

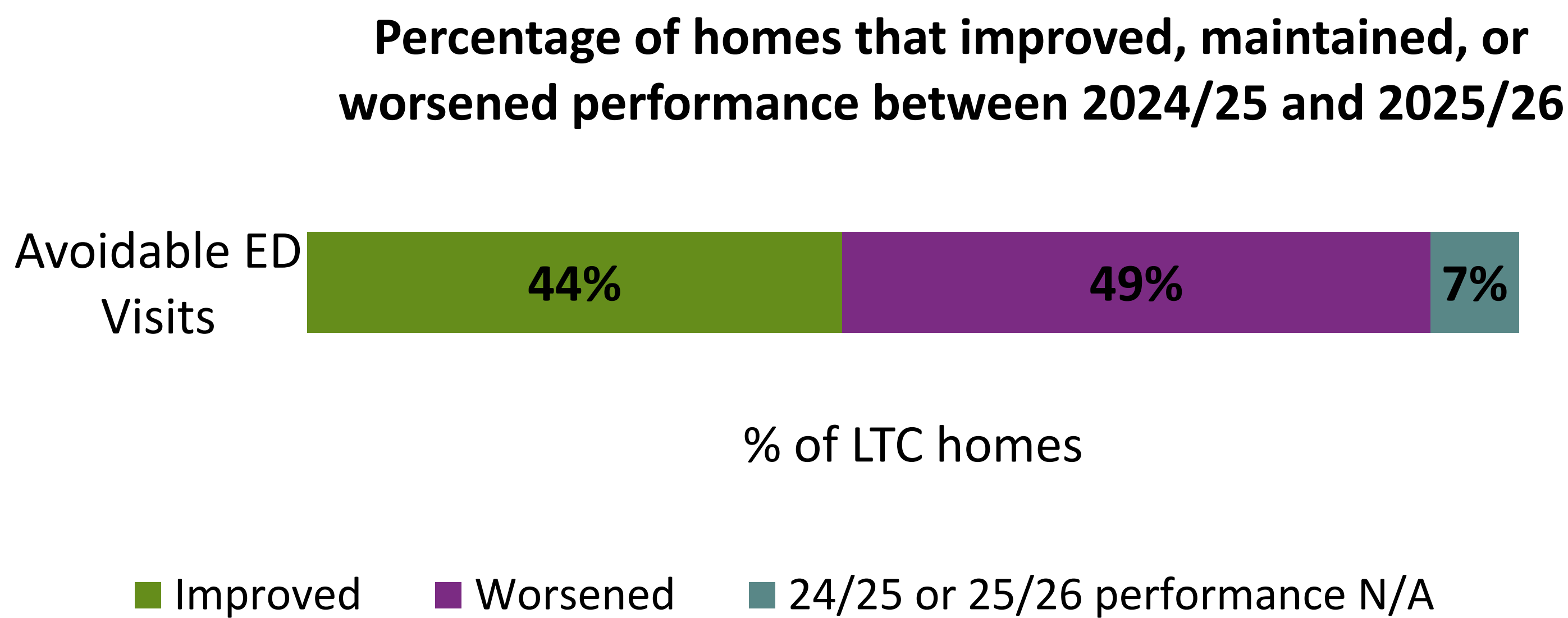
Access and Flow in Long-Term Care: Analysis of the 2025/26 QIP Submissions



Findings from the Quality Improvement Plan (QIP) Progress Report, Narrative, and Workplan

