Omni
Quality Living

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Omni Quality Living Continuous Quality Improvement Initiative Report 2026/27

Prepared in accordance with: *Fixing Long-Term Care Act, 2021* O. Reg. 246/22 – Section 168 Continuous Quality Improvement Initiative Requirements

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Omni Quality Living – Burnbrea Gardens

Continuous Quality Improvement Initiative Report

2026/27

OVERVIEW

At Omni Quality Living, people remain the driving force behind our mission. Since 1975, we have been committed to delivering compassionate, high-quality care, and as we move into our 51st year, we continue to shape the future of long-term care in Ontario with innovation, integrity, and a deep sense of purpose.

Quality is embedded in our culture. Our **Quality Matters** program guides our approach, ensuring that every resident receives care that is safe, timely, effective, and personalized. This framework supports continuous improvement and reinforces our commitment to evidence-based practices, routine evaluation, and industry-leading standards.

We recognize our role in supporting a health system that is sustainable, equitable, and focused on long-term wellness. Our work aligns with Ontario's vision for a value-based universal health care system—one that prioritizes prevention, improves outcomes, reduces hallway medicine, and strengthens access to high-quality care for all Ontarians.

Our **2026/27 Quality Improvement Plan** reflects provincial annual priorities as well as corporate priorities identified across Omni Quality Living. It aligns with regional and provincial strategies and fulfills the requirements of the **Continuous Quality Improvement Initiative Report (CQIIR)** under section 168 of O. Reg. 246/22 of the *Fixing Long-Term Care Act, 2021*.

This plan also supports broader provincial goals: enhancing the health care experience through an integrated, resident-centered continuum of care, and collaborating with partners to build an accountable, high-performing system that reduces disparities and improves outcomes across diverse populations.

Access and Flow

Improving access and flow across Ontario's health system continues to be a shared responsibility, and long-term care plays a vital role in ensuring residents receive the right care in the right place. Omni Quality Living remains committed to strengthening system capacity and

supporting smoother transitions for residents, families, and partners across the continuum of care.

- **Timely and Responsive Admissions**
  All applications for admission are reviewed promptly and responded to in accordance with the *Fixing Long-Term Care Act*. We remain committed to ensuring that individuals waiting for long-term care receive timely decisions and clear communication.
- **Efficient Bed Management**
  Available beds are reported to Ontario Health at Home without delay, and admissions are scheduled as soon as possible to support flow across hospitals, community settings, and long-term care.
- **Expanding Capacity Through Redevelopment**
  We continue to redevelop existing homes, often adding new beds and licenses—and to build new homes in communities across Ontario. These investments support provincial efforts to increase long-term care capacity and reduce pressure on hospitals.
- **Nurse Practitioner–Led Outreach**
  Nurse Practitioner outreach remains a key strategy in enhancing on-site clinical support, reducing avoidable transfers, and improving resident outcomes.
- **Reducing Unnecessary Emergency Department Transfers**
  We continue to strengthen in-home clinical capabilities, early intervention strategies, and staff education to minimize avoidable transfers to emergency departments.
- **Enhanced On-Site Diagnostics**
  Partnerships with local health agencies enable more facility-based services such as X-ray, ultrasound, and laboratory testing—improving access to timely diagnostics and reducing the need for off-site appointments.
- **Improving Transitions Through Technology**
  We continue to advance our use of digital tools to support safe, accurate, and efficient communication with external health partners.
- **Strengthening Medication Reconciliation**
  Many of our homes have adopted the pharmacist-led “Boomer Process” for first-time admissions, ensuring accurate medication reconciliation and safer transitions into long-term care.

Technology

Strengthening digital connectivity across the health system remains essential to improving access, flow, and resident safety. Omni Quality Living continues to expand the use of technology to support accurate, timely, and coordinated transitions of care.

- **Maximizing PointClickCare**
  PointClickCare remains our core clinical information system. We continue to leverage its advanced capabilities, including analytics, dashboards, and real-time reporting—to

support early identification of risk, improved care planning, and stronger communication across the continuum of care.

- **HealthConnex Integration**
  HealthConnex supports secure, streamlined information exchange between long-term care and acute care partners. Expanded use of this platform reduces delays, improves accuracy of shared information, and supports more efficient transitions.
- **Optimizing CHRIS**
  CHRIS remains essential for communication with Ontario Health at Home and community partners. Consistent use supports timely referrals, accurate documentation, and smoother transitions for residents entering or leaving long-term care.
- **Driving Compliance Through CHeCS**
  CHeCS transforms regulatory complexity into operational clarity. This mobile-first, AI-enabled platform standardizes compliance workflows, reduces incident logging time, manages staff training and certifications, and supports adherence to the *Fixing Long-Term Care Act*. By reducing administrative burden, CHeCS enables staff to focus more time on resident care.
- **Advancing Interoperability Through Amplify**
  All Omni homes continue to use Amplify to support safer transitions by connecting clinical data systems between long-term care and acute care. This integration reduces the risk of medication discrepancies, treatment errors, and information gaps during transfers.

Together, these digital tools strengthen our ability to deliver safe, coordinated, and efficient care while supporting broader provincial goals for a more connected and higher-performing health system.

Resident and Family Experience

A positive resident and family experience is central to high-quality long-term care. It reflects every interaction resident and family have within our homes—from daily care and communication to access to information and involvement in decision-making.

At Omni Quality Living, the voices of residents and families guide our quality improvement efforts. We are committed to creating an environment where each person's preferences, needs, and values shape the care they receive.

Resident Experience Survey

We partner with **Metrics at Work**, an independent organization that administers and analyzes our annual Resident Experience Survey. This survey focuses on two key indicators:

- How well residents feel staff listen to them.
- Whether residents feel they can express their opinions without fear of consequences

Survey results provide valuable insight into the lived experience of residents and families. Findings are used to identify opportunities for improvement, guide action planning, and celebrate strengths. Results are shared openly to promote transparency and accountability.

Our goal remains clear: to ensure every resident experiences compassionate, respectful, and individualized care, supported by strong partnerships with families and caregivers.

