Quality Improvement Plan (QIP)

Narrative for Health Care Organizations in Ontario

March 26, 2025

Norfolk COUNTY

Ontario Health

OVERVIEW

Norview Lodge is a 179-bed Long-Term Care Home owned and operated by the Corporation of Norfolk County.

Norview Lodge is situated in an area surrounded by trees and wildlife with three landscaped courtyards featuring covered gazebos, and a pavilion. Norview Lodge has recently had some urban development around the home and there has been a commitment from the new developer to landscape with a peaceful and as close to rural atmosphere as possible. Norview has added additional parking for visitors and the increased number of staff.

The home is a two-storey building featuring eight home areas, one of which is a secure dementia area. Each home area provides both basic and private accommodation for either 22 or 23 Residents, a dining room and shared servery, spa, activity room, family room with fireplace, communication centre and medication room. The central area of the home includes a gift shop, public washrooms, meeting rooms, chapel, hair care salon, therapy room, and a gathering place.

Norview Lodge promotes quality improvement in its day-to-day operations. Our quality improvement plan involves a multidisciplinary approach which encourages and includes ongoing input from staff, through the CQI program process, and from Residents, family members and service providers through surveys, audits, and meetings.

Quality Improvement is on the standing agenda for departmental meetings. The Leadership Team reviews all recommendations and suggestions to determine if the implementation of these will be

successful and effective.

As per the Ministry of Long-Term Care regulations, a written response to all concerns from Resident and Family Council meetings are responded within 10 days.

Community partners such as the Alzheimer's Society, Senior Support Services etc. are integral in providing support and helping Norview to provide the best quality care to suit the individual needs of our Residents.

Norview Lodge's quality indicators show progress in achieving goals as well as reducing risks to Residents through enhanced monitoring of potential areas of concern.

ACCESS AND FLOW

Norview Lodge continues to work diligently to utilize additional funds provided to promote staff enhancement. From the 4 hours of direct care including the funds received for Allied Health Professionals, as well as the nurse practitioner funding, Norview Lodge has hired a Health Care Practitioner to perform the Nurse Practitioner duties within the home. In addition, Norview Lodge added a Supervisor, Education, Training and Infection Prevention and Control (IPAC) Back-Up. This position enhances our ability to educate staff, Residents, and families on all aspects of living and care within the Long-Term Care Home (LTCH). This position assists with improving our IPAC protocols which helps increase the health and safety of all Residents, staff, and family members.

Additionally, Norview Lodge added a permanent part-time Recreation Therapist to the Recreation department to provide additional programming coverage. These enhancements allow Norview Lodge to better serve the mental and therapeutic needs of its Residents. The stimulation that the recreation department provides supports the Residents in many ways.
Norview Lodge has a permanent full-time Restorative Care Aide to assist with required restorative care needs for Residents. Behavioral Supports Ontario (BSO) are an embedded model here at Norview Lodge. Two BSO members are on site for approximately 3-4 days per week assisting Residents. BSO staff provide support related to episodic referrals and transition support through admission. Also, BSO do enter the home for transitional leads and this provided support assists Residents from the community into the LTC home for up to 6 weeks.

We have added a new Medical Director and 2 Attending Physicians to our medical care team. We have also entered into a contract with the Local Led Nursing Outreach Team. They provide transitional assistance for newly admitted Residents to assist with the ALC overcrowding of beds in hospitals, provide and support detailed analysis of the capacity of homes and good fit with additional supports such as feeding suggestions, medical improvements and all nursing interventions.

EQUITY AND INDIGENOUS HEALTH

Norview Lodge is an equal opportunity LTC home as well as Norfolk County is an equal opportunity employer. Staff are provided with the ability to disclose additional languages that they can speak upon hire as well as throughout their employment. This information assists with Resident suffering from limitations of health conditions that bring them back to the primary cultural speaking ability.

Some examples of the training provided to staff are the Respectful Workplace and Violence Prevention Policy located on our electronic training platform Surge Learning. Norfolk County also provides corporate orientation in which some of the related topics addressed are workplace bullying and harassment including a video addressing unconscious bias, and respecting others.

