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)	30.69	28.69	This represents a 2% decrease in avoidable ED visits. Through the implementation of our change ideas, the home expects an improvement over the next 8 months.	NLOT, GMHOP, BSOT, Michael Garon Hospital

Change Ideas

Change Idea #1 To reduce unnecessary hospital transfers, through the use of on-site Nurse practitioner; NP stat program

Methods	Process measures	Target for process measure	Comments
Conduct a needs assessment among registered staff and provide NP-led education sessions and bedside coaching to improve early clinical assessment and intervention.	Number of staff completing needs assessment; number completing NP education; number of bedside coaching sessions.	=90% needs assessment completion within 3 months; 100% education completion within 6 months.	NP collaboration with physicians and families will support early treatment in the home and reduce avoidable ED transfers.

Change Idea #2 To support early recognition of residents at risk for ED visits. by providing preventive care and early treatment for common conditions leading potentially avoidable ED visits.

Methods	Process measures	Target for process measure	Comments
NP and registered staff will identify residents with acute condition and develop individualized care plans with early warning signs and treatment strategies.	Number of residents with acute condition reviewed monthly; staff documentation demonstrating education application; number of avoided ED.	100% staff education completion; monthly review of residents with acute condition ; reduction in avoidable transfers over 8 months.	Improved monitoring and early intervention will help residents remain safely in the home whenever clinically appropriate.

Change Idea #3 To develop an IV Therapy Program in the Home.

Methods	Process measures	Target for process measure	Comments
Enroll registered nursing staff in accredited IV therapy certification programs and implement standardized IV administration protocols within the home.	Number of staff successfully IV-certified. Number of IV therapies administered in the home	At least three (3) staff members IV-certified within 12 months. Achieve a 5% increase in IV therapies delivered within the home	Expanding IV therapy capacity will enhance the home’s ability to deliver timely, on-site clinical interventions. This initiative supports improved resident outcomes by enabling access to treatments such as IV antibiotics within the long-term care setting, reducing unnecessary hospital transfers and promoting continuity of care.

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	This training is mandatory for all current and new staff. This is an ongoing indicator and we will continue to educate 100% of staff in the home.	Surge, Community religious, diversity and other sectors.

Change Ideas

Change Idea #1 To improve the cultural assessment process on admission, such as language, faith, gender preference for care, family roles.

Methods	Process measures	Target for process measure	Comments
Training and re-education of the importance of cultural assessment during admission.	Number of admissions with completed cultural assessments; percentage of staff educated in cultural competency.	100% cultural assessment completion within 6 months; =90% staff education completion.	Ensures resident preferences and cultural needs are reflected in individualized care planning.

Change Idea #2 To increase diversity training through Surge education or live events.

Methods	Process measures	Target for process measure	Comments
To continue the Diversity, Equity and Inclusivity (DEI) education into new staff orientation and annual mandatory training via Surge Learning. To invite external resources to share awareness of different cultures, religions and beliefs.	Number of staff completing training. Number of external resources or stakeholders providing information sharing.	100% of staff completing Surge training. 100% of staff attending the information sharing by the external resources.	Supports culturally competent care and fosters an inclusive workplace environment.

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	CB	94.00	Our current score of 92.53% exceeds the company average. We have decided to aim for a 1.5% increase to continue to exceed company performance.	Surge Education

Change Ideas

Change Idea #1 To engage 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"

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 resident bill of rights #29 on standing agendas. 100% of staff will have education provided via department meetings on right #29. Resident Council will be educated on right #29 at least quarterly.	100% of staff and residents will have had education regarding resident right #29	

Change Idea #2 To integrate the Whistleblower Protection Policy and Zero Tolerance of Resident Abuse, Neglect and Unlawful Conduct policy to resident council and staff monthly and town hall meetings. #3 Resident Services Coordinator (RSC) completing wellness checks with residents

Methods	Process measures	Target for process measure	Comments
Review the policies regarding the Zero Tolerance of Resident Abuse, Neglect and Unlawful Conduct and Whistleblower Protection Policy posted in the home.	Surge Learning and Staff Town Hall to contain information and education regarding zero tolerance for abuse and whistleblower protection policies. PCC progress notes are maintained to provide evidence of visits	100% of staff educated through Surge Learning regarding zero tolerance for abuse and whistleblower protection policies.	

Change Idea #3 Resident Services Coordinator (RSC) – Wellness Checks.

Methods	Process measures	Target for process measure	Comments
Ensure the Resident Services Coordinator (RSC) conducts routine wellness visits with able residents in a private and respectful setting to promote person-centered care and resident engagement.	Documentation of visits through PCC (PointClickCare) progress notes. Evidence of completed and timely wellness checks	100% of able residents to receive monthly wellness visits.	Regular wellness checks support early identification of resident needs, enhance communication, and strengthen therapeutic relationships. Conducting visits in a private space promotes dignity, trust, and resident-centered care, while consistent documentation ensures accountability and continuity of care.

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	8.67	6.50	We are currently below corporate and provincial benchmarks. We aim for 6.5% to continue being below all metrics for this indicator.	

Change Ideas

Change Idea #1 To facilitate weekly Fall Huddles on each unit with the interdisciplinary team

Methods	Process measures	Target for process measure	Comments
Conduct structured weekly interdisciplinary team huddles within each resident home area to review high risk residents’ plan of care, identify fall risks, and implement targeted interventions to prevent falls and fall-related injuries.	Number of weekly Falls Huddles conducted in each unit.	Audit Fall Huddles led by the Falls Lead to ensure 100% completion and consistency of weekly huddles across all units.	

