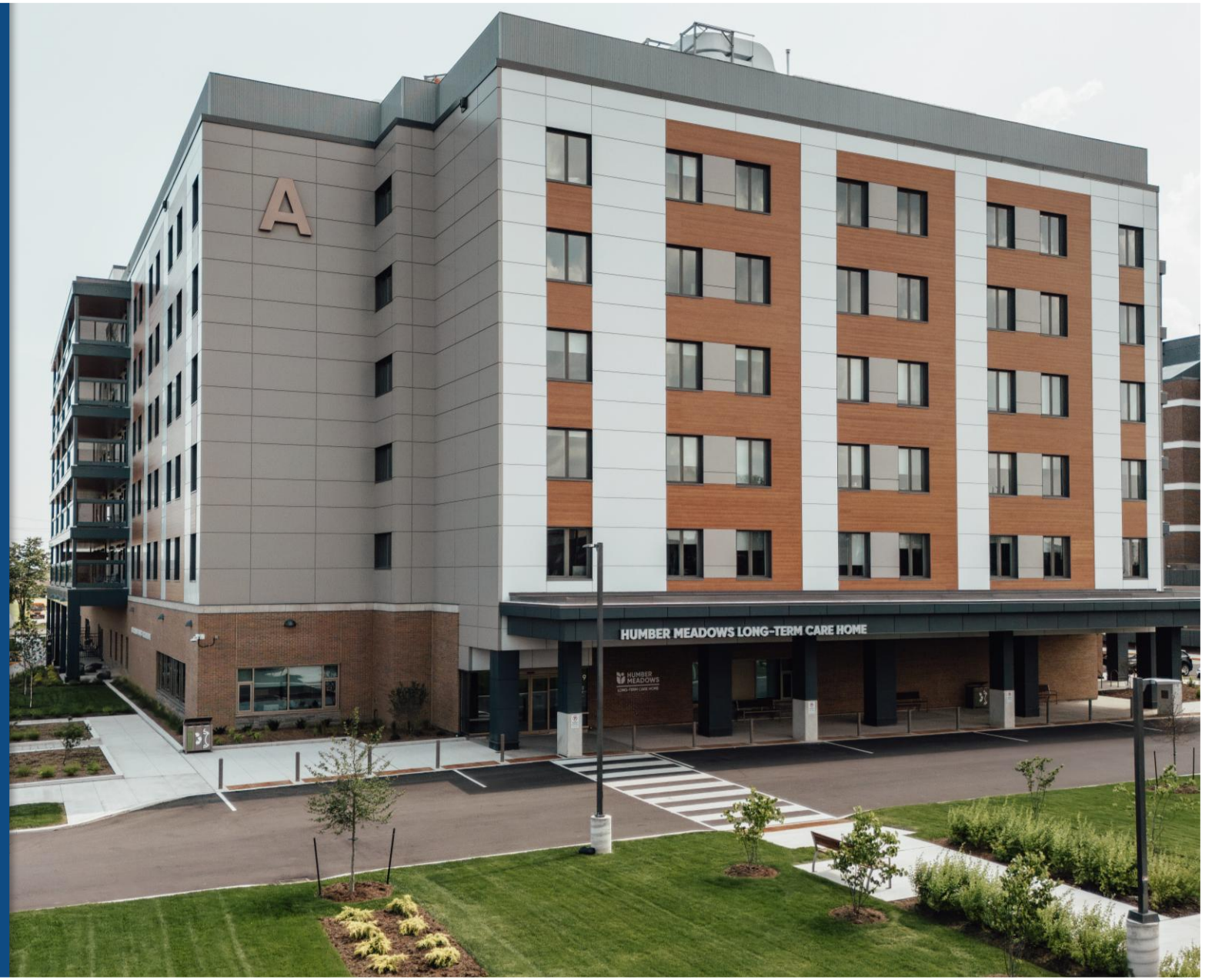
Quality Committee

HUMBER MEADOWS
LONG-TERM CARE HOME

BPSO RNAO BEST PRACTICE SPOTLIGHT ORGANIZATION CANADA

March 5, 2026



Key Quality Initiatives in 2025-26 (I)

- **Implementation of RNAO's Best Practice Guidelines for Person and Family Centered Care**, Palliative/End of Life Care, Falls Prevention and Management in 2025. Home expects to receive BPSO designation in May 2026. 100 BPSO Champions engaged.

- **Antipsychotic Reduction Program -** In 2025, the Home achieved a significant reduction in the number and percentage of residents who were receiving antipsychotic medications and did not have a diagnosis of psychosis. In January 2026 established a process to ensure compliance via monthly reviews to sustain these efforts.

- **Falls –** Achieved reduction in the rate of falls to 12% in Q3 2025/26 which is **30% below** the provincial average of 17.2%.

- **Palliative Care -** Home has collaborated with Ontario Health funded Palliative Care Coach from Dorothy Ley Hospice.

- **Developed a workplan** that which builds registered staff capacity to care for residents who are Palliative / End-of life as well as to provide resources/education to caregivers on the Palliative / End-of-life process.

