

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)	29.66	26.69	As our ED visits continue to climb, we are setting a modest goal of decreasing ED visits by 10%, which we believe is achievable.	

Change Ideas

Change Idea #1 Avoidable ED visit themes will be discussed at the Professional Advisory Committee (PAC) with the NPs and physician group.

Methods	Process measures	Target for process measure	Comments
Transfers will be categorized by reason (i.e. UTI, pneumonia, CHF, etc.) and a quarterly summary report will be prepared and presented at PAC. Action items to avoid future ED visits will be documented in the meeting minutes, and on the residents' charts, as required.	% of identified action items with documented follow-up within 90 days.	100% of quarterly PAC meetings include ED trend review, beginning in April 2026.	We will partner with our Medical Director to set guidelines for the physician group with respect to what requires an ED transfer and alternatives to the ED to manage resident care.

Change Idea #2 Initiate IV antibiotics in-house for appropriate infections.

Methods	Process measures	Target for process measure	Comments
1) Develop eligibility criteria for in-house IV therapy (i.e. cellulitis, pneumonia, etc.). 2) Train registered staff on IV initiation competency and monitoring.	1) % of eligible infections treated with IV antibiotics in-house. 2) % of registered staff trained and deemed competent in IV therapy per quarter.	1) 70% of eligible infections managed in-house by March 31, 2027. 2) 50% of registered staff trained in IV protocol by September 30, 2026. 100% of registered staff trained in IV protocol by end March 31, 2027.	Through partnership with the CPLTC+ program and our physicians, we will set parameters of what infections and IV antibiotic durations are appropriate to treat in-house.

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	We intend to continue DEI training for all new managers and directors.	

Change Ideas

Change Idea #1 Train and track completion of DEI training module for newly hired managers and staff members promoted into management positions.

Methods	Process measures	Target for process measure	Comments
Learning and Development Manager will track completion of DEI training module within the home's LMS.	Percentage of new supervisors, managers, and directors who complete DEI training.	100% of new supervisors, managers, and directors will complete DEI training by the end of their probationary period.	Our ability to succeed in having managers complete DEI training before the end of their probationary period may be impacted by the home tentatively moving to an LMS system. Although completion of the module may be delayed, we do not expect total percent completed before the end of the reporting cycle to be impacted.

Measure - Dimension: Equitable

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of residents with a completed life story documented and available for all staff to better understand the resident, including but not limited to, hobbies and interests, BPSD or trauma triggers, resident history/background, and who are important people in the resident's life.	C	% / LTC home residents	In-home audit / April 1, 2026 to March 31, 2027	0.00	25.00	This will account for current residents and our ability to increase and complete a life story with every new admission.	

Change Ideas

Change Idea #1 Increase resident agreement with the statement: "Some of the staff know the story of my life."

Methods	Process measures	Target for process measure	Comments
Conduct the resident survey at the residents' admissions and annual care conferences' to ensure rolling data collection.	Percentage of residents who respond "Most of the Time" or "All of the Time" to the statement, "Some of the staff know the story of my life."	Increase residents' response to the statement "some of the staff know the story of my life" to 60% by March 31, 2027.	

Change Idea #2 Integrate life stories into the admission process.

Methods	Process measures	Target for process measure	Comments
1) Resident Experience team will complete the life story within 14 days of admission. 2) Quarterly audit to ensure life stories are completed and posted (available for staff to use).	Percentage of new admissions with a completed life story within 14 days. # new admissions with completed life story within 14 days of admission ÷ total new admissions that quarter).	60% of new admissions will have a completed Life Story within 14 days by September 30, 2026 75% of new admissions will have a completed Life Story within 14 days by March 31, 2027.	This change idea focuses simply on the information collection and distribution of the resident life story. Utilization of the life story is captured through another change idea and indicator).

Change Idea #3 Ensure life stories are accessible to staff at the point of care and that staff are aware of and can use the content to support person-centred care.

Methods	Process measures	Target for process measure	Comments
1) The life story will be posted in a standardized and accessible location for all staff (including non-nursing staff) to see and review. 2) At monthly MDAC meetings, interdisciplinary team will be asked to share one learning from a newly completed resident's life story.	1) Number of completed life stories that are posted and available for review. 2) Percentage of audited staff at MDAC who can share one insight learned and one way the information can be applied in resident care or interactions.	1) 80% of new admissions will have a completed Life Story within 14 days by September 30, 2026 90% of new admissions will have a completed Life Story within 14 days by March 31, 2027. 2) A minimum of four staff from three different disciplines will be audited per MDAC and documentation will be captured in MDAC minutes.	The life story QI project is in early stages of development and we expect to have details about location of posting and process to inform the staff of the life story in place by the end of the reporting cycle.

