

The Meadows of Dorchester Continuous Quality Improvement Initiative Report

Designated lead: Tracey Tait, Administrator

Fiscal year end: March 31, 2027

Content	Pages
Introduction	1
Legislative Alignment	1
Our Approach to CQI	2
How We Identify Priority Areas for Quality Improvement	3
How We Monitor Improvement and Identify & Communicate Outcomes	5
Quality Improvement Priorities and Progress	6
Other Quality, Service, and Operational Improvements at Meadows	10
Priority Areas for 2026 -2027	12
Quality Improvement Accomplishments reflections since last report	15
Appendix A: Meadows of Dorchester Survey Results 2025	22

Introduction

Meadows of Dorchester is one of seven long-term care homes owned and operated by the Regional Municipality of Niagara. Located in the Niagara Falls community; it has 120 beds. Meadows of Dorchester is recognized as a best practice spotlight long-term care home and is accredited through Accreditation Canada.

We collaborate with various stakeholders, including team members, volunteers, students, physicians, and the Public Health and Social Services Committee, to ensure that resident care and services are consistently monitored, analyzed, and evaluated. Our approach aligns with resident preferences, best practices, leading standards, and the Fixing Long-Term Care Act 2021 (FLTCA) requirements, Ontario Regulation 246/22,

and Accreditation Canada standards. When opportunities for improvement arise, we work together to develop, implement, and evaluate initiatives to enhance care.

Our Mission

Working together, we provide the highest quality of life for Seniors living in long-term care and in the community.

Our Vision

Exemplary care, Compassionate team, and Community Leader.

Our Values

- Respect
- Serve
- Choice
- Honesty
- Partnership

Legislative Alignment

This report supports the home's annual continuous quality improvement reporting and reflects actions taken to monitor, evaluate, and improve care, services, programs, goods, and accommodation in alignment with the Fixing Long-Term Care Act, 2021 and Ontario Regulation 246/22.

This report was reviewed by the home's leadership and informed by input from the Continuous Quality Improvement Committee, Resident Council, Family Council, and relevant internal oversight committees.

Our Approach to CQI

Niagara Region long-term care homes have a comprehensive quality program that guides our long-term care homes through continuous quality improvement activities.

The Seniors Services Operational plan includes improvement efforts and initiatives across the homes to optimize standardization and decrease variability. We identify the priority areas through in-home committees, audits, reports, resident and family feedback, legislative requirements, and guiding principles.

Our home will monitor progress on strategic priorities to align them with our home needs by focusing on providing the best quality to our residents and embracing our continuous

quality improvement philosophy. Prioritizing improvement opportunities is a critical step in translating data into action.

How We Identify Priority Areas for Quality Improvement

Meadows of Dorchester is committed to fostering a collaborative and inclusive environment where the voices of our residents and their families are integral in shaping the care we provide. Meadows of Dorchester actively engages members of the Resident Councils, Family Connection Meetings and in quarterly Professional Advisory and Continuous Quality Improvement (PAC-CQI) Committee meetings. The insights and experiences of the Resident councils, Family Connection meetings, and the Quality Committee are invaluable in identifying areas for growth and implementing meaningful, actionable plans that are included for the next fiscal year based on the recommendations of the homes and their quality committees.

During these meetings, the management team provides updates on our quality and safety programs, sharing any activities that need discussion and input. We review various topics, including program performance, feedback from residents and families, important incidents, complaints, infection control, and other key focus areas. This collaborative approach ensures that we consistently work towards enhancing the quality of care we provide.

Quality Improvement Plans (QIPs)

Each year, Meadows creates Quality Improvement Plans that correspond with provincial system priorities. The plan for 2026-2027 emphasizes Health Quality Ontario's systemic challenges: Access and Flow, Equity, Safety, and Experience. These priorities align with our organization's goal of enhancing care and improving service quality. The objectives and suggested changes from this plan will often continue as multi-year initiatives, while Meadows works to sustain advancements in effective care, service delivery, and resident experience. Our team will follow the PDSA cycle (Plan, Do, Study, Act).

Identify/Diagnose the Problem

All identified problems that need attention are analyzed using the root cause framework.

- The Meadows team will document the problem and identify opportunities for improvement.
- The Meadows team will gather data to better understand the problem.

- The Meadows team will review the problem statement and team composition needs.
- The Meadows team will analyze the problem and data available using QI methodologies to identify opportunities for improvement.

