Continuous Quality Improvement Initiative Annual Report

Annual Schedule: May 2026

HOME NAME : Heartwood

People who participated in the evaluation of this report

Name and Designation	Date
Quality Improvement Lead	Stephanie Lefebvre - RN	29-May-26
Director of Care	Kristen Renwick-Marshall - RN	29-May-26
Executive Directive	Chelsea Pecore - RN	29-May-26
Nutrition Manager	Nilesh Chavda - NM	29-May-26
Programs Manager	Caroline Seguin	29-May-26
Clinical Consultant	Davina Dowdall	29-May-26
Resident Council Representative	Jacquais Lecuyer	29-May-26
Medical Director	Dr. Archaria	29-May-26
Other	Crystal-Lee Russell (ADOC, RPN), John Tampus NP	29-May-26
Other	Cassandra Lefebvre (RAI, RPN)	29-May-26

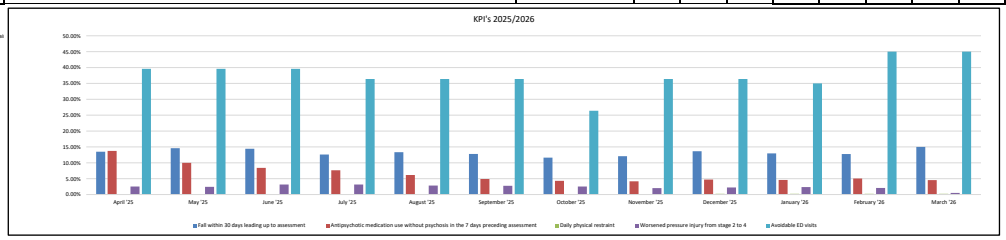
Summary of the Home's priority areas for quality improvement, objectives, policies, procedures and protocols from previous year (2025/2026): What actions were completed? Include dates and outcomes of actions.

