Maxville Manor

Quality Improvement Plan 2026–2027 — Workplan Report

Organization ID: 51882

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Access and Flow

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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.

P Rate per 100

CIHI CCRS, CIHI NACRS / October 1, 2024, to September 30, 2025 (Q3 to the end of the following Q2)

31.43 29.86 We will work towards reducing unnecessary ED transfers by 5% over the next fiscal year.

residents /

LTC home

residents

Change Ideas

Change Idea #1 Increase utilization of paramedic outreach Program

Methods Process measures Target for process measure Comments

Teaching family members the benefits of the paramedic outreach program and services offered. Teaching registered staff of the paramedic outreach program

Continue to provide education to new families and new registered staff regarding paramedic outreach program.

We will strive to reach 100% of families and 100% of registered staff

Discussions will be had with each residents POA/SDM, from registered staff regarding the care that can be provided within the home instead of going to emergency department

Change Idea #2 implement structure and ongoing education program for all nursing staff.

Methods Process measures Target for process measure Comments

Reinforce best practises and organization policies and clinical procedures.

Ensuring consistent and high quality delivery across our home.

We will strive to teach 100% of the registered staff.

Tools will be developed and implemented to support the structure and ongoing education to registered staff.

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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

CB 100.00 Equity, diversity, inclusion, and anti-

racism (EDIA) education is essential to creating a safe, respectful, and inclusive workplace that supports all team members and residents. Ensuring that all executive-level and the management team complete relevant EDIA training demonstrates leadership commitment to these principles and helps embed them into organizational policies, practices, and culture.

A high completion rate establishes accountability, supports consistent application of EDIA practices across all levels of the Manor, and aligns with provincial standards for inclusive workplaces. Tracking this metric also allows the organization to identify gaps and plan ongoing education to maintain a knowledgeable and culturally competent workforce.

Change Ideas

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Change Idea #1 Staff will complete the equity, diversity, inclusion and antiracism training

Methods Process measures Target for process measure Comments

Staff will complete the module titled, "Diversity, Equity, and Inclusion at Work" by Surge Learning. Incorporated an interactive (world map initiative) as part of the education tool, where staff are invited to place a pin on a world map indicating their country of origin or cultural background (voluntary participation).

Staff will be encouraged to complete the training module by the end of calendar year and will be track to ensure the completion of the training module.

100% of staff will complete the online learning module by the end of the calendar year

Improving staff awareness and equity and antiracism principle supports culturally safe, person centered care and fosters a respectful work place environment for residents, families, and team members.

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Experience

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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

In house data, NHCAHPS survey / Most recent consecutive 12-month period

40.74 54.90 Increase resident and family participation in the annual satisfaction survey of 5%

residents

Change Ideas

Change Idea #1 Improve staff communication and active listening skills to enhance residents’ perception that staff listen to them and respond to their concerns.

Methods Process measures Target for process measure Comments

Provide mandatory education sessions for all direct care staff on active listening, empathy, and person-centered communication. Incorporate communication expectations into performance reviews and staff huddles. Recognize and celebrate staff who demonstrate excellence in communication.

Percentage of residents responding positively to the question Percentage of direct care staff who complete communication training.

Increase positive resident responses from baseline Achieve 100% staff completion of communication training

Total Surveys Initiated: 31

Effective listening is foundational to person-centered care and directly impacts resident satisfaction, trust, and quality of life. Strengthening staff communication skills and leadership engagement will foster meaningful interactions, improve responsiveness to resident concerns, and support a culture of respect and dignity within the LTC home. Ongoing monitoring and transparent sharing of results will help sustain improvements.

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Measure - Dimension: Patient-centred

Indicator #4 Type Unit / Population

Source / Period

Current Performance Target Target Justification External Collaborators

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

O % / LTC home

In house data, interRAI survey / Most recent consecutive 12-month period

51.61 54.20 Increase resident and family participation in the annual satisfaction survey of 5%

residents

Change Ideas

Change Idea #1 Improve psychological safety within the home, so residents feels comfortable expressing their opinions, concerns, and preferences without fear of

negative consequences.

