

## 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)	33.65	28.00	1) Above the provincial Average; 2) Through implementation of our change ideas, the home expects an improvement over the next year."	NLOT- NP, Physician, Oxygen vendor, Medline for IV supplies

### Change Ideas

Change Idea #1 1. To reduce unnecessary hospital transfers through root cause analysis of transfers. 2. Registered Nurse in Charge to communicate to physician, a comprehensive resident assessment and to obtain direction from the GP prior to initiating an ER transfer. 3. Review of IV education for use in the home to avoid a hospital transfer.

Methods	Process measures	Target for process measure	Comments
<p>1) Continue efforts to recruit and NP and involvement of physician in assessing changes in resident conditions 2) Educate residents and families about the benefits of and approaches to preventing ED visits. The home's attending MD will review and collaborate with the registered staff on residents who are at high risk for transfer to ED, based on clinical and psychological; develop care plans with early identification signs and treatment plans 3) Conduct needs assessment from Registered Staff to identify clinical skills and assessment that will enhance their daily practice. 4) Utilization of internal hospital tracking tool and analyze each transfer status. ED transfer audit will be completed and reviewed monthly by nursing leadership (DOC, ADOC). Reports will be reviewed at quarterly PAC meetings; and standing agenda in nursing practice meeting 5) Completion of PPS assessment, implementation of use and education for staff, res./families on palliative approach and end of life. Utilization of information brochure or handbook 6) Care plan for resident with responsive expression - indication of triggers and interventions</p>	<p>1) Number of ads placed, efforts to recruit an NP 2) The number of residents whose transfers were a result of family or resident request. Number of staff who demonstrated education application via documentation quarterly. The number of ER transfers averted monthly. Number of transfers to ED who returned within 24 hours; 3) % of staff who complete needs assessments. Completion records for education as a result of needs assessment. 4) Improved confidence and decision making from Registered staff related to clinical assessment. # of education sessions with Registered staff 5) Number of IV therapy/treatments completed with in the home</p>	<p>1) Decrease by 1% until goal is achieved by reviewing all process measures in a quarterly basis; 2) 100% Staff education completed.</p>	<p>Utilize other stake holders such as Medigaso, CareRx Pharmacy and MDs to provide education to registered staff on topics</p>

Change Idea #2 1. To reduce unnecessary hospital transfers through root cause analysis of transfers. 2. Registered Nurse in Charge to communicate to physician, a comprehensive resident assessment and to obtain direction from the GP prior to initiating an ER transfer. 3. Review of IV education for use in the home to avoid a hospital transfer.

Methods	Process measures	Target for process measure	Comments
<p>1) Continue efforts to recruit and NP and involvement of physician in assessing changes in resident conditions 2) Educate residents and families about the benefits of and approaches to preventing ED visits. The home's attending MD will review and collaborate with the registered staff on residents who are at high risk for transfer to ED, based on clinical and psychological; develop care plans with early identification signs and treatment plans 3) Conduct needs assessment from Registered Staff to identify clinical skills and assessment that will enhance their daily practice. 4) Utilization of internal hospital tracking tool and analyze each transfer status. ED transfer audit will be completed and reviewed monthly by nursing leadership (DOC, ADOC). Reports will be reviewed at quarterly PAC meetings; and standing agenda in nursing practice meeting 5) Completion of PPS assessment, implementation of use and education for staff, res./families on palliative approach and end of life. Utilization of information brochure or handbook 6) Care plan for resident with responsive expression - indication of triggers and interventions</p>	<p>1) Number of ads placed, efforts to recruit an NP 2) The number of residents whose transfers were a result of family or resident request. Number of staff who demonstrated education application via documentation quarterly. The number of ER transfers averted monthly. Number of transfers to ED who returned within 24 hours; 3) % of staff who complete needs assessments. Completion records for education as a result of needs assessment. 4) Improved confidence and decision making from Registered staff related to clinical assessment. # of education sessions with Registered staff 5) Number of IV therapy/treatments completed with in the home</p>	<p>1) Decrease by 1% until goal is achieved by reviewing all process measures in a quarterly basis; 2) 100% Staff education completed.</p>	<p>Utilize other stake holders such as Medigaso, CareRx Pharmacy and MDs to provide education to registered staff on topics</p>

## 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	Through education, the Home expects to have an increase understanding of this criteria over the next 6 months	External community partners, Education platform Surge learning

### Change Ideas

Change Idea #1 1. To improve overall dialogue of diversity, inclusion, equity and anti-racism in the workplace. 2. To include diversity in team huddles. 3. To include diversity as part of CQI meetings.

