Experience | Patient-centred | Optional Indicator

Indicator #11

Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences". (Garden City Manor)

Last Year		This Year		
CB	**CB**	**CB**	**--**	**NA**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☐ Implemented ☑ Not Implemented

Process measure

•

Target for process measure

No target entered

•

Lessons Learned

This question wasn't asked on this survey.

Comment

Question asked was "If I have a concern I feel comfortable raising it with staff and leadership" 76% approval

Indicator #10

Percentage of residents responding positively to: "What number would you use to rate how well the staff listen to you?" (Garden City Manor)

Last Year		This Year		
CB	**CB**	**CB**	**--**	**NA**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☐ Implemented ☑ Not Implemented

Process measure

•

Target for process measure

No target entered

•

Lessons Learned

This question was not asked.

Comment

This was not a question on this year's survey.

Experience | Patient-centred | Custom Indicator

	Last Year		This Year		
Indicator #12	**87.00**	**88**	**88.00**	**--**	**NA**
Resident Would recommend this home to others. (Garden City Manor)	Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

To maintain or increase the percentage of residents who state that they would recommend Garden City Manor to others.

Process measure

- This process will be measured by comparing the current score to the 2024 resident satisfaction score.

Target for process measure

- We are aiming to increase the percentage of residents who would recommend the home to others from now until December 31, 2024 by providing excellent care by skilled and compassionate staff and also by improving the physical environment of the home.

Lessons Learned

By promoting a positive and inclusive culture in the home, we were able to meet our target. The home will continue to promote resident satisfaction and a positive experience in the home.

Comment

By promoting a positive and inclusive culture in the home, we were able to meet our target. The home will continue to promote resident satisfaction and a positive experience in the home.

Indicator #3

Family would recommend this home to others. (Garden City Manor)

Last Year		This Year		
63.70	**70**	**79.80**	**--**	**NA**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

To increase the percentage of family members who would recommend Garden City Manor to others.

Process measure

- This process will be measured by comparing the current score with the 2024 family satisfaction survey results.

Target for process measure

- We are aiming to increase the percentage of family who would recommend the home to others from now until December 31, 2024 by improving the physical environment of the home.

Lessons Learned

Increased communication and a positive change in the home culture has improved family satisfaction with the home, and their determination that they would recommend GCM to others.

Comment

We continue to strive for continued improvement in our overall satisfaction scores.

Indicator #6

I am updated regularly about any changes in my home. (Garden City Manor)

Last Year		This Year		
75.60	**76**	**84.00**	**--**	**NA**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

To improve the level of communication with residents in the home.

Process measure

- This score will show an improvement on our next 3rd party resident satisfaction survey.

Target for process measure

- We are aiming to increase resident satisfaction with the communication about changes in the home from now until December 31, 2024 by communicating changes at the monthly resident council meetings and also by sharing important information at regularly scheduled recreation programs.

Lessons Learned

Resident satisfaction with communication from home leadership improved from last year. Managment will continue to inform residents of changes that are happening and the reasons for those changes to ensure continued satisfaction.

Comment

Managment will continue to inform residents of changes that are happening and the reasons for those changes to ensure continued satisfaction.

	Last Year		This Year		
Indicator #4	**76.10**	**77**	**72.00**	**--**	**NA**
I am satisfied with the temperature of my food and beverages. (Garden City Manor)	Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

To improve resident satisfaction with the temperature of their food and beverages.

Process measure

- The percentage of satisfaction on this topic will be increased on the 2024 resident satisfaction survey.

Target for process measure

- We are aiming to increase resident satisfaction of the temperature of foods and beverages from now until December 31, 2024 by providing education to residents and staff to ensure pleasurable dining.

Lessons Learned

The percentage of resident satisfaction with meals has decreased from the last year's results. We will continue to work to improve resident satisfaction.

Comment

will continue to work to improve this result for next year.

Indicator #7

I have input into the recreation programs available. (Garden City Manor)

Last Year		This Year		
76.20	**77**	**72.00**	**--**	**NA**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☐ Implemented ☑ Not Implemented

Residents will feel more satisfied with the amount on input they have into the recreation programming, as demonstrated by an increase in the percentage score on the 2024 Resident satisfaction survey.

