2026/27 Quality Improvement and Safety Plan - APPROVED

2026-04-01

QUALITY FRAMEWORK		Measure						Change				
Pillar	**Aim**	**Measure/Indicator**	**Unit / Population**	**Source / Period**	**Current performance**	**Target**	**Target justification**	**Planned improvement initiatives (Change Ideas)**	**Methods**	**Process measures**	**Target for process measure**	**Comments**
Priorities for FOCUSED ACTION												
Better Provider Experience	**Embody a "People First" Philosophy**	Overall Employment Engagement Score	Overall score	In-house data, Employment Engagement Survey, 2025	82%	>80%	As identified in Quality Framework (2020-2025), long-term improvement goal is to maximize staff experience scores, with target threshold of 80% or above. Initial performance target identified as a 5% increase from baseline by 2025 (from 75% in 2019 to 79% in 2025). This target was met (and exceeded) in in last 3 surveys (2023 - 2025). Current goal is to maintain current performance level.	Follow-up on 2025 Employee Engagement survey results.	Workplan developed following stakeholder engagement of results.	1) Status of workplan development	1) Priorities developed in consultation with staff by end of April 2026	Work in this area aligns multiple streams of work, e.g. Accreditation Canada standards/ROP, Perley Health's focus on People First initiatives, etc. Improvements in this area help support ongoing focus on recruitment and retention.
Better Experience of Care	**Achieve >90% in resident/ family experience scores**	Percentage of residents who responded positively to "I participate in meaningful activities". Percentage of family members who responded positively to "My family member participated in meaningful activities in the past week"	% / Residents	In-house data, interRAI Resident survey; interRAI Family survey / January 1 - December 31 2025	44% resident; 42% family	46%; 44%	As identified in Quality Framework (2020-2025), long-term improvement goal is to maximize resident/family experience scores, with target threshold of 90% or above. These indicators were introduced to the QIP in 2023/24. Initial targets of 5% increase year-to-year have been identified. Although results did improve in 2024, sustained year-to-year improvement has not been observed for both indicators.	1) Pilot unit-based planning of monthly activity programming	Manager TRCA & Recreation Therapists to lead initial meetings with residents in Ottawa & Rideau building to plan for February Activity Calendar	1) Status of initial pilot (Ottawa & Rideau) 2) Embed into TRCA Recreation Programmer workplans (unit-staff workplans) 3) Adapt approach for Gatineau building	1) Completed for March calendars 2) Completed by May 31, 2026 3) Work to begin by June 30, 2026	**New change idea
								2) Sustain & spread "busy bins" across all dementia units	Work is guided by the Family-Focused QI team. Enhance busy bins on G1N in response to staff/family feedback. Engage unit staff in strategies to embed busy bins into resident care. Explore Montessori-principles training to support implementation & sustainability.	1) Enhance & sustain busy bins on G1N 2) Roll-out across applicable units	1) Completed by June 30, 2026 2) Completed by December 31, 2026	

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		Percentage of residents who responded positively to "I enjoy meal times"	% / Residents	In-house data, interRAI survey / January 1 - December 31 2025	60%	63%	As identified in Quality Framework (2020-2025), long-term improvement goal is to maximize resident/family experience scores, with target threshold of 90% or above. This indicator was introduced to the QIP in 2023/24. Initial targets of 5% increase year-to-year have been identified. Although results improved in 2024 (meeting and exceeding the identified target of 56%); results were not sustained in 2025.	1) Spread & sustain dining room changes across all units (as applicable)	Implementation of daily table rotation for meal service using unit calendar - to allow for different tables to be served first on a rotational basis.	1) Roll-out to final unit (G1N) 2) Further evaluation of dining room changes	1) Completed by April 30, 2026 2) Completed by June 30, 2026	
								2) Enhance food preparation & presentation of resident meals (i.e. appearance of meals served)	Initial work to be led by the newly established Pleasurable Dining Committee (amalgamation of the Resident Food Committee and Dining Experience QI team). Committee will leverage Food Quality Survey to identify initial opportunities for improvement	1) Identification of initial priorities for improvement	1) Completed by April 30, 2026	**New change idea
Better Experience of Care	**Achieve >90% in resident/ family experience scores**	Percentage of family members that responded positively to Family Communication and Engagement in Care Domains	% / Family members	In-house data, interRAI survey / January 1 - December 31 2025	88%; 95%	>90%	As identified in Quality Framework (2020-2025), long-term improvement goal is to maximize resident/family experience scores, with target threshold of 90% or above. This indicator was introduced to the QIP in 2024/25. Initial target of 5% increase year-to-year has been identified. Performance increased in 2025, with both indicators exceeding the identified targets (87 and 84%, respectively).	1) Expand on Warm Welcome concept to include a touchpoint with resident/family in preparation for initial and annual care conference	This work leverages RNAO's RFCC BPG and links to care conference redesign improvement work (see #2 below)	1) status of work	1) Care conference touchpoint ready for piloting April 1, 2026	This work links to the Caring Staff domain of the Resident QOL survey
								2) Re-design admission and annual care conference (initial work streams): -expand Warm Welcome, -checklist for residents/POAs -standardized pre-care conference documentation for interprofessional team	New QIP for 2025 - focus on co-designing care conferences with residents and families	1) status of work	1) All workstreams to be ready for initial piloting April 1, 2026	
								3) Enhance Welcome Book	Stakeholder engagement has been completed. Initial prototype in development	1) status of work	1) Initial prototype ready for broader feedback March 31, 2026	
								4)Continue to leverage the Resident and Family Advisor Program	Sustain Family and/or Resident Advisors on QIP teams and working groups (if appropriate)	Percentage of active QI teams with Family/Resident Advisor	100% of QIP teams include Family and/or Resident Advisors by Dec 31, 2026	

