2026/27 Quality Improvement Plan "Improvement Targets and Initiatives"

Org Unit 600 - AGH

Atikokan General Hospital 120 Dorothy Street, Box 2490, Atikokan , ON, P0T1C0

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Issue	Quality dimension	Measure/Indicator	Type	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	Emergency Department return Visit Audits	Executive Compensation	Pay-for-Results Action Plan	External Collaborators	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
ACCESS and FLOW	**Timely**	90th percentile emergency department length of stay for admitted patients	O	Hours / ED patients	CIHI NACRS / December 1, 2024, to November 30, 2025, in alignment with the Pay for Results program	600*	9.4	8.00	25 hours is the target set by the Ontario Pay for Results Program	No	No	Yes		1)Monitor that patients in the Emergency Department are moved to inpatient beds within our target	Ward Clerks will Perform Audits on Registration Time vs. Time Pt leaves ED for Inpatient Bed periodically during each quarter of the year. Nurse Manager will prepare audit document for use and set a schedule	The number of hours it takes our hospital to perform this measure	15% Decrease the number of occurrences where our timing was over our target	Current Performance is auto-populated for this indicator. Timeframe is December 1/2024 to November 30/2025 in alignment with Pay for Results (P4R) program.
ACCESS and FLOW	**Timely**	90th percentile emergency department wait time to inpatient bed	O	Hours / ED patients	CIHI NACRS / December 1, 2024, to November 30, 2025, in alignment with the Pay for Results program	600*	3.2	2.00	Reduce the amount of time waiting to move to inpatient bed	No	Yes	Yes		1)Monitor that patients in the Emergency Department are moved to inpatient beds within our target	Ward Clerks will Perform Audits on ED Disposition Time vs. Time Pt leaves ED for admission as Inpatient periodically during each quarter of the year. Ward Clerks will also indicate the reason why there was any delay in the movement of the Patient. Nurse Manager will prepare audit document for use and set a schedule.	The number of hours it takes our hospital to perform this measure	35% Decrease the number of occurrences where our timing was over our target	Current Performance is auto-populated for this indicator. Timeframe is December 1/2024 to November 30/2025 in alignment with Pay for Results (P4R) program.
														2)Ward Clerks will assist with admission of patients to inpatient in acute	Ward Clerks will porter Patients to Acute for Inpatient Admissions	The number of hours it takes our hospital to perform this measure	35% Decrease the number of occurrences where our timing was over our target	
ACCESS and FLOW	**Timely**	90th percentile emergency department wait time to physician initial assessment	P	Hours / ED patients	CIHI NACRS / December 1, 2024, to November 30, 2025, in alignment with the Pay for Results program	600*	1.4	1.20	Monitor that Emergency Department Patients are being seen in a timely manner by Physicians 3.4Hrs or less is target suggested by Ontario Health	No	No	Yes		1)Mandatory completion of the Registration Time and the Physician Initial Assessment time for every ED Visit	Ward Clerk/ED Nurse to chart on the ED registration, what time registration took place and what time the Physician sees the patient.	Review Data produced by Ontario Health with regard to timing of Physician Initial Assessment in order to meet Ontario Health targets	To Decrease our current performance level to 1.2 hour for time between Triage/Registration and Physician Initial Assessment .	Quarterly results are reported to Quality Council and Quality Committee of the Board for review using Quality Dashboard Report.

