

Apotex Quality Improvement Plan 2026/27 Workplan

Indicator: % of residents who responded positively to “I can express my opinions without fear of consequences”

Current performance: 76%

2026-27 Target	Target Justification
80%	<ul style="list-style-type: none"> The target aims to further close the gap between Apotex’s current performance (76.0%) and the 80th percentile benchmark (86.7%), which would position Apotex above the external median. While results improved last year from 72% to 76%, there remain specific floors with resident response scores well below 80%. In addition, about 10% of residents respond to this question with “sometimes”, highlighting opportunities to strengthen a culture where residents consistently feel safe and supported to speak up and share concerns without fear of reprisal

Change idea	Process measure	Methods	Target
1. Increase response rates on Apotex 2 to more accurately capture feedback on this survey question.	Response rates	Monthly tracking of Apotex 2 response rates as part of survey process. Regularly review commentary received for unfavorable responses.	At least 70% by June
2. Expand performance boards into the neighborhoods	# of neighbourhood boards updated as per schedule	Quality lead will share data with LTC Managers on a quarterly basis and then conduct quarterly audits of performance boards to monitor accuracy and timely data	18 neighborhoods kept up to date on a quarterly basis beginning in the fall.
3. Create facilitated resident–staff sessions that provide a safe, respectful space to come together, share concerns and jointly identify practical opportunities to improve how comfortable residents feel speaking up. Use these sessions to inform micro learning moments with point of care staff to reinforce standards and promote the speak up culture for residents.	# of improvement actions identified and introduced	Document improvement actions and track progress. LTC managers maintain documentation of issues discussed at huddles and actions introduced.	2 sessions per month for for 6 months starting in the Spring with one improvement action identified monthly.

Indicator: % of residents not living with psychosis who were given antipsychotic medication

Current performance: 19.5%

2026-27 Target	Target Justification
16.6%	<ul style="list-style-type: none"> The Apotex did not meet the national 15% target set by the Appropriate Use Coalition (AUC). AUC recommends that homes not meeting the 15% target set a 15% relative reduction as their annual improvement goal The 16.6% target reflects a 15% relative reduction from 19.5%

Change idea	Process measure	Methods	Target
1. Implement a monthly pharmacist and Nurse Practitioner–led review of residents prescribed low-dose atypical antipsychotics (e.g., quetiapine, olanzapine, risperidone, aripiprazole, brexpiprazole) to assess appropriateness and identify opportunities for dose reduction or deprescribing.	% of eligible residents on low-dose atypical antipsychotics who have a taper initiated following medication review	Each month, the pharmacist and Nurse Practitioner review residents on low-dose atypical antipsychotics using a standardized medication tracker, document recommendations, and pilot the process on one unit prior to home-wide implementation. The process will initially be piloted on one neighborhood.	90% of eligible residents will have a taper initiated
2. Implement a targeted antipsychotic deprescribing initiative to identify and review PRN antipsychotic orders not used in the past 60 days.	% of PRN antipsychotic orders not used in the past 60 days that receive a documented deprescribing review.	Each month, PRN antipsychotic orders that have not been used for 60 days will be identified and jointly reviewed by the pharmacist and Nurse Practitioner for deprescribing appropriateness. Recommendations documented, communicated to the care team, and tracked for completion and outcomes.	90% of eligible PRN antipsychotic orders will be discontinued when not used in 60 days
3. Standardize and expand the use of evidence-based non-pharmacological recreation interventions (e.g., music therapy, aromatherapy, sensory stimulation, pet therapy, compassionate touch, and reminiscence) to support residents' behavioural and psychosocial needs.	% of residents receiving a dose reduction or had an antipsychotic deprescribed offered evidenced-based non-pharmacological interventions	Each month, the pharmacist will share the list of residents receiving a dose reduction or had a discontinued antipsychotic for review.	90% of residents identified

Indicator: % of unplanned ED visits (# of unplanned visits to the emergency department/100 residents)

Current performance: 15.9%

2026-27 Target	Target Justification
14.5%	<ul style="list-style-type: none"> 2025 rate of unplanned emergency department (ED) visits increased from 12.9% to 15.9%, Apotex did not meet the 2025/26 QIP target of 12%. In 2025, 72.5% of unplanned ED visits resulted in hospital admission, presenting an opportunity for earlier intervention. The median unplanned ED visit rate over the past 15 quarters is 14.5%, which has been selected as the target for the upcoming year. Achieving a reduction from 15.9% to 14.5% would require approximately 25 fewer transfers annually.

Change idea	Process measure	Methods	Target
1. Develop and trial an integrated care pathways (ICPs), (a multidisciplinary individualized structured protocol including a concurrent Palliative approach to care) for CHF	# of residents with integrated care pathway adoption	Nurse Practitioner to audit charts monthly to confirm accurate completion, track adoption and review	10 residents

Indicator: **Falls with injury rate (rate of falls with injury*/100 residents)**

Current performance: **5.7%**

2026-27 Target	Target Justification
5.3%	<ul style="list-style-type: none"> The target of 5.3% represents a level of performance that was achieved 20% of the time over the past year, making it a strong but realistic improvement goal. To reduce the rate from 5.7% to 5.3%, the number of residents triggering this indicator would need to decrease by 2 per quarter (8 per year).