Provider Experience

A strong provider experience is essential to delivering exceptional resident care. At Omni Quality Living, we are committed to being a workplace where people feel respected, supported, and inspired—across all roles, generations, and career stages.

- **Recruitment, Retention, and Workforce Development**
  We actively recruit and retain qualified candidates while investing in the next generation of long-term care professionals. Our corporate education coordinator strengthens partnerships with colleges and universities, coordinates student placements, and supports preceptorship opportunities.
- **Success Through PREP LTC**
  The PREP LTC initiative has strengthened our ability to support students and new graduates by enhancing preceptor training, improving onboarding, and building confidence among staff who take on mentorship roles. This has contributed to stronger multigenerational teams and a more supportive learning environment.
- **Commitment to Learning and Growth**
  We offer bursaries for continuing education, certifications, and skills training, recognizing that investing in our people strengthens both care quality and job satisfaction.
- **Creating a Supportive Workplace**
  A positive provider experience includes moments of connection, recognition, and joy. Our homes regularly host appreciation events, celebrations, and team-building activities. Every employee also receives a holiday gift card as a gesture of gratitude for their dedication.

Safety

Safety is the foundation of high-quality care. At Omni Quality Living, we view safety as a whole-person commitment that includes physical, emotional, psychological, and social well-being.

Whole-Person Safety

Our approach is grounded in a biopsychosocial understanding of health. We focus on:

- **Physical safety:** Strong IPAC practices, fall prevention, medication safety, and safe clinical procedures.
- **Emotional and psychological safety:** Trauma-informed approaches, respectful communication, and environments free from fear or intimidation
- **Social safety:** Supporting meaningful relationships, reducing isolation, and fostering belonging.

A Culture of Staff Safety

A safe home depends on a safe workplace. We support staff through:

- Clear protocols and training
- Access to tools and technology that reduce risk.
- A culture of open reporting and psychological safety
- Respectful, inclusive environments that promote teamwork.

Learning and Continuous Improvement

We encourage open reporting of incidents and near misses and use this information to guide improvements. Digital tools support consistent documentation, timely communication, and effective follow-up.

Partnering With Residents and Families

Residents and families play an essential role in safety. Their insights help identify risks, improve communication, and strengthen care planning.

Palliative Care

Palliative care at Omni Quality Living is grounded in dignity, comfort, and whole-person support. Our approach enhances quality of life for residents living with progressive, life-limiting illnesses while providing meaningful guidance to families.

Resident-Centered and Culturally Responsive Care

Care plans reflect each resident's physical, emotional, social, psychological, and spiritual needs. From admission, we complete additional assessments to support culturally appropriate advance care planning.

Support for Families

Families are essential partners. We provide education, emotional support, and practical guidance to help them navigate the palliative journey.

Holistic Comfort and Well-Being

Our teams focus on:

- Pain and symptom management
- Emotional and psychological support
- Social connection and belonging
- Spiritual care aligned with personal beliefs

Care in Place

Whenever possible, we provide palliative care within the home to reduce unnecessary hospital transfers and support comfort in familiar surroundings.

A Compassionate, Coordinated Experience

Our approach ensures personalized care, continuity, comprehensive support, and a focus on comfort, dignity, and peace.

Population Health

Long-term care plays a vital and often underrecognized role in improving population health. Omni Quality Living contributes to healthier communities by supporting older adults with complex needs, preventing avoidable hospital use, and promoting well-being across the continuum of care.

- **Supporting Aging Populations with Complex Needs**
  We provide stable, comprehensive, 24-hour care for individuals with chronic conditions, cognitive impairment, mobility challenges, and social vulnerabilities—reducing strain on hospitals and community services.
- **Promoting Wellness and Prevention**
  Our teams focus on early identification of health changes, chronic disease management, fall prevention, nutrition and hydration, and social engagement.
- **Reducing Health System Pressures**
  By providing high-quality care in place, we help reduce avoidable ED visits, unnecessary hospital admissions, ALC pressures, and harmful transitions.
- **Equity and Inclusion**
  We support residents from diverse cultural, linguistic, and socioeconomic backgrounds and ensure care is respectful, inclusive, and aligned with individual values.
- **Strong System Partnerships**
  We collaborate with hospitals, primary care, Ontario Health Teams, community agencies, and specialized services to support coordinated care and improved transitions.

- **Data-Informed Decision-Making**
  We use clinical data, quality indicators, and resident experience feedback to guide improvement and target interventions.
- **Enhancing Quality of Life**
  Population health is about living well. We prioritize meaningful engagement, purposeful activities, social connection, and emotional well-being.

Alignment With the Fixing Long-Term Care Act and CQIIR Requirements

Omni Quality Living's 2026/27 Quality Improvement Plan fully aligns with the *Fixing Long-Term Care Act, 2021* and the **Continuous Quality Improvement Initiative Report** requirements under O. Reg. 246/22.

1. Systematic Approach to Continuous Quality Improvement

Our plan uses a standardized, evidence-informed framework supported by:

- Clinical indicators
- Resident experience surveys
- Safety reports
- Staff feedback

2. Annual Priorities and Targets

- Aligns with provincial priorities
- Includes home-level and corporate-level indicators
- Uses data from PCC, HealthConnex, CHRIS, CHeCS, and surveys
- Sets realistic, evidence-based targets

3. Resident, Family, and Caregiver Engagement

- Use independent Resident Experience Surveys
- Incorporate Resident and Family Council feedback
- Share results and action plans publicly
- Embed resident voice in care planning and safety initiatives

4. Staff Engagement and Provider Experience

- Strengthen workforce development
- Support multigenerational teams
- Promote psychological safety and open reporting

- Encourage staff participation in QI activities

5. Monitoring, Reporting, and Evaluation

- Use real-time data systems
- Conduct audits and interdisciplinary reviews
- Track trends in safety and outcomes
- Report progress to leadership, residents, families, and the public

6. Integration With the Broader Health System

- Strengthen partnerships with hospitals, OHTs, and community agencies
- Use digital platforms to improve transitions
- Support system flow and reduce avoidable transfers
- Contribute to population health and equity

