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Omni Quality Living Continuous Quality Improvement Initiative Report 2026/27

Prepared in accordance with: *Fixing Long-Term Care Act, 2021* O. Reg. 246/22 – Section 168
Continuous Quality Improvement Initiative Requirements

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Omni Quality Living – Frost Manor

Continuous Quality Improvement Initiative Report

2026/27

OVERVIEW

At Omni Quality Living, people remain the driving force behind our mission. Since 1975, we have been committed to delivering compassionate, high-quality care, and as we move into our 51st year, we continue to shape the future of long-term care in Ontario with innovation, integrity, and a deep sense of purpose.

Quality is embedded in our culture. Our **Quality Matters** program guides our approach, ensuring that every resident receives care that is safe, timely, effective, and personalized. This framework supports continuous improvement and reinforces our commitment to evidence-based practices, routine evaluation, and industry-leading standards.

We recognize our role in supporting a health system that is sustainable, equitable, and focused on long-term wellness. Our work aligns with Ontario’s vision for a value-based universal health care system—one that prioritizes prevention, improves outcomes, reduces hallway medicine, and strengthens access to high-quality care for all Ontarians.

Our **2026/27 Quality Improvement Plan** reflects provincial annual priorities as well as corporate priorities identified across Omni Quality Living. It aligns with regional and provincial strategies and fulfills the requirements of the **Continuous Quality Improvement Initiative Report (CQIIR)** under section 168 of O. Reg. 246/22 of the *Fixing Long-Term Care Act, 2021*.

This plan also supports broader provincial goals: enhancing the health care experience through an integrated, resident-centered continuum of care, and collaborating with partners to build an accountable, high-performing system that reduces disparities and improves outcomes across diverse populations.

Access and Flow

Improving access and flow across Ontario’s health system continues to be a shared responsibility, and long-term care plays a vital role in ensuring residents receive the right care in the right place. Omni Quality Living remains committed to strengthening system capacity and

supporting smoother transitions for residents, families, and partners across the continuum of care.

- **Timely and Responsive Admissions**
All applications for admission are reviewed promptly and responded to in accordance with the *Fixing Long-Term Care Act*. We remain committed to ensuring that individuals waiting for long-term care receive timely decisions and clear communication.
- **Efficient Bed Management**
Available beds are reported to Ontario Health at Home without delay, and admissions are scheduled as soon as possible to support flow across hospitals, community settings, and long-term care.
- **Expanding Capacity Through Redevelopment**
We continue to redevelop existing homes, often adding new beds and licenses—and to build new homes in communities across Ontario. These investments support provincial efforts to increase long-term care capacity and reduce pressure on hospitals.
- **Nurse Practitioner–Led Outreach**
Nurse Practitioner outreach remains a key strategy in enhancing on-site clinical support, reducing avoidable transfers, and improving resident outcomes.
- **Reducing Unnecessary Emergency Department Transfers**
We continue to strengthen in-home clinical capabilities, early intervention strategies, and staff education to minimize avoidable transfers to emergency departments.
- **Enhanced On-Site Diagnostics**
Partnerships with local health agencies enable more facility-based services such as X-ray, ultrasound, and laboratory testing—improving access to timely diagnostics and reducing the need for off-site appointments.
- **Improving Transitions Through Technology**
We continue to advance our use of digital tools to support safe, accurate, and efficient communication with external health partners.
- **Strengthening Medication Reconciliation**
Many of our homes have adopted the pharmacist-led “Boomer Process” for first-time admissions, ensuring accurate medication reconciliation and safer transitions into long-term care.

Technology

Strengthening digital connectivity across the health system remains essential to improving access, flow, and resident safety. Omni Quality Living continues to expand the use of technology to support accurate, timely, and coordinated transitions of care.

- **Maximizing PointClickCare**
PointClickCare remains our core clinical information system. We continue to leverage its advanced capabilities, including analytics, dashboards, and real-time reporting—to

support early identification of risk, improved care planning, and stronger communication across the continuum of care.

- **HealthConnex Integration**

HealthConnex supports secure, streamlined information exchange between long-term care and acute care partners. Expanded use of this platform reduces delays, improves accuracy of shared information, and supports more efficient transitions.

- **Optimizing CHRIS**

CHRIS remains essential for communication with Ontario Health at Home and community partners. Consistent use supports timely referrals, accurate documentation, and smoother transitions for residents entering or leaving long-term care.

- **Driving Compliance Through CHeCS**

CHeCS transforms regulatory complexity into operational clarity. This mobile-first, AI-enabled platform standardizes compliance workflows, reduces incident logging time, manages staff training and certifications, and supports adherence to the *Fixing Long-Term Care Act*. By reducing administrative burden, CHeCS enables staff to focus more time on resident care.

- **Advancing Interoperability Through Amplify**

All Omni homes continue to use Amplify to support safer transitions by connecting clinical data systems between long-term care and acute care. This integration reduces the risk of medication discrepancies, treatment errors, and information gaps during transfers.

Together, these digital tools strengthen our ability to deliver safe, coordinated, and efficient care while supporting broader provincial goals for a more connected and higher-performing health system.

Resident and Family Experience

A positive resident and family experience is central to high-quality long-term care. It reflects every interaction resident and family have within our homes—from daily care and communication to access to information and involvement in decision-making.

At Omni Quality Living, the voices of residents and families guide our quality improvement efforts. We are committed to creating an environment where each person's preferences, needs, and values shape the care they receive.

Resident Experience Survey

We partner with **Metrics at Work**, an independent organization that administers and analyzes our annual Resident Experience Survey. This survey focuses on two key indicators:

- How well residents feel staff listen to them.
- Whether residents feel they can express their opinions without fear of consequences

Survey results provide valuable insight into the lived experience of residents and families. Findings are used to identify opportunities for improvement, guide action planning, and celebrate strengths. Results are shared openly to promote transparency and accountability.

