Holland Christian Homes

HCH *Here to Care.*

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Continuous Quality Improvement Report for Grace Manor 2024 into 2025-2026

Grace Manor is part of a larger continuum of care organization, Holland Christian Homes which is located in the City of Brampton and includes another Long-Term Care Home (Faith Manor) and six apartment towers. The mandate of Holland Christian Homes is to provide a supportive, caring, quality Christian environment in order to preserve dignity and enhance the quality of life for people who require long-term care from a team of qualified caregivers. In partnership with residents, caregivers and families, we provide a safe, professional and caring community for seniors based on traditional Christian values, offering a continuum of care and support while respecting their individuality and dignity. Our Quality Improvement Program includes in its scope, the annual development, implementation, monitoring, review, and evaluation of the following activities: Resident Satisfaction Survey, Family Experience Survey, Accreditation Assessment, Results And Action Plans; Staff Engagement Survey And Action Plan; Department Goals/Audits/stats tracking; Funding Agreements, Funding Indicators And Grants; Formal Program Reviews; Advocacy Initiatives (Resident And Family Engagement) – Residents Council, Family Council, Food Committee, Internal Concern Resolution Process; Legislative Requirements / Inspection Reports And Findings; Education And Training.

QUALITY PRIORITIES FOR 2025/26

Grace Manor is pleased to share its 2025/26 Quality Improvement Priorities.

Our long-term strategic plan identifies 5 strategic Directions: People Investment, Capital Investment, Branding & Marketing, Innovation & Excellence, and Sustainability & Stewardship as the core of Holland Christian Homes' with 7 strategic goals. Goals include Workplace Culture, Bethany Place, Branding & Marketing, Memory Care (Bethany Place), High Reliability and leading practices in Long Term Care and Assisted Living, Business Development & Fundraising, Data & Implement Technology Infrastructure. In 2024, Holland Christian Homes strategic plan was refreshed in response to several factors which resulted in a fundamentally changed healthcare landscape. These factors included, amongst others, the ongoing impacts of the COVID-19 pandemic, persistent healthcare worker shortage and burnout, increased public attention on long term care, and increased regulation of an already highly regulated environment. The strategic goals were done in collaboration with teams of staff, external consultant specializing in Strategic Planning, and Board members of Holland

Christian Homes. The results were shared with all key stakeholders to get their input Resident & Tenant experience committees were formed for senior management to update members and get feedback as we work to implement these goals.

The QIP aligns with the Strategic Plan, while navigating challenges and opportunities in our environment.

Grace Manor's QIP is aligned with our Quality Framework embedded within Holland Christian Homes' Core Values, and Success Factors. The high-level priorities for this year's QIP are informed by the quality and safety aims under the various goals of our Holland Christian Homes framework.

- Safe- Keeping Residents Safe
- Effective- Keeping People Healthy
- Resident Centered
- Efficient
- Accessible- Access to Long-Term Care Homes and Community Support Services
- Appropriately Resourced- Staffing

QUALITY OBJECTIVES FOR 2025/26

- Priorities are divided into 4 categories based on the projected scope of work anticipated for the year. Areas for action are included in this report.
- Our QIP Priorities are following Health Quality Ontario Performance Measures and Indicators
  1) Access & Flow
  2) Equity
  3) Experience
  4) Safety

Measure - Dimension: Efficient

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Rate of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents.	O	Rate per 100 residents / LTC home residents	CIHI CCRS, CIHI NACRS / Oct 1, 2023, to Sep 30, 2024 (Q3 to the end of the following Q2)	30.34	27.00	Want to improve at least by 3% in 2025.	

Change Ideas

Change Idea #1 Improve services offered within the home through the use of IV Therapy.

Methods	Process measures	Target for process measure	Comments
Educate registered lead care partners on the use of IV therapy.	Percentage of registered lead care partners trained on the use of IV therapy.	100% of registered lead care partners are trained on IV therapy in 2025.	

Change Idea #2 Increase Residents and Families knowledge about what services the home can provide at End of Life.

Methods	Process measures	Target for process measure	Comments
Percentage of residents and families that are offered information about available services for end of life care during care conference and that one information evening is held in 2025.	Offer End of Life information package to resident and families during annual care conference and hold one information evening for resident and families about what the home can offer as End of Life Care.	100% of residents and families are offered End of Life Care service information during care conferences. The home hosts one information evening for resident and families about available End of Life Care services available within the home by December 31, 2025.	

Equity

Measure - Dimension: Equitable

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education	O	% / Staff	Local data collection / Most recent consecutive 12-month period	100.00	100.00	Continue with having all non-union staff trained on Diversity, Equity and Inclusion education in 2025/2026.	

Change Ideas

Change Idea #1 Mandatory Diversity, Equity and Inclusion education in 2025 for all new non-union that are onboarding.

Methods	Process measures	Target for process measure	Comments
Using online training that includes topics of Diversity, Equity and Inclusion for all non-union care partners.	Percentage of non-unionized care partners that complete Diversity, Equity and Inclusion training against new hires.	100% of all non-union care partners to be trained in Diversity, Equity and Inclusion upon hire in 2025.	Total LTCH Beds: 120 Meeting LSAA local obligations.

Experience

Measure - Dimension: Patient-centered

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of residents responding positively to: "What number would you use to rate how well the staff listen to you?	C	% / LTC home residents	In house data collection / 2025	96.00	100.00	We want to improve by 4% in 2025.	

Change Ideas

Change Idea #1 Incorporate all care partners on training for person directed care and Eden philosophy.

Methods	Process measures	Target for process measure	Comments
Education to be provided to all care partners by the Dementia Care and Services Lead on person directed care and Eden philosophy in 2025.	Percentage of care partners trained on person directed care and Eden philosophy.	100% of care partners trained on person directed care and Eden philosophy by December 31, 2025.	

Measure - Dimension: Patient-centered

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of residents who responded positively to the statement: " I can express my opinion without fear of consequences".	C	% / LTC home residents	Other / 2025	100.00	100.00	Want to maintain and continue to have all residents feel that they can express themselves without fear of consequences.	

Change Ideas

Change Idea #1 Continue to maintain 100% of all residents to respond positively to the statement" "I can express myself without fear of consequences".

Methods	Process measures	Target for process measure	Comments
Education to be provided to care partners by Dementia Care and Services Lead on person centered care and EDEN philosophy for all care partners.	Percentage of care partners trained on person centered care and EDEN Philosophy.	100% of care partners trained on person centered care and EDEN Philosophy by December 31. 2025.	

Safety

Measure - Dimension: Safe

Indicator #5	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment	O	% / LTC home residents	CIHI CCRS / July 1 to Sep 30, 2024 (Q2), as target quarter of rolling 4-quarter average	21.88	20.00	To be more in align with Provincial average. Current Provincial average is 19.65%	

Change Ideas

Change Idea #1 Review new and current residents on antipsychotic medications to determine proper indication for usage and consideration of alternative interventions when warranted.

Methods	Process measures	Target for process measure	Comments
Interdisciplinary Antipsychotics Reduction Committee will review monthly residents that are on antipsychotics medication to determine proper indication for usage and consideration of alternative interventions when warranted.	Percentage of residents reviewed by the antipsychotics Reduction Committee per quarter.	100% of new admissions and current residents that are on antipsychotics medication will be reviewed by Antipsychotics Reduction Committee to determine proper indication for usage and consideration of alternative interventions by March 31, 2025.	

Quality Improvement Plan (QIP)

Narrative for Health Care Organizations in Ontario

May 2, 2025

Ontario Health

OVERVIEW

Grace Manor is part of a larger continuum of care organization, Holland Christian Homes which is located in the City of Brampton, and includes another Long-Term Care Home (Faith Manor) and six apartment towers. The mandate of Grace Manor is to provide a supportive, caring, quality Christian environment in order to preserve the dignity and enhance the quality of life for people who require long term care from a team of qualified caregivers. In partnership with residents, caregivers and families, we provide a safe, professional and caring community for seniors based on traditional Christian values, offering a continuum of care and support while respecting their individuality and dignity. Our Quality Improvement Program includes in its scope, the annual development, implementation, monitoring, review and evaluation of the following activities: Resident Satisfaction and Family Experience Surveys, CARF Accreditation Assessment, Results and Action Plans; Staff Satisfaction Survey and Action Plan; Department Goals/Audits/stats tracking; Funding Agreements, Funding Indicators And Grants; Formal Program Reviews; Advocacy Initiatives (Resident And Family Engagement) – Residents Council, Family Council, Dining Room Food Committee, Internal Concern Resolution Process; Legislative Requirements / Inspection Reports And Findings; Education And Training. The home is CARF accredited. This accreditation report identifies no recommendation. This accomplishment is achieved on only 3 percent of CARF Surveys. We take pride in achieving this high level of accreditation. The accreditation report is also intended to support our continuation of the quality improvement of programs and services and the people we serve.

The medical staff at Holland Christian Homes participates in an independent medical record review; infection control; pharmacy

and therapeutics review; medical advisory review, mortality review; ethical issue reviews, utilization management, review of transfers to other facilities; and serve on several committees including the CQI Committee.

The complex care needs of our long-term care residents have increased. Residents coming into the home are increasingly frail, more medically complex and for those with various forms of dementia; are displaying increased personal expressions. The majority of our residents have some form of Alzheimer's or dementia and almost all need help with eating, bathing, toileting and getting in and out of bed. These increased acuity levels; along with the high level of expectation of residents and families is a challenge when compared to the funding received to meet these needs.

Our 2025/2026 Quality Improvement Plan will focus on Access and Flow, Equity and Indigenous Health, Resident Experience, Safety, Provider Experience, Palliative Care and Population Health Management as required by the Ontario Health Quality Improvement Plan (QIP).

Access and Flow will be achieved through the reduction of unnecessary hospitalizations by the home providing registered lead care partners training on IV therapy, offering residents and families information about what is offered within the home for End of Life Care and by hosting one information evening with the topic of End of Life services available in the home. We will be continuing to utilize the Prevention of Error Based Transfers (PoET)Program to ensure residents goals, values, wishes, and beliefs are documented in order to assist with goals of care conversations that guides proposed treatment options such as emergency room transfers. Equity improvement will be addressed by requiring 100% of all care partners to complete Diversity, Equity and Inclusion education. We will enhance Experience by requiring 100% of our care partners to be trained in person directed care, Eden Philosophy. We continue to provide Safety to our residents through continuing to utilize our interdisciplinary team and review 100% of new admissions and current residents that are on antipsychotic medications to determine proper indication for usage by March 31, 2026. These established priorities, targets, and activities we believe will improve resident quality outcomes.

ACCESS AND FLOW

We are proud of our many partnerships, all of which support integration and continuity of care. Our partnership with Ontario Health at Home ensures LTC applications are processed in a timely manner to avoid any placement delays. Many education and training initiatives which are critical to the success of our Quality Improvement Plan would not be possible without our partnerships with BSO, PSHSA (staff safety), the Regional Infection Control Network, the RGP Program, Wound Care and mobility specialists, and our many contracted service providers (ie. dental, foot-care, pharmacy, physiotherapy, banking, hairdresser etc). Our memberships with AdvantAGE Ontario and Eden Alternative (person centered) is beneficial to support our advocacy and quality improvement initiatives.

