Experience | Patient-centred | Custom Indicator

Indicator #12

Resident Experience-Would Recommend. (Westside)

Last Year		This Year		
93.10	**75**	**87.30**	**--**	**NA**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Maintain Resident satisfaction with services in the home.

Process measure

- On-going communication-respond and follow-up in a timely manner with any questions or concerns

Target for process measure

- Metrics in Engagement Survey. Qualitative comments in survey. Number of Client Service Response Form and Residents' Council Concerns Form.

Lessons Learned

New residents move in, we had 100% resident participation compared to previous year which was a positive improvement. We strived to maintain ongoing communication and follow up on concerns in a timely manner. This will continue going forward.

Indicator #3

Family Experience: Would Recommend (Westside)

Last Year		This Year		
100.00	**85**	**95.40**	**--**	**NA**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Maintain Family Satisfaction with Services in the home.

Process measure

- On-going communication -respond and follow -up with any questions and concerns in a timely manner.

Target for process measure

- Metrics in Experience Survey. Qualitative comments in survey. Number of Client Service Response Forms & Family Council Concerns Forms

Lessons Learned

Communicated with family members and held several residents and family events in the home such as Family Fest event, Summer BBQ, Thanksgiving Dinner, Christmas Bazaar and Christmas Dinner which helped with communication and interacting with families.

Indicator #8	Last Year		This Year		
	79.50	**85**	**74.50**	**--**	**NA**
I am satisfied with the variety of food and beverage options. (Westside)	Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Offer a variety of food and beverage

Process measure

- Review menu at the monthly Food Committee Meetings resident to communicate, items they don't like on the menu at Food Committee meeting so that it can be replaced with an item they like.

Target for process measure

- Metrics in Engagement Survey. Qualitative comments in survey. Number of meetings attended/hosted.

Lessons Learned

Spring/Summer and the Fall/Winter menu was reviewed with the resident at the food committee meetings monthly and Residents' Council. Items were discussed and changes were made as per residents' feedback. Westside is a very multicultural home, and we had 100% of resident participation in the survey. The Recreation Team planned and implemented a variety of food programs throughout the year. We continue to work on this for further improvement.

Indicator #9	Last Year		This Year		
	85.70	**90**	**89.60**	**--**	**NA**
I am satisfied with the variety of spiritual care services. (Westside)	Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Provide more spiritual programs.

Process measure

- Recreation Manager ensure spiritual programs are offer monthly in the Recreation Calendars (Roman Catholic Mass, Non-denominational Worship Services, Bible Study, Community Choirs, & Rosary Programs)

Target for process measure

- Metrics in Engagement Survey. Qualitative comments in survey. Number of Spiritual Programs offered each month in Activity Pro.

Lessons Learned

Implementation of more spiritual programs, two new community church was added monthly.
100% residents' participation in completing the 2024 survey compared to previous year. We almost met our target and will strive to continue to improve.

Indicator #7

I am satisfied with the quality of laundry services for my personal clothing. (Westside)

Last Year		This Year		
86.40	**90**	**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

Improve laundry services for personal clothing.

Process measure

- Daily review of laundry room. Cross train all housekeeping staff to do laundry. Monthly environmental team meetings to discuss issues related to laundry.

Target for process measure

- aily review of laundry room. Cross train all housekeeping staff to do laundry. Monthly environmental team meetings to discuss issues related to laundry.

Lessons Learned

We had 100% of resident participation in the survey. We had several new move ins, new Environment Service Manager, several changes were made in the laundry. although we didn't meet our target we did show some improvement.

	Last Year		This Year		
Indicator #6 I am satisfied with the quality of laundry service for linens (Westside)	**70.70** Performance (2024/25)	**85** Target (2024/25)	**87.30** Performance (2025/26)	**--** Percentage Improvement (2025/26)	**NA** Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Improve laundry services for linens.

Process measure

- Daily review of laundry room. Cross train all housekeeping staff to do laundry. Monthly environmental team meetings to discuss issues related to laundry.

Target for process measure

- Metrics in Experience Survey. Qualitative comments in survey. Number of meetings attended/hosted.

