Experience | Patient-centred | Custom Indicator

	Last Year		This Year		
Indicator #11	**100.00**	**75**	**85.00**	**--**	**NA**
Percentage of residents who would positively respond to the statement "I would recommend this home" on the Annual Resident Satisfaction Survey. (Sara Vista)	Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Ensure all residents are given the opportunity to become involved in Resident Council meetings in the home monthly

Process measure

- Ensure all residents that are invited to attend resident council are tracked monthly

Target for process measure

- Remain above 75% Satisfaction on 2024 Survey to the statement "I would recommend this home"

Lessons Learned

All residents received a personal invitation to each Resident Council Meeting. The Meeting date and time is listed in the Monthly Recreation Calendar. On the day of the meeting, there is always and announcement made of when and where the meeting is being held. All residents who expressed they would like to attend are escorted to the meeting if required. Information on Resident Council is included in the New Admission Package. The tracking tools showed all residents are invited to monthly Resident Council meetings.

Comment

We did see a slip in our results for this indicator but we were still over our target.

	Last Year		This Year		
Indicator #10	**73.30**	**75**	**NA**	**--**	**NA**
Percentage of residents who would positively respond to the statement "I have friends in the home" on the Annual Resident Satisfaction Survey. (Sara Vista)	**Performance (2024/25)**	**Target (2024/25)**	**Performance (2025/26)**	**Percentage Improvement (2025/26)**	**Target (2025/26)**

Change Idea #1 ☐ Implemented ☑ Not Implemented

Provide a Welcome Tea for new residents and introduce residents who have similar interest/hobbies -Creating Bonds

Process measure

- Gather feedback about new programs at Resident Council meetings. Gather resident satisfaction by conducting Activity Pro Program Survey

Target for process measure

- Increase positive response to 75% Satisfaction on 2024 Survey to the statement "I have friends in the home"

Lessons Learned

Residents were welcomed individually. The Recreation Department developed a program for friendly visits with Co-op student. A Friendship Circle program was created. Birthday celebrations for the residents were elevated as food and fun always puts a smile on their faces.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Introduce “Friendly Visits” program weekly to our residents

Process measure

- Gather feedback about new programs at Resident Council meetings. Gather resident satisfaction by conducting Activity Pro Program Survey

Target for process measure

- Increase positive response to 75% Satisfaction on 2024 Survey to the statement "I have friends in the home"

Lessons Learned

The Friendly visits program created in 2024. This program was well received by our residents. At the November 2024 Resident Council Meeting, residents were surveyed and responded they felt they had friends in the home.

Comment

This question was removed from the 2024 Resident Satisfaction Survey therefore we do not have a result beyond the feedback from the Resident Council meeting but feel that this was a successful strategy.

Indicator #9

Percentage of residents who would positively respond to the statement "I am satisfied with the quality of care from doctors" on the Annual Resident Satisfaction Survey. (Sara Vista)

Last Year		This Year		
60.00	**75**	**50.00**	**--**	**NA**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Request invitation to Resident Council to discuss: • Resident expectations of MDs vs Resident experiences with MDs • Role of new NP

Process measure

- DOC will attend Resident Council in March and again in July 2024

Target for process measure

- Increase positive response to 75% Satisfaction on 2024 Survey to the statement "I am satisfied with the quality of care from doctors"

Lessons Learned

DOC attended Resident Council in March but not in July so we were unable to meet our expectations with this. We have a new DOC and will ask that he is invited to more meetings to discuss the expectations and satisfaction with this indicator. The NP we secured last year did not stay in our Region more than 2 months. We will continue to try to access NP resources.

Change Idea #2 ☐ Implemented ☑ Not Implemented

DOC/ADOC/Charge Nurse to follow-up with residents after a MD/NP visit for feedback weekly, tracked and discussed during monthly Quality Days

Process measure

- An analysis of feedback will be completed to determine trends and actioned where appropriate

Target for process measure

- Increase positive response to 75% Satisfaction on 2024 Survey to the statement "I am satisfied with the quality of care from doctors"

Lessons Learned

We had a change of DOC and a period with a temp DOC. This was not actioned. We plan to continue with this change idea as it was flagged as a concern again on the 2024 survey.

