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 quality of maintenance of the physical building and outdoor spaces"	C	% / LTC home residents	In-house survey / Annual resident experience survey	50.00	84.20	Extendicare Benchmark	

Change Ideas

Change Idea #1	ESM will attend Resident Council quarterly meetings and provide updates on maintenance activities from the previous quarter. 2. Gather resident input at Resident Council meetings regarding maintenance services and outdoor spaces, focusing on areas for improvement.		
Methods	Process measures	Target for process measure	Comments
1) The ESM will coordinate with the Resident Council chair to confirm dates and agendas for quarterly meetings. 2) Prior to each meeting, the ESM will compile a summary of maintenance activities completed during the previous quarter, including work orders, preventive maintenance, and ongoing issues. 3) The ESM will prepare a brief, standardized update verbal highlighting completed projects, response times, and upcoming maintenance priorities. 4) During each quarterly Resident Council meeting, the ESM will present the maintenance update and address resident questions or concerns.	1) # of resident Council sessions ESM attended	1) Satisfaction with quality of maintenance of the physical building and outdoor spaces.	

Change Idea #2	Review and discuss the approved Capital Budget and Capital Plan with the Resident Council. Share the 2027 Capital Budget Wishlist with the Resident Council. 2. Take before-and-after photos prior to starting projects and present them at Resident Council meetings. 3. Purchase new outdoor tables and chairs in 2026.		
Methods	Process measures	Target for process measure	Comments

The ESM will review the approved Capital Budget and Capital Plan annually and prepare a summary for Resident Council discussion. 2) The ESM will present and discuss the approved Capital Budget, Capital Plan, and the 2027 Capital Budget Wishlist with the Resident Council during scheduled meetings, allowing time for questions and feedback. 3) Resident input related to capital planning will be documented and considered during future budget planning cycles.4) Prior to the start of any approved capital or major maintenance project, the ESM will take baseline (before) photos of the project area. 5) Upon completion of each project, the ESM will take follow-up (after) photos to document improvements. 6) Before-and-after photos will be organized and presented at Resident Council meetings to demonstrate project progress and outcomes. 7) In 2026, the ESM will identify, select, and purchase new outdoor tables and chairs in accordance with the budget. 8) Completion of the outdoor furniture purchase and installation will be reported to the Resident Council, with photos shared when available. 9) All capital-related updates, photos, and feedback will be documented and reviewed for continuous improvement.	1. 100% of capital projects will have before-and-after photos documented and shared with the Resident Council. 2. Capital Budget and Wishlist will be reviewed with the Resident Council at least annually. 3. Outdoor tables and chairs will be purchased in 2026.	Achieve 100% compliance with capital budget communication, project photo documentation, and Resident Council reporting in 2026, with completion of outdoor furniture purchase by year-end.

Measure - Dimension: Patient-centred

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of residents responding positively to: "In my care conference, we discuss what's going well, what could be better, and how to improve things"	C	% / LTC home residents	In-house survey / Annual resident experience survey	68.80	71.40	Extendicare Benchmark	

Change Ideas

Change Idea #1	1. Encourage residents to provide meaningful feedback during Care Conferences regarding strengths, opportunities for improvement, and recommendations to enhance care and services. 2. Implement a standardized process to remind residents of scheduled Care Conferences one day in advance.

Methods	Process measures	Target for process measure	Comments
1) Social Service Worker or designate will explain the purpose of Care Conferences and actively encourage residents to share feedback on strengths, opportunities for improvement, and recommendations related to their care and services. 2) A standardized set of open-ended questions will be used during Care Conferences to prompt meaningful resident feedback. 3) Resident feedback shared during Care Conferences will be documented in the Care Conference notes and reviewed by the Interdisciplinary team. 4) Action items identified from resident feedback will be assigned to appropriate staff and tracked for follow-up. 5) A standardized reminder process will be implemented to notify residents of their scheduled Care Conference one day in advance - verbal reminder. 6)Responsibility for providing Care Conference reminders will be assigned to the Social Service Worker or designate. 7) Completion of reminders will be documented in Point Click Care. 8)Compliance with the reminder process and resident participation will be monitored regularly to ensure consistency.	1. # of Care Conferences in which standardized, open-ended questions are used to solicit resident feedback. 2. # of Care Conferences with resident feedback documented in the Care Conference notes.3. # of Care Conference-related action items assigned and tracked for follow-up.	Achieve =95% compliance with resident feedback collection and Care Conference reminder processes throughout 2026.	

