Experience

Measure - Dimension: Patient-centred

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
I enjoy eating meals in the dining room	C	% / LTC home residents	In-house survey / Jan to Dec 2026	67.20	76.00	The target of 76% reflects a realistic improvement from the current baseline of 67.2% based on the implementation of the Primary Service Dining Model, enhanced dining equipment, and ongoing review through the Food and Dining Sub-Committee. Progress will be monitored through resident feedback and CQI review to ensure improvements in the overall dining experience.	

Change Ideas

Change Idea #1   Implementation of Primary Service Dining Model

Methods	Process measures	Target for process measure	Comments
Develop written primary service dining workflow and role expectations. Educate dietary and care staff on new model. Pilot model on 3rd floor until March 31, 2026 Collect resident feedback weekly during pilot. Ensure 100% compliance with MealSuite diet type and texture accuracy, including use of show plates to support resident choice and understanding. Review pilot results at Food & Dining Resident Sub-Committee Roll out to remaining dining rooms. Conduct ongoing operational review at the Monthly Food & Dining meeting	Percentage of dining rooms implementing primary service model Percentage of dietary and care staff trained Percentage of Food & Dining Sub-Committee reviews completed Compliance rate with MealSuite diet type and texture accuracy	100% of dining rooms implementing model by May 30, 2026 =95% of dietary and care staff trained by June 30, 2026 12 Food & Dining Sub-Committee reviews completed in 2026 Maintain 100% compliance with documented MealSuite diet and texture accuracy	

Change Idea #2   Enhancement of Food Service Equipment

Methods	Process measures	Target for process measure	Comments
Order and receive equipment - including tableside service option such as soup cauldron and new hot holding carts Train staff on proper use. Monitor meal temperature pre- and post-implementation. Review resident feedback trends quarterly.	Equipment installed and operational Percentage of dietary staff trained on equipment use Completion rate of monthly meal temperature logs Quarterly resident feedback review completed	100% equipment operational by August 31, 2026 =95% dietary staff trained by September 30, 2026 100% of monthly meal temperature logs completed in 2026 4 documented quarterly resident feedback reviews completed	

Measure - Dimension: Patient-centred

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
% of residents/families responding positively to: "Communication from the home leaders (Executive Director, Director of Care and Managers) is clear and timely."	C	% / LTC home residents	In-house survey / Jan to Dec 2026	58.50	70.00	The target reflects a realistic improvement from the current baseline of 58.5% based on the implementation of the home's quality improvement initiatives and ongoing monitoring through the CQI committee. Progress toward the target will be supported through interdisciplinary collaboration, resident and family engagement, and continuous review of performance data.	

Change Ideas

Change Idea #1   Establish Structured, Predictable Leadership Communication Forums

Methods	Process measures	Target for process measure	Comments
conduct communication preference survey (families and residents). Develop annual communication calendar (quarterly family meetings + quarterly CQI invitations). Deliver quarterly family meetings (in-person + virtual). Share meeting summaries within 7 days. Establish a 2-business-day acknowledgment standard for leadership-level inquiries.	Communication preference survey completed 4 quarterly family meetings delivered % meeting summaries distributed within 7 days =90% leadership inquiries acknowledged within 2 business days	Survey completed by Q2 4 family meetings in 2026 100% summaries shared within 7 days =90% leadership inquiries acknowledged within 2 business days	

Change Idea #2   Enhance leadership transparency through centralized communication and information access.