7. Commitment to Resident Safety

- Use a biopsychosocial approach
- Strengthen IPAC, emergency preparedness, and violence prevention
- Encourage open reporting
- Implement technology-enabled safety systems

8. Public Transparency

- Share QI priorities and results openly
- Maintain clear, accessible documentation
- Demonstrate accountability through visible action

Access and Flow

Measure - Dimension: Efficient

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
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)	38.10	20.00	The target Justification has been set to 20%. We feel this goal or better can be reached once we solidify a full time Nurse Practitioner At Burnbrae Gardens. We continue to maintain our positive community partnerships and support from our NP STAT/MD team and new portable XRAY service MDI. Ongoing education with families on admission, 6 week care conference, annually and with any health status change regarding Advanced Directives, the trajectory of illness and quality of life.	Dr. Michelle Albert, NP STAT program, MDI mobilie xray

Change Ideas

Change Idea #1 The home will work to source a full-time Nurse Practitioner to provide shared coverage across our home and two other OMNI sister homes, ensuring timely clinical support and continuity of care.

Methods	Process measures	Target for process measure	Comments
The Director of Care will continue to collaborate with the Corporate Home Office to secure a permanent in-house Nurse Practitioner. In the interim, the home will continue to utilize the services of the NP STAT program to ensure timely clinical support and continuity of care for residents.	The home will continue to actively support the recruitment and onboarding of a full-time Nurse Practitioner (NP) to strengthen in-home clinical care and help reduce unnecessary emergency department (ED) visits.	The home is planning to have a full-time Nurse Practitioner (NP) on-site beginning in the next quarter, which will enhance timely clinical support, resident care management, and in-home intervention capabilities.	A key challenge for the home is its rural location, which can impact access to timely medical services. Our Medical Director is actively supporting the home in achieving the goal of reducing emergency department (ED) visits by providing guidance, education, and clinical support to staff. While a small number of residents may continue to request ED transfers regardless of available in-home support, we remain committed to educating residents and families on the range of care services provided within the home, including support from our Nurse Practitioner and Medical Director, to safely manage care on-site whenever possible.

Measure - Dimension: Efficient

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Elimination of Nursing Staffing Agency Use by the End of 2026	C	% / LTC home residents	In house data collection / January to January	35.00	10.00	We feel that decreasing agency usage from 35% to 10% is an achievable goal over the next year	Omni Quality Living

Change Ideas

Change Idea #1 Omni Quality Living is committed to building a stable, sustainable, and dedicated in-house workforce. Reducing reliance on temporary nursing staffing agencies supports continuity of care, strengthens team cohesion, and enhances resident experience. Burnbrae Gardens collaborates internally and works closely with the OMNI Quality Living Corporate Office to actively recruit and retain qualified registered staff, supporting safe, high-quality care for residents.

Methods	Process measures	Target for process measure	Comments
Recruitment efforts include online advertisements, internal postings, job listings on the OMNI Quality Living website, and word-of-mouth referrals. These strategies aim to attract qualified registered staff to support safe, high-quality resident care.	Monthly monitoring of in-house staffing requirements is conducted to ensure adequate coverage. All qualified applicants are carefully assessed, and interviews are completed to identify the best candidates for available positions.	The goal is to reduce the current use of agency staff for registered positions from 35% to 10%, strengthening in-house staffing stability and enhancing continuity of care for residents.	There is potential for discussions with the Ontario Nurses' Association (ONA) regarding the implementation of 12-hour shifts. In the meantime, the home is exploring creative solutions to maintain coverage, including utilizing registered staff from other departments, such as Quality Care RNs, to support floor shifts as needed.

Equity

Measure - Dimension: Equitable

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
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	100.00	100.00	The home feels passionately about Equity, diversity, inclusion and antiracism education and will remain at 100% compliance	

Change Ideas

Change Idea #1	OMNI continues to enhance its corporate Equity, Diversity, and Inclusion (EDI) program, which was rolled out across the organization in 2025. Our home remains committed to mandatory annual Surge Learning courses, which currently include: Cultural Competence and Indigenous Cultural Safety – 4-part series Accenture Inclusion and The Power of Diversity Accessibility Standards and AODA (2017) Blind Spots: Challenge Assumptions Understanding Gender and Pronouns in Healthcare These courses have achieved a 100% completion rate among staff. In addition, we actively promote diversity and inclusion within the home by posting a monthly diversity calendar from the CLRI for residents, displaying multicultural flags, and ensuring families and staff have visibility of these initiatives. OMNI has also developed a DEI roadmap aligned with the strategic plan, maintaining momentum in the implementation of a framework to support diversity, equity, and inclusion. To support these efforts locally, our home has established a Diversity, Equity, and Inclusion Committee responsible for promoting and monitoring the success of DEI strategies within the home.

Methods	Process measures	Target for process measure	Comments
All staff are required to complete mandatory Surge Learning upon hire and continue with scheduled monthly modules in accordance with the annual training plan. Routine team huddles are used to communicate DEI initiatives, foster discussion, and encourage an inclusive atmosphere within the home. Additionally, regular training programs and meetings focused on DEI principles are scheduled to increase awareness, reduce biases, and promote understanding of diverse cultures and perspectives in the workplace.	All managers are responsible for monitoring Surge Learning statistics and completion rates. Employees who have not completed the required modules within the designated timelines will receive a formal letter outlining expectations for completion. Continued non-compliance will result in further corrective actions, ensuring accountability and adherence to mandatory training requirements.	The home has achieved 100% compliance with mandatory Surge Learning, ensuring all staff complete the annual equity, diversity, inclusion, and anti-racism education. This reflects our commitment to maintaining a knowledgeable, inclusive, and culturally competent workforce.	We continue to collaborate with residents, family councils, and staff to promote all aspects of equity, diversity, inclusion, and anti-racism education, sharing updates on the DEI program as they become available. Additionally, we have implemented a stronger focus on in-house cultural events to celebrate diversity, foster community engagement, and create an inclusive environment for residents, families, and staff.