Change Idea #2 2. Educate families on the importance of resident participation in Care Conferences as a key component of resident-centered care. 2. Provide education to all new residents on the purpose of Care Conferences and the value of resident participation as part of the move-in process.

Methods	Process measures	Target for process measure	Comments
1) Provide Care Conference education to families during admission, care plan meetings, or scheduled family communications. 2) Incorporate Care Conference education into the move-in process for all new residents. 3) Social Service worker or designate to provide Care Conference education at move-in. 4) Provide education verbally to ensure understanding and accessibility. 5) Reinforce Care Conference education during follow-up interactions as needed. 6) Monitor compliance with family and resident education processes on a routine basis.	=95% of new residents and families receive Care Conference education.	95–100% of families will be educated on the importance of resident participation in Care Conferences.	

Measure - Dimension: Patient-centred

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of residents responding positively to: "I am encouraged to provide my input about the food and drink options"	C	% / LTC home residents	In-house survey / Annual resident experience survey	70.60	72.00	Continuous improvement	

Change Ideas

Change Idea #1	The Dietary Manager will attend Resident Council meetings on a monthly basis to obtain resident input regarding food services and meal satisfaction. 2. A “touch-the-table” audit will be completed daily during meal service to actively seek resident feedback on food quality, temperature, and service. 3. The Dietary Manager will engage in daily discussions with residents regarding meals served to gather real-time feedback and address concerns promptly. 4. The Dietary Manager will conduct random weekend check-ins with residents during meal times to ensure consistency of service and to obtain resident input.

Methods	Process measures	Target for process measure	Comments

1) The Dietary Manager will coordinate with the Resident Council chair to attend monthly meetings, ensuring food services and meal satisfaction are included on the agenda. 2) At each Resident Council meeting, the Dietary Manager will present updates on food services and document resident input, questions, or suggestions for follow-up. 3) The Dietary Manager will perform a “touch-the-table” audit daily during meal service, evaluating food quality, temperature, portion size, and presentation. 4) Observations and resident feedback from the touch-the-table audits will be recorded on a standardized tracking form for review and follow-up. 5) The Dietary Manager will engage in daily, informal discussions with residents during meals to gather real-time feedback and address concerns promptly. 6) Random weekend check-ins will be conducted by the Dietary Manager during meal service to ensure consistency of food quality, service, and resident satisfaction across all days. 7) Feedback from weekend check-ins will be documented and reviewed with dietary staff to implement immediate improvements if needed. 8) All resident feedback, audit results, and follow-up actions will be compiled for review at monthly Resident Council meetings and incorporated into ongoing quality improvement initiatives.	=95% of scheduled Resident Council meetings attended by Dietary Manager with documented feedback	Achieve =95% compliance with daily touch-the-table audits and feedback documentation, 100% attendance at Resident Council meetings, and 100% follow-up on resident concerns in 2026.

Change Idea #2	Menus will be approved by the residents and the Resident Council prior to implementation. Resident feedback will be requested, reviewed, and incorporated as appropriate before finalizing the menu.		
Methods	Process measures	Target for process measure	Comments
1) Proposed menus will be presented to residents and the Resident Council prior to implementation during scheduled meetings. 2) Residents and Resident Council members will be actively encouraged to provide feedback on menu. 3) The Dietary Manager will document all resident feedback in a standardized tracking form for review. 4) Feedback will be reviewed and analyzed to determine which suggestions can be incorporated into the final menu, balancing nutritional standards, operational feasibility, and resident preferences. 5) Adjustments to the menu based on resident feedback will be made prior to finalizing and implementing the menu cycle. 6) The final menu, reflecting incorporated resident input, will be communicated to residents, staff, and relevant departments. 7) Ongoing monitoring of resident satisfaction with implemented menus will occur, and feedback will be used to inform future menu cycles.	100% of proposed menus presented to residents and Resident Council before implementation.	Achieve 100% menu presentation	

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	10.22	10.00	continued Improvement to theoretical best	

Change Ideas

Change Idea #1 Falls -Post Incident Assessment & Interdisciplinary team huddles

Methods	Process measures	Target for process measure	Comments
1) Review Post Fall procedure with staff 2) Fall lead in the hoe to attend and/or review Falls - Post Incident Assessment and documentation (review the huddle participants, probable root cause identified	1) # of staff who reviewed Post Fall procedure. 2) # of Fall - Post Incident Assessments that were completed accurately and thoroughly on a monthly basis	1) Staff education on Post Fall procedure will be completed by October 1, 2026. 2) May 1, 2026, 100% of Falls - Post Incident Assessment will be completed as per policy	

