

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)	27.01	19.00	Our current performance has increased during this measurement period from our performance of 19.70 in 2023/24, which was below the provincial average. Our goal is to reach our previous performance of 19.70 or lower.	Ottawa Hospital Nurse Practitioner Outreach Program, PoET Program, Champlain Hospice and Palliative Care Program

Change Ideas

Change Idea #1 To track the number of ED visits that occur between Friday evening and Sunday evening.

Methods	Process measures	Target for process measure	Comments
The NP will review each transfer to hospital to determine the date and time the resident was sent.	The number of residents sent to hospital between Friday evening and Sunday evening	100% of residents sent to hospital between Friday at 6:00 p.m. and Sunday at 8 p.m. will have a review of the decision-making process that occurred that determined the need to send a resident to hospital by December 2026.	

Change Idea #2 To reduce the number of residents sent to the ED due to head lacerations resulting from a fall

Methods	Process measures	Target for process measure	Comments
The Skin and Wound Care lead will educate Registered staff on the use of glue to treat any head lacerations that are 5cm or less.	number of head lacerations treated in home versus those requiring an ED visit	100% of head lacerations 5 cm or less, resulting from a fall, will be treated in home with gluing technique by December 2026.	

Change Idea #3 In accordance with PoET program education, determine a resident's capacity to give consent to either stay on the home or go to hospital, as per their wishes and goals of care. If a resident is incapable to give consent, to ensure that their SDM is acting in the best interest of the resident and respecting the resident's wishes.

Methods	Process measures	Target for process measure	Comments
Upon admission, at the post-admission care conference and annual conference, the team will review the resident's wishes and goals of care, as these may change as a person approaches end of life. The SDM, if the resident is no longer capable to make such decisions, is to respect the resident's wishes and act in the resident's best interests.	the number of care conferences (upon admission, post-admission and annual) at which a resident's goals of care are reviewed and discussed	In 75% of all care conferences held , goals of care will be reviewed with the resident or SDM by December 31, 2026	

Change Idea #4 To improve communication between Registered staff and physicians when reporting a change in condition and possible transfer to ED

Methods	Process measures	Target for process measure	Comments
Education will be provided to Registered staff by the Ottawa Hospital Outreach Nurse Practitioner on improving information being communicated to the physician using the SBAR method.	number of registered staff who received SBAR education	75% of Registered staff will receive SBAR education	

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	87.33	100.00	Education will be completed by all staff upon hire and annually as part of mandatory education.	

Change Ideas

Change Idea #1 All staff will receive annual education on Diversity, Equity, Inclusion and anti-racism

Methods	Process measures	Target for process measure	Comments
DEI and anti-racism education will be provided to all staff through in-person education or on-line modules.	percentage of full- time and part-time staff who completed DEI and anti-racism education	100% of full-time and part-time staff will have completed DEI and anti-racism training by December 31, 2026.	

Change Idea #2 The Wellness and EDI Committee will organize an event to showcase the cultural diversity of our residents and our staff

Methods	Process measures	Target for process measure	Comments
An event will be planned that may focus on cultural food, language, traditions and arts of the diverse cultures of our residents and staff.	number of cultural themed events organized	one event will be planned to showcase the cultural diversity of the residents and staff of the Osgoode Care Centre by December 31, 2026.	

Safety

Measure - Dimension: Safe

Indicator #3	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	22.51	18.00	In Q2 of 2024, the performance for the home was 18.61% and our goal is to reduce the number of residents who fell in the 30 days leading up to their assessment to our previous level of performance, with the goal of reaching the provincial average of 15%.	

Change Ideas

Change Idea #1 To implement the Registered Nurses Association of Ontario (RNAO) Falls Clinical Pathway to improve our falls risk assessment and management program in May 2026.

Methods	Process measures	Target for process measure	Comments
The Osgoode Care Centre is part of cohort 8 of the RNAO Clinical Pathways implementation project. When a resident is admitted to the home, a falls screening is completed. If the resident is screened to be at risk of a fall, a comprehensive assessment is completed and a plan of care to help reduce the risk of falls is completed. IF a fall occurs, a post-fall assessment and management clinical pathway is completed, including a post fall huddle and referrals to other members of the interdisciplinary team to for further assessment. The plan of care is reviewed, updated and reviewed monthly at the Falls Committee to evaluate its effectiveness.	number of residents who had more than one post fall assessment completed in a month had their plan of care reviewed and revised	100% of residents who had more than one fall in a month and had post fall assessment completed will have their plan of care reviewed and revised	There are residents who may have a fall but this is not a regular occurrence. While it is important to work towards preventing falls, it is also important to finds ways to prevent reoccurring falls, thereby increasing the risk of severe injury.