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														2)Education for Nurses and Physicians on eCTAS time standards	Nurse Manager will arrange for training sessions to occur within Q1 of 2026/2027 for all Ward Clerks, ED Nurses, and Physicians	Number of Staff and Physicians who attended training	To Decrease our current performance level to 1.2 hour for time between Triage/Registration and Physician Initial Assessment .	eCTAS 5 will be excluded
														3)Monitor that patients are seen in a timely manner by our phsyicians in the Emergency Department	Ward Clerks will Perform Audits on Registration Time vs. Physician Initial Assessment Time periodically during each quarter of the year to see if within CTAS guidelines	Increase in the number of times the PIA was within the eCTAS timing period quarter over quarter audit	To Decrease our current performance level to 1.2 hour for time between Triage/Registration and Physician Initial Assessment .	eCTAS #5 will be excluded
ACCESS and FLOW	**Timely**	Percent of patients who visited the ED and left without being seen by a physician	O	% / ED patients	CIHI NACRS / April 1, 2024, to March 31, 2025 (i.e., FY 2024)	600*	0.26	0.20	Track how many patients come into ED and the Physician does not see them, and why.	No	No	No		1)Monitor the reasons that patients leave the ER without being seen by a physician. Nurses to use a checklist of possible reasons and review results quarterly	Nurses to make note of why a patient was not seen and the nurse manager to review quarterly	The number of different reasons patients leave without being seen by a physician	less than 10% of ER patients not seen by the physician per quarter	Current Performance is auto-populated for this indicator. April 1/24 - March 31/25
EQUITY	**Equitable**	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	600*	92.42	100.00	Increase the number of all staff of AHCS (AGH & LTC & FHT) who receive EDI training during the year	No	No	No		1)Research different training options for staff and board members	Hire different agencies such as Seven Generations to provide in person learning about EDI and cultural diversity. HR to track who receives the training	The number of staff who have completed the training	25% of staff and 80% of board members receive EDI training	This measure is reporting for all staff working for Atikokan Health and Community Services (Hospital/ Long Term Care/ Primary Care)
														2)Educate staff on the importance of completing participating in the training	Discuss at Team/Unit meeting and huddles. Review the EDI framework and plan with staff as well as truth and reconciliation documents	The number of times EDI is discussed with staff at staff meetings, huddles, board meetings etc.	50% of staff will discuss EDI or take part in EDI training during 2026-27	This measure is reporting for all staff working for Atikokan Health and Community Services (Hospital/ Long Term Care/ Primary Care)

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EXPERIENCE	Patient - Centred	Percentage of respondents who responded "completely" to the following question: Did you receive enough information from hospital staff about what to do if you were worried about your condition or treatment after you left the hospital?	C	% / Discharged patients	Local data collection / most recent 12 month consecutive period	600*	75	80.00	Improve score from patients related to amount of information they receive upon discharge.	No	Yes	No		1)Improve score from patients related to amount of information they receive upon discharge.	Nurse will address any identified issues prior to discharge or provide information for the patient before discharge. Patient will sign off on Discharge Plan indicating they received enough information.	Increase in the the number of patients who identify that they received enough information from hospital staff during Family Health Team follow-up appointment	Collect baseline data on the number of patients who identify they needed more information during Family Health Team Visit.	
														2)Monitor Patients who attend Family Health Team appointment after discharge and indicate they did NOT receive enough information during discharge from Hospital	Family Health Team Staff will ask Patients the question "Did you receive enough information from hospital staff about what to do if you were worried about your condition or treatment after you left the hospital", and submit information to Nurse Manager monthly.	Collect Baseline data regarding Hospital Data from Discharge Plan and Family Health Team Data from Patient at Follow-up	Collect Baseline with target of 80% indicating they received enough information on discharge	
SAFETY	Safe	Medication reconciliation at discharge: Total number of discharged patients for whom a Best Possible Medication Discharge Plan was created as a proportion the total number of patients discharged.	O	% / Discharged patients	Local data collection / Most recent consecutive 12-month period	600*	CB	100.00	Collection of Baseline Data related to this measure/indicator to define need for improvement.	No	No	No		1)Collect Baseline data on number of Best Possible Medication Discharge Plans created	Audits by Health records quarterly on Discharge documents	Increase Quarter over quarter with review by Nurse Manager/Utilization Coordinator	Collecting Baseline	
SAFETY	Safe	Number of Medication related incidents occurring in Emergency and Acute Units that result in Risk Management rating of Harm to the Patient	C	# Medication related incidents rated as Harm to Patient / # of ED and Admitted Patients	Local data collection / Most recent consecutive 12-month period	600*	4	0	Reduce the number of Medication incidents rated as Harm to Patient	No	No	No		1) Pharmacy & Therapeutics Committee review of all incidents related to medication quarterly. Look for patterns and make changes to reduce errors.	Tracking of Medication incidents quarterly through incident reporting system and reporting data to Pharmacy Technician to review with P & T Committee quarterly.	Reduction in number of medication incidents recurring after corrective actions recommended	Reduce Medication Incidents with RM Severity Rating of: Harm Non-Serious, Harm Serious, or Harm Tragic to Zero during monitoring period	Reports are reviewed by the Quality Council and reported to the Quality Committee of the Board.

