Experience | Patient-centred | Custom Indicator

Indicator #3

I am satisfied with the
temperature of my food and beverages.
2023 - 47.2%
No data for 2022
(Hillside Manor)

Last Year		This Year		
47.20	**67.80**	**70.60**	**--**	**NA**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☐ Implemented ☑ Not Implemented

- Ensure steam cart is plugged in at each meal, - temperature sheets to be maintained and documented, - Conduct random food audits temperature and quality audits 3x/ week. - Communicate with Residents in D/R about meal service. - Resident choice meal once a month to be discussed at Resident Council/ and food committee meetings. - New menu coming out from Extendicare Monthly food council meetings.

Process measure

- Obtain feedback from Residents during meal service and in Food Council meetings to determine if they are satisfied with outcomes.

Target for process measure

- Each meal will be within the desired temperature range by April 1st, 2024.

Lessons Learned

Resident's choice meal has been implemented into the menu and Residents are enjoying it. The new Extendicare menu has been implemented. Food temperatures remain a concern for some Residents while others are satisfied. The cart is being consistently plugged in. Food quality is discussed at Resident Council meetings.
A challenge we experience is satisfying all Residents as food preference and temperature is specific to each induvial.

Comment

Food quality and temperature audits are ongoing. Pleasurable dining will continue to be a focus as well as meal satisfaction.

Indicator #7

resident has input into the recreation programs available.
35.3% for 2023
no data for 2022
(Hillside Manor)

Last Year		This Year		
35.30	**47.20**	**57.60**	**--**	**NA**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☐ Implemented ☑ Not Implemented

- Send out survey questions every six months to Families for input. - Promote enrollment in activity pro. - Continue to discuss family input in care conferences. - ED will share monthly emails with Families with updates within the home and activity and food calendars

Process measure

- Family members who visit regularly and who are highly involved in their loved one's care will be asked during their visits if they are satisfied with outcomes.

Target for process measure

- Track progress and feedback at each Family Council meeting.

Lessons Learned

Our home did promote enrollment into activity pro for Families, it is discussed at care conferences, and it has been included in the Family newsletter.
Challenges include Family involvement and lack of understanding or use of technology from families.
We did not meet our goal for sending out survey questions every six months and did not share monthly emails with Families regarding activities and food calendars. Our challenges have been meeting the needs of the demographics of the Residents in our home. Other challenges include frontline Staff recognizing the importance that recreation plays in the lives of our Residents.

Comment

We will prioritize sharing monthly information with Families.

Indicator #2

Family satisfaction
Would recommend - 85.7 (Hillside Manor)

Last Year		This Year		
85.70	**85**	**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

I am satisfied with the variety of spiritual care services. 52.6%

Process measure

- Measured with ongoing feedback with Families during Council meetings and care conferences.

Target for process measure

- Increase target results by July 2024.

Lessons Learned

Additional spiritual programs outside of religious programs were added to the calendar. Recreation participated in online education for Spiritual Care.
Challenges include recognition of what is defined as being spiritual as spirituality is unique to each individual.

Indicator #8

Resident satisfaction would recommend.
88.9 % (Hillside Manor)

Last Year		This Year		
88.90	**75**	**85.30**	**--**	**NA**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

I have input into recreation programs available. 48.3%

Process measure

- Meet with Residents to determine who would like to participate in what kind of programs. Obtain feedback from Residents during Resident council meetings and care conferences.

Target for process measure

- Increase variety of recreation programs and resident participation levels by July 2024.

Lessons Learned

Our home was successful in meeting this goal. Calendar planning was included on the Recreation calendar. Resident requested programs were highlighted on the calendar to help Residents identify which programs they requested.
Challenges include creating programs for Residents who are non-verbal or for those who cannot advocate for themselves. Other challenges include, cognitive Residents not accepting their favorite programs are not on the calendar daily due to need to accommodate to as many preferences as possible.

Safety | Safe | Optional Indicator

Indicator #4

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

Last Year		This Year		
14.29	**15**	**17.87**	**-25.05%**	**15**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

The home will host falls parties to assist in engaging staff in falls prevention. Information such as falls trends, location and time of falls will be shared with Staff via routine huddles. Charting buddies will be implemented for Residents at high risk for falls this will allow for PSWs to provide additional supervision while completing their documentation.

Process measure

- # of Residents reviewed for activity needs/ preferences weekly # of activity programs that occur during change of shift in early afternoon weekly. # of environmental assessments completed monthly # of identified deficiencies from assessments that were corrected monthly.

Target for process measure

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

Lessons Learned

In 2024 we celebrated a reduction in falls. Details of falls are reviewed, and the falls teams meets regularly. The charting buddy's system has been rolled out to Staff. Challenges have been frontline Staff engaging in the buddy system and taking the initiate to recognize and react to Residents at high risk for falls.

