2026/27 Quality Improvement Plan
"Improvement Targets and Initiatives"

Bruyère Health 43 Bruyere Street, Ottawa , ON, K1N5C8

AIM		Measure								Is this indicator related to:				Change				
Issue	Quality dimension	Measure/Indicator	Type	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	Emergency Department retuen Visit Audits	Executive Compensation	Pay-for-Results Action Plan	External Collaborators	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
Access and Flow	**Efficient**	Number of new patients/clients/enrolments	Priority	Number / PC patients/clients	EMR/Chart Review / Most recent consecutive 12-month period	91397*	1432.8	1450.00	Due to system limitations, please note that current performance is 14328 and target is 14500.. This is a corporate target.					1)The Family Health Team will increase the number of new patient enrolments by working with Health Care Connect and the K1N Neighbourhood Project, pending OH funding approval, to attach unattached patients within our local community. Through coordinated referrals and streamlined intake processes, we will prioritize enrolling eligible patients seeking primary care. This initiative aims to improve access to care while increasing overall patient attachment to the team.	The Family Health Team will collaborate with Health Care Connect and the K1N Neighbourhood Project to receive referrals of unattached local patients. Standardized intake and enrolment workflows will be used to support timely patient attachment, with administrative staff tracking referrals and completed enrolments to monitor progress.	Number of rostered patients	14500 rostered patients	
	Timely	Patient/client perception of timely access to care: percentage of patients/clients who report that the last time they were sick or had a health problem, they got an appointment on the date they wanted	Priority	% / PC organization population (surveyed sample)	In-house survey / Most recent consecutive 12-month period	91397*	72	85.00	Benchmarking based on target set by the Alliance for Healthier Communities					1)The Family Health Team will improve patients' perception of timely access to care by increasing communication and awareness of available after-hours clinics and services. Clear, consistent messaging about how and when to access after-hours care will be shared through multiple channels to support timely appointment access when patients are sick or have an urgent health concern.	The Family Health Team will add an after-hours information recording to clinic phone lines and maintain clinic display slides advertising after-hours clinics and services. These tools will provide consistent, accessible messaging to increase patient awareness and support timely access to care.	% of patients who report getting an appointment on the day they wanted	85% of patients report getting an appointment on the day they wanted	
Experience	**Patient-centred**	Discharge Experience - percentage of patients discharged to the community asked "Overall, how would you rate your discharge experience?" who responded Very Good (top box) on the Hospital 2 Home Patient Experience Program survey	Custom	% / Patients discharged to the community	In house data collection / 2026-2027	932*	69	65.00	Maintain current target	No	No	No		1)Develop a Clinical Manager rounding application to support discharge rounding	Quality, Patient Safety, and Risk Management team to develop a power application in collaboration with hospital programs to facilitate tracking of clinical leader rounding	Documentation of completed rounding by clinical leaders across inpatient programs aligned with the established timelines	80% of patients will have been rounded on by clinical leaders within the established timelines	
														2)Implement Clinical Leader rounding within 48 hours of planned discharge	Establish clinical leader discharge rounds	% of patients discharged to the community who had documented Clinical Manager rounding 48 hours before discharge	80% of patients will have been rounded on by the Clinical Manager within established timelines	
														3)Implement Clinical Leader rounding within 48 hours of planned discharge	Establish clinical leader discharge rounds	% of patients discharged to the community who had documented Clinical Manager rounding 48 hours before discharge	80% of patients will have been rounded on by the Clinical Manager within established timelines	
		Family Experience - Would you recommend	Custom	% of top box positive responses "would definitely recommend" on the Palliative Care Family Experience Survey / Family	In house data collection / 2026-2027	932*	90.5	89.60	Maintain current target	No	No	No		1)Develop process to support Clinical Leader rounding to take place 72 hours of admission	Roll out revised rounding process	% of patient/families rounded on by Clinical Manager within established timelines	80% of patients/families will have been rounded on by the Clinical Manager within established timelines	
														2)Continue reinforcing standardized bedside shift reporting across all inpatient programs	Conduct BSSR audits on a quarterly basis with 8-10 beds per inpatient unit	% of audited beds during day to evening shift change where core BSSR elements (inside patient room, HEAL) are observed during the audit	80% of audited BSSR will meet the core elements	
		LTCM & Transitional Care Patient Experience - percentage of top box positive responses to "If long stay care were needed for another family member or friend, would you recommend this facility?"	Custom	% / Long-Term Complex Medical and Transitional Care inpatients	In house data collection / 2026-2027	932*	85.1	82.60	Maintain current target	No	No	No		1)Develop a process to support Clinical Leader admission rounding to take place within the first 5 days of admission	Roll out revised rounding process	% of patient/families rounded on by CM within established timelines	80% of patients will have been rounded on by the Clinical Manager within established timelines	