Change idea	Process measure	Methods	Target
1. Implement a standardized monthly process to identify residents with a Fall Risk Score (FRS) of 5 or higher and conduct a structured review using the Falls Analysis Tool to proactively reduce fall risk.	% of residents with an FRS 5 or greater reviewed using the Falls Analysis Tool monthly	Falls program lead to audit completion of falls analysis tool	90% of targeted residents reviewed through Falls Analysis tool
2. Establish a standardized monthly process to track residents with repeat falls (2 or more falls in the last 90 days) and review psychotropic medication use to reduce fall risk when clinically appropriate	% of residents identified as repeat fallers who receive a monthly review of psychotropic medication use	Falls program lead will generate a monthly report of repeat fallers and consulting pharmacist to conduct a review of psychotropic medication use	100% of repeat fallers have psychotropic medications reviewed
3. Provide the Therapeutic Recreation team with a monthly list of repeat fallers to identify evidence based non-pharmacological interventions such as exercise programs and social prescribing.	% of repeat fallers who receive evidence-based recreation interventions	Falls program lead generate and distribute a monthly list of repeat fallers to the Therapeutic Recreation team, who will review residents for appropriate non-pharmacological interventions	90% of repeat fallers

**Injury: mild with treatment required, moderate, severe, critical*

Indicator: **Total number of NEW Baycrest acquired Stage III and IV Pressure Injury**

Current performance: **8**

2026-27 Target	Target Justification
7	<ul style="list-style-type: none"> In 2025–26, Baycrest focused on establishing a baseline for pressure injury prevalence and improving access to real-time data. In 2026–27, the focus will shift to embedding sustainable processes that support early detection and reduce the risk of pressure injury progression. At present, only six months of data are available, and additional time is required to establish a reliable baseline to inform future target settings. Apotex will aim for a 10% reduction from the 2025-26 baseline

Change idea	Process measure	Methods	Target
1. Implement a weekly standardized interdisciplinary meeting to review new and worsening pressure injuries	# of scheduled weekly interdisciplinary meetings	Program lead review meeting occurrence documentation.	10 meetings held per quarter
2. Implement quarterly skin and wound care education for PSWs, Registered Staff, Caregivers, Families etc	# of education sessions delivered/offered	Review of education calendars, attendance records, and session materials to verify that a skin and wound care education session occurred each quarter. Attendance logs used to confirm participation by PSWs, Registered Staff, Caregivers and Families.	4 education sessions on skin and wound care delivered for the year.
3. Enroll 12 PSWs in “PSW Skin Health Course” to strengthen early identification and prevention of pressure injuries	% of PSWs who complete the wound care course	Track enrollment of the 12 funded PSWs and review monthly	100% complete the course within 6 months

Indicator: % of Hospital and Long-Term Care Home Leaders Complete at least one Foundational and one Applied Equity, Diversity and Inclusion Designated Educational Session by March, 2027

2026-27 Target	Target Justification
65%	Achieving equitable and inclusive workplaces requires sustained investment in education, culture-building, and employee engagement. Baycrest will prioritize building staff and leadership capacity through a structured EDI learning framework that includes foundational and applied education delivered via e-learning, facilitated sessions, expert-led sessions, and external partnerships. Leaders will receive targeted support to embed inclusive practices into hiring, decision-making, accessibility, conflict resolution, and team operations. In parallel, Baycrest will strengthen organizational culture and belonging through coordinated EDI initiatives, cultural recognition events, and inclusive communications aligned with organizational priorities and sector-wide equity goals. Continuous employee voice will be supported through EDI governance structures, committees, communities of practice, and safe feedback channels. Insights gathered through surveys, listening sessions, and forums will inform policy, practice, and program improvements, with clear communication to staff on actions taken. This integrated approach supports measurable progress, accountability, and sustainable culture change.

Change idea	Process measure	Methods	Target
<p>Equip staff and leaders with the knowledge and skills to foster an inclusive workplace.</p> <p>Launch EDI eLearning, development of TAHSN antisemitism eLearning and integration of the EDI learnings into the learning management system</p>	<ol style="list-style-type: none"> 1. Activation attendance tracking 2. LMS tracking for eLearning (completion reports) 	# of modules launched	<p>65% of staff complete at least one foundational EDI learning (justified in context above).</p> <p>6 modules launched throughout the calendar in alignment with various cultural heritage days, dates of significance any relevant foundational EDI training.</p>
Build a culture where employees feel valued, respected, and engaged, and where diverse identities are recognized.	Organizational acknowledgment and reflective activations throughout the year	# of and diversity of cultural recognition and awareness initiatives delivered (holocaust remembrance, black history month, women's history, Asian heritage, pride, national day	6 activations throughout the calendar year in recognition of various cultural heritage days, dates of significance

		for truth and reconciliation, indigenous people's day, etc.) Tracking activations over calendar year: # of activations offered	
Maintain meaningful feedback loops to identify barriers and inform evidence-based improvements. Establishment and operation of EDI governance through a community of practice; regular feedback collection and reporting through staff listening tours	Establish an EDI governance structure in order to expand employee feedback loops	# of quarterly engagements and feedback channels	EDI governance structure/community of practice established and active: at least 1 engagement monthly beginning in May