

# CONTINUOUS QUALITY IMPROVEMENT (CQI) INITIATIVE REPORT

Fairhaven Long-Term Care is a 256-bed, person-centred home committed to delivering high-quality, resident-centred care. Situated in Peterborough, Ontario, Fairhaven provides a safe, welcoming, and supportive environment for individuals requiring long-term care services. Our Quality Improvement Plan (QIP) emphasizes the delivery of personalized, trauma-informed, and culturally safe care that honours the diverse experiences and needs of our residents.

Guided by Accreditation Canada's framework and Health Quality Ontario's (HQO) standards, Fairhaven continuously strives to enhance resident outcomes and overall quality of life. Through a collaborative, multidisciplinary team approach, we are dedicated to providing compassionate, high-quality care to our diverse and growing resident population. The 2026/27 Quality Improvement Plan aligns our mission, vision, and values with the provincial quality agenda and Ontario Health's Quadruple Aim framework. Our vision is *to be the model for excellence in long-term care*.

Our strategic direction encompasses quality perspectives which are:

- **CONTINUOUS QUALITY IMPROVEMENT EFFORTS**
- **WORKPLACE CULTURE**
- **HIGH QUALITY COMPASSIONATE CARE**

In conjunction with the provincial themes for quality, Fairhaven has embraced the following quality priorities:

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Efficient

Equitable

Resident-centred

Safe and Effective Care

## QUALITY PRIORITY AREAS AND OBJECTIVES FOR 2026/27 Fiscal Year

For the 2026/27 fiscal year, we have identified several key quality priority areas that will be the focus of our improvement efforts. These areas reflect our commitment to enhancing the care and experience of our residents. The key priority areas and objectives include:

### Dimension: Efficient

Potentially avoidable emergency department (ED) visits for long-term care residents remain a key quality indicator monitored by Health Quality Ontario and within Fairhaven's Quality Improvement Plan (QIP). Fairhaven is currently performing at 16.77%, meeting the provincial benchmark. Our ongoing objective is to maintain performance at or below the provincial average.

An analysis of ED visit data identified falls as the leading contributing factor. In response, Fairhaven continues to strengthen its Falls Prevention Program, with ongoing monitoring led by the Falls Committee and implementation of the RAO Falls clinical pathway. The committee reviews performance data monthly to identify trends and improvement opportunities. Education for staff, residents, and families is continuously reviewed and updated to support fall prevention strategies and reduce avoidable ED transfers.

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## Dimension: Equitable

To promote an inclusive, respectful, and equitable workplace, Fairhaven tracks the percentage of staff—including leadership and management—who have completed education in equity, diversity, inclusion (EDI), and anti-racism. This education supports staff and leaders in developing the knowledge and skills required to foster a diverse workforce and deliver equitable, person-centred care.

During the reporting period, a Diversity, Equity, and Inclusion (DEI) Committee was established to provide leadership, oversight, and accountability for DEI initiatives across the organization. Ongoing education and monitoring support continuous improvement and help address systemic barriers while reinforcing a culture of respect and fairness.

In addition, trauma-informed care principles have been integrated into education initiatives, supporting staff to better understand the impact of trauma on health, behaviour, and well-being. These approaches continue to inform care practices and workplace interactions, contributing to culturally safe, compassionate, and responsive care for residents, families, and staff.

## Dimension: Resident Centred

The percentage of residents responding positively to the question, *“What number would you use to rate how well the staff listen to you?”*, is a key measure of resident experience. Of the 256 residents living at Fairhaven, 65 residents participated in the survey, representing a limited response rate and acknowledging that the results may not fully reflect the experience of all residents.

Among respondents, 17 residents rated staff listening skills as 9/10 and 12 residents rated 10/10, for a total of 29 residents (44.6%) providing the highest satisfaction ratings measured by the indicator. While an additional 14 residents rated 8/10, these responses are not included in the indicator calculation, as the measure captures only 9/10 and 10/10 ratings.

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Based on the available data and indicator methodology, establishing a target that reflects incremental improvement is appropriate. Although the confidence interval does not meet the threshold for statistical significance and survey participation was limited, the selected target represents a meaningful and achievable goal. This approach balances the constraints of response volume with the organization's commitment to strengthening resident-staff communication and advancing person-centred, high-quality care.

The percentage of residents who responded positively to the statement, "I can express my opinion without fear of consequences," is a key indicator of psychological safety and resident empowerment. Fairhaven's current result of 81.54% indicates that the majority of responding residents feel safe and supported in sharing their opinions and concerns. This result is based on 65 responses from 256 eligible residents, representing a response rate of approximately 25%, which limits the ability to generalize findings across the full resident population.

Fairhaven upholds a zero-tolerance approach to abuse, neglect, and retaliation, supported through established policies, staff education, and formal reporting and follow-up processes. These measures aim to promote trust, transparency, and respectful communication throughout the home. Ongoing quality improvement efforts continue to focus on reinforcing psychological safety, encouraging resident feedback, and strengthening participation in engagement and survey processes to more accurately reflect resident experience.

## Dimension: Safe

The percentage of long-term care residents who experienced a fall within the 30 days prior to assessment remains an important area of focus for continuous quality improvement. Fairhaven's current fall rate is 15.01%, which is slightly above the provincial average of 15.01% and remains higher than the Health Quality Ontario (HQO) benchmark of 9%. In response, Fairhaven has successfully launched the RAO Falls Clinical Pathway to strengthen fall prevention and management practices across the home. This pathway supports early identification of risk, consistent assessment, timely interventions, and enhanced care planning tailored to individual resident needs. The initiative is supported by targeted staff education, interdisciplinary collaboration, and ongoing monitoring to identify trends and opportunities for improvement. Through these

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integrated approaches, Fairhaven continues to work toward reducing fall rates and promoting a safer living environment for residents.

The percentage of long-term care residents without psychosis who received an antipsychotic medication in the seven days preceding their assessment remains an important focus for continuous quality improvement. Fairhaven's current rate is 33.2%, which is above the provincial average of 18.99%. This result reflects the complex clinical needs of the resident population, including residents living in a secure unit, where responsive behaviours and safety considerations may influence antipsychotic use. Fairhaven continues to support appropriate prescribing practices through ongoing interdisciplinary medication reviews, including reviews on admission, care conferences, at three-month medication reviews by the physician, and through regular pharmacist-led reviews. These processes support person-centred care planning and encourage the use of non-pharmacological approaches where appropriate. A target of 29.88% has been established to support a gradual and achievable reduction in antipsychotic use, while prioritizing resident safety, clinical appropriateness, and quality of life.

The percentage of long-term care residents whose pressure ulcers worsened to Stage 2, 3, or 4 is a key indicator of resident safety and quality of care. Fairhaven's current rate is 4.99%, which is above the provincial average of 3.3%, identifying this indicator as an ongoing priority for continuous quality improvement. During the reporting period, Fairhaven implemented focused actions to strengthen skin and wound care practices, including work completed in response to a compliance order related to skin and wound management. These actions included increased staff education, enhancements to documentation and monitoring through updates to the skin and wound mobile application within PCC, the implementation of weekly skin rounds, and an increase in dedicated skin and wound nursing hours. These measures support early identification, consistent monitoring, and timely intervention for changes in skin integrity. A target of 3.3% has been established, aligned with the provincial average. Fairhaven remains committed to sustaining these improvements through continued surveillance, education, and interdisciplinary collaboration while further quality initiatives, including the exploration of clinical pathways, may be considered in future planning cycles (2027).

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The percentage of long-term care residents who experienced worsened pain is an important indicator of resident comfort and quality of life. Fairhaven's current result is 14.7%, which is above the provincial average of 11.5%, identifying this measure as a priority area for continuous quality improvement.

In response, Fairhaven continues to focus on consistent pain assessment, timely reassessment following changes in condition, and individualized pain management strategies within interdisciplinary care planning. The home has been completing education for the RAO clinical pain pathway, with a launch date of April 1<sup>st</sup>, 2026. A target of 11.5%, aligned with the provincial average, has been established to guide improvement efforts while reinforcing the home's commitment to resident comfort, early intervention, and quality of life.

The percentage of long-term care (LTC) home residents in daily physical restraints over the last seven days is an important measure of resident autonomy and quality of care. The home currently reports a rate of 2.53%, which is below HQO's benchmark of 3% but still above the provincial average of 1.60%. While the home has already met the HQO target, efforts will continue to further reduce restraint use and align with the provincial average. Through staff education, alternative safety interventions, and person-centered care approaches, the home remains committed to minimizing restraint use while ensuring resident safety and dignity.

## 2026/27 QIP PLANNING AND PRIORITY SETTING PROCESS

As part of our CQI efforts, the home follows a structured and collaborative process to identify key priorities for the upcoming fiscal year. The Quality Improvement Planning (QIP) cycle begins each Fall and involves multiple stakeholders, including residents, families, staff, and interdisciplinary teams. Feedback is gathered through resident and family councils, satisfaction surveys, daily shift exchanges, and operational committee discussions.

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In addition to stakeholder input, the CQI Committee plays a critical role in data collection, performance review, and priority setting. The committee analyzes key performance indicators (KPIs), regulatory requirements, and provincial benchmarks to identify gaps and areas for improvement. Special attention is given to metrics that fall below the provincial average or fail to meet HQO benchmarks, ensuring that data-driven decisions guide the home's improvement strategies.

Once the data review is complete, the CQI Committee reviews findings, engages stakeholders in discussions, and finalizes priority areas based on the most pressing needs. These priorities are aligned with the home's strategic plan, quality improvement goals, and best practices, including ongoing initiatives such as RNAO's Clinical .

After approval by senior leadership, a workplan is developed, outlining measurable targets, interventions, responsibilities, and timelines. Progress is continuously monitored through regular CQI meetings, staff engagement, and resident feedback, with adjustments made as needed to ensure sustained improvement.

This structured priority-setting process ensures that the home remains responsive to the evolving needs of residents while maintaining high standards of safety, care quality, and resident satisfaction.

