Experience

Measure - Dimension: Patient-centred

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of residents who responded positively to the statement: "If I need help right away, I can get it.	C	% / Residents	In-house survey / 2024	66.70	85.00	85% Extendicare Benchmark	

Change Ideas

Change Idea #1 Implement proactive/purposeful rounding.

Methods	Process measures	Target for process measure	Comments
Provide education session on purposeful rounding process.	# of education session for staff.	100% Education for purposeful rounding 4Ps will be completed by May 31, 2025.	

Change Idea #2 Increase staff awareness of call bell response times.

Methods	Process measures	Target for process measure	Comments
Incorporate on the spot monitoring by leadership walkabout to observe response times.	# of Leadership walkabout completed monthly	Process of Leadership Walkabouts will be in place by April 30, 2025.	

Change Idea #3 Review staffing and routines all shifts.

Methods	Process measures	Target for process measure	Comments
Meet with all shifts to discuss results of survey related to response times.	# of meeting held with each shift.	Meeting with all shifts will be held by April 30, 2025.	

Measure - Dimension: Patient-centred

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of Residents who responded positively to the statement:" I enjoy eating meals in the dining room".	C	% / Residents	In-house survey / 2024	70.60	85.00	85% Extendicare Benchmark	

Change Ideas

Change Idea #1 Provide education on improving the Resident Experience during mealtime.

Methods	Process measures	Target for process measure	Comments
Re-educate on meal service policies and procedures, pleasurable dining.	# of Inservice held to review policy and procedures, pleasurable dining and expectations during mealtimes.	100% of staff will attend in educational in-services by December 31, 2025.	

Change Idea #2 Obtain regular feedback from residents on dining room atmosphere and incorporate changes based on recommendations.

Methods	Process measures	Target for process measure	Comments
Document feedback and determine action that will be taken as a response.	# of recommendations made/changes requested and # responded to with action.	75% of recommendations will be actioned on within a month of recommendation.	

Change Idea #3 Enhance the Environment.

Methods	Process measures	Target for process measure	Comments
Assess current state of dining room to determine external noises and other environmental factors that can impact satisfaction.	# of complaints about noise, # of incidents of noise in DR observed	By July 31, 2025, 85% reduction of noise will be implemented.	

Measure - Dimension: Patient-centred

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of families who responded positively to the statement"The resident has input into the recreation programs available".	C	% / Family	In-house survey / 2024	41.70	85.00	Extendicare Benchmark 85%.	

Change Ideas

Change Idea #1 Monthly Program Meetings to be implemented to engage residents in programs decision making.

Methods	Process measures	Target for process measure	Comments
Add program planning meeting in the calendar. Collect feedback from residents and implement changes based on feedback	# of Meetings throughout the year. # of feedback about programs received # of changes implemented based on feedback	Meetings on each unit with residents will be implemented by June 2025 All agreed upon changes will be implemented by December 2025 based on resident feedback.	

Change Idea #2 Involve families in program planning.

Methods	Process measures	Target for process measure	Comments
Communicate program plan through email, bulletins and family councils to provide opportunity for input.	# of meetings and communications sent out to families on program plans. # of suggestions for programs received. # of suggestions implemented	Communication to be implemented quarterly starting in June 2025. Tracking of suggestions will begin in June 2025. Suggestions provided will be reviewed and implemented as able by Dec 2025.	

Change Idea #3 In-house communication to residents on planned programs.

Methods	Process measures	Target for process measure	Comments
Recreation department to display a board near the front entrance with monthly calendar.	# of monthly programs calendar displayed at the front entrance.	Programs will be displayed monthly beginning May 2025.	

Safety

Measure - Dimension: Effective

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of residents who developed a stage 2 to 4 pressure ulcer or had a pressure ulcer that worsened to a stage 2, 3 or 4 since their previous resident assessment.	C	% / Residents	Other / Oct-Nov-Dec 2024	0.70	0.50	Continue to improve and perform better than Extendicare benchmark of 2%	Solventum/3M, Wounds Canada

Change Ideas

Change Idea #1 Mandatory education for all registered staff on correct staging of pressure ulcer.

