**Experience | Patient-centred | Custom Indicator**

**Indicator #9**

Resident Experience-Would Recommend (Stirling Heights)

| Last Year | | This Year | | |
|---|---|---|---|---|
| **98.30** | **98.50** | **100.00** | **--** | **NA** |
| Performance (2024/25) | Target (2024/25) | Performance (2025/26) | Percentage Improvement (2025/26) | Target (2025/26) |

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

To improve the process and content of the resident care conference to support a meaningful discussion that focuses on what's working well, what can be improved and potential solutions.

**Process measure**

- Utilize the Care Conference Checklist Template to support effective communication and to meet the identified needs of the resident. Resident pre-survey questionnaire has been developed, with the residents' responses used to guide the care conference to support a meaningful discussion for the resident.

**Target for process measure**

- We aim to increase the percentage of residents who would recommend this home with improving the resident's satisfaction with their care conference through ongoing encouragement for the Residents to attend their 6 week and annual care conference. Questionnaire responses being used as guidance tool to ensure resident has the opportunity to communicate what's working well, what can be improved and potential solutions, from now until December 31, 2024 and ongoing.

**Lessons Learned**

Care Conference Checklist and pre survey questionnaire was developed and has supported more effective communication. However, we continue strive for improved satisfaction in this area.

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

To improve and strengthen processes on how residents are updated regularly and can provide feedback about the changes in the home.

**Process measure**

- Resident Council Meetings are on the monthly recreation calendar and posted in the home areas. Resident Council Meetings are on the Recreation Dailies posted on the home areas. Resident Council will invite the Executive Director/delegate to provide home updates on a monthly basis/or more often if required. Resident emails for those who would like to be included on the monthly emailing list for newsletter "Stirling Echo".

**Target for process measure**

- We aim to improve resident's satisfaction through communication of home updates through encouraging Residents to attend and participate at the monthly Resident Council Meetings and having the Executive/delegate to attend Resident Council on a monthly basis as invited. "Stirling Echo" available and delivered to residents (resident choice), from now until December 31, 2024 and ongoing.

## Lessons Learned

100% implemented, however, we continue to look at improved methods of ensuring timely communication and input from our residents. Plan for 2025 is to take Recreation activity planning and leadership/delegate to each home area on a monthly basis to ensure we are meeting the needs and expectation of the RHA residents.

**Indicator #3**

Family Experience-Would Recommend (Stirling Heights)

| Last Year | | This Year | | |
|---|---|---|---|---|
| **91.70** | **92** | **79.40** | **--** | **NA** |
| Performance (2024/25) | Target (2024/25) | Performance (2025/26) | Percentage Improvement (2025/26) | Target (2025/26) |

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

Stirling Heights through defined methods of communication will ensure the interdisciplinary team including the resident and the POA, are aware of resident updates, resident change of status, and the day-to-day life our residents. Shift to Shift and face to face report for the nurse and PSW's, 24 hour report sheets, Home Area Communication Books, Point Click Care Online Chart and Progress notes, phone/in person updates to the resident/POA.

**Process measure**

- The home will monitor the reeducation of staff where necessary to ensure all forms of communication are actively used to ensure staff are informed in a timely manner and are effectively communicating with the resident/POA. Shift to shift reports are occurring on all shifts with full active participation of the home area nurses and PSW's. 24-hour report sheets are completed and reviewed. Home area nurse will pull PCC Online Chart and progress note report at the beginning of each shift. The above will be reviewed and discussed at the Registered Staff Meeting, Huddles, Town Hall. This process will be audited through MBWA's, resident home area huddles for compliance.

**Target for process measure**

- We aim to increase the percentage of families who would recommend this home by improving family satisfaction with communication through ensuring timely effective communication is occurring with the resident's POA, from now until December 31, 2024 and ongoing.

**Lessons Learned**

Re-education occurred with staff to ensure all forms of communication are actively used to ensure staff are communicating clearly and in a timely manner with POA's family's in , through Registered staff meetings,MBWA's, huddles and town hall meetings, with an overall improvement in "Communication from home leadership is clear and timely" from 77.2% to 89.6% and "The care team, communicates clearly in a timely manner about the resident" from 78.2% to 93.8%.

