## 2025/26 Quality Improvement Plan for Ontario Long Term Care Homes

"Improvement Targets and Initiatives"



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AIM		Measure									Change Planned improvement				
		Measure/Indicator	Тура			Organization Id		Target		External Collaborators	initiatives (Change Ideas)		Process measures	Target for process measure	Comments
M = Mandatory (all ce Access and Flow	ells must be complete	d) P = Priority (compl	ete ONLY the co	mments cell if you	are not working	on this indicator)	O+ Optional (do n	ot select if you	are not working	on this indicator) C = Custom	(add any other indicators y	(ou are working on)			
Access and Flow															
	Efficient	Rate of ED visits for modified list of ambulatory care-sensitive conditions* per 100	o	Rate per 100 residents / LTC home residents	CIHE CCR5, CIHE NACR5 / Oct 1, 2023, to Sep 30, 2024 (Q3 to the end of the	96682*	36.55	25.00	The home has steadily been improving over the past year. We have a process that	NP NLOT Ottawa Hospital	1)Reduce avoidable hospital transfers with the support of the on-site Nurse practitioners and NLOT NP through the	All registered staff will be educated on the continued use of the SBAR tool to support standardized communication between clinicians.	This process will be measured based on the gradual and consistent quarterly decrease in the % of avoidable ER visits. The Number of educational sessions corroleted. The	An overall decrease of 11.5 % from the current avoidable ED visits % of 100 % of the	As part of the monthly ED transfer review, the SEAR application will
		long-term care residents.			following Q2)				process that has certainly helped us achieve our goal gradually and plan to		2)Build capacity and improve the overall clinical assessment of the Registered Staff through education on the most 3)Establish	Registered Staff to identify clinical skills and assessments to enhance their daily practice. Review of the ED tracker to identify the most common	home's educator, Narsing management team, and Narse Practitioner will work in collaboration to set up the educational venue and content.	100 % of the Registered Staff will be educated on the clinical topics identified	Other stakeholders involved: Care Rx, Pain and symptom
									mirror in 25-26		partnenhlp/collaboration with the Paramedic LTC + program - provide, in home support, to avoid 4/Breview the ED tracker by the Director of Care and the interdisciplinary	masors for ID transfer. Access to health services 24-7, through in-home and remote methods, such as orline support; Non- emergency home visits and in-home testing procedures; Oregoing monitoring of vital signs to prevent escalation of chemic medical constitute; Businger of internal homital residues tool in analyze	The number of monthly referrals completed to the Paramedic LTC + program and the number of averted unnecessary ED visits as a result of the program. Number of avoidable EB visits/month. Consistent	residents will be referred to the Paramedic LTC + program team by The current	
Equity	Equitable										by the Director of Care and the interdisciplinary team, to determine common reasons for	Review of internal h optical tracking tool to analyze each transfer status. ED transfer audit will be completed and reviewed monthhy by narsing leadership and the interdisciplinary beam. ED transfer reports will be reviewed at quarterly PAC	Number of avoidable ER visits/month. Consistent decrease in avoidable ER visits by the home as per the Ministry potentially avoidable ED visit quarterly report.	The current home's rate is 36.5 %. The home projects to decrease	
			-					200.00					The number of staff that will be trained in relevant	Lange of the second	1
		Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity,	0	% / Staff	Local data collection / Most recent consecutive 12- month period	90017-	100	200.00	Our target is expected to be 200% as this is a part of our mandatory education	Community Based agencies In the area	1)Complete equity, diversity, inclusion, and anti-racism training for staff through Surge education and live events.	Roll out by annual live events on equity, diversity, inclusion, and anti-racism. Continue with the annual Surge education.	equity, divenity, inclusion, and anti-racism education through surge learning and live events.	100% of existing and new staff will be educated on the topics of equity, divenity.	