Process measure

- This will be measured by comparing this current score to that on the 2024 resident satisfaction survey

Target for process measure

- We are aiming to increase resident satisfaction with their level of input into the recreation programs available from now until December 31, 2024 by encouraging residents to provide feedback at resident council meetings and by providing feedback to recreation staff at regularly scheduled programs.

Lessons Learned

This result decreased from last year's percentage. Recreation staff will seek out and promote resident input into the recreation programs being offered to ensure improved satisfaction for next year.

Comment

Recreation staff will seek out and promote resident input into the recreation programs being offered to ensure improved satisfaction for next year.

Indicator #13

The resident has input into the recreation programs available. (Garden City Manor)

Last Year		This Year		
42.10	**55**	**63.10**	**--**	**NA**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Families will have an increased level of satisfaction on the level of input that residents have into the recreation programming in the home.

Process measure

- This will be measured on our 2024 family satisfaction survey

Target for process measure

- We are aiming to increase resident satisfaction with their level of input into the recreation programs available by encouraging their feedback at resident council meetings and also at regularly scheduled programs from now until December 31, 2024.

Lessons Learned

Residents continue to be encouraged to provide input into the recreation programs in the home, through Resident Council Meetings and through informal feedback elicited by the recreation staff.

Comment

The home is pleased with the increase in this score and will continue to promote resident input and satisfaction of the activities in their home.

Indicator #14

There is good choice of continence care products. (Garden City Manor)

Last Year		This Year		
44.30	**55**	**80.30**	**--**	**NA**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

We will educate family members on the high level of satisfaction that residents have with the continence care products.

Process measure

- Families will be confident that residents are pleased with the supply of continence care products, as demonstrated by rating this item higher on the 2024 family satisfaction survey

Target for process measure

- We are aiming to increase family satisfaction with the variety of continence care products offered from now until December 31, 2024 by providing education on what is currently available and the high level of resident satisfaction in this area.

Lessons Learned

Families responded much more positively to this question this year. Our education and follow up proved effective.

Comment

The home will continue to communicate with families, as needed, regarding any changes in continence care products for their loved one, to ensure awareness and continued satisfaction.

Indicator #5

I am satisfied with the variety of spiritual care services. (Garden City Manor)

Last Year		This Year		
44.80	**55**	**50.90**	**--**	**NA**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

To improve the family level of satisfaction of the variety of spiritual care services available in the ome.

Process measure

- The process will be measured by comparing this 2023 score with the 2024 score on the annual family satisfaction survey.

Target for process measure

- We are aiming to increase family satisfaction with the variety of spiritual care services offered from now until December 31, 2024 by providing education on what spiritual care services are.

Lessons Learned

While we were able to improve this score over last year, we fell short of the target and will continue to work to improve this result.

Comment

The home will continue to work to improve this result for next year.

Safety | Safe | Optional Indicator

Indicator #9

Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment (Garden City Manor)

Last Year		This Year		
17.09	**17.03**	**22.63**	**-32.42%**	**17.30**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

To decrease the percentage of residents on antipsychotic medications for residents who do not have a medical diagnosis to support its use through medication reviews.

Process measure

- This process will be measured monthly by reviewing the home indicators, as well as quarterly at the regional quality meetings.

Target for process measure

- The percentage of residents on antipsychotic medications without diagnosis will be reduced by Dec 31, 2024 through medication reviews.

Lessons Learned

We have greatly reduced the number of residents who are using antipsychotic medications without a diagnosis. As residents are removed from the list, the denominator decreases so the reduction is not appropriately reflected in the percentage reported.

Change Idea #2 ☑ Implemented ☐ Not Implemented

To decrease the percentage of residents on antipsychotic medications without a medical diagnosis to support its use through encouraging alternatives to medication for treatment and management.

Process measure

- This process will be measured monthly by reviewing the home indicators, as well as quarterly at the regional quality meetings.

Target for process measure

- The percentage of residents on antipsychotic medications without diagnosis will be reduced by Dec 31, 2024 through the use of non-pharmacological interventions.

Lessons Learned

We have greatly reduced the number of residents who are using antipsychotic medications without a diagnosis. As residents are removed from the list, the denominator decreases so the reduction is not appropriately reflected in the percentage reported.

Change Idea #3 ☑ Implemented ☐ Not Implemented

To decrease the percentage of residents on antipsychotic medications who do not have a medical diagnosis to support its use by ensuring residents have correct diagnoses.

