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)	26.27	25.00	The Home will be working on Percentage Improvement with the goal to improve by 5% each year. Working toward meeting the Provincial Average	

Change Ideas

Change Idea #1 Track and identify residents who are deemed at high risk for avoidable ED transfer for residents with DNR/Do not transfer Advance directives

Methods	Process measures	Target for process measure	Comments
Document goals of care in the resident profiles on PCC on admission and in every change in condition	Percentage of residents will have a documented advance care directive goal which include ED transfer preference in their PCC profile	100% of residents will have documented Advance Care Directive in their PCC profile	Information will be provided to resident and families at the admission and during care conferences

Change Idea #2 Implement a structured education initiative for registered staff, residents, and families on advance directives, with specific emphasis on ED transfer decision-making, to ensure every resident has a documented and up-to-date advance care plan.

Methods	Process measures	Target for process measure	Comments
Develop or update educational materials on advance directives and ED transfer decision-making. Provide education sessions for registered staff (RNs/RPNs) during staff meetings or in-service training. Offer information sessions or resources for residents and families. Incorporate advance care planning discussions into admission, quarterly reviews, and significant change assessments. Audit current documentation to identify residents without completed ACPs. Create a tracking tool to monitor ACP completion rates.	% of residents with a completed and documented advance care plan (including ED transfer direction) % of registered staff who completed ACP/ED transfer education % of new admissions with ACP discussion completed within 30 days.	100% of residents with a completed and documented advance care plan (including ED transfer direction) 80% of registered staff who completed ACP/ED transfer education 100% of new admissions with ACP discussion completed within 30 days.	

Change Idea #3 Implement the use of a point-of-care urine analyzer, supported by standardized assessment protocols and antibiotic stewardship education, to improve early identification and appropriate management of suspected UTIs and reduce avoidable ED transfers.

Methods	Process measures	Target for process measure	Comments
Purchase and implement a validated point-of-care urine analyzer. Develop a protocol outlining when urine testing is clinically indicated (based on symptoms, not screening). Educate registered staff on: Appropriate UTI assessment criteria Proper urine collection techniques Interpretation of urine analyzer results Antibiotic stewardship principles Align prescribing practices with evidence-based UTI guidelines. Incorporate SBAR communication for physician/nurse practitioner notification. Track UTI-related ED transfers before and after implementation. Conduct monthly audits of urine testing and antibiotic prescribing patterns.	% of suspected UTIs assessed using standardized criteria prior to urine testing. % of urine tests meeting clinical indication criteria. % of staff trained on urine analyzer use. % of antibiotic prescriptions aligned with UTI protocol.	100% of suspected UTIs assessed using standardized criteria prior to urine testing. 80% of urine tests meeting clinical indication criteria. 100% of staff trained on urine analyzer use. 80% of antibiotic prescriptions aligned with UTI protocol.	

Change Idea #4 To reduce emergency department (ED) transfers from the home by fully utilizing an internal medicine virtual consult team to provide timely provider access and clinical decision support.

Methods	Process measures	Target for process measure	Comments
a) Establish and implement clear criteria outlining when staff must contact the Virtual Internal Medicine Consult Team prior to initiating an Emergency Department (ED) transfer, except in true medical emergencies b) Provide education and training to registered staff on how to access the virtual consult service, appropriate inclusion criteria for consults and required documentation procedures. c) Monitor and review data monthly to track utilization of the virtual consult service and determine the number of potential ED transfers prevented following consultation.	a) Percentage of non-urgent ED transfers where the Virtual Internal Medicine Consult Team was contacted prior to transfer. b) Number of virtual consults completed each month. c) Number of unavoidable ED transfers prevented following virtual consultation. d) Number of registered staff trained on how to initiate a virtual internal medicine consult by February 2027.	a) 80- 90 % of non-emergent ED transfer decisions will involve consultation with the Virtual Internal Medicine Consult Team. b) Increase utilization of the virtual consult service compared with baseline. c) Demonstrate a reduction in avoidable ED transfers compared with the previous year d) 80% of registered staff will be trained on how to initiate a virtual internal medicine consult by February 2027.	

Experience

Measure - Dimension: Patient-centred

Indicator #2	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	90.00	94.00	The home strives to ensure that residents feel they can share any type of feedback without fear of reprisal/consequences. Currently 90% satisfaction rate and will strive to maintain and/or improve by 4%	

Change Ideas

Change Idea #1 Implement monthly structured Resident Forums where residents can safely raise concerns, provide feedback, and suggest improvements, with documented follow-up and visible action tracking.