## POLICIES, PROCEDURES AND PROTOCOLS FOR THE NEXT FISCAL YEAR

For the upcoming fiscal year, the following policies, procedures, and protocols will be continued to support the CQI initiative:

Fairhaven will continue to support continuous quality improvement through policies, procedures, and protocols that promote consistent practice, accountability, and data-informed decision-making. The CQI framework will guide priority setting and improvement activities across key areas such as resident safety, quality of care, and resident experience. Quality improvement goals will be reflected in the Quality Improvement Plan (QIP) and supported through operational planning, with performance monitored against provincial averages and Health Quality Ontario benchmarks.

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Policies will continue to support the consistent collection, documentation, and review of quality-related data, including resident assessments, incident reporting, clinical documentation, and feedback from residents and families. Data review processes will inform the identification of trends, emerging risks, and opportunities for improvement, supporting timely and responsive quality initiatives.

Staff education and competency development will remain foundational to CQI efforts. Procedures will support ongoing education through orientation, mandatory training, and targeted learning opportunities aligned with priority quality indicators. Staff will be supported to understand their role in quality improvement activities, including accurate documentation, observation, communication, and participation in improvement discussions at the unit and interdisciplinary levels.

Resident and family engagement will continue to be embedded within CQI processes. Protocols will support the collection and use of feedback through surveys, councils, and other engagement mechanisms, ensuring resident and family perspectives inform care practices, service improvements, and quality priorities.

Quality initiatives will be routinely reviewed through established committees and reporting structures. Procedures will support regular evaluation of progress against identified targets, with adjustments to practices, education, or processes made as needed to sustain improvement. Interdisciplinary collaboration will be emphasized to ensure quality initiatives are implemented consistently and effectively across the home.

Transparent reporting and leadership oversight will continue to support accountability for CQI activities. Quality outcomes, including achievements and areas requiring further improvement, will be communicated to relevant stakeholders. These policies, procedures, and protocols will support the ongoing integration of continuous quality improvement into daily operations and sustain a culture of quality, safety, and learning in the coming fiscal year.

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## Process to Monitor and Measure Progress, Identify and Implement Adjustments, and Communicate Outcomes

### *Monitoring and Measuring Progress*

- **Data Tracking and Analysis:** Key project measures are continuously monitored using run charts, and benchmarking data to identify trends in performance.
- **Outcome and Process Measures:** Outcome measures assess whether the home is meeting desired targets, while process measures evaluate compliance with improvement strategies.
- **Regular Review by CQI Committee:** The Continuous Quality Improvement (CQI) Committee conducts quarterly reviews to assess data trends, compliance with key initiatives, and effectiveness of interventions.

### *Identifying and Implementing Adjustments*

- **Root Cause Analysis:** If progress is below target, teams conduct root cause analysis and review process measures to determine whether gaps exist in compliance or if change ideas need refinement.
- **Plan-Do-Study-Act (PDSA) Cycles:** Small-scale tests of new interventions allow for real-time adjustments before full implementation.
- **Staff Coaching and Engagement:** If gaps are identified, additional training, coaching, and frontline staff engagement are prioritized to enhance compliance and effectiveness.

### *Communication of Outcomes*

To ensure transparency and stakeholder engagement, results are shared through multiple communication channels, including:

- Quality Boards and digital screens throughout the home

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- Monthly newsletters for residents, families, and staff
- Updates at staff meetings, Town Halls, Resident & Family Councils, and CQI meetings
- Daily shift huddles to reinforce key updates and best practices

## Resident and Family Experience Survey Process and Findings

The Resident Experience Survey was conducted from October 15<sup>th</sup> to November 4<sup>th</sup>, 2025, with all residents scoring 0-2 on the Cognitive Performance Scale eligible to participate. At the end of the survey period, with 65 surveys were completed (**Appendix A**).

The Family Experience Survey was administered from Oct 7<sup>th</sup> to November 17<sup>th</sup>, 2025, inviting family members and individuals connected to a current resident or a resident who lived at Fairhaven in the past year. A total of 141 survey's were completed, up from 90 in 2024. (**Appendix B**).

## Key Findings & Priority Areas

Following an analysis of both surveys, the most commonly identified areas for improvement included:

- Clinical – focusing on resident health, medical care and overall wellbeing through improved practices and communication
- Resident experience and quality of life – enhanced daily living by addressing personal needs, comfort and resident – centred services
- Health and Safety- Promoting a secure, clean, and well-maintained environment to support resident and staff well-being.
- Continuous Quality Improvement - Driving ongoing enhancements in care, operations, and resident satisfaction through evaluation and innovation

These areas have been integrated into Fairhaven's 2026/27 Quality Improvement Plan (QIP) (**Appendix E**) to guide enhancements in resident care and experience. The full action plan for the resident and family surveys was presented to Family and Resident Council and is attached as **Appendix C**.

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## Stakeholder Engagement & Communication of Results

Survey results and next steps have been communicated to various stakeholder groups, with discussions focused on addressing concerns and prioritizing improvements.

Date	Committee	Items
December 8 <sup>th</sup> , 2025	<b>CQI Committee</b>	CQI planning day. Project Summaries, risk register, training and development to form base for KPI's for QIP and strategic planning.
December 15 <sup>th</sup> , 2025	<b>CQI Sub-Committee</b>	Beginning of action plans. Review of survey findings, highlighting strengths and opportunities for improvement (Family Council Member present). Working on action plans.
January 5 <sup>th</sup> , 2026	<b>CQI Sub-Committee</b>	Working on action plans. Survey results to inform QIP development and build on the resident and family satisfaction survey.
February 4 <sup>th</sup> , 2026	<b>CQI Sub-Committee/Resident Council</b>	Action plans presented to resident council and open for discussion and input into CQI report/QIP.
February 25 <sup>th</sup> , 2026	<b>CQI Sub-Committee/Family Council</b>	Action plans presented to family council and open for discussion and input into CQI report/QIP.
February 26 <sup>th</sup> , 2026	<b>CQI Committee</b>	Review of QIP indicators, narrative, CQI initiative report and feedback from action plans from Resident and Family Council.

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March 4 <sup>th</sup> , 2025	<b>Resident Council</b>	Overview of Strategic Plan, QIP and CQI initiative report.
March 11 <sup>th</sup> , 2026	<b>Board of Directors</b>	Discussion of QIP/CQI Initiative Report and Strategic Plan.
March 25 <sup>th</sup> , 2025	<b>Family Council</b>	Discussion of QIP/ CQI initiative Report and Strategic Plan.

## Actions to Improve Care and Services (Appendix D)

- Continued implementation of RNAO Clinical Pathways, including Admissions, Delirium, Responsive Behaviours (RFCC), Falls, and Pain, to support consistent, evidence-based, resident- and family-centred care.
- Strengthened falls prevention practices through ongoing weekly huddles and interdisciplinary review, with early success noted through improved care plan quality and consistency.
- Maintained performance below benchmark for restraint use, supported by continued emphasis on least-restraint practices and individualized care planning.
- Launched interRAI assessments and integrated reporting (IRRS) to improve standardized data collection, real-time reporting, continuity of care, and data security.
- Enhanced dementia-care preparedness through the use of RSSC room decals.
- Continued improvements in infection prevention and control, including reductions in outbreak days, resident isolations, and occupational illness compared to the prior year.
- Sustained focus on IPAC education and outbreak management, building on practices strengthened in previous CQI cycles.

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- Established a Living Classroom partnership with Fleming College, supporting ongoing staff learning, student placement, and workforce development.
- Continued Accreditation Canada 2027 preparation, maintaining alignment with national quality and safety standards following prior Exemplary Standing.
- Expanded resident programming and engagement, including new wellness, recreational, and seasonal activities, building on prior investments in meaningful leisure.
- Continued investment in resident technology and engagement tools, including assistive and interactive devices to enhance quality of life.
- Strengthened volunteer recruitment, onboarding, and engagement, sustaining strong volunteer contribution levels.
- Maintained collaborative Admissions and Social Services processes, supporting smooth resident transitions and sustained high occupancy.
- Continued delivery of Spiritual Care services, including worship, one-to-one support, and end-of-life care, reinforcing holistic resident well-being.
- Advanced nutrition service improvements, including equipment upgrades, staff education, and ongoing resident feedback through food committees and satisfaction surveys.
- Maintained stable and secure information technology systems to support clinical care, communication, and operational continuity.
- Continued emergency preparedness improvements, including enhanced drills and staff training to support resident safety, with a monthly focus.
- Sustained environmental and housekeeping improvements, including dedicated staffing models that support consistent routines and strong IPAC practices.
- Completed and continued building and infrastructure upgrades, including lifts, therapeutic surfaces, lighting, and climate control, building on prior physical environment improvements.
- Ongoing collaboration with the Ministry of Long-Term Care, supporting regulatory compliance and quality improvement under increased oversight.

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- Strengthened financial oversight and accountability, including regular budget monitoring, departmental reporting, and collaboration with municipal partners to manage increasing wage, benefit, and regulatory pressures while sustaining high-quality resident care.
- Continued communication and transparency with residents, families, staff, and councils regarding quality initiatives and operational updates.

## DESIGNATED LEAD:

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APPENDIX A – CQI INITIATIVE REPORT

The Resident Experience Survey was conducted from October 15<sup>th</sup> to November 4<sup>th</sup>, 2025, with all residents scoring 0-2 on the Cognitive Performance Scale eligible to participate. At the end of the survey period, with 65 surveys were completed. Results and actions plans developed and presented to Resident Council February 4<sup>th</sup>, 2026.

