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)	27.56	22.30	In 2025/26 we were able to exceed the target of reducing ED transfers by 10%. We have chosen to attempt to decrease ED transfers by 10% again in 2026/27.	Niagara Health System, Henley Place, Burton Manor, King Nursing Home

Change Ideas

Change Idea #1 All annual and initial care conferences will include 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 supports 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	Improve nursing staff competency in the assessment and management of cardiac and respiratory distress through simulation-based education.		
Methods	Process measures	Target for process measure	Comments
Nursing staff will participate in hands-on simulation sessions focused on cardiac and respiratory distress, including assessment, early recognition, and appropriate interventions. Competency will be assessed during the session, and feedback will be provided to support skill development and confidence in managing acute changes in condition within the home.	The Education Coordinator or designate will track the percentage of nursing staff who complete simulation training and demonstrate competency in assessment, recognition, and intervention during simulation.	Within 12 weeks, 100% of nursing staff will complete simulation training, and 90% will demonstrate competency in assessment and management of cardiac and respiratory distress.	Strengthening nursing competency in managing acute changes in condition supports early intervention and may reduce avoidable emergency department transfers.

Change Idea #3	At every scheduled care conference, the physician will review each resident's risk for avoidable ED transfers and discuss strategies to support care within the home.		
Methods	Process measures	Target for process measure	Comments
The physician will use a standardized template during care conferences to review key information, including diagnoses, recent transfer history, CPR status, and disease trajectory. This will support consistent discussion with residents and families regarding goals of care and options to manage changes in condition within the home.	The Care Conference Coordinator or designate will conduct monthly audits of care conference documentation to verify that ED transfer risk and prevention strategies were reviewed and documented.	By March 31, 2027, 90% of care conferences will include documented discussion of ED transfer risk and strategies to prevent avoidable transfers.	Structured discussions during care conferences support proactive care planning and help ensure residents and families are informed about options for managing care within the home.

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	In 2025, Henley House was able to achieve 100% so we feel confident that we can achieve 100% again.	

Change Ideas

Change Idea #1 Ensure all staff complete equity, diversity, inclusion, and anti-racism education as part of onboarding and annual training requirements.

Methods	Process measures	Target for process measure	Comments
Mandatory Diversity, Equity, and Inclusion (EDI) training will be delivered through the RELIAS Learning platform as part of general orientation and annual education. Completion will be monitored and tracked by the Education Coordinator.	The Education Coordinator or designate will track the percentage of staff who complete required EDI training.	100% of staff assigned EDI training will complete the training by January 1, 2027.	Ensuring all staff complete EDI education supports culturally responsive care and promotes an inclusive and respectful environment for residents, families, and staff.

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	94.64	100.00	In 2025 we were able to successfully achieve 100% on satisfaction surveys therefore we believe we will be able to successfully complete again in 2026.	

Change Ideas

Change Idea #1 Provide residents and families with opportunities to share feedback following annual and move-in care conferences.

Methods	Process measures	Target for process measure	Comments
Following each annual or move-in care conference, a QR code linking to a standardized feedback survey will be provided to residents and/or families in printed form or via email. Staff will explain how to access the survey and document distribution. Survey responses will be tracked monthly and reviewed by the care team to identify opportunities for improvement in communication and care planning.	The Social Worker or designate will track the percentage of annual and move-in care conferences where a feedback survey is provided to residents and/or families.	100% of annual and move-in care conferences will have a feedback survey provided to residents and/or families by June 30, 2026.	Total Surveys Initiated: 160 Providing structured opportunities for feedback supports resident and family engagement and helps improve communication and responsiveness of care.

Change Idea #2 Increase participation of capable residents in feedback surveys by providing direct support to complete the survey.

Methods	Process measures	Target for process measure	Comments
Residents will be identified using RAI-MDS data (CPS score). Residents with a CPS score of 0–3 will be approached following annual or move-in care conferences and offered support to complete the survey using a QR code or alternative format as needed.	The Care Conference Facilitator or designate will track the percentage of eligible residents (CPS =3) who are approached and offered support to complete the survey.	100% of eligible residents (CPS =3) will be approached to complete the survey following annual or move-in care conferences by December 31, 2026.	Supporting capable residents to participate in feedback surveys increases response rates and ensures resident perspectives are captured to improve communication and care experiences.

