Baycrest

2025/26 Workplan
Apotex, Jewish Home for the Aged

Access and Flow

Indicator: % of unplanned ED visits (# of unplanned visits to the emergency department/100 residents)
Source: Internal data
Current performance: 12.9%
Reporting period: January 1 – December 31, 2024

2025-26 Target	Target Justification
12%	Over the past eight quarters, our top 25th percentile is 12%, with an increase in the number of unplanned ED visits over the last 6 months. In order to meet or exceed this previous performance and target next year, we will need to decrease the number of unplanned emergency department visits by 2 residents per quarter from April 1 through to December 2025.

Change idea	Process measure	Methods	Target
1. **Advanced care planning:** develop a new advanced care planning process and documentation tool	# of meeting scheduled and held (every 2 months)	Leveraging data and feedback collected from the meetings, develop associated processes and a draft or revised version of the advanced care planning tool	At least 5 meetings scheduled with interdisciplinary collaborators to draft the new tool and processes by end of fiscal year.
2. **IV Antimicrobial Therapy:** Provide IV antimicrobial therapy to residents in the Apotex rather than being sent to hospital for medication administration (eg: antibiotic therapy, Remdesivir)	% increase in IV therapy orders	On a monthly basis, the pharmacy consultant will generate a comprehensive list of IV therapy orders that have been administered to residents in Apotex	IV administration orders will increase by 10% compared to 2024

3. **Falls Analysis Checklist:** develop and trial checklist on residents identified to be transferred to the emergency department related to a fall	% of residents sent to ED as a result of falls with falls checklist completed	On a monthly basis, review to the hospital transfer log to identify residents transferred to the ED related to falls	100% of residents sent to the ED related to falls will have a checklist reviewed completed

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Safe and Effective

Indicator: Percent of residents not living with psychosis who were given antipsychotic medication
Source: CCRS, CIHI
Current performance: 13.8%
Reporting Period: October 2023- September 2024

2025-26 Target	Target Justification
15%	• Antipsychotic medications are frequently utilized in long-term care environments to address severe behavioral and psychological symptoms associated with dementia. These residents may not have a formal diagnosis of psychosis and therefore, the use of such medications may be deemed "potentially inappropriate" (as per the CIHI definition). In the Apotex, over 70% of residents have a diagnosis of dementia, and over 80% exhibit responsive behaviors. • While we have seen significant improvement over the past number of quarters, our internal data from Q3 indicates that the rate has increased (to over 18%). • More than 30% of newly admitted residents are coming into the Apotex on an antipsychotic medication (an increase from the same time last year) • Over the next year, our primary objective is to maintain and build upon our improvements made over the past few years to ensure antipsychotic medications are prescribed exclusively for clinically appropriate indications, at the optimal dosage, and for the shortest duration necessary • The target of 15% aligns with a proposed National benchmark target and while it is higher than our current performance, reflects a reasonable goal given the nature and complexity of the residents who live in the Apotex.

Change idea	Process measure	Methods	Target
1. **Formalized referral pathway:** the behavioral assessment process will incorporate an interdisciplinary approach to dose reduction	% of residents receiving a dose reduction	On a monthly basis, verify that residents undergoing dose reductions are included in the formal referral pathway and have completed the necessary assessments with the designated interdisciplinary team members.	Collecting baseline
2. **Low dose medication review:** all residents on atypical antipsychotic medications (Quetiapine, Olanzapine, Risperidone) will be identified and	% of residents reviewed and brought forward for discussion	On a monthly basis, the quality specialist and consultant pharmacist will identify residents receiving low doses of these three	90% of identified residents will have a taper initiated

