2025/26 Quality Improvement Plan
"Improvement Targets and Initiatives"

Niagara Health System 1200 Fourth Ave. St. Catharines . ON. L2S0A9

Long Term Care

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AIM	Measure									Change						Progress Towards implementation of Change Ideas		(insert NEW change idea that was not included in last year's Workplan)				
Quality dimension	**Measure/Indicator**	**Type** - Mandatory - Priority - Additional - Custom - Optional	**Unit / Population**	**Data Source / Period**	**Organization Id**	**Current performance**	**Target Performance**	**Target justification**	**External Collaborators**	**Planned improvement initiatives (Change Ideas)**	**Indicator** **- We will not be working on this indicator** **- We are performing well on this indicator (i.e., above provincial average)** **- We have included a custom indicator related to this theme** **- We are prioritizing other areas of focus** **- Other**	**Methods**	**Process Measures**	**Target for process measure**	**Comments**	**Overall Progress on Change Idea**	**What were your successes and/or challenges?** **Share the results of your processmeasures** **Comment on barriers and/or enablers that impacted your initiatives**	**Description of change idea**	**Overall Progress on Change Idea**	**What were your successes and/or challenges?** **Share the results of your processmeasures** **Comment on barriers and/or enablers that impacted your initiatives**	**Additional comments and plans for future improvement**
M = Mandatory (all cells must be completed) P = Priority (complete ONLY the comments cell if you are not working on this indicator) A= Additional (do not select if you are not working on this indicator) C = Custom (add any other indicators you are working on) O = Optional																						
Equity - Equitable	Percentage of the Niagara Health Team (staff and Physicians) who have completed relevant equity, diversity, inclusion and anti-racism education.	**O = Optional**	Nia LTC Staff	Local data collection	511585	48%	85%	We priority to ensure a high percentage of NH Team Members have received this training. 85% is the goal to compensate for those who may not complete the training due to leaves, part-time, etc. who may still be captured in the staff data totals.	Collaborators include patient partners on DEI Committee and community agencies providing the training modules.	Monthly audits of dans and the sharing of the completion rates.		Audit data will be provided to unit managers to support their individualized plans to support staff in completing the training. Other strategies that will be used to support completion include: YouTube video option for group viewing, DEI video series link to this module which provides a certificate upon completion and highlighting the importance of completing this training during Celebrate Diversity Month.	Completion rates updated monthly	85% completion rate		Implemented	Continue to audit and encourage staff to complete training.	Youtube module for group viewing and completion	Implemented	We were able to add the video viewing onto another training so staff were already present; this was effective at increasing completion.	Connect this activity to another MANDATORY training to facilitate time and organization.
Experience	Percentage of residents who responded positively to the following statement: "I can express my opinion without fear of consequences."(0-5 response)	**O = Optional**	LTC residents	Patient Survey	511585	N=42 97.62%	98%	This measure helped leaders track and send reminders but had limited impact on overall compliance.		Targeted staff education related to resident rights.		Develop and implement a staff education process (i.e., huddles, modules, lunch and learns, workshops) focus on ensuring staff understand resident rights and appropriate, respectful and collaborative methods for communicating with residents. Sessions to be developed with adult learning principles with interactive activities.	# of staff completing training # of trainings held	100% of front line staff and volunteers to complete training. 75% of EVS and other support staff to receive training.		Implemented	Annual mandatory training consists of 4 hours of training mandated by the MOLTC included in this training is Resident Rights Training. Results of Process/Measures: Target met. 100% of frontline staff completed training related to resident's rights. Barriers and Target Challenges: organizing training for staff that are casual/part time as well as ensuring				
										Leadership engagement at Resident Council Meetings		LTC Leadership will request a session with the resident council to obtain feedback from residents in relation to this survey item. This will then be integrated in to staff training to ensure current concerns and ideas are integrated in to the training.	# of meetings attended by leadership # of items incorporated into training	Bi-annual meeting attendance by leadership. 100% of feedback incorporated in the training.		Implemented	Results of Process/Measure:Every member of the readership team attended at least 2 Resident Council meetings. The results of the annual resident satisfaction survey was discussed. Feedback from residents was noted and a multidisciplinary team developed an ELL+ "Strategic Plan" based on the results of the survey. Barriers and Target Challenges: time constraints and workload challenges on				
	Do residents feel they have a voice and are listened to by staff? The percentage of residents who responded positively (a response of 6 or 7 on the 1-to-7 scale) to the statement "What is important to me?"	**O = Optional**	LTC residents	Patient Survey	511585	N=42 100%	95%	Patient experience is a priority for NH. 95% is the target as it will ensure that we maintain a high average for this item.		Review and updating of the Resident Handbook		Leadership, together with the resident council will review and update the resident handbook to ensure that information is included for residents regarding how to express their ideas and have a voice in their care. This will be reviewed and finalized in collaboration then distributed to current and future residents.	# of updated handbooks distributed	100% of residents both current and new admissions will receive the updated handbook		Implemented	Results of Process/Measure: Handbook updated. 100% of residents (current and new admissions) receiving updated version of handbook. Barriers and Target Challenges: time constrains and workload challenges required meet target.				
Safety-Effective	Worsened Pressure Injury. This percentage of long-term care residents whose stage 2 to 4 pressure ulcer worsened.	**O = Optional**	LTC residents	CIHI reported data	511585	8.46%	6%	The target was chosen as a step wise process to work towards the Ontario Benchmark.		Collaborate with the NH Pressure Injury Steering Committee to support key learnings for the ECU Skin and Wound Committee		An LTC Rep will be part of the PISC with the goal of taking learnings from this committee back to the LTC Skin and Wound Committee to support local unit action plans.	# of learnings shared, types of learnings shared and implemented	100% of learnings shared with PISC 100% of appropriate and feasible actions from the PISC implemented in the LTC		Implemented	ECU Rep at PISC has been sharing information with the Skin and Wound Committee in the LTC home. She participated 1 PISC meeting during the reporting quarter. Workload from her primary portfolio was a barrier to attendance. New and worsening pressure injuries decreased from 9.22% o 8.37% (Q2 CIHI results).				
										Implementation of Staff Education to improve skin and wound care		Increase the educational offerings internally for staff and from outside external partners (eg. external partner providing restorative care program with intent to maintain or restore resident abilities with ADLs)	# of staff who completed annual training # of PSWs that completed Ministry-funded training # of Just-In-Time Huddles focused on skin and wound # of staff trained on restorative programming	100% staff are trained per program		Implemented	100% of front line staff received skin and wound education as well as restorative care education related to prevention, identification and management of new or worsening pressure injuries (approximately 101 staff). We conducted 8 huddles during this reporting period to reinforce and re-educate learnings and restorative care as it relates to skin and wound care and prevention. Average attendance at each huddle was 8-10 staff. We conducted 3 Skin and Wound Committee meetings in the reporting time period to discuss education planning, and new or worsening wounds, restorative care.				