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)	44.26	43.00	The home will be at or below the provincial Average. Through implementation of our change ideas, the home expects an improvement over the next 12 months.	North Simcoe Muskoka Specialized Geriatric Services, Behavioural Supports Ontario, Nurse Practitioner, North Simcoe Muskoka Palliative Care Network

Change Ideas

Change Idea #1 Explore development of an in-home IV therapy program to support treatment within the home where clinically appropriate, reducing unnecessary ED transfers.

Methods	Process measures	Target for process measure	Comments
Hold training sessions to provide education and/or Re-Education Registered staff on IV therapy within LTC home	Number of Registered Staff who attended education IV therapy education sessions. Number of IV therapies successfully initiated and/or completed in the home.	At least 3 Registered Staff at the home attend IV training session.	Will utilize Nurse Practitioners who are on-site 3 days per week to facilitate ongoing education opportunities and assist with IV therapy as needed.

Change Idea #2	Enhance early recognition of residents at risk for ED transfers by improving preventative assessments and early treatment strategies for common conditions associated with potentially avoidable ED visits (ie. dehydration, infections, pain, behavioural changes).		
Methods	Process measures	Target for process measure	Comments
Utilization of internal hospital tracking tool to analyze each ED transfer. ED transfers to be reviewed monthly by nursing leadership (DOC, ADOC) and reports will be reviewed at quarterly PAC meetings; and standing agenda in nursing practice meeting. Utilize internal hydration and PRN analgesic tracking tool to identify residents not meeting fluid or pain goals with follow-up notifications to Dietician, MD, Nurse Practitioner as appropriate.	Number of SBARs and/or Dietician referrals completed by Registered staff following reduced fluid intake or prolonged PRN analgesic use. Number of avoidable hospital transfers	80% of communication between physicians, NP and registered staff will occur in SBAR Format by December 2026 Reduction in number of avoidable hospital transfers.	DOC/ADOC regularly review internal tracking tools to ensure completion and appropriate follow-up as appropriate to ensure improvements to preventative assessments or early intervention occur.

Change Idea #3	Strengthen advanced care planning processes and ensure inclusion to resident care plans as discussions occur with residents and/or family members.		
Methods	Process measures	Target for process measure	Comments
- Incorporate structured goals-of-care discussions during care conferences where goals of care, treatment preferences and decisions related to hospital transfers or comfort-focused care are discussed and clarified. - Collaborate with NSMHPCN to provide staff education on palliative approaches ot care and end of life as appropriate. - 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	- Staff attendance at palliative education sessions that are supported by NSMHPCN. - The number of residents whose transfers were a result of family or resident request. - The number of 'goals of care' conversations/education with family or residents that occurred during care conferences	80% staff will have attended an in-person education session related to palliative care, end of life or responsive behaviours by end of year. 100% of family members and/or residents will have had opportunity to discuss goals of care during care conferences.	Will continue to facilitate staff education sessions in collaboration with North Simcoe Muskoka Palliative Care Network and utilize as additional resource for family/residents education in the home.

Change Idea #4	Involvement of Behavioural Supports Ontario/North Simcoe Muskoka Specialized Geriatric Services to support early assessment, intervention and staff response to prevent ED transfers related to unmet needs or acute medical conditions exhibited as responsive expressions.		
Methods	Process measures	Target for process measure	Comments
- Hold monthly education sessions on topics related to responsive expressions and dementia. - Ensure care plans for resident with responsive expression are updated appropriately with indications of triggers and current successful interventions - Residents to be referred to BSO in timely manner and as appropriate	Number of BSO referrals initiated and BSO case reviews completed. Number of staff who attended education sessions that are held in collaboration with BSO.	80% staff will have attended an in-person education session related to palliative care, end of life or responsive behaviours by end of year. 100% of resident care plans updated with BSO recommendations as appropriate.	The home will continue to improve assessment and management of responsive expressions to help identify underlying issues earlier and reduce avoidable hospital visits.