Methods	Process measures	Target for process measure	Comments
Re-introduce confidential and anonymous feedback options by utilizing the "Let's connect program"	# of completed "Let's Connect" form received in paper and electronically monthly % of concerns documented and resolved within 10 business days	completed form tracked and trended and shared to the Resident and Family council monthly 100% of concerns documented and resolved within 10 business days	Total Surveys Initiated: 100

Change Idea #2 Implement weekly leadership walkabouts where managers, ADOC and DOC speak directly with residents using structured questions

Methods	Process measures	Target for process measure	Comments
Track all resident concerns and publicly communicate resolutions through: committee meetings, newsletters, resident and family council meetings	total number of concerns received weekly with corrective actions within 10 business	100% of concerns received will have corrective actions within 10 business days	

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	13.36	12.70	The home current performance is below Provincial average but will continue to strive to lower the percentage	

Change Ideas

Change Idea #1 Expand the implementation of the Falling star program to identify residents that are very high risk and develop fall prevention strategies on all resident home areas.

Methods	Process measures	Target for process measure	Comments
Roll out Falling star program by July 2026	Number of residents identified that are very high risk for falls with fall prevention strategies in their plan of care	100% of residents identified will have fall prevention strategies in their plan of care	

Change Idea #2 Registered staff will screen all newly admitted identifying those at risk for falls and their fall risk factors

Methods	Process measures	Target for process measure	Comments
Complete RNAO Clinical Pathways N Adv - Admission Assessment and Falls Risk Screening, Assessment and Management	% of resident who have completed Admission assessment and falls risk screening, assessment and management.	100% of newly admitted residents must have completed Admission assessment and management	

Change Idea #3 The home will sustain strategies aimed at preventing falls and reducing injuries from falls by providing education/training of staff annually and upon hire

Methods	Process measures	Target for process measure	Comments
Staff to receive training on falls prevention and management annually and upon hire	Total number of staff received training/education on falls prevention and management annually and upon hire	100% of staff trained or received education on falls prevention and management annually upon hire	

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	14.20	13.50	The home's current performance is below Provincial Average but will continue to reduce the use of antipsychotic without diagnosis by 5% in the next 12 months	

Change Ideas

Change Idea #1 Establish a multidisciplinary team led by the BSO Lead, and include Medical Director, Attending Physician, NP, DOC, ADOC, Rai Coordinators and Pharmacist. Review and map current process for prescribing and monitoring antipsychotic use, including triggers, assessments and follow-up.

Methods	Process measures	Target for process measure	Comments
Analyze baseline antipsychotic usage rates be reviewing Inter-RAI data, pharmacy reports and clinical notes	Identify residents receiving antipsychotic medication without approved diagnosis	Total number of residents receiving antipsychotic medication without approved diagnosis	

Change Idea #2 The home will conduct comprehensive reviews of all residents receiving antipsychotics. Validate diagnoses and reassess the necessity of ongoing use. Identify residents suitable for gradual dose reduction

Methods	Process measures	Target for process measure	Comments
Utilize non-pharmacological interventions for responsive behaviour. Utilize BSO Lead expertise and community support to implement behaviour management strategies.	Pharmacy utilization reports. Monitor monthly antipsychotic dispensing rates and trends. Review dose reduction attempts success rates	Increase the use of non-pharmacological approach by 20%. Achieve 75% compliance with gradual dose reduction attempts.	

Change Idea #3 Improve the proactive review and appropriate reduction of antipsychotic medications by establishing a standardized process that supports regular assessment of residents for potential dose reduction.

Methods	Process measures	Target for process measure	Comments
a) Develop and implement a weekly flow algorithm for staff to follow when reviewing residents prescribed antipsychotic medications. b) Include key clinical and situational criteria within the algorithm (e.g., absence of recent falls, absence of behavioural symptoms such as calling out, stable clinical status, wheelchair-bound status where appropriate, and family support for dose reduction). c) Enable nursing staff to identify residents who may be appropriate candidates for a trial dose reduction and escalate these for physician review. d) Provide staff education on the use of the algorithm to promote confidence and consistency in identifying residents suitable for reduction trials.	a) Completion and distribution of a standardized weekly antipsychotic review algorithm for staff use. b) Documentation of family discussion or support regarding potential dose reduction. Percentage of residents prescribed antipsychotics who are reviewed weekly using the algorithm. Documentation rate of algorithm criteria (e.g., falls, behavioural symptoms such as calling out, mobility status, family support for reduction). c) Number and percentage of residents identified by staff as potential candidates for antipsychotic dose reduction. Number of recommendations for dose reduction communicated to the physician. d) Percentage of nursing staff trained on the use of the algorithm.	a) Algorithm developed and implemented within the unit by June 1st 2026 b) 80% of residents identified for reduction have documented family discussion when appropriate. 90% completion of required documentation fields during weekly reviews. 90% of residents on antipsychotics reviewed weekly. c) 100% of residents meeting algorithm criteria flagged for physician review. d) 90% of nursing staff trained within the first month of implementation.	