2025/26 Quality Improvement Plan "Improvement Targets and Initiatives" AGH

Black Continue from 24/25, Green New 25/26

Atikokan General Hospital 120 Dorothy Street, Box 2490, Atikokan , ON, P0T1C0

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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
Access and Flow	*Efficient*														
	Timely	Time between decision to admit and actual admission to Acute from emergency department is being completed appropirately	C	Hours / ED patients	CIHI NACRS / Q1 and Q2 FY25/26	600*	2.65 hrs	2 hrs	Documentation is completed accurately in order to ensure that hospital is meeting or exceeding the provincial target of 8 hours.		Monitor and track the length of actual time between deciding to admit a patient to Acute Care Unit from Emergency Department and actual time the patient is admitted to Acute Care Unit.	Nurse charts on ER Registration for the time when the physician decides to admit a patient to Acute Care unite from Emergency Department. Nurse charts the actual time the patient is admitted to Acute Care and moved to the floor.	Length of time that the patient waits in the Emergency Department for admission (movement) to the Acute Care Unit bed.	Decrease the time to 2 hours maximum during Q1 and Q2 of FY 25/26	It has been noted that the Physician Decision to Admit time is usually the same as time to the TIME TO THE Acute Care Unit. This not accurate and needs to be monitored/tracked for accuracy and improvement. Current Performance shown has been pre-populated for this indicator
		90th percentile ER wait time to physician initial assessment	P	Hours / ED patients	CIHI NACRS / ERNI hospitals: Dec 1, 2023 to Nov 30, 2024	600*	1.3 hours	1.0 hours	Monitor that Emergency Department Patients are being seen within the defined CTAS level timeframe as defined by Hospital Policy and Procedure.		Monitor that patients are seen in a timely manner by our phsyicians in the ER according to CTAS level at triage.	Chart on the ER registration what time the phsyician sees the patient. Data is collected from the ministry and reported to us monthly.	Data is collected by the ministry and reported to health records monthly.	Decrease our current performance level to 1.0 hour for patient seen by Physician within the defined CTAS Level timing assigned upon registration monthly.	Current Performance is auto-populated for this indicator. CTAS Level Timing CTAS Level 1 = 0 min CTAS Level 2 = 15 min CTAS Level 3 = 30 min CTAS Level 4 = 60 min CTAS Level 5 = 120 min
		% of patients who visited the ED and left without being seen by a physician	O	% Patient who left without seeing Physician/ ED patients	CIHI NACRS / Apr 1 to Sept 30, 2024 (Q1 and Q2)	600*	0.16	0.10	Track how many patients come into ER and the Physician does not see them.		Improve the number of patients who attend the ER without being seen by a physician	Health records to TRACK the number of times a patient was not seen by the phsycian	The number of ER registration forms that indicate not seen by physician or signed off only by nurse	less than 10% of ER patients not seen by the physician per quarter	Current Performance is auto-populated for this indicator.
		Percentage of Patients who presented with Mental Health/Addictions Issues to Emergency Department who were offered after hours services by Community Counselling Services while they were in the Emergency Department or an inpatient of Acute Unit.	C	% / All Patients	In House data collection/ Calendar Year 2025	600*	CB	90%	Track the number of Patients who were offered services		Educate staff to document the patients who are offered after hours services for Mental Health issues while in Emergency Department or admitted to Acute Care during their stay in order to establish a Baseline on the use of this service.	Locally track the number of referrals offered to patients for after hour services by a counsellor to see if there are barriers to receiving the service.	The # of patients who accessed after hours services offered or refused services in the ER or Acute Care Departments per month	Establish baseline during 2025, Aim for 90% of patients offered services.	
Equity	Equitable	Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education	O	% / Staff (this for all AHCS staff incl AGH & LTC)	Local data collection / Most recent consecutive 12-month period	600*	78.7%	90%	Increase the number of all staff of AHCS (AGH & LTC) completing their required training through Surge Learning and other methods as defined by Management Team		1)Provide access to required annual education as well as ongoing educational opportunities on this topic as available to all staff.	Add Mandatory Training to Surge Learning as available	The number of staff who have completed the mandatory training as assigned	90% of all staff having completed their mandatory training in Equity, Diversity, Inclusion and Anti-Racism within the FY 2025/2026	This measure is reporting for all staff working for Atikokan Health and Community Services (Hospital/ Long Term Care)
											2) Educate staff on the importance of completing their required training	Discuss at Team/Unit meeting and huddles. Managers and Lead Hands enforce the need for mandatory training to be completed.	Increase in the number of staff having completed training on a quarterly basis	90% of staff will have completed their training by deadline in FY 2025/26	
		Percentage of Patients/Clients who completed sociodemographic data collection questions during ER Visit, Acute Admission,	C	% / All Patients	EMR/Chart Review / Calendar Year 2025	600*	86%	95%	Gain clear understanding of the diversity of the clients/patients we serve or the volume we serve and be able to provide appropriate information to them in their preferred language and method of their choice		1)Use of updated admission questions being asked of Clients/Patients	Health records will track the number of Patients completing this information	Percentage of patients who were asked if they self identify as Indigenous and what they regard as their mother tongue language and they provided an answer to the questions.	95% answer the question and don't have "unable to answer" filled in.	This question has to be answered during registration but if there is already an answer in the box then they can skip past it. Ward clerks are trained to update any boxes that say the patient was unable to answer the question.
											2)Educate all staff on the importance of offering this option and requesting information related to sociodemographic data	Assign mandatory education through Surge Learning to completed by all staff. Managers and Lead Hands will be enforcing the need for completion of the mandatory training.	# of Staff who have completed the Surge Learning Course by the end of Q3 annually	90% of all staff will have completed the mandatory training.	