Leadership care partners sit at various sector table groups ensuring we are informed of current trends and changes in the healthcare system affecting our home and resident care. Grace Manor has been very strong proponents of providing as much care as possible without transferring or admitting residents to hospital. We have enhanced our ability to do this through several initiatives. Our full-

time Nurse Practitioner has enabled us to provide treatments and diagnosis for our residents to prevent the need to transfer to hospital. When a resident is admitted to hospital, the NP is able to coordinate and facilitate a faster discharge by ensuring care is available upon their return home. In addition, our NP provides training to our registered staff to increase their ability to do critical thinking and increase their skills within their scope of practice. Additionally, we utilize our partners such as the Nurse Lead Outreach Team (NLOT) out of William Osler and a specialized Neurobehavioral Nurse Practitioner Team to assist in management of individuals living with dementia. Our Quality Improvement Plan ensures that these partnerships /networking continue as a priority indicator.

Grace Manor offers a variety of in-house diagnostic and imaging services through our contracted partnerships. This allows the residents to stay in their home to receive services such as blood work, ECG, X-rays/Ultrasound. We have also invested in equipment such as a bladder scanner, suction machine and hand-held doppler which can be helpful in preventing avoidable ED transfers. We also utilize technology such as secure video conferencing and e-Consultation through OTN to bring services to the bedside.

Optimizing system capacity, timely access to care, and patient flow ultimately improve outcomes and the experience of care for our residents. We continue to partnership across care sectors on initiatives to avoid unnecessary hospitalizations and avoid visits to emergency departments through improving our communication within the home through the use of the SBAR Tool to align towards the provincial average to ensure the right care in the right place at the right time.

Grace Manor has adopted the Eden Alternative Philosophy as an person directed approach to care, enhancing the environment and resident experience through a more collaborative approach between residents, families and care partners.

We recognize the importance of advanced care planning. We continue to utilize the PoET form to guide conversations related to residents values, wishes, and beliefs around their healthcare. This has been an important tool to help guide conversations related to goals of care, and prevent unnecessary hospital transfers.

EQUITY AND INDIGENOUS HEALTH

Holland Christian Homes is committed to fostering diversity, inclusion, and cultural competency. Holland Christian Homes seeks to identify opportunities for ongoing enhanced education and training in the following areas: cultural competency, age, gender identity/expression/orientation, spiritual beliefs, socioeconomic status, disability, and language. When resources are not available internally, Holland Christian Homes will seek to develop resources so that all team members are provided the opportunity to develop a greater awareness and sensitivity to the needs of person's served, stakeholders, and the community.

We have a Diversity, Equity, Inclusion Plan that includes Health Equity, Antiracism, First Nations, Inuit, Metis, and Urban Indigenous (that include existing provincial priorities such as French language health services, Disabilities Act, Black Health Plan, etc.) based on Service Accountability Agreement obligations.

Holland Christian Homes is an Equal Employment Opportunity

employer. We are committed to the elimination of barriers that restrict the employment opportunities.

Holland Christian Homes provides equal employment opportunities for the good of the public without regard to race, color, national origin, ancestry, sex, religious creed, age, mental or physical disability, veteran status, socioeconomic status, medical condition, marital status, sexual orientation, sexual harassment, or pregnancy.

We will continue to provide training requirements for care partners that are listed in Holland Christian Home's employee manual. Training will not be influenced by race, ethnicity, age, gender, color, religion, national origin, sexual orientation, veteran's status, socioeconomic status, or disability.

All Managers and Leadership care partners are trained and will continue to be trained in equity and indigenous Health programs in order to be ensure that our approaches to care are culturally appropriate as we endeavor meeting community needs and priorities.

The home has also committed to 100% of all care partners to complete Diversity, Equity, Inclusion training by December 31, 2025. All care partners receive annual code of conduct policy to affirm they will act ethically at all times.

INDIGENOUS LAND ACKNOWLEDGEMENT

Land acknowledgements are the first step to reconciliation because they allow us to recognize how colonialism continues to impede on the lives of Indigenous generations. Acknowledgement gives us the opportunity to reflect on our privileges as settlers on traditional territory. At Holland Christian Homes, we approach this land acknowledgement with the commitment to walk side-by-side with Indigenous communities by listening and learning from Indigenous voices towards the road to reconciliation.

A plaque continues to be displayed in the entrance of Grace Manor stating the following:

"Holland Christian Homes acknowledges that its operations are located within Treaty 19 (Ajetance Treaty) territory, the treaty lands of the Mississaugas of the Credit. We further recognize that these lands comprise the traditional territory of several indigenous peoples, including the Wendat, Haudenosaunee and Anishinaabeg (including the Mississaugas of the Credit First Nation). We are grateful to work and provide care within these lands, which continue to be home to many diverse First Nations, Métis and Inuit peoples. With a spirit of reconciliation, Holland Christian Homes is committed to walking side-by-side with indigenous communities, respecting their long-standing relationships with the land, and learning from their traditions and stewardship practices."

The above acknowledgement is read and acknowledged at special meetings of the organization and whenever external partners meet at HCH.

CULTURAL COMPETENCY, DIVERSITY, AND INCLUSION ACTION PLAN

To further enhance Holland Christian Homes commitment to cultural competency, a Cultural Competency, Diversity, and Inclusion Action Plan is reviewed and updated annually.

The plan is updated as needed to ensure that our care partners, residents, tenants, and other stakeholders develop awareness and sensitivity specific to the diversity of our service population. This plan addresses diversity in terms of culture, age, gender, identify/expression, sexual orientation, spiritual beliefs, socioeconomic status, language, and other factors relevant to Holland Christian Homes service population.

Goals of the Cultural Competency, Diversity, and Inclusion Action Plan
1. To assess the cultural diversity of stakeholders within Holland Christian Homes
2. To recognize cultural and multi-faith celebrations
3. To recognize that food plays a significant role in cultural diversity and faith traditions
4. Develop and maintain communication tools to enhance team member and resident engagement
5. Continue to engage and develop partnerships with community stakeholders to further enhance our tag line of “Here to Care”
6. Advance Indigenous Health Strategies and Outcomes
7. Advance equity, inclusion, diversity, and anti-racism strategies to improve health outcomes
8. To recognize that cultural considerations are not limited to ethnicity but include spiritual beliefs, language, financial status, gender identity/expression/orientation, disability, and other attributes.

PATIENT/CLIENT/RESIDENT EXPERIENCE

Holland Christian Homes (HCH) tagline of being "Here to Care" sets the foundation of our community that we are serving on a day-to-day basis. Our community consists of our vulnerable seniors that reside in the manors, our families, stakeholders, and our dedicated care partners that help us fulfill our mission.

Grace Manor is embarking on the Eden Philosophy of Care and person-directed care movement that improves the well-being and quality of life of our residents. We are reframing the culture of aging, we want to increase resident, family care partner and employee care partner satisfaction and strengthen relationships. Together, we will create home by introducing pets, plants, ambiance and encouraging intergenerational connections and visits. Aging is a normal part of human life. We are all complete human beings as we age or live with different abilities. A caring, inclusive and vibrant community enables all of us, regardless of age or ability, to experience well-being. Everyone has a great value to our community and should be seen and honored for that value. No matter our age, or life challenges, residents want to be included as active, vital partners in their own care.

We believe in eliminating loneliness, helplessness, and boredom for everyone on the care partner team.
We will support choice, dignity, respect, self-determination, and purposeful living for everyone we serve.
We believe that care means helping another to grow.
We promote a person-directed approach to care that puts the person first.
We believe in an approach that doesn’t see the needs of caregivers as separate from care receivers but promotes the well-being of the whole care partnership.
We are all partners in care.
Care partner teams work together collaboratively to eliminate

loneliness, helplessness, and boredom.

We are empowering all care partners to live the EDEN Alternative philosophy every day, seeking to remake the experience of ageing and creating a better world for our residents and care partners. There is a commitment to keep residents secure, content and joyous in their home and through person-directed care we strive to combat loneliness, helplessness, and boredom. It is about creating a real home, providing opportunities for building relationships, placing residents first and setting a standard of excellence. The EDEN Alternative enables us to move away from the departmentalized, task-orientated, institutional models. By changing the culture to bring decision making closer to the resident, we support creating a meaningful life for them. This approach empowers our residents to direct their lives, creating a true atmosphere of home. We are a community, we will be introducing neighborhoods' each with their own unique flair and flavor. The personality and character of each neighborhood will always be evolving, shaped by both residents and care partners. Each of our neighborhoods is home to our residents, and each neighborhood will have a name with community and historical significance. This fosters a sense of connectedness and enhances the feeling of home for all members of the Holland Christian Homes community.

Holland Christian Homes believes that the organizational health and wellness are important to each individual employee. Individual health may affect the ability of employee's contribution to meet the mission and values of HCH. To promote a positive and healthy culture in the workplace, HCH has organized a dedicated Workplace Social and Wellness Committee. This committee will plan and execute social events to help HCH promote a culture of engagement, belonging and fun among all HCH employees e.g care partner appreciation week, holiday parties etc.

Holland Christian Homes values the opinions and suggestions of care partners for improving the work environment while enhancing resident care. In addition to the Workplace Social and Wellness Committee, Holland Christian Homes invites all care partners to be a voluntary member of 12 additional committees that steer the organization's goals and objectives to enhance the quality of care we provide to enhance the resident experience. We believe that including s care partners as members of these committees brings an important perspective, allowing their voice to be heard, as key members of the Holland Christian Homes family.

Holland Christian Homes partners with an Employee and Family Assistance Program that provides onsite counseling support and shares important resources to care partners such as: Highlighting Resilience: Bouncing back from Burnout, Coping with Anxiety, Adjusting after the Pandemic Response, Feeling Safe and Engaged, Fostering Trust and Commitment.

It continues to be a challenging time for health care organizations with unprecedented human resources
challenges. Our home is currently implementing innovative practices to improve workplace culture,
through employee engagement surveys and outcome analysis and development of action plan in areas of needed improvement and is shared with care partners. Action plan includes but is not limited to recognition events, manager/supervisor open door policy, succession planning, care partner wellness committee to further enhance our employee satisfaction.

Holland Christian Homes is committed to operating our long-term care homes with transparency and accountability. We support and encourage ways that provide opportunities for residents and families to stay engaged in all aspects of the home. Our poster called, “Your Voice Counts” lets residents and families know how they can get involved and share in the management of our home and create a voice for all residents at Grace Manor. Residents and Families are also able to complete CQI suggestion forms and/or concern forms.

Residents participate in our Dining Room Committee and Residents Council. Families participate in Family Council. There is a designated staff assistant to ensure these councils are easily able to meet and have their meetings documented. The leadership team is made aware of concerns, complaints and comments and there is immediate follow-up by Leadership/Administration. Residents and families also participate in our annual program reviews and evaluations. An annual Resident Satisfaction Survey was completed by competent residents (with or without impartial assistants) and SDMs for care for residents who are not mentally capable to complete them.