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

To provide better understanding to POA/family to the resident's choice and participation in Recreation 1.Recreation Manager will provide education through the Stirling Newsletter "Stirling ECH0" speaking to the monthly planning meeting that was implemented to ensure that residents had a voice into their choice of programs that is held with residents to plan the month's recreational activities and outings. 2.The monthly newsletter will include the Recreation Calendar, which encourages the resident's POA to sign up for the Family Portal where they can access their loved one's Participation in recreation events, one to one support offered, and the monthly menu.

**Process measure**

- Education will be provided through the "Stirling Echo" and at Family Council. "Stirling Echo" is emailed monthly to the POA/family group email and available by paper copies at reception. "Stirling Echo" will include the recreation Calendar, where families are encouraged to sign up for the Family Portal where they can access their loved one's Participation in recreation events, and one to one support offered, and the monthly menu.

**Target for process measure**

- We aim to increase the percentage of families who would recommend with an increase in the POA/family understanding of resident's choice and participation in Recreation from now, until December 31, 2024, and ongoing through education in the monthly newsletter, the recreation calendar being included in the monthly newsletter and encouragement to sign up for the Family Portal.

**Lessons Learned**

100% of plan was implemented, we continue to work closely with families to educate on home processes in this area and encourage active participation of residents and families.

| | Last Year | | This Year | | |
|---|---|---|---|---|---|
| **Indicator #5** Overall, I am satisfied with the continence care products. (Stirling Heights) | **58.10** Performance (2024/25) | **67** Target (2024/25) | **74.40** Performance (2025/26) | **--** Percentage Improvement (2025/26) | **NA** Target (2025/26) |

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

Education to be provided to the families regarding continence care products..

**Process measure**

- Number of families satisfied with continence care products will improve.

**Target for process measure**

- We aim to increase family satisfaction with the understanding of their loved one's continence care products from now until December 31, 2024.

**Lessons Learned**

Continence Care education, provided by Prevail. Positive Feedback from family members, that the education was very informative and helpful in better understanding the continence assessments and products.

| | Last Year | | This Year | | |
|---|---|---|---|---|---|
| **Indicator #4** | **58.30** | **67.40** | **65.60** | **--** | **NA** |
| I am satisfied with the quality of cleaning withing the resident's room. (Stirling Heights) | Performance (2024/25) | Target (2024/25) | Performance (2025/26) | Percentage Improvement (2025/26) | Target (2025/26) |

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

To improve the quality of cleaning and upkeep of the resident room.

**Process measure**

- On spot audit results will be reviewed at morning report, to identify areas of improvement and progress. Resident room cleanliness and upkeep will be included in the MBWA which will be reviewed and discussed at Family/Resident Council Meetings, to monitor level of satisfaction of Family/Resident council.

**Target for process measure**

- We aim to increase family satisfaction with the quality of cleaning within the resident's room, through and increase in audits, a review of the outcomes at Family and Resident Council reeducation of housekeeping staff from now, until December 31 2024.

**Lessons Learned**

On spot audits and MBWA continue, supporting quick response to identified issues. Overall resident satisfaction has improved from 2023 results and exceed the LTC Division Overall.Family Satisfaction has improved, however, did not successfully meet target nor the LTC Division Overall 2024. This Indicator remains one of our high priority areas, with defined change ideas for 2025.

**Indicator #10**

Resident satisfaction with the quality of care from physiotherapy. (Stirling Heights)

| Last Year | | This Year | | |
|---|---|---|---|---|
| **63.60** | **76** | **82.90** | **--** | **NA** |
| Performance (2024/25) | Target (2024/25) | Performance (2025/26) | Percentage Improvement (2025/26) | Target (2025/26) |

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

Increase the physiotherapy assistant role within the home to better support the needs of the residents.

**Process measure**

- # of residents being supported by the physiotherapy assistants, # of interdiscplinary group exercise programs

**Target for process measure**

- We aim to increase resident satisfaction with the percent of resident satisfaction with quality and quantity of physiotherapy services through the increase in physio assistant hours and increase in the number of interdisciplinary group exercise programs from now until December 31, 2024 and ongoing.

