Experience

Measure - Dimension: Patient-centred

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of residents responding positively to: "In my care conference we discuss what's going well, what could be better and how we can improve things"	C	% / LTC home residents	In-house survey / Annual resident experience survey	30.00	66.90	Extendicare Benchmark	

Change Ideas

Change Idea #1 Ensure all residents are given the opportunity to become involved in resident care conference meeting 2)Encourage residents to attend their annual care conference

Methods	Process measures	Target for process measure	Comments
1)All residents are invited to care conference meetings 2) Communicate to residents when their annual care conference is scheduled in advance of meeting 3) Remind resident morning of meeting and assist as needed to meeting 4) Provide copy of plan of care 5) Allow time for discussion and obtain feedback on what could be improved.	1) # of annual care conferences where residents attend 2) # of care conferences where plan of care was discussed with resident	1) Residents will be encouraged to attend their annual care conferences beginning April 1, 2025. 2) There will be a 42% improvement in this indicator by December 2025.	

Change Idea #2 Review annual care conference process. 2) At each care conference, ask the resident and document if there are any questions or concerns.

Methods	Process measures	Target for process measure	Comments
1) Complete review of current care conference process including scheduling, agenda 2) Adjust agenda if required to include time for discussions with resident. 3) Ask resident if they felt their needs and feedback were addressed	1) # of reviews of care conference process completed 2) # of modifications to agenda 3) % of positive feedback resident responses post care conference	1) Review of current care conference process will be 100% completed by April 2025. 2) By October 2025 there will be an improvement on resident survey to 75% for positive responses for care conference process.	

Measure - Dimension: Patient-centred

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of residents responding positively to "I am satisfied with the quality of care from personal support staff, health care aides"	C	% / LTC home residents	In-house survey / Annual resident experience survey 2024	67.90	81.00	Extendicare Benchmark	

Change Ideas

Change Idea #1 Implementing Care Champions

Methods	Process measures	Target for process measure	Comments
1. Clarify the responsibilities of Care Champions (e.g., mentoring staff, identifying care gaps, supporting patient advocacy). 2. Provide education for staff on customer service 3. Introduce program to Resident council and inform families	# of education sessions for staff % of positive feedback received from residents	100% of staff will complete Customer service training by April 30, 2025. Program will be introduced to resident council and families before May 30, 2025.	

Change Idea #2 Engage in regular discussion with residents on their satisfaction with the quality of care received from PSW's.

Methods	Process measures	Target for process measure	Comments
1) Quality of Care from PSW's will be considered a standing agenda item for resident council. 2) Managers will ask residents for feedback during their walk abouts. 3) Evaluate results from the feedback to provide further opportunities for improvement	# of times quality of care from PSW's was discussed on agenda at resident council # of walkabouts completed where feedback received about quality of care from PSW's # of feedback received from residents and actioned on	Quality of Care from PSW's will be added to standing agenda for resident council by May 30, 2025 100% of feedback received by walkabouts about quality of care from PSW's will be reviewed and actioned by June 30, 2025.	

Measure - Dimension: Patient-centred

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of residents responding positively to "I am satisfied with the variety of food and beverage options."	C	% / LTC home residents	In-house survey / annual resident experience survey	39.30	67.90	Extendicare Benchmark	

Change Ideas

Change Idea #1 Improve the menu choices for the residents 2) Adjusting menu to include seasonal availability.

Methods	Process measures	Target for process measure	Comments
1.Dietary Manager to meet with the Residents' Council/Food Committee to discuss menu. 2. Make changes to menu as per resident suggestions. 3. Menu updated with resident suggestions and reviewed by Dietitian prior to implementation. 4. Dietary Manager to complete walkabouts during meals to talk to residents. 5) Monitor seasonal availability of fruits and vegetables and incorporate where possible 6) Ensure Residents are aware of fresh fruits and vegetables being utilized.	1)# of resident suggestion incorporated into the spring/summer menu. 2)# of Seasonal foods to be incorporated in each menu cycle 3) Advertisement of seasonal fruits / vegetables and seasonally appropriate menu items incorporated 4) # of walkabouts completed by Dietary manager during meals 5) # of dietitian reviews completed of menu	1) at least 3 Seasonal food changes will be made to menu each cycle accordingly starting May 2025 2) Advertisement of these seasonal changes will be completed at the Food committee meeting with the residents starting April 2025. 3) Meetings with Resident council and food committee to discuss menu will begin by April 2025. 4) Walkabouts by Dietary manager will commence by April 2025	

Change Idea #2 Increase residents' participation in menu planning and food choices.

