Access and Flow | Efficient | Optional Indicator

Indicator #8	Last Year		This Year		
Rate of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents. (Extendicare Mississauga)	**15.53** Performance (2024/25)	**14** Target (2024/25)	**14.88** Performance (2025/26)	**4.19%** Percentage Improvement (2025/26)	**NA** Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

To educate all Registered Staff on the SBAR tool.

Process measure

- # of nursing staff education on SBAR

Target for process measure

- To have 100% of active Registered Staff educated on the SBAR tool by December 15, 2024.

Lessons Learned

100% of registered staff have been educated on the SBAR and this change idea contributed to the success of this Indicator. Will continue using the SBAR

Change Idea #2 ☑ Implemented ☐ Not Implemented

Utilize the SBAR tool prior to transferring a resident to the Emergency Department.

Process measure

- Total number of ED transfers divide by number of SBAR tools completed.

Target for process measure

- Our goal is to have 100% of our ED transfers assessed with the SBAR tool prior to the transfer by December 31, 2024.

Lessons Learned

SBAR tool was used prior to transferring resident to the hospital. This helped to evert a number of transfer to the hospital in 2024

Change Idea #3 ☑ Implemented ☐ Not Implemented

To educate Nurses on management of chronic diseases utilizing clinical pathways.

Process measure

- Total number of registered staff educated divide by total number of active registered staff.

Target for process measure

- To maintain current performace and/or be below provincial average by December 31, 2024.

Lessons Learned

Education done with registered staff on the utilization of the clinical pathway. Re. Staff were able to recognize early symptoms where residents were treated in-house.

Comment

This target was met.

Experience | Patient-centred | Custom Indicator

	Last Year		This Year		
Indicator #2 Family Experience: Overall Satisfaction. Percentage of Family who would recommend the Home to others. (Extendicare Mississauga)	**84.40** Performance (2024/25)	**85** Target (2024/25)	**93.40** Performance (2025/26)	**--** Percentage Improvement (2025/26)	**NA** Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Deliver monthly newsletter through email to families regarding updates within the Home.

Process measure

- # of newsletters sent out to families

Target for process measure

- Newsletters will begin to be sent to families by April 2024.

Lessons Learned

Regular updates were sent out by email to families during the year of 2024. This was done to keep them informed of the operations of the Home.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Program Manager to facilitate monthly Family Townhall Meetings regarding updates on the Home.

Process measure

- Total number of Townhall Meetings facilitated from April to December 2024.

Target for process measure

- Monthly Townhall Meetings to begin April 2024.

Lessons Learned

The Home continues to facilitate townhall meetings with families on a monthly basis

Change Idea #3 ☑ Implemented ☐ Not Implemented

Invite Family to attend and participate in monthly program planning.

Process measure

- # of Program Planning meetings # of family members that attend Program Planning meetings # of suggestions for programs provided # of suggestions for programs implemented

Target for process measure

- Family to be invited to attend Program Planning meetings at April Townhall.

Lessons Learned

2024 - e-mail blast were sent out to families to attend the monthly program planning with the scheduled date.

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

Monthly updates to Family and Resident Council Presidents.

Process measure

- No process measure entered

Target for process measure

- No target entered

Lessons Learned

Weekly in person meetings with the Council Presidents during 2024 , along with the quarterly family and resident councils meetings.

Comment

Frequent touch points with families, engaging residents in decision making led to the success of this indicator.

Indicator #5

Percentage of Resident satisfied with the variety of food and beverage options in 2024. (Extendicare Mississauga)

Last Year		This Year		
86.70	**90**	**93.60**	**--**	**NA**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Implement quarterly resident meal opinion survey.

Process measure

- # of feedbacks received quarterly # of completed action items from survey

Target for process measure

- The first quarterly survey will be provided to residents by June 2024.

Lessons Learned

The dietary department presented the options on the current menu at the Food Committee Meetings and the residents have an opportunity to vote on current choices.
this was done on a quarterly basis in 2024.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Incorporate monthly themed meals

Process measure

- # of theme meals provided within the year

Target for process measure

- Dietary department will facilitate first theme meal by June 2024.

Lessons Learned

During 2024 dietary department served 2 to 3 themed meals per month. e.g. St. Patrick Day, Chinese New Year, Halloween, Mothers Day, Valentine Day, Diwali and Black History month.

Change Idea #3 ☑ Implemented ☐ Not Implemented

Create food tasting events for residents to provide feedback on menu items

Process measure

- Total number of food sampling and/or tasting events held within the year. the number of suggestions/feedback provided.

Target for process measure

- First food tasting event to take place by June 2024.

Lessons Learned

Food tasting events were created twice in 2024 during the fall/winter menus since revision is done twice a year with monthly ongoing Food Committee support meetings.

Comment

The stated change ideas led to the success of this indicator.