Experience

Measure - Dimension: Patient-centred

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of residents responding positively to: "What number would you use to rate how well the staff listen to you?"	O	% / LTC home residents	In house data, NHCAHPS survey / Most recent consecutive 12-month period	92.86	100.00	Burnbrae feels we can continue to meet our target with continued education to all staff which is provided upon hire, also as a refresher throughout each year with mandatory surge learning. BSO team provides interventions in caring for residents with responsive behaviors. We also have had outside community partners join us on site for in person education focusing on effective listening, Ufirst, GPA	BSO/ PASE

Change Ideas

Change Idea #1	Burnbrae continues to utilize the resident satisfaction survey in partnership with OMNI and Metrics at Work, a leading provider of organizational measurement and consulting. This process will continue into 2026/27. Resident Council members contribute to the development of survey questions each year, ensuring that resident perspectives are represented. We also encourage residents to participate in their annual care conferences alongside their loved ones, providing an opportunity to voice questions or concerns directly. This allows the interdisciplinary team to actively listen and develop action plans aimed at improving the quality of care and overall resident experience.

Methods	Process measures	Target for process measure	Comments
Burnbrae utilizes a quantitative and qualitative survey designed by Metrics at Work to ensure that residents and families understand that completing the surveys provides meaningful input into the culture of the home, without fear of repercussions. Survey topics are discussed monthly at Resident Council meetings to ensure residents feel comfortable and are aware of who to approach and how to report concerns openly at any time. The home maintains an open-door policy for addressing any concerns, assuring residents that their issues will be taken seriously. Residents are encouraged to contact the Executive Director immediately if raising a concern causes any distress or fear, so that it can be addressed promptly and appropriately.	Surveys are completed electronically via computer or tablet, with staff available to assist residents in entering their responses to ensure accurate data collection. Resident survey results may vary year to year due to changes in the resident population, including cognitive impairments such as dementia. Families are encouraged to provide input on behalf of residents who are unable to fully express their views. Finalized survey results are reviewed and discussed at both Resident and Family Council meetings. Any areas scoring below 80% trigger a required action plan, which is also reviewed at council meetings and posted on the Resident Council board. The home works collaboratively with residents and families to incorporate their input into the development and implementation of improvement action plans, fostering engagement and continuous quality enhancement.	The information gathered from the electronic survey has provided the home with an accurate understanding of our residents' and families' current experiences. This data enables us to reflect on and act upon their feedback while developing action plans that are openly discussed with all parties involved. In the category "What number would you use to rate how well the staff listen to you," 100% of responding residents rated positively, with an overall score of 93.8% based on 30 completed surveys. Given our smaller resident population, we recognize that fluctuations in the number of responses can significantly impact percentage results.	Total Surveys Initiated: 31 Burnbrae continues to achieve 100% participation in this survey category. The information gathered enables the home to respond effectively to any resident or family concerns. All entries are documented in the Concern and Complaint Log, with a response and action plan provided to the family within 10 days, ensuring timely resolution and transparency.

Measure - Dimension: Patient-centred

Indicator #5	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
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	96.77	100.00	We strive to reach this target at 100% as we feel we provide continuous opportunity for residents to safely expression their opinion.	

Change Ideas

Change Idea #1 Burnbrae Gardens continues to utilize the resident satisfaction survey in partnership with OMNI and Metrics at Work, a leading provider of organizational measurement and consulting. This partnership and survey process will continue into 2026/27, supporting ongoing evaluation and improvement of the resident experience.

Methods	Process measures	Target for process measure	Comments
Burnbrae Gardens utilizes a quantitative and qualitative survey designed by Metrics at Work to ensure residents and families understand that completing the survey allows them to provide input into the culture of the home without fear of consequences. Survey topics are discussed at Resident Council meetings to ensure residents feel comfortable and know how, who, and where they can report concerns openly at any time. The home maintains an open-door policy for addressing any concerns, assuring residents that their issues will be taken seriously. Residents are encouraged to contact the Executive Director or any manager they feel comfortable with immediately if raising a concern causes fear or distress, so that it can be addressed promptly and appropriately.	Surveys are completed electronically via computer or tablet, with staff available to assist residents in entering their responses to ensure accurate results. Survey outcomes may vary year to year due to changes in the resident population, including cognitive impairments such as dementia. Families are encouraged to provide input on behalf of residents who are unable to respond for themselves. Finalized survey results are reviewed at monthly Resident Council meetings and quarterly Family Council meetings. Any results scoring below 80% trigger a required action plan, which is reviewed at both Resident and Family Council meetings. Resident and family input is strongly encouraged throughout the development and implementation of these improvement plans.	The information gathered from this electronic survey provides the home with an accurate understanding of our residents' and families' current experiences. This data enables us to reflect on and act upon their feedback while developing action plans that are openly discussed with all parties involved. In the category, "I can express my opinion without fear of consequences," 96% of residents responded positively, based on 28 completed surveys. Given our smaller resident population, fluctuations in the number of responses can have a significant impact on the overall percentage.	Total Surveys Initiated: 31 Burnbrae was successful this year with a 90.3% survey completion rate among residents and families. We extend our gratitude to all residents who participated and to families who assisted the home in completing surveys, particularly supporting loved ones who were unable to respond independently due to dementia or cognitive impairment.

Safety

Measure - Dimension: Safe

Indicator #6	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
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	10.23	6.00	The home will continue to strive to attain this goal over the next quarter	

Change Ideas

Change Idea #1 The full-time Physiotherapy Assistant (PTA) program continues, providing increased one-to-one strengthening and balance exercises. This has had a positive effect on residents' mobility, stability, and overall physical well-being.

Methods	Process measures	Target for process measure	Comments
The Physiotherapy Assistant (PTA) will document attendance at daily group exercise classes as well as one-to-one sessions, ensuring accurate tracking of resident participation and engagement in mobility and strength programs.	The Physiotherapist (PT) continues to complete assessments upon admission, quarterly, and as needed (PRN) to monitor resident progress. Findings are communicated to families, frontline staff, and registered staff to ensure coordinated care and support ongoing mobility, strength, and overall well-being.	The goal is to achieve a 4% reduction in resident falls over the next quarter, through ongoing strength and balance programs, proactive monitoring, and targeted falls prevention strategies.	Burnbrae remains committed to its Falls Prevention Program, prioritizing resident safety and well-being through ongoing education, strength and balance initiatives, and proactive monitoring.