We conducted our annual program evaluation day for the year 2024 in which we reported on and evaluated 31 programs and set goals for those programs to be completed in 2025. Staff, CEO, managers, board members, medical director, pharmacist, dietician, family and resident council representatives, a pastor, and residents all participate in this evaluation day. It is a great opportunity for everyone to share in the successes and to learn more about how we will work to improve in the areas needing improvement. Families and residents were very appreciative of being invited to participate and commented about how much they learned from participation in this day and appreciated the transparency that our home was providing.

The Grace Manor leadership team and care partners are engaged in an organizational wide (Holland Christian Homes) quality improvement program. We have developed many programs which are interdisciplinary through committees, evaluations, huddles, and communication methods such as audits, reports, in-services and feedback forms. These programs and initiatives are coordinated through our CQI Program Coordinator who compiles the results in the form of reports which provide feedback and direction for future initiatives.

All volunteers and employees of Holland Christian Homes are expected to participate in ongoing and systematic quality improvement efforts through quality assessment activities, such as annual staff satisfaction surveys, specialized program review meetings, infection control surveillance, utilization management, and medical record review.

Our interdisciplinary specialized program teams look at particular issues to identify opportunities to improve processes and outcomes through the establishment of goals. Goals are acted upon, monitored, reported at and evaluated by the applicable in-house team and/or department(s). Front line staff and even residents and families are often engaged through this process.

PROVIDER EXPERIENCE

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the foundation of our community that we are serving on a day-to-day basis. Our community consists of our vulnerable seniors that reside in the manors, our families, stakeholders, and our dedicated care partners that help us fulfill our mission.

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Holland Christian Homes partners with an Employee and Family Assistance Program that provides onsite counseling support and shares important resources to care partners such as: Highlighting Resilience: Bouncing back from Burnout, Coping with Anxiety, Adjusting after the Pandemic Response, Feeling Safe and Engaged, Fostering Trust and Commitment.

It continues to be a challenging time for health care organizations with unprecedented human resources challenges. Our home is currently implementing innovative practices to improve workplace culture, through employee engagement surveys and outcome analysis and development of action plan in areas of needed improvement and is shared with. Action plan includes but is not limited to recognition events, manager/supervisor open door policy, succession planning, care partner wellness committee to further enhance our employee satisfaction.

SAFETY

RESIDENT SAFETY PLAN

Senior management is committed to guiding the execution of the Long-Term Care Resident Safety Plan across all the Holland Christian Homes Long Term Care homes and Seniors Services programs.

Our mission is to provide effective, high-quality, safe and efficient long-term care services in a home-like setting. Our purpose is to ensure our residents feel safe while in our homes. This Resident Safety Plan drives continuous improvement to quality and safety throughout our home and builds upon our mission, vision and values.

Our Resident Safety Plan is developed in conjunction with Resident Safety Goals within the resident safety areas of culture, work life/workforce, communication, medication use, infection control, falls prevention, and risk management. The goal is to enhance resident /client safety and to minimize risk.

In 2024 Holland Christian Homes received CARF Accreditation with no recommendation until 2027 meeting our LSAA Agreement.

This document articulates the go forward strategy for quality and safety at Grace Manor, Holland Christian Homes Long Term Care Homes and Seniors Services Programs. Strong multi- disciplinary experience, quality improvement practices, collaboration, and Leadership throughout our programs, services and departments will foster attention to continuous quality improvement and drive improved performance in quality and safety for Residents, families, staff and our community.

The Resident and Tenant Safety Plan is readily available to all residents, families and staff. The Plan is reviewed and updated annually. All staff receive and sign off annually the Code of Conduct reaffirming their commitment to act ethically at all times.

PALLIATIVE CARE

We have worked hard to provide our care partners with palliative care training, which not only prepares them to provide end-of-life care in a comfortable home-like environment, but also to educate families on how their home is usually the best place for their loved one during palliation, but also to engage resident and families in the palliative and EOL journey. Over the past year we have made some enhancements to our EOL program with the addition of a guide which provides information for families and residents nearing the end of life. We now offer a special EOL care team meeting should the resident and family choose to specifically explore any particular wishes and needs related to their care plan at the end of life.
In 2025 we hope to bring back our end-of-life volunteer program which will continue to enhance the care we offer during the residents' final days.

POPULATION HEALTH MANAGEMENT

Population health–based approaches involve a broadening focus to include being proactive in meeting the
needs of our residents. This includes providing proactive services to promote health, prevent disease,
and help people live well with their conditions in every interaction. We provide care from a person directed approach
and work in partnership with other health providers as needed to care for the unique needs of our residents within our home.
Grace Manor understands the importance of preventative health approach. As such, we have several inhouse clinics such as Eye Clinics, Dental Clinics, Foot Care Clinics, Hearing Devices. Additionally, we have in-house laboratory and diagnostic imaging services that come into the home and this can be helpful in chronic disease management. We work closely with Public Health to ensure that our vaccination is up to date. We have an Infection Prevention and Control (IPAC) Program, a full-time Lead and Committee that focuses its efforts on policies and procedures on IPAC with a goal of reducing the risk of transmission of infections agents, surveillance, hand hygiene program, education for residents, care partners and families. The IPAC Lead ensures that enhanced precautions are strictly observed and carried out by all department care partners at all times. This is managed through various activities daily, monthly or annually as required.

CONTACT INFORMATION/DESIGNATED LEAD

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905-463-7002 EXT. 5255

Arleen Downer-Reid
CQI and Risk Mitigation Specialist
arleen.downer@hch.ca
905-463-7002 ext. 5240

SIGN-OFF

It is recommended that the following individuals review and sign-off on your organization's Quality Improvement Plan (where applicable):

I have reviewed and approved our organization's Quality Improvement Plan on **March 31, 2025**

Tracy Kamino, Board Chair / Licensee or delegate

Justine Dudziak, Administrator /Executive Director

Arleen Downing-Reid, Quality Committee Chair or delegate

Other leadership as appropriate

QIP PLANNING CYCLE AND PRIORITY SETTING PROCESS

Grace Manor has developed QIPs as part of the annual planning cycle since 2015, with QIPs submitted to Health Quality Ontario (HQO) every April. Grace Manor's QIP planning cycle typically begins in January, and includes an evaluation of the following factors to identify preliminary priorities:

- progress achieved in recent years;
- ongoing analysis of performance data over time available from the Canadian Institute for Health Information (CIHI); with areas indicating a decline in performance over time and/or where benchmarking against self-identified peer organizations suggests improvement required
- resident, family, and staff experience survey results;
- emergent issues identified internally (trends in critical incidents) and/or externally;
- input from residents, families, staff, leaders, and external partners, including the MHLTC.
- Health Quality Ontario (HQO)
- Central West Ontario Health Team (CWOHT)

Preliminary priorities are subsequently presented and discussed at various forums to validate priorities and identify additional priorities that may have been missed. These forums include the broader leadership team, Resident Council, Family Council, and the Care Committee of the Board of Directors. This is an interactive process with multiple touchpoints of engagement with different stakeholder groups as QIP targets and high-level change ideas are identified and confirmed. The final review of the QIP is completed by the CEO and shared with the Care Committee of the Board.

GRACE MANOR'S APPROACH TO CQI (POLICIES, PROCEDURES, AND PROTOCOLS)

Every staff has a responsibility for CQI. Grace Manor's nursing, departmental, and administrative policies, combined with practice standards, provide a baseline for staff in providing quality care and service. Interprofessional quality improvement teams, including resident and family advocates, work through the phases of the annual quality improvements.

DESIGNATED LEAD

Currently hiring for a new CQI and Risk Mitigation Specialist. In the interim the designated lead is:

Justine Dudziak
Administrator
justine.dudziak@hch.ca
905-463-7002 ext.5255

****We encourage all staff, residents and families to get involved, join a committee, and make a suggestion. Contact the above designated lead for more information on how to make a difference!*

Comparative Databases, Benchmarks, Professional and Best Practice Standards:

Holland Christian Homes uses comparative data (such as but not limited to RAI-MDS, CIHI, HQO, and RNAO Best Practice Guidelines) (whenever available) to incorporate a process for continuous assessment with similar organizations, standards, and best practices. This assessment then leads to action for improvement as necessary.

Continuous Quality Improvement Processes and Methodology:

The Continuous Quality Improvement Plan is a framework for organized, ongoing, and systematic measurement, assessment, and performance improvement activities. The components of this plan include:

- A quick fix process will be used for problems that do not need a comprehensive approach to problem-solving and solution implementation (i.e. concern and suggestion forms).
- Quality assessment activities, such as quality of life resident satisfaction, family experience surveys, staff engagement surveys, infection control surveillance, utilization management, and medical record review.
- CQI Summary Report, which provides summary data about selected indicators, prepared for the Board, Continuous Quality Improvement Committee, and medical staff.
- Outside sources/comparative databases, such as RAI-MDS, CIHI, HQO, and AdvantAGE professional practice standards (RNAO, etc.) for benchmarking, will be used to compare our outcomes and processes with others, identifying areas to focus on continuous quality improvement efforts.
- Central Ontario Health designated quality Indicators as outlined in the L-SAA Funding Accountability Agreements.

- Medical Directors attend quarterly and annual Continuous Quality Improvement reviews to provide input on activities, assessments and performance improvement. They are held accountable to their contract.
- Quality Improvement Teams consisting of departmental and established interdisciplinary in-house committees which look at particular issues to identify opportunities to improve processes and outcomes through the establishment of goals. Goals are acted upon, monitored, reported at, and evaluated by the applicable in-house committee and/or department(s). They are accountable to report goal outcomes annually to the CQI Committee.
- Establishment of high-level interdisciplinary priority improvement targets and initiatives to measure outcomes. This includes establishing the improvement initiative, methods, and results tracking. Such improvement targets and initiatives are measured against the previous year's actual outcome to the current year's improved targeted outcome.

The continuous quality improvement methodology used for acting on the high-level interdisciplinary priority improvement targets and initiatives is as follows:

Step One - SET STANDARDS

Standards are written statements outlining expectations, policies, procedures, and work rules related to a goal/improvement initiative. Each goal/improvement initiative will have a standard or a set of rules that tells everyone in Holland Christian Homes what to do, how to do it, and when. The standards determine the program and make it clear what is expected - how, when and from whom. They also clarify what employees can expect from management.

Standards provide the 'bar' or 'starting point' against which we evaluate whether what we are trying to accomplish or achieve is working. Implementing clear, effective, approved standards is an indication of the strong leadership that is essential for an effective and successful goal/improvement initiative.

Step Two - COMMUNICATE

Communicating standards means ensuring that all appropriate people in Holland Christian Homes have a clear understanding of what is expected of them as employees, and what they can expect from others regarding the goal/improvement initiative. Communication increases awareness of the goal/improvement initiative and encourages employees to give us feedback and tell us their observations about the goal/improvement initiative and how it can be improved.

What is communicated?

- Specific information, rules or workplace expectations that have been set for the goal/improvement initiative to appropriate people etc.
- Updates on improvements to meet the goal/improvement initiative.

How we communicate?

