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)	21.74	20.00	The home will be focusing on interventions to support the team in assessments and difficult conversations to ensure transfers to ED are validated. We continue to track the reasons for transfers to trend this data and investigate system improvements. We will continue to struggle with the lack of timely diagnostic testing which results in some requests for resident transfers to ED.	

Change Ideas

Change Idea #1 To provide education sessions for the registered staff team with support from physicians, NP and other resouces on critical thinking, resident assessments, acute changes in resident status and supporting the resident and family with difficult conversations with the goal to decrease avoidable ED visits.

Methods	Process measures	Target for process measure	Comments
To identify gaps within our current processes by reviewing past emergency room transfers and input from team. To develop a schedule of training to occur over the year. To investigate if alternative funding model is available to access the services of a Nurse Practitioner.	Number of residents sent to ED for assessment evening, night and weekends. Number of residents sent to ED who were admitted. Number of residents deceased at acute care	The home will provide a minimum of four education sessions for the registered staff by December 2026 with the focus on enhancing assessment skills and building capacity within the team	

Change Idea #2 To enhance IPAC practices within the home to reduce the rate of outbreaks and infections which result in resident transfers to ED.

Methods	Process measures	Target for process measure	Comments
To install additional hand hygiene dispensers throughout the home at point of care for ease of staff and resident access. To aquire 20 PPE carts to be used when a resident is isolated. Education to residents, family and staff on the importance of hand hygiene. Education to residents, family and staff on the importance of following PPE recommendations and using PPE correctly. To implement and enforce a hand hygiene program for residents before and after meal service.	# of team member handwashing audits completed monthly # of PPE audits completed monthly # of outbreaks monthly and identified organism	To have a compliance rate of 85% with handwashing audits and PPE audits monthly.	

Safety

Measure - Dimension: Safe

Indicator #2	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	34.42	32.00	The home experienced an increase in resident deaths in 2025 resulting in residents requiring the use of Haldol to manage nausea at end of life- this medication is an antipsychotic resulting in our data being skewed. The home will continue with our change ideas and track residents who take antipsychotics for other reasons so we are able to speak to the performance of the home in this indicator.	

Change Ideas

Change Idea #1	To conduct a comprehensive assessment at the time of resident admission to home to determine if antipsychotic medications are being used and whether there is an appropriate diagnosis that justifies their use.		
Methods	Process measures	Target for process measure	Comments
BoomR team in support with Consultant Pharmacist and most responsible physician to complete a collaborative BPMH to determine if antipsychotics are required and rationale for use. Review each order for antipsychotics quarterly at the 3-month medication review for orders in collaboration with the care team to plan if dose can be titrated down or other changes made. Review any antipsychotic order that does not have a supporting diagnosis to justify continued use using DOS charting, review of progress notes, etc.	# of antipsychotic orders identified and referred to physician # of medication reconciliations completed by the contracted pharmacy provider	100% of new resident admission to the home have a BPMH completed to evaluate the use of an antipsychotic and if a supporting diagnosis is documented.	

Change Idea #2	Non-pharmacological methods/ interventions using DementiAbility methods will be trialed prior to ordering antipsychotic medication unless there is risk to the resident or others.		
Methods	Process measures	Target for process measure	Comments
To continue to educate the multidisciplinary team on DementiAbility and the importance of knowing who the resident is as this guides the team in gaining insight as to what the resident is communicating as an unmet need. This approach reduces emotional response from escalating To certify two team members as in house DementiAbility trainers to be able to support the team as well as assist in the ongoing training of new team members.	Number of team members trained in DementiAbility by December 2026. Number of team members certified in DementiAbility by December 2026. Number of emotion based audits conducted monthly by Leadership team.	An additional 20 team members will be trained in DementiAbility by December 2026. 90% of residents being ordered an antipsychotic without a diagnosis of psychosis will have a team meeting to evaluate the appropriateness of the order and review plan of care.	

Change Idea #3 To implement the RNAO Clinical Pathways Depression and Dementia.

Methods	Process measures	Target for process measure	Comments
RNAO Gap analysis for Depression and Dementia to be completed with the team. Develop an action plan of items where the home does not meet best practice and determine heirarchy for implementation. Identify champions who have a passion for Depression and Dementia to lead the implementation of the pathway with the team and by participating in train the trainer education sessions with RNAO. Implementation of work flow for new pathway shared with the team. Update policies related to Depression and Dementia.	Number of areas identified not meeting best practice when the gap is completed. Number of training sessions hosted. Number of registered staff attending training sessions. Gather baseline information on the number of residents with depression prior to the implementation of the pathway.	The home will go live with the RNAO Clinical Pathway Depression and Dementia by March 2027.	

Measure - Dimension: Safe

Indicator #3	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	3.89	3.20	Residents were admitted to the home with impaired skin integrity and a priority focus for this year is to increase awareness of the team on the priority of early identification of impaired skin to prevent wounds from worsening which greatly impacts the residents quality of life.	

Change Ideas

Change Idea #1	Implement a standardized process to ensure all residents with a Pressure Ulcer Risk Score (PURs) of 5 or greater are identified promptly and provided with a therapeutic surface to prevent pressure injuries.		
Methods	Process measures	Target for process measure	Comments
Identify residents assessed with PURS of 5 or greater by auditing outcome scores post LTCF Inter-RAI assessment. Implement referral/request process for initiating new surface when new assessment completed with PURS of 5 or greater Ensure supply of surfaces are available Complete a bed entrapment audit to ensure bed and therapeutic surface are safe together. Document in plan of care if resident declines surface after health teaching or is assessed to not be safe to use a surface due to falls risk as an example.	% of resident with a PURs score of 5 or greater who received a therapeutic surface within 72 hours of assessment.	90% of residents with a PURs score of 5 or greater will receive a therapeutic surface within 72 hours of assessment by March 2027.	

Change Idea #2	Implementation of comprehensive, structured and validated wound assessment tool.		
Methods	Process measures	Target for process measure	Comments
Finalize skin and wound assessment tool. Provide education for Registered staff on new skin and wound assessment tool Provide education on wound staging and wound measurement to the registered staff for consistency in assessing a wound.	% of Registered staff educated on new skin and wound assessment tool Audit weekly skin and wound documentation tool over the first 3 months of implementation to ensure consistency and accuracy of the documentation. Review wound pictures/ complete wound rounds to audit accuracy in determining stage of wound and wound measurement.	90% of registered staff will be trained on new skin and wound assessment tool by December 2026. 90% of Registered staff will be educated on correct staging and measurement of pressure injuries by December 2026.	

Change Idea #3	Preventative skin program to be implemented focusing on moisturizing skin and importance of repositioning as prevention strategies to prevent skin breakdown		
Methods	Process measures	Target for process measure	Comments
Review current products used in home for prevention to ensure compliance with established protocols Education sessions for PSW's on all shifts about skin health and importance of daily moisturizing as an intervention to prevent skin breakdown. Education sessions for direct care team on the importance of repositioning and reviewing individual resident cases to develop plan of care on how to reposition, i.e. where to place pillows to off load.	Number of PSW staff trained on moisturizing skin daily as a preventative intervention. Number of direct care team staff trained on the importance of repositioning to prevent skin breakdown.	Current products will be reviewed for compliance with established protocols by June 2026. 85% of PSW staff will be trained on moisturizing skin as a preventative intervention by December 2026. 85% of direct care staff will be trained on the importance of repositioning to prevent skin breakdown.	