**Lessons Learned**

Great success in this area, brought enhanced awareness through Stirling's Newsletter, and postings within the home areas of our Physio team, their roles enhanced their collaboration with the homes recreation and restorative programs. The resident satisfaction results with the quality of care from physiotherapist increased from 63.6% to 82.9%.

| | Last Year | | This Year | | |
|---|---|---|---|---|---|
| **Indicator #6** | **77.60** | **80** | **87.00** | **--** | **NA** |
| Overall, I am satisfied with the meal, beverage and dining service. (Stirling Heights) | Performance (2024/25) | Target (2024/25) | Performance (2025/26) | Percentage Improvement (2025/26) | Target (2025/26) |

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

Improve the dining experience and the quality/temperature of food served

**Process measure**

- Dietary/dining room audits demonstrate compliance a pleasurable dining experience, with meal quality/safety being supported with effective use so steam wells (lids in place except when actively serving the entrees), plate warmers and Meal Suite in use. Bimonthly Chez Maison

**Target for process measure**

- We aim to increase the percent of resident satisfaction with the meal, beverage and dining service from now until December 31, 2024.

**Lessons Learned**

Successfully implemented the use of plate warmers, met the meal suite utilization target and the return of our Bimonthly Chez Maison. Resident satisfaction with the food and beverages served to me increased from 68.9% to 72.4%. Resident satisfaction with the variety of food and beverage options increase from 68.5% to 72.4%. Resident satisfaction with the temperature of my food and beverages decreased from 67.8% to 67.2%. We continue with regular audits and re education with dietary staff on ensuring the temperature of food is maintained through the use of plate warmers, and keeping steam well lids in place on except when actively serving.

**Safety | Safe | Custom Indicator**

**Indicator #1**

% of LTC residents with restraints (Stirling Heights)

| Last Year | | This Year | | |
|---|---|---|---|---|
| **0.49** | **0.45** | **0.98** | **--** | **NA** |
| Performance (2024/25) | Target (2024/25) | Performance (2025/26) | Percentage Improvement (2025/26) | Target (2025/26) |

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

Review all residents currently utilizing restraints.

**Process measure**

- # residents reviewed monthly, # of meetings held with families/residents to discuss alternatives monthly, # of action plans in place for reduction of restraints in collaboration with family/resident monthly

**Target for process measure**

- We aim to maintain/reduce the number of restraints through 100% of restraints being reviewed and plans implemented for trialing alternatives by Sept 2024

**Lessons Learned**

Stirling Heights remains successful in remaining below the target of 4.00, with a YTD average of .98, with only one resident utilizing a restraint in 2024.

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

Re-educate staff on restraint policy and use of alternatives to restraints

**Process measure**

- # of staff that have received their re-education on restraint policy and alternatives to the use of restraints monthly

**Target for process measure**

- We aim to maintain/reduce number of restraints through 100% of staff re-education on restraint policy and alternatives to restraints by Sept 2024

**Lessons Learned**

100% of all staff received their re-education on restraint policy and alternatives to restraint use.

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

Education for Families

**Process measure**

- Monitor monthly QI CIHI percent of resident with restraints.

**Target for process measure**

- We aim to maintain/reduce percentages from now until December 31st, 2024 by providing on going education to families and/or residents as need is identified.

**Lessons Learned**

Completed with a monthly percentage of 1%

**Change Idea #4** ☑ Implemented ☐ Not Implemented

Offer alternate interventions such as involving recreation, medication review.

**Process measure**

- Montior monthly QI CIHI percent.

**Target for process measure**

- We aim to maintain/reduce current percentage through offering alternate interventions from now until December 31, 2024.

**Lessons Learned**

Completed monthly

**Comment**

Stirling Heights remains successful in remaining below the target of 4.00, with a YTD average of .98, with only one resident utilizing a restraint in 2024. Stirling's interdisciplinary  will continue with the noted successful interventions.

