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

Chelsey Park (Oxford) Nursing Home 310 OXFORD STREET WEST, London , ON, N6H4N6

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 on)															
Access and Flow	**Efficient**	Rate of ED visits for modified list of ambulatory care–sensitive conditions* per 100	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	51510*	28.91		1) At the provincial Average; 2) Through implementation	NP; BSO; PRCs: RNAO BP Consultant; MD Paramedic LTC +	1)1) To reduce unnecessary hospital transfers, through the use of on-site Nurse practitioner; education to families; education to staff;	1) Education and re-education will be provided to registered staff on the continued use of SBAR tool and support standardize communication between clinicians. 2) Educate residents and families about the benefits of and approaches to preventing ED visits. The	1) Number of communication process used in the SBAR format, between clinicians per month; 2) The number of residents whose transfers were a result of family or resident request. Number of staff who demonstrated education application via documentation quarterly. The	1) 80% of communication between physicians, NP and registered staff will	Utilize Nurse Practitioner, other stake holders such as Medigas, CareRx
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	51510*			Through education, the Home expects to have an increase understanding of	Surge Education; BSO; Cultural based organization in the community	1)1) To improve overall dialogue of diversity, inclusion, equity and anti-racism in the workplace; 2) To increase diversity	1) Training and/or education through Surge education or live events; 2) Introduce diversity and inclusion as part of the new employee onboarding process; 3) Celebrate culture and diversity events; educational opportunities 4) Monthly quality meeting standing	1) Number of staff education on Culture and Diversity; 2) number of new employee trained of Culture and Diversity;	80-100% of staff educated on topics of Culture and Diversity	1) 80-100% staff education on Culture and Diversity; 2) number of new
Experience	**Patient-centred**	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	51510*		82.73	Target is based on corporate averages. We aim to meet or exceed		1)1) To increase our goal from 80% to 90%. Engaging residents in meaningful conversations, and care conferences, that allow	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 standing agendas will have Residents' Bill of Right #29 added, for review by December 2025. 100% of all staff will have education via department meetings on Resident Bill of Rights #29 by December 2025. 100% of resident Council meeting	100% of all staff and residents and families will have completed the education on	
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	51510*	21.18		Target is based on corporate averages. We aim to meet or exceed,	RNAO BP Coordinator; PT; NP	1)1) To facilitate a Weekly Fall Huddles on each unit; with the interdisciplinary team 2) Establishing documentation/charting	1) Complete a weekly meeting with unit staff regarding ideas to help prevent risk of falls or injury related to falls; 2) To increase participation with RNAO Best Practice Coordinators navigate falls processes; completion of GAP analysis 3) To increase training	1) Number of weekly meeting in each unit; 2) number of staff participants on the weekly falls meeting; 3) number of GAP analysis completed related to falls, 4) Number of medication changes (addition of fracture prevention medication) 5) Number of environmental	100% of staff participation on Falls Weekly huddle in each unit	
		Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7	O	% / LTC home residents	CIHI CCRS / July 1 to Sep 30, 2024 (Q2), as target quarter of rolling 4-quarter	51510*	20.72		Target is based on corporate averages. We aim to do better than or in line	NP STAT, BSO LHIN, Lakeridge Mental Health Services, Ontario Shores Centre For Mental Health Sciences, Alzheimer Society	1)1) The MD, NP, BSO internal and external (including Psychogeriatric Team), with nursing staff will meet monthly to review	1) Number of meetings held monthly by interdisciplinary team. Number of antipsychotics reduced as a result monthly. Number of PAC meetings held quarterly, where discussion and reviews on strategies have resulted in a decrease of	1) Number of meetings held monthly by interdisciplinary team. Number of antipsychotics reduced as a result monthly. Number of PAC meetings held quarterly, where discussion and reviews on strategies have resulted in a decrease of	1) 100% of newly admitted residents will have been reviewed for the appropriateness of	
		Percentage of LTC residents who develop worsening pain	C	% / LTC home residents	CIHI CCRS / July 1, 2024 - Sept 30 2024 (Q2) as target quarter rolling 4 quarter	51510*	3.15		Target is based on corporate averages. We aim to meet or exceed		1)1. Enhancement of the end of life, palliative care program 2. Utilization of pain tracker, to monitor the use of prn analgesic 3) RAI	1. Conduct through assessment of the resident, pallative care, end of care. Completion of PPS score, current medication regiment, involve the interdisciplainary team, family and resident with care planning decisions. 2. Establish palliative care order set	1) Number of staff provided education, Pain management 2) Number of care plans revised to pain management 3) Number of referrals completed		
		Percentage of LTC residents who develop worsening pressure injury stage 2-4	C	% / LTC home residents	CIHI CCRS / July 1, 2024 - Sept 30 2024 (Q2) as target quarter rolling 4 quarter	51510*	2.95		Target is based on corporate averages. We aim to meet or exceed	NSWOC, NP, MD, Medline consultants	1)1) Provide education and re-education on wound care assessment and management. Education provided by NSWOC (during	1) Arrange education for Registered staff and PSW, with NSWOC 2) Develop a list of resident who PURS is 3 or greater, review plan of care, for the appropriate pressure relieving devices, review of surfaces in place 3) Utilization of skin and wound tracking tool, to	1) Number of Registered staff and PSW educate. 2) Number of changes to surface, Number of plans of care updated 3) Number of pressure related injuries which have resolved	100 % of Registered staff to be educated 90% of PSW 100% of resident with PURs	