Experience

Measure - Dimension: Patient-centred

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
I am satisfied with the schedule of programs available.	C	% / LTC home residents	In-house survey / 2025	70.10	77.11	Goal is to increase indicator by 10% to 77.11% and to be higher than the Extendicare average of 76.20.	

Change Ideas

Change Idea #1 Provide daily routines to team members to ensure programming is occurring 3-4 x/day for each member.

Methods	Process measures	Target for process measure	Comments
1) Review existing schedules. 2) Provide daily routines for days and evenings. 3) Ensure 3-4 programs are added to each routine. 4) Avoid last minute changes. 5) Maintain a regular, predictable schedule with feedback from residents.	1) # of new routines reviewed and signed. 2) # of increased programs as a result of following standard on days and evenings. 3) % of positive feedback received from residents.	1) Daily routines will be reviewed, modified, and signed by April 2025. 2) Program offerings will increase by 5 as a result of new routines 3) Residents will provide feedback on program times 1x/year in RC or Program Planning Meetings.	

Measure - Dimension: Patient-centred

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
I have input into the recreation programs available.	C	% / LTC home residents	In-house survey / 2025	64.10	70.51	Goal is to increase indicator by 10% to 70.51% and to be higher than the Extendicare average of 65.60%.	

Change Ideas

Change Idea #1 Use real-time feedback tools such as evaluations of programs, seeking resident feedback on enjoyment and satisfaction of program in real time.

Methods	Process measures	Target for process measure	Comments
1) Select up to 5 programs per month to aduit. 2) Use evaluation templates, activitypro, or other documentation to complete. 3) Review and action after each evaluation.	1) # of audits completed throughout the year. 2) Rate of satisfaction of program. 3) # of Change actions.	1) 5 audits will be completed monthly to evaluate level of enjoyment/satisfaction. 2) There will be a 10% improvement with satisfaction of program by August 2025.	

Change Idea #2 Engage residents at monthly calendar planning meetings to seek input into the recreation programs available.

Methods	Process measures	Target for process measure	Comments
1) Plan monthly calendar meetings. 2) Discuss this indicator with the residents to. 3) Change/modify/add schedule of programs as necessary.	1) # of monthly calendar meetings. 2) # of times this indicator was discussed. 3) # of times the schedule was changed/modified, or programs were added.	Indictor will be discussed at all monthly calendar planning meetings.	

Measure - Dimension: Patient-centred

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
I am satisfied with the variety of recreation programs.	C	% / LTC home residents	In-house survey / 2025	74.70	82.17	Goal is to increase indicator by 10% to 82.17% and to be higher than the Extendicare average of 77.10.	

Change Ideas

Change Idea #1 Include a variety of 1:1, small, large group, and outings into monthly calendars.

Methods	Process measures	Target for process measure	Comments
1) Complete review # of group size offerings/month. 2) Complete review # of times residents are able to get into community. 3) Identify and address gaps in offerings. 4) Communicate gaps with residents in planning meetings and seek feedback. 5) Make changes based on feedback.	1) Increase in variety of group size offerings throughout monthly program calendar. 2) Reduced number of Residents at Risk each month. 3) Increase number of community outings. 4) Increase resident choice offerings via program planning meetings.	1) # of 1:1 programs will be increased weekly by 2. 2) # of small group programs will be increased weekly by 2. 3) # of large group programs will be increased weekly by 1. 4) Resident at Risk report will have 5 or less per unit on any given day as a result of changes to program offerings. 5) Monthly outings to the community will be offered March 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	9.63	9.40	Home below Extendicare and Provincial average. Striving for a 2.39% decrease to 9.40%.	

Change Ideas

Change Idea #1 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 April 2025 2) Environmental assessments of each of the identified resident rooms will be completed by May July 2025. 3) Lights will be installed by July 2025. 4) Review baseline vs. post installation data for falls for residents with enhanced lighting by December 2025.	

Change Idea #2 Review Activity programming during times when most falls occur.

Methods	Process measures	Target for process measure	Comments
1) Review times when most falls are occurring. 2) Review Program preferences for residents who are at risk of falls. 3) Implement program at time of day when falls are occurring 4) Monitor results.	1) # of residents reviewed who are high risk for falls. 2) % of program review completed. 3) # of new programs implemented during peak times for falls. 4) # of high-risk residents who did not fall during month when activity was occurring.	1) Review of falls and times when occurring will be completed by April 2025. 2) Review of high-risk resident's program preferences will be completed by May 2025. 3) Suitable fall program will be implemented during indicated times by June 2025.	

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	8.65	8.50	The home is below Extendicare and Provincial averages. This indicator has been higher in all other quarters: Q2 2024 10.70%. Q1 2024 14.70%. Q4 2023 15.80%. Q3 2023 15.80%. The goal is to strive for a 1.73% decrease to 8.50.	

Change Ideas

Change Idea #1 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 June 2025. 3) Alternatives will be in place and reassessed if not effective within 1 month of implementation with process in place by October 2025.	

Change Idea #2 Enhance collaboration with Behavioral Supports Ontario (BSO) Lead and interdisciplinary team.

Methods	Process measures	Target for process measure	Comments
1. Invite BSO lead to PAC meeting, or other interdisciplinary meetings for increased visibility 2. Remind staff to refer to BSO for supports	1). # of interdisciplinary meetings BSO invited to attend. 2.) # of monthly referrals to BSO	BSO will have increased collaboration and visibility in home by June 2025.	

Measure - Dimension: Safe

Indicator #6	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of residence who had a pressure ulcer that recently got worse.	C	% / LTC home residents	CIHI CCRS / 2025	0.50	0.48	Home is already below Extendicare and Provincial average. Striving for a -4.0% decrease to 0.48%.	

Change Ideas

Change Idea #1 Implement per unit 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 active Registered staff will have attended education sessions on tracking tool by June 2025. 2) Tracking tools will be correctly completed on a monthly basis by July 2025 3) Process for review, analysis and follow up of trends from tools will be 100% in place by August 2025.	

Change Idea #2 Adopt a new point of care (POC) alert process to notify nursing staff of by exception issues for early identification of skin issues

Methods	Process measures	Target for process measure	Comments
1) Educate staff on new alert process on all shifts 2) Registered staff to check end of shift for outstanding alerts 3) DOC/ADOC or designate audit compliance monthly and follow up with any additional educational requirements	# of staff that have been educated # of audits completed # of alerts that were completed on a monthly basis	1) Staff are educated on the new process by June 2025 2) Registered staff will complete 30 of audits by July 2025 3) Alerts will be 100% implemented on each unit by August 2025	