Process measure

- This process will be measured monthly by reviewing the home indicators, as well as quarterly at the regional quality meetings.

Target for process measure

- By ensuring residents have appropriate diagnoses, we will decrease the percentage of residents on antipsychotic medications without a diagnosis by Dec 31, 2024.

Lessons Learned

We have greatly reduced the number of residents who are using antipsychotic medications without a diagnosis. As residents are removed from the list, the denominator decreases so the reduction is not appropriately reflected in the percentage reported.

Change Idea #4 ☑ Implemented ☐ Not Implemented

To decrease the percentage of residents on antipsychotic medications without a medical diagnosis to support its use by engaging external resources.

Process measure

- This process will be measured monthly by reviewing the home indicators, as well as quarterly at the regional quality meetings.

Target for process measure

- By engaging external resources, we will decrease the percentage of residents on antipsychotic medications without a diagnosis by Dec 31, 2024.

Lessons Learned

We have greatly reduced the number of residents who are using antipsychotic medications without a diagnosis. As residents are removed from the list, the denominator decreases so the reduction is not appropriately reflected in the percentage reported.

Comment

The home continues to work with our nurses, doctors, and specialists to trial other medications and alternative therapies for residents to reduce antipsychotic medication use wherever possible. Unfortunately, as residents are removed from the list, the denominator decreases so the reduction is not appropriately reflected in the percentage reported.

Indicator #8

Percentage of LTC home residents who fell in the 30 days leading up to their assessment (Garden City Manor)

Last Year		This Year		
22.44	**15**	**19.14**	**14.71%**	**15**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

To ensure residents are able to ambulate safely.

Process measure

- This process will be measured monthly in the home through our monthly indicator review and quality meeting, as well as quarterly in the regional quality meetings, to ensure a reduction in the number of resident falls.

Target for process measure

- By ensuring use of appropriate footwear, the number of resident falls will be reduced by Dec 31, 2024.

Lessons Learned

This score improved over last year but is not yet at the target. The home will continue to monitor, assess and promote safe ambulation and transfers for residents to ensure improved score for next year.

Change Idea #2 ☑ Implemented ☐ Not Implemented

To reduce falls through timely staff intervention.

Process measure

- This process will be measured monthly in the home through our monthly indicator review and quality meeting, as well as quarterly in the regional quality meetings, to ensure a reduction in the number of resident falls.

Target for process measure

- By ensuring staff promptly answer call bells and bed alarms, the number of resident falls will be reduced by Dec 31, 2024.

Lessons Learned

This score improved over last year but is not yet at the target. The home will continue to monitor, assess and promote safe ambulation and transfers for residents to ensure improved score for next year.

Change Idea #3 ☑ Implemented ☐ Not Implemented

To reduce the number of resident falls due to residents attempting to toilet themselves.

Process measure

- This process will be measured monthly in the home through our monthly indicator review and quality meeting, as well as quarterly in the regional quality meetings, to ensure a reduction in the number of resident falls.

Target for process measure

- By ensuring use of scheduled toileting programs, the number of resident falls will be reduced by Dec 31, 2024.

Lessons Learned

This score improved over last year but is not yet at the target. The home will continue to monitor, assess and promote safe ambulation and transfers for residents to ensure improved score for next year.

Change Idea #4 ☑ **Implemented** ☐ **Not Implemented**

To reduce the number of resident falls by ensuring that residents can easily call for staff assistance when needed.

Process measure

- This process will be measured monthly in the home through our monthly indicator review and quality meeting, as well as quarterly in the regional quality meetings, to ensure a reduction in the number of resident falls.

Target for process measure

- By ensuring resident call bells are within resident reach, the number of resident falls will be reduced by Dec 31, 2024.

Lessons Learned

This score improved over last year but is not yet at the target. The home will continue to monitor, assess and promote safe ambulation and transfers for residents to ensure improved score for next year.

Comment

Staff continue to be SALT trained annually, and our Falls Committee meets regularly, including our dedicated Falls lead and our physiotherapist, to ensure we are doing all we can to promote resident independence while also keeping residents safe from harm.

Safety | Safe | Custom Indicator

Indicator #1

% of Residents with worsening pressure ulcers at stage 2-4 (Garden City Manor)

Last Year		This Year		
4.50	**2**	**2.90**	**--**	**NA**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

To maintain the percentage of residents with worsening pressure ulcers under the set target of 6% through specialized nurse management of the wound care program.