brought forward for possible dose reduction		medications. These medications will be reviewed during the quarterly medication assessment with the Most Responsible Physician (MRP) to evaluate the potential for deprescribing.	
3. **PRN removal:** identify residents that are prescribed PRN antipsychotics without a scheduled order	# of residents with PRNs	Audit all PRN medication that have been removed based on administration schedule	2-3 residents per quarter
4. **Dosing Observation:** identify all newly admitted residents with an antipsychotic order and track doses increased, decreases and discontinued	% of residents with dose discontinued and dose reduced captured each quarter	Through quarterly medication reviews, track residents admitted with antipsychotic; those with doses increased; those with doses decreased and those with doses discontinued	Increase in the % of residents with dose discontinued and dose reduced
5. **Social prescribing:** expand aromatherapy offerings including before episodes of care as well as expand music therapy offerings.	# of sessions administered	Quarterly review of consent received, progress notes documenting non-pharm intervention was offered, and average engagement score, observation of behaviour during or after care routines documented	Collecting baseline

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Safe and Effective

Indicator: Percent of residents with a worsened stage 2 to 4 pressure ulcer
Source: CCRS, CIHI
Current performance: 3.8%
Reporting Period: October 2023- September 2024

2025-26 Target	Target Justification
3.5%	Our target represents the top 20th percentile over the last 8 quarters. While we have seen significant improvement, a review of our internal data from Q3 shows an increase in the rate. As a result, the Ontario Provincial Average of 3.5% (unadjusted) will remain the target for the upcoming reporting period. To meet the target, we would need to reduce the number of residents with worsened pressure ulcers by one each quarter from now through to September 2025.

Change idea	Process measure	Methods	Target
1. **Enhance nursing capacity:** introduce 2 PT RPN positions focused on skin and wound	% of weekly skin and wound care assessments completed wounds with pictures	Conduct a monthly audit to ensure all wounds have a weekly assessment completed with photos of each wound in Point Click Care	80% of residents will have an assessment completed and photo uploaded
2. **Wound Care Team:** residents with a stage 3 or greater pressure injury will have wound reviewed by wound care team	% of residents with a stage 3, stage 4 or unstageable pressure injury reviewed by wound care team	Skin and wound assessments will be reviewed on a weekly basis to identify staging	100% of residents with a stage 3, stage 4 or unstageable pressure injury have wound reviewed by wound care team
3. **Care Planning:** PURS score of 3 or greater will have an individualized plan of care updated by documentation nurses and available in the Kardex	% of residents identified with a PURS score of 3 or greater have an individualized care interventions in place.	On a monthly basis, all residents with a PURS score of 3 or greater will be shared with documentation nurses to ensure the resident's plan of care is updated	100% of residents with a PURS score of 3 or greater will have an individualized plan of care and available in the Kardex

Resident Voice

Indicator: Percent of residents who responded positively to the following statement "I can express my opinions without fear of consequences"
Source: interRAI Quality of Life Survey
Current performance: 72.2%
Reporting Period: January 1 – December 31, 2024

2025-26 Target	Target Justification
80%	Over the past 18 months, our performance declined. In calendar year 2023, 86% of residents surveyed (n=105) responded that they can either always or most of the time express their opinions without fear of consequences. In 2024 this dropped to 72% (n=108). Our target is to reduce the gap between our 2024 performance and the international 80th percentile benchmark (86.7%) by half. If successful, we would also surpass the external median. To achieve the target, at least 20 out of 25 responses must be positive (responding always or most of the time) each quarter.

Change idea	Process measure	Methods	Target
Resident feedback: a) seek routine feedback at RAC to understand contributing factors to feeling they cannot speak up without fear of consequences; b) add prompting question in the resident quality of life survey for those who respond sometimes/rarely/never and review comments	% of sometimes and rarely responses	Collect survey data and comments to monitor changes in the % of unfavorable (sometimes/rarely/never) responses	Prompting questions added by March 1, 2025; ≤15% unfavorable responses
Staff support and Performance Monitoring: a) Deliver ongoing messaging to point of care staff on Apotex 2, 3EI and 3GS to support staff with active listening and self-reflection strategies based on resident feedback; b) management conduct monthly huddles based on resident quality of life data with day and evening shift to share resident feedback about expressing their opinions	# of sessions conducted on day and evening shift	Management routine meeting with staff; quality auditing of performance boards	At least 3 sessions per month on each neighborhood; performance boards updated monthly

