

Access and Flow | Efficient | Optional Indicator

Indicator #6	Last Year		This Year		
	Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)
Rate of ED visits for modified list of ambulatory care-sensitive conditions* per 100 long-term care residents. (Albright Gardens Homes Inc.)	22.42	18	19.37	13.60%	17

Change Idea #1 Implemented Not Implemented In Progress

NP-Led Preventive Care: Strengthen NP-led assessments and screenings for ambulatory care-sensitive conditions, enabling early identification and management, thus preventing ED visits. NPs will also collaborate with the care team to create prevention plans for high-risk residents. Improved Care Coordination: Enhance communication between long-term care and primary care providers to ensure continuous care. Regular updates and collaborative planning will help address issues early, avoiding unnecessary hospital visits. Staff Training on Early Intervention: Provide ongoing staff training to recognize and address early signs of ambulatory care-sensitive conditions. Early intervention will prevent escalation and reduce the need for ED visits. These initiatives will help manage health conditions within the home, decreasing avoidable ED visits.

Process measure

- Number of NP-led preventive care assessments completed per month This will track the number of preventive care assessments conducted by the Nurse Practitioner (NP) each month for residents. A higher number indicates greater access to preventive care, which could potentially reduce ED visits. Percentage of care coordination meetings held with primary care providers per month The Care Coordination team will track the percentage of care coordination meetings held between long-term care providers and primary care physicians monthly, aiming to ensure effective communication and care planning. Percentage of staff completing training on early intervention per quarter This measure will track the percentage of staff who have completed the training on early identification of health issues and interventions that may reduce ED visits. These process measures will be reviewed monthly or quarterly to track whether the change ideas are being implemented and if they are leading to improvements.

Target for process measure

- NP-led preventive care assessments completed per month: Target: Achieve 90% of residents receiving a preventive care assessment from the NP monthly by December 31, 2025. Care coordination meetings with primary care providers per month: Target: Ensure 80% of residents have at least one care coordination meeting with their primary care provider per month by December 31, 2025. Staff completing training on early intervention per quarter: Target: Achieve 85% of staff completing early intervention training by the end of Q2 2025, with sustained quarterly training rates at or above 85% thereafter. These targets are specific, measurable, and achievable within the given timeframe. Each target directly contributes to reducing ED visits for ambulatory care-sensitive conditions by improving preventive care, coordination, and early intervention strategies

Lessons Learned

The home saw improvement in the rate of emergency department visits during the reporting period. Increased clinical oversight and collaboration between physicians, the Nurse Practitioner, nursing staff, and other members of the care team helped support earlier identification of changes in resident condition. These efforts helped reduce avoidable transfers to hospital. While the target was not fully reached, resident acuity and complex health needs can still lead to situations where hospital care is required.

Comment

The home will continue to focus on early identification of changes in resident condition and collaboration among the care team to help manage health concerns within the home whenever possible.

Equity | Equitable | **Optional Indicator**

Indicator #5	Last Year		This Year		
	Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)
Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education (Albright Gardens Homes Inc.)	CB	100	99.70	--	100

Change Idea #1 Implemented Not Implemented In Progress

Mandatory education for all staff equity, diversity, inclusion, anti-racism & bullying for all staff

Process measure

- The number and percentage of staff at the executive, management, and general levels who complete EDI-AR education will be tracked quarterly through HR records. Attendance data from the LMS and in-person training sessions will be reviewed to measure participation. Reports will be generated and analyzed to assess progress, identify trends, and address gaps. Findings will be presented in management meetings, with results informing future training efforts. An annual summary will be included in the QIP to ensure accountability and continuous improvement.

Target for process measure

- By December 31, 2025, at least 100% of management, and general staff will have completed equity, diversity, inclusion, and anti-racism (EDI-AR) education. Progress will be monitored quarterly, with targeted follow-ups to ensure engagement and completion.

