

## Experience

### Measure - Dimension: Patient-centred

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Resident is satisfied with the food and drinks served to him/her	C	% / LTC home residents	In-house survey / Annual Resident Experience Survey	78.10	80.00	Continuous Improvement	

## Change Ideas

### Change Idea #1 Adjust menu to include seasonal availability

Methods	Process measures	Target for process measure	Comments
Monitor seasonal availability of fruits and vegetables and incorporate where possible. Ensure residents are aware of fresh fruits and vegetables being utilized. Incorporate more hearty menu options during winter months and lighter/cold options in summer months.	[#] seasonal foods incorporated in each menu cycle. Seasonal fruits/vegetables and seasonal menu items advertised each cycle. Timelines: Seasonal food changes will be made to the menu each cycle by [date]. Advertisement of seasonal changes will be completed [#] weeks in advance of each change.	3 seasonal foods incorporated in each menu cycle. Seasonal fruits/vegetables and seasonal menu items advertised each cycle. Timelines: Seasonal food changes will be made to the menu each cycle by Q2 2026. Advertisement of seasonal changes will be completed 2 weeks in advance of each change.	

## Change Idea #2 Increase special food programs through the program team

Methods	Process measures	Target for process measure	Comments
Review previous year's calendar to determine [#] food-related events. Brainstorm new ideas (breakfast clubs, friendship luncheons, food trucks, outings, BBQs, "around the world" programs). Review resident interests in Program Planning Meetings. Host food-focused programs monthly.	[#] food-related programs offered. Attendance tracked for each program. Resident feedback through Resident Council and Program Planning meetings.	At least 1 food-related programs incorporated on the monthly calendar. Attendance at food-related programs is comparable to, and in many cases exceeds, attendance at other programs. At least three food- and beverage-related ideas originating from the Resident Council were incorporated.	

## Measure - Dimension: Patient-centred

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Residents is satisfied with the quality of care from doctors who work in the home	C	% / LTC home residents	In-house survey / 2025 Annual Resident Experience Survey	87.10	90.00	Continuous Improvement	

## Change Ideas

### Change Idea #1 Communicate roles of Medical Director and Physicians/NPs, allow opportunities for feedback

Methods	Process measures	Target for process measure	Comments
Medical Director meets at minimum annually with Family and Resident Councils. Discuss feedback and areas for improvement. Provide updates at CQI meetings on action items.	[#] Council meetings attended by Medical Director. [#] suggestions provided by Councils. [#] CQI meetings where action items were discussed.	Medical Director will attend Family Council by Q1 2026 Medical Director will attend Resident Council by Q1 2026 Action items reviewed at CQI Committee with Medical Director by Q3 2026	

### Change Idea #2 Tracking of in-person resident visits

Methods	Process measures	Target for process measure	Comments
Create list of physician/NP resident assignments to ensure each resident receives at least one in-person visit per quarter.	[#] residents per physician/NP. [#] residents who had an in-person visit during each quarter.	Tracking list developed by Q1 2026. All residents will receive a minimum one in-person visit per quarter by Q2 2026.	

## Measure - Dimension: Patient-centred

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
If Resident needs help right away, he/she can get it	C	% / LTC home residents	In-house survey / 2025 Annual Resident Experience Survey	91.20	95.00	Continuous Improvement	

## Change Ideas

### Change Idea #1 Implement purposeful rounding

Methods	Process measures	Target for process measure	Comments
Provide education sessions for staff on purposeful rounding. Deliver 4P's (Pain, Positioning, Personal needs, Possessions) education. Audit call bell frequency and response times following training.	[#] education sessions completed. [#] staff who received 4P's education. [#] audits completed.	Purposeful rounding education completed by Q3 for 100% of staff. 4P's education delivered by Q2 2026.	

### Change Idea #2 Review staffing levels and routines on all shifts

Methods	Process measures	Target for process measure	Comments
Meet with all shifts to discuss survey results related to response times. Identify root causes of any delays. Develop and implement an action plan. Hold follow-up meetings to review progress.	[#] meetings held with each shift. [#] staff in attendance at each meeting. [#] root causes identified and strategies developed. [#] strategies implemented. [#] follow-up meetings completed.	Root causes and action plan completed by Q3 2026. Action plan implemented by Q3 2026.	

## Safety

### Measure - Dimension: Safe

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of LTC home residents who fell in the 30 days leading up to their assessment	O	% / LTC home residents	CIHI CCRS / July 1 to September 30, 2025 (Q2), as target quarter of rolling 4-quarter average	10.96	10.00	Continues Improvement	

### Change Ideas

Change Idea #1 1) Re-educate staff on Fall Prevention and Injury Reduction program - putting an emphasis on new hires.

Methods	Process measures	Target for process measure	Comments
1) Clinical Lead will provide education sessions on Fall Prevention and Injury Reduction program to care staff 2) Managers and/or program lead will audit and monitor program to identify compliance and/or gaps - minimum of 15 resident's audited quarterly	1) # of education sessions provided to PSW and Registered staff 2) # of audits completed	1) Education sessions for PSW/HCA and Registered staff will be completed by April 2026. 2) Audits on Fall Prevention and Injury Prevention program will begin by May 2026.	

