Access and Flow | Efficient | Priority Indicator

Indicator #19	Last Year Performance (2023/24)	Last Year Target (2023/24)	This Year Performance (2024/25)	This Year Target (2024/25)
Rate of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents. (Woodingford Lodge - Ingersoll)	X	0	X	0

Change Idea #1 ☑ Implemented ☐ Not Implemented

Woodingford Lodge Ingersoll is aiming to maintain this performance by communicating with practitioners prior to sending a resident to the ED.

Process measure

- 1) The number of resident's sent to the ED 2) The number of resident's sent to the ED that could have been prevented/managed within the facility.

Target for process measure

- 1) The number of residents sent to ED each quarter will remain consistently low as we have seen in previous years. 2) The number seen here will be low or as close to "0" as possible

Lessons Learned

This goal has been met, as Woodingford Lodge Ingersoll continues to have very low numbers of transfers to the ED. Current number from the MOLTC is NR (not reportable as it is lower than the reportable amount).

Experience | Patient-centred | Priority Indicator

	Last Year		This Year	
Indicator #17 Percentage of residents responding positively to: "What number would you use to rate how well the staff listen to you?" (Woodingford Lodge - Ingersoll)	**38.46** Performance (2023/24)	**78** Target (2023/24)	**41.18** Performance (2024/25)	**NA** Target (2024/25)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Despite achieving high results Woodingford Lodge Ingersoll knows initiates are imperative to maintaining this high standard.

Process measure

- 1) Education to be provided in orientation and annually on Surge Learning. 2) Residents will have this process completed as part of their admission process.

Target for process measure

- 1) 100% of new hires will receive training in orientation and 100% of current staff will receive training annually on Surge 2) 100% of residents will have this survey completed and put into their care plan

Lessons Learned

All staff did receive training on the residents bill of rights and resident and family centered care. Residents and families also receive education on admission. A residents satisfaction survey is completed annually to provide Woodingford Lodge with their opinions on the services offered and their experience in the home.

Indicator #18

Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences". (Woodingford Lodge - Ingersoll)

Last Year		This Year	
78.57	**83**	**94.44**	**NA**
Performance (2023/24)	**Target (2023/24)**	**Performance (2024/25)**	**Target (2024/25)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

Despite achieving high results Woodingford Lodge Ingersoll knows initiates are imperative to maintaining this high standard.

Process measure

- 1) Education to be provided in orientation and annually on Surge Learning. 2) Total number of residents/POA's/families participating in FTP vs admissions 3) Total number of anonymous suggestions/concerns vs those with follow up

Target for process measure

- 1) 100% of new hires will receive training in orientation and 100% of current staff will receive training annually on Surge 2) Increase the number of residents/POA's/families participating in FTP by 50% of their current participation rates 3) 100% suggestions & concerns will have follow up within a timely manner

Lessons Learned

All staff did receive training on the residents bill of rights, resident and family centered care and retaliation. Residents and families also receive education on admission. A residents satisfaction survey is completed annually to provide Woodingford Lodge with their opinions on the services offered and their experience in the home.

Safety | Safe | Priority Indicator

Indicator #16

Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment (Woodingford Lodge - Ingersoll)

Last Year		This Year	
10	**10**	**13.39**	**NA**
Performance (2023/24)	**Target (2023/24)**	**Performance (2024/25)**	**Target (2024/25)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

Antipsychotic Reviews will be completed by BSO RPNs using the Antipsychotic Review Assessment Tool on a quarterly basis. This will be reviewed quarterly by the NP, and Pharmacy for further review with family and resident at annual care conferences. BSO RPNs and Pharmacy will examine our resident's diagnoses and medications as well prior to annual care conferences to decrease inappropriate medication usage. Admissions and Transitions will have increased supports to decrease the need for antipsychotic use on admission for responsive behaviours due to change in environment.

