Holland Christian Homes

HCH *Here to Care.*

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

Faith 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 (Grace 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 and Family Experience Surveys, 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

Faith 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 2023, 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. A resident & tenant experience committee 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.

Faith 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, as determined by the Holland Christian Homes' Board of Directors:

- 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

Access and Flow

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)	24.23	21.00	Want to improve by at least 3%.	William Osler Health System, Behavioural Support Ontario, Neurobehavior Team, Ontario Health At-Home

Change Ideas

Change Idea #1 Improve communication within the home through the use of SBAR Tool

Methods	Process measures	Target for process measure	Comments
Education to be provided by DRCs to registered staff and track training progress	Number of staff trained on the use of SBAR tool	100% of registered staff trained on SBAR by December 31, 2025.	

Change Idea #2 Utilize bladder scanner as a diagnostic tool to prevent ED transfer in individuals with urinary retention

Methods	Process measures	Target for process measure	Comments
Number of registered and medical staff trained on the use of the bladder scanner	Number of registered and medical staff trained on the use of the bladder scanner	100% of registered and medical staff trained on the use of the bladder scanner by December 31, 2025	

Change Idea #3 Build nursing care capacity within the home by increasing access to IV therapy in the Long Term Care setting			
Methods	Process measures	Target for process measure	Comments
Train registered staff on IV insertion and maintenance	Number of registered staff trained on IV maintenance, and number of registered staff who can insert IVs.	100% of registered staff will be trained on IV maintenance, and maintain a minimum of at least 5 registered staff who can insert IVs by December 31st, 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	To continue with having all non-union staff trained for diversity, equity and inclusion.	Rainbow Health, Ontario Health

Change Ideas

Change Idea #1 Mandatory diversity, equity and inclusion education in 2025 for onboarding

Methods	Process measures	Target for process measure	Comments
Using online training that includes topics of diversity, equity and inclusion for all non-union staff	Percentage of new hire non-unionized staff that complete Diversity, equity and inclusion training	New non-unionized staff to be trained on diversity, equity and inclusion by December 31, 2025.	Total LTCH Beds: 160 Meeting LSAA local obligations

Experience

Measure - Dimension: Patient-centred

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?"	O	% / LTC home residents	In house data, NHCAHPS survey / Most recent consecutive 12-month period	94.00	100.00	We want to improve by 6%.	

Change Ideas

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

Methods	Process measures	Target for process measure	Comments
Training to be provided by Dementia Care and Services Lead on person directed care and EDEN Philosophy for all care partners.	Percentage of care partners trained on person directed care and EDEN Philosophy	100% of care partners trained with person directed care and EDEN Philosophy by December 31, 2025	Total Surveys Initiated: 100 Total LTCH Beds: 160

Measure - Dimension: Patient-centred

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".	O	% / LTC home residents	In house data, interRAI survey / Most recent consecutive 12-month period	97.00	100.00	100% of residents to respond positively to the statement indication of resident satisfaction with care being received. EDEN Alternative Philosophy to be a corner stone for training in the current year in order to achieve 100% response in the 2025 Resident Satisfaction Survey.	

Change Ideas

Change Idea #1 Incorporate all care partners on person directed care and EDEN Philosophy education.

Methods	Process measures	Target for process measure	Comments
Education to be provided to staff by Dementia Care and Services Lead on person directed care and EDEN Philosophy for all care partners	Percentage of care partners trained with person directed care and EDEN Philosophy	100% of care partners trained on person directed care and EDEN Philosophy by December 31, 2025	Total Surveys Initiated: 100 Total LTCH Beds: 160

Safety

Measure - Dimension: Safe

Indicator #5	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of LTC home residents who fell in the 30 days leading up to their assessment	O	% / LTC home residents	CIHI CCRS / July 1 to Sep 30, 2024 (Q2), as target quarter of rolling 4-quarter average	16.64	14.00	Reduced by 2.6%.	RNAO, William Osler Health System, Behavioural Support Ontario, Silver Fox Pharmacy - Pharmacist, Ontario Health At- Home, Achieva Health, Home Medical Equipment

Change Ideas

Change Idea #1 Retrain all staff on purposeful hourly rounding

Methods	Process measures	Target for process measure	Comments
Fall Lead and Champions of change to provide education to all staff on purposeful hourly rounding	Number of interdisciplinary team members that have received purposeful hourly rounding training.	100% of interdisciplinary team trained by December 31, 2025.	

Change Idea #2 Audit the process of purposeful hourly rounding to evaluate the quality of rounding.

Methods	Process measures	Target for process measure	Comments
Falls Lead will conduct 5 audits on all shifts per month	Number of audits completed per month by the Falls Lead	100% of purposeful hourly rounding will be completed by November 30, 2025.	

Measure - Dimension: Safe

Indicator #6	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	13.39	13.00	Provincial average in 2024 was 20.4. Faith Manor is well below this target and continues to take measures to ensure the appropriate use and prescribing of antipsychotic medications. Maintain below provincial average.	William Osler Health System, Neurobehavioural Team, Silver Fox Pharmacy - Pharmacist, Behavioural Support Ontario, Physiatry, Physiatry, TRCs

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 Antipsychotic Reduction Committee will review monthly residents that are on antipsychotic medication to determine proper indication for usage and consideration of alternative interventions when warranted.	Number of residents reviewed by the Antipsychotic Reduction Committee	100% of new admissions and current residents that are on antipsychotic medications will be reviewed by interdisciplinary Antipsychotic Reduction Committee to determine proper indication for usage and consideration of alternative interventions by March 31, 2026	

Quality Improvement Plan (QIP)

Narrative for Health Care Organizations in Ontario

April 1, 2025

Holland Christian Homes

Ontario Health

OVERVIEW

Faith 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 (Grace Manor) and six apartment towers. The mandate of Faith 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, 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 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 feeding, bathing, toileting and getting in and out of bed. In order to meet these increased acuity levels, we continue to utilize our community partners to ensure on-going continuum of care.

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). We will focus on potentially avoidable emergency room transfers, the use of antipsychotic medications without a prescribed diagnosis, and residents' satisfaction with communication, falls prevention as well as an indicator on training on Equity, Diversity and Inclusion targets. The established priorities, targets, and activities will take into consideration how we can best improve resident quality outcomes and safety. Some examples of this include our on-going efforts to reduce falls with continued purposeful hourly rounding for all of our residents. We also 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.