														2)Develop a process to support Clinical leader rounding during long stay admissions to take place monthly during the course of admission	Roll out revised rounding process	% of patient/families rounded on by Clinical Manager within established timelines	80% of patients will have been rounded on by the Clinical Manager within established timelines	
														3)Continue reinforcing standardized bedside shift reporting across all inpatient programs	Conduct BSSR audits on a quarterly basis with 8-10 beds per inpatient unit	% of audited beds during day to evening shift change where core BSSR elements (inside patient room, HEAL) are observed during the audit	80% of audited BSSR will meet the core elements	
		Patient Experience - Percentage of patients responding definitely (top box) to the question "Would you recommend this hospital"	Custom	% / top box positive responses to the CPES-IC + Rehab module survey	In house data collection / 2026-2027	932*	CB	CB	With the transition to standardized email survey methodology, a new target will be set based on 6 quarters of email survey data	No	No	No		1)Clinical leader rounding to take place within 5 days of admission	Roll out revised rounding process	% of patient/families rounded on by Clinical Manager within established timelines	80% of patients will have been rounded on by the Clinical leader within established timelines	
														2)Continue reinforcing standardized bedside shift reporting across all inpatient programs	Conduct BSSR audits on a quarterly basis with 8-10 beds per inpatient unit	% of audited beds during day to evening shift change where core BSSR elements (inside patient room, HEAL) are observed during the audit	80% of audited BSSR will meet the core elements	
														3)Continue to hardwire focused rounding	Develop an updated focused rounding audit process in Q1	The top 5 units with falls will have quarterly focused rounding audits completed	80% of audit elements will be met	
														4)Care boards as a tool for communication	Continue training and education on use of care boards in hospital programs	Quarterly care board audits	80% is the target for the process measure	
														5)Reinforce use of AIDET as a patient care communication tool	Continue to provide AIDET education during orientation as well as ongoing unit huddle reviews of the principles	% of top box responses to "did nurses/MDs/therapists explain things in a way you could understand" in survey	> 65% top box responses	

		Percentage of residents who responded positively to: "The care and support I get help me live my life the way I want."	Custom	% / LTC home residents	In house data, interRAI survey / 2026-2027	51651*	80.88	75.00	Increasing target to 75% from previous year target of 70%.					1)Enhance the care conference process by strengthening resident participation and improving interdisciplinary coordination.	1.1) Review current practices around resident involvement in care conferences and develop new guidelines. 1.2) Enhance interdisciplinary communication by using a standardized online invitation. 1.3) Review care conference documentation practices and update the UDA tool in PCC.	1.1) Enhanced resident-centred guidelines will be embedded into the invitation workflow. 1.2) Percentage of care conferences scheduled using the standardized online invitation workflow. 1.3) Enhanced care conference guidelines including use of updated UDA in practice.	1.1) By December 2026, the enhanced resident attendance process will be implemented. 1.2) By September 2026, the standardized online invitation process will be in practice. 1.3) By March 2027, the revised guidelines and UDA will be followed and used.	
														2)Develop and implement a standardized charting template (UDA) within PointClickCare (PCC) to capture key 'Getting to Know the Resident' information, ensuring consistent documentation of resident preferences, personal history, and psychosocial needs.	2) A multidisciplinary working group will co-design or adopt one or more UDA(s) that reflect person-centred care domains. The template(s) will be built into PCC and will be shared with all staff for awareness and training on how to use or pull information.	2) Percentage of new residents who moved in with a completed 'Getting to Know the Resident' UDA within 14 days of admission.	2) By March 2027, achieve 90% completion of the 'Getting to Know the Resident' template for all new admissions within 14 days.	
		Percentage of residents who responded positively to: "The care and support I get help me live my life the way I want."	Custom	% / LTC home residents	In house data, interRAI survey / 2026-2027	53536*	56.25	65.00	Target adjusted to continue aiming for improvement					1)Enhance the care conference process by strengthening resident participation and improving interdisciplinary coordination.	1.1) Review current practices around resident involvement in care conferences and develop new guidelines. 1.2) Enhance interdisciplinary communication by using a standardized online invitation. 1.3) Review care conference documentation practices and update the UDA tool in PCC.	1.1) Enhanced resident-centred guidelines will be embedded into the invitation workflow. 1.2) Percentage of care conferences scheduled using the standardized online invitation workflow. 1.3) Enhanced care conference guidelines including use of updated UDA in practice.	1.1) By December 2026, the enhanced resident attendance process will be implemented. 1.2) By September 2026, the standardized online invitation process will be in practice. 1.3) By March 2027, the revised guidelines and UDA will be followed and used.	
