

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

Indicator #6	Last Year		This Year		
	If I need help right away, I can get it. (Extendicare Tecumseh)	<b>68.60</b> Performance (2025/26)	<b>75</b> Target (2025/26)	<b>50.00</b> Performance (2026/27)	<b>--</b> Percentage Improvement (2026/27)

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

Increase staff awareness of call bell response times.

**Process measure**

- 1. Number of call bell audits completed 2. Reduction in average call bell response times."

**Target for process measure**

- 1. Run digital call bell report from Tracera prior to initiating in person call bell audits and result sharing April 7th, 2025 2. Develop and initiate in person call bell audits on each unit by April 30th, 2025. 4. Run Tracera call bell report post initiation of call bell audits and result sharing June 2nd, 2025. 5. Evaluate need for continued audits June 2nd, 2025." 6. There will be a 15% improvement in response times by June 2025

**Lessons Learned**

Overall, our numbers have declined in this area. We have completed random call bell audits in rooms on all four units on all three shifts with varied results. Improvement is marked when audits are active, the challenge remains sustainability and long-term improvement.

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

Review staffing and routines for all shifts.

**Process measure**

- 1. Number of staff that attended meeting to review response times. 2. The number of actionable items brought forward by care team. 3. Reduction in average call bell response times.

**Target for process measure**

- 1. Staff meeting with PSWs will be fully completed by April 15th, 2025. 2. Create the action plan by April 30th, 2025. 3. Share action plan with unit staff on each home area by May 15th, 2025 3. Update current routines and create new ones for new positions by June 1st, 2025. 4. Schedule quarterly town hall meetings to review the progress in June, September, December.

**Lessons Learned**

Overall, staffing has been increased to improve direct care hours. We have increased the number of PSW staff on each unit from 3 PSW to 4 PSW on the day and evening shift and from 1 PSW to 2 PSW on the night shift. We have also implemented float nurses on the day shifts and evening shifts.

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

Implemented new designated resident assignments.

**Process measure**

- No process measure entered

**Target for process measure**

- No target entered

**Lessons Learned**

the home implemented and educated staff on the new PSW staff assignments from 3 residents' section to 4 resident section per unit. The home also developed new job description and routines to accommodate increase in staff.

**Comment**

noted decline from 68.5% in 2024 to 50.0% in 2025 for a total of 18.6%. The home also did not meet the organizational divisional average of 70.7%. The home will add education regarding responding to residents when help is needed at the multidisciplinary week unit huddles.

Indicator #5	Last Year		This Year		
	I enjoy eating meals in the dining room. (Extendicare Tecumseh)	<b>70.90</b> Performance (2025/26)	<b>80.90</b> Target (2025/26)	<b>57.10</b> Performance (2026/27)	<b>--</b> Percentage Improvement (2026/27)

Change Idea #1  Implemented  Not Implemented  In Progress

Implement pleasurable dining within the home.

**Process measure**

- 1. Number of leadership members attended the meeting to review policy. 2. Number of staff educated on pleasurable experience. 3. Number of home areas pleasurable dining have roll out completed. 4. Number of audits completed.

**Target for process measure**

- 1. Leadership meeting will held by April 30th, 2025. 2. 100% of education will be completed by May 30th, 2025. 3. Expectations will be reviewed with resident council by June 24th, 2025. 4. Roll out will take place on all home areas monthly starting July 1st, 2025 and ending August 31st, 2025. 5. Evaluations to be initiated by September 30th, 2025

**Lessons Learned**

Mealtime audits were completed on the second-floor units for breakfast and for lunch. Initially the meal times had improved but the challenge remained sustainability. Overall, our numbers have declined.

**Comment**

This question is also part of our QIP plan for 2026/27.

	Last Year		This Year		
<b>Indicator #1</b> Communication from home leadership (Administrator, Executive Director, and Managers) is clear and timely. (Extedicare Tecumseh)	<b>66.70</b> Performance (2025/26)	<b>73.70</b> Target (2025/26)	<b>62.20</b> Performance (2026/27)	<b>--</b> Percentage Improvement (2026/27)	<b>NA</b> Target (2026/27)

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

Improve communication with the leadership team.

**Process measure**

- 1. Number of managers who attended the resident council meeting. 2. 100% of managers to be educated on the process by May 30th, 2025. Percentage of completed follow ups from resident council concerns.

**Target for process measure**

- 1. Completed at resident council by April 30th, 2025. 2. Education to be completed by May 15th, 2025. 3. Process to be reviewed at resident council May 20th, 2025. 4. All concerns from resident council will follow this process as of May 20th, 2025.

**Lessons Learned**

Overall, we increase our manager presence in resident council meetings as invited with a minimum of two managers at every resident council meeting.

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

Increase communication to residents from the leadership team.

**Process measure**

- 1. Number of residents added to the email list. 2. Number of residents with CPS score of 2 or below

**Target for process measure**

- 1. All CPS scores report will be assessed by April 7th, 2025. 2. All residents with a CPS of 0-2 will be asked by the Social Worker if they want to be on the email list by April 30th. 3. Social worker will have email updated with each new admission or request with 24 hours of change.

**Lessons Learned**

We have an active email list including resident emails. CPS scores were reviewed and 3 residents were added to the email list.

**Comment**

In 2024, the home did not achieve the target of 66.7%, with performance declining to 62.2%, representing a total decrease of 4.5%. The home also did not meet the divisional overall target of 69.6%, falling short by 7.4%. The home has invested in new TV screens and communication boards strategically placed throughout the building. These tools are being used to share important updates, highlight upcoming programs and events, and promote greater awareness of services and activities within the home.