Process measure

- 1) % residents receiving antipsychotic medications without diagnosis 2) % residents receiving antipsychotic medications total 3) # gradual dose reductions generated from antipsychotic reviews quarterly by NP/BSO RPNs, and annually by BSO RPNs/Pharmacy

Target for process measure

- 1) Ingersoll –maintain below the provincial benchmark (2023) 2) Dose Reductions: Ingersoll- max 4/month

Lessons Learned

This goal was implemented and will continued to be reviewed routinely in the home. All residents who currently receive an antipsychotic medication were reviewed to ensure that they have diagnoses or a reason to support the use of the medication. The goal for 2024/2025 will be to reduce the percentage in the home.

Safety | Effective | Custom Indicator

Indicator #14

Percentage of home care patients who developed a stage 2 to 4 pressure ulcer (Woodingford Lodge - Ingersoll)

Last Year		This Year	
8.20	**4**	**6**	**NA**
Performance (2023/24)	**Target (2023/24)**	**Performance (2024/25)**	**Target (2024/25)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

1.Skin and Wound Application implementation and continuous review 2. Wound rounds occurring monthly in all home areas 3. Dietician to be notified of all compromised skin integrity

Process measure

- 1.100% of nursing staff feel comfortable using skin and wound application to ensure that information is accurate 2. All stage 2 or greater wounds being assessed monthly 100% of the time 4.Referral being sent to dietician 100% of the time that a new skin issue is identified

Target for process measure

- 1.To see nursing working at full scope and implementing treatments within their scope 2. To ensure timely treatment for residents identified as having altered skin integrity. 3.To see improvement in the stage 2-4 worsening wounds numbers based on strategies of early nursing interventions and early dietary consultation

Lessons Learned

The first two change ideas were initiated in the home and were a success. All wounds are now being assessed via the skin and wound app on PCC. However further education is required for staff, as some have decreased wound knowledge. Education will be a goal for 2024 with the hiring of a full time Wound Care Nurse. Wound care rounds were initiated in the home starting in August and have been successful at reviewing residents who are high risk. Wound care rounds have been an improved communication method to allow for the dietician to be informed, however this does not occur 100% of the time.

Indicator #12

Palliative - Increase volunteers available for residents at End-Of-Life (Woodingford Lodge - Ingersoll)

Last Year		This Year	
CB	**5**	**NA**	**NA**
Performance (2023/24)	**Target (2023/24)**	**Performance (2024/25)**	**Target (2024/25)**

Change Idea #1 ☐ Implemented ☑ Not Implemented

Increase the number of volunteers that are available to provide support at End Of Life for Woodingford Lodge Ingersoll Residents.

Process measure

- Number of available volunteers.

Target for process measure

- Will have 5 volunteers available for EOL support

Lessons Learned

This did not occur during 2023/2024. This goal has been moved to an internal focus for 2024/2025. The home has a goal of connecting with a local hospice to determine if some of their volunteers would also like to volunteer at this facility.

	Last Year		This Year	
Indicator #15 Percentage of long-term care home residents who experienced moderate pain daily or any severe pain during the 7 days prior to their most recent resident assessment (Woodingford Lodge - Ingersoll)	**9.30** Performance (2023/24)	**5** Target (2023/24)	**19.10** Performance (2024/25)	**NA** Target (2024/25)

Change Idea #1 ☐ Implemented ☑ Not Implemented

Currently the screening times are not ideal at capturing accurate pain levels. With the adjustment of these times and the prompt and proper follow up it is the expectation that Woodingford Lodge Ingersoll could capture unmanaged pain and implement strategies and/or orders to alleviate or improve the level of pain

Process measure

- 1) Refer to NP when residents have a pain score of 2 or 3 on their RAI Assessment 2) Comprehensive pain assessments completed on residents who have unmanaged pain that meet the criteria for the assessment 3) Ensure follow-up is completed post comprehensive pain assessment

Target for process measure

- 1) Resident's with pain scores of 2 or 3 will have a decrease in their score on their next assessment 2) Residents with incidents of unmanaged pain will have a comprehensive pain assessment completed 3) Education to staff regarding indications of pain and sequences of interventions to be put in place for those experiencing pain

Lessons Learned

This goal was not met for 2023/2024 as seen in the significant increase in the percentage of residents in the home having pain. These goals will become an internal focus for 2024/2025 for the Woodingford Lodge pain committee.