Change Idea #2	The home actively utilizes falls prevention funding to acquire and maintain equipment that supports resident safety, mobility, and independence. This includes tools and devices designed to reduce fall risk and enhance the effectiveness of the Falls Prevention Program.		
Methods	Process measures	Target for process measure	Comments
Falls reports are reviewed monthly and as needed (PRN). The Physiotherapist (PT) assesses the effectiveness of interventions and equipment in place for resident falls prevention. The Director of Care (DOC) reviews the falls prevention budget and equipment allocation to ensure the home maintains a variety of safety-promoting equipment, including HILO beds, personal alarms, bed alert mats, and fall mats. Monthly falls are also discussed at the Quality Meeting, with the PT in attendance to review interventions and support ongoing strategies to reduce falls.	The Director of Care (DOC) will submit invoices and review the falls prevention budget on a monthly basis. Falls rates will also be reviewed monthly and discussed at both the Nursing Practice Meeting and the Quality Improvement (QI) Meeting to monitor trends, evaluate interventions, and guide ongoing falls prevention strategies.	Through increased utilization of falls prevention equipment, the home aims to reduce resident falls by 4%, from 10% to 6%, over the next quarter. This target will be supported by ongoing monitoring, staff education, and targeted interventions to enhance resident safety.	At Burnbrae, we have successfully maintained a reduced falls rate of 10% and aim to further decrease this rate to 6% over the next year, focusing on targeted interventions for individual residents and ongoing falls prevention strategies.

Change Idea #3 Burnbrae will utilize an RNAO GAP Analysis to identify areas of strength and opportunities for improvement in the home's falls prevention program. Findings from the analysis will guide the implementation of additional targeted interventions to enhance resident safety and further reduce falls.

Methods	Process measures	Target for process measure	Comments
The online or in-house GAP Analysis tool will be completed in collaboration with Tonya Davis from RNAO and members of the Falls Committee. This process will help identify areas of strength and opportunities for improvement, guiding enhancements to Burnbrae's Falls Prevention Program.	One hundred percent of falls risk assessments will be reviewed monthly by the Director of Care (DOC) and Quality Lead during the Quality Meeting. All falls will be reviewed by the Physiotherapist (PT) to ensure that appropriate interventions are in place to reduce risk. Additionally, 100% of care plans for high-risk residents will be updated to reflect current risk levels and corresponding interventions aimed at minimizing fall risk.	The home's goal is to reduce the resident fall rate from 10% to 6% over the next year through enhanced monitoring, targeted interventions, and ongoing education for staff and residents.	Burnbrae Gardens is committed to decreasing resident fall risk while promoting resident independence. The resident population and their changing care needs can influence fall rates. Many residents experience variations in mobility assistance requirements—ranging from independent walking, walking with a four-wheeled walker, to wheelchair use—as well as cognitive changes such as dementia, which can increase the risk of falls. The home implements individualized interventions to support safety while maintaining autonomy and quality of life.

Measure - Dimension: Safe

Indicator #7	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
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	0.00	0.00	The home will continue to strive to attain this goal over the next quarter.	Dr. Michelle Albert, CareRx Pharmacy

Change Ideas

Change Idea #1	Burnbrae Gardens has improved communication with community partners and hospital discharge planners to support safe transitions of care. The Director of Care (DOC) and Executive Director (ED) have completed in-person, on-site hospital visits to strengthen collaboration. Additionally, the home works toward obtaining a thorough review of residents' medication lists upon admission, including details on the indication, duration, and rationale for antipsychotic use. Assessments are conducted to determine whether continued use of antipsychotic medications is appropriate, particularly for residents prescribed these medications without a corresponding diagnosis, ensuring safe and evidence-based medication management.

Methods	Process measures	Target for process measure	Comments
The BOOMR program continues to support the home in the medication review process in collaboration with CareRx Pharmacy, with oversight and discussion from the Medical Director to ensure current medications are appropriate. Communication with community partners and the Home and Community Care Support Services (HCCSS) has improved, allowing the home to access past assessments, medication reviews, and prior orders, which supports safe, informed, and evidence-based care for residents.	Antipsychotic usage is monitored through monthly Quality Meetings and quarterly MDS assessments, with reports pulled to track any reductions in usage. An antipsychotic monitoring tool is in place to guide safe reduction strategies. Results are discussed at monthly Quality Improvement (QI) meetings, and with the CareRx Pharmacy consultant and Dr. Albert during quarterly MAC/PAC meetings. The Medical Director reviews antipsychotic use quarterly and as needed (PRN) to ensure effective interventions are in place. CareRx also conducts annual and PRN reviews to support ongoing safe medication management.	One hundred percent of residents' medications will be reviewed quarterly by the Medical Director and annually by the Pharmacy consultant to ensure safe, appropriate, and evidence-based medication management.	Challenges in the home include the BOOMR system's processing time, which requires at least 48 hours to complete effectively. A second challenge arises when residents are admitted on antipsychotic medications without a family physician, making it difficult to obtain their previous medical and medication history.

Measure - Dimension: Safe

Indicator #8	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of long-term care residents whose stage 2 to 4 pressure ulcer worsened	O	% / LTC home residents	CIHI CCRS / July 1 to September 30, 2025 (Q2), as reporting quarter for the rolling 4-quarter average	9.41	5.00	Burnbrae can reach the goal of 5% worsened stage 2-4 pressure damage.	

Change Ideas

Change Idea #1	Staff will maintain 100% compliance with the New Skin and Wound app, implemented in 2025, to ensure at least weekly monitoring of all levels of skin damage. Any deterioration in wound status will be accurately documented and communicated promptly to the Director of Care, supporting timely clinical intervention and optimal resident outcomes.

