Experience | Patient-centred | Optional Indicator

Indicator #9

Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences". (The Village Seniors Community)

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

Change Idea #1 ☑ Implemented ☐ Not Implemented

Complete resident satisfaction surveys and encourage participation from all capable residents.

Process measure

- Increased participation in resident survey.

Target for process measure

- 70% participation from qualified residents (prior participation 66%).

Lessons Learned

Participation was improved this year from 67% to 85.3% of eligible residents. This question was not asked on this year's resident survey.

Comment

Survey question not asked - similar question of "I can raise concerns to staff" rated favorably at 79.3%. Score is over the organizational goal.

	Last Year		This Year		
Indicator #8	**CB**	**CB**	**CB**	**--**	**NA**
Percentage of residents responding positively to: "What number would you use to rate how well the staff listen to you?" (The Village Seniors Community)	Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Complete resident satisfaction surveys and encourage participation from all capable residents.

Process measure

- Increased participation in resident survey.

Target for process measure

- 70% participation from qualified residents (prior participation 66%).

Lessons Learned

Resident participation increased to 85.3% from 66.7% of eligible residents in 2023. A dedicated action plan was created to ensure a non-biased but relatively familiar member of staff was available to approach and re-approach residents to encourage participation and facilitate using our iPad-based survey app.

Comment

Question not asked on future surveys - unclear if this will continue to be a target. Residents answer positively (79.3%) that they can raise concerns to staff, and 99% that they trust staff in the home.

Experience | Patient-centred | Custom Indicator

	Last Year		This Year		
Indicator #10	**89.00**	**75**	**79.30**	**--**	**NA**
Resident Satisfaction – Residents Would Recommend this home to others (The Village Seniors Community)	Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

The home will implement an action plan based on the areas that need improvement from the survey with an overall goal of driving up the results of the "Residents would recommend to others" question in our annual surveys

Process measure

- 2024 Resident Surveys

Target for process measure

- 75% - Corporate Target.

Lessons Learned

Improved our maintenance task tracking process to ensure all maintenance requests are logged and tracked for auditing and quality assurance.
Residents are happy with the homelike atmosphere at our facility, and we encourage bringing in personal belongings, furniture, and memorabilia and assist with hanging and installation of items to promote belonging and comfort in the home.

	Last Year		This Year		
Indicator #11	**56.00**	**75**	**100.00**	**--**	**NA**
Resident Satisfaction I am satisfied with the quality of care from physio and occupational therapist. (The Village Seniors Community)	Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

- The home will have a new contracted physiotherapist in the home starting in January 2024. This physio therapist will be here 1 day per week and will participate in the MRCC Meetings weekly, Quality Committee Meetings quarterly and will be directly involved in resident assessment and physio treatment. - The home will offer to have the physiotherapist attend a Resident's Council Meeting if invited to discuss the different services available to the residents, answer resident questions and take resident - The home will post information related to physiotherapy services throughout the home for residents and families to review including contact information for inquiries.

Process measure

- 2024 Resident Surveys

Target for process measure

- 75% performance on future resident and family survey.

Lessons Learned

Despite the actions in place and the high level of involvement of the physiotherapist in the home assessing residents, family impressions of the physiotherapist remained low. Families and residents express an opportunity to increase education regarding the purpose and implementation of physiotherapy regimens for residents across the spectrum of needs.

Indicator #14

Resident Survey - I have input into the Recreation Programs Available—69% (The Village Seniors Community)

Last Year		This Year		
69.00	**75**	**88.50**	**--**	**NA**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

- The home will put out a survey to residents related specifically to the types of programs they would like to see offered in the home. The activity calendar will reflect programs that the residents would like based on this survey. - Residents Council will discuss programs as a standing agenda item at each of their monthly meetings and will be asked for input into what types of programs they would like to see on the calendar for upcoming months.

Process measure

- Review of implementations with residents council to discuss whether or not they feel the implementations are well received. 2024 resident satisfaction survey will ultimately be the measure of success.

Target for process measure

- 75% on Annual Satisfaction survey in 2024

Lessons Learned

We continue to have a robust residents' council and a defined planning process for future event calendars that involves all residents.

