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)	24.75	21.70	This target is set to meet the provincial average	

Change Ideas

Change Idea #1	Increase access to on-site diagnostic tools, tests, and treatments (e.g., x-rays, ultrasounds, bladder scanner, lab tests, intravenous therapy) to manage conditions within the home		
Methods	Process measures	Target for process measure	Comments
To increase access to on-site diagnostic tools, tests, and treatments (e.g., x-rays, ultrasounds, bladder scanners, lab tests, intravenous therapy) at Fairhaven, the method begins with assessing current resources to identify any gaps in equipment, resources, or staff training. A collaborative planning process involves engaging clinical staff, management, and healthcare providers to prioritize the most critical tools needed for effective care. Once identified, necessary resources are acquired through vendors or local healthcare partnerships. Staff are trained on the proper use of new diagnostic tools, and scheduled on-site diagnostic and treatment services are implemented. Ongoing monitoring ensures these services meet resident needs and regulatory standards, ultimately enhancing the ability to manage conditions within the home.	The staff training completion rate; decrease in ED visits; resident satisfaction for on-site diagnostics (CB)	100% of relevant registered staff receive training on new equipment/annual education; set to meet provincial average; resident satisfaction for on-site diagnostics (CB)	This initiative's success will rely on strong partnerships with local healthcare providers, ensuring timely access to necessary diagnostic tools and treatments. Collaborating with multidisciplinary teams, including physicians, technicians, and allied health professionals, is essential for effective implementation. Additionally, integrating these services with existing care programs, such as chronic disease management and prevention programs, will enhance overall resident care.

Change Idea #2 Strengthen fall prevention programs to reduce injury-related ED visits by using environmental modifications, regular assessments, and mobility aids			
Methods	Process measures	Target for process measure	Comments
To strengthen fall prevention and reduce injury-related ED visits, Fairhaven will focus on environmental modifications, regular fall risk assessments, and mobility aids. Regular assessments using validated tools will ensure personalized care plans, and mobility aids will be provided as needed. Staff will receive ongoing training on fall prevention and risk management to support these efforts.	Number of staff training completion for falls prevention; number of RHA's (Resident Home Area's) mobility aid and environmental modification audits completed.	100% of all staff on falls prevention strategies; 4 out of 8 RHA's completed for mobility aid and environmental audits	It is essential to involve residents and their families in the process, ensuring they are educated on fall prevention strategies and encouraged to communicate any concerns. A collaborative approach with healthcare providers can also help tailor interventions more precisely to each resident's needs. Regular feedback from staff and residents can help identify additional areas for improvement. Additionally, ensuring that the program aligns with broader safety and quality improvement initiatives will maximize its impact and sustainability.

Change Idea #3	To reduce avoidable ED visits, the CQI committee will implement a system-wide review and improvement of current protocols for early identification and management of conditions that typically lead to ED visits, such as respiratory issues, dehydration, or infections.		
Methods	Process measures	Target for process measure	Comments
Initially, analyzing data on the most common causes for ED visits across the home, focusing on patterns related to specific conditions, care processes, and times of year will occur during the CQI committee. A review of current protocols for managing these conditions would be conducted to identify any areas for improvement, such as more frequent monitoring, better early detection tools, or clearer communication between teams. Staff training on recognizing early warning signs and effective interventions would be implemented, using simulation exercises and case studies. Additionally, enhancing care coordination by improving communication systems would ensure timely alerts for potential issues, allowing staff to intervene proactively. Continuous monitoring and adjustment of strategies would be performed through regular audits of ED visit data to assess the effectiveness of these changes.	A decrease in ED visits; a decrease in specific cause rates; percentage of relevant staff trained on early warning signs and effective interventions (topic specific).	Provincial average; 10% decrease in specific causes (i.e. behaviours/infections/falls); 100% staff trained on	By focusing on early detection, staff education, and proactive care coordination, we aim to significantly reduce avoidable ED visits and enhance resident care. Regular feedback from staff will be essential for identifying challenges and refining the process. Additionally, maintaining an open dialogue with residents and families about the importance of preventive care will help ensure that everyone is aligned with the goals of this initiative. Tracking progress and adjusting strategies based on outcomes will be crucial to sustaining long-term success.

