Experience | Patient-centred | Custom Indicator

	Last Year		This Year		
Indicator #2 Percentage of family responding positively to " I have an opportunity to provide input to food and beverages options" (Kennedy Lodge)	**72.90**	**85**	**82.50**	**--**	**NA**
	Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Sharing the Residents Food Committee minutes to the families.

Process measure

- Increase percentage on the survey by 10%.

Target for process measure

- Ongoing feedback from the residents on the satisfaction with the food and beverages staff provided.

Lessons Learned

Successful outcomes of sharing resident Food Committee minutes to visitors as it is posted throughout the home and easily accessible to families and residents at any time.

Change Idea #2 ☐ Implemented ☑ Not Implemented

Engaged and invite resident to participate in the food tasting panel and get their feedback.

Process measure

- Increase percentage on the survey results and increase satisfaction to food and beverages served.

Target for process measure

- Ongoing feedback from the resident and the food committee of the food and beverages served.

Lessons Learned

Due to some challenges encountered throughout the year such as outbreaks, we were unable to implement a food tasting panel. We still strive to have one in 2025 to allow residents an opportunity to express their opinions and offer feedback on the taste and quality of the food.

	Last Year		This Year		
Indicator #8 Percentage of resident responding positively to " I am satisfied with the food and beverages served." (Kennedy Lodge)	**61.10** Performance (2024/25)	**75** Target (2024/25)	**88.90** Performance (2025/26)	**--** Percentage Improvement (2025/26)	**NA** Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Engage in regular discussion with residents on their satisfaction with food and beverages served.

Process measure

- Increase scores on survey, discussion will occur each day on at least one meal.

Target for process measure

- Ongoing feedback from the residents about the staff service being provided.

Lessons Learned

Successful food committee meetings happen monthly where residents are given opportunities to provide their input, any changes and inclusions to the menus. The Dietary Manager regularly engages residents at least once per day to ensure satisfaction with meals provided.

	Last Year		This Year		
Indicator #9 Percentage of residents positively responding to "My care conference is a meaningful discussion that focuses on what's working well, what can be improved and potential solutions" (Kennedy Lodge)	**61.80** Performance (2024/25)	**75** Target (2024/25)	**78.20** Performance (2025/26)	**--** Percentage Improvement (2025/26)	**NA** Target (2025/26)

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

Interpreter will be present during the care conference and physicians will use simple layman's terms when communicating to the residents.

Process measure

- Increase participation and involvement of the resident in their care.

Target for process measure

- Increase satisfaction survey result related to survey questions meaningful care conference.

Lessons Learned

The home found it challenging to implement a consistent interpreter during care conferences. In 2025, we will strive to recruit internal interpreters to assist residents during their care conferences and to continue empowering residents to make personal care decisions that they fully understand.

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

Improve residents' engagement.

Process measure

- keep track of the residents that is attending the care conference.

Target for process measure

- Improve residents' involvement in their care planning and communication from the interdisciplinary team.

Lessons Learned

Successful usage of the Care Conference Audit to track resident's engagement and participation as evidenced by a large improvement in our survey score.

	Last Year		This Year		
Indicator #1 Family Satisfaction - Would recommend by 10%. (Kennedy Lodge)	**91.10** Performance (2024/25)	**85** Target (2024/25)	**88.80** Performance (2025/26)	**--** Percentage Improvement (2025/26)	**NA** Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Continue to collaborate with the family and continue with the open door policy.

Process measure

- Increase survey result would recommend by 2%.

Target for process measure

- Ongoing feedback from the family

Lessons Learned

This was successful. The team will need to further implement open door policy to ensure that we are meeting expectations set by family members.

Indicator #3

Percentage of family responding positively to" The resident has input into the recreation programs available" (Kennedy Lodge)

Last Year		This Year		
79.75	**85**	**96.10**	**--**	**NA**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Engage in regular discussions with the family about the resident choice program in the home.

Process measure

- Increase percentage on the survey by 10%

Target for process measure

- Ongoing feedback from the family.

Lessons Learned

The home engages family by various methods of communication such as newsletters, posters and email regarding resident choice programs and we have received positive feedback.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Improve collaboration with the family to encourage them to access the activity pro portal.

Process measure

- # of specific activities that were chosen by the residents.

Target for process measure

- Increased number of family accessing the activity pro portal.

Lessons Learned

Families are not actively using ActivityPro but we encourage them to sign up for the portal by re-introducing the portal to Family Council and send out communication via email to spread awareness.

Indicator #10

Percentage of residents responding positively to " Staff take time to chat with me" (Kennedy Lodge)

Last Year		This Year		
56.80	**75**	**94.80**	**--**	**NA**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Staff to engage residents in meaningful conversations.

Process measure

- Increase percentage on the survey by 20%

Target for process measure

- All active staff will complete the re-education and training by June 30, 2024

Lessons Learned

Staff engage with residents during their care and outside of their care to create a welcoming and positive living environment. This approach has been beneficial for both staff and residents,

Change Idea #2 ☑ Implemented ☐ Not Implemented

Engage in regular discussion with residents during the resident's council meeting and or care conferences to gauge if the staff are taking time to converse with them.

