Experience | Patient-centred | Custom Indicator

	Last Year		This Year		
Indicator #9	**84.10**	**85**	**80.00**	**--**	**NA**
Resident Satisfaction – Would Recommend Home (Extendicare Tecumseh)	Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Home to restructure the Interdisciplinary Team Conferences to have all disciplines attend all meetings.

Process measure

- 1) # of meetings where all disciplines attend. 2) # of accurately completed assessments prior to IDTCs.

Target for process measure

- Restructured IDTC meetings will begin March 2024.

Lessons Learned

1) 168
2)See Chart bellow of accurately completed IDTC documenation:
Month # of Correct
March 1/19
April 0/12
May 4/15
June 1/11
July Data unavailable
August 10/11
September Data Unavailable
October 0/17
November 11/14
December 15/16

Successes: 168 IDTC assessments completed between March 1, 2024 - February 14, 2025, with 100% of IDTC meetings being interdisciplinary.
Challenges: Staff continue to struggle to complete portions of the assessment prior to the IDTC.
Ongoing: On going auditing and education are provided to staff to ensure that IDTC documentation is completed prior to the IDTC.

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

Home to update family email list to increase communication to families and friends of residents about the happenings in the home.

Process measure

- # of families and friends added to the email list.

Target for process measure

- Family and friends email list to be updated by May 2024.

Lessons Learned

Success: 66 emails were added to the list with the admissions in the home.
We continue to provide the program Manager's email to families through the Newsletter to ensure all friends/families are given the opportunity to be added to the email list.
Social worker continues to provide families the opportunity to be added to our email list on admission.
Challanges: We have found that some residents are their own POA, or would also like to have their emails added to the list. We are currently looking into revising our family email consent page to add a space for residents.

Indicator #8

Resident Satisfaction - I have input into the recreation programs available. (Extendicare Tecumseh)

Last Year		This Year		
34.10	**85**	**69.80**	**--**	**NA**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Complete an in-house 8 question survey to gain insight into resident recreation preferences.

Process measure

- 1)# of resident surveys completed 2)# of changes made to the program calendar.

Target for process measure

- 1)Survey to be completed by March 31st, 2024. 2)New programs and program calendar implemented by June 1st, 2024.

Lessons Learned

1)39 surveys completed- which is 90% of residents with a CPS score of 3 or less

2)The following updates were made from this survey:
Updates to Calendar from Survey Responses:
#1-Changed name of Food and Resident Council to “Food/Resident Council/Calendar Planning Meeting” so that residents know that this is the time to have input
#2-We have increased in Outdoor programming when weather permits
3) Addition of monthly computer classes
4) Program staff educated and audits completed weekly to ensure programs start on time according to calendar

Overall the survey was a success with all changes being able to be implemented.

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

Complete program audits to ensure program plans and program delivery are implemented and carried out in a standardized method.

Process measure

- 1)# of Program Plans that require updating. 2)# of follow up items from the weekly program audits required at Recreation Staff Meeting.

Target for process measure

- 1)Annual Program Plan Audits will be completed by April 30th, 2024. 2)Follow-Up from Program Audits added to the Recreation Staff Meeting Agenda by February 2024.

Lessons Learned

1) All program plans were required to be converted to digital form on Activity pro. Therefor 100% of care plans were updated as they were placed into the new format.
2) The following items were noted from weekly audits and were successfully implemented:
#1 In General: Programs not starting on time
#2 BINGO- larger ball caller purchased to accommodate caller
#3 Sing A long w/ Greg- created focus groups
#4 Ball Drumming- Location should be dining room not TV lounges (for all large programs/programs or those with large supplies)
#5 Fun & Fitness- lots of extra supplies/equipment available to make session more interesting
#6 Food issues sheets required for all food programs and are printed the morning of the program
#7 Parachute games- large group programs should include residents from all units which is continually being monitored and audited.
Audits have identified some deficiencies, and all deficiencies are able to be corrected. Ongoing monitoring is still required.

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

Resident Program Manager to add “Calendar Planning” to the monthly Food and Resident Council Meeting as a standing agenda item.

Process measure

- # of calendar change suggestions brought at the Food/Resident Council & Calendar Planning Meeting.

Target for process measure

- Calendar Planning will be added as a standing agenda item and title change of meeting to take place for March 2024.

Lessons Learned

The following chart highlights the number of suggestions brought forward from council meetings per month:
Month Suggestions:
Jan 2
Feb 4
March 4
April 1
May 3
June 6
July 3

Challanges: Some suggestions are unable to be completed within budget, or may not be feasible due to safety concerns, staffing levels etc. However, we have seen some success in implementing suggestions.

Indicator #10

Resident Satisfaction- I am satisfied with the temperature of my food and beverages. (Extendicare Tecumseh)

Last Year		This Year		
46.80	**85**	**NA**	**--**	**NA**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Main Kitchen Audit to be completed monthly to ensure equipment works properly in the kitchen and serveries.

