Experience | Patient-centred | Optional Indicator

Indicator #8

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

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

We did not have this indicator in our 2024 workplan. We had other areas of focus from our resident and family survey as priorities.

	Last Year		This Year		
Indicator #7	**CB**	**CB**	**CB**	**--**	**NA**
Percentage of residents responding positively to: "What number would you use to rate how well the staff listen to you?" (Fosterbrooke)	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

We did not include this indicator in our 2024 workplan. Instead, we had other areas from our resident and family survey as a focus.

Experience | Patient-centred | Custom Indicator

Indicator #9

Resident Satisfaction – Would Recommend (Fosterbrooke)

Last Year		This Year		
90.90	**75**	**73.10**	**--**	**NA**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

1)Address concerns from residents timely 2)Engage residents when managers are completing management by walk about

Process measure

- Improved score on Resident Satisfaction Survey Improved score on Resident Satisfaction Survey

Target for process measure

- Quarterly review of all CSRs will demonstrate timely response for 100% of concerns by September 2024 Monthly MBWA review will show no trends related to concerns from residents by September 2024.

Lessons Learned

CSRs addressed in a timely manner. Increase in MBWA numbers in 2024. Managers all have an open door policy for both staff and residents. We continue to monitor all quality indicators to ensure resident satisfaction.

Comment

Increase in resident participation in 2024 may have affected these numbers.

Indicator #12

Temperature of Food and Beverages (Fosterbrooke)

Last Year		This Year		
59.10	**67.80**	**68.00**	**--**	**NA**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

1) Ensure steam tables are turned on and to the correct temperature and cold wells at temperature 2)Ensure beverages are served at the appropriate temperature each meal and snack time 3)FSS to complete rounds of tables with different meal services to monitor service is good and obtain feedback from the residents

Process measure

- Resident Satisfaction Survey score

Target for process measure

- Monthly audit of food temps will show all within range by September 2024. Monthly audit of beverage temps will show all within range by September 2024. Monthly MBWA review will show no trends related to food/beverage temps by September 2024.

Lessons Learned

Significant improvement noted in this area. Monthly audit of food and beverage temperatures were within range. Walkabout in dining room by Nutrition Manager showed no trend related to food or beverage temperatures. No food or beverage temperature complaints received at monthly food committee meetings.

Comment

We will continue to monitor our processes to sustain results, but have not included this as a priority area in our action plan.

Indicator #10

Spiritual Care (Fosterbrooke)

Last Year		This Year		
61.50	**73**	**68.80**	**--**	**NA**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

1)Spiritual care to be offered every other Sunday, possibly by an outside clergy 2)Spiritual Care Coordinator to organize a spiritual program for self or recreation staff to provide on Sundays 3)Make available virtual church services on Sundays for the residents

Process measure

- Resident Satisfaction Survey score

Target for process measure

- Review spiritual care satisfaction and ask for input at Resident's Council monthly

Lessons Learned

We do now offer spiritual care services every sunday. Virtual was not necessary as we were able to have outside clergy every week which was well received. We also have one non-denominational service provided by local church per month. We continue to have a spiritual care co-ordinator 6 hours per week in house.

Comment

We will continue to monitor our current processes to sustain results, but have not included as a priority area in our action plan.

Indicator #4

Family Satisfaction – Would Recommend (Fosterbrooke)

Last Year		This Year		
80.00	**85**	**96.60**	**--**	**NA**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

1)Managers have open door policy for families 2)All departments are represented at the resident care conferences

Process measure

- Family Satisfaction Survey score

Target for process measure

- Communication included in newsletter by September 2024. Care conference audits will show all departments represented 85% of the time by September 2024.

Lessons Learned

Successful implementation of this change idea has shown a significant improvement in this indicator. Communication provided via family newsletter, family portal and family council regularly by September. All departments attended care conferences 85% of the time or provided a report by September. Families do take advantage of the open door policies of managers within the home.

Comment

For 2025 we will continue to monitor our current processes to sustain results.

Indicator #3

Continence Care for Loved Ones (Fosterbrooke)

Last Year		This Year		
57.60	**66.10**	**89.30**	**--**	**NA**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

1)Invite Prevail/Medline product provider to attend a Family Council meeting to provide an education session for families 2)Program lead or delegate to provide an in-service on the program at Fosterbrooke 3) Review resident continence at care conferences with families

Process measure

- Family satisfaction survey score

Target for process measure

- Education will be completed by September 2024 Leadership team will be aware of enhanced care conference process by April 2024.

