

Quality Improvement Plan (QIP)

Narrative for Health Care Organizations in Ontario

March 13, 2026



OVERVIEW

Norview Lodge is a 179-bed Long-Term Care Home owned and operated by the Corporation of Norfolk County.

Norview Lodge is situated in an area surrounded by trees and wildlife with three landscaped courtyards featuring covered gazebos, and a pavilion. The urban development continues around the perimeter of the building, and the intent is to maintain a peaceful and rural atmosphere.

The home is a two-storey building featuring eight home areas, one of which is a secure dementia area. Each home area provides both basic and private accommodation for either 22 or 23 Residents, a dining room and shared servery, spa, activity room, family room with fireplace, communication center and medication room. The central area of the home includes a gift shop, public washrooms, meeting rooms, chapel, hair care salon, therapy room, and a gathering place.

Norview Lodge promotes quality improvement in its day-to-day operations. Our quality improvement plan involves a multidisciplinary approach which encourages and includes ongoing input from staff, through the CQI program process, and from Residents, family members and service providers through surveys, audits, and meetings. Norview Lodge provides ongoing training for staff in-person and through the online platform Surge Learning for mandatory topics as well as crucial areas like GPA, equity, diversity, inclusion and anti-racism.

Quality Improvement is on the standing agenda for departmental meetings. The Leadership Team reviews all recommendations and

suggestions to determine if the implementation of these will be successful and effective.

As per the Ministry of Long-Term Care regulations, a written response to all concerns from Resident and Family Council meetings are responded within 10 days.

Community partners such as the Alzheimer's Society, Senior Support Services etc. are integral in providing support and helping Norview to provide the best quality care to suit the individual needs of our Residents.

Norview Lodge's quality indicators show development towards achieving goals as well as reducing risks to Residents through enhanced monitoring of potential areas of concern.

ACCESS AND FLOW

Norview Lodge continues to work diligently to utilize additional funding provided to support staff enhancement initiatives. This includes utilizing the funding allocated for Allied Health Professionals, through which Norview Lodge has successfully hired additional staff to meet the ministry-mandated requirement of four hours of direct care per Resident per day.

Norview Lodge continues to support its Residents and provide quality care through the Medical Care Team consisting of a Medical Director, 2 Attending Physicians and a Nurse Practitioner. Norview Lodge continues to collaborate with the Nurse Led Outreach Team. They provide transitional assistance for newly admitted Residents to assist with the ALC overcrowding of beds in hospitals, provide and support detailed analysis of the capacity of homes and good fit with additional supports such as feeding suggestions, medical improvements and all nursing interventions. They assist with supporting staff to assess Residents and provide more services to the Residents at Norview Lodge. Their assistance is being utilized to help reduce the number of Residents who are being transferred to the Emergency Department.

EQUITY AND INDIGENOUS HEALTH

Norview Lodge is an equal opportunity LTC home as well as Norfolk County is an equal opportunity employer. Staff are provided with the ability to disclose additional languages that they can speak upon hire as well as throughout their employment. This information assists with Resident suffering from limitations of health condition that bring them back to the primary cultural speaking ability.

Some examples of the training provided to staff are the Respectful Workplace and Violence Prevention Policy located on our electronic training platform called Surge Learning and staff Intranet for staff to access. Norfolk County also provides corporate orientation in which some of the related topics addressed are workplace bullying and harassment including a video addressing unconscious bias, and respecting others.

Norview Lodge understands the importance of providing education and will continue to provide education to all staff on complex topics of equity, inclusion, diversity, anti-racism, racial discrimination, human rights and Indigenous Health. Norfolk County, including Norview Lodge, observes and recognizes National Truth and Reconciliation Day as a statutory holiday. Education including a webinar and information sheet was provided to staff increase awareness on the history and importance of this national holiday.

As outlined in the Service Accountability Agreement (SAA), Norview Lodge must provide service in French, submit the appropriate French language reports and post documents in both English and in French.

PATIENT/CLIENT/RESIDENT EXPERIENCE

Norview Lodge takes this category very seriously, as it presents a meaningful opportunity to make positive and impactful changes for our Residents and their families.

There are questions asked on satisfaction surveys as well as consistent interaction with Residents both daily and at Multi-teams/Care Conferences. These survey questions are used in proactive plans to enhance the care needs identified by the Residents as well as by family members to create action strategies. The goal continues to be to increase the number of respondents for both the Resident and Family Satisfaction Survey for a more fair and accurate representation of the Home. In addition, Resident council meetings provide an interaction with Residents to find out their experiences, level of satisfaction and future needs. The Resident and Family Councils review and provide input on the questions for each of the surveys.