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	76.06	100.00	Through education, the home expects to have an increase understanding of these criteria over the next 6 months and have 100% completion this year.	Behavioural Supports Ontario, Surge Learning Education, Leadership Team

Change Ideas

Change Idea #1 Introduce culturally inclusive initiatives to celebrate diversity an reinforce equity and inclusion within the home.

Methods	Process measures	Target for process measure	Comments
- Include culturally familiar foods on the menu and invite families to share recipes to consider for inclusion on menu in the home - Celebrate culture and diversity events; educational opportunities	How many family recipes included on the menu for the 2026 year. How many culture and/or diversity related events occurred in the home for the 2026 year	Have at least 1 diversity, cultural or religious celebration completed in the home every month for a total of 12 per year. Have at least 1 recipe shared by family included on the menu each quarter.	The home will continue to promote culturally inclusive initiatives and reinforce equity and inclusion in the home through related celebrations and collaborations with families and residents and

Change Idea #2	Establish regular monitoring of education completion rates and provide reminders for completion. Leadership follow-up and recognize strategies to support ongoing participation in educational opportunities.		
Methods	Process measures	Target for process measure	Comments
Education through Surge education or live events Monthly review of course completion via Surge Learning to ensure timely completion	Number of staff who complete relevant equity, diversity, inclusion and anti-racism education via Surge Learning. Memo postings for education completion reminders.	100% of staff will complete relevant equity, diversity, inclusion and anti-racism education via Surge Learning by December 2026.	The home will ensure education completion on relevant equity, diversity, inclusion, and anti-racism education and continue to welcome opportunities as they arise for further learning.

Change Idea #3	Cultural assessment to be completed on admission, to discuss and identify language, faith, gender preference and/or family roles and included in care plan.		
Methods	Process measures	Target for process measure	Comments
Care plans are updated to include resident faith, language, gender preference and/or family roles when information is available.	Number of care plans that include religious beliefs, spiritual beliefs, gender preference, and/or family roles. Number of care plans updated to include religious beliefs, spiritual beliefs, gender preference, and/or family roles. Number of care conferences where family share new information related to diversity, inclusion and equity and are added to care plan.	100% of residents have focus related to equity, diversity, inclusion, or antiracism included in current care plan.	The home will continue to update care plans on admission and post care conferences when new information related to equity, diversity, inclusion and anti-racism is shared by either the family or resident as appropriate.

Change Idea #4 To improve overall dialogue and awareness of diversity, inclusion, equity and anti-racism in the workplace

Methods	Process measures	Target for process measure	Comments
Support staff involvement in cultural events or celebrations in the home when appropriate. Share information about these events through staff memos and internal communications to promote awareness, inclusion and engagement. Develop and distribute educational materials and resources for staff (posters, newsletters) that promote equity, diversity inclusion and anti-racism in the workplace. Leadership to model inclusive communication and reinforce expectations related to equity, diversity inclusion and anti-racism through team huddles and say-to-day interactions.	Number of staff communications (memos, newsletters, postings) shared with staff on related QI Number of cultural awareness or inclusion events promoted or recognized within the home.	At least 1 communication (memo, newsletter, posting) each quarter At least 2 cultural awareness events or recognitions per year. 1 staff meeting per quarter will include discussion or reminder related to inclusion and respectful workplace culture.	The home with promote equity, diversity, inclusion and anti-racism through cultural awareness activities, staff communications and leadership reinforcement of related expectations in the workplace.

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	92.50	93.00	Continue to remain at or above corporate benchmarks	Surge Learning, Social Service Worker, Leadership Team

Change Ideas

Change Idea #1 Improve opportunities for residents to express opinions and provide feedback in a safe and supportive environment.