Lessons Learned

We had 92.9% of family participation in the survey. We had several new move ins, new Environment Service Manager, several changes were made in the laundry. This change ideas was effective and we have positive improvement this year and exceeded our target.

Indicator #5	Last Year		This Year		
	71.40	85	86.20	--	NA
I am satisfied with the quality of cleaning within the resident's room. (Westside)	Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Ensure resident's room are cleaned.

Process measure

- Environmental Services manager to audit each floor daily, monthly audit by Marquise Monthly environmental team meetings to discuss issues and related standards.

Target for process measure

- Metrics in Experience Survey. Audit Results. Qualitative comments in survey.

Lessons Learned

New Environment Service Manager, audits were completed.

	Last Year		This Year		
Indicator #4 I am satisfied with cleaning services throughout the home. (Westside)	**71.40** Performance (2024/25)	**85** Target (2024/25)	**86.20** Performance (2025/26)	**--** Percentage Improvement (2025/26)	**NA** Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Ensure Cleanliness of the Home

Process measure

- Environmental Services manager to audit each floor daily, monthly audit by Marquise Monthly environmental team meetings to discuss issues and related standards

Target for process measure

- Metrics in Experience Survey. Audit Results. Qualitative comments in survey.

Lessons Learned

We have a new Environment Service Manager. There was a positive improvement in this indicator, and we exceeded our target. We will continue to strive to improve.

Safety | Safe | Optional Indicator

	Last Year		This Year		
Indicator #10 Percentage of LTC home residents who fell in the 30 days leading up to their assessment (Westside)	**12.32** Performance (2024/25)	**15** Target (2024/25)	**14.42** Performance (2025/26)	**-17.05%** Percentage Improvement (2025/26)	**13** Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Conduct assessment of high-risk fallers

Process measure

- Review risk management, Falls Huddles with allow interdisciplinary approach to develop root cause, develop a work towards change.

Target for process measure

- Quality lab which allows for collaboration and hearing successes of other teams Continuous quality improvement audits that determine gaps and support prompt action planning

Lessons Learned

Risk Management completed for each fall, and we had a root cause analysis done for the falls. We were able to stay below our target but will continue to work on improvement in this indicator.

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

Environment assessment was completed and was successful in helping us to identify potential fall risk areas.

	Last Year		This Year		
Indicator #11	**18.77**	**17.30**	**17.79**	**5.22%**	**17.30**
Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment (Westside)	**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

We had a staffing change with a new BSO Nurse, Interim DOC this year. We were able to improve in our indicator results but will continue to work on this to meet our target.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Implementation of Extendicare Antipsychotic Reduction Tool

Process measure

- 1.Interdisciplinary assessment, behaviours huddles and rounds to allow staff to understand reason behind beahviour.2. Quality labs with interdisciplinary approach to develop root cause, develop and work towards change, while collaborating and hearing successes of other teams.

Target for process measure

- Review the number of residents of antipsychotics medication without a diagnosis quarterly. Continuous Quality Improvement Audits that determine gaps and support prompt action planning.

Lessons Learned

Staffing change new BSO Nurse, Interim DOC Huddles were done with frontline staff days and evening shifts, we participate in quality labs and collaborate with the interdisciplinary team - DementiAbility interventions were all effective strategies and will continue.

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

DementiAbility Intervention

Process measure

- No process measure entered

Target for process measure

- No target entered

Lessons Learned

Roll-out of DementiAbility Boxes in each home area for residents with responsive behaviours was effective and will continue.

Comment

We will continue to focus on this indicator in our 2025 workplan as we strive to further improve.

Safety | Safe | Custom Indicator

	Last Year		This Year		
Indicator #2 % of LTC residents with worsened ulcers stages 2-4 (Westside)	**2.34** Performance (2024/25)	**2.50** Target (2024/25)	**2.08** Performance (2025/26)	**--** Percentage Improvement (2025/26)	**NA** 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. Utilizing wound care app to ensure accurate assessment and treatment plan.

Target for process measure

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

Lessons Learned

On-going assessment and monitoring skin and wounds was successful strategy. Challenges included several new admissions and resident returning from hospital with wounds.

Change Idea #2 ☐ Implemented ☑ Not Implemented

Improve Registered staff knowledge on identification and staging of pressure injuries.

