Access and Flow | Efficient | Optional Indicator

	Last Year		This Year		
Indicator #8 Rate of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents. (Cummer Lodge)	**17.52** Performance (2024/25)	**15** Target (2024/25)	**19.28** Performance (2025/26)	**-10.05%** Percentage Improvement (2025/26)	**17.50** Target (2025/26)

Change Idea #1 Implemented

Admission Care Plan Development – Foster interprofessional collaboration upon move in, to ensure the resident's care plan addresses any known risk of falls, behaviors, dehydration, and/or infections which may prevent a transfer to hospital

Process measure

• % of new admission care plans developed using an interprofessional approach

Target for process measure

• 100% of new admission care plans will be developed using an interprofessional approach and reviewed by the Clinical Nurse Manager

Lessons Learned

All new residents were assessed by the interprofessional care team through admission notices, referrals, team huddles, and care plan reviews. Audits assisted the team to identify gaps and flag high risk areas for further follow up.

Change Idea #2 Implemented

Clinical Rounds - Identify residents at risk and identify early changes in health status to involve external resources (NLOT and/or NP) to provide early treatment and engage interprofessional collaboration at the home-level

Process measure

• % of scheduled high risk clinical rounds

Target for process measure

• 100% of scheduled high risk clinical rounds completed

Lessons Learned

Clinical rounds were held each week for high-risk residents where care plan and interventions were reviewed. Ad-hoc care conferences were scheduled if there was a decline or change in health status. The Physician and care team attended these meetings to discuss and review goals of care with the SDM, resident and/or POA. Weekly care plan review huddles were conducted by the interprofessional team members. The huddles were scheduled for each home area at times that were convenient for the front-line team. External partners such as NLOT and GMHOT were consulted if appropriate.

Change Idea #3 Implemented

Tracking and Analysis – ED transfers will be tracked and analyzed on the daily 24-hour report and ED tracking sheet to identify any trends and high risk transfers.

Process measure

• % of ED transfers reviewed and analyzed

Target for process measure

• 100% of ED transfers will be reviewed and included in the trending review

Lessons Learned

From January to November of 2024, there were 199 ED transfers. 100% of these ED transfers were reviewed using an ED visit tracking sheet and monthly ED visit huddles took place which were attended by the Medical Director, Nurse Practitioner and Nurse Managers.

Comment

The home will continue to monitor in 2025.

Equity | Equitable | Optional Indicator

	Last Year		This Year		
Indicator #7 Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education (Cummer Lodge)	40.39 Performance (2024/25)	100 Target (2024/25)	79.82 Performance (2025/26)	97.62% 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

Divisional training on Equity, Diversity and Inclusion was provided.

Comment

Training will continue in 2025.

Experience | Patient-centred | **Custom Indicator**

	Last Year		This Year		
Indicator #4 Percentage of residents who responded "the home provides an enjoyable mealtime experience" (Cummer Lodge)	**95.00** Performance (2024/25)	**95** Target (2024/25)	**93.00** Performance (2025/26)	**--** Percentage Improvement (2025/26)	**NA** Target (2025/26)

Change Idea #1 Implemented

Increase overall meal service satisfaction

Process measure

• % of sessions/huddles in which front-line teams, residents and family members are engaged for feedback and evaluation % of completed meal service audits

Target for process measure

• 100% of scheduled consultation sessions with front-line teams, residents and family members 100% completion of meal service audits

Lessons Learned

Team meetings were held with all department staff to review new menu highlights, as well as changes in meal and snack items. New menu food photos were ordered for residents and updated.. Meetings were held with nursing leadership and table rotation calendar was implemented. A pilot dining room initiative started in Quarter 3 on the second floor to trial having assigned staff ordering and

delivering food items, while all remaining staff remain in assignments to assist with feeding. A new dining audit was created to take on a collaborative approach. Focus groups with each dining room were held in the months of September and October where family members, residents and staff were invited to provide their feedback on the unique challenges and strengths of each dining room. Focus group meetings were held Swith the goal of consulting with residents, family members, staff and volunteers to discuss current process and areas of improvement for dining service, new menu items and incorporating new cultural foods.

	Last Year		This Year		
Indicator #5 Percentage of resident's who responded "the variety and quality of food meets my needs". (Cummer Lodge)	**85.00** Performance (2024/25)	**90** Target (2024/25)	**76.00** Performance (2025/26)	**--** Percentage Improvement (2025/26)	**NA** Target (2025/26)

Change Idea #1 Implemented

Incorporation of new cultural foods, including Halal, Kosher, and Asian food choices.

Process measure

• 1. % of completed assessments 2. % of scheduled focus group sessions 3. % of cultural days held

Target for process measure

• 1. 100% of completed nutrition assessments in PCC 2. 100% of scheduled sessions documented 3. 100% cultural days held from April to December 2024

Lessons Learned

Focus groups with each dining room were held with family members, residents and staff to provide their feedback on the unique challenges and strengths of each dining room. Focus group meetings were held with the goal of consulting with residents, family

members, staff and volunteers to discuss current process and areas of improvement for dining service, new menu items and incorporating new cultural foods was a key area of improvement.