														2)Develop and implement a standardized charting template (UDA) within PointClickCare (PCC) to capture key 'Getting to Know the Resident' information, ensuring consistent documentation of resident preferences, personal history, and psychosocial needs.	2) A multidisciplinary working group will co-design or adopt one or more UDA(s) that reflect person-centred care domains. The template(s) will be built into PCC and will be shared with all staff for awareness and training on how to use or pull information.	2) Percentage of new residents who moved in with a completed 'Getting to Know the Resident' UDA within 14 days of admission.	2) By March 2027, achieve 90% completion of the 'Getting to Know the Resident' template for all new admissions within 14 days.	
Safety	**Safe**	AI Scribe: Percentage of clinicians in the primary care practice utilizing this provincial digital solution	Optional	% / Staff	Local data collection / Most recent information available	91397*	0	100.00	100% set as intention to have all primary care providers use digital solution					1)Pending hospital approval following independent third-party PIA per Bill 194 legislation, an AI scribe solution will be trialed with all physicians and nurse practitioners.	Subject to hospital approval following independent third-party PIA per Bill 194 legislation, the Family Health Team will pilot an AI scribe solution with all physicians/Nurse Practitioners. Training and implementation support will be provided, and physician and NP participation will be monitored to assess utilization.	% of providers who have access to an AI solution in clinic	100% of providers have access to an AI solution in clinic	
		eReferral: Percentage of clinicians within the primary care practice utilizing this provincial digital solution	Optional	% / Staff	Local data collection / Most recent information available	91397*	0	100.00	100% set as intention to have all primary care providers use digital solution					1)Implement and expand clinician utilization of the provincial eReferral system. A small pilot group of clinicians will trial the solution, with referral clerks integrated into workflows to support consistent use.	The Family Health Team will implement a phased rollout of the provincial eReferral system, beginning with a pilot group of clinicians. Referral clerks will be integrated into clinical workflows to support consistent use, and feedback from the pilot will be collected to inform expansion to the full primary care team.	% of providers using e-referral in their practice	100% of providers using e-referral in their practice	
		Number of faxes sent per 1,000 rostered patients	Priority	Number of faxes / PC patients/clients	Other / Most recent quarter of data available (consecutive 3-month period)	91397*	849	764.00	Aiming for a 10% improvement					1)Efforts will continue from the previous year, with an expanded focus on identifying and mapping available digital alternatives. Adoption and consistent use of existing technologies (including, Ocean, eForms, and eReferral) will be reinforced to further replace fax-based workflows.	1) Expand pilot for use of E-forms 2) Expand pilot for #providers using eReferrals 3) Use of secure platform (SYNC) for chart transfers rather than faxing	1) % of providers using e-forms 2) % of providers using eReferrals 3) % of chart transfers sent by secure platform (SYNC) vs sent by fax	1) 50% 2) 85% 3) 95%	
		Online Appointment Booking: Percentage of clinicians within the primary care practice utilizing this provincial digital solution	Optional	% / Staff	Local data collection / Most recent information available	91397*	0	80.00	Setting 80% target for phase one of implementation					1)A clinic-wide implementation of online appointment booking will be undertaken, starting with resident schedules and ideally expanding to providers, allied health, etc. Emphasis on prioritizing online booking with residents given we are a teaching clinic.	The Family Health Team will implement online appointment booking in a phased, clinic-wide approach, beginning with resident schedules and expanding to physicians, nurse practitioners, and allied health providers. Scheduling templates and workflows will be adjusted as needed, and clinician participation will be monitored to track utilization.	% of providers and residents utilizing online appointment booking	100% of providers and residents will use online appointment booking	
		Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment	Optional	% / LTC home residents	CIHI CCRS / July 1 to September 30, 2025 (Q2), as target quarter of rolling 4-quarter average	51651*	19.61	18.00	Following Canada's Drug Agency guidelines while ensuring feasibility through fluctuations seen					1)Strengthen interdisciplinary capacity to reduce inappropriate antipsychotic use by prioritizing education for all interdisciplinary team members.	1) Implement a comprehensive education initiative for all interdisciplinary team members focused on person-centred alternatives to antipsychotic use.	1) Percentage of interdisciplinary staff who complete education on "non pharmaceutical" interventions to decrease responsive behaviour.	1) By March 2027, at least 75% of interdisciplinary team members will complete enhanced education "non pharmaceutical" and/or antipsychotic-reduction best practices.	
