

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

Indicator #6	Last Year		This Year		
	Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)
Resident Experience:I have input into the recreation programs available (Extencicare Medex)	49.40	64	67.70	--	NA

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

Identify each resident’s individual preferences, interests, and abilities to ensure all programs and interactions are tailored to their unique needs through increased attention to personalized details and direct communication.

**Process measure**

- 1.# of resident interviews conducted to have person centric programs 2.# of resident room audits done for personalized elements 3.# of new/modified programs launched specific to resident need

**Target for process measure**

- 1.There will be a 15 % improvement with satisfaction of program by October 2025. 2. 100% of residents will receive person centered programming by October 2025 and there will be at least 2 new resident centric programs offered each quarter.

**Lessons Learned**

Individual resident preference interviews were completed and incorporated into the MDS activity schedules to strengthen person-centred programming. Information gathered from residents helped guide the planning and modification of programs across all three floors. Several new programs and adjustments to existing programs were introduced based on resident interests, abilities, and feedback.

A feedback survey was also implemented to evaluate resident engagement and satisfaction with the new or modified programs. Overall, the approach improved alignment between programming and resident preferences, though coordinating interviews and ensuring consistent documentation required additional staff time.

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

Program planning meetings (formerly Unit Meetings) were rebranded to improve clarity for residents and staff and to reinforce the focus on person-centred programming. A standardized agenda was introduced across all three floors to support consistent review of resident preferences, program participation, and opportunities for program adjustments. This change helps ensure that programming decisions are informed by resident feedback, preference interviews, and engagement outcomes.

**Process measure**

- No process measure entered

**Target for process measure**

- No target entered

**Lessons Learned**

Rebranding Unit Meetings to Program Planning Meetings improved clarity for residents and staff and reinforced the home’s focus on person-centred programming. The standardized agenda supported more consistent discussion of resident preferences, participation levels, and opportunities to adjust programming across all floors. This approach strengthened interdisciplinary collaboration and improved the home’s ability to tailor activities to residents’ interests and abilities.

**Comment**

Future improvements will include ongoing review of resident preference data, regular feedback surveys, and continued refinement of programs to support meaningful engagement for residents with varying cognitive and physical abilities.

	Last Year		This Year		
<b>Indicator #5</b>	<b>55.80</b>	<b>70.80</b>	<b>50.00</b>	<b>--</b>	<b>NA</b>
Resident Experience: I am satisfied with the variety of food and beverage options in home (Extendicare Medex)	Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

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

The plan is to include trying new products and involving the Resident Food Committee in menu planning developing Medex-specific seasonal menus.

**Process measure**

- 1.# of new products tested 2. # of suggestions received from food committee for menu planning 3. # of seasonally appropriate menu items advertised and incorporated into menu

**Target for process measure**

- 1.Increase Resident's Culinary Satisfaction by 10 % by October 2025 2. At minimum 20 new products will be included in menu based on resident feedback by December 2025. 3.Advertisement of these seasonal menu change in Yodeck will be completed 1 week in advance of each change.

**Lessons Learned**

The change idea for improving the overall food and dining process has been successful. The current resident's council has developed subcommittees, one of which focuses on food and dining. At this subcommittee, residents were consulted in menu and recipe planning. The subcommittee also participated in testing more than 20 plus new products which have been included in the menu based on resident feedback. This was also an opportunity to advertise seasonal specific menu changes so residents are

The Resident Council established a Food and Dining Subcommittee to provide a dedicated forum for residents to discuss the dining experience. Through this group, residents provide feedback not only on food choices but also on other aspects of dining such as meal service, presentation, and the overall mealtime environment.

Feedback from this committee has helped guide several improvements and has informed the development of the home's current Quality Improvement Plan focused on enhancing the dining experience. While the performance indicator declined this year, resident engagement in discussions related to dining has increased and feedback has been valuable in identifying areas for continued improvement.