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 & the Ontario Health Team 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 (i.e. dental, foot-care, pharmacy, physiotherapy, banking, hairdresser e.t.c.). Our memberships with AdvantAGE Ontario, and EDEN Alternative (person directed care) are 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. Faith 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.

Faith 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 machines, 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.

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

Lastly, we recognize the importance of advanced care planning. We 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 staff 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 at executive level care partners 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 committed to 100% of all care partners to complete Diversity, equity, inclusion training by December 31, 2025. All care partners will 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 is displayed in the entrance of the 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 includes antiracism, First Nations, Inuit, Metis, and Urban Indigenous based on Service Accountability Agreement obligations.

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.

Faith 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 Home 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 staff 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 staff members 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 Assistance Program that provides onsite counseling support and shares important resources for 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 staff. Action plan includes but is not limited to recognition events, manager/supervisor open door policy, succession planning, staff 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 Faith 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 on February 26, 2025 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, dietitian, Family Council and Residents’ 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 are 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 Faith 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, residents and families are engaged through this process.

PROVIDER EXPERIENCE

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HCH values the opinions and suggestions of staff for improving the work environment while enhancing resident care at Holland Christian Homes. In addition to the Workplace Social and Wellness Committee, HCH invites all staff 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 staff members as members of these committees brings an important perspective, allowing their voice to be heard, as key members of the HCH family.

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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 staff. Action plan includes but is not limited to recognition events, manager/supervisor open door policy, succession planning, staff wellness committee to further enhance our employee satisfaction.

SAFETY

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 Long-Term Care homes and Seniors Services programs, and builds upon our mission, vision and values.

The Long-Term Care Resident Safety Plan is developed in conjunction with the 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 accredited with no recommendation until 2027 meeting our LSAA Agreement obligations.

This document articulates the go forward strategy for quality and safety at the 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 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.

Faith 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 and Spasticity Clinic. 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, staff and families. The IPAC Lead ensures that enhanced precautions are strictly observed and carried out by all department staff at all times. This is managed through various activities daily, monthly or annually as required.

CONTACT INFORMATION/DESIGNATED LEAD

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Administrator
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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

Sellinor Ogwu, Administrator /Executive Director

Arleen Downer-Reid, Quality Committee Chair or delegate

Other leadership as appropriate

QIP PLANNING CYCLE AND PRIORITY SETTING PROCESS

Faith Manor has developed QIPs as part of the annual planning cycle since 2015, with QIPs submitted to Health Quality Ontario (HQO) every April. Faith 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 Satisfaction, Family Experience, and staff engagement 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, who then shares with the Care Committee of the Board.

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

Every staff has a responsibility for CQI. Faith 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:

Sellinor Ogwu
Administrator
sellinor.ogwu@hch.ca
905-463-7002 ext.5356

****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 suggestions 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, AdvantAGE, and 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 inhouse 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 workplace 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 mass 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 make adjustments 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 is 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

<u>Evaluating a goal/improvement initiative</u>

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 your 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 take action 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 quarterly 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. We also welcome and embrace resident and family involvement in our committee(s).

Evaluation (Monthly, Quarterly, Annual):

Progress is evaluated monthly during our committee working groups where all CQI activities for all programs and services offered within Faith 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 Faith 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 – OUR 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. 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 Faith 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 Councils, Family Councils
- Huddles at change of shift
- Use of Champions to communicate directly with peers

Quality Improvement Plan / Progress Report on the 2024/25 QIP

See Below

Access and Flow | Efficient | Optional Indicator

	Last Year		This Year		
Indicator #5 Rate of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents. (Faith Manor Nursing Home)	**31.31** Performance (2024/25)	**26** Target (2024/25)	**24.23** Performance (2025/26)	**22.61%** Percentage Improvement (2025/26)	**21** Target (2025/26)

Change Idea #1 0 Implemented □ Not Implemented

Improve communication within the home through the use of SBAR Tool

Process measure

- Number of staff trained on the use of SBAR

Target for process measure

- 100% of registered staff trained on SBAR by December 31, 2024.

Lessons Learned

Goal was to prevent ED transfers and have residents to continue to receive care in the home. SBAR prepared the nurse to relay proper information to doctors in order to make proper medical decisions and avoid unnecessary transfers. We did not reach our target based on our current performance for the year 2024. We will continue to work on this indicator in the current year.

Change Idea #2 0 Implemented □ Not Implemented

Utilize recently purchased bladder scanner as a diagnostic tool to prevent ED transfer in individuals with urinary retention

Process measure

- Number of registered and medical staff trained on the use of the bladder scanner

Target for process measure

- 100% of registered and medical staff trained on the use of the bladder scanner

Lessons Learned

This equipment assisted care provided to residents and avoid unnecessary transfers.

Change Idea #3 0 **Implemented** □ **Not Implemented**

The home will arrange a situational care conference following each hospital return to review and update goals of care if required to avoid future unnecessary hospitalizations.

Process measure

- Percentage of situational care conferences held

Target for process measure

- 100% of residents who have been transferred to hospital will receive a situational care conference within one to two weeks of their return.

Lessons Learned

It was difficult to measure this goal as most residents that needed to go to hospital had medical needs that would not be cared for here. For example, g-tube insertion, dialysis line complications.

Comment

We were not able to meet our set target for the year. We will continue to work on this indicator in the coming year and improve on our numbers.
Jan to March - There was a decrease of 10 ED transfers this quarter compared to last quarter!
6 residents went to the ED 2 or more times in the past quarter (2 residents made up 8 ED transfers due to g-tube issues)
April to June - 6 residents went to the ED 2 or more times in the past quarter (3 residents made up 9 ED transfers)
July to Sept - 6 residents went to the ED more that 2 time in the past quarter (sometimes for the same issues – 2 of these individuals passed away).
Oct to Dec -
LHIN Data Q2 2023-2024 to Q1 2024-2025: Avoidable ED transfer rate is 24.8 for the Central West LHIN (per 100 residents)
Faith Manors avoidable ED transfer rate in this reports is: 29.1 (per 100 residents) - slightly above CW average.
However, quarterly rates are trending down:
Q2 2023/2024: 13.2
Q3 2023/2024: 7.4
Q4 2023/2024: 7.1
Q1 2024/2025: 8.3
The top reasons for transfer to the ED in the CW LHIN are:
#1: Falls
#2: Pneumonia
#3: Mental Health Disorder
#4: CHF
#5: Septicemia

This quarter half of the resident transferred to the ED were admitted.
The top avoidable reasons for transfer this quarter were Sepsis (5 - urosepsis, infected graft, osteomyelitis), Injuries post fall (3), Pneumonia (3), CHF (2).
Other reasons for transfer (not avoidable) include: g-tube dislodgement, abnormal labs, bleeding fistula, partial bowel obstruction, UGI bleed, UTI, DVT.