Process measure

- The process will be measured by tracking the monthly home indicator and quality meetings, as well as quarterly quality meetings.

Target for process measure

- To ensure the percentage of residents with worsening pressure ulcers stays under the target of 6%, a specialized wound care nurse with a qualified back up will manage the wound care program in the home by December 31, 2024.

Lessons Learned

Through audits and education we have been able to improve this percentage. We will continue to monitor and provide education to ensure continued progress.

Change Idea #2 ☑ Implemented ☐ Not Implemented

To maintain the percentage of residents with worsening pressure ulcers under the set target of 6% through frontline staff education.

Process measure

- The process will be measured by tracking the monthly home indicator and quality meetings, as well as quarterly quality meetings.

Target for process measure

- To ensure the percentage of residents with worsening pressure ulcers stays under the target of 6%, education will be provided to front line staff on appropriate skin and wound care and the required follow up by Dec 31, 2024.

Lessons Learned

Through audits and education we have been able to improve this percentage. We will continue to monitor and track this information, and to provide education to ensure continued progress for 2025.

Change Idea #3 ☑ Implemented ☐ Not Implemented

To maintain the percentage of residents with worsening pressure ulcers under the set target of 6% through 3M education.

Process measure

- The process will be measured by tracking the monthly home indicator and quality meetings, as well as quarterly quality meetings.

Target for process measure

- To ensure the percentage of residents with worsening pressure ulcers stays under the target of 6%, 3M will be called in to provide education to staff by Dec 31, 2024.

Lessons Learned

Education was provided and was helpful in maintaining a lower average. Education will continue to be provided to maintain awareness.

Change Idea #4 ☑ Implemented ☐ Not Implemented

To maintain the percentage of residents with worsening pressure ulcers under the set target of 6% through management oversight of the skin and wound program.

Process measure

- The process will be measured by tracking the monthly home indicator and quality meetings, as well as quarterly quality meetings.

Target for process measure

- To ensure the percentage of residents with worsening pressure ulcers stays under the target of 6%, a clinical member of the management team will be responsible to oversee the program by Dec 31, 2024.

Lessons Learned

ADOC is dedicated to overseeing the Skin and Wound program, and to provide additional education as needed. this will help us to further improve in this indicator.

Comment

The home will continue to monitor and provide education to ensure continued progress in this area for 2025 workplan.

Indicator #2

% Residents with daily Physical Restraints (Garden City Manor)

Last Year		This Year		
1.70	**1.65**	**1.70**	**--**	**NA**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

To maintain the average percentage of residents with daily physical restraints under the Target 2.5% by educating residents and family members.

Process measure

- This process will be measured through the monthly indicators and the quarterly regional quality meetings.

Target for process measure

- To ensure the percentage of residents with daily physical restraints stays under the target of 2.5%, education will be provided to residents and families by Dec 31, 2024.

Lessons Learned

Education is key in maintaining a low percentage of resident restraints. This continues as outlined and has been effective.

Change Idea #2 ☑ Implemented ☐ Not Implemented

To maintain the average percentage of residents with daily physical restraints under the Target 2.5% by educating residents and families when there is a significant change.

Process measure

- This process will be measured through the monthly indicators and the quarterly regional quality meetings.

Target for process measure

- To ensure the percentage of residents with daily physical restraints stays under the target of 2.5%, education will be provided to residents and families when there is a significant change in resident status by Dec 31, 2024.

Lessons Learned

Education is key in maintaining a low percentage of resident restraints. This continues as outlined and has been effective.

Change Idea #3 ☑ Implemented ☐ Not Implemented

To maintain the average percentage of residents with daily physical restraints under the Target 2.5% by encouraging alternatives.

Process measure

- This process will be measured through the monthly indicators and the quarterly regional quality meetings.

Target for process measure

- To ensure the percentage of residents with daily physical restraints stays under the target of 2.5%, alternative interventions will be discussed with residents and families by Dec 31, 2024.

Lessons Learned

Education is key in maintaining a low percentage of resident restraints. This continues as outlined and has been effective.

Change Idea #4 ☑ **Implemented** ☐ **Not Implemented**

To maintain the average percentage of residents with daily physical restraints under the Target 2.5% by educating staff members.

Process measure

- This process will be measured through the monthly indicators and the quarterly regional quality meetings.