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

Educate residents and team members to increase awareness about clinical nutrition

**Process measure**

- 1.# of education sessions held 2. # of clinical nutrition resources provided 3. # of residents who required additional support for nutritional needs

**Target for process measure**

- 1. There will be 20% increase in Resident's Clinical Nutrition Satisfaction by October 2025 2. There will be at least 1 education session provided by Dietitian on clinical nutrition by September 2025

**Lessons Learned**

As menus evolve and new best practices and food guidelines are introduced, education provided by the Registered Dietitian may also change. While residents who regularly participate in the Food and Dining Subcommittee have received more detailed information regarding menu planning and nutrition, this education has not yet been consistently shared with all residents throughout the home.

As a result, this change idea remains in progress and will continue as part of the next Quality Improvement Plan to support broader resident education and engagement regarding nutrition and menu changes.

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

Implement a structured meal review process involving members of the Resident Council Food and Dining Subcommittee and dietary staff. Residents participating in the committee complete meal evaluations providing feedback on taste, appearance, portion size, and overall satisfaction. Cooks also complete the same review tool to assess meal quality and presentation from the kitchen perspective. Feedback from these reviews is used to identify opportunities for improvement and support ongoing enhancements to the dining experience.

**Process measure**

- No process measure entered

**Target for process measure**

- No target entered

**Lessons Learned**

The meal review process increased resident and staff engagement in evaluating meal quality and presentation. Feedback from residents and cooks has helped identify opportunities to improve menu items and the dining experience. A challenge has been coordinating reviews consistently across units.



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

Increase communication from leadership by implementing monthly newsletter and to establish structured communication channels including printed and digital newsletters, resident meetings and feedback mailbox

**Process measure**

- 1.# of survey with positive feedback 2. # of feedback submissions received through the mailbox 3. # of resident concerns or suggestions that result in actionable changes or improvements 4. # of resident and family council meetings information discussed

**Target for process measure**

- 1. Monthly Newsletter will be sent out to all residents and families till 31st December 2025 and then revisited for feedback 2. Discussions with resident and family council about newsletter will occur monthly to 31st December 2025 and then process reviewed 3. Satisfaction survey scores related to communication from leadership will improve by at least 15% by October 2025

**Lessons Learned**

The change idea of increasing communication from the leadership team was successful with multiple types of communication platforms used. For feedback we added a clickable email link in the original monthly newsletter for digital submissions of ideas/concerns. We reviewed the feedback monthly as well as at our in-person discussions at residents' council and its subcommittees of suggestions on how to further improve communications. The information they

The home implemented a quarterly Medex Moments newsletter and a monthly Medex Moments Enrichment Edition to improve communication with residents, families, and staff. The enrichment edition highlights activities, the monthly recreation calendar, and special events, while the quarterly newsletter shares updates on quality indicators, initiatives, and home improvements. These initiatives have improved transparency and communication across the home, although the overall indicator showed only modest improvement.

**Safety | Safe | Custom Indicator**

	Last Year		This Year		
<b>Indicator #2</b>	<b>1.31</b>	<b>1</b>	<b>0.00</b>	<b>--</b>	<b>NA</b>
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 Medex)	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 Incontinence Associated Dermatitis (IADs) Training

**Process measure**

- 1. # of educational session 2. # of staff who pass the post training assessments.

**Target for process measure**

- 100% completion of training for of Registered staff on IAD by June 31,2025

**Lessons Learned**

100% of nursing staff had in-person and/or virtual education on incontinence associated dermatitis and proper peri-care procedures.

**Safety | Safe | Optional Indicator**

Indicator #3	Last Year		This Year		
	Percentage of LTC home residents who fell in the 30 days leading up to their assessment (Extendicare Medex)	<b>13.38</b> Performance (2025/26)	<b>12</b> Target (2025/26)	<b>15.51</b> Performance (2026/27)	<b>-15.92%</b> Percentage Improvement (2026/27)

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

Increase awareness of falls that are occurring in the home.

**Process measure**

- 1.# of residents who have fallen monthly # of digital boards updated monthly with real-time fall data

**Target for process measure**

- 1. Digital boards will have fall data posted monthly starting May 2025. 2. Data will be 100% updated by 30th of every month starting May 2025.

**Lessons Learned**

The change idea of implementing digital boards to display real-time fall data, which would be a part of keeping staff informed of trends and high-risk areas/residents for proactive interventions was implemented this year utilizing our current yodek system. Our physiotherapy team updated the boards monthly with new data and information bringing awareness to our team and assisting in managing falls in the home and awareness of new processes, reasons for and root cause of falls, and providing our team data and education to reduce the overall falls in the home. There were no challenges to this process as it is straightforward data entry. The information was well received by the staff who also felt the yodek was a very effective method in sharing data, providing education and snapshots of current status.