Lessons Learned

The home achieved a very high completion rate for equity, diversity, inclusion, and anti-racism education through the Surge Learning module during the reporting period. This helped reinforce expectations related to respectful and inclusive practices across the organization. Ongoing education and awareness will remain important to support an inclusive environment for residents, families, and staff.

Comment

The home will continue to support equity, diversity, inclusion, and anti-racism through ongoing education and awareness efforts.

Experience | Patient-centred | **Optional Indicator**

	Last Year		This Year		
Indicator #3	90.63	93	CB	--	90
Percentage of residents responding positively to: "What number would you use to rate how well the staff listen to you?" (Albright Gardens Homes Inc.)	Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

Change Idea #1 Implemented Not Implemented In Progress

1. Enhanced Staff Training on Active Listening - Provide mandatory training on active listening, empathy, and communication. - Use role-playing and real-life scenarios for reinforcement. - Conduct quarterly refresher sessions. 2. Structured Resident Feedback Mechanisms - Implement real-time feedback tools like surveys and suggestion boxes. - Review feedback monthly and address concerns promptly. - Share positive feedback to reinforce good practices. 3. ****Increased Leadership Rounding**** - Conduct regular leadership walkarounds to engage with residents. - Launch "Listening Rounds" for focused resident interactions. - Track trends to drive communication improvements. 4. Resident-Centered Care Conferences - Enhance care conferences to focus on resident concerns. - Involve interdisciplinary teams for comprehensive discussions. - Document feedback in care plans for follow-up. These initiatives will foster a culture of listening and improve staff-resident communication.

Process measure

- 1. Staff Training on Active Listening - Percentage of staff completing training per quarter. 2. Resident Feedback Collection - Number of surveys completed monthly. - Percentage of residents providing feedback via suggestion box. 3. Leadership Rounding Impact - Number of leadership rounds conducted per month. - Percentage of resident concerns addressed within a set timeframe. 4. Care Conference Effectiveness - Number of care conferences held per month. - Percentage of residents reporting satisfaction with communication post-conference. These measures ensure progress is tracked systematically and adjusted as needed.

Target for process measure

- 1. Staff Training on Active Listening - Target: 90% of staff to complete active listening training by June 30, 2025. 2. Resident Feedback Collection - Target: Achieve a 75% response rate on resident surveys monthly by December 31, 2025. 3. Leadership Rounding Impact - Target: Conduct 100% of scheduled leadership rounds per month and address 80% of resident concerns within 7 days by December 31, 2025. 4. Care Conference Effectiveness - Target: Hold care conferences for 95% of residents every quarter, with 85% resident satisfaction by December 31, 2025. These targets are designed to ensure measurable progress and drive continuous improvement within a specific timeframe.

Lessons Learned

The exact question used for this indicator was not included in the resident satisfaction survey this year. A related question about the availability and helpfulness of nursing staff was used as the closest measure of resident experience with staff communication. Responses to this question were positive and suggest that residents who participated generally feel supported by staff. However, the number of survey responses was limited, which may influence how well the results reflect the experience of all residents in the home. The survey will be updated in the future to include a question that more closely reflects the QIP indicator about how well staff listen to residents, and efforts will be made to encourage greater participation in resident surveys.

Comment

The home will update the resident satisfaction survey to include a question that more directly measures whether residents feel staff listen to them. This will allow for more accurate reporting and comparison in future Quality Improvement Plans.