We use the most effective means of communication to ensure that everyone in Holland Christian Homes knows what is expected of them. This can mean notices on bulletin boards, emails, meetings, newsletters, posters, pictures, memos, or guest speakers. We have invested in software that allows us the ability to send messages using Staff Schedule Care for staff and Cliniconex for families, which is extremely helpful for immediate messaging. We make sure that literacy and language issues are accommodated.

One of the best ways we communicate positive messages about a goal/improvement initiative is by getting people to actively participate in achieving the goal/improvement initiative. This shows that people value the effort put into achieving the goal/improvement initiative.

To whom we communicate?

We communicate to employees, families, residents, volunteers, and visitors as identified in our goal/improvement initiative standard. This may include all employees or a selection of them. We may need to communicate different information to employees and different information to residents and families. We think about what people need to know and when they need to know it and who needs to know it.

We make communication two-way

We give information and ask for feedback. We adjust when employees offer good suggestions and then show them how we used their suggestions.

- We formulate the information in a language and manner that people will understand, and deliver it at a time and place that will maximize their comprehension.
- We vary the ways that we communicate so that new information is noticed and does not become mundane.

Step Three - TRAIN

Training means that management, supervisors, and workers all attain the knowledge and skills appropriate for their jobs. For each goal/improvement initiative, we determine who needs what knowledge and skills, and how they will be developed. To meet the goal/improvement initiative requirements, training is completed, or verified, within each year (January 1 to December 31).

How training is done?

Workplace training can be delivered in various ways (i.e. In-services, webinars, outside training, etc.). What is important is that the knowledge and skills needed to achieve the goal/improvement initiative are learned and practiced.

Effective training:

- Follows adult learning principles.
- Is delivered in the way that allows employees/residents/families to benefit most. For example, classroom training works where group discussion and sharing of ideas are important.
- For specific training, practical one-to-one hands-on experience training using tools or equipment is needed.
- Computer-based training works where independent learning is needed. We include opportunities to practice and demonstrate what is learned.
- Training is relevant and applicable to the learner's duties.

What training is done?

Training on our standards for each goal/improvement initiative is provided to those who have responsibility and accountability for knowing and using the information. For example, orientation training is important for everyone when they are first hired, when they change locations or jobs, or after a long absence from Holland Christian Homes. Training or retraining in safe work procedures is ongoing. We keep written records of who was trained in what and when the training occurred.

- We vary the ways that we do training to help keep it interesting.
- We use visual aids and real-life case studies as tools for learning.
- We discuss our training needs with other managers to create opportunities to share resources or information.
- We consider train-the-trainer courses, so we can have a qualified trainer to deliver programs on-site.
- We provide a training checklist and sign-off sheet for the supervisor and workers so we are sure each topic is covered and acknowledged.
- We keep training records, meeting notes, sign-off sheets, attendance forms, certificates or record of training and training evaluation forms with our goal documentation.

Step Four - EVALUATE

Evaluating a goal/improvement initiative

Evaluating each goal/improvement initiative is an important process; it helps us make sure we are carrying out the standard, the goal/improvement initiative is properly communicated, and effective training has taken place. It is also an opportunity to see if the goal/improvement initiative is working — is it effective and up-to-date?

Evaluating our goal/improvement initiative helps us to see where the strengths and weaknesses are. We are then better able to make effective improvements with the feedback we receive.

Going through the process of evaluation also helps keep our goal/improvement initiative fresh and top-of-mind for residents, families, volunteers, workers and supervisors as we ask questions and check to see the status of the goal. This is a good time to give positive feedback, which will encourage more good work.

How and when do we evaluate?

Once Steps 1, 2, and 3 have been completed, the evaluation may begin. The evaluation step is completed during the calendar year. However, it may not be practical to evaluate our goal near the end of the year if it was very recently implemented. We follow our action plan and have it implemented no later than February 1st of the following year.

Ways we evaluate:

- Observing: walk around to see if a process or task is being completed according to the standard. This is done during our regular workplace inspections.
- Looking for trends: examine workplace records.
- Asking questions about the implementation of the standard: employees will often give the best feedback.
- Asking a third party: have them look at the work processes and give us feedback.

Some questions we ask:

- Has legislation changed? Are there new best practices in the industry?
- Is the goal/improvement initiative standard being implemented and met?
- Is communication about the standards, both to and from employees, clear and understood?
- Is training to the goal/improvement initiative standards being completed and are employees, residents, families, and volunteers benefiting from it?
- Are employees following the goal/improvement initiative?

Ways we evaluate our goal/improvement initiative:

- We use a program evaluation template and evaluate the goal/improvement initiative as part of an applicable or associated program review.
- We keep logbooks that we refer to at evaluation time. We record the good practices, as well as those needing improvement.

- We keep notes throughout the year. For example, if we do training, audits, inspections, or if there are incidents, then we write them down as we go so that when it is time to evaluate we can refer to the notes.
- We try to build confidence by keeping expectations reasonable. Standards, and ways to evaluate them, will be improved over time.
- We are not afraid of negative results. We cannot improve if we do not try different methods and approaches. We will act aimed at improving the goal/improvement initiative, even if the evaluation results show problems.

Step Five - ACKNOWLEDGE SUCCESS AND MAKE IMPROVEMENTS

Based on the results of our evaluation, we look for opportunities for improvement and create a documented plan or recommendations to implement changes. When evaluation indicates a need for improvement, we use cooperative mechanisms to significantly improve our performance.

Our objectives include:

- Raise performance to Holland Christian Homes standards.
- Raise Holland Christian Homes standards and expectations.

We keep everyone informed of the plans for improving the goal/improvement initiative such as:

- Sending a letter from the Board of Directors/department heads congratulating all staff for their contribution to meeting the goal/improvement initiative.
- Run an article in the CQI newsletter or on the website highlighting successes.
- Include commendations in the minutes of the annual general meeting.
- Acknowledge and congratulate those who have contributed to our goal/improvement initiative. We do this by publicly recognizing Holland Christian Home's overall performance and improvements and individual contributions to improved performance. We also explore employee recognition, incentive programs, and performance appraisals.

These 5 steps are used in a repeating cycle to allow continuous reflection and improvement of the care and services provided to our residents.

Communication:

The Continuous Quality Improvement Committee provides oversight and functions as the central clearing house for quality data and information collected throughout the home. The CQI Committee tracks, trends, and aggregates data from all sources to prepare reports for the Board of Directors and the medical staff. A bi-annual CQI newsletter is published to update residents, tenants, families, staff, and volunteers.

Education:

All staff and volunteers are given the responsibility and authority to participate in our Continuous Quality Improvement Plan. To fully accomplish this, all volunteers and staff are provided with education regarding the CQI Plan during their initial orientation, and on an annual basis thereafter. This education will include a description of the CQI Plan and how they fit into the plan, based on their particular job or volunteer responsibilities. Education is also provided to contractors and agencies who are involved in resident care.

Evaluation (Monthly, Quarterly, Annually):

Progress is evaluated monthly during our committee working groups where all CQI activities for all programs and services offered within Grace Manor are benchmarked against our set goals. Action plans are revised to ensure a focus on continuous improvement. Our established CQI Committee meets quarterly with identified key stakeholders, including representation from family/resident councils where Grace Manor reviews quarterly metrics and completes a comparative analysis of all action items and sets further action priorities.
Our overall CQI Plan (and all associated activities, program matrices, benchmarks) is evaluated on an annual basis for effectiveness in achieving the goal of assuring that the most appropriate quality of care and services are being provided to our residents, tenants, and clients. This will be done following the Holland Christian Homes standard template provided for this purpose. A summary of activities, improvements made, care delivery processes modified, projects in progress, and recommendations for changes to this CQI Plan, are compiled and maintained on file.

Documentation and Reporting:

A detailed summary of activities, improvements made, care delivery processes modified, projects in progress, and recommendations for changes to this Quality Improvement Plan, are compiled and maintained on file. In addition to regular CQI updates, a detailed formal summary highlighting the quality improvement activities for the year will be prepared and posted publicly within the home and on the Holland Christian Homes website.

OVERALL SUMMARY - PROCESS TO MONITOR AND MEASURE PROGRESS, IDENTIFY AND IMPLEMENT ADJUSTMENTS AND COMMUNICATE OUTCOMES

A key component of the sustainability plan is the collection and monitoring of the key project measures over time. Run charts and Statistical Control Charts, with established rules for interpretation, are essential to understanding if there has been an improvement or deterioration in performance. Analysis of the Outcome measure(s) will be used to

identify if the Home is achieving the desired outcomes or not. If not achieving desired outcomes, the team can review the Process measure(s) over time to either confirm compliance with key change ideas (suggesting the change idea may not be as effective at improvement outcomes) or identify gaps in compliance that need to be addressed. Based on the results of this analysis, the team may consider alternative change ideas, provide coaching to staff to enhance compliance, engage with staff to better understand gaps in compliance, etc.

Communication strategies are tailored to the specific improvement initiative. These include, but are not limited to:

- Posting on the Grace Manor Quality Improvement Board, in common areas and in staff lounges
- Publishing stories and results on the website, on social media or via the CQI newsletter
- Direct email to staff and families and other stakeholders
- Handouts and one: one communication with residents
- Presentations at staff meetings, townhalls, Resident Council, Family Council
- Huddles at change of shift
- Use of Champions to communicate directly with peers

Access and Flow | Efficient | Optional Indicator

Indicator #4

Rate of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents. (Grace Manor)

Last Year		This Year		
26.97 Performance (2024/25)	**25** Target (2024/25)	**30.34** Performance (2025/26)	**-12.50%** Percentage Improvement (2025/26)	**27** Target (2025/26)

Change Idea #1 0 Implemented □ Not Implemented

Improve communication within the home through the use of the SBAR.

Process measure

- number of staffs trained on the use of SBAR as a means to improve communication.

Target for process measure

- 100% registered staff trained on SBAR 2024.

Lessons Learned

100% of all registered staff were trained on SBAR.

Comment

The home did not achieve target likely due to several factors such as POA request to transfer to hospital and increase of complex medical conditions.

Equity | Equitable | Optional Indicator

Indicator #3

Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education (Grace Manor)

Last Year		This Year		
CB	**100**	**100.00**	**--**	**100**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Improvement (2025/26)	Target (2025/26)

Change Idea #1 0 Implemented □ Not Implemented

Incorporate Diversity, Equity and Inclusion education in 2024.

Process measure

- Nonunion staff to complete Diversity, Equity and Inclusion (DEI) training in 2024.

Target for process measure

- 100% of nonunion staff trained on Diversity, Equity and Inclusion (DEI) in 2024.

Lessons Learned

100% of all nonunion staff completed.

Experience | Patient-centered | Custom Indicator

Indicator #2

Percentage of residents responding positively to: "What number would you use to rate how well the staff listen to you?"

(Grace Manor)

Last Year		This Year		
88.00	**100**	**96.00**	**--**	**NA**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Improvement (2025/26)	Target (2025/26)

Change Idea #1 0 Implemented □ Not Implemented

Increase to 100% of residents to respond positively to the question "Do you feel listened to".

Process measure

- Using on line learning platform.

Target for process measure

- 100% of staff trained on customer service in 2024.