Our goal remains clear: to ensure every resident experiences compassionate, respectful, and individualized care, supported by strong partnerships with families and caregivers.

Provider Experience

A strong provider experience is essential to delivering exceptional resident care. At Omni Quality Living, we are committed to being a workplace where people feel respected, supported, and inspired—across all roles, generations, and career stages.

- **Recruitment, Retention, and Workforce Development**
We actively recruit and retain qualified candidates while investing in the next generation of long-term care professionals. Our corporate education coordinator strengthens partnerships with colleges and universities, coordinates student placements, and supports preceptorship opportunities.
- **Success Through PREP LTC**
The PREP LTC initiative has strengthened our ability to support students and new graduates by enhancing preceptor training, improving onboarding, and building confidence among staff who take on mentorship roles. This has contributed to stronger multigenerational teams and a more supportive learning environment.
- **Commitment to Learning and Growth**
We offer bursaries for continuing education, certifications, and skills training, recognizing that investing in our people strengthens both care quality and job satisfaction.
- **Creating a Supportive Workplace**
A positive provider experience includes moments of connection, recognition, and joy. Our homes regularly host appreciation events, celebrations, and team-building activities. Every employee also receives a holiday gift card as a gesture of gratitude for their dedication.

Safety

Safety is the foundation of high-quality care. At Omni Quality Living, we view safety as a whole-person commitment that includes physical, emotional, psychological, and social well-being.

Whole-Person Safety

Our approach is grounded in a biopsychosocial understanding of health. We focus on:

- **Physical safety:** Strong IPAC practices, fall prevention, medication safety, and safe clinical procedures.
- **Emotional and psychological safety:** Trauma-informed approaches, respectful communication, and environments free from fear or intimidation
- **Social safety:** Supporting meaningful relationships, reducing isolation, and fostering belonging.

A Culture of Staff Safety

A safe home depends on a safe workplace. We support staff through:

- Clear protocols and training
- Access to tools and technology that reduce risk.
- A culture of open reporting and psychological safety
- Respectful, inclusive environments that promote teamwork.

Learning and Continuous Improvement

We encourage open reporting of incidents and near misses and use this information to guide improvements. Digital tools support consistent documentation, timely communication, and effective follow-up.

Partnering With Residents and Families

Residents and families play an essential role in safety. Their insights help identify risks, improve communication, and strengthen care planning.

Palliative Care

Palliative care at Omni Quality Living is grounded in dignity, comfort, and whole-person support. Our approach enhances quality of life for residents living with progressive, life-limiting illnesses while providing meaningful guidance to families.

Resident-Centered and Culturally Responsive Care

Care plans reflect each resident's physical, emotional, social, psychological, and spiritual needs. From admission, we complete additional assessments to support culturally appropriate advance care planning.

Support for Families

Families are essential partners. We provide education, emotional support, and practical guidance to help them navigate the palliative journey.

Holistic Comfort and Well-Being

Our teams focus on:

- Pain and symptom management
- Emotional and psychological support
- Social connection and belonging
- Spiritual care aligned with personal beliefs

Care in Place

Whenever possible, we provide palliative care within the home to reduce unnecessary hospital transfers and support comfort in familiar surroundings.

A Compassionate, Coordinated Experience

Our approach ensures personalized care, continuity, comprehensive support, and a focus on comfort, dignity, and peace.

Population Health

Long-term care plays a vital and often underrecognized role in improving population health. Omni Quality Living contributes to healthier communities by supporting older adults with complex needs, preventing avoidable hospital use, and promoting well-being across the continuum of care.

- **Supporting Aging Populations with Complex Needs**
We provide stable, comprehensive, 24-hour care for individuals with chronic conditions, cognitive impairment, mobility challenges, and social vulnerabilities—reducing strain on hospitals and community services.
- **Promoting Wellness and Prevention**
Our teams focus on early identification of health changes, chronic disease management, fall prevention, nutrition and hydration, and social engagement.
- **Reducing Health System Pressures**
By providing high-quality care in place, we help reduce avoidable ED visits, unnecessary hospital admissions, ALC pressures, and harmful transitions.
- **Equity and Inclusion**
We support residents from diverse cultural, linguistic, and socioeconomic backgrounds and ensure care is respectful, inclusive, and aligned with individual values.
- **Strong System Partnerships**
We collaborate with hospitals, primary care, Ontario Health Teams, community agencies, and specialized services to support coordinated care and improved transitions.

- **Data-Informed Decision-Making**
We use clinical data, quality indicators, and resident experience feedback to guide improvement and target interventions.
- **Enhancing Quality of Life**
Population health is about living well. We prioritize meaningful engagement, purposeful activities, social connection, and emotional well-being.

Alignment With the Fixing Long-Term Care Act and CQIR Requirements

Omni Quality Living's 2026/27 Quality Improvement Plan fully aligns with the *Fixing Long-Term Care Act, 2021* and the **Continuous Quality Improvement Initiative Report** requirements under O. Reg. 246/22.

