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

West Park Health Centre 103 PELHAM ROAD, St. Catharines , ON, L2S1S9

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 / Oct 1, 2023, to Sep 30, 2024 (Q3 to the end of the following Q2)	51554*	24.39	20.00	1) At/Below the provincial Average; 2) Through implementation of our change ideas, the home expects an improvement over the next 12 months - December 2025.	NP; BSO; PRCs RNAO BP Consultant; MD, Paramedic, LTC, ET nurse		1)1) During admissions and annual care conferences, discussion with resident and families, regarding advance care planning	1) 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	1) The number of residents whose transfers were a result of family or resident request over the total number of ED transfers.The number of ED transfers averted monthly over the total number of ED Transfers.	4.4% reduction of ED visits by December 2025.	Utilize Nurse Practitioner, other stake holders such as Medigas, Carelfx
												2)OOC to review ED tracker, for the common reasons for transfer to ED - review in Nursing practice meetings, to develop strategies to	2)Utilization of the internal ED hospital tracking tool with an analysis of each ED transfer. ED transfer audit will be completed and reviewed monthly by nursing leadership (OOC, ADOC, NP, CC & interdisciplinary team members). Reports will be reviewed at quarterly PAC	2) Review of ED tracker monthly and identify trends and develop action plans to further mitigate ED transfer	4.4% reduction of ED visits by December 31st 2025.	
												3)Development of IV program in the home	3)Education on IV therapy (initiating IV), IV antibiotic.	3) Number of IV therapy/treatments completed with in the home over the total number of IV therapy/treatments that required a ED visit.	4.4% reduction of ED visits by December 2025.	
												4)Utilization of the PPS Palliative Performance Score to determine disease progression - revision of care plan.	4)Nurse Practitioner on site will provide education theoretically and at bedside to identify changes in condition to complete a PPS score.	4) The number of registered staff educated on PPS score over the total number of registered staff in the home.	4.4% reduction of ED visits by December 2025 and 100% of registered staff will	
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	51554*	100	100.00	Through education, the Home expects to have an increase understanding of this criteria over the next 12 months - December 2025.	Surge Education; BSO; Cultural based organization in the community, LGBTQIA2S+ & front line staff		1)To increase diversity training through Surge education or live events.	1) Training and/or education through Surge education or live events.	1) Number of staff education on Culture and Diversity compared total number of staff.	100% of staff educated on topics of Culture and Diversity by December 2025.	100% of new hire & existing employees will be trained on Culture and
												2)To facilitate ongoing feedback and open door policy with the management team.	2) During huddles and departmental staff meetings the open door policy will be a standing agenda and be discussed at every meeting.	2) Total number of discussion held over the total number of meetings completed	100% of staff educated on topics of Culture and Diversity by December 2025.	
												3)To include a chosen Cultural Diversity topic of the month as part of the Monthly Mandatory Program Meetings,	3) The home will highlight the topic of the month on the Cultural Diversity board to display various Cultural Diversities based on care, end of life, celebrations etc. This topic of the month will then be added to the Monthly Mandatory Program Meetings, Bi-weekly	3) Total number of topics presented over the total number of calendar months.	100% of interdepartmental staff educated on topics of Culture and Diversity by	
												4)Creation of culture board, of the cultures of the resident and team members in the home.	4) Leadership team will develop a cultural board that will highlight monthly cultural celebrations, fun facts & the topic of the month.	4) Total number of celebrations in the home over the total number of displayed cultures on the board.	100% of staff educated on topics of Culture and Diversity by December 2025.	
Experience	**Patient-centred**	Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences".	O	% / LTC home residents	In house data, interRAI survey / Most recent consecutive 12-month period	51554*	86	90.00	Target is based on corporate averages. We aim to meet or exceed corporate goals and benchmarks by December 2025.	Recreation, leadership team and front line staff		1)To increase our goal by 4.29% (as compared to previous year 85.71%) to 90%. Engaging residents in meaningful conversations,	1) Add resident right #29 to standing agenda for discussion on monthly basis by Recreation Manager during Resident Council meeting.	1) All interdepartmental meetings will include a standing agenda for the Residents' Bill of Right #29 added by May 2025.	100% of all staff and residents and families will have completed the education on	100% of new admissions will be educated on the Complaints process and a
												2)Review of the Whistleblower policy	2) Review of 100% of all staff on the Whistleblower policy at department meetings monthly by department managers. All residents during admission, care conferences and at Resident Council.	2) 100% of all staff will have a review via department meetings and on Surge Learning on Whistleblower policy and 50% of Residents will have reviewed the Whistleblower policy by December 2025.	100% of all staff will have completed a review on the Whistleblower	
												3)Review the Complaint and Concern process in the home on admission, during annual Care Conference and at the Resident Council	3) Review of the Complaint and Concern process with resident and family with admission and Care Conferences	3) 100% of new admissions and existing Residents will have reviewed the Complaints and Concerns process. The total number of complaints/Concerns received over the total number of Residents in the home.	100% of residents will have the knowledge of the Complaints and Concerns process	
Safety	**Effective**	Percentage of Long Term Care residents who developed worsening pressure injury stage 2-4	C	% / LTC home residents	Local data collection / Most recent consecutive 12 month period	51554*	2.07	2.00	Target is based on corporate averages. We aim to meet or exceed corporate goals, benchmarks by December 2025.	NSWOC, NP, MD, Medline consultants		1)Provide education and re-education on wound care assessment and management. Education provided by ET Nurse	1) Arrange education for Registered staff and PSWs with Medline consultant.	1) Number of frontline nursing staff that have completed education compared to total number of front line staff.	1) 85% of front line nursing staff to be educated by December 2025.	
