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)	16.67	15.00	Improve target to lower than current performance. Remain below Provincial average.	Norfolk General Hospital

Change Ideas

Change Idea #1	Implement standardized SBAR communication for escalation of resident clinical concerns. Provide enhanced RN assessment training to strengthen clinical decision-making and early identification of changes in resident condition. Establish a clear on-call NP/Physician escalation pathway to support clinical decision-making prior to hospital transfer. Implement a falls-without-injury in-house monitoring protocol to ensure appropriate observation and reassessment before considering ED transfer. Conduct staff education sessions focused on early recognition and management of common conditions that may lead to ED visits.

Methods	Process measures	Target for process measure	Comments
Staff education sessions will be conducted to improve the early identification and management of conditions such as infections, dehydration, and changes in resident status that may lead to emergency department transfers. A standardized SBAR communication tool will be used for escalation of concerns to ensure consistent and structured communication among staff and providers. Prior to any potential hospital transfer, the on-call Nurse Practitioner or Physician will be consulted, when clinically appropriate, to review the resident's condition and determine if management can be safely provided within the home. Additionally, enhanced RN assessment training will be implemented to strengthen clinical evaluation and decision-making skills. A falls-without-injury in-house monitoring protocol will be used to ensure residents are closely observed following a fall, including reassessment and monitoring, to support safe in-home management and reduce unnecessary ED transfers.	95% of Registered Staff trained in early recognition and management of common conditions that may result in ED visits. 95% of potential transfers where the SBAR communication tool is completed prior to escalation. 100% of cases where the on-call Nurse Practitioner (NP) or Physician is consulted prior to ED transfer when appropriate. Number of ER transfer/month tracked by the RAI coordinator. Monthly review on CTAS Levels from NGH.	Staff Training: 95% of Registered Staff staff will complete training on early recognition and management of common conditions that may lead to ED visits by December 31, 2026. SBAR Utilization: SBAR communication will be completed in 95% of resident clinical escalations or potential transfers by December 31, 2026. Provider Consultation: The on-call Nurse Practitioner (NP) or Physician will be consulted in 95% of potential ED transfers, when clinically appropriate, prior to transfer by December 31, 2026. Falls Monitoring: 100% of residents experiencing falls without injury will have the in-house monitoring protocol completed and documented within 24 hours of the incident.	

Change Idea #2	Strengthen Advance Care Planning (ACP) and Goals of Care (GOC) discussions with residents and families early after admission. Implement quarterly audits of Goals of Care documentation to ensure compliance and timely follow-up. Provide family education sessions on palliative care, advance care planning, and end-of-life decision-making. Reinforce completion of GOC documentation through the admission checklist process. Increase staff education on palliative care assessment tools and end-of-life communication.

Methods	Process measures	Target for process measure	Comments
Advance Care Planning and Goals of Care discussions will be initiated with residents and families within the first 30-45 days of admission and documented in the resident's Care Plan. Staff will be reminded to complete GOC documentation through reinforcement of the admission checklist during the intake process. Quarterly Goals of Care documentation audits will be conducted to monitor compliance and identify residents who require updated discussions. Education will be provided to staff to improve confidence in conducting end-of-life conversations and using standardized palliative assessment tools. Family education sessions will be offered to improve understanding of palliative care options, symptom management, and decision-making at end of life. These interventions aim to ensure that residents' wishes are clearly documented and followed, reducing unnecessary or avoidable hospital transfers during the last stages of life.	Percentage of newly admitted residents with documented Goals of Care discussions within 30-45 days of admission. 100% of residents with Goals of Care reviewed or updated during quarterly audits. 75% of families attending education sessions on palliative care and advance care planning. 75% of admissions with completed admission checklist including GOC documentation.	Increase documented Goals of Care discussions within 30-45 days of admission from 50% to 90% by December 31, 2026. Achieve 95% completion of the admission checklist including GOC documentation for new residents by December 31, 2026. Ensure 100% of residents have GOC reviewed or confirmed during quarterly chart audits by December 31, 2026. Provide at least two family education sessions per year, with 75% family participation of newly admitted residents.	