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	The home had 100% compliance with EDIAR training for 2024, and will strive to maintain the same target for 2025.	

Change Ideas

Change Idea #1 Indigenous Cultural Safety and Awareness Training Opportunities - Ensure that all staff are given opportunity to complete Indigenous Cultural Safety and Awareness training to promote an understanding of Indigenous peoples' histories, traditions, and healthcare needs.

Methods	Process measures	Target for process measure	Comments
Develop and implement Indigenous Cultural Safety and Awareness training for all staff members. The training will focus on fostering cultural sensitivity, understanding the impacts of colonization, and recognizing the importance of culturally safe care for Indigenous residents.	Percentage of staff who have completed the Indigenous Cultural Safety and Awareness training.	20% of staff complete training	Total LTCH Beds: 256 This target of 20% aims to make gradual progress in promoting cultural safety within the home. As the training becomes integrated into staff development, the goal is to expand participation over time, fostering an inclusive and respectful environment for Indigenous residents.

Change Idea #2	Implement Trauma-Informed Care (TIC) practices across all levels of care to improve residents' well-being and ensure a safe, supportive environment for individuals with a history of trauma.		
Methods	Process measures	Target for process measure	Comments
Provide training for all staff on the principles of Trauma-Informed Care, including understanding the impact of trauma on health, recognizing trauma-related behaviors, and applying trauma-sensitive approaches in daily care practices. Integrate trauma-informed practices into care planning and interactions with residents.	Percentage of staff who have completed Trauma-Informed Care training.	100% of staff have completed the training.	Implementing Trauma-Informed Care will create a safer and more supportive environment for residents, acknowledging and addressing the potential effects of trauma. This approach promotes trust, safety, and empowerment, allowing residents to feel more comfortable and supported in their care. Over time, as more staff complete the training, the home will continue to improve its ability to meet the emotional and psychological needs of residents.

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	34.55	67.00	Given that 19/55 respondents rated 9/10 or 10/10, and the majority rated 8/10 or higher, setting a target of 67% is a realistic and data-driven choice. This target includes respondents who rated 8/10 or higher, reflecting the overall satisfaction level and ensuring the goal aligns with the QIP's focus on high-quality care. While the confidence interval does not fully meet the desired threshold for statistical significance, aiming for 67% provides a feasible target for improvement, building on the strong base of positive feedback already present.	

Change Ideas

Change Idea #1	Incorporating residents' knowledge, values, beliefs, and cultural background into care planning and delivery through the implementation of clinical pathways.		
Methods	Process measures	Target for process measure	Comments
Implement clinical pathways that integrate cultural competence and person-centered care, ensuring staff have the necessary tools and guidance to include residents' values, beliefs, and cultural preferences in care planning and delivery. Regular assessments and updates to care plans will ensure these elements are consistently addressed.	Percentage of resident care plans that reflect cultural preferences, values, and beliefs as documented in clinical pathways; percentage of staff educated on Resident and Family Centred Care (RFCC).	100% of resident care plans incorporate cultural preferences, values, and beliefs; 100% registered staff trained on clinical pathway (RFCC).	Total Surveys Initiated: 61 Total LTCH Beds: 256 The implementation of clinical pathways will provide structured guidance for staff to integrate residents' personal and cultural factors into care. This approach promotes individualized care, improves resident satisfaction, and strengthens the relationship between residents and staff, contributing to a more inclusive and respectful care environment.

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	75.44	100.00	The home upholds a strict zero tolerance policy towards abuse and neglect, ensuring that every resident feels safe and valued. We are committed to fostering an environment where all residents can freely express their opinions without fear of retaliation.	

