Experience | Patient-centred | Custom Indicator

	Last Year		This Year		
Indicator #2	**70.00**	**80**	**94.00**	**--**	**NA**
The percentage of newly admitted residents and families who share their positive care transition experiences. (Yee Hong Centre - Mississauga)	Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Introduce and launch a new video about the home and service for new residents and families.

Process measure

- Video developed and launched.

Target for process measure

- Video will be completed and launched by December 31, 2024.

Lessons Learned

• Met target and exceeded by 14 points.
• Created the video in December 2024 offering detailed information about what to expect on the day of admission and outlining the daily routines of residents at Yee Hong.
• Scheduled the video launch for Feb 2025 to support the admission process, prepare residents and their families, and set expectations.
• Needed to seek the most appropriate language and terminology to ensure clients understand the video's information.
• Video presented in English, some residents may not speak or understand English, plan to create video in Chinese in the future.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Enhance communication between resident/family and care team by reviewing the newly admitted resident's plan of care within 2 weeks of admission.

Process measure

- Percentage of care plan discussed with newly admitted residents and families within two weeks of new admission.

Target for process measure

- 100% of newly admitted residents' care plan will have been reviewed, discussed, and revised with residents and families within two weeks of new admission by December 31, 2024.

Lessons Learned

• 100% of the newly admitted resident's care plan was completed within 24 hours of admission.
• Implemented a 24-hour care plan template checklist to guide staff in ensuring completeness and accuracy during resident admissions.
• After the resident's care plan was developed by the interprofessional team, the primary nurse reviewed, discussed, and revised the care plan with the newly admitted residents and their families within two weeks of admission, and documented.
• The RN team leads continued to coach staff on using the 24-hour care plan template checklist when developing and completing care plans.

Change Idea #3 ☑ **Implemented** ☐ **Not Implemented**

Evaluate care transition experiences of newly admitted residents and families after 4 to 6 weeks during the care conference.

Process measure

- The percentage of newly admitted residents and families shared their care transition experiences during the admission care conference.

Target for process measure

- 100% of newly admitted residents and families will have shared their care transition experiences by December 31, 2024.

Lessons Learned

• 100% of newly admitted residents and families shared their care transition experiences during the new admission care conferences, and the results were positive overall.
• Continued to encourage newly admitted residents and families to share their care transition experiences, fostering an open and communicative environment.
• The Social Worker or the Assistant Director of Resident Care asked the newly admitted residents and families to share their experiences on the care transition during the admission care conference and documented their feedback.
• While some residents and families have shared positive experiences regarding care transitions during the admission care conference, others have indicated a need for more time to adjust to the new environment and routine. This highlights the importance of providing ongoing support.

Indicator #1

Percentage of residents who respond positively to the statement: "Are staff involving you in planning your care?" (Yee Hong Centre - Mississauga)

Last Year		This Year		
69.00	**80**	**90.00**	**--**	**NA**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Arrange training and education on updating care plans for nurses and personal support workers (PSWs).

Process measure

- The percentage of staff received training.

Target for process measure

- 100% of full-time nurses and PSWs staff will have received training on updating care plans by March 31, 2024.

Lessons Learned

• Met target and exceeded by 10 points.
• Trained 100% of full-time nurses and PSWs on updating care plans.
• Arranged multiple training sessions to increase staff accessibility.
• Delivered multiple training delivery methods, such as hands-on demonstrations, handouts and shared at the floor and departmental meeting to promote staff engagement.
• Provided refresher training for staff to reinforce practice and maintain sustainability of the training outcomes.
• Posted the training handout at each nursing station for staff to reference.
• Involved capable residents in developing and modifying their care plan, such as falls prevention, behavior management, continence care, wound care, or any care routines. This was achieved by assessing the resident and collaboratively reviewing the plan of care together. All communications are documented in the electronic health record.
• Ensuring staff maintaining consistent practice and involving residents in care planning required continuous monitoring and reinforcement. Nurse managers consistently reminded staff to engage capable residents in developing and modifying a care plan and then document in the electronic health record.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Involve capable residents (Cognitive Performance Scale (CPS) score is from 0 to 2) in developing and modifying the care plan.

Process measure

- The percentage of capable residents involved in developing and modifying the care plan quarterly.

Target for process measure

- 100% of capable residents will have been involved in developing and modifying care plans by December 31, 2024.

Lessons Learned

• Involved 100% of cognitively capable residents in developing and modifying care plans during admission and whenever there is a change in condition.
• Utilized communication tools, such as the Communication Log Sheet, to keep teams informed of the updated care plan.
• Developed a care plan update timeline to guide staff on when to update care plans which facilitated collaboration with capable residents. For example, if a resident has a wound, staff would re-assess and review the care plan with the resident.
• Ensured that Resident Assessment Instrument Minimum Data Set (RAI MDS) assessments were completed in a timely manner and accurately reflected resident's true Cognitive Performance Scale (CPS) scores.
• Encountered challenges in identifying cognitive level changes early when residents' health conditions change. This required continuous monitoring and assessment.
• Nurse Managers led the discussion with the interprofessional team to regularly identify cognitive level change.

Change Idea #3 ☑ **Implemented** ☐ **Not Implemented**

Seek feedback and suggestions from capable residents about their care plan and care needs, and share the feedback with inter-professional team, as appropriate.

Process measure

• a. The percentage of capable residents provided feedback and suggestions on their care plan. b. The percentage of residents' feedback and suggestions about the care plan shared with the team as appropriate. c. The percentage of care plans updated based on the feedback from residents.

Target for process measure

• a. 100% of capable residents will have provided feedback and suggestions on their care plan by December 31, 2024. b. 100% of residents' feedback and suggestions about the care plan will be shared with the team by December 31, 2024. c. 100% of care plans will be updated based on capable residents' feedback by December 31, 2024.

Lessons Learned

• Received feedback from 100% cognitively capable residents.
• Reviewed care plans by nurses with Personal Support Workers and capable residents to obtain their feedback and suggestions on a monthly basis.
• Shared the feedback with the interprofessional team. During monthly interprofessional team meetings, team members discussed residents' care needs and updated the care plan accordingly.
• Based on the feedback and suggestions, 100% of care plans were updated to ensure that the residents' needs and preferences were reflected.
• Educated residents on Care Planning during the resident council meeting in February 2024 and the annual resident orientation in June 2024. All capable residents participated in the discussion during the training sessions to improve their understanding of care planning.
• Continued working on improving the timely completion of documentation, ensuring care plan is up to date.
• Require ongoing reinforcement to ensure completion. Will explore alternative methods such as electronic format of alert to streamline the process and enhance efficiency.