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

Implement the use of updated SBAR forms to better communicate concerns with MD/NP • Provide education to registered staff on SBAR use on a as needed basis

Process measure

- Will seek feedback from MD/NP to see if the information in the SBAR is providing improved communication and action any gaps identified

Target for process measure

- Increase positive response to 75% Satisfaction on 2024 Survey to the statement "I am satisfied with the quality of care from doctors"

Lessons Learned

The SBAR form was updated and education was provided to registered staff. This was a new process and with a new DOC, there was not a consistent follow up with the new process. Registered staff reverted to their previous practice and we did not see the improvement we hoped to. We are working to improve this process.

Comment

We were unsuccessful in increasing our outcome for this indicator. We are keeping this question in this years QIP to seek a better result.

	Last Year		This Year		
Indicator #1	**69.20**	**85**	**76.90**	**--**	**NA**
Percentage of families who would positively respond to the statement "I would recommend this home" on the Annual Family Satisfaction Survey. (Sara Vista)	Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Ensure all families are provided information on how to form a Family Council

Process measure

- Audit new admission package to ensure "How to form a Family Council information" is included. Track which months "How to form a Family Council" information is included in the Newsletters and Family Forum meetings

Target for process measure

- 100% of families receive information on how to form a Family Council

Lessons Learned

Our audits were successful in that all new admission packages had information on how to form a Family Council. The process was also addressed at each Family Forum meeting.
April 2, 2024
June 25 2024
Sept 10 2024
Dec 10 2024

Change Idea #2 ☑ Implemented ☐ Not Implemented

Ensure all families receive invitations to attend quarterly Family Forum meetings

Process measure

- Complete tracking to ensure all families receive invitations to Family Forum

Target for process measure

- 100% of our families will receive notification or an invitation to quarterly Family Forum meetings

Lessons Learned

Tracking tool showed that all families received an invitation to Family Forum.
Invitations were included in the Family Newsletter, all contacts that consented to receiving email were sent emails and it was posted in the home. Even with these points of contact, the attendance was not significantly increased. When some were asked, families said they had no concerns and were looking forward to receiving the minutes. We also trialed a time in the evening and attendance was lower so we went back to our afternoon meeting.

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

Family members to be included in quarterly Quality Council meetings

Process measure

- Family members will be called to determine if they would be interested and available to attend a Quality Council meeting. If response is positive, an invite will be sent by email or Canada Post if there is no email

Target for process measure

- Family members will be in attendance at all Quality Council Meetings

Lessons Learned

Quality Council mins will reflect family attendance at each of the quarterly Quality Council Meetings. Some families attend in person and some attend virtually.

Comment

We improved over the previous survey but were unable to reach our target.

Indicator #3

Percentage of family members who would positively respond to the statement "I am satisfied with the timing and schedule of spiritual care services" on the Annual Family Satisfaction Survey. (Sara Vista)

Last Year		This Year		
50.00	**75**	**66.70**	**--**	**NA**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Provide family Education of “What is spirituality?”

Process measure

- Complete tracking tool to ensure all families receive spirituality education and the online survey.

Target for process measure

- Increase positive response to 75% Satisfaction on 2024 Survey to the statement "I am satisfied with the timing and schedule of spiritual care services"

Lessons Learned

Education was provided to all families in the Family Newsletter and Family Forum. The focus of the education was on Spirituality vs Religion. New programming focused on ways for residents to seek comfort and peace in their life.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Develop an Online Survey, with paper format if required, for families soliciting input about what spirituality means to them and their expectations of spirituality timing and schedule of spiritual care services

Process measure

- Evaluate results from online survey to provide further opportunities for improvement.

Target for process measure

- Increase positive response to 75% Satisfaction on 2024 Survey to the statement "I am satisfied with the timing and schedule of spiritual care services"

Lessons Learned

A survey was sent to all families and only 5 were completed. The suggestion to add Salvation Army was taken forward however the Salvation Army has not been back in touch with the family or the home.

Comment

We have improved over the previous survey however we did not reach our target.

Indicator #4

Percentage of family members who would positively respond to the statement "The resident has input into the Recreation Programs available: on the Annual Family Satisfaction Survey. (Sara Vista)

Last Year		This Year		
50.00	**75**	**63.20**	**--**	**NA**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Share with families the results of "Suggested Programs for the future" agenda item from Resident Council. Additionally, share with families the results of monthly Pulse Survey's completed by residents about Recreation Programs.

Process measure

- Create a tracking tool to ensure all families receive the monthly newsletter and quarterly Family Forum invitations and minutes

Target for process measure

- Increase positive response to 75% Satisfaction on 2024 Survey to the statement "The resident has input into the Recreation Programs available"

Lessons Learned

All families received the monthly Family Newsletter and invitations to Family Forum.