Lessons Learned

100% were trained on Customer Service approaches. We found that it really helped with staff resident engagement.

Comment

The home did not reach the target likely due to other educational gaps that we are planning to address this year and provide the Eden Philosophy training to all care partners in order to reach the target of 100%.

Safety | Safe | Optional Indicator

Report Accessed: March 31, 2025

Indicator #1

Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment (Grace Manor)

Last Year		This Year		
23.98 Performance (2024/25)	**20** Target (2024/25)	**21.88** Performance (2025/26)	**8.76%** Percentage Improvement (2025/26)	**20** Target (2025/26)

Change Idea #1 **0** Implemented □ Not Implemented

Review of diagnosis and update to add hallucinations delusions and reassessment of RAI coding to reassess resident diagnosis.

Process measure

- Utilize use of interdisciplinary team to review residents on antipsychotic, reassess behavior, care plan and discontinue medication when appropriate. Review of diagnosis and update to add hallucinations delusions and reassessment of RAI coding to reassess resident diagnosis.

Target for process measure

- Continue to utilize our interdisciplinary team to review 100% of new admissions and current residents that are on antipsychotic medications to determine proper indication for usage by March 31, 2025.

Lessons Learned

Interdisciplinary team to review residents on antipsychotic, reassess behavior, care plan and discontinue medication when appropriate. Review of diagnosis and update to add hallucinations delusions and reassessment of RAI coding to reassess resident diagnosis. Care plans were completed 100%. The home has improved performance in this AIM.

Comment

The home has made progress towards target but likely due to new admissions coming with antipsychotic medication it made it difficult to achieve target.

DATE OF THE ANNUAL PROGRAMS EVALUATION AND WHO PARTICIPATED

Our 2025 Annual Programs Review and Evaluation occurred on **February 25, 2025.**

The following people participated:

#	Name	Position
1.	Tracy Kamino	CEO
2.	Justine Dudziak	Administrator
3.	Jenny Steward	DRC
4.	Benz Tran	RPN (BSL)
5.	Dr. Omar Elahi	Medical Director
6.	Amarjot Boughan	Nurse Practitioner
7.	Jody Clarke	Director of Programs & Services
8.	Rosa Manuela	Personal Support Worker (PSW)
9.	Dora Quarshie	RPN Program Lead Restorative Care
10.	Behije Mulaj	Housekeeping & Laundry Manager
11.	Kristine Nielsen	Resident Advocate and Programs Manager
12.	Michael Wells	Director of Human Resources
13.	Pastor Richard Bodini	Pastor
14.	Rohit Sharma	Dietary Manager
15.	Pamela Whiteley	Activation Aide
16.	Neha Thapor	RPN
17.	Mebratu Gebru	Spiritual Care Coordinator
18.	Michelle VanBeusekom	Family Council Chair
19.	Arleen Downer-Reid	CQI & Risk Mitigation Specialist
20.	Luyen Loc	IPAC Lead

21.	Chloe Turgeon	Registered Dietician
22.	Case Geleynse	Chair of the Board
23.	Ingrid Malmberg	Emergency Management Coordinator
24.	Glenda McKay	Volunteer Coordinator
25.	Amanda Ally	Training and Development Coordinator
26.	Janet Stephens	Housekeeping Aide
27.	Kaitlan Laviolette	BPSO Nurse Practitioner
28.	Puneet Gill	RAI Coordinator
29.	Sujitha Jayakumar	Human Resources Manager
30.	Gina Hoolveld	Food Service Worker
31.	Gus Van Weert	Resident Council Chair
32.	Omer Rogers	Senior Manager of Environmental Services
33.	Manpreet Jhita	ADRC Skin and Wound, Falls Lead
34.	Jacquie Vezeau	Dementia Care and Services Lead
35.	Dermal Dias	Residents' Council Co-Chair
36.	Amina Stan	Housekeeping Laundry Aide
37.	Cheryl Abid	Activities Aide
38.	Pranav Amin	Pharmacist

RESIDENT AND FAMILY ANNUAL SURVEYS

A resident satisfaction and family experience surveys are prepared annually, in consultation with the Residents' and Family Councils. Once consultations are completed the survey is distributed. The residents and family are given time to complete the survey.

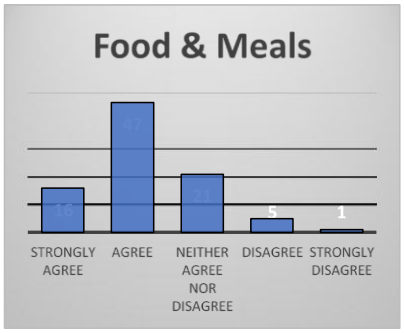
Once the data from the survey are in they are distributed to Family Council and reviewed with the residents. At this time an action plan is developed. Residents' Council then provides feedback and documented for input into the action plan. Family Council holds meetings to give feedback with regards to their input into the action plan. The action plan is then reviewed with both Residents' and Family Councils for a final review, and adjustments, utilizing the results from the survey, including dates actions were implemented and the outcomes of the actions taken. The action plan is then shared with Resident and Family Councils as well as shared on the CQI board in each

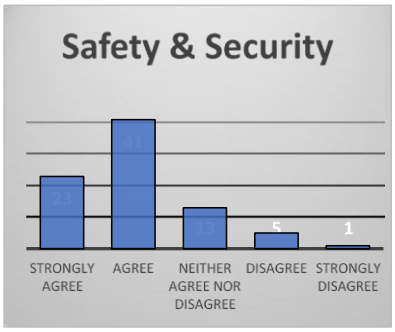
Manor for staff, families, and visitors to view.

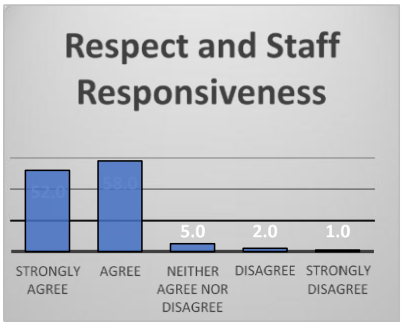
Grace Manor Quality Improvement Completion Dates			
Resident Satisfaction Survey		**Family Experience Survey**	
Survey taken to Residents' Council (draft)	October 30, 2024	Survey taken to Family Council (draft)	November 13, 2024
Date survey distributed to residents	November 12, 2024	Date survey distributed to families	November 20, 2024
Distribution method	Paper and on-line through survey monkey with assistance from volunteers	Distribution method	Via email – online through survey monkey
End date to complete Survey	December 17, 2024	End date to complete survey	December 17, 2024
Duration to complete survey	November 19 to December 17, 2024		November 19 to December 17, 2024
Date results and action plan presented to Residents' Council for review	February 24, 2025	Date results and action plan presented to Family Council for review	February 12, 2025
Date that the 2024 Annual Programs Review and Evaluation held		February 25, 2025 – see attendance list above.	

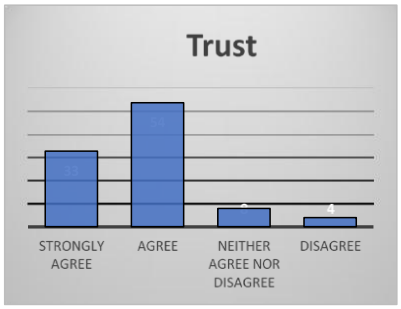
Holland Christian Homes

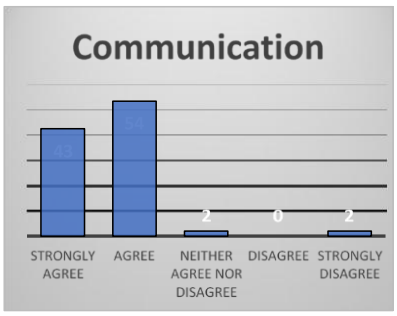
GRACE MANOR FAMILY EXPERIENCE SURVEY RESULTS 2024

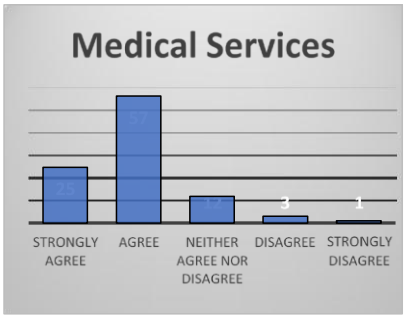


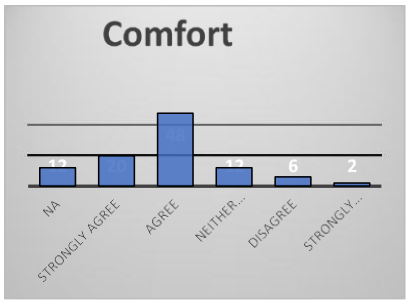


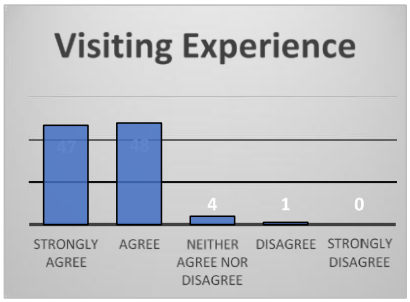


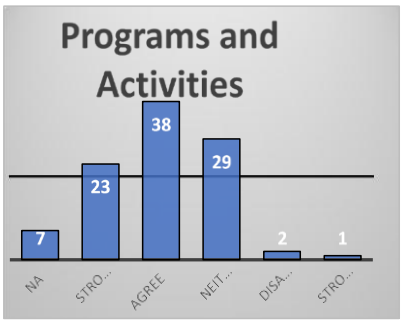


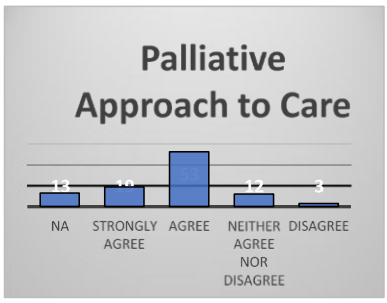


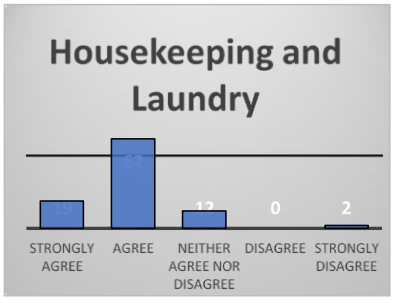




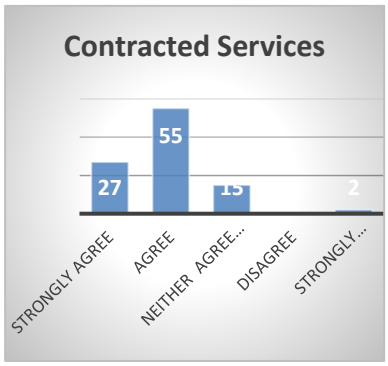









Spiritual Care
16
50
17
2
STRONGLY AGREE
AGREE
NEITHER AGREE...
DISAGREE
STRONGLY...


