Equity

Measure - Dimension: Equitable

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education	O	% / Staff	Local data collection / Most recent consecutive 12-month period	CB	100.00	100% Staff Completion	

Change Ideas

Change Idea #1 Completion of the Surge Learning 'Cultural Competence and Indigenous Cultural Safety' module for all staff.

Methods	Process measures	Target for process measure	Comments
Review of Surge Learning History reports to ensure staff completion.	percentage of staff completion reviewed monthly.	100% completion of 'Cultural Competence and Indigenous Cultural Safety' Surge Learning module by all staff no later than December. 31st, 2024.	

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 have a concern I feel comfortable raising it with the staff and leadership"	C	% / LTC home residents	In-house survey / 2023	65.40	78.50	LTC Provincial Average	

Change Ideas

Change Idea #1 Implement Town hall newsletter to engage residents and family members feedback on a regular basis.

Methods	Process measures	Target for process measure	Comments
Town hall newsletters are sent out on a regularly scheduled basis involving all department managers to provide residents and family members with a comprehensive update of home operations and to then enable them to provide feedback.	# of Town hall newsletters per year	Town hall newletters will be sent out on a monthly basis to engage resident and family member feedback by April 2024.	An anonymous method for feedback will be available.

Change Idea #2 To increase residents comfort levels of raising concerns with staff and leadership, all direct care staff will receive empathy training.

Methods	Process measures	Target for process measure	Comments
Conduct empathy training for all direct care staff. Training material will be provided during daily huddles as well as nursing and PSW practice meetings.	percentage of direct care staff trained	100% of all direct care staff will be trained by June 2024 prior to relocating to Extendicare Crossing Bridge.	A training resource will be further discussed in the April 2024 PAC and CQI Committee Meeting.

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 have input into the recreation programs available".	C	% / LTC home residents	In-house survey / 2023	33.30	63.90	LTC Provincial Average	

Change Ideas

Change Idea #1 Implement Calendar Planning Meetings to engage residents and family members in providing ongoing feedback regarding programs within the home

Methods	Process measures	Target for process measure	Comments
Calendar Planning Meetings will now occur on a monthly basis	# of Calendar Planning Meetings	By June 2024, the Recreation team will be hosting monthly Calendar Planning Meetings to elicit resident feedback and incorporate their input into all future programs.	

Change Idea #2 Implement Program-Specific Resident Survey's to empower residents and family members with feedback regarding programs within the home

Methods	Process measures	Target for process measure	Comments
The Program -Specific Resident Survey will be made available by the recreation team when a resident expresses a negative statement regarding programs.	# of Program-Specific Resident Surveys submitted on a quarterly basis	50% of all residents that have expressed a negative statement about a program will be offered the option of completing a Program-Specific Resident Survey by June 2024, 75% by December 2024.	

Measure - Dimension: Patient-centred

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of residents who responded positively to the statement "I am satisfied with the variety of spiritual care services".	C	% / LTC home residents	In-house survey / 2023	50.00	73.70	LTC Provincial Average	

Change Ideas

Change Idea #1 Engage resident feedback in regards to spiritual care services by implementing the Spiritual Assessment Tool.

Methods	Process measures	Target for process measure	Comments
Spiritual Assessment Tools will be provided by the Recreation team on a quarterly basis	# of Spiritual Assessment Tools completed	The Recreation team will review 100% of received Spiritual Assessment Tools by the end of each corresponding quarter and provide an update during the next Resident Council Meeting.	Shared area of improvement from both resident satisfaction survey and family satisfaction survey.

Measure - Dimension: Patient-centred

Indicator #5	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of residents who responded positively to the statement "I am satisfied with the timing and schedule of spiritual care services".	C	% / LTC home residents	In-house survey / 2023	50.00	73.00	LTC Provincial Average	

Change Ideas

Change Idea #1 Engage resident feedback in regards to timing and schedule of spiritual care services by implementing the Spiritual Assessment Tool.

Methods	Process measures	Target for process measure	Comments
Spiritual Assessment Tools will be provided by the Recreation team on a quarterly basis.	# of spiritual assessment tools completed	The Recreation team will review 100% of received Spiritual Assessment Tools by the end of each corresponding quarter and provide an update during the upcoming Resident Council Meeting.	Subsequent action planning based on feedback.

Safety

Measure - Dimension: Safe

Indicator #6	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 2023–September 2023 (Q2 2023/24), with rolling 4-quarter average	11.19	10.50	We strive to improve our performance and exceeding Extendicare's Target (15.0%)	Achieva, Pharmacy

Change Ideas

Change Idea #1 Root cause analysis of falls occurring within the home to determine efficient and effective strategies to decrease incidence, risk, and severity of all falls.