Norview Lodge understands the importance of providing education and in 2025 will be providing education to all staff on complex topics of equity, inclusion, diversity, anti-racism, racial discrimination, human rights and Indigenous Health. Norfolk County, including Norview Lodge, observes and recognizes National Truth and Reconciliation Day as a statutory holiday.

As outlined in the Service Accountability Agreement (SAA), Norview Lodge must provide services in French, submit the appropriate French language reports and post documents in both English and in French.

PATIENT/CLIENT/RESIDENT EXPERIENCE

Norview Lodge takes this category very seriously as this is where there is an opportunity to make positive changes for our Residents and families.

There are questions asked on satisfaction surveys as well as consistent interaction with Residents both daily and at Multi-teams/Care Conferences. These survey questions are used in proactive plans to enhance the care needs identified by the Residents as well as by family members to created action strategies. In addition, Resident council meetings provide an interaction with Residents to find out their experiences, level of satisfaction and future needs.

When this information is received, many of the programs and interactions have tailored outcomes to achieve what is needed to enhance the Resident experience. Our Leadership Team is provided with department specific and related questions from the surveys as well as individual meetings (Resident, family council and multi-teams) to respond with outcomes. Norview Lodge has a very in-depth response process that also incorporates direct follow-up even if it is a phone call if that is what is requested.

Regular rounds, audits and inspections are conducted by members of the Leadership Team and applicable staff of their respective areas and responsibilities. Dining room, Health and Safety, Infection Control and Personal Safety Device Audits are conducted as required to continue to go over items and support staff, Residents and family needs.

The additional two Attending Physicians and Medical Director to our medical team aims to provide timely and better quality of services to all Norview Residents. The addition of the Local Lead Nursing Outreach team will ensure additional supports to new and current Residents for a wide variety of nursing elements.

PROVIDER EXPERIENCE

Norview Lodge is a department of Norfolk County and although that brings many benefits, these are challenging times for all LTCHs. While recruitment has taken on many required changes, Norview Lodge continues to do the best possible job to ensure staff feel educated and prepared for their start at Norview Lodge. Candidates are interviewed where they are given the opportunity to request workplace accommodation, as required. If successful, staff are then verbally offered the position where the conversation begins with a mutually agreed start date. This allows the candidate to ensure a significant length of time is provided for notice to their current employer as well as if they need to make a medical appointment or arrange items for home life that can be achieved. Recruitment, along with staff onboarding is now completed electronically, allowing for a reduction of paper however causing an increased dependence on technology for Norview Lodge, Norfolk County and the potential new employees.

When the staff are officially onboarded, they are provided in writing with enhanced direction of what is needed and the steps with time provided for this process. Staff orientation includes a complete first day of training usually with a coworker to go over all pertinent policies for both safety and Resident needs.

Norfolk County has found multiple ways to recognize staff. Staff appreciation events continue to happen recognizing significant years of service.

Norview Lodge continues to hire as required on an ongoing basis and as it is part of Norfolk County, is fortunate to provide a very respectful compensation package to all staff. In addition, Norview Lodge has a wonderful reputation within the community as well as surrounding areas. Many applicants come from within the community, but also other staff have been coming to Norview from surrounding locations. This has helped with our recruitment.

One of our main concerns is staff burn out along with recruitment and retention of staff. When it comes to staff burn out, we must adapt and find new, positive ways to address as previous methods are no longer applicable. The ability to remain flexible within the collective agreement, including shift switch flexibility was helpful as vacations were adapted to provide an opportunity for staff to have time off.

SAFETY

Whenever there is a near miss and/or actual incident that involves a Resident or staff member, these situations are reviewed by applicable staff, the Joint Health and Safety Committee and the Leadership Team to develop an action plan to reduce the risk and hopefully prevent any future recurrence.

All assessments that are conducted including Skin and Wound, Falls and Pain, provide an area of focus and potential improvement or at least action plans to assist for treatments moving forward. Other assessments require a review and potentially discussed outcomes at a committee meetings, such as Pharmacy and Therapeutics and Infection Prevention and Control (IPAC), where some of the information requires a more detailed discussion and analysis to happen.

Each Critical Incident (CIS) is reviewed and signed off. When the CIS is submitted, the analysis has begun to look for further development, and any potential improvements.