Quality Improvement Objective	Policies, procedures and protocols used to achieve quality improvement	Outcomes of Actions, including dates
I am satisfied with the variety of recreation programs, goal to reach target of 80% from a performance of 62%.	**Integrate specific activities, programs, and strategies to include all 5 domains.** The home increased resident satisfaction with the variety of programs offered by implementing several targeted interventions. These include increasing the variety of group size offering	Outcome performance of 81.6%. The changes of increased spiritual offerings,
In my care conference we discuss what's going well what could be better and how we can improve things to reach target of 80% from current performance 52.5%	**Care Conference Communication and Engagement** Home increased resident and family satisfaction with care conferences by enhancing communication and participation, can collaboration throughout the care planning process. Interventions include providing advance notification and email invitations for care conferences to support attendance and preparation, sharing and reviewing the plan of care after the conference to ensure understanding of any changes, and scheduling of sufficient time for discussion so resident, families and substitute decision-makers do not feel rushed. The home offered through a variety of formats, including phone, TEAMs, these initiatives strengthen meaningful engagement.	Outcome performance of 81.79%. Residents were encouraged to attend their annual care conferences, which saw a 20% improvement by December. Survey questions were developed for feedback relating to the care conferences
I would recommend this home to others goal to reach target of 80% from a current performance of 71.6%.	**All staff will receive customer service education.** To improve resident and family satisfaction and increase the percentage of residents who would recommend the home to others, several initiatives were implemented. All staff received education on customer service principles, with a focus on respectful communication, responsiveness, and resident centered care. Customer service expectations and opportunities for improvement were regularly reviewed during interdisciplinary meetings to promote accountability and continuous quality improvement. Mentorship/preceptor program was developed to support orientation and integration of new staff, ensuring consistent standards, and fostering positive care environment.	Outcome performance of 80.80%. 100% of staff were educated on customer service by September 2025. Establishment of mentors for new staff, was ongoing.
If i need help right away, I can get it, target goal of 70% from 49.3% Performance 2025 49.3% Performance 2026 89.51%	**Increase staff awareness of call bell response times.** An improvement was accomplished in improvement resident satisfaction with timely access to assistance by strengthening call bell response processes and staff accountability. Initiatives included conducting regular call bell audits, review of call bell response tie, and discussing performance with PSW, to identify opportunities for improvement. During manager walkabouts, call bell response time was monitored. Education provided to the interdisciplinary team on the responsibility of all to respond to call bells.	Outcome performance of 89.51%. Routine audits of call bell logs, communication of response times to staff, and leadership walkabouts.
Percentage of LTC home residents who fell in the 30 days leading up to their assessment, target goal of 10%, from current performance of 12.18%.	**Implement 4 P's Rounding** The home did not meet the established target of 10%, the home implemented a number of initiatives which assisted in decreasing the fall rate in the home. Initiatives implemented, providing education with the PSW on the 4Ps (Pain, Positioning, Personal needs, and Placement), implementing weekly falls huddles with the interdisciplinary team to review incidents and identify prevention strategies, and conducting comprehensive admission assessments for resident with history of falls, to assist with the development of the plan of care. Additional initiatives include the proactive rounding, staff education on safe lifting and transferring techniques and comprehensive reviews of resident falls status and trends during monthly quality meeting. These interventions, have strengthened falls prevention practices, improve resident safety, and reduce falls rates.	Outcome performance of 12.65%. Implementation of 4P rounding, which is an ongoing process. Staff education sessions on fall reduction, audits of safe lift and handling procedures.
Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their assessment, target goal of 17.3% from current performance of 31.15%.	**Collaborate with the physician to ensure all residents using anti-psychotic medications have a medical diagnosis and rationale identified.** The home, continues to develop interventions in the reducing the use of antipsychotic medication without a diagnosis, through comprehensive medication reviews, by the interdisciplinary team. Collaboration with the Internal and External Behavioural Support teams, to develop the resident plan of care, with focus on de-prescribing medication, non-pharmalogical interventions. Additional interventions include DOS monitoring during the initiation, adjustment and de-prescribing of anti-psychotic medication, to determine the effectiveness. Staff have also received, re-education on the referral process to the BSO team to ensure timely access to specialized supports.	Outcome performance 4.76%. Increased BSO collaboration and visibility in the home. Medication and diagnosis review on a regular basis.
Percentage of long-term care home residents in daily physical restraints over the last 7 days. Target of 0% from current performance of 3.1%.	**Admission coordinator /designate will review each application received for restraints prior to admission** To support the reduction of restraint use, the home implemented to review all new admission who requested a restraint, or current had restraint in place to assess the reason for its use and determine the need for the restraint. Education provided to the family members regarding the risk and potential adverse effects associated with restraints, promoting informed decision-making and resident centered care. The interdisciplinary team, continue to review resident's plan of care to identify and implement appropriate alternative to restraints, ensuring interventions are individualized, quarterly review of the use. These initiatives where implemented to enhance resident safety, dignity, and quality of life while minimizing restraints.	Outcome performance 0.25%. Process for review of admission applications for restraints wad implemented, BSO team consultation to identify alternatives.
Percentage of long-term care home residents who developed a stage 2-4 pressure ulcer or had a pressure ulcer that worsened to a stage 2 to 4, target performance of 2%, from current performance of 3.1%.	**Turning and repositioning re-education.** To reduce the incidences of Stage 2-4 pressure injuries, the home implemented several quality improvement initiatives focused on early identification, preention and effective management of alteration in skin. Education was provided to registered staff and PSW on the indentification and assessments of pressure related injuires. Wound care lead, was established within the home to provide clinical oversight, support of best practices, and enhance wound management processes. Implementation of Skin and wound tracker, which provided, data on the prevelance rate, time in which the pressure injuries to resolve. Home consulted with NSWOC, to provide treatment options.	Outcome performance 2.93%. Tracking tool implemented with ongoing use, and re-education provided on turning and repositioning.

Key Performance Indicators

KPI	April '25	May '25	June '25	July '25	August '25	September '25	October '25	November '25	December '25	January '26	February '26	March '26
Fall within 30 days leading up to assessment	13.50%	14.59%	14.43%	12.60%	13.35%	12.78%	11.63%	12.07%	13.63%	12.97%	12.75%	15.00%
Antipsychotic medication use without psychosis in the 7 days preceding assessment	13.74%	10.00%	8.39%	7.64%	6.17%	4.91%	4.32%	4.17%	4.73%	5%	5%	5%
Daily physical restraint	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0%	0.25%	0.25%	0.25%	0.25%
Worsened pressure injury from stage 2 to 4	2.53%	2.43%	3.15%	3.15%	2.83%	3%	3%	2%	2%	2%	2%	1%
Avoidable ED visits	39.60%	39.60%	39.60%	36.40%	36.40%	36.40%	26.40%	36.40%	36.40%	35.00%	45.00%	45.00%

Integrate specific activities, programs and strategies to include all 5 domai



How Annual Quality Initiatives Are Selected

The continuous quality improvement initiative is aligned with our mission to provide quality care and services through innovation and excellence. The home has a Continuous Quality Improvement Committee comprised of interdisciplinary representatives that are the home's quality and safety culture champions. An analysis of quality indicator performance with provincial benchmarks for quality indicators is completed. Quality indicators below benchmarks and that hold high value on resident quality of life and safety are selected as a part of the annual quality initiative. Emergent issues internally are reviewed for trends and incorporated into initiative planning. The quality initiative is developed with the voice of our residents/families/POA's/SDM's through participation in our annual resident and family satisfaction survey and as members of our continuous quality improvement committee. The program on continuous quality improvement follows our policies based on evidence based best practice.

