

Access and Flow | Efficient | Optional Indicator

Indicator #3	Last Year		This Year		
	Rate of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents. (AgeCare Westbury)	11.16 Performance (2025/26)	10 Target (2025/26)	24.35 Performance (2026/27)	118.19 Percentage Improvement (2026/27) %

Change Idea #1 Implemented Not Implemented In Progress

Ensure comprehensive monitoring of emergency visits through inclusion in the 24-hour report and progress notes.

Process measure

- % of ED Transfers tracked and reviewed by interprofessional committees

Target for process measure

- 100% of ED Transfers will be tracked and reviewed.

Lessons Learned

Emergency department transfers were incorporated into the 24-hour report and documented in progress notes to ensure timely communication and review. This improved awareness among the interdisciplinary team and supported more consistent tracking of transfer trends.

A key success was improved visibility. All transfers were reviewed, and discussions occurred during leadership and clinical meetings, allowing the team to identify patterns such as respiratory concerns, falls, and oxygen-related events.

One challenge identified was that monitoring alone does not prevent transfers. While documentation and tracking improved, earlier clinical intervention and structured escalation processes need further strengthening to reduce avoidable transfers.

Change Idea #2 Implemented Not Implemented In Progress

Facilitate high risk careplan rounds to identify residents at risk, changes in health status, and to validate external resources are utilized such as NP stat

Process measure

- % of scheduled high risk care plan reviews completed.

Target for process measure

- 90% of high risk care plans will be reviewed.

Lessons Learned

The intent of this initiative was to facilitate structured high-risk care plan rounds to proactively identify residents at risk and respond early to changes in condition. While NP Stat services were utilized appropriately when clinical concerns were identified, high-risk care plan rounds were not completed as consistently as planned throughout the reporting period.

A key success was timely use of external resources, including NP Stat and physician consultation, once residents were identified as clinically unstable. However, the process for proactively identifying at-risk residents before deterioration requires strengthening.

Moving forward, the home will work toward improving consistency in identifying residents at higher risk for transfer and strengthening interdisciplinary communication to support earlier intervention where appropriate.

Change Idea #3 Implemented Not Implemented In Progress

enhance Home's palliative and end-of-life program.

Process measure

- Timely Palliative Care Assessment: Percentage of residents identified for palliative care who undergo a comprehensive assessment within 48 hours of identification. Communication and Shared Decision-Making: Frequency of documented family conferences and shared decision-making discussions in the development of the care plan. Individualized Care Plan Development: Indicator: Percentage of residents with an individualized care plan addressing pain management, symptom control, emotional support, and spiritual needs. Target: 95% of identified residents. Target: Conduct family conferences for at least 90% of residents in palliative care. Target: 100% of residents in palliative care have an updated and individualized care

Target for process measure

- Target: 95% of identified residents. Target: Conduct family conferences for at least 90% of residents in palliative care. Target: 100% of residents in palliative care have an updated and individualized care plan.

Lessons Learned

The home continued to strengthen palliative and end-of-life discussions with residents and families, particularly when there were changes in health status. Greater emphasis was placed on reviewing and confirming Goals of Care to ensure they reflected the resident’s current condition and wishes.

A key success was improved communication between the interdisciplinary team and families during periods of clinical decline. Moving forward, the home will continue to prioritize timely review of Goals of Care during significant changes in condition and reinforce ongoing communication with families to support appropriate care planning.

Comment

Moving forward, the home will place greater emphasis on early recognition of changes in health condition and timely communication with physicians and nurse practitioners. Strengthening early clinical assessment and escalation will support more proactive in-home management when appropriate.

The home will also continue to reinforce ongoing conversations with residents and families regarding Goals of Care, particularly during significant changes in condition. Ensuring that Goals of Care are reviewed and clearly documented will help guide decision-making and align care with resident wishes.

These efforts will focus on improving early intervention, strengthening interdisciplinary communication, and supporting appropriate clinical decision-making to reduce avoidable transfers.

Equity | Equitable | Optional Indicator

	Last Year		This Year		
Indicator #2	100.00	100	100.00	0.00%	100
Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education (AgeCare Westbury)	Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

Change Idea #1 Implemented Not Implemented In Progress

Enhancing Equity, Diversity, Inclusion, and Anti-Racism Education for Staff.

Process measure

- Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education.

Target for process measure

- 100% completion rate for the relevant education modules on Surge for all new staff onboarded.