Contracted Services
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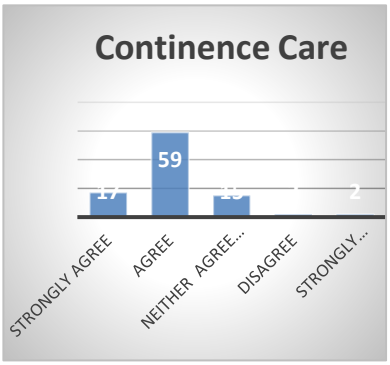
STRONGLY AGREE
AGREE
NEITHER AGREE...
DISAGREE
STRONGLY...


Continence Care
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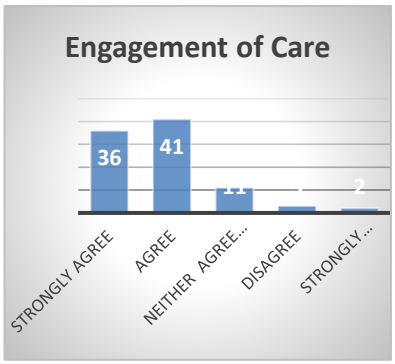
AGREE
NEITHER AGREE...
DISAGREE
STRONGLY...


Engagement of Care
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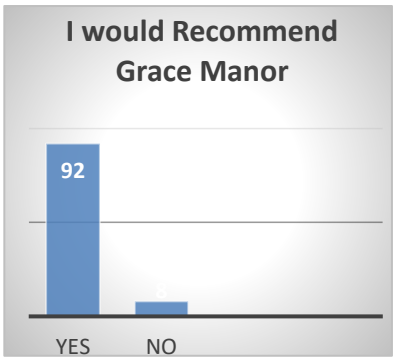
STRONGLY AGREE
AGREE
NEITHER AGREE...
DISAGREE
STRONGLY...

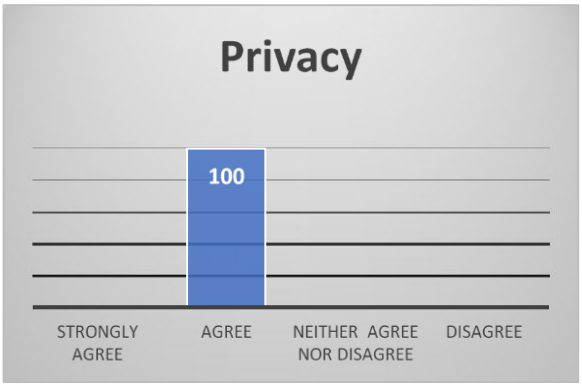

I would Recommend Grace Manor
92
YES
NO

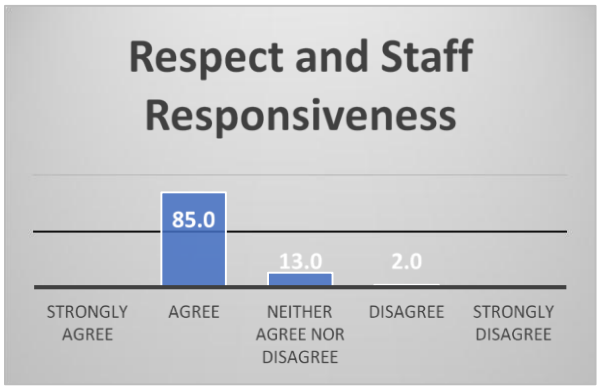
Holland Christian Homes

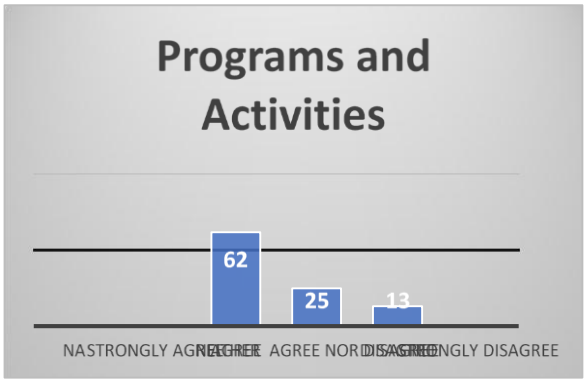
HCH *Here to Care.*

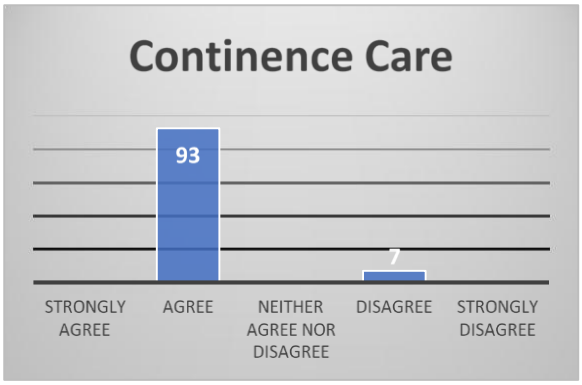
Holland Christian Homes Inc.
7900 McLaughlin Road South
Brampton, ON L6Y 5A7
T. 905.459.3333
www.hch.ca

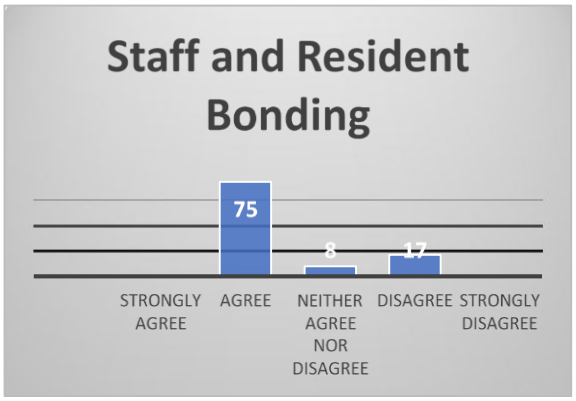
GRACE MANOR RESIDENT SATISFACTION SURVEY RESULTS FOR 2024

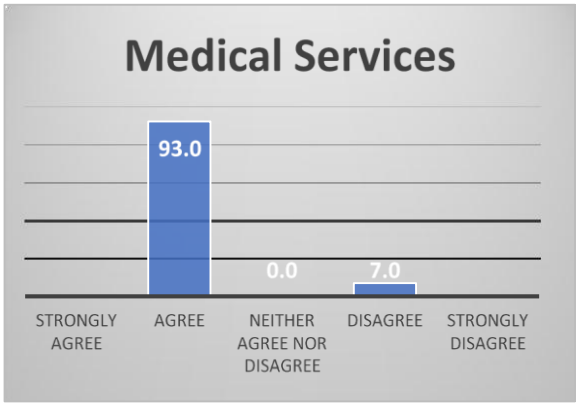


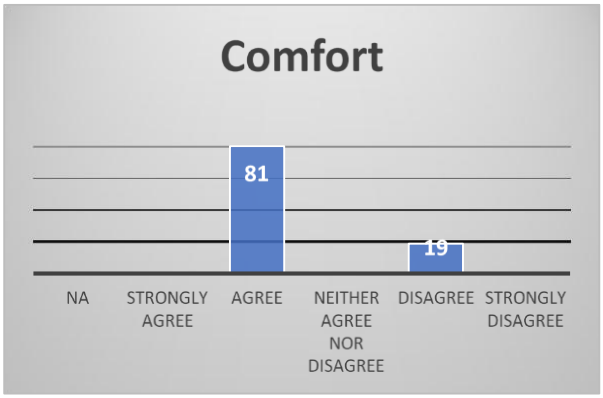


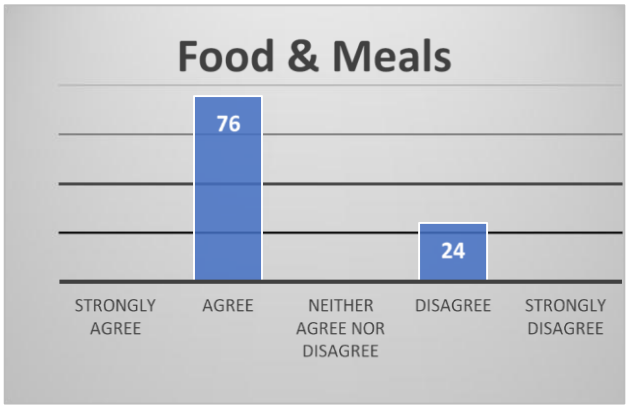


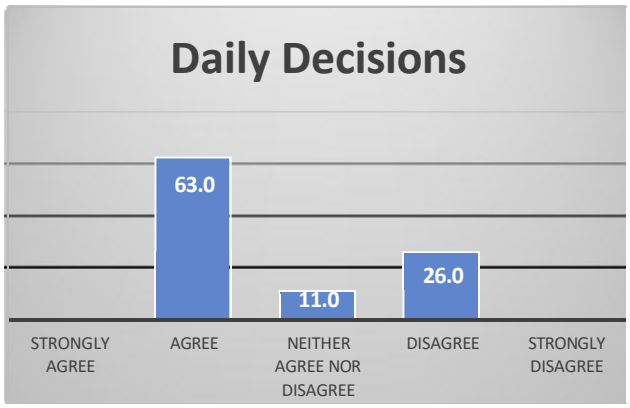


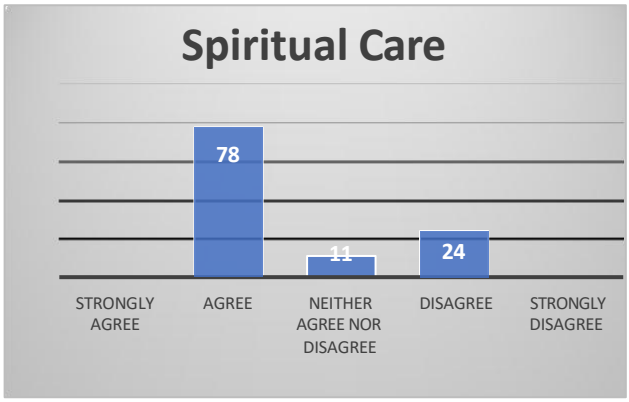


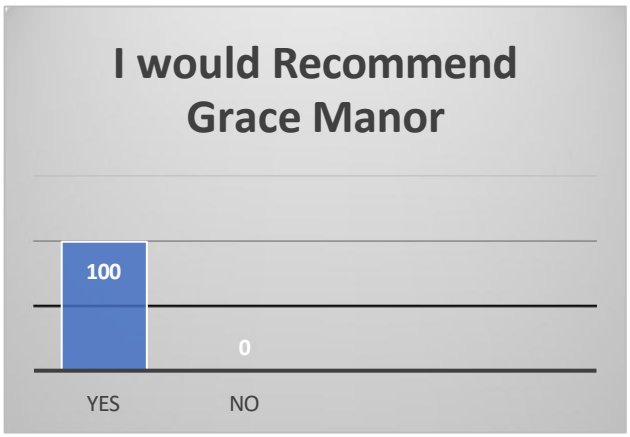












HQO Questions	Agree	Maybe	Disagree
I can express my opinions without fear of consequences	100%	0%	0%
How well staff listen to me	74%	22%	4%
I would recommend this home	100%	0%	0%

Holland Christian Homes

Grace Manor

2023 Resident Satisfaction Survey

2023 Family Experience Survey

2024 Action Plan

Description

Our Grace Manor Annual Resident Satisfaction and Family Experience Survey was started in November 5, 2023 with a deadline of December 15, 2023. The CQI Coordinator tabulated both resident satisfaction and family experience survey results that were then shared on February 4, 2024 with both Resident's and Family Council. It was decided between both councils that a combined action plan would be the approach this year and thus our temporary action plan working group was formed that included residents, family and staff altogether. The survey sample size was the following; 37of the 44 residents (identified as able to complete) participated in the 2023 survey (breakdown of resident numbers:114 on census, 44 identified as able to complete, 24 new admissions not included and 6 empty beds). The 35 of the 84 families participated in the 2023 survey (breakdown of family numbers:114 on census, 24 new admissions not included and 6 empty beds). Residents participated through volunteer assistance to complete the online survey monkey link if needed and families participated with the online survey monkey link directly. Below is the action plan to be completed in 2024 based on the results of the 2023 Resident Satisfaction and Family Experience Surveys.