1. Systematic Approach to Continuous Quality Improvement

Our plan uses a standardized, evidence-informed framework supported by:

- Clinical indicators
- Resident experience surveys
- Safety reports
- Staff feedback

2. Annual Priorities and Targets

- Aligns with provincial priorities
- Includes home-level and corporate-level indicators
- Uses data from PCC, HealthConnex, CHRIS, CHeCS, and surveys
- Sets realistic, evidence-based targets

3. Resident, Family, and Caregiver Engagement

- Use independent Resident Experience Surveys
- Incorporate Resident and Family Council feedback
- Share results and action plans publicly
- Embed resident voice in care planning and safety initiatives

4. Staff Engagement and Provider Experience

- Strengthen workforce development
- Support multigenerational teams
- Promote psychological safety and open reporting

- Encourage staff participation in QI activities

5. Monitoring, Reporting, and Evaluation

- Use real-time data systems
- Conduct audits and interdisciplinary reviews
- Track trends in safety and outcomes
- Report progress to leadership, residents, families, and the public

6. Integration With the Broader Health System

- Strengthen partnerships with hospitals, OHTs, and community agencies
- Use digital platforms to improve transitions
- Support system flow and reduce avoidable transfers
- Contribute to population health and equity

7. Commitment to Resident Safety

- Use a biopsychosocial approach
- Strengthen IPAC, emergency preparedness, and violence prevention
- Encourage open reporting
- Implement technology-enabled safety systems

8. Public Transparency

- Share QI priorities and results openly
- Maintain clear, accessible documentation
- Demonstrate accountability through visible action

Access and Flow

Measure - Dimension: Efficient

Indicator #2	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)	X	0.00	Our goal is to maintain a rate of 0% of avoidable ED visits over the year 2026	Ross Memorial Hospital

Change Ideas

Change Idea #1 A new Nurse Practitioner was onboarded in December 2025. The home will utilize the homes in house Nurse Practitioner as well as the NP STAT program to assist in ensuring meeting the goal of 0% avoidable ED visits for 2026.

Methods	Process measures	Target for process measure	Comments
The home will monitor and track resident incidents that were managed in home by Nurse Practitioner that avoided and ED visit.	The home will review all ED visits monthly at QI meetings to ensure a plan is in place for any ED visits that were avoidable. This rate of residents sent to the ED room will be evaluated monthly.	0% of residents transferred to the ED over 2026 will be avoidable ED visits.	

Change Idea #2 Review transfer to hospital process with all nursing staff quarterly at staff meetings.

Methods	Process measures	Target for process measure	Comments
Nurses will follow a process to ensure proper steps are taken prior to transfer to hospital. Ensuring MRP s contacted, POA is contacts and residents advanced care directive is followed.	The home will review all ED visits monthly at QI meetings to ensure a plan is in place for any ED visits that were avoidable.	There will be 0 incidents of missed processes related to transfers to ED over the next quarter to ensure the home meets target for this indicator.	

Equity

Measure - Dimension: Equitable

Indicator #3	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	Frosts target date for 100% complete EDI learning modules by June 1st, 2026. Frost Manors current compliance with surge module on EDI is 100% for active staff for 2025	

Change Ideas

Change Idea #1 Frost Manor which is a subsidiary of Omni Quality Living has many plans to increase the amount of staff and managers alike who have taken and subsequently completed a relevant equity, diversity, inclusion and anti-racism course/education. 1) We are currently working with Omni Head Office to ensure that we are following the most recent policies and procedures in relation to E.D.I. Also as the program evolves, any new programs or initiatives that Frost Manor can potentially take part in, including education, will be implemented. 2) Frost Manor has been utilizing Surge Learning as an external education partner. There are courses that are being added to this platform through head office which then go out to all staff members. 3) A vast majority of Frost Manor Leaders (managers) have attended in-service speakers / classes pertaining to EDI. This education continues. 4) Frost Manor endeavors to continue to promote EDI within our Home. To that end the inclusion of specific informative calendars and other educational based tools will be utilized within the Home

Methods	Process measures	Target for process measure	Comments
Frost Manor will utilize Surge Learning tracking to observe the completion of each educational course that is offered in relation to E.D.I. This tool in conjunction with engagement with Omni Quality Living Head Office to ensure that new toolkits/information posters etc are utilized within the Home as they are devised.	All of the planned improvement changes can be measured in various ways. Surge Learning instances are measured within the program and that data can be used to make sure that each staff member has received the required training. Further, through staff meetings and open-door policy, questions and feedback can be fielded and subsequently documented by the management team.	TO ensure that the home is in 100% compliance with E.D.I education in the upcoming year	

Experience

Measure - Dimension: Patient-centred

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
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	95.00	100.00	(Actual current performance is 93.4%) Frost Manors goal is to increase our performance in this area by approximately 6.6% over the next year.	

Change Ideas

Change Idea #1 #1) Frost Manor would like all residents to feel as if they can speak about anything they would like and that our staff will listen. Increased education on various diagnosis for our staff would be an avenue that could be taken such as GPA. Staff are more informed; they can relay that knowledge to real life scenarios. 2) Focus on having more information given to residents and family members RE: completing the survey. There were a few individuals who did not provide an answer for this indicator and we would like to increase same so that we can have a more accurate indication for this metric. 3) Continue to encourage open communication between staff and residents as well as an open door policy for residents to communicate with management. This way, depending on the topic at hand a resident can feel heard by speaking to or being directed to speak to the most assistive individual for the scenario. 4) Increased focus on communication and concerns surrounding communication at residents council meetings

Methods	Process measures	Target for process measure	Comments
Metrix @ Work - OMNI Quality Living Resident Experience Survey was completed in August of 2025. This Survey was completed by residents, families and life enrichment staff (for those residents who were not comfortable with a computer) in August of 2025. Our goal is to increase our percentage and have 100% of residents complete the survey. In 2025 our percentage of participation was 90.9%. Therefore, we endeavor surpass to 44/44 residents completing the survey or 100%	Continue with Metrics@Work surveys for 2025 and work with our QI plan with our team/home to continue to improve.	Our aim at Frost Manor is to improve from our currently reported 93.40% (from August 2025) of residents responding positively to: Percentage of residents who responded positively to the statement: "What number would you use to rate how well the staff listen to you". The next survey is scheduled to be completed in 2026	Total Surveys Initiated: 40

Measure - Dimension: Patient-centred

Indicator #5	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	90.91	98.00	(Actual current performance 91.4%)Frost Manors goal to eventually have all residents answer positively with this question and in order to hit that milestone, there must be achievable and attainable markers to indicate if changes are efficient.	

