

## Experience

### Measure - Dimension: Patient-centred

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Communication from home leaders is clear and timely	C	% / LTC home residents	In-house survey / March 1 - Sept 1	51.70	66.70	Internal Target	

### Change Ideas

Change Idea #1 To increase awareness and retention of the evolving events and changes occurring in our home

Methods	Process measures	Target for process measure	Comments
In addition to monthly newsletters, quarterly townhalls and memos, we will create a monthly programs of news and views in each RHA monthly to recap and discuss updates and changes.	The total number of "news and views" programs held monthly and yearly	6 programs to be held monthly. 54 programs to be held April -December, 2026.	

**Measure - Dimension: Patient-centred**

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
I am encouraged to provide my input about the food and drink options.	C	% / LTC home residents	In-house survey / March 1 - Sept 1	49.10	54.00	Internal Target	

**Change Ideas**

Change Idea #1 Resident Choice monthly lunch menu introduced in 2025 to be expanded to monthly resident choice dinner in 2026

Methods	Process measures	Target for process measure	Comments
Resident Choice menu selection to be determined by Resident Home Area and rolled out to whole home. Total of 24 resident choice menus a year, based on each RHA choosing 4 meals a year.	Total # of resident lunch meals served per year Total # of resident dinner meals served per year Total # of resident choice meals selected from each resident home area	A total of 18 resident choice meals to be served April - Dec -9 dinner resident choice meals -9 lunch resident choice meals -3 resident choice meals selected for each resident home area	

**Measure - Dimension: Patient-centred**

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
I am satisfied with the quality of food and drinks served to me.	C	% / LTC home residents	In-house survey / March 1 - Sept 1	42.60	47.60	Internal Target	

**Change Ideas**

Change Idea #1 To ensure consistency of hot food being served.

Methods	Process measures	Target for process measure	Comments
• Ensure food temperature at POS dinner time is acceptable – 6 dinner audits per week.	6 dinner audits to be completed and review weekly for 6 weeks	By May 30, dinner POS temperature will be within 60-75 degrees Celsius.	

Change Idea #2 To improve the dining room noise level.

Methods	Process measures	Target for process measure	Comments
FSS and RD to retrain staff on pleasurable dining on each RHA – including addressing noise level in DR.	# of FT and PT staff serving in dining room completing live training module.	All FT and PT to review Pleasurable dining by September 30, 2026	

Change Idea #3 To ensure snack pass is consistent

Methods	Process measures	Target for process measure	Comments
Snack audits to be conduct weekly and reviewed for gaps	# of snack audits completed and reviewed weekly for 6 weeks.	6 audits (1 from each RHA) to be reviewed weekly for 6 weeks by May 30,2026.	

## Measure - Dimension: Patient-centred

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Resident Satisfaction: Would recommend?	C	% / LTC home residents	In-house survey / 2026	88.30	90.00	Internal target	

## Change Ideas

Change Idea #1 To increase residents' sense of pride and ownership of their home whereby they would recommend it to others.

Methods	Process measures	Target for process measure	Comments
Continue with welcome committee of existing residents to welcome new residents to the community to create a sense of ownership and pride of our home.	# of members of welcome committee	# of new residents engaged by social committee	

Change Idea #2 To increase participation from resident voice of what they are proud about in their home

Methods	Process measures	Target for process measure	Comments
Add to quarterly townhall and new monthly news and views program as a discussion point of what the residents are most proud of and what they would say to a ie. tour if asked would you recommend this home. What would they recommend we do different.	# of townhall and monthly meetings where "would you recommend our home" discussion took place.	90% # of residents who would recommend our home	

## 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 residents	CIHI CCRS / July 1 to September 30, 2025 (Q2), as target quarter of rolling 4-quarter average	15.09	13.00	Internal Target	

### Change Ideas

Change Idea #1 Ensure residents who are high risk for falls have individualized and updated care plans for fall prevention.

Methods	Process measures	Target for process measure	Comments
1) Identify residents who are at high risk for falls and review each resident's care plan. 2) Collaborate with the Falls Lead and care staff to discuss preventative strategies, involving the resident when possible. 3) Communicate and review any care plan changes with the care team to ensure consistent implementation.	1) # of resident at high risk for falls. 2) # of high-risk resident care plans reviewed and updated as required. 3) # of sessions held with staff to communicate and reinforce care plan changes.	1) # of high-risk resident care plans reviewed and updated as required. 2) # of sessions held with staff to communicate and reinforce care plan changes.	

Change Idea #2 Review program activities for times when falls occur most such as day, time and shift.

Methods	Process measures	Target for process measure	Comments
1)Review times when most falls are occurring. 2)Implement programs at time of day when falls are mostly occurring. Monitor for results.	1)# of programs implemented during peak times of falls. 2) # of high-risk residents who did not experience a fall during the month in which the intervention was implemented.	The review of program preferences for high-risk residents will be completed by May 2026. The review of high-risk resident falls and associated times will be completed by April 2026.	

Change Idea #3 Falls-post incident assessment and interdisciplinary team huddles

Methods	Process measures	Target for process measure	Comments
1)Review post fall procedure with staff. 2)The Falls Lead will review all fall incidents, including the post-incident assessment and documentation, and identify possible root causes based on information gathered from huddle participants.	1)Staff education on post fall procedure will be completed by May 2026. 2) 100% of falls assessments will be completed as per policy.	The review of program preferences for high-risk residents will be completed by May 2026. The review of high-risk resident falls and associated times will be completed by April 2026.	