Methods	Process measures	Target for process measure	Comments
Encourage open discussions during resident council meetings and provide regular opportunities to share feedback. Ensure residents informed about how to raise concerns or suggestions (speaking with leadership, resident council) Leadership and staff will respond to resident feedback respectfully and in a timely manner. Promote awareness of resident rights and ability to voice concerns without fear of consequences through Surge Learning education and posted materials and discussions.	Number of resident council meetings where resident encouraged to share feedback Number of opportunities provided for residents to submit feedback (food committee meeting, CQI meeting, resident council meeting).	Resident council meetings held monthly for a total of 12 per year and meeting minutes posted. Food committee meetings held monthly for a total of 12 per year.	Total Surveys Initiated: 40 The home will continue to support resident engagement and ensure resident voices are heard with timely follow-up as applicable.

Change Idea #2	Review "Resident's Bill of Rights" more frequently, 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
Continue to have Resident Bill of Rights posted in the home Review the Resident Bill of Rights with Residents during Resident Council Meetings, which specific focus on Resident Right #29	Number of times reviewed resident's rights at Resident Council Meetings Number of times reviewed resident right with staff at the home Number of staff completion of Resident Rights Modules on Surge Learning	100% of staff will have completed relevant Surge Learning modules on Resident Rights by December 2026 Resident Bill of Rights reviewed during Resident Council meetings at least 4 times per year.	The home will continue to reinforce residents' ability to express opinions and concerns without fear of consequences by reviewing Resident Bill of Rights, with particular focus on Resident Right #29 to increase resident awareness of their rights.

Change Idea #3	Social Service Worker will provide regular check-ins with residents to provide opportunities for residents to share concerns, feedback or opinions.		
Methods	Process measures	Target for process measure	Comments
The Social Service Worker will meet with residents individually or in group setting regularly. Residents will be encouraged to discuss concerns, suggestions or provide feedback in addition to discussions during routine visits. Any concerns raised will be communicated to leadership for timely follow-up	Number of resident check-ins completed by the Social Service Worker Number of referrals completed to Social Service Worker	At least 1 round with residents quarterly and more frequently as needed	Regular check-ins with the Social Service Worker will provide residents with an additional safe and supportive opportunity to express opinions, concerns or provide feedback.

Change Idea #4	Reinforce staff awareness of reporting and accountability policies to ensure residents can express opinions without fear of consequences		
Methods	Process measures	Target for process measure	Comments
Staff to complete relevant Surge Learning modules annually and during orientation, on whistleblower and duty to report policies and procedures. Include discussions about residents' rights and safe expression in staff huddles and/or meetings	Number of staff completion of relevant Surge Learning modules Number of staff meetings or communications where the whistleblower/duty to report are reviewed.	100% of staff complete relevant Surge Learning modules by December 2026	Reinforcing awareness of current related policies supports staff understanding of how to handle concerns appropriately. Staff adherence to these policies ensures residents' concerns are addressed and followed up on without fear of consequences.

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	19.75	15.50	Target is based on corporate averages. We aim to meet corporate benchmarks by December 2026.	Physiotherapist, Nurse Practitioner, Pharmacist Consultant, Family Members

Change Ideas

Change Idea #1 Implement recreation activities to engage residents where appropriate. Utilize fall tracking data to recognize patterns and align with engagement times.

Methods	Process measures	Target for process measure	Comments
- Collaboration with interdisciplinary team during monthly Fall Committee meetings to discuss current fall interventions and development of new resident specific interventions for high-risk fallers. - Review monthly fall tracking tool to identify patterns in time and location	Number of resident identified as having high fall risk who are offered targeted recreation/engagement activities during peak fall-risk times identified through fall tracking tool.	80% of high falls risk residents are offered or engaged in activity during identified high-risk periods.	The home will use data from internal falls tracking tool to identify trends rleated to resident falls in the home. Will collaborate with team to implement engagement activities to reduce risk for falls.

