# Experience

## Measure - Dimension: Patient-centred

| Indicator #1 | Type | Unit / Population | Source / Period | Current Performance | Target | Target Justification | External Collaborators |
|---|---|---|---|---|---|---|---|
| Bladder and Bowel - To improve the process of providing feedback about the type of incontinent products used | C | % / LTC home residents | In-house survey / Jan - Dec | 66.70 | 71.03 | 5% increase goal. Increase from 40% in 2024 but remains below the LTC division of 78.3% | |

### Change Ideas

Change Idea #1 1) Invite Product vendor to Resident council and Family council meeting to discuss products.

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| 1) Product vendor for continence to be invited to Resident and Family Council meeting to discuss products. 2) Feedback provided by committees will be actioned and discussed at CQI committee 3) Follow up with councils on results of action items. | 1) [#] of times product vendor attended Resident and Family Council meeting. 2) [#] of action items as a result of feedback received. 3) [#] of actions completed monthly. 4) [#] of meetings with councils where progress on action items reviewed." | 1) Product vendor will attend resident council and family council by May 30 2026. 2) Action plan will be in place for feedback items by May 30 2026. 3) Follow up on action plan will be communicated to Resident and Family Council by June 12 2026." | Working with Prevail vendor to assist with |

Change Idea #2 2) Review sizing and selection of products for residents.

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| "1) Complete audit of residents using incontinent products for correct sizing and selection of product. 2) Product Vendor to assist with audit and on the spot education of staff for proper placement on all shifts." | 1) [#] of residents using incontinence products per shift. 2) [#] of audits completed by shift. 3) [#] of on the spot education sessions completed by shift. | 1) 100% of residents who use incontinent products will be audited for correct sizing and selection of product by May 30 2026 . 2) Product vendor will be contacted to assist with audit and on the spot education provided by March 4 2026 | |

## Measure - Dimension: Patient-centred

| Indicator #2 | Type | Unit / Population | Source / Period | Current Performance | Target | Target Justification | External Collaborators |
|---|---|---|---|---|---|---|---|
| To improve satisfaction of the quality of the care conference | C | % / LTC home residents | In-house survey / Jan - Dec | 68.80 | 72.24 | 5% increase goal. Increase from 40% in 2024 but remains below LTC division of 71.4% | |

### Change Ideas

Change Idea #1 1) Encourage residents to attend their annual care conference.

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| "1) Communicate to residents when their annual care conference is scheduled in advance of meeting. 2) Remind resident morning of meeting and assist as needed to meeting. 3) Allow time for discussion and obtain feedback on what could be improved. | 1) [#] of annual care conferences where residents attended. 2) [#] of care conferences where the resident was reminded in advance of the meeting. 3) [#] of meetings when feedback was requested and obtained from resident. | 1) Residents will be encouraged to attend their annual care conferences beginning May 1 2026. 2) There will be a [5%] improvement in this indicator by December 2026. | |

Change Idea #2 2) Obtain feedback on annual care conference process from residents and families.

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| 1) Determine survey questions to ask post care conference for feedback. 2) Post care conference ask for feedback via survey or discussion with families and residents on how process can be improved. 3) Review responses and determine plan of action for improvement. 4) Communicate feedback results and actions to Resident and Family Council. | 1) [#] of survey questions. 2) [#] of feedback responses received monthly. 3) [#] of improvement actions implemented. 4) [#] of Resident and Family Council meetings attended where results discussed. | 1) Survey questions will be developed by May 1 2026. 2) Process for post care conference feedback will be in place by May 1 2026. 3) Feedback/survey results will be shared with Resident and Family Council with action for improvement by Dec 30th 2026 | |

## Measure - Dimension: Patient-centred

| Indicator #3 | Type | Unit / Population | Source / Period | Current Performance | Target | Target Justification | External Collaborators |
|---|---|---|---|---|---|---|---|
| To improve ability to provide input about food and drink options | C | % / LTC home residents | In-house survey / Jan - Dec | 75.00 | 80.00 | above LTC division 65.3%- continuous quality improvement | |

### Change Ideas

Change Idea #1 1) Residents will have a survey tool for real time feedback in an accessible area to comment on food and drink options.

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| 1) Create and implement survey. | 1) # of surveys completed. | 1) % of survey responses will have positive feedback by May 1 2026. | Nutrition manager to work closely with food committee in 2026 |

Change Idea #2 2) Nutrition Manager will obtain feedback from Resident and Family Councils.

