**Experience | Patient-centred | Optional Indicator**

| | Last Year | | This Year | | |
|---|---|---|---|---|---|
| **Indicator #14** | **CB** | **CB** | **NA** | **--** | **NA** |
| Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences". (Mackenzie Place) | 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 particular question was not part of the 2024 resident voice survey.

**Comment**

The new Resident voice survey did not include this specific question. 88.2% of residents felt staff are friendly and can be trusted. 82.4% of residents feel comfortable raising concerns with staff and leadership.

## Indicator #13

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

| 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 particular question was not part of the 2024 Resident voice survey.

**Comment**

The new Resident voice survey did not include this specific question. 88.2% of residents felt staff are friendly and can be trusted. 82.4% of residents feel comfortable raising concerns with staff and leadership.

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

| | Last Year | | This Year | | |
|---|---|---|---|---|---|
| **Indicator #10**<br>% of Residents who would respond to the statement "I would recommend the Home" on the annual resident engagement survey (Mackenzie Place) | **95.20**<br>Performance (2024/25) | **75**<br>Target (2024/25) | **76.50**<br>Performance (2025/26) | **--**<br>Percentage Improvement (2025/26) | **NA**<br>Target (2025/26) |

**Change Idea #1** ☑ Implemented ☐ Not Implemented

Ensure all residents are given the opportunity to become involved in resident council meeting in the home monthly.

**Process measure**

- Meeting times will be posted, individual residents will be invited to meetings.

**Target for process measure**

- Resident positive response to the statement "I would recommend the Home" will be maintained above 75% on the annual resident experience survey.

**Lessons Learned**

Meeting times are include in the monthly calendar, daily sheet and personal invitation by recreations staff.

**Change Idea #2** ☑ Implemented ☐ Not Implemented

Provide resident specific information handbook about the home for newly admitted residents

**Process measure**

- number of new admissions receiving the resident handbook in their welcome basket.

**Target for process measure**

- 100% of all new admissions will be provided with a resident handbook upon admission by the end of May.

**Lessons Learned**

All existing residents and new residents have received the resident handbook. The handbook was reviewed at RC meeting for further information they would like to see included.

| | Last Year | | This Year | | |
|---|---|---|---|---|---|
| **Indicator #3** | **80.00** | **85** | **86.70** | **--** | **NA** |
| % of families who would positively respond to the statement" I would recommend this home" on the annual family experience survey (Mackenzie Place) | **Performance (2024/25)** | **Target (2024/25)** | **Performance (2025/26)** | **Percentage Improvement (2025/26)** | **Target (2025/26)** |

**Change Idea #1** ☑ Implemented ☐ Not Implemented

Ensure families are provided information on how to form a family council.

**Process measure**

- Audit new admission packages quarterly to ensure "How to form a Family Council" is included. Quarterly this information will be reviewed at Family Forum meetings.

**Target for process measure**

- 100% of families will receive information on how to form a family council by May 2024.

**Lessons Learned**

Family is provided information on forming a family council in the admission package as well as it is reviewed quarterly at the family forum meeting. To date there is no organized family council in the Home

**Change Idea #2** ☑ Implemented ☐ Not Implemented

Ensure families receive invitations to attend family forum meetings.

**Process measure**

- Complete tracking to ensure families receive invitations to quarterly family forum meetings

**Target for process measure**

- 100% of families receive notification of invitations to quarterly family forum meetings.

**Lessons Learned**

Monthly family communication includes date of upcoming family forum meetings, Invitations are emailed and posted. Families have an option to attend in person or virtually.

**Indicator #2**

% of families who would positively respond to he statement "There is a good choice of continence care products" on the annual family engagement survey (Mackenzie Place)

| Last Year | | This Year | | |
|---|---|---|---|---|
| **46.20** | **85** | **86.70** | **--** | **NA** |
| Performance (2024/25) | Target (2024/25) | Performance (2025/26) | Percentage Improvement (2025/26) | Target (2025/26) |

**Change Idea #1** ☐ Implemented ☑ Not Implemented

Provide education to families on the continence care products and program offered at home. Education will be provided through live presentation and written information.

