QUALITY IMPROVEMENT PLAN (QIP) INITIATIVES

CONTENTS

INTRODUCTION

This QIP supports the active monitoring, alignment, and evaluation of all quality improvement (QI) initiatives across Northwood and Shoreham. It ensures each initiative is structured, strategic, and measurable, contributing to our broader commitment to quality, safety, and continuous improvement.

An important complement to this structured approach is the ongoing use of feedback to inform planning and decision-making. Client and Family Experience Survey results, Workforce Surveys, and Community Engagement feedback are reviewed on a regular basis and inform separate but integrated Action Plans. These are maintained by the Quality, Research and Organizational Performance Team and/or relevant leadership groups.

While not all actions are captured within the formal QIP, initiatives that involve system-level changes, interdepartmental coordination, or that align with organizational priorities and accreditation standards are incorporated into the QIP to support alignment, visibility, and oversight.

This integrated approach ensures that feedback from clients, families, staff, and community members informs continuous quality improvement and drives meaningful change across the organization.

INSTRUCTIONS

- Complete one row per quality improvement initiative under the relevant Strategic Priority.
- Refer to the **Integrated Quality and Performance Management Program (QPMP) document** for definitions, expectations, and guidance.
- Each initiative must have a completed **Quality Improvement Charter**, **SBAR**, or **equivalent project document** outlining the rationale, project team, timelines, measures, and alignment with organizational priorities.
- Identify clear SMART objectives, key performance indicators (KPIs), and evaluation criteria.
- Populate all required fields, including stakeholders, resources, data sources, and milestones.
- Initiative leads are responsible for maintaining progress updates and completing a **Closure Report** at project end to assess results, sustainability, and lessons learned.

STRATEGIC PRIORITY 1: CREATE CLIENT-CENTRED SOLUTIONS IN A HOME AND COMMUNITY FIRST FRAMEWORK

Initiative Title	Program/ Service Area	Guiding Framework(s) Alignment	SMART Objective	Relevant Standards/ Regulations	KPIs	Data Sources	Resources Required	Timeline (Start/ End/ Milestones	Evaluation & Success Criteria	Progress Notes	Initiative Lead(s)
HAND HYGIENE QUALITY IMPROVEMENT PLAN	Org-Wide	• **CQPS**: Supports goals of Safe Care and Integrated Care through improved infection control and standardized hand hygiene practices. • **Aim**: Enhances client and family experience, staff well-being, and system efficiency by reducing infection transmission. • **Quality Dimensions**: Safety, Work-life, Continuity, and Population-Focused	By March 31, 2026, develop and sustain a Hand Hygiene Quality Improvement Plan to maintain compliance rates of 90% or higher across all care, administrative, and public settings at Northwood and Shoreham, including LTC and Homecare, through education, monitoring, and targeted support.	• Accreditation Infection Prevention and Control Standards and RSP • NS Dept. of Health: Infection Control Guidelines • Occupational Health and Safety	• % Hand Hygiene Compliance (monthly) • # of Audits • Infection Rate per 1,000 resident/client days • Staff training completion rate	• IPAC Audit Logs • Infection Reports (PCC) • Power BI Dashboards • Staff Education Records • Client Feedback (Surveys)	• IPAC Auditors • Hand hygiene supplies & stations • Education & communication materials • Power BI • IT/Data Analytics FTEs	• **Start:** Apr 2025 • **End:** Mar 2026	• ≥90% compliance sustained across all areas for 3 consecutive quarters • ≥15% reduction in infection rates in high-risk areas • Positive feedback from staff and clients on education & awareness • adoption of a new HH target of 90%	The QIP has been drafted, and the team leading this work for Accreditation preparation will reconvene on September 17, 2025.	• Infection Control Managers • Data Analytics Team • Educators • Program Managers
CLIENT AND STAKEHOLDER ENGAGEMENT FRAMEWORK	Org-Wide	• **CQPS:** Person-Centred, Population-Focused, Continuity, Appropriateness, Safety Culture • **Aim:** Strengthens client and family engagement • **Quality Dimensions:** Person-Centred, Appropriateness,	By March 2027, enhance the Client and Family Advisor model and stakeholder engagement structures by implementing a revised framework with LTC- and Homecare-specific advisory	• Accreditation RSP HSO 5006:2025 Partnering with Clients to Improve Safety • NS Department of Health and Wellness Home Care Standards • Long-Term Care Program Requirements	• % of organizational programs with active client/family advisory presence • # of client safety initiatives co-developed or reviewed by advisors • Client satisfaction score related to	• Meeting minutes (Advisory Councils, QI Committees) • Client Experience Survey (LTC and Homecare) • Education reports • Engagement plan review documents • Board and leadership reports	• Staff time to develop • Engagement framework and evaluation tools • Training materials and facilitators • Translation/ interpretation or accessibility supports as needed • People resources for council coordination and expansion	• **Start:** August 2025 **Milestones:** • **Oct 2025:** Mapping of current advisory and engagement structures • **Jan 2026:** Draft revised engagement framework • **Feb 2026:** Stakeholder	• Revised client engagement framework approved by Quality Council • Established Homecare-specific advisory structure and LTC engagement enhancement • Measurable improvement in client-reported engagement	• Preliminary discussions are in progress, and information is being gathered to inform the framework.	• Manager, Quality and Risk • Client Relations Coordinator • Client and Family Advisor Council • Resident Council • Family Council • Program Directors (LTC and Homecare)

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		Population-Focused, Continuity, Accessibility	councils, aligned with Accreditation Canada standards.		involvement in decision-making • Attendance rate at advisory council meetings • Number of staff trained on client engagement and safety			consultation and co-design, including assessment of the need for additional Client and Family Advisory Committees • **End Date:** March 2027 – Framework finalized, including any new committees, and implementation initiated	metrics • Demonstrated alignment with HSO 5006:2025 standards through self-assessment • Staff trained and resources disseminated for ongoing engagement		
REDUCING UTIS	LTC	• **CQPS:** Supports goals of Safe Care and Appropriate Care • **Aim:** Improves client and family experience through timely and appropriate care, enhances staff well-being by reducing uncertainty and variation in clinical decision-making, and promotes efficient resource use by decreasing avoidable antibiotic use and hospital transfers. • **Quality Dimensions:** Aligns with Safety, Appropriateness, Person-Centred, and Work-life	To review current practices associated with identifying, treating, and evaluating resident UTIs to identify improvement opportunities, reduce incidence, and enhance outcomes within the resident population.	• CNISP Pilot Surveillance Protocol for Symptomatic UTI in LTCHs • LTC Infection Prevention and Control Standards • PHAC and IPAC Canada surveillance definitions	• % Decrease in symptomatic UTIs per 1,000 resident days • % Timely urine collection and treatment initiation • % Compliance with documentation standards in Point Click Care (PCC) • % Implementation of improved care path (if developed)	• CNISP UTI Surveillance Reports • PCC Audit Logs • Lab Reporting Timelines (NS Health Partnership) • Manual and electronic chart reviews • Internal audit tracking tools	• Infection Control Manager • Nurse Practitioner • Nursing Managers • Educators • PCC Infection Control Module • Lab staff collaboration (NS Health) • CNISP/PHAC reporting toolkit and Excel templates	• **April 2025:** Began audits and surveillance using CNISP tools • **Spring–Summer 2025:** Completed 6-month retrospective UTI audit, implemented infection control module in PCC, identified education and documentation gaps, Real-time surveillance and input to CNISP working group • **Fall 2025:** Initial improvement actions (education, documentation, lab reporting), Continued data collection under Phase 1 (6 months) • **2026:** Phase 2 of CNISP surveillance (12 months)	• ≥10% reduction in documented UTIs within 12 months • 100% of UTIs audited and tracked in PCC • ≥90% compliance with standardized documentation practices • Improved timeliness and clarity in lab result reporting • Engagement in CNISP Phase 2 and contribution to protocol refinement	• All UTIs audited over the past 6 months, with ongoing tracking • Gaps identified: personal care education, documentation inconsistencies, no formal UTI care path • Partnership with NS Health Lab to improve lab result turnaround • Providing real-time feedback to CNISP tool development • Invited to participate in CNISP Phase 2 • Opportunity for national reporting and broader impact	• Infection Control Manager • Nursing Managers • Nurse Practitioner • Educators