Measure - Dimension: Efficient

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Potentially avoidable emergency department visits for long-term care residents	C	Number / LTC home residents	In house data collection / April 01/2026 -March 31/2027	9.00	5.00	Reduce avoidable ER transfers by 50 %.	Norfolk General Hospital

Change Ideas

Change Idea #1	Implement standardized SBAR communication for escalation of resident clinical concerns. Provide enhanced RN assessment training to strengthen clinical decision-making and early identification of changes in resident condition. Establish a clear on-call NP/Physician escalation pathway to support clinical decision-making prior to hospital transfer. Implement a falls-without-injury in-house monitoring protocol to ensure appropriate observation and reassessment before considering ED transfer. Conduct staff education sessions focused on early recognition and management of common conditions that may lead to ED visits.

Methods	Process measures	Target for process measure	Comments
Staff education sessions will be conducted to improve the early identification and management of conditions such as infections, dehydration, and changes in resident status that may lead to emergency department transfers. A standardized SBAR communication tool will be used for escalation of concerns to ensure consistent and structured communication among staff and providers. Prior to any potential hospital transfer, the on-call Nurse Practitioner or Physician will be consulted, when clinically appropriate, to review the resident's condition and determine if management can be safely provided within the home. Additionally, enhanced RN assessment training will be implemented to strengthen clinical evaluation and decision-making skills. A falls-without-injury in-house monitoring protocol will be used to ensure residents are closely observed following a fall, including reassessment and monitoring, to support safe in-home management and reduce unnecessary ED transfers.	95% of Registered Staff trained in early recognition and management of common conditions that may result in ED visits. 95% of potential transfers where the SBAR communication tool is completed prior to escalation. 100% of cases where the on-call Nurse Practitioner (NP) or Physician is consulted prior to ED transfer when appropriate. Number of ER transfer/month tracked by the RAI coordinator. Monthly review on CTAS Levels from NGH.	Staff Training: 95% of Registered Staff staff will complete training on early recognition and management of common conditions that may lead to ED visits by December 31, 2026. SBAR Utilization: SBAR communication will be completed in 95% of resident clinical escalations or potential transfers by December 31, 2026. Provider Consultation: The on-call Nurse Practitioner (NP) or Physician will be consulted in 95% of potential ED transfers, when clinically appropriate, prior to transfer by December 31, 2026. Falls Monitoring: 100% of residents experiencing falls without injury will have the in-house monitoring protocol completed and documented within 24 hours of the incident.	

Change Idea #2	Strengthen Advance Care Planning (ACP) and Goals of Care (GOC) discussions with residents and families early after admission. Implement quarterly audits of Goals of Care documentation to ensure compliance and timely follow-up. Provide family education sessions on palliative care, advance care planning, and end-of-life decision-making. Reinforce completion of GOC documentation through the admission checklist process. Increase staff education on palliative care assessment tools and end-of-life communication.

Methods	Process measures	Target for process measure	Comments
Advance Care Planning and Goals of Care discussions will be initiated with residents and families within the first 30-45 days of admission and documented in the resident's Care Plan. Staff will be reminded to complete GOC documentation through reinforcement of the admission checklist during the intake process. Quarterly Goals of Care documentation audits will be conducted to monitor compliance and identify residents who require updated discussions. Education will be provided to staff to improve confidence in conducting end-of-life conversations and using standardized palliative assessment tools. Family education sessions will be offered to improve understanding of palliative care options, symptom management, and decision-making at end of life. These interventions aim to ensure that residents' wishes are clearly documented and followed, reducing unnecessary or avoidable hospital transfers during the last stages of life.	Percentage of newly admitted residents with documented Goals of Care discussions within 30-45 days of admission. 100% of residents with Goals of Care reviewed or updated during quarterly audits. 75% of families attending education sessions on palliative care and advance care planning. 75% of admissions with completed admission checklist including GOC documentation.	Increase documented Goals of Care discussions within 30-45 days of admission from 50% to 90% by December 31, 2026. Achieve 95% completion of the admission checklist including GOC documentation for new residents by December 31, 2026. Ensure 100% of residents have GOC reviewed or confirmed during quarterly chart audits by December 31, 2026. Provide at least two family education sessions per year, with 75% family participation of newly admitted residents.	