														2)Embedding the use of the antipsychotic toolkit and non-pharmacological approaches as standard practice with residents and families.	2) The antipsychotic toolkit will be introduced, with a structured process for using it during care conferences and family meetings for every resident currently prescribed an antipsychotic.	2) Percentage of residents on antipsychotics whose families receive the antipsychotic toolkit during appropriate times.	2) By March 2027, at least 50% of residents prescribed antipsychotics will have documented use of the antipsychotic toolkit during family engagement.	

Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment	Optional	% / LTC home residents	CIHI CCRS / July 1 to September 30, 2025 (Q2), as target quarter of rolling 4-quarter average	53536*	26.23	23.00	Following Canada's Drug Agency guidelines while ensuring feasibility through fluctuations seen					1)Strengthen interdisciplinary capacity to reduce inappropriate antipsychotic use by prioritizing education for all interdisciplinary team members.	1) Implement a comprehensive education initiative for all interdisciplinary team members focused on person-centred alternatives to antipsychotic use.	1) Percentage of interdisciplinary staff who complete education on "non pharmaceutical" interventions to decrease responsive behaviour.	1) By March 2027, at least 75% of interdisciplinary team members will complete enhanced education "non pharmaceutical" and/or antipsychotic-reduction best practices.	
												2)Embedding the use of the antipsychotic toolkit and non-pharmacological approaches as standard practice with residents and families.	2) The antipsychotic toolkit will be introduced, with a structured process for using it during care conferences and family meetings for every resident currently prescribed an antipsychotic.	2) Percentage of residents on antipsychotics whose families receive the antipsychotic toolkit during appropriate times.	2) By March 2027, at least 50% of residents prescribed antipsychotics will have documented use of the antipsychotic toolkit during family engagement.	
Falls per 1000 resident days	Custom	Rate per 1,000 / LTC home residents	In house data collection / 2026-2027	51651*	7.89	7.20	Aim to return falls to similar level as previous year					1)Enhance and post a visual fall-trends dashboard to track key information such as fall rates by home area and time of day (e.g. per shift).	1) Adapt the current "monthly fall target" posters to include additional reported information and engage staff to interact with the boards.	1) Number of enhanced visual fall dashboards posted within the first half of each month.	1) By September 2026, all home areas will have a posted, updated monthly fall-trends dashboard.	
												2)Develop and pilot a standardized process in which staff record the number of prevented falls at the end of each shift, increasing awareness of proactive fall-prevention actions and strengthening a culture of safety that directly contributes to reducing overall fall incidents.	2) Introduce a shift-based fall-prevention reporting page on select home area(s) where staff document prevented falls and the interventions that contributed to prevention (e.g., timely toileting, assisting with mobility, identifying hazards, modifying environment).	2) Standardized process and pilot developed and trialed.	2) By March 2027, develop and pilot the standardized process to record prevented falls on at least one home area.	
Falls per 1000 resident days	Custom	Rate per 1,000 / LTC home residents	In house data collection / 2026-2027	53536*	9.23	6.30	Aim to return falls to similar level as previous year					1)Enhance and post a visual fall-trends dashboard to track key information such as fall rates by home area and time of day (e.g. per shift).	1) Adapt the current "monthly fall target" posters to include additional reported information and engage staff to interact with the boards.	1) Number of enhanced visual fall dashboards posted within the first half of each month.	1) By September 2026, all home areas will have a posted, updated monthly fall-trends dashboard.	
												2)Develop and pilot a standardized process in which staff record the number of prevented falls at the end of each shift, increasing awareness of proactive fall-prevention actions and strengthening a culture of safety that directly contributes to reducing overall fall incidents.	2) Introduce a shift-based fall-prevention reporting page on select home area(s) where staff document prevented falls and the interventions that contributed to prevention (e.g., timely toileting, assisting with mobility, identifying hazards, modifying environment).	2) Standardized process and pilot developed and trialed.	2) By March 2027, develop and pilot the standardized process to record prevented falls on at least one home area.	