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		dimensions by ensuring best practices in UTI management, supporting clinical confidence, and improving health outcomes for residents.						Potential care path development and real-time feedback loop, evaluation of reduction in UTI rates and quality of documentation			
CHESTNUT LAKE SPECIALIZED BEHAVIOURAL SUPPORT UNIT	LTC	• **CQPS**: Person-Centred Care, Safe Care, Appropriate Care, Population-Focused Care • **Aim**: Improve client experience, improve health and well-being, improve staff well-being, and health equity • **Quality Dimensions**: Safety, Appropriateness, Person-Centred, Population-Focused, Work-Life	By October 2026, reduce responsive behaviour incidents by 20% on the Chestnut Lake unit through implementation of a specialized behavioural support model, targeted interdisciplinary care planning, and system-wide knowledge sharing.	• LTC Program Requirements • Accreditation Canada LTC Standards	• % reduction in responsive behaviour incidents • % of internal Northwood placements supported • % of targeted external placements filled • Staff and family satisfaction with communication and care • # of external consultations or homes supported	• Behavior Occurrence Reports • Bed Utilization Reports • Placement and Referral Data • Staff and Family Survey Feedback • Clinical Team Meeting Notes	• Foundation support for outdoor and lounge renovations • Grant funding for program development and staffing (confirmed through 2026) • Software/hardware for resident locating and staff safety • Recreation and therapeutic equipment • Environmental modifications • Interdisciplinary staffing and training • Protected time for consultation and capacity-building	• **Start**: October 2022 • **End**: October 2026 (extended funding into 2026) • Milestones: **Q1 2023:** Interdisciplinary team established; stakeholder engagement session held **Q2–Q3 2023:** Begin environment upgrades and equipment procurement **Q4 2023:** Implement care model and begin tracking KPIs **2024:** Expand support to other Northwood sites and SLTC homes; continue training and evaluation **2025–2026:** Ongoing monitoring, sustainability planning, and potential scale-up	• ≥20% reduction in behavioural incidents • Clear referral and placement tracking system in place • Positive bed utilization aligned with unit goals • Increased satisfaction among families and staff • Interdisciplinary team functioning and meeting regularly • Documented internal and external consultation impacts • Approved sustainability and integration plan	• Interdisciplinary team is meeting weekly • Environmental upgrades in progress • Bed utilization trends positive • Planning underway for post-project sustainability	• Senior Director, LTC • Manager, Nursing Services • Medical Director • Behavior Support Committee

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ADVANCED FOOT CARE PROGRAM	LTC	• **CQPS:** Safe Care, Appropriate Care • **Aim:** Improved resident safety and experience, better staff workflows, cost-effectiveness • **Quality Dimensions:** Safety, Efficiency, Work-life, Appropriateness	By December 2025, implement a formalized and documented Advanced Foot Care Program at Shoreham that meets IPAC's position statement standards, including updated policy/ procedure, auditing protocols, equipment compliance with MIFUs, and cost evaluation.	• IPAC Canada Position Statement on Reprocessing of Foot Care Devices • CSA Standards for Reprocessing Critical Devices • Manufacturer's Instructions for Use (MIFU) • Accreditation Canada's Infection Prevention and Control Standards	• % of foot care equipment compliant with MIFU/CSA requirements • Updated policies and procedures completed and implemented • # of audits completed on reprocessing and infection control practices • Cost evaluation and procurement finalized • Ongoing evaluation structure developed	• Policy and procedure tracking logs • Internal audit tools (MIFU, reprocessing, infection control) • Procurement and financial records • Training and compliance documentation • Quality improvement reports	• Time and expertise for policy development • IPAC and clinical leadership involvement • Procurement support and budget allocation • Staff training and communication • Administrative time for documentation and auditing	• **Fall 2023:** Initial review and planning • **August 2024:** First supplier contact complete; site meeting being arranged • **Fall 2024:** Audit and gap analysis; policy drafting underway • **Fall/Winter 2025:** Final documentation, procurement actions, and QI evaluation	• AFC program policies finalized and approved • Program aligned with IPAC position statement and CSA standards • Audit schedule and quality monitoring tools in place • Equipment upgrades completed where needed • Staff trained and compliant with practices • Cost-effectiveness reviewed and reported	• Supplier contacted August 2024; cost and audit tools in development • Site meeting to be scheduled with IPAC, managers, and AFC team • Gap analysis and policy drafts pending internal review	• Senior Director, LTC • Infection Control Specialist • Nursing Managers • Advanced Foot Care Nurses
PALLIATIVE AND END-OF-LIFE CARE PROGRAM	LTC	• **CQPS**: Person-Centred Care, Integrated Care, Appropriate Care • **Aim**: To enhance end-of-life care through a formalized palliative care program that ensures consistent, compassionate, and coordinated support for residents and their families. • **Quality Dimensions**:	To establish and implement a unified, person-centred palliative care approach across Northwood and Shoreham by June 2026, including consistent education, communicatio n tools, staff and volunteer support, and site-specific practices for	• Accreditation Canada LTC Standards • Nova Scotia Health Palliative Care Approach • Canadian Hospice Palliative Care Association Guidelines	• % of staff trained in palliative education (LEAP or equivalent) • Volunteer engagement metrics (if implemented) • Site adoption of standardized end-of-life practices (e.g., Code Butterfly)	• Staff education and training records • Admission checklist audits • Volunteer program participation data • Resident/ family surveys • Meeting minutes	• LEAP and SPA-LTC course access/ funding • Pamphlet design • Staff time for committee meetings and implementation • Volunteer training models (curriculum, facilitators) • Communication and consent processes for Code Butterfly	• **July 2025**: Committee launch and first meeting • **Sept 2025**: Review and finalize education, volunteer, and Code Butterfly actions • **Winter 2025**: Begin pilot of LEAP and distribute pamphlet • **Spring 2026**: Finalize and align end-of-life practices across sites	• Implementation of consistent tools and practices across sites • Positive feedback from staff, volunteers, and families • Increased staff confidence in providing palliative care • Volunteer program feasibility assessed and implemented or declined with rationale	• Committee launched July 2025 • LEAP education being investigated • Pamphlet drafted, awaiting clarification on 90-day reference • Volunteer program feasibility under review • Shoreham's Code Butterfly practice being reviewed for broader application	• Clinical Resource and IPAC Manager • Nurse Managers • Volunteer Coordinator • Hospice Nurse • Spiritual Care Liaison

