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

Craiglee Nursing Home 102 CRAIGLEE DRIVE, Scarborough , ON, M1N2M7

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 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)	51348*	29.79	20.00	1) At/Below the provincial Average; 2) Through implementation of our change ideas, the home expects an improvement Mar. 2027	MD, NP, NLOT, Home at Health, GMHOT, Baycrest	1)To reduce avoidable hospital transfers, through the use of on-site Nurse practitioner; Physicians and NLOT	1) Utilize in-house NP or external NLOT resources. 2)The home's attending NP/MD will review and collaborate with the registered staff on residents who are at high risk for transfer to ED, based on clinical and psychological assessments; 3) Nurse Practitioner &	1) Number of ED transfers coinciding with Nurse Practitioner's on site scheduled shifts 2) % of active staff who completed needs assessments 3) Number of active staff who completed education as a result of needs assessment 4) # of education sessions with active	100% Staff education completed by December 31 2026; Reduction of 80%	Utilize Nurse Practitioner, other stake holders such as Medigas, CareRx,
											2)Implementation of the Nursing PLEDGE Initiative program to build capacity and improve overall clinical assessment skills of	Senior Registered Staff will provide mentorship, education to enhance the clinical knowledge of Registered Staff regarding physical assessment skills, documentation (PCC and SBAR), communication with physicians and families and the management of	Number of Registered staff who initiated an avoidable transfer to ED over the Number of Registered staff who participated in the initiative.	80% of ED visits were assessed appropriately based on resident outcome and	
											3)SBAR Documentation - Registered staff to communicate a comprehensive resident assessment to Physician or	Education/re-education to active Registered staff on the continued use of SBAR tool a standardize communication between clinicians and families.	1)Number of improved communication processes used in the SBAR format, between clinicians and family per month; 2) number of active staff educated on SBAR. 3)# of education sessions with active Registered staff	80% of communication to Physician/NP or families is documented in S-	
											4)Advanced Care Planning/Goals of Care discussed with resident and families during care conferences; Education on	1) Utilization of the PPS Palliative Performance Score to determine disease progression; 2) Utilize in-house NP or external NLOT resources. 3) Educate residents and families about the benefits of and approaches to preventing ED visits. 4)The home's attending NP/MD will	Continue to use and analyze the ED tracker for the number of residents whose transfers were a result of family or resident requests, nurse initiated and resident outcome; Number of transfers to ED who returned within 24 hours; Increased SBAR communication &	100% of care conferences discussed advanced care planning/goals of	
											5)Build capacity and improve overall clinical assessment skills of Registered Staff; through education supported by NP.	1) Utilize in-house NP or external NLOT resources. 2) Clinical Lab to provide practice setting to maintain competency quarterly in IV program.	Number of active Registered staff who maintain competency in IV insertion/maintenance on quarterly basis 2)Number of IV therapy/treatments completed with in the home .	100% of Active Registered staff will maintain IV therapy competency by	
Equity	**Equitable**	Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education	O	% / Staff	Local data collection / Most recent consecutive 12-month period	51348*	99.54	100.00	Through education, the Home expects to have an increase understanding of this criteria over the next 6 months		1)To improve overall dialogue of diversity, inclusion, equity and anti-racism in the workplace;	Celebrate culture and diversity events; educational opportunities; Monthly Quality meeting standing agenda- review the number of programs, education completed; Culturally familiar foods -special menu; Ensure correct pronunciation of names; Flexible	3) Number of Celebration completed in the home	100% of active staff educated on topics of Culture and Diversity by December 31 2026	
											2)To increase diversity training through Surge education or live events;	1) Training and/or education through Surge education or live events	Number of active staff completed education on Culture and Diversity; Number of newly hired staff completed education on Culture and Diversity	100% of active staff will have completed SURGE education on Culture and	
											3)To facilitate ongoing feedback through open door policy and daily manager walkabouts	At Risk Management meetings, reminders of open door policy; Direct person to appropriate team member to address concerns	Number of reminders documented in Risk Management over Number of Risk Management meetings	100% of reminders documented by December 31, 2026	
											4)Development of Cultural Diversity team within the home compromised of staff, resident and family members- to assist with	Celebrate Monthly culture and diversity events and activities; Offer Culturally familiar foods for staff and residents (special menu);	Number of Cultural events/celebrations completed in the home	100% of cultural events planned will be celebrated monthly by December 31 2026	