Indicator #2

Continence: Percentage of residents with an indwelling catheter. (Woodingford Lodge - Ingersoll)

Last Year		This Year	
5.30	**1**	**7.10**	**NA**
Performance (2023/24)	**Target (2023/24)**	**Performance (2024/25)**	**Target (2024/25)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

Woodingford Lodge Ingersoll needs to look at factors that may increase the need for residents to have indwelling catheters. Consequently Woodingford Lodge will look at any factors that are modifiable keeping the goal of a 5 % overall decrease in this number for 2023.

Process measure

- 1) Number of residents requiring an indwelling catheter. 2) For those residents complete a bladder scan at designated times of the day.

Target for process measure

- 1) 100% of residents with indwelling catheters to be assessed for possible removal in 2023. 2) All newly admitted residents with indwelling catheters be assessed for possible removal in 2023.

Lessons Learned

The number of residents with a catheter did increase at WDFL Ingersoll, despite reviewing each individual. There are a few residents that were attempted to have their catheter out, but retain urine and had to be reinserted. This was successful in ensuring that only those who medically required a catheter had them. This change idea will continue into 2024 as a standing process in the home.

Indicator #1

Continence - Percentage of Resident's with Worsened Bowel Incontinence. (Woodingford Lodge - Ingersoll)

Last Year		This Year	
20.30	**15**	**16.20**	**NA**
Performance (2023/24)	**Target (2023/24)**	**Performance (2024/25)**	**Target (2024/25)**

Change Idea #1 ☑ **Implemented** ☐ **Not Implemented**

To affect change in this indicator Woodingford Lodge would need to determine factors contributing to fecal incontinence in the residents.

Process measure

- 1) Identify those residents requiring PRN laxative use on a monthly basis. 2) For those residents review the routine laxative regime with the NP and fluid intake levels with the RD for possible adjustment.

Target for process measure

- 1)100% of residents requiring PRN laxative use to be reviewed by DOC/SCR of the unit in partnership with the NP.

Lessons Learned

Not all residents were routinely assessed. However, when looking at PRN laxative use and adjusting routine accordingly did help improve worsening bowel. Also having a discussion with the RD to help with dietary options was successful.

Indicator #11	Last Year		This Year	
Palliative - Improve documentation at EOL (Woodingford Lodge - Ingersoll)	**CB** Performance (2023/24)	**CB** Target (2023/24)	**NA** Performance (2024/25)	**NA** Target (2024/25)

Change Idea #1 ☐ Implemented ☑ Not Implemented

Reg Staff to initiate TAR Items/POC Tasks for Residents receiving Palliative Care including: Palliative Oral Care and Turn/Reposition Schedule A Palliative Care focus in the Care Plan will be initiated at EOL which includes MD/NP Palliative Consultation; Nursing; Recreation; Physiotherapy; Spiritual An End of Life progress note will be completed each shift once a person is deemed EOL.

Process measure

- 100% Residents at EOL will have these measures implemented

Target for process measure

- POC Tasks and Palliative Care Plans will be initiated

Lessons Learned

This did not occur during 2023/2024. This goal has been moved to an internal focus for 2024/2025. The home has a goal of creating and then implementing a End of Life check list to ensure that all EOL tasks are completed, including proper documentation.

	Last Year		This Year	
Indicator #10	**CB**	**CB**	**NA**	**NA**
Palliative - Improve communication at EOL (Woodingford Lodge - Ingersoll)	**Performance (2023/24)**	**Target (2023/24)**	**Performance (2024/25)**	**Target (2024/25)**

Change Idea #1 ☐ Implemented ☑ Not Implemented

Reg Staff to send referrals to NP and Dietician for all Residents with PPS =/<30% Reg Staff will initiate Palliative Consultation Note with AAR (Assessment, action and response) after reviewing Resident with NP/MD.

