Safety | Safe | Optional Indicator

Indicator #3

Percentage of LTC home residents who fell in the 30 days leading up to their assessment (Hallowell House)

Last Year		This Year		
24.31	15	20.83	14.32%	15
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

1) Implement specific activity program at afternoon change of shift for residents who are at high risk for falls . 2) Conduct environmental assessments of resident spaces to identify potential fall risk areas and address areas for improvement

Process measure

- # of residents reviewed for activity needs/preferences weekly # of activity programs that occur during change of shift in afternoon weekly

Target for process measure

- Specific activity program at afternoon change of shift will be implemented by June 2024

Lessons Learned

We continue to review our change of shift activities to reduce high risk falls . We have been diligent in assessing the resident spaces to identify potential falls risks and it has assisted with reducing frequency of falls for some residents .

Comment

We have increased the frequency of falls meetings to 2x per month in order to facilitate early identification of trends and reduce the frequency of frequent falls for residents with multiple incidents. We have also looked at follow up with referrals with Physio to enhances strengthening and balance .

	Last Year		This Year		
Indicator #4	**23.53**	**10**	**17.00**	**27.75%**	**10**
Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment (Hallowell House)	**Performance (2024/25)**	**Target (2024/25)**	**Performance (2025/26)**	**Percentage Improvement (2025/26)**	**Target (2025/26)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

1) Medication reviews completed for all residents currently prescribed antipsychotics

Process measure

- # of residents reviewed monthly # of plans of care reviewed that have supporting diagnosis # of reduction strategies implemented monthly

Target for process measure

- All residents currently prescribed antipsychotics will have a medication review completed by July 2024

Lessons Learned

We have been able to reduce our residents who are on antipsychotics without a diagnosis of psychosis and currently we are meeting the provincial goal of 20.1%.

Change Idea #2 ☑ Implemented ☐ Not Implemented

2) Provide educational material to families and/or residents on antipsychotics and the importance of minimizing use.

Process measure

- # of families provided with best practice information on reducing antipsychotics monthly # of tour and admission packages provided with antipsychotic reduction information included monthly

Target for process measure

- Educational material will be provided to families and/or residents on antipsychotics and important of minimizing use by Sept 2024

Lessons Learned

The team reviews the medications on admission and identify usage that is not supported by a diagnosis. We review our findings take an opportunity during care conferences and educate around the safe usage of antipsychotics. The leads for Quality also participate in monthly meetings to review the current practice in home and address performance which has assisted in analysis of the program and performance of the home .

Comment

The team continues to enhance practices and educate the Registered staff on identifying the use of Antipsychotics in the home as well as ensuring proper diagnosis and usage .

Safety | Safe | Custom Indicator

Indicator #1

% of LTC residents with restraints (Hallowell House)

Last Year		This Year		
1.50	**0**	**3.60**	**--**	**NA**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

1) Review current restraints and determine plan for trialing alternatives to restraints

Process measure

- 1) residents reviewed monthly 2) meetings held with families/residents to discuss alternatives monthly 3) of action plans in place for reduction of restraints in collaboration with family/resident monthly

Target for process measure

- 100% of residents with restraints will be reviewed quarterly or as needed for reduction

Lessons Learned

The successes in the past year were that the home has not aquired any further restraints and continue to have 1 resident utilizing a seat belt . The challenges in reducing and meeting the goal of no restraints are related to family resistance . We continue to educate the family on restraint usage to remove the current restraint .

	Last Year		This Year		
Indicator #2 % of residents with worsened ulcers stage 2-4 (Hallowell House)	**11.30** Performance (2024/25)	**5** Target (2024/25)	**5.90** Performance (2025/26)	**--** Percentage Improvement (2025/26)	**NA** Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

1) Review current bed systems/surfaces for residents with PURS score 3 or greater.

