Access and Flow | Efficient | Optional Indicator

Indicator #6

Rate of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents. (Henley House)

Last Year		This Year		
33.80	**21.17**	**27.56**	**18.46%**	**22.30**
Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

Change Idea #1 ☑ Implemented ☐ Not Implemented ☐ In Progress

Include risk status and family/resident preferences related to ED transfers into discussion at all care conferences on admission, annually and ad hoc.

Process measure

- Ensure resident and family preferences are discussed at 80% of care conferences in 2025.

Target for process measure

- 80% of residents will have their preferences related to risk status and ED transfers discussed at care conferences this year.

Lessons Learned

Implemented Ad hoc only. Not implemented at care conferences. Clear communication on who starts this conversation needed.

Change Idea #2 ☑ Implemented ☐ Not Implemented ☐ In Progress

To reduce the number of ED transfers by implementing in-house treatments such as IVs and G-tube care.

Process measure

- Track number of interdisciplinary meetings regarding avoidable transfers to ED. Percentage of residents at high risk for an ED visit who had a change in condition documented on shift report in 24 hours prior to ED visit (high risk residents are defined as those admitted to the LTC Home within the last 30 days, readmitted to the LTC Home from an ED visit or hospitalization within the last 30 days, those residents who have experienced a change in medication, treatment, plan or significant change in condition as per RAI/MDS within the last 7 days). Track number of avoidable transfers to ED.

Target for process measure

- 10% reduction in avoidable ED transfers by December 2025.

Lessons Learned

IV training provided to nurses in-house and successfully implemented once. G-tube associated ED transfer avoided once this year.

Change Idea #3 ☑ **Implemented** ☐ **Not Implemented** ☐ **In Progress**

Reduce number of falls resulting in ED transfer

Process measure

- Number of residents who were toileted on or before their toileting time.

Target for process measure

- 100% of residents will be toileted at or before their toileting time.

Lessons Learned

2024: 19 falls with transfer for ED visit only 2025: 19 falls with transfers for ED Visit only

Comment

Continue to discuss at monthly quality meetings and IDCCs with families. Implement full time NP in the home.

Equity | Equitable | Optional Indicator

Indicator #5

Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education (Henley House)

Last Year		This Year		
82.22	**100**	**100.00**	**21.62%**	**100**
Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

Change Idea #1 ☑ Implemented ☐ Not Implemented ☐ In Progress

New hires will receive DEI training

Process measure

- The number of hires will match the number of training sessions completed in DEI. 100% of new hires will complete their DEI training by the end of their general orientation.

Target for process measure

- 100% of all new hires will complete DEI education in RELIAS upon orientation/hire.

Lessons Learned

Starting June 2025, all new hires were required to complete DEI training prior to start date.

Change Idea #2 ☑ Implemented ☐ Not Implemented ☐ In Progress

Existing staff will receive DEI education

Process measure

- DEI education will be added to annual courses for all existing staff for the year 2025.

Target for process measure

- 100% of staff hired prior to 2025 will complete DEI education by December 2025. 204 staff = 51 staff per quarter.

Lessons Learned

100% of existing staff completed mandatory training that included DEI education in 2025.

Comment

Will continue to require that all staff (new or existing) complete mandatory training on EDI yearly or upon hire. Home based EDI committees will be implemented in 2026.

Experience | Patient-centred | Optional Indicator

	Last Year		This Year		
Indicator #3 Percentage of residents responding positively to: "What number would you use to rate how well the staff listen to you?" (Henley House)	**9.38** Performance (2025/26)	**100** Target (2025/26)	**94.64** Performance (2026/27)	**908.96 %** Percentage Improvement (2026/27)	**100** Target (2026/27)

Change Idea #1 ☑ Implemented ☐ Not Implemented ☐ In Progress

To encourage participation in survey for capable residents, survey will be provided at care conferences.

Process measure

- The number of care conferences held will match the number of surveys provided.

Target for process measure

- 50% of all surveys provided will be answered.

Lessons Learned

Successes included positive responses, but low completion rate.

Change Idea #2 ☐ Implemented ☐ Not Implemented ☑ In Progress

Discuss at resident council meetings

Process measure

- Review meeting minutes to confirm if question was asked and if question was answered.

Target for process measure

- 100% of resident council meetings held will have the question asked and answered.

Lessons Learned

Started in January 2026

Change Idea #3 ☑ Implemented ☐ Not Implemented ☐ In Progress

To reduce the number of staff to resident or resident to staff incidents

Process measure

- 1)the number of reported staff to resident and resident to staff incidents

Target for process measure

- 1)0 incidents. 2) Increasing the number of staff who are GPA trained from 15 to 100 in 2025.

