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

Hope Street TERRACE

Hope Street Terrace 20 HOPE STREET SOUTH, Port Hope , ON, L1A2M8

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)

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	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)	51606*	30.59	25.00	As an organization, we believe that a target of 25.00 is both a measurable and an attainable goal. Through implementation of our change ideas, the home expects an improvement over the next 12 months.		1)Support early recognition of residents at risk for ED visits by providing preventive care and early treatment for common	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	Number of staff who demonstrated use of education in SBAR documentation quarterly.	Decrease in ED visits by 5% by implementing the use of proper SBAR	Utilize Southbridge Nurse Practitioner, NP Stat, other stake
											2)Data Review of all ED transfers using tracker; identify any trends such as time of day, diagnosis, process for potential in	Continue to use the hospital transfer tracking tool and review by the quality team during monthly quality meetings to identify trends.	% decreased in avoidable ED visits due to trend identification.	5% decrease in avoidable ED visits due to trend identification by February 28th,	
											3)Director of Care or designate to review ED tracker, for the common reasons for transfer to ED - review in Nursing practice	ED transfer audit will be completed and reviewed monthly by nursing leadership (DOC, ADOC). Audit findings will be reviewed at quarterly PAC meetings; and standing agenda in nursing practice meeting.	% of Registered staff involved in monthly practice meeting	100% of Registered Staff will be educated on the monthly identified trends from the ED	
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	51606*	100	100.00	Through education, the Home expects to have an increase understanding of this criteria over the next 6 months	Surge Learning Education, CLRI	1)To improve overall dialogue of diversity, inclusion, equity and anti-racism in the workplace	Training and/or education through Surge education online learning modules	% of staff educated on Culture and Diversity	100% of staff educated on Culture and Diversity. December 31,	
											2)To increase awareness and diversity training through Surge education or live events;	Introduce diversity and inclusion as part of the new employee onboarding process, through surge education. Cultural Diversity to be added as standing agenda at townhall meetings. Activation department to introduce cultural diversity special events.	% of new staff educated on Culture and Diversity	100% of new staff educated on Culture and Diversity by December 31 2025	
											3)Creation of culture/diversity board representing and promoting relevant equity, diversity, inclusion and anti-	Implement cultural/diversity survey to resident council and staff to identify prominent ethnic backgrounds, religion, and gender identities within the home.	% of participants in the survey.	80% of resident and staff completion of survey by June 30, 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	51606*	90.91	91.00	We aim to exceed current facility performance as we have surpassed corporate average of 89.66 with a current performance of 91.	Satisfaction Survey	1)To exceed our goal of 85% from the previous year to maintaining above 90% for this current year. Engaging residents in	Add resident right #29 to standing agenda for discussion on monthly basis by program Manager during Resident Council meeting. Re-education and review to all staff on Resident Bill of Rights specifically #29 at department meetings monthly by department	100% of all department meetings will have Residents' Bill of Right #29 discussed, will be review by July 31, 2025 to ensure it is implemented as a standing agenda item.	100% of all staff and residents and families to have been re-educated on resident Bill of	Total Surveys initiated: 55 Total LTC beds: 77
											2)Review of Complaints and Concerns process in the home on admission and during annual care conference	Review of policy with resident and family on admission and care conferences	% of residents and families educated on policy on admission and during care conferences by December 31, 2025.	80% of residents and families educated by December 31, 2025.	
											3)Engage residents' council members and /or non resident council members in various committees.	Committee leads to encourage residents to participate in meaningful discussions to ensure their voices and input can be heard and taken into consideration.	% of residents participating in committees.	100% of committees requiring residents as part of their membership will	
Safety	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	51606*	16.55	15.00	We aim to meet corporate average of 15%.	RNAO, CareRX Pharmacy, NP Stat, Southbridge Nurse Practitioner, Physio Therapist, Registered Dietician, MDs	1)To facilitate a Weekly Fall Huddles on each unit with members of the interdisciplinary team.	Complete a weekly huddle with unit staff regarding ideas to help prevent risk of falls or injury related to falls.	Number of staff participants in the weekly falls huddle.	90% of staff participation on Falls Weekly huddle on each unit	
											2)Monthly collaboration with Falls committee, and external resources for the development of the resident's plan of care.	Falls committee to discuss changes to plan of care for residents who are frequently falling or suffered injury due to a fall at monthly CQI meeting.	% of CQI meetings where fall committee discuss plan of care for frequent falling residents.	100% of CQI meetings consist of discussion from fall committee regarding plan of	
											3)Re-education of falls program, specifically required documentation for post-fall process.	Education and re-education provided to registered staff on the completion of post fall documentation process.	% of registered staff who have been educated/re-educated on the completion of post fall documentation process.	100% of all registered staff to be educated/re-educated on the completion of post	
		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	51606*	15.29	15.00	Continue to work on reducing this target that was successfully met in previous year and maintain below corporate average of 17.5%.	PASE Team, NP Stat, Southbridge Nurse Practitioner, Medical Director, Attending Physicians, GABU	1)Residents who are prescribed antipsychotics for the purpose of management of Responsive expressions, will have a	BSO lead and nursing team will ensure that residents who receive antipsychotics for responsive expressions with have their medication, plan of care reviewed, quarterly by the interdisciplinary team (including resident and family)	% of residents prescribed antipsychotics medications over the number of residents who have received a medication review in the last quarter.	100% of residents prescribed antipsychotic medications to receive a	
											2)Ensure appropriate diagnosis of psychosis for residents with psychotic symptoms	RAI Coordinator to consult with DOC or designate who will follow up with MD regarding residents who are being coded with psychotic symptoms who do not have a diagnosis to determine if diagnosis of psychosis is appropriate	% of residents with psychotic symptoms who receive a diagnosis of psychosis or other psychotic class diagnosis	100% of residents with psychotic symptoms will be referred to MD for diagnosis	
											3)Medication Review quarterly of residents prescribed antipsychotic medication without diagnosis.	Referrals to be sent to the pharmacist for all residents quarterly and all new admissions who are prescribed antipsychotic medication without diagnosis to determine if antipsychotic medications continue to be an appropriate intervention.	% of residents reviewed who are prescribed antipsychotic medication without diagnosis.	10% reduction in residents without psychosis diagnosis who were given antipsychotic	