Process measure

- Increase staff and residents' engagement and increase survey results.

Target for process measure

- Ongoing feedback from the residents on how the staff interact with them.

Lessons Learned

As evidenced by the survey results, staff's engagement with residents have improved and residents feel staff that staff are approachable staff take an interest in residents' daily activities.

	Last Year		This Year		
Indicator #11 Residents' satisfaction - Would recommend by 10% (Kennedy Lodge)	**80.20**	**75**	**87.40**	**--**	**NA**
	Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

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

Increase collaboration with resident council.

Process measure

- Number of Managers collaborated with the resident council.

Target for process measure

- To increase satisfaction survey result would recommend by 25% on next survey.

Lessons Learned

We were unable to increase the collaboration with residents council and managers in the home that are not required to be there as per legislation. in 2025, a Resident's Council Town Hall is scheduled to continue to meet this goal.

Safety | Safe | Optional Indicator

Indicator #4

Percentage of LTC home residents who fell in the 30 days leading up to their assessment (Kennedy Lodge)

Last Year		This Year		
11.58	**15**	**9.24**	**20.21%**	**8**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Review care plan for all high-risk fallers.

Process measure

- Outcome of the audits to be reviewed and re-audited for compliance.

Target for process measure

- To remain below CIHI benchmark monthly.

Lessons Learned

Care plan audits are ongoing and successful. Review of audits are done monthly.

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 ongoing. We continue to implement our robust falls prevention plan to continue being below benchmark.

Indicator #7

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

Last Year		This Year		
14.81	**17.30**	**13.43**	**9.32%**	**12**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Residents on antipsychotics medications without diagnosis will be reviewed and audited. Diagnosis will be updated to reflect CiHI definition.

Process measure

- Will continue with monthly CMAI for those residents on antipsychotics medication without diagnosis.

Target for process measure

- Will further decrease the number of residents without diagnosis by September 30, 2024

Lessons Learned

Antipsychotic Deprescribing Program is successful and in place to improve the de-escalation of antipsychotic reduction. Kennedy Lodge implements the Cohen-Mansfield to measure behaviours exhibited by our residents.

Change Idea #2 ☑ Implemented ☐ Not Implemented

To reduce the number of residents on anti- psychotic medication as per LTC Fixing the Long-Term care act

Process measure

- Audits and monthly CMAI - Cohen Mansfield agitation index, GDS - Geriatric depression score and implementation of PIECES assessment.

Target for process measure

- Reduce the number of residents on anti-psychotics medication without diagnosis by 5% on the next quarter.

Lessons Learned

Behaviour audits are reviewed monthly and successful usage of external BSO continues. The antipsychotic medication monitoring tool is generated monthly to monitor compliance.

Safety | Safe | Custom Indicator

Indicator #6

Percentage of LTC home residents with Worsened Pressure ulcers stage 2 -4 ulcers. (Kennedy Lodge)

Last Year		This Year		
1.00	**2**	**0.71**	**--**	**NA**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Continue to complete worsening wound checklist and re-evaluate treatment plan for worsening wounds.

Process measure

- Continue with monthly skin and wound care audits

Target for process measure

- To maintain below benchmark.

Lessons Learned

Monthly skin and wound audits, along with weekly skin assessments continue to be completed and successful in monitoring wounds.

Change Idea #2 ☑ 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

We continue to substitute regular mattresses with air mattresses when needed to sustain and prevent worsening pressure ulcers. Environmental Services Manager continue to perform environmental scans to ensure the integrity of all mattresses in the facility.

Safety | Safe | Custom Indicator

	Last Year		This Year		
Indicator #5 Percentage of LTC home residents with daily physical restraints. (Kennedy Lodge)	**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

- # of residents reviewed monthly # of meetings held with families/residents to discuss alternatives monthly

Target for process measure

- No restraints in the home

Lessons Learned

Kennedy Lodge currently and previously had zero restraints. We removed existing siderails without a PASD Agreement in place. Annual bedrail assessments, education to families upon admission and no lap belts on wheelchairs, along with mandatory annual education for all staff continues to be a success.

Equity

Measure - Dimension: Equitable

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education	O	% / Staff	Local data collection / Most recent consecutive 12-month period	100.00	100.00	Managers received education and training on Indigenous Culture and Sensitivity and Equity, Inclusion, Diversity and Anti – Racist (EIDA-R).	

Change Ideas

Change Idea #1 Include information on bulletin board in home dedicated to Equity, diversity inclusion and antiracism.

Methods	Process measures	Target for process measure	Comments
1). Have information visible on bulletin board that provides education on topics related to equity/diversity 2). include contact information for further discussion.	This information will be posted in the home for 6 months related to equity, diversity, inclusion and antiracism on bulletin board.	Information will be posted on bulletin board by April 2025.	Total LTCH Beds: 228

Experience

Measure - Dimension: Patient-centred

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Communication from home Leadership.	C	% / LTC home residents	In house data collection / September 2024	74.80	90.00	Extendicare Benchmark.	