Change Ideas

Change Idea #1	Provide ongoing education on policies related to whistleblowing and resident rights, ensuring that this information is reviewed during resident council meetings, upon admission, and at care conferences.		
Methods	Process measures	Target for process measure	Comments
Educational materials will be provided to residents and families, ensuring they understand their rights and the processes in place for raising concerns or reporting issues. Regular audits will be conducted to ensure that these discussions are occurring as scheduled, and feedback will be collected from residents to assess the effectiveness of these educational sessions. Additionally, staff will receive ongoing training to stay updated on policy changes and best practices.	Track the percentage resident council meetings where whistleblowing and resident rights policies are reviewed.	100% of meetings will have a discussion on resident rights.	Total Surveys Initiated: 57 Total LTCH Beds: 256 This initiative is essential for promoting a culture of transparency, respect, and accountability within the home. Regularly reviewing whistleblowing and resident rights policies ensures that residents are fully informed about their rights and how to safely report concerns. By incorporating this education into resident council meetings, we foster an environment where residents feel empowered and supported. Additionally, it reinforces the home's commitment to providing a safe and dignified living experience.

Change Idea #2	Help staff become more knowledgeable about providing resident-centered care. Offer regular training and resources to help staff focus on individualized care, communication, and meeting each resident's unique needs.		
Methods	Process measures	Target for process measure	Comments
Staff will attend training sessions on resident-centered care, covering topics like communication, personalized care planning, and understanding resident preferences. Educational materials will be provided, and staff will share experiences and strategies in regular team meetings to ensure effective implementation.	Percentage of staff completing the training	85% of direct care staff education completion	This initiative will help ensure residents feel respected and cared for according to their personal needs. By improving staff skills in resident-centered care, we aim to enhance the overall quality of life for residents. Regular training and team discussions will support staff in applying these principles every day.

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	15.56	9.00	The home continues to perform below provincial averages, and strives to meet HQO's benchmark of 9%.	

Change Ideas

Change Idea #1	Implementing a clinical pathway for fall prevention in partnership with RNAO and PCC will standardize the approach to assessing and managing fall risks for all residents. This pathway will ensure consistent identification of those at risk and timely interventions, including environmental modifications, mobility aids, and regular monitoring. By providing clear guidelines and a structured process, the pathway aims to reduce the frequency of falls and enhance overall resident safety.

Methods	Process measures	Target for process measure	Comments
The method involves introducing the clinical pathway across all care teams, starting with a detailed review of current fall prevention practices and identifying areas for improvement. Training will be provided to all staff on the new clinical pathway, including how to conduct fall risk assessments and implement the recommended interventions. Regular audits will ensure the pathway is being followed consistently, and feedback loops will be established to refine the process based on staff and resident outcomes.	% of residents assessed for fall risk upon admission and regularly thereafter; Successful launch of clinical pathways for falls; overall falls reduction due to earlier interventions.	100% of residents are assessed through the clinical pathways after the launch date; 100% successful launch July 31st for GO LIVE date; 9% benchmark for HQO falls met.	Implementing the clinical pathway for falls is a key step in providing more consistent, evidence-based care to residents. Success will depend on the engagement of all staff members and their commitment to following the pathway. Ongoing training and feedback will be essential to ensure that the pathway is effectively integrated into daily practice. Additionally, continuous monitoring and evaluation of fall rates will help refine the pathway, ensuring that it remains responsive to the needs of residents and addresses any barriers that may arise.

Change Idea #2 Enhancing the current 4 P's strategy—Prevention, Positioning, Personalized Care, and Pain Management—by providing targeted re-education to staff. This will reinforce the existing protocols to ensure all staff are fully aligned with the best practices for fall prevention. The goal is to emphasize the importance of consistent, individualized care and environmental strategies to reduce fall risks across all residents.

