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)	36.93	25.00	Current performance is 36.93 ED visits per 100 residents, which is above the provincial benchmark. The home is strengthening internal clinical capacity through the addition of a Nurse Practitioner and collaboration with external partners including Community Paramedicine, NLOT, and St. Joseph's Pain and Symptom Management team. A target of 25.00 has been set as a realistic step toward the provincial benchmark of 22.3.	Henley House, Burton Manor, King Nursing Home, London Health Sciences Centre

Change Ideas

Change Idea #1	All annual and initial care conferences will include a discussion regarding hospitalizations and ED transfers, including care that can be safely provided within the home.		
Methods	**Process measures**	**Target for process measure**	**Comments**
During annual and initial care conferences, the physician will review each resident's risk for emergency department (ED) transfer. The discussion will include recent transfer history, current diagnoses, CPR status, goals of care, and care options that may be safely provided within the home. This discussion will support collaborative care planning with residents and families to reduce avoidable ED visits.	The Director of Care or designate will conduct monthly audits of care conference documentation to verify that ED transfer risk and related information were reviewed during annual and initial care conferences.	By September 30, 2026, 90% of annual and initial care conferences will include documented discussion of ED transfer risk, in-home care options, recent transfers, diagnoses, CPR status, and goals of care.	Including ED transfer discussions during care conferences supports proactive care planning and helps reduce avoidable emergency department visits.

Change Idea #2	Nurses must consult the Charge Nurse prior to sending any resident to the hospital.		
Methods	**Process measures**	**Target for process measure**	**Comments**
Nursing staff will be educated on the requirement to consult the Charge Nurse (CN) before transferring any resident to the emergency department. Charge Nurses will review potential transfers and document a progress note outlining the clinical assessment and rationale for transfer. Targeted education will also be provided to Charge Nurses on assessing whether a resident's condition can be safely managed within the home.	The Director of Care or designate will conduct monthly chart audits of residents transferred to hospital to verify Charge Nurse consultation and documentation prior to transfer.	95% of residents transferred to hospital will have a Charge Nurse progress note documented prior to transfer by September 30, 2026.	Strengthening Charge Nurse oversight supports appropriate decision-making and may reduce avoidable emergency department 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	0.00	100.00	With Relias Portal, 100% staff are expected to complete their EDI module on an annual basis.	Henley House, Burton Manor, London Health Sciences Centre, King Nursing Home, St. Joseph's Pain and Symptom Management

Change Ideas

Change Idea #1 Promote culturally responsive care for residents living in long-term care. Incorporate cultural preferences and diversity considerations into resident plan of care.

Methods	Process measures	Target for process measure	Comments
Staff will ask residents and families about cultural, language, spiritual, and dietary preferences during admission and care conferences. Relevant preferences will be documented in the plan of care to guide care delivery. Staff will review cultural considerations during interdisciplinary team discussions.	The Life Enrichment Manager or designate will maintain a tracking log documenting the percentage of resident who's plan of care include documented cultural, spiritual, or language preference.	By December 31st, 2026, 90% of the residents' plan of care will include documented cultural, Language or spiritual preference.	Documenting resident cultural preferences supports culturally responsive care and helps ensure care practices respect the diverse needs and values of residents and their families.

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: "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	22.64	30.00	Continue to increase the Percentage of residents responding positively to: "What number would you use to rate how well the staff listen to you?".	Henley House, Burton Manor, King Nursing Home

Change Ideas

Change Idea #1 Strengthen staff communication and active listening practices to ensure residents feel heard, respected, and involved in their care.

Methods	Process measures	Target for process measure	Comments
Staff will be encouraged to engage residents in meaningful conversations during daily care interactions and respond respectfully to resident concerns. Leadership will reinforce active listening practices during staff meetings and huddles. Staff will be reminded to involve residents in discussions about their care and daily routines.	Percentage of staff who receive education or reminders regarding active listening and respectful communication practices.	90% of staff will receive education or reminders related to active listening and resident communication by March 31, 2027.	Total Surveys Initiated: 192 Strengthening staff communication practices helps ensure residents feel heard, respected, and involved in decisions about their care.

Change Idea #2 Create opportunities for residents to safely and anonymously share feedback about their care experiences.

