Access and Flow

Measure - Dimension: Efficient

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Rate of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents.	P	Rate per 100 residents / LTC home residents	CIHI CCRS, CIHI NACRS / October 1, 2024, to September 30, 2025 (Q3 to the end of the following Q2)	23.20	20.00	Through implementation of our change ideas, the home expects an improvement over the next year.	

Change Ideas

Change Idea #1 Increase communication on trends and reasons why residents are transferred to ED.

Methods	Process measures	Target for process measure	Comments
1) DOC/designate to review 24 hr report daily. 2). Add ED transfers to standing agenda for morning risk management meetings. 3). Review data with staff and involve them in improvement plan ideas to increase awareness during monthly registered staff meetings	1) # of residents sent to ER daily as per 24/hr report. 2) # of morning meetings where ED transfer discussed 3). # of meetings held with staff to review ED data and discuss improvement strategies based on trends	1)Process for review of 24/hr report by leadership will be in place by March 15, 2026. 2) ED transfers will be added to the standing agenda for morning meetings by March 15, 2026. 3) Process for reviewing ED data and discussing strategies for improvement with staff will be in place by May 1, 2026	Review of monthly data

Change Idea #2 Educate staff on reasons for preventable ED transfers			
Methods	Process measures	Target for process measure	Comments
1).Review data for trends for preventable ED transfers for home. 2). Arrange education sessions with staff by NP/designate on areas identified. 3). Monitor for improvement post sessions	1.) # of identified trends for preventable ED visits per month 2.) # of staff educated monthly	1. There will be a 2% reduction in preventable ED transfers by April 30, 2026 2) . There will be 3 sessions completed by June 30, 2026 with 100% of staff receiving training.	Review of monthly data

Change Idea #3 Improve communication with MD /NP by using SBAR			
Methods	Process measures	Target for process measure	Comments
1). Provide education for Reg staff on use of SBAR 2). Ask MD/NP for feedback 3 months after implementing to see if improvement	1.) # of education sessions on SBAR 2.) # of staff who attended the training 3.) Feedback from MD/NP	1.) Education sessions on SBAR will be completed by May 31, 2026. 2.) 100 % of staff will have completed the SBAR training by May 31, 2026 3). 50% improvement in communication based on feedback from MD/NP by May 31, 2026	Review of monthly data

Change Idea #4 Utilization of the PPS Palliative Performance Score to determine disease progression- revision of care plan			
Methods	Process measures	Target for process measure	Comments
Completion of PPS assessment, implementation of use and education for staff, res./families on palliative approach and end of life. Utilization of information brochure or handbook	Improved confidence and decision making from Registered staff related to clinical assessment. # of education sessions with Registered staff	100% Staff education completed.	Utilize Nurse Practitioner ands MDs to provide education to registered staff on topics

Equity

Measure - Dimension: Equitable

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education	O	% / Staff	Local data collection / Most recent consecutive 12-month period	CB	100.00	Through education, the home expects to have an increased understanding of this criteria	

Change Ideas

Change Idea #1 Provide education sessions for staff on Equity to increase awareness.

Methods	Process measures	Target for process measure	Comments
1)Ensure all staff have access to learning modules on Surge or arrange in person education sessions 2). Monitor completion rates for all departments and leadership	1.) # of staff that have completed education 2) # of leadership staff that have completed education	1.) 100% of staff will have completed education by September 30, 2026 2.) 100 of leadership will have completed education by September 30, 2026	Staff education on Culture and Diversity will be completed

Change Idea #2 Include information on bulletin board in home dedicated to Equity, diversity inclusion and antiracism.

