Experience | Patient-centred | Custom Indicator

	Last Year		This Year		
Indicator #2	**73.00**	**75**	**68.40**	**--**	**NA**
% of residents would recommend this home to others. (Sumac Lodge)	Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Identify 3 areas of focus which the home is confident it can improve upon.

Process measure

- Internal audits will assist in determining some of the focused areas. 2024 resident satisfaction survey will determine if the planned focus areas improved upon the indicator.

Target for process measure

- 75%, corporate target

Lessons Learned

Successfully actioning the findings of our internal audits are met with the challenges of being an older long-term care home. Nonetheless, residents and family members are engaged in exploring change ideas.

Indicator #3

Family would recommend this home to others. (Sumac Lodge)

Last Year		This Year		
73.00	**85**	**88.90**	**--**	**NA**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Identify 3 areas of focus which the home is confident it can improve upon and would be beneficial to residents and family members.

Process measure

- Internal audits will identify progress with some of the action items focused on. The 2024 survey will determine if the 3 areas focused on have improved this indicator.

Target for process measure

- 85%, corporate target.

Lessons Learned

Family Council is active in bringing ideas forward and feel comfortable raising concerns with staff and leadership. We continue to develop this partnership going forward.

Indicator #5	Last Year Performance (2024/25)	Last Year Target (2024/25)	This Year Performance (2025/26)	This Year Percentage Improvement (2025/26)	This Year Target (2025/26)
I am updated regularly about any changes in my home. (Sumac Lodge)	51.00	62	71.40	--	NA

Change Idea #1 ☑ Implemented ☐ Not Implemented

Registered staff to update residents on changes in home (example - out of outbreak). DOC/ADOC to discuss at registered staff meeting(s). - Update residents with a monthly newsletter including a brief update from each department. - Information pamphlet provided to residents. - Create a resident/family quality information board posting items such as satisfaction surveys, survey action plans, QIP, quality indicators, initiatives, capital plans and more. - Regular updates at residents council meetings from department managers, if invited as per process.

Process measure

- 2024 Resident satisfaction survey results specific to this question.

Target for process measure

- 62%, LTC division average

Lessons Learned

Daily huddles with team members, monthly newsletters, quality boards and regular updates at resident council have resulted in improved communication.

Indicator #4

I am satisfied with the quality of maintenance of the physical building and outdoor space. (Sumac Lodge)

Last Year		This Year		
54.00	**71**	**81.50**	**--**	**NA**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

- Focused audits of each room identifying any areas required for improvements with maintenance. - Ensure sustainability methods are adhered to with the homes MBWA audit and applicable logs/audits assessing all areas of the home on a identified cadence with higher risk rooms on a more frequent basis. - Environmental Services Manager to complete maintenance audits as per quality calendar and address any deficiencies. - Respond to any areas of concern raised from residents and family councils in a timely manner. - Complete focused maintenance projects identified at the home.

Process measure

- 2024 survey question will indicate progression of this specific indicator.

Target for process measure

- 72%, corporate target

Lessons Learned

Investments in the physical needs of the long-term care home have proven to be successful. Sustaining these updates has been achieved through the use of audits and maintenance logs.

Safety | Safe | Optional Indicator

Indicator #7	Last Year		This Year		
Percentage of LTC home residents who fell in the 30 days leading up to their assessment (Sumac Lodge)	**11.64** Performance (2024/25)	**15** Target (2024/25)	**21.00** Performance (2025/26)	**-80.41%** Percentage Improvement (2025/26)	**15** Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Improve fall prevention program awareness with all departments.

Process measure

- # of falls per unit decreased. # of staff involved in engagement activities. # of falls teams meetings

Target for process measure

- June 30th, 2024

Lessons Learned

Falls lead provides consistent education to staff and works collaboratively with the expanded rehab program to minimize falls. this has been effective.

Change Idea #2 ☐ Implemented ☑ Not Implemented

Improved fall prevention care planning.

Process measure

- # of care plans audited # of care plan changes (interventions) completed.

Target for process measure

- June 30th, 2024

Lessons Learned

Focused audits have been implemented to improve fall prevention care planning with the inter-disciplinary team.

Change Idea #3 ☑ 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

Fall prevention strategies are in place. The structure and design of the building contributes to congestion in the long-term care home at times.

Change Idea #4 ☑ Implemented ☐ Not Implemented

Implementation of a new 'buddy up' program where a dedicated team member monitors residents have increased risk of falling.

Process measure

- No process measure entered

Target for process measure

- No target entered

Lessons Learned

Falls lead provides education on this new program and works with front-line team members to sustain implementation.

Comment

Expansion of the falls team, implementation of the buddy up program and increased staffing are creating improved falls awareness in the Home. Falls lead is tracking and trending data to identify when and where falls occur more frequently.