## 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 residents	CIHI CCRS / July 1 to September 30, 2025 (Q2), as target quarter of rolling 4-quarter average	2.70	2.65	Internal Target	

## Change Ideas

**Change Idea #1** Documentation: Collaborate with registered staff, physicians, and Behavioral Nurse Practitioners to ensure that all residents prescribed antipsychotics have documented indications for use, including a diagnosis or a clear rationale for symptom management.

Methods	Process measures	Target for process measure	Comments
1) Complete medication reviews for residents prescribed antipsychotic medications. 2) Non-pharmacological approaches will be considered and attempted before initiating antipsychotics, and all assessment findings will be documented in the resident's chart.	1)# of antipsychotic medication reviews completed monthly using the Antipsychotic Decision Support Tool or through quarterly pharmacy medication reviews. 2) # of residents who have been deprescribed antipsychotics and have effective non-pharmacological interventions in place.	Non-pharmacological approaches to care will be documented, and the resident's care plan will be updated accordingly. Interventions will be reassessed monthly, and revised if they are found to be ineffective.	

**Change Idea #2** Enhance collaborative opportunities between the home's interdisciplinary team and the Behavioural Support Network to strengthen coordinated approaches to resident care.

Methods	Process measures	Target for process measure	Comments
1)Invite the Behavioural Supports Lead (BSL) to high-risk behavioural interdisciplinary meetings to increase collaboration with the home's interdisciplinary team. 2) Remind Registered Staff to submit referrals to the Behavioural Support Team as needed, using the PCC Referral: Behavioural Support Team.	1) # of interdisciplinary meetings the Behavioural Support Team was invited to attend. 2) # of monthly referrals submitted to the Behavioural Support Team.	The Behavioural Support Team and Home Leadership will be able to demonstrate increased collaboration and visibility within the home by December 2026.	

Change Idea #3 Gentle Persuasive Approaches (GPA) Basics for responsive behaviours related to dementia (in support of reduction of anti-psychotic use).

Methods	Process measures	Target for process measure	Comments
1) Engage with Certified GPA Coaches in home to roll-out home-level to deliver GPA Basics education to staff.	1)# of staff participated in GPA Basics education sessions. 2) # of staff participated in GPA Bathing education.	Three GPA Basics education sessions will be provided to staff by December 2026. Staff feedback on all GPA education sessions will be reviewed and acted upon by December 2026.	

### 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 residents	CIHI CCRS / July 1 to September 30, 2025 (Q2), as reporting quarter for the rolling 4-quarter average	0.97	0.95	Internal Target	

### Change Ideas

**Change Idea #1** Strengthen pressure injury prevention and management by supporting staff participation in recognized skin and wound education and certification programs offered through the Wound, Ostomy and Continence (WOC) Institute. This includes the PSW and Caregiver Skin Health course as well as the Skin Wellness Associate Nurse (SWAN) certification.

Methods	Process measures	Target for process measure	Comments
1)Skin and Wound lead backup enrolled to SWAN program. 2)PSWs from all units are enrolled in the PSW and Caregiver Skin Health Program through the WOC Institute.	# of SWAN certified staff including wound care lead. # of PSW/caregiver skin health program certified.	100% of staff enrolled in the PSW/Caregiver Skin and Wound Program will have completed their certification by the end of June 2026. Additionally, 100% of staff enrolled in the SWAN (Skin Wellness Associate Nurse) certification program will complete their course within seven months of enrollment.	

**Change Idea #2** Re-enforce point of care(POC) alert process to notifying staff by identifying skin issues for early identification and prevention of pressure injuries.

Methods	Process measures	Target for process measure	Comments
1)Re-educate staff on POC alert system for reporting skin issues on all shifts. 2)Registered staff to review dashboard alert system during and at the end of each shift. 3)Complete weekly audit to identify gaps and educate staff as needed and to ensure all skin and wound assessments are completed timely.	1) # of staff that have been educated. 2) # of alert created through POC alerting system related to Skin issues on a monthly basis. 3) # of audits completed.	Current staff are educated on the new process by April 30, 2026. Ongoing education will be provided to new employees during orientation (ongoing). 100 % of all gaps found from alert audits will be followed up.	

## Change Idea #3 Focus on continence to keep skin clean and dry- Toileting, appropriate brief selection

Methods	Process measures	Target for process measure	Comments
1)The Skin & Wound Lead and the Continence Lead will jointly review the number of residents enrolled in continence programs. Together, they will compare residents on toileting routines with the wound care list generated from Point Click Care to ensure alignment and identify any residents who may require updated interventions.	1) # of residents with skin issue. 2) # of residents with a toileting plan. 3) Conduct a survey with staff and cognitively able residents on the unit to gather feedback on the new incontinence product trialed. The survey will include input from all three shifts to ensure comprehensive evaluation.	1) A trial of a new incontinence product will be conducted on one unit to assess absorbency, comfort, and product integrity. 2)The Wound Care Lead will collaborate with the Continence Lead to ensure the correct incontinence products are being used consistently across the team. 3) Education will be provided to staff as needed to support appropriate brief selection.	

**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 residents	CIHI CCRS / July 1 to September 30, 2025 (Q2), as target quarter of rolling 4-quarter average	0.00	0.00	Internal Target	

**Change Ideas**

Change Idea #1 Admissions coordinator/Designate will review each application for restraints prior to move-in

Methods	Process measures	Target for process measure	Comments
DOC/Designate will review and flag each application that requires the use of restraints. Information will be sent to Ontario Health at Home advising that the home is restraint-free and that alternative strategies will be trialed upon resident move-in.	# of applications received that have a restraint. # of communication sent to applicants and/or family explaining the home's restraint free approach.	A process for reviewing new residents' applications related to restraints will be established and fully implemented by April 2026.	