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											3) Provide In-Person translation services for all patients as needed	Use of Voyce App by all staff to assist patients with primary language other than English	Number of times VOYCE App is accessed and used to assist patients	Collecting Baseline for this new service initiative.	The APP will only provide the total # of times it is accessed by all departments of Atikokan Health and Community Service. FHT and Community counselling services will manually track the number of time they use the APP and report quarterly.
		% of policies and procedures that were translated into another language to accommodate current staff who might prefer the policies and procedures for their department be in their own language.	**C**	**% Translated documents/Departments**	**Local Data Collection/Most recent 12 month period**	**600*AGH**	**CB**	**10%**	**In order to support our diverse workforce translation services are necessary, to provide staff with documents in their preferred language**		**1)Provide staff, who's primary language is not English, with documents in their primary language.**	**Translate Policies and Procedures into various primary languages relevant to staff.**	**Number of documents that have been translated.**	**10% of documents are translated**	
Experience	Patient - Centred	Percentage of respondents who responded “completely” to the following question: Did you receive enough information from hospital staff about what to do if you were worried about your condition or treatment after you left the hospital?	O	% / Survey respondents	Local data collection / Most recent consecutive 12-month period	600* AGH	77%	80%	Improve score from patients related to amount of information they receive upon discharge.		1)Continue with AGH Adult Inpatient Survey in order to access information on Patient Stay and Discharge.	Distribution of the Survey upon Discharge	Track the number of positive Survey responses proportional to the total number of responses received	Increase performance to 80%.	This survey is provided to all discharged patients. Responses are reviewed by the Quality Council and reported to the Quality Committee of the Board.
											2)Create and distribute handouts related to specific conditions to be provided at discharge	Review and update Discharge document ensuring information is adequate and correct, with references to the handouts that are available to be provided at discharge.	Track the number of positive Survey responses proportional to the total number of responses received	Improve our performance to 80% of patients discharged indicating they "COMPLETELY" received enough information upon discharge	This survey is provided to all discharged patients. Responses are reviewed by the Quality Council and reported to the Quality Committee of the Board.
		Percentage of respondents who responded “completely” to the following question: Did you receive enough information from hospital staff about transitioning from ALC to Long Term Care?	**O**	**% / Survey respondents**	**Local data collection / Most recent consecutive 12-month period**	**600* AGH**	**CB**	**75%**	**Improve communication satisfaction with patients/SDM related to amount of information they receive when transitioning from ALC to LTC**		**1)Update Survey Questions, Create and distribute information handouts related to transitioning from ALC to LTC.**	**Review and update information regarding discharge for patients transitioning from ALC to LTC to include new handouts created.**	**Track the number of positive Survey responses proportional to the total number of responses received**	**75% of patients transitioning from ALC to ECW indicating they "COMPLETELY" received enough information.**	**This survey is provided to all discharged patients, including those transitioning to LTC. Responses are reviewed by the Quality Council and reported to the Quality Committee of the Board.**
	Effective	Percentage of Medication Reconciliations on discharge that had errors that were considered clinically significant	C	# Medication Reconciliations that had clinically significant errors on them / # Discharged Patients	Local data collection / Most Recent Quarter	600* AGH	CB	0%	Collection of Baseline Data related to this measure/indicator to define need for improvement.		1) Educate Nursing Staff and Doctors	In-House Training of staff with regards to Medication Reconciliation completion.	AFHT pharmacist will track number that had clinically significant errors (# with errors / # discharged) by quarter	We aim for ZERO clinically significant errors.	
											2) Review quarterly data at P & T meeting to identify common issues occurring, which can be resolved by amending completion process and which need to have a new process put in place to resolve.	**Tracking of the discharged patient Medication Reconciliationsand identifying the clinically significant errors and determining improvements to trial.. Provision of the tracked data to the P & T committee.**	**Decrease by 10% each quarter of the common issues occurring in the previous quarter**	**Establish Baseline in order to identify target for next quarter of the year**	**Get a report from the AFHT pharmacist quarterly**
											3) Use of Revise Medication Reconciliation paperwork to make it more user friendly	**Review updated paperwork to look for clinically significant errors.**	**# of clinically significant errors on paperwork discovered by FHT Pharmacist during review.**	**10% decrease in the # of clinically significant errors on the discharge Medication Reconciliations**	
		Number of Medication related incidents occurring in Emergency and Acute Units	C	# Medications related incidents current Quarter / # Medication incidents recorded in prior Quarter	Local data collection / Most recent consecutive 12-month period reviewed quarterly	600* AGH	Q3 = 20 (+25%) Q2 = 16 (+228%) Q1 = 7 (-38%) Q4 (23/24) = 18	0	Reduce the number of reoccurring incidents related to medication		1) P & T Committee review of all incidents related to medication quarterly. Look for patterns and make changes to reduce errors.	Tracking of Medication incidents quarterly through incident reporting system and reporting data to Pharmacy Technician to review with P & T Committee quarterly.	Reduction in number of medication incidents recurring after corrective actions recommended	**Decrease number of reoccurring incidents each quarter over the previous quarter by 5% example:Q3 24/25 - 20 incidents decrease by 5% = 1 for Q4 24/25 = 19 incidents**	Reports are reviewed by the Quality Council and reported to the Quality Committee of the Board.

