

Experience | Patient-centred | **Custom Indicator**

	Last Year		This Year		
Indicator #4	58.80	68.20	62.80	--	NA
Percentage of residents responding positively to: "I am satisfied with the food and beverages served to me". (Extendicare Crossing Bridge)	Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

Change Idea #1 Implemented Not Implemented In Progress

Commencement of a Food Committee in addition to the standing dedicated time during Resident Council meetings to discuss food complaints and recommendations

Process measure

- 1) # of Food Committee there is allotted specified time during Resident's Council meeting 2) # of Feedback and recommendations discussed with the Food Committee and # of corresponding actions documented and monitored ongoingly

Target for process measure

- 1) Food Committee meetings will be held 12 times per year, occurring monthly - starting on March. 26th, 2025 2) Recommendations will be documented and actioned on within 10 days and feedback on those actions obtained within 14 days post implementation

Lessons Learned

Our food committee has started on March 2025 and running very well.

Change Idea #2 Implemented Not Implemented In Progress

Increase Nutrition/Dietary Manager and supervisor presence within the dining room during meal time to obtain real-time feedback.

Process measure

- No process measure entered

Target for process measure

- No target entered

Lessons Learned

Dietary manager, 2 registered dietitians and dietary supervisor started to audit all 3 mealtimes. They started to be present in dining room to get the feedback from residents and staff. There were many constructive feedback from both staff and residents in 2025. Registered Dietitians, Dietary manager and dietary supervisors continue to be present in meals time in 2026.

Comment

Increase Nutrition/Dietary Manager and supervisor presence within the dining room during meal time to obtain real-time feedback.

	Last Year		This Year		
Indicator #5	41.90	69.10	66.70	--	NA
Percentage of residents responding positively to: "If I need help right away, I can get it". (Extendicare Crossing Bridge)	Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

Change Idea #1 Implemented Not Implemented In Progress

Increase staff awareness of call bell response times

Process measure

- 1) # of call bell response time reviews completed 2) # of times results communicated to staff and to leadership team 3) # of leadership walkabouts completed monthly 4) # of staff follow ups required

Target for process measure

- 1) Call bell response review process will be in place by April. 1st, 2025 2) Communication of call bell responses to staff and to leadership will be in place by April. 1st, 2025 3) Process for leadership walkabouts will be in place by April. 1st, 2025

Lessons Learned

Staff were re-educated about the call bell response time.

Change Idea #2 Implemented Not Implemented In Progress

Implement purposeful rounding.

Process measure

- No process measure entered

Target for process measure

- No target entered

Lessons Learned

Will educate the staff the importance of rounding and addressing the resident's need in timely manner.

Comment

1 additional staff member (PSW) be added in each home area in Day shift in 2026. That will help to address residents need in quicker time.

Indicator #6	Last Year		This Year		
	Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)
Percentage of residents responding positively to: "In my care conference, we discuss what's going well, what could be better and how we can improve things". (Extendicare Crossing Bridge)	53.60	66.90	71.80	--	NA

Change Idea #1 Implemented Not Implemented In Progress

Encourage residents to attend their annual care conference

Process measure

- 1) # of annual care conferences where residents attend 2) # of care conferences where plan of care was discussed with resident

Target for process measure

- 1) Residents will be encouraged to attend their annual care conferences beginning April. 1st, 2025 2) Beginning April 1st, 2025 100% of care conferences will have plan of care discussed with residents attending.

Lessons Learned

Social service worker arranges the IDRCCs and encourage the residents to attend meetings. Families are invited to attend either in person or online. We will continue to implement in 2026.

Comment

NA

Safety | Safe | **Optional Indicator**

Indicator #1	Last Year		This Year		
	Percentage of LTC home residents who fell in the 30 days leading up to their assessment (Extendicare Crossing Bridge)	11.89 Performance (2025/26)	11 Target (2025/26)	5.56 Performance (2026/27)	53.24% Percentage Improvement (2026/27)

Change Idea #1 Implemented Not Implemented In Progress

Implement 4 P's rounding

Process measure

- 1) # of staff educated on the 4 P's process 2) Resident council and family council informed of process

Target for process measure

- 1) 100% of front line staff will be educated on the 4 P's process by May. 23rd, 2025 2) 4 P's cards will be distributed to staff by May. 23rd, 2025 3) Resident council and Family council will be informed of process by May. 23rd, 2025

Lessons Learned

Education to direct care staff, specially PSWs and new hires about the importance of 4 P's rounding is ongoing.

Change Idea #2 Implemented Not Implemented In Progress

Ensure each resident at risk for falls has an individualized plan of care for fall prevention

Process measure

- 1) # of plans of care reviewed 2) # of plans of care updated

Target for process measure

- 1) Residents at risk for falls will be identified by April. 1st, 2025 and maintained on an at minimum quarterly basis 2) Care plans for high-risk residents will be reviewed and updated by April. 1st, 2025 and maintained on an at minimum quarterly basis 3) Changes in plans of care will be communicated to staff within 24-hours of making updates as of April. 1st, 2025

Lessons Learned

Each resident who is at high risk of falls have individualized care plans. We will continue to identify the high-risk faller and review the care plan after Friday falls meeting.

Change Idea #3 Implemented Not Implemented In Progress

Medication review of residents who are assessed as being at risk of falls

Process measure

- 1) # of residents identified as being at risk for falls 2) # of medication reviews completed for residents at risk for falls 3) # of medication changes /alternatives prescribed to decrease fall risk

Target for process measure

- 1) Residents at risk for falls will be identified at minimum on a quarterly basis, starting April. 1st, 2025 2) As of April. 1st 2025, 100% of Medication reviews will be completed for those residents at risk for falls at minimum on a quarterly basis

Lessons Learned

Any resident who are assessed as being risk of falls are being assessed by MD. Almost all of the residents are prescribed Vitamin D (and Calcium as needed). Will continue to implement this idea for 2026.

