Access and Flow | Efficient | Optional Indicator

	Last Year		This Year		
Indicator #6 Rate of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents. (Fudger House)	**19.31** Performance (2024/25)	**18** Target (2024/25)	**18.22** Performance (2025/26)	**5.64%** Percentage Improvement (2025/26)	**3** Target (2025/26)

Change Idea #1 Implemented

Track and trend all emergency visits on 24 hour report and progress notes.

Process measure

• % of ED Transfers tracked and reviewed by interprofessional committees monthly

Target for process measure

• 100% of all ED transfers will be included in the monthly trending review

Lessons Learned

ED transfers' analysis was completed at monthly meeting, focusing on contributing factors identified. The home (NM/DOC/Physician) will collaborate with hospitals regarding the immature discharge back to the home for some residents. Education will be provided to families on the risks of prematurely sending residents to the ED.

Change Idea #2 Implemented

High risk care plan rounds will be held to discuss residents at risk, changes in health status, validate that external resources are being utilized (i.e. NLOT/GMHOT), update plan of care and engage interprofessional collaboration.

Process measure

• % of scheduled high risk care plan rounds

Target for process measure

• 100% of scheduled high risk care plan reviews completed

Lessons Learned

Scheduled care plan reviews completed. Interdisciplinary Ad-Hoc high-risk care plan huddles were held to address residents at risk. Conduct ad hoc huddles to identify strategies for our high-risk fallers to reduce further falls risks.

Comment

The home will continue to monitor in 2025.

Equity | Equitable | Optional Indicator

	Last Year		This Year		
Indicator #5 Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education (Fudger House)	42.60 Performance (2024/25)	100 Target (2024/25)	86.25 Performance (2025/26)	102.46 % Percentage Improvement (2025/26)	100 Target (2025/26)

Change Idea #1 Implemented

Continue with Equity, Diversity and Inclusion training for all staff

Process measure

• % completion rate

Target for process measure

• 100% of managers and staff trained.

Lessons Learned

This will be a continued focus in 2025.

Comment

Training will continue in 2025.

	Last Year		This Year		
Indicator #3 Percentage of resident's responded "My issues, concerns or requests for information are addressed" (Fudger House)	**86.00** Performance (2024/25)	**90** Target (2024/25)	**83.00** Performance (2025/26)	**--** Percentage Improvement (2025/26)	**NA** Target (2025/26)

Change Idea #1 Implemented

All Resident Council Concern Forms will be followed up with in a timely manner

Process measure

• % of concerns followed up with within 10 days

Target for process measure

• 100% of concerns followed up with within 10 days

Lessons Learned

There were no resident concerns form issued to the home for 2024.

Change Idea #2 Implemented

All staff to complete the Customer Service module in ELI

Process measure

• % full time staff completion

Target for process measure

• 100% full time staff compete Customer Service module in ELI

Lessons Learned

All full-time staff completed the ELI training.

Change Idea #3 Not Implemented

Have a “Care Team” board so that residents know who is working every day.

Process measure

• % of units with board

Target for process measure

• 100% units have a board

Lessons Learned

Will continue to work on this for 2025, as there were challenges with supply/vendor.

Comment

The home will continue to enhance communication avenues.

	Last Year		This Year		
Indicator #4 Percentage of resident's responded "the home provides an enjoyable mealtime experience" (Fudger House)	**86.00** Performance (2024/25)	**90** Target (2024/25)	**95.00** Performance (2025/26)	**--** Percentage Improvement (2025/26)	**NA** Target (2025/26)

Change Idea #1 Implemented

To explore surveying residents again to find out more information on their dining experience.

Process measure

• % satisfaction rate based on 24 resident responses.

Target for process measure

• 85% satisfaction rate based on the responses.

Lessons Learned

Monthly surveys were completed from April to August getting feedback from 24 residents per month from all three meal services. The surveys allowed a variety of residents to provide feedback on how they felt about the dining service. Feedback ranged from

feeling rushed, too much chicken, don't like toast to the egg is good, food service is the best, to some residents stating they had no concerns.

The home realizes that all residents are unique and have unique needs, our goal is to adjust the dining experience to ensure we are able to provide a pleasurable experience so that all resident's nutritional needs are met and we are able to alter as necessary.

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 (Fudger House)	**5.31** Performance (2024/25)	**5** Target (2024/25)	**5.21** Performance (2025/26)	**1.88%** Percentage Improvement (2025/26)	**5.21** Target (2025/26)

Change Idea #1 Implemented

Fall incidents/risk management report will be reviewed and analyzed

Process measure

• % of fall incidents reviewed and included in the trending analysis

Target for process measure

• 100% of fall incidents reviewed

Lessons Learned

Fall data was reviewed, and trended, and information was shared in home interdisciplinary team meetings, such as Nursing Practice Meetings, Site QI meetings, and Fall Prevention meetings. These activities increased staff awareness of the fall prevention program.

A lot of new admissions come with pre-existing conditions which puts them at high risk for falls. We are able to conduct ad hoc care plan meetings which helps us identify and prevent unnecessary falls.

Change Idea #2 Implemented

Fall related Critical Incidents will be analyzed and clinical huddle conducted with care team to prevent future incidents

Process measure

• % of CIs reviewed, analyzed and care plan updated

Target for process measure

• 100% of fall related CIs reviewed and analyzed

Lessons Learned

NMs have led CI analysis and care plan review for their assigned unit(s). Clinical support was crucial for sustaining the practice.

Comment

The home is at 5.21% falls rate, which is below the provincial average of 15.29. The home will continue to monitor falls in 2025 which is a contributing factor to emergency visits.

	Last Year		This Year		
Indicator #2 Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment (Fudger House)	**7.00** Performance (2024/25)	**7** Target (2024/25)	**5.85** Performance (2025/26)	**16.43%** Percentage Improvement (2025/26)	**5.85** Target (2025/26)

Change Idea #1 Implemented

New admissions on antipsychotic medications will be reviewed by BSO Lead and medication reconciliation process.

Process measure

• % of new admissions reviewed to identify inappropriate antipsychotic use

Target for process measure

• 100% of new admissions are reviewed

Lessons Learned

BSO Lead screened all new admissions on antipsychotic use, identified potential inappropriate use of antipsychotics, and involved the interdisciplinary team in follow-ups. In collaboration with external resources, such as GHMOT and PRC, the BSO Lead and care team focused on finding strategies to manage behavior.

Change Idea #2 Implemented

2) CIHI QI data on inappropriate antipsychotic use will be reviewed during Site Quality and Nursing Practice Committee meetings.

Process measure

• % of residents on anti-psychotics and CIHI QI report reviewed quarterly by home inter-professional team and BSO Lead.

Target for process measure

• 100% of CIHI QI reports reviewed

Lessons Learned

The Quarterly CIHI report was shared at the home interdisciplinary team meetings to increase team awareness of potential inappropriate antipsychotic use.