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		Person-Centred, Continuity, Appropriateness, Work-life	end-of-life care.					• **June 2026**: Full implementation and evaluation plan	• Reduction in confusion or variability in end-of-life practices		
FOOD SERVICES AND CBORD	LTC	• **CQPS**: Person-Centred, Accessibility, Appropriateness • **Aim**: To improve the efficiency, safety, and sustainability of food service operations in long-term care while maintaining high levels of resident satisfaction and reducing waste and budget overages through standardized menu planning and implementation of CBORD software. • **Quality Dimensions**: Efficiency, Appropriateness, Person-Centred	Implement CBORD menu and inventory management software across all LTC sites to replace manual processes, improve food service efficiency, reduce waste, and stabilize budgets, with full implementation by Feb 2026.	• Accreditation Canada – LTC Services Standards • Food Safety and Infection Control Guidelines • Provincial LTC Nutritional and Budgetary Standards	• Reduction in raw food cost overages (monthly and annually) • Resident food satisfaction ratings (Resident Experience Survey) • Menu duplication eliminated across sites • Reduction in food waste (measured in weight and percentage) • Software implementation milestones completed on time	• Budget Reports • Resident Satisfaction Surveys • Food Waste Audits • Menu planning and inventory software reports • Internal audits of stock distribution and supply access	• CBORD software licensing and IT support • 1 FTE Administrative Dietitian (1-year term) • Dedicated time for Food Services Managers • Funding for temp role and long-term staffing plan	• **Start**: Sept 2024 • Hire Admin Dietitian: Q3 2024 • Menu Development and Standardization: Fall 2024 – Spring 2025 • CBORD Implementation and Testing: Spring – Summer 2025 • **Full Implementation**: Feb 2026	• Resident satisfaction maintained or improved • Food waste reduced to <10% per day • Monthly food budget on track • Software functionality integrates with PCC and includes inventory and costing tools • Audits show secure stock distribution and improved accountability	Implementation will be by site with full roll out by Feb 2026.	• Food Services Managers • CBORD Implementation Team • Senior Director, LTC • LTC Administrative Team
FLOURISHING ENVIRONMENT PROJECT: BEDFORD CAMPUS	LTC	**CQPS**: Person-Centred Care, Safe Care, Accessible Care, Appropriate Care, Integrated Care **Aim**: Improve client and family experience. Improve staff well-being and work-	To enhance 12 resident activity rooms and shared spaces at the Bedford Campus by Jan 2026 to foster a therapeutic, person-centred environment,	• Accreditation Canada LTC Services Standards • Infection Prevention and Control Guidelines (for shared space reopening)	• # of spaces enhanced or reopened • Resident and family satisfaction with shared environments • Increased use of resident activity spaces	• Resident and Family Surveys • Recreation Therapy Program Utilization • Informal Feedback and Focus Groups	• Project Budget: $14,300 • Staff Time (Flourishing Team, Recreation, Facilities, Leadership) • Communication Materials	• **Start**: February 10, 2025 • **Neighborhood Teams Formed**: February–March 2025 • **Design and Planning Phase**: February–April 2025	• All 12 activity rooms and shared spaces reopened and enhanced with therapeutic elements • Positive change in resident/family satisfaction survey responses specific to environment and	Project completion date extended from July 2025 to Jan 2026 to ensure all 12 houses are completed.	• Recreation Therapy • Support Services Supervisor • Social Work • Resident Advisors

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		life, and Optimize use of resources **Quality Dimensions**: Person-Centred, Work-life, Safety, Appropriateness, Efficiency, Population-Focused	with resident and family input guiding improvements and success measured through utilization and satisfaction data.	• Occupational Health and Safety (Work-Life Environments)	• Staff feedback on therapeutic work environment • Improvement in mood indicator (CIHI interRAI assessment)		• Materials: Paint, furniture, comfort items, seasonal décor, storage solutions • Event Supplies: Refreshments for re-opening celebrations	• **Room Enhancements Begin**: Spring 2025 • **Celebration Events (Opening and Reopening's)**: Spring–Summer 2025 • **Project Completion**: Jan 2026	engagement and depressive mood • Increased use of shared spaces based on program participation or sign-ins • Visible resident and family contributions to space design • Neighborhood pride and engagement reflected in feedback and participation levels		
IV THERAPY PROTOTYPE PILOT	LTC	**CQPS**: Supports goals of Safe Care, Appropriate Care, Person-Centred Care, and Integrated Care by enabling timely, evidence based IV therapy in long-term care, reducing unnecessary hospital transfers and ensuring continuity of care. **Aim**: Improves resident experience, staff confidence, and system capacity **Quality Dimensions**: Directly aligns with Safety, Appropriateness,	By Sept 2025, implement a three-phase IV Therapy Prototype at Northwood Bedford Campus, enabling select RNs and LPNs to administer IV therapies in-home reducing hospital transfers and enhancing resident care experience.	• Accreditation Canada RSP (Safe Use of Medical Devices and Equipment, Medication Management) • NS College of Nursing (NSCN) Scope of Practice Guidelines for IV Therapy • SLTC Practice Standards and Education Requirements • HANS and NSH equipment and supply protocols	• % of trained IV Nurse Champions and Learners who achieve competency • # of IV therapies successfully administered in-home • Reduction in hospital transfers for IV-related treatment • Staff satisfaction with scope of practice and support • Resident and family satisfaction with	• Staff training records and competency checklists • Clinical documentation (PCC/EMR) of IV therapy administration • Hospital transfer logs • Resident/family satisfaction surveys • Staff feedback surveys	• IV pumps (NSH) • IV supplies (HANS) • Training and education funding (SLTC) • Clinical leads (RNs, LPNs) and educators • Policy development and support from Clinical Practice and Leadership • Implementation planning support (KPMG)	• **April 2025:** Begin Phase 1 (Training Champions and Policy Drafting) • **May–June 2025:** Train RN/LPN learners, finalize policies, trial use in select units • **Sept 2025:** Go-live with expanded IV therapy across Bedford LTC	• Successful competency demonstration by all trained staff • At least 80% of appropriate IV therapy cases treated in-home • ≥20% reduction in hospital transfers for IV-related care • Positive feedback from staff, residents, and families • Full compliance with Accreditation Canada's standards	Pilot is live in Bedford, with potential t expand to other campuses.	• Nurse Manager Project Lead • Clinical Practice Manager • Senior Nurse Manager • Clinical Resource and Infection Control Manager • Senior Director, LTC

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		Continuity, Work-life, Accessibility, and Efficiency by expanding clinical capabilities in LTC, supporting staff through training, minimizing disruptions for residents, and reducing emergency department utilization.			in-home treatment						
BEDFORD IN-HOUSE LAUNDRY PROJECT	LTC	• **CQPS**: Supports Safe Care, Person-Centred Care, and Integrated Care by improving cleanliness, reducing lost belongings, and aligning laundry services with resident needs. • **Aim**: Enhances resident and staff experience by increasing satisfaction with laundry services, improving linen availability, and reducing personal item loss. • **Quality Dimensions**: Aligns with Safety, Appropriateness, Work-life, Efficiency, and Person-Centred	To implement and evaluate an in-house laundry service pilot for two households (A2 and E1) in Bedford by Sept 2025 to improve linen availability, reduce lost personal items, and increase resident and staff satisfaction. The pilot will involve workflow adjustments, staff engagement, monitoring quality and feedback, and developing a scale-up plan	• Long-Term Care Facility Program Requirements (NS Health & Wellness) • CSA Z317.13 – Infection Control for Laundry in Healthcare Facilities • Occupational Health & Safety Regulations for Laundry Operations	• Resident satisfaction with laundry services • Staff satisfaction with workflow and linen availability • # of reported lost personal belongings • Linen availability (stock-outs) • Laundry poundage tracked	• Resident and staff satisfaction surveys or informal feedback • Incident/loss logs • Laundry poundage tracking reports • Staff workflow observation or audit	• Par supply of linens • Adjusted staff scheduling • Union engagement and communication • Staff training and workflow development • Space/equipment readiness	• **Start**: March 2025 • Pilot Launch: April 2025 • Monitoring: April–August 2025 • Evaluation and scale-up decision: September 2025	• Improved resident and staff satisfaction • Reduction in lost item incidents • Reliable access to clean linens • Feasibility and plan for full implementation	Pilot is ongoing. Primary evaluation was successful and learnings were applied to pilot phase 2. Currently maintaining 2 household linens service. Working on SBAR to expand to full service provided in house and hope to have before senior leadership and board for evaluation by end of Oct 2025.	• Corporate Director, Infrastructure Services • Bedford Support Services Team