When information is received, many of the programs and interactions have tailored outcomes to achieve what is needed to enhance the Resident experience. Our Leadership Team is provided with department specific and related questions from the surveys as well as individual meetings (Resident, family council and multi-teams) to respond with outcomes. Norview Lodge has a very in-depth response process that also incorporates direct follow-up even if it is a phone call if that is what is requested.

Regular rounds, audits and inspections are conducted by members of the Leadership Team and applicable staff of their respective areas and responsibilities. Dining room, Health and Safety, Infection Control, Environmental and Personal Safety Device Audits are conducted as required to continue to go over items and support

staff, Residents and family needs. Any concerns that are brought forward to the respective committees to be discussed for the necessary changes to be made.

The expansion of Norview Lodge's medical team including the Medical Director, 2 Attending Physicians, and the Nurse Led Outreach Team has enabled the provision of additional and enhanced supports for new and existing Residents across a broad spectrum of nursing-related care elements.

PROVIDER EXPERIENCE

Norview Lodge is a department of Norfolk County and although that brings many benefits, we continue to face ongoing challenging similar to all LTCHs. While recruitment has taken on many required changes, Norview Lodge continues to do the best possible job to ensure staff feel educated and prepared for their start at Norview Lodge. Candidates are interviewed where they are given the opportunity to request workplace accommodation, as required. If successful, staff are then verbally offered the position where the conversation begins with a mutually agreed start date. This allows the candidate to ensure a significant length of time is provided for notice to their current employer as well as if they need to make a medical appointment or arrange items for home life that can be achieved. Recruitment, along with staff onboarding is now completed electronically, allowing for a reduction of paper however causing an increased dependence on technology for Norview Lodge, Norfolk County and the potential new employees. Norview Lodge requires staff to have a successful Vulnerable Sector Check (VSC) before they can be offered a position with a mutually agreed start date. Norview Lodge is experiencing ongoing challenges with receiving VSC back in a timely manner and has experienced wait

times of over 3 months. This wait time has caused the home to run short, implement contingency plans, rely more on agency staff and miss out on potential candidates.

When the staff are officially onboarded, they are provided in writing with enhanced direction of what is needed and the steps with time provided for this process. Staff orientation includes a complete first day of training usually with a coworker to go over all pertinent policies for both safety and Resident needs.

Norfolk County has found multiple ways to recognize and appreciate staff. Staff appreciation and recognition events continue to happen recognizing significant years of service as well as promoting and supporting a team environment.

Norview Lodge continues to hire as required on an ongoing basis and as part of Norfolk County, is fortunate to provide a very respectful compensation package to all staff. In addition, Norview Lodge has a wonderful reputation within the community as well as surrounding areas. Many applicants come from within the community, but also other staff have been coming to Norview from surrounding locations. This has helped with our recruitment.

One of our main concerns is staff burn out along with recruitment and retention of staff. When it comes to staff burn out, we must adapt and find new, positive ways to address as previous methods are no longer applicable. The ability to remain flexible within the collective agreement, including shift switch flexibility and was helpful as vacations were adapted to provide an opportunity for staff to have time off.

SAFETY

Whenever a near miss or an actual incident happens, the situation is reviewed by the appropriate staff, the Joint Health and Safety Committee, and the Leadership Team. An action plan is then developed to reduce risk and prevent future recurrence.

All assessments that are conducted including Skin and Wound, Falls and Pain, provide an area of focus and potential improvement or at least action plans to assist for treatments moving forward. Other assessments require a review and potentially discussed outcomes at a committee meeting, such as Pharmacy and Therapeutics and Infection Prevention and Control (IPAC), where some of the information requires a more detailed discussion and analysis to happen.

Norview Lodge has had a change to the Behavioural Support Structure within the home and although BSO will continue to support staff with suggestions for interventions to aid in behavioural challenges, Norview will also be working together more closely with the Pharmacy, Physicians, Nurse Practitioner to also identify the Resident for deprescribing.

Each Critical Incident (CIS) is reviewed and signed off. When the CIS is submitted, the analysis has begun to look for further development, and any potential improvements.

Staff have been educated in the category of risk management assessments. What this does is allow staff to have the ability to use critical thinking to look at a situation and make the best possible judgement to create a safe culture for staff, visitors, families and Residents.

