Access and Flow | Efficient | Optional Indicator

	Last Year		This Year		
Indicator #5 Rate of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents. (Wesburn Manor)	**21.59** Performance (2024/25)	**18** Target (2024/25)	**21.74** Performance (2025/26)	**-0.69%** Percentage Improvement (2025/26)	**20** Target (2025/26)

Change Idea #1 Implemented

1) Review and audit potentially avoidable ED visits by an interdisciplinary team.

Process measure

• % of ED visits reviewed

Target for process measure

• 100% of ED visits reviewed

Lessons Learned

An NP (1 FTE) was hired in June 2024, with a key responsibility of managing the percentage of ED visits. The NP provides timely interventions to help prevent unnecessary ED visits.

Change Idea #2 Implemented

2) Consult NPSTAT, LTC Plus, and an on-call attending physician prior to an ED transfer.

Process measure

• % Resident ED transfer where consult took place before ED transfer

Target for process measure

• 100% Resident ED transfers to have a consult

Lessons Learned

ED transfers are initiated in collaboration with the Nurse Practitioner (NP) and the on-call attending physician. To support this process, an inhouse NP was hired in June 2024.

Change Idea #3 Implemented

3) Collaborate with the medical team and families/residents to increase knowledge about the resident's levels of care.

Process measure

• % of Care Conferences where the Goals of Care are reviewed

Target for process measure

• 100% of Care Conferences with review of Goals of Care

Lessons Learned

Family members (POAs) and caregivers were encouraged to attend care conferences and ask questions about the residents' plan of care to enhance their understanding of the residents' levels of care.

Comment

The home will continue to monitor in 2025.

Equity | Equitable | Optional Indicator

	Last Year		This Year		
Indicator #4 Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education (Wesburn Manor)	**43.08** Performance (2024/25)	**100** Target (2024/25)	**70.10** Performance (2025/26)	**62.72%** 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

Continue providing Equity, Diversity, and Inclusion training for all staff to promote a more inclusive and supportive environment.

Comment

Training will continue in 2025.

Experience | Patient-centred | Custom Indicator

	Last Year		This Year		
Indicator #1 My issues, concerns or requests for information are addressed. (Wesburn Manor)	**81.00** Performance (2024/25)	**85** Target (2024/25)	**89.00** Performance (2025/26)	**--** Percentage Improvement (2025/26)	**NA** Target (2025/26)

Change Idea #1 Implemented

Family Council – Engagement/Development and Visibility

Process measure

• % of families satisfied with communication

Target for process measure

• 70% of families satisfied with communication strategies

Lessons Learned

According to the YOC survey results, 92% of families reported being able to communicate openly and freely regarding care and service needs, while 89% indicated that their issues, concerns, or requests for information were addressed promptly.

	Last Year		This Year		
Indicator #6 Variety and quality of activities meets my family member needs. (Wesburn Manor)	**72.00** Performance (2024/25)	**80** Target (2024/25)	**76.00** Performance (2025/26)	**--** Percentage Improvement (2025/26)	**NA** Target (2025/26)

Change Idea #1 Implemented

Enhance communication and collaboration with residents and families regarding programming, activities, and special events.

Process measure

• % of program recommendations incorporated

Target for process measure

• At least 20% of program recommendations incorporated

Lessons Learned

The activities calendar is updated monthly and posted in various locations, including home areas, to ensure accessibility for residents, families, and staff.

	Last Year		This Year		
Indicator #7 Variety and quality of food meets my family members need. (Wesburn Manor)	**78.00** Performance (2024/25)	**85** Target (2024/25)	**NA** Performance (2025/26)	**--** Percentage Improvement (2025/26)	**NA** Target (2025/26)

Change Idea #1 Implemented

Food and Nutrition events will be communicated with Residents and Families.

Process measure

• % of families satisfied with the variety and quality of food.

Target for process measure

• 85% of families satisfied with the variety and quality of food

Lessons Learned

85% of families were satisfied with “the variety and quality of food and it met their family members needs” thereby reaching the target rate set for 2024.

Safety | Safe | Optional Indicator

	Last Year		This Year		
Indicator #2 Percentage of LTC home residents who fell in the 30 days leading up to their assessment (Wesburn Manor)	**8.68** Performance (2024/25)	**8** Target (2024/25)	**9.79** Performance (2025/26)	**-12.79%** Percentage Improvement (2025/26)	**9.70** Target (2025/26)

Change Idea #1 Implemented

1) Interdisciplinary Falls reviews

Process measure

• % of interdisciplinary post-falls huddles completed.

Target for process measure

• 100% of falls reviewed at post-falls huddles

Lessons Learned

All falls are discussed and analyzed in the monthly Falls Committee meetings to identify root causes and implement prevention strategies.

Change Idea #2 Implemented

Increase involvement from PT

Process measure

• % of meetings PT was invited and attended.

Target for process measure

• 100% % of meetings PT was invited and attended.

Lessons Learned

Physical Therapists (PTs) actively participated in Falls Committee meetings to identify and address the root causes of resident falls, contributing to ongoing efforts to mitigate risks.

Comment

Home is below provincial average of 15.29 but will continue to focus on falls as they are a main factor in ED transfers.

	Last Year		This Year		
Indicator #3 Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment (Wesburn Manor)	**21.07** Performance (2024/25)	**18** Target (2024/25)	**22.14** Performance (2025/26)	**-5.08%** Percentage Improvement (2025/26)	**20** Target (2025/26)

Change Idea #1 Implemented

BSO team review for residents on antipsychotics monthly

Process measure

• % of residents on antipsychotics that were reviewed.

Target for process measure

• 100% of residents on antipsychotics reviewed.

Lessons Learned

Monthly meetings with the Medical Director, BSO Lead, BSO PSW, and Medication Manager focus on reviewing data related to residents on antipsychotic medications. This includes reassessing medications, making updates as necessary, and identifying lessons learned to reduce and improve care and medical interventions.

Change Idea #2 Implemented

2) Ensure diagnoses are entered for all residents' prescribed antipsychotics and decisions are made based on clinical

knowledge.

Process measure

• % of residents on antipsychotics without a diagnosis reviewed with appropriate documentation

Target for process measure

• 100% of residents on antipsychotics without a diagnosis reviewed with appropriate documentation

Lessons Learned

100% of residents on antipsychotics without a formal diagnosis have been reviewed, with appropriate documentation and lessons learned to improve care and medical interventions.

Change Idea #3 Implemented

3) Provide training for FT nursing staff that previously did not receive training

Process measure

• % of FT nursing staff trained GPA/PIECES

Target for process measure

• 100% of FT nursing staff trained GPA/PIECES

Lessons Learned

100% of full-time nursing staff have completed the GPA/PIECES education program, leading to a significant increase in knowledge and skills.

Comment

Home will continue with this indicator as a priority in 2025.