Create a Plan

- Once teams understand underlining causes and align any resident needs, they would define an action plan in collaboration with residents and families.
- The team will be exploring and evaluating those opportunities.
- Meadows of Dorchester will identify how they plan to achieve desired results and document them under the PCC insights and Resident and Family/Caregiver Survey Action Plan and other Project planning tools available.
- The plan should include: (1) Where we are, (2) Where we want to be, (3) How we will do it and who (specific team members are identified to support the improvement activity).
- The team will determine if training is needed and include it as a task.

Set Improvement Aims

The aims set in our plan are developed using an interdisciplinary approach and feedback from family and residents. Data supporting the objective will be collected and used for analysis and benchmarking. Examples of data include scorecards, dashboards, and other facility reports such as employee and resident satisfaction results. Reports available from outside resources, including but not limited to Health Quality Ontario, CIHI, Nquire, and RNAO, are used to set clear paths for improvement. We use the SMART framework (Specific, Measurable, Attainable, Relevant, and Time-Bound) to set goals that will align with the desired improvement target and will help to focus on continuous improvement.

Test Improvement Ideas

Our quality improvement plan relies on teamwork among all staff to analyze problems and propose and implement resolutions. Ideas or interventions are established and monitored for the duration of the plan. The analysis identifies the effectiveness of the improvement activity and if any other approach should be considered. The improvement indicator or activity progress is documented in the Point Click Care (PCC) Insights, Project planner, and Resident and Family/Caregiver Survey Action Plan, and meeting minutes are recorded immediately after each quality meeting.

Implement, Spread and Sustain

Implementation plans are reviewed and evaluated routinely and as often as needed. The interventions are tested and assessed to ensure that any practice changes are

appropriately embedded into our workflow and that staff are aware of the changes. At the end of the testing period, the team will evaluate if interventions or change ideas resulted in improvement. The team will present any opportunities that could result in standardized practices across our long-term care homes to the quality steering committee. The Quality Steering Committee will discuss sustainability and consistency approaches and support the long-term care homes with the resources needed to implement any adaptations.

How We Monitor Improvement and Identify & Communicate Outcomes

Monitoring & Measurement

Meadows champions quality initiatives by leveraging our Continuous Quality Improvement Advisor to support and guide project planning, measurement strategies and accountability. Our quality and risk management program processes include monitoring and evaluating

- Performance indicators at the home and program level
- Priority indicators outlined in the annual quality improvement plans
- Professional and CQI committee
- Core programs meetings
- Municipal benchmarking and Resident and Family/Caregiver Experience survey results
- System-wide indicators

An Interdisciplinary team reviews metrics on PCC and other sources, and monitors progress in line with the core programs by proactively reviewing real-time data and progress across indicators. This allows the team to communicate effectively and adjust strategies to align with any issues identified.

Outcomes

Outcomes are conveyed through a range of resident and family council committees, in addition to PAC and quality committees within the divisional frameworks. The primary outcomes can be divided into the following categories:

- Resident Well-being Outcomes: includes metrics such as decreased hospitalizations and reduced medication errors.
- Resident and Family Engagement Outcomes: align with the goals specified in the Resident and Family Action Plan and involve improvements in care, services and programs.

- Core and Risk Management Outcomes: emphasizes the management and oversight of our clinical indicators, particularly targeting a reduction among different indicators falls, injuries, and pressure injuries.
- System and Organizational Outcomes: outcomes in accreditation and compliance, along with the encouragement of innovation in technologies and processes.

Communication

Strategies are developed following the senior's communication plan but are not limited to home-specific needs and preferences.

Updates to the quality improvement plan are shared through several means, including:

- Postings on the quality board
- Computerized information blast emails using the Cliniconex app.
- Direct e-mails to staff and families
- Newsletters
- Website
- Informal presentations/huddles
- Presentations at staff meetings
- Presentation at Professional Advisory and Quality Committees
- Presentations at Residents' Council meetings
- Presentations at Family Connection meetings (on request)
- Presentations at Public Health and Social Services Committee
- Quarterly reports at the Quality Steering Committee

Quality Improvement Priorities and Progress

Niagara Region Overview

In 2025, Niagara Region advanced initiatives that strengthen innovation, relationships, and well-being across our homes. Guided by the Vibrant – Live Your Best Model of Care, Niagara Region continues to foster safe, inclusive, and supportive environments where residents, families, staff, and visitors feel valued and connected. This model of care brings together our strategic initiatives to support person-centred care, meaningful relationships, and quality of life.