Methods	Process measures	Target for process measure	Comments
Cultivate a sustainable infrastructure that addresses Falls Prevention both proactively and reactively via. our Outcome Measure and Fall Tracking Tool, Falling Star Tracking Tool, Falls Inventory Management database, post fall huddles and their associated tools, and environmental assessments.	# of post fall huddles completed by interdisciplinary team on a monthly basis, percentage of PCC risk management documentation completed with adequate (detailed) incident description and with no errors.	Root cause analysis of all falls occurring within the home to efficiently and effectively determine strategies in decreasing the incidence, risk and severity of falls will be implemented by June 2024. This will be reflective in the risk management assessments and subsequent interventions.	This infrastructure enables our team to utilize a multidisciplinary approach to more effectively conduct root cause analysis.

Change Idea #2 Further develop the comfort rounds process (4 P's) for residents at a high falls risk and for new admissions.

Methods	Process measures	Target for process measure	Comments
Re-educate 4P's process for comfort rounds with staff and to provide effective orientation to new staff on the 4 P's process on hire.	# of education sessions provided to staff on 4 P's process on a quarterly basis, # of orientation sessions on 4 P's for new staff on a monthly basis, percentage of post falls where comfort rounds were maintained and did not attribute to the cause of the fall.	Comfort rounds process will be implemented for 100% of high fall risk residents and new admissions by June 2024.	This change idea is to support our high prevalence of 'found on floor' falls that occur in the residents bedroom and bathroom.

Measure - Dimension: Safe

Indicator #7	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 2023– September 2023 (Q2 2023/24), with rolling 4-quarter average	14.49	13.50	We strive to improve our performance of excellence in exceeding Extendicare's Target (17.3 %)	Medisystem, BSO, Royal Ottawa Hospital-psychogeriatric team

Change Ideas

Change Idea #1	Implementation of a medication review process for all residents on antipsychotic medication that is guided through the Antipsychotic Decision Support Tool.		
Methods	Process measures	Target for process measure	Comments
Complete standardized and systematic review of all residents currently on antipsychotics using an interdisciplinary approach supported by the Antipsychotic Decision Support Tool. Subsequent action planning will be discussed ongoingly with the interdisciplinary team and highlighted in the corresponding committee's to uphold CQI within the home.	# of medication reviews completed on a monthly basis, percentage of residents with 'Action Taken provided' within the AP DST.	Standardized medication review process will be implemented by June 2024. 100% of 'residents with Action Taken' within the AP DST tool will be achieved by January 2024 and maintained throughout the entire 2024 year.	The percentage for 'Action Taken provided' is emailed to all homes on a monthly basis from the home office Quality Reporting and Clinical Informatics team based on the AP DST inputted data.

Change Idea #2	Engage BSOs to capture a CMAI and to review potential triggers for responsive behaviours on all residents on prescribed antipsychotics.		
Methods	Process measures	Target for process measure	Comments
Involve BSOs to review potential triggers and assist with implementing strategies to decrease behaviours when reducing antipsychotics. This initiative is supported through the BSO Meetings with ROH and the corresponding committee.	# of residents reviewed by BSO resource for potential triggers and alternatives to antipsychotic medications on a monthly basis, percentage of residents with Action Taken provided within the AP DST.	Interdisciplinary team process for engaging BSOs in review of potential triggers will be implemented by June 2024. 100% of 'residents with Action Taken' within the AP DST tool will be achieved by January 2024 and maintained throughout the entire 2024 year.	To support our BSO and Smiling Bee initiative of addressing responsive bahaviours within the home.

Measure - Dimension: Safe

Indicator #8	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of LTC residents with daily physical restraints	C	% / LTC home residents	Other / December	0.00	0.00	We strive to maintain our performance of excellence in exceeding the Extendicare's Target (2.5%)	Achieva

Change Ideas

Change Idea #1 Will continue to meet and discuss with families, residents or staff who feel there is a need for a restraint.

Methods	Process measures	Target for process measure	Comments
Evaluate devices used with admissions that may be considered a restraint.	# of admissions to the home will be evaluated and education provided with respect to use of restraint.	Will maintain current target by end of 2024	We currently have 0 restraints in our home. We will continue to monitor current processes to sustain results.

Measure - Dimension: Safe

Indicator #9	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of LTC residents with worsened staged 2 to 4 pressure injuries	C	% / LTC home residents	Other / December	1.74	1.50	We strive to improve our performance of excellence in exceeding Extendicare's Target (2.0%)	Achieva, 3M partners and resources

Change Ideas

Change Idea #1 Ensure Skin Wellness Associate Nurse (SWAN)'s support both the Wound Care Champion and the home's Skin and Wound program in the absence of the Wound Care Champion.

Methods	Process measures	Target for process measure	Comments
In the absence of the Wound Care Champion, our SWANs will take the lead on providing effective wound care within the home while simultaneously providing feedback to the committee, Nurse Management and QRM regarding worsening wounds.	Percentage of 'Skin - Weekly Impaired Skin Integrity Assessment - V4' completed in the PCC UDA in the absence of the wound care champion.	All (100%) of 'Skin - Weekly Impaired Skin Integrity Assessment - V4' will be completed during extended absences of the WCC.	This was a gap in 2023 during a month long WCC absence and this absence will occur again in 2024.