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)	26.42	23.00	Continue to improve in the next year. We have decreased the percentage from %36.55 to 26.42. We plan to decrease this by another 2-5% this upcoming year.	NP NLOT Ottawa Program, Royal Ottawa Health Care Group - BSO/Geri Psych Support

Change Ideas

Change Idea #1 Continue to reduce avoidable hospital transfers by 3% for the upcoming year.

Methods	Process measures	Target for process measure	Comments
Registered staff will continue to be educated regarding use of the SBAR tool, assessment skills and support of NP and MDs to keep residents in the home. SIM labs with collaboration with NP NLOT program will be offered to nurses to improve situation skills. Education will be offered as needed.	Process measure is based on measurement of quarterly decrease in the % of avoidable ED visits and total at end of the year per the 4 quarters.	Overall decrease of 3% from current performance of %26.55 to achieve a performance under provincial average.	Review monthly ED visits with interdisciplinary team and NP NLOT to identify visits that were avoidable and how the resident could have been kept in the home. Also done quarterly at PAC/CQI meetings

Change Idea #2 Enhance goals of care conversations and family engagement

Methods	Process measures	Target for process measure	Comments
Conduct early and ongoing goals of care discussions: Initiate conversations with residents and families upon admission and at regular intervals (quarterly, with significant change, and annually). Use structured communication tools	Percentage of residents with documented goals of care discussions (updated within past year)	100% of residents will have documented goals of care discussions completed or updated within 3 months (new admissions within 2 weeks)	

Change Idea #3 Education for Families

Methods	Process measures	Target for process measure	Comments
Develop family education materials: Create resources explaining: - Dementia as a progressive illness - Benefits of remaining in the home during illness - What to expect at end of life - The risks of hospital transfer for frail elderly (delirium, functional decline, infections)	Number of family education sessions held or materials distributed	75% of families of current residents will receive educational materials about hospital transfer risks and benefits of remaining in the home within 4 months	

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	Our target will be %100 performance as this education is mandatory annually. Will complete more if required.	Community based agencies in the region if required

Change Ideas

Change Idea #1 Continue to meet 100% training completion as Mandatory education. Continue to explore external partnerships to enhance training as needed.

Methods	Process measures	Target for process measure	Comments
Continue with online training platform SURGE with DEI education, annual events and in person training. DEI training as needed, if required more then mandatory requirements.	Amount of staff completed DEI training per quarter on SURGE online training platform. Total calculated with all 4 quarters.	100% of new staff and existing staff will have completed DEI training annually. Part of orientation education.	Continue to reach out and explore agency based partnership to enhance overall DEI training as needed.

Change Idea #2 All employees to be trained in relevant equity, diversity, inclusion, and anti-racism in the year.

Methods	Process measures	Target for process measure	Comments
Include equity, diversity, inclusion, and anti-racism as part of the home's departmental committees' standing agendas. The goal is to maintain a consistent forum to review applicable topics, thus increasing the understanding and knowledge of the staff.	The number of monthly committee agendas that include one of the following topics equity, diversity, inclusion, and anti-racism.	100 % of the home's committees will discuss the following topics; equity, diversity, inclusion, and anti-racism at each of their meetings by March 31/27	

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	84.55	86.49	The home continues to remain committed to improving this indicator. Previous year was at 83.02% and was increased to a better score of 86.49% per 2025 survey results.	

Change Ideas

Change Idea #1 Continue to increase % of this indicator. Current is 86.49%. Looking to improve to by 3%.

Methods	Process measures	Target for process measure	Comments
Recreation to hold monthly resident council meetings where residents can voice concerns and address issues with DOC or ED present. Specific resident rights are discussed and reviewed at each meeting. Identify acute urgent concerns and direct them to the correct avenue for action. Implemented support measures through social work, care conferences and recreation.	Social work to quantify 100% of all new admission care conferences will have the complaint process, open door policy, philosophy and residents bill of rights reviewed.	The home will ensure 100% of new admission care conferences include the review of complaint process, open door policy, philosophy and residents bill of rights by march 31, 2027	Total Surveys Initiated: 110 108 residents were interviewed per CPS requirements. 108/108 responded.

Change Idea #2 Review of the Whistleblower policy with all staff, at resident council and family town halls.

Methods	Process measures	Target for process measure	Comments
Education for staff to be rolled out via Surge learning. The program manager will review the whistleblowing policy annually with the resident council. The Executive Director will review the whistleblowing policy annually during family town hall meetings.	The number of staff educated on the Whistleblower policy in the fiscal year. The number of meetings with the resident council and family townhalls that include the review of the Whistleblower policy.	100% of the staff will be educated on the Whistleblower policy. 100% completion and review of the Whistleblower policy during the resident council and family town hall meetings by March 31/27	

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	19.62	17.50	The home continues to improve with % of residents falling. The home had great improvement this past year with decreasing the number of falls and is confident it will continue to decrease and meet both corporate and provincial averages.	NP NLOT Ottawa Hospital, BIM Physio

Change Ideas

Change Idea #1 Falls committee continues to meet monthly and as needed to identify frequent fallers, and residents at high risk for falls.

Methods	Process measures	Target for process measure	Comments
Completed in person with clinical team at falls meetings. Resident data will be discussed and analysised. .	# of residents reviewed monthly who sustained a fall. # of residents at high or medium risk for falls.	Continue to complete 100% of monthly falls review meetings by March 2027.	

Change Idea #2 Continual education on Purposeful rounding (4 P's).

Methods	Process measures	Target for process measure	Comments
Education via in -person, huddles, online training platforms, to all direct care staff - PSWs and nurses.	The number of direct care staff educated on Purposeful Round (4P's) and # of residents whose care plans include purposeful rounding.	100% of all direct care staff will be educated on purposeful rounding by end of March. Per completion %.	