Methods	Process measures	Target for process measure	Comments
Staff receive education on the proper use of the Skin and Wound app, including accurate documentation on the TAR (Treatment Administration Record) and review of interventions in place to maintain or improve skin integrity. Interventions may include the use of specialized air surfaces, nutritional supplements, individualized seating plans, turn and repositioning schedules, toileting plans, and referrals to the Registered Dietitian (RD) or Physiotherapist (PT) as appropriate. This comprehensive approach supports proactive skin care and resident safety.	The Quality Care (QC) Nurse will follow up at least weekly using the wound report to ensure that Skin and Wound app assessments are complete and align with TAR documentation. Registered staff are responsible for promptly reporting any deterioration in wound status to the Director of Care (DOC) or their designate, enabling timely reassessment and adjustment of treatment plans as required.	Quality Care (QC) registered staff will ensure that wound assessment documentation is completed at least weekly, maintaining 100% compliance with the prescribed treatment plan and supporting consistent, high-quality resident care.	In the MDS/New interRAI, a resident may be coded as having a “worsened” Stage 2–4 pressure injury even if no pressure damage was documented on their previous assessment. Therefore, this coding does not necessarily indicate a true worsening of the condition, but may reflect the first documentation of the injury.

Measure - Dimension: Safe

Indicator #9	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of long-term care residents in daily physical restraints	O	% / LTC home residents	CIHI CCRS / July 1 to September 30, 2025 (Q2), as target quarter of rolling 4-quarter average	0.00	0.00	Burnbrae remains a restraint free home.	

Change Ideas

Change Idea #1 The home maintains a zero percent restraint use policy, reflecting our commitment to resident safety, dignity, and the promotion of independence.

Methods	Process measures	Target for process measure	Comments
The home will continue to monitor resident safety proactively, ensuring that care practices, interventions, and the environment support the well-being, dignity, and independence of all residents.	The home will continue to monitor restraint use, maintaining a zero-restraint approach to ensure resident safety, dignity, and independence.	Burnbrae continues to maintain zero restraint use, demonstrating our ongoing commitment to resident safety, dignity, and the promotion of independence.	Burnbrae remains at zero restraint use, reflecting the home's continued commitment to resident safety, dignity, and independence.

Access and Flow | Efficient | Optional Indicator

	Last Year		This Year		
Indicator #7 Rate of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents. (Burnbrae Gardens)	**34.88** Performance (2025/26)	**10** Target (2025/26)	**38.10** Performance (2026/27)	**-9.23%** Percentage Improvement (2026/27)	**20** Target (2026/27)

Change Idea #1 ☑ Implemented ☐ Not Implemented ☐ In Progress

Continue to source out a new community partner with portable x-ray and U/S services.

Process measure

- Continue to source out a new community partner with portable x-ray and U/S services to reduce ER visits.

Target for process measure

- The home will have a portable x-ray and u/s service within the next quarter.

Lessons Learned

The home has successfully secured a contract with a new portable X-ray service to enhance on-site diagnostic capabilities. A noted challenge has been ensuring timely service delivery, as our rural location can impact the provider's ability to attend the home promptly.

Change Idea #2 ☐ Implemented ☐ Not Implemented ☑ In Progress

Omni Home office has placed advertisement for full time Nurse Practitioner services to be divided between 3 sister homes to work alongside our medical director and NP STAT program with the HCCSS.

Process measure

- No process measure entered

Target for process measure

- No target entered

Lessons Learned

A potential challenge may be recruiting a Nurse Practitioner (NP) to support our home, as well as the two sister homes, due to the remote location. This may impact timely access to on-site clinical support and ongoing primary care initiatives.

Comment

Staff education and ongoing communication regarding residents' advance directives (AD) and care preferences continue to be emphasized. However, residents may, at times, choose to override these directives and request hospital transfers, which are honored. Future improvement goals include leveraging the Nurse Practitioner shared across the homes to provide timely on-site support, with the aim of reducing unnecessary emergency department transfers while respecting resident choice.

Equity | Equitable | Optional Indicator

Indicator #6

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

Last Year		This Year		
100.00 Performance (2025/26)	**100** Target (2025/26)	**100.00** Performance (2026/27)	**0.00%** Percentage Improvement (2026/27)	**100** Target (2026/27)

Change Idea #1 ☐ Implemented ☐ Not Implemented ☑ In Progress

Omni continues to enhance their current EDI program and will be rolled out throughout the corporation. At this time we will continue with mandatory Annual Surge learning courses. Current courses in Surge are as follows: Cultural Competence and Indigenous Cultural Safety - 4 Part series, Accenture Inclusion and The Power of Diversity Accenture - Accessibility Standards and AODA (1) AODA 2017, Blinds Spots Challenge Assumptions, and Understanding Gender and Pronouns in Healthcare-all 100% Completion Rate. The leadership team completed training at our annual FORUM around resiliency and EDI presented by Rick Gourlie, Doneath Stewart and Patsy Morrow in the Fall of 2024. We also post monthly diversity calendar from the CLRI for all the residents, families and staff to view. Omni has also developed a road map that aligns with the strategic plan as well as 6 step process that will initiate and maintain momentum in the implementation of a framework to support Diversity, Equity and Inclusion. Our home is in the process of establishing a Diversity, Equity and Inclusion Committee that will be responsible for promoting the success of DEI strategies in the Home.

Process measure

- All managers to monitor Surge stats and completion rates. If we find that employees have not completed required surge within the timelines then letters are sent out with our expectations for completion and further action steps will be taken if continued non-compliance with completion.

Target for process measure

- 100% compliance with Surge completed regarding relevant equity, diversity, inclusion, and anti-racism education annually.

Lessons Learned

Staff have provided positive feedback regarding the Equity, Diversity, and Inclusion (EDI) program, with policies and procedures in place and consistently followed. Management, in collaboration with the EDI Committee, continues to promote awareness by posting monthly diversity-focused newsletters on the EDI board, reinforcing education, inclusivity, and organizational commitment to a respectful workplace culture.

Change Idea #2 ☐ Implemented ☑ Not Implemented ☐ In Progress

The home has implemented a plan to recognize international days of celebration by having themed days with international cuisine and flags at entrance to the home to highlight our commitment to EDI.

