THEME 1: Access and Flow

DESCRIPTION	High quality health system manages transitions well, providing people with the care they need, when and where they need it		
ON HEALTH PRIORITY INDICATOR FOR LTC	% of potentially avoidable emergency department visits for long term care residents	**PAST PERFORMANCE**	Rate per 100 LTC residents in 2023: 16.0% ED visits from falls Injuries in 2023: 5%
TARGET	Maintain performance to better than the Ontario Average and reduce ED visits attributed to Falls	**JUSTIFICATION**	Safety education will be provided to residents and families
PROVINCIAL AVERAGE	ED Visit Rate: 21.7% (2024) ED visits from Falls injuries: 8.7% (2024)	**CURRENT PERFORMANCE**	Rate per 100 LTC residents: 9.8% (2024) Injuries from falls: 3.4% (2024)

CHANGE IDEAS

PLANNED IMPROVEMENT INITIATIVE	METHODS	PROCESS MEASURES	TARGET	PROGRESS REPORT
• Resident and Family education initiative	• Provide information on resident safety information to residents and families	• Information display completed • Review of resident safety information at resident and family council	• Information displays created for falls management, treatment guidance, palliative care and advance care planning	• Target Met

THEME 2: Equity

DESCRIPTION	*Advancing equity, inclusion and diversity and addressing racism to reduce disparities in outcomes for patients, families, and providers is the foundation of a high-quality health system.*		
ON HEALTH PRIORITY INDICATORS FOR LTC	a) %of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and antiracism education	**PAST PERFORMANCE**	n/a -new indicator for 2024/25
TARGET	a) 85% of staff complete EDI training	**JUSTIFICATION**	a) EDI training will be important for interpersonal relationship and teamwork at Belmont House
PROVINCIAL AVERAGE	N/A	**CURRENT PERFORMANCE**	a) 97.4% staff completed Belmont's EDI training

CHANGE IDEAS

PLANNED IMPROVEMENT INITIATIVE	METHODS	PROCESS MEASURES	TARGET	PROGRESS REPORT
• Staff are educated in equity, diversity, inclusion and antiracism	• Staff will complete inservice on equity, diversity, inclusion • Planning for diversity initiative in 2024 Posters promoting equity, diversity, inclusion and antiracism will be posted on staff bulletin boards	• % staff completion of Inservice • Diversity and inclusion initiative held in 2024 • Posters are selected and posted on bulletin boards	• 85% of staff complete inservice on equity, diversion, inclusion • 1 diversity initiative held in 2024 • Staff bulletin boards contain posters	• Target Met (97%)

THEME 3: Client/Resident Experience

DESCRIPTION	Better experiences result in better outcomes. Tracking and understanding experience is an important element of quality.		
ON HEALTH PRIORITY INDICATORS FOR LTC	b) Do residents feel they have a voice and are listened to by staff? c) Do residents feel they can speak up without fear of consequence	**PAST PERFORMANCE**	Resident Satisfaction Survey 2023: a) 67% usually/always, 23% sometimes/never, 7% don't know, 3% n/a b) 77% usually/always; 13% sometimes/never; 3% don't know; 7% n/a
TARGET	b) Increase positive responses (usually/always) to 80% and above on satisfaction survey c) Implementation of Butterfly model of care	**JUSTIFICATION**	b) Continued awareness on voicing concerns is needed to improve the resident experience and satisfaction c) Implementation of the Butterfly Model is an emotion-centred model of care that will address the needs of residents with dementia.
PROVINCIAL AVERAGE	N/A	**CURRENT PERFORMANCE**	Resident Satisfaction Survey 2024: b) 60% usually/always, 37% sometimes, 3%never c) 76% usually/always; 13% sometimes, 8% never;

CHANGE IDEAS

PLANNED IMPROVEMENT INITIATIVE	METHODS	PROCESS MEASURES	TARGET	PROGRESS REPORT
a) Increase positive responses (usually/always) to 80% and above on satisfaction survey				
• Staff are trained on handling complaints and concerns	Staff complete training on handling complaints and concerns	• % completion on Surge Learning	• 90% completion	• Target Met (97%)
• Awareness in Residents and Families of how to raise concerns/complaints	• Display and communicate information	• Satisfaction survey is conducted • % of positive responses	• Material is displayed and distributed to family members	• Target Met

