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)	17.44	21.90	Below target. Through implementation of our change ideas, the home expects to sustain or reduce by 2% from the current performance.	NP, BSO, RNAO BP Consultant, MD, Pain and Symptom Management Consultant, Psychogeriatician

Change Ideas

Change Idea #1	To reduce unnecessary hospital transfers, through the use of on-site Nurse practitioner; 2)Use of SBAR -Registered in charge nurse to communicate to physician and NP, a comprehensive resident assessment, to obtain direction prior to initiating an ER transfer 3) 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. 4) Build capacity and improve overall clinical assessment skills of Registered Staff; through education supported by NP 5) Implementation of clinical pathways for UTI, Shortness of Breath and Congestive Heart Failure 6) During care conferences, disussion with resident and families, regarding advance care planning (Resident and Family focused centered care) 7) DOC to review ED tracker, for the common reasons for transfer to ED - review in Nursing practice meetings, to develop strategies to prevent future ED visits 8) Development of IV program in the home 9) Utilization of the PPS Palliative Performance Score to determine disease progression- revision of care plan 10) Education on palliative approach and end of life for staff, residents and families

Methods	Process measures	Target for process measure	Comments

1) NP is in the home 4 days per week 2) Education/re-education to registered staff on the continued use of SBAR tool a standardize communication between clinicians. 3) Educate residents and families about the benefits of and approaches to preventing ED visits. The home's attending NP/MD will review and collaborate with the registered staff on residents who are at high risk for transfer to ED, based on clinical and psychological; develop care plans with early identification signs and treatment plans 4) Conduct needs assessment from Registered Staff to identify clinical skills and assessment that will enhance their daily practice. 4) Nurse Practitioner on site will provide education theoretically and at bedside. 5) Education with registered staff and interdisciplinary team on clinical pathways. Education for PSW/reg. staff on STOP and WATCH 6) Utilization internal hospital tracking tool and analyze each transfer status. ED transfer audit will be completed and reviewed monthly by nursing leadership (DOC, ADOC). Reports will be reviewed at quarterly PAC meetings; and standing agenda in nursing practice meeting 7) Completion of PPS assessment, implementation of use and education for staff, res./families on palliative approach and end of life. 8) Care plan for resident with responsive expression - indication of triggers and interventions	1) Number of NP recurited and hours worked on-site 2) Number of communication process used in the SBAR format, between clinicians per month; number of staff educated. 3) The number of residents whose transfers were a result of family or resident request. Number of staff who demonstrated education application via documentation quarterly. The number of ER transfers averted monthly. Number of transfers to ED who returned within 24 hours; 4) % of staff who complete needs assessments. Completion records for education as a result of needs assessment. 5) Improved confidence and decision making from Registered staff related to clinical assessment. # of education sessions with Registered staff 5) Increased SBAR documentation and improved communication within clinical team 6) Number of IV therapy/treatments completed with in the home	1) 80% of communication between physicians, NP and registered staff will occur in SBAR Format by the end of quarter 4; 2) Continue to sustain below Provincial average by reviewing all process measures in a quarterly basis; 3) 100% Staff education completed.	Utilize Nurse Practitioner, other stake holders such as Mediox, CareRx Pharmacy and 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	100.00	100.00	Through education, the Home expects to have an increase understanding of this criteria over the next 6 months	Surge Education, BSO, Huron County Immigration

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 or live events; 3) To facilitate ongoing feedback or open door policy with the management team; 4) To include Cultural Diversity as part of CQI meetings 5) Develop of Cultural Diversity team with in the home comprised of staff, resident and family members- to assist with develop programs, recognition with the home 6) Creation of culture board, of the cultures of the resident and team members in the home 7) Cultural assessment on admission, (language, faith, gender preference for care, family roles)

