

## 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)	27.02	25.02	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 Develop a standardized process for tracking, analyzing, and trending potentially avoidable ED transfers.

Methods	Process measures	Target for process measure	Comments
-Mandatory documentation of all ED transfers within 24 hours in the electronic tracking system. -Conduct a structured interdisciplinary huddle within 7 days of post transfer review. - Generate monthly trending and analysis report on avoidable ED transfers.	- 100% of registered staff will be trained on how to accurately utilize and document Hospital Tracking in Point Click Care. - The interdisciplinary team will review all ED transfers to identify the gaps, educational needs, and policy changes/updates if needed. -The interdisciplinary team will run a monthly hospital tracking report from PCC that will identify trending and analysis stats/data such as repeat ED transfers, resident home area, time of day and diagnosis.	- Decrease the homes ED visits by 7.40% by February 2027 - The home will continue to utilize allied health staff, registered staff, and external stakeholders to decrease the rate of the homes ED visits	

**Change Idea #2** To improve early detection and on-site management of acute clinical changes through expanded use of Point-of-Care (POC) testing, including Hemocue hemoglobin testing, thereby reducing potentially avoidable Emergency Department (ED) transfers.

Methods	Process measures	Target for process measure	Comments
- Develop written guidelines outlining when POC/Hemocue testing should be performed. Provide hands-on training sessions on device operation, quality control procedures, and interpretation of results. -Analyze correlation between POC testing and reduction in avoidable ED transfers and the findings will be brought forward to Quality Council.	- 10% of registered staff will be trained in Point of care and Hemocue testing by February 2027. -Conduct monthly audits of compliance with testing criteria and documentation completeness when utilizing POCT and Hemocue by February 2027.	To decrease the rate of ED visits by utilizing POCT and Hemocue.	

**Change Idea #3** 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.	

## 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	80.00	80.00	Achieving a high completion rate strengthens staff awareness, reduces the risk of bias and discrimination, and enhances culturally competent care. Ongoing education in EDI and anti-racism also supports improved communication, teamwork, and decision-making, ultimately contributing to better resident outcomes and alignment with regulatory and organizational quality standards.	

### Change Ideas

**Change Idea #1** Strengthen organizational capacity to provide equitable and inclusive care by increasing staff knowledge and awareness of equity, diversity, inclusion (EDI), and antiracism principles through completion of relevant education.

Methods	Process measures	Target for process measure	Comments
a. Identify and implement approved EDI and antiracism training modules appropriate for all staff. b. Integrate EDI and antiracism education into staff orientation and annual mandatory education requirements. c. Track staff completion of training through the organization's learning management system or internal education records.	Percentage of designated staff who have completed approved equity, diversity, inclusion, and antiracism education.	90% of designated staff complete EDI and antiracism education within the reporting year.	

**Change Idea #2** Promote an inclusive and culturally safe environment by increasing staff engagement and participation in related events or therapeutic learning sessions.

Methods	Process measures	Target for process measure	Comments
a. Organize EDI-focused events such as workshops, guest speaker sessions, reflective practice discussions, or cultural awareness activities. b. Offer therapeutic or reflective sessions that allow staff to discuss experiences, biases, and strategies for culturally safe care. c. Collaborate with internal leaders or external experts to facilitate educational or experiential sessions. d. Schedule events throughout the year to maximize staff participation across shifts and departments.	a Percentage of designated staff who have completed approved equity, diversity, inclusion, and antiracism education. b. Number of EDI- and antiracism-focused events or therapeutic learning sessions (e.g., workshops, reflective practice sessions, cultural awareness activities) offered to staff annually. c. Percentage of staff who participate in at least one EDI or antiracism event or therapeutic session during the reporting period	80% of designated staff complete EDI and antiracism education within the reporting year. At least 2–4 EDI-related events or therapeutic learning sessions offered annually. 70% of staff participate in at least one event or therapeutic session per year.	

## 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	91.00	80.00	Achieving and sustaining a high positive response rate will enhance resident experience, strengthen relationships between staff and residents, and contribute to improved care outcomes by ensuring that resident voices are heard and acted upon	

### Change Ideas

Change Idea #1 To increase residents', experience that staff actively listen to their concerns, preferences, and feedback.

Methods	Process measures	Target for process measure	Comments
<ul style="list-style-type: none"> <li>- Implementing "listening circles" as part of recreation program QI initiative to gather resident feedback about their preferences, choices and recommendation. This will be ongoing.</li> <li>- Conduct interdisciplinary team rounds focusing on communication and engagement.</li> </ul>	<ul style="list-style-type: none"> <li>- Implement listening circle tracking form by June 2026. This tracking form includes the following questions: what is going well, what is not working, and what would you like to see more of.</li> <li>- Percentage of scheduled interdisciplinary rounds completed.</li> </ul>	75% of residents will respond positively to "What number would you use to rate how well the staff listen to you?"	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 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	17.66	16.00	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** To reduce the percentage of residents without psychosis who receive antipsychotic medications by promoting appropriate prescribing, non-pharmacological interventions, and regular medication review.