Equity

Measure - Dimension: Equitable

Indicator #3	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	86.30	100.00	100% of staff will be assigned mandatory education regarding equity, diversity, inclusion, and anti-racism.	

Change Ideas

Change Idea #1	Provide staff education and training on 2SLGBTQIA+ inclusive care and culturally competent communication. Integrate inclusive language and gender identity documentation into resident admission and assessment forms. Promote visible inclusive policies and signage to support a welcoming environment. Incorporate resident-centered care practices that respect gender identity, preferred name, and pronouns. Encourage staff awareness and reflection using guidance from Best Practice Guideline Promoting 2SLGBTQI+ Health Equity.

Methods	Process measures	Target for process measure	Comments
Education sessions will be provided to interdisciplinary staff to improve knowledge and confidence in delivering inclusive care to residents who identify as 2SLGBTQIA+. Training will focus on respectful communication, understanding health disparities, and creating a safe and inclusive care environment. Admission documentation will be updated to include options for gender identity, sexual orientation, preferred name, and pronouns, ensuring resident preferences are respected and documented. Staff will be encouraged to use inclusive language in daily interactions and care planning. Visual indicators of inclusion (such as posters or statements supporting diversity and inclusion) will be displayed within the home to promote a welcoming environment for residents, families, and staff. Periodic audits and feedback sessions will be conducted to assess compliance with inclusive practices and identify opportunities for improvement.	100% of staff who complete education on 2SLGBTQIA+ inclusive care. 100% of new resident admission assessments that include documentation of gender identity and preferred pronouns. 80% of staff reporting increased confidence in providing inclusive care following education sessions. Completion of environmental review to ensure visible inclusive policies and signage.	100% of staff will complete education on 2SLGBTQIA+ inclusive care by December 31, 2026. 100% of new resident admissions will include documentation of gender identity and preferred pronouns by December 31, 2026. 80% of staff will report improved confidence in providing inclusive care following training. Conduct one environmental inclusion review annually to ensure visible inclusive practices and policies are in place.	

Change Idea #2	Embed person-centred care principles as outlined in the RNAO BPG, ensuring care is respectful of and responsive to individual resident preferences, needs, and values. Integrate documentation of residents' cultural, spiritual, and identity preferences into individualized care plans at admission and updates. Provide mandatory cultural safety and Indigenous health education for all staff to enhance awareness, respect, and culturally responsive care. Conduct resident and family satisfaction surveys focused on inclusion, respect, and cultural safety to inform ongoing improvements. Develop and formalize at least one partnership with a local Indigenous organization or community representative to guide culturally appropriate programming and care. Incorporate cultural safety principles into daily practice through staff coaching, reflective practice sessions, and team discussions