### Q1 Resident Activities

Answered: 65 Skipped: 0

	YES	SOMETIMES	NO	N/A	DON'T KNOW	TOTAL
Do you receive assistance from Fairhaven staff to assist you in doing activities you like (e.g. reading, writing letters, using the computer etc.)?	78.46% 51	7.69% 5	6.15% 4	6.15% 4	1.54% 1	65
Are holidays, personal anniversary, and important dates celebrated in a respectful compassionate and cultural manner?	92.31% 60	3.08% 2	3.08% 2	1.54% 1	0.00% 0	65
Do you participate in the activities offered by the home?	55.38% 36	29.23% 19	15.38% 10	0.00% 0	0.00% 0	65
If NO, is this important to you?	45.45% 5	36.36% 4	9.09% 1	9.09% 1	0.00% 0	11
Do Fairhaven's activities and programs meet your needs/interest?	56.92% 37	27.69% 18	9.23% 6	3.08% 2	3.08% 2	65
Do we offer activities at an appropriate time?	47.62% 30	28.57% 18	7.94% 5	6.35% 4	9.52% 6	63
Have you provided input or suggestions for activities?	15.38% 10	4.62% 3	64.62% 42	6.15% 4	9.23% 6	65

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	YES	SOMEWHAT	NO	N/A	DONT KNOW	TOTAL
Are the physiotherapy programs effective to assist you with your independence?	47.69% 31	15.38% 10	1.54% 1	30.77% 20	4.62% 3	65
Are you satisfied with the care provided by your physician?	63.08% 41	9.23% 6	24.62% 16	0.00% 0	3.08% 2	65
Are you satisfied with the services provided by the Pharmacy?	86.15% 56	4.62% 3	1.54% 1	3.08% 2	4.62% 3	65
Are you satisfied with the services provided by the Dental Clinic?	29.23% 19	3.08% 2	9.23% 6	47.69% 31	10.77% 7	65
Do we meet your religious and spiritual needs? (If resident doesn't have spiritual needs, rate as N/A)	83.08% 54	4.62% 3	4.62% 3	4.62% 3	3.08% 2	65
Are you satisfied with the hair dresser services offered?	64.62% 42	3.08% 2	3.08% 2	29.23% 19	0.00% 0	65
Are you satisfied with the foot care provider?	69.23% 45	4.62% 3	6.15% 4	16.92% 11	3.08% 2	65
Are you aware Fairhaven has a Behaviour Support Ontario team?	12.50% 7	0.00% 0	71.43% 40	7.14% 4	8.93% 5	56
Have you ever been involved in the process for Behaviour Support Ontario team?	7.14% 4	0.00% 0	76.79% 43	7.14% 4	8.93% 5	56
Can you access your trust fund when you need to?	92.31% 60	3.08% 2	3.08% 2	1.54% 1	0.00% 0	65

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	YES	SOMETIMES	NO	N/A	DONT KNOW	TOTAL
Are you involved in decisions about your health condition and treatment plan by the members of your care team (includes physician, nurses, physiotherapist, etc.)?	78.46% 51	9.23% 6	12.31% 8	0.00% 0	0.00% 0	65
Are you involved in decisions about your care and daily routine (food preferences, sleeping, dressing and bathing schedules)?	84.62% 55	9.23% 6	6.15% 4	0.00% 0	0.00% 0	65
Do you receive monthly statements of account of transactions in your trust account and for your accommodations charges?	81.54% 53	0.00% 0	10.77% 7	6.15% 4	1.54% 1	65
Do you look at posted signs; Newsletter, Fairhaven TV, or Activity Calendars for information?	73.85% 48	7.69% 5	10.77% 7	4.62% 3	3.08% 2	65

**Q5 I can express my opinion without fear of consequences.**

Answered: 65 Skipped: 0

ANSWER CHOICES	RESPONSES	
Rarely	6.15%	4
Sometimes	9.23%	6
Most of the time	7.69%	5
Always	73.85%	48
Don't know	3.08%	2
No response	0.00%	0
<b>TOTAL</b>		<b>65</b>

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	YES	SOMETIMES	NO	N/A	DONT KNOW	TOTAL
Do you feel staff treat you with respect, politeness and courtesy?	83.08% 54	13.85% 9	3.08% 2	0.00% 0	0.00% 0	65
Do you feel volunteers treat you with respect, politeness and courtesy?	93.85% 61	6.15% 4	0.00% 0	0.00% 0	0.00% 0	65
Does the staff follow up on your requests in a timely manner (e.g. call bells, concerns/complaints)?	83.08% 54	10.77% 7	6.15% 4	0.00% 0	0.00% 0	65
Do you avoid providing feedback for fear of retaliation (e.g. abuse, withholding care etc.)?	12.31% 8	9.23% 6	76.92% 50	1.54% 1	0.00% 0	65
Do staff respect your personal privacy (knocking before entering your room) and physical privacy (privacy curtains drawn during personal care)?	82.81% 53	17.19% 11	0.00% 0	0.00% 0	0.00% 0	64

## Q7 What number would you use to rate how well the staff listen to you from 0 being the worst possible to 10 best possible

Answered: 65 Skipped: 0

ANSWER CHOICES	RESPONSES	
0	0.00%	0
1	0.00%	0
2	1.54%	1
3	3.08%	2
4	0.00%	0
5	13.85%	9
6	6.15%	4
7	9.23%	6
8	21.54%	14
9	26.15%	17
10	18.46%	12
<b>TOTAL</b>		<b>65</b>

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	YES	SOMETIMES	NO	N/A	DONT KNOW	TOTAL
Within the last 12 months, have you had any personal items go missing? (clothing, jewellery, money, etc.)?	33.85% 22	0.00% 0	63.08% 41	0.00% 0	3.08% 2	65
Do you feel safe in the home and on the home's external property (garden areas, patios, etc.)?	89.23% 58	9.23% 6	1.54% 1	0.00% 0	0.00% 0	65

	YES	SOMETIMES	NO	N/A	DONT KNOW	TOTAL
Is the temperature comfortable for you day and night?	77.78% 49	17.46% 11	4.76% 3	0.00% 0	0.00% 0	63
Is the lighting adequate for you in all areas of the home?	96.83% 61	3.17% 2	0.00% 0	0.00% 0	0.00% 0	63
Is the noise level acceptable day and night?	66.67% 42	23.81% 15	9.52% 6	0.00% 0	0.00% 0	63
Is the home clean and well maintained (for example repairs, decorating, or painting)?	92.06% 58	7.94% 5	0.00% 0	0.00% 0	0.00% 0	63
Is your room clean and tidy?	92.06% 58	6.35% 4	1.59% 1	0.00% 0	0.00% 0	63
Are your clothes cleaned and returned within two (2) days?	65.08% 41	11.11% 7	15.87% 10	7.94% 5	0.00% 0	63

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	YES	SOMETIMES	NO	N/A	DONT KNOW	TOTAL
Are you offered a choice at meal time (main entrée, dessert, and beverage)?	95.24% 60	4.76% 3	0.00% 0	0.00% 0	0.00% 0	63
Does the food taste good and look appetizing at breakfast?	79.37% 50	14.29% 9	0.00% 0	6.35% 4	0.00% 0	63
Does the food taste good and look appetizing at lunch?	76.19% 48	20.63% 13	3.17% 2	0.00% 0	0.00% 0	63
Does the food taste good and look appetizing at supper?	73.02% 46	23.81% 15	3.17% 2	0.00% 0	0.00% 0	63
Is the food served at the proper temperature (e.g. is hot food hot and cold food cold)?	92.06% 58	3.17% 2	4.76% 3	0.00% 0	0.00% 0	63
Are you offered snacks and beverages between meals?	93.65% 59	3.17% 2	3.17% 2	0.00% 0	0.00% 0	63
Do you feel you have enough time to complete your meal without rushing?	100.00% 63	0.00% 0	0.00% 0	0.00% 0	0.00% 0	63
Is the overall dining experience pleasurable?	79.37% 50	15.87% 10	4.76% 3	0.00% 0	0.00% 0	63

## APPENDIX A – CQI INITIATIVE REPORT

	YES	SOMETIMES	NO	N/A	DONT KNOW	TOTAL
If required, do the staff assist you in cleaning your teeth?	34.92% 22	11.11% 7	3.17% 2	49.21% 31	1.59% 1	63
If required do the staff assist you with your nail care?	69.84% 44	7.94% 5	6.35% 4	14.29% 9	1.59% 1	63
If you are currently using an incontinent product, is it well concealed under your clothes?	88.89% 56	0.00% 0	0.00% 0	9.52% 6	1.59% 1	63
Is the incontinent product comfortable?	74.60% 47	9.52% 6	4.76% 3	11.11% 7	0.00% 0	63
Does the incontinent product meet your bladder and bowel control needs?	88.89% 56	0.00% 0	0.00% 0	11.11% 7	0.00% 0	63
Are your bathing needs met on a consistent basis?	90.48% 57	6.35% 4	1.59% 1	1.59% 1	0.00% 0	63
Is the temperature in the spa room appropriate and comfortable?	84.13% 53	3.17% 2	9.52% 6	3.17% 2	0.00% 0	63
Do you currently have any discomfort, or have you had discomfort such as pain, heaviness, burning or hurting with no relief?	12.70% 8	12.70% 8	73.02% 46	1.59% 1	0.00% 0	63

APPENDIX A – CQI INITIATIVE REPORT

	YES	SOMETIMES	NO	N/A	DONT KNOW	TOTAL
Are you provided care and treatment in the language of your choice?	100.00% 63	0.00% 0	0.00% 0	0.00% 0	0.00% 0	63
Do you feel that the nursing staff know your care routine?	84.13% 53	12.70% 8	1.59% 1	0.00% 0	1.59% 1	63
Are your overall care needs being met?	87.30% 55	9.52% 6	1.59% 1	0.00% 0	1.59% 1	63
Do you feel there is enough staff available to provide the care and assistance needed without having to wait a long time?	41.27% 26	23.81% 15	31.75% 20	0.00% 0	3.17% 2	63

	EXCELLENT	VERY GOOD	GOOD	FAIR	POOR	TOTAL	WEIGHTED AVERAGE
Overall how would you rate the quality of care and services you receive?	34.92% 22	39.68% 25	20.63% 13	4.76% 3	0.00% 0	63	1.95

## Q14 Would you recommend our home to a family member or friend?

Answered: 63 Skipped: 2

ANSWER CHOICES	RESPONSES	
Yes	82.54%	52
Maybe	12.70%	8
No	4.76%	3
<b>TOTAL</b>		<b>63</b>

	YES	NO	TOTAL	WEIGHTED AVERAGE
Do you know about Resident Council?	56.45% 35	43.55% 27	62	1.44
Do you participate in Resident Council	29.03% 18	70.97% 44	62	1.71
Do you know about Family Council?	33.87% 21	66.13% 41	62	1.66
Do you participate in Family Council?	9.68% 6	90.32% 56	62	1.90

## APPENDIX B – CQI INITIATIVE REPORT

The Family Experience Survey was administered from Oct 7<sup>th</sup> to November 17<sup>th</sup>, 2025, inviting family members and individuals connected to a current resident or a resident who lived at Fairhaven in the past year. A total of 141 survey's were completed, up from 90 in 2024. Results and action plans were presented on February 25<sup>th</sup>, 2026.