Methods	Process measures	Target for process measure	Comments
1) Have information visible on bulletin board that provides education on topics related to equity/diversity 2) include contact information for further discussion	1.) # of months that there is information related to equity, diversity, inclusion and antiracism on bulletin board.	1.) Information will be posted on bulletin board by April 15, 2026	All staff will be trained on Culture and Diversity

Change Idea #3 To improve overall dialogue of diversity, inclusion, equity and anti-racism in the workplace

Methods	Process measures	Target for process measure	Comments
Introduce diversity and inclusion as part of the new employee onboarding process;	# of new employee trained of Culture and Diversity;	100% of new employees will be educated on topics of Culture and Diversity	

Change Idea #4 Provide education on AODA

Methods	Process measures	Target for process measure	Comments
Training and/or education through Surge education or live events	# of staff education on AODA	100% of staff educated on topics of AODA	

Experience

Measure - Dimension: Patient-centred

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences".	O	% / LTC home residents	In house data, interRAI survey / Most recent consecutive 12-month period	97.00	97.50	Through the implementation of change ideas the home expects an improvement over the next year	

Change Ideas

Change Idea #1 Review the Concern process in the home on admission and during annual care conference

Methods	Process measures	Target for process measure	Comments
Review of policy with resident and family with admission and care conferences	Review of policies added to the admission process, care conference	100% of all care conferences and admissions will review the Concern process.	Total Surveys Initiated: 100

Change Idea #2	Resident Rights #29. "Every resident has the right to raise concerns or recommend changes in policies and services on behalf of themself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else"";"		
Methods	Process measures	Target for process measure	Comments
Add resident right #29 to standing agenda for discussion on monthly basis by program Manager during Resident Council meeting. Re-education and review to all staff on Resident Bill of Rights specifically #29 at department meetings monthly by department managers;	100% of all department standing agendas will have Residents' Bill of Right #29 added, for review by July 31, 2026	100% of all staff and residents and families will have completed the education on resident Bill of Rights #29	

Change Idea #3	Review of the Whistleblower policy		
Methods	Process measures	Target for process measure	Comments
Policies -Zero tolerance to abuse, and Whistleblower posted in the home	100% of all staff will have education via department meetings on Policies -Zero tolerance to abuse, and Whistleblower by July 31, 2026	100% of all staff and residents and families will have completed the education on Zero Tolerance to Abuse and Whistleblower Policy	

Change Idea #4	Resident Feedback review in Quality meetings		
Methods	Process measures	Target for process measure	Comments
Review feedback during monthly quality meetings collected by weekly rounding with 1 resident per home area.	% of meetings where resident feedback is reviewed	100% of residents feedback will be reviewed at monthly quality meetings.	

Safety

Measure - Dimension: Safe

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of LTC home residents who fell in the 30 days leading up to their assessment	O	% / LTC home residents	CIHI CCRS / July 1 to September 30, 2025 (Q2), as target quarter of rolling 4-quarter average	13.97	12.00	Results continue to improve through change ideas	

Change Ideas

Change Idea #1 Increased communication during shift report for newly admitted residents and during outbreaks			
Methods	Process measures	Target for process measure	Comments
1) Remind staff about increased risk of falls when in outbreaks and during admission period. 2) Registered staff to communicate list of residents on isolation and/or new admissions during each shift report to oncoming staff 3) Residents identified as being at increased risk of falls d/t isolation or new admission will have enhanced monitoring by all staff for two week period . 4) enter task in POC for enhanced monitoring and plan of care updated	1) # of staff receiving reminders for resident fall risk 2) # of shift reports where registered staff communicated list of high risk residents 3) # of residents on enhanced monitoring per shift 4)	1) Reminders for staff will be communicated by April 15, 2026 2. Shift report process for communicating high risk residents will be in place by April 30, 2026 3. Process for enhanced monitoring for those on isolation or newly admitted will be in place by May 15, 2026	

Change Idea #2 Establishing documentation/charting buddies, (PSW complete documentation with resident's at high risk for falls - assists with the identification/reason for falls			
Methods	Process measures	Target for process measure	Comments
Remind staff during daily huddles of residents who are charting buddies. Registered staff to communicate residents on their home areas during shift report.	# of huddles including charting buddies # of shift reports where registered staff communicated which residents are charting buddies	Communication for the implementation of Charting buddies by April 15, 2026. Shift report process for communicating charting buddies will be in place by April 30, 2026.	

