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)	30.00	25.00	The home has been reviewing the root cause of the ED visits. A new process will be rolled out to ensure new and current Reg staff have the knowledge to further enhance their documentation and communication skills when communicating acute residents' conditions with the interdisciplinary team, thus reducing avoidable ED transfers	Local NLOT NPs

Change Ideas

Change Idea #1 Increase capacity within the Reg.Staff team to accurately and timely communicate to the interdisciplinary team of any acute changes in residents' conditions ,thus avoiding unnecessary ED visits when possible .

Methods	Process measures	Target for process measure	Comments
All registered staff will be educated on the use of the SBAR tool to support standardized communication between clinicians	This process will be measured by the number of staff trained on the SBAR tool.	100 % of all registered staff will be educated on the SBAR tool by June 30/2026	As part of the monthly ED Transfer review the SBAR will be utilized during the Monthly Nursing meeting to review any avoidable ER visits and provide extra education where needed to to Registered staff

Change Idea #2	Building Capacity with the Registered staff in discussion around establishing early and ongoing Goals of Care during admission as well as when changes arise in resident health status .		
Methods	Process measures	Target for process measure	Comments
Conduct an education needs assessment with Registered staff to identify clinical skills and assessments to enhance their daily practice . Review of the ED Tracker to identify the most common reasons for ED Transfers and focus education specific to those areas identified.	The number of educational sessions completed . The homes educator , Nursing Management Team , and Nurse Practitioners will work in collaboration to set up educational venue and content .	100% of Registered staff will be educated on the clinical topics identified by the team reviewing the Reasons for ED visits by June 30,2026	Other Stakeholders involved will be Care RX, NLOT NP, Medical Director, In-House Physicians, and clinical consultant

Change Idea #3	Review of the ED Tracker by the DOC / ADOC and interdisciplinary team to determine common reasons for transfer to the ED and intervention to prevent unnecessary ED visits		
Methods	Process measures	Target for process measure	Comments
Monthly review of the Internal Hospital Tracking tool to analyze each transfer status . ED transfer audit will be completed and reviewed monthly by the nursing leadership and interdisciplinary team. ED reports will be reviewed quarterly at the PAC meetings and Nursing meetings	Number of monthly ED tracker review meetings held in the year	100 % of the planned monthly ED tracker review meetings (12) will be carried out. Target date March 31/27.	

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	70.00	100.00	Our target is 100% as this is part of our mandatory annual education process	Mohawk and Algonquin Communities

Change Ideas

Change Idea #1 Complete Equity , Diversity , Inclusion and anti-racism training for staff through SURGE education and live training .

Methods	Process measures	Target for process measure	Comments
Continue with annual SURGE Education . Roll out of annual live events on equity , diversity , inclusion and anti-racism	The number of staff trained in relevant equity, diversity, inclusion, and anti-racism education through Surge Learning and Live events.	100% existing and new staff will be educated on the topics of equity, diversity, inclusion, and anti-racism by December 31/26	The home has already implemented cultural specific events within the monthly program calendar and included staff and residents within the events . The intent is to expand on the events in the future

Change Idea #2	Promote knowledge and understanding of the home's staff on equity, diversity, inclusion, and anti-racism by providing open forums for discussion and dialogue		
Methods	Process measures	Target for process measure	Comments
Include equity , diversity , inclusion and anti-racism as part of the home's departmental committees standing agendas. The goal is to maintain consistent forum to review applicable topics , thus increasing the understanding and knowledge of the staff.	The number of monthly committee meetings that include one of the following topics: equity, diversity , inclusion, and anti-racism.	100% of the home's committees will include the following topics on their monthly agenda: equity, diversity, inclusion, and anti-racism. Target date March 31/27.	Departmental leads to ensure these topics are covered at each meeting

Change Idea #3	The home will explore opportunities to partner with external stakeholders to assist staff education on equity, diversity, inclusion, and anti-racism.		
Methods	Process measures	Target for process measure	Comments
The home will develop partnerships with community-based organizations focusing on equity, diversity, inclusion, and anti-racism. The objective is to increase resources available and the inclusion of subject matter experts to strengthen the home's education program with lived experiences.	The home will hold 2 events in the year on one of the following topics: equity, diversity, inclusion, and anti-racism.	100% completion of the bi-annual events on one of the following topics: equity, diversity, inclusion, and anti-racism will be held by March 31/27.	

Safety

Measure - Dimension: Safe

Indicator #3	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	19.54	17.50	The home has experienced an improvement over the past year. Current practices will continue to lead to home perform below the provincial average.	

Change Ideas

Change Idea #1 Complete Weekly Fall Huddles for each Unit with the interdisciplinary team .

Methods	Process measures	Target for process measure	Comments
Complete a weekly huddle with unit staff regarding ideas to help prevent risk of falls or injury related to falls	Number of weekly falls huddles per unit per month	Total number of weekly falls huddles held per month. Target date: March 31/27	

Change Idea #2 In collaboration with the Falls committee , the Falls Lead and interdisciplinary team, , residents who are at high risk of falls will be reviewed monthly and strategies and action plans will be created and ongoingly enhanced to reduce falls risks .

