Bethammi Nursing Home

2025/26 Quality Improvement Plan
"Improvement Targets and Initiatives"

St. Joseph's Care Group 35 North Algoma Street Box 3251, Thunder Bay , ON, P7B5G7

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AIM		Measure								Change			
Issue	Quality dimension	Measure/Indicator	Type	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure
Equity	**Equitable**	Percentage of New Admissions Who Have Received a Self-ID	Custom	% / New Admissions	Local data collection / July 2025 to March 2026	Bethammi Nursing Home	CB	85.00	SJCG Standard of Excellence	1)Establish compliance auditing on self-identity (Self-ID) during resident admission.	Self-ID compliance audit process (tool and reporting schedule) developed by PointClickCare facilitator (with input from clinical team and IH) to monitor compliance by end of Q1.	Clinical team conducts audits quarterly (Q2-Q4) to monitor compliance of self-ID process.	We are aiming to achieve the target of 85% of new admissions/intakes have completed the Self-ID question by Q4 2025/2026.
		Percentage of staff who have completed relevant equity, diversity, inclusion, anti-racism education - Repairing the Sacred Circle 1 (Bethammi Nursing Home)	Custom	% / Staff	In house data collection / April 2025 to March 2026	Bethammi Nursing Home	18.5	30.00	SJCG 3-year target plan of 30%, 60%, 90%	1)Establish education plan to provide Repairing the Sacred Circle 1 (RSC 1) to all staff.	"a. IH team to Implement communication plan for RSC 1 mandatory education requirement and sessions via email to: all staff (January & April), Managers (March), and the public (April). b. IH team and corporate learning team to include RSC 1 as mandatory education starting April 1, 2025 (available at general orientation and for staff sign up). c. Corporate learning to add RSC 1 to the current Manager LMS Quarterly compliance report."	"a. Communication is sent to all identified groups by end of April 2025. b. All employees have RSC 1 added to their LMS dashboard as mandatory education. c. Managers review RSC 1 LMS staff compliance and continue to communicate mandatory expectation."	Improve performance from 18.5% to 30% by March 31, 2026.
Experience	**Patient-centred**	Bethammi Nursing Home - "Do you feel that you can raise a concern about staff without it negatively affecting your (or your family members') care?" Response: Yes Definitely	Custom	% / LTC home residents	In-house survey / 2025	Bethammi Nursing Home	40	42.00	5% improvement on current performance	1)Develop action plan, with the Resident and Family Council, to Improve current communication strategy.	Administrators/clinical team and Resident and Family Council will identify gaps with raising a concern and develop improvement idea action plan from those gaps.	Progress report of action plan discussed at each Resident and Family council meeting.	Increase performance from 40% to 42% by March 31, 2026.
		Bethammi Nursing Home - "What do you think about the overall dining experience in the Home?" Response: Excellent	Custom	% / LTC home residents	In-house survey / 2025	Bethammi Nursing Home	11.9	13.00	10% improvement on current performance	1)Develop action plan, with the Resident and Family Council, to address gaps with the dining experience.	Administrators/clinical team and Resident and Family Council will identify gaps with dining experience and develop improvement idea action plan from those gaps.	Progress report of action plan discussed at each Resident and Family council meeting.	Increase performance from 11.9% to 13% by March 31, 2026.
Safety	**Safe**	Number of incidents of racism & discrimination reported by Bethammi Nursing Home staff	Custom	Number / Staff	In house data collection / April 2025 to March 2026	Bethammi Nursing Home	CB	CB	Collect baseline to understand current performance	1)Increase staff awareness and utilization of the Incident Learning System (ILS) for reporting incidents of racism and discrimination.	Update ILS to include type of incident "Racism and Discrimination" by IT by April 1, 2025 including communication of change to Management team and staff in April 2025.	All racism and discrimination incidents are captured under this incident type.	Collect baseline data to help inform accurate measures and improvement moving forward; including developing a rating system of non-physical harm to ensure incidents are appropriately recognized and addressed.