Methods	Process measures	Target for process measure	Comments
Rebrand medexnewsletter.com into a centralized leadership information hub (Medex Connect). Publish quarterly leadership newsletter via Mailchimp with tracked analytics. Include recurring "You Said – We Did" segment in all family meetings and newsletters. Post CQI summaries and quality performance slide deck quarterly. Embed website reference in admission package and care conference materials. Review Mailchimp analytics quarterly to assess engagement.	Number of leadership newsletters published Average Mailchimp open rate Percentage increase in subscriber list Number of quarterly CQI/quality slide deck updates posted Percentage of admission packages including website reference Number of "You Said – We Did" segments delivered Number of website analytics reviews completed	4 leadership newsletters published in 2026 Increase average Mailchimp open rate from 58.9% to =62% by December 31, 2026 Increase subscriber list by 10% by December 31, 2026 4 quarterly CQI summaries and quality slide deck updates posted in 2026 Website link included in 100% of new admission packages 4 "You Said – We Did" segments delivered in 2026 4 quarterly analytics reviews completed in 2026	

Measure - Dimension: Patient-centred

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
If I have a concern I feel comfortable raising it with the staff members in my home	C	% / LTC home residents	In-house survey / Jan to Dec 2026	71.40	81.00	The target of 81% reflects a realistic improvement from the current baseline of 71.4% based on initiatives that strengthen open communication between residents and staff, including DementiAbility-informed care approaches, structured resident interviews, and ongoing staff education focused on encouraging residents to express concerns and feedback. Progress will be monitored through CQI review and ongoing resident feedback.	

Change Ideas

Change Idea #1 Strengthen Psychological Safety in Staff-Resident Interactions			
Methods	**Process measures**	**Target for process measure**	**Comments**
Deliver DementiAbility-informed relational safety training to 100 interdisciplinary staff focusing on active listening, emotional validation, and non-defensive response to concerns. Implement "Pause & Validate" scripting tools for staff receiving concerns. Introduce a 48-hour repair conversation expectation following relational breakdowns, documented in progress notes when applicable. Enrichment Coordinator to provide structured unit-based coaching and modelling (minimum once per quarter per unit). Conduct structured interviews with residents with CPS scores 1–2 to assess comfort raising concerns and identify barriers. Review feedback themes twice annually and integrate findings into coaching focus areas.	additional staff completing relational safety training unit-based coaching sessions delivered % eligible CPS 1–2 residents interviewed thematic feedback reviews completed	100 additional staff complete relational safety training by December 31, 2026 Minimum 1 coaching sessions per unit per quarter =60% of eligible CPS 1–2 residents interviewed by September 30, 2026 2 thematic feedback reviews completed in 2026	

Change Idea #2   Implement Consultant-Supported DementiAbility Relational Safety Model

Methods	Process measures	Target for process measure	Comments
Host DementiAbility Consultant for structured site visit including: Formal DementiAbility audit Workshop delivery Floor-based collaborative coaching Case study deep dives Revise care plan template to include: Preferred communication style Emotional triggers "What helps me feel heard" Schedule follow-up consultant visit for certification exams and trainer certification to support sustainability.	DementiAbility audit completed consultant collaborative coaching days completed % resident care plans updated with emotional communication profile staff completing trainer certification	100 additional staff complete relational safety training by December 31, 2026 Minimum 1 coaching session per unit per quarter =60% of eligible CPS 1–2 residents interviewed by September 30, 2026 2 thematic feedback reviews completed in 2026	

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	15.51	14.00	The target reflects a realistic improvement from the current baseline of 15.51%. The home has implemented a comprehensive falls prevention strategy including structured PSW preceptorship training, enhanced monitoring through a Falls Captain role, and the use of a 72-hour Falls Observation Record following fall events. These initiatives strengthen staff practice consistency, early risk identification, and interdisciplinary review of fall trends. Progress toward the target will be monitored through CQI review and quarterly analysis of CIHI CCRS data.	