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		Care through timely service, reduced loss, and streamlined staff workflows.	based on outcomes.								
ORAL HEALTH CARE	LTC	• **CQPS**: Supports goals of *Safe Care* and *Client-Centred Care* by improving oral health care plan quality and ensuring evidence-based assessment practices. • **Aim**: Enhances residents' comfort, oral health outcomes, and quality of life through staff education, individualized care planning, and use of the InterRAI LTCF Oral Health Assessment. • **Quality Dimensions**: Safety, Client-Centred, Effective, and Work-Life.	By March 31, 2026, implement enhanced oral health education and transition to the InterRAI LTCF Oral Health Assessment across all LTC sites to: • Improve the quality and specificity of oral health care plans • Ensure staff can effectively translate assessment findings into individualized daily care interventions • Eliminate duplication of assessments while maintaining compliance and alignment with best practice	• Accreditation Canada: LTC Services Standards • NS Department of Health Licensing Standard 6.6 – Oral Health Outcome • InterRAI LTCF Assessment Requirements	• % of residents with individualized, detailed oral care plans documented in PCC • % of staff completing oral health education module • % of residents receiving daily oral care as per individualized plan • Qualitative feedback from residents, families, and staff on oral care quality and comfort	• PCC (Care Plans and InterRAI Assessments) • Staff Education Records (HUB) • CIHI and Licensing Reports • Resident/Family Feedback Surveys	• Educators and Nurse Managers • Clinical Leadership & Quality Assurance • Staff education materials • Data Analytics support for monitoring care plan quality • PCC configuration for InterRAI-only assessment workflow	• Start: Fall 2025 • InterRAI LTCF Oral Health Assessment implemented: Jan 2026 • Education rollout across sites: Feb 2026 • Evaluation and feedback collection: Mar 2026	• ≥90% of residents with comprehensive, individualized oral care plans • ≥90% of staff complete oral health education • Demonstrated reduction in duplication of assessments • Positive resident/family/staff feedback on oral care quality • Licensing and CIHI feedback reflects improved oral health outcomes	Draft procedure completed. Transition to InterRAI LTCF Oral Health Assessment planned for Jan 2026 to eliminate duplication and streamline documentation. Education materials developed and rollout to begin Feb 2026, led by Nurse Managers and Educators. Resident, family, and staff feedback will be collected to evaluate impact.	• Nurse Managers • Educators • Clinical Practice Manager • Data Analytics Team
SCOTIADERM SKIN INTEGRITY PILOT	LTC	• **CQPS:** Supports goals of Person-Centred Care, Safe Care, and	By April 2026, complete an eight-week pilot to	Accreditation Canada/ HSO Standards	• % of residents with maintained or improved skin	• ScotiaDerm Skin Assessment • End-User Surveys	• ScotiaDerm product supply	**Start:** January 2026 **End:** Completion of six-week pilot and	Evidence of stable or improved skin condition for the majority of	• QIP tools (posters, assessment logs) finalized and in distribution	Nurse Manager

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		Appropriate Care through standardized skin assessment and management of moisture-associated skin damage. • **Aim:** Enhances resident comfort and dignity, supports staff confidence and efficiency, and promotes equitable skin care practices through clear guidance and education. • **Quality Dimensions:** Safety, Person-Centred, Appropriateness, Continuity, and Work-Life.	evaluate the potential benefits of ScotiaDerm skin care products in LTC using standardized assessments and staff feedback.	Infection Prevention and Control Skin Integrity and Wound Prevention Medication Management	integrity over the six-week period • Staff satisfaction and confidence scores (End-User Surveys)	• Education attendance records • Informal staff feedback and observations • Quality Improvement summary reports	• Laminated educational posters and job aids • Printed six-week assessment logs • Staff education sessions • Data collation and summary support	evaluation summary	participating residents Minimal reported adverse reactions Positive staff feedback indicating: • Improved confidence in skin assessment • Improved clarity in product selection • Clear recommendations for sustainment, modification, or scale-up • Interpretation of results will account for the small pilot sample size and focus on directional trends, feasibility, and staff experience rather than statistical significance.	• End-User Survey #1 largely completed; alternate access arranged for CCAs without email • Education sessions underway with strong engagement • Project start adjusted to ensure readiness and staff support • Pilot currently includes 19–20 residents, representing a small cohort relative to Halifax; this reflects a lower-than-anticipated number of residents meeting eligibility criteria, which is a positive indicator of overall skin integrity at Shoreham. • Small sample size will be considered when interpreting performance indicators and trends.	
GROUP SCHEDULING	HC	• **CQPS**: Appropriateness, Efficiency, Person-Centred Care	By December 2025, Homecare will successfully demonstrate that Group	•DSLTC Quality Standards •Accreditation Standards	% of clients meeting the consistency of care criteria	Scheduling Software (Procura)	Supervisors Staffing Officers HSWs	**Start**: August 1st, 2025 **Ends:** December 31st, 2025	For this initiative to be successful, we will need to see an improvement in consistency of care with no negative	Project initiated, slight delay due to staffing change but currently being monitored.	Homecare Supervisors – D Region

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		• **Aim**: Enhancing the client experience, Improving the work life and well-being of staff, Improving efficiency • **Quality Dimensions**: Appropriateness, Efficiency, Person-Centred, Work-life	Scheduling can improve consistency of care for clients and staff.						consequences as a result of the change in scheduling models.		

STRATEGIC PRIORITY 2: BE AN ORGANIZATION OF CHOICE TO WORK, VOLUNTEER AND GROW

Initiative Title	Program/ Service Area	Guiding Framework(s) Alignment	SMART Objective	Relevant Standards/ Regulations	Key Performance Indicators (KPIs)	Data Sources	Resources Required	Timeline (Start/ End/ Milestones	Evaluation & Success Criteria	Progress & Notes	Initiative Lead(s)
TEAM LAVENDER INTERDISCIPLINARY PEER-SUPPORT MODEL	Org-Wide	• **CQPS**: Safe Care, Person-Centred Care, Integrated Care • **Aim**: Improves staff well-being, retention, and resilience by providing internal peer-support mechanisms during high-stress events. • **Quality Dimensions**: Work-life, Safety, Continuity	To create and implement an interdisciplinary peer-support team (Team Lavender) by the end of 2026, accessible across the organization, to support staff well-being during times of crisis and stress.	• Occupational Health & Safety Standards • Mental Health Commission of Canada – Psychological Health and Safety in the Workplace • Accreditation Canada – Work-life and Safety Dimensions	• Increased awareness and utilization of Team Lavender support • Improvement in staff survey metrics (psychological safety, burnout, stress) • Team Lavender education and communication materials completed and distributed	• Workforce Survey (Baseline: 2022, 2025) • Staff feedback forms • Utilization tracking logs • Training attendance records	• Staff time for development and engagement • Training and educational materials • Supplies for peer-support tools (e.g., wellness kits) • Communications support (emails, posters, Hub)	• Review models and materials (Fall 2025) • Team development – Fall/Winter 2025 (Pilot at Halifax) • Full rollout in 2026	• Team Lavender is established and staff are engaging with the team • Measurable improvement in staff survey indicators related to well-being • Staff report increased sense of support and psychological safety • Feedback from JOHSC and managers supports continuation/ expansion	• Recruitment of Team Lavender members for Halifax Pilot • Training planned for Sept 2025	• Spiritual Care Liaison • Manager, OH&S • Admin Assistant Org Health • Manager, Quality & Risk • Corporate Director, Community Development • Clinical Resource and IPAC Manager

