

Quality Improvement Plan (QIP)

Narrative for Health Care Organizations in Ontario

May 15, 2025

OVERVIEW

Glen Stor Dun Lodge (also known as “The Lodge”) is a 132-bed non-profit home, offering long term care and outreach services to the citizens of our community. The Lodge is a municipal long-term care home proudly owned and operated by the City of Cornwall and provides support to citizens of Cornwall and the United Counties of Stormont, Dundas, and Glengarry.

The Lodge is a four-story building where the ground floor consists of social amenities and community areas. The three upper floors are resident areas with 108 private rooms (two of which are short-stay rooms), 12 semi-private rooms (with two beds each), resident galleries, dining rooms, activity rooms, and personal care areas.

The Lodge houses a special care unit with 44 residents divided into male and female home areas a garden with a raised vegetable bed. A gardening program is available for all special care residents.

The Lodge also runs Outreach Programs: Meals on Wheels - offering 25,000 meals per year to the community; Alzheimer's and Senior Day Programs (in English and French) and a Telephone Assurance Program.

This year's Quality Improvement Plan will help us focus on quality of life by targeting emergency department avoidance, improved resident experiences and engagement, and decrease anti-psychotic medication utilization while also prioritizing equity diversity and inclusivity within our home. Our goal is to build on our successes and strive to maintain and exceed provincial averages by reviewing our Quality Improvement Plan goals on a quarterly basis.

ACCESS AND FLOW

The Glen Stor Dun Lodge recognizes the importance of providing the necessary care to our residents within the home and avoid unnecessary hospital visits.

Since the recruitment of our part-time Nurse Practitioner, we have elevated our patient care by diagnosing, treating, and managing acute and chronic illnesses. The NP also assists with ordering and interpreting diagnostic tests. Their assistance has been crucial in mitigating and avoiding unnecessary transfers to the hospital. During the past year, our Nurse Practitioner has also been able to utilize and train staff on our new bladder scanner, which has provided diagnostics capabilities within the home, further preventing unnecessary hospital visits.

With the addition of new equipment and technologies in our home, along with associated education and training for our staff, we can provide a greater reassurance to the residents and their families. This allows staff the ability to complete accurate diagnosis in-house and avoid transfers to the hospital when not necessary.

Glen Stor Dun Lodge has purchased an ECG machine that will enhance services provided to our residents and further decreasing unnecessary ED visits. We are hoping to have the training complete and ECG equipment utilized by the end of 2025.

Lastly, we are excited to share, the Lodge has ordered a wheelchair accessible van that will be arriving in summer of 2025.

We will continue investing in education and technology for our staff to streamline and expedite diagnostic and treatment capabilities,

overall enhancing residents' care within our facility.

EQUITY AND INDIGENOUS HEALTH

The Glen Stor Dun Lodge, in alignment with the Corporation of the City of Cornwall, is committed to the prioritization of equity diversity and inclusion. We are fortunate to be geographically located in proximity to our indigenous neighbors in Akwesasne.

Initiatives planned for 2025, include welcoming indigenous peoples from Akwesasne and share their cultural traditions, participate with residents through traditional activities, and display their artwork with our residents and staff.

In 2025, the Glen Stor Dun Lodge will continue training and education to advance our employees' awareness of equity, diversity and inclusion, along with its importance when serving our residents and their families. We are proud to be a part of a Corporation that recognizes National Day of Truth and Reconciliation. We continuously strive to raise awareness surrounding the painful history of our indigenous neighbors along with the ongoing impacts of residential schools. Participation in events surrounding National Day of Truth and Reconciliation are promoted annually, and staff are encouraged to attend.

Currently at The Lodge, we have two employees who sit on the municipality's Equity, Diversity and Inclusion Committee. This has been a great asset with information sharing enlightening our representative with upcoming education sessions, events, and resources that can be brought back to our staff and shared. Also within the facility, we have a Spiritual, Cultural and Awareness initiative, which shares and educates on one spiritual, one cultural, and one awareness event for every month. In 2025, we will have an

official Spiritual, Cultural, and Awareness Board in the main lobby to have these educational pieces on display for residents, families, and staff.

PATIENT/CLIENT/RESIDENT EXPERIENCE

The Glen Stor Dun Lodge continues to promote the Resident/Caregiver survey in order to gather feedback about resident experiences and their feelings surrounding the care offered in our home.

Our home is always looking for new and innovative ways to engage with our residents and receive their feedback. We want to support residents with the completion of the survey while also making it easy and accessible and easy to complete we are reviewing how our team can assist in helping residents complete the survey while also looking at how surveys and input from families can be more easily obtained we have implemented an electronic platform for soliciting feedback as well as using Care Conferences to help promote the survey completion.