PALLIATIVE CARE

Norview Lodge provides high-quality palliative care services to all Residents through ongoing education for all direct care staff, including Personal Support Workers and registered staff, on palliative and end-of-life care. This training explores the various care options available to individuals, outlines the roles and responsibilities of staff and caregivers, and emphasizes the delivery of Resident-centered support during this important stage of life.

Norview Lodge has a Palliative Care Committee committed to inform and provide staff with information, updates and best practices relating to pain, palliative and end of life care. This committee contains staff from each department as well as community partners where staff have the opportunity to ask questions, discuss and review policies and procedures relating to pain management and palliative and end-of-life care.

Norview Lodge continues to use a Palliative Performance Scale (PPS) in order to assist staff with making better-informed decisions and information to provide to the Doctor regarding the care for each Resident.

Furthermore, Norview Lodge utilizes palliative care nursing kits which are stored in each of the Resident Home Area Medication rooms to ensure that when a Resident is receiving palliative care or is end-of-life, these supplies are ready and available for the Resident. These kits are kept stocked with all the required supplies for quick and easy access. Palliative care carts include support pamphlets, education, nourishments and supplies for family members that are readily accessible as they are located on each of the Resident Home Areas. Chairs and/or bed recliners are available

to family members who wish to stay overnight with their Resident when they are palliative and/or end of life in the Resident's room.

POPULATION HEALTH MANAGEMENT

Norfolk County participates in the Associated Ontario Health Team by being involved in the executive leadership group. As well as members of Norview Lodge sit on the Complex Care Resolution Table, IPAC hub meetings for the surrounding area as community partners. Internally, Norview Lodge conducts quarterly medical advisory and pharmacy and therapeutic meetings which involve community partners. Norview Lodge is an active member AdvantAge which provides updates to all not-for-profit Long-Term care Homes in Ontario.

With the previous additions to the Norview Lodge medical team; a new Medical Director and two attending physicians, allows Norview Lodge to expand its areas of expertise and partner with more local medical professionals in the nearby area.

The contract with the Nurse Led Outreach Team is another supplement providing additional support to Norview Lodge from the community.

In addition, hospital and community or shared health services information is easily accessible. Some examples of additional community groups include the Alzheimer's society who provide staff training and support, and Senior Support Services offer transportation services. Norview Lodge's Administrator sits on the Dementia Committee for Brant, Brantford Ontario Health Team.

SIGN-OFF

It is recommended that the following individuals review and sign-off on your organization's Quality Improvement Plan (where applicable):

I have reviewed and approved our organization's Quality Improvement Plan on

March 19, 2026

Board Chair / Licensee or delegate

Bill Nolan

Administrator / Executive Director

[Signature]

Quality Committee Chair or delegate

[Signature]

Deputy Mayor, Adam Veri, Norfolk County

Wicky Florio

Access and Flow | Efficient | Optional Indicator

Indicator #6	Last Year		This Year		
	Rate of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents. (Norview Lodge)	14.03 Performance (2025/26)	13.50 Target (2025/26)	18.70 Performance (2026/27)	-33.29% Percentage Improvement (2026/27)

Change Idea #1 Implemented Not Implemented In Progress

1. Utilization of the Nursing Led Outreach Team to support nursing staff in assessment of Residents in home to reduce unnecessary transfers to hospital 2. Continue to use Hospital Tracking tool to review all hospital transfers and identify trends.

Process measure

- 1. Number of ED Visits

Target for process measure

- 1. The number of hospital transfers will be reduced by 0.53. 2. All hospital transfers will be reviewed

Lessons Learned

This goal was not met and has been moved forward into 2026/2027 QIP initiatives. The Hospital Tracking Portal in Point Click Care was used for ED visits and was effective in aiding the Home to review details surrounding each Resident transfer to hospital. Fall related injury and post call follow up were identified as frequent reasons for transfer to hospital. Tracking of all hospital transfer will continue in 2026/2027 with review of transfers at quarterly CQI and Medical Advisory meetings. Collaboration with the NLOT team has been helpful in supporting nursing staff to assess Residents and provide more services at Norview Lodge.

Comment

This goal has been carried forward into the 2026/2027 QIP initiatives.