Summary of Resident and Family Satisfaction Survey for Previous Fiscal Year

Date Resident/Family Survey Completed for 2024/25 year:	October/November 2025
Results of the Survey (*provide description of the results*):	Areas for opportunity: Satisfaction of care from OT, social worker, and doctor. Response time for needing help, residents attendance in care conferences. Success Areas: I feel comfortable raising concerns with staff and leadership •I am satisfied with maintenance of the physical building and outdoor spaces •I can express my opinion without fear of consequences •There is someone i can talk to about my medications •Overall, i am satisfied with laundry, cleaning, and maintenance services.
How and when the results of the survey were communicated to the Residents and their Families (including Resident's Council, Family Council, and Staff)	Results of the survey were communicated to resident and family councils and staff in March of 2026 at the meetings and posted with the resident council and finally council board minutes. They were discussed at the CQI meetings.

Client & Family Satisfaction	Resident Survey				Family Survey				Improvement Initiatives for 2026
	2026 Target	2025 (Actual)	2024 (Actual)	2023 (Actual)	2026 Target	2025 (Actual)	2024 (Actual)	2023 (Actual)	
Survey Participation	90.00%	100.00%	100.00%	67.30%	90.00%	52.33%	90.00%	8.40%	Encourage families to provide immidiate feedback to frontline staff Add suggestion boxes, digital surveys, include feedback opportunities during care conferences.
Would you recommend	90.00%	80.87%	71.60%	85.70%	90.00%	90.23%	71.00%	88.90%	Review feedback and implement necessary changes, and update families via the newsletter
If I have a concern, I feel comfortable raising it with the staff and leadership	95.00%	91.52%	66.70%	87.90%	95.00%	81.96%	95.20%		Engage residents in meaningful conversations and care conferences to allow them to express their opinions review the concern process in the home on admission and during annual care confefrences

Summary of quality initiatives for 2026/27: Provide a summary of the initiatives for this year including current performance, target and change ideas.

Initiative	Target/Change Idea	Current Performance
Decrease the rate of avoidable ED visits.	Target: To seek improvement from 36% to 34% **Change idea #1**Support early recognition of residents at risk for ED visits. by providing preventive care and early treatment for common conditions leading potentially avoidable ED visits. **Change idea #2** Development of IV and hypodermoclysis programs in the home **Change idea #3** Education on palliative aproach and end of life for staff, residents and families	January 2026 - 36%

Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education	Target: to remain at 100% **Change idea #1** To continuously encourage overall dialogue of diversity, inclusion, equity and anti-racism in the workplace; **Change idea #2** To maintain diversity training through Surge education or live events; **Change idea #3** Cultural Diversity Recognition with in the home comprimised of recreation staff, resident and family members- to assist with develop programs, recognition with the home	December 2025 - 100%
Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences".	Target: Increase from 90.32 to 95% **Change idea #1**. Engaging residents in meaningful conversations, and care conferences, that allow them to express their opinions. Review ""Resident's Bill of Rights"" more frequently, at residents' Council meetings monthly. With a focus on Resident Rights #29. ""Every resident has the right to raise concerns or recommend changes in policies and services on behalf of themself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else""; **Change idea #2** Review of the Whistleblower policy **Change idea #3** Review the Concern process in the home on admission and during annual care conference	October 2025 - 90.32%
Percentage of LTC home residents who fell in the 30 days leading up to their assessment	Target: To reduce from 12.65% to 10.65% **Change idea #1** To facilitate a Weekly Fall Huddles; with the interdisciplinary team **Change idea #2** Purposeful rounding, for resident at high risk for falls **Change idea #3** Collaboration with recreation, to implement recreation activites, to engage residents (analysis to when falls are occurring to develop timing	2025-2026 Q3 - 12.65%
Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment	Target: To reduce from 4.76% to 4% **Change idea #1** The MD, NP, BSO internal and external (including Psychogeriatric Team), with nursing staff will meet monthly to review newly admitted residents on antipsychotic medication for diagnosis and indication for use. This is standing item in CQI/PAC quarterly meeting agenda. **Change idea #2** Residents who are prescribed antipsychotics for the purpose of management of Responsive expressions, will have a quarterly review, for the potential of reduction or the discontinuation of medication. Utilization of tracking tool (antipsychotic) **Change idea #3** Gentle Persuasive approaches (GPA) training/education -establish GPA trainers, educators in the home	2025-2026 Q3 - 4.76%
Percentage of long-term care residents whose stage 2 to 4 pressure ulcer worsened	Target" To reduce from 2.93% to 2% **Change idea #1** To reduce the percentage of resident who develop, or experience worsening pressure injury **Change idea # 2** Conducting audit of resident surface (bed/w/c), for the appropriate surface for pressure relieving **Change idea #3** Prompt identification and documentation of worsening pressure injuries	2025-2026 Q3 - 2.93%
Top 5 Priorities from Family Survey 1. I am updated regularly about any changes in the home (79%) 2. I am satisfied with: The variety of spiritual care services (79.41%) & 3. The resident has input into Spiritual care services (79.52%) 4. I am satisfied with the quality of: Laundry services for personal clothing (79.43% 5. Continence care products: Are comfortable (79.75%)	Top 5 Priorities from Family Survey 1. I am updated regularly about any changes in the home (79%) To enhance communication within the home, the action plan will be based off on these two key themes: transfer of accountability and overnight and communication to residents and families. Transfer of Accountability and Oversight Short-Term Immediate · Conduct audits for shift reports on all home areas to identify deficiencies · Initiate utilization of 24-hour report for all RPN · Develop and implement training resource that aligns with the homes internal process for shift report requirements and expectations · Standardize Charge Role and Duties per shift · Implement communication and huddle binders at each nursing stations · SBAR education to be completed by NP · Assign Clinical Leadership to each home floor Long-Term Sustainability DOC/DQR NP DOC/DQR February 14/26 January 29/26 February 14/26 January 29/26 January 29/26 February 14/26 February 2/26 · Randomized audits on all home areas to ensure compliance and key information sharing for shift report · Standardize clinical onboarding to reflect homes process for shift report requirements and expectations (Surge Video) · Annual re-education to all registered staff on homes process for shift report (Surge Video) Communication to Residents and Families Short-Term Immediate · Education to all staff on Customer Service, Complaints, Privacy & Confidentiality · Enhancing care conference involvement from interdisciplinary team · Implementation of weekly newsletter · Enhancement of monthly newsletter · Meet and greet with homes leaders and Family Council Long-Term Sustainability · Survey to both residents and families on communication and information sharing satisfaction 2. I am satisfied with: The variety of spiritual care services (79.41%) &3. The resident has input into Spiritual care services (79.52%) Short-Term Immediate · Focused survey to families to gather their feedback on variety of spiritual programming Program Manager/RSC February 23, 2026 · Education sessions to be provided at Family Council on what spiritual care encompasses including our current spiritual services provided within the home · Feedback from Family Council on recommendations for spiritual care within the home · Survey to residents on current spiritual needs, services, and suggestions Long-Term Sustainability · Quarterly survey to residents to identify how the home is performing, improvements and new idea sharing 4. I am satisfied with the quality of: Laundry services for personal clothing (79.43%) Short-Term Immediate · Standardize personal linen delivery process · Weekly review and organization from frontline staff · Follow up to ensure all personal linen carts leave the laundry room daily Long-Term Sustainability · Enhance general onboarding to review requirements for linens and personal clothing processes within the home · Audit by leadership through MBWA · Review of complaints related to laundry or missing items incidents weekly through Weekly Metrics & Goals Review 5. Continence care products: Are comfortable (79.75%) Short-Term Immediate · Reassess all residents using the Prevail Product Guide · Continence assessments for residents triggering increased need to ensure correct product ADOC January 29/26 · Audit effectiveness and compliance to ensure residents are wearing the appropriate product · Identify continence champions to support continence care Long-Term Sustainability · Implement Medline continence products while ensuring appropriate size and fit · Ongoing randomized audits to ensure compliance · Reassess residents upon admission, with any significant change, and quarterly · Surveys to be conducted at the admission and annual care conference to ensure comfort and satisfaction of products	Top 5 Priorities from 2025 Family Survey 1. 79% 2. 79.41% 3. 79.52% 4. 79.43% 5. 79.75%