Falls with injury	Custom	Rate per 1,000 / All inpatients	In house data collection / 2026-2027	932*	1.6	1.60	Aim to stabilize fall with injury rate	No	No	No		1)Develop and roll out a comprehensive fall audit and feedback process	1) Develop an updated focused rounding audit process in Q1 2) QPR & NPP to develop an environmental audit process to support fall prevention best practices	1) The top 5 units with falls will have quarterly focused rounding audits completed 2) Percent of units where the following fall prevention practices are appropriate: flag outside patient room, sign above bed, environmental elements (bed at lowest position with brakes on, mobility, assistive devices, telephone and call bell in reach, proper footwear and clear paths/spills)	1) 80% of audit elements will be met 2) Environmental audits will acheve 80% compliance with the audit elements	
Percentage of residents who developed a stage 2 to 4 pressure ulcer or had a pressure ulcer that worsened to a stage 2, 3 or 4 since their previous resident assessment	Custom	% / LTC home residents	PCC Performance Insights / 2025-2026	51651*	1.16	3.00	Reducing target to 3.0% from previous year target of 3.6%					1)Enhance wound cleansing practices by conducting a comprehensive review of current wound-cleansing practices and products.	1.1) An interdisciplinary team will review current wound-cleansing practices against evidence-based best practices and compare with those of other long-term care homes. 1.2) Education will be delivered to PSWs and nursing staff.	1.1) Enhanced wound cleansing guidelines in practice. 1.2) Percentage of staff who complete the updated wound-care and wound-cleansing education sessions.	1.1) By December 2026, develop and implement the enhanced wound cleansing guidelines. 1.2) By March 2027, have 90% of PSWs and nursing staff trained on the new practices.	
												2)Enhance the accuracy and consistency of wound-related documentation by reviewing the skin and wound assessment tool and providing education to staff.	2) Conduct a comprehensive review of the current skin and wound assessment tool and in-services with staff led jointly by the SWAN and ADOC.	2) Enhanced skin and wound assessment tool or its use to ensure its alignment with best-practice guidelines and improve clarity, usability, and completeness.	2) By December 2026, review completed and in-services provided for the skin and wound assessment tool.	
												3)Strengthen pressure injury prevention by reviewing residents who may benefit from Twin Turners, standardizing repositioning practices, integrating sling-removal procedures, and developing a comprehensive repositioning protocol that includes equipment use, pictograms, and clear staff guidance to improve skin integrity and reduce workplace injuries.	3) An interdisciplinary team will review all residents who may benefit from Twin Turners, integrate this review with the sling-removal project to streamline safe repositioning workflows and reduce staff injury risk. A standardized repositioning protocol will be developed that includes pictograms and standardized care plan interventions.	3) Residents who benefit from Twin Turners identified and new practices developed and implemented around the use of Twin Turners.	3) By March 2027, develop and implement the pictograms and standardized care plan interventions.	
Percentage of residents who developed a stage 2 to 4 pressure ulcer or had a pressure ulcer that worsened to a stage 2, 3 or 4 since their previous resident assessment	Custom	% / LTC home residents	PCC Performance Insights / 2025-2026	53536*	3.08	2.40	Maintaining same target as previous year					1)Offer internal Nurse specializing in Wound, Ostomy and Continence (NSOWC) services.	1) Register and support an internal registered nurse to the NSWOC program.	1) Registered nursing staff successfully completing the specialized training.	1) By March 2027, NSWOC specialized services being offered in the home.	
												2)Strengthen pressure injury prevention by reviewing residents who may benefit from Twin Turners, standardizing repositioning practices, integrating sling-removal procedures, and developing a comprehensive repositioning protocol that includes equipment use, pictograms, and clear staff guidance to improve skin integrity and reduce workplace injuries.	2) An interdisciplinary team will review all residents who may benefit from Twin Turners, integrate this review with the sling-removal project to streamline safe repositioning workflows and reduce staff injury risk. A standardized repositioning protocol will be developed that includes pictograms and standardized care plan interventions.	2) Residents who benefit from Twin Turners identified and new practices developed and implemented around the use of Twin Turners.	2) By March 2027, develop and implement the pictograms and standardized care plan interventions.	

		Pressure Injuries - the percent of long stay patients who develop or have Stage 2 or greater PI that worsens during their admission to LTCM (2N, 4N & 5N), Transitional Care (4S, 2BD, BOE5).	Custom	% / Long-Term Complex Medical and Transitional Care inpatients	RAI-MDS / 2026-2027	932*	5.73	6.60	Maintain current target	No	No	No		1)All LTCM and transitional units will use appropriate linen layers	NPP education and audits on a quarterly basis	% of patients with appropriate linen layers	80% of eligible patients will have appropriate linen layers	
														2)Continue roll out of the Pique pad removal process across all LTCM and Transitional units.	Unit based roll out of Pique removal process	% of LTCM and Transitional units where Pique pads have been removed from clinical use	100% of units will have Pique pads removed from clinical use	