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														2) Education for all Staff related to RM Severity Rating for Medications Incidents and reporting in online system (Surge QRM)	Assign readings of Policies and Procedures related to Severity Rating. Discuss with staff at meetings and huddles.	Number of staff trained or that attest to having adequate knowledge of the Severity Rating system.	All Staff who have a role in medication administration receive training.	
SAFETY	**Safe**	Percent of ED Patients who were discharged without vital signs being taken.	***C***	# Discharge Vital Signs Taken / # of ED Patients Discharged	Local data collection/ Quarter Q2 & Q3 2026/27	600*	CB	CB	Ensure Vital Signs at Discharge are recorded and if Abnormal brought to attention of Physician	YES	No	No		1) Mandatory completion of Discharge Vital Signs with communication to Physician if abnormal.	Add a DISCHARGE VITAL SIGNS line to the Emergency Department Discharge Form	The number of times Discharge Vital Signs are not taken or are abnormal but not relayed to Physician within 6 month period of Q2-Q3 2026/27FY. Monitored by Health Records with reports to Nurse Manager monthly.	Collect Baseline	Part of EDRVQP Audits Quarterly
														2) Education of staff on Vitals/Frequency based on CTAS	Nurse Manager will assign or hold training, retraining, and refresher sessions, on Vitals/Frequency based on CTAS for all Nursing Staff of Emergency Department.	The number of staff who attend the training and attest to being trained/competent during Q2-Q3 2026/27 FY.	Collect Baseline	
SAFETY	**Safe**	Percentage of Medication Reconciliation forms on ADMISSION that had discrepancies	**C**	# Medication Reconciliations that had discrepancies / # Patients admitted	Local data collection / Most recent Quarter	600*	CB	0.00	Collection of Baseline Data related to this measure/indicator to define need for improvement.	No	No	No		1)Collect Baseline on discrepancies	Pharmacy conducts quarterly audits	Collect Baseline with target to Decrease Quarter over quarter for FY	Collect Baseline	Implemented new form in November 2025.

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Org Unit 92250 FHT

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Issue	Quality dimension	Measure/Indicator	Type	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	External Collaborators	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
ACCESS AND FLOW	Efficient	Percentage of clients with type 2 diabetes mellitus who are up to date with HbA1c (glycated hemoglobin) blood glucose monitoring	O	% / PC patients/clients	EMR/Chart Review / Most recent consecutive 12-month period	92250*	93	100.00	All Patients needing A1C monitoring should be up to date		1)Survey A1C clients to see why they are not up to date with A1C monitoring	Program Support staff will call clients not up to date to find out why they didn't get their A1C monitoring done	Track the number of responses and reasons provided by Patients	<10% of responses said it was due to lack of available appointments	
ACCESS AND FLOW	Efficient	Number of NEW patients/clients enrolled in a Family Health Team programs as a self referral due to becoming aware through FHT Advertising Program	C	Number / PC patients/clients	Local data collection / mo	92250*	CB	10.00	10% of New enrollments in Family Health Team programs resulted from FHT Advertising Program		1)Increase the number of communications related to the various programs offered and how to access them	Create and Monitor the communications /advertising that are put forth in community quarterly.	The number of yearly communications /advertising produced	Four (4) yearly communications /advertisings produced	Collecting Baseline
						92250*					2)Monitor number of new patients/clients who register for FHT programs who self referred	Ask patients/clients how they found out about the FHT programs they are registering for.	Percent of New Patients/Clients who self refer due to advertising during most recent 12 month period	Collect baseline data on percent of self referrals who registerd due to FHT advertising	
ACCESS AND FLOW	Timely	Patient/client perception of timely access to care: percentage of patients/clients who report that the last time they were sick or had a health problem, they got an appointment on the date they wanted	P	% / PC organization population (surveyed sample)	In-house survey / Most recent consecutive 12-month period	92250*	73	85.00	85 - 100% is the target corridor set by Alliance for Healthier Communities		1)Have appointments open in all schedules for same day/next day	Survey Patients	Track the number of patients who got their appointments when they wanted them	one (1) appointment each day is open for same day appointment	