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	19.38	100.00	In 2025, we had 100% positive responses to this question. We are confident that we can achieve 100% again in 2026.	

Change Ideas

Change Idea #1 Provide residents and families with opportunities to safely share feedback following annual and move-in care conferences.

Methods	Process measures	Target for process measure	Comments
Following each annual or move-in care conference, a QR code linking to a standardized feedback survey will be provided to residents and/or families in printed form or via email. Staff will explain how to access the survey and document distribution. Survey responses will be tracked monthly and reviewed by the care team to identify opportunities for improvement.	The Social Worker or designate will track the percentage of annual and move-in care conferences where a feedback survey is provided to residents and/or families.	100% of annual and move-in care conferences will have a feedback survey provided to residents and/or families by April 1, 2027.	Total Surveys Initiated: 160 Providing structured opportunities for feedback supports a culture where residents and families feel safe expressing opinions and concerns without fear of consequences.

Change Idea #2 Increase participation of capable residents in feedback surveys by providing direct support to complete the survey.

Methods	Process measures	Target for process measure	Comments
RAI-MDS reports will be used to identify residents with a CPS score of 0–3. These residents will be approached following annual or move-in care conferences and offered assistance to complete the survey using a QR code or alternative format as needed.	The Social Worker or designate will track the percentage of eligible residents (CPS =3) who are approached and offered support to complete the survey.	100% of eligible residents (CPS =3) will be approached to complete the survey following annual or move-in care conferences by December 31, 2026.	Supporting capable residents to participate in feedback surveys increases response rates and helps ensure residents feel safe expressing their opinions and concerns.

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	17.65	16.00	Henley House has placed a large focus on falls and injury prevention and we are confident that we will reduce the number of residents who have fallen.	Niagara Health System, A&B Therapy

Change Ideas

Change Idea #1 Ensure residents who experience a fall receive an interdisciplinary review and updated fall-prevention care plan with targeted interventions.

Methods	Process measures	Target for process measure	Comments
Residents who experience a fall will undergo a structured interdisciplinary review to identify contributing factors such as mobility, medications, environment, and comorbidities. Care plans will be updated with targeted interventions, including environmental modifications, mobility supports, and individualized strategies. Interventions will be monitored for effectiveness, and all actions will be documented in the resident record.	The Falls Lead or designate will track the percentage of residents who experience a fall and receive an interdisciplinary review and documented fall-prevention care plan update.	100% of residents who experience a fall will have an interdisciplinary review and updated fall-prevention care plan in place by March 31, 2027.	Timely interdisciplinary review and intervention supports identification of contributing factors and helps prevent future falls.

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

Methods	Process measures	Target for process measure	Comments
Residents identified as at risk for falling from bed will receive an interdisciplinary assessment of contributing factors, including mobility, cognitive status, and sleep patterns. Individualized interventions such as bed height adjustments, positioning strategies, bed or chair alarms, floor mats, and toileting schedules will be implemented. Care plans will be updated to document interventions, and effectiveness will be monitored through regular review.	The Falls Lead or designate will track the percentage of residents identified as 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 reduce the risk of bed-related falls.

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	31.38	25.99	The home has prioritized reducing unnecessary antipsychotic use to enhance resident safety, minimize adverse effects, and align with best practices in person-centered care.	CareRX, BSO, SMHO

Change Ideas

Change Idea #1	Ensure residents receiving antipsychotic medications without a documented clinical indication undergo interdisciplinary review and care plan updates with consideration of non-pharmacological interventions.		
Methods	Process measures	Target for process measure	Comments
The interdisciplinary team will review residents prescribed antipsychotic medications without a documented appropriate indication. Reviews will assess behavioural triggers, current symptoms, and potential non-pharmacological interventions. Care plans will be updated to reflect alternative strategies, deprescribing opportunities where appropriate, and monitoring requirements. Reviews and updates will be documented and tracked monthly using pharmacy and PCC reports.	The Director of Care 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.	100% of residents receiving antipsychotic medications without a documented clinical indication will have an interdisciplinary review and care plan update by March 31, 2027.	Regular interdisciplinary review supports appropriate medication use and promotes non-pharmacological approaches to managing responsive behaviours.

