learning.

Overall reminders for the moments of hand hygiene will be redistributed to all staff.

# Appendix A: Shoreham Village Board of Directors – Management Contract Performance Measures

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Indicator | Measure (over 12 months) | Data Source | Finding (actualperformance) | Value |
| Quality of Care | Resident experience /quality of care  | Resident experience survey to be completed at a minimum of every 2 years. An action plan is established. All actions will be complete within 6 months unless the action is deemed more complex and/or requires additional funding to achieve.  | Accrued report |  |  |
| Occupancy rate | Seniors and Long-Term Care (SLTC) Target of 99.2%  | Scorecard |  | /5 |
| Incident rate | Incident Rate Per 1000 Resident Days remains under 20 / quarter | Scorecard |  | /5 |
| Responsive behaviours | Rate Per 1000 Resident Days remains under 5/ quarter | Scorecard |  | /5 |
| Falls | Fall Rate Per 1000 Resident Days remains under 8/ quarter | Scorecard |  | /5 |
| Medication errors | Rate Per 1000 Resident Days remains under 5/ quarter | Scorecard |  | /5 |
| Respiratory infections | Rate Per 1000 Resident Days remains under 5/ quarter | Scorecard |  | /5 |
| UTIs | Rate Per 1000 Resident Days remains under 10/ quarter | Scorecard |  | /5 |
| Pressure Injury Prevalence  | Point Prevalence = [number of pressure injuries / # residents that day] x100. Internal benchmark 2% or less.  | Scorecard |  | /5 |
| Gastrointestinal problems | Rate Per 1000 Resident Days remains under 5/ quarter | Scorecard |  | /5 |
| Licensing status | Continued good standing | licensing report |  |  |
| Accuracy of forecasts | Forecast variances can be explained | Regular Board Meeting Report |  | /2.5 |
| Financial and RiskManagement |
| Timeliness of financial reporting | No unreasonable delays in reporting | Regular Board Meeting Report |  | /2.5 |
| Risk identification and mitigation | Monitors Trends and develops Action Plans where required Identifies and responds to emergent risk issuesCommunicates with The Board in accordance with the Risk Management Framework which includes Service Delivery Risks (indicators noted above) and Corporate Risks:* Compliance Risks (Standards and Licensing and Annual Audit Process)
* Financial Risk (Monthly financial reporting, Annual Audited statements)
* Operational Risks (Cyber security and COVID-19 2 solid indicators that the Partnership provides operational depth/redundancies, expertise and support as

opposed to a stand-alone structure | CEO report/ Risk Report/Scorecard |  | /5 |
|  | * Reputational Risk (Public reporting, transparency)
* Strategic Risk (Strategic Planning Process, progress toward established goals

Emergent Risks are communicated to the Board via email. Risk Report tracking, monitoring and progress reports are communicated through the Scorecard, Financial Reports and Audited Statements and theCEO Report to the Board of Directors. |  |  |  |
|  |
| HRManagement | Workplace safety | Same as or improved rate of injury/WCB claims | Scorecard |  | /5 |
| absenteeism | Same as or improved rate of absenteeism | Scorecard |  | /5 |
| Staff recruitment, training, retention and succession planning | Turnover rate | Scorecard |  | /5 |
| Volunteer recruitment, training and retention | Steady or growing volunteer base | Scorecard |  | /5 |
| Staff experience  | Accreditation Survey tool minimum Q 4 years. Staff experience survey to be completed at a minimum of every 2 years. An action plan isestablished. All actions will be complete within 6 months unless the action is deemed more complex and/or requires additional funding to achieve. | Scorecard |  | /5 |
| Shoreham reputation with stakeholders (families, community,government, sector) | Greater than 4 out of five star rating by all stakeholders | Survey/key informant interviews |  | /10 |
| Values and Engagement |
| Confidence in leadership | Greater than 4 out of five star rating by all board members | Survey/key informantinterviews |  | /10 |
|  |  |  |  |  |
| Total score (80 or higher, vote to renew; score below 80, review for improvement. Score below 70, consider termination) | /100 |