Process measure

- # of residents with PURS score 3 or greater # of reviews completed of bed surfaces/mattresses monthly # of bed surfaces /mattresses replaced monthly

Target for process measure

- A review of the current bed systems/surfaces for residents with PURS score 3 or greater will be completed by August 2024

Lessons Learned

The home has been able to stay on course with reviewing the residents with a PURS score of 3 or greater

Change Idea #2 ☑ Implemented ☐ Not Implemented

1) Improve Registered staff knowledge on identification and staging of pressure injuries 2) Improve Registered Staff and PSW education of proper seating positioning and surfaces used

Process measure

- # of education sessions provided monthly for Registered staff on correct staging of pressure injuries # education sessions with restorative champion and wound care champions

Target for process measure

- 100% of registered staff will have received education on identification and staging of pressure injuries by Sept 2024

Lessons Learned

The Registered staff were provided with annual education on the Skin and Wound program . The leads and several Registered staff have received enhanced training in October and November of 2024. The percentage of residents with worsened pressure areas has decreased since last report although we have not quite reached the goal of 5% have

Comment

Although we did not quite meet our target, we were able to make significant progress this year. We will continue to work on this indicator for 2025.

Experience

Measure - Dimension: Patient-centred

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
I am satisfied with the quality of care from the dietitian	C	% / LTC home residents	In-house survey / Sept 2024- Oct 2025	9.50	50.00	To continue to improve performance as we strive to reach corporate target of 85%	

Change Ideas

Change Idea #1 Enhance resident and family members knowledge of the Role of the Dietician vs Nutritional Care Manager as well as enhance interaction between the Dietician and residents.

Methods	Process measures	Target for process measure	Comments
1.Create a short survey to gather more detailed information on the areas requiring improvement. 2. Analyse the results 3. Share with the dietitian and Nutritional Care Manager and gather input from the RD to create the action plan.3. Share action plan at Resident council 4. In six months survey the same residents and compare scores from previous survey	# of surveys sent # of surveys completed # of gaps identified # of Resident council meetings held where action plan discussed # of actions implemented # of follow up surveys completed	By May 30, 2025 a survey will have been sent to residents asking for feedback with at least 50% response rate. By June 30, 2025 100% of surveys will have been reviewed and action plan developed to address and shared with Resident council. By December 30, 2025 a follow up survey will be sent to residents and there will be a 25% improvement in results.	

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 from the doctors	C	% / LTC home residents	Other / Sept 2024- Oct 2025	31.80	85.00	to ensure 85% of the residents feel satisfied with the quality of care of the doctors	

Change Ideas

Change Idea #1 Review and improve current process for MD and NP rounds

Methods	Process measures	Target for process measure	Comments
1)Share the details of the survey results with the in-house physicians and NP and gather feedback from them on process for rounds. 2) Provide education to the Nurses completing rounds on any changes and to optimize contact between the MD and residents. 3) In 6 months resurvey the same residents and compare results	1) # of physicians and NP who reviewed survey results 2) # of feedback/suggestions for improvement received from physicians and NP 3) % of nurses who completed education session on rounds 4) % of residents surveyed in 6 months and results	100% of physicians and NP will have reviewed the survey results by June 1,2025 date. 100% of nurses will have completed the education on revised process by June 1,2025 date. By December 2025 there will be a 53% % improvement in results for this area in resident survey.	

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 religious and spiritual programs offered	C	% / LTC home residents	In-house survey / Sept 2024- Oct 2025	45.50	75.00	To continue to improve performance and work toward corporate target of 85%	

Change Ideas

Change Idea #1 Do a complete review of the Religious and Spiritual programs offered at the home.

Methods	Process measures	Target for process measure	Comments
1)Review the Current services provided by the home for the residents and current needs of residents .2) Complete an annual program evaluation on all current religious and spiritual programs as follow up to ensure gaps have been addressed. 3)Review the results and implement changes as requested.	% of review completed of the Religious and Spiritual programs offered in home % of residents requiring spiritual and religious programs # of programs offered currently % of program evaluation completed # of gaps identified and actioned	There will be a 100% review of the current spiritual and religious program in the home and services provided completed by June 30, 2025. Annual Program evaluation will be completed by September 30, 2025 and there will be 10% improvement in number of programs offered by December 30, 2025.	

Change Idea #2 Enhance the Cultural and Spiritual programs offered based on the Current population in the home. .