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Safety											2) P & T Committee review previous quarter recommendations against current quarter occurrences for ongoing issues	Review errors occurring after changes in process initiated	# of errors recurring after corrective action implemented from P & T recommendations	Decrease number of reoccurring incidents each quarter over the previous quarter by 5% example:Q3 24/25 - 20 incidents decrease by 5% = 1 for Q4 24/25 = 19 incidents	
	Safe	Percent of Best Possible Medication correctly completed at admission to ACUTE	C	# of BPM correctly completed at admission/# of persons admitted to Acute x 100	Local data collection / Most recent consecutive 12-month period reviewed quarterly	600* AGH	CB	80%	Gather baseline data to reduce the number of incidents related to medication		1) BPMH was updated and put on the medication rec that is completed by the physician on admission	Pharmacy will audit to see how often they are done correctly	% of incomplete BPMH	Establish Baseline	BPMH is now on the med rec form
											2)Educate Nurses on the implementation and use of this new form	Unit meetings, Huddles, formal training.	# of Nurses to who are trained	Establish Baseline	
		Percent of Medication reconciliation forms filled out for admission to ACUTE that were 100% correct	C	% of Med Reconciliations 100% correctly completed at admission to Acute/# of persons admitted to Acute x 100	Local data collection / Most recent consecutive 12-month period reviewed quarterly	600* AGH	CB	80%	Gather baseline data to reduce the number of Med Rec 100% correctly completed on admission		1) Use of the new form that combines the medication reconciliation and the BPMH for patients admitted to Acute.	Pharmacy will audit to see how often they are done correctly	% of 100% correctly completed Med Reconciliations for admissions	Establish Baseline	Launching a new form that combines the Med Reconcialition and the BPMH
											2)Educate Physicians on the implementaiton and use of this new form	Communication/Training at MAC Meetings	# of Physicians trained	Establish Baseline	

