Access and Flow | Efficient | Optional Indicator

Indicator #22

Rate of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents. (Cassellholme)

Last Year		This Year		
27.61	6.50	15.79	42.81%	10
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

1)Changes in assessment protocols, new positions (NP), additional resources (physicians), changes in Home processes

Process measure

- Ongoing review of CIHI and in house stats

Target for process measure

- Current target to be maintained or minimized further.

Lessons Learned

Significant reduction in rates of ED transfers.

Comment

We have seen a significant reduction in ER visits with the addition of new physicians and Nurse Practitioners

Access and Flow | Efficient | Custom Indicator

Indicator #14	Last Year Performance (2024/25)	Last Year Target (2024/25)	This Year Performance (2025/26)	Percentage Improvement (2025/26)	This Year Target (2025/26)
Nursing Restorative Services (Nursing Rehab) - % of resident utilizing nursing rehab services. (Cassellholme)	18.00	18.50	25.00	--	NA

Change Idea #1 ☑ Implemented ☐ Not Implemented

To maintain or increase current nursing restorative services in the Home.

Process measure

- Ongoing review of resident that are on the nursing restorative caseload. Nursing rehab to continue to assess residents per request by staff. Collaboration with physiotherapy to maximize restorative services to promote independence and/or maintain current level of functioning. Evaluation ongoing by nursing rehab nurse.

Target for process measure

- To maintain or maximize current percentage of residents that utilize nursing restorative, as appropriate.

Lessons Learned

This is an ongoing QI for the home. We have seen an increase in residents who are candidates for the Nursing Restorative program.

Indicator #12

Laundry (Cassellholme)

Last Year		This Year		
90.40	**93**	**96.40**	**--**	**NA**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

To reduce turnaround time for personal clothing to 48 hours

Process measure

- Increased auditing of clothing carts, including on weekends.

Target for process measure

- 93% on laundry satisfaction on annual resident survey

Lessons Learned

The laundry services and processes were audited to find efficiencies, although family and resident satisfaction has seemed to improve, we are still not at the 48hr turnaround time consistently.

Equity | Equitable | Custom Indicator

Indicator #27

Volunteer (Cassellholme)

Last Year		This Year		
100.00	**100**	**100.00**	**--**	**NA**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Orientation for New Volunteers

Process measure

- Enrichment Lead to ensure completion of orientation and requirements prior to start of volunteering

Target for process measure

- 100% Volunteer complete orientation prior to start

Lessons Learned

Volunteers require the orientation prior to being able to go on the units. More success with 16 - 18 hrs time frame

Indicator #24

Staff Orientation (Cassellholme)

Last Year		This Year		
100.00	**100**	**100.00**	**--**	**NA**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Orientation Process in Place

Process measure

- Checklist completed and signed off after departmental

Target for process measure

- Completion of all new hires to meet ministry standards

Lessons Learned

Completed

Indicator #25

Staff Training (Cassellholme)

Last Year		This Year		
100.00	**100**	**100.00**	**--**	**NA**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Staff Training Yearly for all employees

Process measure

- Report run of completion and email updates to remind staff to complete

Target for process measure

- 100 % Completion of all staff to meet ministry standards

Lessons Learned

Safety 24/7

Indicator #26

Staffing Plan - Clinical (Cassellholme)

Last Year		This Year		
100.00	**100**	**100.00**	**--**	**NA**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Staffing plan in place and reviewed annually

Process measure

- Documented of review occurred.

Target for process measure

- provide for a staffing mix that is consistent with residents' assessed care and safety needs; set out the organization and scheduling of staff shifts; promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection.

Lessons Learned

Contingency plan updated as required

Indicator #1

Abuse Policy Review (Cassellholme)

Last Year		This Year		
100.00	**100**	**100.00**	**--**	**NA**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Review of the Abuse Policy Annually

Process measure

- Document and Date Abuse Policy Review

Target for process measure

- 100% completion of review of the Abuse policy by March 2025

Lessons Learned

This was completed as planned

Equity | Equitable | Optional Indicator

	Last Year		This Year		
Indicator #19	**CB**	**CB**	**100.00**	**--**	**100**
Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education (Cassellholme)	Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Designated one of our team members to undergo specialized training in 'Diversity, Inclusion, and Equity"

Process measure

- Completion of Nipissing University training and other appropriate training programs

Target for process measure

- Completion of training template in 'Diversity, Inclusion, and Equity" for all staff members in 2025

Lessons Learned

1 staff completed this training, however all senior leadership completed some DEI training throughout this year.