Methods	Process measures	Target for process measure	Comments
Care plans will be co-developed with residents and families, reflecting the RNAO BPG emphasis on shared decision-making, dignity, and respect, and explicitly documenting cultural, spiritual, and identity preferences. All staff will complete education on cultural safety, Indigenous health, and person-centred care, utilizing RNAO BPG resources and Indigenous community expertise to ensure comprehensive understanding. Resident and family satisfaction surveys will assess perceptions of inclusion, respect, and person-centred cultural safety annually. Results will be used to tailor education and care approaches. A formal partnership will be established with local Indigenous organizations or representatives to support culturally relevant programming, staff education, and ongoing relationship-building. Regular staff coaching and team reflection sessions will focus on applying RNAO's person-centred care principles and culturally safe practices, encouraging continuous quality improvement	Percentage of residents with documented cultural, spiritual, and identity preferences in their plan of care. Percentage of staff who complete cultural safety and Indigenous health education. Percentage increase in resident and family reported sense of inclusion and cultural respect measured through satisfaction surveys. Number of formal partnerships established with local Indigenous organizations or community representatives. Percentage of staff participating in cultural safety coaching or reflection sessions.	Achieve 100% documentation of residents' cultural, spiritual, and identity preferences in care plans by Q4 2026. Achieve 100% staff completion of cultural safety and Indigenous health education by Q4 2026. Increase resident and family reported sense of inclusion and cultural respect by 15% in satisfaction surveys conducted annually, with a baseline survey completed by Q3 2026. Establish at least one formal partnership with a local Indigenous organization or community representative by Q4 2026. Ensure 75% of staff participate in cultural safety coaching or reflective practice sessions by Q4 2026.	

Experience

Measure - Dimension: Patient-centred

Indicator #4	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	76.47	100.00	This is part of our mission of delivering exceptional care and creating an engaging, safe and compassionate home where residents thrive and staff shine. So our goal is 100% of respondents feel like staff listen to them	

Change Ideas

Change Idea #1	Implement staff training on effective communication, active listening, and resident engagement aligned with the Resident Bill of Rights. Integrate regular resident check-ins and feedback opportunities into daily care routines to ensure residents feel heard. Utilize annual resident satisfaction surveys specifically measuring residents' perceptions of being listened to and having a voice. Establish a continuous quality improvement (CQI) process to review survey results and implement action plans addressing communication barriers. Promote awareness and accessibility of the Resident Bill of Rights to residents, families, and staff through education and visible postings

Methods	Process measures	Target for process measure	Comments
Staff will receive education and coaching focused on communication skills that promote respect, empathy, and active listening in interactions with residents. Daily care schedules will include structured opportunities for residents to express their needs, preferences, and concerns. An annual satisfaction survey will include specific questions on whether residents feel they have a voice and are listened to by staff. Survey results will be analyzed quarterly and shared with the care team to inform targeted improvement initiatives. The Resident Bill of Rights will be reviewed with new residents upon admission and displayed prominently in common areas. Staff will be reminded regularly of its principles during team meetings. A continuous quality improvement framework will guide ongoing monitoring, with measurable goals and follow-up actions to enhance resident-staff communication.	Percentage of staff completing communication and active listening training. Frequency of resident check-ins or feedback opportunities documented in care routines. Percentage of residents completing the annual satisfaction survey including voice and communication questions. Percentage of care team meetings reviewing resident feedback and communication improvement plans. Percentage of residents and families who report awareness of the Resident Bill of Rights.	Achieve 90% staff completion of communication and active listening training by December 31, 2026. Conduct resident check-ins or feedback opportunities for 95% of residents by December 31, 2026. Achieve 80% resident participation in the annual satisfaction survey by December 31, 2026. Ensure 100% of quarterly care team meetings include review of resident communication feedback and follow-up plans by December 31, 2026. Ensure 95% of residents and families report awareness of the Resident Bill of Rights by December 31, 2026.	Total Surveys Initiated: 28

Measure - Dimension: Patient-centred

Indicator #5	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	44.44	75.00	2025 survey question was "Do you feel comfortable raising concerns?" and 75% answered positively. The 2026 Resident Survey will ask specifically "I can express my opinion without fear of consequences" with the following options "Never, Rarely, Sometimes, Most of the time, Always, or Don't know"	

Change Ideas

Change Idea #1	Implement staff training grounded in the RNAO Person-Centred Care BPG, emphasizing psychological safety, trauma-informed communication, and creating supportive environments where residents feel safe to express concerns without fear of consequences. Engage families using person-centred communication approaches to support resident advocacy and collaborative care. Implement anonymous feedback systems to complement direct communication, allowing residents to share concerns confidentially. Develop and clearly communicate non-retaliation policies and residents' rights, ensuring all residents and families understand their voice is respected and protected, in alignment with person-centred care principles.