Change Idea #3 During admission process, review with resident and history of falls, and interventions implemented			
Methods	Process measures	Target for process measure	Comments
Determine if the resident is at risk for fall. Implement interventions prior to the residents admission and have them all in place prior to the resident being admitted.	# of residents determined to be at risk for falls upon admission.	100% of new admissions will be reviewed for falls risk prior to actual admission	

Change Idea #4 Medication review of residents who are assessed as being at risk of falls

Methods	Process measures	Target for process measure	Comments
1) determine residents at risk for falls.2) review prescribed medications for residents at risk of falls 3) Determine medications that have side effects that could potentially contribute to falls 4) Notify staff of potential risks and incorporate into plan of care for monitoring 5) Discuss with physician/pharmacist/NP if there are alternatives to prescribed medications that might decrease risk of falls	1) # of residents identified as being at risk for falls 2) # of medication reviews completed for residents at risk for falls 3) # of medications prescribed per resident that increase risk of falls 4) # of care plans updated to reflect risk 5) # of medication changes /alternatives prescribed to decrease fall risk	1) Residents at risk for falls will be identified by April 30, 2026 2) 100% of Medication reviews will be completed for those residents at risk for falls by May 31, 2026 3) Staff will be notified about potential risks and care plans updated by May 31, 2026 4) Discussions with physician/pharmacist/NP about alternatives or changes to medications will be completed for high risk residents by May 31, 2026	

Measure - Dimension: Safe

Indicator #5	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment	O	% / LTC home residents	CIHI CCRS / July 1 to September 30, 2025 (Q2), as target quarter of rolling 4-quarter average	18.00	16.00	Improve to meet corporate target below provincial averages	

Change Ideas

Change Idea #1	GPA education for training for responsive behaviours related to dementia.		
Methods	Process measures	Target for process measure	Comments
1)Engage with Certified GPA Coaches to roll-out home-level education 2). Register participants for education sessions.	1)# of GPA sessions provided 2). # of staff participating in education 3.) Feedback from participants in the usefulness of action items developed to support resident care.	1.) GPA sessions will be provided for 60% staff by December 31, 2.) Feedback from participants in the session will be reviewed and actioned on by December 31, 2026 (will review after each session)	

Change Idea #2	The MD, NP, BSO internal and external (including Psychogeriatric Team), with nursing staff will meet monthly to review newly admitted residents on antipsychotic medication for diagnosis and indication for use. This is standing item in CQI/PAC quarterly meeting agenda.		
Methods	Process measures	Target for process measure	Comments
Meetings held monthly by interdisciplinary team where discussion and reviews on strategies have resulted in a decrease of antipsychotics	1) Number of meetings held monthly by interdisciplinary team. Number of antipsychotics reduced as a result monthly. Number of PAC meetings held quarterly, where discussion and reviews on strategies have resulted in a decrease of antipsychotics;	100% of newly admitted residents will have been reviewed for the appropriateness of antipsychotics use	

Change Idea #3	Residents who are prescribed antipsychotics for the purpose of management of Responsive expressions, will have a quarterly review, for the potential of reduction or the discontinuation of medication. Utilization of tracking tool (antipsychotic)		
Methods	Process measures	Target for process measure	Comments
BSO lead and nursing team will ensure that residents who receive antipsychotics for responsive expressions will have their medication, plan of care reviewed, quarterly by the interdisciplinary team	Number of residents prescribed antipsychotics medications	100% of residents who are prescribed antipsychotic medications will receive a 3 month review to determine potential for reduction in dosage or discontinuing antipsychotics.	

Change Idea #4 Collaborate with the physician to ensure all residents using anti-psychotic medications have a medical diagnosis and rationale identified.

Methods	Process measures	Target for process measure	Comments
1) complete medication review for residents prescribed antipsychotic medications 2) Review diagnosis and rationale for antipsychotic medication . 3) consider alternatives as appropriate	1) # of medication reviews completed monthly 2) # of diagnosis that were appropriate for antipsychotic medication use 3) # of alternatives implemented	1) 75% of all residents will have medication and diagnosis review completed to validate usage by September 30, 2026 3) Alternatives will be in place and reassessed if not effective within 1 month of implementation with process in place by July 31, 2026	

Measure - Dimension: Safe

Indicator #6	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of long-term care residents whose stage 2 to 4 pressure ulcer worsened	O	% / LTC home residents	CIHI CCRS / July 1 to September 30, 2025 (Q2), as reporting quarter for the rolling 4-quarter average	1.47	1.00	The team set a goal as we continue to strive for improvement	

Change Ideas

Change Idea #1 Turning and repositioning re-education			
Methods	Process measures	Target for process measure	Comments
1) Educate staff on the importance of turning and repositioning to off load pressure 2) Night staff to audit those resident that require turning and repositioning 3)Review this during the Skin and Wound committee meetings for trends	# of staff that have been educated # of audits completed # of reviews completed by Skin and Wound committee	100% of PSW will have attended education sessions on turning and repositioning by September 30, 2026.	