2025/26 Quality Improvement Plan "Improvement Targets and Initiatives" Family Health Team

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Access & Flow	Efficient	Percentage of eligible patients overdue for Colorectal Screening	C	% / Patients - Screen eligible individualss 50 - 74 years old	Local data collection / most recent consecutive 12 month period	**92250* FHT**	**45%**	40%	Increase the number of eligible patients participating in colorectal screening program		1)Decrease the number of individuals age 50 - 74 , who are eligible but over due for colorectal screening annually.	PC Staff will utilize EMR searches in order to identify screen-eligible individuals, 50-74 years old, who are overdue for colorectal screening in each calendar year. PC Administrative staff with make phone call to individuals as a reminder that they are overdue for the screening.	Percentage of eligible individuals who remain overdue for colorectal screening each calendar year.	5% reduction in number of eligible individuals overdue for colorectal screening within the next calendar year	
	Timely	Percent of Patients receiving Same Day / Next Day access to Nurse Practitioner	C	% / Patients	Local data collection / most recent 12 month period	**92250* FHT**	70%	75%	Improve access to Nurse Practitioner for Same Day/Next Day appointments over the next 12 month period		1)Increase the number of patients receiving same day/next day appointments with Nurse Practitioner	Open appointment spots with Nurse Practitioner for same day/next day appointments	Number of patients receiving same day/next day appointments when requested. Administration will collect and track this data	Increase access to NP for urgent same day/next day appointments by 5% during next 12 month period.	
		Percentage of Patients responding "strongly agree" and "agree" to the Survey question - "The option of attending an Evening Clinic Appointment is of benefit to me"	**C**	**% Survey ++ Respondents /Surveys Initiated**	**Local data collection / most recent 12 month period**	**92250* FHT**	**CB**	**80%**	**Understand the need to hold Evening Clinics to accommodate Patients.**		**1)Increase the number of patients being seen through Evening Clinics to accommodate patients that are unable to attend daytime appointment.**	**Track the positive responses "Stongly Agee" and "Agree" to the Outpatient Survey question on a quarterly basis**	**% of patients who respond"strong agree andagree" to the question if they feel they would benefit to having evening clinics at the FHT.**	**Collecting Baseline Reaching a response from patients/clients of 80% agree that it is of benefit to them."**	
		Completion of sociodemographic data collection	O	# of Patients completing /Total Patients asked	EMR/Chart Review / Most recent consecutive 12-month period	**92250* FHT**	CB	10%	To better understand the diversity of the clients/patients we serve or volume that we serve and provide appropriate information for them in a method they prefer/ understand		1)Update questions is being asked of Clients/Patients	Intake questions updated	Number of patients completing sociodemographic data that agree to answer the questions / the total number of patients asked	Increase the number of patients completing sociodemogrphic data	Include a disclaimer so they know they don't have to provide any answers to the questions if they are uncomfortable.
											2) Change data collection method to using Ocean	Utilize Ocean to survey patient via email	Number of patients completing sociodemographic data	Increase the number of patients completing sociodemogrphic data	Include a disclaimer so they know they don't have to provide any answers to the questions if they are uncomfortable.

