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)	32.79	28.00	Improvement towards provincial averages with realistic target acknowledging challenging complexity of residents	Community Paramedicine, Nurse Practitioner, Physicians

Change Ideas

Change Idea #1	1) Use of on-site Nurse Practitioner 2) Build capacity and improve overall clinical assessment skills of registered staff; supported by education from NP, clinical consultants, and Nurse PLEDGE program. 3) DOC to review ED tracker and analyze most common reasons for transfer, review at nursing meetings to develop strategies to prevent further transfers. 4) Implement IV program in the home. 5) Educate staff, residents, and families on palliative approach, end of life care, and goals of care. 6) Utilize community paramedics services

Methods	Process measures	Target for process measure	Comments
1) Contact NP via phone and/or referrals as needed. 2) Provide education, coaching and mentorship to the registered staff to improve capacity and assessment skills. 3) Utilize internal ED tracker tool to analyze transfers, monthly audit to be completed and reviewed monthly by DOC at nursing and PAC meetings. 4) Set out the procedures for initiating and maintaining IV therapies in the home, ensure all registered staff have education. 5) Host education sessions for staff, educate residents and families during care conferences and conversations on home areas about palliative approach, end of life care, and goals of care. 6) screen residents for appropriate use of community paramedicine services rather than ED transfer	1) number of NP hours worked on site, number of NP referrals completed. 2) Improved confidence and decision making from registered staff, # of education sessions completed, # of nurse PLEDGE hours completed. 3) analysis of ED transfers completed and reduction strategies identified. 4) Number of IV therapy/treatments completed. 5) number of education sessions held, number of staff educated. 6) number of community paramedicine services visits.	100% staff education completed. 100% nurse PLEDGE hours utilized.	Continue to work with collaborators to reduce avoidable ED visits - NP, MD, community paramedics.

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	100.00	100.00	Maintain requirements for completion of education on hire and annually for all staff	

Change Ideas

Change Idea #1 1) To improve overall dialogue of diversity, inclusion, equity and anti-racism in the workplace. 2) To increase diversity training through Surge education. 3) To facilitate ongoing feedback or open door policy with the management team. 4) Cultural assessment on admission, (language, faith, gender preference for care, family roles). 5) Include cultural diversity as part of CQI meetings.

Methods	Process measures	Target for process measure	Comments
1) training and education through surge. 2) Introduce diversity and inclusion as part of the employee onboarding process. 3) Celebrate culture and diversity events. 4) culturally familiar foods on the menu. 5) Standing agenda item during monthly CQI meetings. 6) flexible accommodations for religious observations.	1) number of staff educated on culture and diversity. 2) number of new staff trained in culture and diversity. 3) number of cultural events celebrated in the home.	100% of staff completed education on culture and diversity.	

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	93.00	95.00	Aim to improve by 2%	

Change Ideas

Change Idea #1	1) To increase our goal from 90% to 95%. Engaging residents in meaningful conversations, and care conferences, that allow them to express their opinions. Review ""Resident's Bill of Rights"" more frequently, at residents' Council meetings monthly. With a focus on 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""; 2) Review of the Whistleblower policy 3) Review the Concern process in the home on admission and during annual care conference 4) Social worker, completing wellness checks with residents

Methods	Process measures	Target for process measure	Comments
1) Resident right #29 on 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; 2) Review of policy with resident and family with admission and care conferences 3) Policies -Zero tolerance to abuse, and Whistleblower posted in the home 4) Review of Investigation process in the home (during admission and care conferences) 5) Social worker visits with residents	staff will have completed education on the resident's bill of rights #29 by December 2026. Resident bill of rights will be reviewed at all of the resident and family council meetings in 2026.	100% of staff completed education by December 2026.	Total Surveys Initiated: 100

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	22.24	20.00	Improvement towards provincial average with keeping realistic achievable target	

Change Ideas

Change Idea #1	1) Continue to facilitate weekly falls huddles on each unit with the interdisciplinary team. 2)Ensure that care staff complete documentation in areas with visibility of residents at high risk for falls 3) Integrate review of FRS into weekly falls huddles to ensure appropriate medications are prescribed to prevent bone density loss and fractures 4) Collaborate with recreation team to implement activities to engage residents 5) Utilize internal falls tracking tool, analyze fall data and review at monthly nursing meetings to develop strategies to prevent falls in the future.

