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)	36.43	34.43	At the provincial average.	Registered Nurses of Ontario, NP, ROH - Geripsych

Change Ideas

Change Idea #1 1) Support early recognition of residents at risk for ED visits. by providing preventive care and early treatment for common conditions leading potentially avoidable ED visits.

Methods	Process measures	Target for process measure	Comments
1) Education/re-education to registered staff on the continued use of SBAR tool a standardize communication between clinicians. 2) Educate residents and families about the benefits of and approaches to preventing ED visits. The home's attending NP/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) Uilization 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	1) 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; 2) % of staff who complete needs assessments. Completion records for education as a result of needs assessment. 4) Increased SBAR communication within clinical team, reviewed at PAC quarterly.	1) 75% of communication between physicians, NP and registered staff will occur in SBAR Format by Q4; 2) 100% Staff education completed by Q4	

Change Idea #2 2) Development of IV and hypodermoclysis programs in the home

Methods	Process measures	Target for process measure	Comments
1) Collaborate with Paramedic + LTC program to provide education to res./families/reg. staff. Implement work flow for contacting prior to ER transfer when appropriate. 2) Conduct needs assessment from Registered Staff to identify clinical skills and assessment that will enhance their daily practice.	1) # of referrals completed the Paramedic LTC + program 2) Number of IV therapy/treatments completed with in the home	1) Number of referrals completed to the Paramedic + LTC program prior to transfer to hospital; 50% by the end of Q3. 2) Number of IV therapy/treatments completed within the home; 50% by the end of Q4.	

Change Idea #3 3) Education on palliative approach and end of life for staff, residents and families

Methods	Process measures	Target for process measure	Comments
1) Completion of PPS assessment, implementation of use and education for staff, res./families on palliaitve aproach and end of life. Utilization of information brochure or handbook 2) Conduct needs assessment from Registered Staff to identify clinical skills and assessment that will enhance their daily practice. 3) Nurse Practitioner on site will provide education theoretically and at bedside. 4) Utilization 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	1) 100% completion of PPS completed on admission 2) Number of PPS completed quarterly and significant changes 3) Number completion of goals of care conference for residents with PPS less than or equal to 40 4) Staff receiving palliative education quarterly 5) Number of identified palliative residents whose families are offered palliative approach information 6) Completion of registered staff needs assessment.	1) 100% completion of PPS completed on admission; end of Q4 2) 100% of PPS completed quarterly and significant changes; quarterly completion 100% by the end of Q2 3) 100% completion of goals of care conference for residents with PPS less than or equal to 40; 50% completion by the end of Q2, 100% completion by the end of Q4. 4) 5 staff receiving palliative education per quarter 5) 100% of identified palliative residents whose famillies are offered palliative approach information; by the end of Q4. 6) Completion of registered staff needs assessment; RN capacity 50% by the end of Q2.	

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 maintain understanding of this criteria over the next 6 months	

Change Ideas

Change Idea #1 To continuously encourage overall dialogue of diversity, inclusion, equity and anti-racism in the workplace.

Methods	Process measures	Target for process measure	Comments
1) Celebrate culture and diversity events; educational opportunities	1) Number of staff education on Culture and Diversity;	1) 100% of staff educated on topics of Culture and Diversity	

Change Idea #2 To maintain diversity training through Surge education or live events;

Methods	Process measures	Target for process measure	Comments
1) Training and/or education through Surge education or live events;	1) Percent of staff who complete at least one diversity-related education session anually.	1) 100% of staff who complete at least one diversity-related education session anually, by the end of Q4	

Change Idea #3	3) Cultural Diversity Recognition with in the home comprised of recreation staff, resident and family members- to assist with develop programs, recognition with the home		
Methods	Process measures	Target for process measure	Comments
1) Introduce diversity and inclusion as part of the new employee onboarding process; 2) Culturally familiar foods at cultural events planned with recreation	1) Number of culturally diverse events/programs offered in collaboration with residents/families and recreation staff. 2) Number of cultural events that include culturally familiar food and/or culturally meaningful programming.	1) One multicultural week annually within the home; 1 culturally diverse event per quarter. 2) 2 cultural events with culturally familiar food and culturally meaningful programming per quarter.	