Experience	**Patient-centred**	Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences".	O	% / LTC home residents	In house data, interRAI survey / Most recent consecutive 12-month period	51348*	98.55	100.00	Target is based on corporate averages. We aim to meet or exceed corporate goals, benchmarks.		1)To maintain or exceed our goal of 98.55%. Engaging residents in meaningful conversations, and at care conferences, that allow	Resident's Bill of Rights #29, Whistleblower Policy and Complaints/concerns process will be reviewed during Admission and Care Conferences, reinforce home's practice of the open door policy and daily management walk abouts to encourage discussions; Social Worker	Number of care conferences that reviewed Resident Bill of Rights #29, Whistleblower policy and Complaints/concerns process over Number of Care Conferences; Number of Social Work visits with residents monthly	100% of Care conferences will review Bill of Rights #29, Whistleblower policy and	
											2)Continue reviewing Resident's Bill of Rights at Monthly Resident council meetings with a focus on Resident Rights #29; Review	Bill of Rights #29 will be a standing agenda item at monthly Resident Council meetings. Policies -Zero tolerance of abuse, and Whistleblower posted in the home 4) Review of Investigation process in the home (during admission and care conferences)	Number of Resident council meetings that have reviewed the Bill of Rights #29 over the number of Resident council meetings annually	100% of Monthly Resident Council meeting will have Residents' Bill of Right #29 reviewed	
											3)Re-education and review to all staff on Resident Bill of Rights specifically #29 at department meetings monthly by department	Bill of Rights #29 reflected in minutes of the monthly meetings per department	Number of Departmental meetings minutes address Bill of Rights # 29 over number of Departmental meetings annually; Number of staff who attended departmental meetings over number of departmental staff	100% of all Departmental meeting standing agendas will have Resident Bill of	

											4)Add focus to review Resident Bill of Rights #29 at Family council quarterly meetings	Resident Bill of Rights as a Standing agenda item at quarterly meetings	Number of meeting minutes that have Resident Bill of Rights #29 reviewed over the number of meetings	100% of all Family Council meeting minutes include Resident Bill of Rights #29 by	
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 September 30, 2025 (Q2), as target quarter of rolling 4-quarter average	51348*	10.83	8.00	Target is based on corporate averages. We aim to maintain or exceed the corporate average.		1)To facilitate a Weekly Fall Huddles on each unit; with the interdisciplinary team	1) Weekly interdisciplinary team huddles on resident home area to review resident plan of care, to mitigate the risk of falls or injury related to falls;	1) Number of weekly meeting in each unit; 2) number of interdisciplinary staff participation in the Weekly Falls Huddles meeting;	100% of interdisciplinary staff will participate at weekly Falls huddle	
											2)Establishing documentation/charting buddies, (PSW complete documentation with resident's at high risk for	1) Additional training and/or education of Falls program and documentation; 2) During shift report review residents at high risk for falls, frequent falls; 3) Review of the resident's plan of care (identification of the triggers, related to the fall); Use of fall prevention	# of active PSW staff who attended the education/training; # of high risk residents reviewed at shift report; # of high risk residents who have falls prevention equipment in place	100% of PSW will have completed Falls and documentation education; 100% of	
											3)Establish/re-establish the restorative care program in the home (provide education on how residents qualify for the program)	Restorative education provided to the designated PSW's in the program; Lead RPN to Identify residents who qualify for the program and reassess resident's progress every two (2) weeks;	Number of residents on restorative care program specific to falls prevention; Number of residents who were successfully discharged from restorative program	Number of high falls risk residents who successfully reduced # of falls by 80% post	
											4)Injury prevention - review of FRS, ensure appropriate medication prescribed for prevention of bone density loss	Resident list of FRS of 3 or greater, offer fracture prevention medication 2)Referrals to MD/NP for medication reviews, 3) Use of falls prevention aides to prevent injury, use of hip protectors, floor mats, bed and chair alarms	Number of residents with an FRS of 3 or greater who had medication changes prescribed (addition of fracture prevention medication) over number of residents referred for medication review	90% of residents will have medications prescribed for prevention of bone	
											5)Create activity bins, for resident to assist with engagement. Collaboration with Program department, to implement recreation	Program Department will participate in weekly falls huddles and provide guidance/support in creation of resident specific activity bins and programming in relation to the specified time during a shift of falls	Number of activity bins created over number of residents referred to Program department; Number of Resident Falls prior to implementation of Programs during a specified time in the shift over the number of Resident Falls post implementation during a specified	80% reduction in resident falls during a specified time of shift post implementation of	
