Experience

Measure - Dimension: Patient-centred

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Satisfaction with the quality of care from doctors	C	% / LTC home residents	In-house survey / 2024	67.90	75.00	Continued improvement to Extendicare benchmark of 85%	

Change Ideas

Change Idea #1 Communicate role of Medical Director and Physicians and give opportunity 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) # of meetings with Councils where Medical Director attended 2) # of suggestions provided by councils 3) # of CQI meetings where action items were discussed with Medical Director	1) Medical Director will attend Family Council by May 2025 2) Medical Director will attend Resident Council by May 2025 3) Action items and plan will be discussed at CQI committee with Medical Director by June 2025.	

Change Idea #2 2) Improve visibility of physicians in home with residents and families.

Methods	Process measures	Target for process measure	Comments
1) Order Extendicare name tags for physicians 2)Utilize a communication board for families /residents so they are aware of when physician is going to be onsite.	1) Order Extendicare name tags for physicians 2)Utilize a communication board for families /residents so they are aware of when physician is going to be onsite.	1) Name tags will be ordered for all physicians in home by May 2025 2) Process for utilizing communication board for posting of visit schedules will be 100% implemented by July 2025	

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

Methods	Process measures	Target for process measure	Comments
1) 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) # residents per physician 2) # of residents who had in person visit during quarter	1) List will be developed by physician for tracking by April 2025 2) Each resident will have an in person visit with physician / NP at minimum 1 per quarter by June 2025	

Measure - Dimension: Patient-centred

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
I am satisfied with the quality of cleaning in the resident's room	C	% / Residents	In-house survey / 2024	67.90	78.00	We improved last year by 5% and would like to continue to improve 10% more with the plan for this year	

Change Ideas

Change Idea #1 Review deep cleaning schedules for residents' rooms

Methods	Process measures	Target for process measure	Comments
1) Environmental Manager to review deep clean schedules to ensure all resident rooms are included 2) track resident rooms completed 3) Spot check audits of resident rooms to ensure decluttering and deep cleaning is completed	1) # of times deep clean schedule reviewed 2) # of resident rooms who have had deep cleaning completed 3) # of audits completed of resident rooms to ensue deep cleaned 4) # of deficiencies noted based on audit results	1) EVS will review deep cleaning schedule by April 30 2) 100% of resident rooms will have been deep cleaned by Sept 30 3) There will be 90% improvement in completion of deep clean audits by June 30	

Change Idea #2 Review of high touch area and dusting schedule

Methods	Process measures	Target for process measure	Comments
1) EVS manager to review high touch and dusting schedule and update as needed 2) Track resident rooms as per schedule to ensure al residents have areas cleaned 3) Follow up audits to be completed to ensure completion	# of times EVS manager reviewed cleaning schedule e2) # of resident rooms who had high touch areas and dusting completed 3) # of follow up audits completed and # of identified deficiencies	1)EVS Manager will review and update high touch cleaning and dusting schedule by April 30. 2) 1005 of resident rooms will be completed as per schedule by Sept 30. 3) There will be a 90% improvement in completion of high touch areas and dusting audits by Sept 30	

Change Idea #3 Training for staff on proper use of microfiber cleaning systems

Methods	Process measures	Target for process measure	Comments
1) Education sessions held for housekeeping staff on use of microfiber cleaning systems. 2) Keep track of those who attended 3) Audit post education to see if improvement monthly	# of education sessions held for housekeeping on use of microfiber cleaning systems 2) # of housekeeping staff that attended the education 3) # of follow up audits completed per month	1) Education session for housekeeping staff will be held by April 30 20 100% of housekeeping staff will have completed education by April 30 3) There will be 90% improvement in completion in follow up audits for cleaning	

Measure - Dimension: Patient-centred

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Families are satisfied with the quality of maintenance of physical building and outdoors	C	% / Family	In-house survey / 2024	57.10	68.52	Improve by 20% from previous year	

Change Ideas

Change Idea #1 Complete regularly scheduled audits of maintenance building and outdoor spaces

Methods	Process measures	Target for process measure	Comments
1) Review schedule for audit of building maintenance and of outdoor spaces 2) Identify any areas or gaps based on audits 30 Create action plan to address	1) # of audits completed monthly 2) # of deficiencies identified and actioned 3) # of action items addressed	1) 100% audits will be completed monthly with 100% audits being completed by Sept 30 2) There will be a 90% improvement of identified deficiencies from audits by Sept 30 3) By Sept 3- 100% of action items will be addressed	

Change Idea #2 Education for staff on maintenance care work order system

Methods	Process measures	Target for process measure	Comments
1) have education session for staff on maintenance care work order system 2) Review post education if improvement sin entering data into the system. 3) Follow up as required	1) # of education sessions held 20 # of staff who attended education sessions 30 # of areas for improvement identified post education 4) # of follow up completed	1) Education sessions will be held for staff on maintenance care work order system by April 30 2) 100% of staff will have attended education by June 30 3) There will be a 90% improvement seen post education by Sept 30	

Change Idea #3 Improve Communication re: capital planning to resident and family councils