Target for process measure

- To ensure the percentage of residents with daily physical restraints stays under the target of 2.5%, education will be provided to staff members by Dec 31, 2024.

Lessons Learned

Education is key in maintaining a low percentage of resident restraints. This continues as outlined and has been effective.

Comment

We continue to work on this for 2025 as we strive for further improvement.

Experience

Measure - Dimension: Patient-centred

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Resident satisfaction with the quality of care from the dietitian.	C	% / LTC home residents	In-house survey / Sept 2024- Oct 2025	44.00	67.00	67% is the target as that is the number achieved by the LTC division this year	

Change Ideas

Change Idea #1 Increase opportunities for Residents to book one-on-one sessions with the Dietitian within their home.

Methods	Process measures	Target for process measure	Comments
1) Requests to be sent through nursing or the resident council assistant. 2) Dietititan to confirm appointment date and time with Resident. 3) Feedback received will be reviewed and actioned. 4) Action items and plan discussed at CQI committee for follow up.	1) # of requests to meet with Dietitian 2) # of one-on-one sessions with Dietitian that occurred. 3) # of action items received from feedback 4) # of action items implemented	1) Process for sending requests to Dietitian will be in place by June 2025. 2) One-on-one sessions with Dietitian will be in place by June 2025 with at least 2 sessions per week. 3) Action items and plan will be discussed at CQI committee with Dietitian by June 2025.	

Change Idea #2 Increase awareness of role of dietitian in home with residents

Methods	Process measures	Target for process measure	Comments
1) Dietitian to meet at minimum annually with Resident council 2) Feedback on services and areas for improvement will be discussed 3) update at CQI meeting on action plan	1) # of meetings with Council where Dietitian attended 2) # of suggestions provided by council 3) # of CQI meetings where action items were discussed with Dietitian	1) Dietitian will attend Resident Council by June 2025. 2) Action items and plan will be discussed at CQI committee with Dietitian by June 2025.	

Measure - Dimension: Patient-centred

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Resident satisfaction with the quality of care from the doctors.	C	% / LTC home residents	In-house survey / Sept 2024- Oct 2025	48.00	64.00	The LTC division average this year is 64% so it will be our target as it will be a good improvement from this year's result.	

Change Ideas

Change Idea #1 Improve visibility of physicians in home with residents and families.

Methods	Process measures	Target for process measure	Comments
1) Order Extendicare name tags for physicians. 2) Include days of week that physicians attend the home in the newsletter so residents and families are aware of when physician is going to be onsite. 3) Have sign on nursing station when doctor is in the building.	1) # of name tags ordered. 2) % of newsletters with physician visits included	1) Name tags will be ordered for all physicians in home by June 2025. 2) Process for utilizing newsletter and sign for posting of visit schedules will be 100% implemented by June 2025.	

Measure - Dimension: Patient-centred

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Family satisfaction with the timing and schedule of spiritual care services.	C	% / Family	In-house survey / Sept 2024- Oct 2025	45.50	64.00	The LTC division average for this item was 64%	

Change Ideas

Change Idea #1 Increase family awareness of spiritual care service offerings in the home due to families sharing that they are unaware of what is offered and being unsure if their loved one is attending or not.

Methods	Process measures	Target for process measure	Comments
1. ED will request an invitation to Family Council to share information. 2. Review schedule of spiritual care programs and timings at Family Council. 3. Review the Family Portal online with families at the Family Council and as requested by families. 4. Encourage families to sign up for the ActivityPro Family Portal to view loved one's participation. 5. Review with families where to find a paper recreation calendar each month in the home. 6. Avoid last minute changes to the schedule. 7. Maintain a regular, predictable schedule with feedback from residents and families. 8. Provide education on what is spiritual care at Family Council and in the newsletter. 9. Expand the services provided by our home Chaplain to improve variety by developing a weekly routine.	1.# of families signed up with ActivityPro Family Portal. 2.# of programs offered by home Chaplain (increase). 3. % of positive feedback received from residents and families. 4. # of family council members who attended education	1. ED/RSC will attend Family Council by June 2025. 2. Families will provide feedback on spiritual care programs timing and schedule at minimum once a year at Family Council and will be completed by June 2025. 3. Education on what is spiritual care will be provided to all Family council members by June 2025.	By ensuring family members are aware of the schedule of spiritual programs, and what their loved one is attending, they will better be able to positively answer questions about their satisfaction with this schedule.