Process measure

- No process measure entered

Target for process measure

- No target entered

Lessons Learned

A new change initiative is planned for the upcoming quarter to further enhance culturally diverse theme days, meals, and recreational activities. This initiative aims to promote inclusivity, celebrate the diverse backgrounds of our residents and staff, and enrich the overall home environment through meaningful cultural engagement.

Comment

We will continue to promote equity, diversity, inclusion, and anti-racism education through Surge Learning. We look forward to the enhanced implementation of our DEI policies, procedures, and new programs. Efforts will also focus on improving communication about DEI initiatives with residents and families. Please refer to our workplan for further details.

Experience | Patient-centred | Custom Indicator

Indicator #1

A Palliative Approach to Care (Burnbrae Gardens)

Last Year		This Year		
CB	**100**	**95.00**	**--**	**NA**
Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

Change Idea #1 ☑ Implemented ☐ Not Implemented ☐ In Progress

Continue to work with our community RNAO Best Practice Guidelines for a palliative approach to care in the last 12 months of life and the BPG a palliative approach to care in the last days and hours.

Process measure

- Over the next 12 months Learning and development will continue to be implemented for all staff departments for a holistic approach to palliative care. Family members will receive more in depth conversations to identify areas which will improve a more holistic approach.

Target for process measure

- 100 percent of all Burnbrae staff, current residents and future admissions & their families will be part of the Palliative approach to care committee by Dec 31 2025.

Lessons Learned

Burnbrae has successfully completed the collaborative project with the Centre for Learning, Research and Innovation in Long-Term Care (CLRI) and continues to promote ongoing education and awareness among all staff. We actively participate in funded education programs offered through CLRI to support best practices, enhance staff knowledge, and strengthen quality of care within our home.

Change Idea #2 ☑ Implemented ☐ Not Implemented ☐ In Progress

Awareness and compassionate care and documentation remain key, Education to significant others of what to be expected during final days, hours, education continues with focus on difficult conversations with significant others from admission and throughout their care journey.

Process measure

- No process measure entered

Target for process measure

- No target entered

Lessons Learned

The Burnbrae Palliative Care Team has successfully completed the Palliative Care Collaborative Approach to Care Project. Throughout this initiative, staff demonstrated outstanding commitment and passion for providing high-quality, compassionate, and person-centered palliative care. Their dedication to the palliative approach to care program reflects the team's ongoing focus on supporting patients and families with dignity, comfort, and respect.

Comment

Continued awareness of education opportunities, reaching out to our local community partners to ensure staff and employees have access to education opportunities and awareness of supports

Experience | Patient-centred | Optional Indicator

	Last Year		This Year		
Indicator #4 Percentage of residents responding positively to: "What number would you use to rate how well the staff listen to you?" (Burnbrae Gardens)	**83.33** Performance (2025/26)	**100** Target (2025/26)	**92.86** Performance (2026/27)	**11.44%** Percentage Improvement (2026/27)	**100** Target (2026/27)

Change Idea #1 ☑ Implemented ☐ Not Implemented ☐ In Progress

Burnbrae continues to utilize the resident satisfaction survey with OMNI's partnership with Metrics at Work and this will continue into 2025/26 Metrix at work is a leading provider of organizational measurement and consulting. Resident council also have input on developing the resident satisfaction survey questions each year. We are going to encourage residents to join their annual care conference with there loved ones so that the individual resident can voice and questions and or concerns and allow the multi disciplinary to listen and create action plan for improvement.

Process measure

- Completing the Surveys via computer/tablet, an electronic qualitative and quantitative survey, ensure tablets and computers available with staff to assist residents with inputting the data for more accurate results. Resident population year to year will affect the survey results due to dementia with confusion. Families are encouraged to assist and add input when willing and able. Finalized results are then discussed at resident and family council meetings. Any flagged result below 80% will have a required action plan that will also be reviewed at both council meetings. We will work with our Resident and family councils and encourage input within the action plan for improvement.

Target for process measure

- The information received from this electronic survey has provided the home with an accurate account of our resident/ family current experience. We believe that this information will allow us to reflect and act upon our residents and families current experience as well we develop an action plan with those results being openly discussed with all parties involved. 100% Percentage of residents who responded positively to the statement: What number would you use to rate how well the staff listen to you. Our home scored 83.6% in this category out of 30 surveys completed. In light of our smaller resident population we find that this has an effect on our percentage's.

Lessons Learned

Concern: Ensuring consistent and timely communication among all staff remains an area of focus to support collaboration and continuity of care.

Success: As reflected in our data, Burnbrae has demonstrated measurable success in effectively utilizing the Concern and Complaint Form, promoting transparency, accountability, and timely resolution of identified issues.

Change Idea #2 ☐ Implemented ☐ Not Implemented ☑ In Progress

Management strives to ensure timely follow up with all or any resident concerns or complaints as soon as have been reported. Management takes the time to listen to concerns, complete the OMNI concerns and complaint form and follow up with the resident & POA within the designated timeline. We ensure to meet the timeline requirements of the MOLTC.

Process measure

- No process measure entered

Target for process measure

- No target entered

Lessons Learned

Successes noted improvement through resident satisfaction survey 2025, continue to follow same Policy and procedure as per regarding concerns and complaints and strive to continue to improve the rate to 100%

Comment

Annual Surge learning in place for all staff with reminders of the importance of timely reporting as well as signage up throughout the home.

Indicator #5

Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences". (Burnbrae Gardens)

Last Year		This Year		
83.33	**100**	**96.77**	**16.13%**	**100**
Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

Change Idea #1 ☑ **Implemented** ☐ **Not Implemented** ☐ **In Progress**

Burnbrae Gardens continues to utilise the resident satisfaction survey with OMNI's partnership with Metrics at work and this will continue intro 2025/26. Metrics at work is a leading provider of organizational measurement and consulting.