Lessons Learned

Continence care program lead did present at Family Council meeting. Continence care program and resident's specific needs discussed at each care conference with opportunity for feedback.

Comment

For 2025 we will continue monitor our current processes to sustain results.

Indicator #11

Spiritual Care of a Loved One (Fosterbrooke)

Last Year		This Year		
50.00	**57.60**	**87.50**	**--**	**NA**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

1)Spiritual care to be offered every other Sunday, possibly by an outside clergy 2) Spiritual Care Coordinator to organize a spiritual program for self or recreation staff to provide on Sundays 3) Make available virtual church services on Sundays for the residents

Process measure

- Family satisfaction survey

Target for process measure

- Review spiritual care satisfaction and ask for input at Family Council annually.

Lessons Learned

Significant improvement noted in family satisfaction in this area. Community clergy in house each sunday. Monthly non-denominational church service provided and well attended. Spiritual care coordinator providing services 6 hours per week.

Comment

We will continue to monitor our current processes to sustain results, but have not included as a priority area in our action plan.

Safety | Safe | Optional Indicator

	Last Year		This Year		
Indicator #6	**22.01**	**17.30**	**24.34**	**-10.59%**	**17.30**
Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment (Fosterbrooke)	**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 without diagnosis

Process measure

- # of residents reviewed monthly # of reduction strategies implemented monthly

Target for process measure

- All residents currently prescribed antipsychotics without supporting diagnosis will have a medication review completed by July 2024

Lessons Learned

Pharmacist and MD did medication reviews on all residents and worked toward de-prescribing as appropriate. Antipsychotic Decision Support Tool was implemented and completed monthly to update all action taken on any residents triggering this indicator. Total of 19 residents no longer triggering this indicator.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Medication reviews completed for all residents currently prescribed antipsychotics without diagnosis

Process measure

- # of residents reviewed monthly # of reduction strategies implemented monthly

Target for process measure

- All residents currently prescribed antipsychotics without supporting diagnosis will have a medication review completed by July 2024

Lessons Learned

Pharmacist and MD did medication reviews on all residents and worked toward de-prescribing as appropriate.

Comment

We will continue to implement new change ideas for this indicator in 2025 as we work toward our goal.

	Last Year		This Year		
Indicator #5	**13.17**	**15**	**14.07**	**-6.83%**	**13**
Percentage of LTC home residents who fell in the 30 days leading up to their assessment (Fosterbrooke)	**Performance (2024/25)**	**Target (2024/25)**	**Performance (2025/26)**	**Percentage Improvement (2025/26)**	**Target (2025/26)**

Change Idea #1 ☑ 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

Target for process measure

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

Lessons Learned

Successful implementation of this change idea has resulted in maintenance of this indicator below target. Environmental room scans completed monthly on all high risk residents - an average of 8 per month. Multidisciplinary falls committee held every week to review all falls each week for root cause and interventions, and reviewed again in one month or sooner as necessary.

Comment

We will continue to work on change ideas for this indicator in 2025 as we work to maintain and improve.

Safety | Safe | Custom Indicator

Indicator #2

% of LTC residents with restraints (Fosterbrooke)

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

Target for process measure

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

Lessons Learned

No residents with any physical restraints for 2024. Continue to educate families at time of admission and as questions arise regarding least restraint policy and risks.

Comment

For 2025 we will continue to monitor our current processes to sustain results.

Indicator #1

% if LTC residents with worsening ulcers stages 2 - 4 (Fosterbrooke)

Last Year		This Year		
1.40	**2**	**3.47**	**--**	**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 bed systems/surfaces for residents with PURS score 3 or greater.

Process measure

- # 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

16 bed systems/surfaces were replaced. Wound Care Champion educated by 3M and all clinical staff educated annually on skin and wound program.

Comment

All residents with PURS score of 3 or higher were given a therapeutic surface. It has increased our awareness of the necessity to continue with that proactive step with all new admissions and as residents decline.

Experience

Measure - Dimension: Patient-centred

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
I am satisfied with the variety of recreation programs.	C	% / LTC home residents	In-house survey / 2024	70.60	78.00	Continued improvement as we strive to achieve Extendicare target of 85%	

Change Ideas

Change Idea #1 Integrate specific activities, programs and strategies to include all 5 domains.

Methods	Process measures	Target for process measure	Comments
1. Include all 5 domains in discussion when Program Planning. 2. Audit calendars prior to print to ensure balance of all domains. 3. Source new pet therapy and implement.	1. Monthly balances in domains in calendar. 2. Resident feedback on programs at each Resident Council meeting. 3. Program planning section added to Resident Council Agenda.	1. Create balance within all 5 domains by Sept. 30, 2025. 2. Program Planning agenda addition by March 2025.	