Equity | Equitable | Optional Indicator

	Last Year		This Year		
Indicator #4 Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education (Faith Manor Nursing Home)	**100.00** Performance (2024/25)	**100** Target (2024/25)	**100.00** Performance (2025/26)	**0.00%** Percentage Improvement (2025/26)	**100** Target (2025/26)

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

Incorporate Diversity, Equity and inclusion education in 2024

Process measure

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

Target for process measure

- 100% of non-union staff to be trained on Diversity, Equity and Inclusion (DEI) in 2024.

Lessons Learned

100% of non-union staff received training on DEI. Cultural shift/change starting from the top prepared the executives to be able to be more open, and understanding of the expectations of DEI in the workplace

Comment

Will continue to train any new staff members of non-union staff that would join the organization. This training will be continuous in order to ensure that staff are prepared to provide the care with DEI expectations in mind. Year 2025/26, we will focus on training new non-unionized staff in order to reach the desired percentage target.

Experience | Patient-centred | Custom Indicator

	Last Year		This Year		
Indicator #2 Percentage of resident responding positively to: "what number would you use to rate how well the staff listen to you?" (Faith Manor Nursing Home)	**85.00** Performance (2024/25)	**100** Target (2024/25)	**94.00** Performance (2025/26)	**--** Percentage Improvement (2025/26)	**NA** Target (2025/26)

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

To see an increase in the number of residents responding positively to the question "Do you feel listened to?"

Process measure

- HR will utilize online learning platform (Surge) to offer customer service training

Target for process measure

- 100% of staff trained on customer service in 2024

Lessons Learned

Training completed for all staff on customer service. Incorporated this training in Annual Mandatory Training training in order to reach 100% of staff.

Comment

We continue to provide training to all staff in order to reach our target of 100%. During the up coming year, we will continue to provide this training and incorporate the EDEN Alternative training to all staff across the board in order to reach our target of 100% response to residents on how well they "feel listened to".

	Last Year		This Year		
Indicator #3 Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences". (Faith Manor Nursing Home)	**95.00** Performance (2024/25)	**100** Target (2024/25)	**97.00** Performance (2025/26)	**--** Percentage Improvement (2025/26)	**NA** Target (2025/26)

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

To see an increase in the number of residents responding positively to the question "I can express my opinion without fear or consequences".

Process measure

- HR will utilize online learning platform (Surge) to offer customer service training

Target for process measure

- 100% of staff trained on customer service in 2024

Lessons Learned

There was an improvement in the number of resident responding to the questions on expressing their opinions without fear or consequences. This was more largely due to on-going training on Customer Service that has been embedded in our Annual Mandatory Training

Comment

We will continue to provide customer service training to all staff in order to ensure that the residents are able to be treated with dignity, respect and express themselves without fear or consequences. EDEN Alternative Philosophy will be our focus in improving this number this current year.

	Last Year		This Year		
Indicator #1 Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment (Faith Manor Nursing Home)	**10.83** Performance (2024/25)	**9** Target (2024/25)	**13.39** Performance (2025/26)	**-23.64%** Percentage Improvement (2025/26)	**13** Target (2025/26)

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

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

Process measure

- Interdisciplinary Antipsychotic Reduction Committee will review monthly residents that are on antipsychotic medication to determine proper indication for usage and consideration of alternative interventions when warranted.

Target for process measure

- Utilize the use of the interdisciplinary Antipsychotic Reduction Committee to review 100% of new admissions and current residents that are antipsychotic medications to determine proper indication for usage and consideration of alternative interventions by March 31, 2025.

Lessons Learned

Decreased antipsychotic use in the home, trending below the % of the Provincial average.

Comment

Decreased antipsychotic use in the home, trending below the % of the Provincial average. Although we have seen an increase in the complexity of the resident being admitted to the home as reflected in our DUR continuous work in collaboration with the BSO team as well as our medical team has helped residents to have medications reviews, and discontinue as necessary. DUR indicates lower drug usage as compared to most homes, this is a benefit to those we serve as it reduces medications burdens. Training provided to staff on various topics such as: Medication Administration of Narcotics and Controlled Substances, Medication Administration Practice Reflection Checklist and CNO Practice Standard, how to check eMAR/TAR before administering the medications as per MD/NP orders, processing scriberly orders on time, 8 rights of Med administration etc. has helped to prepare nursing teams to continue to provide medications in a safe way, ensuring the safety of the residents. Although our numbers are higher than what we had planned for as our goal, there has been no fatal outcomes affecting

those we serve.

DATE OF THE ANNUAL PROGRAMS EVALUATION AND WHO PARTICIPATED

Our 2024 Annual Programs Review and Evaluation occurred on **February 26, 2025.**

The following people participated:

#	Name	Position
1.	Tracy Kamino	CEO
2.	Sellinor Ogwu	Administrator
3.	Dr. A.S. Thind	Medical Director
4.	Kamaljeet Sekhon	Director of Resident Care
5.	Olasupo Ayeni	Director of Resident Care
6.	Arleen Downer-Reid	CQI & Risk mitigation Specialist
7.	Pranav Amin	Pharmacist
8.	Sara Umar	Registered Dietician
9.	Valerie Spencer	Personal Support Worker (PSW)
10.	Marilyn Phillipson	Registered Practical Nurse (RPN)

11.	Relinda PeBenito	Registered Practical Nurse (RPN)
12.	Kaitlan Laviolette	Nurse Practitioner
13.	Case Geleynse	Chair Board of Directors
14.	Keith Ambtman	Board of Directors
15.	Donna Wood	Board of Directors
16.	Amanda Ally	Training and Development Coordinator
17.	Michael Wells	Director of Human Resources
18.	Prudence Blake	Specialized Program Team Lead
19.	Pastor Bodini	Pastor
20.	Afnan El-Bogi	Dietary Manager
21.	Magna Fordjour	BSO Lead
22.	Marlene Ragbir	Activation Staff