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Better Experience of Care	**Achieve >90% in resident/ family experience scores**	Percentage of residents that responded positively to Staff Responsiveness Domain	% / Residents	In-house data, interRAI survey / January 1 - December 31 2025	81%	85%	Indicator introduced to the QIP in 2025/26, with work scheduled to begin winter/spring 2026. Overall domain score identified as placeholder until specific domain question confirmed. Performance increased in 2025, but did not meet annual target (84%).	1) Complete a call bell data analysis to understand current performance (by unit & shift) 2) Review and discuss results at unit and shift level to identify small-scale change ideas	New QIP focus. Work to be guided internally (data analysis and engagement with residents) as well as externally (through focused work of SQLI)	1) Status of work	1) Data review and staff discussions to be completed by May 31, 2026	**New change idea Note: Staff Responsiveness has been identified as an area of focused improvement by Seniors Quality Leap Initiative (SQLI)
Priorities for MODERATE ACTION												
Better Experience of Care	**Provide "right" care 100% of the time**	Percentage of Residents who Experienced Pain	% / Residents	CIHI CCRS / July - September 2025	9.7	9.2	2025/26 target (11%) achieved, with performance over time showing statistical evidence of improvement (Q2 2022 to Q2 2025). NOTES: Provincial average = 3.8% (Q2 2025); however, the literature suggests proportion of LTC residents with some level of pain is around 40-80%.	1)Enhance existing pain documentation practices (including evaluation of current pain assessment tools, pain monitoring approach and tools, care planning approach, etc.)	This work will be led by Pain QI team	1) Status of workplan	1) Implementation of identified changes completed by December 31, 2026	Publicly reported indicator (CIHI Your Health System; HQO Long Term Care Performance) Aligns with full implementation of RNAO Best Practice Guideline.
								2)Further evaluation and enhancements to PainChek.	Work to be supported by Pain QI Team and Clinical Quality Lead	1) Status of workplan	1) Ongoing throughout 2026	
Better Experience of Care	**Provide "right" care 100% of the time**	Percentage of residents that were transferred to hospital within 30 days of death	% / Residents	Local data collection (PCC)/Jan - Mar 2025	Collecting Baseline	Collecting Baseline	Target to be set once following collection of baseline data.	1)Enhanced Palliative and End-of-life education/resources for the interprofessional team, including Palliative Volunteers: --provide Palliative Skills Day content to all nurses -develop Palliative Skills "Day" for PSWs[1] -nursing & interprofessional staff to attend NHWD palliative education session[2]	[1]PSW skills day content to be developed in partnership with Champlain Hospice. [2]NHWD (New Hire Welcome Day) - attended by all new hires since its introduction April 2024. All nursing/interprofessional staff hired pre-NHWD targeted to receive this education session (in person).	1) # of nursing staff that have received skills day education 2) # of PSWs that have received new education 3) # of nursing /interprofessional staff that attended NHWD session	1) 75 RNs/RPNs by December 31, 2026 2) 50 PSWs by December 31, 2026 3) 60 staff by March 31, 2027	
								2)Enhance process for accessing Comfort Care Suite	Aligns with work related to Comfort Care Carts and Chairs	1) Status of workplan	1) New process launched by September 30, 2026	**New change idea

