

Experience

Measure - Dimension: Patient-centred

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences".	O	% / LTC home residents	In house data, interRAI survey / Most recent consecutive 12-month period	CB	80.90	Meets the 2025 LTC Division Overall	

Change Ideas

Change Idea #1 2) Newsletters will be sent with a standing item on how to raise concerns.

Methods	Process measures	Target for process measure	Comments
Add a section about concerns in the newsletter.	# of newsletters that note the concern process.	[50%] of newsletters explain how to raise concerns by December 2026.	

Change Idea #2 Quarterly plan of care reviews will be completed with each resident input.

Methods	Process measures	Target for process measure	Comments
"1) On a quarterly basis when plan of care is reviewed meet with resident if able to discuss goals, wishes. 2) Update plan of care based on discussions. "	"1) [#] of plan of care meetings held with resident present. 2) [#] of resident plans of care updated to reflect goals and wishes after discussion. "	"1) Plan of care meetings will begin to held with resident/POA in attendance by April 03, 2026. 2) 100 % of plans of care will be updated within 1 week of the review and 100% completed by December 2026.	

Measure - Dimension: Patient-centred

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
I feel encouraged to share my ideas about the recreation and leisure activities offered on the calendar.	C	Other / LTC home residents	In-house survey / 2026	66.70	72.40	Meets 2025 LTC Division Overall	

Change Ideas

Change Idea #1 Monthly Program Planning Meetings will occur on each home area with their designated recreation assistant to inform and engage residents in program decision making. Designated recreation assistant will meet one on one with 5 residents per RHA, that do not attend calendar planning meetings to receive their ideas and input and to discuss independent leisure opportunities

Methods	Process measures	Target for process measure	Comments
1) Add Program Planning Meetings on the calendar, 1x/month for each home area. 2) Document on meeting minute template. 3) Share and post minutes in common area."	1) # of meetings throughout the year (12). 2) # of change ideas provided in meeting implemented (75%). 3) # of residents participating on each home area with an additional one on one 5 residents per RHA (25%).	1) Program will be introduced and implemented as of March 01, 2026. 2) Residents will meet monthly on each unit, providing feedback on programs and selecting upcoming events by March 1, 2026.	

Change Idea #2 Revitalizing the Resident Home Areas' Dementiability Corners to offer person centered leisure activities

Methods	Process measures	Target for process measure	Comments
Recreation Manager, BSO Lead and Recreation BSO assistant will meet to review recreation assessments, determine individual interests and purchase, stock and maintain the Dementiability Corners	% of Dementiability Corners available by April 03,2026	Dementiability Corners Program will be introduced through Resident/Family Council, Newsletter, Stirling Talk and Home Area Huddles,implemented as of April 03, 2026. 2) Residents will meet monthly on each unit, providing feedback on programs and selecting upcoming events."	

Measure - Dimension: Patient-centred

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
In my care conference what is going well, what can be done better and how to improve things	C	Other / LTC home residents	In-house survey / 2026	63.60	71.40	Meets 2025 LTC Division Overall	

Change Ideas

Change Idea #1 Review annual care conference process.

Methods	Process measures	Target for process measure	Comments
1) Complete review of current care conference process including scheduling. 2) Adjust agenda if required to include time for discussions with resident. 3) Ask resident if they felt their needs and feedback were addressed."	"1) [#] of reviews of care conference process completed. 2) [#] of modifications to agenda. 3) [%] of positive feedback resident responses post care conference."	"1) Review of care conference process, including changes to agenda will be completed by May 31, 2026 2) There will be an improvement in overall positive responses post care conference by August 31, 2026 "	

Change Idea #2 Education to the interdisciplinary team regarding the mandatory requirements of the Resident 6 week and annual care conference, proper process and ensuring the resident and family have the opportunity to know and express what is going well, what can be done better and how to improve things.

Methods	Process measures	Target for process measure	Comments
Allow time for discussion and obtain feedback on what could be improved.	# of meetings when feedback was requested and obtained from resident.	There will be an improvement in this indicator by December 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	13.84	13.00	To meet Provincial/ Extendicare benchmark and to continue to support Stirling Height's residents to ensure their safety, and ongoing quality of life.	

Change Ideas

Change Idea #1 1) Re-educate staff on Fall Prevention and Injury Reduction program

Methods	Process measures	Target for process measure	Comments
"1) Falls Lead will provide education sessions on Fall Prevention and Injury Reduction program to care staff 2) Program lead will audit and monitor program to identify compliance and/or gaps - minimum of 15 resident's audited quarterly" 3)An updated list of High-risk residents will be provided at the beginning of each month to each home area(nursing), Recreation and the Dedicated Care Team(BSO)	"1) # of education sessions provided to PSW and Registered staff 2) # of audits completed" 3)# of Updated List of high risk resident provided to home area (Nursing), Recreation, Physiotherapy and the dedicated care team	"1) Education sessions for PSW/HCA and Registered staff will be completed by April 03, 2026 2) Audits on Fall Prevention and Injury Prevention program will begin by January 01, 2026 "	

Change Idea #2 Review Activities, Restorative and Dementiability programming during times (day, time, shift) when most falls occur

Methods	Process measures	Target for process measure	Comments
"1) Review times when most falls are occurring 2) Review activities and program preferences for residents who are at risk of falls 3) Implement program/activity at time/day/shift when falls are occurring 4) Monitor results "	"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"	"1) Review of falls and times is completed monthly through: Risk Management Module RMM incident analysis and Falls prediction and prevention report(FPPR), commencing January 2026 2) Review of high risk residents program preferences will be completed monthly by April 03, 2026 3) Resident focused programs will be implemented during peaks time by April 6, 2026	