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ACCESS AND FLOW	Timel;y	Percentage of screen-eligible people who are up to date with breast screening	O	% / PC organization population eligible for screening	EMR/Chart Review / Q2 2025 (covering 2 years of participation for mammography up to September 2025)	92250*	52	75.00	Ontario Health set target as 65%		1)Provide education on where to get mammograms as bus not coming here this year	Create communications about mammogram access	# of communications created	three (3) communications a year	Current performance based on Q2 Results
						92250*					2)Assist patients in planning or actually getting their screening completed by understanding where they get screening done	Add a survey question on the patient survey to ask about the patient's experience with mammography in our area	Track the number of responses to the survey regarding location their screening took place and if they had a travel grant.	25% of those eligible for mammograms respond with information	Provide data on affect of loss of Screening Bus visits to our population.
ACCESS AND FLOW	Timely	Percentage of screen-eligible people who are up to date with cervical screening	O	% / PC organization population eligible for screening	EMR/Chart Review / Q2 2025 (covering 42 months of participation for cytology (Pap) testing, and 66 months of participation for HPV testing up to September 2025)	92250*	75	80.00	Ontario Health set target as 60%		1)Increase the number of cervical screens completed monthly during Quarter 2 of 2026/2027	Create advertising about the availability of cervical screening through the FHT and adjust the NP schedule to allow for more screenings to take place.	The number of patients who booked appointment each month for screening	Two (2) patients per month successfully completed Cervical Screening with Nurse Practitioner, resulting in 80% of patients being up to date with screening.	Current Performance based on Q2 results 2025/2026
ACCESS AND FLOW	Timely	Percentage of screen-eligible people who are up to date with colorectal tests	O	% / PC organization population eligible for screening	EMR/Chart Review / Q2 2025 (covering 2 years of participation for FIT and 10 years of participation for flexible sigmoidoscopy or colonoscopy up to September 2025)	92250*	43	65.00	Ontario Health set target as 65%- We want to meet or exceed that		1) Track the number of patients who get their screening done vs. who is eligible for screening	Contact all patients who are due and encourage them to complete their FIT test or get their colonoscopy completed	Of eligible Patients - Track the number of patients who are up to date with screening	65% of eligible patients are up to date with screening	Current Performance based on Q2 Results (2025/2026)

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EQUITY	Equitable	Completion of sociodemographic data collection	O	% / Patients	EMR/Chart Review / Most recent consecutive 12-month period	92250*	CB	75.00	65-100% is target corridor set by Alliance for Healthier Communities		1)Request patients/clients to provide data during REGISTRATION FOR Primary Care Use Only.	Reception Staff will ask OHA Questions as Patient/Clients are being registered and add to records.	Percent of Patients/Clients answering sociodemographic data questions as part of Registration	Collect Baseline Data with Target of 75% of Patients/Clients answering sociodemographic data over the most recent 12 month period	
EXPERIENCE	Patient-centred	Do patients/clients feel comfortable and welcome at their primary care office?	O	% / PC organization population (surveyed sample)	In-house survey / Most recent consecutive 12-month period	92250*	94	100.00	Maintain or improve upon Patient opinions regarding if they feel comfortable and welcome at the Primary Care Office.		1)Ask Patients/Clients to complete the voluntary In-House Out-Patient Survey in order for Family Health Team to understand if we need to improve our services	Out-Patients completed surveys during or immediately after their office visit	Track the number of positive responses (agree/strongly agree) proportional to the total number of responses received	Increase to 100% of Patients/Clients indicating they feel comfortable/welcome (agree/strongly agree) on the Out-Patient Survey.	Currently Performance based on Q1-3 survey results 2025/2026 FY
SAFETY	Safe	Number of paper faxes sent or received by Nurse Practitioner at Primary Care Office.	C	Number of paper faxes sent or received by Nurse Practitioner / Number of patients/clients of Nurse Practitioner	In House Data - Number of paper faxes sent or received by Nurse Practitioner / Quarter 2 FY 2026/2027	92250*	CB	CB	Collect Data on number of paper faxes sent or received by Nurse Practitioner in Quarter 2 of 2026/2027 FY		1)Collect Baseline data related to the use of paper faxes by the Nurse Practitioner during Quarter 2 of 2026/2027	Reception will Track the number of paper faxes sent from or received by the Nurse Practitioner for Quarter 2 of 2026/2027	Collect Baseline Data	Collect Baseline Data	