											6)Purposeful rounding, for resident at high risk for falls	Increase training and/or education of Falls program; Implementation of the 4 "P"s; Ensuring Use of night lights (motion sensor/or on during the night), hip protectors, floor mats, bed and chair alarms as applicable; During shift report review resident high risk	# of residents identified as high risk for falls monthly	100% of high risk residents will have purposeful rounding completed on each	
											7)During admission process, a falls history and interventions will be reviewed with resident and/or family member	Residents with FRS of 3 or greater, offer fracture prevention medication; Review identification of the triggers related to falls - use of night lights motion sensor, hip protectors, floor mats, bed and chair alarms; Review the plan of care with resident/ families, Vision	Number of residents admitted with a history of falls	100% of residents admitted will have a review of their history of falls history and	
		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 September 30, 2025 (Q2), as target quarter of rolling 4-quarter average	51348*	17.54	14.00	Target is based on corporate averages. We aim to do better than or in line with corporate average.	BSO, GHMOT, Baycrest NLOT, MD, NP, Ontario Shores	1)During admission conference, review with families, reason for the prescribing of antipsychotic medication, interventions	Discussion with resident and family on the indications for use and risks related to antipsychotic administration. Plan of care reviewed with resident, family and the interdisciplinary team to develop a person-centered approach to responsive expressions	Number of Admission conferences with documented discussions related to antipsychotic usage.	1) 100% of newly admitted residents prescribed antipsychotics will have had, during	
											2)The MD, NP, BSO internal and external (including Psychogeriatric Team), with nursing staff will meet monthly to review newly	1) Maintain Log (tracker) of newly admitted residents prescribed antipsychotic medication by BSO Lead 2) BSO Lead will schedule meetings with interdisciplinary team each month	1) Number of residents admitted with prescribed antipsychotic medications over number of residents admitted monthly 2) Number of scheduled meeting held monthly with interdisciplinary team	1) 100% of newly admitted residents prescribed antipsychotics will have been	
											3)Residents who are prescribed antipsychotics for the purpose of management of Responsive expressions, will have a	Prior to quarterly medication review of residents prescribed antipsychotics, a comprehensive assessment will be completed for analysis including DOS, Cohen's Mansfield, Pain, 72 hour sleep pattern, Psychosis, Delirium screening, BPSD, review of behavioural notes	1) Number of residents enrolled in antipsychotics reduction program over number of eligible residents for antipsychotics reduction program. 2) Number of comprehensive assessments completed over number of residents prescribed antipsychotics medications	100% of residents who are prescribed antipsychotic medications will receive a quarterly	
											4)Gentle Persuasive approaches (GPA) training/education - establish GPA trainers, educators in the home	Establish GPA trainers and educators in the home; Scheduled GPA training sessions for all active staff	1)Number of active staff who completed GPA education over number of active staff in home; 2) Number of GPA sessions offered in a 6 month period	100% of active staff receive GPA training by December 31 2026	
		Percentage of LTC residents who develop worsening pain	C	% / LTC home residents	CIHI CCRS / July 1 to Sept 30, 2025 (Q2)	51348*	9.67	7.50	Target is based on Corporate Averages. We aim to meet or exceed Corporate Benchmark	MD, NP, External Pain and Palliative Network, Pharmacist, NLOT, Spasticity Clinic	1)Enhancement of the Palliative Care and End of Life program	1) Establish Palliative care order sets; 2) Scheduled monthly Palliative care and EOL education for staff by the Pain and Palliative Network; 3) Conduct thorough assessments of the residents, Palliative care, End of Care; Current medication regiment; Involve the	1) Number of staff who completed Pain and Palliative education over Number of staff 2) Number of referrals completed Pain specialist/consultant 4) Number of medication reviews related with analgesic change	1) 100% of staff complete Pain/Palliative series education by December 31, 2026	
											2)Utilization of pain tracker, to monitor the use of PRN analgesic with discussion with resident how pain was previously managed and the	Education to Registered Staff on Pain Management by the Pain and Palliative Network 2) Resident who triggers for worsening pain will have a Comprehensive pain assessment completed and review of routine analgesics with MD/NP 3) Involvement of Interdisciplinary team in	1) Number of Registered staff completed Pain Management education 2) Number of comprehensive Pain assessments completed related to PRN tracker; 3) Number of Medication Order changes for Analgesics 4) Number of care plans revised to include interdisciplinary	1) 100% of staff will complete Pain management education 2) 100% of residents who	