Comment

We will continue to emphasize the importance of providing enhance supervision to Residents who are at high risk for falls. We will cleebrate our falls reduction successes and consider feedback from other homes.

Indicator #5

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

Last Year		This Year		
16.48	**17.03**	**18.79**	**-14.02%**	**17.30**
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 care plans reviewed that have supporting diagnoses # of reduction strategies implemented monthly.

Target for process measure

- Residents who are currently prescribed antipsychotics will have a medication review completed by July. 2024.

Lessons Learned

Our home has improved greatly with reducing antipsychotic's med reviews were completed. In December 2024 we were within the target benchmark for antipsychotics. Antipsychotic reduction involves collaboration with the multidisciplinary team including, Nursing, Physician, Pharmacy and our BSO team.
Challenges include implementing effective alternative strategies to manage responsive behaviors in order to reduce/eliminate antipsychotics.

Comment

We will continue to focus on managing antipsychotic usage and continue to involve our BSO and care team in trialing alternatives to antipsychotic's.

Safety | Safe | Custom Indicator

	Last Year		This Year		
Indicator #1	**1.60**	**2**	**1.60**	**--**	**NA**
% of LTC residents with worsened ulcers stages 2-4 (Hillside Manor)	Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Conduct a review of therapeutic surfaces e.g. beds for Residents who have a PURS score of 3 or greater. Enhance Registered Staff knowledge on early identification of wounds and staging of pressure injuries. Education for PSW's related to importance of turning and repositioning.

Process measure

- - Determine number of Residents with PURS score of 3 or greater. - # of monthly reviews completed on bed surfaces. - # of bed surfaces requiring replacing monthly. - # of monthly education sessions for Registered Staff related to staging of pressure ulcers.

Target for process measure

- Review of current bed surfaces for residents with a PURS score of 3 or greater by August. 2024.

Lessons Learned

Our home ensured PURS scores were reviewed, and proper interventions were in place.
Therapeutic devices to support prevention of pressure ulcers were ordered. Nov 26th Aseptic technique/ NSWAC Nurse was here, and education was initiated. Education was provided to PSW's on wound prevention strategies.
Challenges include education for all Staff on each shift especially for our casual staff members. Other challenges include connecting with our Physio Therapist for feedback on days he is here.

Safety | Safe | Custom Indicator

Indicator #6

percentage of residents with restraints. (Hillside Manor)

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

Change Idea #1 ☑ Implemented ☐ Not Implemented

Maintain least restraint usage home through ongoing communication.

Process measure

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

Target for process measure

- least restraint utilization.

Lessons Learned

Our home was successful in maintaining the least number of restraints possible. Education is provided to Staff, residents, and families when a restraint is being considered, and least restraint options are tried first. If the restraint is still requested, we collaborate the usage with our multidisciplinary team and Physican. We also monitor the Resident using the restraint for its duration.
When a restraint is still requested by a Resident or family member, it can be challenging finding alternatives to trial, resulting in the potential to be above the restraint benchmark.

Experience

Measure - Dimension: Patient-centred

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Improve the quality of care from Physicians.	C	% / LTC home residents	In-house survey / 2024 -2025	55.90	60.00	Manageable target for improvement. We will strive to continue to improve to meet corporate target 85%	

Change Ideas

Change Idea #1 Increase communication to residents by Physicians.

Methods	Process measures	Target for process measure	Comments
- Notify Residents in advance when Physicians are on vacation or on a leave. - Enhance privacy for Residents during Physicians rounds for assessments/conversations. - Allow standing agenda on Residents Council to include residents input into Physician services. -include observations of residents on random MBWA's (manager walkabouts) by any Manager Discuss any concerns during weekly Leadership meetings that were brought during MBWA audit.	# of communications to residents in advance of physician vacation or leave # of times discussion regarding physician services is held at Residents Council # of feedback received from Resident council and from MBWA's about physician services # of MBWA's that were completed weekly # of leadership meetings were feedback was discussed	Process for communicating physician vacation or leaves will be 100% in place by May 30, 2025 Physician services feedback will be added to standing agenda at resident council meetings by May 30, 2025 . Feedback will be reviewed at weekly leadership meeting and actioned starting May 30, 2025 with a 20% improvement seen in results by October 30, 2025.	

Measure - Dimension: Patient-centred

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Input into the Recreation programs available.	C	% / LTC home residents	In-house survey / 2024 -2025	57.60	62.00	Manageable target for our home as we continue to strive to achieve corporate targets of 85%	

Change Ideas

Change Idea #1 Input into the Recreation programs available.