Methods	Process measures	Target for process measure	Comments
1) Training and/or education through Surge education or live events; 2) Introduce diversity and inclusion as part of the new employee onboarding process; 3) Celebrate culture and diversity events; educational opportunities 4) Monthly quality meeting standing agenda- review the number of programs, education completed 5) Culturally familiar foods, on the menu (special menu) 6) Ensure correct pronunciation of names	1) Number of staff education on Culture and Diversity; 2) number of new employee trained of Culture and Diversity; 3) Number of Celebration completed in the home	100% of staff educated on topics of Culture and Diversity	1) 80-100% staff 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	88.00	92.00	Target is based on corporate averages. We aim to meet or exceed corporate goals, benchmarks.	Surge Education, Social Worker

Change Ideas

Change Idea #1	1) To increase our goal to 100%. 2)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" 3) Review of the Whistleblower policy 4) Review the Concern process in the home on admission and during annual care conference 5) Social Service Worker completing wellness checks with residents.

Methods	Process measures	Target for process measure	Comments
1) 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; 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 Service worker visits with residents	100% of all department standing agendas will have Residents' Bill of Right #29 added, for review by December 31, 2026 . 100% of all staff will have education via department meetings on Resident Bill of Rights #29 by December 31, 2026. 100% of resident Council meeting will have Residents' Bill of Right #29, added at each monthly review by 100% of Standing Agenda for family by December 31, 2026. Council will have added Resident Bill of Right #29 for review. Review of policies added to the admission process and at care conferences.	100% of all staff and residents and families will have completed the education on resident Bill of Rights #29	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	17.54	15.50	Target is based on corporate averages. We aim to meet or exceed, corporate goal.	RNAO BP Coordinator; PT; NP; Physician, Pharmacist consultant; Family member

Change Ideas

Change Idea #1	1) To facilitate a Weekly Fall Huddles on each unit; with the interdisciplinary team 2) Establishing documentation/charting buddies, (PSW complete documentation with resident's at high risk for falls - assists with the identification/reason for falls 3) To reduce the number of falls in the home 4) Establish/re-establish the restorative care program in the home (provide education on how residents qualifty for the program) 5) Injury prevention - review of FRS, ensure appropriate medication prescribed for prevention of bone density loss 6) Purposeful rounding, for resident at high risk for falls 7) During admission process, review with resident and history of falls, and interventions implemented 8) Collaboration with recreation, to implement recreation activities, to engage residents (analysis to when falls are occurring to develop timing)

Methods	Process measures	Target for process measure	Comments
1) Weekly interdisciplinary team huddles on resident home area to review resident plan of care, to mitigates the risk of falls or injury related to falls; 2) To increase training and/or education of Falls program; 3) Resident list of FRS of 3 or greater, offer fracture prevention medication 4) Education and re-education provided to registered staff on the completion of post fall analysis 5) 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 6) PT/OT referrals as required 7) Interdisciplinary team comprehensive post fall analysis, post resident fall, 9) Use of falls, aides to prevent injury, use of hip protectors, floor mats, bed and chair alarms 11) During shift report review resident high risk for falls, frequent falls, 12) Review of the plan of care with families, 13) Pain assessment, to assess for potential pain/unmanaged pain 15) Delirium screen (potential reason for falls)	1) Number of weekly meeting in each unit; 2) number of staff participants on the weekly falls meeting; 3) number of GAP analysis completed related to falls, 4) Number of medication changes (addition of fracture prevention medication) 5) Number of environmental and pharmacist referrals 6) Number of residents on restorative care program 7) Number of resident who successful discharged from restorative program	100% of staff participation on Falls Weekly huddle in each unit, 100% of staff to complete the required education, 100% of resident who experience a fall will have a comprehensive post fall assessment and huddle completed, 100% of admission to the home will have fall assessment 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	10.98	10.80	Meeting provincial targets therefore improvement aim with in 2 %	NP, MD, Psychogeriatrician, Seniors Mental Health in Huron County

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 pharmacological 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) Gentle Persuasive approaches (GPA) training/education - establish GPA trainers, educators in the home 6) Social worker, NP wellness check 7) BSO admission process, responsive expressions, the initiating of the DOS to establish baseline, (review the Behavioural assessment, completed team huddle prior to admission)