**Process measure**

- Two live sessions will be offered during family forum meetings May and November. Written material will be provided to all families through monthly communication newsletter.

**Target for process measure**

- Increase positive response to 85% satisfaction on the family engagement survey to the statement "There is a good choice of continence care products on the 2024 survey.

**Lessons Learned**

Education was provided twice in 2024 by Prevail to both residents and families. No family attended sessions offered.

**Change Idea #2** ☑ Implemented ☐ Not Implemented

Provide continence care program and product information to admission package and provide during annual care conferences.

**Process measure**

- Audit admission package information material to ensure inclusion of continence care program poster/brochure.

**Target for process measure**

- 100% of admission packages will include information regarding the continence care program by May 2024.

**Lessons Learned**

Information is now provided in the admission package regarding continence products.

**Change Idea #3** ☐ Implemented ☑ Not Implemented

POA will be provided with written information when resident has a change in continence and requires continence care products.

**Process measure**

- Documented communication with POA regarding continence care product education.

**Target for process measure**

- 100% of residents with a change in continence care product will have a documented note regarding education

**Lessons Learned**

Changes in continence product is discussed and documented with the POA.

| Indicator #4 | Last Year | | This Year | | |
|---|---|---|---|---|---|
| % of family who would respond positively to the statement "I have an opportunity to provide input on food and beverage options" on the family engagement survey. (Mackenzie Place) | **50.00**<br>Performance (2024/25) | **85**<br>Target (2024/25) | **NA**<br>Performance (2025/26) | **--**<br>Percentage Improvement (2025/26) | **NA**<br>Target (2025/26) |

**Change Idea #1** ☑ Implemented ☐ Not Implemented

Provide family an opportunity for input into menus options.

**Process measure**

- Review of new menu 2 times per year with the implementation of the spring/summer menu and fall/winter menu with families as part of family forum meetings.

**Target for process measure**

- increase positive response to 85% satisfaction on family engagement survey to the statement "I have an opportunity to provide input on food and beverage options"

**Lessons Learned**

Menus reviewed at Family Forum and sample menu sent out to family in monthly communication when there is a seasonal menu change.

**Change Idea #2** ☑ Implemented ☐ Not Implemented

Review food preferences at admission care conferences with family if resident is unable to verbalize preferences.

**Process measure**

- Document food/beverage preferences on resident plan of care, if Resident can not make choices at mealtimes.

**Target for process measure**

- Increase positive response to 85% satisfaction on family engagement survey to the statement "I have and opportunity to provide input on food and beverage options" by next survey date.

**Lessons Learned**

Resident/Family are asked about food preferences during nutritional intake assessment and documented.

**Change Idea #3** ☑ Implemented ☐ Not Implemented

Ensure families are aware of process residents provide feedback on food and beverage options

**Process measure**

- Increase awareness of families how feedback regarding food is sought on a monthly basis by reviewing in monthly communication and family forums

**Target for process measure**

- Information is added to monthly communication by end of April.

**Lessons Learned**

Family are aware through family forum meeting and monthly communication.

**Comment**

This specific question was not included in the 2024 Resident experience survey so unable to compare impact of actions.

| | Last Year | | This Year | | |
|---|---|---|---|---|---|
| **Indicator #1** | **57.10** | **85** | **80.00** | **--** | **NA** |
| % of families that would respond positively to the statement "Communication by home leadership is improving" on the family engagement survey. (Mackenzie Place) | Performance (2024/25) | Target (2024/25) | Performance (2025/26) | Percentage Improvement (2025/26) | Target (2025/26) |

**Change Idea #1** ☑ Implemented ☐ Not Implemented

Increase awareness of changes through enhanced communication in the Home between families and home leadership.

**Process measure**

- Audit family contact information and preferred method to receive information monthly to ensure information is reaching families.

**Target for process measure**

- Satisfaction increases to 85% regarding clear and timely communication by the Home's leadership by the next resident and family experience survey.

