Equity | Equitable | Optional Indicator

Indicator #9

Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education (Extendicare Crossing Bridge)

Last Year		This Year		
CB	100	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

Completion of the Surge Learning 'Cultural Competence and Indigenous Cultural Safety' module for all staff.

Process measure

- percentage of staff completion reviewed monthly.

Target for process measure

- 100% completion of 'Cultural Competence and Indigenous Cultural Safety' Surge Learning module by all staff no later than December. 31st, 2024.

Lessons Learned

100% of staff completed the Surge Learning 'Cultural Competence and Indigenous Cultural Safety' module in 2024.

Experience | Patient-centred | Custom Indicator

	Last Year		This Year		
Indicator #8	**65.40**	**78.50**	**93.90**	**--**	**NA**
Percentage of residents who responded positively to the statement "If I have a concern I feel comfortable raising it with the staff and leadership" (Extendicare Crossing Bridge)	**Performance (2024/25)**	**Target (2024/25)**	**Performance (2025/26)**	**Percentage Improvement (2025/26)**	**Target (2025/26)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

Implement Town hall newsletter to engage residents and family members feedback on a regular basis.

Process measure

- # of Town hall newsletters per year

Target for process measure

- Town hall newletters will be sent out on a monthly basis to engage resident and family member feedback by April 2024.

Lessons Learned

In 2024, Townhall newsletters were changed to video format to provide an efficient and effective medium of both home and redevelopment updates. It included standing Q&A sessions to promptly answer stakeholder inquiries.

Change Idea #2 ☑ Implemented ☐ Not Implemented

To increase residents comfort levels of raising concerns with staff and leadership, all direct care staff will receive empathy training.

Process measure

- percentage of direct care staff trained

Target for process measure

- 100% of all direct care staff will be trained by June 2024 prior to relocating to Extendicare Crossing Bridge.

Lessons Learned

The Dietitian provided empathy training to our team members.

	Last Year		This Year		
Indicator #7	**33.30**	**63.90**	**67.90**	**--**	**NA**
Percentage of residents who responded positively to the statement "I have input into the recreation programs available". (Extendicare Crossing Bridge)	Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Implement Calendar Planning Meetings to engage residents and family members in providing ongoing feedback regarding programs within the home

Process measure

- # of Calendar Planning Meetings

Target for process measure

- By June 2024, the Recreation team will be hosting monthly Calendar Planning Meetings to elicit resident feedback and incorporate their input into all future programs.

Lessons Learned

In April 2024, our Calendar Planning meetings became monthly rather than quarterly to elicit more effective and frequent communication for resident feedback. From re-evaluating these meetings, we now promote the utility of both the Program-Specific Resident Survey and the Spiritual Assessment Tool on a monthly basis.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Implement Program-Specific Resident Survey's to empower residents and family members with feedback regarding programs within the home

Process measure

- # of Program-Specific Resident Surveys submitted on a quarterly basis

Target for process measure

- 50% of all residents that have expressed a negative statement about a program will be offered the option of completing a Program-Specific Resident Survey by June 2024, 75% by December 2024.

Lessons Learned

In April 2024, our Calendar Planning meetings became monthly rather than quarterly to elicit more effective and frequent communication for resident feedback. From re-evaluating these meetings, we now promote the utility of both the Program-Specific Resident Survey and the Spiritual Assessment Tool on a monthly basis.

Comment

From re-evaluating the Calendar Planning Meetings, we now promote the utility of both the Program-Specific Resident Survey and the Spiritual Assessment Tool on a monthly basis. This has enabled us to improve the recreation and spiritual care programs within the home to meet our resident needs.

Indicator #6

Percentage of residents who responded positively to the statement "I am satisfied with the variety of spiritual care services". (Extendicare Crossing Bridge)

Last Year		This Year		
50.00	**73.70**	**84.20**	**--**	**NA**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Engage resident feedback in regards to spiritual care services by implementing the Spiritual Assessment Tool.

Process measure

- # of Spiritual Assessment Tools completed

Target for process measure

- The Recreation team will review 100% of received Spiritual Assessment Tools by the end of each corresponding quarter and provide an update during the next Resident Council Meeting.

Lessons Learned

In April 2024, our Calendar Planning meetings became monthly rather than quarterly to elicit more effective and frequent communication for resident feedback. From re-evaluating these meetings, we now promote the utility of both the Program-Specific Resident Survey and the Spiritual Assessment Tool on a monthly basis.

Comment

From re-evaluating the Calendar Planning Meetings, we now promote the utility of both the Program-Specific Resident Survey and the Spiritual Assessment Tool on a monthly basis. This has enabled us to improve the recreation and spiritual care programs within the home to meet our resident needs.

	Last Year		This Year		
Indicator #5	**50.00**	**73**	**55.60**	**--**	**NA**
Percentage of residents who responded positively to the statement "I am satisfied with the timing and schedule of spiritual care services". (Extendicare Crossing Bridge)	Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Engage resident feedback in regards to timing and schedule of spiritual care services by implementing the Spiritual Assessment Tool.

Process measure

- # of spiritual assessment tools completed

Target for process measure

- The Recreation team will review 100% of received Spiritual Assessment Tools by the end of each corresponding quarter and provide an update during the upcoming Resident Council Meeting.

Lessons Learned

In April 2024, our Calendar Planning meetings became monthly rather than quarterly to elicit more effective and frequent communication for resident feedback. From re-evaluating these meetings, we now promote the utility of both the Program-Specific Resident Survey and the Spiritual Assessment Tool on a monthly basis.