Experience | Patient-centred | Custom Indicator

Indicator #21

Physical Examination (Cassellholme)

Last Year		This Year		
100.00	**100**	**100.00**	**--**	**NA**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Physician to conduct a physical examination

Process measure

- Ensure completion with PCC chart audit

Target for process measure

- Meet Ministry standards

Lessons Learned

100 % completion, list provided to NPs at end of year to provide completion. Challenges with documentation in PCC, assessment now completed.

Indicator #2

Activities (Cassellholme)

Last Year		This Year		
94.40	**97**	**98.20**	**--**	**NA**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Maintain 3 quality contacts per resident per week.

Process measure

- Activity manager will review Activity Pro Data weekly

Target for process measure

- 95% of residents will receive at least 3 contacts per week by March 31st, 2025

Lessons Learned

Challenges: outbreaks make it more difficult to meet the goals. The goal was met with residents having had at least 3 visits on most weeks.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Increase weekend activities

Process measure

- Activity Calendar will be reviewed

Target for process measure

- Deliver at least 2 global activities on weekends per month, as well as unit-based weekend activities by March 31, 2025

Lessons Learned

We have added more global activities during the weekends such as a wine and cheese every other weekend, Kingdom Hall every Sunday, non denominational back in person

Change Idea #3 ☑ **Implemented** ☐ **Not Implemented**

Increase enrollment in Activity Pro Family Portal

Process measure

- Activity Pro data will be reviewed

Target for process measure

- 25% of residents will have at least one family member enrolled in the Activity Pro family portal by March 31st 2025

Lessons Learned

Goal Implemented

	Last Year		This Year		
Indicator #6 Dietary (Cassellholme)	**90.30** Performance (2024/25)	**93** Target (2024/25)	**98.20** Performance (2025/26)	**--** Percentage Improvement (2025/26)	**NA** Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Improve plate presentation of meal

Process measure

- Managers and Coordinators observing meal service, conducting dining room audits, and resident satisfaction surveys.

Target for process measure

- 93% on resident satisfaction survey for Question: What do you think of the variety of food, the presentation, and nutrition

Lessons Learned

We have completed training with staff showing them pictures of suitable plating.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Improve food temperature

Process measure

- Managers and Coordinators observing meal service, conducting dining room audits, and resident satisfaction surveys.

Target for process measure

- 93% on resident satisfaction survey for Question: What do you think of the variety of food, the presentation, and nutrition

Lessons Learned

Significant number of staff training opportunities. We also looked at service and worked on some interventions to help speed it up so residents who are receiving trays get them in a timelier manner.

Indicator #16

Palliative (Cassellholme)

Last Year		This Year		
CB	**100**	**100.00**	**--**	**NA**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

1) Creating a palliative information board in staff space 2) Revising palliative policies 3) Updating staff end-of-life and after-death checklist 4) Updating pallative checklist to include a pallative assessment tool 5) Include pallative checklist on huddle board 6) Standardize wording in staff communication about resident deaths

Process measure

- Reviewed at each palliative meeting

Target for process measure

- 100% positive feedback of palliative experience from families of resident that passed from April 1, 2024 to March 31, 2025.

Lessons Learned

All completed, challenges educate staff, find opportunities. All implemented. Incorporating NPs with education plan

Indicator #4

Care Conference (Cassellholme)

Last Year		This Year		
100.00	**100**	**100.00**	**--**	**NA**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Complete an initial care conference within 6 weeks, and an annual care conference for every resident

Process measure

- Review Monthly number of residents completed

Target for process measure

- 100% of residents have completed a care conference within 6 weeks, and/or an annual care conference by April 2025.