Change Ideas

Change Idea #1 Our change idea for 2026 is to provide more clear instructions for residents, and for families to allow residents to answer for themselves. We provided iPads for all residents and families to complete as well as using email for our families and residents who preferred this method. 2) Another improvement initiative is to have more residents complete the survey. Frost Manor endeavors to complete this by having more interaction with the residents and their families during the survey completion times. This way more help is available if there are any questions or concerns. 3) We want to ensure that residents opinions and thoughts are competently understood and that the residents themselves feel empowered to speak. To that end we will have a renewed focus on residents council meetings and making sure that any concerns that are brought up are addressed. 4) Increased communication with family members/POAs. Frost Manor does a great job at communicating changes to residents, POA's/family members and is able to follow through with any concerns about said changes. However there are occasionally times where a concern is not related to a change. Therefore Frost Manor endeavors to get in touch with all families during the course of a year to ensure that there are no other concerns that they have not brought forward at that time. This should also theoretically increase general rapport so that POA's also utilize the open door policy that we have here at Frost Manor.

Methods	Process measures	Target for process measure	Comments
Metrix @ Work - OMNI Quality Living Resident Experience Survey was completed in August of 2025. This Survey was completed by residents, families and life enrichment staff (for those residents who were not comfortable with a computer) in August of 2025. 40/44 Surveys were completed, or 90.3% of the population in August of 2025. Our goal is to increase our percentage and have 100% of residents complete the survey. We endeavor to surpass to 44/44 residents completing the survey or 100%	Continue with Metrics@Work surveys for 2025 and work with our QI plan with our team/home to continue to improve.	Our aim at Frost Manor is to improve from our currently reported 91.4% (from August 2025) of residents responding positively to: Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences". The next survey will be completed in 2026	Total Surveys Initiated: 44

Change Idea #2 Our change idea for 2026 is to provide more clear instructions for residents, and for families to allow residents to answer for themselves. We provided iPads for all residents and families to complete as well as using email for our families and residents who preferred this method. 2) Another improvement initiative is to have more residents complete the survey. Frost Manor endeavors to complete this by having more interaction with the residents and their families during the survey completion times. This way more help is available if there are any questions or concerns. 3) We want to ensure that residents opinions and thoughts are competently understood and that the residents themselves feel empowered to speak. To that end we will have a renewed focus on residents council meetings and making sure that any concerns that are brought up are addressed. 4) Increased communication with family members/POAs. Frost Manor does a great job at communicating changes to residents, POA's/family members and is able to follow through with any concerns about said changes. However there are occasionally times where a concern is not related to a change. Therefore Frost Manor endeavors to get in touch with all families during the course of a year to ensure that there are no other concerns that they have not brought forward at that time. This should also theoretically increase general rapport so that POA's also utilize the open door policy that we have here at Frost Manor.

Methods	Process measures	Target for process measure	Comments
Metrix @ Work - OMNI Quality Living Resident Experience Survey was completed in August of 2025. This Survey was completed by residents, families and life enrichment staff (for those residents who were not comfortable with a computer) in August of 2025. 40/44 Surveys were completed, or 90.3% of the population in August of 2025. Our goal is to increase our percentage and have 100% of residents complete the survey. We endeavor to surpass to 44/44 residents completing the survey or 100%	Continue with Metrics@Work surveys for 2025 and work with our QI plan with our team/home to continue to improve.	Our aim at Frost Manor is to improve from our currently reported 91.4% (from August 2025) of residents responding positively to: Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences". The next survey will be completed in 2026	

Safety

Measure - Dimension: Effective

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Number of agency staff used to cover unfilled shifts in the home	C	Shifts / Staff	In-home audit / 2025	729.00	0.00	Frost Manor and Omni have set a goal to completely eliminate agency use for staffing buy the end of 2026 to ensure continuity of care through recruitment and retention of our own staff.	

Change Ideas

Change Idea #1 Frost Manor and Omni as a whole has a goal to completely eliminate agency use by the end of 2026. To do this the home will work on the recruitment and retention plan. The home will also continue to work with local colleges for student placement to assist with recruitment and retention. Contingency plans are reviewed annually incase of staffing shortages and will indicate how staff are to work when there is a staffing shortage.

Methods	Process measures	Target for process measure	Comments
The QI team will monitor agency use each month at team meetings and implement further intervention when any identified concerns arise. As there are vacancies available the management team will ensure the job is posted and filled in a timely manner to eliminate the possibility of an unfilled shift.	Number of agency staff used will be reviewed by the QI team monthly	The home utilized agency for a total of 729 shifts over the year 2025. Frost Manors goal is to decrease eliminate agency use in the home by 50% by June of 2026 and eliminate agency use completely by December of 2026	

Measure - Dimension: Safe

Indicator #6	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	13.49	10.00	Frost Manors goal is to continue to remain below the provincial average related to this metric. It would be beneficial to be able to further lower our percentages while we maintain our current level below the provincial average	

Change Ideas

Change Idea #1 In order to remain below the provincial average of 17.2% Frost Manor endeavors to focus on the following areas of potential improvement. 1) Frost Manor currently has a very active multidisciplinary falls team that looks at ways to decrease falls in general but also looks at ways to mitigate harm to residents if there is a prevalence for falls. Frost Manor will continue to utilize this team and look at ways within same to increase efficiency. 2) Frost Manor endeavors to grow its current falls team by adding more frontline staff members. This will grow the interprofessional team and will provide further insight on the day to day life of an individual resident. With this increase to the team it is hypothesized that there will be better individualized care provided. 4) Increased focus on education for all staff members at Frost Manor. Currently many staff are aware of interventions set in place for specific residents. Frost Manor endeavors to increase knowledge on specific apparatuses / fall prevention items in order to better facilitate engagement and ideas from all staff members.