The Glen Stor Dun Lodge obtains input from our Resident Council and Family Council. Both of these councils allow information surrounding concerns and opportunities for improvement to flow through our Social Worker to the appropriate member of the leadership team for follow up.

The Lodge continues to support not only residents experiences, but seniors within our community as well with programs such as: Meals on Wheels (hot and frozen meal deliveries), Senior Day-away program (offering social, emotional, cognitive, and physical experiences), and Telephone Assurance program (volunteers calling seniors in the community to encourage social interactions with others). Surveys for these clients occur annually to obtain feedback,

and ideas for future improvement and program development.

As we continue to review and develop innovative ways to engage with our residents, we are committed to promoting resident-centered care, where residents can feel empowered to openly communicate and be a part of the shared decision-making process.

PROVIDER EXPERIENCE

The Glen Stor Dun Lodge, despite its ongoing human resource challenges, has continued to develop strategies to support and invest in our employees.

In 2024, the Glen Stor Dun Lodge began on-boarding according to the completed Service Delivery Review recommendations and we continue with the recruitment process to fill vacancies.

In the past year, we created a casual pool of registered staff, to ensure provider experience continues even when regularly scheduled staff are away, before deploying agency for coverage. To mitigate the impacts of staff shortages, the Glen Stor Dun Lodge continues to on-board employees from staffing agencies to ensure our employees have adequate support and coverage to assist them in caring for our residents. These agency staff members receive the same training as new Glen Stor Dun Lodge employees and are only called to assist with coverage as a contingency for unplanned absences. The home is hoping to reduce the usage of agency staff particularly registered staff, with the implementation of our Service Delivery Review staffing model as internal staffing and coverage will become more stable..

The Glen Stor Dun Lodge has continued to support the Unity

Committee, which is the multidisciplinary team that recommends and develops strategies to improve processes, boost morale, in hopes of benefiting both, staff and residents.

This year we created internal email accounts for all our staff to encourage more efficient communication. To improve staff morale, information shared includes: newsletters (highlighting events), shooting star initiative, shout-outs to coworkers, and updates to keep informed.

Increasing mobile technology has improved efficiency and experience of the staff, which enables staff to chart even while being with residents, and continuing care.

This year, we will be initiating Meal Suites menu programing to enhance the dinning experience for residents and staff. Introduced communal snack, which has helped bring staff together to work collaboratively.

We strive to promote a more positive work culture by improvement staff recognition and morale.

Finally, the Glen Stor Dun Lodge is frequently viewed as the top selection for students who are required to perform placement in long term care setting. We are fortunate to welcome a large pool of students each semester who receive an introduction to long-term care, earn valuable hands-on experience, and potentially return to the home as an employee of the Lodge, following the completion of their education.

We have also successfully participated in the CCPN, LEAP and BEGIN subsidy programs, where students feel financially supported while

completing their program. The placement partnerships that the Glen Stor Dun Lodge is a part of, further enable our own staff to take on roles as preceptors giving them valuable opportunities to apply their own skills they have learned in their careers, while mentoring upcoming students in the sector.

SAFETY

We, at the Glen Stor Dun Lodge, continue to prioritize safety. The Lodge is constantly looking for new and innovative ways to keep our home a safe place to live and work.

The Resident Safety Committee at the Glen Stor Dun Lodge meets on monthly basis to review residents' safety concerns (both individual and as a home). This team consists of nursing leadership, RAI coordinator, physiotherapy, CQI, staff development, BSO, and social worker. Meaningful discussions are held to assess whether staff have the resources available to ensure their safety in the home, or whether additional supports such as fall mats, chair alarms, adjusting toileting schedules, and/or updating individual care plans are necessary.

Staff education and training plays a critical role in our ability to prioritize safety in our home. Health and safety training for all staff is organized is a corporate wide initiative. Yearly training schedule for emergency management is proactively planned and scheduled. In addition to training, we are continuing to review and update policies and procedures and incorporate any updates and changes into our training procedures.

In the past year, an Automated Dispensing Cabinet was purchased and implemented. Upon completion of staff training, this unit provided access and security of the home's emergency drug supply,

reduced medication errors, and support collaboration with our pharmacy provider.

This year, we will be working with ISMP to implement improvement to medication safety. We have started the project by focusing on our medication records on readmissions after hospitalization, as it was determined they have not completed in full: they were not transcribed properly into the residents' chart, missing proper coding, secondary signature is missing, or diagnosis was missing. We are striving to improve the medical records to prevent medication errors and promote resident safety.

Glen Stor Dun Lodge will be implementation of Lab Integration module to Point Click Care (PCC) software. This module will allow staff to both request lab work and also receive completed lab work directly via our PCC dashboard. This initiative is led by Ontario Health to get homes off faxing their lab work and will streamline and expedite the lab requisition to lab results workflow process.