Methods	Process measures	Target for process measure	Comments
An anonymous resident-friendly feedback system will be implemented using simple check-box surveys and picture-based options for residents with cognitive or communication challenges. Surveys will be available through drop boxes placed in common areas and through electronic submission using tablets.	The Social Worker or designate will maintain a tracking log documenting the percentage of eligible residents (CPS =3) who are offered the anonymous feedback survey.	90% of eligible residents (CPS =3) will be offered the anonymous feedback survey by March 31, 2027.	Providing residents with accessible ways to share feedback supports psychological safety and encourages residents to express concerns or suggestions.

Measure - Dimension: Patient-centred

Indicator #4	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	21.88	85.00	Continue to increase the percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences".	Henley House, Burton Manor, King Nursing Home

Change Ideas

Change Idea #1 Create opportunities for residents to safely and anonymously share feedback to support a culture where residents feel comfortable expressing opinions and concerns.

Methods	Process measures	Target for process measure	Comments
An anonymous, resident-friendly feedback system will be implemented using simple check-box surveys and picture-based options for residents with cognitive or communication challenges. Surveys will be available through drop boxes placed in common areas and through electronic submission using tablets. The Social Worker will maintain a tracking log to monitor survey distribution and participation.	The Social Worker or designate will maintain a tracking log documenting the percentage of eligible residents (CPS =3) who are offered the anonymous feedback survey and will update the log monthly to monitor participation.	90% of eligible residents (CPS =3) will be offered the anonymous feedback survey by March 31, 2027.	Total Surveys Initiated: 192 Providing residents with multiple accessible ways to share feedback supports psychological safety and encourages residents to express opinions and concerns without fear of consequences.

Safety

Measure - Dimension: Safe

Indicator #5	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	22.67	18.00	The home's baseline rate is 20.46%, and the target goal for this year is 18% to drive measurable improvement and move to provincial value.	CareRx, Henley House, Burton Manor, King Nursing Home, A & G Physio

Change Ideas

Change Idea #1 Implement weekly falls risk huddles on each home area to review all residents identified as high risk for falls.

Methods	Process measures	Target for process measure	Comments
During weekly huddles, the interdisciplinary team will review residents identified as high risk for falls, discuss recent changes in condition, and evaluate current fall-prevention interventions. Individualized fall-prevention plans of care will be updated as needed. Action items will be documented and communicated to staff to ensure interventions are implemented consistently.	The Falls Lead or designate will track the percentage of home areas completing weekly falls-risk huddles and document residents reviewed and interventions implemented.	By June 30, 2026, 100% of home areas will implement weekly falls-risk huddles to review residents identified as high risk for falls.	Regular interdisciplinary review of residents at high risk for falls supports early intervention and helps maintain low fall rates.

Change Idea #2 Ensure residents identified as being at risk for falling from bed have an individualized fall-prevention plan implemented.

Methods	Process measures	Target for process measure	Comments
Residents identified as being at risk for falling from bed will receive an interdisciplinary assessment to identify contributing factors. Individualized interventions such as bed height adjustments, positioning strategies, floor mats, alarms, and toileting schedules will be implemented. Care plans will be updated within one week of risk identification and reviewed regularly for effectiveness.	The Falls Lead or designate will track the percentage of residents identified as being at risk for falling from bed who have an individualized fall-prevention plan documented within one week of risk identification.	100% of residents identified as at risk for falling from bed will have an individualized fall-prevention plan documented within one week of risk identification by March 31, 2027.	Implementing individualized fall-prevention strategies supports resident safety and helps maintain the home's fall rate below the provincial average.

Measure - Dimension: Safe

Indicator #6	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	33.86	29.00	To be at or below provincial average.	Henley House, Care Rx, Burton Manor, Ontario AUA Innovator Network

Change Ideas

Change Idea #1	Ensure residents receiving antipsychotic medications without a documented clinically appropriate indication undergo an interdisciplinary review to assess ongoing need and explore non-pharmacological alternatives.		
Methods	Process measures	Target for process measure	Comments
The interdisciplinary team will review residents prescribed antipsychotic medications without a clearly documented indication. The review will assess behaviours, identify triggers, and explore non-pharmacological interventions. The resident's plan of care will be updated to reflect alternative interventions, deprescribing opportunities, and monitoring requirements. Reviews and care plan updates will be documented in the resident's chart and monitored through pharmacy and PCC Insight reports.	Antipsychotic Reduction Team Lead or designate will track the percentage of residents receiving antipsychotic medications without a documented clinical indication who receive an interdisciplinary review and care plan update.	By March 31, 2027, 100% of residents receiving antipsychotic medications without a documented indication will receive an interdisciplinary review and care plan update.	Regular interdisciplinary medication review supports appropriate prescribing practices and promotes the use of non-pharmacological approaches to manage responsive behaviours.