Methods	Process measures	Target for process measure	Comments
Frost Manor will continue to use Quality Improvement metrics to indicate if current interventions are effective at decreasing the percentage of residents who fell in the 30 days leading up to their assessment. Further, data collected by the current Falls Team will also be a great method of tracking the effectiveness of the initiatives.	The process measure that will be used in this instance will be the percentage of LTC Home residents who fell in the 30 days leading up to their assessment. This will be the number one indicator of the effectiveness of the aforementioned change initiatives.	Our current metric of 13.49% remains below the provincial average of 17.2%. We want to ensure that we remain below this threshold and also endeavor to push ourselves even further to attempt to decrease this number to 10.00% over the next year.	

Measure - Dimension: Safe

Indicator #7	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	17.86	16.00	Frost Manor is currently recorded at 17.86% of residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment, in 2025. For the next year Frost Manors goal is to remain below the provincial average of 18.99% while continuing to monitor and decrease the use of antipsychotics without a diagnosis.	

Change Ideas

Change Idea #1 #1) Increased education and subsequent efficiency of DOS tracking systems utilized in Frost Manor. Increased instances of one:one, group huddles and group training / reminders to front line staff surrounding DOS tracking. Registered staff will also be included to ensure that direction and/or questions can be answered competently. Change idea #2: Increased communication as a whole. Stress the importance of same with all staff to increase the quantity and quality of communication within Frost Manor. Change Idea #3: Reminders/education as needed for registered staff, including registered agency staff to review medication orders to evaluate if an order needs to be reassessed. Change Idea #4: The home now has a RN supervisor role on days which is new. This RN can assist with monitoring medication use and behaviors and ensure clear communication with physicians regarding medication needs/requirements.

Methods	Process measures	Target for process measure	Comments
Data is collected in the home monthly and metrics are completed quarterly and sent to CE LHIN BSO program for continuation of funding. Metrics are discussed at our monthly QI meeting and Registered Staff Practice Meetings regarding those residents on our BSO program and those receiving antipsychotic medications. Further Metrics are also discussed at certain staff/group huddles.	At this time Frost Manor has 42/44 - Residents to beds. Of these 44 residents, 17.89% triggered the parameters as "being on an antipsychotic without a corresponding diagnosis" indicating that during the look back period 17.89% of residents who are utilizing a psychotropic medication did not display indicators of hallucinations, delusions or Huntington's disease. The provincial average is currently 21.9% which places Frost Manor 4.01% below the provincial average. Frost Manor endeavors to remain below the provincial average to ultimately lower our average even further. BSO and RAI teams will be vital in this endeavor as a large percentage of residents who come to Frost Manor are already prescribed anti-psychotic medications. Also ensuring that we capture the need for the medication, or subsequently ensuring we capture that a resident does not need a specific medication is also very important to ensuring that we are maintaining or improving our residents quality of life	Our target is to surpass our current metrics, which are 4.01% below the provincial average. With the vast majority of our residents having a diagnosis of dementia this will be an interprofessional endeavor. We believe that by achieving this target we can subsequently ensure that we are maintaining and improving the quality of life of our residents while giving them a sense of hope, belonging and purpose.	

Measure - Dimension: Safe

Indicator #8	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	4.00	2.00	Frost Manors goal is to decrease this indicator by 2% to ensure the home remains under the provincial average.	

Change Ideas

Change Idea #1 1 manager and 1 staff have recently been enrolled in the SWAN program to further assist with enhancing the homes staff education regarding wound care. This will assist it quick corrective action for any challenging wounds that the home has.

Methods	Process measures	Target for process measure	Comments
The clinical care coordinator and wound care champions will monitor all residents skin conditions closely daily and ensure early intervention is implemented to prevent worsening of pressure injuries. Monthly wound audits will be completed and assessed by wound care champions to ensure all correct interventions are in place.	The percentage of residents whose pressure ulcer worsened will be monitored monthly by the QI team as well as monthly at the wound care team meetings	With the homes newly trained staff the home aims to have 0% residents with worsened stage 2-4 pressure ulcers.	

Change Idea #2 The home is currently working on having air surfaces applied to all residents' beds, so that there can be quick intervention when an air surface is required. The nurse would just need to attach the pump and start the air surface

Methods	Process measures	Target for process measure	Comments
Each month the wound care lead will monitor all skin conditions and ensure this intervention has been implemented as an early intervention for further skin breakdown for all residents.	At each monthly QI meeting the QI team will review the statistics and implement any further monitoring to ensure the home is meeting the goal of 0% of worsened pressure ulcers.	Frost Manors aim is to have 0% of residents with a worsened stage 2-4 pressure ulcer	javascript:__doPostBack('ctl00\$maincontent\$btnSaveClose','')

Measure - Dimension: Safe

Indicator #9	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	0.00	0.00	Frost Manors goal is to maintain a 0% average of restraints in the home.	

Change Ideas

Change Idea #1 The home will continue to follow the least restraint last resort policy to limit restraint use in the home

Methods	Process measures	Target for process measure	Comments
Continue to follow the homes policy on restraints and use as a very last resort. Utilize alternatives such as BSO, pharmacy and MRP support to ensure all other options have been utilized.	The number of restraints used each quarter will be monitored monthly by the QI team	Frosts goal is to continue to have 0% restraints over the next year	

Access and Flow | Efficient | Optional Indicator

Indicator #6	Last Year		This Year		
	Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)
Rate of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents. (Frost Manor)	16.00	12	X	--	0

Change Idea #1 Implemented Not Implemented In Progress

Frost Manor endeavors to work closer with the NPSTAT team over the next year.