	Last Year		This Year		
Indicator #10 Resident has input into the recreational programs available. (Extendicare Mississauga)	**69.90** Performance (2024/25)	**85** Target (2024/25)	**65.80** Performance (2025/26)	**--** Percentage Improvement (2025/26)	**NA** Target (2025/26)

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

To send monthly event calendar to residents regarding upcoming special events.

Process measure

- # of monthly event calendars sent # of residents attending special events offered at the home

Target for process measure

- Monthly event calendars to be sent to residents starting April 2024.

Lessons Learned

Program Calendar were sent out on a monthly basis to both residents and families 2024. This kept residents and families engaged in the process and also on the scheduled programs.

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

To have Activity Aide participate in the monthly Townhall Meetings.

Process measure

- # of Townhall meetings from April to December 2024 attended by Activity Aide.

Target for process measure

- Activity Aide to attend Townhall Meetings starting April 2024.

Lessons Learned

Will include this change idea in 2025.
Activity Aide participated twice within the year of 2024. This change idea was well received by the families.

Comment

The Home did not meet the set target. This indicator will be added to 2025 Workplan.

	Last Year		This Year		
Indicator #9	**98.70**	**99**	**97.40**	**--**	**NA**
Resident Experience: Overall Satisfaction. Percentage of resident who would recommend the Home to others (Extendicare Mississauga)	Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

To facilitate special events such as Summer BBQ, Carnivals to have a combination of families and residents together.

Process measure

- Number of Special Events held within the year.

Target for process measure

- To hold our summer events by August 2024.

Lessons Learned

In 2024:These changed ideas were scheduled and took place during the summer and winter months. Families Residents and staff attended these events. These events were successful.

Comment

The Home did not meet the set target. This indicator will be added to the 2025 workplan.

	Last Year		This Year		
Indicator #1	**70.10**	**85**	**92.90**	**--**	**NA**
Family Experience: There is a good choice for continence products in the Home. (Extendicare Mississauga)	**Performance (2024/25)**	**Target (2024/25)**	**Performance (2025/26)**	**Percentage Improvement (2025/26)**	**Target (2025/26)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

Have Prevail Representative present at a Family Council Meeting to educate families on the different continence products available in the Home.

Process measure

- # of education sessions provided for those present at Family Council meeting # of concerns or questions raised at meeting

Target for process measure

- Prevail will present on continence products at Family Council by July 2024.

Lessons Learned

June 15th. 2024:Continence Team met with Prevail and was able to communicate suggestion to families which was successful.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Education to take place for all frontline staff regarding the different continent products available in the Home.

Process measure

- # of frontline staff educated on the continence products available in the home.

Target for process measure

- Continence product education to be completed by September 2024.

Lessons Learned

Education was completed with frontline staff. This was a standing Agenda item during Staff meeting which was held quarterly for 2024.

Comment

Quarterly meetings with Prevail Rep. and the team has lead to this indicator's success. The Home will continue with the present strategies.

Safety | Safe | Custom Indicator

	Last Year		This Year		
Indicator #6	**1.65**	**1.50**	**0.00**	**--**	**NA**
Percentage of residents who developed a stage 2 to 4 pressure ulcer or had a pressure ulcer that worsened to a stage 2, 3 or 4 since their previous resident assessment (Extendicare Mississauga)	Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Wound Care Coordinator to utilize the Pressure Ulcers Treatment and Prevention Tracking Tool.

Process measure

- The number of residents identified with resident specific interventions and treatment plan in place.

Target for process measure

- Tracking tool will be in place with an improvement in the wound treatment and interventions by December 31, 2024.

Lessons Learned

Residents who were high risk for pressure ulcers were identified using the Pressure Ulcer Tracker and these residents were audits for compliance monthly in 2024. This intervention was successful. Will continue with this change idea.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Education with all registered staff on the Wound Care Program.

Process measure

- The number of staff educated on the Wound Care Program.

Target for process measure

- All registered staff will have been educated by December 31, 2024

Lessons Learned

100% of all registered staff were educated on the wound care program in 2024.
Will continue with ongoing education to all new hires and registered staff. This change idea was successful as evidence by the home meeting the target.

Change Idea #3 ☑ Implemented ☐ Not Implemented

Identify the number of residents who are at risk with a PURS score of greater than 3

Process measure

- Audit the care plan for residents with a PUR score greater than 3 for specific interventions and treatment plan.

Target for process measure

- The number of completed care plans for at risk residents greater than 3 PURS score will be 100% by Dec 2024.

Lessons Learned

Residents who were high risk for pressure ulcers were identified using the Pressure Ulcer Tracker and these residents were audits for compliance monthly in 2024. This intervention was successful. Will continue with this change idea.

Comment

The Home have met the target on this Indicator, will continue with the change ideas to sustain.

	Last Year		This Year		
Indicator #7	**0.00**	**0**	**0.00**	**#Error**	**NA**
Percentage of residents who were physically restrained every day during the 7 days preceding their resident assessment. (Extendicare Mississauga)	Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☐ Implemented ☑ Not Implemented

To educate all Nursing Staff on the minimization and alternatives to restraints.