Methods	Process measures	Target for process measure	Comments
Staff education will incorporate the RNAO BPG framework on person-centred care, focusing on building trusting relationships, respecting resident autonomy, and supporting meaningful resident participation in care decisions. Clear policies on non-retaliation and residents' rights will be introduced and reviewed regularly with residents and families, reflecting RNAO's emphasis on dignity, respect, and advocacy. Anonymous feedback mechanisms will be established and monitored to ensure concerns are captured and addressed, reinforcing a culture of safety and respect	Percentage of staff completing RNAO Person-Centred Care BPG-based training, including psychological safety and trauma-informed communication. Percentage of residents and families informed about non-retaliation policies and residents' rights consistent with person-centred care principles. Rate of anonymous feedback tool usage by residents. Percentage of family engagement activities employing person-centred communication approaches.	Achieve 100% staff completion of RNAO Person-Centred Care BPG-based training by December 31, 2026. Ensure 100% of residents and families receive information on non-retaliation policies and residents' rights within six weeks of admission and annually thereafter.	Total Surveys Initiated: 27

Safety

Measure - Dimension: Safe

Indicator #6	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	9.88	7.50	Q3 in 2025 was 7.5. Remain below provincial average.	

Change Ideas

Change Idea #1	Implement the RNAO Best Practice Guideline for Preventing Falls and Reducing Injury from Falls to guide evidence-based fall prevention strategies. Conduct ongoing screening for fall risk assessments for residents. Implement hourly rounding using the 4P's approach (Pain, Position, Personal Needs, Placement) to proactively address resident needs and reduce fall risk. Conduct post-fall assessments and reviews to identify contributing factors and implement individualized prevention strategies. Strengthen interdisciplinary fall review processes involving nursing, physiotherapy, occupational therapy, physicians, and other care team members. Ensure individualized fall prevention interventions are documented and updated in the resident's plan of care. Provide staff education on evidence-based fall prevention practices and post fall management based on RNAO BPG recommendations

Methods	Process measures	Target for process measure	Comments

Residents will receive fall risk assessments using standardized tools aligned with the RNAO BPG on Falls Prevention. Identified risk factors will inform individualized fall prevention strategies documented in each resident's plan of care. Staff will implement hourly rounding for residents at higher risk of falls, using the 4P's framework: Pain, Position, Personal Needs (such as toileting), and Placement of personal items within reach. This proactive approach helps identify and address unmet needs that could contribute to falls. Following any fall incident, a post-fall assessment will be completed to determine contributing factors including medication changes, environmental hazards, mobility limitations, or health status changes. The interdisciplinary team will review falls and implement individualized interventions such as mobility aids, physiotherapy referrals, environmental adjustments, medication reviews, and enhanced supervision when necessary. Fall data will be monitored regularly through the home's continuous quality improvement process, allowing the team to identify trends and evaluate the effectiveness of prevention strategies	Percentage of residents with documented fall risk assessments completed. Percentage of post-fall assessments completed. Percentage of hourly rounding completed for high-risk residents using the 4P's framework. Percentage of residents with individualized fall prevention interventions documented in their plan of care. Percentage of falls reviewed through interdisciplinary team review aligned with RNAO BPG recommendations	Achieve 100% completion of fall risk assessments as outlined in the RNAO BPG by December 31, 2026. Achieve 100% completion of post-fall assessments by December 31, 2026. Achieve 90% compliance with hourly rounding documentation using the 4P's framework for at risk residents by December 31, 2026. Ensure 100% of residents who experience a fall have their plan of care reviewed and updated with individualized prevention strategies.

Measure - Dimension: Safe

Indicator #7	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	23.77	21.04	The provincial average is 18.99, so we are targeting to stay below the provincial average.	

