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)	12.86	12.50	The home already exceeds provincial average. goal to improve by 2 %	

Change Ideas

Change Idea #1 To reduce unnecessary hospital transfers, through the use of onsite NP. 2) Build capacity and improve overall clinical assessment skills of registered staff through education supported by NP. 3) During care conferences discuss with families, regarding advanced care planning. 4) Develop an IV program in the home.

Methods	Process measures	Target for process measure	Comments
1) Engagement with the NP through the referrals. 2) Conduct needs assessment from Registered Staff to build Clinical Skills and enhance their daily practice. 3) Provide education for Registered Staff on therapeutic relations. 4) Provide IV education to Registered Staff to enhance their skills.	1) Number of hours of NP worked onsite. 2) Percentage of staff who complete needs assessments. 3) Improve confidence in Registered Staff regarding having open discussion's with families regarding difficult decision's. Number of education sessions and staff attendance. 4) Number of Registered Staff trained in IV therapy/ treatments.	1) Scheduled NP hours fulfilled. 2) 100% of Registered Staff will complete needs assessment. 3) 80% of Registered Staff will be in attendance for education. 4) Educate a minimum of six registered staff on IV therapy.	We continue to strive towards the least amt of ED transfers as possible utilizing the expertise and hands on abilities of our NP.

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	Maintain requirements for staff to receive on hire and annually	

Change Ideas

Change Idea #1 To facilitate ongoing feedback or open door policy with the management team. 2) Cultural assessment on admission, (language, faith, gender preference for care, family roles). 3) To improve overall dialogue of diversity, inclusion, equity and anti-racism in the workplace.

Methods	Process measures	Target for process measure	Comments
1) Provide education during onboarding of new staff and at regularly at staff meetings 2) Complete spiritual care and recreation assessment on admission. 3) Training and/or education through Surge education or live events.	1) # of new employees onboarded who received education. 2) # of new admissions assessed. 3) # of staff educated on culture and diversity.	1) 100% of staff 2) 100% within 14 days of admission 3) Number of staff education on Culture and Diversity.	To help facilitate inclusion in the home

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	82.00	93.00	Achieving corporate benchmark	

Change Ideas

Change Idea #1 Review the Concern process in the home on admission and during annual care conference. 2) Review of the Whistleblower policy. 3) Medical Team, completing wellness checks with residents.

Methods	Process measures	Target for process measure	Comments
1) Policies -Zero tolerance to abuse, and Whistleblower posted in the home. 2) Review concern reporting process with resident and family with admission and care conferences. 3) Medical Team including over all wellness check as part of routine visits.	1) 100% of resident Council meeting will have Residents' Bill of Right #29, added at each monthly review by 100% of Standing Agenda for family Council. 2) Number of care conferences and admissions that include how to report a concern processes during the admission process. 3) Number of concerns identified through Medical Team wellness checks.	1) 100% of all staff and residents and families will have received the education on resident Bill of rights #29. 2) All care conferences and admission will include how to report a concern.	Total Surveys Initiated: 100 Our home will continue to promote resident centered care as much as possible.

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	15.35	15.00	Strive towards being within the corporate benchmark	

Change Ideas

Change Idea #1 1) To reduce the number of falls in the home. 2) During admission process, review with resident and history of falls, and interventions implemented. 3) Injury prevention - review of FRS, ensure appropriate medication prescribed for prevention of bone density loss.

Methods	Process measures	Target for process measure	Comments
1)) Monthly collaboration with the Fall committee, (during Quality meeting), to review the resident's plan of care (identification of the triggers, related to the fall) referrals to MD/NP for medication reviews, PT for physio regiment/programming. 2) Develop/review of the plan of care with families, consider Use of falls, aides to prevent injury, use of hip protectors, floor mats, bed and chair alarms. 3) Resident list of FRS 3 or greater, offer fracture prevention medication.	1)) Number of GAP analysis completed related to falls. 2) # of care plans revised / reviewed. 3) Number of medication changes (additional of fracture prevention medication).	1) Falls QI will be within the target. 2) 100% of admission to the home will have fall assessment completed. 3) 100% of resident with a FRS of 3 or higher will be assessed.	Reduce falls and injuries from falls and ensure documentation for falls is completed.

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	9.94	9.50	Strive to remain within the corporate benchmark	

Change Ideas

Change Idea #1	1) BSO admission process, responsive expressions, the initiating of the DOS to establish baseline, (review the Behavioural assessment, completed team huddle prior to admission), BSO team to co-ordinate review of related antipsychotic medication. 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) Medical Team, NP, wellness checks.

Methods	Process measures	Target for process measure	Comments
1) 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. 2) Quarterly medication review with NP/MD. 3) Health Teaching with family and residents on the risk of use of antipsychotic medication.	1) Number of resident, to which the antipsychotic was decrease, or de-prescribed/discontinued. 2) Number of resident who plan of care has been reviewed. 3) Number of resident/POA/SDM conversations of antipsychotic reduction or elimination held.	1) 100% of residents who are prescribed antipsychotic medications will receive a 3 month review to determine potential for reduction in dosage or discontinuing antipsychotics. 2) 100% of newly admitted residents will have been reviewed for the appropriateness of antipsychotics use; 3) 100% of residents who are prescribed antipsychotic medications will receive a 3 month review to determine potential for reduction in dosage or discontinuing antipsychotics including a conversation with resident/POA/SDM for consent on purposed changes to plan of care.	To remain within the benchmark for 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	2.58	2.00	Striving towards corporate benchmark	

Change Ideas

Change Idea #1	1) Prompt Identification and documentation of worsening pressure injuries. 2) Identification of residents at risk for alteration in skin. 3) Conducting audit of resident surface (bed/w/c), for the appropriate surface for pressure relieving.		
Methods	Process measures	Target for process measure	Comments
1) 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. 2) Develop a list of residents who PURS is 3 or greater, review plan of care, for the appropriate pressure relieving devices, review of surfaces in place. 3) Develop a list of residents with Purse 3 or greater review plan of care, for the appropriate pressure relieving devices, review of surfaces in place.	1) Number of visits in home and virtually by the NSWOC. 2) Number of care plans updated. 3) Number of changes to surfaces.	1) Number of pressure related injuries which have resolved. 2) 100% of resident with PURs 3 or greater, comprehensive assessment completed. 3) percentage of residents with purse of 3 or greater will have a surface review routinely.	To reduce amount of pressure ulcers in the home and remain within the benchmark.