Process measure

- The Home will utilize the amount of ED visits as a process measure as we move through the year to determine if there is a positive change related to this change idea. Increased communication with MRP and MD from Registered Staff within the Home. Work with any agency Registered staff to ensure that they also understand the importance of communication and the use of the NPSTAT team to decrease ED visits.

Target for process measure

- We plan to have an increased percentage of interaction with the NPSTAT team for this change idea. Also endeavor to have any Agency and new staff orientated to this process so that there are no deviations or potential increases to this metric.

Lessons Learned

The NPStat was utilized multiple times over the year 2025 and was successful

Change Idea #2 Implemented Not Implemented In Progress

Increased focus on using mobile teams within the community such as x-ray and ultrasound.

Process measure

- The Home will look at the number of times that an issue arises that can be competently satisfied by using a mobile team.

Target for process measure

- The Home will continue to attempt to use mobile teams instead of sending residents to the hospital when it comes to activities that they can complete, such as x-ray and ultrasound. We would like to endeavor to have a metric of above 85% use of mobile teams, taking into consideration variables that could decrease this number (POA request, nature/urgency of the need etc.)

Lessons Learned

Mobile x-ray and ultrasound have been helpful in limiting transfers. Focus on the update policy around follow up has also been helpful

Change Idea #3 Implemented Not Implemented In Progress

Promote health teaching to newly hired Registered Staff and agency staff, specifically to this measure.

Process measure

- The main process measure will be an overall decrease in ED visits from the Home. With a caveat of a 100% rate of communication with either the MRP, NPSTAT or both

Target for process measure

- 100% rate of communication with MRP and/or NP to deviate from an ER visit by the end of the year.

Lessons Learned

Biweekly staff meeting for education have assisted with education around transfers to hospital. Reviewing the process prior to transfer with all registered staff

Change Idea #4 Implemented Not Implemented In Progress

Potential to have increased support from dedicated Nurse Practitioners through the Nurse Practitioner Initiative - Hiring More Nurse Practitioners for LTC (HMNP for LTC)

Process measure

- Apply for the program and set up interviews for potential NPs that want to fill this role.

Target for process measure

- Hire a new NP for this role with the secondary target of decreasing ED visits

Lessons Learned

A new NP was hired in December 2025 for the home and has been successful in assisting limiting transfers.

Comment

Continue to provide education on the steps to take before transferring resident to the hospital/ Utilize NP STAT and the homes NP to complete assessment where possible.

Access and Flow | Efficient | Custom Indicator

	Last Year		This Year		
Indicator #7	77.10	90	84.70	--	NA
Sufficient Life Enrichment programs / activities are offered in the evenings (Frost Manor)	Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

Change Idea #1 Implemented Not Implemented In Progress

New activities to be developed over the course of the next year

Process measure

- Family and resident satisfaction will be measured. Audits can be completed to determine if residents are satisfied with the changes

Target for process measure

- in relation to this indicator Frost Manor is looking to increase this metric by 12.9% to reach 90% by the end of the year. In relation to this improvement initiative we are looking at increasing both the quantity and quality of programs offered in the evening.

Lessons Learned

The LEC department was able to implement changes to the programs

Change Idea #2 Implemented Not Implemented In Progress

Resident feedback on various games / activities / entertainment that would be beneficial in the evening.

Process measure

- Increased communication with residents and getting the residents input into the specific activities that they would like in the evening

Target for process measure

- in relation to this indicator Frost Manor is looking to increase this metric by 12.9% to reach 90% by the end of the year. In relation to this improvement initiative we are looking at having increased interaction and feedback from the Residents of the Home and then attempting to implement these ideas.

Lessons Learned

This was discussed at resident council and family council and new programs were put into place as well as volunteer requirement and SSM adjusting hours.

Change Idea #3 Implemented Not Implemented In Progress

Staff Recruitment and Retention

Process measure

- Staffing levels should represent the methodology of this change idea, in the fact that all available staff lines are filled.

Target for process measure

- 100% of available lines in this department are filled

Lessons Learned

There have been many challenges with recruiting in this department

Change Idea #4 Implemented Not Implemented In Progress

Increased Obie Projector Usage

Process measure

- With the usage of the projector we could have more interaction in the evenings with activities

Target for process measure

- Frost Manor aims to have an increase of 25% of this device over the next year

Lessons Learned

This has been challenging as there have been difficulties with the Obie projector

Change Idea #5 Implemented Not Implemented In Progress

Residents council representee offered to complete a weekend afternoon program for the residents such as bingo

Process measure

- No process measure entered

Target for process measure

- No target entered

Lessons Learned

This was implemented and went well.

Comment

SSW has altered on shift every other Friday to assist with evening programming and volunteers were onboarded to assist with evening and weekend programming

Indicator #5	Last Year		This Year		
	Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education (Frost Manor)	100.00 Performance (2025/26)	100 Target (2025/26)	100.00 Performance (2026/27)	0.00% Percentage Improvement (2026/27)

Change Idea #1 Implemented Not Implemented In Progress

Frost Manor has been utilizing Surge Learning as an external education partner. There are courses related to EDI that are being added to this platform through head office which then go out to all staff members to complete.

Process measure

- Monitor the percentage completion of these courses within Surge Learning.

Target for process measure

- Remain with 100% completion rate for Frost Manor

Lessons Learned

Surge learning modules have been a great way for staff to independently at their own pace learn more about DEI and how it is implemented at Frost Manor

Change Idea #2 Implemented Not Implemented In Progress

Managers continue to build on their knowledge base RE: EDI through guest speakers at the annual Forum.

