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)	18.48	18.00	Below the provincial Average. Through implementation of our change ideas, the home expects a 2% improvement over the next year."	Nurse Let Outreach Team (NLOT), Geriatritian, Canadian Nurse Practitioner Services

Change Ideas

Change Idea #1 To reduce unnecessary hospital transfers, through the use of on-site Nurse practitioner.

Methods	Process measures	Target for process measure	Comments
Recruitment of one full-time Nurse Practitioner with engagement from Canadian Nurse Practitioner Services by June 2026	Number of hours of nurse practitioner service at the home	75 hours biweekly of nurse practitioner services at Kennedy Lodge.	

Change Idea #2	Provide education on palliative care approach and end of life for families and residents, during admission and care conferences.		
Methods	**Process measures**	**Target for process measure**	**Comments**
Completion of PPS assessments and implementation of use and education for residents and/or families on palliative approach and end of life. Utilization of information brochure and discussions upon admission and during care conferences.	Number of admissions and care conferences that had education regarding palliative approach to care.	100% of admissions and care conferences will include end of life and palliative care approach education as well as brochures/handbook for residents and families.	Utilize NP, MD, and Social Workers in end of life discussions.

Change Idea #3	DOC to review ED tracker to find trends for transfer to ED - review monthly during Registered Staff meetings to brainstorm strategies and discuss resident situations confidentially.		
Methods	**Process measures**	**Target for process measure**	**Comments**
Utilization of home-level hospital tracking tool and document each transfer status. ED transfer tracking tool will be reviewed to identify trends and action accordingly. This will be added as a standing agenda item at monthly nursing staff meetings and reported back to the professional advisory committee with attending physicians and nurse practitioner quarterly.	# of monthly staff meetings where hospital transfers are discussed and analyzed.	100% of staff meetings will have a discussion regarding hospital transfer trends after June 2026.	

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	100% of all staff will complete the equity, diversity, inclusion and anti-racism education annually.	Surge Learning, Apple Creek 7th Day Adventist Church, Grace Anglican Church, Cham Shan Buddhist, Tzu Chi Group, Chinese Christian Church, Chinese Baptist Church, Beno Chinese Group

Change Ideas

Change Idea #1 To increase diversity training through Surge education or live events.

Methods	Process measures	Target for process measure	Comments
Training and education through Surge education and live events.	Percentage of staff who were educated on culture and diversity.	100% of staff will be educated on culture and diversity through surge learning and live events	Staff are open minded and respectful toward each other due to the diverse community.

Change Idea #2 Spiritual assessment to be completed on admission in consultation with the resident and family member on their language, faith, traditions, language preference, and family roles.

Methods	Process measures	Target for process measure	Comments
The spiritual assessment will be used as a tool to plan activities/events that celebrate cultural diversity in alignment with resident preferences.	# of residents who have a spiritual assessment completed within 14 days of admission to the home.	100% of residents will have a spiritual assessment completed within 14 days of admission.	All staff respect the culture, beliefs and practices of our residents based on their spiritual needs.

Change Idea #3 To improve overall dialogue of diversity, inclusion, equity and anti-racism between the staff in the workplace.

Methods	Process measures	Target for process measure	Comments
Celebrate culture and diversity events and recognize the cultural events/holidays throughout the year. Quarterly Continuous Quality Improvement meetings will have cultural diversity and events as a standing agenda item for discussion.	% of scheduled cultural activities completed each quarter.	1 cultural event and celebration will happen every quarter.	

Experience

Measure - Dimension: Patient-centred

Indicator #3	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	95.00	97.00	Target is based on corporate averages. We aim to meet or exceed corporate benchmarks. We will continue to improve on this target by 2% in the next survey round. Currently we sit at 95.30%.	Ontario Residents Council Association

Change Ideas

Change Idea #1 Review the concern/complaint process in the home upon admission and at care conferences annually.

Methods	Process measures	Target for process measure	Comments
Discuss the process of when the home receives a complaint and the process we take including timelines to address and investigate concerns during admission and annual care conferences.	Number of admissions and care conferences where the concern/complaint process is discussed	100% of admissions and annual care conferences will touch on the concern process in the home and asking for resident feedback on the care.	Total Surveys Initiated: 100 We pride ourselves in timely response to concerns and complaints upon receiving the complaint to ensure that residents and families are being heard and respected.

Change Idea #2 A renewed approach to reviewing Residents' Bill of Rights #29 will be incorporated into meetings this year.

Methods	Process measures	Target for process measure	Comments
Review Resident Bill of Right more frequently at Resident's Council and at our monthly Quality Committee Meetings with a focus on #29 which indicates "Every Resident has the right to raise concerns or recommend changes in policies and services on behalf of themself or others to the following persons and organizations without interference and without the fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else. Assign Resident Bill of Right #29 to monthly Quality Meetings and Resident's Council Meetings. Review #29 with all staff at monthly town halls.	Percentage of quality meetings, resident council meetings and staff townhalls will have Residents' Bill of Rights #29 reviewed	100% of meetings will include a discussion on Residents' Bill of Rights #29.	