Methods	Process measures	Target for process measure	Comments
Completion of the Monthly Clinical Falls review meetings	The number of completed Monthly Clinical Falls review meetings in the year	100% completion of all clinical falls review meetings by March 31/27	

Change Idea #3 Relaunch of Purposeful Rounding for residents at medium or high risk for falls

Methods	Process measures	Target for process measure	Comments
Educate all staff on purposeful rounding . The home will ensure that residents who are determined to be at medium and high risk for falls their plan of care will include the purposeful rounding	The number of staff educated on Purposeful Rounding and the number of residents whose care plans include purposeful rounding	100% of all nursing staff are educated on purposeful rounding by June 30/26	

Measure - Dimension: Safe

Indicator #4	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	11.02	11.00	The home has a process that has been able to reduce the use of antipsychotics without a diagnosis of Psychosis. Currently, we are below the provincial average.	

Change Ideas

Change Idea #1 The MD , NP, BSO internal and External members will review all residents with responsive behaviors .			
Methods	Process measures	Target for process measure	Comments
Monthly Collaborative Care team meetings are held with the interdisciplinary team to focus on Antipsychotic use and interventions for the reduction / tapering of antipsychotic medication usage . Review dada during quality meetings and PAC meetings	The number of meetings held monthly by the interdisciplinary team to review the antipsychotic usage	100% of residents on antipsychotics without a diagnosis of psychosis will be assessed	The interdisciplinary team are currently seeing a slight rising trend when new admissions are received and have been successful in reducing the target

Change Idea #2 The residents who are prescribed antipsychotics for the purpose of managing Responsive Behaviors will have a routine review			
Methods	Process measures	Target for process measure	Comments
The BSO lead and nursing team will ensure that residents who receive antipsychotics for responsive expressions will have their medications , plan of care reviewed at minimum quarterly by the interdisciplinary team	Number of residents on Antipsychotic medications whose care plan have been reviewed on a quarterly basis	100% of residents on Antipsychotic medications will have their care plan reviewed quarterly by April 30.2026	

Change Idea #3 Development of plans of care with non pharmacological approach, identification of triggers and interventions .			
Methods	Process measures	Target for process measure	Comments
Review of plan of care for all residents for non-pharmacological approaches , and triggers leading to personal expressions	The number of residents whose plan of care have been reviewed for both non-pharmacological and trigger interventions	100% of residents on Antipsychotics will have their care plans reviewed for non-pharmacological approaches by June 30, 2026	The home is in the process of enhancing their Responsive Expression program including reviewing educational needs for Non- Pharmacological approaches

Measure - Dimension: Safe

Indicator #5	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	3.72	2.00	The home has seen a gradual improvement over the past year in our management of worsened stage 2-3 skin ulcer.	

Change Ideas

Change Idea #1 Ensure that all inhouse staff and new employees are educated on the Skin and Wound program including wound care management , assessment and skin care .

Methods	Process measures	Target for process measure	Comments
DOC and Wound Care Champion to arrange for education for Registered staff and PSWs with products and the wound care program .	Number of Registered staff and PSW educated on the wound care management, assessment, and skin care.	100% of Nursing staff will be educated on wound care management, assessment, and skin care by September 30/26.	The current trends in the home are indicating the processes as working to reduce the worsening of wounds .

Change Idea #2 Monthly Review in the Quality Meeting of residents with pressure-related wounds			
Methods	Process measures	Target for process measure	Comments
Utilization of the Skin and Wound tracking tools to analyze pressure-related injuries in the home and development of the plan of care, determine trends, and appropriate prescribed wound and skin products	Number of monthly reviews of all pressure-related wounds in the home.	100% of monthly reviews of all pressure-related wounds in the home will be held by March 31/27	

Change Idea #3 Referral for wounds to the Skin and Wound Champion as well as outside resources for inhome consults			
Methods	Process measures	Target for process measure	Comments
Refer to NLOT for wounds that fail to heal within 4-6 weeks after appropriate basic measures are not meeting the optimal healing process	Number of referrals submitted to the NLOT (NSWOC) per month	100% of the wounds that fail to heal within 4-6 weeks after the appropriate basic measures are not meeting the optimal healing process will be referred to NLOT for further assessment. Target date March 31/27	The home is currently working with the clinical consultant to re-launch the Skin and Wound program to improve resident outcomes.

Measure - Dimension: Safe

Indicator #6	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	1.53	1.53	The home has been following the Least Restraint policy at this time and will continue to do so . The home continues to work collaboratively with the POA to explore alternatives to daily restraints .	

Change Ideas

Change Idea #1 The home will continue to provide information to families and residents on least-restraint policies and alternatives to assist families in making informed decisions regarding the use of restraints vs alternatives

Methods	Process measures	Target for process measure	Comments
1) Provide a restraint prevention and the use of alternatives to new admissions, care conferences, and during tours 2) Meeting with resident and family councils to provide education throughout the year on Least Restraints and risks associated with Restraints and alternatives.	Number of new admissions, care conferences, and tours where the least-restraint policy and alternatives are reviewed with SDMs and residents as appropriate.	100% of new admissions, care conferences, and tours where the least-restraint policy and alternatives will be reviewed with SDMs and residents as appropriate. Target date: March 31/27.	