Process measure

- Continue to have managers attend the Forum and observe feedback from same.

Target for process measure

- In order to continue with our current 100% completion/compliance rate, we will continue to have managers attend the Forum that Omni Quality Living sets up.

Lessons Learned

managers found this helpful in bringing these ideas back to the home and have suggested this be an ongoing education

Change Idea #3 Implemented Not Implemented In Progress

Continue to promote EDI within the Home via the Homes Resident Council and Family Council meetings.

Process measure

- Continue to provide education to these groups. The Home is looking for increased engagement within the Family Council and Resident Council meetings.

Target for process measure

- Speak to EDI at each Resident Council and Family Council meeting.

Lessons Learned

This is a conversation at meetings and has been successful in helping families and residents understand

Change Idea #4 Implemented Not Implemented In Progress

Frost Manor endeavors to continue to promote EDI within our Home. To that end the inclusion of specific informative calendars and other educational based tools will continue to be utilized within the Home.

Process measure

- With the usage of the Calendars within the Home, we can measure how well staff members and residents are participating. This can also open up communication and subsequent education surrounding various events.

Target for process measure

- It is the endeavor of the Home to see this process implemented fully and interacted with by more staff and residents over the next year.

Lessons Learned

LEC continues to complete programing and activities around this calendar and has been successful

Comment

The home is always learning and growing around DEI and continues to focus strongly on providing this education on going to staff.

Experience | Patient-centred | Optional Indicator

	Last Year		This Year		
Indicator #3	97.14	99	95.00	-2.20%	100
Percentage of residents responding positively to: "What number would you use to rate how well the staff listen to you?" (Frost Manor)	Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

Change Idea #1 Implemented Not Implemented In Progress

Staff education has been a focus for the Home, however increased education, specifically pertaining to disease diagnosis such as dementia can assist in ensuring that residents feel heard.

Process measure

- Have increased staff attendance and participation in staff meetings. Utilize the BSO board to provide further opportunities for education.

Target for process measure

- Have an increase of 20% of staff members attending staff meetings over the next year. Implement a further focus on BSO education.

Lessons Learned

All staff were trained for GPA, maintaining this going forward is a priority. Coaching staff on the spot has also assisted with this

Change Idea #2 Implemented Not Implemented In Progress

Continue to promote communication between staff and residents as well as promote the Home's open-door policy for residents and POAs to communicate with managers.

Process measure

- Observe to see if we can have an increase in attendance at both of these meetings, as well observe to see if we have increased interaction with staff, residents and managers alike.

Target for process measure

- Frost Manor is currently at a 97.14% for this metric, however if we can increase this number over the next year via this change idea, that would be beneficial and subsequently shown in the percentage for the next annual survey.

Lessons Learned

At each multidisciplinary care conference this is discussed as well as follow ups from the SSM to check in and allow opportunities to express concerns. there was a period of time where the home did not have a SSM which may have contributed to the decrease in this area.

Change Idea #3 Implemented Not Implemented In Progress

Continue to work with Metrics at work and the annual survey to ensure that objective data is collected to assist in determining if these change ideas, once implemented are in fact, working.

Process measure

- We use the percentage that is produced with Metrics at work to assist in making changes within the Home. We want to make sure that all residents feel listened to.

Target for process measure

- Our target is to get to 99% for this metric from our current percentage.

Lessons Learned

This is helpful in recognizing where improvement is needed

Change Idea #4 Implemented Not Implemented In Progress

Frost Manor will also focus on having more information given to residents and family members RE: completing the survey. There were a few instances where answers were not provided and we would like to increase the amount of answers so that we can have a more accurate indicator of same.

Process measure

- We would like to increase our number of surveys completed in the year, also increasing the amount of questions that we can answer for clarification. Decreasing the amount of "unknown" answers that are submitted.

Target for process measure

- For this indicator we aim for 99% by the end of the year - that residents feel listened to.

Lessons Learned

Education was provided through email and there was an increase in surveys completed

Comment

Continue to have managers present on the floor with the residents so that they are always comfortable with bringing concerns forward.

	Last Year		This Year		
Indicator #4	90.91	95	90.91	0.00%	98
Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences". (Frost Manor)	Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

Change Idea #1 Implemented Not Implemented In Progress

Have an increase in surveys that are completed by residents and/or family members assisting.

Process measure

- Overall for this initiative we want to increase our overall participation with the Survey so that we can have more data to make design decisions on.

Target for process measure

- The target for this process measure is 95% and the goal of this change method is to increase the overall participation and decrease the amount of "unknown" answers

Lessons Learned

Providing follow up with families was helpful in having an increase in this area

Change Idea #2 Implemented Not Implemented In Progress

Renewed focus RE: residents opinions and thoughts are competently understood and that our residents themselves feel empowered to speak or bring up concerns.

Process measure

- We would like to have an increase in communication from residents, specifically at resident council meetings. This is in effort to make residents feel that there are no consequences to same.

Target for process measure

- The target for this process measure/indicator is 95% and the goal of this change method is to increase resident, staff and management relationships even further then they are now.

Lessons Learned

Reminders of this at residents council and multidisciplinary meetings was helpful

Change Idea #3 Implemented Not Implemented In Progress

Increased communication with Family members/POAs, so that they also feel free to express their opinions without fear of consequence.

Process measure

- We are looking to increase our overall rating of the metric - "I can express my opinion without fear of consequences". This is a multifaceted endeavor as we discussed in a previous change idea RE: increased communication with residents.

