2025/26 Quality Improvement Plan for Ontario Long Term Care Homes
"Improvement Targets and Initiatives"

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AIM		Measure				
Issue	**Quality dimension**	**Measure/Indicator**	**Type**	**Unit / Population**	**Source / Period**	**Organization Id**
M = Mandatory (all cells must be completed) P = Priority (complete ONLY the comments cell if you are not working on this indicator) O= Optional (do not select if you are not working on th						
Access and Flow	**Efficient**	Rate of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents.	O	Rate per 100 residents / LTC home residents	CIHI CCRS, CIHI NACRS / Oct 1, 2023, to Sep 30, 2024 (Q3 to the end of the following Q2)	52127*
		Laundry	C	Rate per 100 / LTC home residents	In-house survey / April 1 2025 to March 31 2026	52127*
		Nursing Restorative Services (Nursing Rehab) - % of resident utilizing nursing rehab	C	% / Rehab	In-home audit / April 1 2025 - March 31 2026	52127*
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	52127*
		Abuse Policy Review	C	% / Staff	In-home audit / April 1 2025 to March 31 2026	52127*
		Staff Orientation	C	% / Staff	In-home audit / April 1, 2025 to March 31, 2026	52127*

		Staff Training	C	% / Staff	In-home audit / April 1, 2025 to March 31, 2026	52127*
		Staffing plan Clinical	C	% / Staff	In-home audit / April 1, 2025 to March 31, 2026	52127*
		Volunteer	C	% / Volunteer	In-home audit / April 1, 2025 to March 31, 2026	52127*
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	52127*
		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	52127*
		Activities	C	% / LTC home residents	In house data collection / April 1, 2025 to March 31st 2026	52127*
		Care Conference	C	% / LTC home residents	In-home audit / April 1, 2025 to March 31, 2026	52127*
		Dietary	C	% / Staff	In-home audit / April 1 2025-March 31 2026	52127*

		Dietician Weight Review	C	% / LTC home residents	In house data collection / April 1, 2025 to March 31, 2026	52127*
		Infection Control	C	% / Staff	In-home audit / April 1 2025-March 31 2026	52127*
		Menu Planning	C	% / LTC home residents	In house data collection / April 1, 2025 to March 31, 2026	52127*
		Palliative	C	% / Staff	In-home audit / April 1, 2025 to March 31, 2026	52127*
		Physical Examination	C	% / LTC home residents	In-home audit / April 1 2025-March 31 2026	52127*

Safety	**Effective**	Boilers	C	% / N/A	In-home audit / April 1 2025-March 31 2026	52127*
		Continence Care	C	% / LTC home residents	CIHI NACRS / April 1 2025- March 31 2026	52127*
		Emergency Plan	C	% / Staff	In-home audit / April 1 2025-March 31 2026	52127*
		Heat Prevented Illness	C	% / LTC home residents	In-home audit / April 1 2025-March 31 2026	52127*
		Housekeeping	C	% / LTC home residents	In house data collection / April 1 2025-March 31 2026	52127*
		Pain	C	% / LTC home residents	In house data collection / April 1 2025-March 31 2026	52127*
		Pharmacy Destruction	C	% / Staff	In-home audit / April 1 2025-March 31 2026	52127*
		Responsive Behaviours	C	% / LTC home residents	In-home audit / April 1 2025-March 31 2026	52127*

		Wound Care	C	% / LTC home residents	CIHI CCRS / April 1 2025- March 31 2026	52127*
	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 Sep 30, 2024 (Q2), as target quarter of rolling 4-quarter average	52127*
		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 Sep 30, 2024 (Q2), as target quarter of rolling 4-quarter average	52127*

Current performance	Target	Target justification	External Collaborators
is indicator) C = Custom (add any other indicators you are working on)			
15.79	10.00	We believe that this is doable due to the fact that we have seen a reduction in ER visits due to the ability to complete more interventions in home. We have added a bladder scanner, IV equipment, as well as other diagnostic equipment.	
96.4	98.00	We have seen an increase in the resident and POA satisfaction Survey and believe that we are moving in the right direction. We are confident that we will see another increase in resident satisfaction with the interventions that were implemented.	
25	25.00	We would like to maintain or increase the number of residents on the Nursing Restorative Program.	
100	100.00	Maintain or increase education of executives and other staff about DEI education.	
100	100.00	As Mandated in FLTCA	
100	100.00	As mandated in FLTCA	

100	100.00	As mandated by FLTCA	
100	100.00	As mandated by FLTCA	
100	100.00	As mandated in current legislation	
95	96.00	We believe that this is achievable with the interventions that have been implemented	
88	90.00	We believe that this is achievable with the interventions implemented	
98	99.00	We believe that this is achievable based on the interventions that we have implemented	
100	100.00	As mandated in current legislation	
98	98.00	We would like to maintain the overall positive comments, however, would like to increase the number of people who answer Excellent on the resident satisfaction survey.	