Experience

Measure - Dimension: Patient-centred

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of prolonged call bell response times (>15 minutes).	C	% / LTC home residents	In house data collection / April 1, 2026 to March 31, 2027	CB	50.00	We expect it is reasonable that the % of call bells response times that are 15 minutes or more will decrease by 50% with intervention.	

Change Ideas

Change Idea #1 Unit-level monitoring of >15 minute call bell response time.

Methods	Process measures	Target for process measure	Comments
Monthly call bell duration reports and coaching when patterns are identified and staff accountability.	Number of coaching and staff follow up required.	Collecting baseline. Unable to set target at this time. Decrease number of coaching and staff follow-up by to-be-determined number each quarter.	After having two months of data (April and May 2026), a target will be set to decrease required staff follow up.

Change Idea #2 Proactive rounding of residents.

Methods	Process measures	Target for process measure	Comments
1) Implement structured hourly rounding schedule and reinforce "4 Ps" rounding (pain, position, personal needs, possessions). 3) Track correlation between rounding compliance and >15 minute events.	1) Number of required rounding intervals completed and documented. 2) Percentage of >15 minute events.	1) 80% rounding compliance rate September 30, 2026. 90% rounding compliance rates by March 31, 2026. 2) Units achieving 80% rounding compliance will demonstrate a 30% reduction in >15-minute events within two quarters of implementation. By March 31, 2027, reduction will be 50%.	Our average call bell duration is 3.2 minutes (November 2025 to February 10, 2026). Therefore, we are targeting a significant reduction in outlier call bells that ring for >15 minutes.

Measure - Dimension: Patient-centred

Indicator #5	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of long-term care residents demonstrating improvement in behavioural symptoms (personal expressions), as measured by LTCF behaviour-related outcome scales.	C	% / LTC home residents	POC/PCC Audits / April 1, 2026 to March 31, 2027	8.00	7.20	This indicator is tied to the life stories implementation. We are setting a modest target as the rollout of life stories will be slow, with a target of 25% of residents having a life story completed by the end of the reporting cycle.	

Change Ideas

Change Idea #1 Embed life stories in plan of care

Methods	Process measures	Target for process measure	Comments
Nursing leadership with audit a sample of residents with behaviours monthly to determine if the life story is integrated into the plan of care.	Percentage of residents with behavioural symptoms who have at least one life story-informed intervention documented in their care plan.	By June 30, 2026, 60% of residents who have had a life story completed will have at least one life story-informed intervention documented in their care plan. By September 30, 70% By December 31, 2026, 80% By March 31, 2027, 95%	This change idea will require education of where and how life story information should be documented in the care plan. Education will be built into annual training of the Dementia and Behaviours Management program.

Safety

Measure - Dimension: Safe

Indicator #6	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	10.27	9.00	We are improving in our falls performance. This target provides us a goal for falls reduction while allowing us to focus directly on the root cause of falls.	

Change Ideas

Change Idea #1 Establish a standing interdisciplinary Falls Committee that meets monthly.

Methods	Process measures	Target for process measure	Comments
1) Review monthly falls data including location, time, and cause of fall. 2) Action items assigned with clear accountability (DOC or designate tracks completion). 3) Reporting of completion of action items at quarterly CQI committee.	1) Number of monthly falls committee meetings held 2) Percentage of repeat fallers who do not have any falls recorded in their next LTCF quarterly assessment. 3) Percentage of assigned action items completed within 30 days	1) 100% of scheduled monthly falls committee meetings will occur from April 1, 2026 to March 31, 2027. 2) 75% of residents with documented falls will not have any falls recorded in their next LTCF quarterly assessment. 3) 70% of action items arising from meetings will be completed within 30 days of assignment by June 30, 2026. 90% of action items arising from meetings will be completed within 30 days of assignment by September 30, 2026.	We expect the initiation of our monthly falls committee meetings to have a significant impact on our monitoring of falls and ability to reduce falls.

Change Idea #2 Target self-transfer falls using Pareto data, and develop interventions at the monthly falls committee meeting.

Methods	Process measures	Target for process measure	Comments
Identify and review residents whose falls are attributed to a) unassisted bed-to-chair/bed-to-standing transfers b) unassisted toilet transfers c) attempted mobility without device. Develop tailored plan of care interventions including but not limited to bed/chair alarms, scheduled toileting, lower bed positioning, strengthening and conditioning program.	1) Percentage of identified self-transfer fallers with updated care plan interventions, as required, within 72 hours of the falls committee meeting. 2) Percentage of plan-of-care-documented falls reduction strategies aligned with falls prevention strategies in use.	1) 80% of plan of care interventions will be updated within 72 hours of the falls committee meeting by June 30, 2026. 100% of plan of care interventions will be updated within 72 hours of the falls committee meeting by September 30, 2026. 2) 80% of documented falls reduction strategies will be aligned with falls prevention strategies in use by June 30, 2026. 95% of documented falls reduction strategies will be aligned with falls prevention strategies in use by September 30, 2026.	Self-transfers are the most common cause of resident falls, accounting for ~70% of all falls. By addressing self-transfers, we expect to significantly decrease our total number of falls.

