

**Access and Flow | Efficient | Optional Indicator**

	Last Year		This Year		
<b>Indicator #2</b>	<b>47.62</b>	<b>37</b>	<b>27.38</b>	<b>42.50%</b>	<b>18</b>
Rate of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents. (AgeCare Parkhill)	Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

**Change Idea #1**  Implemented  Not Implemented  In Progress

To reduce the number of ED visits to the provincial average by reviewing residents Goals of Care as it relates to DNR and Code Status and Expressed Wishes around their care.

**Process measure**

- Review of the Quality Indicators at the home and corporate level to review the number of ED visits on a quarterly basis. In home review of the number of ED visits and the reason for the visit.

**Target for process measure**

- 100% of new admissions will have had the DNR and Code status/level of care discussion. ED transfers will be minimized in keeping with residents' Expressed Wishes where applicable.

**Lessons Learned**

We continue to strengthen the review of residents' Goals of Care, including DNR and Code Status, on admission, annually at care conferences, and with any significant change in condition. This process is completed by the registered staff team with oversight from the Quality Nurse to ensure wishes are clearly documented and supported.

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

Improved communication to the physician when a resident has a change in condition.

**Process measure**

- Evidence of use of the tools in resident progress notes which denotes clear communication to physicians.

**Target for process measure**

- At least 50% of staff utilize the tools when a resident has a change in condition.

**Lessons Learned**

Improved staff and physician relationships have fostered greater trust and strengthened communication, resulting in more thorough and collaborative exchanges.

**Comment**

We will continue to monitor the status of ER visits and identify opportunities for reduction. This includes ongoing review of Goals of Care and DNR status, continued strengthening of staff relationships and assessment skills, and the development of supportive partnerships with external providers such as NLOT (contract in place) and Community Paramedicine, with plans to enroll.

**Experience | Patient-centred | Custom Indicator**

	Last Year		This Year		
<b>Indicator #3</b>	<b>55.00</b>	<b>65</b>	<b>80.00</b>	<b>--</b>	<b>NA</b>
Residents who agree to the statement "I am offered activities that meet my interests". (AgeCare Parkhill)	Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

**Change Idea #1**  Implemented  Not Implemented  In Progress

Gather information related to the residents interests upon move-in.

**Process measure**

- % of residents who have a completed assessment and All-About-Me tool completed upon move-in.

**Target for process measure**

- 100% of residents who have a completed assessment and All-About-Me tool completed upon move-in.

**Lessons Learned**

We have completed "All about Me" posters and gathered and shared this information for all residents and posted this in their rooms. Plus our recreation team uses this to ensure they are offered and attending programs of interest.

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

Monitoring resident engagement in activities and where engagement is low, meet with resident to discuss individual interests.

**Process measure**

- Variety of programs on the calendar. Feedback about the programs. # of residents at risk of isolation.

**Target for process measure**

- Calendar will have a variety of different types of programs to meet a variety of preferences. Surveys will be done as per auditing schedule and will show positive feedback. No residents will be at risk of isolation as group, individual and 1:1 programs will be tailored to meet each individual residents' needs.

**Lessons Learned**

Recreation team continues to monitor for resident at risk, and implement plans to increase their program participation.

**Comment**

Recreation manager has created a goal for 2026 to increase programs to be specific to those who do not generally participate in generic programs. Working with the team to identify niche programs, guests and ideas to incorporate all living in the home.

**Safety | Safe | Optional Indicator**

	Last Year		This Year		
<b>Indicator #1</b>	<b>20.09</b>	<b>18</b>	<b>20.47</b>	<b>-1.89%</b>	<b>NA</b>
Percentage of LTC home residents who fell in the 30 days leading up to their assessment (AgeCare Parkhill)	Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

**Change Idea #1**  Implemented  Not Implemented  In Progress

To improve early identification of residents who are at risk of falls utilizing the Scott Fall Risk Assessment and interdisciplinary team review.

**Process measure**

- All residents will have a Scott Fall Risk Assessment completed by a Registered Nurse upon admission, annually and with change in status.

**Target for process measure**

- 100% of residents will receive the admission, annual and with change Scott Fall Assessments.

**Lessons Learned**

Following our documentation guide and all residents are assessed with Scotts Fall Risk Assessment on admission, annually, and post fall with serious injury, and with multiple falls (more than 2 falls in the last 6 months). Residents at high risk above 12 utilize a Falling Star Visual Identifier. This is completed by registered staff and audited by the Falls Lead.

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

To review and implement interventions to reduce the fracture risk of residents at risk for falls.

**Process measure**

- # of residents referred to the physician for fracture prevention medication or using hip protectors. # of hip fractures.

**Target for process measure**

- Decrease in # of hip fractures quarter over quarter. 100% of residents will have a review of the fracture risk assessment and interventions. 100% of associated referrals will be completed

**Lessons Learned**

Increased purchasing of and utilization of hip protectors, and 1 resident using falls prevention helmet. All residents are assessed on admission and residents at high risk for fracture are referred to the physician for Osteoporosis Pharmacological interventions such as Vitamin D and Calcium.

**Change Idea #3**  Implemented  Not Implemented  In Progress

Maximize restorative care programs such as the walking program where able to increase strength, balance and stamina as a falls prevention strategy for residents able to participate. Utilize additional supports such as physio and BSO in falls prevention.

**Process measure**

- # of residents participating on walking programs. # of physio referrals. # of residents followed by BSO.

**Target for process measure**

- 100% of all residents who are high risk for falls or have fallen will be considered for referral to restorative, physio or BSO for additional fall prevention measures.

**Lessons Learned**

Case load continues to remain stable with currently 19 residents on caseload working on walking, transfer and ROM programs.

**Comment**

We will continue to work on early identification, implementing visual identifiers for those who remain high risk, implementing injury prevention interventions, and refer to restorative and PT as needed.