Staff have been educated in the category of risk management assessments. What this does is allow staff to have the ability to use critical thinking to look at a situation and make the best possible judgement to create a safe culture for staff, visitors, families and Residents.

PALLIATIVE CARE

Norview Lodge provides high quality palliative care services to all Residents through ongoing education to all direct care staff including personal support workers and registered staff on palliative and end of life care. These training courses examine the various choices available to individuals, the responsibilities of staff and caregivers and how to provide client focused support on this important matter.

Norview Lodge has a Palliative Care Committee committed to informing and providing staff with knowledge, updates and best practices relating to pain, palliative and end of life care. This committee contains staff from each department as well as community partners where staff have the opportunity to ask questions, discuss and review policies and procedures relating to pain management and palliative and end-of-life care.

Norview Lodge has implemented a Palliative Performance Scale (PPS) in order to assist staff with making better-informed decisions and information to provide to the Doctor regarding the care for each Resident.

Furthermore, Norview Lodge has created palliative care nursing kits and they are stored in each of the Resident Home Area Medication rooms to ensure that when a Resident is receiving palliative care or is end-of-life, these supplies are ready and available for the Resident. These kits are kept stocked with all the required supplies for quick and easy access. Palliative care carts have been created with support pamphlets, education, nourishments and supplies for family members that are located on each of the Resident Home Areas. Chairs and/or bed recliners are available to family members who wish to stay overnight with their Resident when they are palliative and/or end of life in the Resident's room.

POPULATION HEALTH MANAGEMENT

Norfolk County participles in the Associated Ontario Health Team by being involved in the executive leadership group. As well as members of Norview Lodge sit on the Complex Care Resolution Table, IPAC hub meetings for the surrounding area as community partners. Internally, Norview Lodge conducts quarterly medical advisory and pharmacy and therapeutic meetings which involve community partners. Norview Lodge is an active member AdvantAge which provides updates to all not-for-profit Long-Term care Homes in Ontario.

With the additions to the Norview Lodge medical team; a new Medical Director and two attending physicians, allows Norview Lodge to expand its areas of expertise and partner with more local medical professionals in the nearby area.

The contract with the Local Led Nursing Outreach Team is another supplement providing additional support to Norview Lodge Resident's from the community.

In addition, hospital and community or shared health services information is easily accessible. Some examples of additional community groups include the Alzheimer's society who provide staff training and support, and Senior Support Services offer transportation services. Norview Lodge' s Administrator sits on the Dementia Committee for Brant, Brantford Ontario Health Team.

SIGN-OFF

It is recommended that the following individuals review and sign-off on your organization's Quality Improvement Plan (where applicable):

I have reviewed and approved our organization's Quality Improvement Plan on March 26, 2025

Board Chair / Licensee or delegate

Administrator /Executive Director

Quality Committee Chair or delegate

Other leadership as appropriate

Access and Flow | Efficient | Optional Indicator

	Last Year		This Year		
ndicator #7					
ate of ED visits for modified list of ambulatory care–sensitive onditions* per 100 long-term care residents. (Norview Lodge)	**11.79**	**2.90**	**14.03**	**-19.00%**	**13.50**
	Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☐ Implemented ☑ Not Implemented

Provide education and awareness to Registered Staff/Resident/Families about what can be managed in house. 2. Utilize the ED transfer data, to assist the home in reasons that contribute to ED transfers.

Process measure

- 1. Number of ED Visits

Target for process measure

- Maintain number of ED transfers at status quo

Lessons Learned

This goal was not met and has been moved forward into 2025/26 QIP initiatives.
The tracking tool for ED visits was effective in aiding the home to review details surrounding each Resident transfer to hospital. It was identified that the most common reasons for hospital transfers were infections (UTI, pneumonia). Tracking of all hospital transfers will continue in 2025/26 with review of transfers at Medical Advisory meetings.
Norview Lodge added a Nurse Practitioner to the team in 2024 which was effective to provide additional accessibility to assessment for Residents in collaboration with the nursing staff.

omment

his goal was not met and has been moved forward into 2025/26 QIP initiatives. Staff will utilize the tracking tool for ED visits to review at committee meetings.