Methods Process measures Target for process measure Comments

Review survey result at quarterly committee meetings and management meetings. Provide education to staff on respectful communication, active listening, and resident's rights through Surge Learning annually.

Percentage of resident who respond positively. Percentage of staff who complete the education.

Increase of percentage of resident of respond positively to the statement.

Total Surveys Initiated: 31

Promoting psychological safety aligns with resident-centered care principles and supports residents’ rights to autonomy, dignity, and participation in decision-making. By strengthening communication practices, increasing leadership visibility, and implementing structured feedback mechanisms, the home aims to foster a culture of openness, trust, and accountability.

Continuous monitoring and transparent follow-up (“You said, we did”) will help sustain improvements and demonstrate responsiveness to resident feedback.

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Safety

Measure - Dimension: Safe

Indicator #5 Type Unit / Population

Source / Period

Current Performance Target Target Justification External Collaborators

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

O % / LTC home

CIHI CCRS / July 1 to September 30, 2025 (Q2), as target quarter of rolling 4- quarter average

22.64 21.51 We will work towards reducing the number of falls by 0.11% in the upcoming fiscal yea

residents

Change Ideas

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Change Idea #1 The interdisciplinary team will meet to discuss all falls in our high risk falls review meetings monthly and document for every resident with 2 or more

falls with interventions being utilized and a plan to help mitigate falls.

Methods Process measures Target for process measure Comments

90% residents with 2 or more falls will have a documented falls review progress note

90% of residents who fall will have an interdisciplinary team meeting to discuss possible causes/risks in our high risk falls review meetings

High risk falls review occur every 2 weeks with interdisciplinary team.

Falls remain a significant clinical risk within the long-term care population due to resident frailty, cognitive impairment, polypharmacy, and mobility limitations. While some falls may not be fully preventable, the organization recognizes that structured, evidence- informed prevention strategies can reduce overall fall incidence and severity.

Our goal is to reduce preventable falls while maintaining resident mobility, autonomy, and quality of life, recognizing the importance of balancing safety with independence.

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Measure - Dimension: Safe

Indicator #6 Type Unit / Population

Source / Period

Current Performance Target Target Justification External Collaborators

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

O % / LTC home

CIHI CCRS / July 1 to September 30, 2025 (Q2), as target quarter of rolling 4- quarter average

23.00 21.85 We will work towards seeing a decrease in the number of residents

residents

on antipsychotics without a diagnosis of psychosis from 23.00 to

21.85 over the next 12 months

Change Ideas

Change Idea #1 Taper MD has been implemented and is being utilized by our MD/NP and Pharmacists for all quarterly medication reviews.

Methods Process measures Target for process measure Comments

Taper MD is used for all quarterly reviews.

We will see a decrease in the number of residents on antipsychotics without a diagnosis of psychosis over the next 12 months.

We will strive to see a decrease in the use of antipsychotics for our residents who do not have a diagnosis of psychosis from 23.00% to 21.85% over the next 12 months.

Our organization is focused on reducing unnecessary antipsychotic use by implementing person-centred, non- pharmacological interventions, conducting regular interdisciplinary medication reviews, engaging families in care planning, and auditing prescribing patterns. These strategies aim to ensure residents receive the safest, most appropriate care while maintaining quality of life and dignity.

