Equity

Measure - Dimension: Equitable

Indicator #2	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	100.00	100.00	LSAA requirement - all management continues to receive required training.	

Change Ideas

Change Idea #1 All managers will participate in required training.

Methods	Process measures	Target for process measure	Comments
Include mandatory training modules in orientation process.	Number of managers who have completed mandatory training.	100% completion of education by September 2025	Total LTCH Beds: 70

Experience

Measure - Dimension: Patient-centred

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of residents who indicate yes when answering question "In my care conference, we discuss what's going well, what could be better, and how we can improve things".	C	% / LTC home residents	In-house survey / 2024	65.40	75.00	Continued improvement toward corporate target 85%	

Change Ideas

Change Idea #1 Review annual care conference process and implement annual and 6 week post-admission care conference scheduling

Methods	Process measures	Target for process measure	Comments
1) Complete review of current care conference process including scheduling , agenda 2) Adjust agenda if required to include time for discussions with resident 3) Ask resident if they felt their needs and feedback were addressed	1) # of reviews of care conference process completed 2) # of modifications to agenda 3) % of postive feedback resident responses post care conference	1) Review of care conference process, including changes to agenda will be completed by March 31, 2025 2) there will be a 20% improvement in overall postive responses post care conference by December 31, 2025.	

Change Idea #2 1)Encourage residents to attend their annual care conference

Methods	Process measures	Target for process measure	Comments
1) Communicate to residents when their annual care conference is scheduled in advance of meeting 2) Remind resident morning of meeting and assist as needed to meeting 3) Provide copy of plan of care, where applicable and relevant 3) Allow time for discussion and obtain feedback on what could be improved.	1) # of annual care conferences where residents attend 2) # of care conferences where plan of care was discussed with resident	1) Residents will be encouraged to attend their annual care conferences beginning March 31, 2025. 2) There will be a 20% improvement in this indicator by December 2025.	

Measure - Dimension: Patient-centred

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of families answering yes to "I am satisfied with the quality of care from physiotherapist"	C	% / Family	In-house survey / 2024	50.00	60.00	Division score 67.9%. Resident score is 85.7%, up from 56.3% in 2023 survey.	

Change Ideas

Change Idea #1 Highlight Physiotherapist in monthly newsletter to increae awareness

Methods	Process measures	Target for process measure	Comments
1) Highlight in monthly newsletter about physiotherapist, who they are, role etc. 2) Send newletter to residents and families and post on bulletin board to increase awareness.	1) # of newsletters where physiotherapist was highlighted 2) # of newletters sent to residents and families 3) Newlsetter posted on bulletin board.	1) Monthly newsletter will highlight physiotherapist and role by April 1, 2025 2) Newsletters will be sent to residents and families by April 30, 2025 3) Newsletter will be posted on bulletin board by April 1, 2025	

Change Idea #2 Improve visibility of physiotherapy in home with residents and families

Methods	Process measures	Target for process measure	Comments
1) PT 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) Review and feedback from Resident and Family Council	1) PT will attend Family Council by June 2025 2) PT will attend Resident Council by June 2025 3) Action items and plan will be discussed at CQI committee with OT by June 2025	

Measure - Dimension: Patient-centred

Indicator #5	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of residents who indicate "yes" to the question "If I need help right away, I can get it" on the annual resident survey.	C	% / LTC home residents	In-house survey / 2024	70.00	75.00	Continued improvement to corporate target 85%	

Change Ideas

Change Idea #1 Increase staff awareness of call bell response times

Methods	Process measures	Target for process measure	Comments
1) DOC/designate to review call bell response times on weekly basis 2) Communicate results to staff and leadership team weekly basis. 3) Incorporate on the spot monitoring by leadership walkabouts to observe response times. 4) Follow up with staff for any areas of improvement for response times.	1) # of call bell response time reviews completed 2) # of times results communicated to staff and to leadership team 3) # of leadership walkabouts completed monthly 4) # of staff follow ups required.	1) Call bell response review process will be in place by April 30, 2025 2) Communication of call bell responses to staff and to leadership will be in place by April 30, 2025 3) Process for leadership walkabouts will be in place by April 1, 2025	

Safety

Measure - Dimension: Effective

Indicator #1	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 that worsened	C	% / LTC home residents	Other / October - December 2024	4.30	2.00	Extendicare target	Solventum/3M, Wounds Canada

Change Ideas

Change Idea #1 1) Mandatory education for all Registered staff on correct staging of Pressure ulcers

Methods	Process measures	Target for process measure	Comments
1) Communicate to Registered staff requirement to complete education. 2) Registered staff to complete in-person education regarding staging of pressure ulcers 3) DOC/designate to monitor completion rates	1) # of communications to Registered staff mandatory requirement to complete education. 2) # of Registered staff who have completed required education 3) # of audits of completion rates completed by DOC/designate and follow up as required.	1) Communication on mandatory requirement will be completed by May 1, 2025 2) 100% of Registered staff will have completed education on correct wound staging by June 30, 2025 3) Audits of completion rates will be completed monthly with required follow up will occur by 1st week of each month and process is to be in place by June 30, 2025	