Change Idea #2 Implemented

Implementation of hot food carts to improve quality of tray service

Process measure

• 1. Development of internal process 2. % of staff educated on new equipment 3. % of concerns

Target for process measure

• 1. Documentation of internal process 2. 100% of active staff will be educated on new equipment 3. 50% reduction in concerns

Lessons Learned

Burlodge training sessions with nursing and dietary staff to support the implementation of new carts.

	Last Year		This Year		
Indicator #6 Percentage of rooms that have a completed readiness checklist prior to move in (Cummer Lodge)	**CB** Performance (2024/25)	**CB** Target (2024/25)	**CB** Performance (2025/26)	**--** Percentage Improvement (2025/26)	**NA** Target (2025/26)

Change Idea #1 Implemented

Current Rooms – Implementation of a home-wide room audit schedule and audit system to ensure all rooms are continually audited

Process measure

• % of rooms audited

Target for process measure

• 100% of scheduled room audits will be completed as per schedule

Lessons Learned

Room audits were completed. and any deficiencies were logged as work orders for follow up by the maintenance team. Monthly audits continue to sustain this initiative and to ensure any deficiencies are addressed immediately. From January to November of 2024, the Home has not received any concerns from residents or families regarding any structural concerns in resident rooms.

Change Idea #2 Implemented

Vacant Rooms – Vacant rooms will have a readiness checklist completed from the nursing and building services team, prior to a move-in or internal transfer

Process measure

• % of vacant rooms with a completed checklists

Target for process measure

• 100% of vacant rooms will have a completed checklist

Lessons Learned

An updated process utilizing the pre-admission checklist was implemented. Process was sustained of and 100% of vacant rooms are ready on day of admission.

	Last Year		This Year		
Indicator #3 Percentage of resident's responded "The variety and quality of activities meets my family member's needs" (Cummer Lodge)	**88.00** Performance (2024/25)	**90** Target (2024/25)	**91.00** Performance (2025/26)	**--** Percentage Improvement (2025/26)	**NA** Target (2025/26)

Change Idea #1 Implemented

Recreational Activities – Improve passive resident participation and engage residents, as well as resident council for feedback on preferred types of activities.

Process measure

• % of communication e-mails with programming information % of scheduled monthly outings

Target for process measure

• 100% of monthly calendars will be communicated to family members 100% of monthly outings will include participation from passive and active residents

Lessons Learned

Activity evaluation survey launched online from July 2 to July 26 and the second round of the survey launched from November 18 to November 29. Results will inform 2025 programming. Monthly calendar and programming information, along with Cummer Capers newsletter were e-mailed out at the beginning of each month to inform family members.

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 (Cummer Lodge)	**10.67** Performance (2024/25)	**9.67** Target (2024/25)	**9.92** Performance (2025/26)	**7.03%** Percentage Improvement (2025/26)	**9** Target (2025/26)

Change Idea #1 Implemented

Risk Management - Fall incident reports will be reviewed, analyzed and trended to identify high risk areas that require

focused attention

Process measure

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

Target for process measure

• 100% of fall incidents will be reviewed

Lessons Learned

A new post-fall process came into effect in March of 2024 and interprofessional team huddles were held for each fall incident to review incident factors. Monthly falls data was shared at Nursing Practice meetings and also posted at each nursing station. All fall incidents related to a critical incident have been reviewed by the interprofessional care team.

Change Idea #2 Implemented

Critical Incidents – Falls leading to hospital transfers and Critical Incident reporting will be analyzed with a root cause

analysis to prevent recurrence

Process measure

• % of CIs reviewed, analyzed and care plan updated

Target for process measure

• 100% of fall related to CIs will be reviewed and analyzed

Lessons Learned

Fall incidents that resulted in Critical Incidents were reviewed by an Interprofessional team during Post Fall Huddles and Weekly Care Plan Review meetings. Care Plans were updated based on the team assessment of resident's needs.

Comment

The home is below the provincial average of 15.29 but will be a priority in 2025 since falls are the primary factor for ED 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 (Cummer Lodge)	**16.34** Performance (2024/25)	**15** Target (2024/25)	**13.84** Performance (2025/26)	**15.30%** Percentage Improvement (2025/26)	**12** Target (2025/26)

Change Idea #1 Implemented

New Admissions – New residents moving in with antipsychotic medications will be reviewed by the BSO team through

the medication reconciliation process.

Process measure

• % of new admissions reviewed to identify inappropriate antipsychotic use

Target for process measure

• 100% of new admissions will be reviewed

Lessons Learned

All new residents who moved into the Home and were on antipsychotic medication were added to the BSO caseload for further assessment and follow up. The BSO team collaborated with the Physician team to review antipsychotic medication usage and its appropriateness.

Change Idea #2 Implemented

Interprofessional Review – Monthly review of antipsychotic medication usage will be shared with interprofessional team to ensure RAI-MDS assessment coding is accurate and to ensure appropriate documentation is in place.

Process measure

• % of residents on anti-psychotic medication reviewed

Target for process measure

• 100% of residents on antipsychotic medications will be reviewed

Lessons Learned

Huddles were held each month with the interprofessional team to review antipsychotic medication usage. Residents who were flagged as inappropriate antipsychotic medication usage were reviewed.