Equity | Equitable | Optional Indicator

	Last Year		This Year		
Indicator #5	154.41	100	100.00	-35.24%	100
Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education (Norview Lodge)	Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

Change Idea #1 Implemented Not Implemented In Progress

Provision of in-house education to Staff related to equity, diversity, inclusion and anti-racism education

Process measure

- Number of Staff who have received relevant education.

Target for process measure

- We are aiming to increase the number of staff receiving relevant education to 100% by November 15, 2025.

Lessons Learned

This goal was met as the number of staff to receive the relevant training was 100%. Education was added to Surge Learning for completion. This education has been brought forward into 2026/2027 to maintain completion of training by 100% of staff.

Comment

Education will be continued for all new staff hired in 2026/2027.

Experience | Patient-centred | Optional Indicator

Indicator #3	Last Year		This Year		
	Percentage of residents responding positively to: "What number would you use to rate how well the staff listen to you?" (Norview Lodge)	70.97 Performance (2025/26)	90 Target (2025/26)	77.55 Performance (2026/27)	9.27% Percentage Improvement (2026/27)

Change Idea #1 Implemented Not Implemented In Progress

- Increase awareness on how Residents can give feedback and provide their input on the care and services they receive
- Provide more opportunities for Residents to provide feedback and input on their care

Process measure

- 1. Number of Surveys 2. Number of Residents who completed Surveys 3. Number of Family Members/SDM/POA who completed Surveys

Target for process measure

- 1. 100% of Residents will have a positive response to the question "What number would you use to rate how well the staff listen to you?"

Lessons Learned

An observed increase in positive responses was observed this year although our goal was not met. 49 Resident Surveys were completed, which was an increase from 31 surveys in 2024. All surveys were completed in person with the Residents with assistance from the CQI Lead and Social Service Worker. It was observed that there were times of day that were better for survey completion due to Resident's schedules. This will be taken into consideration next year when planning times to meet with Residents to complete surveys. All surveys were reviewed by the Leadership Team upon completion so that follow-up with any concerns could be addressed. This practice will continue going forward.

Comment

This will be carried forward into the 2026/2027 QIP with a focus on increasing survey participation.

Indicator #4	Last Year		This Year		
	Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences". (Norview Lodge)	61.29	87	79.59	29.86%
	Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

Change Idea #1 Implemented Not Implemented In Progress

1. Provide more opportunities for Residents to give feedback and input on their care. 2. Continue to send out Surveys with monthly billings to increase knowledge and ability of Residents and family members and encouragement to complete Surveys

Process measure

- 1. Number of Surveys 2. Number of Residents who completed Surveys 3. Number of Family Members/SDM/POA who completed Surveys

Target for process measure

- 1. 100% of Residents will have a positive response to the statement "I can express my opinion without fear of consequences".

Lessons Learned

The Family Surveys were included in the monthly billings, and we saw an increase in Family Survey completion. The Family Satisfaction Survey was offered to all families to complete. There was a decrease in the number of family surveys completed this year as only 39 were completed compared to 60 surveys completed during the previous year. Increasing awareness of survey availability will be a focus for near year with information being included in the monthly newsletter. There was an increase in the number of Resident satisfaction surveys completed in 2025 as 49 were completed compared to 31 from the previous year.

Comment

This will be carried forward into the 2026/2027 QIP with a focus on increasing survey participation.

Safety | Safe | Optional Indicator

Indicator #1	Last Year		This Year		
	Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)
Percentage of LTC home residents who fell in the 30 days leading up to their assessment (Norview Lodge)	16.53	15	13.41	18.87%	13

Change Idea #1 Implemented Not Implemented In Progress

1. Utilization of the 4 P’s Method to reduce falls 2. Continue to review all falls to identify precipitating factors and make recommendations for improvements

Process measure

- 1. Number of Residents who fell

Target for process measure

- 1. The percentage of residents who fell will be reduced by 1.53.

Lessons Learned

There was an observed decrease in the number of Residents who fell and our target for fall reduction was surpassed. All falls continue to be reviewed at the quarterly falls committee meetings to discuss circumstances surrounding falls, fall prevention items in place and steps and suggestions to prevent future falls.

The 4 Ps method was not implemented as other projects were the focus for implementation in 2025. With the home transitioning to the RNAO clinical pathways, purposeful rounding will be implemented with the Falls Clinical Pathway. Annual fall prevention education was on Surge Learning for Staff to complete. Post fall assessment continues to be completed by Registered staff will any witnesses to the fall. Fall intervention items are assessed and implemented as necessary.

