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

Chippawa Creek at Bella Care Residence 8720 WILLOUGHBY DRIVE, Niagara Falls , ON, L2G7X3

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
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															
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)	54403*	24.3	20.00	This will be achieved by recognizing and managing resident conditions and improve staff awareness to recognize changes.		1)Increase communication on trends and reasons why residents are transferred to ED	1)24 hour report will be reviewed and discuss strategies for improvement in morning meetings 2)Add ED transfers to Communication Sheet at morning meetings	1)# of residents sent to ED 2)# of morning meetings where ED transfers were discussed	All ED transfers will be reviewed and communicated to the team, including identifying trends and reasons by June 30/26.	
Equity	**Equitable**	Percentage of staff (executive-level, management, or all) who have completed	O	% / Staff	Local data collection / Most recent consecutive 12-month period	54403*	CB	100.00	We will improve staff completion of equity, diversity, inclusion and anti-racism education. We will train,		1)Provide education for staff on DEI to increase awareness	1)Mandatory online education modules through Surge Learning 2)Create a DEI bulletin board to increase awareness 3)Hold an Ethnic Potluck day for culture awareness	1)% of staff completed online modules 2)# of events posted on the board 3)# of different food items provided at the Potluck	80% of Full-time Staff will be educated regarding DEI by Sept 30/26	
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	54403*	CB	80.00	This will be achieved through staff education, promoting resident-centered care, and ongoing monitoring of survey results.		1)Baseline data is unavailable because the questions were not included in the survey. Targets will be established after the next satisfaction survey.	The organization will revise the resident satisfaction survey to include the missing questions related to staff listening.	Process measures will include the percentage of residents and families participating in the updated survey.	Target: 100% of resident satisfaction surveys include the two new questions	These indicators could not be reported due to omission from the previous survey tool. This gap has been identified and corrective action is underway to ensure alignment with QIP requirements.

		Percentage of residents responding positively to: "I can express my opinion without fear of consequences"	C	% / LTC home residents	In house data, NHCAHPS survey / most recent consecutive 12 month period	54403*	93	95.00	This will be achieved by promoting a culture of respect, encouraging residents to have a voice and ongoing monitoring of resident feedback through satisfaction survey.		1)Baseline data is unavailable because the questions were not included in the survey. Targets will be established after the next satisfaction survey.	The organization will revise the resident satisfaction survey to include the missing questions related to staff listening.	Process measures will include the percentage of residents and families participating in the updated survey.	Target: 100% of resident satisfaction surveys include the two new questions	These indicators could not be reported due to omission from the previous survey tool. This gap has been identified and corrective action is underway to ensure alignment with QIP requirements.
Safety	**Effective**	Percentage of residents with identified Palliative Care needs who have a documented Palliative Care Plan addressing pain and symptom management	C	% / LTC home residents	In-home audit / most recent consecutive 12 month period	54403*	CB	CB	Improve in-house results		1)Improve timely identification of residents with Palliative Care needs to support early initiation of appropriate Palliative Care planning	1)Provide mandatory education to Nursing staff on recognizing clinical indicators of Palliative Care needs 2)Conduct regular audits of Care Plans to assess timely identification and documentation of Palliative status 3)Review residents with potential or identified Palliative Care needs at Pain & Palliative Care meetings	1)# of staff that have completed Palliative Care education 2)% of residents with a decline or change in condition whose Care Plan was updated accordingly 3)% of residents identified with Palliative Care need reviewed at Pain & Palliative meeting	Palliative Care needs will be recognized and documented in a timely manner by Sept 30/26	
											2)Provide education to nursing staff on recognizing pain and palliative symptoms and add to Care Plans	1)Assign mandatory Surge Learning Pain & Palliative modules 2)Reinforce pain and palliative symptom recognition during Staff Meetings 3)Incorporate Pain & Palliative Care education to new new staff Orientation 4)Conduct regular reviews of palliative care documentation to ensure pain and symptom management is addressed	1)% of nursing staff who have completed Pain & Palliative education 2)% of residents identified as palliative who have a documented Care Plan addressing pain and symptom management 3)% of Palliative Care plans reviewed and updated following a change in condition	Staff will be able to recognize pain and palliative symptoms and complete Pain & Palliative Care Plans by April 30/26	
	Safe	Percentage of long-term care residents in daily physical restraints	O	% / LTC home residents	CIHI CCRS / July 1 to September 30, 2025 (Q2), as target quarter of rolling 4-quarter average	54403*	0.97	0.00	We currently have only 1 resident with a restraint due to family persistence.		1)Educate families and residents on least restraint policies	1) Provide restraint brochure in admission package 2) Discuss risks and benefits at Care Conferences	1) # of restraint brochures in admission package 2) Review # of Care Conferences where risks and benefits are discussed	1) 100% of admission packages will have restraint brochure by beginning of first quarter 2) 100% of the residents who have restraints will have a Care Conferences that includes risks and benefits of restraints by June 30	Currently we have 1 resident with a restraint due to family request. We will continue to educate.

