Experience

Measure - Dimension: Patient-centred

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Resident Satisfaction Survey - I am satisfied with the quality of care from Doctors.	C	% / LTC home residents	In-house survey / Sept 2024- Oct 2025	63.40	75.00	Continued improvement toward Extendicare target of 85%	

Change Ideas

Change Idea #1 Communicate role of Medical Director and Physicians and give opportunities for feedback.

Methods	Process measures	Target for process measure	Comments
1. Medical Director to meet at minimum annually with Family and Resident councils. 2. Feedback on services and areas for improvement will be discussed. 3. Update at CQI meeting on action plan.	1) Number of meetings with councils where medical director attended. 2) Number of suggestions provided by councils. 3) Number of CQI meetings where action items were discussed with Medical Director.	1) Medical Director will attend Family Council by June 30, 2025. 2) Medical Director will attend Resident Council by June 30, 2025. 3. Action items and plan will be discussed at CQI committee with Medical Director by June 30, 2025.	

Change Idea #2 Improved visibility of Physicians in home with residents and families.

Methods	Process measures	Target for process measure	Comments
1.Ordering Extendicare name tags for Physicians. 2. Introduction letter from Physicians to be included in all welcome packages for residents and families. 3. Physicians to attend Newcomer Event.	1. Number of name tags ordered. 2. Number of introduction letters included in welcome packages. 3. Number of times Physicians attend Newcomer Event.	1. Name tags will be ordered by June 30, 2025. 2. Introduction letters will be included in welcome packages by June 30, 2025. 3. Physicians will attend Newcomer Event by July 31, 2025.	

Change Idea #3 Tracking of in-person resident visits to ensure every one has a visit.

Methods	Process measures	Target for process measure	Comments
Create list of each physicians/NP residents to track in person visits to ensure each resident meets with physician/NP at least once per quarter .	1) Number of residents per physician 2) Number of residents who had in person visit during quarter	1) List will be developed by physician for tracking by June 30, 2025. 2) Each resident will have an in person visit with physician / NP at minimum 1 per quarter by June 30, 2025.	

Measure - Dimension: Patient-centred

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
I am satisfied with the quality of care from my Dietitian	C	% / LTC home residents	In-house survey / Sept 2024- Oct 2025	60.50	75.00	Extendicare target for the Survey to be over 75%	

Change Ideas

Change Idea #1 Increase awareness of role of dietitian in home with residents and families

Methods	Process measures	Target for process measure	Comments
1) Dietitian to meet at minimum annually with Family and Resident councils 2) Feedback on services and areas for improvement will be discussed 3) Update at CQI meeting on action plan	1) Number of meetings with Councils where Dietitian attended 2) Number of suggestions provided by councils 3) Number of CQI meetings where action items were discussed with Dietitian	Dietitian to attend resident and family council meeting by July 30 ,2025 Action plans for suggestions will be 100% completed and implemented by June 1, 2025. Dietitian will attend CQI meeting to discuss action plan by April 30, 2025	

Change Idea #2 2) Increase opportunities for Residents to discuss their dietary preferences and/or plan of care with the Dietary Manager/Dietitian within their home.

Methods	Process measures	Target for process measure	Comments
1) Requests to be sent through nursing PCC referral. 2) Dietary Manager/Dietitian to confirm appointment date and time with Resident. 3) Feedback received will be reviewed and actioned 4) Action items and plan discussed at CQI committee for follow up	1) Number of requests to meet with Dietary Manager/Dietitian 2) Number of meetings with Dietary Manager/Dietitian that occurred. 3) Number of action items received from feedback 4) Number of action items implemented	1) Process for sending requests to Dietary Manager/Dietitian will be in place by April 30, 2025. 2) Meetings with Dietary Manager/Dietitian will be in place by April 30, 2025 3) Action items and plan will be discussed at CQI committee with Dietary Manager/Dietitian by April 30, 2025.	

Change Idea #3 Plan education sessions/lunch and learns with Residents with the Dietary Manager/Dietitian (areas of focus should be suggested by Residents)

Methods	Process measures	Target for process measure	Comments
1) Plan regularly scheduled education sessions (with inclusion of food in education, if possible). 2) Sessions to be advertised. 3) Potentially work with programs department as an activity. 4) Consider and action as able any suggestions received	1) Number of education sessions held 2) Number of education advertisements posted 3) Number of residents who attended 4) Number of suggestions received	1) three education sessions will be offered within the next 6 months. 2) Planned changes based on feedback and recommendations will be discussed at CQI committee with Dietary Manager/Dietitian by April 30, 2025.	

Measure - Dimension: Patient-centred

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
I have input into the recreation programs.	C	% / LTC home residents	In-house survey / Sept 2024- Oct 2025	52.90	85.00	Extendicare target 85%	

Change Ideas

Change Idea #1 1) Increase staffing to 1 team member/house

Methods	Process measures	Target for process measure	Comments
1) Review existing schedules 2) Identify gaps in days, evenings, and weekend programming 3) Develop scheduled that compliment and address noted gaps	1) Increased # of programs/week/month/quarter/year 2) Increased # of staff	1) Post and hire qualified staff by April 30, 2025 2) Increase number of programs by 40% by June 30, 2025 3) Fill part-time/casual vacancy by April 30, 2025.	

