2025/26 Quality Improvement Plan for Ontario Long Term Care Homes
"Improvement Targets and Initiatives"

SOUTHBRIDGE CARE HOMES
Creating Caring Environments

Maitland Manor 290 SOUTH STREET, Goderich , ON, N7A4G6

AIM		Measure									Change				
Issue	Quality dimension	Measure/Indicator	Type	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	External Collaborators	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
M = Mandatory (all cells must be completed) P = Priority (complete ONLY the comments cell if you are not working on this indicator) O= Optional (do not select if you are not working on this indicator) C = Custom (add any other indicators you are working on)															
Access and Flow	Efficient	Rate of ED visits for modified list of ambulatory care–sensitive conditions* per 100	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	51210*	38.2	34.00	Aiming for a 10% improvement. Accounting for increased complex acuity		1)1) To reduce unnecessary hospital transfers, through the use of on-site Nurse practitioner; NP stat program (if avaliable)	1) Education and re-education will be provided to registered staff on the continued use of SBAR tool and support standardize communication between clinicians. 2) Educate residents and families about the benefits of and approaches to preventing ED visits. The home's	1) Number of communication process used in the SBAR format, between clinicians per month; 2) The number of residents whose transfers were a result of family or resident request. Number of staff who demonstrated education application via documentation quarterly. The	1) 80% of communication between physicians, NP and registered staff will	
Equity	Equitable	Percentage of staff (executive-level, management, or all) who have completed relevant equity,	O	% / Staff	Local data collection / Most recent consecutive 12-month period	51210*	100	100.00	Through education, the Home expects to have an increase understanding of		1)1) To improve overall dialogue of diversity, inclusion, equity and anti-racism in the workplace; by including Cultural Diversity	1) Training and/or education through Surge education or live events 2) Celebrate culture and diversity events; educational opportunities 3) Monthly quality meeting standing agenda- review the number of programs, education completed	1) Number of staff education on Culture and Diversity; 2) number of new employee trained of Culture and Diversity; 3) Number of CQI meetings completed with inclusion of Culture Diversity as agenda topic	80-100% of staff educated on topics of Culture and Diversity	Home will be increasing to 160 beds
Experience	Patient-centred	Percentage of residents who responded positively to the statement: "I can express my	O	% / LTC home residents	In house data, interRAI survey / Most recent consecutive 12-month period	51210*	89.33	93.00	Target is based on corporate averages. We aim to meet or exceed corporate		1)1)Review "Resident's Bill of Rights" more frequently, at residents' Council meetings monthly. With a focus on Resident Rights	Add resident right #29 to standing agenda for discussion on monthly basis by program Manager during Resident Council meeting. Re-education and review to all staff on Resident Bill of Rights specifically #29 and whistleblower policy at department meetings	Number of all department standing agendas will have Residents' Bill of Right #29 added. # of all staff who have education via department meetings on Resident Bill of Rights #29. Number of resident Council meeting that have Residents' Bill of Right #29 reviewed Number	100% of all staff and residents and families will have completed the education on	Will be going up to 160 beds
Safety	Safe	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	51210*	20.45	15.00	Target is based on corporate averages. We aim to meet or exceed,		1)1) Continue to facilitate a Weekly Fall Huddles on each unit; with the interdisciplinary team. For route cause analysis of falls	1) Complete a weekly meeting with unit staff and interdisciplinary team to review all falls generating new interventions to help prevent risk of falls or injury related to falls 2) Establish new restorative program lead and team, provide education on restorative	1)Number of weekly hall huddles completed 2)Members of team established. Number of staff educated on restorative program. Number of residents participating in restorative program. Number of quality meetings completed to include restorative program	1)At least 48/52 weeks have huddle completed 2)100% of restorative team will receive	
		Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7	O	% / LTC home residents	CIHI CCRS / July 1 to Sep 30, 2024 (Q2), as target quarter of rolling 4-quarter	51210*	8.04	8.00	We aim to continue to exceed provincial and corporate benchmarks.		1)1) The MD, NP, BSO internal and external (including Psychogeriatric Team), with nursing staff will meet monthly to review	1) Meetings held monthly by interdisciplinary team. Number of antipsychotics reduced as a result monthly. Number of PAC meetings held quarterly, where discussion and reviews on strategies have resulted in a decrease of antipsychotics; 2) BSO lead and nursing	1) Number of meetings held monthly by interdisciplinary team. Number of antipsychotics reduced as a result monthly. Number of PAC meetings held quarterly, where discussion and reviews on strategies have resulted in a decrease of antipsychotics;	1) Completed all 12 months with interdisciplinary participation 2) 100% of residents	
		Percentage of LTC residents who develop worsening pain	C	% / LTC home residents	CIHI CCRS / February 2025	51210*	13.06	10.00	Target is based on corporate averages. We aim to meet or exceed corporate		1)1. Enhancement of the end of life, palliative care program. 2. Utilization of pain tracker, to monitor the use of prn analgesic 3)	1. On admission screen residents for diagnosis of life limiting illness. Discuss palliative approach philosophy and palliative and end of life services available in the home. Complete assessment of the resident using Palliative Performance Scale score, involve the	1. A)Number of admission care conferences completed with documentation of palliative approach to care strategies discussed. B)Number of registered staff educated on palliative care program. C) Number of residents who have PPS assessment completed on	1. A)100% of admission care conferences B) 100% of registered staff will receive	
		Percentage of LTC residents who develop worsening pressure injury stage 2-4	C	% / LTC home residents	CIHI CCRS / February 2025	51210*	3.35	2.50	Target is based on corporate averages. We aim to meet or exceed corporate		1)1) Provide education and re-education on wound care assessment and management. Education provided by Wound	1) Arrange education for Registered staff and PSW, with Wound Specialist 2) Educate wound champion on referral process for wound specialist 3) Establish ROHO champions. Provide education on ROHO cushions to PSW/Reg staff	1) Number of staff attending education with wound specialist 2) wound champion completion of education. Number of wound specialist referrals completed monthly 3) Number of champions established. Number of staff educated on ROHO cushions	1) 2 staff per q6 week wound specialist visit 2) 100% wound champion	