Change Idea #2	Establish "documentation/charting buddies" - PSW complete documentation in proximity with residents at high risk for falls - assists with the identification/reason for falls		
Methods	Process measures	Target for process measure	Comments
- Provide list of residents who are a high-risk for falls for PSW to remain in close proximity while charting - Track compliance through random monthly audits of PSW documentation locations.	Percentage of shifts where PSW complete documentation in proximity to resident identified as being high risk.	85% of shifts demonstrate implementation of documentation/charting buddies for residents identified as high risk for falls.	Charting in close proximity to high fall risk residents will encourage increased observation and support fall prevention strategies.

Change Idea #3	Injury prevention - review of FRS, ensure appropriate medication prescribed for prevention of bone density loss		
Methods	Process measures	Target for process measure	Comments
- Ensure physiotherapy referrals completed as required for regiment/programming and MD/NP notified to complete medication review. - Audit of fall related equipment for high-risk fallers (ie, bed alarm, fall mat, hip protectors).	Percent of residents referred to physiotherapy following identified fall risk or fall.	100% of admissions to the home will have fall assessment completed. 100% of residents triggering QI will have a fall focused care plan review	The home will continue to use fall injury prevention equipment, interdisciplinary team and falls assessment completion to reduce falls and injuries related to falls.

Change Idea #4	Staff to complete 4 P's - purposeful rounding for residents who are at a high risk for falls		
Methods	Process measures	Target for process measure	Comments
- Education and re-education provided to registered staff on the completion of the 4 P's - Documentation in point-of-care charting of 4 P's each shift for high-risk fallers	Number of fall huddles completed monthly Number of staff completing falls prevention education including the 4P's Percentage f residents identified as high risk for falls who receive documented 4 P purposeful rounding each shift.	95% compliance with documented 4P purposeful rounding for residents identified as high risk for falls through 2026.	Purposeful rounding supports proactive care and helps reduce fall risk for high risk fallers.

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	14.94	14.00	Target is based on corporate benchmark. We aim to do better than or in line with corporate average	Pharmacist Consultant, Medical Director, Behavioural Supports Ontario, North Simcoe Muskoka Specialized Geriatric Services

Change Ideas

Change Idea #1 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.

Methods	Process measures	Target for process measure	Comments
Utilize antipsychotic tracking tool to identify and track medication changes for those on antipsychotic medications. Quarterly medication review to be provided to NP/MD for completion in a timely manner.	Number of resident, to which the antipsychotic was decrease, or de-prescribed/discontinued	100% of residents who are prescribed antipsychotic medications will receive a 3 month review to determine potential for reduction in dosage or discontinuing antipsychotics.	The home with work with interdisciplinary team to track and reassess residents' antipsychotic medications for residents living without psychosis.

Change Idea #2 Development of plans of care, with non-pharmacological approach - identification of triggers and interventions			
Methods	Process measures	Target for process measure	Comments
- Collaborate with Behaviour Supports Ontario to develop individualized and effective interventions to manage responsive expressions. - Implementation of DOS, with change in responsive expressions, analysis of the DOS, with review of plan of care - Assess for psychosis, Delirium (screen), BPSD	Number of residents who plan of care has been reviewed Number of referrals to Behavioural Supports Ontario Number of assessments completed for psychosis, delirium, BPSD	100% of newly admitted residents will have been reviewed for the appropriateness of antipsychotics use through 2026 100% of residents who have responsive expressions will have non-pharmacological interventions included in their care plan.	Continue to re assess plan of care with interdisciplinary team and update care plans throughout 2026

Change Idea #3 Gentle Persuasive approaches (GPA) training/education -establish GPA trainers, educators in the home			
Methods	Process measures	Target for process measure	Comments
GPA training to be held in the home to reduce barriers for completion (ie. transportation) Have staff from all departments participate in training sessions	Number of staff receive education GPA /number of sessions Number of training sessions completed Number of GPA trainers in the home.	Have at least 1 GPA trainer in the home through 2026 Have at least 3 GPA training sessions for staff in the home in 2026. Have 50% of staff trained by December 2026	Continue to enhance staff ability to manage responsive expressions and support growth and learning within the home.

