

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)
Satisfied with variety of food and beverages (Riverside Place)	52.20	60	64.50	--	NA

Change Idea #1 Implemented Not Implemented In Progress

Improved communication methods for residents regarding menus

Process measure

- # of food committee meetings held annually # Menustream menu board installed

Target for process measure

- 1) Food committee will meet monthly beginning March 31, 2025 2) Menu boards 100% installed by June 30, 2025

Lessons Learned

Ongoing communication has increased this. New menu board was implemented June 2025. Remains ongoing challenges with resident population under 65 and their preference differences compared to other residents in the home.

Comment

Ongoing food committee meetings to identify ongoing opportunities to improve

Indicator #5	Last Year		This Year		
	Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)
Satisfied with quality care of doctors (Riverside Place)	53.30	60	81.50	--	NA

Change Idea #1 Implemented Not Implemented In Progress

Improved resident communication and visibility of doctors

Process measure

- 1) Doctors name tags are clear for all residents to see 2)# of concerns unaddressed brought forward at Residents' Council 3) Increase in satisfaction during 2025 survey

Target for process measure

- 1) New name tags provided to all doctors in home by March 31, 2025 2) Concerns specific to satisfaction with physician to be reviewed at Residents' Council monthly by March 31, 2025 3) Satisfaction increased by next survey by 20% to 64%

Lessons Learned

Change ideas were communicated at the Professional Advisory Committee meeting and subsequently to Residents' Council. There were no reported issues from residents related to communication

Comment

Ongoing communication with MD's providing resident feedback if any regarding quality of service

Indicator #1	Last Year		This Year		
	In my care conference, we discuss what's going well, what could be better and how we can improve things (Riverside Place)	54.80 Performance (2025/26)	60 Target (2025/26)	63.00 Performance (2026/27)	-- Percentage Improvement (2026/27)

Change Idea #1 Implemented Not Implemented In Progress

Increase resident participation in care conference by sending out invitations

Process measure

- # invitations for care conference sent to residents # of residents who are supported to attend care conference # of residents who attended care conference

Target for process measure

- By December 30, 2025 100% of invitations will be sent to residents with a CPS of 3 or better . 100% of capable residents are able to attend their care conference by December 1, 2025

Lessons Learned

Resident care conference participation has increased, invites are sent however not all POA / family bring the resident if they attend themselves.

Comment

Ongoing communication with POA / family regarding resident participation, even if they cannot fully participate.

Safety | Safe | **Optional Indicator**

Indicator #2	Last Year		This Year		
	Percentage of LTC home residents who fell in the 30 days leading up to their assessment (Riverside Place)	14.84 Performance (2025/26)	13 Target (2025/26)	14.76 Performance (2026/27)	0.54% Percentage Improvement (2026/27)

Change Idea #1 Implemented Not Implemented In Progress

Review Post fall huddles for more details/information

Process measure

- # of staff who reviewed policy and completed education for post fall huddles # of reviews of post fall huddle documentation by ADOC/falls lead

Target for process measure

- Staff education on post fall huddles will be completed with annual clinical education by Oct 31, 2025 Process for review of post fall huddle documentation will be 100% in place by October 31, 2025 with 15% improvement.

Lessons Learned

Many falls during the year were not past fallers, but rather new falls of previous independent residents. Post fall huddle reviews assist in reducing subsequent falls

Change Idea #2 Implemented Not Implemented In Progress

Ensure each resident at risk for falls has an individualized plan of care for fall prevention

Process measure

- 1) # of residents at risk for falls 2) # of plans of care reviewed 3) # of new strategies determined 4) # of plans of care updated 5) # of sessions held to communicate changes with staff

Target for process measure

- 1) 100% of residents at risk for falls will be identified by June 30, 2025 2) 100% of care plans for high-risk residents will be reviewed and updated by July 31, 2025 3) Changes in plans of care will be 100% communicated to staff by August 15, 2025

Lessons Learned

Part of review process included auditing care plans post fall which was successful

Change Idea #3 Implemented Not Implemented In Progress

Buddy Up program

Process measure

- 1) # of education sessions provided to PSW and Registered staff 2) # of audits on Buddy Up program with no deficiencies

Target for process measure

- 1) Education sessions for PSW and Registered staff will be completed by Jun 30,) Manager audits of program will begin July 1, 2025 and will show 100% improvement by November 1, 2025.

Lessons Learned

Some hours issues with falls lead led to a delay in updating new residents on to the program. Will be addressing in 2026.

Comment

Reviewing supervision of buddy up program in 2026 and better methods to ensure new participants are added in a timely manner and are assigned daily at morning report

	Last Year		This Year		
Indicator #3	16.73	16	15.81	5.50%	17.30
Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment (Riverside Place)	Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

Change Idea #1 Implemented Not Implemented In Progress

Maintain Extencicare's Antipsychotic Reduction Program which includes using the Antipsychotic Decision Support Tool

Process measure

- 1) # meetings scheduled for antipsychotic review 2) Percentage of residents with an action plan inputted 3) # of newly admitted residents with antipsychotic medication prescribed

Target for process measure

- 1) Antipsychotic review meetings will be held quarterly beginning by June 2025 2) 100% of residents triggering antipsychotic QI have an action plan inputted into the decision support tool within 3 to 6 months of admission

Lessons Learned

Utilization of Antipsychotic Decision Support Tool and regular review and communication with MD's ensure this was successful

Comment

Continuing to follow process with MD meeting with BSO RPN prior to any new antipsychotic being prescribed to ensure alternative interventions have been exhausted first

Safety | Safe | Custom Indicator

	Last Year		This Year		
Indicator #4	2.40	2	2.35	--	NA
Percentage of residents who had a pressure ulcer that recently got worse (Riverside Place)	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 June 30, 2025 2) 100% of Registered staff will have completed education on correct wound staging by August 31, 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 September 30, 2025

Lessons Learned

Initial online training was completed however the modules were postponed due to transition to LTCF

Change Idea #2 Implemented Not Implemented In Progress

Turning and repositioning re-education

Process measure

- # of staff that have been educated # of audits completed # of reviews completed by Skin and Wound committee

Target for process measure

- 1) 100% of PSW will have attended education sessions on turning and repositioning by June 1, 2025 2) Check in with staff and will be correctly completed on a monthly basis by July 1, 2025 3) Process for review, analysis and follow up of monthly trends from tools will be 100% in place by April 30, 2025

Lessons Learned

Completed with all PSWs. Challenges with complex residents and compliance with routines

Change Idea #3 Implemented Not Implemented In Progress

Focus on continence to keep skin clean and dry- toileting, appropriate brief selection

Process measure

- # of residents with skin issues # of residents with a toileting plan in place # of brief audit checks completed # of education sessions provided # of residents on restorative toileting program

Target for process measure

- 1) The leads for Skin/Wound and Continence will complete their resident review by July 1, 2025 2) Review of correct sizing and type of incontinence products will be completed weekly by continence lead by May 31, 2025 3) Education sessions for product selection will be completed by April 30, 2025 4) Annual review of continence program will be completed by March 31, 2026

Lessons Learned

Toileting and continence was determined to not be a contributing factors top home pressure ulcers

Comment

Ongoing focus on residents coming to the home with pre-existing complex wounds or at high risk to develop complex wounds