## Safety | Safe | Custom Indicator

| | Last Year | | This Year | | |
|---|---|---|---|---|---|
| **Indicator #2** | **1.38** | **1.30** | **1.11** | **--** | **NA** |
| % of LTC residents with worsened ulcers stages 2-4 (Stirling Heights) | Performance (2024/25) | Target (2024/25) | Performance (2025/26) | Percentage Improvement (2025/26) | Target (2025/26) |

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

Residents with a complex diagnosis are assessed on move in, and as needed for preventive skin and wound devices, preventative pressure ulcer interventions. Review current bed systems/surfaces for residents with PURS score 3 or greater.

**Process measure**

- 1) Develop list of residents with PURS score 3 or greater 2) Skin/wound team to review residents list to determine if surface meets their needs 3) Replace mattress/surface if required

**Target for process measure**

- We aim to reduce the number of worsened pressure ulcers through review of the current bed systems/surfaces for residents with PURS score 3 or greater will be completed by June 2024.

**Lessons Learned**

This list was developed by Stirling's skin and wound nurse, and plan was implemented and completed to replace any mattresses as required.it was very successful as a strategy.

**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

**Target for process measure**

- We aim to reduce the number of worsened pressure ulcers by 100% of registered staff receiving education on identification and staging of pressure injuries by June 2024.

**Lessons Learned**

Skin and Wound Lead, guest speaker at Registered Staff Meetings re: Dressings and PURS. This helped to increase knowledge for our registered staff and was effective.

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

Education for Skin and Wound Leads

**Process measure**

- Completion of the enhanced education program.

**Target for process measure**

- We are aim to reduce the number of residents with worsened pressure ulcers from now until December 31, 2024, through enhanced education of our Skin and Wound Lead and ADOC.

**Lessons Learned**

Skin and Wound Lead attended enhanced education.

Skin and Wound Lead enrolled in SWAN program which was beneficial.

**Change Idea #4** ☑ Implemented ☐ Not Implemented

Review new skin and wound issues

**Process measure**

- Monitoring the UDA daily to ensure that assessments are being completed in a timely manner.

**Target for process measure**

- We aim to reduce the number of residents with worsened pressure ulcers from now until December 31, 2024, through monitoring the UDAs daily to ensure assessments are being completed.

**Lessons Learned**

Plan fully implemented to ensure that assessments are being completed in a timely manner. Process is ongoing .

**Comment**

Stirling has successfully remained below the benchmark and celebrated improved performance from 2023. We will continue ongoing education for Stirling's frontline staff and compliance to the skin and wound program.

## Safety | Safe | Optional Indicator

**Indicator #7**

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

| Last Year | | This Year | | |
|---|---|---|---|---|
| **10.53** | **10** | **16.09** | **-52.80%** | **15** |
| Performance (2024/25) | Target (2024/25) | Performance (2025/26) | Percentage Improvement (2025/26) | Target (2025/26) |

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

Implement specific exercise programs throughout the home, with a focus on scheduling these exercises at high-risk time of day(afternoon change of shift). Interdisciplinary approach for residents who are high risk for falls.

**Process measure**

- The falls analysis from the previous month are reviewed at the monthly clinical quality meetings. Indicator results for the month are reviewed and compared against previous months for trending (and to ensure we are heading in the right direction). Measurement is completed by 1) comparing data from previous months (has an increase in falls been noted at shift change?)

**Target for process measure**

- We aim to ensure process measures are in place and will continue to support the safety and quality of life of Stirling residents, and will monitor the impact of the specific exercise program, target is April 2024.

**Lessons Learned**

Fall's analysis from previous month was
taken to clinical meetings. High risk areas identified during the night and from change of shift till supper time. This information led to night meetings with the ADOC/Falls to review high risk falls interventions in place and plans moving forward. This has led to success with night falls decreasing.

**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**

- We aim to reduce the number of falls through environmental risk assessments of resident spaces to identify fall risk by June 2024.

**Lessons Learned**

100% of all new move in's in 2024. No deficiencies noted related to potential fall risk areas, however, education was required with residents/POA/Families re: positioning of furniture and overcrowding of rooms with furniture and accessories to ensure a safe rooms, with a focus on comfort and safety.

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

Analysis of Falls trends and attributing factors.

**Process measure**

- Reduction in the identified trend from the previous month.