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ACCESS and FLOW	Efficient	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)	53529*	21.62	20.00	Reduce non-emergency visits to Emergency Department by Long Term Care Residents	1)Develop a list of conditions that should be treated by Physicians at the Long Term Care home and not in Emergency Department	Staff and Physician education on List of Conditions. Deal with Local Pharmacy for Medication supplies not Emergency Department. Add List of Conditions to Physician orientation	Track Number of Education Sessions for LTC Staff and Physicians	Decrease Emergency Department visits by 10% to 20 visits for non-emergent care	Share data twice a year at MAC for all Physicians.
EXPERIENCE	Patient-Centred	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	53529*	62.5	95.00	Through the Provision of Exceptional Service to the Long Term Care Residents in our Home, we will increase the number of LTC Residents/Representatives who positively respond to the In-House Survey with #9 or #10 to this question.	1)Continue with In-House Resident Experience Survey in order to encourage resident engagement.	Voluntary In-House survey distributed to all resident annually in September	Track the number of positive responses (#9, #10) proportional to the total number of responses received from the survey.	Increase positive responses (#9, #10) on the survey to 95% of responses received over 2025/2026 survey results	This survey is provided annually to all residents in September. AGH only has 26 LTC beds total with approximately a 73% response rate to the 2025/26 survey. Responses are reviewed by the Quality Council and reported to the Quality Committee of the Board. Survey results are shared with both the Resident and Family Councils
						53529*				2)Ask for feedback from Residents and the Resident Council on how to improve communications	LTC Manager to attend Resident Council meetings quarterly to present and ask for feedback regarding this question. Perform Listening Rounds quarterly to ask Residents for feedback on their opinions related to this matter.	Track feedback from quarter to quarter for improvements	Increase positive number of responses to the annual survey question for the September 2026 Survey.	
						53529*				3)Ask for feedback from Residents and Resident Support Persons/Representatives about how well they feel listened to.	Hold Listening Rounds with residents quarterly where they can freely express their opinions on if staff listen to them	Track feedback from quarter to quarter for improvements in responses.	Increase positive responses by 10% over 2025/2026 survey responses.	

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						53529*				4)Share results of Survey with the staff so they know how the Residents/Representatives are feeling about this matter.	Annually provide staff with the results of the In-House Survey in order to assist them in improving their responses to the Residents. Review Survey results with the Long Term Care Continuous Quality Improvement Committee.	Track the number of positive (#9, #10) responses proportional to the total number of responses received and review them with staff.	Increase positive responses (#9, #10) to 95% during the September 2026 In-House Resident Satisfaction Survey	
EXPERIENCE	**Patient-Centred**	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	53529*	53.85	90.00	Only 16 of 26 Residents completed the Survey. Of those 16 respondents Agree or Strongly Agree (88%) that they can express their opinion without fear of consequence. The question on our Survey will be updated to reflect the grading system in the QIP.	1) Update the question on the Annual In-House Resident Survey to reflect the correct answer grading sequence 0 = never 1 = Rarely 2 = Sometimes 3 = Most of the Time 4 = Always 6 = Don't Know 7 = Refused 8 = No Response or cannot be coded from response	Administration will update the Survey before next issuance in September 2026	Track the number of responses rated as #3 or #4 over # of survey responses	Annual survey is updated	
										2)Continue with In-House Resident Experience survey in order to encourage resident/representative engagement and feedback.	Voluntary In-House survey distributed to all residents annually	Track the number of positive responses proportional to the total number of responses received	Increase number of positive responses to this question to 90% of LTC residents responding to survey Current Performance 14 of 16 responses recorded as strongly agree/agree to the survey out of 26 residents	This survey is provided annually, in September, to all residents. AGH has low volume (AGH has only 26 LTC beds total with approximately a 70% response rate). Responses are reviewed by the Quality Council and reported to the Quality Committee of the Board. Survey results are shared with both the Resident and Family Councils.