Change Ideas

Change Idea #1 Implement a Structured PSW Preceptorship Program to Improve Practice Consistency

Methods	Process measures	Target for process measure	Comments
Identify 12 full-time PSWs to serve as trained preceptors. Deliver 8-hour structured education session focused on: Facility-specific processes Falls prevention standards Proactive toileting and incontinence routines Ensuring frequently used items remain within reach Meaningful engagement and programming to reduce boredom-related falls Intentional resident pairing and supervision practices DementiAbility-informed care approaches Provide standardized preceptor handbook and onboarding checklist. Pair each new PSW hire with a trained preceptor for 3 structured onboarding days. Require completion of onboarding checklist focused on high-risk care practices. Conduct mid-probation and pre-probation evaluations to confirm competency.	Number of PSWs trained as preceptors Percentage of new PSW hires paired with a trained preceptor for 3 structured onboarding days Percentage of onboarding checklists completed in full Percentage of new hires demonstrating competency in falls prevention practices at probation review	12 PSWs trained as preceptors by April 30, 2025 100% of new PSW hires paired with a trained preceptor 100% onboarding checklists completed =90% of new hires demonstrate competency in falls prevention practices at probation review	

Change Idea #2   Enhance Monitoring and Accountability Through Falls Captain Role and 72-Hour Falls Observation Record (FOR)

Methods	Process measures	Target for process measure	Comments
Redistribute PSW assignments to ensure balanced workload and clearer accountability. Assign one Falls Captain per shift. Require first-round safety checks of equipment and environment. Identify high-risk residents at start of shift and plan coverage during breaks and high-risk periods. Introduce 72-hour Falls Observation Record (FOR) following fall, near miss, or change in condition. Require PSW completion of FOR; registered staff to review and implement strategies. Reinforce shift-change monitoring practices.	Percentage of shifts with designated Falls Captain Percentage of qualifying events followed by completed 72-Hour FOR Percentage of completed FOR reviewed by registered staff within 24 hours Quarterly review of trends identified through FOR implementation	100% of shifts have designated Falls Captain =90% of qualifying events followed by completed FOR =95% of FOR reviewed by registered staff within 24 hours 4 quarterly trend reviews completed in 2026	

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	7.50	6.50	The target reflects a realistic improvement from the current baseline of 7.50%. The home has strengthened interdisciplinary review of antipsychotic use through behavioural rounds, implementation of the Anti-psychotic Decision Support Tool (AP-DST), and collaboration with Behavioural Supports Ontario and geriatric psychiatry resources. These approaches support non-pharmacological interventions and regular medication review to reduce unnecessary antipsychotic use.	

Change Ideas

Change Idea #1	Staff Education on Gentle Persuasive Approaches (GPA) Basics and Dementiability to show how to assess for unmet needs that can turn into responsive behaviours in persons with Dementia and how this can be minimized and / or eliminated

Methods	Process measures	Target for process measure	Comments
1. Medex certified trainer in collaboration with the Royal Ottawa and Regional Certified Trainer to provide GPA Basics and Refresher Education Sessions. 2. Dementiability Program training Provided to staff to recognize unmet need, how it contributes to responsive behaviour	1. # of staff participated in 'GPA Basics' education 2. Feedback from staff participants on the experience and usefulness of 'GPA Basics' and Dementiabiliy education to support resident care that minimzes / eliminates responsive behaviour r/t unmet needs. 3. # of Staff who attended specialized educational session(s) on Dementiability that supports non-pharmacological approaches to care.	1. 'GPA Basics' education will be provided for 10% of staff by November 30, 2026. 2. Feedback from staff on GPA and Dementiability education will be reviewed and actioned within 14 days of the session provided. 3. 60% of staff will have attended Dementiability education by November 30, 2026.	

Change Idea #2	Residents prescribed AP's will be reviewed during Behaviour Rounds to assess appropriateness of use and develop individualized action plans using the AP Decision Support Tool. (AP-DST)

Methods	Process measures	Target for process measure	Comments
1. Resident's on Antipsychotics (without a corresponding Psychiatric Dx) will be referred to the BST Lead. 2. BSL will refer residents to the Resident Enrichment Coordinator (REC) when behaivours to unmet needs identified. 3. Individualized non-pharmacological interventions will be implemented and documented in the resident care plan. 4.Effectiveness of interventions will be reviewed during Behaviour rounds.	1. # of residents on AP's with an action plan documented on the AP-DST. 2. # of residents reviewed during Behaviour Rounds.	100 % of residents using AP's will have and individualized action plan documented in the AP-DST.	

