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

Shelburne

AIM		Measure										Change				
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
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 this indicator) C = Custom (add any other indicators you are working on)																
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 /	53238*	40.40%		1) At/Below the provincial Average; 2) Through implementation of our change ideas, the home expects an improvement over the next _____	NP; BSO; PRCs; RNAO BP Consultant; MD Paramedic LTC +		1) To reduce unnecessary hospital transfers, through the use of on-site Nurse practitioner; education to families; education to staff; Use of SBAR, Root cause analysis of transfers. Registered in charge nurse to communicate to physician and NP, a comprehensive resident assessment, to obtain direction prior to initiating an ER transfer; 2) Support early recognition of residents at risk for ED visits. by providing preventive care and early treatment for common conditions leading potentially avoidable ED visits. 3) Build capacity and improve overall clinical assessment to Registered Staff; through education of the most common transfers to ED 4) Development of IV program in the home	1) Education and re-education will be provided to registered staff on the continued use of SBAR tool and support standardize communication between clinicians. 2) Educate residents and families about the benefits of and approaches to preventing ED visits. The home's attending NP/MD will review and collaborate with the registered staff on residents who are at high risk for transfer to ED, based on clinical and psychological; 3) Conduct needs assessment from Registered Staff to identify clinical skills and assessment that will enhance their daily practice. 4) . Registered Staff education on IV therapy (initiating IV), IV antibiotic	1)Percent of communication process used in the SBAR format, between clinicians per month; 2) Percent of residents whose transfers were a result of family or resident request. 3) Percent of staff completing needs assessment related to clinical and assessment skills 4) Percent of eligible Registered staff educated on IV therapy/treatments	1) 50% of communication between physicians, NP and registered staff will occur in SBAR Format by Sept 2025 2) 25% of ED transfers will be prompted by family or resident request 3) 90% of registered staff will complete both survey and education related to assessments and clinical skills 4) 80% of eligible staff will complete education on IV therapy	
Equity		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	53238*	100%	80%	Through education, the Home expects to have an increase understanding of this criteria over the next 6 months	Surge Education; BSO; Cultural based organization in the community		1) To mandate diversity training through Surge education or live events; 2) To include Cultural Diversity as part of PAC meetings 3) To include live events and activities within the home related to culture, diversity and inclusion 4) To include both resident and staff in activities within the home related to culture, diversity and inclusion	1) Training and/or education through Surge education or live events; 2)To add item to standing agenda of PAC meeting 3) Celebrate culture and diversity events; educational opportunities 4) Post upcoming schedule of events in newsletters, and withing the home on the activety boards, as well as staff communications	1) Percentage of staff education completion on Culture and Diversity; 2) Percentage of PAC meeting that include item on standing agenda 3) Percentage of cultural and diversity event occurring within the home 4)Percentage of events that had resident and staff participation	1) 100% of staff will complete mandatory education related to culture, equity and inclusion 2) 100% of PAC meeting will include culture, equity and inclusion withing the standing agenda 3) 6 events related to culture inclusion and diversion will occur by Dec 31, 2025 4) 100% of events will have staff and resident participation	confirm the number of family visits per quarter
Experience	**Patient-centered**	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	53238*	Resident Satisfaction Survey 2024 - communication 80.17	92%	Target is based on corporate averages. We aim to meet or exceed corporate goals, benchmarks.	External Stakeholders such as Medline, care rx, Alzheimer's Society		1) To maintain or surpass our home rate as compared to the previous year's result 2) Review resident rights at Resident Council 3) Invite Residents to attend resident-focused education provided within the home 4) Social worker to complete wellness checks with residents	1) Complete annual Resident Satisfaction survey and compare to previous year's results 2) Include resident rights as a standing agenda item to the residents council meeting agendas 3) Ensure residents are aware of upcoming resident-focused education opportunities within the home by adding to RC meetings and posting within the home 4) Ensure all residents admitted to the home receive a visit from the SW within 2 months.	1)Percentage of eligible residents responding positively to the statement "I can express my opinion without fear of consequences." 2) Percentage of residents council meeting including a review of residents rights 3)Percentage of resident-focused education that had resident attendance 4)Percentage of residents that receive support from social worker within 2 months of admission	1) 92% of eligible residents will express "I can express my opinion without fear of consequences" 2) 100% of all resident council meetings will include a review of resident rights 3) 50% of resident-focused education will have resident attendance 4) 50% of residents will receive support from the social worker within 2 months of admission.	
