Experience | Patient-centred | Custom Indicator

	Last Year		This Year		
Indicator #3	**35.20**	**75**	**57.70**	**--**	**NA**
I am satisfied with the quality of care from the following interdisciplines: Physician; Dietitian; Social Worker and Leadership Team (Extendicare Maple View)	Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

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

Rounding for all management team starting Feb 2024:

Process measure

- # of rounding tools completed daily by each member of leadership team # of rounding tools signed off daily by Administrator/designate # of gaps identified monthly # of actions implemented to address monthly

Target for process measure

- Rounding checklists will be initiated by February 2024. Process for review of gaps and action plan to address will be in place by June 2024

Lessons Learned

Often faced challenging barriers such as:
Competing priorities across interdisciplinary teams

Consistent documentation of rounding activity

Change Idea #2 ☑ Implemented ☐ Not Implemented ☐ In Progress

Increase the visibility of the interdisciplinary team at Family Council and Resident Council

Process measure

- # of meetings each discipline is invited and presents at Family council # of meetings each discipline is invited and presents at Resident Council

Target for process measure

- Family Council and Resident Council are knowledgeable of the management/leadership structure. (roles and responsibilities) by December 2025. Each interdisciplinary/management/Leadership has attended annually to both Resident Council and Family Council by December 2025.

Lessons Learned

Ensure at least one representative from each discipline attends Family Council and Resident Council monthly.

Provide brief updates on initiatives, quality improvements, and upcoming events.

Rotate presenters so all departments are visible throughout the year.

Change Idea #3 ☑ **Implemented** ☐ **Not Implemented** ☐ **In Progress**

1) Implement Town hall newsletter to inform and engage residents and family members on a regular basis

Process measure

- 1) # of times newsletter was sent to residents and families 2) # of resident and family council meetings information 3) # of months newsletter was posted on bulletin board.

Target for process measure

- 1) Newsletter will be sent out to all residents and families as of April 2025 2) Discussion with resident and family council about newsletter will occur by mid April 2025 3) Newsletter will be posted on bulletin board by April 2025

Lessons Learned

Monthly updates provided by Executive Director to both councils Include updates on staffing, programs, quality indicators, and upcoming events.

Change Idea #4 ☐ **Implemented** ☐ **Not Implemented** ☑ **In Progress**

Have "Tea and Chats" or social sit-down programs with residents, families, and leadership teams to inform and engage on a regular basis.

Process measure

- 1) # of times programs was implement 2) # of people participated in program

Target for process measure

- 1) Program will be introduced and implemented as of May 2025

Lessons Learned

Difficulty maintaining consistent engagement activities

Competing priorities across interdisciplinary teams

Change Idea #5 ☐ Implemented ☐ Not Implemented ☑ In Progress

Consistent rounding tool for all leadership/management to document findings etc

Process measure

- No process measure entered

Target for process measure

- No target entered

Lessons Learned

It’s not just “walking around” — it’s purposeful engagement.

1)Resident Engagement
Greet residents by name
Ask about comfort, meals, activities, and care experience
Note any concerns or compliments

2. Family Engagement
Introduce yourself when families are visiting
Ask if they have questions or feedback
Provide quick updates when appropriate

3. Staff Engagement
Check in with PSWs, nurses, dietary, housekeeping, recreation
Ask what’s working well and what barriers they’re facing
Recognize good work on the spot

4. Environment & Safety Checks
Cleanliness
Equipment availability
Safety risks
Dining room and common area atmosphere

5. Follow Up
Document themes
Assign action items
Close the loop with residents, families, and staff

Comment

Leadership Open-Door — families can drop in.

Resident Experience Rounds — leadership rounds focused on quality of life, not clinical issues.