Indicator #13

Resident Survey - I am satisfied with temperature of my food (The Village Seniors Community)

Last Year		This Year		
70.00	**75**	**NA**	**--**	**NA**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

- Pleasurable Dining audits will be completed monthly. During these audits we will ensure that food temperatures are taken and recorded right before meal service. - Education will be provided to all dietary staff around ensuring food is kept covered until such time it is being served. This will also be a standing review during dietary staff meetings - Corporate audit of dining rooms to take place in April of 2024.

Process measure

- Audit results and education/process changes if warranted based on these results The 2024 Resident Satisfaction Survey Results will ultimately determine whether or not this action plan has been successful

Target for process measure

- 75% performance on future resident and family survey.

Lessons Learned

Question not asked on our most recent survey, however 93.1% of residents agree they are satisfied with food and beverage service, variety of options, and the dining room experience.

Indicator #12

Resident Satisfaction My care conference is meaningful discussion that focuses on what is working well, what can be improved and potential solutions - 70% (The Village Seniors Community)

Last Year		This Year		
70.00	**75**	**65.40**	**--**	**NA**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☐ Implemented ☑ Not Implemented

- A new schedule of care conferences will be created between DOC and Charge Nurse to ensure care conferences are carried out with residents present when they wish to be. - DOC will request to be invited by Residents Council and will discuss Resident Care Conferences. During this conversation will remind residents of their right to review their care plan and discuss what they feel is working well, what can be improved and potential solutions.

Process measure

- Ultimately, the 2024 resident satisfaction survey will determine the success of this action plan.

Target for process measure

- 75 target on annual action survey.

Lessons Learned

Care planning process remained a challenge related to staffing and vacancy needs in the home. Residents and families were kept in continual contact with the home about medications, care needs as per our usual process. This remains an action item for improvement in 2025.

Indicator #3

Family Survey - Families would recommend this home to others (The Village Seniors Community)

Last Year		This Year		
82.00	**85**	**100.00**	**--**	**NA**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

The home will implement an action plan based on the areas that need improvement from the survey with an overall goal of driving up the results of the "Families would recommend to others" question in our annual surveys

Process measure

- 2024 Family Survey review and action planning.

Target for process measure

- 85% performance on future family and resident survey.

Lessons Learned

Family engagement is low related to societal forces and home in outbreak at the time of the survey. Goal is to improve family participation and awareness for the 2025 survey, and to maintain high satisfaction results.

	Last Year		This Year		
Indicator #5	**61.00**	**70**	**100.00**	**--**	**NA**
Family Surveys - Quality of the physical building and outdoor spaces (The Village Seniors Community)	Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

1. The home will have a spring clean up completed including all gardens being weeded and prepped and courtyard cleaned up and prepped for spring use. 2. The home will utilize minor capital funding from the MOH for LTC Projects to ensure the physical building is upkept. This will include building upkeep to HVAC/Plumbing, Electrical and general repairs and maintenance. 3. The home will be replacing one dining room floor in 2024 as a capital project 4. Maintenance Care (software used to track and action on maintenance needs in the home) will be reviewed daily during morning leadership meetings. This review will allow the home to ensure outstanding required maintenance are being actioned on in a timely manner

Process measure

- Ultimately the success of these action plans will be determined based on results from the 2024 family surveys

Target for process measure

- 70% performance on future resident and family survey.

Lessons Learned

Families appreciate their ability to bring in personal items and have recreation, maintenance and nursing staff accommodate with installation and hanging of personal memorabilia to increase the home-like feel of the facility for our residents.

Indicator #4

Family Survey Laundry Services in the home are improving (The Village Seniors Community)

Last Year		This Year		
55.00	**70**	**83.30**	**--**	**NA**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

1. Laundry Job Routines will be updated in Q1 of 2024. Routines will be updated with input of the laundry staff as well as the ESM. 2. Complaint logs will be reviewed quarterly during Quality Committee Meetings. Any concerns of laundry will be discussed and reviewed for root cause and actioned to avoid trends or reoccurrence of laundry concerns. 3. A frequent routine has been developed amongst the service providers of our laundry machines and our chemicals to ensure that machines are up and running as designed and that chemicals are working properly within the machines 4. A new stain remover is being brought in to improve with stain removal during laundry services.

Process measure

- The overall success of this action plan will be measured by 2024 Family Satisfaction Survey Results.