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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	**92250* FHT**	80.0%	90%	Increase the number of staff completing their required training through Surge Learning and other methods as defined by Management Team		1)Provide access to required annual education as well as ongoing educational opportunities on this topic as available to all staff.	Add Mandatory Training to Surge Learning as available	The number of staff who have completed the mandatory training as assigned	90% of all staff having completed their mandatory training in Equity, Diversity, Inclusion and Anti-Racism within the FY 2025/2026	
											2) Educate staff on the importance of completing their required training	Discuss at Team/Unit meeting and huddles. Managers and Lead Hands enforce the need for mandatory training to be completed.	Increase in the number of staff having completed training on a quarterly basis	90% of staff will have completed their training by deadline in FY 2025/26	
Experience	Patient-Centred	Do patients/clients feel comfortable and welcom at their primary care office?	***O***	% / PC organizartion population (surveyed sample)	In-house survey / Most recent consecutive 12 month period	**92250* FHT**	**98%**	100%	Maintain or improve upon Patient opinions regarding if they feel comfortable and welcome at their care office		1)Ask Patients to complete the voluntary In-House survey in order for FHT to understand if we need to improve our services.	Out-Patients complete surveys during or immediately after their office visits	Track the number of positive responses proportional to the total number of responses received	100% of patients/clients indicate they feel comfortable and welcome	Current Performance based on survey results fom April 2024 (AFHT pt surveys amalgamated with AHCS)
Safety	Safe	**Percent of Patients remaining for the required 30 min after allergy injection**	***C***	**% / # of Patients remaining / # of Administered injections**	**Local data collection / most recent 12 month consecutive period**	**92250* FHT**	**CB**	**90%**	**Collecting Baseline Data as we set a new target of 30 min stay**		**1)Educate patients about importance of remaining in the waiting room for at least 30 minutes following an allergy serum injection**	**Nurse to communicate with Patients why 30 minute stay is necessary Communication Nurse/Reception as to amount of wait time for patient. Reception monitors using timer**	**Track and Review the number of patients that do not remain quarterly**	**90% of Patients remain for the required 30 minutes**	**Reports are reviewed by the Quality Council and reported to the Quality Committee of the Board.**

2025/26 Quality Improvement Plan

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Access and Flow	Efficient	Meet the standard number of days between LTC bed vacancy and bed occupancy	***C***	Days / Discharged patients	Local data collection / Calendar Year 2025	53529* LTC	**CB**	5	With an average of wait time of 227 days for admission to our LTC location improving on the # of days beds are unoccupied is best practice.		1)Establish a standard timeframe for families to remove belongings from vacated room when resident discharged/deceased.	Create Policies and Procedures related to standard discharge for removal of personal affects. Add this information to the Handbook for families.	Audit timeframe it takes for families to remove personal items from the vacant room.	Set standard of 2 DAYS for the personal item removal. We aim to maintain our current performance of 5 days between discharge and admission for each quarter of Fiscal Year 2025/2026	
											2)Establish appropriate standard timeframes for required maintenance / room repairs to be completed after room is vacant.	Create Policies and Procedures related to standard timelines and monitoring for adherance	Use of Maintenance Care for entry of room VACANT and needing repairs and Maintenance completed. Audit timeline through Maintenance Care for room maintenance and repairs completion .	Maximum of **3 days** once notified in Maintenance Care that the room is vacant and requires repairs.	We aim to maintain our current performance of 5 days between discharge and admission for each quarter of Fiscal Year 2025/2026
											3)Establish appropriate standard timeframes for required housekeeping to clean room after room is vacant and maintenance has performed required repairs.	Create Policies and Procedures related to timelines and procedure for monitoring adherance LTC Staff Submit Request to Housekeeping Staff for room once vacant and ready for occupancy.	Audit timeline for the completion of Housekeeping for the room after notified maintenance is complete	Maximum of 1 day once notified room is ready for housekeeping Housekeeping will often go into the room as soon as maintenance is finished fixing up the room so the aim is for housekeeping to do this the same day Maintenance is finished.	We aim to maintain our current performance of 5 **days** between discharge and admission for each quarter of Fiscal Year 2025/2026