Change Idea #2	Ensure residents admitted on antipsychotic medications receive an interdisciplinary review during the move-in process to assess clinical indication and consider non-pharmacological alternatives.		
Methods	Process measures	Target for process measure	Comments
During the move-in process, the interdisciplinary team will review residents prescribed antipsychotic medications. The review will include assessment of clinical indications, behavioural triggers, and potential non-pharmacological interventions. Care plans will be updated to reflect alternative strategies, monitoring requirements, and any deprescribing opportunities. Reviews and updates will be documented and audited quarterly	The Director of Care or designate will track the percentage of residents admitted on antipsychotic medications who receive an interdisciplinary review and care plan update during the move-in process.	100% of residents admitted on antipsychotic medications will have an interdisciplinary review and care plan updated during the move-in process by December 31, 2026.	Early review of antipsychotic medications at admission 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	6.32	3.30	Henley House has recently placed a large focus on pressure ulcer prevention and promotion of wound healing.	Essity, Niagara Health System, Align, Wound Specialist

Change Ideas

Change Idea #1 Implement a standardized wound care protocol and product formulary to improve consistency in prevention and treatment.

Methods	Process measures	Target for process measure	Comments
Registered staff will be trained on the Essity wound care products and standardized wound care protocol. The protocol will be implemented on one home area and then expanded to all home areas. The Skin and Wound Lead will support education, implementation, and monitoring of adherence to the protocol.	The Skin and Wound Lead or designate will track the percentage of registered staff who complete training on the standardized wound care protocol and the percentage of home areas implementing the protocol.	90% of registered staff will complete training on the standardized wound care protocol by May 1, 2026. 100% of home areas will implement the standardized wound care protocol by March 31, 2027.	

Change Idea #2	Ensure residents identified as moderate to high risk for pressure ulcers (PURS ≥4) have updated plans of care that include appropriate preventive interventions.		
Methods	Process measures	Target for process measure	Comments
The Skin and Wound Lead will review PURS scores quarterly and audit charts of residents identified as moderate to high risk. The audit will confirm that pressure-relieving devices and preventive interventions are in place and documented. Identified gaps will be addressed with the interdisciplinary team, and care plans will be updated accordingly.	The Skin and Wound Lead or designate will track the percentage of residents identified as moderate to high risk (PURS =4) who have documented pressure-relieving devices and preventive interventions in their plan of care.	95% of residents identified as moderate to high risk (PURS =4) will have documented pressure-relieving devices and preventive interventions in place by March 31, 2027.	Ensuring timely implementation of preventive interventions for residents at higher risk supports early intervention and helps reduce the likelihood of pressure ulcer deterioration.

Change Idea #3	Ensure residents with worsening pressure injuries receive timely interdisciplinary review and care plan updates with targeted interventions.		
Methods	Process measures	Target for process measure	Comments
When a resident's pressure injury worsens, the Skin and Wound Lead will trigger an interdisciplinary review. The team will assess the wound and update the plan of care with targeted interventions such as specialized support surfaces, repositioning schedules, and appropriate wound care products. Changes will be communicated to care staff, and follow-up monitoring will continue until the wound stabilizes or improves.	The Skin and Wound Lead or designate will track the percentage of residents with worsening pressure injuries who receive an interdisciplinary review and documented care plan update within one week.	100% of residents with worsening pressure injuries will receive an interdisciplinary review and documented care plan update within one week by March 31, 2027.	Timely interdisciplinary review and intervention supports early escalation of care and may reduce further wound deterioration.

Measure - Dimension: Safe

Indicator #8	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	3.11	2.00	In 2026, physical restraints were reduced from 4 residents to 3 due to reviewing falls prevention and alternatives to restraints.	

Change Ideas

Change Idea #1 Maintain low use of physical restraints through education and use of alternative strategies.

Methods	Process measures	Target for process measure	Comments
When a physical restraint is requested, the Restraints Lead or designate will review the resident's clinical needs and provide education to staff and families on alternatives to restraints. Appropriate non-restraint interventions will be implemented and documented in the resident's plan of care.	The Restraints Lead or designate will track the percentage of physical restraint requests that are reviewed and include documented education and alternative interventions.	100% of physical restraint requests will be reviewed and include documented education and alternative interventions by March 31, 2027.	Promoting alternatives to restraints supports resident safety, dignity, and autonomy while maintaining compliance with least-restraint best practices.