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)	29.79	20.00	1) At/Below the provincial Average; 2) Through implementation of our change ideas, the home expects an improvement Mar. 2027	MD, NP, NLOT, Home at Health, GMHOT, Baycrest

Change Ideas

Change Idea #1 To reduce avoidable hospital transfers, through the use of on-site Nurse practitioner; Physicians and NLOT

Methods	Process measures	Target for process measure	Comments
1) Utilize in-house NP or external NLOT resources. 2)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 assessments; 3) Nurse Practitioner & NLOT on site will provide education theoretically and at bedside. 4) Education for PSW/Registered staff on STOP and WATCH; 5) Review ED tracker monthly for the common reasons for transfer to ED - review in Nursing Practice meetings, to develop strategies to prevent future ED visits.	1) Number of ED transfers coinciding with Nurse Practitioner's on site scheduled shifts 2) % of active staff who completed needs assessments 3) Number of active staff who completed education as a result of needs assessment 4) # of education sessions with active Registered staff	100% Staff education completed by December 31 2026; Reduction of 80% of avoidable ED transfers on days Nurse Practitioner is on site by December 31 2026	Utilize Nurse Practitioner, other stake holders such as Medigas, CareRx, Pharmacy to provide education to registered staff on topics related to management of avoidable ED visits

Change Idea #2 Implementation of the Nursing PLEDGE Initiative program to build capacity and improve overall clinical assessment skills of Registered Staff by supporting mentorship of nurses, enhancing quality of care and workforce stability.

Methods	Process measures	Target for process measure	Comments
Senior Registered Staff will provide mentorship, education to enhance the clinical knowledge of Registered Staff regarding physical assessment skills, documentation (PCC and SBAR), communication with physicians and families and the management of interventions/treatments to minimize avoidable ED visits	Number of Registered staff who initiated an avoidable transfer to ED over the Number of Registered staff who participated in the initiative.	80% of ED visits were assessed appropriately based on resident outcome and transferred to the ED by December 31, 2026	

Change Idea #3	SBAR Documentation -Registered staff to communicate a comprehensive resident assessment to Physician or Nurse Practitioner , if able, to obtain direction prior to initiating an ED transfer. 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
Education/re-education to active Registered staff on the continued use of SBAR tool a standardize communication between clinicians and families.	1)Number of improved communication processes used in the SBAR format, between clinicians and family per month; 2) number of active staff educated on SBAR. 3)# of education sessions with active Registered staff	80% of communication to Physician/NP or families is documented in S-BAR format by December 31 2026	

Change Idea #4	Advanced Care Planning/Goals of Care discussed with resident and families during care conferences; Education on palliative approach and end of life for staff, residents and families. Introduce the use of Gold Standard Framework to help with Identification Guidance-GSF (PIG), is a guide for clinicians to assist with earlier recognition of decline for patients considered to be in their final year(s) of life.		
Methods	Process measures	Target for process measure	Comments
1) Utilization of the PPS Palliative Performance Score to determine disease progression; 2) Utilize in-house NP or external NLOT resources. 3) Educate residents and families about the benefits of and approaches to preventing ED visits. 4)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; 5) Education for staff, residents/families on palliative approaches and end of life. 6)Utilization of information brochure or handbook	Continue to use and analyze the ED tracker for the number of residents whose transfers were a result of family or resident requests, nurse initiated and resident outcome; Number of transfers to ED who returned within 24 hours; Increased SBAR communication & documentation. Number of IV therapy/treatments completed with in the home .	100% of care conferences discussed advanced care planning/goals of care By December 31 2026 2) 100% monthly analysis of ED tracker by May 31 2026; 80% of communication and documentation utilized the SBAR format by December 31 2026; 80% of IV therapy/treatments completed at the home level by September 30 2026	

Change Idea #5	Build capacity and improve overall clinical assessment skills of Registered Staff; through education supported by NP. Development of IV program in the home by supporting skills competency. (NLOT)		
Methods	Process measures	Target for process measure	Comments
1) Utilize in-house NP or external NLOT resources. 2) Clinical Lab to provide practice setting to maintain competency quarterly in IV program.	Number of active Registered staff who maintain competency in IV insertion/maintenance on quarterly basis 2)Number of IV therapy/treatments completed with in the home .	100% of Active Registered staff will maintain IV therapy competency by December 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	99.54	100.00	Through education, the Home expects to have an increase understanding of this criteria over the next 6 months	

Change Ideas

Change Idea #1 To improve overall dialogue of diversity, inclusion, equity and anti-racism in the workplace;