Indicator #3	Last Year		This Year		
	Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)
Family Satisfaction - I am satisfied with the Variety of food and beverage options for residents. (Extendicare Tecumseh)	73.70	75	79.70	--	NA

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

Improve family satisfaction with food and beverage options.

**Process measure**

- 1. Number of highlighted changes shared with family council. 2. Number of specialty days completed. 3. number of family council members educated on food council meetings

**Target for process measure**

- 1. Meet with family council by April 30th, 2025. 2. 100% of family council members will have awareness about food council meetings by April 30, 2025 3. There will be at least 6 specialty food days held by October 2025.

**Lessons Learned**

Each month has multiple days of specialty items usually corresponding with the holiday(s) of that month. Example: March 2025, St. Paddy's day pub, Shamrock shakes.  
Residents enjoy a special Christmas dinner.

**Comment**

overall individual average was 70.9% and the home exceed this average by 8.8% for a total percentage 79.7%. Increase in 6.0% in 2024 from 73.7 to 79.7%. In April 2026 education will be provided at the family council meetings regarding the process of resident's food preferences. Resident food preference and menu options are also reviewed at each care conference.

Indicator #2	Last Year		This Year		
	Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)
Family satisfaction - I am satisfied with the food and beverages served to residents. (Extendicare Tecumseh)	<b>76.30</b>	<b>80</b>	<b>78.90</b>	<b>--</b>	<b>NA</b>

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

Improve family satisfaction with food and beverages served.

**Process measure**

- 1. The number of snack options provided at snack times each season.

**Target for process measure**

- 1. Meet with family council by April 15th, 2025. 2. Request to be added to the Family council agenda to provide families the opportunity to present suggestions for menu changes to the resident council by May 30th, 2025. 3. Initiate two options for snacks by June 1st, 2025.

**Lessons Learned**

This target was partially met. There was a 2.60% increase in satisfaction results which correlates with a positive change. Snack options have been updated to include fresh fruit options. Families have given positive feedback about the delivery of fresh grapes, apple slices, and other fruit options.

**Comment**

The home improved in this area, meeting the homes set target by 2.6% from 2024 as well exceed the organizational divisional average of 70.7% by 8.2%. The home has been committed to continue to improve in this area. We have also added diet drink options to beverage list from feedback from residents and families.

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 doctors. (Extendicare Tecumseh)	77.10	80	76.70	--	NA

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

Improve family satisfaction with the quality of care from the doctors.

**Process measure**

- 1. Percentage of improvement in satisfaction on the 2025 survey in comparison to the 2024 survey results.

**Target for process measure**

- 1. Meet with family Council by April 5th, 2025. 2. Meeting with physicians to take place by April 30th. 2. Request with Family Council to be added to the agenda to review new process by May 30th 2025.

**Lessons Learned**

We have exceeded the organizational target of 73.0 by 3.7%. The home was able to educate family members on the process of physician visits and how to communicate directly with the physicians.

**Comment**

In 2025 we had a slight decrease of 0.4% compared to 2024 results. However, exceed the divisional average by 3.7%. In 2026 the home will obtain a new medical director and attending physician plan will be to schedule a meet and greet with the new team and families to review the processes of visits and communication methods.

**Safety | Safe | Custom Indicator**

	Last Year		This Year		
<b>Indicator #8</b>	<b>5.70</b>	<b>2</b>	<b>3.60</b>	<b>--</b>	<b>NA</b>
Percentage of LTC residents with worsened ulcers stages 2-4 (Extendicare Tecumseh)	Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

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

Reduce the prevalence of new and worsening wounds

**Process measure**

- 1. Number of actionable causes. 2. Number of strategies implemented. 3. Number of resolved wounds. 4. Number of mini meetings assigned to the home.

**Target for process measure**

- 1. Identify root causes in weekly meetings by May 30th, 2025. 2. Mini meetings monthly beginning May 30th all resident wounds have healed, Reassess need for continued need for meetings when wounds are healed. 3. Review number of resolved wounds each quarter with committee day.

**Lessons Learned**

Overall, we have seen a marked improvement in our skin and wound indicator for pressures stage 2-4, meeting the target for the last four months of the year.

Ongoing monitoring is needed to improvement the quality of coding in regard to wounds in order to reduce the number of incorrectly identified wounds.

**Comment**

in 2024 the home indicator was 5.70% for 2025 the home performance was 3.60 showing a decline by 2.14%. However, the home did not meet the organization target of 2.0% by 1.6%. The home is committed to improving this indicator through continued educating and investment into staff through specialized training in wound care. We currently have 3 RPN's SWAN certified and 1 RN training in the NSWOOC program.

**Safety | Safe | Optional Indicator**

	Last Year		This Year		
<b>Indicator #7</b>	<b>13.64</b>	<b>12</b>	<b>14.54</b>	<b>-6.60%</b>	<b>13</b>
Percentage of LTC home residents who fell in the 30 days leading up to their assessment (Extendicare Tecumseh)	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 use of the nordic chairs for residents that fall frequently.

**Process measure**

- 1. Number of staff educated on the nordic chair. 2. Number of residents identified at weekly huddles. 4. Number of residents identified who benefitted from use of the nordic chair.

**Target for process measure**

- 1. 100% of staff educated on the Nordic chair by June 1st, 2025 2. Discussion to be initiated into weekly falls meeting and fully implemented by June 19th, 2025. 3. Initiate reviews of residents using the Nordic chair July 10th, 2025.

**Lessons Learned**

Overall, we have had an improvement in our fall indicator, meeting the target 7 out of 12 months of the year. The home did experience an increase in performance from the previous year. Feedback from residents and staff that the Nordic chair was identified as a successful intervention.

**Comment**

The home showed a decline in performance from 2024 of 13.64 to 14.54 for 2025 for a difference of 0.76%. The home did exceed the organization target 15.0 by 1.36%.