Measure - Dimension: Patient-centred

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Family satisfaction with the variety of spiritual care services.	C	% / Family	In-house survey / Sept 2024- Oct 2025	50.90	65.00	65% is chosen as our goal as it was the LTC division average this year and would be a positive improvement over our current score.	

Change Ideas

Change Idea #1 Increase family awareness of spiritual care service offerings in the home due to families sharing that they are unaware of what is offered.

Methods	Process measures	Target for process measure	Comments
1. ED will request an invitation to Family Council to share information. 2. Review schedule of spiritual care programs at Family Council. 3. Review the Family Portal online with families at the Family Council. 4. Encourage families to sign up for the ActivityPro Family Portal to view loved one's participation. 5. Review with families where to find a paper recreation calendar each month in the home. 6. Avoid last minute changes to the schedule. 7. Maintain a regular, predictable schedule with feedback from residents and families. 8. Provide education on what is spiritual care at Family Council and in the newsletter. 9. Expand the services provided by our home Chaplain to improve variety by developing a weekly routine.	1.# of programs offered by home Chaplain (increase). 2. % of positive feedback received from residents and families. 3. # of family council members who attended education	1. ED/RSC will attend Family Council by June 2025. 2. Families will provide feedback on spiritual care programs schedule at minimum once a year at Family Council by June 2025. 3. Education on what is spiritual care will be provided by June 2025 for all family council members.	Recreation department continues to work with residents and volunteers to ensure that a variety of of spiritual programs are available for residents in the home.

Measure - Dimension: Patient-centred

Indicator #5	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Family satisfaction with resident input into recreation programs available.	C	% / Family	In-house survey / Sept 2024- Oct 2025	63.10	70.00	We have made a great improvement over last year's score of 42% and are pleased to be above the current target and are looking to further improve.	

Change Ideas

Change Idea #1 Home will educate families on the resident feedback structure regarding programs.

Methods	Process measures	Target for process measure	Comments
1. ED will request invitation to attend Family Council to educate families on the structured resident feedback. 2. Inform Families that feedback is gathered each month through the Resident Council meetings. Residents are given opportunity to give suggestions and are encouraged to give feedback on activities they enjoy or don't enjoy. 3. Inform families that recreation staff have regular discussions with residents over what programs are liked, not liked, and ones they would like to try. 4. Inform family members through monthly newsletter about how residents have input into the programs in the home.	1. # of family members satisfied with resident input into programs to be measured twice a year by asking at family council. 2. % of positive responses based on feedback received	1. ED/RSC will attend Family Council by June 2025. 2. Newsletter to be published with this information around resident input by May 1, 2025.	This score is a great improvement over last year's survey which was just 42%. We will continue to encourage resident input on programs and discuss these with family members to ensure a high level of satisfaction.

Measure - Dimension: Patient-centred

Indicator #6	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Resident satisfaction with, "If I need help right away, I can get it."	C	% / Residents	In-house survey / Sept 2024- Oct 2025	56.00	70.00	Continue to improve results with manageable targets.	

Change Ideas

Change Idea #1 Review staffing and routines all shifts

Methods	Process measures	Target for process measure	Comments
1)Meet with all shifts to discuss results of survey related to response times. 2) Determine root cause of any potential delay in responses for resident assistance. 3) Discuss action plan to address. 4) Implement action plan based on root causes identified. 5) Follow up meeting with all shifts to review progress for improvement.	1) # of meetings held with each shift. 2) # of staff in attendance at each meeting. 3) # of root causes and strategies determined. 3) # of strategies implemented post meetings. 4) # of Follow up meetings held with each shift	1) Meetings with all shifts will be held by June 2025. 2) Root causes for response delays will be determined and action plan created by July 2025. 3) Action plan will be implemented by July 2025. 4) Follow up meeting with shifts to review progress will be held by 4th quarter.	