Change Idea #4 During admission conference, review with families, reason for the prescribing of antipsychotic medication and interventions effective in management of responsive expressions.			
Methods	Process measures	Target for process measure	Comments
- Facilitate discussions related to responsive behaviours that include pharmacological and non-pharmacological interventions. - Discuss what is working, and what could be improved.	Number of admission car conferences where antipsychotic medication uses and non-pharmacological interventions are reviewed with residents/families when applicable.	90% of admission care conferences include documented discussion of responsive behaviours and/or antipsychotic medication use and any non-pharmacological interventions.	Admissions care conference discussions support information sharing and can assist in determining appropriate use for antipsychotic medication.

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	1.96	1.50	We aim to maintain corporate benchmarks through the year of 2026	

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
- Develop a list of residents who PURS is 3 or greater, review plan of care, for the appropriate pressure relieving devices and review of surfaces in place. - 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,	- Number of residents reviewed during quality committee meetings - Number of residents who had PURS greater than 3 and following review of plan of care	100% residents who are triggering QI are reviewed and discussed during quality committee meetings held once per month Pressure relieving devices are reviewed for 100% of residents with PURS 3 or greater and appropriate	The home will continue to review residents who are at risk of developing pressure injuries and will be identified by PURS scare review and those with worsening pressure injuries will be reviewed during quality committee meetings monthly.

Change Idea #2 The home will collaborate with NSWOC to provide in home and virtual consults			
Methods	Process measures	Target for process measure	Comments
- Registered staff to complete wound rounds with the NSWOC to enhance knowledge on wound care management - Coordinate routine visits with NSWOC and virtual consults as needed or required for residents identified as having worsening pressure injuries.	Number of virtual consults completed by the NSWOC Number of in-person consults completed by the NSWOC Number of referrals made to NWSOC	100% of residents with worsening pressure injuries are assessed by NSWOC through 2026	Continue to collaborate with NSWOC to reduce worsening pressure injuries in the home through referral process and routine visits to the home.

Change Idea #3 During admission process, complete comprehensive review of resident status, and risk level for alteration in skin to develop plan of care			
Methods	Process measures	Target for process measure	Comments
Completion of PURS assessment on admission Completion of Head-to-toe assessment on admission for early identification of pressure injuries.	Number of PURS and head-to-toe assessments completed within 24hrs of admission to home Care plans updated in timely manner to reflect pressure injury risk or pressure injuries identified.	100% of residents admitted to the home have PURS and head to toe assessment completed	Pressure injury risk will be identified on admission and existing pressure injuries will be assessed and identified on admission.

Change Idea #4 Prompt identification and documentation of worsening pressure injuries			
Methods	Process measures	Target for process measure	Comments
Utilization of internal skin and wound tracking tool, to assist in revision and timely assessments of pressure related injuries in the home. Internal tracking tool will be used to track treatments ordered by providers Weekly assessments will be completed for all pressure injuries in the home by skin and wound care champion.	Number of residents entered into internal skin and wound tracking tool Number of residents reviewed on skin and wound tracker during quality committee meetings.	100% of residents who have worsening pressure injuries are reviewed at monthly quality committee meetings through 2026. 100% of residents with worsening pressure injuries will be assessed by NSWOC through 2026 year.	The home will use internal skin and wound tracker and quality indicator triggers to identify worsening pressure injuries in the home

Change Idea #5 Support Registered staff knowledge on pressure injury prevention, pressure relieving devices, and skin and wound management

Methods	Process measures	Target for process measure	Comments
Annual Surge Learning education - Skin and wound care management Completion of rounds with NSWOC Facilitate education in collaboration with NSWOC on pressure injury related topics	Number of Registered staff and PSW who have completed education. Number of education sessions related to skin and wound and/or pressure injuries	100% of Registered staff complete skin and wound management course via Surge Learning by December 2026. 80% of Registered staff complete additional education session on related topics by December 2026.	The home will continue to support Registered Staff competencies related to pressure injury, including identification, management and prevention through 2026.