Change Idea #2 2) Add time and day feedback to Monthly Program Planning Meetings to ensure feedback is being collected with respect to time of day and day of week, in addition to interests

Methods	Process measures	Target for process measure	Comments
1) Add Program Planning Meetings on the calendar, 1x/month for each home area 2) Document findings on meeting minute template 3) Share and post minutes in common area	1) # of meetings throughout the year 2) # of change ideas provided in meeting that were implemented 3) # of residents participating on each home area	1) Program planning meetings will be introduced and implemented monthly in each home area as of June 2025 2) Residents will meet monthly on each home area, providing feedback on program schedule by June 30, 2025	

Safety

Measure - Dimension: Effective

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Pressure ulcers: Percentage of residents who had a pressure ulcer that recently got worse	C	% / LTC home residents	Other / Oct-Dec 2024	3.50	2.00	Corporate Target	Solventum/3M, Wounds Canada

Change Ideas

Change Idea #1 1) Mandatory education for all Registered staff on correct staging of Pressure ulcers

Methods	Process measures	Target for process measure	Comments
"1) Communicate to Registered staff requirement to complete education. 2) Registered staff to complete online modules on wound staging by end of third quarter of year. 3) DOC/designate to monitor completion rates "	1) Number of communications to Registered staff mandatory requirement to complete education. 2) Number of Registered staff who have completed online modules on wound staging on a monthly basis. 3) Number of audits of completion rates completed by DOC/designate and follow up as required. "	1) Communication on mandatory requirement will be completed by April 30, 2025 2) 100% of Registered staff will have completed education on correct wound staging by April 30, 2025 3) Audits of completion rates will be completed monthly with required follow up will occur by 1st week of each month and process is to be in place by April 30, 2025	

Change Idea #2 Turning and repositioning re-education

Methods	Process measures	Target for process measure	Comments
1) Educate staff on the importance of turning and repositioning to off load pressure 2) Night staff to audit those resident that require turning and repositioning 3)Review this during the Skin and Wound committee meetings for trends	# of staff that have been educated # of audits completed # of reviews completed by Skin and Wound committee	"1) 100% of PSW will have attended education sessions on turning and repositioning by [date]. 2) Check in with staff and will be correctly completed on a monthly basis by [date] 3) Process for review, analysis and follow up of monthly trends from tools will be 100% in place by [date.]	

Change Idea #3 Focus on continence to keep skin clean and dry- toileting, appropriate brief selection

Methods	Process measures	Target for process measure	Comments
1) The skin and wound lead and continence lead to look at the number of residents on a toileting routine and compare with wound list already generated from PCC. 2)Wound Care lead will work with the continence lead internally to ensure that the correct incontinence product is being used for each resident 3) Provide education sessions as required for brief selection. 4) Review restorative goals if on restorative toileting program 5) DOC to audit this process and part of the evaluation process of the program	# of residents with skin issues # of residents with a toileting plan in place # of brief audit checks completed # of education sessions provided # of residents on restorative toileting program.	1) The leads for Skin/Wound and Continence will complete their resident review by June 30, 2025. 2) Review of correct sizing and type of incontinence products will be completed by June 30, 2025. 3) Education sessions for product selection will be completed by June 30, 2025. 4) Annual review of continence program will be completed by December 31, 2025.	

Measure - Dimension: Safe

Indicator #5	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	O	% / LTC home residents	CIHI CCRS / July 1 to Sep 30, 2024 (Q2), as target quarter of rolling 4-quarter average	13.68	12.50	Continuing to improve and maintain results better than Extendicare target of 15%	Achieva, Behavioural Supports

Change Ideas

Change Idea #1 Review Activity programming during times when most falls occur.

Methods	Process measures	Target for process measure	Comments
1) Review times when most falls are occurring 2) Review Program preferences for residents who are at risk of falls 3) Implement program at time of day when falls are occurring 4) Monitor results	1) # of residents reviewed who are high risk for falls 2) % of program review completed 3) # of new programs implemented during peak times for falls 4) # of high risk residents who did not fall during month when activity was occurring	1) Review of falls and times when occurring will be completed by June 30, 2025 2) Review of high risk residents program preferences will be completed by June 30, 2025 3) DementiAbility program will be implemented during shift change by June 30, 2025	

Change Idea #2 1) Reassess Falling Star program and re educate staff on program

Methods	Process measures	Target for process measure	Comments
1) ADOC will provide education sessions on Falling Star/Leaf Program to all PSW and Registered Staff on all units on all shifts. 2) Managers will audit and monitor progress to ensure implementation.	1) # of education sessions provided to PSW and Registered staff 2) # of audits completed on Falling star program monthly 3) # of audits on Falling star program with no deficiencies	1) Education sessions for PSW and Registered staff will be completed by December 31, 2025. 2) Audits on Falling star program will begin by April 1, 2025.	