Methods	Process measures	Target for process measure	Comments
Re-education will involve refresher training sessions for all staff, focusing on the key components of the 4 P's. These training sessions will include practical examples, role-playing scenarios, and case studies to reinforce the importance of fall risk prevention. Staff will be educated on conducting thorough risk assessments, the role of positioning and mobility aids, the critical aspects of pain management, and providing personalized care for each resident. In addition, a home wide audit and organization of mobility devices will be planned for 2025 to ensure that each resident has the appropriate equipment.	% of relevant staff educated on 4 P's	100% direct care staff trained/re-trained on 4 P's; decrease in overall falls for 2025 to meet HQO benchmark.	Enhancing the 4 P's strategy through re-education will help ensure that staff have a deep understanding of the importance of each component in fall prevention. The initiative aims to strengthen consistency and adherence to best practices across all care teams, leading to safer environments for resident and will be reinforced by the clinical pathways.

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	30.99	26.62	The home is aiming for a 14.10% reduction in year one of a three year plan to reach the provincial average of 19.65%, while in the beginning phases of Healthcare Canada Excellences "Sparking Change" QI initiative, as well as implementing the Clinical Pathways with the RNAO.	Healthcare Canada Excellence, RNAO, Point Click Care

Change Ideas

Change Idea #1	The home will focus on reducing the use of antipsychotics by participating in the Sparking Change AUA project. This initiative aims to implement best practices for the appropriate use of antipsychotic medications, emphasizing non-pharmacological interventions, and reducing unnecessary prescriptions. By participating in this project, the home will align with evidence-based strategies to improve care, ensuring residents receive the most appropriate treatments for their needs while minimizing the use of antipsychotic medications.

Methods	Process measures	Target for process measure	Comments
The method includes collaborating with the Sparking Change AUA project team to review current practices, identify residents who may be receiving unnecessary antipsychotic medications, and implement alternative, evidence-based approaches. Staff will receive training on non-pharmacological interventions and the importance of minimizing the use of antipsychotics when possible. Regular monitoring and review of residents' medication regimens will be conducted to ensure appropriate use and to track the progress of reducing antipsychotic use. Data will be collected on the outcomes of these interventions, and adjustments will be made as necessary to improve care.	Through the PDSA cycle, the home is focusing on one RHA (Resident Home Area) for this project as a base for change. % of residents on antipsychotic medications pre and post QI project.	The home is aiming for a 10% decrease on the RHA; and 10% homewide	

Change Idea #2	Strengthen engagement with families and substitute decision-makers (SDMs) in medication management by integrating structured discussions into care planning to ensure informed decisions regarding antipsychotic use.		
Methods	Process measures	Target for process measure	Comments
Conduct scheduled care conferences with families and SDMs to review each resident's medication regimen, discussing the risks, benefits, and potential non-pharmacological alternatives before making changes to antipsychotic prescriptions. Provide educational materials and decision-making support to promote understanding and shared decision-making. Document discussions in the care plan and ensure ongoing communication as part of medication reviews.	Percentage of residents on antipsychotics with documented family/SDM discussions in plan of care.	70% of all residents will have a documented conversation with the MRP	Enhancing family and substitute decision-maker (SDM) engagement in medication decisions ensures a collaborative approach to reducing unnecessary antipsychotic use. By involving families in discussions about risks, benefits, and alternative interventions, the initiative promotes informed decision-making and person-centered care. Regular care conferences will help build trust, improve transparency, and ensure that medication changes align with residents' best interests and overall care goals. Tracking documented discussions will support accountability and measure the effectiveness of engagement efforts.