Lessons Learned

The number of staff to resident abuse incident have reduced significantly compared to previous year. We've seen a significant improvement in that area

Change Idea #4 ☑ Implemented ☐ Not Implemented ☐ In Progress

Provide orientation to all staff regarding customer service and residents bill of rights, zero tolerance of abuse and neglect

Process measure

- Percentage of staff completing customer service and residents bill of rights. Percentage of reduction in complaints/CIs related to Abuse and neglect

Target for process measure

- 100% of the staff completing customer service and residents bill of rights. 0% of complaints/CIs related to abuse and neglect

Lessons Learned

It is included in the general orientation and also a standard agenda item in the monthly meeting.

Comment

Increase the response rate and satisfaction rate by closely following up with residents and family.

Indicator #4

Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences". (Henley House)

Last Year		This Year		
18.13	**20**	**19.38**	**6.89%**	**100**
Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

Change Idea #1 ☑ Implemented ☐ Not Implemented ☐ In Progress

Provide residents with education on how to advocate for themselves

Process measure

- Utilization of survey

Target for process measure

- 10% more residents will respond positively to this statement in the survey than last year.

Lessons Learned

Discussed at resident council, however, participation in resident council is low.

Change Idea #2 ☑ Implemented ☐ Not Implemented ☐ In Progress

Increase rate of participation in survey

Process measure

- Review resident council minutes

Target for process measure

- 10% more responses to this question on the survey will be answered positively.

Lessons Learned

Implemented offering survey at care conferences, however this did not increase participation rates.

Change Idea #3 ☑ Implemented ☐ Not Implemented ☐ In Progress

To reduce the number of staff to resident or resident to staff incidents

Process measure

- 1)the number of reported staff to resident and resident to staff incidents

Target for process measure

- 1)0 incidents. 2) Increasing the number of staff who are GPA trained from 15 to 100 in 2025.

Lessons Learned

2024 total CIs for abuse/neglect = 16
2025 total CIs for abuse/neglect = 13.

Comment

Actively engage residents to attend resident council, add to admission process. Continue survey process at IDCCs and encourage residents and families to complete survey.

Safety | Safe | Optional Indicator

Indicator #1

Percentage of LTC home residents who fell in the 30 days leading up to their assessment (Henley House)

Last Year		This Year		
21.19	**18.33**	**17.65**	**16.71%**	**16**
Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

Change Idea #1 ☑ **Implemented** ☐ Not Implemented ☐ In Progress

Reduce number of falls due to residents attempting to self-toilet

Process measure

- Number of residents who were toileted on or before their toileting time.

Target for process measure

- 100% of residents will be toileted at or before their toileting time.

Lessons Learned

Trending downwards in resident falls when attempting to self-transfer to the toilet. 7% of falls occurred in washroom or related to toileting in documentation.

Change Idea #2 ☐ Implemented ☑ **Not Implemented** ☐ In Progress

Implementation of PSW teams

Process measure

- Training on PSW teams will be completed and implementation on floors will be rolled out one home area per month

Target for process measure

- Training completed by May 31st, 2025, and by August 31st, 1st floor implementation will be completed, by November 30th implementation will be completed on second floor.

Lessons Learned

Not implemented

Comment

Continue to track process metrics, meet on a monthly and quarterly basis to review progress on change idea.

Indicator #2

Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment (Henley House)

Last Year		This Year		
30.83	**20.40**	**31.38**	**-1.78%**	**25.99**
Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

Change Idea #1 ☑ Implemented ☐ Not Implemented ☐ In Progress

To improve the number of residents receiving antipsychotics without a diagnosis of psychosis

Process measure

- 1)Pharmacist provides recommendation for reduction or removal of antipsychotic medication. 2) Nursing assesses the effectiveness of medication change before and after removal.

Target for process measure

- Reduce the number of residents receiving antipsychotics without a diagnosis by at least 2 each month with a goal of 18 in 2025.

Lessons Learned

All residents who are receiving antipsychotic medication have been reviewed for appropriate diagnosis.

Change Idea #2 ☑ Implemented ☐ Not Implemented ☐ In Progress

Continue to utilize community resources such as PRC, TRC NBNP team to identify schizoaffective disorder symptoms and manage responsive behaviors

Process measure

- Percentage of residents referred to community resources to manage responsive behaviors. Percentage of staff trained on identifying the symptoms of schizoaffective disorder.

Target for process measure

- All new move in residents with antipsychotic use without the diagnosis of psychosis will be referred to community resources for further interventions to manage responsive behaviors.

Lessons Learned

ISMP AUA innovator network collaborative program implemented to decrease number of residents who are prescribed antipsychotics without appropriate diagnosis. Sessions completed with PRC related to schizoaffective disorders and managing responsive behaviors.

Change Idea #3 ☑ Implemented ☐ Not Implemented ☐ In Progress

Initiate monthly multi-disciplinary AUA meetings to review residents on antipsychotics and to ensure appropriate use of antipsychotics with and without CIHI approved diagnosis.

Process measure

- No process measure entered

Target for process measure

- No target entered

Lessons Learned

Implemented on all home areas.

Comment

Will continue to review residents who are taking antipsychotic medications for appropriate use and reduction.