Target for process measure

- 70% performance on future resident and family survey.

Lessons Learned

Specialized closet checks and inventory were implemented for a few residents at risk of excess clothing wear and tear related to behaviours and physical needs to good effect, reducing complaints and concerns of unaccounted-for laundry and items.

Safety | Safe | Optional Indicator

Indicator #7

Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment (The Village Seniors Community)

Last Year		This Year		
9.78	**18**	**X**	**--**	**12**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

1. Review of all residents receiving antipsychotic medications as required with the organization's Antipsychotic Deprescribing Program

Process measure

- Number of residents receiving antipsychotics without a diagnosis will remain below target/BSO will report on residents requiring or suitable for medication adjustments and reductions or continuation of current therapies in monthly meetings Residents receiving antipsychotic medications will have appropriate diagnoses on their charts and/or progress notes and care plan additions to support continuing treatment in the absence of a related diagnosis.

Target for process measure

- Continue to remain below target by obtaining appropriate diagnoses and participate in the organization's Antipsychotic Deprescribing Program throughout 2024.

Lessons Learned

New toolkit rolled out across the organization that prompts review of residents who take antipsychotic medications on a monthly basis, requiring review of interventions, physician follow-up and further steps to ensure appropriate use for all residents.

Indicator #6

Percentage of LTC home residents who fell in the 30 days leading up to their assessment (The Village Seniors Community)

Last Year		This Year		
12.09	**13**	**10.71**	**11.41%**	**10**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

1. Review of location, time and space trends for residents each quarter utilizing physiotherapy report provided quarterly along with falls prevention team 2. Participation of physiotherapist in weekly multi-resident care conference meetings and quarterly Quality Improvement meetings 3. Re-education of nursing staff regarding organization's fall policies and care planning requirements 4. Updating of admission assessment assignment process to reduce gaps in admission careplanning for residents at risk of falls and fall related injuries

Process measure

- Number of residents with no quarterly falls risk assessment or updated falls risk screen at time of fall to reduce to 0 by end of year 2024.

Target for process measure

- To remain below target on total resident falls throughout 2024.

Lessons Learned

New admission toolkits rolled out in the home to ensure quick review and assessment of resident risk of falls on admission. Monthly falls meetings in place with an interdisciplinary team to review individual resident falls and trends within the home. A new tool rolled out late in the year to allow staff to review time, place and contributing factors to falls across residents. Our BSO team has been re-established to help provide direction and implementation of dementiability programming for restless, wandering and at risk residents to reduce falls related to restlessness in the evenings in particular.

Safety | Effective | Custom Indicator

	Last Year		This Year		
Indicator #1 % of LTC residents with restraints (The Village Seniors Community)	**9.00** Performance (2024/25)	**17.30** Target (2024/25)	**0.00** Performance (2025/26)	**--** Percentage Improvement (2025/26)	**NA** Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

1) Review current restraints and determine plan for trialing alternatives to restraints 2) Re-educate staff on restraint policy and use of alternatives to restraints

Process measure

- # of action plans in place for reduction of restraints in collaboration with family/resident monthly # of education sessions held monthly

Target for process measure

- 100% of staff will be re-educated on restraint policy and alternatives to restraints by Sept 2024

Lessons Learned

Family and resident education was a high priority to reduce, remove, or avoid implementation of unnecessary resident restraints. Conversion to alternative methods to ensure resident safety as well as careful implementation of PASDs supported resident needs and safety while reducing risk.

Indicator #2

% of LTC residents with worsened ulcers stages 2-4 (The Village Seniors Community)

Last Year		This Year		
4.10	**2.50**	**5.10**	**--**	**NA**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Review current bed systems/surfaces for residents with PURS score 3 or greater. Improve Registered staff knowledge on identification and staging of pressure injuries

Process measure

- # of residents with PURS score 3 or greater # of reviews completed of bed surfaces/mattresses monthly # of bed surfaces /mattresses replaced monthly # of education sessions provided monthly for Registered staff on correct staging of pressure injuries

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

Lessons Learned

Staff are aware of the devices available and there are an ample number in the home. Some exploration was made of suitability for residents in niche circumstances with low or high bodyweight, etc. Bed and equipment audits were completed per our usual algorithm and mattresses replaced when needed.

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	