		Percentage of long-term care residents whose stage 2 to 4 pressure ulcer worsened	O	% / LTC home residents	CIHI CCRS / July 1 to September 30, 2025 (Q2), as reporting quarter for the rolling 4-quarter average	54403*	3.81	2.50	This will be achieved by focusing on early identification of skin breakdown, timely interventions, and consistent monitoring of at-risk residents. Our Wound Care Champion has just achieved certification as a SWAN and continues to work closely with the Nurse Practitioner.		1)1)Educate PSW staff on identifying all stages of Pressure Injuries	1)Assign online skin and wound modules on Surge Learning 2)Arrange education from external vendor (Prevail) for wound staging	1)# of staff who have completed online modules 2)# of PSWs who have been educated by vendor (Prevail) for wound staging	PSW staff will have the education to identify all stages of Pressure Injuries	
											2)1)Educate Registered Staff on recognizing, staging, treating pressure injuries	1)On spot training by Wound Care Champion 2) Assign online skin and wound modules on Surge Learning 3)Add wound care presentation by Wound Care Champion to new hires during orientation	1)# of on spot training by Wound Care Champion 2)# of staff who have completed online modules 3)# of new hires educated by Wound Care Champion during orientation	Registered Staff will recognize, stage and treat pressure injuries by December 31/26	
		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	54403*	20.47	15.00	Working towards Corporate targe of 15%		1)1)Improved awareness of environmental hazards	1)Implement checklist to include bed/chair height, call bell access, proper footwear, mobility aid access, lighting/clutter, fall mats etc. 2)Perform random audits in various locations 3)Identify environmental hazards	1)# of environmental checklists implemented 2)# of environmental audits completed 3)# of education sessions held after audit results	Staff will have improved awareness of environmental hazards by September 30/26	
											2)2)Promote engagement with residents in lounges to reduce risk for falls	1)PSWs will ensure TV will remain on at all times by performing random audits 2)Ensure meaningful activities are available	1)# of audits performed 2)# of activities implemented	Residents will be engaged in lounges by April 30/26	
											3)3)Roll out "Stop and Go" model to all staff	1)Create "Stop and Go" signs and post throughout home 2)Educate staff and residents of "Stop and Go" model 3)Add to Orientation Package for new hires 4)Share the model with Resident and Family Council	1)# of falls compared to previous month	"Stop and Go" model will be implemented by Sept 30/26	

		Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident	O	% / LTC home residents	CIHI CCRS / July 1 to September 30, 2025 (Q2), as target quarter of rolling 4-quarter average	54403*	53.57	40.00	Working towards the Provincial average of 19.8%		1)Strengthen anti-psychotic program for residents receiving antipsychotics without appropriate diagnosis	1)Conduct regular reviews of all residents receiving antipsychotics without appropriate diagnosis 2)Educate staff on ruling out pain prior to administering antipsychotics 3)Collaborate with the physicians to ensure they add an appropriate diagnosis when prescribing antipsychotics and on admission	1)% of residents receiving antipsychotics without the appropriate diagnosis 2)# of PRN antipsychotics administered following a pain assessment 3)% of residents receiving antipsychotic medications who have a documented appropriate diagnosis at time of prescribing or on admission	At least 90% of residents receiving antipsychotics without an appropriate diagnosis will have documented medication review completed within the last quarter by Dec 31/26	