Methods	Process measures	Target for process measure	Comments
1) weekly interdisciplinary falls huddles on resident home areas to review resident plan of care/ current falls prevention strategies. 2) Create designated spaces for staff to complete documentation in areas where residents can be observed. 3) Create resident list of FRS 3 or greater to be reviewed regularly, implement care plan interventions and offer fracture prevention medication. 4) Implement recreational programming to engage residents at high risk for falls.	Number of weekly falls huddles occurring on the home areas, number of medication changes to address fracture prevention	100% of residents who are eligible and consent for fracture prevention medication will have orders in place.	

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	7.91	7.50	Currently exceeding provincial averages therefore goal to improve by 5%	

Change Ideas

Change Idea #1	1) 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. 2) 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) 3) Development of plans of care, with non pharmalogical approach - identification of triggers and interventions 4) During admission conference, review with families, reason for the prescribing of antipsychotic medication, interventions effective in management of responsive expressions (if admission from another LTC home, inquire if care plan can be sent for review, review of Behavioural assessment provided by Ontario Home at Health) 5) BSO admission process, responsive expressions, the initating of the DOS to establish baseline, (review the Behavioural assessment, completed team huddle prior to admission) BSO team to co-ordinate related antipsychotic medication

Methods	Process measures	Target for process measure	Comments

1) Monthly interdisciplinary team meetings to discuss residents with orders for antipsychotics. Number of antipsychotics reduced as a result. PAC meetings held quarterly, where discussion and reviews on strategies have resulted in a decrease of antipsychotics; 2) 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 (including resident and family) -to develop a person centered approach 3) Use pain assessments (PAINAD), to identify pain is not trigger for the responsive expressions 4) Utilization of antipsychotic medication tracker (for de-prescribing). Review/assess the prn use of antipsychotic (medication- indication for use) 5) Referral to internal and external BSO for comprehensive assessment. Implementation of DOS, with change in responsive expressions, analysis of the DOS, with review of plan of care 6) Quartlery medication review with NP/MD	Number of residents who have antipsychotics prescribed, number of residents with inappropriate antipsychotic use, number of PRN antipsychotic doses.	1) 100% of newly admitted residents will have been reviewed for the appropriateness of antipsychotics use; 2) 100% of residents who are prescribed antipsychotic medications will receive a 3 month review to determine potential for reduction in dosage or discontinuing antipsychotics.

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	1.12	1.10	Performance meeting meeting targets currently therefore goal for improvement is with in 2%	

Change Ideas

Change Idea #1	1) To reduce the percentage of resident who develop, or experience worsening pressure injury 2) Home to collaborate with NSWOC/ET nurse to provide in home and virtual consults 3) Conducting audit of resident surface (bed/w/c), for the appropriate surface for pressure relieving 4) RD review of nutritional and hydration status of residents 5) During admission process, complete comprehensive review of resident status, and risk level for alteration in skin, and develop plan of care 6) Idenification of resident at risk for alteration in skin 7) Prompt Identification and documentation of worsening pressure injuries

Methods	Process measures	Target for process measure	Comments
1) Develop a list of resident who PURS is 3 or greater, review plan of care, for the approrpriate pressure relieving devices, review of surfaces in place 2) Utlization of skin and wound tracking tool, to analysis the pressure related injuries in the home - and the development of plan of care 3) Annual Surge education - Skin and wound care management 4) 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, 5) Referral to PT and OT for reviewing of seating 6) Wound care lead with in the home 7) 4P's implemented (pain, positioning, personal items, personal needs) hourly checks completed by PSWs	number of resolved pressure injuries, number of ET nurse referrals, number of ET nurse visits, number of specialty surfaces in place, number of residents with PURS 3 or higher with specific care plan interventions	100% of residents with PURS 3 or higher have been assessed and care plan interventions are in place	