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						53529*				3)Ask for feedback from Residents and Residents Council and how to improve communications	Attend Resident Council meetings quarterly to present and ask for feedback regarding this question Perform Listening Rounds quarterly to ask Residents for feedback on how their opinions	Track Feedback from quarter to quarter for improvements	Increase positive number of responses to the annual survey question administered in September 2026.	Provide staff with feedback results from this idea
						53529*				4)Ask for feedback from Residents and Residents support persons about how well they are listened to	Hold Listening Rounds with Residents quarterly where they can freely express their opinion on if staff listen to them	Track Feedback from quarter to quarter for improvements	Increase positive number of responses to the annual survey question administered in September 2026.	Provide staff with feedback results from this idea
						53529*				5)Share results with the staff so they know how residents are feeling and can improve their responses to them	Annually provide staff with results of the In-House Survey in order to assist them in improving their responses to the residents	Track the number of positive responses proportional to the total number of responses received	Increase number of positive responses to this question to 90% of LTC residents responding to survey	Current Performance 14 of 16 responses recorded as strongly agree/agree to the survey out of 26 residents
EXPERIENCE	**Patient-Centred**	Percentage of Residents who responded positively to Survey Question " How do you rate the Laundry Services"	C	% / LTC home residents	In-house survey / most recent 12 month consecutive period	53529*	CB	CB	Collect Data from LTC Residents/Representatives who positively responded to the In-House Survey with (Agree/Strongly Agree) to this question, in order to provide exceptional service to the Residents.	1)Add the Question to the Annual In-House Resident Experience Survey administered in September annually to collect baseline data regarding satisfaction with Laundry Services	Voluntary In-House survey distributed to all residents annually	Track the number of positive responses proportional to the total number of responses received	Collect Baseline data	

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Issue	Quality dimension	Measure/Indicator	Type	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
EXPERIENCE	Patient-Centred	Residents who responded positively (Agree/Strongly Agree) when asked "Overall I am satisfied with the Recreational Activities offered in ECW" on the annual Voluntary In-House Resident Satisfaction Survey	C	# who responded "Agree/Strongly Agree" / # LTC home residents who responded to question	In-house survey / 2026 In-House Resident Satisfaction Survey	53529*	93	95.00	Putting more focus on the provision of more and varied Recreational Activities for Long Term Care Residents	1)Increase the variety of recreation options availble for Residents to participate in outside of the Home. (Coffee meetings off site, Lunch dates off site, Pioneer Centre activities off site)	Work with the Recreation Coordinator to increase the variety of activities offered within each quarter for FY 2026/27	Track the variety of activites offered and the frequency of each during each quarter and the number of residents who are participating in the activities.	Increase positive response rate of residents to 95% by end of Q3 FY 2026/27	Current Performance based on 14 or 15 Surveys completed indicating Strongly Agree or Agree for 2025/26. Responses are reviewed by the Quality Council and reported to the Quality Committee of the Board. Survey results are shared with both the Resident and Family Councils
						53529*				2)Encourage Residents/Representatives to participate in Recreation Activities offered and to provide feedback to Recreational Coordinator.	Provide schedule of activities well in advance. Ensure residents/representatives are aware of the activities being offered.	Track participation in offered activities by resident daily. Ask them for feedback on satisfaction with the activity they participated in and track their responses. (Agree or Dis-Agree)	Increase the participation by residents by 95% between Q1 and Q3 FY2026/27	Responses are reviewed by the Quality Council and reported to the Quality Committee of the Board. Survey results are shared with both the Resident and Family Councils.
						53529*				3)Encourage Residents to complete the Annual In-House Extended Care Resident Survey in order for AGH-LTC to provide appropriate recreational activities	Allow the Resident/Representatives to complete the Survey verbally or in writing regarding satisfaction with recreational activities.	Track participation in offered activities by resident daily. Ask them for feedback on satisfaction with the activity they participated in and track their responses. (Agree or Dis-Agree)	Increase the participation by residents by 95% between Q1 and Q3 FY2026/27	Responses are reviewed by the Quality Council and reported to the Quality Committee of the Board. Survey results are shared with both the Resident and Family Councils.
						53529*				4)Increase the availability of Recreational activities for residents	Addition of another recreation staff member to assist with activities	Track the number of activities presented to Residents	Increase in positive responses from Residents during Annual Satisfaction Survey in September 2026	