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								3) Develop consistent after death processes to address visual inequity between veteran and community residents (i.e. when deceased resident escorted out of facility): -establish unit-level process for escorting resident out of facility	New area of focus for Palliative QI team in 2025. Work will initially focus on establishing unit-level (local) processes before shifting to facility-level.	1) Status of workplan	1a) Initial PDSA on 1 unit completed by April 1, 2026 1b) Process implemented on all units by December 31, 2026	
								4) Enhance resources for residents/families	Focus on written (possibly digital) materials available to families on comfort care cart	1) Status of workplan	1) Designated materials created and added to cart by June 30, 2026	
								5) Re-design admissions/annual care conferences	New QIP team launched winter 2025. Focus on co-design with residents and families	1) see RFCC section above	1) see RFCC section above	
								6) Strengthen Interprofessional communication r/t palliative care & EOL (earlier and more consistent communication across teams)	New stream of work for 2026	1) workplan TBD	1) to be determined	**New change idea

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Better Experience of Care	**Provide "right" care 100% of the time**	Percentage of residents on antipsychotics without a diagnosis of psychosis	% / Residents	CIHI CCRS / July - September 2025	23.5	22.3	2025/26 target was achieved (23.8%); with performance over time showing statistical evidence of improvement (Q2 2023 - Q2 2025). Current performance remains above provincial average @ 19%. Short-term target is 5% decrease year-over-year. Long-term target is to remain consistently at or below 20% (aligned with prov average and our historic baseline). Background info: In early 2018, Perley Health introduced a 20-bed Specialized Behavioural Support Unit (SBSU) for residents with high risk behaviours. This resulted in the introduction of a high antipsychotic user group, accounting for ~25% increase in QI indicator.	1)Sustain & enhance antipsychotic optimization approach	This work is led by Clinical Quality Lead in collaboration with MDs/NPs, Pharmacy Committee and 3Ds team. Explore Montessori-principles training to support this work (i.e. non-pharmacological approaches in managing BPSD)	1) Compliance with key processes (i.e. review of all residents triggering indicator, review by NP)	1) 100% compliance	Publicly reported indicator (CIHI Your Health system).
Better Experience of Care; Better Value & Efficiency	**Provide "right" care 100% of the time; Optimize use of "system resources"**	Number of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents.	Rate per 100 residents / LTC home residents	CIHI CCRS, CIHI NACRS / July - Sept 2025	3.6	<5	Indicator was elevated from monitoring to active QIP work in 2025/26 QIP. Most recent performance has returned to historic levels, achieving the target, and continuing to perform better than provincial average (@7.2 Q2 2025).	1)Review/audits of all transfers to ED to identify local opportunities for improvement as well as systemic trends	To be completed by Mgrs Resident Care (unit level) and Clinical Quality Lead (systems based)	1) % of transfers reviewed	1) 100% of transfers	**Identified as an LTC QIP Priority for 2026/27. This work aligns with SeeMe, RFCC, EOL Care.**
								2)Ongoing participation in Community Paramedic/LTC Program	Focused on falls with suspected or actual injuries, acute changes in condition where diagnostics may be required, etc.	1) % of falls that resulted in call to community paramedics 2) % of acute health events that resulted in call to community paramedics prior to ED	1) 70% of falls 2) 50%	

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								3)Launch interactive e-module in Surge Learning ("Preventing Avoidable Emergency Department Transfers")	Content of this interactive e-module was developed internally by SMEs, and is aligned with SeeME philosophy. It is designed to expand on the concepts covered in the introductory e-module ("Navigating conflict following an acute health event"). Note: both e-modules will be made available to broader sector as key SeeME KT assets	1) % of RNs & RPNs that have completed the e-module	1) 100% of RNs/RPNs by June 1, 2026	
								4)Deliver nursing competency training on variety of topics related to ED transfers (clinical competencies, SeeMe, goals of care, acute health event mgmt)	To be developed by internal SMEs	1) % of RNs that have completed the competency training	1) 100% of RNs by December 31, 2026	
								5) Complete gap analysis against RNAO's Transitions in Care BPG	New RNAO BPSO contract requirement	1) status of work	1) gap analysis completed and action plan developed by May 31, 2026	**New change idea