Methods	Process measures	Target for process measure	Comments
Celebrate culture and diversity events; educational opportunities; Monthly Quality meeting standing agenda- review the number of programs, education completed; Culturally familiar foods - special menu; Ensure correct pronunciation of names; Flexible accommodations for religious observances	3) Number of Celebration completed in the home	100% of active staff educated on topics of Culture and Diversity by December 31 2026	

Change Idea #2 To increase 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	Number of active staff completed education on Culture and Diversity; Number of newly hired staff completed education on Culture and Diversity	100% of active staff will have completed SURGE education on Culture and Diversity by December 31 2026	

Change Idea #3 To facilitate ongoing feedback through open door policy and daily manager walkabouts			
Methods	Process measures	Target for process measure	Comments
At Risk Management meetings, reminders of open door policy; Direct person to appropriate team member to address concerns	Number of reminders documented in Risk Management over Number of Risk Management meetings	100% of reminders documented by December 31, 2026	

Change Idea #4 Development of Cultural Diversity team within the home compromised of staff, resident and family members- to assist with developing cultural and recognition events/programs within the home			
Methods	Process measures	Target for process measure	Comments
Celebrate Monthly culture and diversity events and activities; Offer Culturally familiar foods for staff and residents (special menu);	Number of Cultural events/celebrations completed in the home	100% of cultural events planned will be celebrated monthly by December 31 2026	

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	98.55	100.00	Target is based on corporate averages. We aim to meet or exceed corporate goals, benchmarks.	

Change Ideas

Change Idea #1 To maintain or exceed our goal of 98.55%. Engaging residents in meaningful conversations, and at care conferences, that allow them to express their opinions.

Methods	Process measures	Target for process measure	Comments
Resident's Bill of Rights #29, Whistleblower Policy and Complaints/concerns process will be reviewed during Admission and Care Conferences, reinforce home's practice of the open door policy and daily management walk abouts to encourage discussions; Social Worker visits with residents	Number of care conferences that reviewed Resident Bill of Rights #29, Whistleblower policy and Complaints/concerns process over Number of Care Conferences; Number of Social Work visits with residents monthly	100% of Care conferences will review Bill of Rights #29, Whistleblower policy and Complaints/concerns process by December 31 2026	Total Surveys Initiated: 69

Change Idea #2	Continue reviewing Resident's Bill of Rights at Monthly Resident council meetings with a focus on Resident Rights #29; Review of the Whistleblower policy, Complaint/Concern process in the home		
Methods	Process measures	Target for process measure	Comments
Bill of Rights #29 will be a standing agenda item at monthly Resident Council meetings. Policies -Zero tolerance of abuse, and Whistleblower posted in the home 4) Review of Investigation process in the home (during admission and care conferences)	Number of Resident council meetings that have reviewed the Bill of Rights #29 over the number of Resident council meetings annually	100% of Monthly Resident Council meeting will have Residents' Bill of Right #29 reviewed by December 31 2026	

Change Idea #3	Re-education and review to all staff on Resident Bill of Rights specifically #29 at department meetings monthly by department managers		
Methods	Process measures	Target for process measure	Comments
Bill of Rights #29 reflected in minutes of the monthly meetings per department	Number of Departmental meetings minutes address Bill of Rights # 29 over number of Departmental meetings annually; Number of staff who attended departmental meetings over number of departmental staff	100% of all Departmental meeting standing agendas will have Resident Bill of Rights # 29 added for review by March 31, 2026; 100% of staff will have education via department meetings on Resident Bill of Rights # 29 by March 31 2026;	

Change Idea #4	Add focus to review Resident Bill of Rights #29 at Family council quarterly meetings		
Methods	Process measures	Target for process measure	Comments
Resident Bill of Rights as a Standing agenda item at quarterly meetings	Number of meeting minutes that have Resident Bill of Rights #29 reviewed over the number of meetings	100% of all Family Council meeting minutes include Resident Bill of Rights #29 by December 31 2026	

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	10.83	8.00	Target is based on corporate averages. We aim to maintain or exceed the corporate average.	