Safe and Effective

Indicator: WPV incidents that result in lost time reported per 100 FTE hospital and LTC workers within a 12 month period
Source: internal data collection
Current performance: collecting baseline
Reporting period: April 1 2023 – March 31 2024

2025-26 Target	Target Justification
Collecting baseline	Collecting baseline data on workplace violence incidents resulting in lost time is essential to help the organization understand current state, measure progress, identify risk factors and develop targeted prevention strategies. This initial data collection is crucial for setting informed targets and measuring progress over time. Over the next year, Occupational Health & Safety will be working with Acclaim (3rd party WSIB company) to generate reports, baseline data and to understand the root cause for the lost time due to workplace violence.

Change idea	Methods	Process measure	Target
Process Improvement: Improve WSIB return to work process: foster ongoing collaboration between Acclaim, OHS & Management to enhance efficiency and effectiveness in supporting employees' return to work	OHS monitor RTW and types of Workplace Injuries tracking from Acclaim	% of Workplace Violence WSIB Claims	Setting base line for the 25/26 FY
Policy: Update the workplace violence and harassment policy and provide staff education	HR will track policy training completed	60% of staff provided with training on the updated policy within the first year of implementation	Policy approved by Q3
Education: Support managers and point of care staff through safety culture training including leadership forums, safety huddles and reinforcement of code of conduct	OHS to track # of huddles and attendance, survey attendees to track effectiveness of huddles.	24 safety huddles/training sessions conducted withing FY25/26	2 safety huddles/training sessions per month

Equity

Indicator: % of all Baycrest hospital and long term care staff who have completed relevant EDI and antiracism education
Source: internal data collection
Current performance: 46.4%
Reporting Period: January 1 – December 31, 2024

2025-26 Target	Target Justification
60%	The improvement target reflects the important work to deliver meaningful and accessible training to our staff as well as building leadership capacity in this area (with a goal that 80% of leaders attend in person training). Recognizing the tremendous education and training that our staff already complete throughout the year, the 10% improvement target acknowledges the importance of offering a diverse approach to EDI and antiracism education. There is also significant work required to align the organization's learning management systems to better capture and integrate EDI offerings and data tracking.

Change idea	Methods	Process measure	Target
Expand in person EDI educational offerings to Baycrest hospital and LTC leadership (i.e. managers, advanced practice leads, supervisors, directors, executive, physician leaders)	EDI/OE to collect attendance and competency evaluation	% of management attending in person training; # of in person offerings	At least 80% of leaders; at least 3 in person sessions held by end of Q2
Relaunch anti-Black racism eLearning, development of antisemitism modules and integration of the EDI micro-learnings into the learning management system	OE/EDI track quarterly data collection	Module completion rates	Launch anti-Black racism education all staff by the end of the calendar year; Antisemitism training modules launched for all staff by end of calendar year
Develop an Inclusive, Diverse, Equitable, Accessible, Anti-racist, Anti-oppressive Systems (IDEA³s) Integration Plan in alignment with our Accreditation Canada standards and corporate values that aims to establish a Leadership Community of Practice for supporting IDEA³s Integration policy development, education, leadership capacity-building, and systemic maturity through cross-entity collaboration and equity impact assessments.	Community of Practice will inform the development and monitor completion and approval of IDEA³s Integration policy	Extent of collaboration and engagement across Baycrest contributing on development of coordinated and integrated policy standards with measurable KPI and equity impacts	Development of integration framework, key performance indicators and policy draft by August 2025

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Develop robust organization-wide practice and Identity-Based Data Governance policy that emphasizes the collection and utilization of socio-demographic data to drive equity in healthcare and employment/ recruitment and that aligns with existing privacy and cybersecurity polices, legislation, reporting, and use of equity data (covering patient/ resident and employees data).			