Lessons Learned

All residents had their care conferences as scheduled

Indicator #7

Dietician Weight Review (Cassellholme)

Last Year		This Year		
100.00	**100**	**100.00**	**--**	**NA**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Weights of all residents reviewed Monthly

Process measure

- Monthly report sent to NFS and Clinical team

Target for process measure

- 100% Weights audit monthly to meet ministry standard

Lessons Learned

RNs review monthly weights and send referral to dietician and Uuni MAnagers complete monthly Audit

Indicator #13

Menu Planning (Cassellholme)

Last Year		This Year		
100.00	**100**	**98.20**	**--**	**NA**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Improve resident satisfaction of meal offering

Process measure

- Resident satisfaction survey, waste audits, food committee feedback, and following up with residents in dining rooms.

Target for process measure

- 93% satisfaction on resident survey

Lessons Learned

All audits were implemented as intended, resident food committee input was used to help with menu planning, Staff training conducted to ensure platting was more visually appealing.

Experience | Patient-centred | Optional Indicator

	Last Year		This Year		
Indicator #17	**84.21**	**90**	**95.00**	**12.81%**	**96**
Percentage of residents responding positively to: "What number would you use to rate how well the staff listen to you?" (Cassellholme)	Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Follow up with resident/ family after Critical Incident

Process measure

- Resident Satisfaction Survey Results

Target for process measure

- Increase satisfaction from families/resident response to 90% on the question "What number would you use to rate how well the staff listen to you?" on the Resident Satisfaction Survey

Lessons Learned

improvement in the response on this year's satisfaction survey.

Indicator #18

Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences". (Cassellholme)

Last Year			This Year		
95.79	**98**		**88.00**	**-8.13%**	**90**
Performance (2024/25)	Target (2024/25)		Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Campaign the Unit Manager

Process measure

- Satisfaction Survey results to the question "Having Your Say"

Target for process measure

- 98% of residents score that they rate their comfort level of Good Or Excellent in expressing an honest opinion to Cassellholme Staff.

Lessons Learned

A Photo of each Unit Manager was added to the admission package for families and residents to review. 100% of the people surveyed answered average to excellent with this one.

Comment

Will review

Safety | Effective | Custom Indicator

Indicator #28

Wound Care (Cassellholme)

Last Year		This Year		
3.90	**3.40**	**3.30**	**--**	**NA**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Initiating end of life skin assessment Education for staff, residents and families

Process measure

- Wounds will continue to be monitored by wound committee

Target for process measure

- maintain or decrease worsened stage 2-4 pressure ulcers by 0.5% to equal the provincial average as outlined in Q2

Lessons Learned

Imbedded in end of life policy. Mail chimp family educational info sent. Grief cafe evening movie/documentary shown. Not specifically documented in PCC

Indicator #5

Continence Care (Cassellholme)

Last Year		This Year		
27.70	**27.70**	**27.70**	**--**	**NA**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Acquiring a bladder scan and training staff on its use and Staff training on continence care by Tena

Process measure

- Data collected from continence survey and CIHI Q2 unadjusted rates, reviewed by continence committee

Target for process measure

- Maintain current worsened bladder continence score of 27.7% based on CIHI Q2 unadjusted rates.

Lessons Learned

Bladder scanner was purchased, staff trained, rep in to do family satisfaction survey

Indicator #8

Emergency Plan (Cassellholme)

Last Year		This Year		
100.00	**100**	**100.00**	**--**	**NA**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Emergency plan in place and reviewed annually

Process measure

- Reviewed by the home's health and safety manager. Reviewed by Resident and Family Council

Target for process measure

- 100% completion of Emergency Plan review by April 1 2025

Lessons Learned

Plan was reviewed as required

Indicator #23

Responsive Behaviours (Cassellholme)

Last Year		This Year		
15.90	**12.50**	**18.30**	**--**	**NA**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

"1) Develop an individualized, non-pharmacological delirium prevention plan for residents screened ""at risk""
2)Increase sensory stimulation activities

Process measure

- Progress of implementation by goal dates will be monitored by Responsive Behavior Committee

Target for process measure

- Reduce symptoms of delirium to 7.60% and worsened behaviours to 12.5% based on CIHI Q2 unadjusted rates.