23.	Jody Clarke	Director of Programs & Services
24.	Romayne Manners	IPAC Lead
25.	Rimel Tina Thomas	Restorative Care Lead
26.	Behije Mulaj	LTC Housekeeping & Laundry Manager
27.	Glenda McKay	Volunteer Coordinator
28.	Omer Rodgers	Senior Manager Environmental Services
29.	Sujitha Jayakumar	Human Resources Manager
30.	Timen Jensen	Residents' Council - President
31.	Ralph Andrews	Residents' Council Co-Chair
32.	Marcy Tacmo	Housekeeping Aide
33.	Ingrid Malmburg	Emergency Management
34.	Barbara Leja-Plaza	Resident Advocate

35.	Peter Dykstra	Family Council Chair

36.	Jacquie Vezeau	Dementia Care and Services Lead
37.	Mebratu Gebru	Spiritual Care Coordinator
38.	Sharmane Martin	Housekeeping & Laundry Supervisor
39.	Guntas Khullar	Activities Aide
40.	Parneet Kaur	Activities Aide

Holland Christian Homes

HCH *Here to Care.*

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RESIDENT SATISFACTION AND FAMILY EXPERIENCE ANNUAL SURVEYS

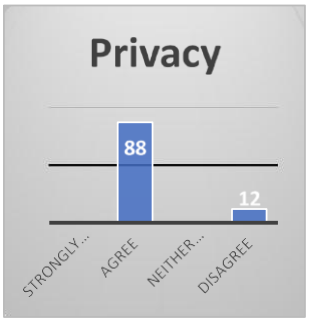
A resident satisfaction and family experience surveys are prepared annually, in consultation with the Residents' and Family Council. Once consultations are completed the survey is distributed. The residents and family are given time to complete the survey. Once the data from the survey are in they are 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' Council and Family council 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 Residents' Council and Family Council as well as shared on the CQI board in each Manor for staff, families, and visitors to view.

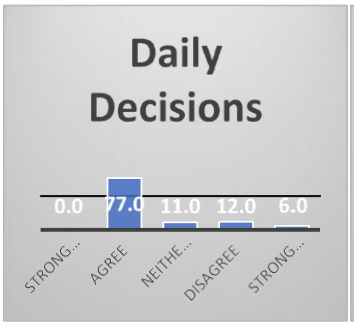
Resident Satisfaction & Family Experience Surveys Communication Dates

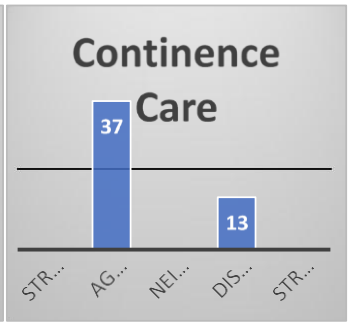
Faith Manor Quality Improvement Completion Dates			
Resident Satisfaction Survey		**Family Experience Survey**	
Survey taken to Residents' Council (draft)	October 21/2024	Survey taken to Family Council (draft)	October 9/2024
Date survey distributed to residents	November 12, 2024	Date survey distributed to families	November 19 & 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	Duration to complete survey	November 19 to December 17, 2024
Date Results and action plan presented to Residents' Council for review and approval	March 12, 2025	Date Results and action plan presented to Family Council for review and approval	March 27, 2025
Date that the 2024 Annual Programs Review and Evaluation held		February 26, 2025 – see attached attendance list.	