Methods	Process measures	Target for process measure	Comments
1) Training and/or education through Surge education or live events; 2) Introduce diversity and inclusion as part of the new employee onboarding process; 3) Celebrate culture and diversity events; educational opportunities 4) Monthly quality meeting standing agenda- review the number of programs, education completed 5) Culturally familiar foods, on the menu (special menu) 6) Ensure correct pronunciation of names 7) Flexible accommodations for religious observances	1) Number of staff education on Culture and Diversity; 2) number of new employee trained of Culture and Diversity; 3) Number of Celebration completed in the home	100% of staff educated on topics of Culture and Diversity	1) 80-100% staff education on Culture and Diversity; 2) number of new employee trained of Culture and Diversity

**Change Idea #2** 1. To improve overall dialogue of diversity, inclusion, equity and anti-racism in the workplace. 2. To include diversity in team huddles. 3. To include diversity as part of CQI meetings.

Methods	Process measures	Target for process measure	Comments
1) Training and/or education through Surge education or live events; 2) Introduce diversity and inclusion as part of the new employee onboarding process; 3) Celebrate culture and diversity events; educational opportunities 4) Monthly quality meeting standing agenda- review the number of programs, education completed 5) Culturally familiar foods, on the menu (special menu) 6) Ensure correct pronunciation of names 7) Flexible accommodations for religious observances	1) Number of staff education on Culture and Diversity; 2) number of new employee trained of Culture and Diversity; 3) Number of Celebration completed in the home	100% of staff educated on topics of Culture and Diversity	1) 80-100% staff education on Culture and Diversity; 2) number of new employee trained of Culture and Diversity

**Change Idea #3** 1. To improve overall dialogue of diversity, inclusion, equity and anti-racism in the workplace. 2. To include diversity in team huddles. 3. To include diversity as part of CQI meetings.

Methods	Process measures	Target for process measure	Comments
1) Training and/or education through Surge education or live events; 2) Introduce diversity and inclusion as part of the new employee onboarding process; 3) Celebrate culture and diversity events; educational opportunities 4) Monthly quality meeting standing agenda- review the number of programs, education completed 5) Culturally familiar foods, on the menu (special menu) 6) Ensure correct pronunciation of names 7) Flexible accommodations for religious observances	1) Number of staff education on Culture and Diversity; 2) number of new employee trained of Culture and Diversity; 3) Number of Celebration completed in the home	100% of staff educated on topics of Culture and Diversity	1) 80-100% staff education on Culture and Diversity; 2) number of new employee trained of Culture and Diversity

## 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	90.16	92.67	Target is based on corporate averages. We aim to meet or exceed corporate goals, benchmarks.	Resident survey, Social worker

## Change Ideas

Change Idea #1 1. To increase our goal from current percentage 85.34 % by 2% this year. 2. Review the concern process in the home on admission and during annual care conferences. 3. Social worker visits.

Methods	Process measures	Target for process measure	Comments
1) Add resident right #29 to standing agenda for discussion on monthly basis by program Manager during Resident Council meeting. Re-education and review to all staff on Resident Bill of Rights specifically #29 at department meetings monthly by department managers; 2) Review of policy with resident and family with admission and care conferences 3) Policies -Zero tolerance to abuse, and Whistleblower posted in the home 4) Review of Investigation process in the home (during admission and care conferences) 5) Social worker visits with residents 6. Newsletter to families	100% of all staff will have education via Surge Learning. 100% of resident Council meeting will have Residents' Bill of Right #29, added at each monthly review by 100% of Standing Agenda for Family Council. Review of policies added to the admission process, care conference	100% of all staff and residents and families will have completed the education on resident Bill of Rights #29	Total Surveys Initiated: 61

## 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	23.36	20.00	Target is based on corporate averages. We aim to meet or exceed, corporate goal.	Physiotherapist, Occupational therapist, Resident and family members, Physician, Pharmacist consultant (CareRx)

### Change Ideas

Change Idea #1 1) To re-educate staff at huddles about Purposeful Rounds, when residents are in bed keep the doors open and curtains pulled back to monitor for safety; transfer high fall risk residents into their wheelchair when awake 2) Implement a buddy system while charting, PSWs sit with resident at high risk for falls. 3) Plan calming activities for residents targeting evening and sundowning. (colouring, puzzles, etc.)