	Last Year		This Year		
Indicator #4	**56.30**	**75**	**78.70**	**--**	**NA**
In my care conference, we discuss what's going well; what could be better and how we can improve things. (Extendicare Maple View)	**Performance (2025/26)**	**Target (2025/26)**	**Performance (2026/27)**	**Percentage Improvement (2026/27)**	**Target (2026/27)**

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

review annual care conference process

Process measure

- 1) # of reviews of care conference process completed 2) # of modifications to agenda 3) % of positive feedback resident responses post care conference

Target for process measure

- 1)Review of care conference process, including changes to agenda will be completed by end of April 2025 2) there will be a [80 %] improvement in overall positive responses post care conference by September 2025

Lessons Learned

Develop a guide for structuring discussion, documenting notes, and prompting team reflection. Scheduled the care conference one day per week

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

Focused on strengths, successes, and stability. This helps set a positive tone and highlights what should be continued. This reinforces what the team is doing right and what the resident responds well to. This is for identifying challenges, unmet needs, or areas where the resident's condition or experience could be improved. The goal isn't to assign blame—it's to surface issues early and honestly.

Process measure

- No process measure entered

Target for process measure

- No target entered

Lessons Learned

The team can then collaborates on actionable, realistic next steps. Interdisciplinary input is key.

Comment

To continually improve the care conference process, we are establishing a clear, resident centered approach to explore what's going well, identify what could be better, and collaborate on meaningful ways to enhance care.

Indicator #2

Bladder care products are readily available to keep the resident dry and comfortable

(Extendicare Maple View)

Last Year		This Year		
63.90	**75**	**85.00**	**--**	**NA**
Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

Change Idea #1 ☑ Implemented ☐ Not Implemented ☐ In Progress

Develop a product distribution system and an inventory spreadsheet of available products on hand at times.

Process measure

- 1) # of residents who are using incontinent products 2) # of residents to be asked for feedback per month /per home area 3) # of responses received 4) # of action items received based on survey

Target for process measure

- 1. List of residents who are using incontinent products will be created by end of March 2025 2. Process for ongoing feedback will be in place by April 2025 with approx. 50% of residents per month per home area.

Lessons Learned

Bladder care products are stocked generously to keep residents dry, comfortable, and dignified

Change Idea #2 ☑ Implemented ☐ Not Implemented ☐ In Progress

o decrease the usage of pull□ups in a care environment while still protecting resident comfort, dignity, and dryness. Pullups are not always the most effective product for bladder management.

Process measure

- No process measure entered

Target for process measure

- No target entered

Lessons Learned

Process Flow
Step 1 — Forecasting Needs
Determine average daily use per residen

Step 2 — Distribution
Assign product quantities to each unit/wing/resident

Refill at set intervals (e.g., every morning shift)

Step 3 — Monitoring
Staff record usage at point□of□care

Step 4 — Reordering
Trigger purchase orders based on minimum stock levels

Maintain vendor list and delivery schedules

□ Inventory Spreadsheet in place

Comment

Implement Scheduled Toileting / Prompted Voiding
This is one of the most effective ways to reduce pull□up use.
Toilet residents every 2–3 hours
Use prompts and cues
Document successes

Adjust schedule based on patterns

When residents stay dry more often, staff naturally rely less on pull□ups.

Safety | Safe | Custom Indicator

Indicator #1

Percentage of residents who were physically restrained (daily)

Last Year		This Year		
2.60	**2.50**	**0.50**	**--**	**NA**
Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

(Extendicare Maple View)

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

Continue to educate families and staff on risk of restraints and least restraint policy

Process measure

- 1) # of meetings held with families to provide education on least restraint policy. 2) # of education sessions held monthly 3) # of resident safety meetings held monthly 4) # of action plans created if indicator changes.

Target for process measure

- Education sessions will be implemented by September 2025 Process for meeting with families about restraints will be in place by June 2025 Resident safety meetings will be organized and in place by September 2025

Lessons Learned

A successful restraint reduction program was built on alignment:

1) Physician Engagement -- Clinical authority, medication review, consistent messaging -- Reduced unnecessary orders and reinforces restraint free culture
2) Family Education-- Trust, understanding, reduced pressure to use restraints - Families become partners instead of drivers of restraint use
3) Strong Leadership - Vision, resources, accountability Ensures sustainability and staff confidence

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

Accountability with compassion
Track restraint use, follow up on outliers, and support family/staff who feel anxious about change.

Process measure

- No process measure entered

Target for process measure

- No target entered

Lessons Learned

Real-time coaching
Leaders who round on units, observe care, and coach staff in the moment accelerate culture change.

Comment

Leadership Actions
Clear policy with zero-restraint vision
Not punitive—aspirational, evidence-based, and supported by training.