Methods	Process measures	Target for process measure	Comments
1)Obtain feedback and input from the Resident Food Committee, Resident Council and the family council if applicable. 2)Monthly review of feedback/input.	# of suggestions elicited from our residents on food choices that are incorporated into menu planning or food choices.	Home to incorporate at least 1 suggested change into the menu planning/food choice each month starting May 2025.	

Safety

Measure - Dimension: Safe

Indicator #4	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	7.22	6.50	Continued improvement to theoretical best	Achieva, Behavioural Supports

Change Ideas

Change Idea #1 Implement /Reassess Falling Star program and re-educate staff on program

Methods	Process measures	Target for process measure	Comments
ADOC will provide education sessions on Falling Program to all PSW and Registered Staff on all units on all shifts. 2) Managers will audit and monitor progress to ensure implementation.	# 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	Education sessions for PSW and Registered staff will be completed by April 1, 2025 2) Audits on Falling star program will begin by April 2, 2025.	

Change Idea #2 Ensure each resident at risk for falls has a individualized plan of care for fall prevention.

Methods	Process measures	Target for process measure	Comments
Determine residents at risk for falls 2) Review plan of care for each resident at risk 3) Discuss strategies with fall team and staff 4) update plan of care 5) communicate changes in plan of care with care staff.	1) # of residents at risk for falls 2) # of plans of care reviewed 3) # of new strategies determined 4) # of plans of care updated 5) # of sessions held to communicate changes with staff	1) Residents at risk for falls will be identified by April 1, 2025 2) Care plans for high-risk residents will be reviewed and updated by May 1, 2025. 3) Changes in plans of care will be communicated to staff by continuously (As applicable) beginning April 1, 2025.	

Measure - Dimension: Safe

Indicator #5	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	11.54	10.50	Continued improvement to theoretical best	Medisystem, Behavioural supports

Change Ideas

Change Idea #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). Schedule regular meetings for antipsychotic review 3). Attendance to the Quality Labs 4.) Percentage of residents with an action plan inputted.	1). Home team will be established by April 30, 2025. 2). Education and training completed by April 1, 2025. 3). Antipsychotiuc review meetings are occuring every 4 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 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 April 1, 2025 2) Alternatives will be in place and reassessed if not effective within 1 month of implementation with process in place by May 1, 2025.	

Measure - Dimension: Safe

Indicator #6	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of LTC residents with Worsened Pressure Injury stages 2-4	C	% / LTC home residents	Other / Oct-Dec 2024	2.88	2.00	Extendicare Benchmark	Solventum/3M, Wounds Canada

Change Ideas

Change Idea #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 modules on wound staging annually and upon orientation. 3) DOC/designate to monitor completion rates	1) # of communications to Registered staff mandatory requirement to complete education. 2) # of Registered staff who have completed online modules on wound staging on a monthly basis. 3) # of audits of completion rates completed by DOC/designate and follow up as required.	1) Communication on mandatory requirement will be completed by April 1, 2025. 2) 100% of Registered staff will have completed education on correct wound staging by April 1, 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 March 1, 2025.	

Change Idea #2 Education on Product selection wound care.

Methods	Process measures	Target for process measure	Comments
1) Education sessions set up for all registered staff on products on wound care protocol 2) Sessions to be arranged for all shifts 3) audits to be completed by wound care lead of home for correct usage of products	# of education sessions /shift # of audits completed monthly # of audits that identified areas for improvement monthly	1) Education sessions on products and selection of products will be completed for all Registered staff by May 1, 2025 2) Audits will show a [90 %] improvement in compliance by August 1, 2025.	