

Access and Flow | Efficient | Optional Indicator

| Indicator #5 | Last Year | | This Year | | |
|---|-----------------------|------------------|-----------------------|----------------------------------|------------------|
| | Performance (2025/26) | Target (2025/26) | Performance (2026/27) | Percentage Improvement (2026/27) | Target (2026/27) |
| Rate of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents. (PeopleCare Meaford) | 0.00 | 21.66 | 19.08 | -- | 17.17 |

Change Idea #1 Implemented Not Implemented In Progress

Staff Training and Education on ambulatory care–sensitive conditions Management

Process measure

- This change idea will be measured by the percentage of staff who complete training on ambulatory care–sensitive conditions management each quarter.

Target for process measure

- 100% of registered staff will complete training on ambulatory care–sensitive conditions management by December 31, 2025.

Lessons Learned

MRP provided education at staff meetings to articulate MRP's personal expectations of hospital transfers. Continuous training provided at monthly registered staff meetings.

Change Idea #2 Implemented Not Implemented In Progress

Improved Communication and Coordination with Primary Care Providers

Process measure

- This change idea will be measured by the percentage of ED transfers that utilized SBAR with the MRP prior to decision of ED transfer being made.

Target for process measure

- 100 % of ED transfers will have utilized SBAR with MRP prior to decision of ED transfer being made through December 31, 2025.

Lessons Learned

During the reporting period, a new MRP adopted a more precautionary clinical approach following resident falls, requesting hospital transfers for CT imaging to rule out potential injury. This change in practice resulted in an increased number of ED transfers and contributed to the rise in the rate of ED visits despite ongoing quality improvement efforts aimed at reducing avoidable hospital utilization.

Change Idea #3 Implemented Not Implemented In Progress

Increase resources for in-house procedures

Process measure

- This change idea will be measured by the percentage of ambulatory care–sensitive conditions related ED transfers.

Target for process measure

- Achieve a reduction in the percentage of ambulatory care–sensitive conditions related ED transfers to the provincial average by December 31, 2025

Lessons Learned

During the reporting period key diagnostic equipment, including the ultrasound and bladder scanner, were not operational. As a result, residents requiring these assessments continued to be transferred to hospital for diagnostic testing, which contributed to ongoing ED visits despite efforts to manage conditions within the home where appropriate.

Comment

New medical room built within the facility allowing for treatments to be provided in house that were not previously achievable. New Spasticity Program being implemented.

Equity | Equitable | **Optional Indicator**

| Indicator #4 | Last Year | | This Year | | |
|--|---------------------------------------|-----------------------------------|---|---|-----------------------------------|
| Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education (PeopleCare Meaford) | CB Performance (2025/26) | 100 Target (2025/26) | 100.00 Performance (2026/27) | -- Percentage Improvement (2026/27) | 100 Target (2026/27) |

Change Idea #1 Implemented Not Implemented In Progress

To gain deeper understanding, DEI Leads will complete education program " Creating a Culture of Belonging: From Awareness to Action" which will provide tools and knowledge needed to foster a more inclusive and affirming environment for residents, care partners/care givers, and fellow team members.

Process measure

- The number of DEI Leads completed training on Creating Culture of Belonging: From Awareness to Action training.

Target for process measure

- 100% of DEI leads will complete the training by the end of 2025, with ultimate goal to create and share the education with staff.

Lessons Learned

DEI Lead unable to attend " Creating a Culture of Belonging: From Awareness to Action" due to unforeseen circumstances, will look into attending future sessions.

However there were other opportunities in which the management team participated in which featured LGBTQ inclusive health teaching.

Change Idea #2 Implemented Not Implemented In Progress

Share information on equity, diversity, inclusion and anti-racism topics with residents by scheduling information sessions.

Process measure

- The number of information sessions offered/completed at the resident and family council meetings. Number of time the information was shared via monthly newsletters.

Target for process measure

- All members of resident and family council will at least attend one session in 2025. Quarterly newsletters will contain information about equity, diversity, inclusion and anti-racism topics

Lessons Learned

Information on DEI has been added to monthly residents council meetings with positive feedback received from residents.

Comment

To continue expanding on our DEI initiatives, through more learning opportunities and information sessions

Experience | Patient-centred | Optional Indicator

| | Last Year | | This Year | | |
|--|-----------------------|------------------|-----------------------|----------------------------------|------------------|
| Indicator #3 | 85.86 | 100 | 91.40 | 6.45% | NA |
| Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences". (PeopleCare Meaford) | Performance (2025/26) | Target (2025/26) | Performance (2026/27) | Percentage Improvement (2026/27) | Target (2026/27) |

Change Idea #1 Implemented Not Implemented In Progress

Continue open communication with residents and ensure that their opinions are valued and heard.

Process measure

- Monitor survey results

Target for process measure

- Continue to track volunteer and one to one visits with recreation staff in order to maintain favorable results.