Methods	Process measures	Target for process measure	Comments
1) ED to attend resident and family council to discuss priority areas for capital planning for major equipment 2) Provide update in Townhall or newsletter to families and resident	1) # of resident and family council meetings where ED attended and discussed capital plans 2) # of updates provided via newsletter or town hall	1) ED will attend resident and family council meeting by June 2025 2) Communication updated will be provided via Town hall or Newsletter to families and residents by May 30	

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	11.24	10.10	10% decrease in number of falls within 30 days of assessment. We are near the benchmark currently and feel we can improve a further 10 % below benchmark with the measures we identify for this year.	Achieva, Behavioural Supports

Change Ideas

Change Idea #1 Implement the 4 Ps rounding

Methods	Process measures	Target for process measure	Comments
Educate Staff on 4Ps process 2) Provide 4Ps cards to staff as reminder 3) Inform resident council and family council what 4P process is.	# of staff educated on the 4Ps process 2) # of 4P cards provided 3) Resident council and family council informed of process	1) 100% of front line will be educated on 4P process by May 31, 2025. 2) 4P cards will distribute to staff by June 15, 2025, 3) Resident council and Family council will be informed of process by May 30, 2025	

Change Idea #2 Re-implement Post fall huddles

Methods	Process measures	Target for process measure	Comments
1) Review policy on post fall huddles with staff 2) Falls lead in home to attend and/or review post fall huddles documentation and provide further education as needed	1) # of staff who reviewed policy for post fall huddles 2) # of post fall huddles that were completed as per policy on monthly basis	1) Staff education on post fall huddles will be completed with Falls Lead and Nursing Leadership with 100% participation by June 30 of post fall huddle documentation will be completed sp er policy.	

Change Idea #3 Medication review of all residents who are assessed as being a falls risk

Methods	Process measures	Target for process measure	Comments
1) determine residents at risk for falls. Review prescribed medication for residents at risk for falls 3) Determine medications that have side effects that could potentially contribute for falls 4) Notify staff of potential risks and incorporate into plan of care for monitoring. 5) Discuss with Physician if there are alternatives to prescribed medications that might decrease risk for falls.	1) # of residents identified as being at risk for falls 2) # of residents identified as being at risk for falls 3) # of medications prescribed per resident that increase risk of falls 4) # of care plans updated to reflect risk 5) # of medication changes/alternative prescribe to decrease fall risk.	1) Residents at risk for falls will be identified by May 30 2025 2) 100% of medication reviews will be completed for those residents at risk for falls by May 30 2025. 3) Staff will be notified about potential risks and care plans updated by April 30 2025 4) Discussions with Physician about alternatives or changes to medication will be completed for high risk residents sby April 30	

Change Idea #4 Enhance lighting at bedside and in bathrooms for residents who fall between 7pm and 7 am			
Methods	Process measures	Target for process measure	Comments
1) Fall Team to review falls data for residents who would benefit from enhanced lighting at bedside/bathroom 2) Environment assessment of room completed by falls team for placement of lights 3) Order lighting and install 4) monitor pre and post data for improvement	1) # of residents identified as benefiting from enhanced lighting 2) # of environmental assessments completed 3) # of lights installed at bedside, and in Bathroom	1) Residents will be reviewed for enhanced lighting by April 30 2025. 2) Environmental assessments of each of the identified resident rooms will be completed by April 30 2025 3) Lights will be ordered by April 30 2025. 4) Review baseline vs post installation data for falls for residents with enhances lighting by April 30 2025	

Change Idea #5 Reassess Falling Star program and re educate staff on program			
Methods	Process measures	Target for process measure	Comments
1) ADOC Falls Lead will provide education sessions on Falling Star program to all PSW/PSAs and registered Staff on all home areas. 2) Mangers will audit and monitor progress to ensure implementation.	1) # of education sessions provided to PSW/PSA and Registered Staff 2) # of audits completed on Falling Star Program Monthly 3) # of audits on Fallin Star program with no deficiencies	1) Education sessions for PSW/PSA and Registered Staff will be completed by May 30. 2) Audits on Falling Star program will begin June 10 2025.	

Change Idea #6 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 increased risk of falls r/t isolation or new admission will have enhanced monitoring by all staff for 2 week period.	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 enhances monitoring per shift	1) Reminders for staff will be communicated by April 30 2) shift report process for communication high risk residents will be in place by April 30 3) Process for enhanced monitoring for those on isolation or newly admitted will be in place by May 30	

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	9.35	9.00	Continue to improve and maintain results better than Extendicare target of 17.3%	Medisystem, Behavioural Supports

Change Ideas

Change Idea #1 BSO lead to attend Quality lab on a regular basis

Methods	Process measures	Target for process measure	Comments
Monthly Quality Lab will be attended by BSO Lead to review and report on antipsychotics and share successes from other homes.	# of Quality labs attended	BSO Lead will regularly attend Quality labs by June 2025	

Change Idea #2 Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment

Methods	Process measures	Target for process measure	Comments
BSO lead will participate in all new hire orientation	DOC will track BSO attendance at all orientation by adding to orientation checklist and tracking monthly- and reporting at Qday and then quarterly at PAC	BSO lead will participate in 100% of orientation sessions for all new hires.	