Process measure

- # of education sessions provided quarterly 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

Was unable to do education with Registered staff due to staffing change and compliance

Comment

We had some improvement in this indicator but will continue to work to further improve our results.

Safety | Safe | Custom Indicator

	Last Year		This Year		
Indicator #1 % of LTC residents with restraints (Westside)	**0.00** Performance (2024/25)	**2.50** Target (2024/25)	**0.00** Performance (2025/26)	**#Error** Percentage Improvement (2025/26)	**NA** Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Maintain Zero Restraints in the home.

Process measure

- Residents reviewed quarterly and upon admission. Meetings held with families/residents to discuss alternatives during interdisciplinary care conferences. Audits in place for maintenance of zero restraints quarterly (CIHI)

Target for process measure

- Home will remain restraint free.

Lessons Learned

On-going reviewing with families and provide alternatives which has been effective at maintaining our good result.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Educate staff on restraint policy and use of alternatives to restraints.

Process measure

- Education sessions held annually.

Target for process measure

- 100% of staff will be re-educated on restraint policy and alternatives to restraints by April 2024

Lessons Learned

100% staff Mandatory education completed, and this was beneficial to increase awareness about restraints.

Comment

We continue to maintain 0% for our restraints. We will continue to monitor and maintain current processes which were successful but will not include in our 2025 workplan.

Experience

Measure - Dimension: Patient-centred

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Resident:I am satisfied with the variety of food and beverage options.	C	% / LTC home residents	In-house survey / 2024	74.50	85.00	To achieve Extendicare target of 85%	

Change Ideas

Change Idea #1 Incorporate an "Always Available menu" offering a standard set of alternatives when scheduled meal options do not appeal to the Resident

Methods	Process measures	Target for process measure	Comments
1) Develop a list of food items (with input from Residents) that will be available at all meals and snacks that can be provided at point of service 2) Adjust the items available regularly based on Resident feedback 3) Increase in overall satisfaction related to this question	1) Implementation of an "Always Available" menu 2) Schedule will be developed to review feedback and determine changes to implement 3) Increase in overall satisfaction related to this question	1) Home will have enter # alternate items available at each meal 2) Alternate items available will be reassessed enter # times per year	

Measure - Dimension: Patient-centred

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Resident: I am satisfied with the variety of food and beverage served to me	C	% / LTC home residents	In-house survey / 2024	78.40	85.00	To achieve Extendicare target 85%	

Change Ideas

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

Methods	Process measures	Target for process measure	Comments
1) Plan schedule for when cook and/or Dietary/Nutrition Manager will be present in Dining room for meals (ensure that all meals are covered in schedule). 2) Determine specific questions that will be asked to gather feedback. Ask additional questions as needed and confirm understanding with Resident. 3) Where appropriate make required changes. 4) Follow-up with the Resident	1) Improvement in overall Resident satisfaction scores for this question. 2) Increase in positive responses to questions asked within the dining room. 3)# of concerns that were rectified	1) Cook/Manager will attend meal service enter 10 times per week to obtain feedback beginning March 30,2025	

Measure - Dimension: Patient-centred

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Resident: I am satisfied with the quality of care from physiotherapist.	C	% / LTC home residents	In-house survey / 2024	82.80	85.00	To achieve Extendicare target 85%	

Change Ideas

Change Idea #1 Improve visibility of Physiotherapist in home with residents

Methods	Process measures	Target for process measure	Comments
1) PT to meet at minimum annually with Resident councils 2) Feedback on services and areas for improvement will be discussed 3) update at CQI meeting on action plan	1) Review and feedback from Resident Council	1) PT will attend Resident Council by April 30, 2025 2) Action items and plan will be discussed at CQI committee with PT by June 30, 2025	

Measure - Dimension: Patient-centred

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Family: I am satisfied with the quality of cleaning within the resident's room.	C	% / Family	In-house survey / 2024	86.20	90.00	Continue to improve to exceed Extendicare target 85%	

Change Ideas

Change Idea #1 Review deep clean schedules for resident rooms

Methods	Process measures	Target for process measure	Comments
1) Environment 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	1) Environment Services manager will review deep clean schedule by March 30,2025 2) 50% of resident rooms will have been deep cleaned by June 30,2025, with 100% being completed by December 30,2025 3)There will be a 100% improvement in completion of deep clean audits by December 30,2025	

