Experience

Measure - Dimension: Patient-centred

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of residents responding to: "I have input into the recreation programs available"	C	% / LTC home residents	In-house survey / Sep. 3 - Oct.11. 2024	70.50	80.00	Although we have made improvements based on the 2023 survey, residents have requested opportunities to select their activities. Allowing residents to choose their activities gives them a sense of ownership and helps improve both the quality of service and their overall quality of life.	

Change Ideas

Change Idea #1 Request for Resident Input for More Flexible Schedule during monthly resident's council meeting.

Methods	Process measures	Target for process measure	Comments
1. Schedule Calendar Planning meeting with residents, where an Activity Staff member will meet with residents on each floor to discuss and plan activities monthly. 2. Incorporate resident ideas for programs into monthly calendar	1. # Residents who attended planning meetings monthly. 2. # of calendar planning meetings held with residents monthly 3. # program ideas suggested by residents 4. # of ideas implemented	1. To achieve 10% improvement in resident satisfaction by end of 2025 2. there will be at least 6 calendar planning meetings with residents to discuss programs by October 2025. 3. There will be at least 3 program suggestions by residents which are implemented by November 2025	

Change Idea #2 Request for families input during monthly town hall meeting

Methods	Process measures	Target for process measure	Comments
1) Holding monthly town hall meetings with families to gather their suggestions on the recreation programs 2) Collect feedback and program manager will review 3) Share ideas with residents at calendar planning meeting 4) Implementing a new program based on feedback	1)# of monthly town hall meetings held with families 2) # of suggestions received and # reviewed 2) # of suggestions implemented 3) # of ideas shared with residents at calendar planning meeting	Monthly town hall meetings with families where program suggestions discussed will be held by June 2025. Feedback will be collected and reviewed within 2 weeks of town hall meeting by Program manager beginning June 2025. There will be at least 3 new programs implemented based on resident and family feedback by December 2025.	

Measure - Dimension: Patient-centred

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of residents responding to: "I am satisfied with the schedule of religious and spiritual programs currently offered".	C	% / LTC home residents	In-house survey / September 3 - October 11. 2024	73.50	80.00	The residents' survey results indicated that satisfaction with the schedules for religious programs was 73.5% in 2024, compared to 77.4% in the 2023 survey. Although the Extendicare target was met, the 2024 survey highlighted requests to review both the schedules and variety of religious and spiritual programs. In response, the home has developed a plan and set goals to better address residents' spiritual needs and preferences.	

Change Ideas

Change Idea #1 Review and adjust program schedules to better accommodate residents' preferences

Methods	Process measures	Target for process measure	Comments
1. Request feedback during residents' council meeting, Review feedback and adjust program schedules as able 2. Communicate changes made to resident council as follow up.	1. Track # of participation and attendance at religious and spiritual before and after schedule adjustments. 2. # of feedback received 3. # changes implemented	1. Assess attendance patterns and preferences to optimize scheduling for higher number of residents participation by August 2025. 2. Feedback on spiritual preferences will begin by March 31 with at least 50% of feedback implemented by December 2025	

Change Idea #2 Expand the variety of religious and spiritual programs

Methods	Process measures	Target for process measure	Comments
1. Determine needs of residents to see what program needs to be added 2. Collaborate with local religious organizations to offer diverse services 3. collect feedback on an ongoing basis from residents for additional programs	1. # of external faith-based organizations participating in programs. 2. # of different programs required to meet resident needs 3. % of positive feedback on programs implemented	1. Analysis of current program and resident needs will be 100% completed by May 1, 2025, 2. There will be collaboration with at least 3 Local religious organizations by May 2025. 3. There will be at least 10% improvement in feedback by October 2025.	

Measure - Dimension: Patient-centred

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of residents responding to: " I am satisfied with the care I receive"	C	% / LTC home residents	In-house survey / September 3 - October 11. 2024	82.10	90.00	The 2024 resident survey indicated an 82.1% satisfaction rate with the care received compared to 90.2% in the 2023 survey. In response, the home has developed a plan and set a goal to better address residents' requests and needs, focusing on improving the quality of care and responsiveness to their concerns.	

Change Ideas

Change Idea #1 Provide additional training for staff to improve residents' care quality.

