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.	O	Rate per 100 residents / LTC home residents	CIHI CCRS, CIHI NACRS / Oct 1, 2023, to Sep 30, 2024 (Q3 to the end of the following Q2)	35.66	28.00	Review of current performance, regional average, implementation of planned change ideas	

Change Ideas

Change Idea #1 Implementation of RNAO's Clinical Pathways Admission Assessment which has an increased focus on delirium, falls and pain in April 2025; and implementation of pain and falls updated assessments by December 31, 2025.

Methods	Process measures	Target for process measure	Comments
Education will be provided to all current registered staff, and will be incorporated into orientation for new registered staff, regarding delirium, falls and pain screening to support the standard and accurate assessment, incorporating resident centred interventions on admission and throughout their LTC stay.	Track the number of staff trained to use Clinical Pathways. Track the number of Admission Clinical Pathways completed within 24 hours of admission; and, ongoing assessments as per pain and falls policies.	100% of staff will be trained in clinical pathways by April 2025 and December 2025. 100 % of new admissions will have delirium, fall and pain screening completed within 24 hours of admission. 100 % of fall and pain assessments will be completed as per policy.	Early identification and screening for delirium, falls and pain can help prompt interventions being put in place earlier which may help decrease avoidable ED visits.

Change Idea #2	Partner with local hospital, Facilities Operator Group (FOG) and pharmacy to continue/support work on "Transitions in Care" between hospital and long-term care. Work will focus on accurate, timely and effective communication of resident care information, services, and care planning to minimize ED visits.

Methods	Process measures	Target for process measure	Comments
Quarterly discussions at FOG. Revitalization of working group with local hospital and long-term care home representation. Effective utilization of Project Amplifi software and information. All registered staff will receive training and access to e-connect for Terrace Lodge residents.	Set and track the frequency of meetings. Track the number of strategies developed and implemented as a result of the working group; and the success of each. Ensure that both hospital and long term care home fully implement and utilize project amplifi. Track the effective use of econnect by registered staff.	100 % of registered staff and clinical management staff will effectively utilize project amplifi and/or econnect to support transitions in care by November 30, 2025. Terrace Lodge manager/designate will participate in 100 % of transition in care and FOG meetings. Reduce the number of hospital/ED visits within 30 day of a previous admission/visit to 20% by March 31, 2026.	Prior to COVID pandemic, the local hospital and representatives from the long-term care homes developed a working group to support effective transitions in care with the implementation of some communication strategies. Discussions have continued at FOG meetings as able. The revitalization of the working group has been identified as an opportunity to support transitions in care and ultimately reduce readmission/transfer to Emergency department. Project Amplifi was implemented across our 3 Homes but is only effective if utilized by both Hospital and long-term care home which has been inconsistent to date.

Change Idea #3	Recruitment of Nurse Practitioner role to work collaboratively with the interdisciplinary team across the three long-term care homes through the Hiring More Nurse Practitioners funding/initiative to support early identification/screening/assessments/care planning and minimize hospital/ER visits and admissions.		
Methods	**Process measures**	**Target for process measure**	**Comments**
Development of Nurse Practitioner job description in consultation with medical directors. Recruitment of Nurse Practitioner. Application for funding through the Hiring More Nurse Practitioners funding initiative. Onboarding of the nurse practitioner with a focus on preventing emergency room visits/hospital admissions through onsite treatment within scope of practice.	Track the number of residents assessed/treated/care plan updates by the Nurse Practitioner. Track the number of hospital/ER visits, admissions/readmissions.	Nurse Practitioner role to be onboarded and onsite at Terrace Lodge 2 days/week by June 30, 2025 pending securing the Hiring More Nurse Practitioner initiative funding. 25-50 % of high risk for ER transfer residents will be assessed/treatment provided onsite within scope/care plans updated by Nurse Practitioner by September 30, 2025. Reduction of ER visits/hospital admissions by 20% by February 28, 2026.	This change idea is dependent on securing Hiring More Nurse Practitioner initiative funding and will be implemented as a one year trial.