"I would recommend this home" includes strongly agree and agree (does not include not unsure or neither agree or disagree). Family Experience Survey Results in 2023 was 80% Resident Satisfaction Results were 88%. The 2024 Family Experience results were 92% and the Resident Survey results were 100% and increased significantly.

Areas to Improve	Action Plan (to be carried out in 2024)	Person Responsible	Date Completed	Outcomes of Actions
Personal Care and Services	PSW Staff to be re-educated on the Resident Bill of Rights by May 15, 2024.	Training and Development Coordinator, DRC, ADRC	May 7,2024 completed 100%.	Staff are more aware of the Resident Bill of Rights.
Privacy **Resident Bonding** **Respect** **Daily Decisions**	Revise outbreak Communication to ensure timely communication through Clinic Conex, and website information update by February 2, 2024.	DRC, ADRC, Ed-Co, Tenant Business Services, Resident Advocate, IPAC	Jan 8, 2024, Feb 2,2024, Apr 5 2024, Jun 24, 2024, Jul 03 2024 Dec 24, 2024.	Resident and families were able to have timely outbreak information.
Personal Relationships **Comfort**	Nursing staff to be re-educated on effective communication with residents of varying degrees of cognitive decline and customer service approach using the surge learning module by November 31, 2024.	DRC, ADRC, TDC	Nov.5,2024 97%, Nov 31 2024 100% completed customer service	Staff are more comfortable communicating with residents with various degrees of cognition.
Staff Responsiveness	Staff to be re-educated on the bathing/grooming/oral care/ toileting routines by April 15, 2024.	DRC, ADRC	Completed April 5,2024	Satisfaction increased from 46% to 85% in 2024 for toileting/oral and grooming care.
Trust **Communication** **Visiting Experience**	Re-Educate staff by December 15,2024 on the "Who am I "poster and review how to carry out the areas identified by the resident/ family. Complete at least 25 demonstrations- 5 per RHA	DRC, ADRC, Administrator	Nov 5 and Nov 19, 2024.100% completed Dec. 15, 2024.	Residents receive individual care as staff embrace this knowledge.
	Identify 5 staff (1 from each home area) who can become the HCH Champions of Eden in	ADMIN, DRC, ADRC,	Eden Champion	160 staff were trained as Certified Eden Associates successfully.

	2024. Enroll these 5 staff in the program to become champions in the Eden Alternative approach (timing will depend on Eden management). Hold monthly meetings with the champions to assist in carrying out the "Who am I Demonstrations" and other person-centered Care initiatives.	Department Heads, TDC	name changed to Person Centered Care Champions and then changed to Champions of Change to include RNAO, RAP and Eden all under one umbrella-certification completed on Dec 2,3,4 and 11,12,13 2024.	
	Empower the registered staff with leadership training to ensure enhanced PSW interactions with residents to promote informal ex-change and reduce loneliness through surge learning by November 15th, 2024.	DRC, ADRC, TDC	Nov. 5, 2024 87% completed and 100% complete on surge learning Nov 15, 2024.	Staff completed training and expressed more comfort with leadership on neighborhoods. We also had 160 staff completed the Eden Associate Certification.

	Review the lost items protocol during registered and laundry staff meetings by April 30, 2024.	DRC, ADRC, Laundry Housekeeping Manager	Completed April 2, 2024	Lost items were reduced and resident satisfaction results were 100% in 2024 an increase from 2023.
	Remind the PSW staff to double check clothing labels before dressing residents as per job description during monthly staff meetings by April 2, 2024.	DRC, ADRC,	April 2, 2024 Completed	Lost items greatly reduced however, some clothing items found in another resident room. Training and audits for the laundry and PSW staff will be increased.
Programs/ Activities **Spiritual Care** **Participation**	Create an ADHOC Men's Committee to find out what they would like to do per neighborhood and increase programming specific for men and gather those with similar interests such as baseball, car racing by June 15,2024	RA, Activity Coordinator, Spiritual Care Coordinator, Recreation Staff	March 1, 2024 completed	Men's group was very well received by residents' events such as watching sports such as Superbowl, men's cart activity as evidenced by attendance records and increased level of engagement scores.
	Implement a monthly King or Queen for a day program incorporating "all about me," "who am I" by April 20, 2024.	Activity Coordinator, Rec staff	Completed March 1, 2024	Resident and families expressed positive feedback and increased level of engagement as evidenced through attendance records. Residents served as King or Queen for the day were very engaged and happy.
	Implement independent purposeful engagement activity kits to reduce boredom on each resident home area by May 15,2024.	Dir of programs, Recreation, Admin	May 15, 2024 completed and ongoing	Kits well received by residents as evidenced of engagement score, that we extended the idea further working collaboratively with Family Council to create better kits with more activity themes to increase joy and reduce boredom.
	Enhancing resident spotlight (Old legacy) program, to be person centered quarterly evidence of it on calendar of events by April 15, 2024.	Dir of Programs, Recreation, Admin	Completed April 2, 2024	Residents and staff were able to know specific residents more personally enhancing personal relationships, improving overall respect for each other.
	Hire a Spiritual Care Coordinator to ensure understanding of resident spiritual needs/ preferences and enhance the overall delivery	Dir of Programs, Admin, HR	new SSC onboarded April 10, 2024.	May 1, 2024 edition of "Tie that Binds" shared information on himself SCC, information at Residents' and Family Councils March 18, 2024 then April 10, 2024, Spiritual

	of spiritual programming to meet standards of FLTCA by April 15, 2024.			Care Coordinator commenced his position. Bible session study reflection added May 20, 2024.
	Change the Resident Advocate role to include/ Activity Program Manager to provide additional oversight to provide meaningful activities to the activity programming by February 20, 2024.	Dir of Programs, Admin, HR	Completed February 20, 2024	Increase of meaningful engagement activities as evidence of attendance and action plan program goals achieved.
	Implement opportunities for residents to assist pre and post meal set up by April 15 ,2024.	RA / Activity Coordinator, Dietary Manager	Completed April 15, 2024 and reviewed again to reinforce on July 24, 2024.	Four residents continue to enjoy with meal preparation such as saying prayer before meals and folding clothing covers as evidence in engagement attendance. Revisit in 2025 with our newly hired Dementia Care Lead. In collaboration with Family Council kit project to implement dining related activities in 2025.
Meal Service **Snacks** **Dietitian**	Re-educate residents on spice caddies through Resident Council & Food Committee Meeting by April 15, 2024.	Dietary Manager	Completed April 22,2024 and October 28, 2024	2023 survey results were 58% this increased to 80% in 2024. Resident got increase of flavors tasting of food.
	Provide Steak Option during BBQ months in summer to increase satisfaction by August 30, 2024.	Dietary Manager	Completed July 2, 2024 and August 1, 2024.	Resident feedback most did not select steak option as it was difficult to chew and selected the other BBQ option choice. Was not successful.
	Enhance Dining experience through improved ambience such as music, décor & greeting residents as they enter by March 15, 2024.	RA/ Activity Coordinator/ Dietary Manager	Completed March 15, 2024. Sound system for dining completed	Resident and families are able to enjoy more enhanced dining experience. Further improvements to décor will continue for themed fun events.

			Sept 23 2024.	
	Ensure Taste caddies are regularly replenished and placed on tables by March 15, 2024.	Dietary Manager	Completed March 15, 2024	Residents provided feedback and additional items were added to spice caddies in March such as salt and pepper.
Accommodation **Housekeeping** **Laundry**	Inform residents & families through memo and at admission that the bedside table has a top-drawer lock option and key provided by April 30, 2024.	Laundry Housekeeping Manager	Completed April 22,2024 reviewed with RC and FC and again reviewed July 29, 2024. Memo Aug. 22, 2024 mailed out to POA.	POA received memo through the billing which families felt it was a successful way to communicate this information. More residents using this drawer for storing personal and monetary items.
	Retrain Laundry Staff to deliver laundry to the correct room through staff meeting by April 30, 2024.	Laundry Housekeeping Manager	April 30, 2024 Completed	2024 survey results 100%.
Resident Advocate Palliative Care /End of Life	Supply Care Plan at every 6-week, post admission care conference, and as requested at any time.	RA/PM, DRC, ADRC	March 20, 2024 completed	Some residents /families indicated it was not necessary to provide care plan and declined but all were provided with the option to receive at any time. Survey results satisfaction increased from 69% in 2023 to 82% in 2024.
Medical Services	At the admission and annual care conferences, families and residents will be reminded of the	NP	Completed February 4, 2024	Residents and families are more aware of how to contact MD, requests in the MD binder have increased and a reduction of concerns raised in this regard.

	process to speak with the physician or nurse practitioner.			
	At the quarterly MAC-PAC meeting in February 2024, physicians will be reminded to communicate with residents and families about significant changes to resident's health status (Labs, medications, diagnosis).	NP, Admin	Completed February 20, 2024.	Residents and family's feedback on survey result comments of MD not providing updated medical information has decreased in 2024.
Volunteer	Enhance volunteer recruitment efforts to increase volunteer base & support resident group activities by September 20, 2024.	Volunteer Coordinator, RA/PM, Director of Program services	5 Additional volunteers onboarded May 10, 2024. 2 Additional volunteers recruited September 9, 2024. Continue to recruit.	Volunteer recruitment has been slow after Covid19, however recruitment continues survey results in 2024 indicate residents really enjoy the volunteers that help at hymn sing and bingo and welcome more to take them out in the warm summer months. We will utilize summer students in 2025. Volunteer hours continue to increase.
Environmental **Safe & Secure Maintenance**	Improve call bell alert system through purchase & installation of new Spectralink phones on each home area by April 20, 2024.	Director of Environmental Services	Completed April 22, 2024.	Positive feedback from staff that new spectralink phones are more reliable than the older pager style.

Holland Christian Homes

Grace Manor

2024 Resident Satisfaction Survey

2024 Family Experience Survey

2025 Action Plan

Description

Our Grace Manor Annual Resident Satisfaction and Family Experience Survey was launched on November 12, 2024 and November 20, 2024 with a deadline of December 17, 2024. The CQI Coordinator tabulated both resident satisfaction and family experience survey results which were then shared on February 12, 2025 with both Resident and Family Council. Both councils jointly decided in favor of creating a combined Action Plan and formed a temporary Action Plan Working Group including residents, family and staff.