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	90.32	95.00	Target is based on corporate averages. We aim to meet or exceed corporate goals, benchmarks.	

Change Ideas

| Change Idea #1 | 1) Engaging residents in meaningful conversations, and care conferences, that allow them to express their opinions. Review ""Resident's Bill of Rights"" more frequently, at residents' Council meetings monthly. With a focus on Resident Rights #29. ""Every resident has the right to raise concerns or recommend changes in policies and services on behalf of themself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else"";

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) Social worker visits with residents	1) Number of staff will have education via Surge Learning on Resident Bill of Rights #29 Annually. 2) Number of resident Council meeting will have Residents' Bill of Right #29, added at each monthly review. Council will have added "resident Bill of Right #29 for review. 3)Number of review of policies added to the admission process, care conference	1) 100% of all staff will have Residents' Bill of Right #29 reviewed on Surge Learning by Q4. 2)100% of resident Council meeting will have Residents' Bill of Right #29, added at each monthly review by Q4. Council will have added ""resident Bil of Right #29 for review. Review of policies added to the admission process, care conference 3)100% of review of Residents Bill of Rights #29 added to the admission process, care conference	Total Surveys Initiated: 62

Change Idea #2	Review of the Whistleblower policy

Methods	Process measures	Target for process measure	Comments
1) Review of policy with resident and family with admission and care conferences 2) Policies -Zero tolerance to abuse, and Whistleblower posted in the home	1) Number of residents/families obtaining policy education regarding zero tolerance of abuse. 2)Posted policy regarding zero of abuse and whistleblower at the front entrance	1) 100% of residents/families obtaining policy education regarding xero tolerance of abuse, annually 2)Posted policy regarding zero of abuse and whistleblower at the front entrance, by the end of Q1.	

Change Idea #3	Review the Concern process in the home on admission and during annual care conference

Methods	Process measures	Target for process measure	Comments
1) Review of Investigation process in the home (during admission and care conferences)	1) Percentage of new admissions informed of concern/complaint process during admission	1) 60% of new admissions by the end of Q3	

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	12.65	10.65	Target is based on corporate averages. We aim to meet or exceed, corporate goal.	Pharmacy, NP

Change Ideas

Change Idea #1 To facilitate a Weekly Fall Huddles; with the interdisciplinary team

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) Education and re-education provided to registered staff on the completion of post fall analysis 3) PT/OT/Nursing Rehab referrals as required 4) Review of the plan of care with families, 5) Delirium screen (potential reason for falls)	1) Number of residents on restorative care program 2) Number of resident who successful discharged from restorative program 3)Upon completion of interRAI, any residents with FRS score of 3 or greater will be referred to pharmacy 4)Number of fall rounds completed by the multidisciplinary team quarterly	1) Number of residents on restorative care program; 3-5 residents enrolled per quarter. 2) Number of resident who successful discharged from restorative program; 1 per quarter 3)Upon completion of interRAI, any residents with FRS score of 3 or greater will be referred to pharmacy ; 60% by the end of Q2. 4)75% of residents who fell in the quarter will have a fall rounds completed.	

Change Idea #2 Purposeful rounding, for resident at high risk for falls

Methods	Process measures	Target for process measure	Comments
1) To increase training and/or education of Falls program; 2) During shift report review resident high risk for falls, frequent falls,	1) number of staff receiving 4P rounding education per quarter 2) number of shift report have high risk residents reviewed	1) 6 staff per quarter receiving 4P rounding education per quarter. 2) 50% by Q2 and 75% Q4 of shift report have high risk residents reviewed.	

Change Idea #3 Collaboration with recreation, to implement recreation activities, to engage residents (analysis to when falls are occurring to develop timing)

Methods	Process measures	Target for process measure	Comments
1) Referral of residents with >2 falls in a month to recreation	1) Percentage of residents with >2 falls in one month who are referred to recreation for falls prevention programming. 2) Percentage of referred residents who receive a recreation assessment and individualized falls-prevention activity plan.	1) 90% of residents with >2 falls in one month will be referred to recreation within 7 days 2) 60% of referred residents who receive a recreation assessment and individualized falls-prevention activity plan by the end of Q3.	