Change Idea #3	Implement Gentle Persuasive Approaches (GPA) training to strengthen staff competency in managing responsive behaviors using non-pharmacological, person-centered strategies, ultimately reducing reliance on antipsychotic medications.		
Methods	Process measures	Target for process measure	Comments
Audit current certificates and refreshers required for direct care staff. Deliver structured, quarterly GPA training sessions focused on dementia care, de-escalation techniques, and individualized behavioral support strategies. Training will include interactive components such as case studies, role-playing, and hands-on practice to reinforce learning. Staff will be equipped with practical techniques to assess and respond to responsive behaviors in a way that prioritizes resident dignity, safety, and well-being. Ongoing coaching and refresher sessions will ensure sustained knowledge retention and application in daily care practices.	Percentage of frontline staff who have successfully completed GPA training	Achieve 40% completion of GPA training among frontline staff within the next year.	Due to the pandemic and continued staffing shortages, the home has elected to chose a realistic goal for certification status of staff. The successful implementation of Gentle Persuasive Approaches (GPA) training relies on strong leadership support, dedicated time for staff participation, and ongoing reinforcement through coaching and refresher sessions. Partnerships with specialized dementia care organizations, behavior support teams, and external GPA-certified trainers will enhance the quality and effectiveness of the training. Additionally, this initiative aligns with regulatory requirements outlined in under the Fixing Long-Term Care Act, 2021, which emphasizes the importance of training staff in resident-centered care, de-escalation techniques, and alternative approaches to medication use. By integrating GPA training into the home's broader quality improvement strategy, this initiative supports compliance, enhances resident outcomes, and contributes to a culture of non-pharmacological, person-centered care.

Measure - Dimension: Safe

Indicator #7	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of long-term care home residents who developed a stage 2 to 4 pressure ulcer or had a pressure ulcer that worsened to a stage 2, 3 or 4	C	% / LTC home residents	CIHI CCRS / CIHI CCRS/Jul1 to Sep 30, 2024 (Q2), as target quarter of rolling 4-quarter average	2.10	1.00	While the home is performing below provincial averages, HQO's benchmark is set for 1%.	

Change Ideas

Change Idea #1	Improve Wound Assessment and Documentation. Increase staff competency in managing complex wounds and reducing wound complications through education and training.		
Methods	Process measures	Target for process measure	Comments
Offer wound care workshops and competency assessments for frontline staff. Focus on best practices for chronic wounds, infection control, and wound dressing choices.	Percentage of frontline staff who complete wound care education.	100% frontline staff complete mandatory wound care education	This initiative aims to enhance staff knowledge and skills in wound care management, which is crucial for reducing complications and improving patient outcomes. Regular education and competency assessments will ensure that staff are equipped with the latest best practices for managing chronic wounds, infection control, and appropriate dressing selection. By establishing regular workshops, we are providing ongoing learning opportunities for frontline staff, ensuring that they stay up-to-date on evidence-based techniques.

Change Idea #2 Enhance Wound Prevention and Management Practices Based on Accreditation Canada Standards.			
Methods	Process measures	Target for process measure	Comments
Develop and implement standardized wound assessment protocols, including the use of evidence-based tools for assessing pressure ulcer risk with the admission clinical pathway. Train staff on proper wound care techniques, dressing choices, and infection prevention. Monitor wound healing progress through regular assessments and documentation.	Percentage of residents at risk for pressure ulcers who receive regular assessments and preventive measures according to the standardized protocols.	90% of residents at risk will receive regular wound assessments and preventive interventions by Q3 2025.	As part of our commitment to improving wound care, the home is currently in phase one of the clinical pathway implementation with the RNAO and is planning to complete the Continence and Pressure Injury Clinical Pathway in year three, starting in 2027. This pathway will standardize care practices and enhance the prevention and management of pressure injuries by utilizing evidence-based protocols. In the meantime, staff will continue to receive education and training on wound care and pressure injury prevention in preparation for the full implementation of this pathway. This initiative aligns with Accreditation Canada standards, ensuring we are continuously working towards providing the best care for our residents.

Measure - Dimension: Safe

Indicator #8	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of long-term care home residents who experienced moderate pain daily or any severe pain during the 7 days prior to their most recent resident assessment	C	% / LTC home residents	CIHI CCRS / CIHI CCRS/ Jul 1 to Sep 30, 2024 (Q2) as target rolling 4-quarter average	1.10	1.10	The home maintains below provincial average performances, and is aiming to remain stable at 1.1%	

Change Ideas

Change Idea #1 Implementing the RNAO Clinical Pathway for Pain Management.