Initiative Title	Program/ Service Area	Guiding Framework(s) Alignment	SMART Objective	Relevant Standards/ Regulations	Key Performance Indicators (KPIs)	Data Sources	Resources Required	Timeline (Start/ End/ Milestones	Evaluation & Success Criteria	Progress & Notes	Initiative Lead(s)
E-STAFF SAFETY INCIDENT CASE MANAGEMENT SYSTEM IMPLEMENTATION	Org-Wide	• **CQPS:** Safe Care, Appropriate Care, Integrated Care • **Aim:** Enhances staff safety, confidence, and work-life by streamlining incident reporting and case management, ensuring timely follow-up, and supporting organizational learning. • **Quality Dimensions:** Safety, Efficiency, Work-life, Continuity, Integrated Support	By Fall 2026, implement a fully integrated staff safety and case management system across all Northwood sites to ensure ≥90% of staff safety incidents are reported electronically within 48 hours, ≥95% of follow-ups are completed within established timeframes, and designated users are 100% trained prior to go-live.	• Workers' Compensation Board (WCB) Reporting Requirements • NS Occupational Health and Safety Act • Accreditation Canada LTC/Home Care standards and RSP Workforce Safety and Well-Being • WHMIS and related workplace safety regulations	• % of incidents reported electronically within 48 hrs • % of follow-ups completed within the established timeframe (14 days for minor, 2–4 weeks for workplace violence, 30 days for harassment) • % of designated users trained prior to go-live • System uptime (%) during pilot and implementation • User satisfaction score (≥85% positive)	• System Reports • Training Reports • Vendor/Uptime Monitoring Reports • Post-launch User Surveys	• Project Team (People Services, Quality, IT) • Vendor partner for system configuration and hosting • Training materials, SOPs, and guides • IT support and data analytics resources • Budget allocation for licensing, implementation, and training	• Start: July 2025 (Planning & Mapping) • Vendor Selection & Configuration: Oct 2025 – Jan 2026 • Pilot & Training: Feb – May 2026 • Organization-Wide Rollout: June – Fall 2026	• Successful deployment of a secure, integrated system with Avanti connectivity • ≥90% electronic incident reporting within 48 hours sustained across all sites • ≥95% follow-ups completed within the defined timelines • 100% of designated users trained prior to go-live • System uptime ≥99% during pilot and rollout • ≥85% positive user satisfaction ratings • Lessons learned documented; sustainability plan in place	• Initial planning meeting held July 29, 2025 • Project charter development underway • Cross-functional working group to be formed • Process mapping to be completed before vendor selection • Change management strategy will be embedded into rollout	• Senior Director, People Services (Project Leads) • Kim Croft, Manager, Occupational Health & Safety (Project Manager) • Tasha Ross, Manager, Quality, Research & Performance/Privacy Officer (Support) • IT Team • Program Leads & Operational Managers
DIVERSITY, HEALTH EQUITY AND INDIGENOUS INCLUSION STRATEGY	Org-Wide	• **CQPS**: Person-Centred Care, Accessible Care, Safe Care, Appropriate Care, Integrated Care • **Aim**: Improves client experience, advances health equity, supports staff well-being, strengthens population health	TBD – additional details to be added soon.								

Initiative Title	Program/ Service Area	Guiding Framework(s) Alignment	SMART Objective	Relevant Standards/ Regulations	Key Performance Indicators (KPIs)	Data Sources	Resources Required	Timeline (Start/ End/ Milestones	Evaluation & Success Criteria	Progress & Notes	Initiative Lead(s)
		• **Quality Dimensions**: Accessibility, Appropriateness, Person-Centred, Population-Focused, Safety, Work-life, Continuity									
RN AUTHORIZED PRESCRIBER PROGRAM	LTC	• **CQPS**: Safe Care, Appropriate Care, Integrated Care • **Aim**: Improve client/family experience; Improve population health and well-being • **Quality Dimensions**: Safety, Appropriateness, Efficiency, Continuity	Enable RNs to prescribe for defined conditions within scope by Fall 2025 to improve timely, appropriate treatment access for LTC residents.	• NSCN RN Prescribing Standards • Homes for Special Care Regulations (NS DSLTC) • Internal RN Prescriber Policy (in development)	• % of RNs certified as RN Prescribers • # of residents treated via RN Prescriber • Wait time for treatment • # of delayed treatment incidents	• Education and certification records • Medication administration records • Internal audits • Clinical treatment access data	• RN coursework time and support • Physician/NP preceptors • Policy development resources • Ongoing medical oversight	• 2023–2024: Cohorts 1 and 2 • Fall 2025: Clinical implementation • Ongoing: Evaluation and scope/policy updates	• RN Prescribers working within NSCN and internal scope • Improved access to treatment • Positive resident outcomes • Regulatory compliance and audit results	Formal 6-month evaluation commenced Sept 8th 2025 supported by KPMG and SLTC.	• Medical Director • Senior Director, LTC • Clinical Practice Manager
REDUCING TIME LOSS CLAIMS	LTC/ Homecare	• **CQPS**: Safe Care, Person-Centred Care, Integrated Care • **Aim**: Improve staff well-being and work life; Optimize use of resources • **Quality Dimensions**: Safety, Work-life, Efficiency, Appropriateness	Reduce WCB time loss claims by 25% across Homecare and LTC by early 2026 by implementing an early and safe Stay at Work/ Return to Work program that supports injured employees to	• Workers' Compensation Act (NS) • Occupational Health and Safety Act (NS) • Internal RTW/SAW Guidelines	• # and % of time loss claims • # of employees supported through SAW/RTW program • Average duration of time loss • Cost savings on WCB premiums	• WCB claims data • Internal HR/OHS records • SAW/RTW tracking codes (in development) • Financial tracking and payroll data	• RTW/SAW people resources • Modified duties tracking system • Wage replacement funding • Supervisor training	• 2023: Pilot in Homecare • 2024: Expansion to LTC • 2025-early 2026: Full implementation and evaluation	• Measurable reduction in time loss claims • Positive employee feedback • Maintained or improved safety outcomes • Financial impact analysis on WCB premiums and wage costs	**Oct 6, 2025**: Work is underway to enhance tracking and evaluation of the SAW/RTW program, including new coding and upcoming training for leaders. A data review with WCB is scheduled,	• Senior Director, People Services • Occupational Health and Safety Manager • Org Health Team

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			remain engaged when medically appropriate.							with current rates showing positive trends. Full implementation and evaluation may extend into next year to allow for meaningful results.	