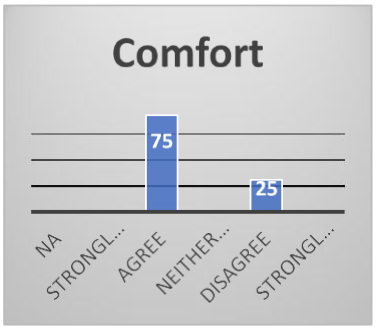
HOW ARE WE DOING AT FAITH MANOR

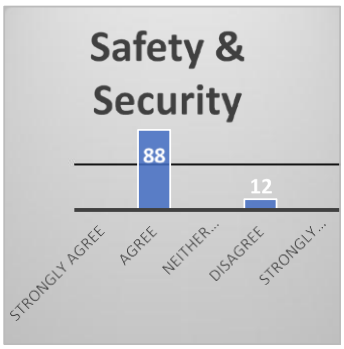
Resident Experience 2024 SURVEY

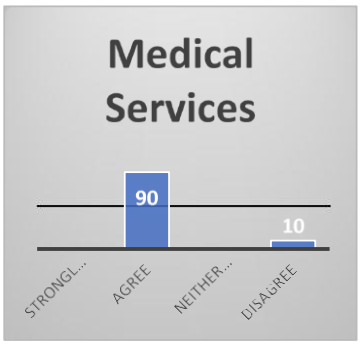


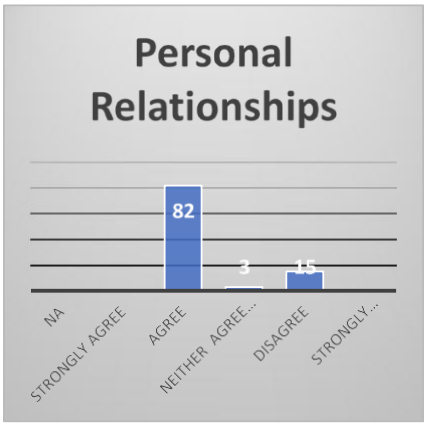


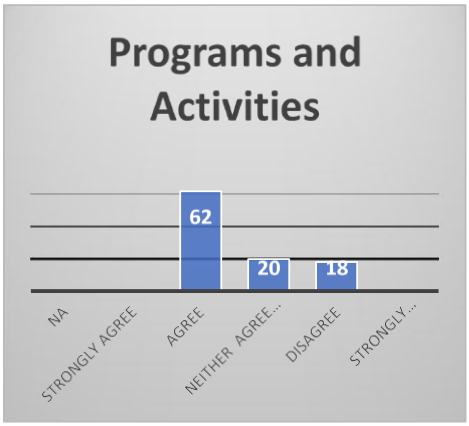


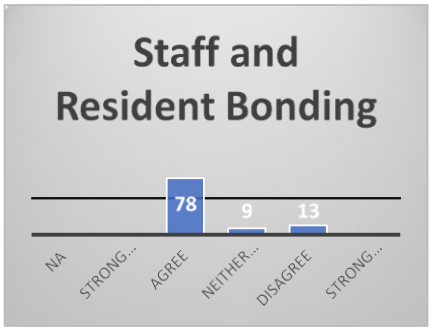


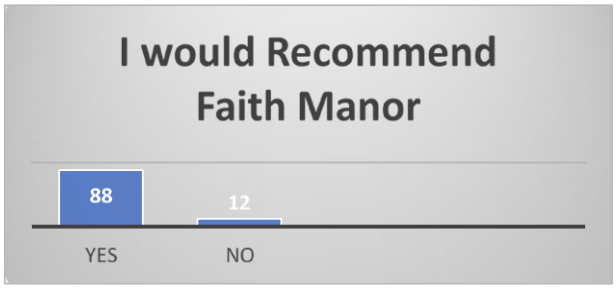








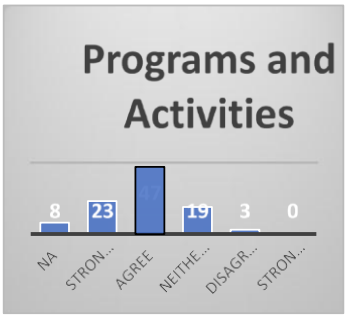


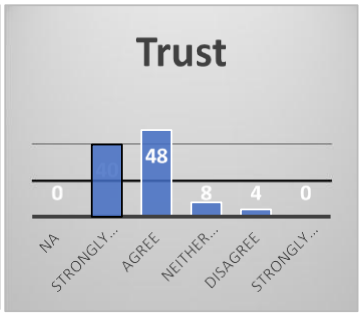


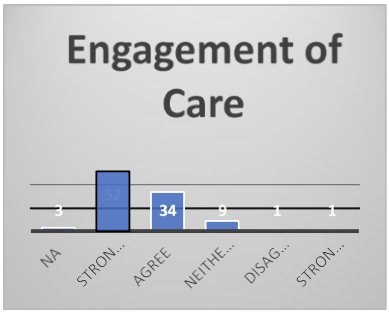
HQO Questions	Agree	Maybe	Disagree
I can express my opinions without fear of consequences	97%	0%	3%
How well staff listen to me	94%	0%	6%
I would recommend this home	88%	0%	12%

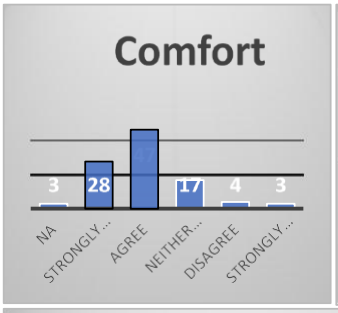
HOW ARE WE DOING AT FAITH MANOR

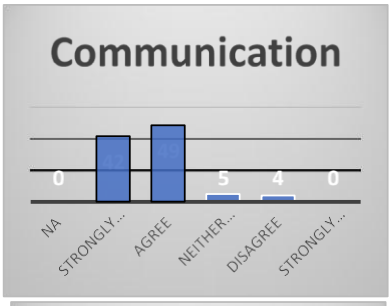
Family Experience 2024 SURVEY

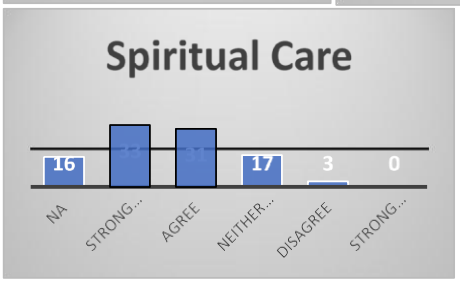


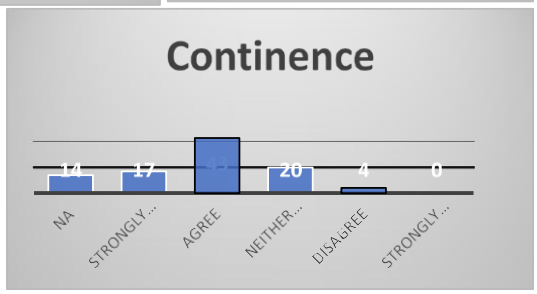


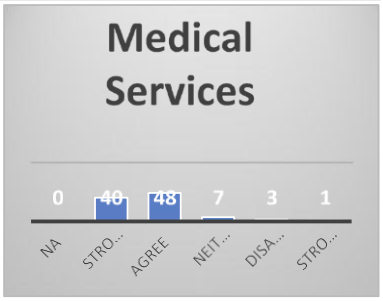


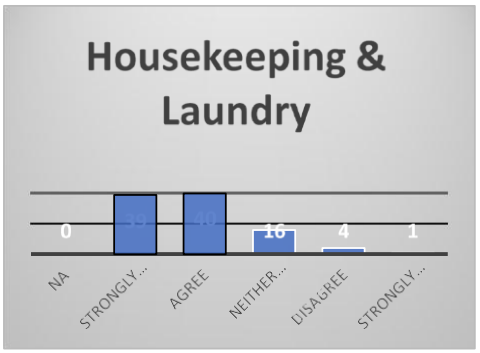


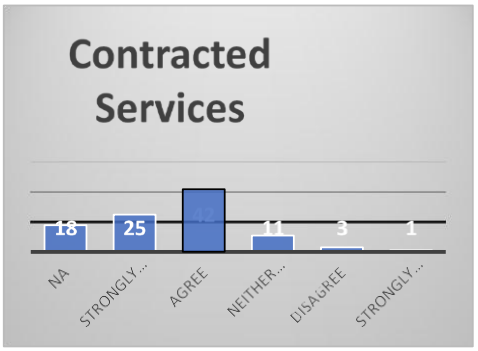


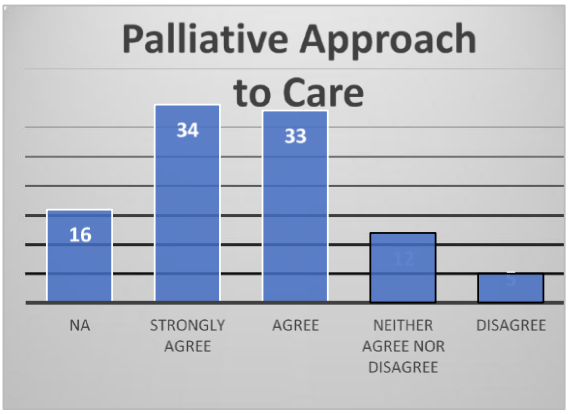


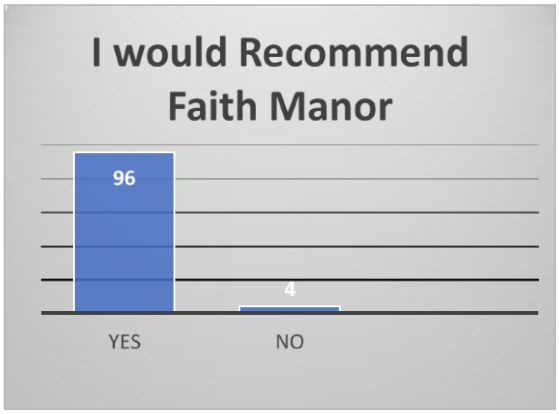












Faith Manor

2023 Resident Satisfaction Survey

2023 Family Experience Survey

Action Plan

(Please do not remove. If you need a copy, please see your administrator)