Lessons Learned

Successful open door policy allows residents to voice opinions and receive support from any staff member at anytime

Change Idea #2 Implemented Not Implemented In Progress

Add "Over the Rainbow" Program to allow residents time to discuss sensitive issues such as palliative care and anxiety related to end of life.

Process measure

- We will receive feedback from residents about their experience with the program and assess if any changes need to be made.

Target for process measure

- We will measure this programs success by seeing improved communication with residents and more open dialogue regarding sensitive topics.

Lessons Learned

Program was implemented and initially well received however after the first few sessions the attendance drastically decreased as resident were no longer having concerns. The admission process was and care conferences now cover many frequently addressed concerns, reducing anxiety amongst families and residents.

Change Idea #3 Implemented Not Implemented In Progress

Resident's Council will continue to review and receive feedback from residents in order to improve communication.

Process measure

- We will track attendance at the Resident's Council meetings and continue to review the meeting minutes and agenda to make adjustments as necessary.

Target for process measure

- Improved resident satisfaction with information sharing and follow-up to issues brought forward.

Lessons Learned

It was added to residents council meetings to allow for open discussion of concerns that can be received and reviewed. This has been well received from residents.

Comment

We will continue to receive and review feedback from residents as concerns arise. Understanding that there is always room for improvement.

Safety | Safe | **Optional Indicator**

| Indicator #2 | Last Year | | This Year | | |
|--------------|--|--|----------------------------------|--|--|
| | Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment (PeopleCare Meaford) | 31.40 Performance (2025/26) | 19 Target (2025/26) | 19.40 Performance (2026/27) | 38.22% Percentage Improvement (2026/27) |

Change Idea #1 Implemented Not Implemented In Progress

Comprehensive Medication Review

Process measure

- This change idea will be measured by percentage of residents without psychosis who are given antipsychotic medications in the 7 days preceding their resident assessment.

Target for process measure

- Achieve a reduction in the percentage of residents without psychosis who are prescribed antipsychotic medications to the provincial average by December 31, 2025

Lessons Learned

NP has been working diligently with BSO and RAI coordinator to review medications quarterly and adjust medications as needed. Ensuring diagnosis are up to date and accurate.

Change Idea #2 Implemented Not Implemented In Progress

Staff Education on Antipsychotic Use in Non-Psychotic Patients

Process measure

- This change idea will be measured by the number of staff attending antipsychotic use education sessions.

Target for process measure

- 100% of registered staff complete the educational sessions on antipsychotic use by December 31, 2025

Lessons Learned

BSO and RAI Coordinator attended education on Appropriate usage of Anti-psychotics and are working with NP to ensure resident are receiving medication as appropriate.

Change Idea #3 Implemented Not Implemented In Progress

Enhanced Documentation and Care Planning

Process measure

- This change idea will be measured by the percentage of residents whose care plan includes documented reasons for antipsychotic use.

Target for process measure

- 100% of residents prescribed antipsychotic medications have clear documentation in their care plan by year end.

Lessons Learned

Documentation has been enhanced through DOS and sleep mapping being completed on regular basis after medication changes to capture improvements.

Comment

Continue with current plan as it has been effective with improving antipsychotic usage effective

Safety | Safe | **Custom Indicator**

| Indicator #1 Percentage of home care patients who developed a stage 2 to 4 pressure ulcer (PeopleCare Meaford) | Last Year | | This Year | | |
|---|---|--|---|--|--|
| | <p>6.93</p> <p>Performance (2025/26)</p> | <p>6.70</p> <p>Target (2025/26)</p> | <p>1.58</p> <p>Performance (2026/27)</p> | <p>--</p> <p>Percentage Improvement (2026/27)</p> | <p>NA</p> <p>Target (2026/27)</p> |

Change Idea #1 Implemented Not Implemented In Progress

Process change for Altered Skin Integrity Assessments

Process measure

- This change will be measured by the the percentage of residents who have New Stage 2-4 PU in the 7 days preceding their assessment.

Target for process measure

- Achieve a reduction in the percentage of residents who have New Stage 2-4 PU to the provincial average by December 31, 2025.

Lessons Learned

During implementations there were several technological issues that arose. Despite challenges, assessment quality has improved, and streamlined the overall process with positive feedback from staff.

Change Idea #2 Implemented Not Implemented In Progress

Staff education on Pont Click Care Skin & Wound Application

Process measure

- This change idea will be measured by the number of staff who attend the education.

Target for process measure

- 100% of Full Time registered staff attend the provided education. 100% of PT/casual staff either attend the education or receive 1:1 training with a registered staff who attended the education. To be completed by March 31/2025.

Lessons Learned

Training was well received by staff, aside from technical issues.

Comment

There is a new AI component to be implemented this year that will be able to generate statistics of wounds within the home that we can review for quality.