Methods	Process measures	Target for process measure	Comments
1) Weekly interdisciplinary team huddles on resident home area to review resident plan of care, to mitigate the risk of falls or injury related to falls; 2) Monthly collaboration with the Fall committee, (during Quality meeting), to review the resident's plan of care (identification of the triggers, related to the fall) referrals to MD/NP for medication reviews, PT for physio regiment/programming 3) PT/OT referrals as required 4) Interdisciplinary team comprehensive post fall analysis, post resident fall 5) Use of visual depth cues, use of night lights (motion sensed/or on during the night) 6) Use of falls aides to prevent injury, use of hip protectors, floor mats, bed and chair alarms, bariatric mattresses 7) During shift report review resident high risk for falls, frequent falls, 8) Review of the plan of care with families, 9) Vision and hearing checks 10) Pain assessment, to assess for potential pain/unmanaged pain 11) Completion of environmental audits 12) 4P's implemented (pain, positioning, personal items, personal needs)	1) Number of weekly meeting in each unit; 2) number of staff participants on the weekly falls meeting; 3) number of GAP analysis completed related to falls, 4) Number of medication changes (addition of fracture prevention medication) 5) Number of environmental and pharmacist referrals 6) Number of residents on restorative care program 7) Number of resident who successful discharged from restorative program	100% of staff participation on Falls Weekly huddle in each unit 100% of staff to complete the required education 100% of resident who experience a fall will have a comprehensive post fall assessment and huddle completed 100% of admission to the home will have fall assessment completed	

Change Idea #2 1) To re-educate staff at huddles about Purposeful Rounds, when residents are in bed keep the doors open and curtains pulled back to monitor for safety; transfer high fall risk residents into their wheelchair when awake 2) Implement a buddy system while charting, PSWs sit with resident at high risk for falls. 3) Plan calming activities for residents targeting evening and sundowning. (colouring, puzzles, etc.)

Methods	Process measures	Target for process measure	Comments
1) Weekly interdisciplinary team huddles on resident home area to review resident plan of care, to mitigate the risk of falls or injury related to falls; 2) Monthly collaboration with the Fall committee, (during Quality meeting), to review the resident's plan of care (identification of the triggers, related to the fall) referrals to MD/NP for medication reviews, PT for physio regiment/programming 3) PT/OT referrals as required 4) Interdisciplinary team comprehensive post fall analysis, post resident fall 5) Use of visual depth cues, use of night lights (motion sensed/or on during the night) 6) Use of falls aides to prevent injury, use of hip protectors, floor mats, bed and chair alarms, bariatric mattresses 7) During shift report review resident high risk for falls, frequent falls, 8) Review of the plan of care with families, 9) Vision and hearing checks 10) Pain assessment, to assess for potential pain/unmanaged pain 11) Completion of environmental audits 12) 4P's implemented (pain, positioning, personal items, personal needs)	1) Number of weekly meeting in each unit; 2) number of staff participants on the weekly falls meeting; 3) number of GAP analysis completed related to falls, 4) Number of medication changes (addition of fracture prevention medication) 5) Number of environmental and pharmacist referrals 6) Number of residents on restorative care program 7) Number of resident who successful discharged from restorative program	100% of staff participation on Falls Weekly huddle in each unit 100% of staff to complete the required education 100% of resident who experience a fall will have a comprehensive post fall assessment and huddle completed 100% of admission to the home will have fall assessment completed	

**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	11.63	10.00	Target is based on corporate averages. We aim to do better than or in line with corporate average.	Physician, BSO external supports, Psychiatrist

**Change Ideas**

Change Idea #1 1) Re-education of all staff on Gentle Persuasive approaches (GPA) training/education -establish GPA trainers, educators in the home 2) Re-educate on use of Behaviour Note heading for responsive expressions documentation in the progress notes; remind registered staff to chart on responsive expressions, to not normalize behaviours as they occur. 3) Implement the Southbridge Antipsychotic Reduction Program.