Methods	Process measures	Target for process measure	Comments
- Initiate DOS during the 7-day assessment period to capture symptoms of psychosis ie. hallucinations and delusions. - The interdisciplinary team will continue to apply the antipsychotic deprescribing algorithm on a quarterly basis to review and optimize resident medication regimens. - To monitor, evaluate, and optimize antipsychotic use in LTC residents, ensuring appropriate prescribing, reducing unnecessary medication, and promoting resident safety and quality of care monthly.	- To reduce inappropriate use of antipsychotics without diagnosis by 5% by March 2027. - Identify residents who are prescribed antipsychotics without a documented diagnosis of psychosis and develop a deprescribing plan. - Monitor resident behavior and clinical status frequently, especially during dose reductions, and track changes in behaviors and adverse effects.	Reduce the use of antipsychotics without diagnosis by 5% by March 2027.	

**Change Idea #2** To ensure all resident behaviors are accurately documented, preventing the assumption that repeated behaviors are “normal” and promoting timely, individualized interventions

Methods	Process measures	Target for process measure	Comments
- Train staff on the importance of documenting all behaviors, even if they are frequent or familiar. - Staff to implement a standardized tracking tool when a new, worsening, or as needed behaviors are demonstrated. - Link documented behaviors directly to care plan interventions, non-pharmacological strategies.	- All staff will be trained on how to document and report behaviors even if they are frequent and familiar. - Percentage of new, worsening, or as-needed behaviors that are documented using the standardized tracking tool at the point of care. - Percentage of documented behaviors that are reviewed and linked to corresponding care plan interventions and non-pharmacological strategies.	80% of staff will be trained to ensure competency in documenting behaviors consistently to prevent normalization to ensure the residents are obtaining the appropriate interventions.	

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
<p>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.</p>	<p>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.</p>	<p>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.</p>	

**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	3.14	2.00	Achieving this target will contribute to reducing the incidence and severity of skin breakdown, improving healing outcomes, and supporting continuous quality improvement efforts aligned with best practices and regulatory expectations	

**Change Ideas**

Change Idea #1 Implementation of a new skin and wound tracking tool to measure type, severity, healing progress, and trends of wounds.

Methods	Process measures	Target for process measure	Comments
-Provide education to all registered staff on how to input data in the new skin and wound tracking tool. - Ensure there is consistent and accurate documentation in the skin and wound tracker by conducting weekly audits.	- The number of education sessions held for registered staff on the skin and wound tracker - The number of skin and wound tracking tools reviewed on monthly basis for trends and analysis - Trends and analysis report will be reviewed in the quality meetings to measure the impact of interventions over time.	- 100% of registered staff will be educated on the skin and wound tracker. - The skin and wound ADOC and the staff development coordinator will educate 100% of staff on prevention strategies on skin and wound care. - 100% of staff will receive education on skin and wound management policies.	

Change Idea #2 To improve early identification and prevention of skin breakdown by ensuring consistent use of the PURS (Pressure Ulcer Risk Scale) tool and aligning care plan interventions with residents' risk levels.

Methods	Process measures	Target for process measure	Comments
<p>a) Provide education and refresher training to staff on the appropriate use and interpretation of the PURS tool to identify residents at risk for skin breakdown. b) Ensure the interdisciplinary team reviews resident care plans to confirm that prevention and treatment interventions align with the resident's PURS score. Reviews will occur quarterly, annually, with any change in condition, and as needed. c) Monitor and analyze trends in skin integrity outcomes to identify areas for improvement and adjust prevention strategies accordingly. d) Continue to maintain the monthly Skin and Wound Committee, which will review, monitor, and track all skin conditions and wounds to support early identification of concerns and prevent deterioration of existing wounds.</p>	<p>a) Percentage of residents with a completed and up-to-date PURS assessment. b) Percentage of care plans aligned with the resident's PURS score and risk level. c) Number and severity of new or worsening pressure injuries. d) Number of skin issues reviewed by the Skin and Wound Committee and follow-up actions implemented. e) Number of staff educated on using the PURS tool.</p>	<p>a) 100% of residents will have a current PURS assessment completed and documented. b) 100% of residents identified as high risk will have appropriate prevention interventions documented in their care plan. c) Reduction in new or worsening pressure injuries compared with the previous year. d) Quarterly care plan audits will be conducted to ensure interventions implemented to ensure interventions implemented are effective on admission, change in status, and as needed. K15 e) 100% of Registered staff to be educated on the importance of the PURS assessment and score by May 2026. O11</p>	<p>Data will be reviewed monthly by the Skin and Wound Committee and reported to leadership and the Quality Committee. Quarterly trend analysis will be conducted to evaluate progress and guide improvement strategies.</p>

Change Idea #3 Improve Resident safety by increasing family understanding of the multifactorial causes of wound development, including the impact of overall medical decline and reduced intake/nutrition.

Methods	Process measures	Target for process measure	Comments
a) Provide education and support to families regarding factors contributing to wound development. b) Facilitate care conferences with the physician to discuss the resident's overall condition and care plan. d) Promote interdisciplinary collaboration to ensure consistent messaging and support for families.	a) Percentage of families of residents with wounds who receive education on factors contributing to wound development b) Percentage of residents with complex wounds who have a care conference scheduled with the physician and or care team. c) Frequency of interdisciplinary team discussions regarding residents with wounds (e.g., during care conferences, rounds, or team meetings).	a) 70% of families receive education or resource information on factors contributing to wound development b) 80% of identified residents have a care conference within 14 days of concern escalation c) Residents with wounds reviewed at least monthly in interdisciplinary meetings.	