Experience

Measure - Dimension: Patient-centred

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
If I need help right away, I can get it.	C	% / LTC home residents	In-house survey / 2024	54.20	60.00	Continue to improve our results as we strive to achieve corporate target of 85%	

Change Ideas

Change Idea #1 Creating education to all front-line staff regarding for regular rounding expectations

Methods	Process measures	Target for process measure	Comments
1) Education will be provided for front line staff on rounding expectations 2) Managers will survey residents following the delivery of the education and will survey 20 residents in one month pertaining to " If I need help right away, I can get it. 3) Managers will do survey using weekly inspection report 4) follow up will occur if gaps are identified.	# of education sessions held on regular rounding expectations % of staff who attended sessions # of post education surveys completed by managers monthly # of gaps identified and follow up completed	1) Education for front line staff will be completed by July 30 ,2025 with 100% completion rate. 2) 20 surveys will be completed by management team post education and will be completed by August 31, 2026. 3) 100% Follow up on identified gaps will be completed by September 2025.	

Change Idea #2 Attend resident council to discuss response times and get feedback for improvement			
Methods	Process measures	Target for process measure	Comments
1) Ask for invite to Resident council meeting 2) Leadership to review with the residents process and expectations for call bell response 3) Gather feedback and follow up with any concerns	# of times attended resident council to discuss call bell response process # of feedback received from residents # of concerns that require follow up and # follow up completed	By June 30 ,2025 Leadership will have attended Resident council and gathered feedback on response times. Follow up on identified concerns will have been 100% addressed by June 30, 2025.	

Change Idea #3 Initiate call bell audits on all 3 shifts			
Methods	Process measures	Target for process measure	Comments
1) DOC to create call bell audit tracker for each unit 2) Call bell response times will be reviewed and tracked 3) Follow up on identified gaps in audits	Number of Call bell audits completed per month by leadership team Number of gaps identified that required follow up.	60 Audits to be completed and reviewed and gaps followed up by June 30,2025 with action to address in place and actions 100% completed by September 30,2025	

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 care by the social worker.	C	% / LTC home residents	In-house survey / 2024	58.50	65.00	To continue to improve and strive for Extendicare benchmark 85%	

Change Ideas

Change Idea #1 Introduction to the social worker to new residents			
Methods	Process measures	Target for process measure	Comments
Social worker to arrange meeting with new resident and family upon admission to discuss role Track visits completed monthly	# of new admissions monthly # of social worker visits with new admissions monthly	100% of new admissions will have received visits from the social worker as of December 2025	

Change Idea #2 Social worker to provide their information to the new admissions.			
Methods	Process measures	Target for process measure	Comments
Social worker will provide a welcome letter to each new resident. Social will track completion using resident new move in list.	# of new admissions monthly # of welcome letters given to new residents	Welcome letter will be developed by Social worker and process initiated by June 30,2025. 100% of new admissions to receive this new welcome letter from Social Worker by December 30, 2025	

Change Idea #3 Social worker will facilitate resident and family support groups			
Methods	Process measures	Target for process measure	Comments
1) Determine population, need and interests of the home 2) Group participants and assess needs 3) Schedule at least quarterly for family support/education groups 4) Schedule monthly resident support groups	1) # of special populations at home 2) # of support groups offered 3. # of people in attendance	1) Social Worker will coordinate schedule by June 30,2025 2) 20% of residents will participate in support group by June 2025	

Measure - Dimension: Patient-centred

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
In my care conference, we discuss what is going well, what could be better and how we can improve things.	C	% / LTC home residents	In-house survey / 2024	59.00	65.00	To continue to improve results and strive to achieve corporate target of 85%	

Change Ideas

Change Idea #1 Create a Care Conference checklist surrounding discussions on what is going well, what could be better and what how can we improve

Methods	Process measures	Target for process measure	Comments
Develop care conference checklist which includes all areas to be discussed Charge nurses to track by the completing the checklist on the day of the care conference Charge nurse to submit checklist to DOC to review to ensure completed	# of conference checklists completed by Charge nurse # of checklists submitted to DOC for review # of reviews completed by DOC	Checklist will be developed by May 30, 2025 Process for completing checklists and submitting for review will be 100% in place by June 30, 2025	

Change Idea #2 Create letter for POA and resident as invitation to attend initial/yearly care conference

Methods	Process measures	Target for process measure	Comments
1) Ward clerk to create new communication letter format to invite POA/resident to attend their care conferences. 2) Ward clerk to gather returned forms confirming resident attendance utilizing attendance tracker	# of letters sent to POA/residents # of responses received to confirm attendance # of POA and # of residents in attendance at care conferences	Communication letter will be created By May 30th 2025 Process for tracking attendance and response rates will be fully in place by June 30, 2025. Target is for 50% improvement in attendance by family and residents at conferences by September 2025.	

Change Idea #3 Obtain feedback on annual care conference process from residents and families

Methods	Process measures	Target for process measure	Comments
1) Determine survey questions to ask post care conference for feedback. 2) Post care conference ask for feedback via survey or discussion with families and residents on how process can be improved. 3) Review responses and determine plan of action for improvement 4) Communicate feedback results and actions to Resident and Family council.	1) # of survey questions 2) # of feedback responses received monthly 3) # of improvement actions implemented. 4) # of Resident and Family council meetings attended where results discussed	1) Survey questions will be developed by May 30th 2025. 2) Process for post care conference feedback will be in place by June 30th,2025. 3) Feedback/survey results will be shared with resident and family council with action for improvement by Aug 31,2025	

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	11.33	10.00	Justification of absolute target is to have a realistic goal and consistency try to decrease the percentage of the indicator	Achieva

Change Ideas

Change Idea #1 Identify residents who require slider sheets for safety.