Safety	**Safe**	Percentage of LTC home residents who fell in the 30 days leading up to their assessment	O	% / LTC home residents	CIHI CCRS with rolling 4-quarter average	53238*	PCC Insight - CIHI - 4 Qtr. Average-9.76%	15% - Corporate Average	Target is based on corporate averages. We aim to meet or exceed, corporate goal.	RNAO BP Coordinator; PT; NP		1) To facilitate a Weekly Fall Huddles on each unit, with the interdisciplinary team 2) Completion and assessment of Falls tracker for common themes and times of falls 3) Establishing documentation/charting buddies, (PSW complete documentation with resident's at high risk for falls - assists with the identification/reason for falls 4) Establish/re-establish the restorative care program in the home (provide education on how residents quality for the program)	1) Complete a weekly meeting with unit staff regarding ideas to help prevent risk of falls or injury related to falls; 2) Information will be collected and documented within the falls tracker with every resident fall, which will be reviewed and analyzed monthly during Quality meetings. 3)(Staff will receive updates and notification upon completion of fall huddles to identify high risk residents that require "charting buddies" 4)onboarding and Education of additional Restorative Care staff	1) Number of weekly meetings occurring 2) Number of falls captured in the tracker 3) Number of residents identified as needing a charting buddy 4) Number of residents on restorative care program	1) 1 weekly falls huddle will occur per week 2) 100% of falls will be captured in the tracker 3) 100% of residents identified as needing charting buddies will have documented in their care plan 4) 50% increase in residents participating in the restorative care program	
Safety		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 , with rolling 4-quarter average	53238*	PCC Insight - CIHI - 4 Qtr. Average-13.11%	17.30%	Target is based on corporate averages. We aim to do better than or in line with corporate average.	NP STAT, BSO LHIN, Lakeridge Mental Health Services, Ontario Shores Centre For Mental Health Sciences, Alzheimer Society of Ontario, GMAH, Royal		1) The MD, NP, BSO internal and external (including Psychogeriatric Team), with nursing staff will meet monthly to review newly admitted residents on antipsychotic medication for diagnosis and indication for use. 2) Reduce inappropriate use of antipsychotic medications. 3) Development of plans of care, with non pharmalogical approach - identification of triggers and interventions 4) Gentle Persuasive approaches (GPA) training/education - Establish GPA trainers, educators in the home	1) Track and review antipsychotic medications during monthly quality meetings. 2) Identify residents with potential to reduce or remove use of antipsychotic medication. 3) All residents on antipsychotics will have non-pharmacological care planned interventions. 4) GPA training to be held in the home	1) Number of meetings held monthly by interdisciplinary team. 2) Number of residents triggering the inappropriate antipsychotic use. 3) Percentage of residents on antipsychotics that have non-pharmacological care planned interventions. 4) Percentage of staff who receive GPA education	1) 100% of quality meetings will review antipsychotic medication use. 2) 2% reduction in residents triggering the inappropriate antipsychotic use. 3) 100% of residents on antipsychotics will have non-pharmacological care planned interventions. 4) 50% of staff will have received GPA education	
		Percentage of LTC residents who develop worsening pressure injury stage 2-4	O	% / Staff	Local data collection / Most recent consecutive 12-month period	53238*	PCC Insight - CIHI - 4 Qtr. Average-1.83%	2%	Target is based on corporate averages. We aim to meet or exceed corporate goals, benchmarks.	NSWOC, NP, MD, Medline consultants		1) Provide education and re-education on wound care assessment and management. 2) Referral to NSWOC for in home and virtual consults 3) Monthly review in Quality meeting of residents with Pressure related injuries 4) ROHO education, implement ROHO champion	1) Arrange education for Registered staff and PSW staff with Medline. 2) Develop a list of resident who have worsening stage 2-4 pressure ulcers and refer to NSWOC for consult. 3) Utilization of skin and wound tracking tool, to analyze the pressure related injuries in the home. 4) Arrange ROHO education and implement a ROHO Champion within the home.	1) Number of education sessions provided. 2) Number of residents identified with stafe 2-4 pressure ulcers and referred to NSWOC for consult. 3) Number of stage 2-4 pressure ulcers identified on tracker 4) Number of PSW staff completed ROHO education and Number of ROHO champions implemented.	1) 4 Sessions of education sessions by Medline will be provided by December 31 2) 100% of residents identified with stage 2-4 pressure ulcers will be referred to NSWOC for consult. 3) 100% of number stage 2-4 pressure ulcers identified on the skin and wound tracker. 4 100% of PSW staff will have completed ROHO education and 2 ROHO Champions will be implemented in the home by December 31.	
		Percentage of LTC residents who develop worsening pain	O	% / Staff	Local data collection / Most recent consecutive 12-month period	53238*	PCC Insight - CIHI - 4 Qtr Average-6.11	8%	Target is based on corporate averages. We aim to meet or exceed corporate goals, benchmarks.			1. Enhancement of the end of life, palliative care program 2. Utilization of pain tracker, to monitor the use of prn analgesic 3) RAI consultant, to provide education to RAI coordinators, on coding requirements for end of life/palliative residents/pain 4) Provide education on the non pharmalogical interventions/approaches	1. Reimplementation of the Palliative Care Committee 2. Registered staff to receive education related to purpose and use of the pain tracker 3. Schedule and complete education with RAI coordinator regarding pain and palliation 4.Invite external pain/palliative resources into the home to provide education to front line nursing staff	1) Number of staff participating in the Palliative Care committee 2) Percentage of registered staff completing education related to pain tracker 3) Percentage of reg staff receiving coding education 4)Number of front line staff receiving education from external resources related to pain and palliation	1) 100% of residents receiving palliative care orders will be supported by the palliative care committee 2)100% of registered staff will complete education related to the pain tracker 3)100% of MDS coding staff (registered) will complete receive education related to pain and palliation 4)100% of scheduled education session related to pain and	