STRATEGIC PRIORITY 3: PROGRAMS AND PARTNERSHIPS THAT MAKE THE COMMUNITY STRONGER

Initiative Title	Program/ Service Area	Guiding Framework(s) Alignment	SMART Objective	Relevant Standards/ Regulations	Key Performance Indicators (KPIs)	Data Sources	Resources Required	Timeline (Start/ End/ Milestones	Evaluation & Success Criteria	Progress & Notes	Initiative Lead(s)
HIGH-DENSITY HOUSING PILOT	Community	• **CQPS:** Safe Care, Person-Centred Care, Integrated Care • **Aim:** Improves health outcomes, enhances client experience, supports staff well-being, reduces healthcare utilization • **Quality Dimensions:** Accessibility, Appropriateness, Efficiency, Person-Centred, Work-life, Continuity,	By **March 2026**, implement and evaluate a shift-based, integrated health and social care model at the Gordon B. Isnor public housing facility to improve continuity of care, reduce frailty-related risk, enhance staff utilization, and increase tenant access to social and wellness	• PHAC (2018) Health Inequalities Indicators for Older Adults • WHO ICOPE (2017) Guidelines • PHIA and Occupational Health and Safety Regulations (NS) • Continuing Care Program Regulations (NSHA)	• Client satisfaction • % increase in tenant access to health & social supports • Referrals made and fulfilled • % of CCA time spent on homecare vs others tasks • Staff satisfaction and safety perceptions • # of tenants engaging with Drop-In Centre	• Procura (staffing, service utilization, case notes) • Tenant and staff surveys • Program attendance and service referral logs	**Staffing:** • 3.3 FTE Home Support staff • 1.0 FTE Community Support Worker • 0.2 FTE Home Support Supervisor **Training:** GPA, Mental Health First Aid, ICOPE, OH&S, Cultural Competency **Facilities:** Drop-In Centre space, common room, secured storage, accessible hygiene facilities **IT and Evaluation:**	• Project Planning & Resourcing – Jan 2023 – Sept 2023 • Drop-In Centre Setup & Staff Recruitment – June 2023 – Sept 2023 • Staff Training – Aug 2023 – Sept 2023 • Program Launch & Community Engagement – Sept 2023 – Ongoing • Assessment & Wellness Planning (ACT, ICOPE, Frailty) – Dec 2023 – Ongoing	**Client-Level:** • ≥ 40% of tenants engaged in the program • Improvement in WISH Scores over 6 months • Positive client-reported satisfaction and trust **System-Level:** • Reduction in avoidable ED use and hospitalizations • Increased continuity of care (stable staff-client relationships) **Staff-Level:**	• **Enhanced Continuity of Care:** Stable staff-tenant relationships have been fostered through consistent, tenant-focused programming and consistency of care for Continuing Care clients. Currently 76 active participants • **Diverse Service Delivery:** A multi-faceted approach includes: ○ **Social** (Coffee Talks, outings) to reduce isolation. ○ **Health & Wellness** (footcare, fitness, education) to support physical health. ○ **Practical Support** (IADLs, transportation, tech help)	• Senior Director, Home and Community Care • Corporate Director, Community Development • Manager, Community Development • Wellness Outreach Coordinator

Initiative Title	Program/ Service Area	Guiding Framework(s) Alignment	SMART Objective	Relevant Standards/ Regulations	Key Performance Indicators (KPIs)	Data Sources	Resources Required	Timeline (Start/ End/ Milestones	Evaluation & Success Criteria	Progress & Notes	Initiative Lead(s)
		Population-Focused	supports demonstrating improved client and staff outcomes and informing future service models.		• Program/service attendance rates • Access to culturally relevant supports		Devices, Survey Monkey, data analyst support **Sundries & Programming Supplies:** Hygiene kits, meals, transportation support **Partner Collaboration:** NSHA, Housing NS, Central Zone Meal Pilot, North End Community Health Centre, YMCA, Halifax Public Library, Food Bank	• Monthly Steering Meetings, Evaluation & Reporting – Sept 2023 – March 2026 • Final Evaluation & Transition Planning – Oct 2025 – March 2026	• Increased staff satisfaction and reduced sick time • Improved productivity and flexibility of care delivery **Sustainability Readiness:** • Data story developed to support future scale-up • Final report with actionable recommendations delivered	to overcome daily living barriers. • **Strategic Community Partnerships:** Collaborations with organizations like Northwood Recreation, Halifax Public Library, and Dalhousie University expand service reach and resource availability without increasing internal costs. • **Engagement & Outcomes:** High participation in key programs like footcare clinics and weekly social events demonstrates the model's success in creating a supportive community that enables tenants to live well at home.	
MEALS ON WHEELS	HC	• CQPS: Person-Centred Care, Accessible Care, Appropriate Care, Integrated Care • **Aim:** Improving the client and family experience, Improving the health and well-being of the populations we serve,	By March 2026, we will have implemented a sustainable model for meal service delivery for Northwood homecare clients.		• # of clients receiving meals # of meals/month	Invoice Data	Homecare team Meals on Wheels DSLTC	Start: January 2024 Pilot Phase until March 2025 Evaluation completed and submitted to DSLTC Jun 2025 Ends: March 2026	For this initiative to be successful, we will have a service agreement in place that stipulates a rate/meal that enables us to fund the appropriate resources to support it.	Project initiated, pilot phase complete and now working on new proposed rate/meal that covers the cost of a coordinator and finance support.	Senior Director Home and Community care and Manager of Client Care

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		Optimizing resource use to ensure sustainable, high-quality care, Advancing health equity to address disparities and promote fairness in health outcomes ***Quality Dimensions:*** Appropriateness, Continuity Efficiency, Person-Centred Services, Population-focused,									

STRATEGIC PRIORITY 4: ENCOURAGE DISCOVERY & LEARNING

Initiative Title	Program/ Service Area	Guiding Framework(s) Alignment	SMART Objective	Relevant Standards/ Regulations	Key Performance Indicators (KPIs)	Data Sources	Resources Required	Timeline (Start/ End/ Milestones	Evaluation & Success Criteria	Progress & Notes	Initiative Lead(s)
DATA STRATEGY	Org-Wide	• **CQPS**: Safe Care, Person-Centred Care, Integrated Care, Effective Care, Efficient Care • **Aim**: Improved Outcomes, Better Experience of Care, Lower	Starting in Summer 2025, develop and implement an organization-wide data strategy, fully operational by December 2027, to	• Personal Health Information Act (PHIA) • Freedom of Information and Protection of Privacy Act (FOIPOP) • Accreditation Canada Standards	• % of program indicators available in Power BI • # of staff trained in data use (by role) • Data quality scores (accuracy, completeness,	• Power BI dashboards • HRIS (Avanti) • Incident Reporting Systems • LTC/DSLTC/CIHI reports • Survey responses (training	• Research and Data Analytics Specialists • Manager, Quality & Risk • IT and Power BI Licenses • Staff time for training and working group participation	• **Start**: Summer 2025 • Phase 1 – LTC: Summer 2025 to April 2026 • Phase 2 – Home Support: May 2026 to December 2026 • Phase 3 – Community/	• 80% of LTC managers and Data Leads report confidence in dashboard use by April 2026 • Power BI dashboards embedded into monthly and	• Policy development, indicator inventory underway and Power BI licensing decision (Summer-Fall 2025)	• Manager, Quality & Risk • Research and Data Analytics Specialists • Data Leads (Program-Specific) • Program Directors/Managers