Process measure

- Completing the Surveys via computer/ tablet, an electronic qualitative and quantitative survey, ensure tablets and computers available with staff to assist residents with inputting the data for more accurate results. Resident population year to year will affect the survey results due to dementia with confusion. Families are encouraged to assist and add input. Finalized results are then discussed at resident monthly and family quarterly meetings and any flagged result below 80% will have a required action plan that will also be reviewed at both resident and family council meetings and our resident and family input is strongly encouraged.

Target for process measure

- The information received from this electronic survey has provided the home with an accurate account of our resident/ family current experience. We believe that this information will allow us to reflect and act upon our residents and families current experience as well as develop an action plan with those results being openly discussed with all parties involved. 100% Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences. Our home scored 84.3% in this category after completing 30 surveys. In light of our smaller resident population we find that this has an effect on our percentage's.

Lessons Learned

Residents are encouraged to continue to express any concerns and reminded at monthly resident council meetings to be open and report all concerns and complaints immediately to ensure timely follow up. Management spends time with residents post investigation to ensure they are aware their concerns are valid and promote feeling of safety.

Comment

Total Survey Initiated=31 # of LTCH beds=31
We will continue to provide education for all staff around Respect Always, Residents first and our Resident bill of rights. We also have PASE onsite to provide education on approach and response. See our workplan for further details.

Safety | Safe | Optional Indicator

Indicator #2

Percentage of LTC home residents who fell in the 30 days leading up to their assessment (Burnbrae Gardens)

Last Year		This Year		
10.34	**5**	**10.23**	**1.06%**	**6**
Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

Change Idea #1 ☐ Implemented ☐ Not Implemented ☑ In Progress

PTA program increased to full time with increased 1:1 strengthening/ balancing exercises. We have noticed huge improvement in this area, with the increase in our physio time.

Process measure

- The PT will complete upon admission, quarterly and PRN Physio assessments to track resident progress and communicate to families, front line and registered staff.

Target for process measure

- Falls will decrease by 10% over the next quarter.

Lessons Learned

The continued positive impact of having a full-time Physiotherapy Assistant (PTA) in the home has been evident through the promotion of residents' strength, balance, and overall mobility. This dedicated role supports ongoing restorative programming, contributes to fall prevention initiatives, and enhances residents' independence and quality of life.

Change Idea #2 ☐ Implemented ☐ Not Implemented ☑ In Progress

Continue to utilize improved RISK management falls report on PCC. It includes a more streamlined assessment tool which provides risk management analysis on all falls.

Process measure

- DOC and Admin will review Surge learning stats and orientation package completion. Falls policy attached on back of registered staff report sheet to improve completion per policy and continued education provided at Nursing practice meeting, falls prevention meeting.

Target for process measure

- 100% staff trained on orientation and as required on Post falls Policy. 100% compliance with falls prevention education on surge learning completed annually.

Lessons Learned

100% of staff are utilizing the post-fall risk management assessment tool to guide documentation, ensure thorough evaluation, and support appropriate follow-up interventions.

Change Idea #3 ☐ Implemented ☐ Not Implemented ☑ In Progress

Utilization of falls prevention funding for equipment.

Process measure

- DOC will submit invoices and review budget monthly. DOC will review falls rates monthly and discuss at monthly nursing practice meeting.

Target for process measure

- Increased utilization of falls prevention equipment will decrease falls by 5% (10% to 5%) over the next quarter.

Lessons Learned

The home has acquired fall mats and personal alarm devices to strengthen our falls prevention strategy. These additional safety measures support individualized care planning, enhance resident monitoring, and reduce the risk of injury associated with falls.

Change Idea #4 ☐ Implemented ☑ Not Implemented ☐ In Progress

Home intends to complete a RNAO falls prevention Gap analysis to see where the home could improve. "Preventing falls and reducing injury from fall"

Process measure

- No process measure entered

Target for process measure

- No target entered

Lessons Learned

This initiative is scheduled to be implemented later this year; therefore, there are no lessons learned to report at this time. We anticipate gaining further clarity and identifying areas for improvement based on the upcoming GAP analysis results over the next quarter.

Comment

Home has noted slight improvement in falls rate due to implementing the above change ideas

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Indicator #3

Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment (Burnbrae Gardens)

Last Year		This Year		
X	**5**	**0.00**	**--**	**0**
Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

Change Idea #1 ☑ Implemented ☐ Not Implemented ☐ In Progress

Improved communication with community partners, and discharge planners at Hospital. We have also completed in person and onsite hospital visits from DOC/ED. We also work towards obtaining a more thorough review of medication list on admissions of the why's, when, how long. Assessments are in place to determine the need for having the medications in place on admission due to being on prescribed antipsychotics without diagnosis.

Process measure

- Monitor antipsychotic usage with monthly Quality meeting and quarterly MDS assessment, pull report to determine if usage decreased. Antipsychotic monitoring tool in place when attempting to decrease usage. Discuss results at monthly QI meeting. MD to review quarterly and PRN for other effective interventions. CareRx to review annually and PRN.

Target for process measure

- 100% of residents medications will be reviewed on a quarterly bases by MD and annual by Pharmacy consultant.

Lessons Learned

Effective and ongoing communication within the interdisciplinary (MDC) team continues to support appropriate medication management. Antipsychotic medications have been successfully discontinued where clinically appropriate and safe to do so.

The home remains at 0% for the quality indicator measuring the percentage of long-term care residents without a diagnosis of psychosis who were administered antipsychotic medication in the seven days preceding their resident assessment, reflecting our continued commitment to evidence-based prescribing practices and resident safety.

Change Idea #2 ☑ Implemented ☐ Not Implemented ☐ In Progress

Utilizing BOOMR CareRx program to complete Medication reconciliation when able with discussions between Dr. Albert, past Pharmacy, past family doctor with review of Past medical history and any supporting documents ie GAIN/PASE notes

Process measure

- No process measure entered

Target for process measure

- No target entered

Lessons Learned

BOOMR was implemented in 2025; however, challenges have been identified related to timelines, specifically the alignment between resident admission dates and CareRx processing times, which may exceed 48 hours. These timing gaps can impact workflow efficiency and medication reconciliation processes during admission.

Comment

Continued open communication with family and MDC team to ensure safe and appropriate usage of Antipsychotics