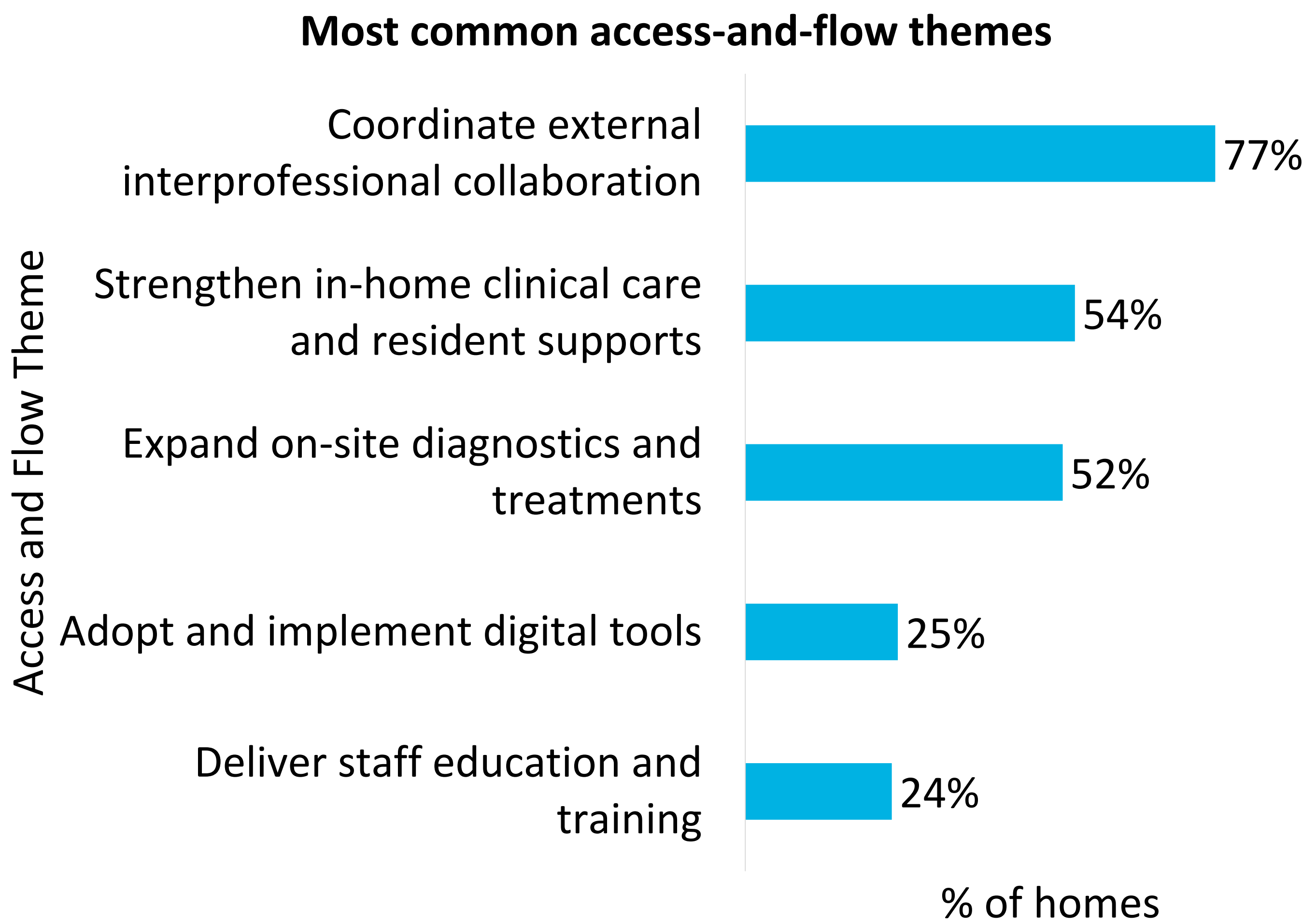
Progress Report

 **369 LTC homes reported on the Avoidable ED Visits indicator**
84% of planned change ideas (791/939) were implemented.



- **Key success factors:**
 - Staff education and training
 - On-site diagnostics and clinical supports
 - Nurse practitioner availability and leadership
 - Improved communication using SBAR
 - Palliative and admission planning
- **Key challenges:**
 - Balancing family and resident expectations
 - Staff turnover and resource constraints
 - Maintaining consistent nurse practitioner coverage
 - Communication gaps across care teams
 - Limited access to in-home diagnostics and specialized equipment

Narrative



- Initiatives reflecting common access-and-flow themes**
-  **Health system collaboration:** Ontario Health atHome, nurse-led outreach teams, infection-prevention-and-control hubs
 -  **Resident care supports:** End-of-life care, skin and wound management, fall prevention
 -  **Diagnostics and treatments:** Intravenous therapy, x-ray services, lab testing
 -  **Digital tools and integration:** Project AMPLIFI, eConnect/ClinicalConnect, ConnectingOntario ClinicalViewer
 -  **Staff education and training:** Gentle persuasive approaches, U-First!, PIECES approach

Workplan

 **60% of LTC homes (363/605) selected the Avoidable ED Visits indicator in their 2025/26 QIPs.**