Methods	Process measures	Target for process measure	Comments
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1) Number of meetings held monthly by interdisciplinary team. Number of antipsychotics reduced as a result monthly. Number of PAC meetings held quarterly, where discussion and reviews on strategies have resulted in a decrease of antipsychotics; 2) BSO lead and nursing team will ensure that residents who receive antipsychotics for responsive expressions will have their medication, plan of care reviewed, quarterly by the interdisciplinary team (including resident and family) -to develop a person centered approach 3) Monitor of sleep hygiene, (adequate rest) 4) GPA training to be held in the home 5) Pain assessments (PAINAD), identify pain is not trigger for the responsive expressions 6) Utilization of antipsychotic medication tracker (for de-prescribing) 7) Referral to internal and external BSO for comprehensive assessment 8) Implementation of DOS, with change in responsive expressions, analysis of the DOS, with review of plan of care 9) Assess for psychosis, Delirium (screen) , BPSD 10) Review/assess the prn use of antipsychotic (medication-indication for use) 11) HT with families and resident on the use risks related to the use of antipsychotic medication 12) Reducation of environmental stimuli (increase to noise, commotion) 13) Quartlery medication review with NP/MD

1) Number of meetings held monthly by interdisciplinary team. Number of antipsychotics reduced as a result monthly. Number of PAC meetings held quarterly, where discussion and reviews on strategies have resulted in a decrease of antipsychotics; 2) Number of residents prescribed antipsychotics medications over the number of residents who have received a medication review in the last quarter. 3) Number of resident who plan of care has been reviewed 4) Number of staff receive education GPA /number of sessions 5) Number of resident, to which the antipsychotic was decrease, or de-prescribed/discontinued

1) 100% of newly admitted residents will have been reviewed for the appropriateness of antipsychotics use; 2) 100% of residents who are prescribed antipsychotic medications will receive a 3 month review to determine potential for reduction in dosage or discontinuing antipsychotics. 3) 100% of full time, nursing staff receive GPA training

**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	3.85	3.00	Target is based on corporate averages. We aim to meet or exceed corporate goals, benchmarks.	NSWOC, physician, Registered dietician, Occupational therapist, CareRx pharmacist consultant

**Change Ideas**

Change Idea #1 1) RD review of nutritional status of residents. 2) Increased use of and Re-education of staff on care and use of pressure relieving surfaces (ie. no incontinence pad on top of the air mattress) 3) Monthly review of residents with pressure injuries at Quality Meetings, review of the plan of care.

Methods	Process measures	Target for process measure	Comments
<p>1) Arrange education for Registered staff and PSW, with NSWOC, Medline wound consultant 2) Develop a list of resident who PURS is 3 or greater, review plan of care, for the appropriate pressure relieving devices, review of surfaces in place 3) Utilization of skin and wound tracking tool, to analysis the pressure related injuries in the home - and the development of plan of care 4) Registered staff to complete wound rounds with the NSWOC to enhance knowledge on wound care management 5) Annual Surge education - Skin and wound care management 6) Review of resident status, with pressure related injuries during Quality meetings (case by case review) review of plan of care, progression/stalled/deteriorating pressure injuries, 7) Referral to PT and OT for reviewing of seating 8) ROHO education, implementation ROHO champion 9) Use of Remedy products for skin care management 10) Wound care leads with in the home</p>	<p>1) Number of Registered staff and PSW who have completed education. 2) Number of changes to surface, 3) Number of pressure related injuries which have resolved 4) Number of visits in home and virutally by the NSWOC 5) Number of care plans updated 6) Number of seating assessment completed</p>	<p>100 % of Registered staff to be educated 100% of PSW 100% of resident with PURs 3 or greater, comprehensive assessment completed, 100% of resident with stage 3 or greater will have routine assessment completed by NSWOC 100% of admissions to the home to have pressure injury assessment completed</p>	

**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	2.80	2.00	Target is based on corporate averages. We aim to meet or exceed corporate goals, benchmarks.	Physiotherapist, Resident and family members, Occupational therapist

**Change Ideas**

## Change Idea #1 Home to be restraint free

Methods	Process measures	Target for process measure	Comments
1) Family and resident engagement, health teaching provided on the risk associated with restraints, and alternative interventions 2) Medication review (potential side effects of medication causing restlessness/agitation) 3) Clinical review of the resident, to determine no underlying causes, (pain) 4) Annual education with staff, related to use and risks of restraints	1) Number of restraints being used in the home (reason) 2) Number of restraints, successfully removed from use in the home 3) Number of resident admitted to the home with use of restraint	100% of staff to completed education	