Methods	Process measures	Target for process measure	Comments
The home will adopt the RNAO Clinical Pathway for Pain Management, focusing on standardized assessments, individualized pain management plans, and ongoing monitoring for residents experiencing pain. Staff will receive training on evidence-based practices for pain management, including the use of appropriate pain assessment tools such as the PAINAD. Regular audits will be conducted to ensure adherence to the clinical pathway.	Percentage of residents with a documented pain management plan based on the RNAO clinical pathway.	90% of residents experiencing pain will have a documented individualized pain management plan by Q4 2025.	This change initiative aligns with best practices set by RNAO and aims to improve pain management across the home. By implementing the clinical pathway, the home is committed to providing evidence-based care that ensures all residents' pain is assessed and managed effectively. Training and ongoing monitoring will support staff competency in providing high-quality, person-centered care.

Measure - Dimension: Safe

Indicator #9	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of long-term care home residents in daily physical restraints over the last 7 days	C	% / LTC home residents	CIHI CCRS / CIHI CCRS Jul1 to Sep 30, 2024 (Q2) as target rolling 4-quarter average	2.60	1.60	The home has surpassed HQO's benchmark for restraints (3%), and is aiming to stay below the benchmark, and reach the provincial average of 1.6%.	

Change Ideas

Change Idea #1 Ensure appropriate use of restraints by enhancing documentation, evaluation, and decision-making processes.

Methods	Process measures	Target for process measure	Comments
Review current process in place and complete a GAP analysis. Implement a standardized restraint assessment and documentation tool. Introduce a mandatory review process requiring interdisciplinary team evaluation of all residents with restraints within FLTCA legislation to assess ongoing necessity and explore alternatives.	Percentage of restraint assessments completed per policy and percentage of residents with documented interdisciplinary restraint reviews.	100% of residents are reviewed monthly that have restraints;	

Change Idea #2 Reduce the use of restraints by promoting alternative interventions and ensuring staff competency in least-restraint practices.

Methods	Process measures	Target for process measure	Comments
Develop and implement a least-restraint policy with clear guidelines for staff. Provide training sessions on alternative strategies such as environmental modifications, de-escalation techniques, and individualized resident care plans. Require documentation of all alternative measures attempted before applying a restraint.	Percentage of staff trained on least-restraint practices and percentage of restraint use cases with documented alternative interventions.	100% of registered staff trained on least restraint methodology	The home remains committed to a least-restraint approach, ensuring that restraints are only used as a last resort when all other alternatives have been exhausted. By implementing a standardized process for documentation and evaluation, we aim to enhance accountability and promote resident safety. Ongoing staff education and policy reinforcement will support a shift in practice towards individualized, least-restrictive interventions. Additionally, regular audits and interdisciplinary reviews will ensure compliance and help identify opportunities for further reducing restraint use.

Quality Improvement Plan (QIP)

Narrative for Health Care Organizations in Ontario

March 11, 2025

Fairhaven
Caring for Generations

Ontario Health

OVERVIEW

Fairhaven Long-Term Care is a 256 bed, community-oriented home dedicated to providing high-quality care for its residents. Located in Peterborough, Ontario, Fairhaven offers a safe, comfortable, and supportive setting for individuals requiring long-term care. At Fairhaven, we are committed to continuously improving the care and services we provide to our residents. Through our Quality Improvement Plan (QIP), we are focusing on enhancing personalized, trauma-informed, and culturally safe care that respects the diverse needs of our residents. We have started to make significant strides in implementing clinical pathways to improve care planning, promoting staff training in cultural competency, and supporting residents through education on their rights. Additionally, our focus on reducing the use of antipsychotic medications, worsening pressure ulcers, pain, restraints, and addressing falls through evidence-based practices reflects our dedication to improving overall resident outcomes. By working collaboratively across teams and incorporating resident feedback, we are creating an environment where every resident is treated with dignity, respect, and compassion. Our goal is to foster a culture of continuous improvement, ensuring that each resident's care is not only safe and effective but also reflective of their personal values and preferences. The specific indicators we are working on are as follows:

- Rate of ED visits for modified list of ambulatory care–sensitive conditions
- Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education
- Percentage of residents responding positively to: "What number

would you use to rate how well the staff listen to you?"
• Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences".
• Percentage of LTC home residents who fell in the 30 days leading up to their assessment
• Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment
• Percentage of long-term care home residents who developed a stage 2 to 4 pressure ulcer or had a pressure ulcer that worsened to a stage 2, 3 or 4
• Percentage of long-term care home residents who experienced moderate pain daily or any severe pain during the 7 days prior to their most recent resident assessment
• Percentage of long-term care home residents in daily physical restraints over the last 7 days

ACCESS AND FLOW

Our organization is committed to ensuring that residents receive the right care at the right time in the right place. To achieve this, we are focusing on optimizing system capacity through collaboration across various sectors, including long-term care, primary care, hospitals, and home and community care. By integrating care and promoting interprofessional team collaboration, we aim to improve the overall experience and outcomes for our residents.

We are working to reduce unnecessary hospitalizations and emergency department visits by proactively managing resident care and ensuring timely access to evidence-based care. This includes implementing leading practices, such as regular assessments and care coordination, to address residents' healthcare needs before they escalate to more intensive interventions. For example, our initiative to strengthen fall prevention programs, implement clinical pathways for managing conditions, and reduce the use of antipsychotic medications is aimed at preventing unnecessary hospital visits.

We are also focused on enhancing timely access to primary care providers, ensuring that residents have continuous and coordinated care. Through collaboration with local healthcare partners, we aim to facilitate smoother transitions between care settings and improve the overall care experience. By developing and co-developing quality improvement plans with organizations in other sectors, we are fostering a holistic approach to healthcare that prioritizes patient-centered care and promotes the well-being of our residents in all stages of their care journey.

EQUITY AND INDIGENOUS HEALTH

Our organization is committed to advancing health equity and Indigenous health by focusing on cultural safety and inclusion in all aspects of care. We are in the process of developing an Equity, Diversity, and Inclusion (EDI) workplan, which will help address health inequities and promote the wellness of Indigenous residents, including First Nations, Inuit, Métis, and Urban Indigenous communities.

To support these efforts, we are offering Indigenous Cultural Safety and Awareness training to all staff. The training will focus on understanding Indigenous peoples' histories, cultures, and healthcare needs to ensure culturally sensitive and respectful care. Additionally, we are incorporating Trauma-Informed Care practices to address the impacts of historical trauma and systemic inequities on Indigenous individuals.

Collaboration with local Indigenous communities is also a key element of our workplan. By engaging with Indigenous leaders and organizations, we aim to ensure that their voices are included in care planning and that our approach to care is aligned with their values and traditions. This workplan reflects the provincial priorities of addressing barriers to care and health services, particularly for populations that experience significant health disparities. We will continue to monitor and refine our approach to ensure that Indigenous health and cultural safety remain central to our quality improvement initiatives.

PATIENT/CLIENT/RESIDENT EXPERIENCE

Our organization values feedback from residents, families, and staff, as it is essential for improving care. We regularly collect and analyze feedback from experience surveys, resident and family councils, and staff input to identify areas for improvement and successes to build on.

This feedback is reviewed and actioned through care team meetings, with action plans developed in partnership with resident and family council members. These plans focus on addressing key areas, such as communication and responsiveness to resident needs, with necessary adjustments made to practices or training.

By incorporating feedback into our improvement activities, we aim to enhance the care experience, improve resident outcomes, and ensure our approach is responsive and resident-centered. Our goal is to make sure care reflects the voices and needs of those we serve.