Process measure

- # of equipment deficiencies found on monthly audits. # of corrective actions implemented to fix deficiencies

Target for process measure

- Increased audits will begin February 2024.

Lessons Learned

Sucesses: We are able to identify root causes of cold food, identify and replace items and equipment in a timely manner.
Challenges:
On Going: Food service manager continues to complete audits in the main kitchen and serveries.
Ongoing: Updates to kitchen equipment occurs regularly.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Dining Room and Meal Service Audit to be completed weekly to ensure a standardized meal service.

Process measure

- # of deficiencies found through weekly audits. # of corrective actions implemented to fix deficiencies.

Target for process measure

- Increased audits will begin March 2024.

Lessons Learned

Audits continue to be completed in the dining room.
Successes: Deficiencies are often corrected onsite with available staff.
Challenges: Gaps in pleasurable dinning program have been identified.

Change Idea #3 ☑ Implemented ☐ Not Implemented

Provide ongoing education to dietary and care staff based on the identified deficiencies and corrective actions.

Process measure

- # of items requiring education. # of staff educated.

Target for process measure

- Education sessions begin April 2024.

Lessons Learned

Sucesses: Multiple education opportunities have arose for dietary and care staff in regard to: temperature of foods, ordering by name, diet textures, serving of courses, etc.
Challanges: However, further education is still required to enhance pleasurable dinning experience for the residents and items continue to be founded in audits.
Ongoing: The pleasurable dining roll-out continues within the home for all current staff and new hires.
Education is still required in all areas.

Comment

This question was not asked on the 2024 survey but in general, questions related to dining service showed improvement from the 2023 survey results.

Specific numerical data not available as previous Food Service manager is no longer wiht the home.

	Last Year		This Year		
Indicator #1 Family Satisfaction – Would Recommend Home (Extendicare Tecumseh)	**82.80** Performance (2024/25)	**85** Target (2024/25)	**94.70** Performance (2025/26)	**--** Percentage Improvement (2025/26)	**NA** Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Home to restructure the Interdisciplinary Team Conferences to have all disciplines attend all meetings.

Process measure

- # of meetings where all disciplines attend. # of accurately completed assessments prior to IDTCs.

Target for process measure

- Restructured IDTC meetings will begin March 2024.

Lessons Learned

Successful: Care conferences have gone well with 100% of IDTC involving members of the team from different disciplines.
Challenges: Some team members struggled to update their part of the IDTC prior to the care conference, follow up is provided in that case.

Indicator #3

Family Satisfaction- The resident has input into the recreation programs available. (Extendicare Tecumseh)

Last Year		This Year		
41.90	**85**	**78.60**	**--**	**NA**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Present home specific action plans to improve resident satisfaction related to “I have input into the recreational programs available.” at Family Council.

Process measure

- # of suggestions provided by family.

Target for process measure

- Family Council Meeting to take place in March 2024.

Lessons Learned

Sucess: Family council was educated on process for suggesting recreational program ideas.
Program manager was invited to attend 2 Family council meetings.
Challanges: There were no suggestions submitted from family council this past year.
Ongoing: Program Manager continues to keep open communication with family council and attends meetings when requested.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Home to increase social media presence with a minimum of one post per month on home Facebook page.

Process measure

- # of posts per month. # of family and friends' engagement on Facebook post.

Target for process measure

- Month in review photo post will begin in March 2024, showcasing February 2024 activities. This will be ongoing monthly to engage further with family and friends who may not be aware of the activities happening in the home.

Lessons Learned

1) Month Posts Interactions
Jan 0 0
Feb 1 16
March 3 82
April 1 32
May 2 58
June 1 33
July 1 5
August 0 0
Sept 2 53
Oct 7 144
Nov 7 82
Dec 8 256
Videos 3 1,353

2) Followers: 249 Jan 2024 292 Dec 2024

Sucess: Program Manager continues to update the socila media pages regularly, with interactions from families.
Challanges: Many residents do not have photo consent leading to limited photos being able to be utilized.
Ongoing: Program manager is comoketin sudits of consent forms for a quick view to make postings a faster process.

	Last Year		This Year		
Indicator #2	**45.60**	**85**	**NA**	**--**	**NA**
Family Satisfaction- I have an opportunity to provide input on food and beverage options. (Extendicare Tecumseh)	**Performance (2024/25)**	**Target (2024/25)**	**Performance (2025/26)**	**Percentage Improvement (2025/26)**	**Target (2025/26)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

Food Service Manager will attend IDTC meetings to increase communication with families.

Process measure

- # of IDTC meetings that Food Service Manager attends. # of changes to resident's meal preference within their plan of care.

Target for process measure

- The Food Service Manager will attend will IDTCs for residents starting March 2024.

Lessons Learned

Successes: Food service manager is attending 95% of the care conferences.
There is typically little change to a resident's meal preferences, but families are able to make suggestions about milk products, meat selections, fresh fruit at snack.. etc. On occasion when there is a change a dietary referral is sent.
Challenges: suggestions from families are often reflective of one resident's preference at a time, budget constraints, availability of products.
Ongoing: we continue to provide the opportunity for families to present suggestions and attempt to fulfill the requests as often as possible.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Educate food service manager on using audience appropriate language during IDTC.