Measure - Dimension: Safe

Indicator #7	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	2.94	2.65	We continue to perform well on this indicator and intend to focus on antipsychotic stewardship to decrease our utilization of antipsychotics.	

Change Ideas

Change Idea #1 Implement a quarterly antipsychotic stewardship review for residents without a diagnosis of psychosis to ensure ongoing clinical appropriateness.

Methods	Process measures	Target for process measure	Comments
1) Quarterly data extraction from LTCF and interdisciplinary review including medication Lead, Charge RN, Director of Care, Pharmacist, Nurse Practitioner, and Medical Director. Where clinically appropriate, gradual dose reduction or discontinuation plans will be initiated. 2) Documentation will reflect rationale when continuation is clinically justified.	1) Percentage of residents receiving antipsychotics without psychosis who receive a documented quarterly interdisciplinary medication review. 2) Percentage of residents without psychosis who are receiving antipsychotics and have documented evidence of clinical indication and non-pharmacological interventions in the past 90 days.	95% of residents without psychosis who are receiving antipsychotic medication will have documented interdisciplinary medication review within 90 days, sustained quarterly through the fiscal year, as of April 30, 2026.	We will focus our change ideas on antipsychotic stewardship, as our current utilization of antipsychotics is low and we intend on sustaining our current %.

Change Idea #2 Implement targeted education for nursing staff and PSWs on behaviour mapping and documentation standards to support appropriate antipsychotic use.

Methods	Process measures	Target for process measure	Comments
1) Develop and deliver education content that includes use of BSO Ontario Behaviour Mapping tool and how to utilize the tool (PSW). Develop education on assessment and documentation of behaviours to support use or discontinuation of antipsychotic (registered staff).	Percentage of nursing staff and PSWs who complete targeted education on behavioural assessment, non-pharmacological interventions, and documentation standards within 60 days of education rollout.	100% of nursing staff and PSWs will complete targeted education within 60 days of rollout, sustained annually.	We have identified our Dementia and Behaviours program as an opportunity to review current policies and procedures and will align the rollout of this education with a review of our program.

Measure - Dimension: Safe

Indicator #8	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	3.02	3.02	Although this indicator shows satisfactory number of worsening pressure ulcers, our internal data shows that we have had a substantial increase in worsening pressure ulcers. Consequently, our goal is to return our worsening pressure ulcer performance to the "current performance" as listed in this indicator.	

Change Ideas

Change Idea #1 Implement a standardized visual "Turning Clock" tool at the point of care to clearly identify required repositioning frequency and document the most recent repositioning time for residents.

Methods	Process measures	Target for process measure	Comments
Residents requiring repositioning will have an individualized repositioning schedule documented in the care plan and a Turning Clock visual tool placed at the bedside to indicate the last and next repositioning time.	Percentage of audited Turning Clocks accurately reflecting the most recent repositioning time.	60% of audited Turning Clocks will accurately reflect last repositioning time by June 30, 2026. 90% of audited Turning Clocks will accurately reflect last repositioning time by September 30, 2026.	We expect the use of the Turning Clock will decrease the number of worsening pressure ulcers at the home, and will support healing of stage 2-4 pressure ulcers.

Measure - Dimension: Safe

Indicator #9	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	2.90	2.61	We are performing strong in this indicator and intend to focus our efforts on reducing the number of PASD bedrails.	

Change Ideas

Change Idea #1 Review appropriateness of bedrails and standardize criteria to have bedrails installed for ADL support.

Methods	Process measures	Target for process measure	Comments
Complete monthly audits to ensure appropriate assessments have occurred prior to installation of bedrails.	Percentage of residents with bedrails who have a completed and up-to-date Bedrail Assessment Tool on file	100% compliance with 72-hour sleep observation completed prior to the installation of bedrails by June 30, 2026. 100% compliance with process of DOC/designate approving bedrail requests before installation by June 30, 2026.	This practice aligns with our refreshed policy and procedures related to restraints, PASDs, and bedrails.

Change Idea #2 All requested bedrails will be submitted through WorxHub (maintenance work order system) and signed off by Environmental Services Manager prior to installation.

Methods	Process measures	Target for process measure	Comments
1) Nursing will complete the 72-hour sleep observation assessment in PointClickCare when a bedrail is being considered. If clinically indicated, a WorxHub work order must be submitted prior to installation. Environmental Services Manager will approve and document installation.	Percentage of installed bedrails with a corresponding approved WorxHub work order and completed 72-hour sleep observation assessment prior to installation.	100% compliance by June 30, 2026. 100% compliance ongoing.	This procedure has been included with the refresh of our restraints, PASDs, and bedrails policise.