Target for process measure

- The target for this process measure is 95% and the goal of this change method is to increase communication with family members and/or POAs to ensure that they also feel comfortable expressing their opinions to staff and/or management

Lessons Learned

This was ongoing with the SSm which the home did not have from January of 2025-October of 2025. But this is currently in progress and has shown to be successful

Change Idea #4 Implemented Not Implemented In Progress

Continue to work with Metrics at work by completing annual surveys to ascertain if the change ideas are working proficiently

Process measure

- Using the results gathered from the yearly survey to see if there is a positive correlation with specific change ideas.

Target for process measure

- The target for this process measure is 95% and the goal of this change method is to maintain our usage of the survey and to analyze the results to ensure we are making positive changes.

Lessons Learned

This has shown to be effective so that the home can make changes.

Comment

Managers are now more present at residents' council and on the floor so that residents can openly express their concerns at the time they arise

Safety | Safe | **Optional Indicator**

Indicator #1	Last Year		This Year		
	Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)
Percentage of LTC home residents who fell in the 30 days leading up to their assessment (Frost Manor)	17.47	10	13.49	22.78%	10

Change Idea #1 Implemented Not Implemented In Progress

Frost Manor will continue to utilize our in house, interprofessional falls team to provide education and interventions when needed for residents with increased falls risk.

Process measure

- Find ways to better utilize the team, specifically from a preventative / upstream approach

Target for process measure

- Our target for this process measure is to decrease the percentage of falls related to this metric to 13.5% or better. In regards to this planned initiative we would like to see less falls overall within the Home.

Lessons Learned

Ensuring scheduling meetings on dates where the entire interdisciplinary team can be present has assisted in clear communication and understanding of residents needs and care plan updates

Change Idea #2 Implemented Not Implemented In Progress

Frost Manor would like to increase the size of the Falls Team, specifically by attempting to introduce more PSW / Frontline staff members to same.

Process measure

- Increase the amount of individuals that attend the interdisciplinary falls team meetings by one.

Target for process measure

- Our target for this process measure is to decrease the percentage of falls related to this metric to 13.5% or better. In regards to this planned initiative we would like to see more PSW staff attend these meetings and find ways to improve the overall efficiency of these meetings.

Lessons Learned

The home has had challenges in getting front line staff to join the team. Team lead continues to try and provide further insight to gain interest to front line staff

Change Idea #3 Implemented Not Implemented In Progress

Utilization of falls prevention funding for equipment

Process measure

- DOC will submit invoices and review budget monthly. DOC will review falls rates monthly. Falls team will discuss all of these changes during their monthly meetings.

Target for process measure

- Increased utilization of falls prevention equipment will decrease falls by 7.5% (17.5% to 10%) over the next quarter

Lessons Learned

The home purchased falls prevention alarms to assist with decreasing the number of falls

Change Idea #4 Implemented Not Implemented In Progress

PCC utilization has been initiated and includes a more streamlined assessment tool which provides risk management analysis on all falls.

Process measure

- DOC and ED will review Surge learning stats and orientation package completion. Health teaching provided as needed for staff related to PCC and falls.

Target for process measure

- 100% staff trained on orientation and as required on Post falls Policy 100% compliance with falls prevention education on surge learning completed annually

Lessons Learned

Updates to PCC were made and were effective in streamlining documentation

Comment

The home will continue to ensure that each fall is reviewed as a team monthly. DOC continues to evaluate each fall through the Risk management tab and provides education for any areas of improvement.

	Last Year		This Year		
Indicator #2	18.75	15	17.86	4.75%	16
Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment (Frost Manor)	Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

Change Idea #1 Implemented Not Implemented In Progress

Increased education and subsequent efficiency of DOS tracking systems utilized by Frost Manor

Process measure

- increased rate of fully completed DOS's.

Target for process measure

- Frost Manor endeavors to achieve 100% DOS completion rate, in a competent presentable manner.

Lessons Learned

There were multiple education sessions regarding DOS completion. Without a BSO nurse it has been challenging to ensure follow up for DOS but a plan is in place.

Change Idea #2 Implemented Not Implemented In Progress

Reminders / education as needed for registered staff, including registered agency staff to review medication orders to evaluate effectiveness of same and if the order needs to be reassessed.

Process measure

- Overall decrease in antipsychotic administration, specifically without a diagnosis of psychosis.

Target for process measure

- we are currently at 18.75% and we would like to decrease to 15.00% overall. This means that this planned initiative would be put in place to contribute to that 3.75% differential.

Lessons Learned

Ongoing education continues to remind staff to ensure follow ups are completed with medication changes. It continues to be a challenge.

Change Idea #3 Implemented Not Implemented In Progress

Increased communication as a whole within the Home. This includes communicating changes that residents may be experiencing and care plan updates.

Process measure

- Increased attention to care plans, specifically behavioral related instances / situations. Increased communication as a whole within our staff / interprofessional healthcare team.

Target for process measure

- Overall an increase in communication related to the above topics. 100% completion of care plans and communication of same. This planned initiative will assist in the overall measure that we want to decrease the percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment

Lessons Learned

This change idea is always in progress as it has been challenging without the BSO nurse to ensure this communication is clear throughout the nursing team. Utilizing the Kardex and MD communication binder has been helpful in assisting with this

Change Idea #4 Implemented Not Implemented In Progress

A renewed focus on having staff engage with the BSO whiteboard.

Process measure

- Monitor how many staff read the information / health teaching provided. Increase the information available to read.

Target for process measure

- Increase the amount of staff that look at the board by 1-5 per week. Increase the amount of information that is included on the board for staff to read.

Lessons Learned

This has not been implemented due to not having a BSO nurse. Ther home continues to be hopeful that this will be implemented once a BSO nurse is onboarded,

Comment

The home is working on recruiting a BSO nurse to ensure the interventions in place to assist with change ideas can be implemented effectively.