Grace Manor has 120 residents. 32 residents were deemed capable of participating in the survey. Of those, 30 residents who completed the survey (5 completed the online survey with volunteer assistance). 114 families were eligible to complete the survey (based on a 6-month residency requirement). Of those, 43 families participated in the 2024 survey. Family responses were submitted via Survey Monkey.

Below is the Action Plan created by the Working Group in response to the 2024 Resident Satisfaction and Family Experience survey results.

In 2023, 88% of residents responded affirmatively to the statement "I would recommend this home to others". In the 2024 Action Plan, the target for responses to this question was set at 90%. 100% of residents responded affirmatively to this statement in the 2024 survey. The target for 2025 will remain at 100%.

In 2023, 80% of families responded affirmatively to the same statement. The target established in the 2024 Action Plan for responses to this statement was 85%. 92% of families responded affirmatively to this statement in the 2024 survey. The target for 2025 will be 100%.

Areas to Improve	Action Plan (to be carried out in 2025)	Person Responsible	Date Completed	Outcomes of Actions
Personal Care and Services • **Daily decisions** • **Personal relationships** • **Privacy** • **Trust** • **Comfort and Facilities**	Educate all Care Partners, that residents and family can access the first available care partner and not just those assigned to the resident. This education will be provided through in-person huddles and learning circles and annual mandatory training by November 1, 2025.	Training and Development Coordinator, DRC, ADRC		Care partners will take more time during care routines to engage positively with residents - will improve resident satisfaction resulting in less concerns; improve relationships and confidence in care delivery.
	Re-educate and perform the Hourly Rounding protocol and ensure that all 4 P's are completed for each resident (pain, position, personal needs, personal belongings) audited daily to ensure completion. This will be tracked on the registered staff audit tool check list starting May 1, 2025.	DRC, ADRC, Team Leads		Ensure hourly rounding is completed and that staff are engaging positively with residents and meeting unmet needs.
	Care partnering with residents and honoring resident's daily rhythm of life by empowering choice and dependence, autonomy, and providing dignity, respect and care measured by the Warmth Survey by October 31, 2025.	Dementia Care and Services Lead		Following Eden philosophy helps resident's well-being through honoring resident's daily rhythm of life by empowering choice and dependence, autonomy, and providing dignity and respect.
	All care partners will respect resident choices. This will be achieved by re-educating care partners on the Resident Bill of Rights during the annual training by October 31, 2025.	Training and Development Coordinator, DRC, ADRC		Honoring personal preferences makes residents feel valued and in control of their lives, supporting their dignity and well-being as per Eden philosophy.
	Reducing the institutional appearance of the environment by removing unnecessary PPE stored on walls and relocating them to	IPAC Lead		Reducing visibility of PPE supplies creates a home-like environment.

	designated storage areas while ensuring easy access to care partners by June 30, 2025.			
	Care partners will be empowered to identify environmental factors (such as sound levels, lighting, clutter) during regular hourly rounding. Education will be provided to support this practice by October 31, 2025.	Training and Development Coordinator, DRC, ADRC		Incorporating environmental checks into existing routines helps maintain a calm, safe, and home setting.
Care Partners, Resident Bonding, & Relationships	Share results of the Eden Alternative Warmth Survey with Family and Resident Councils. The survey will also be provided to all residents, families and care partners to determine Grace Manor's culture baseline by June 30, 2025.	Dementia Care and Services Lead		Care Partners, residents and families in all neighborhoods will be more aware of how Grace Manor will be working towards creating a caring, inclusive environment empowering resident's independence, choice and promoting well-being based on actin plan after survey results.
	Add a section within the Annual Mandatory training sign off to identify care partners that speak other languages to serve as internal interpreters to residents whose primary language is not English/French. Once 100% of care partners complete the training, create a list and provide to the leadership team by October 1, 2025.	Training and Development Coordinator		List of care partners who can serve as translators for residents whose first language is not English. Use of translation tools or services will improve communication between residents and care partners resulting in individualized, holistic resident care. Residents will have access to care partners who can understand their language, impowering communication.
	Provide enhanced communication training to ensure care partners communicate effectively and empathetically with residents, speaking only English when providing care for a resident unless the resident speaks another language for which the care partners also speaks. Training to be delivered during neighborhood huddles and through monthly onboarding education to start April 1, 2025.	Training and Development Coordinator		Resident and care partners will not feel they have been left out due to not understanding what is being said. Respectful communication.

	Foster deep meaningful connections with Volunteers to enhance resident experience and engagement by September 31, 2025	Volunteer Coordinator		Residents will have increase meaningful engagement through visits with volunteers.
	Utilize the Champions of Change, Certified Eden Associates and Leadership to create a Pilot Neighborhood Action Plan in response to the findings of the completed Eden Warmth Survey by June 1, 2025.	Dementia Care and Services Lead		There will be an action plan to drive Eden change and making Grace Manor a more person-centered home.
	Educate and inform all care partners, residents and family care partners on the Eden journey. Education will include how we can all create a caring, inclusive environment empowering resident's independence, choice and promoting well-being. This will be accomplished through hosting huddles, posters, hand-outs, information boards, Tie that Binds article, Pulse newsletter, etc. by August 30, 2025.	Dementia Care and Services Lead		Providing education on the Eden journey helps shift the culture from task-based care to person-directed living. It builds a shared understanding among care partners, residents, and families about how to support independence, choice, and community.
Daily Decisions & Communication	All care partners will be educated to use resident-centered language, use active listening and compassionate communication with all interactions through "words make worlds" education. This education will be provided through in-person huddle and learning circles and annual mandatory training by October 31, 2025.	Dementia Care and Services Lead and Training and Development Coordinator.		Care partners will use person-center language.
	An email distribution list will be developed for general mass communication to families by October 1, 2025.	IT Support Team, RAI Coordinator, Administrator		Respectful, flexible communication helps build trust, keeps families well-informed, and supports a positive partnership in care.

Activities and Building Community	Install an Ambient ABBY board an interactive gaming device in each neighborhood. Train care partners on how to engage residents (or encourage residents with self-directed usage) with this board by October 30, 2025.	Resident Advocate and Program Manager		To reduce boredom and loneliness through providing meaningful activities residents can easily engage with.
	Enhance activity levels on weekends by exploring the possibly of reducing intervals between activities increasing by two activities and empowering care partners to create meaningful engagement during non-scheduled times on the weekend by July 30, 2025.	Resident Advocate and Program Manager		To reduce boredom and loneliness between activity downtimes through providing meaningful activities residents can easily engage with.
	Complete the Sensory door escape project by October 31, 2025.	Resident Advocate and Program Manager, Administrator		Each resident door will have its own personalized door.
	To foster community engagement of residents by following the Eden model of care and introducing a variety of plants, animals and local community connections by October 31, 2025.	Resident Advocate and Program Manager, Administrator, Dementia Care and Services Lead		Will provide opportunities to maximize social connections by pairing residents with similar interests during group activities; will foster social connections. Engagement with community connection, plants and animals will enhance resident interaction, sensory stimulation and reduce boredom, and loneliness.
Engagement in Care	Enhancing the person-directed care model using the Eden Alternative throughout our community. Identify a community neighborhood to pilot culture change creating	Administrator, Dementia Care and Services Lead		Improve well-being to all residents and community care partners. Pilot neighborhood is chosen, projects, new ideas can be challenged and trialed before rolling out to entire community.

	home and create an action plan as an appendix by June 1, 2025.			
Visiting Experience	Provide knowledge to resident and families of designated spaces available for visiting enjoyment by June 1, 2025.	Behavior Support Lead		Residents, families and care partners to be more aware of designated spaces that family and friends can visit in private and enhance the visiting experience.
Spiritual Care	Offer more accessible religious activities for non-verbal or less mobile residents, by offering interactive prayer sessions or guided spiritual exercises or the audio bible devices (in different languages) by June 30, 2025.	Spiritual Care Coordinator		To increase participation in religious and spiritual programs.
Meal Service, Snacks, & Dietician	Organize a food show for residents, families and care partners to taste food samples for recommendations for new menu by July 31, 2025.	Dietary Manager		Residents and families will have an enhanced opportunity in making food choices.
	Educate all care partners on future environment that is calm and welcoming to ensure resident well-being and encourage families to engage during meals by June 30, 2025.	Dietary Manager, DRC, Dementia Care and Services Lead		Residents and families will enjoy a dining experience together and families will feel welcome and encouraged to participate.
Accommodation • **Housekeeping** • **Laundry**	To reduce misplaced lost and mixed-up clothing, hold care partner huddles with re-training monthly on each neighborhood. First huddle to be held April 8, 2025 and ongoing after that.	Housekeeping and Laundry and PSW's care partners.		Reduce incidents of misplaced items, and decrease the number of concerns received due to lost clothing.
	Monthly audits will be done on resident clothing delivery to ensure items have been correctly delivered to the right resident. 5 residents per unit each month will be audited starting April 1, 2025 and ongoing after	Housekeeping and Laundry Manager		Eliminate concerns regarding lost and/or damage items. Increase attention to detail when handling laundry, including pre- washing checks for stains and proper washing procedures for delicate items and putting into right resident room to decrease incidents.

	that.			
Resident Advocate, Palliative Care & End of Life	Implement the RNAO Palliative and End-of-Life clinical pathways at Grace Manor by November 31, 2025, by coordinating with key stakeholders, providing necessary resources, and ensuring care partners training and readiness for full integration.	Nurse Practitioner, Spiritual Care Coordinator, DRC		Care partners will ensure to capture appropriate information for End-of-Life care.
	Re-engage 100% of end-of-life volunteers by ensuring they complete their training by April 30, 2025, through targeted outreach and providing necessary resources to support training completion.	Volunteer Coordinator		Educated volunteers will continue to be aware of the care expectations at End of Life.
Environmental, Safe and Secure Maintenance	Families will be encouraged to inform registered care partners as the first point of contact on the neighborhood if any repair needs to be completed. Registered Care Partners will then place a request to repair in the “Click Maintenance” portal by April 1, 2025.	Director of Environmental Services, DRC		Maintenance and repairs are reported, fixed and/or replaced in a timely manner.
Medical Care MD/NP	Provide information to resident and family councils about communication process of the MD/NP by May 30, 2025.	Administrator, Nurse Practitioner		Enhance residents and family’s knowledge about MD/NP communication process.
Continence	Complete check-in audits with residents to review satisfaction with continence care and address any concerns by auditing 5 residents per month. First 5 residents to be audited by April 30, 2025, then ongoing monthly.	Restorative Care Lead		Enhanced review of care products to ensure they are meeting individual resident care needs and satisfaction.
Contracted Services	Informed resident and family of contracted services to improve their understanding by May 30, 2025 with move in resource package	Resident Advocate and		Families and residents will better understand contracted services available.

	and annual care conference huddles. Families are empowered to follow through with information given for their signed-up services.	Program Manager		