Access and Flow | Efficient | Optional Indicator

Indicator #5

Rate of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents. (The Norfolk Hospital Nursing Home)

Last Year		This Year		
23.44	**20**	**16.67**	**28.88%**	**15**
Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

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

Partnership with and utilization of the Nurse Led Outreach Team (NLOT) through Norfolk General Hospital

Process measure

- Number of NLOT consults per month Number of ED transfers per month Number of NLOT consults outside of NLOT working hours

Target for process measure

- 100% of actual ED transfers had an NLOT consult prior to transfer

Lessons Learned

Availability hours are 8-4pm

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

All cases of resident transfers to the ED are reviewed monthly by the interdisciplinary team

Process measure

- RAI Coordinator tracks all monthly resident ED transfers and all monthly NLOT consults. The RAI Coordinator provides a monthly schedule of cases to be reviewed at the interdisciplinary care conference

Target for process measure

- 100% of resident transfers to the ED are reviewed by the interdisciplinary team

Lessons Learned

Data tracking is done at a monthly basis. Currently interdisciplinary team is involved on an as needed basis

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

All Residents with Advance Directives Levels 1,2,3,4 will receive information and education on the NGH NLOT Team and consultation process

Process measure

- Distribution of NLOT brochures Follow up education with Residents and POAs Care Conference discussion/action item

Target for process measure

- 100% of Residents/POAs with Advance Directives Levels 1,2,3,4 are provided education on NLOT 100% of Residents/POAs are aware that NLOT will be consulted when ED transfer is being considered 100% of care plans containing Advance Directives Levels 1,2,3,4 contain the NLOT consultation intervention 100% of care conferences included NLOT discussion.

Lessons Learned

Advanced Care levels are educated. NLOT team introduces themselves at time of consultation.

Equity | Equitable | Optional Indicator

Indicator #4

Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education (The Norfolk Hospital Nursing Home)

Last Year		This Year		
2.50	**100**	**86.30**	**3352.00 %**	**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**

Utilize current and available DEI courses on LMS platform - Surge Learning

Process measure

- % of staff completing mandatory assigned courses in Surge Learning - monthly progress audit

Target for process measure

- 100% staff completion of all assigned equity, diversity, inclusion, and anti-racism courses in Surge Learning by March 31, 2026

Lessons Learned

Completed on Surge. Leadership has completed the Indigenous component

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

In partnership with Norfolk General Hospital through the IDEA initiative, identify new and/or emerging best practices and care supports for Residents of NHNH

Process measure

- NHNH IDEA champions completion of IDEA training. NHNH IDEA champions partnership and collaboration with NGH IDEA champions. Visual representations in the Home i.e. posters, infographics reinforcing IDEA initiative

Target for process measure

- 4-6 NHNH staff identified as IDEA champions

Lessons Learned

Exploring additional resources

Comment

Leadership team will audit staff completion on SURGE learning and enforce completion of this mandatory education.

Experience | Patient-centred | Custom Indicator

	Last Year		This Year		
Indicator #3	**CB**	**100**	**CB**	**--**	**NA**
Percentage of Residents responding YES to the statement: "Nursing Staff have discussed my end of life wishes with me" (The Norfolk Hospital Nursing Home)	Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

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

Develop an NHNH palliative care team

Process measure

- NHNH palliative care team membership is formed Terms of Reference are complete

Target for process measure

- First meeting in July 2025

Lessons Learned

Currently in progress with the RNAO Clinical Pathway Palliative Care and EOL. Palliative Care team in place. Refining members for sustainability and multidisciplinary involvement

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

Palliative Care Team surveys residents regarding measure/indicator: % of Residents responding yes to the statement: "nursing staff have discussed my end of life wishes with me"

Process measure

- percentage of surveys completed

Target for process measure

- 100% of residents/POAs respond to survey

Lessons Learned

Currently in progress with the RNAO Clinical Pathway Palliative Care and EOL

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

Survey Results are used to develop targeted improvements to palliative care processes at NHNH

Process measure

- # of proposed improvements to palliative care program at NHNH Proposed improvements are presented and reviewed by the NHNH Quality Committee