Measure - Dimension: Patient-centred

Indicator #5	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Family: I am satisfied with the variety of food and beverage options for residents.	C	% / Family	In-house survey / 2024	85.90	88.00	Continue to perform better than Extendicare target 85%	

Change Ideas

Change Idea #1 Incorporate an "Always Available menu" offering a standard set of alternatives when scheduled meal options do not appeal to the Resident

Methods	Process measures	Target for process measure	Comments
1) Develop a list of food items (with input from Residents) that will be available at all meals and snacks that can be provided at point of service 2) Adjust the items available regularly based on Resident feedback 3) Increase in overall satisfaction related to this question	1) Implementation of an "Always Available" menu 2) Schedule will be developed to review feedback and determine changes to implement 3) Increase in overall satisfaction related to this question	1) Home will have alternate items available at each meal 2) Alternate items available will be reassessed 4 times per year	

Measure - Dimension: Patient-centred

Indicator #6	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Family: I am satisfied with the quality of care from physiotherapists.	C	% / Family	In-house survey / 2024	86.40	88.00	Continue to improve to perform better than Extendicare target 85%	

Change Ideas

Change Idea #1 Improve visibility of Physiotherapist in home with families

Methods	Process measures	Target for process measure	Comments
1) PT to meet at minimum annually with Family councils 2) Feedback on services and areas for improvement will be discussed 3) update at CQI meeting on action plan	1) Review and feedback from Family Council	1) PT will attend Family Council by May 30,2025 2) Action items and plan will be discussed at CQI committee with PT by June 30,2025	

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	14.42	13.00	Continue to strive for excellence and perform better than Extendicare target of 15%	Achieva, Behavioural Supports

Change Ideas

Change Idea #1 Ensure each resident at risk for falls has an 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 plan of care with care 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) Residents at risk for falls will be identified by April 30, 2025 2) Care plans for high-risk residents will be reviewed and updated by April 30,2025 3) Changes in care plans will be communicated to staff ongoing.	

Change Idea #2 Re implement Post fall huddles

Methods	Process measures	Target for process measure	Comments
1) Review policy on post fall huddles with staff 2) Falls lead in home to attend and /or review post fall huddles documentation and provide further education as needed	1) of staff who reviewed policy for post fall huddles 2) # of post fall huddles that were completed as per policy on a monthly basis	1) Staff education on post fall huddles will be completed with 75 % participation by April 30,2025 2) By July 30,2025, 100% of post fall huddle documentation will be completed as per policy	

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	17.79	17.30	Extendicare target	Medisystem, Behavioural Supports

Change Ideas

Change Idea #1 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 April 30, 2025 2) Alternatives will be in place and reassessed if not effective within 1 month of implementation with process in place by July 30, 2025	

Change Idea #2 GPA 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) Contact Regional Manager, LTC Consultant or Manager of Behaviour Services & Dementia Care for support as needed. 3) Register participants for education sessions.	1) # of GPA sessions provided 2) # of staff participating in education 3) # of referrals to Regional Managers, LTC Consultants or Manager of Behaviour Services & Dementia Care. 4) Feedback from participants in the usefulness of action items developed to support resident care	1) GPA sessions will be provided for 75% staff by July 30,2025. 2) Feedback from participants in the session will be reviewed and actioned on by September 30,2025.	

Measure - Dimension: Safe

Indicator #9	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of residents who had a pressure ulcer that recently got worsened	C	% / LTC home residents	In house data, interRAI survey / October - December 2024	2.08	2.00	Extendicare target	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 offload pressure 2) Night staff to audit those residents that require turning and repositioning 3)Review this during the Skin and Wound committee meetings for trends	1)# 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 January 30, 2025. 2) Check in with staff and will be correctly completed on a monthly basis by March 30,2025 3) Process for review, analysis and follow up of monthly trends from tools will be 100% in place by March 30,2025	

Change Idea #2 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 online modules 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 online modules 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 completed by April 30,2025 2) 100% of Registered staff will have completed education on correct wound staging by July 30,2025 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 September 30,2025	