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AIM		Measure								Change				
Issue	Quality dimension	Measure/Indicator	Type	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
SAFETY	Safe	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	53529*	24.14	10.00	Provincial benchmark is 3.0% and we will work towards this target	1)Educate the staff about restraints and work with the residents and the families to figure out better ways to prevent falls other than use of restraints.	Increase awareness of restraints with the staff.	Use the InterRAI information that is reported to Health Quality Ontario to determine our score each quarter. Pull the data from the restraints book quarterly to get current restraint numbers.	Aim for only 10% of residents are restrained by end of Q3 - FY26/27	Responses are reviewed by the Quality Council and reported to the Quality Committee of the Board. Survey results are shared with both the Resident and Family Councils.
SAFETY	Safe	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	53529*	9.41	5.00	Decrease in percentage of residents with worsening pressure ulcers will improve residents health and wellness overall.	1)Addition of full-time Dietitian and Occupational Therapist to Multi disciplinary team will assist with provision of care and solutions to decrease worsening of pressure ulcers	Full time Dietitian and Occupational Therapist will assist with monitoring/intervention and will provide education on wound care to the staff	Track the number of education sessions during a huddle about ways to reduce pressure ulcers.	Aim for only 5% of Residents who had worsened pressure ulcers during Q2 of 2026/2027 FY	Responses are reviewed by the Quality Council and reported to the Quality Committee of the Board. Survey results are shared with both the Resident and Family Councils.
						53529*				2)Provision of additional off-loading devices to assist with resident pressure ulcers	Occupational Therapists and Rehabilitation staff will provide additional access to equipment that they have recently obtained	Track residents who have improved health over those who do not related to pressure ulcers	Aim for only 5% of Residents who had worsened pressure ulcers during Q2 of 2026/2027 FY	Results are reviewed by the Quality Council and presented to the Quality Committee of the Board
SAFETY	Safe	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	53529*	8.05	6.00	Provincial benchmark is 9%, therefore we are targeting to be below the provincial target.	1)Continue to review falls with multidisciplinary team at huddles and falls meetings and implement recommendations / fall prevention interventions.	Falls Committee recommendations shared with staff in a timely manner (multidisciplinary staff safety huddles)	Review the data in RAI for restorative care results.	Reduce the number of falls within 30 days leading to assessment to 3 or less per quarter	"Current Performance is auto populated by MOH. Provincial Benchmark currently = 9%"
						53529*				2)Flag residents who are high falls risk and increase monitoring of these residents	Review flagged residents for improved fall numbers	Review Fall reports monthly	We are aiming to reduce the number of falls to 3 or less in each quarter	Reports are reviewed by the Quality Council and reported to the Quality Committee of the Board. Results are shared with both the Resident and Family Councils.

