

**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)
Percentage of residents responding positively to: I am satisfied with the quality of care from Dietitian (Stoneridge Manor)	62.50	65	NA	--	NA

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

Increase awareness of the role of Dietitian in the home with residents and families.

**Process measure**

- 1) Number of meetings with Council and Forum where RD attended 2) Number of suggestions provided by Council and Forum

**Target for process measure**

- 1) RD will attend Family Forum by June 2025 2) RD will attend Residents Council by June 2025

**Lessons Learned**

Although this was not a specific question in the 2026 survey, increased Dietitian attendance at Resident and Family Council meetings improved awareness of her role and strengthened resident and family engagement.

	Last Year		This Year		
<b>Indicator #5</b> Percentage of residents responding positively to I am satisfied with the variety of recreation programs. (Stoneridge Manor)	<b>66.70</b> Performance (2025/26)	<b>70</b> Target (2025/26)	<b>62.00</b> Performance (2026/27)	<b>--</b> Percentage Improvement (2026/27)	<b>NA</b> Target (2026/27)

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

Integrate specific activities, programs and strategies to include all 5 domains.

**Process measure**

- 1) Previous variances in domains (%) 2) Number of Resident and staff feedback on programs 3) Check the # of domains monthly on calendar

**Target for process measure**

- 1) Recreation Manager to review domains monthly 2) Review number of Resident and staff feedback at Recreation department meeting 1/4ly

**Lessons Learned**

Successful integration of activities and strategies across all five domains of wellness strengthened individualized programming, enhanced resident engagement, and supported overall well-being.

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

Include more seasonal and theme events

**Process measure**

- 1) Note the # of events (seasonal & theme) last years calendars. 2) Review # of unique programs in Activity Pro department multi month report.

**Target for process measure**

- 1) Timeline will be developed by April 11th,2025 2) Process for gathering feedback monthly will be implemented by May 30th, 2025, and ongoing

**Lessons Learned**

The inclusion of additional themed events was highly successful, resulting in increased resident engagement, positive feedback from families, and enhanced overall home morale

	Last Year		This Year		
<b>Indicator #7</b>	<b>62.20</b>	<b>65</b>	<b>60.00</b>	<b>--</b>	<b>NA</b>
Percentage of residents responding positively to: I am satisfied with the variety of food and beverage options (Stoneridge Manor)	Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

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

Adjust menu to include seasonal availability

**Process measure**

- # of seasonal foods to be incorporated in each menu cycle

**Target for process measure**

- Seasonal food changes will be made to menu each cycle May 2025 & October 2025

**Lessons Learned**

- although some small changes were made in the menu, it was not enough to see an increase in satisfaction. The home will continue to review the menu and seek resident feedback to better meet preferences.

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

Increase special food programs in collaboration with Recreation Department

**Process measure**

- 1) # of food related programs being offered 2) Attendance at food related programs 3) Resident feedback at Residents Council meetings, & Program planning meetings.

**Target for process measure**

- Monthly - starting April 2025

**Lessons Learned**

Special food programs were increased with Recreation, but satisfaction scores did not improve as expected. Offer smaller unit-based food programs so more residents can participate.

Safety | Safe | **Custom Indicator**

	Last Year		This Year		
<b>Indicator #2</b>	<b>2.08</b>	<b>2</b>	<b>1.11</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 (Stoneridge Manor)	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 Registered staff who have completed education on wound staging

**Target for process measure**

- 1) Communication on mandatory requirement will be completed by April 30, 2025. 2) 100% of Registered staff will have completed education on correct wound staging by December 2025

**Lessons Learned**

The home has demonstrated measurable improvement in early pressure injury detection, correct staging through nurse-led bedside education. This has resulted in earlier intervention, reduced wound progression, and enhanced accountability in prevention practices.

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

Review team membership to ensure interdisciplinary and that team ensures that all wounds and skin issues in previous month are reviewed during the meetings.