Comment

We want to continue to improve the timing and schedule of religious and spiritual care programs within the home. We will further enhance options in 2025.

Safety | Safe | Optional Indicator

	Last Year		This Year		
Indicator #1 Percentage of LTC home residents who fell in the 30 days leading up to their assessment (Extendicare Crossing Bridge)	**11.19** Performance (2024/25)	**10.50** Target (2024/25)	**11.89** Performance (2025/26)	**-6.26%** Percentage Improvement (2025/26)	**11** Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Root cause analysis of falls occurring within the home to determine efficient and effective strategies to decrease incidence, risk, and severity of all falls.

Process measure

- # of post fall huddles completed by interdisciplinary team on a monthly basis, percentage of PCC risk management documentation completed with adequate (detailed) incident description and with no errors.

Target for process measure

- Root cause analysis of all falls occurring within the home to efficiently and effectively determine strategies in decreasing the incidence, risk and severity of falls will be implemented by June 2024. This will be reflective in the risk management assessments and subsequent interventions.

Lessons Learned

In 2024 we increased the effectiveness of our post fall huddles and provided sufficient education for staff to improve our post fall assessments in PCC. This has enhanced our root cause analysis of falls within the home.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Further develop the comfort rounds process (4 P's) for residents at a high falls risk and for new admissions.

Process measure

- # of education sessions provided to staff on 4 P's process on a quarterly basis, # of orientation sessions on 4 P's for new staff on a monthly basis, percentage of post falls where comfort rounds were maintained and did not attribute to the cause of the fall.

Target for process measure

- Comfort rounds process will be implemented for 100% of high fall risk residents and new admissions by June 2024.

Lessons Learned

We continue to distribute the comfort rounds cards and emphasize there importance at the daily safety huddles. Our monitoring continues to improve.

Comment

On February. 23rd, 2025 we moved to Crossing Bridge. Consequently, we have had a significant influx in new staff to meet our home needs. Our 2025 QIP will include similar change ideas so we continue to strengthen our monitoring and root cause analysis of falls within the home.

Results

	Last Year		This Year		
Indicator #4	**14.49**	**13.50**	**12.37**	**14.63%**	**10**
Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment (Extendicare Crossing Bridge)	Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Implementation of a medication review process for all residents on antipsychotic medication that is guided through the Antipsychotic Decision Support Tool.

Process measure

- # of medication reviews completed on a monthly basis, percentage of residents with 'Action Taken provided' within the AP DST.

Target for process measure

- Standardized medication review process will be implemented by June 2024. 100% of 'residents with Action Taken' within the AP DST tool will be achieved by January 2024 and maintained throughout the entire 2024 year.

Lessons Learned

We utilized the Extendicare Antipsychotic Decision Support Tool to drive antipsychotic reduction action plans.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Engage BSOs to capture a CMAI and to review potential triggers for responsive behaviours on all residents on prescribed antipsychotics.

Process measure

- # of residents reviewed by BSO resource for potential triggers and alternatives to antipsychotic medications on a monthly basis, percentage of residents with Action Taken provided within the AP DST.

Target for process measure

- Interdisciplinary team process for engaging BSOs in review of potential triggers will be implemented by June 2024. 100% of 'residents with Action Taken' within the AP DST tool will be achieved by January 2024 and maintained throughout the entire 2024 year.

Lessons Learned

Our interdisciplinary team, with support from the Royal Ottawa Hospital Geriatric outreach team, worked synergistically to review potential triggers for responsive behaviours on all residents on prescribed antipsychotics.

Comment

We utilized the Extendicare Antipsychotic Decision Support Tool to drive our antipsychotic reduction program within the home.

Results

Safety | Safe | Custom Indicator

	Last Year		This Year		
Indicator #2 Percentage of LTC residents with daily physical restraints (Extendicare Crossing Bridge)	**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**

Will continue to meet and discuss with families, residents or staff who feel there is a need for a restraint.

Process measure

- # of admissions to the home will be evaluated and education provided with respect to use of restraint.

Target for process measure

- Will maintain current target by end of 2024

Lessons Learned

We continue to be a zero restraints home.

Comment

We continue to be a zero restraints home.

Results

	Last Year		This Year		
Indicator #3 Percentage of LTC residents with worsened staged 2 to 4 pressure injuries (Extendicare Crossing Bridge)	**1.74** Performance (2024/25)	**1.50** Target (2024/25)	**0.95** Performance (2025/26)	**--** Percentage Improvement (2025/26)	**NA** Target (2025/26)

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

Ensure Skin Wellness Associate Nurse (SWAN)'s support both the Wound Care Champion and the home's Skin and Wound program in the absence of the Wound Care Champion.

Process measure

- Percentage of 'Skin - Weekly Impaired Skin Integrity Assessment - V4' completed in the PCC UDA in the absence of the wound care champion.

Target for process measure

- All (100%) of 'Skin - Weekly Impaired Skin Integrity Assessment - V4' will be completed during extended absences of the WCC.

Lessons Learned

We focused on developing a Skin and Wound Dressing Change/ Wound Reassessment Schedule to ensure all wounds were attended to as needed. We also utilized the Extendicare Pressure Ulcer TPT to drive proactive wound care performance.

Comment

We focused on developing a Skin and Wound Dressing Change/ Wound Reassessment Schedule to ensure all wounds were attended to as needed. We also utilized the Extendicare Pressure Ulcer TPT to drive proactive wound care performance.

Results