Areas to Improve	Action Plan (to be carried out in 2024)	Person Responsible	Date Completed	Outcomes of Actions
Personal Care and Services • **Privacy** • **Resident Bonding** • **Respect** • **Daily decisions** • **Personal relationships** • **Comfort** • **Staff Responsiveness** • **Trust** • **Communication** • **Visiting Experience**	• Educate families and residents on staff ratios during family and resident council	DRC/ADRC	April 25, 2024 (RC) June 19, 2024 (FC)	Residents and families better understand the nursing envelope and CMI funding. They are also more aware how staffing is allocated to each unit.
	• Working with HR to hire new staff (Especially the Registered Staff) to reduce the agency use	DRC/ADRC	May 16, 2024	In collaboration with HR, a PSW Job Fair was held resulting in hiring 70 PSWs on the spot. We saw a 93% agency usage reduction. This is a positive impact as residents have continuity of care. Staff benefit from having trained staff to work with.
	• Train staff on Customer service and Person-Centered Care.	Education Coordinator	July 25,2024	Staff are more aware of the expectations in regards to providing Customer Service and Person-Centered Care. Numbers of concerns have been greatly reduced compared to the previous year.
	• Re-train staff on Handover Shift report and responsibilities	Education Coordinator	Oct 3,2024	Communication has greatly improved between shifts as well as between nursing, residents and families as

				evidenced through the reduction of the #'s of CIs and complaints.
	• Add "All About Me" Section into Resident Care Plan	DRC/ADRC In Collaboration with Activation	Sep 19,2024	Staff know the residents better in order to provide person-centered, and holistic care evidenced through the reduction of the # of CIs and complaints.
• **Programs/Activities** • **Spiritual Care** • **Participation**	• Enhance programs for the monthly theme for men's group programs i.e. Superbowl, Stanley cup which are targeted for the men-use our male staff to implement this.	Director of Programs/rec team, dietary, pastoral team	April 8, May 2/3, 2024, May 20/ 22, May 11, 18-Blue Jays game group gathering, May 11-mens health group FM 3, June 16-donuts for dads, Father's Day social June 16, FM 2, 3, 4 and 5; men's group coffee club May 14 discussion on Euro soccer sport	Male residents have been actively engaged and enjoying the male group programs as evidenced by attendance records and increased level of engagement scores.
(Continued) Programs and activities	• Revisiting intergenerational groups	Director of Programs	Not fully Completed (partial)	April 18, 2024 Collaborated with sunshine for seniors and youth group volunteers made a plant pot for seniors and delivered them for us to hand out-

				Group wasn't able to coordinate a date for volunteers to come in and do it in person due to outbreak. Worked with 7th day Adventist church group in which the youth ministries made hand drawn cards and letters to inspire and encourage our residents. (April 22 letters dropped off). In addition, outreach with Peel district school board for a pen pal program. Letters were dropped off April 9 and distributed to residents who were interested in receiving and also writing back! Intent was to have students come in person to meet their pen pal but FM was in outbreak over the course of that time.
• **Spiritual Care Participation**	Provide education/resources to residents, staff & families with new spiritual care coordinator-bring awareness to the program and all services currently in place, programs that will be added to enhance the overall delivery	Director of Programs	April 10, 2024 (SCC Hired) Ongoing education in 2024 (see outcomes)	May 1st 2024-edition was released in May Tie that Binds. SCC shared information on himself; Information at Resident council on the new hire of this position March 27/24 2024; note on dashboard on PCC April 16/24 April 10/24 commenced his position at HCH June 27/24 SCC lead introduced at Resident Council meeting.

				2024; first bible session study reflections added May 2-FM 1, FM 2, May 9 FM 3, May 7, FM 4 and FM 5 May 13. Invite to June 19/24 family council mtg - ongoing introductions to front line staff, manager meeting June 11/24 Residents, families and staff are fully aware of the role and responsibilities of the new SCC. Residents, families and staff have access to much more resources with regard to spiritual and religious care. Residents with diverse backgrounds are receiving access to enhanced personalized spiritual care.
	• Team up with Food services on fresh fruit Fridays/seasonal events	Director of Programs	June 7, 21 2024- ongoing until August 23 (bi weekly for the summer season)	During this time period residents enjoyed fresh seasonal fruit every Friday. Healthy eating – fresh food provided more variety of food, while enhancing overall resident health and well-being.
	• Enhancing the resident spot light (Old legacy) program, to be person centered quarterly	Director of Programs	Spotlight programs- Evidence on calendar of events-see website/starting April 18- spotlight FM 2;	Residents and staff were able to know specific residents more personally enhancing personal relationship, improving overall respect for each other.

			monthly department meetings and reminders- ongoing until December 31, 2024.	
• **Programs/activities (Outdoor Activities)**	To review current outing program; look at ways to increase residents' opportunities to have a change of environment: I.e. walk off the floor through the complex, outside in the courtyard (during seasonal times), walk to plaza, walk to the Tulip restaurant for a coffee tea social; plan for larger outings per ¼ (within budget of department and residents). Plan to have volunteer and student support during peak times.	Director of Programs	December 31, 2024	Had placement students (June 17-Aug.17) to enhance opportunity to get residents outside to enjoy the gardens and fresh air (in support or acceptable temperatures; Johnny cash day June 20 (to be outdoors but held inside due to extreme weather alert); 3rd annual Elvis day venue-August 29/24 another Home wide event to enjoy a planned event outdoors. Music in the patio starting July 9, 23 and August 6 and 28th, classic car show August 28th/24; out n about to the Dutch store June 6-Fm 5, 1:1 walks off neighborhood to gardens on all calendar of events see website for specific dates; picnic in the park June 18/24 FM 1 cancelled due to heat alert therefore held it inside. Ice cream truck July 3/24 seasonal until mid-September-creates opportunities for resident to go outside weather permitting.

