Experience | Patient-centred | Custom Indicator

	Last Year		This Year		
Indicator #2 Percentage of family responding positively to " I have an opportunity to provide input to food and beverages options" (Kennedy Lodge)	**72.90** Performance (2024/25)	**85** Target (2024/25)	**82.50** Performance (2025/26)	**--** Percentage Improvement (2025/26)	**NA** Target (2025/26)

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

Sharing the Residents Food Committee minutes to the families.

Process measure

- Increase percentage on the survey by 10%.

Target for process measure

- Ongoing feedback from the residents on the satisfaction with the food and beverages staff provided.

Lessons Learned

Successful outcomes of sharing resident Food Committee minutes to visitors as it is posted throughout the home and easily accessible to families and residents at any time.

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

Engaged and invite resident to participate in the food tasting panel and get their feedback.

Process measure

- Increase percentage on the survey results and increase satisfaction to food and beverages served.

Target for process measure

- Ongoing feedback from the resident and the food committee of the food and beverages served.

Lessons Learned

Due to some challenges encountered throughout the year such as outbreaks, we were unable to implement a food tasting panel. We still strive to have one in 2025 to allow residents an opportunity to express their opinions and offer feedback on the taste and quality of the food.

Indicator #8

Percentage of resident responding positively to " I am satisfied with the food and beverages served." (Kennedy Lodge)

Last Year		This Year		
61.10	75	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

Engage in regular discussion with residents on their satisfaction with food and beverages served.

Process measure

- Increase scores on survey, discussion will occur each day on at least one meal.

Target for process measure

- Ongoing feedback from the residents about the staff service being provided.

Lessons Learned

Successful food committee meetings happen monthly where residents are given opportunities to provide their input, any changes and inclusions to the menus. The Dietary Manager regularly engages residents at least once per day to ensure satisfaction with meals provided.

Indicator #9

Percentage of residents positively responding to "My care conference is a meaningful discussion that focuses on what's working well, what can be improved and potential solutions" (Kennedy Lodge)

Last Year		This Year		
61.80	**75**	**78.20**	**--**	**NA**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☐ Implemented ☑ Not Implemented

Interpreter will be present during the care conference and physicians will use simple layman's terms when communicating to the residents.

Process measure

- Increase participation and involvement of the resident in their care.

Target for process measure

- Increase satisfaction survey result related to survey questions meaningful care conference.

Lessons Learned

The home found it challenging to implement a consistent interpreter during care conferences. In 2025, we will strive to recruit internal interpreters to assist residents during their care conferences and to continue empowering residents to make personal care decisions that they fully understand.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Improve residents' engagement.

Process measure

- keep track of the residents that is attending the care conference.

Target for process measure

- Improve residents' involvement in their care planning and communication from the interdisciplinary team.

Lessons Learned

Successful usage of the Care Conference Audit to track resident's engagement and participation as evidenced by a large improvement in our survey score.

	Last Year		This Year		
Indicator #1	**91.10**	**85**	**88.80**	**--**	**NA**
Family Satisfaction - Would recommend by 10%. (Kennedy Lodge)	Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Continue to collaborate with the family and continue with the open door policy.

Process measure

- Increase survey result would recommend by 2%.

Target for process measure

- Ongoing feedback from the family

Lessons Learned

This was successful. The team will need to further implement open door policy to ensure that we are meeting expectations set by family members.

	Last Year		This Year		
Indicator #3	**79.75**	**85**	**96.10**	**--**	**NA**
Percentage of family responding positively to" The resident has input into the recreation programs available" (Kennedy Lodge)	**Performance (2024/25)**	**Target (2024/25)**	**Performance (2025/26)**	**Percentage Improvement (2025/26)**	**Target (2025/26)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

Engage in regular discussions with the family about the resident choice program in the home.

Process measure

- Increase percentage on the survey by 10%

Target for process measure

- Ongoing feedback from the family.

Lessons Learned

The home engages family by various methods of communication such as newsletters, posters and email regarding resident choice programs and we have received positive feedback.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Improve collaboration with the family to encourage them to access the activity pro portal.

Process measure

- # of specific activities that were chosen by the residents.

Target for process measure

- Increased number of family accessing the activity pro portal.

Lessons Learned

Families are not actively using ActivityPro but we encourage them to sign up for the portal by re-introducing the portal to Family Council and send out communication via email to spread awareness.

	Last Year		This Year		
Indicator #10 Percentage of residents responding positively to " Staff take time to chat with me" (Kennedy Lodge)	**56.80** Performance (2024/25)	**75** Target (2024/25)	**94.80** Performance (2025/26)	**--** Percentage Improvement (2025/26)	**NA** Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Staff to engage residents in meaningful conversations.

Process measure

- Increase percentage on the survey by 20%

Target for process measure

- All active staff will complete the re-education and training by June 30, 2024

Lessons Learned

Staff engage with residents during their care and outside of their care to create a welcoming and positive living environment. This approach has been beneficial for both staff and residents,

Change Idea #2 ☑ Implemented ☐ Not Implemented

Engage in regular discussion with residents during the resident's council meeting and or care conferences to gauge if the staff are taking time to converse with them.

