

2026/27 Quality Improvement Plan for Ontario Long Term Care Homes
 "Improvement Targets and Initiatives"



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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	Rate of ED visits for modified list of ambulatory care-sensitive conditions* per 100 long-term care residents.	P	Rate per 100 residents / LTC home residents	CIHI CCRS, CIHI NACRS / October 1, 2024, to September 30, 2025 (Q3 to the end of the following Q2)	51215*	34.29	29.14	To decrease indicator by 15% with goal to achieve Provincial Average through implementation of the change ideas over the next year. The reduction took into account the younger population and the number of	Home at Health, MD, BSO internal/external	1)#1) Continue to implement regular health screening through IPAC assessments and preventive care measures to help	Registered staff to ensure vaccinations are up to date, educate staff on recognizing early warning signs of health issues and provide them with resources in the home to manage both acute and chronic issues.	Number of focused health assessments reviewed per month by the IPAC and Quality lead	100% compliance with health screening through IPAC assessments completed by											
											2)Implementation of the Nursing PLEDGE Initiative program to build capacity and improve overall clinical assessment skills of	Senior Registered Staff will provide mentorship, education to enhance the clinical knowledge of Registered Staff regarding physical assessment skills, documentation (PCC and SBAR), communication with physicians and families and the management of	Number of Registered staff who initiated an avoidable transfer to ED over the Number of Registered staff who participated in the initiative.	80% of ED visits were assessed appropriately based on resident outcome and											
											3)Nursing Leadership to review and analyze the monthly ED trackers for root cause of transfers and determine appropriateness	Review data at Monthly Mandatory meetings, monthly Registered Staff meetings and Quarterly PAC/CQI meetings	The number of focus SBAR documented progress notes related to ED transfers over the number of ED transfers monthly	15% reduction in avoidable ED visits by December 31,2026	Nursing PLEDGE initiative and other stakeholders such as Oxygen										
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	51215*	100	100.00	Through continued education, the home expects to have an increased understanding by June 30 2026		1)To continue to facilitate ongoing open door policy amongst the management team	At Risk Management meetings, reminders of open door policy 2) Direct staff to specific team member to address concerns	Number of reminders documented over the number of Risk Management meetings	100% of reminders to staff re: open door policy by May 31 2026											
											2)To improve overall dialogue of diversity, inclusion, equity and anti-racism in the workplace;	Cultural events with food, activities in the home, Monthly Universal "YUMS" box to celebrate a specific country, Arm chair travel to coincides with the "YUMS" box	Number of events celebrated over the number of cultural events in a calendar year	100% of cultural events to be celebrated monthly by December 31 2026											
											3)To increase diversity training through Surge education or live events;	1) Training and/or education through Surge education or live events; 2) Introduce diversity and inclusion as part of the new employee onboarding process;	1) Number of active staff educated on Culture and Diversity; 2) Number of new employee trained of Culture and Diversity;	100% of active staff educated on topics of Culture and Diversity by December 31 2026											
Experience	Patient-centred	Percentage of residents responding positively to: "What number would you use to rate how well	O	% / LTC home residents	In house data, NHCAHPS survey / Most recent consecutive 12-month period	51215*	CB				1)				The indicator was not required on the Resident survey 2026										
											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	51215*	82.14	90.00	The home aims to meet or exceed corporate goals and benchmarks through continued practices of the Open door policy and Daily management walkabouts			1)To exceed our goal of 82% by engaging residents in meaningful conversations allowing residents to express their opinions	Add Resident's Bill of Rights #29 to standing agenda during Admission and Care Conferences, maintain practice of the open door policy and daily management walkabouts	Number of care conferences that review resident Bill of Rights #29 over Number of Care Conferences	100% of all Admission and Care Conferences will document the review of Resident	
																					2)Continue reviewing Resident's Bill of Rights # 29 at Monthly resident council meetings	Bill of Rights #29 will be a standing agenda item at monthly meetings	Number of Resident council meetings that have the Bill of Rights #29 reviewed over the number of Resident council meetings	Number of Resident council meetings that have the Bill of Rights #29 reviewed over	
		3)Continue to review Resident Bill of Rights #29 at Family Council quarterly meetings	Continue to review Resident Bill of Rights as a Standing agenda item at quarterly meetings	Number of meetings that have Resident Bill of Rights #29 reviewed over the number of meetings	100% of all Family Council meeting minutes include Resident Bill of Rights #29 by																				
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 September 30, 2025 (Q2), as target quarter of rolling 4-quarter average	51215*	16.94	14.00	Target is based on Corporate benchmark with aim to exceed the Corporate goal	Pharmacy, MD, PT/OT	1)To establish and facilitate an interdisciplinary approach to Weekly Fall Huddles	Weekly interdisciplinary team huddles on resident home areas to review the resident's plan of care, determine potential or actual root cause and mitigate the risk of falls or injury related to falls and completion of environmental audits	The number of interdisciplinary staff members participating in weekly huddles 2) Number of environmental audits completed	100% interdisciplinary participation at Weekly Fall Huddles by June 30											
											2)Injury prevention - review of FRS, ensure appropriate medication prescribed for prevention of bone density loss	1) Resident list of FRS of 3 or greater, offer fracture prevention medication 2) Monthly collaboration with the Fall committee, (during Quality meeting), to review the resident's plan of care (identification of the triggers, related to the fall) referrals to MD and Pharmacist for	1) Number of residents with a FRS of 3 or greater prescribed fracture prevention medications over the Number of residents with a FRS of 3 or greater 2) Number of medication review referrals to MD/Pharmacist over number of residents who	100% of residents who experienced a fall in the month will have completed a											

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)