Invest in alternatives
Mobility aids
Environmental modifications
Staff training in de-escalation
Increased engagement programming

Real-time coaching
Leaders who round on units, observe care, and coach staff in the moment accelerate culture change.

Celebrate wins
Highlight restraint-free success stories in staff meetings and newsletters.

Accountability with compassion
Track restraint use, follow up on outliers, and support faily/staff who feel anxious about change.

Indicator #7

Reduce incidence of worsening pressure ulcers

Last Year		This Year		
0.80	**0.50**	**2.10**	**--**	**NA**
Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

(Extendicare Maple View)

Change Idea #1 ☑ Implemented ☐ Not Implemented ☐ In Progress

Implement per unit tracking for all pressure ulcers to measure status and trends of pressure ulcers in the home.

Process measure

- 1) # of education sessions held for Registered staff on tracking tools 2) # of tracking tools completed monthly 3) # of tracking tools that were reviewed on a monthly basis for trends "

Target for process measure

- 1) 100% of Registered staff will have attended education sessions on tracking tool by May 2025 2) Tracking tools will be correctly completed on a monthly basis by May 2025 3) Process for review , analysis and follow up of trends from tools will be 100% in place by June 2025

Lessons Learned

Across the home, efforts to strengthen wound surveillance, interdisciplinary review, and staff education have contributed to improved awareness and earlier identification of pressure injuries. Challenges primarily related to documentation consistency, staff turnover, and ensuring timely follow□up on all wounds.

Change Idea #2 ☑ Implemented ☐ Not Implemented ☐ In Progress

Review team membership to ensure interdisciplinary. and that team ensures that all wounds and skin issues in previous month are reviewed during their meetings

Process measure

- 1) # of reviews completed on current membership 2) # of new members recruited by discipline 3) Standardized agenda developed which includes review of # pressure ulcers by stage on each unit on a monthly basis"

Target for process measure

- 1) Membership review of skin and wound committee will be completed by Feb 2025 2) Recruitment of new members will be completed by March 2025 3) Standardized agenda will be developed and in place by March 2025

Lessons Learned

Efforts over the past year highlighted the importance of consistent wound surveillance, interdisciplinary collaboration, and ongoing staff education. While progress was made in improving awareness and early detection, challenges related to documentation consistency, staff turnover, and follow□up processes limited the full impact of the change ideas.

Change Idea #3 ☑ Implemented ☐ Not Implemented ☐ In Progress

Education on Product selection wound care.

Process measure

- # of education sessions /shift # of audits completed monthly # of audits that identified areas for improvement monthly

Target for process measure

- 1) Education sessions on products and selection of products will be completed for all Registered staff by End of April 2025 2) Audits will show a 50% improvement in compliance by June 2025

Lessons Learned

Efforts over the past year highlighted the importance of consistent wound surveillance, interdisciplinary collaboration, and ongoing staff education. While progress was made in improving awareness and early detection, challenges related to documentation consistency, staff turnover, and follow□up processes limited the full impact of the change ideas.

Comment

Launch repositioning compliance audits with real-time feedback for skin and wound problems by ensuring consistent off-loading of pressure, identifying missed repositioning early, and reinforcing best practices at the point of care. Real-time feedback improves staff adherence, prevents prolonged pressure on bony prominences, and reduces the likelihood that early skin changes progress to more severe pressure injuries. This intervention increases accountability, supports timely coaching, and directly contributes to reducing the incidence of worsening pressure ulcers in the home.

Safety | Safe | Optional Indicator

Indicator #5

Percentage of LTC home residents who fell in the 30 days leading up to their assessment (Extendicare Maple View)

Last Year		This Year		
20.65	**15**	**19.40**	**6.05%**	**15**
Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

Change Idea #1 ☑ Implemented ☐ Not Implemented ☐ In Progress

2) Complete environmental assessments of resident spaces upon admission to identify potential harms and correct before falls occur.

Process measure

- 1) #of education sessions completed monthly with registered staff

Target for process measure

- 1) Educate all registered staff on how to complete environmental assessments By Sept 2025

Lessons Learned

Completion of assessments reached at least 90%. A practical environmental assessment checklist that aligns with the fall prevention indicator has been implemented. This tool frontline staff can use on admission.