PROVIDER EXPERIENCE

Our organization is focused on improving recruitment, retention, workplace culture, and staff experience by implementing several innovative practices. We are committed to fostering a positive, inclusive, and collaborative culture that values the contributions of all staff members.

To improve recruitment and retention, we are offering professional development opportunities, including mentorship programs and access to relevant training, to help staff grow in their careers. Flexible scheduling options are also being introduced to support work-life balance and reduce burnout, while mental health support programs are available to ensure staff well-being.

Additionally, we are prioritizing workplace culture by fostering open communication, providing regular feedback, and offering team-building activities to strengthen relationships among staff. We encourage staff participation in decision-making processes and feedback forums, ensuring that their voices are heard and they feel valued within the organization.

By implementing these initiatives, we aim to attract and retain high-quality staff, create an environment where staff feel supported and respected, and improve overall workplace culture. These efforts are designed to enhance staff engagement, job satisfaction, and ultimately improve the care experience for residents.

SAFETY

Our organization is committed to creating and sustaining a culture of safety to prevent or reduce patient safety incidents. We focus on proactive risk identification and evidence-based strategies to improve resident outcomes in key areas, including but not limited to falls, antipsychotic use, restraints, and worsening pressure sores.

In alignment with Healthcare Excellence Canada's Rethinking Patient Safety approach, we integrate patient safety into all aspects of care through huddles, root cause analyses, and the development of action plans to address identified risks. By examining incidents through a systems lens, we not only identify individual concerns but also broader system factors that contribute to safety risks.

Our commitment extends to continuous staff education and quality improvement initiatives that ensure best practices are followed. By fostering an environment where staff feel empowered to report concerns and collaborate on solutions, we enhance resident safety and overall quality of care.

PALLIATIVE CARE

Our organization is enhancing palliative care by implementing RNAO clinical pathways and aligning with best practices. A GAP analysis is planned for the fall to assess our program against RNAO best practice guidelines, with an education plan to address gaps and optimize care.

In year one, we are introducing foundational pathways, including admission, delirium, and resident-focused comfort care (RFCC), and integrating tools like the Palliative Performance Scale (PPS) and Edmonton Symptom Assessment Scale (ESAS) to improve symptom management. The RESPECT tool has been adopted to facilitate early identification of residents who may benefit from a palliative approach and guide goals-of-care discussions.

A Palliative Care Handbook is being shared with families, volunteers, and staff, and a dedicated Palliative Care Committee is overseeing improvements. A newly developed end-of-life assessment will enhance symptom management. A visiting PPSM nurse hospice supports staff education, and all staff receive ongoing palliative care training, with registered staff encouraged to attend CAPCE. These initiatives ensure compassionate, high-quality, resident-centered palliative care.

POPULATION HEALTH MANAGEMENT

Our organization is committed to collaborative, person-centered care by partnering with health service organizations to address the unique needs of our community. Through population health management, we focus on identifying health trends, risk factors, and service gaps to implement proactive, integrated solutions.

We are working with local health teams, community partners, and non-traditional healthcare providers to enhance access to care, reduce hospitalizations, and support residents in aging at home. Key initiatives include our falls prevention strategy in collaboration with RNAO and PCC, which standardizes best practices for reducing falls. Additionally, we are participating in the Sparking Change AUA project, aimed at improving antipsychotic use through medication reviews and family engagement.

By incorporating feedback from resident and family councils, we ensure that services are co-designed with lived experiences in mind. Our focus remains on integrating care, reducing inequities, and improving health outcomes, aligning with Ontario Health's priorities for population health management.

CONTACT INFORMATION/DESIGNATED LEAD

Melissa Lasenby
Resident Care Supervisor
CQI Lead
Melissa.lasenby@fairhavenltc.com
705-743-0881

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 11, 2025

Board Chair / Licensee or delegate

Administrator /Executive Director

Quality Committee Chair or delegate

Other leadership as appropriate