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Measure - Dimension: Safe

Indicator #7 Type Unit / Population

Source / Period

Current Performance Target Target Justification External Collaborators

Percentage of long-term care residents whose stage 2 to 4 pressure ulcer worsened

O % / LTC home

CIHI CCRS / July 1 to September 30, 2025 (Q2), as reporting quarter for the rolling 4- quarter average

2.86 2.56 The worsening of Stage 2–4 pressure ulcers is a significant and largely preventable adverse outcome that reflects the quality and effectiveness of clinical care processes within long-term care.

residents

Change Ideas

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Change Idea #1 Focus on early identification, risk assessment, and proactive interventions. Key strategies may include: Standardized skin and risk assessments

Evidence-based repositioning schedules Use of pressure-relieving devices Moisture management and nutrition optimization Staff education and competency on wound care and prevention

Methods Process measures Target for process measure Comments

Conduct skin assessments for at-risk residents and those with stage 2–4 ulcers. Use electronic documentation to track wound progression and interventions. Provide mandatory staff education on pressure injury prevention, wound assessment, and care planning. Implement individualized care plans including repositioning, support surfaces, and nutritional interventions.

Review pressure injury cases quarterly in an interdisciplinary team (nursing, dietitian, physiotherapy). Audit compliance with repositioning schedules and preventive measures.

% of at-risk residents with completed assessment within 24 hours of admission or status change % of residents with stage 2–4 pressure ulcers with an updated care plan % of staff completing pressure injury prevention education Compliance with repositioning schedule (% of residents repositioned per plan) % of residents using appropriate support surfaces

The target is to reduce the percentage of long-term care residents whose stage 2 to 4 pressure ulcer worsens from the current 2.86% to 2.56% by implementing enhanced prevention strategies, including timely risk assessments, individualized care plans, evidence- based repositioning, and the use of support surfaces.

Implementing structured prevention strategies, including timely risk assessments, individualized care plans, evidence-based repositioning, and use of support surfaces, reduces the risk of pressure ulcer worsening. Staff education and interdisciplinary review ensure consistent practice, while monitoring compliance allows timely interventions. These strategies aim to improve resident outcomes, minimize skin deterioration, and maintain overall safety and quality of care.

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Measure - Dimension: Safe

Indicator #8 Type Unit / Population

Source / Period

Current Performance Target Target Justification External Collaborators

Percentage of long-term care residents in daily physical restraints

O % / LTC home

CIHI CCRS / July 1 to September 30, 2025 (Q2), as target quarter of rolling 4- quarter average

5.71 5.42 The organization is committed to reducing the percentage of residents who are in daily physical restraints in alignment with best practices and quality standards.

residents

Change Ideas

Change Idea #1 Staff Education & Coaching Training on responsive behaviors, dementia care, and de-escalation techniques. Coaching on safe transfer and mobility

support. Family & Substitute Decision-Maker Engagement Educate families about risks of restraints. Collaborate on person-centered solutions

Methods Process measures Target for process measure Comments

Deliver Structured Staff Education Provide mandatory in-service training on: Responsive behaviours and dementia care De-escalation techniques Safe transfers and mobility support Engage Families and Substitute Decision-Makers (SDMs) Provide education at admission and care conferences regarding: Risks of physical restraints Monitor and Audit Conduct quarterly audits of restraint use. Track education completion and family discussions. Review restraint cases at Quality Committee meetings.

% of direct care staff who complete annual education on: Responsive behaviours Dementia care De-escalation techniques Safe transfer & mobility support % of new hires receiving restraint reduction education during orientation % of residents in restraints with documented family/SDM education discussion % of restrained residents with documented alternative strategies trialed prior to restraint use

The target is to ensure that at least 100% of staff complete education on responsive behaviours, dementia care, de-escalation, and safe transfers, 100% of new hires receive this education during orientation, and increase family engagement regarding restraints use and having alternatives methods trialed prior to restraint use.

Providing staff education on responsive behaviours, dementia care, de- escalation techniques, and safe transfers enhances staff confidence and promotes safe, person-centered care. Engaging families and substitute decision-makers ensures transparency, shared decision-making, and collaboration on restraint alternatives. Ongoing monitoring, ensuring that physical restraints are used only as a last resort while maintaining resident safety and quality of life.