Change Ideas

Change Idea #1 To facilitate a Weekly Fall Huddles on each unit; 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;	1) Number of weekly meeting in each unit; 2) number of interdisciplinary staff participation in the Weekly Falls Huddles meeting;	100% of interdisciplinary staff will participate at weekly Falls huddle on each unit; 100% of staff to complete the required falls 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 by December 31 2026	

Change Idea #2 Establishing documentation/charting buddies, (PSW complete documentation with resident's at high risk for falls - assists with the identification/reason for falls

Methods	Process measures	Target for process measure	Comments
1) Additional training and/or education of Falls program and documentation; 2) During shift report review residents at high risk for falls, frequent falls; 3) Review of the resident's plan of care (identification of the triggers, related to the fall); Use of fall prevention equipment to prevent injury such as hip protectors, floor mats, bed and chair alarms 4) Assist in completion of environmental audits	# of active PSW staff who attended the education/training; # of high risk residents reviewed at shift report; # of high risk residents who have falls prevention equipment in place	100% of PSW will have completed Falls and documentation education; 100% of high risk residents reviewed at shift report; 100% of high risk resident who have falls prevention equipment in place by June 30 2026	

Change Idea #3 Establish/re-establish the restorative care program in the home (provide education on how residents qualify for the program)

Methods	Process measures	Target for process measure	Comments
Restorative education provided to the designated PSW's in the program; Lead RPN to Identify residents who qualify for the program and reassess resident's progress every two (2) weeks;	Number of residents on restorative care program specific to falls prevention; Number of residents who were successfully discharged from restorative program	Number of high falls risk residents who successfully reduced # of falls by 80% post program over number of high falls risk residents enrolled in restorative program by December 31 2026	

Change Idea #4 Injury prevention - review of FRS, ensure appropriate medication prescribed for prevention of bone density loss

Methods	Process measures	Target for process measure	Comments
Resident list of FRS of 3 or greater, offer fracture prevention medication 2)Referrals to MD/NP for medication reviews, 3) Use of falls prevention aides to prevent injury, use of hip protectors, floor mats, bed and chair alarms	Number of residents with an FRS of 3 or greater who had medication changes prescribed (addition of fracture prevention medication) over number of residents referred for medication review	90% of residents will have medications prescribed for prevention of bone density loss by December 31 2026	

Change Idea #5	Create activity bins, for resident to assist with engagement. Collaboration with Program department, to implement recreation activities, to engage residents (analysis of when falls are occurring to develop timing of activities)		
Methods	Process measures	Target for process measure	Comments
Program Department will participate in weekly falls huddles and provide guidance/support in creation of resident specific activity bins and programming in relation to the specified time during a shift of falls	Number of activity bins created over number of residents referred to Program department; Number of Resident Falls prior to implementation of Programs during a specified time in the shift over the number of Resident Falls post implementation during a specified time in the shift	80% reduction in resident falls during a specified time of shift post implementation of additional programming/activities by September 30 2026	

Change Idea #6	Purposeful rounding, for resident at high risk for falls		
Methods	Process measures	Target for process measure	Comments
Increase training and/or education of Falls program; Implementation of the 4 "P"s; Ensuring Use of night lights (motion sensor/or on during the night), hip protectors, floor mats, bed and chair alarms as applicable; During shift report review resident high risk for falls, frequent falls, Vision and hearing checks	# of residents identified as high risk for falls monthly	100% of high risk residents will have purposeful rounding completed on each shift by December 31 2026	

Change Idea #7 During admission process, a falls history and interventions will be reviewed with resident and/or family member

Methods	Process measures	Target for process measure	Comments
Residents with FRS of 3 or greater, offer fracture prevention medication; Review identification of the triggers related to falls - use of night lights motion sensor, hip protectors, floor mats, bed and chair alarms; Review the plan of care with resident/ families, Vision and hearing checks; Pain assessment, to assess for potential pain/unmanaged pain and Delirium screen (potential reason for falls)	Number of residents admitted with a history of falls	100% of residents admitted will have a review of their history of falls history and interventions implemented by June 30 2026	

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	17.54	14.00	Target is based on corporate averages. We aim to do better than or in line with corporate average.	BSO, GHMOT, Baycrest NLOT, MD, NP, Ontario Shores

Change Ideas

Change Idea #1	During admission conference, review with families, reason for the prescribing of antipsychotic medication, interventions effective in management of responsive expressions (if admission from another LTC home, inquire if care plan can be sent for review, review of Behavioral assessment provided by Ontario Home at Health)		
Methods	Process measures	Target for process measure	Comments
Discussion with resident and family on the indications for use and risks related to antipsychotic administration. Plan of care reviewed with resident, family and the interdisciplinary team to develop a person-centered approach to responsive expressions	Number of Admission conferences with documented discussions related to antipsychotic usage.	1) 100% of newly admitted residents prescribed antipsychotics will have had, during admission conference, discussions for the appropriateness of antipsychotics by June 30 2026	