Change Idea #3	Residents demonstrating responsive behaviour will be assessed for unmet needs and supported with non-pharmacological interventions prior to or alongside AP use

Methods	Process measures	Target for process measure	Comments
1. Behaivour Rounds will identify resident with responsive behavours in addition to early alerts from High Risk Rounds. 2. The Behaviour Support Lead will refer residents to the REC when behaviours r/t unmet needs are identified. 3. Individualized non-pharm interventions will be implemented and doucmented in the resident care plan. 4. Effectiveness of interventions will be reviewed during Behaviour Rounds	1. # of referrals to the Resident Enrichment Team from Behaviour Rounds. 2. # of residents with documented non-pharmacological interventions to their care plan.	Non-pharmacological approaches will be reviewed during Behaviour Rounds and documented in care plans and reassessed within 1 month of implementation.	

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	1.19	0.00	The target reflects a realistic improvement from the current baseline of 1.19%. Through ongoing skin and wound monitoring, interdisciplinary care planning, enhanced repositioning practices, and regular review of residents at risk for pressure injuries, the home aims to reduce the number of residents whose stage 2–4 pressure ulcers worsen. Progress will be monitored through CQI review and quarterly analysis of CIHI CCRS data.	

Change Ideas

Change Idea #1   Training of pressure injury prevention and management

Methods	Process measures	Target for process measure	Comments
Skin and Wound lead to complete continued education on wound care best practices Enroll 12 PSWs in the PSW and caregiver Skin Health Course ROHO and Repositioning education on SURGE for all new hires and annually for all care staff	# of hours of continued education completed by the Wound care lead # of PSWs who are certified in the skin health course # of Care staff completing the virtual education	15 credits/hours of continued education 12 PSWs course certifications by Feb 2027 100% of care staff with education completed	

Change Idea #2   Obtain an Arterial Brachial Index on admission on every resident to prevent and effectively manage venous leg ulcers

Methods	Process measures	Target for process measure	Comments
Purchase an a automated ABI system which will be available in house The Skin and Wound lead, Foot care nurse and Nurse Practitioner will be trained on how to operate the ABI system All new admits and residents at high risk of peripheral vascular disease will have an ABI reading	ABI system available in house by April 30th, 2026 Skin and wound lead, foot care nurse and NP will be trained on operating the ABI system 100% of admissions of 2026 and high risk residents will have an ABI on file by Feb 2027	Timeliness of appropriate clinical interventions by reducing wait times for Ankle-Brachial Index (ABI) testing through the implementation of an in-house ABI machine.	

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Measure - Dimension: Safe

Indicator #7	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	0.14	0.00	The target of 0% reflects the home's commitment to maintaining a restraint-free environment whenever possible. The current baseline of 0.14% represents very limited use of restraints, and ongoing interdisciplinary review, behaviour support strategies, and person-centred care approaches will continue to support the reduction and prevention of restraint use. Progress will be monitored through CQI review and regular care plan evaluations.	

Change Ideas

Change Idea #1	Strengthen Staff Knowledge on Positioning Devices and Restraint Risk #2) Reinforce least-restrictive alternatives through interdisciplinary review and leadership oversight.

Methods	Process measures	Target for process measure	Comments
Develop and deliver structured education on positioning devices and restraint risk Implement quarterly restraint-risk audits Require interdisciplinary review and RN reassessment before or immediately following any restraint consideration Review restraint-related events at CQI	% nursing staff completing restraint education Number of quarterly restraint-risk audits completed % restraint-related events reviewed at CQI	100% nursing staff complete education by June 30, 2025 4 quarterly audits completed in 2025 100% restraint-related events reviewed at CQI	