**Lessons Learned**

Monthly communication is sent via email and is posted in the home for families. Communication rating increased by 20% on the most recent family engagement survey.

**Change Idea #2** ☑ Implemented ☐ Not Implemented

Provide alternate day and evening times of family forum meetings to promote attendance to meet varying schedules of family.

**Process measure**

- The number of family members in attendance at family forum meetings

**Target for process measure**

- Increased attendance at family forum meetings by 50% by December.

**Lessons Learned**

Although meetings are offered at alternating times and the option to attend in person or virtual attendance is unchanged with having 2-3 families attend quarterly.

**Change Idea #3** ☑ Implemented ☐ Not Implemented

Encourage family participation in quarterly Quality Council meetings.

**Process measure**

- The number of family expressing interest in participating in the quarterly quality council meeting

**Target for process measure**

- At least one family members in attendance at the quarterly quality council meeting.

### Lessons Learned

Monthly communication to families identifies the date of the upcoming quality council meeting. Invite is sent to all families and meeting date is posted. Attendance by families has not changed with 0-1 family in attendance.

### Comment

New family experience survey did not include this specific question to compare result of actions implemented. Questions on communication have indicated an increase of 7% in satisfaction with communication with leadership.

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### Indicator #9

% of residents who would positively respond to the statement "I have a good choice of continence care products" on the annual resident experience survey (Mackenzie Place)

| Last Year | | This Year | | |
|---|---|---|---|---|
| **62.50** | **75** | **86.70** | **--** | **NA** |
| Performance (2024/25) | Target (2024/25) | Performance (2025/26) | Percentage Improvement (2025/26) | Target (2025/26) |

---

**Change Idea #1** ☑ Implemented ☐ Not Implemented

Provide education to residents on the continence care products and program offered at home. Education will be provided through live presentation and written information.

**Process measure**

- Presentation will be offered during resident council meeting at resident council members discretion.

**Target for process measure**

- Increase positive response to 75% satisfaction on the resident engagement survey to the statement "There is a good choice of continence care products on the 2024 survey.

**Lessons Learned**

Presentation was provided by prevail to residents.

**Change Idea #2** ☑ Implemented ☐ Not Implemented

Provide continence care program and product information to admission package.

**Process measure**

- Audit admission package information material to ensure inclusion of continence care program poster/brochure.

**Target for process measure**

- 100% of admission packages will include information regarding the continence care program by May 2024.

**Lessons Learned**

Written information was provided to residents and is not part of the admission package information.

**Change Idea #3** ☑ Implemented ☐ Not Implemented

Resident if capable will be provided with written information with a change in continence and requirement of continence care product.

**Process measure**

- Documented communication with resident if capable regarding continence care product education.

**Target for process measure**

- 100% of residents with a change in continence care product will have a documented note regarding education

**Lessons Learned**

Individual residents are part of the discussion of change or options in continence care products.

**Comment**

New Resident experience survey did not include this specific question to compare result of actions implemented. Bladder Care product satisfaction questions are rated all above 86.7% and 80% satisfaction with providing feedback about products.

| | Last Year | | This Year | | |
|---|---|---|---|---|---|
| **Indicator #8** | **59.10** | **75** | **NA** | **--** | **NA** |
| % of residents that positively respond to the statement : I am satisfied with the temperature of my food and beverages" from the annual resident engagement survey. (Mackenzie Place) | Performance (2024/25) | Target (2024/25) | Performance (2025/26) | Percentage Improvement (2025/26) | Target (2025/26) |

**Change Idea #1** ☑ Implemented ☐ Not Implemented

Daily dining room monitoring will include feedback from residents about satisfaction with temperature of food.

**Process measure**

- number of CSR received per month pertaining to food temperatures.

**Target for process measure**

- 100% of CSR's received regarding dissatisfaction with food temperatures will be addressed and resolved to satisfaction.

**Lessons Learned**

No CSR received regarding food temperature concerns.