All families received materials that showed "All about Me", Recreation Assmt, Admission Family Questionnaire, Resident Council Standing Agenda item for Suggested Programs, Results of Recreation Pulse Survey's. At Family Forum we shared what programs (if any) were suggested at Resident Council.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Share with Families our Admission Initial Recreation Assessment, “All About Me”, and how we use it to enhance person centered care and programming.

Process measure

- Create a tracking tool to ensure all families receive a quarterly Family Forum invitation and minutes.

Target for process measure

- Increase positive response to 75% Satisfaction on 2024 Survey to the statement "The resident has input into the Recreation Programs available"

Lessons Learned

Families received all of the materials outline above. When asked at Family Forum meetings about resident input, there were no concerns brought forward.

Comment

We improved on this indicator over the previous survey however we did not meet the target set.

Indicator #2

Percentage of family members who would positively respond to the statement "Continence care products are available when the resident needs them" on the Annual Family Satisfaction Survey.
(Sara Vista)

Last Year		This Year		
50.00	**75**	**76.90**	**--**	**NA**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Report Accessed: March 14, 2025

Change Idea #1 ☑ Implemented ☐ Not Implemented

Provide education by: Attending Family Council to discuss Understandings/beliefs around incontinence products and their use in LTC; including information quarterly in the monthly Family Newsletter on continence products and their use and include family education on incontinence products and their use in LTC with admission packages

Process measure

- Three educational inserts will be placed in monthly Newsletters between April and December. Incontinence products will be discussed at Family Forum at least once between April and December.

Target for process measure

- Increase positive response to 75% Satisfaction on 2024 Survey to the statement "Continence care products are available when the resident needs them"

Lessons Learned

No concerns were brought forward at Family Forum when asked. An audit of the Admission packaged found that there was not information on incontinence products so we will do that in 2025.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Implement use of Prevail signs posted in resident closets for easy referral by PSWs

Process measure

- Cards will be in use by March 31, 2024

Target for process measure

- Increase positive response to 75% Satisfaction on 2024 Survey to the statement "Continence care products are available when the resident needs them"

Lessons Learned

DOC created cards and they were posted in the rooms. With this education in place, auditing found gaps in usage and needed to do PSW specific education.

Change Idea #3 ☑ Implemented ☐ Not Implemented

Create PSW education on use of incontinence products

Process measure

- Two separate education sessions will be held between April and December. The first education session will include a pre-knowledge test and the second session will include knowledge retention test

Target for process measure

- Increase positive response to 75% Satisfaction on 2024 Survey to the statement "Continence care products are available when the resident needs them"

Lessons Learned

Education was given to all PSWs. We continue to monitor to ensure the program is being followed.

Change Idea #4 ☑ Implemented ☐ Not Implemented

Implement use of updated incontinence product change form

Process measure

- All product change requests will be required to be submitted using the updated forms to be processed

Target for process measure

- Increase positive response to 75% Satisfaction on 2024 Survey to the statement "Continence care products are available when the resident needs them"

Lessons Learned

There was a new form created that described why the change was being requested and there needed to be a continence assessment completed to validate the request.

Comment

We improved over our last survey and did better than our target.

Safety | Safe | Custom Indicator

	Last Year		This Year		
Indicator #5 Percentage of long-term care home residents in daily physical restraints over the last 7 days (Sara Vista)	**0.00** Performance (2024/25)	**4** Target (2024/25)	**0.00** Performance (2025/26)	**#Error** Percentage Improvement (2025/26)	**NA** Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Educate staff on restraint policy and use of alternatives to restraints in Annual Mandatory Education

Process measure

- % of Staff to complete Annual Mandatory Education

Target for process measure

- 100% of staff will be educated on restraint policy and alternatives by May 2024

Lessons Learned

We are proud that we were able to maintain our zero use of restraints. 100% of staff completed Annual Mandatory Education which included education of minimizing the use of restraints.

Comment

We are proud to report that we maintained our 0% usage of restraints in 2024.

	Last Year		This Year		
Indicator #7 Percentage of LTC residents with worsened ulcers stages 2-4 (Sara Vista)	**2.50** Performance (2024/25)	**2** Target (2024/25)	**4.00** Performance (2025/26)	**--** Percentage Improvement (2025/26)	**NA** Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Review current bed systems/surfaces for residents with PURS score 3 or greater.