**Target for process measure**

- We aim to reduce the number of monthly falls through the monthly review of RMM and analysis of falls trends from now until December 31, 2024, and ongoing.

**Lessons Learned**

100% completed through monthly Quality Labs, reduction note related to toileting, peak times for falls have been identified and an overall improvement in night falls and interventions put in place. Noted reduction in antipsychotics, to support ongoing compliance and reduction of falls for our residents.

**Change Idea #4** ☑ Implemented ☐ Not Implemented

Enhance communication to front line staff regarding resident's falls care plan.

**Process measure**

- Falls care plan/Kardex audits will be completed for all new admissions, new high-risk residents, and change in risk or change in falls plan interventions.

**Target for process measure**

- We aim to decrease the number of monthly falls through enhanced front line staff knowledge and compliance to resident's falls care plan by December 31, 2024.

**Lessons Learned**

100% completed

**Comment**

The following areas are of focus for 2025 to reduce the number of falls within the home, supporting the safety and quality of life of the residents. Falls focus with the Plan of Care, is being printed for all residents that fall, by the falls lead, for the review by front line and to have full participation of all staff to ensure customized care plan and increased knowledge. Re-introduction of the 4P's. Charge nurses are being trained on New Falls prediction and prevention tool, to review and complete for their designated home area. Med review to be completed for all residents at high risk for falls.

| | Last Year | | This Year | | |
|---|---|---|---|---|---|
| **Indicator #8** | **18.55** | **18** | **14.53** | **21.67%** | **13.50** |
| Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment (Stirling Heights) | Performance (2024/25) | Target (2024/25) | Performance (2025/26) | Percentage Improvement (2025/26) | Target (2025/26) |

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

Stirling Heights BSO home team works closely with our Medical Advisor/attending physicians/psychogeriatrician to review use of Antipsychotics for those residents without a diagnosis and residents who demonstrates a reduction in responsive expressions with the goal of reducing the use of nonpharmacological interventions.

**Process measure**

- # of residents reviewed monthly, # of plans of care reviewed that have supporting diagnosis, # of reduction strategies implemented monthly

**Target for process measure**

- We aim to reduce the percent of residents receiving antipsychotics through all residents currently prescribed antipsychotics will have a medication review completed by June 2024.

**Lessons Learned**

All residents triggering the QI were reviewed on a monthly basis for exclusion criteria from a person-centered perspective. Our goal was to implement 1-2 reduction strategies each month, which resulted in partial success. One of the identified areas was that although residents meet the exclusion criteria, POA and Physician could not always support the deprescribing was in the best interest of the resident.

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

Provide educational material to families and/or residents on antipsychotics and the importance of minimizing use.

**Process measure**

- # of families provided with best practice information on reducing antipsychotics monthly

**Target for process measure**

- We aim to reduce the percentage of residents receiving antipsychotics without a diagnosis, through educational material being provided to families and/or residents on antipsychotics on the importance of minimizing use by June 2024.

**Lessons Learned**

Best practice information was provided to all families who's resident did not meet the exclusion criteria.

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

Implementation and utilization of the DTS tool.

**Process measure**

- Number of residents receiving antipsychotics without a diagnosis as apart of DST tool number of residents receiving antipsychotics with a diagnosis as part of the DST tool CIHI QI percent of residents receiving an antipsychotic without a diagnosis.

**Target for process measure**

- We aim to reduce the percent of resident receiving antipsychotics without a diagnosis from now until December 31st, 2024 through monthly updates and review of antipsychotics reduction program DST tool.

**Lessons Learned**

100% implementation and utilization of the DTS tool.

**Change Idea #4** ☑ **Implemented** ☐ **Not Implemented**

BSO education to frontline staff with non pharmacological vs pharmacological interventions

**Process measure**

- Reviewing and monitoring QI reports at monthly clinical meetings. Monitor DST tool as part of the antipsychotic reduction programs.

**Target for process measure**

- We aim to reduce the number of residents receiving antipsychotics from now until December 31, 2024 through providing additional education to staff.

**Lessons Learned**

BSO education provided to frontline staff, with the support of Stirling's Psycho Geriatrition.