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	4.76	4.00	Target is based on corporate averages. We aim to do better than or in line with corporate average.	Royal Ottawa Hospital, Pharmacy, Nurse Practitioner

Change Ideas

Change Idea #1	The MD, NP, BSO internal and external (including Psychogeriatric Team), with nursing staff will meet monthly to review newly admitted residents on antipsychotic medication for diagnosis and indication for use. This is standing item in CQI/PAC quarterly meeting agenda.		
Methods	Process measures	Target for process measure	Comments
1) Monthly 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) Referral to internal and external BSO for comprehensive assessment 4) Assess for psychosis, Delirium (screen) , BPSD	1) Monthly review 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, 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; 50% completion by the end of Q3	

Change Idea #2	Residents who are prescribed antipsychotics for the purpose of management of Responsive expressions, will have a quarterly review, for the potential of reduction or the discontinuation of medication. Utilization of tracking tool (antipsychotic)		
Methods	Process measures	Target for process measure	Comments
1) Quarterly medication review with NP/MD 2) Assess for psychosis, Delirium (screen) , BPSD 3) 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	1) Number of residents prescribed antipsychotics medications over the number of residents who have received a medication review in the last quarter. 2) Number of resident who plan of care has been reviewed 3) Number of resident, to which the antipsychotic was decrease, or de-prescribed/discontinued	1) 85% of residents prescribed antipsychotics medications over the number of residents who have received a medication review in the last quarter, by the end of Q4 2) 85% of resident who plan of care has been reviewed, by the end of Q4 3) 20% of resident, to which the antipsychotic was decrease, or de-prescribed/discontinued, by the end of Q4.	

Change Idea #3	Gentle Persuasive approaches (GPA) training/education -establish GPA trainers, educators in the home		
Methods	Process measures	Target for process measure	Comments
1) GPA training to be held in the home 2) Number of trained GPA trainers in the home	1) Percentage of staff who complete GAP training 2) 2 GPA trainer in the home by the end of Q4.	1) 50% of direct care staff will complete GPA training by Q4	

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	2.93	2.00	Target is based on corporate averages. We aim to meet or exceed corporate goals, benchmarks.	NSWOC, Medline, NP

Change Ideas

Change Idea #1 To reduce the percentage of resident who develop, or experience worsening pressure injury

Methods	Process measures	Target for process measure	Comments
1) Arrange education for Registered staff and PSW, with SWAN relating to turning and repositioning 2) Annual Surge education - Skin and wound care management 3) Review of resident status, with pressure related injuries during Quality meetings, and referral completed to NSWOC chronic and/or intractable 4) Wound care lead (SWAN) within the home completing education with registered staff	1) Number of Registered staff and PSW who have received education. 2) Number of visits in home and virtually by the NSWOC	1) 4 staff participating in on unit huddle education session per quarter. 2) 5% of visiting in the home virtually by the NSWOC based on referrals from the quality meeting	

Change Idea #2 Conducting audit of resident surface (bed/w/c), for the appropriate surface for pressure relieving

Methods	Process measures	Target for process measure	Comments
1) Referral to PT and OT for reviewing of seating	1) Number of residents referred to OT/PT for seating/surface assessments assessment.	1) 100% of residents with pressure injuries referred to OT/PT for surface assessment byt the end of Q4.	

Change Idea #3 3) Prompt Identification and documentation of worsening pressure injuries

Methods	Process measures	Target for process measure	Comments
1) Registered staff to complete wound rounds with the SWAN to enhance knowledge on wound care management 2) Annual Surge education - Skin and wound care management 3) Wound care lead within the home to audit wound tracker	1) Registered staff to complete wound rounds with the SWAN to enhance knowledge on wound care management 2) Completion of the Skin and tracker, analysis of the data	1) 4 staff participating in on unit huddle education session per quarter. 2) Monthly audit of completion of tracker.	