Infection Prevention and Control (IPAC) measures continue to be an important means of safety promotion within our home. These evidence-based practices and procedures help us to prevent and reduce the risk of transmission of microorganisms to our staff, residents, and visitors. Audits and application of best practices are conducted regularly, inclusive of staff education for how to keep themselves and the residents safe from contracting and spreading illnesses. **Tea room remodeling to meet IPAC standards and accessibility standards. Home improvement enhancement. Furniture in the home have been replaced, and continue to be replaced to meet IPAC standards - in common resident areas and staff areas.

The facility will also be undergoing several renovations to enhance safety in the home. Glen Stor Dun Lodge will be replacing the ageing flooring on three of the four floors which will reduce tripping hazards and support infection control as we will be removing the remainder of the carpeted floors.

All of our emergency exit signage is being updated and replaced, and the exterior building is also receiving some maintenance. In late 2025, we have plans to add accessible spa tubs to the resident Tub Rooms.

PALLIATIVE CARE

Over the last few years, the Glen Stor Dun Lodge has further noted an increased demand for palliative care. An interdisciplinary Palliative Care Committee was formed to review and assess the supports being offered to residents and families experiencing this difficult transition while remaining focused on providing the highest quality of life for residents. Some of the initiatives generated by this committee share a multidisciplinary approach. The Nutrition Care Team has implemented Comfort Cart (self-care items), and Nutrition Carts (refreshments and non-perishable food items) for resident and families, and complimentary meals are provided to families. Efforts such as this prioritize families having quality time with their loved one, without having the need to leave and seek food or refreshments.

The home has also made arrangements to dedicate some funds to support meals costs for families who are in the home with their loved one who is palliative.

The Glen Stor Dun Lodge has also introduced an Honour Guard which enables residents and staff to pay tribute to a deceased

resident. There is an announcement of “Honour Guard” over the intercom when funeral home prepares the resident for departure. This allows other staff and residents to line the hallway and lobby to pay their respects. The Honour Quilt is to be draped over the deceased resident before they exit their room. Lastly, an angel figurine is placed at the resident’s place in the dining room for three meals so everyone can acknowledge the loss.

Inclusive to the facility’s initiatives, we receive and review all feedback from residents and their families and continue to incorporate improvements to our care and support.

POPULATION HEALTH MANAGEMENT

The Glen Stor Dun Lodge has noted changes in our demographics over the past few years, along with increases in unique needs and varying health conditions of our residents.

Over the last year, we have seen a greater population of residents requiring varying behavioural support. The revitalization of the Responsive Behaviours Committee is well prepared to properly assess what supports can be put in place at the home. We further have sought implement more on-on-one supports when PSW and Resident Care Aides resources are available. This has been helpful in providing residents with responsive behaviours with necessary attention and support. We further want to enhance our staff’s knowledge of responsive behaviours so that they have the confidence to effectively support our residents. We have continued our required annual training including behavioural supports and best practices.

As mentioned previously, we observed an increase in palliative care requirements and adapted by creating a Palliative Care Committee

to review, assess our current processes and provide recommendations for improvement. we have also had an increased number of bariatric requirements, as a result, we are enhancing our admission process so that the residents' required aids are prepared prior to admission.

At the Lodge, we continue to work with external health services to encourage all around care is available to our residents. Hearing aid and dental care clinics are held monthly, and we offer complete pharmaceutical care to our residents. We also have trained wound care staff to support specific, complex wound care needs, and physiotherapy is available in-house for residents. During the influenza season, we partner with the local health unit and local paramedic services to complete influenza vaccinations for the interested residents.

To encourage residents’ well-being, we foster social and emotional stimulation by providing stimulating activities daily as provided by out recreation staff. Our Recreologists plan activities based on their residents’ interests, physical and cognitive abilities. They promote an inclusive and stimulating environment for the residents to thrive.

The Lodge also provides an outreach program to host those still living out in the community but offering a space to regularly meet others and enjoy stimulating activities.

CONTACT INFORMATION/DESIGNATED LEAD

Monty Domingo, Deputy Administrator of Operations, 613-933-3384 Ext 4215

OTHER

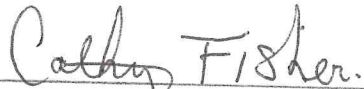
Cathy Fisher, Administrator

SIGN-OFF

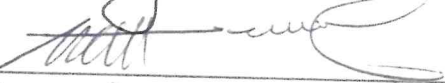
It is recommended that the following individuals review and sign-off on your organization's Quality Improvement Plan (where applicable):

I have reviewed and approved our organization's Quality Improvement Plan on **April 1, 2025**

SGardiner@cornwall.ca, Board Chair / Licensee or delegate



Cathy Fisher, Administrator /Executive Director



Monty Domingo, Quality Committee Chair or delegate

Other leadership as appropriate

EFFICIENT

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

Last Year's Performance (LY)