	ALL OF THE TIME	MOST OF THE TIME	SOMETIMES	NO	N/A	DON'T KNOW	TOTAL
Do you feel the staff looking after you loved one are compassionate and supportive of him or her?	52.48% 74	39.72% 56	7.09% 10	0.71% 1	0.00% 0	0.00% 0	141
Do you feel the nursing staff know your loved ones care routine?	46.10% 65	38.30% 54	12.06% 17	1.42% 2	0.71% 1	1.42% 2	141
Are your loved ones overall care needs being met?	48.23% 68	36.88% 52	13.48% 19	0.71% 1	0.00% 0	0.71% 1	141
Do you feel there is enough staff available to provide the care and assistance needed?	23.40% 33	45.39% 64	13.48% 19	14.18% 20	0.00% 0	3.55% 5	141

APPENDIX B – CQI INITIATIVE REPORT

	ALL OF THE TIME	MOST OF THE TIME	SOMETIMES	NO	N/A	DONT KNOW	TOTAL
Are the physiotherapy programs effective to assist your loved one with their independence?	11.54% 15	16.92% 22	10.77% 14	8.46% 11	29.23% 38	23.08% 30	130
Are you satisfied with the care provided by their physician?	39.69% 52	32.06% 42	9.92% 13	4.58% 6	0.76% 1	12.98% 17	131
Are you satisfied with the services provided by the Pharmacy?	58.78% 77	22.14% 29	4.58% 6	0.00% 0	5.34% 7	9.16% 12	131
Are you satisfied with the services provided by the Dental Clinic?	15.63% 20	10.16% 13	7.81% 10	3.91% 5	46.88% 60	15.63% 20	128
Are you satisfied with the hair dresser services offered?	60.00% 78	16.15% 21	2.31% 3	3.08% 4	12.31% 16	6.15% 8	130
Are you satisfied with the foot care provider?	39.69% 52	12.21% 16	1.53% 2	2.29% 3	20.61% 27	23.66% 31	131
Are you aware Fairhaven has a Behaviour Support Ontario team?	32.81% 42	6.25% 8	4.69% 6	34.38% 44	5.47% 7	16.41% 21	128
Have you ever been involved in the process for Behaviour Support Ontario team?	7.03% 9	5.47% 7	8.59% 11	71.09% 91	5.47% 7	2.34% 3	128

APPENDIX B – CQI INITIATIVE REPORT

	ALL OF THE TIME	MOST OF THE TIME	SOMETIMES	NO	N/A	DONT KNOW	TOTAL
Are you consulted in decisions about your loved ones health condition and treatment plan by the members of your care team (includes physician, nurses, physiotherapist, etc.)?	59.23% 77	24.62% 32	12.31% 16	0.77% 1	2.31% 3	0.77% 1	130
Are you consulted in decisions about your loved ones care and daily routine (food preferences, sleeping, dressing and bathing schedules)?	33.08% 43	26.92% 35	24.62% 32	12.31% 16	2.31% 3	0.77% 1	130
Do you receive monthly statements of account of transactions in their trust account and for their accommodations charges?	77.69% 101	5.38% 7	0.00% 0	5.38% 7	4.62% 6	6.92% 9	130

	ALL OF THE TIME	MOST OF THE TIME	SOMETIMES	NO	N/A	DONT KNOW	TOTAL
Does the staff follow up on your requests in a timely manner (e.g. call bells, concerns/complaints)?	50.00% 63	32.54% 41	10.32% 13	1.59% 2	0.79% 1	4.76% 6	126
Do staff respect your personal privacy when visiting with your loved one? (knocking before entering your room) and physical privacy ?	77.78% 98	15.08% 19	3.17% 4	0.00% 0	1.59% 2	2.38% 3	126

### Q5 What number would you use to rate how well the staff listen to you from 0 being the worst possible to 10 best possible

Answered: 126 Skipped: 15

ANSWER CHOICES	RESPONSES	
0	0.79%	1
1	0.79%	1
2	0.00%	0
3	0.79%	1
4	0.00%	0
5	4.76%	6
6	5.56%	7
7	7.14%	9
8	15.08%	19
9	30.16%	38
10	34.92%	44
<b>TOTAL</b>		<b>126</b>

	YES	SOMETIMES	NO	N/A	DONT KNOW	TOTAL
Within the last 12 months, has your loved one had any personal items go missing? (clothing, jewellery, money, etc.)?	37.90%	14.52%	33.87%	2.42%	11.29%	
	47	18	42	3	14	124

## APPENDIX B – CQI INITIATIVE REPORT

	ALL OF THE TIME	MOST OF THE TIME	SOMETIMES	NO	N/A	DON'T KNOW	TOTAL
Is the noise level acceptable day and night?	36.80% 46	39.20% 49	8.00% 10	0.00% 0	0.00% 0	16.00% 20	125
Is the home clean and well maintained (for example repairs, decorating, or painting)?	56.00% 70	35.20% 44	7.20% 9	1.60% 2	0.00% 0	0.00% 0	125
Is your loved ones room clean and tidy?	44.35% 55	45.16% 56	8.87% 11	1.61% 2	0.00% 0	0.00% 0	124
Do you feel the infection prevention and control measures are present in the home	67.20% 84	24.80% 31	4.80% 6	0.80% 1	0.00% 0	2.40% 3	125
	<b>EXCELLENT</b>	<b>VERY GOOD</b>	<b>GOOD</b>	<b>FAIR</b>	<b>POOR</b>	<b>TOTAL</b>	<b>WEIGHTED AVERAGE</b>
Overall how would you rate the quality of care and services your loved one receives?	56.80% 71	22.40% 28	14.40% 18	6.40% 8	0.00% 0	125	1.70

## Q9 Would you recommend our home to a family member or friend?

Answered: 122 Skipped: 19

ANSWER CHOICES	RESPONSES	
Yes	83.61%	102
Maybe	12.30%	15
No	4.10%	5
<b>TOTAL</b>		<b>122</b>

	YES	NO	TOTAL	WEIGHTED AVERAGE
Do you know about Family Council?	87.50% 105	12.50% 15	120	1.13
Do you participate in Family Council?	13.45% 16	86.55% 103	119	1.87



**ACTION PLAN – (2025 Resident Survey and Family/Caregiver Survey)**  
 Committee: M Abrioux, J Gee, L Anderson, S Cardwell, R Harwood, D Hill, R Lustic  
 Family Member: D Payne, Resident:

Date	Presenting Issue	Action Plan	Responsibility	Target Date	Outcome
January 2026	Communication and information on Services, programs and supports Resident survey Q1, Q2, Q4, Q16, Q18, Family Survey Q3, Several comments throughout both surveys	<p><b>To improve communication with residents, families and caregivers</b></p> <p>*Develop a monthly article for the newsletter communication on – services, staff, programs etc. Create this as a one-page, simple, eye-catching flyer that can be posted and mailed to families. “We are Listening” title for flyer and newsletter column Use the same piece of communication in each place.</p>	<p>Rhonda Lustic to Work with Darlene at Reception to develop a template for “We are Listening” Develop list of topics and assign responsibility for each month, the team will send information to Dar, once she puts it in for the newsletter, we will print post and send out. Present Survey results and Action Plan to resident Council and Family Council</p>	February – December	Improved communication Less concerns

APPENDIX C – CQI INITIATIVE REPORT

		*Present Survey results and Action Plan to resident Council and Family Council	Rhonda Lusic Leanne Anderson	February Meetings	Legislative requirement Positive communication Decreased concerns
		*Promote new initiatives, share changes and updates on Fairhaven TV Get Fairhaven TV for the lobby reinstalled in a better location Continue to educate staff on not turning off the Fairhaven TV's or turning them on or reporting when off	Rob Harwood to complete work order to remove and relocate Fairhaven TV  Rhonda to put item in the Friday Facts for staff regarding turning off the TV's	February	Improved communication Promote events, services, programs, etc.
		*Highlighting positive comments for staff discuss in family information session Post in Lobby	Committee selected comments	Post in February	Improved Staff Morale Visual reminder for residents, caregivers and staff of the good work we are all doing.
		*Hold information sessions for caregivers and residents. Showcase programs and services, equipment, supports etc. Organize a planning committee to plan the event.	Admin Team BSO – Danielle Hill Nancy Rooney Leanne Anderson Debra Payne?	May 2026	Improved communication Decreased concerns Improved awareness Residents and Caregivers know how and where to access relevant information.
	Q 11 Resident Survey- Pain Do you currently have any discomfort or have you had discomfort such as Pain heaviness burning or hurting with no relief	* RNAO Pain Pathway * Promotion of what we do for pain management - Dr., Nurse Practitioner, NP Stat, on-call Doctors, Physiotherapy, etc. *Hospice Nurse education and consultation * Pain and Palliative Care committee * Promote following proper process - RPN to request RN to complete pain assessment when residents report pain. * Improve documentation and new assessments for RN and RPN	Jaime Gee Michelle Abrioux Nursing Leadership Team	April – June 2026	Decreased incidents of unresolved pain.