Process measure

- % Residents at EOL will have these measures implemented

Target for process measure

- 100% of Residents at EOL will have these measures implemented.

Lessons Learned

This did not occur during 2023/2024. This goal has been moved to an internal focus for 2024/2025. The home has a goal of creating and then implementing a End of Life check list to ensure that all EOL tasks are completed, including referring to the NP/RD.

Indicator #13

Palliative - Review EOL Questionnaires annually (Woodingford Lodge - Ingersoll)

Last Year		This Year	
CB	**CB**	**94**	**NA**
Performance (2023/24)	**Target (2023/24)**	**Performance (2024/25)**	**Target (2024/25)**

Change Idea #1 ☑ **Implemented** ☐ **Not Implemented**

Implement a review cycle to ensure that all end of life questionnaires are reviewed annually with Resident's and/or their Power of Attorney.

Process measure

- % EOL Questionnaires reviewed annually

Target for process measure

- 100% EOL Questionnaires reviewed annually

Lessons Learned

This was completed in 2023/2024. At the beginning of quarter 1 100% of residents had their EOL survey completed, however half way through quarter 4 this number dropped to 94% with the goal of 100% before the end of the quarter. The home also reviewed the annual care conference process to include a portion on the EOL survey. This allows for responses to be discussed and determine if any changes need to be made.

Indicator #9

Palliative - CLRI Palliative Care Initiative continued engagement in goals of project. (Woodingford Lodge - Ingersoll)

Last Year		This Year	
CB	**CB**	**CB**	**NA**
Performance (2023/24)	**Target (2023/24)**	**Performance (2024/25)**	**Target (2024/25)**

Change Idea #1 ☐ Implemented ☑ Not Implemented

Increase multidisciplinary team knowledge on Palliative Care to create a support team for residents and families at EOL. With end goal being formal support at EOL is added as an expansion of our already existing Family Transition Program which focuses on supporting residents and families on admission to LTC.

Process measure

- Metric #1: Develop and implement plan for support of residents and families at EOL Metric #2: % of residents/families supported/month Metric #3: Create and implement EOL care survey with CLRI Metric #4: % of surveys completed/month

Target for process measure

- Metric #1 Goal: Summer 2022 Metric #2 Goal: 80% or greater Metric #3 Goal: Summer 2022 Metric #4: 80% or greater

Lessons Learned

This goal was not met in 2024. Residents and families were supported at end of life but no formal processes created. Palliative care will be an internal focus at Woodingford Lodge for 2024/2025. End of life survey's were completed in the home and as of Feb 1, 2024 94% of the survey's were completed with the goal of having 100% completed by March 31, 2024.

Safety | Safe | Custom Indicator

Indicator #20

Residents who have had worsened behavioural symptoms (Woodingford Lodge - Ingersoll)

Last Year		This Year	
19.90	**16**	**13.80**	**NA**
Performance (2023/24)	**Target (2023/24)**	**Performance (2024/25)**	**Target (2024/25)**

Change Idea #1 ☑ **Implemented** ☐ **Not Implemented**

1) Providing options for the admission process, to enable the family and caregiver to better support their loved one moving in on move-in day (ex. alternate day to complete paperwork) 2)All staff in WFL trained in GPA, beginning with frontline care providers

Process measure

- 1)Number of admissions supported into WFL with a diagnosis of dementia and/or a history of responsive behaviours are reviewed prior to admission, supported with the transition on move-in day, and supported by Transitions and BSO Team 3)Number of staff GPA trained

Target for process measure

- 1) 100% of transitions into the home are reviewed and supported with caregiver obtaining background personhood information prior to moving in 3) 100% of frontline staff trained in GPA

Lessons Learned

This goal was met and there was a reduction in the number of residents with worsening behaviours in the home. All staff are being trained in GPA, to learn how to better approach aggressive residents. The homes embedded BSO team continues to be active in the home and provides support to residents, families and staff members.