Methods	Process measures	Target for process measure	Comments
1.Communicate with staff requirement to complete education. 2.Registered staff to complete modules on wound staging by June 2025.	1. # of communication to registered staff mandatory requirement to complete education. 2. # of registered staff who have completed modules on wound staging on a monthly basis.	1. Communication on mandatory requirements will be completed by end April 2025. 2. 100% of registered staff will have completed education on correct wound staging by December 31, 2025.	The Home have met the benchmark for this indicator and have succeeded in sustaining for most of 2024.

Change Idea #2 Implement per home area tracking for all pressure ulcers to measure status and trends of pressure ulcers in the home.

Methods	Process measures	Target for process measure	Comments
1) Provide education for staff on tracking tool on each unit. 2)Implement tracking tool on each unit and shift 3) Wound care lead to collect tools and do analysis for trends	1) # of education sessions held for Registered staff on tracking tools 2) # of tracking tools completed monthly 3) # of tracking tools that were reviewed on a monthly basis for trends	1) 100% of Registered staff will have attended education sessions on tracking tool by end of third quarter 2) Tracking tools will be correctly completed on a monthly basis by Sept 2025.	

Change Idea #3 Have the wound care lead enroll SWAN

Methods	Process measures	Target for process measure	Comments
Ensuring ongoing professional development opportunities	1)weekly wound huddles 2)Swan to complete section M of RAI	Wound care lead will be trained SWAN by December31, 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	14.52	13.00	To continue to improve and perform better than Extendicare benchmark of 15%	Achieva, Behavioural Supports

Change Ideas

Change Idea #1 Team to continue with fall huddles on all home areas to review reasons for falls.

Methods	Process measures	Target for process measure	Comments
Falls committee to review monthly falls statistics to trend and analyzed the factors contributing to falls.	The number of post falls huddles completed monthly.	The number of post fall huddles completed which was trended and analyzed by December 31,2025.	

Change Idea #2 Determine residents that are high risk for Falls/frequent fallers.

Methods	Process measures	Target for process measure	Comments
Identified high risk for falls residents will be reviewed daily by the registered staff with the PSWs.	The number of identified high risk residents will have a care plan specific to fall needs.	The number of residents who were identified as high risks for falls and the number of care plan updated by April 30, 2025.	

Change Idea #3 Registered Staff will identify the residents who are at risk for falls using the FPPR report.

Methods	Process measures	Target for process measure	Comments
Clinical Coordinator and ADOC to educate registered staff on the use of FPPR report to ensure that strategies are in place for identified residents.	The number of staff education sessions completed on FPPR report.	100% of registered staff education on FPPR tool by December 31, 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	X	0.00	The Home will continue to aim and maintain at 0 for this indicator.	Medisystem, GPA, Behavioural Supports

Change Ideas

Change Idea #1 Include Pharmacist in collaboration with the in-house team and family members in deprescribing plan.			
Methods	Process measures	Target for process measure	Comments
Identify residents who are newly admitted with antipsychotic usage without a diagnosis.	The number of Residents who were identified based on assessments with an MD order to deprescribe.	The number of residents who were identified and for whom an order was obtained by the MD to start deprescribing by December 31, 2025.	The Home have successfully achieved and maintained the target set on this indicator, we will continue with our change ideas.

Change Idea #2 Identify the residents whose behaviors have worsened or new onset of behaviors.			
Methods	Process measures	Target for process measure	Comments
Identify Residents using the Cohen Mansfield tool with a score of lower than 80, the use of non- pharmacological intervention will be used for behaviors.	The number of Cohen Mansfield score completed.	The number of residents with a Cohen Mansfield score completed by December 31, 2025.	

Change Idea #3 Collaboration with Registered Staff, RAI MDS coders and BSO to ensure accurate coding.			
Methods	Process measures	Target for process measure	Comments
Document incidences of residents exhibiting hallucinations/delusions in progress notes, who are on inappropriate antipsychotic medication.	The number of residents who are documented as exhibiting hallucinations/delusions within the observation period.	100% of residents who were exhibiting hallucinations/delusions will be documented in progress notes, to be reviewed quarterly with annual analysis by December 31, 2025.	