

Equity

Measure - Dimension: Equitable

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of staff who have completed relevant Palliative/End of Life Education as it pertains to the Policy changes and Palliative Performance Scale.	C	% / Staff	Local data collection / most recent consecutive 12 month period	CB	CB	Education ensures the best working knowledge of Palliative Policy, imperative to quality Palliative and End of Life care.	

Change Ideas

Change Idea #1 Enhance PPS education, review and revised policy and procedure for Palliative/End-of Life.

Methods	Process measures	Target for process measure	Comments
Educate via mini education sessions by Palliative Lead, knowledge board updated routinely, Palliative and End of life Care meetings, Bedside education by RN/RPN/NP.	percentage of staff completed relevant palliative education,	100% of registered staff completed education and implementing PPS effectively for optimal Palliative and End of Life care.	Education is ongoing and Keeping TIPC focused at the time of PPS assessments.

Change Idea #2 Palliative Performance Scale developed for use in Point Click Care to enhance ability to track decline in residents more effectively.

Methods	Process measures	Target for process measure	Comments
internal audits, collaborate with Point Click Care, ADOC and Palliative care lead to align with current policy	PPS in PCC developed within 6 months, Audits completed regularly by Pain and Palliative Lead.	100% of Resident Palliative Performance Scales completed in Point Click Care by December 2026.	to enable HHCC to identify earlier when to initiate end of life care.

Safety

Measure - Dimension: Effective

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of organizational policies reviewed and revised to include explicit DEI, trauma-informed, and person-centred care language.	C	% / N/a	In house data collection / most recent consecutive 12 month period	CB	CB	All relevant policies that to include this DEI and Trauma informed person centred language at start of next QIP period.	

Change Ideas

Change Idea #1 Implementation of centralized policy management, to ensure staff have access to current, consistent policies across all departments reflective of DEI and Trauma Informed Person Centred Care. Quarterly review by Policy Review committee, which is comprised of Department Managers.

Methods	Process measures	Target for process measure	Comments
All departments will review and upload updated policies to Surge Policy Pro on a quarterly basis to ensure policies remain current, accessible to staff, and aligned with regulatory requirements and best practices.	Percentage of departmental policies uploaded and reviewed in Surge Policy Pro.	100% of policies from all departments uploaded and reviewed quarterly, with full implementation completed by January 2026.	

Change Idea #2 % of policy reviews completed by agreed milestones (e.g., minimum quarterly checkpoints)

Methods	Process measures	Target for process measure	Comments
Set quarterly review deadlines; assign accountable lead/manager for appropriate Policy Manuals. Reviewed during QI meetings to ensure completion, determine DEI & TIPC Language expectations	% of updates completed on schedule	to have 100% of all relevant policies includes DEI and TIPCC language.	This helps monitor progress throughout the year.

Change Idea #3 % of all relevant policies that currently include this language at start of QIP period

Methods	Process measures	Target for process measure	Comments
Create policy review committee; develop DEI guidance template; conduct policy audits	$(\text{Number of policies updated with DEI + trauma-informed + person-centred language}) \div (\text{Total number of policies requiring review}) \times 100\%$	100% of policies to reflect DEI and TIPC language.	Dept managers to be responsible for Department specific polices to reflect DEI & TIPC Language.

Measure - Dimension: Safe

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
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 September 30, 2025 (Q2), as target quarter of rolling 4-quarter average	26.19	22.00	HHCC endeavors to reduce the current performance by 16%.	Providence Care Seniors Mental Health, Behavioural Support Services KFL&A

Change Ideas

Change Idea #1 Review medication use data from the home and from pharmacy providers (e.g., indications, new starts, PRNs, administration rates, summary of responsive behaviours, interventions)

Methods	Process measures	Target for process measure	Comments
Our physicians and nurse practitioner and pharmacist will review all residents taking antipsychotics without a diagnosis of psychosis in an attempt to identify possible alternative therapies.	The number of residents currently taking antipsychotics without a diagnosis of psychosis vs. the number of residents taking antipsychotics without a diagnosis of psychosis after a full reassessment has been completed.	quarterly and annual reviews, reviews completed when Behaviours escalate as required	Suggestions for potential change will be forwarded to the SMH or BSO for further assessment and potential changes to treatment plan also involving the resident and/or their POA for personal care or anyone else the resident may request.

Change Idea #2 Educate staff on recognizing and understanding behavioural and psychological symptoms of dementia (BPSD) and non-pharmacological interventions.

Methods	Process measures	Target for process measure	Comments
Increase staff completion of dementia education and Reinforce staff training on consistent documentation related to behaviours, triggers, and individualized interventions. Conduct ongoing audits of documentation and care plans to ensure individualized, person-centred interventions are implemented and monitored.	Education attendance records and training completion Resident care plan and documentation audits	100% of staff education completed related to BPSD and non pharmacological interventions and consistent documentation.	