APPENDIX C – CQI INITIATIVE REPORT

	Q#8 - Laundry Family Survey Q#6 Multiple comments throughout both surveys	*Promote and share upcoming laundry changes – Added night shift, changes in hours and routines.  *Time study completed for laundry staff positions	Rob Harwood Chris Bolton Stephanie Tan	January 2026	Improved laundry services Decrease in lost laundry
		*Edit question for next survey to add “if items have been found”, ie money, wallets, clothes, etc. lost but then found/returned etc. Separate laundry from other items - make 2 questions	Jen Baro	October 2026	Improvement in survey response to lost items. Accurate reports of lost laundry.
		*Improve Lost and Found process/access etc. Continue with Lost and Found days Create Lost and Found Section in Resident Storage Rooms	Chris Bolton Rob Harwood	April 2026	Laundry returned to correct RHA
		*Improve Laundry Cart Set-up - use the same set up for folding and hanging Use dividers between clothing, ensure staff are reading labels during delivery	Rob Harwood Chris Bolton Stephanie Tan	June 2026	Clothes delivered to the correct resident Less missing laundry
		*Communicate labelling process to families and stress the importance of labelling – newsletter, “We are Listening”, Information sessions, etc.	Stephanie Tan	February – April 2026	Improvement in amount of missing laundry Decreased complaints
		*Create a “Labelling Depot” for caregivers to drop off everything that comes into Fairhaven (before it is taken to the RHA/resident) Have printed copies of forms and bags in one central location where everything can be dropped off to be labelled.	Rob Harwood Chris Bolton Stephanie Tan	June 2026	



# 2025 Year in Review





## From the Desk of Nancy Rooney our Executive Director

This past year has been one of excitement, growth, and meaningful moments for our Fairhaven community. We welcomed many new residents and said farewell to those we lost. Each day with our residents is a privilege, and we remain committed to bringing meaning, joy, and fullness to the lives entrusted to our care. While challenges inevitably arise, our dedication to providing a warm, supportive home—and an inspiring workplace—remains unwavering.

One of the highlights of our year was participating in the Walk and Roll Foundation Fundraiser. The event was exceptionally well attended and filled with energy, fun, and community spirit. We also celebrated the incredible commitment of our staff in our Service Awards Ceremony. A particularly heartfelt farewell was extended to Dr. Spink, who concluded more than 30 years of outstanding service as Fairhaven's Medical Director. We are deeply grateful for his leadership, dedication, and compassionate care. We also honoured several retiring staff members with best wishes and thanks, as well as many milestone recipients that we sincerely thank for their years of service!

Summer brought sunshine, beautiful grounds to enjoy, ice cream trucks, and popular summer sale. As the vibrant fall colours arrived, we celebrated our annual Carnival and welcomed residents, families, and friends to share in the fun.

Throughout the year, our team navigated ongoing infection control measures and shifts in outbreak status. Your resilience, teamwork, and dedication have not gone unnoticed. The ability of our staff to respond quickly and effectively has made a tremendous difference in managing each situation.

We also continued to experience increased Ministry of Long-Term Care oversight, with over 60 days spent on-site. While their goal is to help strengthen our practices, we acknowledge the stress this can bring to both staff and residents. Thank you for your professionalism and perseverance during these periods.

As we close the chapter on 2025, I want to express my sincere appreciation for your hard work, compassion, and commitment. Together, we have achieved so much, and I look forward to a prosperous, healthy, and exciting 2026.

Warmest wishes,

*Nancy*



# Nursing Highlights

This year, care quality was strengthened through the implementation of RNAO Clinical Pathways, supporting consistent resident- and family-centred care and standardized admission screening, including delirium screening for all new residents. Falls were reduced through weekly huddles, and the home remained below benchmark for restraint use. We launched interRAI,\* enhanced dementia-care preparedness with RSSC room decals, and continued to see improvements in IPAC outcomes, with Outbreak Days reduced from 226 (2024) to 164 (2025) and Resident Isolations reduced from 227 to 171. Occupational illness also improved, decreasing from 111 cases in 2024 to 71 in 2025. The home established a Living Classroom with Fleming College and continued preparations for the Accreditation Canada 2027 survey, positioning us for continued excellence.

## InterRAI

The benefits of the integrated interRAI reporting system (IRRIS) is that it simplifies data collection by using standardized, comprehensive health information. It supports real-time data submission, improves data standardization, enhances continuity of care by integrating health information across settings, and promotes person-centered care. It also notes that the IRRS Secure Reporting tool strengthens data security and privacy for Canadian health.



## Programs and Support Services

The Programs and Support Services team encompass Resident Programs, Volunteer Resources, Admissions, Social Services, and Spiritual Care. All areas adopt a resident-centred approach, ensuring programs and services reflect residents' interests, abilities, needs, and preferences.

New residents programs introduced during the year included Wellness Walks, Snacks and Series Nights, an Outdoor Summer Market, Seasonal Photo Shoots, Fitness Fridays, and Halloween Trick-or-Treating. Investments were also made in resident technology, including two Abby Machines, a Pixie Projector, and new computers for resident lounges.



Volunteer Resources focused on improving efficiency in volunteer orientation and onboarding by streamlining registration, training, and orientation processes. As a result, volunteer engagement remained strong, with volunteers contributing 5,610 hours in 2025. Volunteer recruitment is an on-going priority with 52 new volunteers registering this year.



Admissions and Social Services collaborated with the nursing team to implement the RAO Admissions Pathway. In total, 95 long-stay residents and 12 respite residents were admitted, meeting our target of a 97% occupancy rate. Social Services supported residents and caregivers during the transition to long-term care and provided on-going psychosocial and well-being support. The Social Services Worker facilitated Family Council and introduced a monthly drop-in support group for family members and caregivers. Social Services and Volunteer Resources coordinated to offer 5 educational opportunities for residents, caregivers, volunteers and staff.



Spiritual Care programs at Fairhaven support residents' diverse traditions and personal preferences and are an integral part of holistic care. The program is supported by dedicated community volunteers and, in 2025, delivered 355 services, including worship services, hymn sings, Bible study, and meditation. Volunteers also provide one-to-one support and end-of-life visits. Additional offerings include Services of Remembrance and "My Wishes" end-of-life planning.



## Nutrition Services

The Nutrition Services team advanced several quality improvements in 2025, including the purchase of new equipment and dining room furnishings to enhance the resident dining experience. Technology and equipment upgrade also enabled the department to surpass ministry standards for food service delivery.

Staff development remained a priority, with expanded education, enhanced training, and adjusted staffing hours to better support resident dining needs. Ongoing food committee meetings, menu reviews, and monthly satisfaction surveys continued to ensure residents play an active role in shaping menu development and service improvements.



## Information Technology

The IT department plays a vital role in supporting the organization by ensuring that all mission-critical systems remain stable, secure, and fully operational. Throughout 2025, the department successfully maintained essential infrastructure—including the nurse call system, phone system, networking systems, battery backup units, servers, and the computers relied upon daily by staff. By continuously monitoring, updating, and troubleshooting these systems, IT safeguarded business continuity and minimized operational disruptions.

In addition, the department provided consistent support for both staff and resident technology needs, ensuring timely assistance with devices, resolving technical issues, and managing access to digital services.

Moving into 2026, the IT department remains committed to delivering the same high standard of reliability, responsiveness, and technical expertise to ensure the organization continues to operate smoothly and effectively.



# Human Resources

In 2025, the Human Resources department continued to strengthen Fairhaven LTC's workforce and work environment by supporting, developing, and recognizing staff across the organization. A major initiative this year was the implementation of the new Human Resources Information System, Payroll, and Scheduling platform—Project UKG. System development has been underway since the fall, with testing currently in progress and a targeted go-live in Spring 2026.

To maintain compliance, HR policies and procedures were reviewed and updated. Notably, the revised HR Call-In Policy has clarified processes that previously caused confusion. Our Attendance Support Program remains active, helping ensure employees are present, punctual, and ready to provide high-quality resident care.

Labour and employee relations continued to grow through meetings, committee work, and staff engagement activities. We celebrated long-service employees during a well-received summer Service Awards Ceremony. In addition, the inaugural Diversity, Equity & Inclusion (DEI) Committee began its work, advancing initiatives that promote an inclusive workplace culture.

Throughout the year, HR continued to support all stages of the employee lifecycle, including recruiting, retaining, releasing, and managing organizational risk.



# Financial Management

The long-term care sector operates within a highly regulated environment that requires the delivery of comprehensive care and services across multiple departments. At Fairhaven, wages and benefits represent more than 80% of the organization's total budget, and annual wage increases continue to outpace the Ministry of Long-Term Care's per diem funding. Fairhaven greatly appreciates the ongoing operation and capital support provided by both the County and the City, which remains essential as the aging facility generates additional operational pressures.

Mandatory and non-mandatory financial and statistical reporting requirements continue to increase sector wide. While this level of accountability to residents, families, and the public is critical, it also brings significant administrative demands that require dedicated time and resources.

The Finance Department provides timely monthly financial reports and budget tracking tools to department managers to support informed oversight of departmental expenditures. A preliminary budget is developed annually with input from managers and is presented to the Board of Directors prior to the start of each fiscal year. The budget is then revised once the Ministry of Long-Term Care releases its annual funding allocation, typically in April.

Fairhaven remains committed to sound financial stewardship while navigating increasing regulatory, staffing, and operational pressures. Through diligent reporting, transparent budget processes, and ongoing collaboration with municipal partners, the organization continues to ensure resources are used effectively to support high-quality care for all residents.



Fairhaven's Board of Directors

# Environmental Services

## Emergency Preparedness

This year, the Environmental Services team advanced resident safety by implementing a more consistent and forward-looking emergency preparedness training schedule. Staff participated in enhanced drills and scenario-based practice, strengthening confidence and response times in real situations. These improvements ensure residents receive calm, coordinated, and efficient support during any unforeseen event.