**Change Idea #2** ☑ Implemented ☐ Not Implemented

review resident feedback regarding food temperatures at monthly food committee meetings

**Process measure**

- Documented number of episodes of food temperature dissatisfaction, through meeting minutes.

**Target for process measure**

- No episodes of food temperature dissatisfaction.

**Lessons Learned**

Food Committee meeting minutes captures complaints as well as Client Service Response forms.

**Change Idea #3** ☑ Implemented ☐ Not Implemented

Investigate options to maintain desired temperature of foods/beverages.

**Process measure**

- number of documented episodes of dissatisfaction of food/beverage temperatures.

**Target for process measure**

- increase resident positive response to 75% with the statement "I am satisfied with the temperature of my food and beverages" on the next resident engagement survey.

**Lessons Learned**

Plate warmer was investigated but was not within the budget to purchase.

**Comment**

New Resident experience survey did not include this question to compare result of actions implemented.

**Indicator #7**

% of residents responding positively to the statement " I am updated regularly about any changes in the home" on the annual resident engagement survey. (Mackenzie Place)

| Last Year | | This Year | | |
|---|---|---|---|---|
| **66.70** | **75** | **81.30** | **--** | **NA** |
| Performance (2024/25) | Target (2024/25) | Performance (2025/26) | Percentage Improvement (2025/26) | Target (2025/26) |

**Change Idea #1** ☑ Implemented ☐ Not Implemented

Increase awareness of changes through enhanced communication in the Home between residents and management.

**Process measure**

- Every Resident Council meeting will include as part of its minutes the monthly report provided by management

**Target for process measure**

- Increase in positive response to 75% on the resident engagement survey to the statement "I am updated regularly about any changes in the Home" by the next survey date.

**Lessons Learned**

Monthly management report is provided to Resident Council and is reviewed.

**Change Idea #2** ☐ Implemented ☑ Not Implemented

In person management presence at resident council meetings at least once per quarter.

**Process measure**

- Resident Council Committee extending invitation to members of management at least quarterly

**Target for process measure**

- Quarterly in person attendance at Resident Council by invitation.

**Lessons Learned**

Resident council is asked monthly if they would like management to attend. Resident council has not requested this but monthly management update is provided to resident council.

**Change Idea #3** ☑ Implemented ☐ Not Implemented

Ensure communication is available to all Residents

**Process measure**

- number of residents expressing desire to receive home communications and preferred method.

**Target for process measure**

- 100% of residents expressing communication interests receive material in a way they prefer .

**Lessons Learned**

Residents are provided with communication verbally and in print as indicated by residents as their preference. Written communication is provided on a standard form for easy identification.

**Comment**

New Resident experience survey did not include this question to compare result of actions implemented. Questions asked about communication are rated at 81.3%

## Safety | Safe | Optional Indicator

| | Last Year | | This Year | | |
|---|---|---|---|---|---|
| **Indicator #12** | **15.04** | **17.30** | **16.67** | **-10.84%** | **15** |
| Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment (Mackenzie Place) | Performance (2024/25) | Target (2024/25) | Performance (2025/26) | Percentage Improvement (2025/26) | Target (2025/26) |

**Change Idea #1** ☑ Implemented ☐ Not Implemented

Medication reviews completed for all residents currently prescribed antipsychotics

**Process measure**

- # of residents reviewed monthly # of plans of care reviewed that have supporting diagnosis # of reduction strategies implemented monthly

**Target for process measure**

- All residents currently prescribed antipsychotics will have a medication review completed by July 2024

**Lessons Learned**

Resident antipsychotic use is assessed monthly using antipsychotic decision support tool. Residents are identified who have a potential to have antipsychotic reduced.

**Change Idea #2** ☑ Implemented ☐ Not Implemented

Provide educational material to families and/or residents on antipsychotics and the importance of minimizing use.

**Process measure**

- # of families provided with best practice information on reducing antipsychotics monthly # of tour and admission packages provided with antipsychotic reduction information included monthly

**Target for process measure**

- Educational material will be provided to families and/or residents on antipsychotics and important of minimizing use by Sept 2024

**Lessons Learned**

Individual family discussions and information provided with best practice information regarding antipsychotics. Despite education family requested continuation of antipsychotics.