	Last Year		This Year		
Indicator #8	**23.15**	**17.30**	**31.36**	**-35.46%**	**17.30**
Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment (Sumac Lodge)	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

Regular reviews continue with an emphasis on deprescribing as able has been effective strategy and will continue.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Consultation with internal and/or external resources to review any prescribing trends.

Process measure

- # of consultations completed. # of changes with alternate prescribing.

Target for process measure

- By July 31st, 2024.

Lessons Learned

The transition to a new medical director occurred in 2024. Additional support provided to explore alternate options.

Change Idea #3 ☑ Implemented ☐ Not Implemented

Improve non-pharmacological approaches to responsive behaviours.

Process measure

- # of staff educated on non-pharmacological interventions available.

Target for process measure

- By July 31st, 2024.

Lessons Learned

Regular education provided to registered team members on non-pharmalogical interventions has been an effective strategy.

Comment

Internal processes altered to include BSO lead input into non-pharmalogical interventions and completion of appropriate assessments prior to medication options.

Safety | Safe | Custom Indicator

	Last Year		This Year		
Indicator #6 Percentage of long-term care home residents who developed a stage 2 to 4 pressure ulcer or had a pressure ulcer that worsened to a stage 2, 3 or 4 (Sumac Lodge)	**2.60** Performance (2024/25)	**2** Target (2024/25)	**1.30** 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

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

Bed systems were replaced for all residents with PURS score 3 or greater.

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 and nutrition/hydration.

Target for process measure

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

Lessons Learned

Wound care overview education provided to registered team members in addition to wound care procedures to prevent infections.

Change Idea #3 ☑ Implemented ☐ Not Implemented

Tracking MASDs and implemented 3 step routine in place.

Process measure

- No process measure entered

Target for process measure

- No target entered

Lessons Learned

3 step process implemented to heal and prevent MASDs. Proven successful.

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

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

Continue with current methods as the home is restraint free.

Process measure

- # of restraints reviewed.

Target for process measure

- # of restraints.

Lessons Learned

Providing education to new residents and families on our approach to least restraints was effective. We continue to remain restraint free in our home.

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	51.60	65.00	Meet or exceed LTC Division average.	

Change Ideas

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

Methods	Process measures	Target for process measure	Comments
1) Order Extendicare name tags for physician 2) Utilize a communication board for families /residents so they are aware of when physician is going to be onsite.	1) # of name tags ordered 2) % of communication boards with physician visits included	1) Name tags will be ordered for all physicians in home by April 2025. 2) Process for utilizing communication board for posting of visit schedules will be 100% implemented by May 2025.	

Change Idea #2 Communicate role of Medical Director and Nurse Practitioners 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 2025 2) Medical Director will attend Resident Council by June 2025 3) Action items and plan will be discussed at CQI committee with Medical Director by June 2025.	

Measure - Dimension: Patient-centred

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
I am satisfied with the food and beverages served to me.	C	% / LTC home residents	In-house survey / 2024	65.80	73.00	Meet or exceed LTC Division Average.	

Change Ideas

Change Idea #1 Ensure dedicated time (standing agenda item) during Resident Council meeting to discuss food complaints and recommendations.

Methods	Process measures	Target for process measure	Comments
1) Set allotted time on the agenda OR have separate sub-committee for Food Council / feedback on food. 2) Agreed upon actions that will be taken and specify timeline. 3) Follow-up on improvement and reassess action if needed.	1) Food Committee will be provided allotted specified time during every Resident's Council meeting. 2) Feedback, recommendations and corresponding actions will be documented and monitored ongoing.	1) Food committed meetings will be held 12 times per year (unless Home is in outbreak) beginning April 2025. 2) Recommendations will be documented and actioned on within 10 days and feedback on those actions obtained within 30 days post implementation beginning April 2025.	

Change Idea #2 Hold food tastings prior to each Menu launch to obtain feedback on types of food to be incorporated into next menu cycle. Could potentially be in collaboration with Recreation Department.

Methods	Process measures	Target for process measure	Comments
1) Schedule food tastings and determine products to be tested. 2) Advertise food tasting event and have sign up sheet for Residents. 3) Plan for event, ensure that home adheres to Residents nutritional plan of care when providing samples to Residents. 4) Order food items required for event.	1) # of food tasting sessions held annually 2) # of items accepted by Residents (and included on the menu) and # of items rejected by Residents 3) Improvement of overall Resident satisfaction score.	1) 3 Food tasting sessions will occur each year by October 2025. 2) 75% of new menu choices will be included as a result of tasting held by the start of the next menu by October 2025.	

Measure - Dimension: Patient-centred

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
I am satisfied with the variety of food and beverage options.	C	% / LTC home residents	In-house survey / 2024	63.20	73.00	Meet or exceed LTC Division Average.	

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 two alternate items available at each meal. 2) Alternate items available will be reassessed 3 times per year.	

Change Idea #2 Increase special food programs through Recreation Team.

