Equity

Measure - Dimension: Equitable

Indicator #1	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	To ensure 100% of our staff continue to be educated and knowledgeable on equity, diversity, inclusivity and antiracism.	

Change Ideas

Change Idea #1 Regular and relevant mandatory education

Methods	Process measures	Target for process measure	Comments
Surge learning modules: 1. Cultural Competence and Indigenous Cultural Safety - 4 Part series 2. From Awareness to Action - 6 part series	Number of active staff (as of Dec. 31 2025) who have completed the required Surge modules	100% of active staff will have completed all required modules	Total LTCH Beds: 150

Change Idea #2 Home policies and procedures are considerate and inclusive to all cultures. Staff are trained and knowledgeable in all procedures.

Methods	Process measures	Target for process measure	Comments
Review of current policies using an equity lens Creation of new policies to address gaps Regular review of applicable policies by staff	Number of current policies reviewed using an equity lens Number of current policies revised using an equity lens Number of new policies to address gaps Number of active staff who reviewed pertinent policies	2 policies reviewed in 2025 1 new policy created in 2025 100% of active staff will review any pertinent policies	

Safety

Measure - Dimension: Safe

Indicator #2	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 Sep 30, 2024 (Q2), as target quarter of rolling 4-quarter average	14.74	12.00	While we are currently below the provincial average for falls (16.5%) we are working towards an ultimate goal of 9% or less (benchmark)	

Change Ideas

Change Idea #1 Regular and relevant online and in-person education and training on falls prevention to all staff

Methods	Process measures	Target for process measure	Comments
Surge learning modules - Preventing Falls in Long-Term Care for Clinical Team Members - Preventing Falls in Long-Term Care for Non-Clinical Team Members In person education session(s) on falls prevention topic	Number of total active staff (as of Dec.31, 2025) who have completed the online course(s) Number of in person sessions offered on falls prevention topic Number of Registered Staff attending in person session Number of Front Line Staff (PSW,HSS,TR) attending in person session	100% of total active staff will have completed the required online courses 1 in-person education topic in 2025 (may have multiple sessions) 75% of FT and PT Registered Staff 75% of FT and PT Front Line Staff	We always aim to meet or exceed our goals for in-person education, targets have been set at 75% in acknowledgement of the difficulties we are facing with HHR and staffing shortages - it can be difficult to backfill staff to attend, and short huddles while effective, can make it challenging to catch everyone.

Change Idea #2 Improved monitoring, review and analysis of falls stats/trends			
Methods	Process measures	Target for process measure	Comments
Utilize risk management module and reporting in PCC.	Number of Registered Staff trained to use the incident reporting module in PCC	100% of FT and PT Staff will be trained	PCC is new to Pioneer Ridge effective April 1, 2025.

Change Idea #3 Improved monitoring, review and analysis of falls stats/trends			
Methods	Process measures	Target for process measure	Comments
Best Practice Clinician and/or Falls Committee Lead will use the incident reporting module to monitor and review the trends related to falls. Reports will be reviewed at the Falls Committee meetings monthly.	Number of resident falls assessed monthly for potential preventative interventions, decreasing risk of injuries, determine cause of fall and review current interventions in place. Number of Fall Committee Meetings	100% of resident falls assessed each month 12 Fall Committee Meetings in 2025	

Measure - Dimension: Safe

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Number of resident whose behavioural symptoms improved from their previous assessment.	C	Number / Residents	EMR/Chart Review / Jan - December 2025	18.00	20.00	With the implementation of the Butterfly model of emotion based care on Monarch Manor we anticipate an improvement in behavioural symptoms including agitation and aggression. Higher is better. Current baseline is based on the total number of residents whose behavioural symptoms improved in 2024. (report from EHR run quarterly)	

Change Ideas

Change Idea #1 Create a more home-like environment on Monarch Manor and move to an emotion based model of care.

Methods	Process measures	Target for process measure	Comments
Butterfly / Emotion Based Care training	Number of FT and PT staff working regularly on Monarch Manor who have completed the Butterfly training	100% of FT and PT staff on Monarch Manor will have completed the training by December 2025	

Change Idea #2 Reduce risk of aggression/injury to staff or others by new residents with a high risk of aggressive behaviours

Methods	Process measures	Target for process measure	Comments
Referral process for new residents identified with higher risk Implementation of high risk interventions for 1 week	Number of new residents on Monarch Manor per quarter Number of new residents referred as high risk per quarter Number of aggressive incidents involving new residents per quarter Number of injuries to staff or others involving new residents per quarter	We will be collecting baseline data on this indicator Our target would be zero aggressive incidents or injuries involving new residents	

Measure - Dimension: Safe

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Reduction in Overall Resident Infection Rate	C	Rate / Residents	In house data collection / 2025	7.90	5.00	Average infection rate in 2024 was 7.9%. We are aiming for a reduction of 36% for an avg. rate of 5% or less. Lower is better.	

Change Ideas

Change Idea #1 Increased IPAC-related auditing

Methods	Process measures	Target for process measure	Comments
Hand Hygiene(HH) audits Personal Protective Equipment (PPE) audits Role-specific audits	Number of HH audits per month Number of PPE audits per month Number of role-specific audits per department per month	40 HH and PPE audits (total) per month 1 role specific audit per department per month	