uity | Equitable | Optional Indicator

	Last Year		This Year		
ndicator #5 'ercentage of staff (executive-level, management, or all) who ave completed relevant equity, diversity, inclusion, and anti-acism education (Norview Lodge)	**CB** Performance (2024/25)	**50** Target (2024/25)	**154.41** Performance (2025/26)	**--** Percentage Improvement (2025/26)	**100** Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

1.Provision of in house education to Staff related to equity, diversity, inclusion and antiracism education

Process measure

- 1. Number of Staff who have received education

Target for process measure

- 1. As this will be an introduction of new education – current performance is 0% 2. Target is to increase number of educated Management and Registered Staff to 50%. 3. To complete training sessions with 68 staff by October 31, 2024 of the Management Team and Registered Staff.

Lessons Learned

Education was added to Surge Learning for completion. This goal was exceeded as the number of staff to receive the relevant training was 105. This education has been brought forward into 2025/2026 with the goal of having all staff at Norview Lodge to receive education.

:omment

ontinue with providing education to all staff through surge learning.

:perience | Patient-centred | Optional Indicator

	Last Year		This Year		
ndicator #3	**100.00**	**100**	**70.97**	**-29.03%**	**90**
'ercentage of residents responding positively to: "What number vould you use to rate how well the staff listen to you?" Norview Lodge)	Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

1. Increase awareness on how Residents can give feedback and provide their input on the care and services they receive 2. Provide more opportunities for Residents to provide feedback and input on their care

Process measure

- 1. Number of Surveys 2. Number of Residents Completing Surveys 3. Number of POA/SDM completing Surveys

Target for process measure

- 1. Increase number of Residents responding positively to "What number would you use to rate how well the staff listen to you?" to 100%?

Lessons Learned

The annual Resident Satisfaction Survey was revised to include a comment section after each question to encourage more opportunity for Resident feedback. The CQI Lead assisted Residents in completion of surveys. The Resident surveys were completed in person.
The CQI Lead attended monthly Resident Council Meetings to discuss changes that were happening around Norview Lodge, and to ask for any feedback, ideas and suggestions from Resident Council. CQI Lead did not attend Family Council meetings however feedback from family council members was provided through Family Satisfaction Surveys. This feedback was collected, and any concerns were addressed and followed up with by Management.
An information poster was created and posted in each Resident Home Area that outlined who to speak to depending on the nature of any questions, concerns, and/or suggestions.
Education on Resident Rights was provided on Surge Learning for all staff.

omment

ontinue to assist Residents with completing the Satisfaction Survey, utilize the information provided to provide improvements, provide information to staff, esident and Family Councils.

	Last Year		This Year		
ıdicator #4	**CB**	**100**	**61.29**	**--**	**87**
ercentage of residents who responded positively to the tatement: "I can express my opinion without fear of onsequences". (Norview Lodge)	Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

1. Provide more opportunities for Residents to give feedback and input on their care. 2. Send out Surveys with monthly billings to increase knowledge and ability of Residents and family members and encouragement to complete Surveys.

Process measure

- 1. Number of Surveys 2. Number of Residents Completing Surveys 3. Number of POA/SDM completing Surveys

Target for process measure

- 1. Increase number of residents who responded positively to the statement "I can express my opinion without fear of consequences" to 100%.

Lessons Learned

The Family Surveys were included in the monthly billings, and we saw an increase in Family Survey completion. The Family Survey was offered to all Families to complete.
60 Families/POA completed the Resident survey in 2024. This was an increase from 54 in 2023.
Resident Surveys were completed from April to December for Residents with a CPS score of 0-2. This was adjusted to include Residents with a CPS score of 3 as it was identified that Residents may score a 3 through use of a bed/chair alarm and were still able to complete Resident Survey.
There was a notable decrease in Resident Survey completion in 2024 related to Resident refusal to complete the survey.
31 Resident Surveys were completed in 2024 which was a decrease from the 60 Resident Surveys that were completed in 2023.
There will be a focus to increase Resident participation in surveys going forward into 2025/2026.

omment

ontinue to assist Residents with completing the Satisfaction Survey, utilize the information provided to provide improvements, provide information to staff, esident and Family Councils.

fety | Safe | Optional Indicator

	Last Year		This Year		
ndicator #2	**17.33**	**16**	**16.53**	**4.62%**	**15**
ercentage of LTC home residents who fell in the 30 days eading up to their assessment (Norview Lodge)	Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