**Comment**

This continues to be an area of focus in 2025.

| | Last Year | | This Year | | |
|---|---|---|---|---|---|
| **Indicator #11** | **6.51** | **15** | **9.41** | **-44.55%** | **9** |
| Percentage of LTC home residents who fell in the 30 days leading up to their assessment (Mackenzie Place) | **Performance (2024/25)** | **Target (2024/25)** | **Performance (2025/26)** | **Percentage Improvement (2025/26)** | **Target (2025/26)** |

**Change Idea #1** ☐ Implemented ☑ Not Implemented

Implement specific activity program at afternoon change of shift for residents who are high risk for falls

**Process measure**

- # of residents reviewed for activity needs/preferences weekly # of activity programs that occur during change of shift in afternoon weekly

**Target for process measure**

- Specific activity program at afternoon change of shift will be implemented by June 2024

**Lessons Learned**

Despite activities being offered the result in number of residents have falls was not effected, as timing of falls was not within the shift exchange time period of later at night and early morning.

**Change Idea #2** ☑ Implemented ☐ Not Implemented

Conduct environmental assessments of resident spaces to identify potential fall risk areas and address areas for improvement

**Process measure**

- # of environmental assessments completed monthly # of identified deficiencies from assessments that were corrected monthly

**Target for process measure**

- Environmental risk assessments of resident spaces to identify fall risk will be completed by June 2024

**Lessons Learned**

Environmental assessments are completed with each new admission and re admission from hospital to flag areas of risk and areas of improvement.

**Comment**

This continues to be an area of focus for 2025 to reduce number of falls.

## Safety | Safe | Custom Indicator

**Indicator #6**

% of LTC residents with restraints (Mackenzie Place)

| Last Year | | This Year | | |
|---|---|---|---|---|
| **0.00** | **2.50** | **0.00** | **#Error** | **NA** |
| Performance (2024/25) | Target (2024/25) | Performance (2025/26) | Percentage Improvement (2025/26) | Target (2025/26) |

**Change Idea #1** ☑ Implemented ☐ Not Implemented

Review current restraints and determine plan for trialing alternatives to restraints

**Process measure**

- # residents reviewed monthly # of meetings held with families/residents to discuss alternatives monthly # of action plans in place for reduction of restraints in collaboration with family/resident monthly

**Target for process measure**

- 100% of restraints will be reviewed and plans implemented for trialing alternatives by Sept 2024

**Lessons Learned**

Close monitoring of residents potential for restraint use has enabled the home to maintain no restraints used in the home.

## Safety | Safe | Custom Indicator

| | Last Year | | This Year | | |
|---|---|---|---|---|---|
| **Indicator #5**<br>% of LTC resident with worsened ulcers stags 2-4 (Mackenzie Place) | **2.00**<br>Performance (2024/25) | **2**<br>Target (2024/25) | **7.32**<br>Performance (2025/26) | **--**<br>Percentage Improvement (2025/26) | **NA**<br>Target (2025/26) |

**Change Idea #1** ☑ Implemented ☐ Not Implemented

Review current bed systems/surfaces for residents with PURS score 3 or greater

**Process measure**

- # of residents with PURS score 3 or greater # of reviews completed of bed surfaces/mattresses monthly # of bed surfaces /mattresses replaced monthly

**Target for process measure**

- A review of the current bed systems/surfaces for residents with PURS score 3 or greater will be completed by August 2024

**Lessons Learned**

Monthly review of resident PURS scored are reviewed. Resident with worsening wounds are provided with an air mattress. New mattresses were ordered in 2024 to replace older mattresses at end of life.