## Change Idea #2 2) Root cause analysis education for registered staff to improve post fall huddles

Methods	Process measures	Target for process measure	Comments
1) Root Cause champion to education registered staff in home 2) Leadership to attend and audit post fall huddles specifically root cause analysis discussion	1) # of registered staff educated 2) # of audits completed	1) Registered Staff education on Root Cause Analysis will be completed by April 2026 2) Audits will start in May	

**Measure - Dimension: Safe**

Indicator #5	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment	O	% / LTC home residents	CIHI CCRS / July 1 to September 30, 2025 (Q2), as target quarter of rolling 4-quarter average	0.00	0.00	Continuous Improvement	

**Change Ideas**

## Change Idea #1 Anti-psychotics Program includes use of the Anti-psychotic Decision Support Tool (AP-DST).

Methods	Process measures	Target for process measure	Comments
1. Establish AP Home Team. 2. Education and support provided by Regional Manager(s). 3. Resident-centred action plans are inputted into the home's Anti-psychotic Decision Support Tool (AP-DST). 4. Escalation to CMO supports (i.e., Anti-psychotics Lead).	1. AP Home Team established. 2. Scheduled regular meetings for antipsychotic review. 3. % of residents on anti-psychotics with an individualized action plan inputted into the home's Anti-psychotic Decision Support Tool (AP-DST). 4. Attendance to Quality Labs by Regional Manager(s) and/or Home Leadership team to share success stories and/or challenges for continuous improvement recommendations.	1. AP Home Team will be established by Q2 2026. 2. Education and training completed by Q2 2026. 3. Resident-centred interdisciplinary reviews of anti-psychotic use are occurring every quarter. 4. Residents triggering the anti-psychotic QI indicator have an action plan inputted into their home's Anti-psychotic Decision Support Tool (AP-DST) within 3 to 6 months of admission and every month thereafter until no longer triggering QI indicator.	At this time, Sherwood Court currently has no anti-psychotics; therefore, for 2026, the home will continue to sustain current processes and outcomes. While results are being maintained, this area has not been included as a priority action plan item.

## Change Idea #2 Family education resources provided for appropriate use of anti-psychotics.

Methods	Process measures	Target for process measure	Comments
1. Provide family resource: Centre for Effective Practice (CEP) - How Anti-psychotic Medications are Used to Help People with Dementia: A Guide for Residents, Families and Caregivers. 2. Make resource available at nurses station for families.	1. # of CEP resources provided to families monthly. 2. # of antipsychotics de-prescribed as a result of increased family awareness.	Copies of CEP resource will be printed and available at nurses station by Q2 2026.	

**Measure - Dimension: Safe**

Indicator #6	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of long-term care residents whose stage 2 to 4 pressure ulcer worsened	O	% / LTC home residents	CIHI CCRS / July 1 to September 30, 2025 (Q2), as reporting quarter for the rolling 4-quarter average	3.42	2.00	Extendicare Benchmark	

**Change Ideas**

Change Idea #1 Mandatory education for all Registered staff on correct staging of pressure ulcers.

Methods	Process measures	Target for process measure	Comments
Communicate to Registered staff requirement to complete education. Registered staff complete online modules on wound staging by end of third quarter of year. DOC/designate to monitor completion rates.	# of communications to Registered staff mandatory requirement to complete education. # of Registered staff who have completed online modules on wound staging on a monthly basis. # of audits of completion rates completed by DOC/designate and follow up as required.	Communication on mandatory requirement will be completed by April 2026. 100% of Registered staff will have completed education on correct wound staging by June 2026. Audits on completion rates will be completed monthly with required follow up will occur by 1st week of each month and process to be in place by July.	

Change Idea #2 Reinforce the Point-of-Care (POC) alert process to notify nursing staff of by-exception skin issues for early identification and prevention of pressure injuries.

Methods	Process measures	Target for process measure	Comments
Educate staff on new alert process on all shifts. Registered staff to check end of shift for outstanding alerts. DOC/designate audit compliance monthly and follow up with any additional educational requirements. # of staff that have been educated.	# of alerts that were completed on a monthly basis. # of audits completed.		Staff are educated on the new process by May 2026. Registered staff will complete audits by August 2026. Gaps from Alert Audit will be 100% followed up with education or actioned.

**Measure - Dimension: Safe**

Indicator #7	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of long-term care residents in daily physical restraints	O	% / LTC home residents	CIHI CCRS / July 1 to September 30, 2025 (Q2), as target quarter of rolling 4-quarter average	0.00	0.00	Continuous Improvement	

**Change Ideas**

## Change Idea #1 Trial alternatives to each restraint in use (change in environment, sensory rooms, etc.)

Methods	Process measures	Target for process measure	Comments
1) Discuss alternatives and options with interdisciplinary team and frontline care staff 2) Review alternatives trialed during each monthly restraint use review	1) # of alternatives trialed per month 2) # of reviews completed	100% of the restraints in the home have had alternatives trialed and documented by Q3 2026	At this time, Sherwood Court currently has no restraints in our home; therefore, for 2026, the home will continue to sustain current processes and outcomes. While results are being maintained, this area has not been included as a priority action plan item.

## Change Idea #2 Admission coordinator/ designate will review each application received for restraints prior to move-in

Methods	Process measures	Target for process measure	Comments
1) Admission coordinator reviews and flags each application received for restraints 2) Information is sent to LHIN, etc. to indicate that home is least restraint and that alternatives will be trialed upon move-in	1) # of applications received that have a restraint 2) # of communications sent back to applicant and family/ sending authority to explain least restraint approach 3) # of acceptances received to trial alternatives upon move-in	Process for review of new resident applications with restraints will be in place by Q3 2026	