Change Idea #4	Comfort Care Rounds for residents identified as being high risk for falls or those identified as having a precarious health condition.		
Methods	**Process measures**	**Target for process measure**	**Comments**
Education regarding comfort rounds was provided to all staff in 2024 through surge learning. It was also discussed by the MRC/RCC during daily huddles. Additional focus on implementation of comfort care rounds in 2025.	The % of residents who experience a high number of falls will decrease with comfort rounds being initiated; the % of staff implementing comfort care rounds.	100% of staff will receive refresher training on comfort rounds by June 2025. 100 % of staff will implement comfort care rounds for identified residents. 25-50 % reduction of falls with residents identified as high risk for falls.	Work began in 2024;refresher education and support for the implementation of comfort care rounds will be prioritized in 2025. Reducing the number of falls and falls with injury will result in a decrease in the number of ER visits related to falls.

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	96.86	100.00	All staff are provided annual education on workplace harassment and discrimination along with civility and respect in the workplace. Additionally, in 2024, all staff were assigned and completed training specific to equity, diversity, inclusion and anti-racism education, inclusive of Indigenous related modules. Training will remain ongoing on orientation and annually for all staff.	

Change Ideas

Change Idea #1	Implementation of an enhanced orientation and onboarding process utilizing CLRI preceptor program with inclusion of a focus on leadership, DEI and anti-racism.		
Methods	Process measures	Target for process measure	Comments
Recruitment, implementation of Education Lead and Coordinator role across the three homes. Development of a coaching/preceptorship program to educate current staff on practices for effective orientation and onboarding. Utilizing the education program through CLRI preceptor resources. Development and implementation of a new hire staff survey. Ongoing analysis of survey results to determine and implement opportunities for improvement to new hire orientation. A focus on registered staff as leaders, DEI and anti-racism will be included in the program.	track # of surveys completed; # of opportunities for improvement implemented; recruitment and retention statistics; # of staff completing education	Recruit education lead/coordinator by May 2025. Recruit and train "coaches/preceptorship" team members by fall 2025. New hire staff Surveys will be developed and implemented by fall 2025 and results reviewed monthly for opportunities for improvement. Annual staff satisfaction survey implemented by Dec. 31, 2025 with analysis of results January 2026.	Total LTCH Beds: 100 A strong orientation and onboarding process with a focus on DEI and anti-racism will support residents, staff and recruitment and retention.

Change Idea #2	Development and implementation of Diversity, equity and inclusion policy specific to long-term care home resident care and services utilizing CLRI diversity tool kit.		
Methods	Process measures	Target for process measure	Comments
Conduct gap analysis and include staff, resident and family councils. Develop policy. Complete education. Include DEI, anti-racism as a standing agenda item on resident and family council meeting agendas and annual satisfaction survey	Conduct pre and post policy survey specific to DEI for residents: # of surveys completed; # of DEI concerns identified within the survey; # of concerns brought forward separate to the survey; # of strategies implemented for resident care needs in support of DEI	Survey to be developed and implemented by June 30, 2025; policy developed and implemented by September 30, 2025; post survey questions will be implemented into the annual satisfaction survey for the fall of 2025 survey	Work began on this change idea in 2024/25 QIP but was not completed. While the corporation has DEI related policy and procedures those policies do not fully incorporate the LTCH resident DEI related care and services. As such, the development of LTC specific policies will further enhance the DEI needs of residents in our Home.

Experience

Measure - Dimension: Patient-centred

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of residents responding positively to "Do you feel you have a voice and are listened to by staff?"	C	% / LTC home residents	In house data, NHCAHPS survey / most recent consecutive 12 month period	92.85	100.00	Goal is for every resident/SDM is to feel as though their voice is heard by LTC staff. This expands on previous year question of "how well do staff listen to you"?	Registered Nurses Association of Ontario - Clinical Pathways

Change Ideas

Change Idea #1 Implementation of RNAO Clinical Pathways Person and Family Centred Care Assessment.