Methods	Process measures	Target for process measure	Comments
1)Gather last fall reports and review residents who have fallen. 2) Compare # all resident falls with slider sheets with current resident list. 3) Rai manager to educate staff to how to use a slider sheet 4) Spot audit use of slider sheets for 2 weeks post education	1)Number of residents who have experienced a fall in last 3 months and require a slider sheet 2) Number of slider sheets provided 3) # of PSWs who attended education on how to use slider sheets 4) # of audits completed post education and # of deficiencies.	50% of resident that have slider sheets will have less falls by June 30th 2025.2) 70% pf residents will have reduced falls with slider sheets by Dec 31,2025 100% PSW's trained by June 30,2025	

Change Idea #2 Enhance the falling star program

Methods	Process measures	Target for process measure	Comments
Rai manager will provide education sessions on Falling star Program to all PSW/HCA and Registered Staff on all units on all shifts.2) Managers will audit and monitor progress to ensure implementation.	1) Gather # of education sessions provided to PSW/HCA and Registered staff 2) Gather # of audits completed on Falling star program monthly.3) # of audits on Falling star program with no deficiencies	1) Education sessions for PSW/HCA and Registered staff will be completed by May 31,2025 2) Audits on Falling star program will begin by July 1st,2025 with 50% improvement noted by September 30,2025	

Change Idea #3 1) Educate staff on how to do environmental risk assessment 2) Staff to complete an environmental risk assessment monthly in each resident's room deemed at risk for a fall

Methods	Process measures	Target for process measure	Comments
1) Educate staff on how to do environmental risk assessment led by Rai manager 2) Staff to complete an environmental risk assessment monthly in each residents room deemed at risk for a fall upon admission	1) # of staff education sessions completed on environmental risk assessment 2) # of environmental risk assessments completed monthly	1)Staff education on completing an environmental risk assessment will be completed for 100% of staff by May 31,2025 2) Process for Environmental risk assessments being conducted on a monthly basis for each high risk resident will be in place by April 30,2025	

Change Idea #4 Enhance weekly 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 Rai/CC to conduct weekly team huddles with fall team on resident care units and prepare minutes of huddles	1) # of staff who reviewed policy for post fall huddles. 2) # of post fall huddles that were completed as per policy on a monthly basis 3) % of staff requiring follow up post education	1) Staff education on post fall huddles will be completed by April with 80% participation. 2) By June 1st 100% of post fall huddle documentation will be completed as per policy.	

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	9.97	9.00	Continue to be below Extendicare target	Medisystem, Behavioural Supports Ontario

Change Ideas

Change Idea #1 Identify residents triggering for first time use of antipsychotic medications.

Methods	Process measures	Target for process measure	Comments
Weekly review with NP, and medical director list of residents. Complete action tab of tool for new triggers. 10% decrease in retriggered residents	Process measures- review audits every 30 days that identify such residents. Number of reviews completed with NP and Medical Director	Weekly review with NP and Medical Director will start by June 30,2025 with a 10% decrease in retriggered residents by September 30,2025	

Change Idea #2 All residents should get a note about behaviors 2x/week from frontline staff/BSO.

Methods	Process measures	Target for process measure	Comments
1) RIA manager to review notes to identify any residents that no longer have behaviors to be candidate for medication reduction 2) Resident will be reviewed at medication review meeting with NP and Physician.	# of reviews of behaviour notes completed by RIA manager # of residents who had medication review and # of residents who had antipsychotic medication reduced as a result.	1-2 residents will have antipsychotic medications reduced by June 30,2025 Review of behaviour notes for 100% of residents with previous behaviours will be completed by RIA manager by June 30,2025	

Measure - Dimension: Safe

Indicator #6	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of LTC residents with worsening stage 2 to 4 pressure injuries.	C	% / LTC home residents	Other / Oct-Dec 2024	2.40	2.00	Improve quality indictor to meet Extendicare targets.	Solventum/3M, Wounds Canada

Change Ideas

Change Idea #1 Mandatory education for Registered staff on correct staging, wound measurement and product selection.

Methods	Process measures	Target for process measure	Comments
1) SWAN to arrange mandatory training with ET for all Registered staff on correct staging, wound measurement and product selection for healing. 2) Track attendance at education 3) SWAN to audit completed wound assessments post education for improvement weekly for 4 weeks	# of education sessions scheduled # of registered staff who attended training # of audits post education completed on wound assessments	1) 100% of registered nursing staff will have completed training by ET nurse by June 30,2025 2) Audits on wound assessments will start July 2025 by SWAN for 4 weeks and there will be 100% accuracy by September 30,2025	

Change Idea #2 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 Registered staff to audit weekly those residents that require turning and repositioning and ensure completed as per plan of care 3) Review audits during the Skin and Wound committee meetings for trends and action/follow up as required	# of staff that have been educated on turning and repositioning # of audits completed by Night Registered staff weekly for residents who require turning as per their plans of care % of audit reviews completed by Skin and Wound committee # of actions /follow up required	1) 100% of PSW will have attended education sessions on turning and repositioning by June 30,2025 2) Audits completed by night Registered staff for turning and repositioning will show no gaps identified by July 31,2025 3) Process for review, analysis and follow up of monthly trends from tools will be 100% in place by August 31st, 2025	