Lessons Learned

Cultural Competence and Indigenous Cultural Safety modules were delivered through Surge Learning and assigned to staff on orientation. However, the broader Diversity, Equity, Inclusion, and Anti-Racism modules and other education were not fully implemented as originally planned.

Change Idea #2 Implemented Not Implemented In Progress

We will actively encourage the inclusion of people from varies backgrounds, cultures, perspectives, and experiences in our home

Process measure

- Number of events held within the year

Target for process measure

- Ensure that all events are postered and communication is sent to all stakeholders. Monthly newsletters, meeting will be utilized along with our dedication Diversity board and social committee. Aim to have monthly events, or at minimum, every other month.

Lessons Learned

The home continued to promote inclusion through cultural events and awareness activities throughout the year.

Comment

Moving forward, the home will strengthen oversight of equity-related education to ensure that Diversity, Equity, Inclusion, and Anti-Racism modules are clearly assigned to all staff and tracked for completion. Equity education will be embedded beyond orientation and reinforced through ongoing cultural awareness initiatives and events throughout the year.

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 residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment (AgeCare Westbury)	5.19	4.50	4.09	21.19%	NA

Change Idea #1 Implemented Not Implemented In Progress

The RAI Coordinator will conduct a thorough review of new admissions prescribed antipsychotic medications, with a specific focus on evaluating the diagnosis and the prescribed antipsychotic medications.

Process measure

- % of new residents on antipsychotics reviewed at the time of admission.

Target for process measure

- 100% of new residents on antipsychotic medications will be reviewed by RAI-Coordinator

Lessons Learned

Reviewing all new admissions who were prescribed antipsychotic medications allowed us to identify early whether there was a clear diagnosis and appropriate clinical indication. This process improved accountability and ensured that medications were not continued without proper reassessment after admission.

A key success was early collaboration between the RAI Coordinator, physician, BSO team, and nursing staff. In several cases, medications were reassessed shortly after admission, and gradual dose reduction or alternative approaches were considered where appropriate. This supported our overall reduction in antipsychotic use.

One challenge was that some residents were admitted with long-standing prescriptions initiated in hospital or previous settings, where documentation did not always clearly outline the rationale. This required additional follow-up with physicians and careful clinical review before changes could be made safely.

Overall, early review at admission strengthened oversight, improved documentation practices, and supported more thoughtful prescribing decisions.

Change Idea #2 Implemented Not Implemented In Progress

The RAI Coordinator will perform quarterly audits on the utilization of antipsychotic medications before data submission, aiming to verify the accuracy of MDS coding.

Process measure

- % of residents on antipsychotics reviewed during audits.

Target for process measure

- 100% of residents on anti-psychotics are tracked and monitored through the auditing process.

Lessons Learned

Quarterly audits completed prior to MDS data submission helped improve the accuracy of coding and ensured that diagnoses and medication use were clearly supported in the clinical record. This reduced the risk of miscoding and allowed the team to identify trends before submission.

A key success was increased awareness among nursing staff regarding documentation requirements related to antipsychotic use. The audit process also created an opportunity to clarify discrepancies and address documentation gaps in real time.

Change Idea #3 Implemented Not Implemented In Progress

The RAI Coordinator will review residents on antipsychotic medications with corresponding diagnoses on a monthly basis during the Nursing Practice meeting.

Process measure

- Monthly Antipsychotic Medication and Diagnosis Review: Conduct a documented review of residents on antipsychotic medications and their corresponding diagnoses during each monthly responsive behaviour committee meeting.

Target for process measure

- Achieve 100% compliance with monthly reviews for all residents on antipsychotic medications.

Lessons Learned

Reviewing residents on antipsychotic medications during the monthly Nursing Practice and Responsive Behaviour meetings strengthened interdisciplinary oversight. A key success was improved collaboration between nursing, BSO, and physicians. Regular discussion encouraged the team to consider non-pharmacological approaches and ensured that medication use remained clinically appropriate.

Comment

Although the home exceeded its target for reduction in antipsychotic use without a diagnosis of psychosis, continued monitoring remains essential. Resident acuity and behavioural complexity require ongoing clinical oversight to ensure medications are used appropriately and only when clinically indicated.

The home will continue quarterly audits, monthly interdisciplinary review, and early evaluation of new admissions to sustain performance. Emphasis will remain on non-pharmacological approaches and collaboration with physicians and the BSO team to ensure resident safety and quality of care