Initiative Title	Program/ Service Area	Guiding Framework(s) Alignment	SMART Objective	Relevant Standards/ Regulations	Key Performance Indicators (KPIs)	Data Sources	Resources Required	Timeline (Start/ End/ Milestones	Evaluation & Success Criteria	Progress & Notes	Initiative Lead(s)
		Cost, Workforce Well-being • **Quality Dimensions**: Safety, Appropriateness, Continuity, Equity, Work-life	enhance decision-making, care quality, and performance monitoring. This will be achieved through phased deployment of Power BI dashboards, staff capacity building, and a robust data governance model, with ongoing maintenance and continuous improvement across all program areas.	• DSLTC Reporting Requirements • CIHI Indicators	timeliness) • Dashboard usage rates by audience level • % of QI initiatives informed by dashboard data • Staff-reported confidence in data use (via survey)	evaluations, user feedback) • Meeting records and action logs	• Communications and Change Management Support • Policy Development	Corporate: January 2027 to December 2027 • **Completion Target**: December 2027	quarterly reviews by end of each implementation phase • Increase in QI initiatives using data from dashboards • Decrease in manual data duplication and improved turnaround time for reporting • Positive staff feedback on training, clarity, and usability (measured via post-training surveys) • Annual review and refresh of Data Strategy aligned with AI strategy and digital maturity model	• Dashboard development and Phase 1 LTC rollout scheduled for Fall 2025	
ARTIFICIAL INTELLIGENCE AND DIGITAL HEALTH STRATEGY	Org-Wide	Still working on this to be added soon - TR									
ALAYACARE & CLIENT PORTAL IMPLEMENTATION	HC	• **CQPS**: Appropriateness, Efficiency, Person-Centred Care • **Aim**: Enhancing the client experience, Improving the work life and well-being of staff,	By April 2026, Northwood will fully implement the AlayaCare software across Homecare services to improve scheduling, care planning, and communication with clients and	•Accreditation Canada Standards (Home and Community-Based Services) • PHIA (Personal Health Information Act) compliance for client data • Privacy Impact Assessment (PIA) and Risk	• % of staff trained in AlayaCare (field and management) • % of client records migrated and validated • Successful payroll and billing runs completed independently	• Financial: Software licensing, IT infrastructure upgrades • People Resources: Super Users, IT, Homecare Leadership, Training teams • Technical: Data conversion tools,	• Project Coordinator •IT Support for data migration •Finance role to support billing and payment transition •AlayaCare University • AlayaCare UAT	•Requirements gathering and Contract negotiation: 2024 • Contract signed: Dec 2024 • Project Kickoff: April 2025 • Workflow mapping: Fall 2025	• All Super Users trained and capable of teach-back • 100% of required workflows functional in production • No critical errors during first payroll and billing cycles • Clients and families can access care	Project is at mid-point, on time and on budget. Team continues to work towards April 2026 go-live date with no major risks or concerns at this stage.	• Project Coordinator • Senior Director, Home and Community Care • HC Accounting • IT • HC Software Support

Initiative Title	Program/ Service Area	Guiding Framework(s) Alignment	SMART Objective	Relevant Standards/ Regulations	Key Performance Indicators (KPIs)	Data Sources	Resources Required	Timeline (Start/ End/ Milestones	Evaluation & Success Criteria	Progress & Notes	Initiative Lead(s)
		Improving efficiency • **Quality Dimensions**: Appropriateness, Efficiency, Client-Centred Services, Work-life	families. The implementation will include data migration, system configuration, staff training, testing, and stabilization.	Management standards	• % of care plans completed	secure sandbox environment • Vendor support: AlayaCare project	• Data Migration reports • Staff and client satisfaction surveys • Billing and payroll performance metrics	• Configuration & system build: Winter 2025 • Super User training & UAT: Q4 2025 • Go-Live: April 2026 Stabilization: June 2026	plans through the portal • Health check confirms all		
CCA STANDARDIZATION	HC	• **CQPS**: Person-Centred Care, Safe Care, Accessible Care, Appropriate Care, Integrated Care • **Aim**: Improving the client and family experience, Improving the health and well-being of the populations we serve, Optimizing resource use to ensure sustainable, high-quality care, **Quality Dimensions**: Accessibility, Appropriateness, Continuity, Efficiency, Person-Centred, Population-Focused, Safety	By March 2026, we will have a sustainable approach to implement standardized screening and oversight of additional CCA tasks being rolled out for all CCAs.	• DSLTC Quality Standards • CCA Competency Framework and Standards of Practice	•% of staff trained •% of eligible supervisors who have implemented % of clients who have access to standardized tasks	Procura Training logs	Homecare Supervisors HSWs Manager of Client Care	Training: Winter 2025 Pilot in C area: Spring/Summer 2025 Rollout to A area: Fall 2025 Full rollout: Winter 2026	For this initiative to be successful, we will have rolled out in all areas and will have processes in place to ensure that all new and reassessed clients are screened for these additional tasks.	All staff are trained, and we have rolled out successfully in the C area, with plans to expand to the A area next. Further discussions about how to roll out in areas that have non-LPN supervisors are in progress.	Manager of Client Care

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ISMP MEDICATION ASSESSMENT AND MEDICATION SAFETY BENCHMARKING PLAN	LTC	• **CQPS**: Aligns with Safe Care, Appropriate Care, and Integrated Care by using data to drive safety improvements, setting meaningful targets, and embedding continuous quality improvement. • **Aim**: Supports client safety and well-being, enhances staff work life through structured processes, and reduces resource waste from preventable harm. • **Quality Dimensions**: Addresses Safety, Appropriateness, Work-life, and Population-Focused Care through data-driven safety practices, high-alert medication oversight, policy audits, and provider engagement.	By March 31, 2026, implement a comprehensive LTC Medication Assessment and Safety Benchmarking Plan to enhance medication safety, reduce preventable harm, and support staff engagement through structured benchmarking, targeted interventions, and continuous monitoring of high-alert medications and antipsychotic use.	• Accreditation Canada LTC Standards • ISMP Canada MSSA-LTC • Choosing Wisely Canada LTC Recommendations • NS DHW Continuing Care Guidelines • National Benchmark for Antipsychotic Use (CIHI) • Accreditation Medication Management standards/ Medication RSPs	• Medication incident rate per 1,000 resident days • % of high-alert meds with harm • % medication reconciliations completed within 24 hrs • % compliance with double-check protocols • % of undocumented PRN or patch meds • % of staff trained in reporting annually • % unique reporters by unit • MSSA-LTC completion rate • % of improvement actions implemented within 6 months • % of residents on inappropriate antipsychotics	• Medication Incident Reports • Resident days reports • Prescribing and administration audits • MSSA-LTC tool • Pharmacy records • Staff training records • Staff engagement survey • Medication Scorecard • Corporate Scorecard • Resident Incident Quarterly Report	• MSSA-LTC tool (completed) • Data analytics support • Dedicated time for audits & policy review • Staff training resources (on safety culture, incident reporting) • Interdisciplinary facilitation for implementation • Communication tools for reporting back trends	• **Winter/Spring/Fall 2023**: MSSA-LTC completed • **Summer–Fall 2024**: Implement MSSA-LTC recommendations • **Fall 2024–Fall/Winter 2025/26**: Establish benchmarking, unit data analysis • **April 2025–March 2026**: Monitor, audit, report and evaluate reduction targets • **April 2026**: Evaluate against QIP success metrics and sustainability	• ≥25% reduction in total medication incidents from baseline • ≥90% compliance with independent double-checks • ≥90% of MSSA-LTC recommendations implemented within 6 months • ≥15% relative reduction in inappropriate antipsychotic use year-over-year to achieving national target of 15% or less • Positive feedback on safety culture from staff surveys (≥80%)	• MSSA-LTC completed in 2023 • Internal benchmarking process under development • Initial reduction targets and reporting framework drafted • National antipsychotic target adopted (15% benchmark; 15% annual relative reduction) • Audit templates and PRN documentation improvement underway	• Clinical Practice Manager • Pharmacy & Therapeutics Steering Committee • Quality & Risk Manager • Research and Data Specialists