Change Idea #2	Ensure residents admitted to the home who are prescribed antipsychotic medications receive an interdisciplinary review during the move-in process to assess clinical indication, behavioural triggers, and potential non-pharmacological alternatives.		
Methods	Process measures	Target for process measure	Comments
During the move-in process, the interdisciplinary team will review residents admitted on antipsychotic medications. The review will assess clinical indications, identify behavioural triggers, and explore non-pharmacological strategies. The resident's plan of care will be updated as appropriate to reflect alternative interventions, monitoring requirements, and any deprescribing opportunities. Reviews and care plan updates will be documented and monitored through quarterly audits.	Antipsychotic Reduction Team Lead or designate will track the percentage of residents admitted on antipsychotic medications who receive an interdisciplinary review with an updated plan of care.	100% of residents admitted on antipsychotic medications will have an interdisciplinary review completed and reflected in the plan of care by the 6-week care conference by December 31, 2026.	Early interdisciplinary review of antipsychotic medications during the move-in process supports appropriate prescribing practices and promotes the use of non-pharmacological approaches to manage responsive behaviours.

Measure - Dimension: Safe

Indicator #7	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	5.03	4.50	By decreasing the percentage of long-term care residents whose stage 2 to 4 pressure ulcer worsened from 5.03 to 4.5 the home would be moving towards the provincial value of 3.3.	Essity, Simulation Canada, Henley House, Burton Manor, Tena, King Nursing Home

Change Ideas

Change Idea #1 Standardize wound care products and dressing procedures across the home.

Methods	Process measures	Target for process measure	Comments
The Essity wound care formulary will be implemented to standardize product selection. Product selection cheat sheets will be distributed to staff to support appropriate dressing choice. Staff will be reminded to prepare all required materials prior to dressing changes and to follow a clean dressing procedure using a dressing tray. A clean procedure checklist will be introduced for registered staff to support consistent dressing change practices.	The Skin and Wound Lead or designate will conduct regular audits to monitor the percentage of dressing changes using standardized Essity products and the percentage of observed dressing changes that follow the clean procedure checklist.	Achieve 90% compliance with clean dressing procedure audits by September 30, 2026 and 90% compliance with standardized product use by December 31, 2026.	Reducing variation in product use and dressing technique supports appropriate moisture balance and infection prevention, helping reduce the risk of wound deterioration.

Change Idea #2 Strengthen wound documentation, monitoring, and early identification of deterioration.			
Methods	Process measures	Target for process measure	Comments
A monthly wound monitoring report will be implemented to track wound status and trends. Weekly wound documentation will be reviewed to ensure reassessments are completed. Staff will receive education on wound documentation standards and early identification of deterioration. Resident and staff feedback will also be gathered to support ongoing improvement in wound care practices.	Percentage of Stage 2–4 wounds with documented weekly reassessment. Completion rate of the monthly wound monitoring report in HealthConnex by the Skin and Wound Lead or designate. Number of wound documentation audits completed monthly.	Achieve 100% weekly wound reassessment documentation by May 31, 2026. Maintain 100% completion of the monthly wound monitoring report beginning May 31, 2026. Complete a minimum of 5 wound documentation audits per month.	Strengthening wound monitoring and documentation supports early identification of deterioration and timely clinical intervention to prevent worsening wounds.

Change Idea #3 Improve wound care competency among registered staff and PSWs through structured education and simulation.			
Methods	Process measures	Target for process measure	Comments
Registered staff will participate in a two-hour Essity wound care education session and a two-hour wound simulation session to strengthen clinical assessment and dressing practices. PSWs will receive wound awareness education focused on early identification and reporting of skin changes. The Skin and Wound Lead position will support ongoing education and monitoring of wound care practices.	The Skin and Wound Lead or designate will track the percentage of registered staff completing wound education and simulation sessions and the percentage of PSWs completing wound awareness education.	Maintain 90% completion of wound education and simulation among registered staff by April 30, 2026. Achieve 90% completion of wound awareness education among PSWs by October 31, 2026.	Education strengthens early identification of deterioration and supports consistent clinical decision-making.