Change Idea #2 Ensure each resident at high risk for falls has an individualized plan of car 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. 3) Discuss strategies with fall 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 with be identified by March 15, 2026 2) Care plans for high-risk residents will be reviewed and updated by March 30, 2026 3) Changes in care plans will be communicated to staff by March 30, 2026	

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	10.47	10.00	continued Improvement to theoretical best	

Change Ideas

Change Idea #1	Documentation: Collaborate with Registered staff, Physician/ Nurse practitioner to ensure all residents using anti-psychotic medication have a documented indication by diagnosis and/or rational for symptom-management identified in the resident's diagnosis list and care plan (i.e., monthly care plan reviews)		
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 using: PCC 'Mental Health - Behavioural Rounds & Incident Debrief Tool'	1) # of resident anti-psychotic reviews completed monthly (which can be part of interdisciplinary behavioral 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 implement and matching # of updates to the home's Anti-psychotic Decision Support Tool (AP - DST)	1) 90% of all residents with anti-psychotic use prescribed will have assessment, management planning and updated documentation completed by July 1, 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 September 1, 2026	

Change Idea #2	Family education resources provided for appropriate use of anti-psychotics.		
Methods	Process measures	Target for process measure	Comments
1) Provide family resources: Centre for Effective Practice (CEP) - How Anti-psychotic Medications are Used to Help People with Dementia: A Guide for Residents, Families and Caregivers. 2) Make Resources available in the admission package for families.	1. # of CEP resources provided to families monthly. 2) # of antipsychotics de-prescribed as a result of increased family awareness.	1. Copies of CEP resources will be printed and provided in the admission packages by March 1, 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	2.70	2.00	Extendicare Benchmark	

Change Ideas

Change Idea #1 Mandatory education for all Registered staff on correct staging of Pressured ulcers

Methods	Process measures	Target for process measure	Comments
1) Communicate to Registered staff requirement to complete education. 2) Registered staff to complete online modules on wound staging by end of third quarter of year. 3) DOC/designate to monitor completion rates	1) # of communications to Registered staff mandatory requirement to complete education. 2) # of Registered staff who have completed online modules on wound staging on a monthly basis. 3) # of audits of completion rates completed by DOC/designate and follow-up as required	1) Communication on mandatory requirement will be completed by April 1, 2026 2) 100% of Registered staff will have completed education on correct wound staging by September 30, 2026 3) Audits of completion rates will be completed monthly with required follow up will occur by 1st week of each month and process is to be in place by July 1, 2026	

Change Idea #2 Education on Product selection wound care.

Methods	Process measures	Target for process measure	Comments
1) Education sessions set up for all registered staff on products on wound care protocol. 2) Sessions to be arranged for all shifts 3) Audits to be completed by wound care lead of home for correct usage of products	1) # of education sessions/shift. 2) # of audits completed monthly. 3) # of audits that identified areas of improvement monthly	1) Education sessions on products and selection of products will be completed for all registered staff by September 1, 2026. 2) Audits will show a 100% improvement in compliance by October 30, 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 Improvement to theoretical best.	

Change Ideas

Change Idea #1 Consult with behavior lead/team to help address behaviors of residents with restraint usage.			
Methods	Process measures	Target for process measure	Comments
1) Provide staff information sheet on restraints and review how a restraint usage can escalate resident responsive behaviours. 2) Consult with behaviour lead/team to identify potential alternatives to restraint usage that would support resident	1)# of residents who had restraint in place. 2)# of behaviour lead/team consults to review alternatives completed.	1) 100% of residents using restraints in the home have been consulted with behaviour lead/team to identify alternatives by March 1, 2026	

Change Idea #2 Social Service worker/ designate will review each application received for restraints prior to move-in			
Methods	Process measures	Target for process measure	Comments
1) Admission coordinator reviews and flags each application received for restraints. 2) Information is sent to Ontario Health, etc. to indicate that home is least restraint and that alternatives will be trained upon move-in.	1) # of applications received that have a restraint 2) # of communications sent back to applicant and family/sending authority to explain least restraint approach 3) # of acceptances received to trial alternatives upon move-in.	1) process for review of new resident applications with restraints will be in place by March 30, 2026.	