Initiative Title	Program/ Service Area	Guiding Framework(s) Alignment	SMART Objective	Relevant Standards/ Regulations	Key Performance Indicators (KPIs)	Data Sources	Resources Required	Timeline (Start/ End/ Milestones	Evaluation & Success Criteria	Progress & Notes	Initiative Lead(s)
EMERGENCY COMMUNICATION (CLINICONEX PILOT)	LTC	• **CQPS**: Safe Care, Appropriate Care, Integrated Care • **Aim**: Improving the work life and well-being of staff; Optimizing resource use; Advancing health equity • **Quality Dimensions**: Safety, Efficiency, Work-life	By **March 2026**, implement and evaluate the Cliniconex Staff Messaging Module at Shoreham to improve emergency communication efficiency and reduce average staff response time by **50%**, enhancing safety and ensuring timely, reliable communication during emergency events.	• Department of Seniors and Long-Term Care (DSLTC) Licensing Requirement – Emergency Call Back • Accreditation Canada: Emergency and Disaster Management (HSO 5050) • Occupational Health and Safety – Emergency Preparedness	• % of staff receiving emergency notifications successfully • % of staff acknowledging messages within set timeframe • Average time from message dispatch to acknowledgment • Staff satisfaction with communication process post-implementation	• Cliniconex system reports (delivery, acknowledgment, and timing indicators) • Avanti • Staff and manager survey feedback	• Cliniconex Staff Messaging Module subscription ($2,171.28 one-year trial) • System configuration and integration with Avanti • Training for managers and administrative staff • Oversight by Manager, Systems for setup, testing, and evaluation	• **September 2025:** Configuration and data upload into Cliniconex • **October 2025:** Internal testing and validation of system accuracy • **November 2025:** Live pilot during annual emergency recall exercise • **December 2025 – March 2026:** Data collection, feedback, and evaluation • **April 2026:** Post-pilot review and decision on broader implementation	Success will be demonstrated through: • ≥ 90% successful message delivery to staff • 80% staff acknowledgment rate within target timeframe • Reduction in manual call-back time by 50% • Positive staff and manager feedback on ease and effectiveness • System validated for reliability and readiness for expansion across sites	• Planning and setup initiated in **September 2025** • Integration with Avanti underway for staff contact synchronization • Pilot testing scheduled for **November 2025** during recall exercise • Staff and manager feedback to guide final evaluation and potential rollout	Manager, Systems & Administrative Services

STRATEGIC PRIORITY 5: FORTIFY CAPACITY TO FULFILL OUR MANDATE

Initiative Title	Program/ Service Area	Guiding Framework(s) Alignment	SMART Objective	Relevant Standards/ Regulations	Key Performance Indicators (KPIs)	Data Sources	Resources Required	Timeline (Start/ End/ Milestones	Evaluation & Success Criteria	Progress & Notes	Initiative Lead(s)
MAINTENANCE IMPROVEMENT PROGRAM	LTC	• **CQPS**: Safe Care, Appropriate Care, Integrated Care • **Aim**: Optimizing resource use to ensure sustainable, high-quality care and improving work life of staff through	By [DATE - TBD], implement a comprehensive preventive maintenance program for all medical devices and	• Accreditation Canada Required Safety Practice (RSP): Safe Use of Medical Devices and Equipment • Provincial legislation and occupational	• % of medical devices and equipment included in the preventive maintenance program • Compliance rate for scheduled	• Preventive Maintenance Management System logs • Equipment inventory and maintenance records • Incident and	• Preventive maintenance software system • Mobile devices and optional barcode scanning equipment for inventory accuracy		• 100% of medical devices and equipment actively included in preventive maintenance • Preventive maintenance completed as scheduled with >95% compliance	• Contracting with HANS Biomedical to provide annual inspections and calibration of all medical devices and equipment	• Corporate Director, Infrastructure Services • Building & Property Maintenance Manager

Initiative Title	Program/ Service Area	Guiding Framework(s) Alignment	SMART Objective	Relevant Standards/ Regulations	Key Performance Indicators (KPIs)	Data Sources	Resources Required	Timeline (Start/ End/ Milestones	Evaluation & Success Criteria	Progress & Notes	Initiative Lead(s)
		safer equipment • **Quality Dimensions**: Safety, Appropriateness, Efficiency, Work-life	equipment, including an enhanced scheduling system and inventory management, to ensure safety, compliance with manufacturer guidelines, and adherence to Accreditation Canada standards.	health and safety standards • Manufacturer maintenance guidelines and evidence-informed best practices	preventive maintenance tasks • # and severity of equipment-related incidents • Equipment downtime and effectiveness of mitigation strategies • Completeness and accuracy of maintenance documentation and recall logs • Staff training and competency validation rates	safety reports • Staff training and competency records • Recall management documentation • Internal and external audit reports	• Staff training on new systems and processes • Time allocated for maintenance tasks and system data management • Funding for software licenses, hardware, and project support		• Equipment-related incident rates reduced by 25% within 12 months of implementation • Full, up-to-date documentation of maintenance and recalls accessible for review • Maintenance staff competencies fully documented and maintained • Positive outcomes in Accreditation Canada surveys related to equipment safety	across all sites begins October 2025 and annually thereafter. • Infrastructure Team reviewing all policies, processes and Terms of Reference to determine any gaps related to the new RSP. Follow up meeting scheduled Nov 6, 2025	• Manager, Support Services • Manager, Facility Services • IT
ECOPILOT – AI-ENHANCED BUILDING AUTOMATION PILOT	LTC	• **CQPS:** Safe Care, Integrated Care, Efficiency • **Aim:** Supports resident comfort and safety, enhances staff work-life and well-being, and optimizes resource use through sustainable building operations. • **Quality Dimensions:** Safety, Efficiency, Work-life	To pilot the Ecopilot AI software overlay on the Building Automation System (BAS) in A2 at Bedford Campus by December 2025, with the goal of reducing heating and cooling costs by 15% while maintaining resident comfort and system reliability.	• CSA Z317.2 – Special Requirements for HVAC Systems in Health Care Facilities • Building Code & Energy Efficiency Standards • Environmental Sustainability Guidelines (NS Department of Environment & Climate Change) • Accreditation Canada Leadership Environmental Stewardship Standards	• % reduction in energy consumption (heating/cooling) • Cost savings as a percentage of baseline energy spend • Indoor temperature and air quality stability metrics • Staff/resident comfort feedback (qualitative)	• BAS energy reports and utility bills • Ecopilot analytics dashboard • Internal environmental monitoring data • Facilities operations feedback	• Ecopilot software licensing and integration • IT and facilities staff coordination • Baseline utility and energy performance data • Maintenance and monitoring support	• **Start**: June 2025 • **Pilot Launch**: August 2025 • Monitoring Period: August–November 2025 • **Evaluation & Recommendation**: December 2025	• Minimum 15% reduction in HVAC-related energy expenditures • Stable indoor environment conditions maintained • Feasibility for broader implementation across sites	**Oct 3, 2025**: Delayed start for installation. Currently targeted for Oct 2025 in Bedford location. Evaluation to follow.	Corporate Director, Infrastructure Services

Initiative Title	Program/ Service Area	Guiding Framework(s) Alignment	SMART Objective	Relevant Standards/ Regulations	Key Performance Indicators (KPIs)	Data Sources	Resources Required	Timeline (Start/ End/ Milestones	Evaluation & Success Criteria	Progress & Notes	Initiative Lead(s)
QUALITY COMMITTEE	HC	**CQPS**: Appropriateness, Efficiency, Person-Centred Care • **Aim**: Enhancing the client experience, & Improving efficiency across Homecare • **Quality Dimensions**: Appropriateness, Efficiency, Client-Centred Services, Work-life	By December 31, 2025, we will demonstrate that the Quality structure within homecare has been embedded into practice and is working efficiently	Accreditation Canada Standards (Home and Community-Based Services) •DSLTC Quality Standards • PHIA (Personal Health Information Act) compliance for client data	• Committee meetings held • % of committee member attendance • # of quality improvement processes developed • # of quality issues resolved % of target procedures reviewed	• Quality Tracker • Meeting minutes Incident reporting tracking tool	Quality Committee members, Initiative leads	Start: April 2025 First Meeting: held in May, Quality Tracker implemented, and agenda items set. Consistent monthly meetings with procedural and quality initiative updates.	For this committee to be successful, we will have consistent monthly meetings, at least 3-5 procedural updates per meeting and consistently share key updates from the committee with the homecare team.	The committee has successfully reviewed and standardized multiple procedures and launched the monthly newsletter to strengthen team awareness of quality initiatives.	•Quality & Change Mgmt. Lead, •Senior Director of Home and Community