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	Extendicare Target	

Change Ideas

Change Idea #1 Empathy Training Video for all staff

Methods	Process measures	Target for process measure	Comments
Designate mandatory Surge Learning for all staff on Empathy Monitor completion rates /month Follow up with staff as required to ensure completed	# of staff who have watched the video	100 percent of all staff, students, and newly onboarded staff and volunteers will watch the Surge Video on Empathy by June 30, 2025	This will be completed with the intention of a follow up Inservice to be completed by the SSW team in conjuntion with DEI Committee

Experience

Measure - Dimension: Patient-centred

Indicator #2	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	47.10	75.00	Continue to improve and strive to achieve corporate target 85%	

Change Ideas

Change Idea #1 All residents will be asked if they would like to attend their care conference, and if they would like to have a representative attend their care conference with them

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 meet 2) Provide copy of plan of care or Kardex once updated 3) Allow time for discussion and obtain feedback on what could be improved.	1) # of annual care conferences where residents attend (/236) 2) # of care conferences where plan of care was discussed with resident (/236)	100% of residents will have documentation of a invitation to participate in their IDTC 2019 and 50% by Dec 31, 2025	

Measure - Dimension: Patient-centred

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
I am satisfied with quality of care from my doctors	C	% / LTC home residents	In-house survey / 2024	50.80	65.00	Continue to improve results to achieve 85% corporate target	

Change Ideas

Change Idea #1 1) Communicate role of Medical Director and Physicians and give opportunity for feedback

Methods	Process measures	Target for process measure	Comments
1) Medical Director 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) # of times Medical Director meets Family and Resident councils annually 2) # of Feedback on services and areas for improvement received and discussed 3) # of updates provided at CQI meeting on action plan	1) Medical Director will attend Family Council by March 13, 2025, and Quarterly 2) Medical Director will attend Resident Council by March 31 3) Action items and plan will be discussed at CQI committee with Medical Director by April 2025.	

Measure - Dimension: Patient-centred

Indicator #4	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	51.60	65.00	Continue to improve results to achieve Corporate target 85%	

Change Ideas

Change Idea #1 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 once a month on every shift on quarterly basis. 2) communicate results to staff and leadership team on a quarterly basis in January, April, July, and October 3) 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 staff follow ups required.	1) Call bell response review process will be in place by June 30, 2025 2) Communication of call bell responses to staff and to leadership will be in place by April 2025	

Measure - Dimension: Patient-centred

Indicator #5	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Communication from home leadership is clear and timely	C	% / LTC home residents	In-house survey / 2024	58.70	75.00	To continuously improve toward Extendicare target 85%	

Change Ideas

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

Methods	Process measures	Target for process measure	Comments
1)Send out newsletter on a regular basis to inform residents and families about important information 2) Ask resident and family councils what information they would like to see included and how often to send out. 3) Post newsletter on bulletin board in home	1) # of newsletter sent out quarterly 2) Feedback from residents and families about information for newsletters. 3) # of times newsletter was posted on board 4) # of Hand deliver Newsletters to residents expressing interest	1) Newsletter will be sent quarterly (March, June, Sept, Dec) 2) Feedback from residents and families about newsletter will begin May 2025 3) Post newsletter on bulletin board in home beginning May 2025	

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 1 to Sep 30, 2024 (Q2), as target quarter of rolling 4-quarter average	15.56	10.00	To continue to improve results and exceed Extendicare Target 15%	Achieva, Behavioural Supports

Change Ideas

Change Idea #1 Physiotherapy will review all residents who have fallen to ensure appropriate fall interventions are in place after every fall which will include reassessment of transfer status and inventory of fall interventions.

Methods	Process measures	Target for process measure	Comments
POST FALL review by physiotherapy, completion of a new safe lift and transfer assessment, fall risk assessment and review and update care plan within 7 days of the fall	# of post fall reviews completed within 7 days of the fall	100% of falls will be thoroughly analyzed by the fall reduction committee to prevent future falls from occurring by June 2025.	

Change Idea #2 Falls Tracking Tool

Methods	Process measures	Target for process measure	Comments
Monthly review of all residents who fell in the previous month to ensure that fall interventions are in place and are appropriate.	# of residents identify high risk of falls with completed Comprehensive FALL Review based on the FTTP Tool assessment	100% of the residents who have fallen in the previous month will have their care plan reviewed for accuracy and integrity consistently by June 2025	This will replace the environmental assessment attempted in 2024/2025 and it is more targeted to our home

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	9.34	8.00	Extendicare Target	Royal Ottawa Hospital - Psychogeriatric Outreach

Change Ideas

Change Idea #1 Review all new admissions for antipsychotic use and where there is no diagnosis of psychosis, educate families on the risks of APS, and deprescribe safely

Methods	Process measures	Target for process measure	Comments
#1 Admission Nurse with screen and refer to the Antipsychotic Reduction committee and provide education to the families #2 MD will consider deprescribing the antipsychotic where appropriate #3 Antipsychotic medication used a PRN will be discontinued	# of MCMR reviews, # of reviews of E-clinical portal information, # of reviews of mental health history. # of referrals by admission nurse # of education provided to families # of medications deprescribed monthly # of antipsychotic prn medications deprescribed monthly	50% of all new admissions will have antipsychotics deprescribed by September 2025.	

Measure - Dimension: Safe

Indicator #8	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of LTC care patients who developed a stage 2 to 4 pressure ulcer that worsened	C	% / LTC home residents	Other / October - December 2024	0.93	0.50	Continue to improve and maintain better results than corporate target of 2%	Solventum/3M, Wounds Canada

Change Ideas

Change Idea #1 All residents who present with a Stage 2+ pressure ulcer will be referred to Wound Care Management.

Methods	Process measures	Target for process measure	Comments
Daily review of reports; Staff to complete wound referrals through the UDA portal; Wound care lead to follow up on wound referrals as received.	# wound referrals sent, # of UDA assessments completed, # of follow up to wound referrals completed, tracking with TPT pressure ulcer tool (corporate)	50% of all newly acquired or inherited pressures will improve in the first three months and heal within 6 months	

Change Idea #2 Monthly Wound and Treatment Care Summary will be prepared and managed by the SWAN to ensure timely wound care push assessments are completed

Methods	Process measures	Target for process measure	Comments
SWAN will prepare monthly wound and treatment care summary SWAN will review weekly to ensure PUSH assessments are completed Registered staff to sign off weekly assessments by unit Follow up by SWAN completed with individual staff as required.	# of weekly skin reviews completed # of weekly skin review completed with no gaps # of weekly assessments accurately signed off by unit # of follow ups required	Process for monthly wound and treatment care summary will be in place by June 2025 There will be a 50% improvement in completion of Weekly PUSH assessments by July 2025 and 75% improvement by September 2025	