CHANGE IDEAS				
PLANNED IMPROVEMENT INITIATIVE	**METHODS**	**PROCESS MEASURES**	**TARGET**	**PROGRESS REPORT**
	• Distribute Resident and Family Satisfaction Survey • Feedback and input is sought at resident and family council on identified improvement areas		• Increase in positive responses in satisfaction survey >80%	• Target Not Met (Low positive responses on satisfaction survey)

CHANGE IDEAS				
PLANNED IMPROVEMENT INITIATIVE	**METHODS**	**PROCESS MEASURES**	**TARGET**	**PROGRESS REPORT**
b) Implementation of Butterfly model of care				
• Butterfly model of care training for direct care staff	• Direct care staff, including new hires will gradually be trained	• # of Staff trained on the Butterfly Model of Care	• 75% of direct care staff will be trained by the end of 2024	• Target Met -100% of direct care staff on 2W and 3W have completed training
• Undergo Butterfly Accreditation	• Prepare staff for Butterfly accreditation • Applicable policies are updated or developed and distributed to staff • Prepare documentation for Butterfly accreditation	• Criteria for Butterfly accreditation are met	• Belmont is accredited as a Butterfly Home in 2024	• Target Met
• Monitor Butterfly Indicators	• Butterfly indicators are tracked and monitored • Audits are conducted quarterly	• Butterfly indicators are reported and reviewed quarterly • Audits are reported and reviewed quarterly	• Improvement in indicators are tracked from baseline • Audits inform improvement areas	• Target Met

THEME 4: Safe and Effective Care

DESCRIPTION	Appropriate Prescribing: potentially inappropriate antipsychotic use in long term care		
ON HEALTH PRIORITY INDICATORS FOR LTC	% of Residents not living with psychosis who were given antipsychotic medications	**PAST PERFORMANCE**	% of residents without psychosis who were given antipsychotic medication: 15.6% (CIHI, 2022-2023)
TARGET	Maintain performance to better than the Ontario Average	**JUSTIFICATION**	Performance has historically been below the provincial average. Indication of use will be the focus for improvement.
PROVINCIAL AVERAGE	20.3% (CIHI 2024)	**CURRENT PERFORMANCE**	17.0% (CIHI, Q2, 2024)

CHANGE IDEAS

PLANNED IMPROVEMENT INITIATIVE	METHODS	PROCESS MEASURES	PROCESS MEASURE TARGET	COMMENTS
• Improve indication of use of antipsychotic drugs	• Residents on antipsychotic drugs without a diagnosis is reviewed quarterly by Behavioural Support (BSO) Nurse for indication of use, in consultation with nursing staff and physicians	• Quarterly reports sent to BSO Nurse for review • # of residents on antipsychotic drugs without a diagnosis • % of residents with indication of use	• Indication of use is documented for each resident	• Target met

THEME 4: Safe and Effective Care (continued)

DESCRIPTION	Falls in LTC Residents		
ON HEALTH PRIORITY INDICATORS FOR LTC	% of LTC Residents who fell in the last 30 days	**PAST PERFORMANCE**	N/A new QIP indicator for 2024/25
TARGET	Maintain performance to better than the Ontario Average	**JUSTIFICATION**	Improvements will focus on post falls assessments and education for staff, families and residents
PROVINCIAL AVERAGE	16.5% (CIHI 2024)	**CURRENT PERFORMANCE**	15.3% (CIHI, 2024)

CHANGE IDEAS

PLANNED IMPROVEMENT INITIATIVE	METHODS	PROCESS MEASURES	PROCESS MEASURE TARGET	COMMENTS
• Reduce falls and falls with injury	• Track completion of post fall assessment • Complete root cause analysis for falls with injuries • Staff training on falls prevention and management • Falls education and awareness for residents and families	• % of post fall assessments completed • % of root cause analysis completed for falls with injury • % of staff who completed training • Education display set up during Falls prevention month	• 85% post fall assessments completed • 100% of root cause analysis completed for falls with injury • 100% of staff complete training • Education display was set up during falls prevention month	• Target Met -96% of post fall assessments completed • Target met -100% of root cause analysis completed • Target met -100% of staff completed training • Target met