				Residents, families and staff were actively engaged and had increased access to more outdoor activities as per attendance records and activity pro-scores.
• **Meal Service** • **Snacks** • **Dietitian**	• Re-educate family members during family council meetings on show plates.	Dietary Manager, Food Service Supervisor, Registered Dietitian	June 19, 2024	Family members are more informed on the meal choices of the day, where residents are able to pick and choose from either or of the show plates with their preferences in order to provide satisfaction during the meal times.
	• Review 3-week cycle menu and snacks to family members during family council meetings.	Dietary Manager	December 30, 2024	Family Council is more informed about how the three-week meal cycle and how HCH promotes transparency and choices on food.
	• Re-educate dietary staff and other registered staff on tray meal service plating to ensure that it is requested upon completing the dining room residents first and that is the food is only plated upon service to ensure accurate food temperature.	Dietary Manager	February 22, March 12, March 13, May 30 and May 31, 2024	Staff are better trained and respond more appropriately to the requirements for tray service and meal rotation. Residents benefit from food being served in a timely manner with meals served at the correct temperature at time of service.
	• Review show plates selection with residents during food committee meeting.	Dietary Manager	October 24, 2024	Residents benefit from knowing they have 2 choices and that they can pick food items from each of the two show

	• Implement opportunities for residents to assist pre and post meal set up by May 15, 2024.	Dietary Manager	Not completed	plates to make a third plate for which they can eat. Many residents were unaware of this option. Attempt was made but not successful. IPAC was an issue. May look to revisit in 2025 with our newly hired Dementia Care and Services Lead.
Accommodation • **Housekeeping** • **Laundry**	• Increase public washrooms audits in order to ensure constant cleanliness due to residents' accidents	Housekeeping/Nursing staff	April 30th, 2024; on-going	Public washroom audits allowed for targeted enhanced cleaning to support prevention of smells and quality of life for residents. Reduction of concerns raised in this regard.
Resident Advocate Palliative Care/ End Of life	Introduce new resources for staff and family re EOL care • Provide education and training on updated Palliative /EOL program to all staff • Prepare for roll out of RNAO Palliative and EOL clinical pathways.	Resident Advocate DRC; Team Members	Developed new EOL checklist for staff, new EOL Team Meetings, new structured progress notes for Palliative/EOL and new resource "Guide for Families and Residents – End of Life at Faith & Grace Manor" 10 in house education	Developed new EOL Checklist for staff, new EOL Team Meetings protocols, structured progress notes in PCC on Palliative/EOL for more accurate tracking and planning. Very successful. Developed a Guide for families and residents on EOL – residents and families and staff much more informed about end of life care. Consistent information is being provided. Feedback from families has increased in positivity. Increase in the amount of end of life care being provided in the Manor.

			sessions completed & ongoing (also provided to all new hires) Started on October 21/24 HCH team members participated in Palliative Care workshop organized by RNAO – June 19 & 20, 2024 Palliative & EOL clinical pathways education, evaluation & sustainability plans completed – Sept 16/24	Registered staff much more informed and able to provide clear consistent information to residents and families on the program. Participation in a Palliative Care Workshop organized by RNAO attended by the HCH leaders of this program allowed for them to bring back ideas and changes/enhancements for upgrading our program policies. Staff who were educated on Palliative & EOL Clinical pathways have expressed more comfort in communicating around end of life issues. These sessions will be ongoing to support and maintain this comfort level amongst staff.
Volunteer	• Enhance volunteer recruitment efforts to increase volunteer base and support resident group activities. (porter to bingo, hymn sing)	Volunteer coordinator, RA/PM, Director Program Services	Ongoing	Recruitment has been slow after covid-19, however our volunteer #'s are slowly increasing. More residents are benefitting from 1:1 support provided from volunteers.

Environmental, Safe and Secure Maintenance	• Support resident safe outdoor outings in the summer months with the involvement of summer students	Activation/Nursing	June 17 to August 16th 2024 (recreation students). Summer student- 8 weeks also supported the rec team.	Residents benefited from increased outdoor activities due to the presence of summer students supporting resident outdoor activities/outings. Evidenced in the level of resident engagement scores and attendance records.

Faith Manor

2024 Resident Satisfaction Survey

2024 Family Experience Survey

Action Plan

(Please do not remove. If you need a copy, please see your administrator)

Areas to Improve	Action Plan (to be carried out in 2025/26)	Person Responsible	Date Completed	Outcomes of Actions
Personal Care and Services • **Daily decisions** • **Personal relationships** • **Privacy** • **Trust** • **Comfort and Facilities**	Create resource binders in each neighborhood that will provide easy access to lists of current key personnel contact information by April 30, 2025.	Resident Advocate, DRC, Team Leads		Families and friends will have easy access to up-to-date key personnel contact information. This will make it easier for families to find and contact the appropriate care partners members, enhancing communication between care partners and family. Ensuring that the right contact person (POA/SDM) is receiving timely information as the situation requires. Families/Friends/visitors are more aware of who is providing care to the residents. Residents are also aware of the names and build care relationships with the care partner serving them at any given time. Residents are consistently informed about the care partners caring for them and any changes in the team.
	Educate all registered care partners on the process of reporting any significant change to family (correct person listed as per contact sheet in PCC) and ensuring documentation includes which family member was informed by May 30, 2025.	DRC, Training and Education Coordinator Registered Care partners, DRC, Team Leads		
	Add name tag checks to shift-change report huddle on each neighborhood to ensure that name tags are clearly visible at all times. First huddle to be held on April 1, 2025 and ongoing each huddle.	DRC, Team Leads		
Care Partners Resident Bonding & relationships	Complete the warmth survey that will be provided to all elders, families and care partners to determine Faith 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 they can create a caring, inclusive environment empowering resident's independence, choice and promoting well-being.
	Add a section on 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	Training and Education Coordinator		

	care partners complete the training, create a list and provide to the leadership team by October 1, 2025.			Enhance the EDEN Alternative throughout the care parameters and provide holistic, research-based approach to care targeting resident well-being and satisfaction. Care Partners will support residents with their daily rhythm of life by focusing on living and providing excellent care and support. 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. 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.
	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 huddles to start April 1, 2025 and ongoing after that.	Training and Education Coordinator		
	Utilize the Champions of Change, and Certified Eden Associates and Leadership to create an action plan in response to the findings of the completed warmth survey by November 1, 2025.	Dementia Care and Services Lead Training and Education Coordinator		
	Educate and inform all care partners and 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 town hall meetings, huddles, posters, hand-outs, information boards, Tie that Binds article, Pulse newsletter etc by August 30, 2025.	Dementia Care and Services Lead Training and Education Coordinator		
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 November 1, 2025.	Dementia Care Lead and Services Training and Education Coordinator		Active listening will improve building connections between residents and care partners. Taking a few minutes each shift by checking in with residents on a personal level will provide more emotional support, enhance resident satisfaction with care and improved relationships and communication.

