

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

Indicator #4	Last Year		This Year		
	Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)
I am satisfied with the quality of care from my dietitian (Northridge)	33.30	67.30	NA	--	NA

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

Increase awareness of dietitian role in the home with residents and families

**Process measure**

- 1) # of meetings with Councils where Dietitian attended 2) # of suggestions provided by councils 3) # of CQI meetings where action items were discussed with Dietitian

**Target for process measure**

- 1) Dietitian will attend Family Council by June 2025 2) Dietitian will attend Resident Council by June 2025 3) Action items and plan will be discussed at CQI committee with Dietitian by April 2025.

**Lessons Learned**

The dietitian attended resident council to speak about her role in the home. Additionally, our dietitian and Food Service Manager attend Resident Food Council which was highly successful and engaging for residents.

**Comment**

This question was not part of the 2025 Resident Survey for year over year comparison.

Indicator #3	Last Year		This Year		
I am satisfied with quality of care from my doctors. (Northridge)	<b>43.20</b>	<b>63.90</b>	<b>55.00</b>	<b>--</b>	<b>NA</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

Communicate role of Medical Director and Physicians and give opportunity for feedback.

**Process measure**

- 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

**Target for process measure**

- 1) Medical Director will attend Family Council by June 2025 2) Medical Director will attend Resident Council by June 2025 3) Action items and plan will be discussed at CQI and PAC committee with Medical Director by April 2025

**Lessons Learned**

11.8% increase in satisfaction as compared to 2024.

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

Improve visibility of physician in home with residents and families

**Process measure**

- 1) # of name tags ordered 2) % of times physician site visits included on communication boards

**Target for process measure**

- 1) Name tags will be ordered for all physicians in the home by April 2025 2) Process for utilizing communication board for posting visit schedules will be 100% in place by April 2025

**Lessons Learned**

Poster communicating MD rounds at front entrance was received positively by residents and families.

**Comment**

In 2026, MD "TLC" Tender Loving Care Visits will be implemented to improve MD visibility in the home

Indicator #2	Last Year		This Year		
	Communication from home leadership is clear and timely (Northridge)	<b>47.70</b> Performance (2025/26)	<b>68.10</b> Target (2025/26)	<b>51.20</b> Performance (2026/27)	<b>--</b> Percentage Improvement (2026/27)

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

Give updates to residents in a more personal manner so they hear what is happening in home.

**Process measure**

- 1) the number residents the newsletter was read with each month 2) the number of resident council members the newsletter was distributed to each month 3) the number of residents with a CPS of 2 or less who received a copy of the newsletter. 4) the number of questions asked

**Target for process measure**

- 1) A recreational program to read the newsletter with residents will be implemented by April 2025. 2) 100% of resident council members will receive a newsletter monthly. 3) 100 % of the residents with a CPS of 2 or less will receive a copy of the newsletter monthly.

**Lessons Learned**

3.5% increase as compared to 2024  
 Lessons Learned: Management Visits will have a schedule and consistency as determined by the Resident Council.

**Comment**

In 2026, our leadership team will each be invited to resident council to discuss their role and answer resident questions. The residents will determine the schedule of visits and topics.

Indicator #5	Last Year		This Year		
	Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)
I am satisfied with the quality of maintenance of physical building and outdoors. (Northridge)	66.70	74.20	61.50	--	NA

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

Complete regularly scheduled audits for maintenance of building and outdoor spaces.

**Process measure**

- 1) # of audits completed monthly 2) # of deficiencies identified 3) # of action items

**Target for process measure**

- 1) One audit completed monthly with 100% of audits being completed by Dec 31, 2025 2) There will be a 75% improvement in identified deficiencies from audits by Dec 31, 2025 3) By Dec 31, 2025, 75% of action items will be addressed.

**Lessons Learned**

Audits were completed for maintenance of building and outdoor spaces.  
 Lawn replacement at front entrance completed including new lawn furniture and umbrellas for main courtyard.  
 Challenges: grounds improvement to main courtyard was late in season. Extremely hot summer. 2026 focus will be on courtyards accessed from resident dining rooms.

**Comment**

In 2026, there will be a focus on improving the aesthetics of outdoor courtyards.

Indicator #8	Last Year		This Year		
	The resident has input into the recreation programs available. (Northridge)	<b>59.30</b> Performance (2025/26)	<b>70</b> Target (2025/26)	<b>53.60</b> Performance (2026/27)	<b>--</b> Percentage Improvement (2026/27)

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

Engage residents and families in quarterly co-design sessions, workshops, or focus groups

**Process measure**

- 1) # of sessions/year 2) # of people participating 3) # of different ideas being presented 4) # of ideas implemented 5) # of reminders posted on communication board and added to monthly calendar

**Target for process measure**

- 1) Co-design program will be introduced in April 2025 and fully implemented as of May 2025 2) Residents and family will participate in April providing feedback on programs and selecting upcoming events with a goal of improving satisfaction by 15% by October 2025

**Lessons Learned**

Residents responded 72.7% to the same question as a monthly resident choice meeting is facilitated by the Recreation Manager.