Change Idea #2 To reduce the number of falls in the home by supporting early identification of patterns or contributing factors.			
Methods	Process measures	Target for process measure	Comments
Conduct monthly interdisciplinary Falls Committee reviews during the QI meetings to evaluate each falls incident, identify contributing factors (e.g. triggers, environmental risks, clinical conditions), and ensure timely updates to residents' plan of care. Facilitate appropriate referrals to the MD/NP for medication review, Physiotherapy (PT) for mobility assessment, and other relevant disciplines as needed.	Number of Falls Committee discussions conducted monthly during the QI meetings involving disciplinary stakeholders.	Reduce the number of residents who fall by at least 1 per month as compared to the previous month, demonstrating sustained improvement over time.	

Change Idea #3 To integrate comprehensive falls risk assessment and history review into the admission care conference process.			
Methods	Process measures	Target for process measure	Comments
During the admission care conference, conduct a structured review of the resident's history of falls and any contributing risk factors (e.g., mobility limitations, medications, cognition, environmental risks). Engage residents and families in identifying risk and co-developing individualized prevention strategies.	Number of care conference notes reflect comprehensive discussions with residents and families regarding identified fall risks and planned interventions.	Achieve 100% of residents identified as high risk for falls having documented discussion and intervention planning during admission care conferences within the calendar year.	

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	12.38	10.38	We are currently below corporate and provincial benchmarks. We are aiming for 10.38% to continue being below benchmark.	BSOT, GMHOP, Geriatric Addiction Specialist

Change Ideas

Change Idea #1 To reduce in the number of residents receiving antipsychotic medication without a diagnosis of psychosis.

Methods	Process measures	Target for process measure	Comments
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.	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;	Ensure 1 interdisciplinary meeting is held monthly between the MD, NP, Psychogeriatrician, and nursing team beginning in April 2026. Ensure discussions are being held at quarterly CQI meetings between MD, NP, and nursing team to review residents currently receiving antipsychotics without a diagnosis of psychosis beginning in April 2026.	

Change Idea #2 To develop plans of care, with nonpharmacological approach - identification of triggers and interventions.

Methods	Process measures	Target for process measure	Comments
Conduct monthly interdisciplinary meetings involving the NP, BSO, nursing team, and Recreation Manager to assess residents, identify behavioral and environmental triggers, and implement individualized non-pharmacological interventions.	Number of interdisciplinary meetings conducted involving including NP, BSO, nursing, Pharmacy Consultant, and Recreation. Number of residents identified as benefitting from non-pharmacological interventions.	At least 1 interdisciplinary monthly meeting beginning in April 2026; Achieve minimum 1% reduction in the antipsychotic use among residents without a diagnosis of psychosis by September 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	1.39	1.20	We are currently below corporate and provincial benchmarks. We aim for 6.5% to continue being below all metrics for this indicator.	ET Nurse, Medline FitRight, External wound care specialist

Change Ideas

Change Idea #1 To reduce the percentage of residents who develop new or experience worsening pressure injuries.

Methods	Process measures	Target for process measure	Comments
Conduct regular interdisciplinary reviews of resident status during Quality Meetings, including case-by-case analysis of residents with pressure injuries. This includes review of current plan of care, monitoring of wound progression (healing, stalled, or deteriorating) Identification of gaps and implementation of targeted interventions.	Number of pressure injuries reviewed during Quality Meetings. Number of resolved/healed pressure injuries following interventions	Achieve a 2.17% reduction in worsening pressure injuries by year-end	Structured and consistent case reviews will support early identification of at-risk residents, enhance care planning, and promote timely interventions. This approach is expected to improve wound healing outcomes, prevent deterioration, and strengthen overall quality of care and resident safety.

Change Idea #2 To strengthen interdisciplinary collaboration with the Registered Dietitian to proactively manage residents' nutritional and hydration status and reduce the risk of pressure injuries.

Methods	Process measures	Target for process measure	Comments
Implement a standardized referral process to the Registered Dietitian (RD) for residents identified with poor nutritional and/or hydration status through PCC (PointClickCare). This includes early identification and referral of at-risk residents, comprehensive nutritional and hydration assessments, active collaboration between dietary services and nursing staff and ongoing monitoring and adjustment of care plans, including fluid intake goals.	Number of RD referrals initiated through PCC. Number of pressure injuries resolved/improved. Number of residents meeting established hydration (fluid) goals.	Achieve a 2.17% reduction in the incidence and worsening of pressure injuries by year-end.	Proactive nutritional and hydration management, supported by strong interdisciplinary collaboration, will improve skin integrity and overall resident health. Early intervention and consistent monitoring are expected to reduce the incidence and progression of pressure injuries while enhancing quality of care.

Change Idea #3	To ensure timely identification, documentation, and monitoring of worsening pressure injuries to support early intervention and improved resident outcomes.		
Methods	Process measures	Target for process measure	Comments
Complete the Skin and Wound Tracker within 24 hours of identifying any new or worsening pressure injury. Ensure accurate and consistent documentation aligned with clinical assessment findings.	Number of entries completed in the Skin and Wound Tracker. Concordance between documented entries and reported pressure injuries (accuracy of data).	100% of identified pressure injuries will be documented in the Skin and Wound Tracker within 24 hours. 100% of entries will be audited for accuracy within one week of documentation	Timely and accurate documentation supports early clinical intervention, enhances communication among the interdisciplinary team, and strengthens monitoring and evaluation processes. This will contribute to reducing the progression and complications associated with pressure injuries.