21.2 **20.8**

2024/25

Target

Current Year's Performance (CY)

30.0 **20.0**

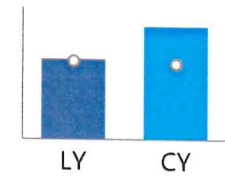
2025/26

Target

ACCESS AND FLOW

↓ Lower is better

○ Target



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)

3.4

2024/25

100.0

Target

Current Year's Performance (CY)

47.4

2025/26

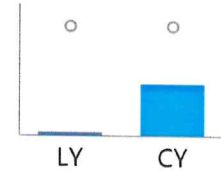
100.0

Target

EQUITY

↑ Higher is better

○ Target



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)

85.5 **100.0**

2024/25 Target

Current Year's Performance (CY)

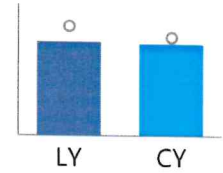
84.1 **90.0**

2025/26 Target

EXPERIENCE

↑ Higher is better

○ 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)

88.9 **100.0**

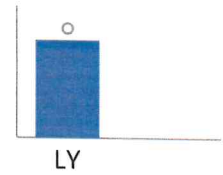
2024/25 Target

Current Year's Performance (CY)

2025/26 Target

↑ Higher is better

○ Target



SAFETY

SAFE

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

Last Year's Performance (LY)

27.2 **15.5**

2024/25 Target

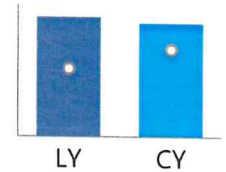
Current Year's Performance (CY)

25.8 **20.0**

2025/26 Target

↓ Lower is better

○ Target



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)

18.3 **16.0**

2024/25 Target

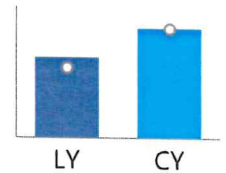
Current Year's Performance (CY)

25.0 **25.0**

2025/26 Target

↓ Lower is better

○ Target



Access and Flow | Efficient | **Optional Indicator**

Indicator #6	Last Year		This Year		
	Rate of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents. (Glen-Stor-Dun Lodge)	21.18 Performance (2024/25)	20.83 Target (2024/25)	30.00 Performance (2025/26)	-41.64% Percentage Improvement (2025/26)

Change Idea #1 Implemented Not Implemented

Invest in diagnostic equipment to help support facilitating care within our home and avoid the need for transfers to hospital.

Process measure

- Number of new diagnostic pieces of equipment implemented.

Target for process measure

- 100% of new equipment fully utilized by end of 2024.

Lessons Learned

Bladder scanner and butterfly scanner implemented.

Change Idea #2 Implemented Not Implemented

Provide reassurance and education to families who frequently request their loved one be transferred to the hospital when not necessary.

Process measure

- Number of families who receive support/education.

Target for process measure

- All families who frequently request hospital transfers receive support/education by end of 2024.

Lessons Learned

The data for this has not been formally tracked, although the clinical staff informally reassure families and advise when a transfer to the ED is not necessary. Care Conferences have been an area to discuss ED transfers, where clinical staff can educate and reassure families that the resources and diagnostic tools utilized in the home are in place the reduces unnecessary visits to the ED.

Change Idea #3 Implemented Not Implemented

Conduct quarterly evaluations of all ED transfers.

Process measure

- Number ED transfers reviewed

Target for process measure

- Reduction in rate of ED visits by end of Q4.

Lessons Learned

Discussed at quarterly CQI and monthly resident Safety meetings.

Change Idea #4 Implemented Not Implemented

Enhance palliative care supports within our home

Process measure

- Number of new initiatives/supports generated surrounding palliative care.

Target for process measure

- A minimum of two new initiatives/supports generated by the end of 2024.

Lessons Learned

We strive to continuously evaluated and implement care that fits our residents and their families' needs during this difficult time.

Comment

ED transfers are regularly discussed at a several meetings to ensure preventative measures are being taken, families are being reassured and educated, and staff are well-informed and trained on appropriate ED transfers.

Equity | Equitable | Optional Indicator

Indicator #5	Last Year		This Year		
	Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)
Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education (Glen-Stor-Dun Lodge)	3.38	100	47.37	1301.48 %	100

Change Idea #1 Implemented Not Implemented

Provide all employees with meaningful Equity, Diversity and Inclusion training.

Process measure

- Number of staff trained.

Target for process measure

- 100% of staff receive training by end of 2024.

Lessons Learned

We have included the EDI training as a part of the annual training for 2025-2026.

Change Idea #2 Implemented Not Implemented

Issue voluntary census to be completed by all staff

Process measure

- Number of employee census' completed.