Key Quality Initiatives in 2025-26 (II)

- **ED Transfers –** Home established a process to track high-risk residents who have avoidable ED transfers and has devised a proactive plan to prevent future avoidable visits.

- HRH **NLOT and LTC+ Hub –** NLOT supported the home to review some of our high-risk for avoidable ED transfer residents resulting in ED avoidance. LTC+ Navigator was leveraged for virtual consults and navigation, ensuring access to hospital diagnostic imaging and specialist clinics resulting in a reduction in avoidable ED transfers.

- **Staff Vacancies –** Achieved a reduction from 22 in May 2025 to 3 on February 27, 2026.

- **Employee Rounding –** Initiated in Spring 2025 with support from HRH Organizational Development.

- **Engage+** portal introduced to provide families with access to portions of the electronic health record, access timely organizational information, access to resident financial account information.

- **Meadow Minutes and Humber Heartbea**t newsletters introduced to strengthen communication.

QIP Indicators
2025/2026 vs. 2026/2027

Measure / Indicator	Sept – Dec 2025 Performance	2025-2026 Goal	2026-2027 Goal
Potentially Avoidable ED Visits	8.7	33	7
Equity	99%	100%	Discontinued
Residents responding 8 and above to the question "What number would you use to rate how well the staff listen to you?“	67%	Not Established	75%
Residents who responded positively to the statement: "I can express my opinion without fear of consequences"	70%	70%	75%
Residents without diagnosis of psychosis who were given antipsychotic medications	14%	20%	14%
Residents who fell in the 30 days leading up to their assessment	12%	16%	12%
Residents with a worsened Stage 2 – 4 Pressure Ulcer	2.7%	Nil	2.1%

QIP Snapshot

Potentially Avoidable ED Visits (I)

Planned Improvement Initiatives	Methods	Process Measures	Goal for Process Measures
Track and identify all residents who are deemed at high risk of an avoidable ED transfer. Primary selection criteria is any resident who had 2+ transfers in the most recent quarter	Each month track all ED transfers including treat and return as well as admissions	Total number of hospital transfers; total number of ED visits resulting in return to facility	100% of high-risk residents with avoidable ED transfers will have their plan of care reviewed and updated by NP/MD/Physician
	Quality and Compliance Lead to conduct a clinical review of each resident with 2+ ED treat and return transfers to assess if each transfer was avoidable or not		
	The findings of the clinical review will be assessed by the NP in collaboration with Physician/MD to identify strategies/tactics to avoid future transfers		
	Appropriate interventions will be provided in the home by NP and external supports such as NLOT, LTC+ Navigator		

Potentially Avoidable ED Visits (II)

Planned Improvement Initiatives	Methods	Process Measures	Goal for Process Measures
Partnership with HRH LTC Remote Monitoring initiative, a program that leverages the PREVIEW- ED(C), a clinical deterioration tool developed from the evidence-based NWES2 scoring system to identify early decline in resident health status and LTC+, which provides virtual supports via an LTC+ Nurse Navigator following intake and triage to community and hospital services, and/or telephone consultations and aims to improve access to outpatient clinics/resources	New hires to receive education on the one-page clinical deterioration tool automated in Point Click Care(PCC) used daily by PSWs to identify early signs of decline in the health status of LTC residents focused on 4 conditions: Pneumonia, dehydration, CHF and UTI PREVIEW ED 3+ scores will be escalated to NP/MD/Physician/Allied health professionals by registered staff NP-led education for registered staff on SBAR, clinical assessments, and proper use of PCC secure conversation to communicate with Physicians especially after hours	Percentage of newly-hired PSW and registered staff who received education on clinical deterioration tool Percentage of Residents who had their PREVIEW ED 3+ scores escalated to NP/Physician/MD/Allied health professionals	100% of newly hired PSWs and registered staff will receive training on clinical deterioration tool. 100% of Residents who had PREVIEW ED 3+ scores will be escalated to NP/Physician/MD/Allied health professionals

Potentially Avoidable ED Visits (III)

Planned Improvement Initiatives	Methods	Process Measures	Goal for Process Measures
Effective and prompt utilization of NP/Physician for a goals of care discussion for residents who are clinically declining and can be deemed Palliative/End of Life based on assessments	Education provided to nurses on Gold Standard Framework for Palliative care for proactive identification of residents who can be deemed Palliative/End of Life NP/Physician will meet with residents/families who are clinically declining and can be deemed as Palliative/End of life care based on the Gold Standard Framework and the RNAO Palliative/EOL Care Screening, Assessment and Management Tool to initiate early goals of care discussion which will ideally minimize avoidable ED transfers Educate families on Palliative/EOL care process and services offered at the Home	Percentage of residents who received goals of care discussion by NP/Physician and avoided ED transfers	100% of eligible residents will receive GOC discussion from NP/Physician 80% of residents who had goals of care discussion by NP/Physician will avoid ED transfers

What number would you use to rate how well the staff listen to you?