Methods	Process measures	Target for process measure	Comments
1) Create a short survey to gather information on cultural background, festivities and spiritual events celebrated by the current residents and review the results. 2) Create an action plan to include any new celebrations or practice not currently being recognized in the home. 3) Engage the necessary external partners to provide enhanced services. 4) If new programs initiated, create a short survey with the same residents to measure improvement after 6 months of implementation of new programs	# of surveys completed # of action plans created to address gaps in programs # of external partners engaged to provide enhanced services # of new programs initiated and % of positive feedback received	A survey will be conducted to gather information on spiritual needs with at least 25% response rate from residents by June 30, 2025. Action plan will be developed that addresses gaps in programming by August 30, 2025. At least 2 new programs will be initiated by December 30, 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	20.83	15.00	To meet the corporate benchmark.	Achieva, Behavioural supports Ontario

Change Ideas

Change Idea #1 Implement the new Falls Prediction and Prevention Report developed by Extendicare

Methods	Process measures	Target for process measure	Comments
1) Falls and Quality Leads to attend the education session by HO on use of FPPR report 2) Review residents on list and ensure strategies are in place to prevent falls 3) Monitor Progress based on data from report	1) # of education sessions 2) # of residents at high risk 3) # of plans of care reviewed to ensure strategies are in place 4) # of residents on list who did not expereince a fall in the previous 30 days	1) Training on Fall Prediction and Prevention Report will be completed by June 30.2025 2) residents listed on the report as being at risk of fall will have strategies reviewed by April 1,2025 3) Ongoing Monitoring to ensure strategies are effective are in place currently twice a month but we will ensure the monitoring currently in place aligns with the FPPR report	

Change Idea #2 Enhance Post Falls Huddles

Methods	Process measures	Target for process measure	Comments
1) Falls leads to review falls on a daily basis 2) Falls program education will be provided to all staff annually 3) The SALT program will be reviewed by all staff annually 4) Falls leads to attend and or review Post Falls Huddles documentation and provide further education as needed 4) Audits to be completed on SALT program procedures weekly and results reviewed by DOC and Falls Lead. 4) Plans of action for identified deficiencies will be put into place	# of Post falls huddles completed # of audits completed weekly # of deficiencies identified # of follow up education sessions required for trained staff	1) Staff SALT and Annual education to be completed by April 30,2025 2)Audits to be completed monthly and results reviewed at Falls Meetings twice monthly by March 31,2025	

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	17.00	10.00	We want to continue to reduce the use of antipsychotics without a diagnosis and maintain better performance than corporate target of 17.3%	Medisystem, Behavioural Supports Ontario, GPA

Change Ideas

Change Idea #1 1) Implement Extendicare's Antipsychotic Reduction program which includes using the Antipsychotic Decision Support Tool (AD-DST)			
Methods	Process measures	Target for process measure	Comments
1) Establish the AP home team 2) Education and Training for Leads by the Central QI team 3) Establish and Action Plan for residents inputted into the decision support tool	1) Home team established and education provided 2) Schedule regular meetings for antipsychotic review 3) Attendance at Monthly Quality labs 4) Percentage of residents with an action plan inputted	1) Home team is established by April 2025 2) Education and Training completed by April 2025 3) Antipsychotic review meetings to occurr every 2 weeks 4) Residents triggering the Antipsychotic QI have an action plan inputted into the decision suppert tool within 3-6 months of admission	For 2025 we are currently working on the monitoring and further reduction of antipsychotics for residents without psychosis

Change Idea #2 Collaborate with the physicians and Nurse Practitioners to ensure all residents using antipsychotic medications have a medical diagnosis and rational identified			
Methods	Process measures	Target for process measure	Comments
1) Complete medication reviews for residents prescribed antipsychotic medications on admission, monthly and as needed upon return from hospital 2) review diagnosis and rationale for antipsychotic medication 3) consider alternatives as appropriate - collaboration with Pharmacist where needed	1) # of medications reviews completed monthly 2)# of diagnosis that were appropriate for antipsychotic medication use 3)# of alternatives implemented	1) 75% of all residents triggered on ADS tool will have medication and diagnosis review completed to validate usage by June 2025 2) Alternatives will be in place and reassessed if not effective within 1 Month of implementation with the process in place by June 2025	

