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

CRESCENT PARK LODGE
A DIVISION OF CONMED HEALTH CARE GROUP

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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)	51535*	22.35	18.00	We believe this is a realistic achievable goal.	Dr. Spencer, Dr. Scher, Dr. Gholam	1)Continued use of hypodermoclysis as a means of low risk hydration for residents at risk due to refusal or inability to take in	RPNs and RNs will contact physician who will order hypodermoclysis.	There will not be an increase in transfer to hospital for dehydration.	To see zero transfer to hospital related to dehydration.	
											2)Continued focus on proactive nursing approaches where new onset symptoms are identified quickly and	RNs and RPNs meet in DOC office daily for huddle to review resident needs and identify and address acute concerns.	To decrease transfer to hospital via early identification with treatment onsite where able.	To decrease transfer to hospital by 5% over the next year.	
											3)Auditing of PPE and hand hygiene to promote compliance with staff.	Statistics reviewed quarterly at PAC meetings and education scheduled as needed.	Decrease in transmission of infection and need for hospitalization related to infections.	Eliminate need for transfer to hospital related to early identification of signs of infection.	
											4)Seek out specialized education for the care team members around understanding and effectively managing	Monthly behaviour meetings with PRC.	Continued collaboration with BSO, SMHO, PRC, social work, resident and family.	To reduce transfers to hospital related to mental health by 5%.	
Equity	Equitable	Percentage of staff (executive-level, management, or all) who have completed relevant equity,	O	% / Staff	Local data collection / Most recent consecutive 12-month period	51535*	CB	100.00	Our target of 100% is achievable for all staff. We have an effective		1)All staff will be expected to complete mandatory cultural sensitivity training to be provided through our on-line education program	Nurse management to monitor education modules for completion rates.	Completion rates to be monitored by management with the expectation of 100% compliance before December 2025.	100% completion rate for cultural sensitivity education modules.	
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	51535*	62.5	100.00	We feel this is an achievable goal.There has been an increase in communication from residents and attendance and quarterly meetings where		1)A new resident/family Satisfaction survey has been developed.	Survey given to families at care conferences, QR code posted around the home, in newsletter, paper copies are made available.	To see an increase in the number of responses to this satisfaction survey by resident and family members.	To meet our goal of 100% satisfaction.	
											2)To increase the percentage of residents responding positively to "What number would you rate how well staff listen to	This is measured through the use of resident satisfaction surveys and asking pointed questions at care conferences about things that they are most satisfied with as well as least.	Responses to satifaction surveys are tracked and in terms of positive and negative, the data is analyzed and shared at quarterly CQI meetings as well theses results are posted within the home and annually on our home website.	100% of residents will respond positively to What number would you rate how well staff	Resident participation and collaboration in care planning is tracked using
		Percentage of residents who responded positively to the statement: "I can express my	O	% / LTC home residents	In house data, interRAI survey / Most recent consecutive 12-month period	51535*	81.25	100.00	100% is achievable.		1)A new resident/family satisfaction survey has been developed.	Survey given to families at care conferences, QR code posted around the home, in monthly newsletter and paper copies made available.	To see an increase in the number of responses to this satisfaction survey by the resident and family members.	To meet our goal of 100% satisfaction.	
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	51535*	14.95	10.00	We feel that 5% is an achievable target.		1)Initiation of the “Falling Leaf Program” where a falling star graphic is placed at the entrance of a resident’s room who has	Data is collected through the "Insights" section of the PCC program quarterly. This information is shared, and discussed at quarterly CQI meetings, PAC meetings, and discussed and analyzed at weekly Falls Prevention Program Meetings. New adoption of RNAO clinical	The number of falls for the previous week are reviewed by he members if the Falls Prevention Program team. FRAT scores and risk factors are reviewed and changes in safety plans are developed if necessary and communication with the care team members, resident	To see a decrease of 5% overall in falls for the next year.	
											2)All new and returning are screened for falls risk as per our newly adopted RNAO Clinical Pathways admission assessment process. From	The success of improvement intitiatives are determined through review and analysis by members of the Falls Prevention Team Program on a weekly basis.FRAT scores are reviewed as well as as information recorded in the Risk Mangement system.	Changes in trends and frequencies of falls are reviwed at wwwkly Falls Prevention Team meetings.Issues if any are idenified and actions plans are then put into place if improvement is required.	There is a plan for a decrease in the frequency of falls as per quarterly assessment data to	
											3)Fall huddles have been incorporated within post-fall assessment UDAs and are now being completed with a higher compliance	Changes and trends in the frequencies and causes of falls are reviewed on a weekly basis at interdisciplinary Falls Prevention Team meetings.This includes input snd reccomendations from our Physiotherapist.	The frequency of the number of falls within the last 30 days prior to a resident assessment is extracted from RAI MDS data, reviwed and analyzed at the Falls Prevention Team Meetings. These resukts are shared at CQI meetings and PAC meetings. Any findings for	Our new target goal for the year ahead is 10%.	

		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	51535*	19.39	15.00	This is an achievable goal based on current trends internally.		1)Engage residents, families, and care partners in discussions about antipsychotic medications, responsive behaviours, and	Run report of prescribed antipsychotics quarterly to ensure coinciding diagnosis on file.This shall be used as a tool in identifying missing documentation.	Continuous and consistent discussion and review in collaboration with our Pharmacy Consultant at quarterly PAC meetings has allowed for greater recognition about the importance of identifying and correcting missing information by all participants on the	Our team feels that 15% is an achievable goal based on new interventions and	
											2)Continued imcorporated use of the Delirium clinical pathway UDA on admission to ensure registered staff have a good understanding	Changes in the frequency and use of antipsychotic medications to be analyzed and reviewed at quarterly PAC meetings in collaboration with the Medical Director and Pharmacy Consultant.This informatkion can be generated from RAI MDS reports as well as Pharmacy	Data to be reviewed and analyzed by members of the Medication Safety Program where results are presented annually at PSC meetoings.	To decrease to 15%	
											3)The pharmacist lead BOOMR process was introduced for new long term admissions. This program has proven to be	Interdisciplinary phone call to gather history from previous physician, previous pharmacist, family, MRP, and nursing team to ensure clear documentation to support indication for medication based on medical history.	To see a decrease in lack of indication for use.	To decrease the incidence of antipsychotic use without a supporting	