		equity, diversity, inclusion, and anti- racism education							process .		2)All employees to be trained in relevant equity, diversity, inclusion, and anti-racism in the year.	Include equity, diversity, inclusion, and anti-racism as part of the horne's departmental committees' standing agendas. The goal is to maintain a consistent forum to review applicable topics, thus increasing the understanding and knowledge of the	The number of monthly committee agendas that include one of the following topics equity, diversity, inclusion, and anti-racism.	100 % of the home's committees will discuss the following toolcs:	Departmental leads to ensure these topics are covered at each meeting
											3)The home will partner with external stakeholders to assist the staff education on equity, diversity. Inclusion. and	The home will develop partnerships with community based focusing on equity, divenity, inclusion, and anti-racism. The objective is to increase the resources available and the inclusion of subject matter experts to strengthen the home's education	The number of events led by external organizations/stakeholders	100 % completion of the bi-annual education sessions conducted by	
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	96682*	83.02	85.00	The home is fully committed to improving this indicator. A robust plan is in place to ensure improvement		1)Increase the home's goal from 83.2% in 20024 to 85%. Engaging residents in meaningful conversations durine care 2)Review of the Whistleblower policy with all staff, at resident council and femily town	Include the review of the resident's bill of rights in the monthly-house constitute explorations for discussion. The Program Manager to review the Resident's Bill of Rights during Busident Council maximum. This provides the Resident Bill of Buthst Education for staff to Be roled out via Surge learning. The program manager will inview the whittlobuwing policy annually with the resident council. The Executive Director and review the	The sumbar of departmental agendas that include the Ravident's Basidentis' Bill of Rayla for arrayed and education by March 31/28. The resident Council will evident the Rasident's Bill of Raylas (2-3 per mention The seadent bill of rehava will be networked The number of staff educated on the WhiteHolower Delivy in the fiscal year. The number of meetings with the resident council and family townhalt that include the review of the WhiteHolower policy.	100% of staff will have completed the resident Bill of Rights education. 100% of the staff will be educated on the Whistleblower	
									improvement in this area.		council and family town halts. 3)Bratew the home's complaint process with residents and SDM's on admission and during the annual case conferences	council. The Executive Director will review the whatlebrain optics annualized using administration buring administration and annual care conferences, the complaint process will be reviewed with the residents and/or SDMs and documented in the "CONTERENCE - interdisciplinary Team Care Conference DIST" assessment .	Include the review of the Whistleblower policy. Number of care conferences in which the complaint process was reviewed per month.	Whistleblower policy 100% 100% of the admission and annual care conferences will include the	
Safety						96682*									
	Safe	Percentage of LTC home residents who fell in the 30 days leading up to their assessment	0	% / LTC home residents	CIHE CCR5 / July 1 to Sep 30, 2024 (Q2), as target quarter of rolling 4-	96682*	24.65	15.00	The home has experienced an improvement over the past year, in	NP NLOT Ottawa Hospital	1)Complete Weekly Fall Huddles for each unit with the interdisciplinary team.	Complete a weekly huddle with unit staff regarding I ideas to help prevent risks of falls or injury related to falls.	Number of weekly fails huddles in each unit per month	100% of staff participation on Falls Weekly huddle in each unit by March	
					quarter average				particular with the fall's clinical day rollout. The home is confident, this venue will		2)In collaboration with the Falls committee, the Falls lead, and the interdisciplinary team residents who are	Completion of the Monthly clinical falls review meetings.	The number of residents reviewed monthly who have recently sustained a fall and are at medium and high risk for falls	100 % completion of all monthly clinical falls review meetings by March 31/26	
									continue to assist the home meet corporate target.		3)Re-launch of Purposeful rounding ( 4 Ps), for residents at medium and high risk for falls 4)Resident list of FRS of 3	Education to the numing staff on Purposeful rounding (4 Pb). The horne will ensure that residents who are determined to be at medium and high risk for fails, their plan of care will include purposeful rounding (4 Pb). Education provided to registered staff on fracture and injury prevention. Involve redocative care lead.	The number of staff educated on Purposeful rounding ( 4 Ps) and the number of residents whose care plans include purposeful rounding. The number of rare nlines undated with	100 % of all nursing staff are to be educated on purposeful rounding by May 100 % of the Reg	
		Percentage of 170	0	% / LTC home	cus cost ()	96682*	16.86	14.00	The borne has a	Rentered Rendermatistics	or greater, offer fracture and injury prevention alternatives, both pharmacological and non- 11The MD. NP. BSD		pharmacological and/or non-pharmacological interventions to reduce the risk of potential injuries.	staff to be educated on fracture and falls related injury 100% of residents	
		Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment		residents	CIHE CCRS / July 1 to Sep 30, 2024 (Q2), as target quarter of rolling 4-				process that has been able to reduce Antipsychotic use for	Regional Psychogeniatric consultation team, Care RX	internal and external (including the Psychogeriatric Tearr), and other members of the 20esidents who are	Monthly meetings with the interdisciplinary team with a focus on Antipsychotic use and interventions for the reduction/tappering of antipsychotic medication usage. Review data during, CQI and PAC meetings. The 850 lead and the numing team will ensure that emidents who receive antisocholics for reasonize	The number of meetings held monthly by the interdisciplinary team and the number of antipsychotic reductions as the result of these meetings.	on antipsychotic medications without psychosis	
		resident assessment							residents without a diagnosis of Psychosis.		prescribed antipsychotics for the purpose of management of Responsive expressions 3Development of plans of	residents who receive antipy-botics for responsive expressions with have their medication, and plan of care reviewed, quarterly by the interdisciplinary team (including resident and femily) Review of the plan of care for non-pharmacological approaches, and triggers leading to Personal	Number of residents on antipsychotic medications whose care plans have been reviewed on a quarterly basis The number of residents whose plans of care have	100 % of the residents on antipsychotic medications will have their 100 % of the	
		Percentage of LTC	c	% / LTC home	Local data	96682*	13.25	8.50	home is below the provincial and corporate averages. The home has	Pain and Symptom	care, with non- pharmacological approach - identification of triggers and interventions. 1)Utilization of the pain tracker, to monitor the use of prn analgesic.	s expressions.	The number of residents whose plans of care have been reviewed for both non-pharmacological and trigger interventions. The number of residents on PRN medications whose	medications will have their 100 % of the residents on Antipsychotics, will have their care plans 100 % of	
		Percentage of LTC residents who develop worsening pain		residents	Local data collection / Most recent consecutive 12- month period / CIHI CCIIS , with				developed an action plan that will help identify regular PRN pain	Pain and Symptom management consultant NLOT Ottawa Hospital NP and Canadian Narse Practitioner Services		utilization of PRN medications to ensure residents are assessed for pain as per the home's policy.	The number of residents on PRN medications whose pain management regime has been adjusted to manage their pain. This data will be collected and analyzed monthly. The number of new residents who had a	100 % of residents who trigger a new pain assessment based on PRN 100 % of all new	
					rolling 4-quarter average				The home has developed an action plan that will help identify regular PRN pain medication use and scheduled pain meds and the effect of these meds on managing pain. With a more comprehensive		2)For all new admissions, the home's pain lead will monitor the completion of a comprehensive pain assessment as per policy. Ultrohexement of the	During the admission process, the pain lead in collaboration with the Reg tatif will monitor the outcome of the pain assessment and pain history, will engage other members of the interdispliniary team to address any pain concerns. Delaws education to the staff on Dellative Care	comprehensive pain assessment completed and had their pharmacological and non-pharmacological interventions adjusted as the result of the comprehensive pain assessment and pain	residents will have a comprehensive pain assessment, 100 % of staff will	
									managing pain. With a more comprehensive assessment and		3)Enhancement of the end of life, palliative care program	Deliver education to the staff on Pallative Care. Focus on Communication Sulls for staff to have open and honest conversations about end-oilife care with residents and families. Re-introduce Comfort Care Rounds: Implement "Comfort Care	The number of staff provided education on pallative care. The number of residents on comfort care rounds. The number of families involved in pallative care end-of-life care conferences The number of staff educated on assessments required	receive education in palliative care and early identification of	
		Percentage of LTC	c	% / LTC home	Local data	96682*	3.97	2.50	The borne has	Canadian Nurse	1800 out education on	DOC to arrange education for Resistered shaff and	Number of Resistered staff and PSWs educated on	100 % of the	
		Percentage of LTC residents who develop worsening pressure injury stage 2-4		residents	collection / Most recent consecutive 12- month period / Local data				seen the gradual improvement of this indicator over the past	Canadian Norse Practitioner Services	wound care management and assessment and skin care. Education to be	DOC to arrange education for Registered staff and PSW, with NSWOC/Medline Utilization of skin and wound trackine tools to	Number of Registered staff and PSWs educated on wound care management, assessment and skin care Number of pressure-related injuries that have	nursing staff to be educated on wound care management 100 % of pressure	
					collection / Most recent consecutive 12- month period				year. In August 2024, the home performed at 20.96 %, down to 4.5% as of		2)Monthly review in the Quality meeting of residents with Pressure related wounds. 3)Referral to NSWDC for	Utilization of skin and wound tracking tools to analyze pressure-related injuries in the horse, the development of the plan of care, and appropriate prescribed wound and skin care products Referrais to the NSWOC for the residents who fall	Number of pressure-related injuries that have resolved as a result of interventions. Number of referrals submitted to the NDWOC per	related injuries that have resolved as a result of 100 % of the	
									Feb /25. The same action plan will be carried forward		in home and virtual consults.	into following categories. Wounds that Pall to Heat Non-healing wounds: If a wound doesn't show signs of healing after 4-6 weeks of appropriate basic care (cleansine, protection, edema control, and	month Number of care plans of care updated as the result of the assessment conducted by the NSWOC.	residents who fall into the worsening pressure injury	