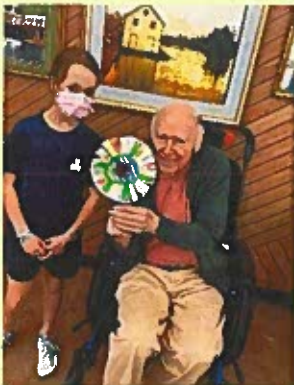
## Housekeeping & Laundry Services

The housekeeping and laundry team increased productivity and improved IPAC efficiency by assigning dedicated housekeepers to each Resident Home Area, allowing for more consistent routines and greater accountability. This approach strengthened infection control practices, helped maintain a cleaner and safer environment, and supported residents' comfort throughout daily living. These improvements promote dignity, reduce health risks, and enhance the overall quality of each resident's home environment.



## Building Maintenance

The maintenance team made significant upgrades this year to support resident safety, comfort, and therapeutic care. The addition of bariatric ceiling lifts and specialized therapeutic surfaces—such as advanced mattresses for skin integrity, wound care, and end-of-life comfort—ensured residents received appropriate support tailored to their individual needs. Retrofit lighting upgrades to modern LED systems improved visibility, safety, and energy efficiency, while the ongoing installation of new heat pumps enhanced climate control and comfort across the building. Through proactive inspections, timely repairs, and infrastructure modernization, the maintenance team continued to create a dependable, accessible environment where residents can live safely and with improved quality of life.



**Access and Flow**

**Measure - Dimension: Efficient**

Indicator #2	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.	P	Rate per 100 residents / LTC home residents	CIHI CCRS, CIHI NACRS / October 1, 2024, to September 30, 2025 (Q3 to the end of the following Q2)	16.77	16.77	The home is striving to maintain current performance of 16.77 and/or remain below provincial average.	

**Change Ideas**

**Change Idea #1 Educate staff, residents, and families about the benefits of preventing ED visits and the services the home has to manage care within the home**

Methods	Process measures	Target for process measure	Comments
Educate staff, residents, and families on the benefits of preventing avoidable ED visits and the range of clinical services the home can provide to safely manage care on-site. Education should emphasize reduced risks, improved continuity of care, faster response times, and decreased stress associated with hospital transfers. Information can be delivered through brief huddles, resident and family care conference, resident and family councils, monthly townhall virtual meetings, admission materials, and simple visual aids or handouts.	Percentage of staff educated; number of family education sessions	90% of registered staff educated by December 31 2026	Success will depend on clear education about the home's clinical capabilities, available on-site services, and established protocols for assessing and treating residents without unnecessary transfers. Partnerships with physicians, nurse practitioners, paramedicine programs, and external rapid-response teams will further strengthen confidence in the home's ability to provide timely, high-quality care.

**Change Idea #2 Involve the resident and their family, care partner or substitute decision-maker in care conferences to review care plan goals and preferences (goals of care), particularly around end-of-life care**

Methods	Process measures	Target for process measure	Comments
Involve the resident and their family, care partner, or substitute decision-maker in care conferences to review goals of care, preferences, and updates to the care plan, with particular attention to end-of-life wishes. Discussions should support shared decision-making, clarify values, and ensure that the plan of care reflects what matters most to the resident.	% of documented goals of care wishes on admission and annually	100% residents have a documented GOC	This initiative is supported by strong partnerships between residents, families, care partners, and the interdisciplinary team, as meaningful engagement is essential for aligning care plans with each individual's goals, values, and preferences. Ensuring consistent involvement in care conferences—particularly when discussing end-of-life care—helps promote shared decision-making, enhances trust, and reduces uncertainty for both residents and their substitute decision-makers.

**Change Idea #3 Build internal capacity within the home by delivering targeted education on pain and symptom management and training staff in best practices for goals of care communication**

Methods	Process measures	Target for process measure	Comments
Provide supplemental education for staff on pain and symptom management, along with skills training to support effective goals-of-care discussions. This training should strengthen clinical confidence, improve communication about changing conditions or end-of-life needs, and build overall capacity within the home to manage resident symptoms and facilitate high-quality, person-centred conversations.	% of staff who complete the supplemental education or skills training.	90% Registered staff complete education annually and on orientation.	This will be incorporated with our integration of the Pain Clinical Pathway, and palliative/EOL Care pathways.

## Equity

### Measure - Dimension: Equitable

Indicator #3	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 was able to successfully complete training for all management staff, and will be expanding the education to all staff, incorporating Indigenous Culture and Awareness training, trauma informed care training, with the support of the DEI committee established in 2025.	

### Change Ideas

**Change Idea #1** Expand the home's existing Equity, Diversity, Inclusion, and Anti Racism (EDIA) initiative to include mandatory Indigenous Cultural Safety education for all staff, including executive leadership and management, to strengthen culturally safe, trauma informed care and improve staff awareness of Indigenous experiences, histories, and health outcomes.

Methods	Process measures	Target for process measure	Comments
To support this change, the home will implement a standardized EDIA curriculum that includes dedicated Indigenous cultural safety modules delivered through recognized Indigenous-led organizations or qualified educational partners. Training will be embedded into orientation for new staff, annual refreshers, and leadership development activities. Completion will be tracked through our learning management system, with reminders provided to staff who have not yet met the requirement. Additional opportunities such as workshops, guest presentations, and sharing circles will be offered to deepen learning and reinforce cultural humility. Expectations related to EDIA and Indigenous cultural safety will also be incorporated into performance and development planning across all departments.	% of all staff completing required training by end of 2026. % management required training for 2026.	100% of education completed.	This requires our educator and DEI team organizing and sourcing the appropriate education, tracking for staff of approx. 450, and follow up for those not completed.

## Experience

### Measure - Dimension: Patient-centred

Indicator #4	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	44.62	50.00	For the question "How well do staff listen?", the current results are based on only a small portion of eligible residents, which means the data may not fully reflect the true experiences across the home. The response rate is low, and the indicator only counts residents who rated staff listening at the very highest levels (9/10 and 10/10). Many residents provided strong scores that were just below the cutoff, and if those were included, the results would paint a more positive and balanced picture. Because of this limited sample and narrow scoring method, a reasonable target is to improve the proportion of top score responses while also focusing on increasing the response rate so that future results better represent the full resident population.	

### Change Ideas

**Change Idea #1** 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	100% mandatory education completed by staff; 85% of direct care staff education completion of additional training	Total Surveys Initiated: 65  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. This indicator will be worked on closely with the indicator "Fear of Consequences"

### Measure - Dimension: Patient-centred

Indicator #5	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	81.54	100.00	Fairhaven has set a target of 100% for residents responding positively to the statement, "I can express my opinion without fear of consequences." This target reflects the organization's zero-tolerance approach to abuse, neglect, and retaliation, and reinforces the expectation that all residents should feel psychologically safe to express concerns, opinions, and feedback at all times. While survey results may be influenced by response rates, the 100% target establishes a clear standard aligned with resident rights, safety, and respectful care.	

## Change Ideas

**Change Idea #1** Create and promote a safe, respectful environment where residents feel comfortable expressing concerns, opinions, and feedback with out fear of retaliation.

Methods	Process measures	Target for process measure	Comments
Promote multiple safe avenues for resident voice, including resident council, one to one conversations, suggestion boxes, and family meetings. Communicate outcomes and changes back to residents to demonstrate that speaking up leads to action.	% of staff who complete education on respectful communication and non-retaliation. % of resident concerns	100% of staff will complete education on zero tolerance for abuse, whistleblowing. 100% resident concerns will be addressed within timeframes.	Total Surveys Initiated: 65  The home has a zero-tolerance approach to abuse and neglect and will continue with this in the upcoming cycle.

**Change Idea #2 Strengthen resident psychological safety by reinforcing education and communication about Zero Tolerance, Mandatory Reporting, and Whistleblower protections so residents feel safe expressing concerns, opinions, or complaints without fear of negative consequences.**

Methods	Process measures	Target for process measure	Comments
The home will strengthen resident awareness of their rights by reviewing Zero Tolerance, Mandatory Reporting, and Whistleblower protections during admission, care conferences, and resident meetings. Staff will complete mandatory education required under the Fixing Long-Term Care Act (FLTCA), ensuring they understand their legal responsibilities to protect residents and respond appropriately when concerns are raised. Staff will also receive coaching on supportive communication to ensure residents feel heard and respected.	Percentage of residents who report feeling safe to express concerns, supported by survey feedback and trends in resident forums and complaints documentation. Staff % completion rates for mandatory FLTCA education.	Increase to 100% as the home has a zero-tolerance for abuse policy; 100% staff training completion	Our home is committed to strengthening psychological safety so residents feel comfortable expressing concerns and opinions without fear of consequences. Staff complete mandatory education under the Fixing Long-Term Care Act (FLTCA), including Zero Tolerance, Mandatory Reporting, and Whistleblower protections, ensuring they understand their legal duties to respond appropriately and supportively. Residents and families receive clear information about their rights during admission, care conferences, and meetings, along with accessible pathways to raise concerns. Leadership reinforces open communication and timely follow-up, helping build trust and ensuring that residents feel listened to, respected, and safe to speak up.

## Safety

### Measure - Dimension: Effective

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Residents with Worsening Pain	C	% / Residents	CIHI eReporting Tool / Q3 2025-2026	14.70	11.50	Provincial risk adjusted data for Q3 2025-2026 is 11.5%.	

### Change Ideas

#### Change Idea #1 Implement RNAO Pain Best Practices Through the Falls Clinical Pathway

Methods	Process measures	Target for process measure	Comments
Implement the RNAO Pain Assessment and Management Pathway by training nursing staff on its components and integrating the pathway into routine resident assessments. Staff will complete standardized pain assessments on admission, quarterly, with significant change, and whenever pain is observed or reported. The pathway will guide consistent documentation, timely reassessment, and care plan updates. The leadership team will support implementation through education, coaching, and routine audits to ensure pathway adherence.	% of required pain assessments completed according to the RNAO Pain Assessment and Management Pathway (e.g., admission, quarterly, significant change).	90% compliance with RNAO Pain Pathway assessment and documentation requirements.	Using this standardized pathway helps ensure that residents receive timely and accurate pain assessments, appropriate follow-up, and individualized interventions. The pathway supports improved communication among nursing staff, physicians, pharmacy, and other interdisciplinary team members by creating a clear process for identifying, reassessing, and documenting pain.

