Experience

Measure - Dimension: Patient-centred

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of residents responding positively to: "I am satisfied with the food and beverages served to me"	C	% / LTC home residents	In-house survey / 2025	62.80	66.20	LTC Division Overall 2025	

Change Ideas

Change Idea #1 Increase Nutrition/Dietary Manager and supervisor presence within the dining room during meal time to obtain real-time feedback.

Methods	Process measures	Target for process measure	Comments
Plan schedule for when Dietary/Nutrition Manager, Registered Dietician and Dietery supervisor will be present in Dining room for meals (ensure that all meals are covered in schedule) 2) Determine specific questions that will be asked to gather feedback. Ask additional questions as needed and confirm understanding with Resident. 3) Where appropriate make required changes. 4) Follow-up with the Resident after the change had occurred. 5) Ensure actions are documented are reviewed with Residents Council	1) Improvement in overall Resident satisfaction scores for this question. 2) Increase in positive responses to questions asked within the dining room. 3) [#] of concerns that were rectified	Manager will attend meal service 3 times per week to obtain feedback beginning May 2026	

Change Idea #2 Ensure dedicated time (standing agenda item) during Resident Council meeting to discuss food complaints and recommendations.

Methods	Process measures	Target for process measure	Comments
1) Set allotted time on the agenda OR have separate sub-committee for Food Council / feedback on food. 2) Agreed upon actions that will be taken and specify timeline 3) Follow-up on improvement and reassess action if needed.	1) Food Committee will be provided allotted specified time during every Resident's Council meeting. 2) Feedback, recommendations and corresponding actions will be documented and monitored ongoing.	1) Food committed meetings will be held 10-12 times per year. 2) Recommendations will be documented and actioned on within 10 days and feedback on those actions obtained within 10-20 days post implementation."	

Measure - Dimension: Patient-centred

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of residents responding positively to: "I can see a Doctor or Nurse Practitioner When I need to.	C	% / LTC home residents	In-house survey / 2025	64.60	70.90	LTC Division Overall 2025	

Change Ideas

Change Idea #1 Communicate role of Medical Director and Physicians/NP and give opportunity for feedback.

Methods	Process measures	Target for process measure	Comments
1) Medical Director to meet at minimum annually with Family and Resident Councils. 2) Feedback on services and areas for improvement will be discussed. 3) update at CQI meeting on action plan.	1) [#] of meetings with Councils where Medical Director attended. 2) [#] of suggestions provided by councils. 3) [#] of CQI meetings where action items were discussed with Medical Director.	1) Medical Director will attend Family Council by July 2026. 2) Medical Director will attend Resident Council by August 2026. 3) Action items and plan will be discussed at CQI committee with Medical Director by September 2026.	

Measure - Dimension: Patient-centred

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of residents responding positively to," If I need help right away, I can get it".	C	% / LTC home residents	In-house survey / 2025	66.70	70.70	LTC Division Overall 2025	

Change Ideas

Change Idea #1 Implement purposeful rounding.

Methods	Process measures	Target for process measure	Comments
1) Provide education session for staff on purposeful rounding process. 2) Provide 4P's education to staff for reminder of 4 areas to ask resident about. 3) Review the staffing load in each shift in all home areas.	1) [#] of education sessions for staff. 2) [#] of staff who received 4P's education. 3) [#] of audits completed. 3) [#]of staff added in each RHA.	1) Education for purposeful rounding (4P's) will be completed by May 2026 for 90% of PSW staff. 2) 4P's education will be provided to staff at education by June 2026. 3)	

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 September 30, 2025 (Q2), as target quarter of rolling 4-quarter average	5.56	5.50	Continued Improvement with a realistic target.	

Change Ideas

Change Idea #1 Re-educate staff on Fall Prevention and Injury Reduction program

Methods	Process measures	Target for process measure	Comments
1) ADOC/designate will provide education sessions on Fall Prevention and Injury Reduction program to care staff 2) Managers and/or program lead will audit and monitor program to identify compliance and/or gaps - minimum of 15 resident's audited quarterly	1) # of education sessions provided to PSW/HCA and Registered staff 2) # of audits completed	1) Education sessions for PSW/HCA and Registered staff will be completed by November 2026 2) Audits on Fall Prevention and Injury Prevention program will begin by June 2026	

Change Idea #2 Ensure each resident at high risk for falls has a individualized plan of care for fall prevention

Methods	Process measures	Target for process measure	Comments
1) Determine residents at high risk for falls 2) Review plan of care for each resident at high risk on quarterly basis 3) Discuss strategies with falls lead and staff in residents circle of care 4) Update plan of care 5) Communicate changes in care plan with care staff	1) # of residents at high risk for falls 2) # of plans of care reviewed 3) # of new strategies determined 4) # of care plans updated 5) # of sessions held to communicate changes with staff	1) Residents at high risk for falls will be identified and reviewed on quarterly basis. 2) Care plans for high-risk residents will be reviewed and updated on ongoing basis 3) Changes in care plans will be communicated to staff as needed.	