100	100.00	As mandated in current legislation	
100	100.00	Meet Fixing Long Term Care Act and Regulations in collaboration with Public Health	
100	100.00	Meet Fixing Long Term Care Act and Regulations	
100	100.00	Ensure that all resident and families have a positive end of life experience a	
100	100.00	Meet Fixing Long Term Care Act and Regulations	

100	100.00	Meet Fixing Long Term Care Act	
27.7	27.70	We believe that this is achievable with the current interventions	
100	100.00	As mandated in current legislation	
100	100.00	Mett Fixing Long Term Care Act requirements	
98	99.00	We believe that this is achievable with the interventions that we have put in place.	
8.3	6.00	We believe that this can be met with the added interventions.	
100	100.00	As mandated in current legislation	
18.3	10.00	Closer alignment to provincial average	

5.4	3.30	Provincial Average	
17.58	12.60	We believe that this is achievable with the current anticipated interventions.	
27.12	22.00	We believe that this is possible with the implementation of our intervention.	

Change
Planned improvement initiatives (Change Ideas)

1)Maintain current interventions. Improve the discussion of Advanced Care Directives with families.
1)To reduce turnaround time for personal clothing to 48 hours and decrease the amount of misplaced items
1)To maintain or increase current nursing restorative services in the Home.
1)We will implement a DEI committee to help with staff education and buy in. Staff education provided with the aid of Nipissing First Nations
1)Review of the Abuse Policy Annually
1)Orientation Process in Place

1)Staff Training Yearly for all employees
1)Staffing plan in place and reviewed annually
1)Orientation for New Volunteers
1)Follow up with resident/ family after Critical Incident
1)Continue with the Campaign the Unit Manager
1)Maintain 3 quality contacts per resident per week.
1)Complete an initial care conference within 6 weeks, and an annual care conference for every resident
1)Improve Meal Service speed, quality and safety. As well as improving variety of choices on the menu within budget. More effective way of ordering products.

1)Weights of all residents reviewed Monthly
1)maintain hand hygiene audit rate of 2400 per year
2)Continue IPAC self-Assessment audit, minimum of 2 per year, and weekly while on outbreak
3)Complete redevelopment IPAC/Construction measure audit biweekly
1)Improve resident satisfaction of meal offering
1)Complete Palliative screening with all new admissions
2)Increase staff competency in palliative care
1)Nurse Practitioners to conduct a physical examination for all residents

1)Boiler Check by outside Source
1)Continue with staff training on continence care by Tena
1)Emergency plan in place and reviewed annually
1)Spring Completion of Heat Assessment of all current residents June, July, August New Admissions
1)Improve room cleanliness of resident areas- dining rooms, front entrance, stairwells, flooring, surface cleaning.
1)Reduce resident pain by improving monitoring and interventions.
1)Bi - Monthly Destruction of Narcotics
1)Continue with the aim of reducing symptoms of delirium to 10% by 3% to more closely align us with the provincial average of 7.70%

1)maintain or decrease worsened stage 2-4 pressure ulcers by 0.7% to equal the provincial average as outlined in Q2.
1)We will strive to reduce the number of Falls in the Home by 5% to an average of 12.6%
1)We will strive to reduce the number of residents who are receiving an antipsychotic medication without a proper diagnosis by 5% to 22%

Methods	Process measures
Increase the comfort level of RNs and RPN TLs in this discussion by enhancing training for staff.	Ongoing review of CIHI and in house stats
Created 4 part-time lines in personal laundry that will provide more consistency of staff	Audit resident closets and resident satisfaction survey
Nursing rehab services monitored at least quarterly. Nursing rehab nurse to continue to disseminate current list of residents weekly. Ongoing collaboration with physiotherapy to continue.	Ongoing review of resident that are on the nursing restorative caseload. Nursing rehab to continue to assess residents per request by staff. Collaboration with physiotherapy to maximize restorative services to promote independence and/or maintain current level
Ongoing education to our entire staff complement,	Completion of Indigenous training and other appropriate training programs
Reviewed by DOC	Document and Date Abuse Policy Review
Mentor program, ensure all mandatory pieces of training completion, departmental, innovative ideas of welcoming and hospitality.	Checklist completed and signed off after departmental

Utilize Dunk and Associates Safety 24/7 Program Monthly Assigned education to be completed	Report run of completion and email updates to remind staff to complete
Reviewed by DOC	Documented of review occurred.
Volunteer coordinator to complete orientation	Volunteer coordinators ensure completion of orientation and requirements prior to start of volunteering
Continue with the application of a procedure to follow up with resident and/or family after a critical incident occurs to ensure that they feel heard about what their experience was.	Resident Satisfaction Survey Results
Introduce the Unit Manager role to families and residents. Inform of how the Unit Manager can be a resource to being heard and ensure aware of whistleblowing policy. Section for orientation day for new residents, email and flyers for current residents	Satisfaction Survey results to the question "Having Your Say"
Monitor contact points through Activity Pro portal, Activity Manger to monitor weekly and review with staff	Activity manager will review Activity Pro Data weekly
Residents scheduled over 12 months period, 3 times per week	Review Monthly number of residents completed
Purchase the meal suite program, TV monitors and handheld tablets. Train staff NFS/PSW on the new system.	Conduct staff Observations in the dining room to ensure system is fully functioning.