Process measure

- No process measure entered

Target for process measure

- No target entered

Lessons Learned

Food service manager is able to communicate effectively with families regarding diet changes, BMI, and weight in kg.

Comment

Our 2024 experience survey was changed in 2024 based on feedback from residents and families. As a result, this question was not on the 2024 survey so we are unable to compare to 2023 results.

Safety | Safe | Custom Indicator

Indicator #6

Percentage of LTC residents with worsened ulcers stages 2-4 (Extendicare Tecumseh)

Last Year		This Year		
1.80	**1.50**	**5.70**	**--**	**NA**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Implement weekly multidisciplinary Skin and Wound meetings with agenda and minutes template to better meet the requirements within the Program Evaluation.

Process measure

- # of weekly meeting utilizing the newest template. # of residents reviewed with injuries, environmental changes, medication changes and revision in care plans in the weekly meetings. This data will be reviewed at program evaluation in June.

Target for process measure

- The template will be implemented with revisions completed by June 2024.

Lessons Learned

Successes: Skin and wound continues to be discussed weekly with unit huddles, root causes are able to be identified for new and or worsening wounds, we met the target for consecutive quarters.
No medication changes resulted from the weekly skin and wound meetings.
Challenges: Meetings have not been consistently run during summer months due to vacations/staffing.
Some staff struggle to fully evaluate the whole body for skin impairments, we are no longer meeting the target. we have included in our workplan for 2025.

Safety | Safe | Custom Indicator

	Last Year		This Year		
Indicator #5 Percentage of LTC residents with restraints (Extendicare Tecumseh)	**0.00** Performance (2024/25)	**0** Target (2024/25)	**0.00** Performance (2025/26)	**--** Percentage Improvement (2025/26)	**NA** Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

The home will continue communication with key community stakeholders to ensure target continues to be met.

Process measure

- # residents utilizing a restraint in the home

Target for process measure

- The home will continue to meet the target for restraints within the home through 2024.

Lessons Learned

Zero residents use restraints in the home.
Least restraint policy is reviewed with new admissions upon review for waitlist and bed offer.
Ongoing: We continue to maintain current processes and explore restraint free options for residents.

Change Idea #2 ☑ Implemented ☐ Not Implemented

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

Process measure

- # of staff completed the mandatory restraint education.

Target for process measure

- 100% of staff will be educated and re-educated on restraint policy and alternatives to restraints by August 2024.

Lessons Learned

100% of staff were re-educated on restraints policy on Surge and have been successful in keeping our restraints to 0 by using alternatives.

Safety | Safe | Optional Indicator

	Last Year		This Year		
Indicator #4	**17.90**	**15**	**13.64**	**23.80%**	**12**
Percentage of LTC home residents who fell in the 30 days leading up to their assessment (Extendicare Tecumseh)	Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Implement a weekly multidisciplinary falls meeting agenda and minutes template to better meet the requirements within the Program Evaluation.

Process measure

- # of weekly meeting utilizing the newest template. # of residents reviewed with injuries, environmental changes, medication changes and revision in care plans in the weekly meetings. This data will be reviewed at program evaluation in November.

Target for process measure

- The template will be implemented with revisions completed by June 2024.

Lessons Learned

Successes: Overall falls have decreased, and we were meeting the target for this indicator for consecutive quarters. Falls continue to be decreased week to week.
Challenges: we are no longer meeting the target for this indicator. the trend of falls appears to be random in nature with no trackable pattern.
Ongoing: Weekly falls meetings will continue into 2025.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Implement identification and screening of frequent fallers at the weekly multidisciplinary falls meetings and share findings with the home areas through updated list.

Process measure

- # of residents added to the frequently faller list in one month. # of residents removed from the frequent faller list in one month. # of falls for each frequent faller on the list in one month in comparison to the previous month.

Target for process measure

- Discussion of resident list at meetings, and updated lists to resident home areas will be implemented by April 2024.

Lessons Learned

weekly identification of residents who have frequent falls has been successful and will continue to be in place as an ongoing strategy.

Change Idea #3 ☑ Implemented ☐ Not Implemented

Analyze results from the FPPR tracker developed by corporate.

Process measure

- No process measure entered

Target for process measure

- No target entered

Lessons Learned

Results from FPPR are shared with interdisciplinary team and used to track trends with residents and to ensure the interventions are updated and current.

	Last Year		This Year		
Indicator #7	**3.07**	**3**	**X**	**--**	**NA**
Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment (Extendicare Tecumseh)	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

Target for process measure

- All residents currently prescribed antipsychotics will have a medication review completed by July 2024

Lessons Learned

We have seen continued success with maintaining 0.00% for the antipsychotic indicator.
Medication reviews continue for those on antipsychotics between Pharmacist, ADOC and BSO.