Experience

Measure - Dimension: Patient-centred

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of residents who respond positively to, "I am satisfied with the food and drinks served to me"	C	% / LTC home residents	In house data, NHCAHPS survey / Most recent consecutive 12 months period	57.50	70.00	To meet Extendicare Benchmark	

Change Ideas

Change Idea #1 Increase Cook and/or Nutrition/Dietary Manager presence within the dining room during meal time to obtain real-time feedback.

Methods	Process measures	Target for process measure	Comments
Food Service Manager will conduct weekly audits during meals and at their food committee meetings to ensure they are satisfied with their food and drinks.	Number of residents satisfied with the meals and beverages will increase by 3%.	We are aiming to increase resident satisfaction in the domain from now until December 30, 2026.	

Change Idea #2 Percentage of Family who respond positively to, "I am satisfied with the variety of food and drink options for residents"

Methods	Process measures	Target for process measure	Comments
Food Service Manager will conduct weekly audits in the dining room and will report at Resident Council meetings. Audit scores will be shared with Family Council.	Number of Residents satisfied with the meals and beverages will increase by 3%.	We are aiming to increase resident satisfaction in the domain from now until December 30, 2026.	

Measure - Dimension: Patient-centred

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of residents responding positively to, "I am satisfied with the quality of care from doctors who work in my home"	C	% / LTC home residents	In house data, NHCAHPS survey / Most recent consecutive 12 months period	60.00	70.00	Extendicare Benchmark	

Change Ideas

Change Idea #1 1) Tracking of in person resident visits to ensure every resident has a visit.

Methods	Process measures	Target for process measure	Comments
1) Create list of each physicians/NP residents to track in person visits to ensure each resident meets with physician/NP at least once per quarter .	"1) [#] residents per physician/NP. 2) [#] of residents who had in person visit during quarter."	"1) List will be developed by physician for tracking by May 31. 2) Each resident will have an in person visit with physician / NP at minimum 1 per quarter by August 31. "	

Measure - Dimension: Patient-centred

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of Family responding positively to, "I am satisfied with the quality of cleaning within the residents room"	C	% / Family	In house data, NHCAHPS survey / Most recent consecutive 12 months period	52.60	70.00	Extendicare Benchmark	

Change Ideas

Change Idea #1 Review deep clean schedules for resident rooms

Methods	Process measures	Target for process measure	Comments
"1) Environmental Service Manager to review deep clean schedules to ensure all resident rooms are included. 2) Track resident rooms completed. 3) Spot check audits of resident rooms to ensure deep cleaning completed.	"1) [#] of times deep clean schedule reviewed 2) [#] of resident rooms who have had deep cleaning completed 3) [#] of audits completed of resident rooms to ensure deep cleaned. 4) [#] of deficiencies noted based on audit results."	"1) Environmental Services manager will review deep clean schedule by March 31. 2) 100 % of resident rooms will have been deep monthly, with 3) There will be a 70% improvement in completion of deep clean audits by June 30	

Change Idea #2 Review of high touch areas and dusting schedule.

Methods	Process measures	Target for process measure	Comments
"1) Environmental Services Manager to review high touch and dusting schedule and update as needed. 2) Track resident rooms as per schedule to ensure all residents have areas cleaned. 3) Follow up audits to be completed to ensure completion. "	"1) Environmental Services Manager to review high touch and dusting schedule and update as needed. 2) Track resident rooms as per schedule to ensure all residents have areas cleaned. 3) Follow up audits to be completed to ensure completion. "	"1) Environmental Services manager will review and update high touch cleaning and dusting schedule by March 31 2)100% of resident rooms will be completed as per schedule by June 30 3) There will be a 70% improvement in completion of high touch areas and dusting audits by June 30"	

Measure - Dimension: Patient-centred

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of Family who respond positively to, "I am satisfied with the variety of food and drink options for residents"	C	% / Family	In house data, NHCAHPS survey / Most recent consecutive 12 months period	63.20	70.00	To meet Extendicare Benchmark	

Change Ideas

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

Methods	Process measures	Target for process measure	Comments
"1) Monitor seasonal availability of fruits and vegetables and incorporate where possible 2) Ensure Residents are aware of fresh fruits and vegetables being utilized. 3) Incorporate more hearty menu options during the winter months and lighter/cold meal items during the summer months"	"1)[#] of Seasonal foods to be incorporated in each menu cycle 2) Advertisement of seasonal fruits / vegetables and seasonally appropriate menu items incorporated."	"1)Seasonal food changes will be made to menu each cycle by 30 June. 2) Advertisement of these seasonal changes will be completed 2 weeks in advance of change."	