Utilizing Point Click Care, Dietician review weights, RNs to complete audit and forward referrals to Dietician	Monthly RN audit completed
Hand hygiene audits are completed using the Speedy Audit app.	Report generated by Speedy Audit App
Added too duties list for outbreaks	IPAC Nurse to maintain
Adding appropriate elements to audit as construction continues, reviewed by Director of facilities and Capitol Projects	IPAC Nurse to maintain
Based on consultation with the resident food committee, removing disliked items and adding requested items to menu rotation. Staff will complete waste audits and use a communication board. Adding more options at meals.	Resident satisfaction survey, waste audits, food committee feedback, and following up with residents in dining rooms.
Implementation of the RNAO Clinical Pathways tool	Percentage of new admissions who have had a palliative assessment
Implement Monthly training sessions for all staff, covering key topics such as pain management, effective communication with families, and providing emotional support to residents.	We will measure success by tracking attendance to the sessions
Physical examination of each resident upon admission and an annual physical examination annually thereafter, and produces a written report of the findings of the examination	Ensure completion with PCC chart audit

Honeywell Contract Honeywell to complete maintenance on the current boilers in the home	Monitored and Documented by Maintenance
Survey residents and families on continence care satisfaction	Data collected from continence survey and CIHI Q2 unadjusted rates, reviewed by continence committee
Fire Drills, Horizontal Fire Drills, A Mock Evacuation, Reference Contacts , annual online training , Slings & Sliders hands-on training ,new hires attend Orientation that includes a Health & Safety Fire Tour of the Home, and Annual Inspection of the Home	Reviewed by the home's health and safety manager. Reviewed by Resident and Family Counci
Form in Point Click Care Completed by Unit RPNS	DOC or Delegate run report to ensure completion
Introduced 6 extra shifts on the weekend January 2025 so this can happen. More housekeeping staff hired.	conduct complete clean audits and resident satisfaction survey.
Reviewing non-pharmacological interventions, review pain management policy, reviewing pain assessment tool to use at both rest and during activity, restructuring pain documentation to include qualitative data, additional staff training on pain assessments, PRN	Continued monitoring of goals by pain committee. Pain assessments reviewed by RPN Team Leads and RNs, as well as during care conferences and med reviews.
Completed with Care Rx Clinical Consultant Pharmacist and RPN Team Lead	In Collaboration with Care Rx
Implementation of the Delirium Clinical Pathways tool	We will measure the number of people with delirium as per Q2 CIHI results.

• Education for staff - Standardized education for the treatment and prevention of pressure ulcers and skin tears reviewing Medical Directives and Best Practice for wound care and wound prevention. • Ensuring Head to Toe skin assessments are being completed on all - resident admissions, readmissions, LOA's • Providing pressure management surface - For resident identified as being high risk for developing pressure ulcers.	The committee will meet on a quarterly basis at minimum this fiscal year follow up with committee discussed items to be ongoing and progress will be evaluated at quarterly meetings
Implement a by-weekly falls review meeting, quarterly Falls committee meeting, education with staff	We will audit the number of falls that we are having and use the CIHI data.
Multidisciplinary Quarterly med review,	We will use the CIHI data to determine improvement

Target for process measure	Comments
To align with Provincial stats	
85% of people will chose Good or Excellent on Resident Satisfaction Survey	
To maintain or maximize current percentage of residents that utilize nursing restorative services	
Completion of training template in ‘Diversity, Inclusion, and Equity” for all staff	
100% completion of review of the Abuse policy by March 2026	
Completion of all new hires to meet ministry standards	

100 % Completion of all staff to meet ministry standards	
provide for a staffing mix that is consistent with residents' assessed care and safety	
100% Volunteer complete orientation prior to start	
Increase in the Excellent category to 50%	
Increasing the amount of respondent who say Excellent to the "Have your say" Question in the resident satisfaction survey to 55%	
95% of residents will receive at least 3 contacts per week by March 31st, 2026	
100% of residents have completed a care conference within 6 weeks, and/or an annual	
85% resident satisfaction on resident surveys.	

100% Weights audit monthly to meet ministry standard	
2400 hand hygiene audits	
Minimum of twice per year, and weekly while on outbreak	
Complete IPAC/Construction Preventative Measures Audit weekly	
98% satisfaction on resident survey	
100% of new admissions will have had a completed Palliative Screening	
Our goal is to have an attendance rate of at least 90%	
Meet Ministry standards	

100% completion of Boilers Checked Annually	
Maintain Current worsened bladder continence score of 20.3% based on CIHI Q2	
100% completion of Emergency Plan review by April 1 2025	
100% completion to Meet Ministry Standards	
90% satisfaction on cleanliness on resident satisfaction survey.	
Decrease worsened pain average to 13% based on CIHI Q2 unadjusted rates.	
100% Completion To Meet Ministry Standards	
We will strive to reach 10%	

The results that we will use to determine success will be the CIHI Quality Indicators	
We will strive to reach a maximum of 12.6% of residents having fallen in the last 30 days.	
We will aim for 22% to more closely align ourselves with the Provincial average.	