**Change Idea #2** ☑ Implemented ☐ Not Implemented

Improve Registered staff knowledge on identification and staging of pressure injuries

**Process measure**

- # of education sessions provided monthly for Registered staff on correct staging of pressure injuries

**Target for process measure**

- 100% of registered staff will have received education on identification and staging of pressure injuries by Sept 2024

**Lessons Learned**

2 sessions were provided in the year. Skin and wound champion also attended specialized training session. Follow up with staff on an individual basis was provided when a discrepancy in staging was noted.

**Comment**

This indicator increased in 2024 due to admission of resident with complex wounds (inherited) and an increase in palliative residents more susceptible to fragile skin conditions. The works very closely with NLOT and wound nurse to manage worsening pressure ulcers. This area continues to be an area of focus for 2025.

# Experience

## Measure - Dimension: Patient-centred

| Indicator #1 | Type | Unit / Population | Source / Period | Current Performance | Target | Target Justification | External Collaborators |
|---|---|---|---|---|---|---|---|
| I am satisfied with quality of care from my doctors | C | % / LTC home residents | In-house survey / 2024 | 58.80 | 80.00 | To meet Extendicare benchmark | |

### Change Ideas

**Change Idea #1** Communicate role of Medical Director and Physicians and give opportunity for feedback

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| 1) Medical Director to meet at minimum annually with Family and Resident councils 2) Feedback on services and areas for improvement will be discussed 3) update at CQI meeting on action plan | 1) # of meetings with Councils where Medical Director attended 2) # of suggestions provided by councils 3) # of CQI meetings where action items were discussed with Medical Director | 1) Medical Director will attend Family Council by September 30, 2024 2) Medical Director will attend Resident Council by September 30, 2024 | |

**Change Idea #2** Develop information brochure regarding physician care in the Home.

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| 1) Develop a information brochure with physician input 2) Bring to Resident and Family Council for feedback 3) Provide to existing family and residents 4) Provide information in admission package. | 100% of Residents/POA will receive information brochure by April 1, 2025. | Increase satisfaction with quality in physician care by 15% by November 2025. | |

## Measure - Dimension: Patient-centred

| Indicator #2 | Type | Unit / Population | Source / Period | Current Performance | Target | Target Justification | External Collaborators |
|---|---|---|---|---|---|---|---|
| To have input into the recreation program available | C | % / LTC home residents | In-house survey / 2024 | 43.30 | 80.00 | To meet Extendicare benchmark of 80% | |

### Change Ideas

Change Idea #1 Implement monthly program audits during resident council meetings to inform and engage residents in program decision making and input

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| 1) Add program audits to monthly resident council meeting 2) Document on meeting minute template 3. Share and post minutes in common area | 1) 3 programs evaluated each month 2) # of change ideas provided in meeting that were implemented | 100% of programs will be evaluated by December 31, 2025 | |

Change Idea #2 Implement information booklet specific to recreation programs.

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| Develop descriptive booklet of recreation programs available at the Home | 1. Work on a description booklet 2. Get resident input on description 3. Provide to each resident with a copy 4. Add to the new resident welcome package | 100% of resident will receive the description booklet by July 1, 2025 | |

## Measure - Dimension: Patient-centred

| Indicator #3 | Type | Unit / Population | Source / Period | Current Performance | Target | Target Justification | External Collaborators |
|---|---|---|---|---|---|---|---|
| Satisfaction with care from personal support workers | C | % / LTC home residents | In-house survey / 2024 | 58.00 | 80.00 | Extendicare benchmark | |

### Change Ideas

Change Idea #1 Person centered care education

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| 1) Educate staff on person centered care topics of care. 2) Provide person centered care information reminders to staff | # of sessions with a focus on person centered care topics # of staff educated on person centered care products | Staff Education session will be completed by September 30, 2025. 100% of staff will have person centered education | |

Change Idea #2 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 (note: GPA Bathing module now available), 2) Contact PRC for support as needed. 3) Register participants for education sessions. | 1) Provide 1 of GPA session per year 2) 16 staff to participate in 3) Feedback from participants in the usefulness of action items developed to support resident care. | 1) GPA sessions will be provided for 16 staff by October 31, 2025 2) Feedback from participants in the session will be reviewed and actioned on by December 31, 2025 | |

