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.	O	Rate per 100 residents / LTC home residents	CIHI CCRS, CIHI NACRS / Oct 1, 2023, to Sep 30, 2024 (Q3 to the end of the following Q2)	28.46	27.90	To decrease the rate of ED visits by applying continuous improvement of quality of care and maximizing engagement of stakeholders.	

Change Ideas

Change Idea #1 Adopt a data driven decision making for continuous quality improvement approach to decrease the number of ED transfers in the home.

Methods	Process measures	Target for process measure	Comments
Document goals of care in the residents' profile in PCC on admission and as needed. 2. Utilize clinical triage algorithm to determine need for ED transfer. 3. Utilize SBAR tool to communicate and assess resident status to determine ED transfer. 4. Utilize preview ED for early identification of changes in residents' health status. 5. Maximize use of point of care blood testing to minimize unnecessary transfers. 6. Maximize use of SCOPE program at THP to minimize ED transfer when appropriate. 7. Bi-weekly review of all ED transfer to identify opportunities for improvement	100% of residents will have a documented advance care directive goal which include ED transfer preference in their plan of care 2. All ED transfers will be evaluated to identify the effectiveness of existing tools and resources on a monthly basis at the CQI committee meeting to address OFI.	To decrease the rate of ED visits by applying continuous improvement of quality of care and maximizing engagement of stakeholders.	Ensure residents and families are provided with information regarding advance care directives and documented in plan 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		70.00	To promote DEIAR into everything we do	

Change Ideas

Change Idea #1 Promote diversity and culturally appropriate programs in the home

Methods	Process measures	Target for process measure	Comments
. Implement at least three (3) culturally specific programs 2. Development and implement cultural menu to reflect the diversity of residents served in collaboration with our Dietary and Programs Department.	Two completed culturally specific program delivered by programs team by March 31st,2026 2. Codesign and approve cultural menu by residents' council		

Change Idea #2 Percentage of staff and management team who have completed relevant equity, diversity, inclusion, and anti-racism education

Methods	Process measures	Target for process measure	Comments
Develop strategy to increase awareness about DEIAR	Promote knowledge development through annual DEIAR assigned education 2. Engage staff on culturally specific programs to celebrate the diversity of the home. 3. Assess the perception of inclusivity in the home through the staff engagement survey.	85% of staff will complete DEI education by March 31st 2026 2. 100 % of Board Members and SLT will complete DEI education by March 31st 2026 3. Conduct Staff engagement survey by August 31, 2025	

Experience

Measure - Dimension: Patient-centred

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of residents responding positively to: "What number would you use to rate how well the staff listen to you?"	O	% / LTC home residents	In house data, NHCAHPS survey / Most recent consecutive 12-month period		65.00	Enhancing resident quality of life and satisfaction through the provision of resident centered care to create an environment where everyone feels heard and work towards positive outcomes while promoting transparency and openness.	

Change Ideas

Change Idea #1 Promote the PCH social model of care and address residents feedback from the 2024 satisfaction survey

Methods	Process measures	Target for process measure	Comments
Execute the 2024 survey satisfaction action plan to address residents and family feedback. 2. Conduct the annual resident satisfaction survey by November 2025 in collaboration with resident and family councils 3. Review survey results, develop and implement action plan with input from families and residents	Establish resident engagement committee by June 2025 2. 100% of Lets connect feedback cards received and actions plan created monthly 3.. 100% of residents council meeting are attended by the social services worker (when invitation is granted) 4. 100% of complaints received are reviewed and addressed within 10 business days	65% Percentage of residents responding positively to: "What number would you use to rate how well the staff listen to you?" by March 31st 2026.	we are confident we will achieve this measure

Measure - Dimension: Patient-centred

Indicator #4	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		65.00	Enhancing resident quality of life and satisfaction through the provision of resident centered care to create an environment where everyone feels heard and work towards positive outcomes while promoting transparency and openness	

Change Ideas

Change Idea #1 Enhancing resident quality of life and satisfaction through the provision of resident centered care to create an environment where everyone feels heard and work towards positive outcomes while promoting transparency and openness.

Methods	Process measures	Target for process measure	Comments
Promote the PCH social model of care and address residents feedback from the 2024 satisfaction survey	. Execute the 2024 survey satisfaction action plan to address residents and family feedback. 2. Conduct the annual resident satisfaction survey by November 2025 in collaboration with resident and family councils 3. Review survey results, develop and implement action plan with input from families and residents	100% of 2024 action plan initiative will be completed by September 30, 2025. 2. Roll out and achieve a 50% participation of eligible residents and families with 65% indicating that they can express their opinion without fear of consequences? 3. 65% of survey participant will indicate that they are satisfy or very satisfy with the overall service received in the home.	

Safety

Measure - Dimension: Safe

Indicator #5	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 Sep 30, 2024 (Q2), as target quarter of rolling 4-quarter average	13.13	12.50	Reduce the falls rate among residents by 5% over the next 12 months	

Change Ideas

Change Idea #1 Implement a falling star program to identify residents that are in very high risk and provide fall prevention interventions.

Methods	Process measures	Target for process measure	Comments
Develop and implement "A falling star program"? by July 2026 2. Provide falls prevention education to all staff as part of the roll out of "A falling start program"? by July 2026 3. ?Continuous monitoring of falls rate and the effectiveness of the fall prevention initiatives through the monthly Falls Prevention Committee. ? 4. Develop falls prevention plan for all residents identified through the program	. Reduce falls rate by 5% by March 31st 2026 2. Achieve 70% education by July 31st 2025 and 100% by March 3, 2026 3. 100% of falls incidents will be reviewed and develop an action plan on a regular basis by the fall lead 4. Continuous monitoring of fall prevention plan of care to evaluate efficacy of interventions on a bi-weekly basis.	To reduce falls y 5% by March 31st, 2026	

Measure - Dimension: Safe

Indicator #6	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 Sep 30, 2024 (Q2), as target quarter of rolling 4-quarter average	20.38	19.50	Reduce the use of antipsychotic without diagnosis by 5% over the next 12 months	

Change Ideas

Change Idea #1 Review and reduce antipsychotic use of medication without a proper diagnosis through an Antipsychotic Surveillance Program

Methods	Process measures	Target for process measure	Comments
Develop and implement the Antipsychotic Surveillance Program ? 2. Establish a quarterly audit of residents' plan of care in which Antipsychotic is been prescribed. ? 3. Monthly review of residents' clinical records to identify those who are receiving antipsychotics without a diagnosis and liaise with MRPs to reassess. ? 4. Provide delirium education to help identify core symptoms and help identify potential causes.	Reduce antipsychotic use without diagnosis by 5% by March 31, 2025 ? 2. Implement Antipsychotic Surveillance Program by August 31, 2025. ? 3. Achieve 70% delirium education by March 31, 2026?	Reduce the use of antipsychotic without diagnosis by 5% over the next 12 months	