

## Equity

## Measure - Dimension: Equitable

Indicator #1	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	Prioritizing Diversity, Equity and Inclusion practice aims to support culturally appropriate care and meaningful growth in long term care while helping to foster an inclusive workplace. Encouraging diversity can lead to increased innovation and collaborative work environment.	

## Change Ideas

**Change Idea #1** To gain deeper understanding, DEI leads will complete education program "Creating a Culture of Belonging: From Awareness to Action" which will provide tools and knowledge needed to foster a more inclusive and affirming environment for residents, care partners/care gives and fellow team members

Methods	Process measures	Target for process measure	Comments
Virtual education to be attended by all the DEI Leads.	The number of DEI Leads completed training on Creating a Culture of Belonging: From Awareness to Action training	100% of DEI Leads will complete the training with an goals to create and share education with staff.	DEI Committee - educate and plan activities for residents, staff, families

**Change Idea #2** Share information on equity, diversity, inclusion and anti-racism topics with residents by providing and sharing information.

Methods	Process measures	Target for process measure	Comments
DEI will develop information displays and articles to be shared in Newsletter.	Number of education instances offered and articles in Newsletter.	Education displays and events, articles in Newsletter will contain information about equity, diversity, inclusion and anti-racism topics.	DEI Committee - educate and plan activities for residents, staff, families

## Experience

### Measure - Dimension: Patient-centred

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of Residents who responded positively to "Did we meet your expectations?"	C	% / LTC home residents	In house data, interRAI survey / January 2026-December 2026	48.33	90.00	To gauge Resident's overall satisfaction	

### Change Ideas

#### Change Idea #1 Increase Resident Satisfaction; "I decide when to get up"

Methods	Process measures	Target for process measure	Comments
RNAO Admission Assessment to identify time. Identify on Care Plan, tasks/kardex. Review at Admission and Annual Care Conference to confirm wishes. Develop plan for breakfast - ala cart options - morning snack cart - labelled food items.	Monitor quarterly Satisfaction Responses.	Increased positive responses to "I when to get up".	

**Measure - Dimension: Patient-centred**

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of Families who responded positively overall to "I would recommend this site/organization to others."	C	% / Family	In house data, interRAI survey / January 2026-December 2026	91.50	95.00	To gauge family overall satisfaction	

**Change Ideas**

Change Idea #1 Increase Family Satisfaction; My family member decides when to get up.

Methods	Process measures	Target for process measure	Comments
RNAO Admission Assessment to identify time. Identify on Care Plan, tasks/kardex. Review at Admission and Annual Care Conference to confirm wishes. Develop plan for breakfast - ala cart options - morning snack cart - labelled food items.	Monitor quarterly Satisfaction Responses.	Increased positive responses to "My family member decides when to get up".	

## 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	23.94	15.01	Reduce falls to meet Provincial Average.	

### Change Ideas

Change Idea #1 Educate and initiate Falls Committee and Champions in the Home.

Methods	Process measures	Target for process measure	Comments
Use RNAO Best Practice Guidelines. Surge education for Falls Champions. Monthly Falls Committee Meetings to develop strategies and interventions to reduce falls.	Monitor number of falls monthly, number of Falls Champions completed education, Falls Committee Minutes.	Decrease number of resident falls in the home and meet or exceed provincial average.	We are a Least Restraint Home. Goals to reduce injury during a fall. Active Physio program and nursing restorative program in place to increase mobility and strength.

**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	25.23	18.99	Meet provincial average	

**Change Ideas**

Change Idea #1 To receive appropriate diagnosis for residents using antipsychotics

Methods	Process measures	Target for process measure	Comments
Communicating with attending physician to review if residents quality for diagnosis	Number of residents utilizing antipsychotics with appropriate diagnosis	Reduce current performance to meet or exceed Provincial Average	Resident admissions already on antipsychotics

Change Idea #2 Reduce number of residents prescribed antipsychotics without indication for use.

Methods	Process measures	Target for process measure	Comments
BSO Team to review antipsychotic usage for identifying potential residents who could have reduction in antipsychotics on an ongoing basis. Quarterly Med Reviews by physician and pharmacy completed.	QIA data entry, number of antipsychotic review completed monthly	Meet or exceed Provincial Average	

**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	3.62	3.30	Reduce worsening pressure ulcers to meet Provincial Average.	

**Change Ideas**

Change Idea #1 Proper identification, management and treatment of wounds, ensuring are appropriate.

Methods	Process measures	Target for process measure	Comments
RAI Lead will join Skin & Wound Committee to review residents triggering for worsening wounds and determining cause. Focused wound care education for Registered and PSW staff as required.	Monitor QI for worsening pressure ulcers.	Decrease worsening Stage 2 to 4 pressure injuries to meet or exceed provincial average.	