Target for process measure

- 100% of census' completed would be ideal, to give a more accurate representation of the make-up of our workplace.

Lessons Learned

Only management staff were polled and questionnaire was specific to training completion. Staffing and training took precedence and we were unable to find a proper avenue to complete a census.

Change Idea #3 Implemented Not Implemented

Seek out opportunities to enhance staff, resident and family awareness of topics under equity, diversity and inclusivity through communications and information sessions.

Process measure

- Number of initiatives launched/promoted to support staff, resident and family enhanced awareness.

Target for process measure

- A minimum of one initiative promoted per quarter.

Lessons Learned

The Unity Committee has one spiritual, one holiday, and one awareness day the recognize and promote each month. These topics are promoted in the monthly newsletters, and advertised on our Unity Board. We have invited many guest speakers and hosted a variety of cultural events for residents and staff.

Change Idea #4 Implemented Not Implemented

Conduct a review of accessibility within the Glen Stor Dun Lodge documentation.

Process measure

- Number of documents reviewed and updated to meet accessibility standards and/or translated.

Target for process measure

- All frequently used external forms/documents be reviewed by end of 2024.

Lessons Learned

Several policies were reviewed and/or revised: Wheelchair, customer service, complaints, zero tolerance/abuse, resident safety policies to name a few.

Comment

Although a census was not formerly conducted, we remain positive that our efforts have been diverse and inclusive of a variety of cultures and learning opportunities for residents, their families, and our staff.

Experience | Patient-centred | Optional Indicator

Indicator #3	Last Year		This Year		
	Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)
Percentage of residents responding positively to: "What number would you use to rate how well the staff listen to you?" (Glen-Stor-Dun Lodge)	85.45	100	84.06	-1.63%	90

Change Idea #1 Implemented Not Implemented

Educate employees on resident-centered care.

Process measure

- The number of staff who complete the training.

Target for process measure

- 100% of employees complete the LTCO. Respecting and Promoting Resident Rights in Long-Term Care training.

Lessons Learned

Staff are to complete training annually on resident-centered care methodologies.

Change Idea #2 Implemented Not Implemented

Review and amend the survey to enhance quality of resident feedback.

Process measure

- Number of enhancements made to survey.

Target for process measure

- Revised survey to be reviewed, revised and distributed to all residents by Q3 of 2024.

Lessons Learned

Paper and digital copies are now available. We will be looking to edit the survey this year for further feedback on areas for improvement.

Change Idea #3 Implemented Not Implemented

Increase the number of completed resident surveys.

Process measure

- Number of residents surveyed per month.

Target for process measure

- 80% return rate on all surveys issued in 2024.

Lessons Learned

No data found on completion of survey in previous years, 2024-2025 was collecting baseline. We are hoping to evolve the survey and increase the number of residents and families responses.

Comment

While we are still gathering baseline survey results, 81% of respondents felt they were always or usually listened to. We hope to continue receiving positive feedback and enhance our quality of care by ensuring residents' feedback is received and new ideas implemented. We continue to advertise survey to encourage residents and their families complete the survey.

Indicator #4	Last Year		This Year		
	Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)
Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences". (Glen-Stor-Dun Lodge)	88.89	100	NA	--	NA

Change Idea #1 Implemented Not Implemented

Promotion of Residents' Bill of Rights and GSDL Whistleblowing Policy

Process measure

- Number of formal communications/engagements with residents/families surrounding the Residents' Bill of Rights and Whistleblowing Policy.

Target for process measure

- 100% of residents and their families receive education/communication about these items before the end of Q3 of 2024.

Lessons Learned

This is reviewed upon admission with all residents and their family. These are posted in the lobby and updated as required. They are available in both official languages. During orientation, and our annual training these are reviewed with staff.

Change Idea #2 Implemented Not Implemented

Modernize complaints process to ensure residents have a forum to express their concerns or complaints.

Process measure

- Number of resident complaints received.

Target for process measure

- Increase in residents who feel they can express their opinion without fear of consequences.

Lessons Learned

108

Change Idea #3 Implemented Not Implemented

Review Resident/Caregiver Survey results at quarterly CQI meetings.

Process measure

- Number of surveys reviewed quarterly.

Target for process measure

- 100% rate for residents who feel they can express their opinion without fear of consequences by end of 2024.

Lessons Learned

72

Change Idea #4 Implemented Not Implemented

Use of Resident and Family Council Meetings to promote survey participation and engagement between staff and residents.

Process measure

- Number of resident-driven/initiated issues and opinions raised at these meetings.

Target for process measure

- 100% of agendas for all Family and Resident Council Meetings contain resident-initiated items and feedback for discussion by end of 2024.

Lessons Learned

~5 per meeting x 10 meetings annually = ~50

Comment

Resident and Family Councils continue to be a platform for residents to share their voice. It continues to be an ongoing strategy with continued promotion through committee meetings as a means to express their opinions.