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

Have designated Falls Champions

**Process measure**

- 1.# of falls champions role designated 2. # of education sessions held for falls champions 3. # of insights/learning reviewed during fall committee meetings brought by fall champions

**Target for process measure**

- 1.100% completion of training for all designated fall champions by September 30, 2025. 2.One fall champion appointed per shift per floor within home by October 31, 2025. 3.The fall champion provides insights on fall incidents during quarterly fall committee meeting by December 31, 2025

**Lessons Learned**

In collaboration with our preceptorship program, we were able to identify and designate fall champions within home as per the next change idea. The falls champions were selected by using one person from each wing on each unit, and is both the full time and their part time counterpart for continuity. We provided education on role and responsibilities to designated falls champions which included rounds, knowledge of falls monitoring devices, the introduction of the Falls Observation record and building capacity with their co workers on how to utilize these devices and observation tools to prevent falls by identifying the true root cause analysis, triggers and unmet needs which are often the reason for falls. With the implementation of the champions we saw an immediate reduction in falls, especially during high-risk times and we continue to trend downwards in falls. The challenges encountered were mostly around ensuring that the falls champions were able to perform their role during the shift report and not engaging in other tasks. The other area that required initial redirection was ensuring the falls champions were getting a thorough report to them post unit report. This was a short lived challenge that was easily redirected through re education and on the spot redirection. Registered staff were able to understand the concept and take the leadership on directing with positive outcomes. The FOR paper worksheet is still in progress and is up for reevaluation at the next falls committee meeting.

**Comment**

The home has implemented a comprehensive falls prevention strategy for 2026 focused on strengthening frontline practice consistency and improving monitoring following falls events. Key initiatives include a structured PSW preceptorship program to ensure consistent application of falls prevention practices and the introduction of a Falls Captain role with a 72-hour Falls Observation Record to support monitoring and early intervention following falls or changes in condition. These strategies aim to strengthen accountability, improve staff competency in falls prevention, and support timely identification of risks in order to reduce the overall incidence of falls.

Indicator #4	Last Year		This Year		
	Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment (Extendicare Medex)	<b>11.79</b> Performance (2025/26)	<b>10</b> Target (2025/26)	<b>7.50</b> Performance (2026/27)	<b>36.39%</b> Percentage Improvement (2026/27)

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

Engage the Behavioral therapist to establish strategies

**Process measure**

- 1.# of behavioral interventions established in quarter. 2. # of referrals to Behavioral therapist

**Target for process measure**

- Personalized behavioral intervention will be placed for 100% of identified residents by June 31,2025 Process for ongoing review of behavioral interventions for effectiveness will be fully in place by July 31, 2025 with a reduction in behaviors by at least 10%.

**Lessons Learned**

The change idea of engaging our BT was successful. This was done at our GROW meetings which occurred every week, not only to discuss residents who are having a quarterly review but also new behaviours exhibited over the past 7 days which were not at baseline. This process was enacted and had a proactive response to having an assessment and behaviour plan put into place once all medical root cause was ruled out, resulting in shorter duration of responsive behaviours and a sustainability plan in place to further reduce future behaviours. Individualized care plans were created with an escalation continuum which was very clear for all staff to follow and understand interventions to utilize for effective management. Challenges is that many of the PSW staff would rely on the behaviour therapist to intervene initially rather than respond as per the continuum, however through redirection the program was successful and has led to further developing our dementiability program this year.

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

1. Interdisciplinary 'Anti-psychotics Program' review process using AP-DST

**Process measure**

- No process measure entered

**Target for process measure**

- No target entered

**Lessons Learned**

The Antipsychotic Decision Support Tool (AP-DST) is being used as intended to track residents prescribed antipsychotic medications and support interdisciplinary review. Residents identified on the tracker are reviewed during behavioural rounds, and individualized action plans are documented to assess appropriateness of use and identify opportunities for non-pharmacological interventions or deprescribing where clinically appropriate.