Change Idea #3 7) Re-education on Safe Resident Handling Policy with Staff

Methods	Process measures	Target for process measure	Comments
"1) Education on Safe Resident Handling program 2) Random auditing of safe resident handling practices in the home 3) Identify deficiencies and develop plan of action for gaps"	"1) # of education sessions held for staff on Safe Resident Handling program 2) # of audits completed 3) # of deficiencies identified 4) # of deficiencies corrected post implementation of action plan	"1) Staff education sessions will be 100% completed by April 30,2026 2) Audits of safe resident handling program will show 50% improvement by August 31 2026, and 75% improvement by December 31, 2026"	

Change Idea #4 10) Increased communication during shift report for residents who have recently moved-in and during outbreaks

Methods	Process measures	Target for process measure	Comments
"1) Remind staff about increased risk of falls when in outbreaks and during move-in period 2) Registered staff to communicate list of residents on isolation and/or new move-in's during each shift report to oncoming staff 3) Residents identified as being at increased risk of falls due to isolation or new move-in's will have enhanced monitoring by all staff for two week period "	"1) # of staff receiving reminders for resident fall risk 2) # of shift reports where registered staff communicated list of high risk residents 3) # of residents on enhanced monitoring per shift "	"1) Reminders for staff will be communicated by April 03, 2026, 2) Shift report process for communicating high risk residents will be in place by April 03, 2026, 3) Process for enhanced monitoring for those on isolation or newly admitted will be in place by April 03, 2026 "	

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	13.69	13.60	To remain below Provincial/Extencare benchmark supporting the safety and quality of life for our Stirling Heights residents.	

Change Ideas

Change Idea #1 GPA education for training for responsive behaviours related to dementia.

Methods	Process measures	Target for process measure	Comments
1). Engage with Certified GPA Coaches to roll-out home-level education (note: GPA Bathing module now available), 2). Contact Regional Manager, LTC Consultant or Manager of Behaviour Services & Dementia Care for support as needed. 3). Register participants for education sessions.	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.	1.) GPA sessions will be provided for 100% staff by Jun 05, 2026, 2.) Feedback from participants in the session will be reviewed and actioned on by June 30, 2026.	

Change Idea #2 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 April 03, 2026. 2. Education and training completed by May 03, 2026. 3. Resident-centered interdisciplinary reviews of anti-psychotic use are occurring during clinical meetings, which occur quarterly. 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. "	

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	1.71	1.70	To remain below Provincial/ Extencicare Target, and to continue to see a home improvement in this indicator to support the comfort and quality of life of our residents.	

Change Ideas

Change Idea #1 1) Mandatory education for all Registered staff on correct staging of Pressure ulcers

Methods	Process measures	Target for process measure	Comments
"1) Communicate to Registered staff requirement to complete education. 2) Registered staff to complete online modules on wound staging by end of third quarter of year. 3) DOC/designate to monitor completion rates "	"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. "	1) Communication on mandatory requirement will be completed by December 2026. 2) 100% of Registered staff will have completed education on correct wound staging by December 2026. 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 December 2026.	

Change Idea #2 Adopt a new point of care (POC) alert process to notify nursing staff of by exception issues for early identification of skin issues

Methods	Process measures	Target for process measure	Comments
"1) educate staff on new alert process on all shifts 2) Registered staff to check end of shift for outstanding alerts 3) DOC /designate audit compliance monthly and follow up with any additional educational requirements "	# of staff that have been educated # of audits completed # of alerts that were completed on a monthly basis"	"1) Staff are educated on the new process by April 03, 2026, 2) Registered staff will complete 45 audits by April 24, 2026, 3) Alerts will be 100% implemented on each unit by May 08, 2026.	

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	0.48	0.00	To ensure compliance to 0 restraint policy, to ensure the safety and quality of life of Stirling Heights residents.	

Change Ideas

Change Idea #1 Provide information to families and residents on Least Restraint.

Methods	Process measures	Target for process measure	Comments
1.) Provide Restraint brochure in move in package packages for new admissions. 2.) Meet with Resident and family councils to provide education on Least Restraint and risks associated with restraint use. 3) Provide Restraint/Alternatives in Stirling Heights Newsletter "The Echo"	"1.) # of admission packages with Restraint brochure included. 2.) # of meetings with Resident and Family council to discuss Least Restraint and Risks. 3) # of Newsletters that provides Restraint/Alternatives education.	"1). 100% of admission packages will have Restraint brochure included for new admissions by April 06, 2026. 2). Meetings with Resident and Family councils will be attended to discuss Restraints by May 2026. 3.) Newsletter will provide Restraint/Alternative education by May 2026.	We currently have no restraints in our home. For 2026 will continue to monitor our current processes to sustain results but have not included as a priority area in our action plan.

Change Idea #2 Provide resource for staff to use when discussing restraints with residents and families.

Methods	Process measures	Target for process measure	Comments
1.) Implement new interdisciplinary FAQ document to assist with discussing restraints, 2). Communicate with staff availability of new resource through huddles, staff meetings and Townhalls.	1.) # of times FAQ was utilized monthly 2). # of sessions held to communicate with staff that FAQ was available as resource	1. FAQ resource will be 100% in place by May 04, 2026 2). Staff will be aware of new resource by April 03, 2026.	