Change Idea #3 Create more awareness about the resident bill of rights within the home.

Methods	Process measures	Target for process measure	Comments
With the involvement of our residents, a video will be created highlighting all resident bill of rights. This multilingual video will represent the diverse culture of the residents, families and staff at Kennedy Lodge.	Number of residents who respond positively to "I can express my opinion without fear of consequences".	There will be an increase in the number of residents who respond positively to the question "I can express my opinion without fear of consequences".	improvement will be assessed through resident satisfaction survey and direct conversations.

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	9.99	9.50	Target is based on corporate averages. We aim to meet or exceed, corporate goal.	Physiotherapist, BSO, MD

Change Ideas

Change Idea #1 To reduce the number of falls at Kennedy Lodge through focus on the root cause analysis of the fall.

Methods	Process measures	Target for process measure	Comments
Staff will be educated/reeducated to conduct a post fall huddle after each fall, through completion of the comprehensive post-fall assessment. From this analysis, staff will determine new interventions to prevent future falls. These interventions will be included in the plan of care.	Percentage of residents who have had a fall and completion of the post fall analysis and care plan review.	100% of resident who experience a fall will have a comprehensive post fall assessment and huddle completed, with review of the plan of care.	

Change Idea #2	A renewed focus on injury prevention, through review of MORSE falls risk and fracture risk scale (FRS) to ensure residents bone health medications are appropriate.		
Methods	**Process measures**	**Target for process measure**	**Comments**
Through review of each residents FRS and MORSE falls scale, fracture prevention medications will be considered.	Number of medication changes (addition of fracture prevention medication)	100% of residents will be assessed for fracture prevention medication.	Fracture Prevention Medication - Vitamin D, Calcium, Biphosphonates.

Change Idea #3	Home will continue to implement a program that supports purposeful rounding for all residents identified at high risk for falls		
Methods	**Process measures**	**Target for process measure**	**Comments**
Educate/reemphasize purposeful rounding as part of the falls preventions measures for residents who have had 2 or more falls in a quarter	# of residents who have had 2 or more falls in the last quarter and are on a purposeful rounding program	100% of residents who have had 2 or more falls in the last quarter will have purposeful rounding implemented as part of their plan of care.	

Measure - Dimension: Safe

Indicator #5	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	1.53	1.00	Target is based on corporate averages. We aim to meet or exceed corporate goals, benchmarks.	Medline, Medical Director, Nurse Practitioner, Wound Champion, Physiotherapist, NLOT, Canadian Nurse Practitioner Services NSWOC

Change Ideas

Change Idea #1 Prompt identification and documentation of worsening pressure injuries, including a notification to the Skin and Wound Champion, as needed.

Methods	Process measures	Target for process measure	Comments
The registered staff will receive education on prompt identification of wound deterioration and notification of the skin and wound lead. The skin & wound lead will audit the weekly PUSH assessments to ensure the correct wound identification and documentation has been completed.	Percentage of residents with a worsening wound that is identified and communicated to the skin and wound lead.	100% of residents showing clinical wound deterioration will receive a referral to the skin and wound lead.	

Change Idea #2 Expand the role of the PSW Coordinator to include leadership as a Pressure Injury Prevention Champion, with a focused responsibility on optimizing resident pressure redistribution surfaces.

Methods	Process measures	Target for process measure	Comments
1.Provide education to PSWs on pressure redistribution surfaces (wheelchair seating and bed surfaces), including when to escalate concerns 2. Implement routine checks (e.g., weekly or biweekly) of high-risk residents to ensure appropriate surfaces are in place and functioning 3. Establish a communication pathway between PSWs, nursing, and rehab (e.g., OT/PT) for timely reassessment of equipment needs	Percentage of residents, who have a PURS of 3 or more, and who are assessed to have appropriate pressure reduction	100% of residents with a PURS of 3 or more, will have an appropriate surface as identified by the interdisciplinary team	

Change Idea #3 RD review of nutritional and hydration status of residents with impaired skin integrity.

Methods	Process measures	Target for process measure	Comments
Staff will be educated on completion of a dietary referral for all new or worsening pressure injuries, diabetic foot ulcers, venous/arterial ulcers, or wounds with depth. The skin and wound lead will audit to ensure that these residents have received a referral to the registered dietician.	Percentages of residents with new or worsening wounds who have been referred to the dietician.	100% of new and worsening wounds will be referred and assessed by the Registered Dietician.	The RD will respond to referrals within 14 days.