Lessons learned: The outcome of monthly resident choice meetings will be communicated to families in the Northridge Chronicles Newsletter. 2026 focus will expand and trial an annual co-design method to increase feedback and engagement for families.

**Comment**

In 2026, the focus will expand and trial an annual co-design method to increase feedback and engagement for families through a combined Resident and Family Councils meeting.

**Safety | Safe | Custom Indicator**

	Last Year		This Year		
<b>Indicator #1</b>	<b>0.80</b>	<b>0.50</b>	<b>0.83</b>	<b>--</b>	<b>NA</b>
% of residents with worsened pressure ulcers Stage 2-4 (Northridge)	Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

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

Mandatory education for all Registered staff on correct staging of Pressure ulcers

**Process measure**

- 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.

**Target for process measure**

- 1) Communication on mandatory requirement will be completed by April 2025 2) 100% of Registered staff will have completed education on correct wound staging by June 2025 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 June 2025 with goal of 75% improvement.

**Lessons Learned**

Successfully provided education to all nurses on the correct staging of pressure ulcers in the first quarter of 2025.

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

Adopt a new point of care (POC) alert process to notify nursing staff of by exception issues for early identification of skin issues

**Process measure**

- # of staff that have been educated # of audits completed # of alerts that were completed on a monthly basis

**Target for process measure**

- 1) Staff are educated on the new process by April 2025 2) Registered staff will audit and clear 100% of alerts at the end of each shift by June 2025. 3) Alerts process will be 100% implemented on each unit by June 2025.

**Lessons Learned**

Staff were educated to use POC Alerts to the nurse in addition to informing them verbally. This intervention was successfully implemented.

**Comment**

In 2026, we will provide Registered staff with annual mandatory education on correct staging of Pressure ulcers and enhanced training for WCC and PSWs

Safety | Safe | **Optional Indicator**

Indicator #6	Last Year		This Year		
	Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)
Percentage of LTC home residents who fell in the 30 days leading up to their assessment (Northridge)	12.40	10	14.17	-14.27%	12

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

Re implement Post fall huddles

**Process measure**

- 1) # of staff who reviewed policy for post fall huddles 2) # of post fall huddles that were completed as per policy on a monthly basis

**Target for process measure**

- 1) Staff education on post fall huddles will be completed with mandatory education with 100 % participation by April 30, 2025. 2) By June 2025, 100 % of post fall huddle documentation will be completed as per policy.

**Lessons Learned**

Interdisciplinary team is actively engaged in Post Fall Huddles.  
In 2026, the Restorative Care Lead will also join the huddles.

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

Implement new Fall Prediction and Prevention Report (FPPR) developed by Extencicare

**Process measure**

- 1) # of education sessions 2) # of residents at high risk reviewed monthly 3) # of plans of care reviewed to ensure strategies in place 4) # of residents on list who did not experience a fall in the previous 30 days.

**Target for process measure**

- 1) Training on Fall Predication and Prevention report will be fully completed by April 30, 2025 2) All residents listed on report as being at risk of fall will have strategies reviewed monthly beginning May 2025.

**Lessons Learned**

Used to gather data and analyze trends in CCQI monthly meetings.

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

Review Activity programming during times when most falls occur

**Process measure**

- 1) # of residents reviewed who are high risk for falls 2) % of program review completed 3) # of new programs implemented during peak times for falls 4) # of high-risk residents who did not fall during month when activity was occurring

**Target for process measure**

- 1) Full review of falls and times when occurring will be completed each month starting April 2025. 2) A review of all high-risk residents' program preferences will be completed each month starting April 2025. 3) Individualized programs will be implemented for all high-risk residents by time of day by June 2025.

**Lessons Learned**

Implementation is currently planning phase.

**Comment**

In 2026 there will be a focus for further collaboration between front-line staff and recreation department.

Indicator #7	Last Year		This Year		
	12.79	11	11.59	9.38%	10
Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment (Northridge)	Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

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

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 10% of Registered and 10% of PSW staff by June 2025 2) All feedback from participants in the session will be reviewed and actioned on by December 2025.

**Lessons Learned**

GPA training was provided in May/June/October of 2025 for 30 staff The education focused on staff who worked in the Secured Unit. The home has a long-term goal for all front-line staff to eventually be GPA trained. GPA training will continue in the 1st Quarter of 2026.

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

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**

- CEP resources will be printed and available at nurses' station by May 2025.

### Lessons Learned

In 2025 the MD was the first contact for Antipsychotic family education. In 2026, written resources for families will be explored.

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

Education for Registered Staff on antipsychotics

#### Process measure

- # of registered staff who attended training session on antipsychotic medications.

#### Target for process measure

- 75% of registered staff will have attended training on antipsychotic medications by December 2025.

### Lessons Learned

Antipsychotic education was provided to all nurses. annually as part of mandatory annual education.

### Comment

In 2026 we will continue to provide staff with opportunities for GPA education using external funding sources. We will implement the availability of family education resources provided for appropriate use of antipsychotics