Indicator #3

Decrease Percentage of residents who have fallen and Increase staff knowledge re Curbell alarms/ set up and reduce falls risk and improve Resident safety.
(Woodingford Lodge - Ingersoll)

Last Year		This Year	
18.90	**3.70**	**24.70**	**NA**
Performance (2023/24)	**Target (2023/24)**	**Performance (2024/25)**	**Target (2024/25)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

Review SURGE learning modules and ensure that the best videos are used for falls prevention/ falls harm reduction strategies Educate staff re: CURBELL ALARMS (how to set up properly) Wall mounted curbell boxes, to reduce falls risk and improve Resident safety.

Process measure

- All staff have an understanding of how to set up a curbell alarm for bed or chair.

Target for process measure

- Staff will complete annual surge modules related to falls and curbell alarm set up/use. Wall mounted curbell boxes, to reduce falls risk and improve Resident safety by eliminating a longer cord and lengthen the life of the Curbell monitors by ensuring they are not dropped or knocked off the bed. The mount keeps the monitors in a consistent place so that staff do not have to search for the monitor to shut it off and ensures it is easily audible when sounding.

Lessons Learned

The number of residents who have fallen increased at Woodingford Lodge Ingersoll despite annual education and education on curbell alarms. This quality indicator will be on the 2024 QIP for the facility as there is still improvements that need to be made to decrease the number of residents who fall in the home.

Indicator #8

IPAC - Increase the number of staff that are current and up-to-date with fit testing (Woodingford Lodge - Ingersoll)

Last Year		This Year	
52	**100**	**100**	**NA**
Performance (2023/24)	**Target (2023/24)**	**Performance (2024/25)**	**Target (2024/25)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

Create a sustainable program with dedicated and trained staff to complete fit testing over a regular and predictable schedule

Process measure

- Metric 1: Staff are trained and available as needed to complete the fit testing Metric 2: Regular schedule set covering all 3 shifts and all 3 sites Metric 3: Staff are current with their fit testing by end of 2023

Target for process measure

- Goal 1: Sustainable program established which enhances respiratory protection of WFL staff and reduces exposures to occupational hazards Goal 2: Quarterly schedule Goal 3: 55 % of active employees

Lessons Learned

Fit testing remained a priority throughout this QIP cycle and new employees were trained to fit staff with a N95. All staff at Woodingford Lodge that were required to be fit tested for a N95 mask had this completed.

	Last Year		This Year	
Indicator #4 IPAC - Ensure all staff are familiar with and practice 4 moments of hand hygiene. (Woodingford Lodge - Ingersoll)	**100** Performance (2023/24)	**100** Target (2023/24)	**100** Performance (2024/25)	**NA** Target (2024/25)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Create a sustainable hand hygiene auditing program with dedicated and trained staff to complete over a regular and predictable schedule

Process measure

- Metric 1: Review surge learning records with education supervisor yearly (November) to determine if staff are missing components of their learning requirements Metric 2: Staff receive a copy of the policy and are expected to have read Metric 3: ABHR placement, exp. dates and accessibility to sinks are audited using COVID-19 self- assessment tool Metric 4: Each home unit will perform weekly audits that are multidisciplinary

Target for process measure

- Goal 1: 85 % of staff have completed surge learning with outstanding modules being completed within 30 days of review Goal 2: 85 % of all staff Goal 3: ABHR is available 100 % of time at point of care Goal 4: 4 moments of hand hygiene are practiced by all staff 85 % of the time

Lessons Learned

Hand hygiene auditing process has been adjusted throughout the year and different auditing platforms have been trialed in the home. Currently the home is using Health Connex and this is working well for front line data collection. The policy on hand hygiene has also been updated and distributed to staff and new ABHR dispensers have been installed in the home.

Indicator #5	Last Year		This Year	
IPAC - Ensure resident room set up for Additional Precautions (AP) has the correct signage and equipment (Woodingford Lodge - Ingersoll)	**CB** Performance (2023/24)	**100** Target (2023/24)	**100** Performance (2024/25)	**NA** Target (2024/25)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Create an accessible and no fail process for staff to set up a room for the necessary additional precautions when residents are at risk of transmitting disease. Create an opportunity for educating, auditing and feedback.