Methods	Process measures	Target for process measure	Comments
- Hold regularly scheduled resident monthly calendar program meetings. - Resident requested programs will be put in a different color on the calendar to identify. - Program attendance will be evaluated at new programs and discussed at Resident Council meeting.	- # of calendar planning meetings held monthly # of Resident choice programs added in different colour to calendar # of residents attending new programs # of times programs and results discussed at Residents Council meetings.	Resident monthly calendar program meetings will be held monthly starting May 2025 with at least 5 resident choice programs in calendar and implemented by December 2025. There will be at least 10% improvement in participation rates at new programs by December 2025. Resident council will review programs and feedback during monthly meetings beginning June 2025.	

Measure - Dimension: Patient-centred

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Satisfied with scheduled religious and spiritual care programs.	C	% / LTC home residents	In-house survey / 2024 -2025	57.60	60.00	Manageable target for home while we continue to strive toward corporate target of 85%	

Change Ideas

Change Idea #1 Review current religious and spiritual programming offered and gather feedback from Resident council

Methods	Process measures	Target for process measure	Comments
- Meet with Resident council to discuss current program offering for religious and spiritual programs in the home. - Gather feedback /suggestions from resident's council members - Action feedback and implement or revise spiritual program based on resident input.	# of resident council meetings attended where spiritual and religious programs were discussed # of feedback or suggestions provided by residents # of changes implemented based on feedback	Home will meet with Resident council to discuss current program offerings for religious and spiritual programs by May 30, 2025. 100% of feedback obtained will be reviewed by Program manager and actioned on by July 30, 2025. There will be a 10% improvement in overall satisfaction of scheduled religious and spiritual programs by September 30, 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	17.87	15.00	Corporate target	Achieva, Behavioural Supports Ontario

Change Ideas

Change Idea #1 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 3) audit post fall documentation to ensure huddles are being completed correctly and interdisciplinary staff are attending.	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 3) # of reviews of post fall documentation completed 4) # of interdisciplinary staff who are attending post fall huddles	1) Staff education on policy for post fall huddles will be completed with 100 % participation by May 30,2025 2) By September 30,2025 100 % of post fall huddles will be completed as per policy with 50% improvement in interdisciplinary attendance.	

Change Idea #2 Engage Physiotherapist for assessment of need for mobility devices for residents who are unsteady when walking.

Methods	Process measures	Target for process measure	Comments
1) Review residents who are at increased risk for falls due to unsteady gait. 2) Communicate to Registered staff to involve physio for assessment upon admission, when change in status 3) Falls lead to do audits of new admissions and residents with change of status to see if physio referral was completed 4) Discuss results at registered staff meetings and in Leadership meetings	1) # of residents reviewed for unsteady gait 2) # of communications given for registered staff regarding referrals to physio 3) # of assessed residents who required mobility devices 4) # of random audits completed by Falls lead monthly for new admissions and change of status 5) # of times results were discussed at Registered staff meetings and at Leadership meetings monthly	1) 100% of new admissions and residents with change of status who are at risk for unsteady gait will have had a physio assessment completed by June 30, 2025. 2) 100% of registered staff will have had communicated to them regarding physio referrals by May 2025 3) Falls lead will begin random audits for physio referrals by June 2025 4) There will be 50% improvement in compliance for physio referrals by September 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	18.79	17.30	Corporate target	Medisystem, Behavioural Supports Ontario

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 June 30, 2025 2.) Alternatives will be in place and reassessed if not effective within 1 month of implementation with process in place by September 2025.	

Change Idea #2 Education for Registered Staff on antipsychotics

Methods	Process measures	Target for process measure	Comments
1) Pharmacy consultant or Nurse Practitioner to provide education session for registered staff on antipsychotic medications including usage, side effects, alternatives etc.	# of registered staff who attended training session on antipsychotic medications.	75% of registered staff will have attended training on antipsychotic medications by November 1, 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 - December 2024	2.23	2.00	corporate target	Solventum/3M, Wounds Canada

Change Ideas

Change Idea #1 Ensure Resident is using a therapeutic surface that is appropriate for their needs.

Methods	Process measures	Target for process measure	Comments
1) Review bed surfaces in home for residents with PURS scores 3 or greater 2) Replace surfaces as needed 3) Keep inventory list of therapeutic surfaces in home	# of residents with PURS scores 3 or greater # of therapeutic surfaces in home by resident Discuss quarterly at PAC meeting	Review of bed surfaces for 100% of residents with PURS score 3 or greater will be completed by July 30, 2025 25% of bed surfaces that require replacing will be completed by December 30, 2025 Quarterly at PAC meeting a review of inventory list and residents with PURS score 3 or more will be reviewed and actioned beginning June 2025.	