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

Methods	Process measures	Target for process measure	Comments
"1) Review previous year calendar to determine [#] of events with food. 2) Brainstorm change ideas including monthly breakfast clubs, friendship luncheons, food trucks, outings, BBQ's, around the world programs, etc. that can incorporate variety. 3) Review in Program Planning Meetings, gathering feedback on resident interests. 4) Host programs monthly. "	"1) [#] of food related programming being offered. 2) Attendance in said programs. 3) Resident feedback in RC or Program Planning Meetings."	"1) Incorporate at least 1 of food related programs each month on programs calendar 2) Implement breakfast programs [1/month] throughout 2025 "	

Safety

Measure - Dimension: Safe

Indicator #5	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	12.04	10.00	Currently the facility is performing better than the benchmark of 15%, we aim to achieve further improvement in line with to continuous quality improvement	

Change Ideas

Change Idea #1 1) Falls - Post Incident Assessment & interdisciplinary team huddles

Methods	Process measures	Target for process measure	Comments
" ""1) Review Post Fall procedure with staff 2) Falls lead in home to attend and/or review Falls - Post Incident Assessment and documentation (review the huddle participants, probable root cause identified)"""	" ""1) # of staff who reviewed Post Fall procedure 2) # of Fall - Post Incident Assessments that were completed accurately and thoroughly on a monthly basis"""	" ""1) Staff education on Post Fall procedure will be completed by May 31st 2) By June 30, 70% of Falls - Post Incident Assessment will be completed as per policy """	

Change Idea #2 Re-educate staff on Fall Prevention and Injury Reduction program

Methods	Process measures	Target for process measure	Comments
1) ADOC/designate 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/HCA and Registered staff 2) # of audits completed"""	1) Education sessions for PSW/HCA and Registered staff will be completed by May 31st 2) Audits on Fall Prevention and Injury Prevention program will begin by April 1"	

Measure - Dimension: Safe

Indicator #6	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	13.90	13.50	Currently the facility is performing better than the benchmark of 17.3%, we aim to achieve further improvement in line with to continuous quality improvement	

Change Ideas

Change Idea #1	1) Gentle Persuasive Approaches (GPA): Basics and GPA Bathing education for responsive behaviours related to dementia (in support of reduction of anti-psychotic use)		
Methods	Process measures	Target for process measure	Comments
" 1) Engage with Certified GPA Coaches to roll out home level education and/or certify home staff as GPA Coaches to deliver education. 2) Contact Reginal Managers for support to identify certified GPA Coaches available for the home, if needed (i.e local psychogeriatric Resource Consultant (PRC)). 3) Deliver GPA Basics education to staff sessions 4) Deliver GPA Bathing education"	"1) # of staff certified as GPA Coaches (as net new coaches) 2) # of staff participated in GPA Basics education and GPA Bathing education. 3) # of staff participated (who develop care plans or administer resident bathing) participated in GPA Bathing education 4) Feedback from staff participants on the experience and usefulness of GPA Basics and GPA Bathing education to support resident care "	1) GPA Basics : education will be provided for [10%] staff by December 31, 2026 2) Feedback from staff on GPA education will be reviewed and actioned on by December 31, 2026."	

Change Idea #2	Documentation: Collaborate with Registered Staff, Physician/Nurse Practitioner to ensure all residents using anti-psychotic medication have a documented indication by diagnosis and/or rationale for symptom management identified in the resident's diagnosis list and care-plan (i.e., monthly care plan reviews).		
Methods	Process measures	Target for process measure	Comments
1) Complete medication reviews for residents prescribed antipsychotic medication 2) Consider non-pharmacological approaches as appropriate to reduce anti-psychotic use, and document assessment findings and management planning using PCC	1. # of resident anti-psychotic reviews completed monthly (which can be part of inter-disciplinary behavioural rounds) and matching # of updates to the home's Anti-psychotic decision Support Tool (AP-DST) 2. # of resident care-plans updated monthly to support appropriate antipsychotic use and matching # of updates to the home's Anti-psychotic Decision Support Tool (AP-DST)	1) 90% of all residents with anti-psychotic use prescribed will have assessment, management planning and updated documentation completed by June, 31, 2026 2) Non pharmacological approaches to care will be documented within resident care-plans and reassessed if not effective within 1 month of implementation by June 31, 2026"	

Measure - Dimension: Safe

Indicator #7	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	2.98	2.00	To meet Extendicare Benchmark	

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) mandatory education for all registered staff on correct staging of pressure ulcers	"1) #of staff that have been educated 2) # of audits completed 3) # of reviews completed by skin and wound committee"	1) Communication on mandatory requirement will be completed by March 31 2) 100% of Registered staff will have completed education on correct wound staging by August 31 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 May 31	

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

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 requirement"	"1) # of staff that have been educated 2)# of alerts that were completed on a monthly basis 3) # of audits completed"	"1) Staff are educated on the new process by May 31 2)Registered staff will complete 5 of audits by May 31 3) Gaps from Alert Audit will be 100% followed up with education or actioned "	

Measure - Dimension: Safe

Indicator #8	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	We currently have no restraint use in our home For 2026 we will continue to monitor our current processes to sustain results, but have not included as a priority area in our action 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-in's 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 council 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-in's by 31 May 2) Meetings with Resident and Family councils will be attended to discuss the least restraint approach by 31 may"	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 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 May 31	