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| 1) Schedule times that Nutrition Manager will attend councils. 2) Attend and solicit feedback. | 1) # of council meetings attended and actioned on feedback. | 1) Residents will have feedback into food and drink options as a standard practice by April 8 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 | 13.76 | 13.75 | Extendicare target is 15%. Continuous quality improvement | |

### Change Ideas

Change Idea #1 Implement purposeful rounding (includes: personal needs, pain, positioning, possessions)

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| (1) Educate all staff on purposeful rounding (2) Inform resident and family council on process and purpose of purposeful rounding | (1) Number of staff educated on purposeful rounding (2) Resident and family council education on process captured in meeting minutes | (1) 100% of staff will be educated on purposeful rounding by June 30, 2026. (2) Resident and family council will be informed of process by June 30, 2026 | |

Change Idea #2 Medication Review of residents who are assessed as being at risk for falls

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| (1) Determine residents at risk for falls (2) Review prescribed medications for residents at risk of falls. (3) Determine | (1) Number of identified at being high risk for falls (2) Number of medication reviews completed for residents at risk for falls (3) Number of medications prescribed per resident that increase risk for falls (4) Number of medication changes/alternatives prescribed to decrease fall risk | (1) Residents at risk for falls will be identified by May 1st 2026 (2) 100% of medication reviews to be completed by June 30th 2026 | This will also tie into Antipsychotic reduction change idea |

## 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 | 12.28 | 12.25 | Extendicare target is 17.3 - Continuous quality 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 April 30, 2026. 2. Education and training completed by July 30th, 2026. 3. Resident-centred interdisciplinary reviews of anti-psychotic use are occurring every 4 weeks. 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. | |

Change Idea #2 Medication review for residents on antipsychotic's without a diagnosis

| Methods | Process measures | Target for process measure | Comments |
| --- | --- | --- | --- |
| (1) Behavioral support Lead will complete medication reviews to identify residents on antipsychotics (2) Consider non-pharmacological approaches as appropriate to reduce anti-psychotic use, and document assessment findings and management | (1) # of residents deprescribed anti-psychotics and replaced with non-pharmacological approaches to care and matching number of of updates to the home's anti-psychotic decision support tool (2) Number of residents care plans updated monthly to support appropriate antipsychotic use | (1) 90% of all residents with anti-psychotic use prescribed will have an assessment, management planning and updated documentation by July 30th 2026 (2) Non-pharmacological approaches to care will be documented within residents' care plans and reassessed if not effective within 1 month of implementation by July 30th | |

## 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 | 2.78 | 2.00 | Extendicare benchmark | |

### Change Ideas

Change Idea #1 Education on wound care product selection

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| (1) Education sessions to be set up for all registered staff (2) Sessions to be arranged for all shifts (3) audits to be completed by wound care lead to ensure correct usage of products | (1) Number of education sessions (2) Number of shifts participated in education (3) Number of audits completed that identified areas of improvement | (1) Education sessions on products and appropriate selection will be completed by May 30, 2026. (2) Audits will show an improvement of 2% | |

Change Idea #2 Focus on moisturizing the skin as prevention strategy to prevent skin breakdown

| Methods | Process measures | Target for process measure | Comments |
| --- | --- | --- | --- |
| (1)Review current products used in the home for prevention to ensure compliance with established protocols. (2)Education sessions for PSW's/HCA's all shifts | (1)# of audits of products that identifies areas for improvement (2)# of education sessions/shift (3)# of staff that attended sessions | (1)Current products will be reviewed for compliance with established protocols by May 30th 2026 (2)Education sessions will be provided on all shifts with 100% of PSW/HCA staff attendance by May 30th, 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 | 0.00 | 0.00 | This is a continued quality improvement plan | |

### Change Ideas

**Change Idea #1** Provide information to families and residents on least restraint approach

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| 1. Provide Restraint information sheet in move-in packages for new move-ins 2. Meet with resident and Family councils to provide education on least restraint approach and risks associated with restraint use. | 1. # of move in packages with Restraint information sheet included 2. # of meetings with Resident and family councils to discuss least restraint approach and risks of restraint use | 1. 100% of move-in packages will have Restraint information sheet included for new move ins by April 1 2026 2. Meetings with Resident and Family councils will be attended to discuss the least restraint approach by April 7 2026 | |

**Change Idea #2** Refocus meeting agenda for interdisciplinary quality team in order to provide more thorough analysis and recommendations for reduction of restraints

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| 1. Review meeting agenda and refocus team 2. Team to review and analyze all restraints in home per unit monthly 3. Team to review what alternatives to restraints have been trialed 4. Make recommendations for removal of restraints (after trial removal) | 1. % completed for review of meeting agenda and refocus team 2. # of restraints reviewed and analyzed per unit monthly 3. # of alternatives to restraints trialed per unit monthly 4. # of recommendations for trial removal of restraints monthly 5. # of restraints removed on a monthly basis | 1. Review and refocus of agenda will be 100% completed by April 1 2026 2. 100% of restraints on each unit will be reviewed monthly by the 1st week of each month 3. 100% of residents with a restraint will have had an alternative by April 1 2026 | |