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)	15.25	15.25	The home has steadily been in the position to maintain avoidable ED visit below the provincial average. For 2025-2026 the home will continue to follow the same change ideas to ensure target is maintained.	Canadian Nurse Practitioner, Skin and wound care specialist, Pain and symptom management consultant, Resident and Family Council

Change Ideas

Change Idea #1 Maintain current avoidable ED visit target by utilizing the onsite NP and other external collaborators and the clinical consultant and Director of Care

Methods	Process measures	Target for process measure	Comments
Nursing team to alert the Nurse practitioner and other external collaborators when changes noted in resident status to allow for prompt assessment and managing acute episodes in house.	Percentage of avoidable ED visits to prevent unnecessary ED transfers.	The home will maintain a 15.25% target for avoidable ED visits compared to provincial average of 22.3%. Target date of Mar 31/2027.	

Change Idea #2	Build capacity in Nursing team by ongoing education on the use of SBAR tool and early detection of signs and symptoms of the most common causes of hospital transfers from 2025 to ensure effective assessment and prompt interventions.		
Methods	Process measures	Target for process measure	Comments
Provide training to staff on use of SBAR and early detection of signs and symptoms of the most common causes of hospital transfers from 2025.	Percentage of registered staff educated on signs and symptoms of most common causes of hospital transfers and SBAR tool.	100 % of the Registered Staff will be educated on the SBAR and signs of symptoms of most common causes of ED transfers by July 31/2026.	

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	Equity, diversity, inclusion, and anti-racism education is part of annual mandatory education for all staff	Surge Education Database

Change Ideas

Change Idea #1 The home will continue to conduct mandatory training on equity, diversity, inclusion, and anti-racism through the year for all staff.

Methods	Process measures	Target for process measure	Comments
completion of Surge learning Modules	Percentage of staff trained on equity, diversity, inclusion, and anti-racism through surge learning modules	100% off all staff will complete will complete their training on equity, diversity, inclusion, and anti-racism by Dec 31/2026	Executive Director to work with department leads to ensure all education is completed.

Change Idea #2 Home will host at minimum 2 events to celebrate equity, diversity, inclusion and provide another venue to educate staff on anti-racism.

Methods	Process measures	Target for process measure	Comments
Communication boards will be reflective of specific events to engage staff, residents and families	Percentage of events completed	100% of targeted events will be carried out by Dec 31/2026.	Explore external collaboration opportunities with community based resources/agencies

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	95.65	95.50	Change ideas implemented in 2025-2026 helped the home achieve higher results from the previous year. Home will continue will continue to apply previous years change ideas.	

Change Ideas

Change Idea #1 The home will continue to encourage residents to express their opinion at Resident council and care conferences.

Methods	Process measures	Target for process measure	Comments
Encourage residents to attend and participate in both Resident council and Care conferences.	All Residents able to participate will be notified of Resident council and care conferences scheduled.	100% of those willing to participate will be given the opportunity to do so.	Total Surveys Initiated: 46 Collaborate with residents when setting up care conference to ensure appropriate timing. Monthly Calendar indicates date of upcoming resident council meetings

Change Idea #2 Review the complaint process with all new admissions and during annual care conferences with residents and SDMs.

Methods	Process measures	Target for process measure	Comments
During admission and annual care conferences, the social worker will review the complaint process with the residents and/or SDMs and documented in the "CONFERENCE - Interdisciplinary Team Care Conference (IDTC)" assessment.	Number of care conferences in which the complaint process was reviewed per month.	100% of the admission and annual care conferences completed prior to Dec 31/2026, will include the review of the complaint process.	

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	12.17	12.00	Maintain	Care Rx pharmacy, Physiotherapy, Occupational therapist

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 risks of falls or injury related to falls.	Number of weekly falls huddles in each unit per month	100% of staff participation on Falls Weekly huddle in each unit by March 31/27	

Change Idea #2	In collaboration with the Falls committee, the Falls lead, and the interdisciplinary team, residents who are determined to be medium to high-risk and have recently sustained a fall will be reviewed for both non-clinical and clinical interventions. This review will also include the resident's plan of care, environmental assessment, Pharmacist/MD/NP for medication reviews, and PT for physio regimen. Residents and SDMs will be active participants in this process.

Methods	Process measures	Target for process measure	Comments
Completion of the Monthly clinical falls review meetings.	The number of residents reviewed monthly who have recently sustained a fall and are at medium and high risk for falls	100 % completion of all monthly clinical falls review meetings by March 31/27	

Change Idea #3	Resident list of FRS of 3 or greater, offering fracture and injury prevention alternatives, both pharmacological and non-pharmacological.