Change Ideas

Change Idea #1	Conduct regular interdisciplinary medication reviews to evaluate the ongoing need for antipsychotic medications. Implement non-pharmacological interventions for responsive behaviours, including individualized care strategies and environmental adjustments. Provide staff education on behavioral and psychological symptoms of dementia and alternatives to antipsychotic medication use. Strengthen person-centred care planning that identifies triggers and individualized approaches to support residents with responsive behaviours. Improve collaboration between physicians, nurse practitioners, pharmacists, and interdisciplinary teams to support safe deprescribing practices. Collaborate with Behavioural Supports Ontario to support assessment, care planning, and implementation of behavioural interventions.

Methods	Process measures	Target for process measure	Comments

Quarterly medication reviews will be conducted by the interdisciplinary team, including physicians, nurse practitioners, pharmacists, and nursing staff, to evaluate the appropriateness of antipsychotic prescriptions for residents without psychosis. Staff will receive education on recognizing triggers for responsive behaviours and implementing non-pharmacological approaches, such as environmental modifications, meaningful engagement activities, and individualized behavioural strategies. The home will collaborate with Behavioural Supports Ontario to support comprehensive behavioural assessments and provide guidance on person-centred interventions for residents exhibiting responsive behaviours. Care plans will be updated to reflect individualized behavioural strategies and non-pharmacological interventions. Residents undergoing antipsychotic dose reduction or discontinuation will be closely monitored to ensure safety, comfort, and stabilization of behaviours. Data on antipsychotic prescribing will be reviewed as part of the home's continuous quality improvement process to monitor progress toward reduction targets	Percentage of residents prescribed antipsychotics who receive quarterly interdisciplinary medication reviews. Percentage of staff completing education on responsive behaviours and non-pharmacological interventions. Percentage of residents with person-centred behavioural care plans identifying triggers and interventions. Percentage of residents referred to or supported by Behavioural Supports Ontario (BSO) when responsive behaviours are present. Percentage of residents on antipsychotics without psychosis who have documented reassessment for deprescribing	Achieve 100% completion of quarterly medication reviews for residents prescribed antipsychotics by December 31, 2026. Ensure 90% of clinical staff complete education on responsive behaviours and non-pharmacological interventions within 12 months. Ensure 100% of residents receiving antipsychotics without psychosis have a documented behavioural assessment and individualized care plan within 6 months. Ensure 90% of residents with significant responsive behaviours receive consultation or support from Behavioural Supports Ontario when appropriate. Ensure 90% of residents undergoing antipsychotic reduction have documented monitoring and follow-up assessments.

Measure - Dimension: Safe

Indicator #8	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	4.55	2.10	The provincial average is 2.1, so we are targeting to meet the provincial average. In collaboration with NLOT	Norfolk General Hospital

Change Ideas

Change Idea #1	Implement the RNAO Best Practice Guidelines for pressure injury prevention and management to guide evidence-based practice. Conduct comprehensive skin assessments for all residents. Strengthen the home's wound management program to ensure early identification, monitoring, and treatment of altered skin integrity. Ensure high-risk residents receive individualized pressure injury prevention interventions, including repositioning, therapeutic surfaces, and nutritional monitoring. Conduct interdisciplinary wound reviews for residents with altered skin integrity or pressure injuries. Provide staff education on pressure injury prevention, early detection, and wound care management based on RNAO BPG recommendations.