Safety | Safe | Optional Indicator

Indicator #1	Last Year		This Year		
	Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)
Percentage of LTC home residents who fell in the 30 days leading up to their assessment (Glen-Stor-Dun Lodge)	27.20	15.54	25.84	5.00%	20

Change Idea #1 Implemented Not Implemented

Ensure that each resident has an individualized plan of care for fall prevention.

Process measure

- Number of care plans updated

Target for process measure

- 100% of residents who are newly added to falls safety checks to receive individualized update to care plan.

Lessons Learned

Every resident receives regular assessments for risk prevention and fall strategies. Residents are reassessed after hospital visit due to illness/injury. Monthly Resident Safety meetings are held to discuss events, or concerns regarding individuals' care plans.

Change Idea #2 Implemented Not Implemented

Review new and innovative opportunities and technology to help support a reduction in falls.

Process measure

- Number of new interventions trialed.

Target for process measure

- Two new interventions trialed by end of 2024.

Lessons Learned

Various technologies already utilized at this facility in an effort to prevent falls. Mechanical lifts, safe lifting techniques, physiotherapy assistance, winged mattresses, floor mats, bed alarms are a few techniques considered when review resident care plans and fall prevention.

Change Idea #3 Implemented Not Implemented

Complete post-fall assessments to identify contributing factors and prevent reoccurrence.

Process measure

- Number of assessments completed.

Target for process measure

- 100% of assessments completed following a resident fall by Q4 of 2024.

Lessons Learned

Many assessments completed with adaptations made to residents' care plans. These concerns are also brought forward on our Resident Safety meetings and discussed with the interdisciplinary team to make adjustments to residents' care plans.

Change Idea #4 Implemented Not Implemented

Provide staff education and training on fall prevention

Process measure

- Number of staff trained

Target for process measure

- 100% completion rate for all fall prevention training by end of 2024.

Lessons Learned

For 2025's annual review and training material, new fall prevention material is to be included. This will continue to be practiced from this point forward.

Change Idea #5 Implemented Not Implemented

Looking to add fall prevention to annual training

Process measure

- No process measure entered

Target for process measure

- No target entered

Lessons Learned

We add the latest fall prevention strategy education to our Surge Learning platform for staff to complete annually.

Comment

Annually retrain staff on fall prevention strategies. Resident Safety committee regularly meets to discuss residents' safety concerns and make changes to residents' care plans as required.

Indicator #2	Last Year		This Year		
	Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment (Glen-Stor-Dun Lodge)	18.31	16	25.00	-36.54%
	Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 Implemented Not Implemented

Conduct reviews of residents on antipsychotic medications via the Responsive Behaviours Committee

Process measure

- Number of residents reviewed at committee meetings.

Target for process measure

- 100% of residents on antipsychotic medications without psychosis to be reviewed monthly.

Lessons Learned

Medical Advisory meetings conducted on a quarterly basis to review antipsychotic medication administrations.

Change Idea #2 Implemented Not Implemented

Educate multidisciplinary team on responsive resident behaviours and review interventions.

Process measure

- Number of education sessions completed in 2024.

Target for process measure

- 100% completion rate of staff education related to responsible behaviours by end of 2024.

Lessons Learned

Informal discussions are conducted at every shift change to review responsive behaviours and other resident concerns that shift. This would occur at Minimum three times daily on each unit.

Change Idea #3 Implemented Not Implemented

Conduct quarterly reviews of pharmacy utilization rates

Process measure

- Quarterly percentage rate of antipsychotics.

Target for process measure

- Quarterly reductions in antipsychotic use.

Lessons Learned

Currently we are trending higher than the average at 24%.

Change Idea #4 Implemented Not Implemented

Seek out new and innovative ways to assist with responsive behaviours to reduce the need for medication interventions.

Process measure

- Number of new initiatives to be trialed.

Target for process measure

- Two new initiatives to be trialed before the end of 2024.

Lessons Learned

We are moving to a new committee format to amalgamate Pain & Palliative care, Resident Safety, Wound Care & Continence, and Responsive Behaviours meetings into one monthly meeting. This will help review the "bigger picture" for the residents who have complex medical concerns.

Comment

Medication reviews are regularly completed by the Medical Director and Nurse Practitioner. The Medical Director further regularly consults with the Royal Ottawa to discuss recommendations. The pharmacy further provides consultation on appropriate medication to be used. Despite an increase in the performance rating, we will continue to strive to reduce the percentage of residents without psychosis being provided antipsychotic medication and aim to meet the provincial average.

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)	30.00	20.00	Continue ensuring residents and their families when an ED transfer is deemed unnecessary. Continue utilizing in-house diagnostic tools, and doctor and nurse practitioner services to reduce hospital visits.	