Process measure

- Total number of active Nursing Staff divide by the total number of Nursing Staff educated.

Target for process measure

- To have 100% of active nursing staff educated on Restraints and PASDs through Surgelearning by December 31, 2024.

Lessons Learned

Did not work on this change idea

Change Idea #2 ☐ Implemented ☑ Not Implemented

To monitor/review and eliminate possible unnecessary restraints.

Process measure

- Total number of current restraints divide by the number of restraints that were discontinued.

Target for process measure

- Our goal is to maintain our performance to 0% by the end of Deecember 2024.

Lessons Learned

Did not work on this change idea

Change Idea #3 ☐ Implemented ☑ Not Implemented

Create a pamphlet regarding restraint minimization in the Home to be given to failies during admission.

Process measure

- Total number of restraint pamphlet handed out to all new admissions divide by total admissions from April to December 2024.

Target for process measure

- To maintain our current performance to be at 0% by end of December 2024.

Lessons Learned

Did not work on this change idea

Comment

This was not a measure that the Home selected to work on as this Indicator is 0%

Safety | Safe | Optional Indicator

	Last Year		This Year		
Indicator #3 Percentage of LTC home residents who fell in the 30 days leading up to their assessment (Extendicare Mississauga)	**7.95** Performance (2024/25)	**7.50** Target (2024/25)	**11.50** Performance (2025/26)	**-44.65%** Percentage Improvement (2025/26)	**11.25** Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Creating an awareness of the number of falls with injuries which occurred in 2024.

Process measure

- Focus will be on time lines incidents are occurring, location and tasks which were preformed by staff at the time the falls occurred.

Target for process measure

- To reduce the number of falls occurring during the specific time lines by 20% by December 2024

Lessons Learned

A monthly Falls tool tracker was created and utilized to track fall incidences and to ensure that falls prevention strategies were in place. This change idea was implemented in 2024 on a monthly basis

Change Idea #2 ☑ Implemented ☐ Not Implemented

Identify Resident who are falling within the specified timelines.

Process measure

- The number of effective recommendations made as a result of the the post fall huddle and post fall assessments completed.

Target for process measure

- The decrease in the number of falls with the identified residents who had effective interventions as result of post fall and assessments completed by December 31, 2024

Lessons Learned

All high risk residents were identified using the Fall Tracker Tool which resulted in the positive clinical outcome for this indicator in 2024.

Change Idea #3 ☐ Implemented ☑ Not Implemented

Introduce the comfort rounds care staff forms and the shift change reports.

Process measure

- The number of comfort rounds care staff forms and the shift change reports completed.

Target for process measure

- The decrease in the number of falls sustained by residents where the comfort rounds care staff forms and the shift change reports were completed by December 31, 2024.

Lessons Learned

This change idea was not implemented because it was not best practice due to double documentation issue.

Comment

Although the Home did not meet its set target, we remain below Extendicare benchmark.
This indicator will be added to the 2025 Workplan.

Indicator #4

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

Last Year		This Year		
14.06	**13**	**12.47**	**11.31%**	**12**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

In - House Behavior Support Ontario Team to utilize the Deprescribing Antipsychotic Reduction Tracking Tool.

Process measure

- Total number of current residents who have an antipsychotic medication order without a proper diagnosis of psychosis.

Target for process measure

- Reduce the number of residents who are identified on the deprescribing antipsychotic tool by 20% by December 31, 2024.

Lessons Learned

Deprescribing of inappropriate antipsychotic usage was facilitated by the BSO Team in collaboration with the Pharmacist Consultant and the Psychogeriatric Team. The Antipsychotic Tracker Tool was used to track these Residents and was effective.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Identify the residents whose behaviors have worsened or new onset of behaviors.

Process measure

- Residents identified using the Cohen Mansfield tool with a score of lower than 80,the use of pharmacological interventions will be utilized for behaviors

Target for process measure

- The number of residents with a Cohen Mansfield score of less than 80 will have non-pharmacological interventions in place by December 31, 2024.

Lessons Learned

Cohen Mansfield Tool was utilized for residents who scored lower than 80. this was done on admission and quarterly for residents who met the criteria in 2024.

Change Idea #3 ☑ Implemented ☐ Not Implemented

Include Pharmacist in collaboration with the in-house team and family members in deprescribing plan

Process measure

- The number of Residents who were identified based on assessments with an MD order to deprescribe.

Target for process measure

- The Total number of residents who were identified and for whom an order was obtained by the doctor to start deprescribing by December 31, 2024.

Lessons Learned

Deprescribing of inappropriate antipsychotic usage was facilitated by the BSO Team in collaboration with the Pharmacist Consultant and the Psychogeriatric Team. The Antipsychotic Tracker Tool was used to track these Residents and was effective.

Comment

Collaboration with the interdisciplinary team including the Pharmacist lead to the improvement of the Indicator