Target for process measure

- 100% of proposed improvements to palliative care program at NHNH are reviewed by the Quality Committee

Lessons Learned

Survey results discussed and implementation of targeted improvements to the palliative process in progress

Safety | Safe | Custom Indicator

Indicator #1

Percentage of long-term care home residents in daily physical restraints over the last 7 days (The Norfolk Hospital Nursing Home)

Last Year		This Year		
6.80	**4**	**6.90**	**--**	**NA**
Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

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

Resident & Family Education on restraint minimization and restraint alternatives in LTC

Process measure

- 1. Percentage of Residents and Families who received the educational brochure 2. Brochure and Restraint use in LTC is reviewed at Resident Council and Family Council 3. Brochure is reviewed with all new admissions to NHNH and at all care conferences where applicable

Target for process measure

- 100 % of Residents/POAs and family members receive education brochure. 100% of care conferences include discussion on restraints where applicable, in addition to restraint best practices and restraint alternatives. 100% of all new admissions include brochure dissemination and restraints discussion

Lessons Learned

Resident and families received pamphlets on "A guide to bed safety", and "Least restraint".

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

Staff Education on Restraint minimization and restraint alternatives in LTC

Process measure

- % of staff completion of surge learning education % of daily huddles with restraint focus # of weeks of education boards on display with restraint focus % positive feedback on Nursing Week Displays with restraint focus memo sign-off completion rates

Target for process measure

- 100% staff completion of Surge Learning Restraint Minimization education by August 1st, 2025 100% of staff meetings will include Restraints as a standing agenda item Nursing Week will include education boards on Restraint minimization 100% of staff will sign off on memos pertaining to restraints

Lessons Learned

Surge learning for all team members on "Minimizing Restraint Use in LTC". Huddles.
Reference for team members posted in the home areas on clarification of restraints and PASD.

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

Policy, Protocol, Assessment and Documentation Review

Process measure

- Inventory identified and compiled Interdisciplinary Team review of all relevant documents is complete All policies, protocols, assessments and documents are updated to reflect best practices and alignment with the FLTCHA. Point Click Care functionality is maximized to support this change initiative

Target for process measure

- 100% of policies, protocols, assessments and documentation reflect best practices 100% of policies, protocols, assessments and documentation support and align with the FLTCHA Point 100% Click Care assessments and documentation reflect best practices

Lessons Learned

Lessons learned: Corrective documentation in RAI to reflect clarity of definition on restraints and PASD.

Safety | Safe | Optional Indicator

Indicator #2

Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment (The Norfolk Hospital Nursing Home)

Last Year		This Year		
24.65	**20**	**23.77**	**3.57%**	**21.04**
Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

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

Implementation of an antipsychotic medication review tool

Process measure

- Standard process is used to identify Residents appropriate for tool use Antipsychotic review tool is consistently used

Target for process measure

- Tool is used at every identified opportunity Tool demonstrates effectiveness toward goal of reducing antipsychotic use where applicable

Lessons Learned

Strategies and review in place

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

Increase staff education and training in GPA & Teepa Snow positive approach to care

Process measure

- Maximize BSO consults on residents taking antipsychotic medications Percentage of staff with current GPA training Percentage of staff with current Teepa Snow training

Target for process measure

- BSO will consult on all residents with new or changing antipsychotic medications Increase staff certification in GPA training by 10% 100% utilization of all Teepa Snow training seats offered to NHNH this fiscal year

Lessons Learned

All team members are being trained in GPA

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

Improve indication of use of antipsychotic medications

Process measure

- Quarterly reports are sent to BSO staff for review and feedback Number of residents taking antipsychotic medications without a diagnosis % of residents taking antipsychotics with indication of use documented

Target for process measure

- 100% of Residents taking antipsychotic medications without a diagnosis are reviewed by BSO 100% of Residents taking antipsychotic medications have a documented indication of use

Lessons Learned

Regular update from pharmacy during our Medication Management team meeting

Comment

We receive monthly medication use reports from the Pharmacy. We review antipsychotic use at Medication Management Meetings and Quality Committee Meetings. GPA is mandatory education for all staff.