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	10.60	9.50	The home has a process that has been able to reduce Antipsychotic use for residents without a diagnosis of Psychosis. Current the home is below the provincial and corporate averages .	Care RX, Royal Ottawa Health Care Group - Psychogeriatric

Change Ideas

Change Idea #1 The MD, NP, BSO internal and external (including the Psychogeriatric Team), and other members of the interdisciplinary team will meet monthly to review newly admitted and existing residents on antipsychotic medication for diagnosis and indication for use. This will also be a standing item in the CQI/PAC quarterly meeting agendas.

Methods	Process measures	Target for process measure	Comments
Monthly meetings with the interdisciplinary team with a focus on Antipsychotic use and interventions for the reduction/tapering of antipsychotic medication usage. Review data during CQI and PAC meetings.	The number of meetings held monthly by the interdisciplinary team and the number of antipsychotic reductions as the result of these meetings.	100% of residents on antipsychotic medications without psychosis will be assessed for the possible reduction or tapering of antipsychotic use. 100 % completion of the monthly interdisciplinary meetings and quarterly CQI/PAC meetings antipsychotic data review.	

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
Review of the plan of care for non-pharmacological approaches, and triggers leading to Personal expressions.	Number of residents on antipsychotic medications whose care plans have been reviewed on a quarterly basis	100 % of the residents on antipsychotic medications will have their quarterly reviews completed. Target date: End of next Quarter.	

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	2.10	1.90	The home has seen the gradual improvement of this indicator over the past year. In August 2024, the home performed at 10.96 %, down to 4.55% as of Feb /25. Currently we are 2.10 and looking to decrease to 1.9 in this year.	NP NLOT Program

Change Ideas

Change Idea #1 Roll out education on wound care management and assessment and skin care . Education to be provided by NSWOC (during wound care rounds), Medline consultant.

Methods	Process measures	Target for process measure	Comments
DOC and Educator to arrange education for Registered staff and PSW, with NSWOC/Medline as required.	Number of Registered staff and PSWs educated on wound care management, assessment and skin care through online and in person education.	100 % of the nursing staff to be educated on wound care management ,assessments and skin care by next quarter.	

Change Idea #2 Monthly review in the Quality meeting of current residents with Pressure related wounds.

Methods	Process measures	Target for process measure	Comments
Utilization of skin and wound tracking tools to analyze pressure-related injuries in the home, the development of the plan of care, and appropriate prescribed wound and skin care products. Consultation with current Skin and Wound lead and ADOC overseeing skin and wound.	Number of pressure-related injuries that have resolved as a result of interventions discussed and implemented per recommendations.	100 % of pressure-related injuries that have resolved as a result of interventions align with the 2.0 % corporate target. Currently, the home performance is 2.10%. target date : Next Quarter.	

Change Idea #3 Referral to NSWOC for in home and virtual consults.

Methods	Process measures	Target for process measure	Comments
Referrals to the NSWOC for the residents who fall into following categories: Wounds That Fail to Heal: Non-healing wounds: If a wound doesn't show signs of healing after 4-6 weeks of appropriate basic care (cleansing, protection, edema control, and antibiotics), it's a strong indicator for referral. Wounds with complications: Wounds with a large necrotic burden, unhealthy peri wound tissue, or those that are recurrent should be evaluated by a wound care specialist. Wounds with exposed tissue: Any wound with exposed bone, tendon, joint capsule, or significant tunneling warrants referral. Chronic wounds: Wounds that persist for more than 6 to 12 weeks, even with appropriate care, should be referred.	Number of referrals submitted to the NSWOC per month Number of care plans of care updated as the result of the assessment conducted by the NSWOC.	100 % of the residents who fall into the worsening pressure injury stage 2-4 category will be referred to the NSWOC. Target date : Next Quarter	2 current staff are enrolled in SWAN program to help with wound care.

Measure - Dimension: Safe

Indicator #7	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of long-term care residents in daily physical restraints	O	% / LTC home residents	CIHI CCRS / July 1 to September 30, 2025 (Q2), as target quarter of rolling 4-quarter average	3.24	2.80	The home continues to decrease daily physical restraints by collaborating with both the Falls committee and POAs	

Change Ideas

Change Idea #1 Introduce and Promote Alternatives to Physical Restraints

Methods	Process measures	Target for process measure	Comments
Equipment Trial: Introduce a range of restraint alternative devices. Evidence-based options include: Mitts, diversional items based on residents background and likes, use of bed and pad alarms and PASDs.	Number of restraint alternative devices used per month (tracked by type).	Increase the monthly usage of restraint alternatives by 50% within three months of introduction starting next April 2026.	

Change Idea #2 Implement, Person-Centered Assessments to address underlying causes of responsive behaviors which have may have led to restraint use.

Methods	Process measures	Target for process measure	Comments
Pain and Discomfort Checks: Implement a standardized protocol for assessing pain, hunger, thirst, toileting needs, or discomfort whenever a resident shows signs of agitation or restlessness. Many behaviors are expressions of unmet needs .	Percentage of behavior incidents where a "unmet need" (pain, hunger, toileting) was ruled out before considering restraint use.	Achieve 90% documentation rate of "unmet need checks" for all behavior incidents within 3 months .	

Change Idea #3 Integrate restraint case review into existing falls prevention meetings

Methods	Process measures	Target for process measure	Comments
Update the purpose of the falls prevention Meeting to include reducing the use of physical restraints as a core objective. Add restraint review as a standing agenda item for every meeting, ensuring it is never overlooked.	Percentage of scheduled falls prevention meetings where the restraint review agenda item was addressed.	100% of scheduled falls prevention meetings will include the restraint review agenda item within 1 month of implementation starting April 2026.	