Change Idea #4 Implemented Not Implemented In Progress

Re-educate staff on Fall Prevention and Injury Reduction program

Process measure

- No process measure entered

Target for process measure

- No target entered

Lessons Learned

Will re-educate staff about fall prevention and injury reduction program on monthly basis.

Comment

Will re-educated staff about fall prevention and injury reduction program on monthly basis.

Indicator #3	Last Year		This Year		
	Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)
Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment (Extendicare Crossing Bridge)	12.37	10	0.00	100.00 %	17.30

Change Idea #1 Implemented Not Implemented In Progress

Implement Extendicare's Antipsychotic Reduction Program which includes using the Antipsychotic Decision Support Tool (AP-DST).

Process measure

- 1) Home team/ committee meeting members established 2) Monthly meetings for antipsychotic review 3) Percentage of residents with an action plan inputted (100% of Residents Triggering AP QI, Res on AP NOT Triggering AP QI as needed)

Target for process measure

- 1) Home team/ committee meeting members will be established by April. 23rd, 2025 2) Antipsychotic review meetings will occur on a monthly basis - commencement of April, 2025 (once per month, more if needed) 3) Residents triggering the Antipsychotic QI have an action plan inputted into the decision support tool within 3 to 6 months of admission starting April. 1st, 2025

Lessons Learned

AP- DST tool has been used in monthly basis and will continue to be used in 2026.

Change Idea #2 Implemented Not Implemented In Progress

Enhance collaboration with Behavioral Supports Ontario (BSO) Lead and interdisciplinary team

Process measure

- 1) # of interdisciplinary meetings BSO invited to attend 2) # of monthly referrals to BSO

Target for process measure

- 1) BSO will have increased collaboration and visibility in home by May. 23rd, 2025

Lessons Learned

BSO program is fully running in Home with ROH support.

Change Idea #3 Implemented Not Implemented In Progress

Education for Registered Staff on antipsychotics

Process measure

- 1) # of registered staff who attended a training session on antipsychotic medications

Target for process measure

- 1) 75% of registered staff will have attended a training session on antipsychotic medications by December. 31st, 2025

Lessons Learned

All registered staff were educated on the use of antipsychotics for elderly patients in Monthly meeting. Will continue to re- educate.

Change Idea #4 Implemented Not Implemented In Progress

Collaborate with the physicians to ensure all residents using antipsychotic medications have a medical diagnosis and rationale identified

Process measure

- 1) # of medication reviews completed monthly 2) # of diagnosis that were appropriate for antipsychotic medication use 3) # of alternatives implemented

Target for process measure

- 1) 75% of all residents will have medication and diagnosis review completed to validate usage by September. 30th, 2025

Lessons Learned

Physicians are encouraged to write the relevant medical diagnosis for the residents who use antipsychotics. We still continue to identify the resident and review with MD to have a medical diagnosis.

Comment

Will go to resident's chart history through e-connect to find relevant diagnosis.

Safety | Safe | Custom Indicator

	Last Year		This Year		
Indicator #2	1.94	1.50	0.80	--	NA
Percentage of LTC residents with worsened staged 2 to 4 pressure injuries (Extendicare Crossing Bridge)	Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

Change Idea #1 Implemented Not Implemented In Progress

Education on product selection for wound care

Process measure

- 1) # of education sessions /shift 2) # of audits completed monthly

Target for process measure

- 1) Education sessions on products and selection of products will be completed for all Registered staff by December. 31st, 2025

Lessons Learned

Sloventum has cancelled its education session in the last minute. Will try to reach out and reschedule this year.

Change Idea #2 Implemented Not Implemented In Progress

Focus on continence to keep skin clean and dry- toileting, appropriate brief selection

Process measure

- 1) # of residents with skin issues 2) # of brief audit checks completed 3) # of education sessions provided 4) # of residents on restorative toileting program

Target for process measure

- 1) The Wound Care Champion will complete their resident review by May. 31st, 2025 2) Review of correct sizing and type of incontinences products will be completed by May. 31st, 2025 3) Education sessions for product selection will be completed by December. 31st, 2025 4) Annual review of continence program will be completed by December. 31st, 2025

Lessons Learned

Appropriate Brief selection process implemented. We have a standardized process to communicate and select the right brief product. Toileting Schedule in place for the resident at high risk of skin breakdown.

Change Idea #3 Implemented Not Implemented In Progress

Mandatory education for all registered staff on correct staging of Pressure ulcers

Process measure

- 1) # of registered staff who have completed online modules on wound staging on a monthly basis 2) % of registered staff who have attended education on correct staging of Pressure Ulcers hosted by the Wound Care Champion

Target for process measure

- 1) 100% of Registered staff will have completed the "Skin and Wound Care for Registered Staff" online module by September. 30th, 2025
- 2) Audits of completion rates will be completed monthly and required follow up will occur within the 1st week of each corresponding month by April. 1st, 2025

Lessons Learned

All RHA has skin and wound binder. Skin and Wound Lead has given the education how to correctly staging pressure ulcer.

Change Idea #4 Implemented Not Implemented In Progress

Turning and repositioning re-education.

Process measure

- No process measure entered

Target for process measure

- No target entered

Lessons Learned

In PSW monthly meeting, the importance of turning and repositioning to prevent the skin breakdown was discussed in 2025. We will continue to re- educate our staff and educate any new hires in 2026.

Comment

Will provide Turning and repositioning re-education to all PSWs in 2026.