Methods	Process measures	Target for process measure	Comments
Change the satisfaction survey wording of how well do staff listen to you - to "Do you feel you have a voice and are listened to by staff?". Completion of RNAO Clinical Pathways Person and Family Centred Care Assessment for all new admissions beginning April 1, 2025. Promotion of completion of satisfaction surveys at resident council, family council and care conferences.	Track the number of completed RNAO Clinical Pathways Person and Family Centred Care Assessments and related care plan updates; # of positive responses to the satisfaction survey question.	100% of residents and families will respond positively as part of the 2025 satisfaction survey. 100 % of RNAO Clinical Pathways Person and Family Centred Care Assessments will be completed within 14 days of admission beginning April 1, 2025.	Our home is implementing the RNAO Clinical Pathways program and the Person and Family Centred Care Assessment will begin April 1, 2025. Staff will be prompted to update resident care plans within 14 days of completion of the assessment to support an approach to care whereby residents feel they are being listened to and have a voice. The wording for this question has been updated in the satisfaction survey as it better aligns with our resident and family centered care focus.

Change Idea #2 Implement multiple avenues/opportunities for communication by residents to provide feedback and learn about home updates.

Methods	Process measures	Target for process measure	Comments
General education and promotion regarding resident centered care at resident council, family council, food committee and care conferences. Increased referrals to social worker for residents identified as requiring additional support to provide feedback and ensure they have a voice.	# of Resident council meetings held. The number of Residents who attend the meetings. The number of Family Council meetings held. The number of family members who attend family council.# of social worker referrals; survey results for this question	Meetings will be offered monthly; will increase attendance at resident council meetings by 10%. 100 % of survey results will reflect positive responses for this question.	Attendance at resident and family council meetings, and completion of survey, tends to vary based on resident needs, capabilities

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 Sep 30, 2024 (Q2), as target quarter of rolling 4-quarter average	22.83	15.52	Our goal is to align with the provincial value through implementation of planned change ideas.	Registered Nurses Association of Ontario - Clinical Pathways

Change Ideas

Change Idea #1 Implementation of RNAO's clinical pathways admission and falls assessment which has an increased focus on falls at admission and with each resident falls assessment. Increase consistency in the plan of care interventions.

Methods	Process measures	Target for process measure	Comments
Education provided to all current registered staff for clinical pathways updated assessments. Training will be incorporated into orientation for new registered staff regarding delirium, falls and pain screening to accurately screen for and implement potential interventions	The number of residents who will be screened for falls risk on admission, change in status and readmission; the number of resident falls/falls with injury	100% of residents will be screened for falls risk with updated assessment by November 30, 2025; 30 % reduction in falls by March 31, 2026.	Early identification for falls will support resident centered fall prevention and management intervention implementation and will result in decreased falls.

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 Sep 30, 2024 (Q2), as target quarter of rolling 4-quarter average	10.84	10.00	Our goal is to maintain or slightly improve in this indicator through the implementation of clinical pathways in 2025.	Registered Nurses Association of Ontario - Clinical Pathways

Change Ideas

Change Idea #1 The implementation of the RNAO Clinical Pathways Delirium Pathway and Delirium Assessment to better identify risk factors for delirium and increase consistency with resident centered care plan interventions.

Methods	Process measures	Target for process measure	Comments
Education provided to all current registered staff and will be incorporated into orientation for new registered staff regarding delirium screening so staff are able to accurately screen for and implement potential interventions.	100% of staff will receive education as indicated by surge learning education report and staff education sign in sheets	100% of residents will be screened for delirium on admission, annual, readmission and change in status beginning April 1, 2025. Continue to reduce the use of antipsychotic medications for residents without a supporting diagnosis.	Early identification and screening for delirium can help prompt interventions being put in place earlier and reduce the use of anti-psychotic medications for residents without a supporting diagnosis.