Methods	Process measures	Target for process measure	Comments
1. Review previous year calendar to determine # of events with food 2. Brainstorm change ideas including monthly breakfast clubs, friendship luncheons, food trucks, outings, BBQ's, around the world programs, etc. that can incorporate variety 3. Review in Program Planning Meetings, gathering feedback on resident interests 4. Host programs monthly.	1. # of food related programming being offered. 2. Attendance in said programs 3. Resident feedback in RC or Program Planning Meetings.	1. Incorporate at least 2 food related programs each month on programs calendar starting June 2025. 2. Implement breakfast programs 2/month for 25% of residents throughout 2025 beginning June 2025. 3. Facilitate at least 1 friendship luncheon monthly for 2025 beginning July 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	21.00	15.00	Corporate Target	Achieva, Behavioural Supports

Change Ideas

Change Idea #1 Review Activity programming during times when most falls occur.

Methods	Process measures	Target for process measure	Comments
1) Review times when most falls are occurring. 2) Review Program preferences for residents who are at risk of falls. 3) Implement program at time of day when falls are occurring. 4) Monitor results	1) # of residents reviewed who are high risk for falls. 2) % of program review completed. 3) # of new programs implemented during peak times for falls. 4) # of high risk residents who did not fall during month when activity was occurring.	1) Review of falls and times when occurring will be completed by April 1, 2025. 2) Review of high risk residents program preferences will be completed by April 15, 2025. 3) Group and individual programs will be implemented during high risk times by May 1, 2025.	

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

Methods	Process measures	Target for process measure	Comments
1) Determine residents at risk for falls. 2) Review plan of care for each resident at risk. 3) Discuss strategies with fall team and staff. 4) Update plan of care. 5) Communicate changes in 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 15, 2025. 2) Care plans for high-risk residents will be reviewed and updated by April 30, 2025. 3) Changes in plans of care will be communicated to staff by April 30, 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	31.36	17.30	Corporate Target	Medisystem, GPA

Change Ideas

Change Idea #1 GPA education for training for responsive behaviours related to dementia.

Methods	Process measures	Target for process measure	Comments
1). Engage with Certified GPA Coaches to roll-out home-level education. 2). 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% of staff by December 2025. 2.) Feedback from participants in the session will be reviewed and actioned on by December 2025.	

Change Idea #2 Collaborate with the physician to ensure all residents using anti-psychotic medications have a medical diagnosis and rationale identified.

Methods	Process measures	Target for process measure	Comments
1) Complete medication review for residents prescribed antipsychotic medications. 2) Review diagnosis and rationale for antipsychotic medication. 3) Consider alternatives as appropriate.	1) # of medication reviews completed monthly. 2) # of diagnosis that were appropriate for antipsychotic medication use. 3) # of alternatives implemented.	1) 75% of all residents will have medication and diagnosis review completed to validate usage by December 2025. 2) Alternatives will be in place and reassessed if not effective within 1 month of implementation with process in place by December 2025.	

Measure - Dimension: Safe

Indicator #6	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of long-term care home residents who developed a stage 2 to 4 pressure ulcer or had a pressure ulcer that worsened to a stage 2, 3 or 4	C	% / LTC home residents	Other / October to December 2024	1.90	1.70	To continue to improve results and remain better than Corporate Target 2%	

Change Ideas

Change Idea #1	Review team membership to ensure interdisciplinary. and that team ensures that all wounds and skin issues in previous month are reviewed during their meetings.		
Methods	Process measures	Target for process measure	Comments
1) Review current membership of Skin and Wound team 2) Recuit new members and ensure each discipline is represented 3) Standardized agenda and follow up by team on skin issues in home.	1) # of reviews completed on current membership. 2) # of new members recruited by discipline. 3) Standardized agenda developed which includes review of # pressure ulcers by stage on each unit on a monthly basis.	1) Membership review of skin and wound committee will be completed by April 30, 2025. 2) Recruitment of new members will be completed by June 30 2025. 3) Standardized agenda will be developed and in place by May 30, 2025.	

Change Idea #2	Focus on continence to keep skin clean and dry- toileting, appropriate brief selection.		
Methods	Process measures	Target for process measure	Comments
1) The skin and wound lead and continence lead to look at the number of residents on a toileting routine and compare with wound list already generated from PCC. 2) Wound Care lead will work with the continence lead internally to ensure that the correct incontinence product is being used for each resident. 3) Provide education sessions as required for brief selection. 4) Review restorative goals if on restorative toileting program. 5) DOC to audit this process and part of the evaluation process of the program.	# of residents with skin issues # of residents with a toileting plan in place # of brief audit checks completed # of education sessions provided # of residents on restorative toileting program	1) The leads for Skin/Wound and Continence will 100% complete their resident review by May 2025. 2) Review of correct sizing and type of incontinence products will be 100% completed by May 2025. 3) Education sessions for product selection will be 100% completed by May 2025. 4) Annual review of continence program will be 100% completed by April 2025.	