Change Idea #2 To reduce the risk of falls due to incontinence

Methods	Process measures	Target for process measure	Comments
A post fall huddle is to conducted after each resident fall, as per the RNAO Falls Clinical Pathway in the post-fall assessment. Through the completion of the post fall huddle, we are better able to determine the possible reason for the fall. From reviews of falls to date, a common occurrence of falls is due to incontinence thought this is not always reported. We can help to reduce the risk of falls due to incontinence by working in collaboration with our Continence Lead to develop ways to reduce this risk e.g. toileting programs, increased rounding, evaluation of continent product use.	number of residents who were referred to the Continence lead to assess the resident and review and revise a resident's plan of care to reduce the risk of falls due to incontinence.	80% of residents who fell due to reason related to incontinence, as determined through a post-fall huddle will be referred to the Continence lead for further assessment and interventions.	

Change Idea #3 To implement the education and interventions as part of the PREVENT knowledge translation program to educate healthcare providers in long-term care on the evidence-based fracture prevention recommendations.

Methods	Process measures	Target for process measure	Comments
As part of the PREVENT study intervention group, the Osgoode Care Centre will be implementing the PREVENT model. The hypotheses of this study is that the PREVENT model will decrease hip fracture rates and improve secondary outcomes. In order to reduce the devastating impact of fractures from falls, routine assessment and interventions for fall and osteoporosis need to be integrated into routine assessments. This project is being lead by our NP and Fall Lead RN. The total duration of the study is 1.5 years.	number of plans of care developed for those residents determined to be at high risk of fracture	100% of residents who are determined to be at a high risk of fracture will have a plan of care for fracture management by February 2027.	

Measure - Dimension: Safe

Indicator #4	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	26.81	22.00	Canada has a national target of 15% for the appropriate use of antipsychotics in long term care. As part of the Health Excellence Canada Sparking change program in 2025, our home has been able to reduce the inappropriate use of antipsychotic, using some of the methods during this program. We will continue to strive to meet the national target using learned QI methods with the goal of becoming certified through the Appropriate Use Coalition. .	

Change Ideas

Change Idea #1 To review use of antipsychotic medication upon admission

Methods	Process measures	Target for process measure	Comments
Upon a resident moving into the home, a medication review is conducted. If the resident is prescribed an antipsychotic medication and a resident does meet the criteria for the appropriate use of an antipsychotic as per LTCF criteria (schizophrenia, Huntington's disease, hallucinations, delusions, end of life, or bipolar (as of June 2026), the requirement for continued use will be evaluated by the physician or NP and BSO team will be consulted to consider possible non-pharmacological approaches to support the resident.	Number of medication reviews of residents admitted to the home who were prescribed an antipsychotic medication in the community and do not meet the LTCF criteria.	80% of residents who move into the home with an antipsychotic medication, who do not meet the LTCF criteria will have the use of their medication reviewed and alternative methods to the support the resident are implemented by February 28, 2027.	

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	4.06	3.30	To meet provincial benchmark	

Change Ideas

Change Idea #1 To develop a Point Click Care referral form to our Skin And Wound Care lead RN for Registered staff to complete with the goal of improved communication and timely access to treatment

Methods	Process measures	Target for process measure	Comments
The Skin And Wound Care Lead RN will develop a referral tool to be integrated into the home's Point Click Care. The PSWs use the Alert tab on Point of Care to alert Registered staff when there is an observed a new or worsening skin issue. The Registered staff will then be able to follow-up with a formal referral to the Skin and Wound Care lead if further expertise is required.	number of referrals to the Skin and Wound Care lead through the new PCC referral process	75% of referrals to the Skin and Wound Care lead will be made through the PCC referral process.	

Measure - Dimension: Safe

Indicator #6	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	3.40	1.50	Often it is families who are requesting the use of residents to reduce the risk of falls without understanding the risk the use of restraints pose. Our is to reduce the use of residents through the implementation of a more robust program of family and staff education, monthly evaluation for the need or continued need of a restraint and implementation of alternatives.	

Change Ideas**Change Idea #1** Education of families of the risk of restraints

Methods	Process measures	Target for process measure	Comments
To present the topic at a Family Council session	number of education sessions to Family Council	one education session on the use of restraints and the the risks will be held by December 31, 2026.	

Change Idea #2 To develop a tool to assist in the monthly reassessment of use of restraints

Methods	Process measures	Target for process measure	Comments
Working with the interdisciplinary team, our current PCC restraint tools will be reviewed and revised promote increased effectively and efficiency in the monthly evaluation of restraints.	number of restraint evaluation tools developed	One tool will be developed and implemented into PCC by December 31, 2026.	Our present tools are cumbersome and time consuming to complete, with no real meaningful information derived from the assessment. A more efficient and effective tool tool will support the completion of a monthly evaluation of the use of a restraint. The information derived from the assessment can also support conversations with families for the discontinuation of a restraint.