												2)Referral to ET Nurse for in home	2) Have Wound Care nurse utilize ET Nurse referrals through PCC	2) Number of residents seen by ET nurse over number of referrals sent to ET Nurse	2) 100% of resident ET referrals will be seen by ET nurse by December	
												3)Monthly review in Quality meeting of resident with Pressure related injuries, review of care plan, progression/lack of healing	3) Utilization of skin and wound tracking tool to analyze the pressure related injuries in the home - and the development of plan of care.	3) Number of care plans developed regarding Pressure Injury compared to the number of residents on the pressure injury tracking tool.	3) 100% of residents with pressure injuries will have care plans updated by	
												4)Conducting audit of resident surface (bed/w/c), for the appropriate surface for pressure relieving & using the pressure relief	4) Develop a list of residents whose PURS is 3 or greater, review plan of care, for the appropriate pressure relieving devices and review of surfaces in place.	4) Total amount of residents who has a PURS score of 3 or above with pressure relieving devices in place compared to total amount of residents with a PURS score of 3 or greater.	4) 100% of residents with a PURS of 3 or above will have a pressure relief	
	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	51554*	16.67	13.00	The home is exceeding the Corporate Benchmark. The current performance for the rolling 4 quarters for febrary 2025 is 14.74%.	RNAO BP Coordinator; PT; NP; Front line staff; Leadership team; MD; Pharmacist		1)Create activity bins, for residents to assist with engagement.	1) Create individualized bins for high risk fallers based on their needs and interests - Try and include families with the individual bin development.	1) Number of bins created and distributed over the number of resident falls.	1) 100% of bins available for identified Residents at high risk for falls.	
												2)Purposeful rounding, for resident at high risk for falls	2) The Nurse Practitioner and or Pharmacist will complete a medication review on every resident who has had a fall.	2) The total number of medication reviews over the total number of falls.	2)100% of medication reviews completed for Residents who had a fall by	
												3)During the admission process, review with resident and history of falls, and interventions implemented	3) Face sheet for new admissions are developed and high risk fallers are identified and appropriate referrals are sent to the falls lead, Nurse Practitioner and or Pharmacist.	3) Number of referrals sent over the number admissions with a history of falls.	3) 100% of referrals sent for high risk of falls with new admissions by	
												4)Collaboration with recreation to review residents Wellz' reports who has sustained a fall.	4) A referral will be sent to the Recreation team to have a review of the residents Wellbi report to identify recreation engagement.	4) Number of Recreation referrals sent over the total number of falls.	4) Have a increase of 10% participation rate with general programs by	
		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	51554*	33.55	19.00	Current performance for rolling 4 quarters for febrary 2025: 24.70%.	Nurse Practitioner, BSO, LHIN, Alzheimer Society of Ontario, Psychogeriatric Resource Nurse		1)The MD, NP, BSO internal and external, Psychogeriatric Team, with nursing staff will meet monthly to review residents	1) The interdisciplinary team will meet monthly to review the antipsychotic usage in home.	1) Total number of residents prescribed antipsychotics over the total number of residents assessed.	1) 100% of residents will have been reviewed for the appropriateness of	
												2)Residents who are prescribed antipsychotics for the purpose of management of Responsive expressions, will have a	2) Every quarterly MDS assessment - if resident is receiving Antipsychotics the Nurse Practitioner will receive a referral to conduct a medication review	2) Number of Medication reviews completed over the number of residents who triggered antipsychotic usage.	2) 100% of residents who are prescribed antipsychotic medications will	
												3)To establish two Gentle Persuasive approaches (GPA) coaches in home.	3) To research educational opportunities in the community for the training.	3) The home will have establish two GPA Coaches in the home.	3)The home will have establish two GPA Coaches in the home by December 2025.	
												4)The home will utilize the antipsychotic useage tracker to identify opportunities to deprescribe.	4) Home will utilize internal tracker monthly to identify Residents who have the potential to deprescribe.	4) The number of Residents who qualify for deprescribing over the number of residents on antipsychotics.	4) 100% of residents on antipsychotics will be reviewed for the potential of	
		Percentage of Long term Care residents who develop worsening pain	C	% / LTC home residents	Local data collection / Most recent consecutive 12 month period	51554*	9.21	8.50	Target is based on corporate averages. We aim to meet or exceed corporate goals, benchmarks.	ET nurse, NP, Pain consultants, MD		1)Enhancement of the end of life and Palliative Care program.	1) Any residents receiving Palliative Care will have a comprehensive pain assessment review completed.	1) Number of comprehensive pain assessments completed over the number of residents receiving Palliative Care.	1) 100% of residents on Palliative Care will have a comprehensive	
												2)Utilization of pain tracker, to monitor the use of prn analgesic	2) At Morning Risk Management discuss the pain tracker and the use of PRN analgesics daily	2) The number of Residents listed on the PRN analgesic tracker for three or more consecutive days over the number of residents who received PRN analgesics	2) 100% of residents receiving prn analgesics will be tracked on the PRN analeasic	
												3)Provide adjuvant and non pharmacological interventions in the plan of care	3) Assess residents who are experiencing pain and explore non pharmacological interventions. Update the care plan accordingly and assess for effectiveness.	3) The total number of Residents with non pharmacological interventions over the total number of residents with only pharmacological interventions.	3) 100% of residents triggering pain QI will have a care plan including non	