Process measure

- Increase staff and residents' engagement and increase survey results.

Target for process measure

- Ongoing feedback from the residents on how the staff interact with them.

Lessons Learned

As evidenced by the survey results, staff's engagement with residents have improved and residents feel staff that staff are approachable staff take an interest in residents' daily activities.

	Last Year		This Year		
Indicator #11 Residents' satisfaction - Would recommend by 10% (Kennedy Lodge)	**80.20** Performance (2024/25)	**75** Target (2024/25)	**87.40** Performance (2025/26)	**--** Percentage Improvement (2025/26)	**NA** Target (2025/26)

Change Idea #1 ☐ Implemented ☑ Not Implemented

Increase collaboration with resident council.

Process measure

- Number of Managers collaborated with the resident council.

Target for process measure

- To increase satisfaction survey result would recommend by 25% on next survey.

Lessons Learned

We were unable to increase the collaboration with residents council and managers in the home that are not required to be there as per legislation. in 2025, a Resident's Council Town Hall is scheduled to continue to meet this goal.

Safety | Safe | Optional Indicator

	Last Year		This Year		
Indicator #4	**11.58**	**15**	**9.24**	**20.21%**	**8**
Percentage of LTC home residents who fell in the 30 days leading up to their assessment (Kennedy Lodge)	**Performance (2024/25)**	**Target (2024/25)**	**Performance (2025/26)**	**Percentage Improvement (2025/26)**	**Target (2025/26)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

Review care plan for all high-risk fallers.

Process measure

- Outcome of the audits to be reviewed and re-audited for compliance.

Target for process measure

- To remain below CIHI benchmark monthly.

Lessons Learned

Care plan audits are ongoing and successful. Review of audits are done monthly.

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

- Environmental risk assessments of resident spaces to identify fall risk will be completed by June 2024

Lessons Learned

Environmental assessments are ongoing. We continue to implement our robust falls prevention plan to continue being below benchmark.

	Last Year		This Year		
Indicator #7	**14.81**	**17.30**	**13.43**	**9.32%**	**12**
Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment (Kennedy Lodge)	**Performance (2024/25)**	**Target (2024/25)**	**Performance (2025/26)**	**Percentage Improvement (2025/26)**	**Target (2025/26)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

Residents on antipsychotics medications without diagnosis will be reviewed and audited. Diagnosis will be updated to reflect CiHI definition.

Process measure

- Will continue with monthly CMAI for those residents on antipsychotics medication without diagnosis.

Target for process measure

- Will further decrease the number of residents without diagnosis by September 30, 2024

Lessons Learned

Antipsychotic Deprescribing Program is successful and in place to improve the de-escalation of antipsychotic reduction. Kennedy Lodge implements the Cohen-Mansfield to measure behaviours exhibited by our residents.

Change Idea #2 ☑ Implemented ☐ Not Implemented

To reduce the number of residents on anti- psychotic medication as per LTC Fixing the Long-Term care act

Process measure

- Audits and monthly CMAI - Cohen Mansfield agitation index, GDS - Geriatric depression score and implementation of PIECES assessment.

Target for process measure

- Reduce the number of residents on anti-psychotics medication without diagnosis by 5% on the next quarter.

Lessons Learned

Behaviour audits are reviewed monthly and successful usage of external BSO continues. The antipsychotic medication monitoring tool is generated monthly to monitor compliance.

Safety | Safe | Custom Indicator

Indicator #6

Percentage of LTC home residents with Worsened Pressure ulcers stage 2 -4 ulcers. (Kennedy Lodge)

Last Year		This Year		
1.00	**2**	**0.71**	**--**	**NA**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Continue to complete worsening wound checklist and re-evaluate treatment plan for worsening wounds.

Process measure

- Continue with monthly skin and wound care audits

Target for process measure

- To maintain below benchmark.

Lessons Learned

Monthly skin and wound audits, along with weekly skin assessments continue to be completed and successful in monitoring wounds.

Change Idea #2 ☑ 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

We continue to substitute regular mattresses with air mattresses when needed to sustain and prevent worsening pressure ulcers. Environmental Services Manager continue to perform environmental scans to ensure the integrity of all mattresses in the facility.

Safety | Safe | Custom Indicator

	Last Year		This Year		
Indicator #5 Percentage of LTC home residents with daily physical restraints. (Kennedy Lodge)	**0.00** Performance (2024/25)	**2.50** Target (2024/25)	**0.00** Performance (2025/26)	**#Error** Percentage Improvement (2025/26)	**NA** Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Review current restraints and determine plan for trialing alternatives to restraints.

Process measure

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

Target for process measure

- No restraints in the home

Lessons Learned

Kennedy Lodge currently and previously had zero restraints. We removed existing siderails without a PASD Agreement in place. Annual bedrail assessments, education to families upon admission and no lap belts on wheelchairs, along with mandatory annual education for all staff continues to be a success.