Comment

Implementation of the RNAO Admission and Resident and Family Centered Care Pathway took priority for implementation. Goal to implement the 4P’s with clinical pathways during 2026-2027. Process for fall assessment will continue as there has been an observed reduction in the number of falls using these methods.

Indicator #2	Last Year		This Year		
	Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)
Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment (Norview Lodge)	30.19	27	34.18	-13.22%	30

Change Idea #1 Implemented Not Implemented In Progress

1. Enhancing staff knowledge on trialing nonpharmacological interventions to minimize the usage of psychotropic medications by providing educational opportunities. 2. BSO Referrals to explore alternative to medication use

Process measure

- 1. The number of staff attending GPA training courses 2. Number of Residents who received antipsychotic medication without a supporting diagnosis

Target for process measure

- 1. 24 staff will receive GPA training by the end of year 2. Number of Residents given antipsychotic medication without a supporting diagnosis will be reduced by 3.19 3. 100% of Residents without a supporting diagnosis will be reviewed by BSO team to explore alternative interventions

Lessons Learned

33 staff received GPA training over the course of the year, and this education will continue in 2026/2027. With changes to the BSO structure within the home, the BSO team did not have a chance to review all Resident's as priority that went to episodic referrals for behavioural challenges. BSO will continue to support the staff with suggestions for interventions to aid in behavioural challenges. Focus for the upcoming year will be on collaboration with pharmacy and physicians/Nurse Practitioner to identify Residents who would be candidates for deprescribing.

Comment

This goal was not met, and focus will be carried forward into our 2026/2027 QIP

Access and Flow

Measure - Dimension: Efficient

Indicator #2	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)	18.70	14.00	The benchmark for number of ED visits is to decrease the number of Residents being transferred to the ED to 14.00	

Change Ideas

Change Idea #1 Change Idea #1: Utilization of Nursing Led Outreach Team (NLOT) to support nursing staff through provision of increased services at Norview Lodge.

Methods	Process measures	Target for process measure	Comments
Ongoing collaboration with NLOT team to provide access to increased variety of skills and equipment offered at Norview Lodge (e.g. IV therapy)	Number of Residents who are sent to the ED for a reason that could have been addressed at Norview Lodge, total number of Residents transferred to ED.	Decrease the number of Residents being transferred to the ED to 14.00.	

Change Idea #2 Change Idea #2: All hospital transfers will be tracked to identify trends using the hospital tracking tool.

Methods	Process measures	Target for process measure	Comments
Utilization of hospital tracking tool to monitor details of hospital transfers.	ED visits reviewed to identify why Residents were sent, outcome of transfer, details surrounding transfer.	Decrease the number of Residents being transferred to ED to 14.00.	

Equity

Measure - Dimension: Equitable

Indicator #3	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	The benchmark for the number of staff who have completed relevant training on equity, diversity, inclusion and antiracism is to maintain at 100%.	

Change Ideas

Change Idea #1 Change Idea #1: Continue with annual education to staff on Surge Learning focused on equity, diversity, inclusion and anti-racism education.

Methods	Process measures	Target for process measure	Comments
Staff complete relevant education focused on equity, diversity, inclusion and anti-racism.	Number of staff who have received education.	Maintain at 100% of staff completing education annually.	

Experience

Measure - Dimension: Patient-centred

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of residents responding positively to: "What number would you use to rate how well the staff listen to you?"	O	% / LTC home residents	In house data, NHCAHPS survey / Most recent consecutive 12-month period	77.55	100.00	To increase positive percentage of Residents to 100%	

Change Ideas

Change Idea #1 Change Idea #1: Incorporate the Resident's knowledge, values, beliefs and cultural background into care planning.

Methods	Process measures	Target for process measure	Comments
Staff will complete Resident and Family Centered Care assessments with all new admissions and incorporate their knowledge, values, beliefs and cultural background into the individualized plan of care.	Number of "Resident and Family Centered Care" Assessments completed for new Residents in 2026.	100% of the Residents who move into the home in 2026 will have a "Resident and Family Centered Care" Assessment completed in PCC.	Total Surveys Initiated: 49

Measure - Dimension: Patient-centred

Indicator #5	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	79.59	100.00	To increase positive percentage of respondents to 100%.	

Change Ideas

Change Idea #1 Change Idea #1: Increase awareness on how Residents can give feedback and provide their input on the care and services they receive.