Change Idea #2	2) Review team membership to ensure interdisciplinary. and that team ensures that all wounds and skin issues in previous month are reviewed during their meetings		
Methods	Process measures	Target for process measure	Comments
1) Review current membership of Skin and Wound team 2) Recuit new members and ensure each discipline is represented - re-implement multidisciplinary rounding 3) Standardized agenda and follow up by team on skin issues in home.	1) # of reviews completed on current membership 2) # of new members recruited by discipline3) Standardized agenda developed which includes review of # pressure ulcers by stage on each unit on a monthly basis"	1) Membership review of skin and wound committee will be completed by June 30, 2025 2) Recruitment of new members will be completed by June 30, 2025 3) Standardized agenda will be developed and in place by May 1, 2025	

Change Idea #3	3) Focus on moisturing 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 2) Education sessions for PSW's all shifts about skin health and importance of daily moisturizing	# of audits of products that identified areas for improvement # of education sessions /shift # of PSW staff that attended sessions	1) Current products will be reviewed for compliance with established protocols by May 1, 2025 2) Education sessions will be provided on all shifts with [enter %]of PSW staff attendance by June 30, 2025	

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 1 to Sep 30, 2024 (Q2), as target quarter of rolling 4-quarter average	10.71	10.00	Current performance is below benchmark with low incidence rate of significant fall-related injury. Target is to maintain performance below benchmark.	Achieva, Behavioural Supports

Change Ideas

Change Idea #1 -Continued monthly falls meetings with designated staff member lead to review falls in the last 30-60 days with interdisciplinary team			
Methods	Process measures	Target for process measure	Comments
1. Implement Monthly falls meetings by March 31, 2025 2. Complete minutes and communicate findings to care team after each monthly falls meeting by March 31, 2025 3. Include report from falls team in quarterly Quality Committee meetings by July 2025.	-Number of fall risk assessments and falls risk screens completed/number of documented evidence for why an assessment was not completed post-fall - Number of monthly falls meetings - Number of reports provided to staff huddles -Number of reports provided to Quality Committee	-Monthly falls meetings occurring each month March-December 2025 -Fall risk assessments/fall risk screens/post-fall screening completed according to policy requirements for 100% of falls by month of October 2025.	

Change Idea #2 2) Enhance lighting at bedside and in bathrooms for residents who fall between 7 pm- 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) Environmental 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 BR	1) Residents will be reviewed for enhanced lighting by June 30, 2025 2) Environmental assessments of each of the identified resident rooms will be completed by June 30, 2025 3) Lights will be ordered by July 15, 2025 and installed within 2 weeks of receipt 4) Review baseline vs post installation data for falls for residents with enhanced lighting by October 31, 2025	

Change Idea #3 3) 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 at increased risk of falls d/t isolation or new admission will have enhanced monitoring by all staff for two 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 who had enhanced monitoring entered as task in POC and plan of care updated (see falls focus)	1) Reminders for staff will be communicated by April 30, 2025 2. Shift report process for communicating high risk residents will be in place by May 1, 2025 3. Process for enhanced monitoring for those on isolation or newly admitted will be in place by May 1, 2025	

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 1 to Sep 30, 2024 (Q2), as target quarter of rolling 4-quarter average	X	12.00	We are currently 12.5% based on the most recent PCC unadjusted data (Oct-Dec 2024). We are striving for continued improvement to theoretical best.	Medisystem, Behavioural Supports

Change Ideas

Change Idea #1 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). Establish AP Home Team 2.) Education and training provided by Central QI team 3.) Action plan for residents inputted into decision support tool.	"1.) home team established 2). Schedule regular meetings for antipsychotic review 3). Attendance to the Quality Labs 4.) Percentage of residents with an action plan inputted	1). Home team will be established by March 31, 2025 2). Education and training completed by March 31, 2025 3). Antipsychotic review meetings are occuring every 4 weeks 4). Residents triggering the Antipsychotic QI have an action plan inputted into the decision support tool within 3 to 6 months of admission.	

Change Idea #2 2) GPA education for training for responsive behaviours related to dementia.			
Methods	Process measures	Target for process measure	Comments
1). Engage with Certified GPA Coaches to roll-out home-level education (note: GPA Bathing module now available), 2). Contact Regional Manager, LTC Consultant or Manager of Behaviour Services & 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 Behaviour Services & Dementia Care. 4.) Feedback from participants in the usefulness of action items developed to support resident care.	1.) GPA sessions will be provided for 50% of all staff by December 2025. 2.) Feedback from participants in the session will be reviewed and actioned on by October, 2025.	

Change Idea #3 3) Collaborate with the physician to ensure all residents using anti-psychotic medications have a medical diagnosis and rationale identified.			
Methods	Process measures	Target for process measure	Comments
1) complete medication review for residents prescribed antipsychotic medications 2) Review diagnosis and rationale for antipsychotic medication . 3) consider alternatives as appropriate	1) # of medication reviews completed 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 October 1, 2025 2) Alternatives will be in place and reassessed if not effective within 1 month of implementation with process in place by June 1, 2025	