Change Idea #3 Enhanced Education for staff including Registered staff on Antipsychotic usage and Non Pharmacological methods to address responsive behaviors			
Methods	Process measures	Target for process measure	Comments
1) Inhouse GPA trained coach will be providing GPA education for all team members by July 1, 2025 . 2) PIECES and UFIRST Training will be completed by external Program providers for identified Champions by July 1,2025 3) education will be provided on the BSO external Program and referral process	1) # of staff who attended training session for GPA 2) # of staff who attended training for PIECES and UFirst 3) # of staff who receive education on the BSO Program	All education will be targeted for completed by July 1 , 2025	

Measure - Dimension: Safe

Indicator #6	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 or had a pressure ulcer that worsened to a stage 2, 3 or 4	C	% / LTC home residents	Other / October - December 2024	5.90	2.00	Corporate target	Solventum/3M, Wounds Canada

Change Ideas

Change Idea #1 Mandatory Training for all Registered staff on correct staging of pressure ulcers

Methods	Process measures	Target for process measure	Comments
1) Communicate to all Registered staff requirement to complete annual education 2) Registered staff to attend education provided 3) DOC / Skin and Wound Leads to monitor completion rates 4) Skin and Wound leads to audit documentation and ensure compliance with program and DOC to develope action plans to correct deficiencies	1) # of sessions communicated to registered staff on Annual Education for Wounds 2) # of registered staff who have completed education provided 3) # audits of completion rates for Registered Staff on education	Communication of education for wounds will be sent to all Registered staff by May 1, 2025. Education sessions will be held by June 1, 2025, with 100% of staff completed. Audits on completion rates will commence July 1st, 2025.	

Change Idea #2 Review Current bed systems / surfaces for residents with PURS Score of 3 or greater

Methods	Process measures	Target for process measure	Comments
1) develope a list of residents with PURS scores of 3 or greater 2) Skin and Wound team to review residents listed to determine if surface meets the residents needs 3) Replace mattress/ surface if required 4) Involve PT in meetings and communication around wounds with Skin and Wound leads	# of reviews completed monthly # of bed surfaces / mattresses replaced monthly # of PT referrals for proper seating cushions and bed surfaces	List of Residents with PURS score of 3 or greater will be completed by June 1,2025. Skin and Wound team will complete review of 100% of residents as determined by list by Jun 30, 2025. Process for replacing mattress/surface will be started by July 1, 2025. PT will be involved in wound meetings by April 1, 2025.	The home currently has biweekly meetings for skin and wound that is multidisciplinary and includes the PT and PTA

Change Idea #3 Improve the interdisciplinary approach to Skin and Wound program.

Methods	Process measures	Target for process measure	Comments
1) review the current membership of the skin and wound team 2) recruit new members and include a champion on each unit. 3) Standardize agenda and follow up by team on skin and wounds in the home 4) review the current tracking tool and trending for each home area 5) Include the Dietitian and PT where able for meetings	# of reviews completed on current membership # of new members recruited by discipline # of new members participating during the Q2 week meetings	Review of current membership and recruitment of members will be completed by April 30, 2025, and will include Physio and Dietitian. Review of tracking tool will begin by home area April 30, 2025.	

Measure - Dimension: Safe

Indicator #7	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of long-term care home residents in daily physical restraints over the last 7 days	C	% / LTC home residents	Other / October - December 2024	3.60	2.50	Coporate target	Achieva, Behavioural supports Ontario

Change Ideas

Change Idea #1 Provide information to families and residents on least restraint Provide education for staff to use when discussing restraints with residents or families

Methods	Process measures	Target for process measure	Comments
1) provide a restraint brochure in admission packages for new admission 2) meet with resident and family councils to provide education on Least Restraints and risks associated with Restraints 3) Implement a new FAQ document to assist with discussing restraints 4) Communicate with staff availability of new resources 5) Include PT for support in discussion of alternatives to restraint with families	# of admission packages with restraint brochure included # of meetings with Resident and family council to discuss least restraint policy # of time the FAQ was utilized monthly # of sessions held to communicate with staff that FAQ is available as a resource	100% of admission packages will contain a brochure on least restraint policy and use of restraints by April 2025 Staff will be aware of new resource when implemented by April 2025 100% of restraints will have alternatives trialed and documented by April 30,2025	The home currently has 1 restraint in use and we continue to connect with family to review alternative options to the seat belt usage for that resident