Change Ideas

Change Idea #1 Implement Lab Integration Solutions as new process in PCC.

Methods	Process measures	Target for process measure	Comments
Train/education staff on how to both request lab work and also receive completed lab work directly via our PCC dashboard.	Percentage of clinical staff trained on Lab Integrations.	90% of clinical staff receive training by the end of 2025.	This initiative is led by Ontario Health to streamline and expedite the lab requisition to lab results workflow process.

Change Idea #2 Strengthen fall prevention training to reduce injury-related ED visits by using environmental modifications, regular assessments, and mobility aids.

Methods	Process measures	Target for process measure	Comments
Surge annual training to educate staff on best practices for preventing injuries.	Percentage of clinical staff completed Surge fall prevention training.	90% of clinical staff receive training by end of 2025.	

Change Idea #3 Implement and utilize ECG machine and diagnostic equipment.

Methods	Process measures	Target for process measure	Comments
Train/educate staff on ECGs.	Percentage of clinical staff trained on ECG machine and CADD pump	90% of eligible clinical staff receive training by the end of 2025.	

Change Idea #4 Updating and reviewing fall program policies

Methods	Process measures	Target for process measure	Comments
Each department review their own policies and update as required.	Percentage of policies reviewed.	75% of internal policies review and revised by end of 2025-2026 QIP year.	

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	47.37	100.00	EDI training has been complete for half managerial staff, and will continue over the next couple of months. All staff will have EDI training as a mandatory online module in their annual training.	

Change Ideas

Change Idea #1 Completion of Managerial 2SLGBTQ+ Inclusive Care Training Program.

Methods	Process measures	Target for process measure	Comments
Bruyere to host another webinar, which remaining staff will be registered to complete.	Percentage of administrative staff who have completed EDI training.	100% of administrative staff to have completed training.	Total LTCH Beds: 132

Change Idea #2 EDI Surge training for all employees

Methods	Process measures	Target for process measure	Comments
Using LMS platform, include three EDI courses for all staff to complete.	Percentage of staff who have completed annual training (including EDI courses) prior to the end of 2025.	90% of all staff to have completed EDI course.	

Change Idea #3 Conduct census for all staff to determine unique cultures and needs of the employees.

Methods	Process measures	Target for process measure	Comments
Have staff voluntarily complete survey to share their cultural and personal histories.	Percentage of staff completing census survey	75% of staff completing the survey.	Survey to include sharing ideas for cultural celebrations and traditions that can be brought to the Unity committee and recreation department to incorporate various cultures and celebrations into programing planning.

Change Idea #4 Continue reviewing Policies and Procedures to ensure they align with accessibility and inclusivity standards

Methods	Process measures	Target for process measure	Comments
Changing verbiage to be in inclusive. Use of proper and inclusive terminology into policies.	Percentage of reviewed policies.	75% of internal policies reviewed and updated by next QIP.	

Change Idea #5 Continue EDI, spiritual, awareness and cultural initiatives

Methods	Process measures	Target for process measure	Comments
Continue monthly awareness initiatives by bringing cultural and spiritual celebrations and events into our home to share with residents, families, and staff.	Number of months of the year with planned cultural and spiritual events.	10 of the 12 months to be filled with planned events and celebrations.	hoping to post online as well, more accessible to staff, residents, and families.

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	84.06	90.00	We remain committed to promoting resident centred philosophy. Our goal is to continue to educate staff on that approach to care and identify any barriers that exist for residents to freely express themselves. Data retrieved from question 9 of RSS.	

Change Ideas

Change Idea #1 Promote participation in Residents' Council and work with the council to make improvements in the home.

Methods	Process measures	Target for process measure	Comments
Educate and promote residents, families, and staff about sharing ideas and opinions through the Resident Council meetings.	Number of new initiatives implemented due to ideas brought forth in Resident Council.	50% of ideas brought forth are implemented into positive changes in the home.	Total Surveys Initiated: 132 Total LTCH Beds: 132

Change Idea #2 Update and Promote new survey

Methods	Process measures	Target for process measure	Comments
Promote survey at each resident care conference, sharing email links several times a year, encouraging families to assist residents in completing survey.	Percentage of residents who have completed the survey.	90% in survey completion, increasing from previous years.	Ask residents which actions on the part of the home (such as religious and spiritual accommodations) or activities (e.g., recreation and dining experiences) bring them enjoyment; put more of these actions into place and offer more of these activities

Change Idea #3 Implement multiple avenues of communication for residents to provide feedback and learn about home updates and important information

Methods	Process measures	Target for process measure	Comments
Put up a communication board that can include printouts of the home's quality improvement plan, Resident Council meeting minutes, ombudsman contact information, etc. Set up an anonymous suggestion box Provide email contacts for department leads.	Number of methods for communication with residents and their families	Increase site visitations - no baseline data currently.	Add digital link to emailed newsletters, add fillable attachment, and mention where to find paper version.