Methods	Process measures	Target for process measure	Comments

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; 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) Monitor of sleep hygiene, (adequate rest) 4) GPA training to be held in the home 5) Pain assessments (PAINAD), identify pain is not trigger for the responsive expressions 6) Utilization of antipsychotic medication tracker (for de-prescribing) 7) Referral to internal and external BSO for comprehensive assessment 8) Implementation of DOS, with change in responsive expressions, analysis of the DOS, with review of plan of care 9) Review/assess the prn use of antipsychotic (medication- indication for use) 10)Quarterly medication review with NP/MD	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; 2) Number of residents prescribed antipsychotics medications over the number of residents who have received a medication review in the last quarter. 3) Number of resident who plan of care has been reviewed 4) Number of staff receive education GPA /number of sessions 5) Number of resident, to which the antipsychotic was decrease, or de-prescribed/discontinued	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. 3) 100% of full time, nursing staff receive GPA training

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	2.83	2.00	Target is based on corporate averages. We aim to meet or exceed corporate goals, benchmarks.	NSWOC, NP, MD, Medline wound consultant; PT/OT

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 to provide in home and virtual consults 3) Conducting audit of resident surface (bed/w/c), for the appropriate surface for pressure releiving 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) Arrange education for Registered staff and PSW, with NSWOC, Medline wound consultant 2) 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 3) Utlization of skin and wound tracking tool, to analysis the pressure related injuries in the home - and the development of plan of care 4) Registered staff to complete wound rounds with the NSWOC to enhance knowledge on wound care management 5) Annual Surge education - Skin and wound care management 6) 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, 7) Referral to PT and OT for reviewing of seating 8) ROHO education, implementation ROHO champion 9) Completion of the Skin and tracker, analysis of the data 10) Use of Remedy prducts for skin care management 11) Wound care lead with in the home 12) Seating assessments 13) 4P's implemented (pain, positioning, personal items, personal needs)	1) Number of Registered staff and PSW who have completed education. 2) Number of changes to surface, 3) Number of pressure related injuries which have resolved 4) Number of visits in home and virutally by the NSWOC 5) Number of care plans updated 6) Number of seating assessment completed	100 % of Registered staff to be educated, 100% of PSW, 100% of resident with PURs 3 or greater, comprehensive assessment completed, 100% of resident with stage 3 or greater will have routine assessment completed by NSWOC. 100% of admissions to the home to have pressure injury assessment completed	

Measure - Dimension: Safe

Indicator #7	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of LTC residents who develop worsening pain	C	Rate per 100 / LTC home residents	Local data collection / Most recent consecutive 12-month period	9.82	9.00	Target is based on corporate averages. We aim to meet or exceed corporate goals, benchmarks.	NP, MD, Pain Management Consultant, NSWOC, PT/PTA

Change Ideas

Change Idea #1 1. Enhancement of the end of life, palliative care program 2) RAI consultant, to provide education to RAI coordinators, on coding requirements for end of life/palliative residents 3) Admission, comprehensive assessment of pain, and how this has been managed previously, and the goal for pain management 4) Consultation with the Pain consultant/ NP/Pharmacist consultant/BSO RPN/PSW/PT/PTA 5) Provide adjacent and non pharmacological interventions in the plan 6) Provide education on the non pharmacological interventions/approaches

Methods	Process measures	Target for process measure	Comments
1. Conduct through assessment of the resident, palliative care, end of care. Completion of PPS score, current medication regiment, involve the interdisciplinary team, family and resident with care planning decisions. 2. Establish palliative care order set 3. Utilization of trackers, for prn use, comprehensive pain assessment completed and review of routine analgesic 4) Palliative care education with staff 5) Resident who trigger for worsening pain will have a comprehensive review completed with MD/NP	1) Number of staff provided education, Pain management 2) Number of care plans revised to pain management 3) Number of referrals completed Pain specialist/consultant 4) Number of medication reviews related with analgesic change	1) 100% of staff complete required education 2) 100% of resident experiencing pain will have comprehensive pain assessment completed	