## Change Idea #2 Weekly huddles to review residents who are triggering new pain or worsening pain

Methods	Process measures	Target for process measure	Comments
<p>Weekly pain-review huddles involve bringing the care team together to review residents who have triggered for new or worsening pain based on EMR alerts, increased PRN use, or staff observations. During the meeting the team discusses each case to confirm whether a pain assessment has been completed, identify what interventions have been attempted, and determine any further steps needed. Responsibilities are assigned, timelines are set, and outstanding items are carried forward to the next week to ensure follow-through.</p>	<p>% of residents who trigger for new or worsening pain and receive the required follow-up—assessment, care-plan update, and monitoring.</p>	<p>80% until RNAO pathway for pain is initiated, which should capture all triggering pain</p>	<p>This initiative enhances early identification and rapid response to new pain by ensuring that residents who trigger a new pain indicator are reviewed during weekly interdisciplinary huddles. These focused discussions allow the team to promptly assess potential causes, evaluate recent changes in condition, and implement appropriate interventions.</p>

## Measure - Dimension: Safe

Indicator #6	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 September 30, 2025 (Q2), as target quarter of rolling 4-quarter average	15.68	15.01	The home is striving to reach provincial benchmarking, while setting sights on HQO's benchmark of 9%.	

## Change Ideas

### Change Idea #1 Continued Implementation of RNAO Falls Clinical Pathway

Methods	Process measures	Target for process measure	Comments
Ongoing education to sustain staff competency and consistency of pathway. Reinforcement of fall risk reassessment, post fall huddles, and monitoring.	# audits of residents have falls risk assessment on admission, readmission, post fall and with any significant change in status.	> 90% of audits of residents charts display the process is being followed appropriately.	Ongoing staff education will be essential to maintaining competency, ensuring accurate fall risk reassessment, and reinforcing the importance of timely post-fall huddles and monitoring. Success will depend on strong interdisciplinary collaboration and the integration of falls-prevention practices into daily routines, shift handovers, and care planning discussions.

### Change Idea #2 Ensure that each resident has an individualized plan of care for fall prevention

Methods	Process measures	Target for process measure	Comments
Develop and maintain individualized fall-prevention plans for every resident by incorporating findings from fall risk assessments, post-fall huddles, and multidisciplinary input. Staff will complete and update care plans upon admission, following any fall, after a significant change in health status, and during regular care plan reviews.	% of residents who have a current, individualized fall-prevention care plan completed	90% residents care plans are up to date with the RNAO new Clinical Pathway care plan libraries, which include the focus for individualized fall prevention	Successful implementation will require strong interdisciplinary collaboration, including nursing, physiotherapy, BSO, and recreation, to ensure interventions are meaningful and aligned with the resident's needs. Engaging residents and families in developing and reviewing these plans supports shared decision-making and improves understanding of fall risks and prevention strategies.

**Change Idea #3** Implement a streamlined medication review process for fall risk residents by having nursing complete the PCC nursing section and emailing the medication review to the pharmacy consultant for timely completion and recommendations.

Methods	Process measures	Target for process measure	Comments
Nursing completes the fall related medication review section in PointClickCare (PCC) and emails it directly to the pharmacy consultant. The pharmacy consultant reviews the information, completes the remaining sections, and sends recommendations back to the team for care plan updates and follow-up.	% of medication reviews initiated by nursing that are completed by the pharmacy consultant	= 90% of medication reviews completed by pharmacy within 5 business days of receiving the PCC nursing section.	This workflow ensures that relevant fall-risk information is accurately captured by nursing and promptly forwarded for pharmacist review.

**Change Idea #4** Weekly Huddles for Residents With Two or More Falls in 30 Days

Methods	Process measures	Target for process measure	Comments
Implement weekly interdisciplinary huddles that automatically flag residents in PCC who have experienced two or more falls within 30 days. The huddles will use PCC data—including fall patterns, time of day, environmental triggers, behavioural notes, medication changes, and mobility status—to quickly identify trends and develop targeted interventions. Action items will be documented directly in PCC during the huddle, with assigned responsibilities and follow-up timelines. This ensures rapid response to escalating fall risk.	% of residents with two or more falls in 30 days who receive a documented weekly huddle review in PCC.	> 95% of high-risk residents (2+ falls in 30 days) have weekly huddle documentation completed in PCC.	These focused discussions allow the team to quickly identify patterns, triggers, and contributing factors, using both clinical observations and PointClickCare documentation to guide decision-making. Weekly huddles support rapid implementation of targeted interventions, improved communication across the team, and more consistent follow-up on identified risks.

## Measure - Dimension: Safe

Indicator #7	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 September 30, 2025 (Q2), as target quarter of rolling 4-quarter average	33.20	29.88	A target of a 10% reduction from the current rate of 33.2% is appropriate and achievable given the unique needs of the secure unit.	

## Change Ideas

### Change Idea #1 Collect and monitor current resident medication use data

Methods	Process measures	Target for process measure	Comments
Have MRP's sign up for MyPractice: Long-Term Care; quarterly reviews of residents triggering indicator DRG01. Once enrolled, MRPs will receive quarterly summaries of residents triggering indicator DRG01, review the cases, and provide clinical follow-up, deprescribing opportunities, or medication adjustments as appropriate.	%of MRPs successfully registered in MyPractice: LTC.	= 90% of residents triggering indicator DRG01 will receive a completed quarterly medication review.	This initiative strengthens the home's ability to monitor high-risk medication use and supports safer prescribing practices by integrating objective data from both PCC and MyPractice: Long-Term Care.

**Change Idea #2** Implement Gentle Persuasive Approaches (GPA) training to strengthen staff competency in managing responsive behaviors using non-pharmacological, person centred strategies, ultimately reducing reliance on antipsychotic medications.

Methods	Process measures	Target for process measure	Comments
Continue to deliver structured GPA training sessions focused on dementia care, de-escalation techniques, and individualized behavioral support strategies. Ongoing coaching and refresher sessions will ensure sustained knowledge retention and application in daily care practices.	% of frontline staff who have successfully completed GPA training.	Achieve 40% completion of GPA training among frontline staff within the next year to those who have outdated training.	The home has elected to chose a realistic goal for certification 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

### Measure - Dimension: Safe

Indicator #8	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of long-term care residents whose stage 2 to 4 pressure ulcer worsened	O	% / LTC home residents	CIHI CCRS / July 1 to September 30, 2025 (Q2), as reporting quarter for the rolling 4-quarter average	4.99	3.30	The home is striving to meet provincial average of 3.3%.	

### Change Ideas

**Change Idea #1 Provide ongoing training on pressure injury prevention, assessment and staging, using current BPGs**

Methods	Process measures	Target for process measure	Comments
Ongoing education on pressure injury prevention, assessment and staging will be provided to nursing staff through scheduled in-services and POC (point-of-care) reinforcement.	# Attendance records; % Chart audit compliance	>90% registered staff complete pressure injury prevention education.	Embedding standardized assessment tools into daily practice supports alignment with existing skin and wound prevention programs and reinforces early intervention strategies. Strong communication during shift handovers, skin rounds, and care conferences will help ensure residents identified as at risk receive timely follow-up and individualized care plans.

## Change Idea #2 Conduct comprehensive risk screening and assessments for every resident.

Methods	Process measures	Target for process measure	Comments
<p>To support improved skin integrity, staff will complete a standardized skin risk assessment ,PURS, which is built into our new RNAO Clinical Pathways for every resident upon admission, and whenever there is a change in health status. Early signs of skin breakdown, moisture concerns, pressure points, or existing wounds will be flagged for further assessment. Alongside this, a full head-to-toe skin assessment will be conducted at each of those intervals. All assessments will be documented promptly and accurately through our EMR including details such as location, appearance, and staging when applicable. Staff will receive training to ensure consistent assessment practices and recognition of early risk indicators. To build reliability into the process, reminders will be integrated into daily workflows, and weekly skin rounds reviewing new and worsening wounds will be conducted to validate assessment completion and follow up with at-risk residents.</p>	<p>% residents who receive PURS and a full skin assessment if anything indicates further risk.</p>	<p>&gt;90% audits show compliance with process</p>	<p>This initiative supports improved resident safety by strengthening early identification and prevention of skin breakdown through consistent and comprehensive risk screening. Success will rely on strong collaboration among nursing staff, wound care teams, and clinical leadership to ensure assessments are completed reliably and that findings are acted on promptly. This also aligns with the homes strategic direction of continuous quality improvement measures.</p>

## Measure - Dimension: Safe

Indicator #9	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of long-term care residents in daily physical restraints	O	% / LTC home residents	CIHI CCRS / July 1 to September 30, 2025 (Q2), as target quarter of rolling 4-quarter average	2.53	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** Implement a clear home-wide policy prioritizing alternatives before any restraint use.

Methods	Process measures	Target for process measure	Comments
Chart audits of residents who experienced a restraint (physical, or chemical) to determine whether alternative interventions were attempted and documented prior to restraint use.	% restraint rationale for why alternatives were ineffective or inappropriate. % restraint episodes with alternatives attempted first. % of documented rationale when alternatives were ineffective.	100% to align with HQO/RNAO and FLTCA.	Success will depend on strong staff education, consistent reinforcement of best practices, and collaboration across the interdisciplinary team to ensure that alternatives such as environmental modifications, de-escalation techniques, and individualized care strategies are used reliably.