Change Idea #4 Educate staff on different attributes of resident-centered care, including empowerment, communication, and shared decision-making

Methods	Process measures	Target for process measure	Comments
Surge annual training; Encourage staff to respect and promote resident rights in long-term care. Review resident rights booklet - staff knowledge, add to each nursing and PSW stations.	Percentage of staff who have completed training.	90% of staff to complete annual training.	CLRI - LTC courses.

Safety

Measure - Dimension: Safe

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of LTC home residents who fell in the 30 days leading up to their assessment	O	% / LTC home residents	CIHI CCRS / July 1 to Sep 30, 2024 (Q2), as target quarter of rolling 4-quarter average	25.84	20.00	The Glen Stor Dun Lodge is continuing to align with provincial targets and reducing the number of resident falls.	

Change Ideas

Change Idea #1 Complete post-fall assessments to identify contributing factors and prevent reoccurrence.

Methods	Process measures	Target for process measure	Comments
Assess and manage fall risk in residents.	Percentage of fall assessments completing post-fall.	100% compliance with assessment completion post-fall	Incident report in post-fall assessment. To be added to risk management meetings.

Change Idea #2 Screen all new residents to identify those at risk for falls and their fall risk factors; determine appropriate interventions

Methods	Process measures	Target for process measure	Comments
Complete an environmental safety checklist for each new resident upon move-in, review preadmission policy to include safety checklist.	Safety checklist to be included in progress notes. Percentage of new admissions that have safety checklists completed.	For 75% of new admissions to include safety checklist in progress notes.	

Change Idea #3 Ensure that each resident has an individualized plan of care for fall prevention; reassess residents after any major health change or quarterly.

Methods	Process measures	Target for process measure	Comments
Add auto-populate assessments quarterly on PCC.	Percentage of resident accounts that have completed quarterly assessments on PCC.	75% of current resident accounts to have at minimum one assessment completed.	Use the score Physio completes assessments quarterly as well.

Change Idea #4 Policy review and revision fall prevention policies.

Methods	Process measures	Target for process measure	Comments
Leadership team to review and revise fall-prevention policies. Ensure that all staff are trained in the proper use of fall prevention devices and are aware of the current fall-policy and processes.	Percentage of staff who have reviewed updated and revised fall-prevention policies by the end of the 2025-2026 QIP year.	75% of clinical staff have reviewed the updated fall-prevention policies.	

Measure - Dimension: Safe

Indicator #5	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment	O	% / LTC home residents	CIHI CCRS / July 1 to Sep 30, 2024 (Q2), as target quarter of rolling 4-quarter average	25.00	25.00	The Glen Stor Dun Lodge is aspiring to align with provincial targets as we continue to look to reduce the number of resident on antipsychotic medications.	

Change Ideas

Change Idea #1 Establish a regular medication review process

Methods	Process measures	Target for process measure	Comments
Use a simple, standardized medication review process	Percentage of MedRecs completed in full	80% of MedRecs will be completed in full after re-admission from hospitals.	review quarterly as ministry req - by physician

Change Idea #2 Review Responsive Behaviours policy. Develop and update individual behaviour care plans

Methods	Process measures	Target for process measure	Comments
For each resident, evaluate whether any potential contributors to behavioural and psychological symptoms of dementia are present (e.g., conduct an assessment for delirium, a general medical and mental health history, a pain assessment, a medication review, a substance use review, and hearing and vision assessments)	Percentage of assessments completed.	95% completion of individual care plans including behavioural assessment.	Currently generic, not necessarily individually focused. Policy review for care plans.

Change Idea #3 Monthly Interdisciplinary Committee Meetings – involving behaviour support leads, physicians, pharmacists, nurses, and personal support workers – for monthly and quarterly medication reviews, Pain & Palliative; Skin, Wound Care & Continence; Resident Safety; QI & Risk Management, BSO

Methods	Process measures	Target for process measure	Comments
To discuss all pertinent health concerns with individual residents and discuss changes in behaviours, necessary assessments, and update care plans accordingly.	Number of Interdisciplinary Committee Meetings completed in the 2025-2026 QIP year.	Minimum of ten meetings annually.	

Change Idea #4 Improve staff education and training on dementia care.

Methods	Process measures	Target for process measure	Comments
Educate staff on antipsychotic medications and the behavioural symptoms of dementia. Train staff to use a person-centred, compassionate, gentle approach to responsive behaviours. Train staff to consistently complete necessary care plan documentation.	Percentage of clinical staff having completed Surge Dementia care training.	75% of clinical staff to complete annual training.	Individual coaching as required. BSO meetings monthly, all welcomed, better promote.