1. Review details surrounding all Falls (time, place, repetitive falls) – Revision of Fall interventions as needed 2. Annual Training for all Staff (Surge Learning) 3. Post Fall Investigation/Post Fall Assessment by Registered Staff

Process measure

- 1. Number of Falls occurring in whole Home

Target for process measure

- 1. 100% of Falls reviewed Quarterly at Falls Committee Meeting 2. 100% of Falls reviewed by unit staff to identify contributing factors/fall prevention items in place/need for new/altered Fall prevention items 3. Number of Falls will decrease by 1.2%.

Lessons Learned

A reduction in falls was observed but the target was not met. This indicator will be carried over into 2025/26.
All falls were reviewed at the quarterly falls committee meetings to discuss circumstances surrounding falls, fall prevention items in place and steps and suggestions to prevent future falls. A Falls Committee Review progress note was created for documentation of falls review discussions. This progress note was also modified into a working tool to document circumstances surrounding each Resident and fall. This tool is provided to all falls committee members for review during falls committee meetings and attached to the falls committee review minutes.
Annual fall prevention education was added to the Surge Learning platform for all nursing staff to complete.
Post fall assessment continues to be completed by Registered staff with any witnesses to the fall. Fall intervention items are assessed and implemented as necessary.

omment

taff will continue to review Resident falls at the quarterly meetings, implement falls prevention measures, monitor progress notes, provide education and post alls assessments. All these measures will be used to assist to prevent Resident falls.

ıfety | Safe | Custom Indicator

	Last Year		This Year		
ndicator #6 'ressure Ulcers-Percentage of LTC Home Residents who leveloped a Stage 2 or higher pressure ulcer. (Norview Lodge)	**3.90** Performance (2024/25)	**2.90** Target (2024/25)	**3.15** Performance (2025/26)	**--** Percentage Improvement (2025/26)	**NA** Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

New Skin and Woung Application to be implemented in Point Click Care-Education for Registered Staff on how to use application. 2. Education for all Staff on Skin Care/Repositioning for pressure ulcer prevention. 3. Wound Care Nurse continues to complete rounds and assessments of wounds weekly.

Process measure

- 1. Number of Registered Staff Trained on using the Skin and Wound Application 2. Number of Nursing Staff receiving training on pressure ulcer prevention

Target for process measure

- 1. 100% of Registered staff feel comfortable using Skin and Wound Application to ensure information is accurate 2. 100% of all nursing staff will receive training on pressure ulcer prevention

Lessons Learned

There was an observed decrease in the development of new pressure ulcers. The Skin and Wound application was implemented in Point Click Care. Training was completed with all Registered Staff in use of the new Skin and Wound Application.
Education was included in Surge Learning for all nursing staff to complete with focus on skin care, pressure ulcer prevention and repositioning.
The Wound Care Nurse continues to complete weekly wound care rounds to assess and update wound plan of care for residents with high-risk wounds.

ndicator #1 nd of Life Care Discussions (Norview Lodge)	Last Year		This Year		
	0.00 Performance (2024/25)	**100** Target (2024/25)	**CB** Performance (2025/26)	**--** Percentage Improvement (2025/26)	**NA** Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Creation of a Goals of Care Discussion Progress Note. 2. Continue to use End of Life Care Plan templates within Point Click Care.

Process measure

- 1. Number of Residents/POA/SDM who have had Goals of Care Discussions documented in Resident chart. 2. Number of Residents receiving End of Life Care that have had EOL Care Plan initiated.

Target for process measure

- 1. Goal that 100% of New Admissions will have this implemented and working toward whole home documentation in Goals of Care Discussions progress notes. 2. Goal that 100% of Residents receiving End of Life Care will have Care Plan in place.

Lessons Learned

The Goals of Care Discission Progress Note was created and implemented for use for all new admissions coming into Norview Lodge. Discussion was completed by Social Service Worker and documented in Resident chart. This is available for nursing staff to review with Resident and POA/SDM on an as needed basis.
The End-of-Life care plan outline was utilized for all Residents receiving end-of-life care. This was implemented when end-of-life orders were received by the physician. A new set of End-of-Life care tasks were also created and implemented for Residents. This process will continue going forward.