Methods	Process measures	Target for process measure	Comments
Information about how to complete the Resident and Family Surveys will be included in the monthly newsletter. CQI Lead will continue to assist Residents in completion of satisfaction survey. CQI Lead will attend Resident Council meetings with updates.	Number of Residents completing the satisfaction survey.	There was a total of 49 surveys completed in 2025. The goal for 2026 is to increase to 60 surveys completed.	Total Surveys Initiated: 49

Safety

Measure - Dimension: Effective

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
% of long-term care home Residents who experienced pain.	C	% / LTC home residents	CIHI CCRS / July 1 to September 30, 2025 (Q2) as target of rolling 4-quarter average	24.70	20.00	The benchmark for this indicator is to decrease the number of Residents experiencing pain 20.00.	

Change Ideas

Change Idea #1 All Residents with uncontrolled pain will be identified and reviewed by the physician/Nurse Practitioner to ensure adjustments to pain control regimen completed to ensure effective pain management.

Methods	Process measures	Target for process measure	Comments
All Residents will have a comprehensive pain assessment completed using the RNAO Clinical Pain Pathway. Residents experiencing uncontrolled pain will be referred to a Physician/Nurse Practitioner to review treatment plans to ensure effective management of pain.	Number of pain assessments completed with uncontrolled pain identified.	Decrease in Residents experiencing pain to 20.00	

Change Idea #2 Change Idea #2: All direct care staff will complete education on recognizing pain and pain management strategies.

Methods	Process measures	Target for process measure	Comments
All direct care staff will complete pain management education module on Surge Learning focusing on recognizing pain, strategies for comfort and how to report and record pain.	Number of staff who complete education on pain recognition and management strategies.	100% of direct care staff will complete education in 2026	

Measure - Dimension: Safe

Indicator #6	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	13.41	13.00	The benchmark for this indicator is to reduce the number of falls to 13.00.	

Change Ideas

Change Idea #1 Change Idea #1: Decrease the number of Residents who fell as a result of self-transfer.

Methods	Process measures	Target for process measure	Comments
Staff will complete "Purposeful Rounding" and check if Residents require the washroom, are experiencing any pain, have required items within reach, call button and other devices in place including fall prevention items.	Number of falls will be reviewed at falls committee meetings to identify trends.	Reduce the number of falls to 13.00	

Measure - Dimension: Safe

Indicator #7	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	34.18	30.00	The benchmark for this indicator is to review all the Residents on antipsychotics medication quarterly and reduce the number of Residents on the medication without an appropriate diagnosis by 4.18.	

Change Ideas

Change Idea #1 Change Idea #1: Development of quarterly antipsychotic use assessment to assess Residents who are on antipsychotic medication and assess need for continued use. Collaboration with pharmacy to deprescribe for identified Residents.

Methods	Process measures	Target for process measure	Comments
Antipsychotic use assessment to be developed for use. Residents on antipsychotic medication will be assessed quarterly for necessity for continued use or potential for deprescribing.	Residents identified as candidates for deprescribing will be identified through completion of assessment. Collaboration with pharmacy to determine course of action for deprescribing.	100% of Residents with antipsychotics will be reviewed quarterly with medication review.	

Change Idea #2 Change Idea #2: Identification of Residents who no longer require prescribed antipsychotics through increasing knowledge of Registered Staff in medication deprescribing.

Methods	Process measures	Target for process measure	Comments
Registered Staff who work closely with physicians and those who assist with medication review to complete online deprescribing course.	100% of Residents receiving an antipsychotic will be reviewed quarterly.	Reduction in the number of Residents without an appropriate diagnosis by 4.18.	

Measure - Dimension: Safe

Indicator #8	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	4.36	4.00	The benchmark for this indicator is to decrease the number of Residents who stage 2 4 pressure ulcer worsened from 4.36 to 4.0	

Change Ideas

Change Idea #1 Change Idea #1: All new pressure ulcers will be identified and referred to the Nurse Practitioner for assessment and follow up.

Methods	Process measures	Target for process measure	Comments
The Home will adjust the process for tracking wounds with a skin and wound referral note being completed for all new wounds. The skin and wound assessment will be revised to include a referral to the Nurse Practitioner for all new wounds. The Nurse Practitioner will track wounds in the Home and collaborate with the NLOT team and Skin and Wound nurse to ensure effective plan of treatment.	New and existing pressure ulcers will be monitored by the Nurse Practitioner and Skin and Wound nurse to ensure effective treatment in place with goal of resolution.	Target will be a decrease from 4.36 to 4.00.	