	Last Year		This Year		
Indicator #4	90.63	94	CB	--	90
Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences". (Albright Gardens Homes Inc.)	Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

Change Idea #1 Implemented Not Implemented In Progress

Encourage Open Dialogue through Regular Resident Council Meetings Increase the frequency of resident council meetings to encourage open communication between residents, management, and staff. These meetings will provide a safe space for residents to voice concerns and opinions without fear of retaliation. Implement Leadership Rounding Focused on Resident Feedback Conduct leadership rounds where management and staff actively seek resident feedback on their care experience. This initiative will ensure that residents feel heard and that their opinions are valued. Staff Training on Creating a Safe and Supportive Environment Provide training for all staff on the importance of fostering a safe and supportive environment where residents feel comfortable expressing their opinions. This will include recognizing and addressing any behaviors that could intimidate or discourage residents from sharing feedback. Confidential Feedback Mechanisms Implement anonymous feedback systems, such as surveys or suggestion boxes, that allow residents to share their opinions without fear of identification. This will help residents feel more comfortable in expressing their true feelings about their care and environment. These initiatives will help create an atmosphere of trust and respect, encouraging residents to freely share their thoughts and opinions.

Process measure

- Number of residents surveyed per quarter on their ability to express opinions without fear of consequences. Percentage of staff who attend training on fostering an open and supportive communication environment. Number of leadership rounding sessions conducted monthly to assess residents' comfort in expressing their opinions. Number of anonymous feedback submissions received per quarter through surveys or suggestion boxes. These measures will track whether the strategies put in place (such as surveys, leadership rounding, and training) are helping to achieve the goal of residents feeling safe and supported in expressing their opinions.

Target for process measure

- This is the organization's/OHT's target for process measure (goal). The target/goal should be SMART – specific, measurable (numerical if possible), achievable, realistic, and time sensitive. E.g., “60% of complex patients will have documentation of a shared care plan at discharge by June 30, 2019 and 70% by Dec 31, 2020”

Lessons Learned

A question related to this indicator was included in the resident satisfaction survey; however, a different response scale was used than the one required for the QIP calculator. Because of this, the results could not be calculated using the Navigator tool. Survey responses still suggest that many residents feel comfortable expressing their opinions. However, the number of survey responses was limited, which may influence how well the results reflect the experience of all residents in the home. Future surveys will be updated to better align with the QIP indicator scale so results can be measured and compared more accurately.

Comment

The home will continue to support resident voice through resident council meetings, leadership rounding, and open communication with staff. Future surveys will include questions that better align with the QIP indicator so results can be measured more accurately.

Safety | Safe | Optional Indicator

Indicator #1	Last Year		This Year		
	Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)
Percentage of LTC home residents who fell in the 30 days leading up to their assessment (Albright Gardens Homes Inc.)	20.63	16	22.33	-8.24%	19.80

Change Idea #1 Implemented Not Implemented In Progress

Increase staff training on fall prevention: Implement regular training and workshops on fall risk factors, prevention strategies, and interventions for all staff members, including nurses, physiotherapists, and personal support workers. This will help increase awareness and enhance fall prevention strategies across the home. Enhance fall risk assessments and individualized care plans: Regularly conduct comprehensive fall risk assessments for each resident, using validated tools. Develop and update individualized care plans based on the assessments to ensure that each resident has personalized interventions and preventive measures in place to reduce the risk of falls

Process measure

- Number of fall risk assessments completed per month: Track how many residents receive fall risk assessments on a monthly basis. This will be monitored as a percentage of the total resident population to ensure that every resident is receiving timely and comprehensive assessments. Number of fall prevention interventions implemented per resident: Monitor how many personalized fall prevention strategies (e.g., mobility aids, environmental modifications) are put in place after risk assessments are completed.

Target for process measure

- Target: By December 31, 2025, 100% of residents will have completed a fall risk assessment within the last 30 days of their assessment. Additionally, at least 80% of residents will have fall prevention interventions in place based on the results of their individual assessments by the end of 2025. This goal is SMART as it is specific (fall risk assessments), measurable (percentage of assessments completed and interventions implemented), achievable (building on current practices), realistic (with the proper training and resources), and time-sensitive (by December 31, 2025). The target emphasizes comprehensive, individualized care and supports a high standard of preventive measures for all residents.