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											4)LTC Coordinatory/Staff to plan ahead when resident is nearing end-of-life to determine if internal moves will be required to happen after death / discharge.	LTC Coordinator to maintain an up-to-date internal transfer list for planning ahead when beds are vacated in order to speed the notification process to maintenance, housekeeping and LTC staff.	Audit the timeline between vacant bed and occupied bed to assess the usefulness of the Plan and effectiveness of the notification process/completion to meet target	We aim to maintain our current performance of **5 days** between discharge and admission for each quarter of Fiscal Year 2025/2026	
	Timely														
Equity	Equitable														
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	53529* LTC	38%	95%	Increase the number of LTC Residents/Representatives who positively responded to the In-House Survey with (#9-#10) to this question, in order to provide exceptional service to the Residents.		1)Continue with In-House Resident Experience survey in order to encourage resident engagement.	Voluntary In-House survey distributed to all residents annually	Track the number of positive responses (#9, #10) proportional to the total number of responses received not the percentage	Increase positive number (#9, #10) of responses to 95% over the 2025 calendar year.	This survey is provided annually to all residents. AGH has only 26 LTC beds total with approximately a 40% response rate. Responses are reviewed by the Quality Council and reported to the Quality Committee of the Board. Survey results are shared with both the Resident and Family Councils.
											2)Share results of Survey with the staff so they know how Residents/Representatives are feeling.	Annually provide staff with results of the IN-House Survey in order to assist them in improving their responses to the residents Review with the LTC continuouse quality improvement committee.	Track the number of positive responses proportional to the total number of responses received and review them with staff.	Increase positive number (#9, #10) of responses to 95% over the 2025 calendar year.	This survey is provided annually to all residents. AGH has only 26 LTC beds total with approximately a 40% response rate. Responses are reviewed by the Quality Council and reported to the Quality Committee of the Board. Survey results are shared with both the Resident and Family Councils.

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		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	53529* LTC	23%	90%	Increase the number of LTC Residents/Representatives who positively responded to the In-House Survey with (Agree/Strongly Agree) to this question, in order to provide exceptional service to the Residents.		1)Continue with In-House Resident Experience survey in order to encourage resident/representative engagement and feedback.	Voluntary In-House survey distributed to all residents annually	Track the number of positive responses proportional to the total number of responses received	Increase number of positive responses to this question to 90% of LTC residents Current Performance 6 of 7 responses recorded as strongly agree/agree to the survey out of 26 residents	This survey is provided annually to all residents. AGH has low volume (AGH has only 26 LTC beds total with approximately a 40% response rate). Responses are reviewed by the Quality Council and reported to the Quality Committee of the Board. Survey results are shared with both the Resident and Family Councils.
											2)Share results with the staff so they know how residents are feeling and can improve their responses to them	Annually provide staff with results of the In-House Survey in order to assist them in improving their responses to the residents	Track the number of positive responses proportional to the total number of responses received	Increase number of positive responses to this question to 90% of LTC residents Current Performance 6 of 7 responses recorded as strongly agree/agree to the survey out of 26 residents	
		Residents who responded positively with (Agree/Strongly Agree) when asked "Overall I am satisfied with the recreational activites offered in ECW" on Voluntary In-House Survey.	*C*	# who responded Agree/Strongly Agree / # LTC home residents who responded	In house data / 2025 Calendar year	53529* LTC	55%	95%	Putting more focus on the provision of more and varied Recreation Activities for Residents		1)Increase the variety of recreations options availble for Residents to participate in.	Work with the Recreation Coordinator to increase the variety of activities offered within each quarter for FY 2025/26	Track the variety of activites offered and the frequency of each during each quarter and the number of residents who are participating in the activities.	Increase positive response rate of residents to 95% by end of Q3 FY 2025/26	Responses are reviewed by the Quality Council and reported to the Quality Committee of the Board. Survey results are shared with both the Resident and Family Councils.
											2)Encourage Residents/Representatives to participate in Recreation Activities offered and to provide feedback to Recreational Coordinator.	Provide schedule of activities well in advance. Ensure residents/representatives are aware of the activities being offered.	Track particpation in offered activities by resdient daily. Ask them for feedback on satisfaction with the activity they participated in and track their responses. (Agree or Dis-Agree)	Increase the participation by residents by 95% between Q1 and Q3 FY25/26	Responses are reviewed by the Quality Council and reported to the Quality Committee of the Board. Survey results are shared with both the Resident and Family Councils.