Activities and Belonging	Install an Ambient ABBY board, 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 September 15, 2025.	Director of Programs and Services		To reduce resident boredom and loneliness through providing meaningful activities residents can easily engage with. Intergenerational engagement with babies will enhance resident interaction, sensory stimulation and reduce boredom, and loneliness. Will provide opportunities to maximize social connections by pairing residents with similar interests during group activities; will foster social connections. Care partners will be able to offer more one-on-one or small group activities for residents who may be less receptive to large group settings. Care Partners will be able to identify individual hobbies or interests (like music, art, or games) and offer customized activities that align with those preferences.
	Complete the Sensory door escape project by July 30, 2025.	Director of Programs and Services		
	Increase the number of intergenerational programs by 3 per year (through community outreach, baby day, singing groups, etc.) by November 30, 2025.	Director of Programs and Services		
	Train PSW and Activation care partners on how to ensure residents receive individualized programs/activities based on their personal preferences and abilities through learning huddles by July 30, 2025. Maximize social connections by pairing residents with similar interests during group activities.	Director of Programs and Services		
Engagement in Care	Provide care partner families and residents with information at Resident Council and Family Council on the importance of attending Care Conferences by May 1, 2025.	Restorative Care Lead Training and Development Coordinator		Improve Care partners familiarity with individual cases. Structured template and front-line care partners attendance will provide meaningful, actionable information that is specific to the resident's evolving care needs. Attending front line care partners will have thoroughly reviewed residents' files before the meetings to be prepared with specific, individualized updates, rather than providing general information. Limit redundancy in information shared during
	Develop a structured conference reporting template to be used for consistent reporting at care conferences. Ensure that a front-line nurse, and PSW attend the care conferences by June 30, 2025.	DRC Resident Advocate		

				conferences, focusing on updates regarding progress, challenges, and any necessary changes in care.
Visiting Experience	Provide an information sheet and education on the appropriate locations that can be used for visiting while in Faith Manor (and surrounding community) for residents, and care partners including families during resident council and family council and monthly care partner meetings by May 30, 2025. Add this information to the Resident / Family Information Handbook.	DRCs Administrator Resident Advocate		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		Support residents' spiritual needs. External partners will be readily available to provide residents with spiritual support that is inclusive. Residents are made aware of programs that are available meeting their spiritual needs.
	Establish a relationship with cultural and multi-faith centers in Peel region and create a reference list to allow more inclusive and multi-faith services by June 30, 2025**.**	Spiritual Care Coordinator		

Meal Service **Snacks** **Dietitian**	Hold 4-6 in-services with nursing, food service care partners and PSW care partners on pleasurable dining by June 30, 2025.	Dietary Manager Dietitian DRC Training and Education Coordinator		Resident and families will have an enhanced opportunity in making food choices. Care partners will enhance the dining experience through providing a pleasurable

	Educate family and residents during care conference on the availability of the seasoning caddy starting April 1, 2025.	Dietary Manager Dietitian DRC Training and Education Coordinator		dining environment for all residents. Seasoning caddies will contain seasonings based on resident preferences and likes. Nutrition discussions during care conferences will enhance understanding of food availability, choices, and provide on-the-spot responses to questions on food enquiries.
	Purchase a dementia friendly food picture book to enhance pleasurable dining experience by promoting resident choice. Pilot on Garden neighborhood (FM1) effective June 1, 2025.	Dietary Manager Dietitian PSW Registered Staff		

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 1, 2025 and ongoing after that.	Housekeeping / Laundry Manager and Supervisor		Reduce incidents of misplaced items, and decrease the number concerns received due to laundry handling. 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.
	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 that.	Housekeeping / Laundry Manager and Supervisor		
Resident Advocate Palliative Care/ End Of life	Implement the RNAO Palliative and End-of-Life clinical pathways at Faith Manor by December 31, 2025, by coordinating with key stakeholders, providing necessary resources, and ensuring care partners training and readiness for full integration.	DRC, NP, Spiritual Care Coordinator		Care partners to be more prepared in providing end of life care. Educated volunteers will continue to be aware of the care expectations at end of life.
	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.	DRC, NP, Spiritual Care Coordinator		
Volunteer	Increase visibility and knowledge of the volunteer program by creating and posting a “Did You Know?” poster by May 1, 2025.	Volunteer Coordinator		Residents and families will better understand the activities of various volunteers and how many hours are donated in order to improve the care of the residents in various areas.
	Increase visibility and knowledge of the volunteer program by including current statistics in the monthly Tie That Binds – Volunteer Department article by April 1, 2025.	Volunteer Coordinator		
	Provide Resident and Family Councils with a quarterly report including the number of hours donated by volunteers by May 31, 2025.	Volunteer Coordinator		

Environmental, Safe and Secure Maintenance	Run a weekly call-bell report to analyze response times and address any delays immediately with care partners starting the week of March 17th, 2025.	DRCs, Maintenance Manager		Residents can be assured of timely response when they call for assistance. Timely responses can prevent incidents e.g. falls, incontinence. Will also be able to address any deficiencies and hold care partners accountable for appropriate response time.
Medical Care MD/NP	Provide re-education to resident and family councils about the availability of the MD/NP by May 30, 2025.	NP Administrator		Enhance residents and family's knowledge about MD/NP availability, allowing them to bring forward any medical concerns immediately so that they can be addressed and communicated while the physician is present, or in more urgent cases by the NP.
Continence	Schedule regular check-in audits with residents/families to review satisfaction with continence care and address any concerns by auditing 5 residents per home area per month. First 5 residents to be audited by April 30, 2025, then ongoing monthly.	DRCs, Specialized Programs Lead		Enhanced review of care products, to ensure they are meeting individual resident care needs and satisfaction.
Contracted Services	Educate resident and family councils on the frequency/availability of contracted services to improve their understanding and expectations of in-house services by May 30, 2025.	DRCs Administrator		Families and residents will better understand the schedules of contracted services and frequencies. Improve communication regarding healthcare services and availability, ensuring families are informed of any changes or updates.