Lessons Learned

Ongoing with Clinical Pathways.

Indicator #11

Infection Control (Cassellholme)

Last Year		This Year		
100.00	**100**	**100.00**	**--**	**NA**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

maintain hand hygiene audit rate of 2400 per year

Process measure

- Report generated by Speedy Audit App

Target for process measure

- 2400 hand hygiene audits

Lessons Learned

All hand hygiene observations were completed. We had assigned staff members that were to complete a number of observations, this was hit or miss due to other obligations.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Continue IPAC self Assessment audit, minimum of 2 per year, and weekly while on outbreak

Process measure

- IPAC Nurse to maintain

Target for process measure

- Minimum of twice per year, and weekly while on outbreak

Lessons Learned

Completed as mandated in all areas

Change Idea #3 ☑ Implemented ☐ Not Implemented

Introduce PHO Risk Assessment Related to Routine Practices and Additional Percautions

Process measure

- IPAC Nurse to maintain

Target for process measure

- Introduce to staff and update PHO Assessment Related to Routine Best Practices and Additional Precautions

Lessons Learned

Staff training was started; however this is a work in progress

Change Idea #4 ☑ Implemented ☐ Not Implemented

Complete redevelopment IPAC/Construction measure audit biweekly until October 2024

Process measure

- IPAC Nurse to maintain

Target for process measure

- Complete IPAC/Construction Preventative Measures aduit weekly until October 2024, for a total of 18

Lessons Learned

This is ongoing as the redevelopment schedule has been delayed.

Safety | Safe | Custom Indicator

	Last Year		This Year		
Indicator #15 Pain (Cassellholme)	**15.20** Performance (2024/25)	**13** Target (2024/25)	**10.90** Performance (2025/26)	**--** Percentage Improvement (2025/26)	**NA** Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Reduce resident pain by improving monitoring and interventions.

Process measure

- Continued monitoring of goals by pain committee. Pain assessments reviewed by RPN Team Leads and RNs, as well as during care conferences and med reviews.

Target for process measure

- Decrease worsened pain average to 13% based on CIHI Q2 unadjusted rates.

Lessons Learned

Training in Pain Assessments has been completed with Nursing staff to be able to better recognize and treat pain. New Physician group has also been helpful in enhancing our pain management program.

Indicator #10

Housekeeping (Cassellholme)

Last Year		This Year		
95.00	**96**	**98.20**	**--**	**NA**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Clear definition of "Clean Resident Room" for housekeeping staff.

Process measure

- Room audits and annual resident and family satisfaction survey

Target for process measure

- Goal of 96% satisfaction on cleanliness on resident satisfaction survey.

Lessons Learned

Room audits were completed which highlighted areas of improvement, Resident satisfaction survey showed 98% of residents and families were satisfied with Home cleanliness.

Safety | Safe | Custom Indicator

	Last Year		This Year		
Indicator #3 Boilers (Cassellholme)	**100.00** Performance (2024/25)	**100** Target (2024/25)	**100.00** Performance (2025/26)	**--** Percentage Improvement (2025/26)	**NA** Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Boiler Check by outside Source

Process measure

- Monitored and Documented by Maintenance

Target for process measure

- !00% completion of Boilers Checked Annually

Lessons Learned

Boilers have been serviced as required

Indicator #9

Heat Related Illness Prevention (Cassellholme)

Last Year		This Year		
100.00	**100**	**100.00**	**--**	**NA**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Spring Completion of Heat Assessment of all current residents June, July, August New Admissions

Process measure

- DOC or Delegate run report to ensure completion

Target for process measure

- 100% completion to Meet Ministry Standards

Lessons Learned

Completed, All residents reviewed

Indicator #20

Pharmacy Destruction (Cassellholme)

Last Year		This Year		
100.00	**100**	**100.00**	**--**	**NA**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Bi - Monthly Destruction of Narcotics

Process measure

- In Collaboration with Care Rx

Target for process measure

- 100% Completion To Meet Ministry Standards

Lessons Learned

Completed