Change Idea #2	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. Meetings will be discussed as a standing item in CQI/PAC quarterly meeting agenda.		
Methods	Process measures	Target for process measure	Comments
1) Maintain Log (tracker) of newly admitted residents prescribed antipsychotic medication by BSO Lead 2) BSO Lead will schedule meetings with interdisciplinary team each month	1) Number of residents admitted with prescribed antipsychotic medications over number of residents admitted monthly 2) Number of scheduled meeting held monthly with interdisciplinary team	1) 100% of newly admitted residents prescribed antipsychotics will have been reviewed for the appropriateness of antipsychotics by April 30 2026	

Change Idea #3	Residents who are prescribed antipsychotics for the purpose of management of Responsive expressions, will have a quarterly review, for the potential reduction or the discontinuation of medication. Utilization of tracking tool (antipsychotic)		
Methods	Process measures	Target for process measure	Comments
Prior to quarterly medication review of residents prescribed antipsychotics, a comprehensive assessment will be completed for analysis including DOS, Cohen's Mansfield, Pain, 72 hour sleep pattern, Psychosis, Delirium screening, BPSD, review of behavioural notes and identified triggers with a review of Plan of care. BSO lead and nursing team will work collaboratively with the Physician, Pharmacist, Nurse Practitioner and external BSO team to discuss and complete a quarterly medication review for residents who receive antipsychotics for Responsive expressions to determine eligibility (with reference to exclusion criteria) for deprescribing program. When eligibility is confirmed, discussion with resident and families on the use and risks related to antipsychotic medication, the reduction program and discuss consent for program	1) Number of residents enrolled in antipsychotics reduction program over number of eligible residents for antipsychotics reduction program. 2) Number of comprehensive assessments completed over number of residents prescribed antipsychotics medications	100% of residents who are prescribed antipsychotic medications will receive a quarterly review to determine potential for reduction in dosage or discontinuing antipsychotics by December 31 2026	

Change Idea #4	Gentle Persuasive approaches (GPA) training/education -establish GPA trainers, educators in the home		
Methods	Process measures	Target for process measure	Comments
Establish GPA trainers and educators in the home; Scheduled GPA training sessions for all active staff	1)Number of active staff who completed GPA education over number of active staff in home; 2) Number of GPA sessions offered in a 6 month period	100% of active staff receive GPA training by December 31 2026	

Measure - Dimension: Safe

Indicator #6	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of LTC residents who develop worsening pain	C	% / LTC home residents	CIHI CCRS / July 1 to Sept 30, 2025 (Q2)	9.67	7.50	Target is based on Corporate Averages. We aim to meet or exceed Corporate Benchmark	MD, NP, External Pain and Palliative Network, Pharmacist, NLOT, Spasticity Clinic

Change Ideas

Change Idea #1 Enhancement of the Palliative Care and End of Life program

Methods	Process measures	Target for process measure	Comments
1) Establish Palliative care order sets; 2) Scheduled monthly Palliative care and EOL education for staff by the Pain and Palliative Network; 3) Conduct thorough assessments of the residents, Palliative care, End of Care; Current medication regiment; Involve the interdisciplinary team, family and resident with care planning decisions. 4) Resident who trigger for worsening pain will have a comprehensive review completed with MD/NP.	1) Number of staff who completed Pain and Palliative education over Number of staff 2) Number of referrals completed Pain specialist/consultant 4) Number of medication reviews related with analgesic change	1) 100% of staff complete Pain/Palliative series education by December 31, 2026 2) 100% of resident experiencing pain will have comprehensive pain assessment completed by December 31 2026	

Change Idea #2	Utilization of pain tracker, to monitor the use of PRN analgesic with discussion with resident how pain was previously managed and the goal for pain management.		
Methods	Process measures	Target for process measure	Comments
Education to Registered Staff on Pain Management by the Pain and Palliative Network 2) Resident who triggers for worsening pain will have a Comprehensive pain assessment completed and review of routine analgesics with MD/NP 3) Involvement of Interdisciplinary team in Pain Management strategies 4)Consultation with the Pain consultant/ NP/Pharmacist consultant/BSO RPN/PSW/PT/PTA	1) Number of Registered staff completed Pain Management education 2) Number of comprehensive Pain assessments completed related to PRN tracker; 3) Number of Medication Order changes for Analgesics 4) Number of care plans revised to include interdisciplinary non pharmacological strategies related to Pain Management 5)) Number of referrals to Pain specialist/consultant	1) 100% of staff will complete Pain management education 2) 100% of residents who trigger the PRN tracker will have comprehensive pain assessments completed 3) 100% of resident's care plans will include interdisciplinary non pharmacological strategies to manage pain by December 31 2026	