Methods	Process measures	Target for process measure	Comments
Education provided to registered staff on fracture and injury prevention. Involve restorative care lead .	The number of care plans updated with pharmacological and/or non-pharmacological interventions to reduce the risk of potential injuries.	100 % of the Reg staff to be educated on fracture and falls-related injury prevention by December 31/26.	

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	11.84	11.00	maintain	Care Rx, Ontario Shores Centre For Mental Health Sciences

Change Ideas

Change Idea #1	The MD, NP, BSO internal and external (including the Psychogeriatric Team), and other members of the interdisciplinary team will meet monthly to review newly admitted and existing residents on antipsychotic medication for diagnosis and indication for use. This will also be a standing item in the CQI/PAC quarterly meeting agendas.		
Methods	Process measures	Target for process measure	Comments
Monthly meetings with the interdisciplinary team with a focus on Antipsychotic use and interventions for the reduction/tapering of antipsychotic medication usage. Review data during CQI and PAC meetings.	The number of meetings held monthly by the interdisciplinary team and the number of antipsychotic reductions as the result of these meetings.	100% of residents on antipsychotic medications without psychosis will be assessed for the possible reduction or tapering of antipsychotic use. 100 % completion of the monthly interdisciplinary meetings and quarterly CQI/PAC meetings, and antipsychotic data review. target date: March 31/27.	

Change Idea #2	Residents who are prescribed antipsychotics for the management of Responsive expressions will have a quarterly review for the potential of reduction or discontinuation of medication. Utilization of tracking tool (antipsychotic)		
Methods	Process measures	Target for process measure	Comments
The BSO lead and the nursing team will ensure that residents who receive antipsychotics for responsive expressions with have their medication, and plan of care reviewed, quarterly by the interdisciplinary team (including resident and family)	Number of residents on antipsychotic medications whose care plans have been reviewed on a quarterly basis	100 % of the residents on antipsychotic medications will have their quarterly reviews completed. Target date: March 31/27.	

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	3.15	2.00	Home is confident in the application of best practices and the continued reduction in worsened stage 2-4. The home is aiming to be below provincial average.	Skin and wound care specialist, Nurse practioner, Medline

Change Ideas

Change Idea #1 Roll out education on wound care management and assessment, and skin care. Education to be provided by NSWOC (during wound care rounds), Medline consultant.

Methods	Process measures	Target for process measure	Comments
DOC to arrange education for Registered staff and PSW, with NSWOC/Medline	Number of Registered staff and PSWs educated on wound care management, assessment and skin care	100 % of the nursing staff to be educated on wound care management, assessments, and skin care by September 30/26	

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 skin and wound tracking tools to analyze pressure-related injuries in the home, the development of the plan of care, and appropriate prescribed wound and skin care products	Number of pressure-related injuries reviews held in the year	100 % of pressure-related injury reviews will be completed by March 31/27	

Change Idea #3 Referral to NSWOC for in-home and virtual consults.

Methods	Process measures	Target for process measure	Comments
Referrals to the NSWOC for the residents who fall into following categories: Wounds That Fail to Heal: Non-healing wounds: If a wound doesn't show signs of healing after 4-6 weeks of appropriate basic care (cleansing, protection, edema control, and antibiotics), it's a strong indicator for referral. Wounds with complications: Wounds with a large necrotic burden, unhealthy peri wound tissue, or those that are recurrent should be evaluated by a wound care specialist. Wounds with exposed tissue: Any wound with exposed bone, tendon, joint capsule, or significant tunneling warrants referral. Chronic wounds: Wounds that persist for more than 6 to 12 weeks, even with appropriate care, should be referred.	Number of referrals submitted to the NSWOC per month Number of care plans of care updated as the result of the assessment conducted by the NSWOC.	100 % of the residents who fall into the worsening pressure injury stage 2-4 category will be referred to the NSWOC. Target date : March 31/27	

Measure - Dimension: Safe

Indicator #7	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	1.14	1.14	Home currently has no restraints in the home. We will continue to minimize the use of restraints by utilizing alternate options.	Resident and Family Council

Change Ideas

Change Idea #1 The home will continue to have zero Residents utilizing daily physical restraints.

Methods	Process measures	Target for process measure	Comments
Continue to provide education to Staff, Families and residents on alternate options to restraints and the risks associated with restraint use.	The home will continue to utilize zero restraints in 2026.	The home will provide education to 100% of staff via surge learning. And 100% of Residents and Families will be provided with least restraint information in the admission package and at admission/annual care conferences through Dec 31/2026	