Access and Flow

Measure - Dimension: Efficient

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Rate of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents.	O	Rate per 100 residents / LTC home residents	CIHI CCRS, CIHI NACRS / Oct 1, 2023, to Sep 30, 2024 (Q3 to the end of the following Q2)	14.03	13.50	Target was not met last year and will be carried forward into initiatives for 2025/26	

Change Ideas

Change Idea #1 1. Utilization of the Nursing Led Outreach Team to support nursing staff in assessment of Residents in home to reduce unnecessary transfers to hospital 2. Continue to use Hospital Tracking tool to review all hospital transfers and identify trends.

Methods	Process measures	Target for process measure	Comments
1. Collaboration with Nursing Led Outreach Team by Registered Staff and Physician to support in reduction of unnecessary transfer to hospital 2. Utilization of Hospital Tracking tool in to monitor details of hospital transfers. These details will be reviewed to identify trends	1. Number of ED Visits	1. The number of hospital transfers will be reduced by 0.53. 2. All hospital transfers will be reviewed	

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	154.41	100.00	1. We are aiming to increase the number of staff receiving relevant education to 100% by November 15, 2025.	

Change Ideas

Change Idea #1 Provision of in-house education to Staff related to equity, diversity, inclusion and anti-racism education

Methods	Process measures	Target for process measure	Comments
Education will be included on the Surge Learning platform for all staff to complete relevant education focused on equity, diversity, inclusion and antiracism.	Number of Staff who have received relevant education.	We are aiming to increase the number of staff receiving relevant education to 100% by November 15, 2025.	Total LTCH Beds: 179 Last year, all Management level and Registered Staff completed relevant education on equity, diversity, inclusion and anti-racism education. This year education will be given to all home staff with a goal for 100% of the home's staff to receive relevant education in 2025.

Experience

Measure - Dimension: Patient-centred

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of residents responding positively to: "What number would you use to rate how well the staff listen to you?"	O	% / LTC home residents	In house data, NHCAHPS survey / Most recent consecutive 12-month period	70.97	90.00	To increase positive percentage of respondents to 100%	

Change Ideas

Change Idea #1	1. Increase awareness on how Residents can give feedback and provide their input on the care and services they receive 2. Provide more opportunities for Residents to provide feedback and input on their care		
Methods	Process measures	Target for process measure	Comments
1. Revise Resident Satisfaction Survey with updated questions. Survey will be completed with each Resident this year in person by CQI Lead and/or designate. The Family Satisfaction Survey will continue to be available as a paper copy and electronically. 2. CQI Lead to attend bimonthly Resident Council Meetings to discuss changes, ask for feedback/suggestions from Council.	1. Number of Surveys 2. Number of Residents who completed Surveys 3. Number of Family Members/SDM/POA who completed Surveys	1. 100% of Residents will have a positive response to the question "What number would you use to rate how well the staff listen to you?"	Total Surveys Initiated: 31 Total LTCH Beds: 179

Measure - Dimension: Patient-centred

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences".	O	% / LTC home residents	In house data, interRAI survey / Most recent consecutive 12-month period	61.29	87.00	To increase positive percentage of residents to 100%	

Change Ideas

Change Idea #1 1. Provide more opportunities for Residents to give feedback and input on their care. 2. Continue to send out Surveys with monthly billings to increase knowledge and ability of Residents and family members and encouragement to complete Surveys

Methods	Process measures	Target for process measure	Comments
1. Revise Resident Satisfaction Survey with updated questions. Survey will be completed with each Resident this year in person by CQI Lead and/or designate. The Family Satisfaction Survey will continue to be available as a paper copy and electronically. 2. CQI Lead to attend bimonthly Resident Council Meetings to discuss changes, ask for feedback/suggestions from Council. 3. All surveys will be reviewed by the Leadership Team to identify and address any areas of concern	1. Number of Surveys 2. Number of Residents who completed Surveys 3. Number of Family Members/SDM/POA who completed Surveys	1. 100% of Residents will have a positive response to the statement "I can express my opinion without fear of consequences".	Total Surveys Initiated: 31 Total LTCH Beds: 179