Measure - Dimension: Patient-centred

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
In my care conference we discuss what is going well, what could be better and how we can improve things.	C	% / LTC home residents	In-house survey / 2024	59.10	70.00	Continued improvement as we strive for Extendicare benchmark of 85%	

Change Ideas

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

Methods	Process measures	Target for process measure	Comments
1. Communicate to residents when their annual care conference is scheduled in advance of the meeting. 2. Remind resident morning of meeting and assist as needed to the meeting. 3. Allow time for discussion and obtain feedback on what could be improved.	1. # annual care conferences where residents attend (goal is 25).	Residents will be encouraged to attend their annual care conferences beginning March 2025.	

Measure - Dimension: Patient-centred

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
I am satisfied with the quality of care from my dietitian.	C	% / LTC home residents	In-house survey / 2024	62.50	70.00	Continued improvement as we strive to achieve Extendicare target 85%	

Change Ideas

Change Idea #1 Increase awareness of role of dietitian in home with residents and families.

Methods	Process measures	Target for process measure	Comments
1. Dietitian to meet at minimum annually at Family meeting and at Resident council. 2. Feedback on services and areas for improvement will be discussed.	1. # meetings with Councils and meetings where dietitian attended (goal is 2 per year).	1. Dietitian will attend Family meeting and Resident council meeting each by September 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	14.07	13.00	To continue to improve results and remain better than Extendicare benchmark 15%.	Achieva, Behavioural Supports

Change Ideas

Change Idea #1 Increase awareness of residents at high risk for falls

Methods	Process measures	Target for process measure	Comments
1. Provide education sessions on Falling Star program to all PSW and Registered Staff. 2. Managers to audit and monitor progress to ensure implementation.	1. # of education sessions provided to PSW and Registered staff.	1. Education sessions for PSW and Registered Staff will be completed by June 2025.	

Change Idea #2 Increased communication during shift report for newly admitted and residents and during outbreaks.

Methods	Process measures	Target for process measure	Comments
1. remind staff about increased risk of falls when in outbreaks and during admission period. 2. Registered staff to communicate list of residents on isolation and/or new admissions during each shift report to oncoming staff.	1. managers will do random audits of PSWs to determine if high risk for falls, isolated and residents communicated at shift report.	1. use 6.7 audit to audit 10% of PSW staff per month. Goal is 100% yes.	

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	24.34	17.30	Extendicare benchmark.	Medisystem, Behavioural Supports

Change Ideas

Change Idea #1 Implement Extendicare's Antipsychotic Reduction Program which includes use of the Antipsychotic Decision Support Tool.

Methods	Process measures	Target for process measure	Comments
1. Review at Multidisciplinary Meeting which residents trigger indicator. 2. Action plan for residents inputted into decision support tool.	1. Schedule regular meetings for Antipsychotic review. 2. Attendance to quality labs.	1. Antipsychotic review meetings to occur 8 times per year. 2. Residents triggering the antipsychotic QI have an action plan inputted into the decision support tool within 3 to 6 months of admission.	

Change Idea #2 Enhance collaboration with Behavioural Supports Ontario Lead and interdisciplinary team.

Methods	Process measures	Target for process measure	Comments
1. Invite BSO lead to attend Multidisciplinary meetings for increased visibility. 2. Remind staff to refer to BSO for supports. 3. BSO lead to do CMAI on residents that trigger as appropriate.	1. # interdisciplinary meetings BSO lead invited to attend. 2. # of monthly referrals to BSO. 3. # CMAI completed.	1. BSO will have increased collaboration and visibility in the Home by June 30, 2025.	

Measure - Dimension: Safe

Indicator #6	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Worsened stage 2 to 4 pressure ulcers.	C	% / LTC home residents	Other / October to December 2024.	3.47	2.00	Extendicare benchmark.	Solventum/3M, Wounds Canada

Change Ideas

Change Idea #1 Mandatory education for all Registered staff on Wound Care policies.

Methods	Process measures	Target for process measure	Comments
All registered staff will have education at staff meeting then 1:1 until completed.	# registered staff that have had education.	All registered staff to have education done by March 31, 2025.	

Change Idea #2 Mandatory education for all registered staff on Kennedy Terminal Ulcers and Diabetic ulcers.

Methods	Process measures	Target for process measure	Comments
All registered staff will have education on kennedy terminal ulcers and diabetic ulcers - how to identify assess and code.	# registered staff educated.	100% of registered staff will have education completed by September 30, 2025.	