Change Idea #3 Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment			
Methods	Process measures	Target for process measure	Comments
BSO Lead will work with Nursing leadership to continue to complete and update all 1:1 binders with personhood, triggers, actions to avoid triggers to responsive behaviours	DOC will track completion of all 1:1 binders monthly with resident care audits and report results at Qday and quarterly at PAC	BSO lead and or delegate will complete 100% of all 1:1 binders and 100% of the binders will also be updated when changes to care plan occur.	

Change Idea #4 GPA education for training for responsive behaviors related to dementia			
Methods	Process measures	Target for process measure	Comments
1) Engage with certified GPA coaches to roll out home level education 2) Contact Regional manager LTC Consultant or Manager of Behavior Service for Dementia Care for Support as needed 3) Register participants for education sessions.	1) # of GPA sessions provided 2) # of staff participating in education 3) # of referrals to regional managers, LTC Consultants or manager of Behavior Services and Dementia Care 4) Feedback from participants in the usefulness of action items developed to support resident care.	1) GPA sessions will be provided for 100% of PSWs and PSAs by September 30. 2) Feedback from participants in the session will be reviewed by actioned by November 30.	

Change Idea #5 Family education resources provided for appropriate use of Antipsychotics			
Methods	Process measures	Target for process measure	Comments
1) Provide Centre for Effective Practice resource for appropriate use of antipsychotics when families have questions about appropriate antipsychotic prescribing 2) Make resource available at nursing station if family have question	1) # of CEP resources provide to families monthly 2) # of antipsychotic d/c as a result of increase family awareness	1) CEP resources will be printed and available at nurse station by June 30	

Change Idea #6 Collaborate with the Physician to ensure all residents using anti-[sychotics have a medical diagnosis and rationale identified.

Methods	Process measures	Target for process measure	Comments
1) complete medication review of residents prescribed antipsychotics 3) Review diagnosis and rational for antipsychotics 3) consider alternative as appropriate	1) # of medication reviews complected 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 2) Alternatives will be in place and reassess if not effective within 1 month of implemented with process in place by July 30	

Measure - Dimension: Safe

Indicator #6	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of LTC Residents with worsened ulcers Stage 2-4	C	% / LTC home residents	Other / October - December 2024	3.30	2.00	Extendicare target	Solventum/3M, Wounds Canada

Change Ideas

Change Idea #1 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 residents that require Turing and reposition 3) Review this during the Skin and Wounds 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 June 30. 2) Check in with staff and will be correctly completed a monthly basis by June 39 3) Process for review, analysis and follow up of monthly trends from tools will be 1005 in place by June 30	

Change Idea #2 Focus on moisturizing skin as prevention strategy to prevent skin breakdown			
Methods	Process measures	Target for process measure	Comments
1) review current products used in home for prevention to ensure compliance with established protocols. Education sessions for PSWs all shifts about skin health and importance of daily moisturizing	# of audits of products that identified areas for improvement # of education sessions/shift. # of PSWs staff that attended sessions	1) Current products will be reviewed for compliance with established protocols by June 30. 2) Education sessions will be provided on all shifts with 100% attendance by June 30	

Change Idea #3 Focus on continence to keep skin clean and dry-toileting, appropriate brief selection			
Methods	Process measures	Target for process measure	Comments
10 Teh skin and wound lead and continence lead to look at the number of residents on a toileting routine and compare with wound list already generate from PCC. 2) Wound Care lead will work with the continence lead internally 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 of 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 toileting plan in place # of brief audit checks completed # of education sessions provided- # or residents on restorative toileting program	1) The leads for Skin/Wound and Continence will complete their resident review by May 30. 2) Review of correct sizing and type of incontinence products will be completed by May 30. 3) Education sessions for product selection will be completed by June 30. 4) Annual review of continence program will be completed by June 30	

Change Idea #4 Ensure appropriate surfaces and seating for residents at risk of skin issues by improving communication with PT			
Methods	Process measures	Target for process measure	Comments
1) Meet to discuss process to improve communication between the PT and skin and would lead. 2)Educate Registered staff on importance of sending referrals to PT 3) Wound care lead to provide an updated list of skin and seating issues to the PT internally 4) Review surfaces and seating during Skin and Would committee meetings for any follow up 5) Tracking of specialty services and preventative maintenance program for equipment 6) DOC to audit this process and part of the evaluation process of the skin and would care annal program	# education session s provided for Registered Staff # of residents requireing PT referrals # of referrals received by PT # of seating assessments completed # of surfaces reviewed # of specialty surfaces and pumps # of audits that showed areas for improvement t	1) Wound care Lead to provide refresh education for Registered Staff on improving communication by June 30. 2) Standardized communication process will be in place by May 30 3) Seating assessment sill be completed for al t risk resident by June 30 4) All surfaces for at risk resident swill have been reviewed by June 30	