**Process measure**

- 1) # of new members recruited by discipline 2) Standardized agenda which includes review of # pressure ulcers by stage on each home area on a monthly basis

**Target for process measure**

- 1) Membership review of skin and wound committee will be completed by April 30, 2025, 2) Recruitment of new members to be completed by April 30th, 2025, 3) Standardized agenda will be developed and in place by April 30th, 2025

**Lessons Learned**

Monthly interdisciplinary Skin and Wound meetings have strengthened oversight, improved early identification of skin issues, and supported timely interventions to prevent wound progression

Indicator #1	Last Year		This Year		
	Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)
LTC Resident who used a daily restraint (Stoneridge Manor)	<b>1.98</b>	<b>1.50</b>	<b>1.27</b>	<b>--</b>	<b>NA</b>

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

Provide information to families and residents on Least restraint policy

**Process measure**

- 1) # of admission packages with restraint information included 2) Minutes & Attendance from meeting with resident council and family forum to discuss least restraint and evaluate potential knowledge gaps.

**Target for process measure**

- 1) 100% of admission packages will have restraint information included for new admissions April 1, 2025, 2) Resident Council will occur by September 2025 and Family forum by September 2025 to discuss restraints.

**Lessons Learned**

A key challenge has been addressing long-standing beliefs that restraints prevent falls. Ongoing family education and engagement have been essential in supporting a shift toward evidence-based, least-restraint practices.

Safety | Safe | **Optional Indicator**

	Last Year		This Year		
<b>Indicator #3</b>	<b>17.57</b>	<b>15</b>	<b>16.21</b>	<b>7.74%</b>	<b>15</b>
Percentage of LTC home residents who fell in the 30 days leading up to their assessment (Stoneridge Manor)	Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

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

Reassess falling star program and re-educate staff on program

**Process measure**

- 1) # of staff attending education 2) # of audits completed on Falls Program

**Target for process measure**

- 1) Education Sessions for PSW's & Registered Staff to be completed by June 30, 2025. 2) Falls Program Audits to be completed on a quarterly basis to be initiated April 1st, 2025

**Lessons Learned**

The Falling Star program was reassessed, and staff were re-educated on its purpose and application, resulting in improved awareness of high-risk residents and more consistent implementation of fall prevention strategies. This led to a reduction in falls.

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

Review Safe Lift and Handling Policy and procedures Program with staff

**Process measure**

- 1) # of Education sessions provided for staff on safe lift and handling procedures. 2) # of deficiencies identified

**Target for process measure**

- 1) Staff education sessions will be 100% completed by December 31, 2025.

**Lessons Learned**

Safe lift and transfer practices were reviewed with staff, supported by an external educator, resulting in improved technique, increased staff confidence, and enhanced resident safety during transfers.

**Comment**

The team will maintain a prevention-focused approach by reviewing fall trends monthly, reinforcing staff accountability, and ensuring individualized interventions are consistently implemented and evaluated for effectiveness.

	Last Year		This Year		
<b>Indicator #4</b> Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment (Stoneridge Manor)	<b>20.49</b>	<b>17.30</b>	<b>7.14</b>	<b>65.15%</b>	<b>5</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**

Implement Extendicare's Antipsychotic reduction program which includes using the Antipsychotic decision support tool

**Process measure**

- 1) Home team established 2) Schedule regular meetings for antipsychotic review 3) Attendance to Regional/National Quality labs 4) Percentage of residents with an action inputted

**Target for process measure**

- 1) Home team will be established by April 30, 2025 2) Education and training completed by June 30, 2025). Antipsychotics review monthly/ongoing.

**Lessons Learned**

Successful implementation of Extendicare's Antipsychotic Reduction Program, including consistent use of the Antipsychotic Decision Support Tool, has enhanced clinical oversight and contributed to a sustained decrease in inappropriate antipsychotic prescribing.

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

To ensure Behaviour Rounds are being completed on a consistent basis

**Process measure**

- 1) # of rounding sessions scheduled 2) # of behavioural rounding completed per month 3) # of audits completed when required

**Target for process measure**

- 1) Behavioral Leads will contact team supports to arrange for guidance and training by April 15th, 2025, 2) Behavioral Rounding schedule and expectations to be communicated by April 30, 2025, 3) Audit process will be in place for compliance by May 31, 2025

**Lessons Learned**

Ensuring Behaviour Rounds are completed consistently has strengthened interdisciplinary collaboration, improved proactive care planning, and supported safer, more responsive resident-centered interventions.