# 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 Sep 30, 2024 (Q2), as target quarter of rolling 4-quarter average | 9.41 | 9.00 | We are currently performing better than corporate average of 13%, and provincial average 15.4 % but strive to continue to reduce falls. | |

### 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) 90% of front line staff will be educated on 4P process by September 30, 2025 2) 4P cards will be distributed to staff by October 31, 2025 3) Resident council and Family council will be informed of process by September 30, 2025 | |

Change Idea #2 Increase awareness of fall hazards in residents environment

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| 1) Have a hazard room set up as training for staff as visual education on fall risks 2) have specified times for staff to participate 3) track education | 1) # of staff participating in hazard room for fall risks | 1) Hazard room for fall risks will be in place with 80 staff% participation by October 31, 2025 | |

## 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 Sep 30, 2024 (Q2), as target quarter of rolling 4-quarter average | 16.67 | 15.00 | We are performing better than the Corporate Target of 17.3 % and provincial target is 20.4, but strive to continually reduce the use of antipsychotic Medications. | |

### Change Ideas

| Change Idea #1 Family education resources provided for appropriate use of Antipsychotics | | | |
|---|---|---|---|
| Methods | Process measures | Target for process measure | Comments |
| 1 Provide 'Centre for Effective Practice (CEP)' resource for appropriate use of anti-psychotics when families have questions about appropriate antipsychotic prescribing 2) Make resource available at nurses station if family who have questions and present at family forum meeting. | 1) # of CEP resources provided to families monthly 2) # of antipsychotics d/c as a result of increased family awareness. | 1) CEP resources will be printed and available at nurses station by April 30, 2025. | |

| Change Idea #2 Education for Registered Staff on antipsychotics | | | |
|---|---|---|---|
| Methods | Process measures | Target for process measure | Comments |
| Nurse Practitioner or Pharmacy consultant to provide education session for registered staff on antipsychotic medications including usage, side effects, alternatives etc.. | # of registered staff who attended training session on antipsychotic medications. | 80% of registered staff will have attended training on antipsychotic medications by July 1, 2025 | |

## Measure - Dimension: Safe

| Indicator #6 | Type | Unit / Population | Source / Period | Current Performance | Target | Target Justification | External Collaborators |
|---|---|---|---|---|---|---|---|
| % of residents who had a pressure ulcer recently got worse | C | % / LTC home residents | Other / October to December 2024. | 7.32 | 2.00 | To achieve our corporate target of 2%. | Solventum/3M, Wounds Canada |

### Change Ideas

Change Idea #1 Turning and repositioning re-education

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| 1) Educate staff on the importance of turning and repositioning to off load pressure 3) Use harmony room as a demonstration room for training 3)Review trends during the Skin and Wound committee meetings for trends | # of staff that have been educated 2) # of audits completed 3) # of reviews completed by Skin and Wound committee | 1) 100% of PSW will have attended education sessions on turning and repositioning by April 31, 2025. 2) Process for review, analysis and follow up of monthly trends from tools will be 100% in place by May 30, 2025 | |

Change Idea #2 Audit surfaces and seating for appropriateness for residents at risk of developing pressure injuries.

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| 1)Wound Care Lead to provide updated list to PSW of residents with pressure injuries 2) Review surfaces and seating during Skin and Wound committee meetings for any follow up 3) ADOC to audit this process and part of the evaluation process of the skin and wound care annual program | 1) Weekly the wound care lead will provide a list to PSW and review at shift exchange. 2)# of surfaces to be reviewed by May 31, 2025. 3) # of surfaces identified to be corrected 4) ADOC to report results of annual program evaluation and get recommendations from skin and wound committee. | 1) 100% of PSW will be aware of residents at risk for worsening pressure injuries 2) 100% of surfaces will be audited for appropriateness by May 31, 2025. 3) 100% of Residents will have appropriate surfaces related to their risk of developing pressure injuries. 4) 100% of recommendations will be implemented by September 30, 2025. | |