**Change Idea #2 Partner with residents and families to discuss restraint policies, risks and alternatives during care conferences.**

Methods	Process measures	Target for process measure	Comments
Review of care conference documentation to determine whether restraint policies, risks and alternatives were discussed with resident and/or SDM.	% of CC where restraint policies, risks and alternatives were discussed and documented. % of individualized alternative to restraint strategies in care plan.	>90% restraint risk and alternatives are discussed and documented in the care plan.	This initiative also complements related programs such as behaviour support, dementia care strategies, and falls prevention

Quality Improvement Plan (QIP)

# Narrative for Health Care Organizations in Ontario

March 31, 2026



## 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. Our Quality Improvement Plan (QIP) focuses on enhancing personalized, trauma-informed, and culturally safe care that respects the diverse needs of our residents.

The home uses Accreditation Canada's framework and Health Quality Ontario's (HQO) standards of care to continuously improve the quality of life for our residents. We are committed to providing high-quality and compassionate care to our diverse and expanding population through a multidisciplinary team approach. The 2026/27 QIP aligns closely with our organization's mission, vision, and values and supports the provincial quality agenda. Fairhaven strives to be the model for excellence in long-term care.

Our strategic direction encompasses the following quality perspectives:

High-Quality, Compassionate Care

Workplace Culture

Continuous Quality Improvement Efforts

In conjunction with the provincial themes for quality, Fairhaven has embraced the following quality priorities for the year: efficient, safe, patient-centred, and effective care. These priorities reflect the expectations of the provincial quality framework and align with the needs and experiences of our residents, families, and staff. The home has embarked on a three year CQI journey to implement the RAO Clinical Pathways, which focus on improvements for the admission process, Resident and Family Centred Care, Delirium

Screening, Falls, Pain, Palliative and End-of-Life care, Dementia, Depression, Continence and Pressure Injuries. They guide our improvement efforts and reinforce our commitment to reliable clinical practices, strong communication, resident empowerment, and high-performing interdisciplinary teamwork. Through this QIP, Fairhaven continues to build on its strengths while addressing opportunities to further enhance the resident and staff experience across the home.

### **ACCESS AND FLOW**

Supporting residents to receive the right care in the right place at the right time remains a key priority for our home. Over the past year, we strengthened several ED-avoidance practices, including early assessment by nursing and the NP, same-day communication with physicians, and daily leadership huddles when a resident shows clinical change. These approaches, combined with proactive use of goals-of-care discussions, help ensure that residents receive timely, appropriate treatment and avoid unnecessary hospital transfers. Our partnerships with PRHC, local on-call physicians, BayCrest continue to improve access to urgent care support, after-hours guidance, and outreach services that stabilize residents in place whenever possible. The home has a full-time NP, and uses NP STAT as well for after-hours. Looking ahead, we plan to enhance weekend and after-hours processes, as well as strengthen communication workflows that allow staff to escalate concerns quickly and systematically. This year's QIP also emphasizes resident and family engagement in discussions about care preferences to reduce unwanted transfers and improve alignment with personal goals. By focusing on interdisciplinary coordination and timely clinical response, we aim to further reduce preventable ED visits and improve resident experience with transitions in care.

### **EQUITY AND INDIGENOUS HEALTH**

Fairhaven Long Term Care is committed to strengthening equity, diversity, inclusion, and accessibility (EDIA) across our organization, so every person feels safe, respected, and valued. Since being established in 2025, our committee has met monthly to guide our efforts toward building a more inclusive and supportive workplace.

The committee's first priorities include developing a formal policy and exploring meaningful, accessible education options for all staff. As part of this work, we are implementing training that supports inclusive communication, cultural awareness, and psychological safety, ensuring Fairhaven remains a welcoming environment for residents, families, and all staff. This includes integrating Indigenous cultural safety training and expanding cultural awareness education to help staff better understand diverse backgrounds, histories, and experiences. To date, all of our management and administrative staff have completed training, marking an important first step in building a shared foundation of understanding and accountability. We are also committed to celebrating a variety of cultural days and observances throughout the year to honour and learn from the diverse traditions represented in our community.

Additionally, our committee is working to identify and reduce language and disability-related barriers by exploring improved communication supports, accessible resources, and practices that ensure equitable participation for everyone. As part of this ongoing work, our recruitment processes will also be enhanced to ensure they support equitable hiring practices and attract a diverse, inclusive workforce that reflects the community we serve. Our ongoing efforts reflect our dedication to fostering belonging and promoting equitable practices throughout our Fairhaven

community.

## **PATIENT/CLIENT/RESIDENT EXPERIENCE**

Resident experience remains a central focus of our QIP, and this year we are prioritizing feedback from surveys, care conferences, and everyday conversations with residents. While survey results reveal many areas of strength, the overall response rate was low, with only 65 out of 256 residents participating. This limits the representativeness of the results and underscores the need for more intentional engagement in the coming year. Residents identified key themes related to communication, listening, and concerns about expressing opinions without fear of consequences. These findings were reviewed by our Resident Experience Survey Committee, which is identifying specific change ideas to address the themes and integrate resident voice into everyday practice. To improve response rates and ensure broad input, we plan to introduce assisted survey completion, increase in-person rounding for feedback, and explore the use of volunteers or family partners to support residents in sharing their views. Family feedback, collected through one-to-one meetings, care conferences, resident welcome teas, resident and family council, leadership walks, will also help supplement resident perspectives. Our QIP incorporates targeted initiatives to promote psychological safety, reinforce reliable communication processes, and ensure residents are consistently heard and respected

## **PROVIDER EXPERIENCE**

We recognize that staff experience is closely connected to resident experience and overall quality of care. Over the past year, staffing pressures and increasing resident acuity have placed significant demands on the team, reinforcing the importance of fostering a supportive, resilient workplace culture. Our home continues to invest in staff wellness initiatives, psychological safety, and meaningful opportunities for staff to provide input into care processes. Training in EDIA principles, communication, and key clinical skills—including pain assessment and responsive behaviour management—remains a priority.

To strengthen retention and support new team members, we are enhancing our onboarding, mentorship, payroll and scheduling programs to ensure staff feel confident and well supported. This year's QIP also emphasizes recognition, teamwork, and opportunities for interdisciplinary learning. Additional efforts include offering more flexible work schedules and expanding staff appreciation initiatives to acknowledge the dedication and contributions of our team.

By strengthening workplace culture and supporting staff well-being, we aim to improve overall provider experience and build a stable, empowered workforce capable of sustaining high-quality care. These priorities align with our revised strategic plan, which identifies workplace culture as a key strategic direction.

## SAFETY

Our approach to safety extends beyond preventing harm to building a culture where risks are identified early, concerns are raised openly, and safety practices are continually strengthened. Over the past year, we enhanced real-time safety monitoring through daily huddles, proactive assessment processes, and began a revision of structured reviews of indicators such as falls, medication safety, and skin health. Staff are encouraged to report near misses, allowing the team to learn from potential risks before harm occurs. This year's QIP focuses on promoting psychological safety so staff feel confident speaking up, as well as expanding our use of early warning indicators and rapid response processes when residents' conditions change. We continue to implement and refine safety programs in the areas of pain, falls, skin and wound, medication safety, antipsychotic usage and restraints, while reinforcing a home-wide culture of transparency, learning, and shared responsibility. Our goal is to strengthen resilience and responsiveness, ensuring that safety is integrated into every aspect of care.

## PALLIATIVE CARE

Palliative care is integrated throughout the resident journey in our home, ensuring comfort, dignity, and the highest possible quality of life for residents with life-limiting illnesses and their families. Our approach emphasizes early identification, open communication, and coordinated, holistic support.

Key components of our program include daily nursing rounds focused on proactive symptom assessment; goals-of-care conversations that help residents and families understand options and express preferences; and strong NP and MRP involvement to manage complex symptoms at end of life. We consistently use validated tools such as the RFCC, PPS, and RESPECT tool to support

timely identification, accurate prognostication, and effective care planning. Cultural and spiritual needs are honoured through our multi-faith partnerships, ensuring care remains personalized and meaningful.

Our palliative care handbook provides standardized guidance for staff, while vigil volunteers offer presence and comfort during end-of-life moments. The home also maintains an honour guard when a resident is leaving our home after death to recognize the resident, supporting dignity and acknowledging each individual's life and legacy. In addition, our hospice liaison participates in the palliative care committee to strengthen collaboration and continuity of support.

In late 2026, the home will implement the RAO Palliative and End-of-Life Care Clinical Pathway to further enhance consistency and best-practice alignment. Families remain engaged throughout the process through clear communication, education, and opportunities for reflection and bereavement support. Data from assessments, audits, validated tools, and family feedback guide continual improvement in symptom management, communication, and care transitions.

Our focus for the coming year is to expand interdisciplinary training, strengthen documentation of resident preferences and goals, and deepen collaboration with community partners who provide palliative, hospice, and spiritual supports.

## POPULATION HEALTH MANAGEMENT

Our home continues to embrace population health management as a framework for understanding and responding to the diverse needs of our residents and community. By reviewing data related to clinical risk, functional status, and social determinants of health, we are better identifying residents who may benefit from proactive interventions. We work closely with the Brain Injury Clinic, BayCrest, PASE, Dementiability, Align, Acheiva, BSO Supports Ontario, PRHC, GABU, RNAO, PointClickCare, NPSTAT, CareRx, Fleming College, Trent University, Oxford College, and several other community partners, to coordinate care and ensure timely access to specialized services. Residents with higher-risk needs—such as complex chronic disease, cognitive decline, wound care needs, or social isolation—are identified through huddles, interRAI triggers to initiate tailored supports. This year, we aim to deepen our participation in regional initiatives related to dementia care, wound management, and mental health outreach. By integrating health data, strengthening partnerships, and co-designing solutions with residents and families, we strive to deliver care that is proactive, person-centred, and aligned with the broader health needs of our community.


## CONTACT INFORMATION/DESIGNATED LEAD

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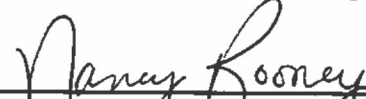
## SIGN-OFF

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



Board Chair / Licensee or delegate



Administrator / Executive Director



Quality Committee Chair or delegate

Other leadership as appropriate