Lessons Learned

Despite implementing fall prevention education and assessment strategies, the percentage of residents experiencing falls increased during the reporting period. Falls remain a challenge in our home, as many residents have mobility limitations, cognitive impairment, or health conditions that increase their risk of falling. This highlighted the need to strengthen follow-up after each fall and focus more on identifying patterns and contributing factors. Improving team review of fall incidents and using this information to guide prevention strategies will be an important focus moving forward.

Change Idea #2 Implemented Not Implemented In Progress

The home has begun tracking multiple factors for every fall to help identify patterns and risk areas. This includes information such as the location of the fall, resident mobility, and which shift the fall occurred on.

Process measure

- No process measure entered

Target for process measure

- No target entered

Lessons Learned

Through reviewing fall incidents, the home recognized the need for more detailed information to better understand why falls are occurring. As a result, the team began tracking multiple factors for every fall, including but not limited to the location of the fall, resident mobility, whether the fall occurred from bed, from a chair, or while walking or standing, and the shift when the fall occurred. Reviewing this information helps the team identify patterns and contributing factors so that prevention strategies can be better targeted.

Comment

The home will continue to review fall trends and use the additional data collected to guide prevention strategies and targeted interventions.

	Last Year		This Year		
Indicator #2	27.33	21	21.91	19.83%	NA
Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment (Albright Gardens Homes Inc.)	Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

Change Idea #1 Implemented Not Implemented In Progress

Staff Education and Training: Implement a comprehensive education program focused on the appropriate use of antipsychotics in long-term care. This program will include sessions on recognizing and diagnosing conditions that warrant antipsychotic medication, such as dementia or agitation, and will highlight non-pharmacological alternatives. By ensuring staff is well-educated, we aim to reduce unnecessary prescribing and use of antipsychotic medications in residents. Multidisciplinary Review and Medication Audits: Establish a multidisciplinary team to regularly review resident medication profiles, particularly focusing on those prescribed antipsychotics without a documented appropriate diagnosis. This team will work to identify residents who may benefit from alternative treatments and to ensure that prescribed medications are aligned with clinical guidelines. Regular audits will be conducted to monitor the medication use, ensuring adherence to evidence-based practices and regulatory standards.

Process measure

- Number of residents on antipsychotic medications without a documented appropriate diagnosis: This will be tracked monthly by the pharmacy team. Number of medication audits conducted per month: The pharmacy team will conduct monthly audits to ensure that antipsychotic use is appropriate and based on diagnosis. Percentage of staff who have completed antipsychotic medication training: The HR department will track training completion rates on a monthly basis. These process measures will help evaluate if the implemented changes, like staff education and medication audits, are effectively addressing the use of antipsychotics without proper diagnoses.

Target for process measure

- Target: By December 31, 2025, reduce the percentage of residents on antipsychotic medications without a documented appropriate diagnosis to 5% or less, based on monthly audits of medication records. Rationale: This target is specific (focus on reducing the use of antipsychotics without appropriate diagnosis), measurable (5% or less), achievable (based on current trends and improvement initiatives), realistic (given the support from the pharmacy team and staff education), and time-sensitive (set for completion by the end of 2025).

Lessons Learned

The home saw a significant and ongoing reduction in the use of antipsychotic medications among residents without a diagnosis of psychosis during the reporting period. Regular medication reviews and increased collaboration between physicians, the Nurse Practitioner, pharmacy, and the care team helped support more appropriate prescribing practices. Deprescribing efforts, including gradual dose reduction and the use of tapering tools when appropriate, also supported this improvement. Staff also increased their focus on non-medication approaches to support residents with responsive behaviours. These efforts helped improve medication use and resident care.

Comment

The home will continue to monitor antipsychotic medication use through regular medication reviews and interdisciplinary discussions. We are seeing significant improvement quarter over quarter, supported by stronger deprescribing practices and increased use of non-medication approaches to support residents. Antipsychotic use will continue to be monitored through routine clinical oversight and quality review.