Top 5 Priorities from Resident Survey 1. Communication from home leadership is clear and timely 70.83% 2. I am updated regularly about any changes in the home 70.92% 3. My concerns are addressed in a timely manner 74.52% 4. I am satisfied with the quality of care from: Physiotherapist/occupational therapist 76.43% 5. I am satisfied with the quality of care from: Social Worker/Social Service Worker 78.57%	1. Communication from home leadership is clear and timely 70.83% & 2. I am updated regularly about any changes in the home 70.92% Communication Short-Term Immediate · Education to all staff on Customer Service, Complaints, Privacy & Confidentiality · Enhancing care conference involvement from interdisciplinary team · Enhancement of monthly newsletter · Meet and greet with homes leadership on admission day · Enhancing engagement during leaders' daily walkabouts Long-Term Sustainability Education to be included in annual education as well as onboarding for all new staff · Survey to both residents and families on communication and information sharing satisfaction Transfer of Accountability and Oversight Short-Term Immediate · Conduct audits for shift reports on all home areas to identify deficiencies RSC/ADOC All leaders ED/Programs All Leaders All Leaders RSC RSC DOC/DQR February 11, 2026 By end of Q1 February 1, 2026 By end of Q1 Ending in Q3 Ending in Q3 Ending in Q3 February 14, 2026 · Initiate utilization of 24-hour report for all RPN · Develop and implement training resource that aligns with the homes internal process for shift report requirements and expectations · Standardize Charge Role and Duties per shift · Implement communication and huddle binders at each nursing stations · SBAR education to be completed by NP · Assign Clinical Leadership to each home floor Long-Term Sustainability · Randomized audits on all home areas to ensure compliance and key information sharing for shift report · Standardize clinical onboarding to reflect homes process for shift report requirements and expectations (Surge Video) · Annual re-education to all registered staff on homes process for shift report (Surge Video) 3. My concerns are addressed in a timely manner 74.52% Short-Term Immediate · Education to all staff and leadership on Customer Service, Complaints, Privacy and Confidentiality · Add the review of the Have a Concern document to Resident Councils standing agenda · Enhancing engagement during leaders' daily walkabouts · Formalize shift to shift hand-off tools All leaders Program Manager All leaders DOC February 11, 2026 March 1, 2026 By end of Q3 February 11, 2026 Long-Term Sustainability · Education to be included in annual education as well as onboarding for all new staff · Internal tracking of concern logs to identify trends with quarterly review and analysis · Designate Communication Liaison · Enhance feedback loop 4. I am satisfied with the quality of care from: Physiotherapist/occupational therapist 76.43% Short-Term Immediate · Conduct a Comprehensive Needs Assessment · Conduct focus groups and surveys to gather specific feedback from families regarding physiotherapy and occupational therapy services. · Identify common themes to address any areas of concern or improvement. · Enhance Communication of Services · o Service Promotion: Create informative materials (e.g., brochures, flyers) outlining the services offered by physiotherapists and occupational therapists, including descriptions of therapies and their goals. Long-Term Sustainability · Regular Updates: Include updates about available services in monthly newsletters or bulletin boards, focusing on new programs and schedule changes 5. I am satisfied with the quality of care from: Social Worker/Social Service Worker 78.57% Short-Term Immediate · Develop a "Welcome Ambassador" Program: Train existing residents or dedicated volunteers to serve as welcoming companions for new residents during RSC March 14, 2026 their first few weeks, helping them navigate the home, introducing them to activities, and offering peer support. · Create a Comprehensive Digital & Physical Welcome Kit: Beyond basic information, include a personalized welcome letter, a "resident roadmap" for key services, frequently asked questions, photos of key staff members, and a small comfort item or welcome gift. Long-Term Sustainability · Host Bi-Monthly "New Family Connect" Sessions: Facilitate informal group sessions for families of recently admitted residents to share experiences, ask	Top 5 Priorities from 2025 Resident Survey 1. 70.83% 2. 70.92% 3. 74.52% 4. 76.43% 5. 78.57%

Process for ensuring quality initiatives are met

Our quality improvement plan (QIP) is developed as a part of our annual planning cycle, with submission to Health Quality Ontario. The continuous quality team implements small change ideas using a Plan Do Study Act cycle to analyze for effectiveness. Quality indicator performance and progress towards initiatives are reviewed monthly and reported to the continuous quality committee quarterly.

Participants of Evaluation Name and Signatures:	*Print out a completed copy & obtain signature and file.*	Date Signed:
Quality Improvement Lead	Stepahnie Lefebvre	29-May-26
Executive Director	Chelsea Pecore	29-May-26
Director of Care	Kristen Renwick-Marshall	29-May-26
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