Safety

Measure - Dimension: Safe

Indicator #5	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	16.53	15.00	1. The percentage of residents who fell will be reduced by 1.53	

Change Ideas

Change Idea #1 1. Utilization of the 4 P's Method to reduce falls 2. Continue to review all falls to identify precipitating factors and make recommendations for improvements

Methods	Process measures	Target for process measure	Comments
1. The 4 P's Method for reduction in falls will be implemented in the home 2. All falls will continue to be reviewed at Quarterly Falls Committee Meetings to discuss circumstances surrounding falls, fall prevention items in place and suggestions to prevent future falls.	1. Number of Residents who fell	1. The percentage of residents who fell will be reduced by 1.53.	

Measure - Dimension: Safe

Indicator #6	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	30.19	27.00	Ongoing review of anti-psychotic medication usage with each Resident at their 3 month review and education to staff.	

Change Ideas

Change Idea #1 1. Enhancing staff knowledge on trialing nonpharmacological interventions to minimize the usage of psychotropic medications by providing educational opportunities. 2. BSO Referrals to explore alternative to medication use

Methods	Process measures	Target for process measure	Comments
1. Review staff that are currently trained in GPA. Continue to offer education sessions to support all staff in updating their GPA to maintain currency. 2. All Residents receiving antipsychotic medication will be reviewed by physicians, pharmacy and team at medical advisory meetings to determine areas for reduction and/or elimination. 3. Referral to BSO for Residents who are receiving antipsychotic medications to explore alternatives to medication use	1. The number of staff attending GPA training courses 2. Number of Residents who received antipsychotic medication without a supporting diagnosis	1. 24 staff will receive GPA training by the end of year 2. Number of Residents given antipsychotic medication without a supporting diagnosis will be reduced by 3.19 3. 100% of Residents without a supporting diagnosis will be reviewed by BSO team to explore alternative interventions	

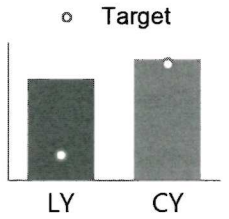
ACCESS AND FLOW

EFFICIENT

Rate of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents.

Last Year's Performance (LY)		Current Year's Performance (CY)	
11.8	**2.9**	**14.0**	**13.5**
2024/25	**Target**	**2025/26**	**Target**

↓ Lower is better

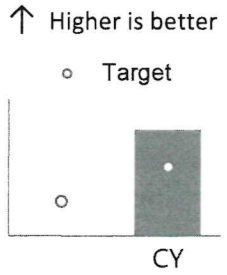


EQUITY

EQUITABLE

Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education

Last Year's Performance (LY)		Current Year's Performance (CY)	
CB	50.0	154.4	100.0
2024/25	Target	2025/26	Target

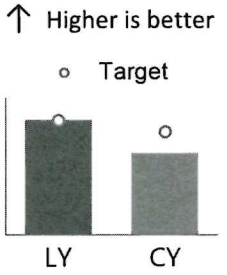


EXPERIENCE

PATIENT-CENTRED

Percentage of residents responding positively to: "What number would you use to rate how well the staff listen to you?"

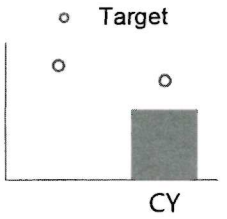
Last Year's Performance (LY)		Current Year's Performance (CY)	
100.0	100.0	71.0	90.0
2024/25	Target	2025/26	Target



PATIENT-CENTRED

Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences".

Last Year's Performance (LY)		Current Year's Performance (CY)	
CB	100.0	61.3	87.0
2024/25	Target	2025/26	Target



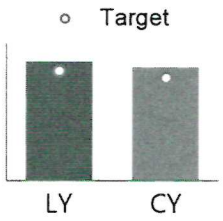
SAFETY

SAFE

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

Last Year's Performance (LY)		Current Year's Performance (CY)	
17.3	16.0	16.5	15.0
2024/25	Target	2025/26	Target

↓ Lower is better



SAFE

Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment

Last Year's Performance (LY)		Current Year's Performance (CY)	
36.1		30.2	27.0
2024/25	Target	2025/26	Target

↓ Lower is better