Planned Improvement Initiatives	Methods	Process Measures	Goal for Process Measures
Staff will use AIDET as a communication tool to strengthen resident and family engagement	Champions will reinforce key principles	Total number of staff trained	100% of staff will be trained

I can express my opinion without fear of consequences

Planned Improvement Initiatives	Methods	Process Measures	Goal for Process Measures
Each newly-admitted resident will have the RNAO (BPG) Person and Family Centered Care Assessment completed	Complete organizational Gap Analysis for People Centered Care BPG Develop strategies to address each identified gap	Total number of gaps identified; total number of strategies to address developed Percentage of residents who had RNAO Person and Family Centered Care assessment completed on admission	Gap analysis completed with strategies developed to address each identified gap. 100% of each newly-admitted resident will have Person and Family Centered Care assessment completed on admission
Mandatory education on SURGE Learning re: PFCC for all staff and new hires	All staff including the new hires will complete mandatory education on Person Centered Care through SURGE learning platform	Total number of staff who completed education	100% of staff completed the mandatory education

Residents without diagnosis of psychosis (I)

Planned Improvement Initiatives	Methods	Process Measures	Goal for Process Measures
Conduct comprehensive reviews of all residents receiving antipsychotics, this will include validation of diagnoses, assessment of the necessity for ongoing use, and identification of residents suitable for gradual dose reduction (GDR)	Each month, BSO Lead will analyze Antipsychotic usage report and identify residents suitable for Gradual Dose Reductions (GDR) based on the selection criteria Residents on Antipsychotic Reduction Program will be closely monitored to assess their responses to GDR	Pharmacy Utilization Reports: Monitor monthly antipsychotic dispensing rates and trends. Review dose reduction attempts and success rates	Successfully complete GDR for 75% of eligible residents
Staff education on Gentle Persuasive Approach and ADKAR and other non-pharmacological approaches to prevent/respond to responsive behaviors	Education will be provided to staff on Gentle Persuasive Approach and ADKAR All residents on Antipsychotic Reduction Program will have Non-Pharmacological Interventions such as: Enhance the use of person-centered care, non-drug interventions for responsive behaviors and utilize BSO Lead's expertise to implement behavior management strategies	Track the percentage of staff trained on Gentle Persuasive Approach and ADKAR Increase Utilization of Non-Pharmacological approaches for residents on Antipsychotic Reduction Program	60% of staff to be trained for GPA 100% of residents on ARP will experience an increase in the number of non-pharmacological interventions

Residents who fell in the 30 days leading up to their assessment

Planned Improvement Initiatives	Methods	Process Measures	Goal for Process Measures
HMLTC will use RNAO Best Practice Guidelines for Prevention and Management of Falls with a focus on reduction of injury from falls	All residents will have RNAO's BPG and Universal Fall Prevention strategies in the plan of care	Number of residents with Universal Fall prevention strategies in the plan of care	100% of residents will have Universal Fall Prevention strategies in the plan of care
Registered staff will screen all newly-admitted residents to identify those at risk for falls and their fall risk factors	Complete RNAO Clinical Pathways- N Adv Can Admission Clinical Pathway LTCF Version and N Adv Can Falls Risk Screening, Assessment and Management tool on admission	Percentage of residents who have a completed N Adv Can Admission Clinical Pathway LTCF Version and N Adv Can Falls Risk Screening, Assessment and Management tool on admission	100% of newly-admitted residents will have a completed Admission assessment and falls risk screening assessment and management tool
The home will sustain strategies aimed at preventing falls and reducing injuries from falls by providing education/training to staff annually and upon hire	Staff to receive training on falls prevention and management annually and upon hire.	Total number of staff received training/education on falls prevention and management annually and upon hire	100% of staff trained on falls prevention and management annually and upon hire
The home will focus on clinical interventions (eg: Mobility protocols, toileting routines) to reduce falls	Each month analyze falls data to identify trends and develop action plans	Total number of falls per month	5% reduction in all falls

Residents with a worsened Stage 2 – 4 Pressure Ulcer (I)

Planned Improvement Initiatives	Methods	Process Measures	Goal for Process Measures
Establish a multidisciplinary team involving NP, Skin and Wound Program Lead, Skin and Wound Champions, RAI Coordinator and Quality Lead. Assign specific roles and responsibilities to monitor, intervene and follow up	Each month, analyze all Stage 2 – 4 Pressure Ulcers to identify worsened Stage 2 – 4 Pressure Ulcers and to recommend strategies to achieve improvement All Residents with stage 2 – 4 Pressure Ulcers will be reviewed by ET to assess the effectiveness of treatment advised Skin and Wound Program Lead in collaboration with RAI Coordinators will review the skin and wound assessments completed by registered staff for residents who have Stage 2 – 4 Pressure Ulcers. The assessments will be reviewed to identify gaps in assessment/evaluation and ensure improper assessments are re-done	Total number of residents with worsened Stage 2 – 4 Pressure Ulcers	Percentage of residents with worsened Stage 2 – 4 Pressure Ulcers

Residents with a worsened Stage 2 – 4 Pressure Ulcer (II)

Planned Improvement Initiatives	Methods	Process Measures	Goal for Process Measures
Implement re-training program for registered staff to enhance their knowledge and skill on wound care assessment and evaluation	Training sessions will be provided in collaboration with NP and external partners	Percentage of registered staff who completed the training	100% of registered staff will complete the training