Change Ideas

Change Idea #1 Implementation of email communication to family members/Residents who utilize technology and updating residents via Residents Council.

Methods	Process measures	Target for process measure	Comments
Implementation of email communication to family members/Residents who utilize technology and updating residents via Residents Council.	# of resident and family council meetings information discussed and emails regarding updates around the home.	1) Newletters are being sent out to families and residents as it is our current process. 2) Discussion with resident and family council about updates (if invited) otherwise, 3) email updates commenced with updates regarding the home.	

Measure - Dimension: Patient-centred

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Care conference outcomes.	C	% / LTC home residents	In-house survey / September 2024	78.20	83.00	Extendicare Benchmark	

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 meeting 2) Remind resident morning of meeting and assist as needed to meeting 2) Provide copy of plan of care 3) Allow time for discussion and obtain feedback on what could be improved.	1) # of annual care conferences where residents attend 2) # of care conferences where plan of care was discussed with resident	1) Residents will be encouraged to attend their annual care conferences beginning February 19, 2025 2) There will be a 5% improvement in this indicator by December 2025.	

Measure - Dimension: Patient-centred

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Resident Survey Question: "If I need help, I can get it".	C	% / LTC home residents	In-house survey / September 2024	79.10	85.00	Extendicare Benchmark	

Change Ideas

Change Idea #1 Increase staff awareness of call bell response times

Methods	Process measures	Target for process measure	Comments
1) DOC/designate to review call bell response times on quarterly basis. 2) communicate results to staff and leadership team quarterly basis. 3) Incorporate on the spot monitoring by leadership walkabouts to observe response times. 4) Follow up with staff for any areas of improvement for response times.	1) # of call bell response time reviews completed 2) # of times results communicated to staff and to leadership team 3) # of leadership walkabouts completed monthly 4) # of staff follow ups required.	1) Call bell response review process will be in place by May 2025 2) Communication of call bell responses to staff and to leadership will be in place by May 2025 3) Process for leadership walkabouts will be in place by February 2025	

Safety

Measure - Dimension: Safe

Indicator #5	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of LTC home residents who fell in the 30 days leading up to their assessment	O	% / LTC home residents	CIHI CCRS / July 1 to Sep 30, 2024 (Q2), as target quarter of rolling 4-quarter average	9.24	8.00	Below extendicare benchmark however we want to continue to improve.	

Change Ideas

Change Idea #1 Implement/Reimplement/Reassess Falling Leaf /Star program and re educate staff on program.

Methods	Process measures	Target for process measure	Comments
ADOC will provide education sessions on Falling Star/Leaf Program to all PSW and Registered Staff on all units on all shifts and during staff meetings.	# of education sessions provided to PSW and Registered staff and PSWs.	Education sessions for PSW and Registered staff will be completed by May 2025.	

Measure - Dimension: Safe

Indicator #6	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment	O	% / LTC home residents	CIHI CCRS / July 1 to Sep 30, 2024 (Q2), as target quarter of rolling 4-quarter average	13.43	12.00	Antipsychotic Deprescribing Program (ADP) and Cohen Mansfield test are implemented in our facility to monitor and decrease the use of antipsychotics without a diagnosis.	

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) medication reviews will be completed during annual care conferences or when needed.	1) 75% of all residents will have medication and diagnosis review completed. 2) Alternatives will be in place and reassessed if not effective quarterly by February 19, 2025.	

Measure - Dimension: Safe

Indicator #7	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Worsened Pressure Injuries	C	% / LTC home residents	CIHI portal / January - December 2024	0.71	0.50	Externally acquired pressure ulcers and poor skin integrity from the community is a challenge to improve as residents are admitted to long-term care.	

Change Ideas

Change Idea #1 Ensure appropriate surfaces and seating for residents at risk of skin issues by improving communication with OT/PT.

Methods	Process measures	Target for process measure	Comments
Meet to discuss process to improve communication between the OT/PT and the skin and wound lead. Wound Care lead to provide a updated list of skin and seating issues to the OT/PT internally.	# of residents requiring OT referrals. # of surfaces reviewed.	Wound care lead to provide refresh education for Registered staff on improving knowledge of wound care products by February 13, 2025. All surfaces for at risk residents will be reviewed by April 2025.	

Measure - Dimension: Safe

Indicator #8	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Restraints	C	% / LTC home residents	CIHI portal / January - December 2024	0.00	0.00	Educating families upon admission that we are zero policy for restraints and bed rails are not being utilized in a long-term care home setting.	

Change Ideas

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

Methods	Process measures	Target for process measure	Comments
1.) Provide Least Restrain Policy in admission packages for new admissions. 2) Meet with Resident and family councils to provide education on Least Restraint and risks associated with restraint use.	1.) 100% of admission packages with Restraint Policy included. 2.) annual review of Restraint Policy with Resident & Family Councils to review risks of restraints.	1). 100% of admission packages will have Restraint brochure included for new admissions by April 2025. 2). Resident Council representative will discuss Least Restraint policy by April 2025.	