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 September 30, 2025 (Q2), as target quarter of rolling 4-quarter average	0.00	17.30	Extendicare Benchmark	

Change Ideas

Change Idea #1	Enhance home team collaborative opportunities with Behavioural Support Lead (BSL) (often BSO team members in Ontario) and home's interdisciplinary team.		
Methods	Process measures	Target for process measure	Comments
1. Invite Behavioural Supports Lead (BSL) to PAC meetings or other interdisciplinary meetings for increased opportunity for collaboration with interdisciplinary home team. 2. Remind Registered Staff to refer to Behavioral Support Team, when needed, using PCC Referral - Behavioural Support Team.	1. # of interdisiplinary meetings the Behavioural Support Team were invited to attend. 2. # of monthly referrals to the Behavioural Support Team.	1. The Behavioural Support Team and Home Leadership will be able to endorse increased collaboration and visibility in home by December 2026.	Our current performance is not Zero. We have set up our target as per Extendicare benchmark.

Change Idea #2	Documentation: Collaborate with Registered Staff, Physician / Nurse Practitioner to ensure all residents using anti-psychotic medications have a documented indication by diagnosis and/or rationale for symptom-management identified in the resident's diagnosis list and care plan		
Methods	Process measures	Target for process measure	Comments
1. Complete medication reviews for residents prescribed antipsychotic medications. 2. Consider non-pharmacological approaches as appropriate to reduce anti-psychotic use, and document assessment findings and management planning	1. # of resident anti-psychotic reviews completed monthly (which can be part of interdiscplinary behavioural rounds) and matching # of updates to the home's Anti-psychotic Decision Support Tool (AP-DST). 2. # of resident care plans updated monthly to support appropriate antipsychotic use and matching # of updates to the home's Anti-psychotic Decision Support Tool (AP-DST). 3. # of residents de-prescribed anti-psychotics and replaced with non-pharmacological approaches to care implemented and matching # of updates to the home's Anti-psychotic Decision Support Tool (AP-DST).	1. 90% of all residents with anti-psychotic use prescibed will have assessment, management planning and updated documentation completed by December 2026. 2. Non-pharmacological approaches to care will be documented within residents' care plans and reassessed if not effective within 1 month of implementation by December 2026	

Measure - Dimension: Safe

Indicator #6	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	13.33	2.00	Extendicare Benchmark	

Change Ideas

Change Idea #1 Turning and repositioning re-education

Methods	Process measures	Target for process measure	Comments
1) Educate staff on the importance of turning and repositioning to offload pressure 2) Night staff to audit those resident that require turning and repositioning. 3) Review this during the skin and wound committee meeting for trends.	1) # of staff that have been educated. 2) # of audits completed. 3) # of review completed by skin and wound committee.	1) 100% of PSW will have attended education session on turning and repositioning by September 2026. 2) Check in with staff and will be correctly completed on a monthly basis by December 2026 3) Process for review, analysis and follow up of monthly tools will by 100% in place by December 2026.	

Change Idea #2 Dietician referral communication process with home for worsened and healed skin issues/ pressure injuries.

Methods	Process measures	Target for process measure	Comments
1) Education to improve communication between the dietician and the skin and wound lead to look at the skin and wound tracker. 2) Wound care lead to provide a updated list of skin issues to the dietician internally. 3) DOC/ADOC to audit this process as part of the evaluation process of the program.	# of skin issues followed up by the dietician # of audits completed monthly. # of audit that identifies improvement monthly.	1) Wound care lead to provide refresher education on improving Dietician referrals communication by October 2026. 2) Standardized communication process will be in place 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 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	Continued with current plan of minimizing the restraints.	

Change Ideas

Change Idea #1 Provide information to families and residents on least restraint approach

Methods	Process measures	Target for process measure	Comments
1) Provide Restraint information sheet in move- in packages for new move-ins 2) Meet with resident and family councils to provide education on least restraint approach and risk associated with restraint use.	1) # of move in packages with restraint information sheet included. 2) # of meetings with resident and family council to discuss least restraint approach and risk of restraint use.	1) 100 % of move in packages will have restraint information sheet included for new move in by June 2026 2) Meetings with resident and family councils will be attended to discuss the least restraint approach by October 2026.	

Change Idea #2 Personalize activity plans to engage resident in activities of interest.

Methods	Process measures	Target for process measure	Comments
Review with recreation, resident specific activity plans and identify additional engaging activities for resident.	1) # of reviews completed with recreation for activity plans. 2) # of residents who had an in increase in activity engagement.	100 % of residents using restraints in the home have been engaged in more activities by November 2026.	