Methods	Process measures	Target for process measure	Comments
1. Arrange training sessions for staff on education topic: Dementiability. 2. Track attendance 3. Post education follow up by resident feedback on their primary care staff care	1. # of residents who are satisfied with their primary care staff. 2. # of education sessions provided on DementiAbility to Staffs. 3. # of Staff who completed training	1. 90% of staff will have completed training on Dementiability by May 2025. 2. There will be improvement to 90% in satisfaction of residents to care they receive by October 2025	

Change Idea #2 Develop survey to ask residents for their feedback on the care provided

Methods	Process measures	Target for process measure	Comments
1. Obtain feedback on care from residents during care conference 2. Ask Resident council for feedback on care and follow up on any concerns raised and action.	# of surveys completed on a quarterly basis # of residents who are satisfied with the care they receive # of areas actioned based on feedback	Process for Quarterly Survey to track residents' satisfaction of the care will begin April 1, 2025. There will be a 10% improvement in number of concerns raised by June 2025 and 25% improvement by September 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	13.24	11.00	The Home has successfully reduced falls to below the Extendicare benchmark of 15%. For this year, the home will continue to focus on improving the quality of resident's lives and preventing fall-related injuries, with the goal of maintaining a fall rate 11%.	Achieva

Change Ideas

Change Idea #1 Implement /Reassess Falling Star program and reeducate staff on program

Methods	Process measures	Target for process measure	Comments
1. ADOC will provide education sessions on Falling Star 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. 100% of Education sessions for PSW and Registered staff will be completed by June 2025 2. Audits on Falling star program will begin by July 2025 with 100% compliance by December 2025.	

Change Idea #2 Staff training and education on fall prevention strategies, recognizing fall risk factors and providing individualized care plans for residents.

Methods	Process measures	Target for process measure	Comments
1) Attend education session on use of Falls Prediction & Prevention Report (FPPR). 2) Review residents on list and ensure that strategies are in place to prevent falls. 3) monitor progress based on data from report.	1) # of education sessions. 2) # of residents at high risk. 3) # of plans of care reviewed to ensure strategies in place. 4) # of residents on list who did not experience a fall in the previous 30 days.	1) Training on Fall Predication and Prevention report will be completed by June 30. 2) Residents listed on report as being at risk of fall will have strategies reviewed by End of each Month. 3) Ongoing monitoring to ensure strategies are effective will be in place by July 30, 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	12.47	8.00	Our Home has achieved the goal set by Extendicare, which is 17.3%. For 2025, we will continue to maintain a target goal of 8%, surpassing the Extendicare target as we continue to strive for improvement.	Pharmacy Consultant, Physician, Geriatric Outreach Royal Ottawa Hospital

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.The antipsychotic Program lead will continue to monitor residents who are on antipsychotic medications. 2.Those who do not meet exclusion criteria will be reviewed for potential in the use of antipsychotic medications. 3. Alternatives will be considered as part of review	1. # Medication reviews completed monthly 2. # of diagnosis that were appropriate for antipsychotics 3, # of alternatives implemented	1. Antipsychotic review meetings are occurring quarterly beginning by April 2025 2. Residents triggering Antipsychotic QI have an action plan inputted into the decision support tool within 3 to 6 months of admission starting in April 2025.	

Change Idea #2 GPA education for training for responsive behavior’s related to dementia.			
Methods	Process measures	Target for process measure	Comments
1) Register Staff for GPA education sessions. 2)Educate staff recognizing early signs of agitation and aggression and environmental modification to reduce triggers.3) track attendance	1) # of staff who attended GPA training	1) GPA sessions will be provided for 15-20 staff by Dec. 2025	

Measure - Dimension: Safe

Indicator #6	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	C	% / LTC home residents	Other / Oct-Dec 2024	1.90	1.00	We achieved the Extendicare goal, but Our Home is planning to reduce the worsened pressure ulcer indicator from 1.9% to 1% to improve resident health outcome, quality of care, and skin integrity. The plan can lead to: 1. Better resident comfort and well being 2. Reduce risk infection and complication 3. Improve care practice and preventive measures	1. 3M, 2. Nurse Practitioner

Change Ideas

Change Idea #1 Scheduled Weekly skin assessments for high-risk residents for early detection and prevention of pressure ulcers.

Methods	Process measures	Target for process measure	Comments
1. Communicate to Registered staff requirement to complete the assessments. 2. Registered staff to complete online modules on wound staging by end of third quarter of year. 3. DOC/designate to monitor completion assessments.	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. Conduct Quarterly Progress and assessment review by May 27. 2. Complete 100% Staff training on skin assessments and early intervention by June 30, 2025. 3. By September 30, 2025 there will be 100% completion rates	

Change Idea #2 Establish a turning and repositioning schedule while residents are in bed.

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	1) # of staff that have been educated 2) # of audits completed 3) # of reviews completed by Skin and Wound committee	1) Train all Registered Nurses and PSWs on proper repositioning techniques by May 2025 2) Conduct compliance audits to ensure adherence to the repositioning protocol every month beginning June 30,2025 3) Review QI Pressure ulcer data Monthly starting April 1, 2025	