Change Idea #3 10) Increased communication during shift report for newly admitted residents and during outbreaks

Methods	Process measures	Target for process measure	Comments
1) Remind staff about increased risk of falls when in outbreaks and during admission period. 2) Registered staff to communicate list of residents on isolation and/or new admissions during each shift report to oncoming staff 3) Residents identified as being at increased risk of falls d/t isolation or new admission will have enhanced monitoring by all staff for two week period . 4) enter task in POC for enhanced monitoring and plan of care updated	1) # of staff receiving reminders for resident fall risk 2) # of shift reports where registered staff communicated list of high risk residents 3) # of residents on enhanced monitoring per shift 4) # of residents who had enhanced monitoring entered as task in POC and plan of care updated.	1) Reminders for staff will be communicated by April 1, 2025. 2. Shift report process for communicating high risk residents will be in place by April 30, 2025 3. Process for enhanced monitoring for those on isolation or newly admitted will be in place by April 30, 2025.	

Measure - Dimension: Safe

Indicator #6	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	O	% / LTC home residents	CIHI CCRS / July 1 to Sep 30, 2024 (Q2), as target quarter of rolling 4-quarter average	23.76	17.30	Extendicare benchmark	Medisystem, Behavioural Supports

Change Ideas

Change Idea #1 1) Implement Extendicare's Antipsychotic Reduction Program which includes using the Antipsychotic Decision Support Tool (AP-DST).			
Methods	Process measures	Target for process measure	Comments
"1). Establish AP Home Team 2.) Education and training provided by Central QI team 3.) Action plan for residents inputted into decision support tool.	"1.) home team established 2). # of regular meetings for antipsychotic review monthly 3). Attendance to the Quality Labs 4.) Percentage of residents with an action plan inputted.	"1). Home team will be established by June 2025 2). Education and training completed by Sept 2025 3). Antipsychotic review meetings are occurring every 2 weeks 4). Residents triggering the Antipsychotic QI have an action plan inputted into the decision support tool within 3 to 6 months of admission.	

Change Idea #2 Family education resources provided for appropriate use of Antipsychotics			
Methods	Process measures	Target for process measure	Comments
1. Provide 'Centre for Effective Practice (CEP)' resource for appropriate use of anti-psychotics when families have questions about appropriate antipsychotic prescribing 2). Make resource available at nurses station if family have questions).	1.) # of CEP resources provided to families monthly 2.) # of antipsychotics d/c as a result of increased family awareness.	1) CEP resources will be printed and available at nurses station by April 30st.	

Change Idea #3 Collaborate with the physician to ensure all residents using anti-psychotic medications have a medical diagnosis and rationale identified.			
Methods	Process measures	Target for process measure	Comments
1) complete medication review for residents prescribed antipsychotic medications 2) Review diagnosis and rationale for antipsychotic medication . 3) consider alternatives as appropriate	1) # of medication reviews completed monthly 2) # of diagnosis that were appropriate for antipsychotic medication use 3) # of alternatives implemented	1) 75% of all residents will have medication and diagnosis review completed to validate usage by June 30, 2025. 2.) Alternatives will be in place and reassessed if not effective within 1 month of implementation with process in place by April 30th.	

Measure - Dimension: Safe

Indicator #7	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Restraints: Percentage of residents who were physically restrained (daily)	C	% / LTC home residents	Other / Oct-Dec 2024	2.10	2.00	Corporate Benchmark	Achieva, Behavioural Supports

Change Ideas

Change Idea #1 10) Resident Services Coordinator will review each application received for restraints prior to admission.

Methods	Process measures	Target for process measure	Comments
1.) Resident Services Coordiantor reviews and flags each application received for restraints 2) Information is sent to Ontario Health @Home to indicate that home is least restraint and that alternatives will be trialed upon admission	1.) # of applications received that have a restraint 2). # of communications sent back to applicant or designate and Ontario Health @Home to explain least restraint policy 3). # of acceptances received to trial alternatives upon admission	1) Process for review of admission applications for restraints will be 100% in place by May 1, 2025.	

Change Idea #2 3) Provide information to families and residents on Least Restraint.

Methods	Process measures	Target for process measure	Comments
1) Provide Restraint brochure in admission packages for new admissions. 2) Meet with Residents' and Family Councils to provide education on Least Restraint and risks associated with restraint use. "	1) # of admission packages with Restraint brochure included. 2) # of meetings with Resident and Family council to discuss Least Restraint and Risks.	1). 100% of admission packages will have Restraint brochure included for new admissions by May 1, 2025 2). Meetings with Residents' and Family Councils will be attended to discuss Restraints by December 31, 2025	

Change Idea #3 4) Provide resource for Registered Staff to use when discussing restraints with residents and families.

Methods	Process measures	Target for process measure	Comments
1.) Implement new FAQ document to assist with discussing restraints 2). Communicate with staff availability of new resource.	1.) # of times FAQ was utilized monthly 2). # of sessions held to communicate with staff that FAQ was available as resource.	1. FAQ resource will be 100% in place by April 30, 2025 2) Staff will be aware of new resource by April 1, 2025	