Process measure

- 1) Monthly, review residents that had RAI/MDS assessment to determine residents with PURS score 3 or greater 2) Monthly review identified resident to determine if surface meets their needs 3) Monthly visually inspect bed surface/mattress of identified residents to determine if they need to be replaced

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

Residents with skin breakdown of 3 or greater were reviewed for a therapeutic surface. Monthly surfaces were reviewed and inspected. New surfaces were ordered where needed. With the small number of residents in the home, even 1 ulcer makes a significant impact to our performance.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Registered staff to receive education on how to appropriately use the PCC Skin and Wound Applicaiton

Process measure

- Review entries in the APP to verify accuracy. Provide individualized education when required

Target for process measure

- Improved accuracy of information to ensure appropriate interventions are being used. This should reduce our indicator to the benchmark of 2% or better

Lessons Learned

RAI Coordinator and Regional Clinical Manager provided education and auditing with the PCC Wound App which was beneficial. Weekly wound rounds are completed by a registered staff member.

Comment

We were unsuccessful in improving this indicator. We had a number of residents become end of life and we could not improve wounds. Our small denominator (46) contributes to a higher percentage as any wound significantly impacts our results. We will continue to focus on this indicator in 2025.

Safety | Safe | Optional Indicator

	Last Year		This Year		
Indicator #6 Percentage of LTC home residents who fell in the 30 days leading up to their assessment (Sara Vista)	**16.17** Performance (2024/25)	**13** Target (2024/25)	**19.30** Performance (2025/26)	**-19.36%** Percentage Improvement (2025/26)	**15** Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Establish weekly Interdisciplinary meetings to review falls and interventions to reduce falls.

Process measure

- 1) Two residents reviewed for activity needs/preferences weekly 2) On each fall, run report to determine if resident meets criteria and if so, look for patterns and discuss in weekly falls meeting to determine potential personalized interventions"

Target for process measure

- Number of falls that high-risk residents have decreases

Lessons Learned

Weekly IDCC meetings started this year and that has helped provide a more fulsome conversation about what is and is not working. This is interdisciplinary and they are able to look at falls from different lenses. Departments outside of nursing became more engaged as they had a better overall knowledge of the resident.

Change Idea #2 ☐ Implemented ☑ Not Implemented

Create falls kit (bed pressure alarm, chair pressure alarms, motion detector alarm, clip alarm and selection of sizes of non skid socks, include location of falls mat storage) that is accessible to staff and provide education to staff

Process measure

- Audits completed weekly to ensure there are kits available and all there are no missing items

Target for process measure

- Number of falls decrease from current performance of 16.17%

Lessons Learned

Audits were infrequent and that lead to kits not always being fully intact. We will review the process and see where we can make improvements, so kits are always available and have all necessary parts.

Comment

We were unsuccessful in improving this indicator. Our small denominator (46) contributes to a higher percentage as any fall impacts our results. We will continue to work on this in our 2025 plan.

	Last Year		This Year		
Indicator #8	**X**	**18**	**X**	**--**	**17.30**
Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment (Sara Vista)	**Performance (2024/25)**	**Target (2024/25)**	**Performance (2025/26)**	**Percentage Improvement (2025/26)**	**Target (2025/26)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

Ensure all new residents admitted on antipsychotic medications without a diagnosis are reviewed by the Medical Director

Process measure

- Monthly all new admissions on antipsychotic medications without a diagnosis will be reviewed by Medical Director

Target for process measure

- 100% of all new admissions on antipsychotic medications without a diagnosis will be reviewed by Medical Director

Lessons Learned

Dr/Medical Director reviews all new admissions on antipsychotic medications which has been successful. We discovered when a new RAI Coordinator started there were some issues in the way this indicator was being looked at. The home will be transitioning to a new Medical Director in 2025 and antipsychotic use will be reviewed for all residents that currently receive them.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Ensure antipsychotics are prescribed appropriately

Process measure

- Monthly, review residents that had annual RAI/MDS assessment and complete Cohen Mansfield Agitation Inventory when determined appropriate, begin plan to attempt reduction in Antipsychotic Prescribing

Target for process measure

- Identified residents will successfully have a reduction in antipsychotic prescribing

Lessons Learned

Dr/Medical Director to review assessments and make any changes where appropriate. We will continue to engage with our BSO Support team and engage our Head Office Clinical Lead to do a presentation at our Professional Advisory Committee meeting (PAC).

Comment

We stayed at 0% through the reporting period.