Process measure

- Metric 1: Complete packages for AP are accessible to staff at the onset of precautions being put into place and photo of set up is with equipment Metric 2: Review surge learning records with education supervisor yearly (November) to determine if staff are missing components of their learning requirements Metric 3: Resident rooms with AP's are audited using COVID-19 self assessment tool q 2 wks and when initiate

Target for process measure

- Goal 1: Packages are ready-to-go with outbreak equipment as per bi-weekly audit with COVID self- assessment tool Goal 2: 85 % of staff have completed surge learning with outstanding modules being completed within 30 days of review Goal 3: 95 % of rooms have correct signage, equipment and timely removal when dc'd

Lessons Learned

PPE and isolation precaution process for the home was reviewed. Policies were reviewed, signage updated to make it easier to understand and follow, and supplies have been audited. The IPAC team in the home have also made "grab and go" packages for all of the different types of isolation in the home. These packages contain all of the correct isolation signage that is required to be placed on a residents door or in the residents room. This change idea was a success.

Indicator #7

IPAC - Ensure the infection and control lead designated under the FLTCA, 2021 works regularly in that position on site at the home (Woodingford Lodge - Ingersoll)

Last Year		This Year	
CB	**17.50**	**17.50**	**NA**
Performance (2023/24)	**Target (2023/24)**	**Performance (2024/25)**	**Target (2024/25)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

Ingersoll site requires a dedicated IPAC lead who has the education and experience in IPAC practices as per FLTCA and can provide on site IPAC support for a minimum of 17.5 hours/week

Process measure

- Metric 1: Recruitment process to be initiated. Metric 2: Successful candidate to be provided education, orientation and training for the role to support best practices in the home. Metric 3: Support the preparation to certify with the Certification Board of Infection Control and Epidemiology (CIC) within 3 years of the act coming into force

Target for process measure

- Goal 1: Process initiated in March and completed in April 2023 Goal 2: Provide access to IPAC education through an accredited education institution meeting IPAC requirements Goal 3: Encourage mentoring opportunities, communities of practice to learn and share, offer tools required to prep for the exam

Lessons Learned

Met - Ingersoll did appointment an IPAC lead for the home who was there for a minimum of 17.5 hours a week. This individual did complete education to help them move towards being CIC trained. However in January 2024 this individual decided to leave this role in Ingersoll, therefore a new lead would need to be recruited. This has occurred and there is a new individual in this role who is taking education and planning to write their CIC exam.

	Last Year		This Year	
Indicator #6 IPAC - Ensure that the training for staff in infection prevention and control (IPAC) at orientation and yearly cover the topics required by the FLTCA, 2021. (Woodingford Lodge - Ingersoll)	**CB** **Performance (2023/24)**	**100** **Target (2023/24)**	**100** **Performance (2024/25)**	**NA** **Target (2024/25)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

Ensure the surge learning modules required to provide staff education and re-training are up-to-date and meet the requirements of Act and best practices offered by Accreditation Canada. Ensure there is auditing of completion of surge learning modules. Ensure there is opportunity for learners to evaluate their learning and provide feedback once modules are completed. Ensure staff know where to find policies to support IPAC and practices.

Process measure

- Metric 1: All staff at orientation are offered the required training topics as outlined, in person and surge learning Metric 2: All staff are offered yearly re-training on the required topics as outlined, in person and or surge learning Metric 3: Review surge learning records yearly (November) to determine if staff are missing components of their learning requirements Metric 4: IPAC audits and feedback to be used to determined knowledge gaps

Target for process measure

- Goal 1: 100 % of topics covered at orientation meet FLTCA requirements and re-evaluated yearly. Goal 2: 100 % of staff are offered core competencies modules Goal 3: 85 % of staff complete the training within the year Goal 4: 85 % of audits demonstrate competency with feedback/ re-training offered prn

Lessons Learned

Goal Met - 100% of staff at Woodingford Lodge completed IPAC training modules as part of their annual education.