Change Idea #2 Focus on continence to keep skin clean and dry- toileting, appropriate brief selection			
Methods	Process measures	Target for process measure	Comments
1) The skin and wound lead and continence lead to look at the number of residents on a toileting routine and compare with wound list already generated from PCC. 2)Review restorative goals if on restorative toileting program	# of residents with skin issues # of residents with a toileting plan in place # of brief audit checks completed # of residents on restorative toileting program	The leads for Skin/Wound and Continence will complete their resident review by May 31, 2026	

Change Idea #3 Conducting audit of resident surface (bed/w/c), for the appropriate surface for pressure relieving			
Methods	Process measures	Target for process measure	Comments
Develop a list of resident who PURS is 3 or greater, review plan of care, for the appropriate pressure relieving devices, review of surfaces in place	Number of changes to surface	100% of resident with PURs 3 or greater, comprehensive assessment completed by July 31, 2026	

Change Idea #4 RD review of nutritional and hydration status of residents

Methods	Process measures	Target for process measure	Comments
Review of resident status, with pressure related injuries during Quality meetings (case by case review) review of plan of care, progression/stalled/deteriorating pressure injuries,	Number of care plans updated	100% of residents with pressure related injuries will be reviewed for nutritional and hydration status	

Measure - Dimension: Safe

Indicator #7	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of long-term care residents in daily physical restraints	O	% / LTC home residents	CIHI CCRS / July 1 to September 30, 2025 (Q2), as target quarter of rolling 4-quarter average	1.27	0.00	The team has set a goal for 0 restraints	

Change Ideas

Change Idea #1 Provide information to families and residents on Least Restraint.			
Methods	Process measures	Target for process measure	Comments
1.) Provide Restraint brochure in admission packages for new admissions. 2). Meet with Resident and family councils to provide education on Least Restraint and risks associated with restraint use.	1.) # of admission packages with Restraint brochure included. 2.) # of meetings with Resident and Family council to discuss Least Restraint and Risks. "	1). 100% of admission packages will have Restraint brochure included for new admissions by May 1, 2026 2). Meetings with Resident and Family councils will be attended to discuss Restraints by July 31, 2026	100% of the homes admission packages will include Restraints brochures

Change Idea #2 Provide resource for staff to use when discussing restraints with residents and families.			
Methods	Process measures	Target for process measure	Comments
1) Implement new FAQ document to assist with discussing restraints 2) Communicate with staff availability of new resource.	1.) # of times FAQ was utilized monthly 2). # of sessions held to communicate with staff that FAQ was available as resource.	1. FAQ resource will be 100% in place by July 31, 2026 2). Staff will be aware of new resource by April 30, 2026	

Change Idea #3 Residents Services Coordinator will review each application received for restraints prior to admission.			
Methods	Process measures	Target for process measure	Comments
1) Residents Services Coordinator reviews and flags each application received for restraints 2) Information is sent to LHIN etc. to indicate that home is least restraint and that alternatives will be trialed upon admission	1)# of applications received that have a restraint 2). # of communications sent back to applicant and family /sending authority to explain least restraint policy 3). # of acceptances received to trial alternatives upon admission	Process for review of admission applications for restraints will be in place by April 30, 2026	

Change Idea #4 Utilization of alternatives to restraints

Methods	Process measures	Target for process measure	Comments
Family and resident engagement, health teaching provided on the risk associated with restraints, and alternative interventions	1) Number of restraints being used in the home (reason) 2) Number of restraints, successfully removed from use in the home 3) Number of resident admitted to the home with use of restraint "	100% of staff to completed education	