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Issue	Quality dimension	Measure/Indicator	Type	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
						53529*				3)Provide access to and encourage participation in restorative care exercises and physical activity for residents offered through Rehabilitation Department	Review results of restorative care exercises and physical activity of residents	Review Surge QRM Fall reports monthly	We are aiming to reduce the number of falls to 3 or less in each quarter	Reports are reviewed by the Quality Council and reported to the Quality Committee of the Board. Results are shared with both the Resident and Family Councils.
SAFETY	**Safe**	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	53529*	40.35	34.00	Appropriate Use Coalition target of 15% reduction year over year until indicator value is 15%	1)Have the pharmacist regularly review the medications to see if they can be on something different and educate the physicians about other drugs or change the diagnosis of the resident	Do medication reviews with LTC Pharmacy including antiphysciotic quarterly *Make physician aware"	Quarterly medication reviews focusing on antipsychotic medications	Track the number of changes made to medications in each quarter of the past 12 consecutive months.	
SAFETY	**Safe**	Number of Medication related incidents occurring in LTC	C	# Medication related incidents current quarter / # Medication related incident prior quarter	Local data collection / most recent 12 month consecutive period	53529*	1.4	0.00	Reduce the number of incidents related to medication errors	1)Review of all medication related incidents with recommendations for improvement/changes to process	Review incidents with LTC Pharmacist and LTC Coordinator	Track Medication incidents in Surge QRM with quarterly review	Decrease the number of incidents occurring quarter over quarter by 1 with 0 target by Q3 of FY26/27	Reports are reviewed by the Quality Council and reported to the Quality Committee of the Board.
SAFETY	**Safe**	Number of Resident on Resident Verbal Confrontations	C	# of requests to work with resident over verbal abuse / LTC home residents	Local data collection / Q1 and Q2 FY26/27	53529*	CB	0.00	Reduce the Number of Resident Verbal Confrontations	1)Integrate the BSO role into BSO Therapeutic Recreation Coordinator. Use of Psycho Geriatric Resource Coordinator (CMHA) for behaviours that escalate beyond our scope.	Review incidents with LTC Care Team at Huddles and provide information for handling these situations	BSO Therapeutic Rec Coordinator will track the number of requests and see if the number of incidents reduce over the six month period	Collect Baseline Data over Q1 & Q2 (6 months) of 2026/27 FY	
						53529*				2)Continue providing training to LTC Staff (CPI, GPA, Responsive Behaviours)	Onsite training offered to all staff. Mandatory CPI training every 2 years, Surge Learning training for all staff on responsive behaviours	Track Violent incidents in Surge QRM with Quarterly reviews	Continue with our attempts to eliminate/reduce the number of violent incidents occurring in Long Term Care	Reports are reviewed by the Quality Council and reported to the Quality Committee of the Board.

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Issue	Quality dimension	Measure/Indicator	Type	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
SAFETY	Safe	Percentage of Long-Term Residents experience Pain	C	% / LTC home residents	CIHI CCRS / Q2 quarter for rolling 4quarter average	53529*	CB	CB	Decrease in the percentage of Residents experiencing Pain will improve overall Health and Wellness.	1)Educate staff about the importance of addressing resident's pain regularly during their shift.	Use an approved pain scale to monitor resident's pain and discuss results at daily huddles with staff	Track the number of residents who report a decrease in their pain	Reduce the number of residents complaining of pain by 10% during Q1 over Q3 of FY 2026/27	
SAFETY	Safe	Percentage of workplace violence incidents resulting in lost time injury	C	% / Staff	Local data collection / most recent 12 month consecutive period	53529*	CB	0.00	Reduce the number of incidents related to violence (behavioural responses) causing staff injury and lost time	1)Review all employee injury/incidents related to behavioural responses injuries causing lost time	Review incidents with LTC Manager, employee and Occ Health	Track incidents in Surge QRM with quarterly reviews	Continue with our attempts to eliminate/reduce the number of violent incidents occurring Long Term Care	Reports are reviewed by the Quality Council and reported to the Quality Committee of the Board.
						53529*				2)Continue to encourage staff to report all incidents of violence	Provide access to Surge QRM program in order to complete incident reports	The number of reports in Surge QRM by staff of LTC Home quarterly	Continue with our attempts to Zero violent events occurring int Long Term Care	Reports are reviewed by the Quality Council and reported to the Quality Committee of the Board
						53529*				3)Continue providing training to LTC Staff (CPI, GPA, Responsive Behaviours)	Onsite training offered to all staff. Mandatory CPI training every two years. Surge Learning training for all staff on responsive behaviours	Track violent incidents in Surge QRM with Quarterly reviews	Continue with our attempts to eliminate/reduce the number of violent incidents occurring in Long Term Care	Reports are reviewed by the Quality Council and reported to the Quality Committee of the Board.
						53529*				4)Educate Staff on identifying when to report the Workplace Violence Incident in our online reporting system	On-site training offered to all staff during meetings, education sessions, mandatory Learning, Huddles, and one-on-one situations.	Increase in the correct reporting of these incidents by staff.	75% of LTC staff trained on online incident reporting system by the end of Q3 2026/2027 FY	