Change Idea #2 ☐ Implemented ☐ Not Implemented ☑ In Progress

Review and update lighting for high-risk residents

Process measure

- # of residents assessed # of lights ordered # of lights installed at bedside, and in Bedroom/bathroom # of falls per month preinstallation and post installation

Target for process measure

- 1) Lights will be ordered by [June] and installed by [Sept 2025] 4) Review baseline vs post installation data for falls for residents with enhanced lighting by Dec 2025

Lessons Learned

Poor lighting is one of the most common environmental contributors to falls.
Night lights, motion sensor lights, were installed as a pilot for residents to navigate safely. Process measures not completely implemented i.e 1) Percentage of high risk residents with a completed lighting assessment within 24 hours of admission.2) Number of lighting hazards identified and corrected within 48 hours.
3) Maintenance response time for lighting related work orders.

Comment

To implement a clinical leadership walkabout as a powerful, evidence‐supported strategy to reduce falls in long‐term care by increasing visibility, strengthening communication, and ensuring real‐time problem‐solving at the point of care.

	Last Year		This Year		
Indicator #6	**12.06**	**10**	**11.00**	**8.79%**	**11**
Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment (Extendicare Maple View)	Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

Change Idea #1 ☑ Implemented ☐ Not Implemented ☐ In Progress

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

Process measure

- 1.) home team established 2.) Schedule regular meetings for antipsychotic review 3.) Attendance to the Quality Labs 4.) Percentage of residents with an action plan inputted.

Target for process measure

- 1). Home team will be established by end of third quarter 2). Education and training completed by beginning of fourth quarter 3). Antipsychotics review meetings are occurring every 4 weeks as of September 2025 4). Residents triggering the Antipsychotic QI have an action plan inputted into the decision support tool within 3 to 6 months of admission.

Lessons Learned

Key Actions
Trained Nursing and clinical staff train on AP□DST use.

Integrated AP□DST into admission, quarterly, and significant□change assessments.

Reviewed all current antipsychotic orders for residents without psychosis.

Conducted monthly audits and case reviews.

Change Idea #2 ☐ Implemented ☐ Not Implemented ☑ In Progress

2) GPA education for training for responsive behaviours related to dementia.

Process measure

- 1). # of GPA sessions provided 2). # of staff participating in education 3). # of referrals to Regional Managers, LTC Consultants or Manager of Behaviour Services & Dementia Care. 4.) Feedback from participants in the usefulness of action items developed to support resident care.

Target for process measure

- 1.) GPA sessions will be provided for [75%]staff by end of third quarter 2.) Feedback from participants in the session will be reviewed and actioned on by Nov 2025

Lessons Learned

2 staff members trained as GPA trainers

Change Idea #3 ☑ Implemented ☐ Not Implemented ☐ In Progress

3) Family education resources provided for appropriate use of Antipsychotics

Process measure

- "1.) # of CEP resources provided to families monthly 2.) # of antipsychotics d/c as a result of increased family awareness.

Target for process measure

- 1) CEP resources will be printed and available at nurses' station by beginning of third quarter.

Lessons Learned

Verbal Education & Discussion
1) Nurses, physicians, and interdisciplinary team members:

2) Explain the rationale for avoiding unnecessary antipsychotics

3) Review the resident's behaviour patterns and triggers

4) Discuss alternatives such as GPA strategies, environmental adjustments, and activity□based interventions

5) Encourage families to share insights about the resident's preferences and history

6) All discussions are documented in the resident's chart.

Change Idea #4 ☑ Implemented ☐ Not Implemented ☐ In Progress

Ensure antipsychotic use is clinically justified, regularly reviewed, and aligned with best practice.

Process measure

- No process measure entered

Target for process measure

- No target entered

Lessons Learned

Conduct interdisciplinary medication reviews monthly.

Flagged residents without psychosis who are receiving antipsychotics for case review.

Documented rationale for continuation or tapering.

Comment

Schedule GPA Basic and GPA Recharged sessions for all care staff.
Track completion rates and ensure new hires receive training within 90 days.
Reinforce GPA strategies during huddles and care conferences.