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											3)Encourage Residents to complete the Semi-Annual In-House Survey in order for AGH-LTC to provide appropriate recreational activities	Allow the Resident/Respresentatives to complete the Survey verbally or in writing regarding satisfaction with recreational activities.	Track the number of positive responses proportional to the total number of responses received.	Increase positive responses to 95% with regards to the recreational opportunities offered.	Survey administered Semi-Annually to all Residents. Current response rate to survey is low with only 40% of 26 residents providing response
Safety	Safe	Percentage of LTC home residents who fell in the 30 days leading up to their assessment	*O*	# LTC Residents who fell / # Total LTC Residents assessed	CIHI CCRS / Q2 July-September 2024 with rolling 4-quarter average	53529* LTC	10.53%	8.00%	Provincial target is 9%, therefore we are targeting to be below the provicial target.		1)Continue to review falls with multidisciplinary team at huddles and falls meetings and implement recommendations / fall prevention interventions.	Falls Committee recommendations shared with staff in a timely manner (multidisciplinary staff safety huddles)	Review the data in RAI for restorative care results.	Reduce the number of falls within 30 days leading to assessment to 3 or less per quarter	Current Performance is auto populated by MOH. Provincial Benchmark currently = 9% *INTERNAL INFO FROM QIP page - This indicator is not risk-adjusted and represents a rolling four quarter average. Provincial value: 15.52% [Q2 2024]*
											2)Flag residents who are high falls risk and increase monitoring of these residents	Review flagged residents for improved fall numbers	Review Fall reports monthly	We are aiming to reduce the number of falls to 3 or less in each quarter	Reports are reviewed by the Quality Council and reported to the Quality Committee of the Board. Results are shared with both the Resident and Family Councils.
											3)Provide access to and encourage participation in restorative care exercises and physical activity for residents offered through Rehabilitation Department	Review results of restorative care exercises and physical activity of residents	Review Surge QRM Fall reports monthly	We are aiming to reduce the number of falls to 3 or less in each quarter	Reports are reviewed by the Quality Council and reported to the Quality Committee of the Board. Results are shared with both the Resident and Family Councils.

2025/26 Quality Improvement Plan

"Improvement Targets and Initiatives" LTC

Black Continue from 24/25, Green New 25/26

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TYPE - P = Priority (if not working on must explain why) O= Optional C = Custom (add any other indicators you are working on)

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
		Percentage of LTC home residents who are restrained	***C***	**# LTC Residents restrained / # Total LTC Residents assessed**	**RAI Data / Quarterly**	**53529* LTC**	**28.10%**	**10%**	**Provincial benchmark is 3.0% and we will work towards this target.**		**Educate the staff about restraints and work with the residents and the families to figure out better ways to prevent falls other than use of restraints.**	**Increase awareness of restraints with the staff.**	**Use the RAI information that is reported to Health quality Ontario to determine our score each quarter. Pull the data from the restraints book quarterly to get current restraint numbers.**	**Aim for only 10% of residents are restrained by end of Q3 - FY25/26**	**Current Performance 28.10% is from 2022/23 Provincial Data. This is big change for the home home and will need a lot of education in order to reduce the number of restrained residents.**
		Number of Medication related incidents occurring in Long Term Care	***C***	# Medications related incidents current Quarter / # Medication incidents recorded in prior Quarter	Local data collection / Most recent consecutive 12-month period reviewed quarterly	53529* LTC	3	0	Reduce the number of incidents related to medication errors		1)Review of all medication related incidents with recommendations for improvement/changes to process	Review incidents with LTC Pharmacist and Nurse Manager/LTC Coordinator	Track Medication incidents in Surge QRM with quarterly review	**Decrease the number of incidents occurring quarter over quarter by 1 with 0 target by Q3 of FY25/26**	Reports are reviewed by the Quality Council and reported to the Quality Committee of the Board.
		Rate of workplace violence incidents - Long Term Care	***C***	# of incidents / # of Staff	Local data collection / most recent consecutive 12-month period	53529* LTC	**0**	**0**	Continue with current number of incidents related to workplace violence		1)Continue to encourage staff to report all incidents of violence	Provide access to the Surge QRM program in order to complete incident reports.	The number of reports in surge QRM by staff of LTC Home quarterly	Continue with our attempts to Zero violent incidents occurring in Long Term Care	Reports are reviewed by the Quality Council and reported to the Quality Committee of the Board.