Change Idea #2 Implement purposeful rounding

Methods	Process measures	Target for process measure	Comments
1) Provide education session for staff on purposeful rounding process. 2) Provide 4P's cards to staff for reminder of 4 areas to ask resident about. 3)audit call bell frequency and response times post education.	1) # of education sessions for staff 2) # of staff who received 4P's cards. 3) # of audits completed	1) Education for purposeful rounding (4P's) will be completed by June 2025 for 50% of staff. 2) 4P's cards will be provided to staff at education by June 2025	

Safety

Measure - Dimension: Safe

Indicator #7	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 Sep 30, 2024 (Q2), as target quarter of rolling 4-quarter average	19.14	15.00	15% is the current Extendicare Target.	Achieva, Behavioural Supports Ontario

Change Ideas

Change Idea #1 Implement 4 P's rounding

Methods	Process measures	Target for process measure	Comments
1) educate staff on 4P's process. 2) Provide 4P's cards to staff as reminder. 3) Inform resident council and family council what 4P process is.	1) # of staff educated on the 4P's process. 2) # of 4P cards provided. 3) Resident council and family council informed of process.	1) 100% of frontline staff will be educated on 4P process by Oct 2025 2) 4P cards will be distributed to all frontline staff by July 2025 3) Resident council and Family council will be informed of process by June 2025	

Change Idea #2 Ensure each resident at risk for falls has a individualized plan of care for fall prevention

Methods	Process measures	Target for process measure	Comments
1) Determine residents at risk for falls. 2) Review plan of care for each resident at risk 3) Discuss strategies with fall team and staff. 4) Update plan of care.5. Communicate changes in resident plan of care to staff.	1) # of residents at risk for falls. 2) # of plans of care reviewed. 3) # of new strategies determined 4) # of plans of care updated. 5) # of sessions held to communicate changes with staff.	1) 100% of residents at risk for falls will be identified by May 2025. 2) Care plans for high-risk residents will be fully reviewed and updated by June 2025.3. Changes in plan of care will be shared with all front-line staff by June 2025.	

Measure - Dimension: Safe

Indicator #8	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 Sep 30, 2024 (Q2), as target quarter of rolling 4-quarter average	22.63	17.30	This is the Extendicare target.	Medisystem, GPA

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. 2). Register participants for education sessions.	1). # of GPA sessions provided. 2). # of staff participating in education. 3). Feedback from participants in the usefulness of action items developed to support resident care.	1.) GPA sessions will be provided for 50% staff by Dec 2025. 2.) All feedback from participants in the session will be reviewed and actioned on by Dec 2025	

Change Idea #2 Collaborate with the physician to ensure all residents using anti-psychotic medications have a medical diagnosis and rationale identified.			
Methods	Process measures	Target for process measure	Comments
1) complete medication review for residents prescribed antipsychotic medications. 2) Review diagnosis and rationale for antipsychotic medication. 3) Consider alternatives as appropriate.	1) # of medication reviews completed monthly. 2) # of diagnosis that were appropriate for antipsychotic medication use. 3) # of alternatives implemented	1) 75% of all residents will have medication and diagnosis review completed to validate usage by Oct 2025. 3) Alternatives will be in place and reassessed if not effective within 1 month of implementation with process in place by June 2025.	

Measure - Dimension: Safe

Indicator #9	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
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	C	% / LTC home residents	CIHI CCRS / October - December 2024	2.90	2.00	This is the Extendicare target.	Solventum/3M, Wounds Canada

Change Ideas

Change Idea #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 education 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 education 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 100% completed by June 2025. 2) 100% of Registered staff will have completed education on correct wound staging by Oct 2025. 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 Dec 2025	

Change Idea #2 Review team membership and ensure that all wounds and skin issues in previous month are reviewed during their meetings

Methods	Process measures	Target for process measure	Comments
1) Review current membership of Skin and Wound team. 2) Recruit new members. 3) Standardized agenda and follow up by team on skin issues in home.	1) # of reviews completed on current membership 2) # of new members recruited 3) Standardized agenda developed which includes review of # pressure ulcers by stage on each unit on a monthly basis	1) Membership review of skin and wound committee will be completed by May 2025. 2) Recruitment of new members will be completed by June 2025. 3) Standardized agenda will be developed and in place by June 2025.	

Measure - Dimension: Safe

Indicator #10	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
% of residents with daily restraint	C	% / LTC home residents	CIHI CCRS / October - December 2024	1.70	1.50	To continue to reduce restraints in our home and maintain better performance than corporate target of 2.5%	Achieva

Change Ideas

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

Methods	Process measures	Target for process measure	Comments
Provide Restraint brochure in admission packages for new admissions.	# of admission packages with Restraint brochure included.	100% of admission packages will have Restraint brochure included for new admissions by June 2025.	