Methods	Process measures	Target for process measure	Comments

All residents will receive a comprehensive skin assessment, using standardized tools aligned with the RNAO pressure injury prevention guidelines. Residents identified as high risk for skin breakdown will have individualized prevention strategies implemented. These may include repositioning schedules, use of pressure-relieving mattresses or cushions, nutritional assessment and support, moisture management, and enhanced monitoring. Residents with altered skin integrity or pressure injuries will be managed through the home's wound management program, following RNAO BPG recommendations for assessment, staging, treatment, and monitoring. The interdisciplinary care team—including nursing, physicians, dietitians, and other relevant professionals—will review wound cases regularly to ensure appropriate treatment and prevention strategies. Resident care plans will be reviewed and updated to reflect individualized skin care interventions, ensuring staff follow-through and consistent care delivery. Skin integrity data will be monitored through the home's continuous quality improvement process, including audits of assessments, prevention interventions, and pressure injury incidence.	Percentage of residents with documented skin assessments. Percentage of high-risk residents with pressure injury prevention interventions documented in their plan of care. Percentage of residents with altered skin integrity monitored and managed according to the wound management program and RNAO BPG recommendations. Percentage of residents with care plans updated to reflect individualized skin and wound interventions. Percentage of wound cases reviewed through interdisciplinary team review.	Achieve 100% completion of skin assessments for all residents by December 31, 2026. Ensure 95% of high-risk residents have documented pressure injury prevention interventions in their care plan by December 31, 2026. Ensure 100% of residents with altered skin integrity are monitored and managed according to the wound management program and RNAO BPG recommendations. Ensure 100% of care plans for residents with skin concerns are reviewed and updated. Ensure 100% of wound cases receive interdisciplinary review and follow-up.

Measure - Dimension: Safe

Indicator #9	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	11.39	2.20	Current performance is 6.9 in Q3 2025. Provincial average is 1.2. Continue to minimize the use of restraints, explore and implement restraint alternatives.	

Change Ideas

Change Idea #1	Develop and maintain individualized behaviour support plans for residents demonstrating responsive behaviours. Promote least restraint practices, ensuring restraints are used only as a last resort and reviewed regularly. Implement strategies aimed at the reduction and elimination of daily physical restraints where safe and appropriate. Introduce and optimize the use of Personal Assistive Safety Devices (PASDs) such as low beds, bed alarms, mobility aids, and therapeutic seating to enhance safety without restricting movement. Implement non-pharmacological interventions such as meaningful engagement, environmental adjustments, and individualized care approaches. Provide staff education on behaviour management, restraint reduction strategies, and the safe use of PADs. Conduct interdisciplinary reviews for residents using daily restraints to explore alternative strategies

Methods	Process measures	Target for process measure	Comments

Residents exhibiting responsive behaviours will undergo a comprehensive behavioural and safety assessment to identify underlying causes such as pain, unmet needs, environmental triggers, or changes in physical or cognitive status. Individualized behaviour support plans will be developed and documented in the resident's plan of care, outlining non-pharmacological interventions tailored to the resident's needs and preferences. For residents currently using daily physical restraints, the interdisciplinary team—including nursing staff, physicians, physiotherapists, occupational therapists, and other care providers—will conduct regular reviews to identify opportunities to reduce or eliminate restraint use. Alternative safety strategies will include the use of Personal Assistive Safety Devices (PASDs) such as low beds, fall mats, mobility aids, therapeutic seating systems, and monitoring devices to promote safety while supporting mobility and independence. Staff will receive education on least-restraint principles, behaviour management techniques, and the appropriate use of PASDs. Data on restraint use, behaviour support plans, and intervention outcomes will be monitored through the home's continuous quality improvement process.	Percentage of residents with responsive behaviours who have individualized behaviour support plans documented and updated. Percentage of staff trained in behaviour management strategies, least restraint practices, and the appropriate use of Personal Assistive Safety Devices. Percentage of residents using daily physical restraints who have documented interdisciplinary review and alternative intervention strategies. Percentage of residents with Personal Assistive Safety Devices implemented as part of individualized safety interventions. Percentage of residents with documented non-pharmacological interventions implemented prior to restraint use	Achieve 100% of residents with responsive behaviours having updated behaviour support plans documented in their care plans by December 31, 2026. Achieve 95% staff completion of training on behaviour management, least restraint practices, and use of Personal Assistive Safety Devices by December 31, 2026. Ensure 100% of residents currently using daily physical restraints receive interdisciplinary review and documented alternative strategies within 30 days. Ensure 90% of residents at risk have appropriate Personal Assistive Safety Devices implemented when clinically appropriate.