

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

	Last Year		This Year		
<b>Indicator #5</b>	<b>43.80</b>	<b>70</b>	<b>81.00</b>	<b>--</b>	<b>NA</b>
Percentage of residents responding positively to: I have input into the recreation programs available. (Extendicare Kapuskasing)	Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

Change Idea #1  Implemented  Not Implemented  In Progress

To increase the opportunities for input of residents for recreation programs available to them

**Process measure**

- # of meetings with residents where options were discussed # of programs chosen by residents # of suggestions provided by residents # of programs implemented based on feedback from resident

**Target for process measure**

- list for available programs will be ready by April 30 2025 review of ideas presented by residents will occur by May 2025 Suggestions will be implemented by June 2025 Process for ongoing review by residents will be fully in place by December 2025

**Lessons Learned**

Suggestion and ideas for new activities are asked at the monthly residents' council meeting, as well as during admission, assessments and annual IDTCs. This has allowed for great improvement on resident satisfaction in this area.

Indicator #7	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: I am satisfied with the quality of care from doctor (Extendicare Kapuskasing)	<b>66.70</b>	<b>70</b>	<b>81.00</b>	<b>--</b>	<b>NA</b>

Change Idea #1  Implemented  Not Implemented  In Progress

Tracking of physician visits to ensure visits are occurring for each resident.

**Process measure**

- 1) # residents per physician 2) # of residents who had in person visit during quarter

**Target for process measure**

- 1) List will be developed by physician for tracking by May 2025 2) Each resident will have an in person visit with physician at minimum 1 per quarter by March 2026

**Lessons Learned**

The physician has maintained his scheduled visits and increased his availability for urgent care visits and palliative residents, thus improving satisfaction greatly.

Indicator #6	Last Year		This Year		
	Percentage of residents responding positively to: If I need help right away, I can get it. (Extendicare Kapuskasing)	<b>66.70</b> Performance (2025/26)	<b>75</b> Target (2025/26)	<b>70.80</b> Performance (2026/27)	<b>--</b> Percentage Improvement (2026/27)

Change Idea #1  Implemented  Not Implemented  In Progress

Increase satisfaction by decreasing wait times when residents need help.

**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 May 2025 2) Communication of call bell responses to staff and to leadership will be in place by May 2025 3) Process for leadership walkabouts will be in place by May 2025.

**Lessons Learned**

Home gained access to call bell reports aiding in monitoring response times and staff have been educated on the importance of prompt response times. Continued monitoring and updated job routines have allowed for increased resident satisfaction in this area

**Comment**

PSW job routines have been updated which now allow more time for the staff to address resident concerns.

Safety | Safe | **Optional Indicator**

Indicator #3 Percentage of LTC home residents who fell in the 30 days leading up to their assessment (Extendicare Kapuskasing)	Last Year		This Year		
	<b>28.00</b>	<b>15</b>	<b>29.11</b>	<b>-3.96%</b>	<b>15</b>
	Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

**Change Idea #1**  Implemented  Not Implemented  In Progress

PSWs will be in resident area while charting to increase monitoring and result in less falls.

**Process measure**

- The number of staff educated on new charting system The number of feedback received, and changes made to process The number of falls pre and post implementation of new process

**Target for process measure**

- 100% of front-line staff will be educated on new charting system by May 1, 2025. Feedback will be gathered post implementation by May 15, 2025 Review of falls pre and post implementation will be tracked and evaluated for improvement in falls by May 30, 2025

**Lessons Learned**

The increase of monitoring assisted in lowering the number of falls. We experienced new challenges in decreasing the percentage of falls due to increase in status changes in residents and an influx resulting from resident behaviors and noncompliance to recommendations made.

**Change Idea #2**  Implemented  Not Implemented  In Progress

Determine root cause of falls in order to reduce amount of falls

**Process measure**

- Audit the number of huddles and assessment 100% completed vs number of falls # of gaps identified based on the audits

**Target for process measure**

- Audits will begin by April 30, 2025 Each resident who has experienced a fall will have a post fall huddle and post fall assessment completed for 100% of falls by May 30, 2025.

**Lessons Learned**

Increased supervision was successful in reducing the number of falls for some high-risk residents. Some root causes identified include newly admitted residents and residents in isolation related to outbreaks

**Comment**

We will continue to prioritize this indicator in 2026/27 through focusing on identified root cause and appropriate interventions related to the same

Indicator #4	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 Kapuskasing)	17.27	15	26.67	-54.43%	17.30

**Change Idea #1**  Implemented  Not Implemented  In Progress

Medication reviews completed for all residents currently prescribed antipsychotics, reviewed with pharmacist, physician and BSO lead

**Process measure**

- Will be measured by increased or decreased behaviors within a set time frame of medication changes # of medication reviews completed for those currently prescribed antipsychotics # of reviews completed with pharmacist, physician and BSO

**Target for process measure**

- Medication review process will be 100% implemented by May 30, 2025.

**Lessons Learned**

Medication reviews continue to be completed as scheduled and as required. De-prescribing initiatives and ongoing use of our antipsychotic reduction tool continue to support the monitoring and improvement of this indicator.

**Comment**

We will continue to prioritize this indicator in 2026/27 focusing on purposeful behavioural rounding along with increased education for Registered Staff.



Safety | Safe | **Custom Indicator**

Indicator #2	Last Year		This Year		
	Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)
Percentage of long-term care home residents who developed a stage 2 to 4 pressure ulcer or had a pressure ulcer that worsened to a stage 2, 3 or 4 (Extendicare Kapuskasing)	<b>1.90</b>	<b>1.80</b>	<b>2.37</b>	<b>--</b>	<b>NA</b>

**Change Idea #1**  Implemented  Not Implemented  In Progress

Create a standardized schedule for pressure wounds to be monitored

**Process measure**

- # of wounds assessed weekly as per schedule # of assessments completed Mondays and # completed Tuesday on a weekly basis
- 3) # of Registered staff who have received education on scheduling system

**Target for process measure**

- Scheduling for weekly wounds assessments will be 100% in place and functioning by May 30, 2025. 100% of Registered staff will have received education on scheduling system by May 1, 2025

**Lessons Learned**

This was implemented and continues to be followed. A new policy was integrated and a similar method of follow up assessment are entered into the tars post skin and wound referrals. We will continue to focus on this indicator in 2026/27 strengthening our referral process and skin and wound team.

Indicator #1	Last Year		This Year		
	Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)
percentage of long-term care home residents in daily physical restraints over the last 7 days (Extendicare Kapuskasing)	<b>1.90</b>	<b>1.80</b>	<b>0.00</b>	<b>--</b>	<b>NA</b>

Change Idea #1  Implemented  Not Implemented  In Progress

Provide information to families and residents on Least Restraint.

**Process measure**

- 1.) # of admission packages with Restraint brochure included. 2.) # of meetings with Resident council and Family meetings to discuss Least Restraint and Risks. "

**Target for process measure**

- 1). 100% of admission packages will have Restraint brochure included for new admissions by June 30, 2025 2). Meetings with Resident Council and Family meeting will be attended to discuss Restraints by September 30, 2025

**Lessons Learned**

The challenge was to educate families and residents coming from a hospital setting where all the beds have bedrails. However, with consistent approach and communication we were able to improve our performance