Several initiatives have been implemented to support the Vibrant – Live Your Best approach. This include the PAWsitivity Program, which enhances residents' quality of life through meaningful interactions with animals. To strengthen engagement, Seniors Services implemented Policy AD02-007 – On-Site Leadership Presence, supporting the

Leading with HEART philosophy. This initiative fosters authentic connections between leaders and team members, enhancing morale, communication, and trust through regular HEART Walks—visible leadership rounds focused on recognition and meaningful dialogue.

Resident Satisfaction and Engagement

Residents, family members, and caregivers were invited to participate in the annual Experience Survey. Volunteers, students, recreation staff, support workers, and family members were available to assist residents who wished to share their experiences. The survey included eleven questions rated on a five-point scale. Responses were scored from 1 to 5 and averaged to summarize results for each home.

Three additional reportable questions were included, using a ten-point scale and a six-point scale, respectively. Open-text questions also allowed residents and families to provide further comments and insights.

The Work Routine Project officially launched in the Nursing Department of Meadows of Dorchester in September 2025. A key milestone was the standardization of nursing start and stop times to promote coordination and stronger communication by ensuring that registered staff and personal support workers (PSWs) begin and end their shifts consistently across all units and homes. Standardizing routines allows staff to find more meaningful time to spend with residents, strengthening therapeutic relationships and reinforcing our commitment to person-centered care.

By reducing inconsistencies and operational inefficiencies, the project enables caregivers to focus on what matters most connecting with residents and enhancing quality of life.

Diversity, Equity, and Inclusion

In 2025, Niagara Region implemented a Facilitation of Smudging and Indigenous Ceremonies Policy, supporting the practice of smudging, an Indigenous healing ceremony and providing guidance to ensure culturally respectful practices are available for Indigenous residents, staff, and visitors in our long-term care homes.

Hospital Transfer Reduction

In collaboration with LifeLabs, Point of Care Testing (POcT) was introduced to the home in 2025 to increase timely access to medical testing to improve resident care and health outcomes. The LIAT ROCHE - gives PCR results for COVID, RSV and FLU A&B, allowing the ability to initiate prompt antiviral treatment, if indicated. The iStat device runs the Chem 8 panel - (sodium, potassium, chloride, ionized calcium, total CO (2),

glucose, blood urea nitrogen (BUN) and creatinine), BNP and Troponin tests, while the CLINITEK completes Urinalysis in about 1 minute.

Meadows Resident and Family/Caregiver Experience 2025 Survey Results & 2026 Action Plan

Meadows of Dorchester made significant progress during 2025-2026 across key areas, particularly in enhancing understanding of rehabilitation & physiotherapy services, improving food & snack quality, and enhancing physician services. Regular Resident Council (RC) and Family Council (now Family Connection) meetings throughout 2025 have been instrumental in sharing updates, gathering feedback, and implementing action plans. The 2024-25 Survey Action Plan achievements are noted in Table 2 at the end of this document. These initiatives, supported by quarterly PAC/CQI Committee meetings, reflect a resident-centered approach and a commitment to continuous improvement in care and quality of life. A full action plan is available upon request.

Resident & Family/Caregiver Experience Survey Results 2025

Meadows of Dorchester conducted its annual Resident and Family/Caregiver Experience Surveys to gather feedback from residents and their families about the services provided. The purpose of the survey is to facilitate improvements and ensure that care meets each resident's needs. In 2025, the survey was available from September 22nd to October 17th, 2025, and we received a total of 111 responses, including 68 from residents and 43 from families.

The Resident and Family/Caregiver Experience Survey results will show a variance between 2024 and 2025 due to a change in methodology. The 2024 survey used a 100-point rating scale, while the 2025 survey used a five-point Likert scale. Because these scales measure responses differently, year-over-year comparisons should be interpreted with caution and should not be treated as a direct, like-for-like change in performance or satisfaction at this time. As a result, baseline data is being collected to enable like for like comparison from 2025 and onwards.

The feedback we receive is invaluable as it helps us identify our strengths and areas for improvement, while also reinforcing our commitment to enhancing the quality of life in our homes. Overall care satisfaction was 4.16 out of 5, Services 4.12 out of 5, Programs 3.91 out of 5, and Products 4.08 out of 5. 85.37% of families and 94.12% of residents rated this home as either Excellent or Good. The following are the results compiled for the family and resident surveys. Please see survey results in Appendix A.

Resident and Family/Caregiver Survey Action Plan from the 2025 Survey

Three areas received lower satisfaction scores: enjoyable mealtimes, programs accessibility and enjoyment of programs. On January 19, 2026, the survey results were shared with the residents' council, followed by a presentation at the quarterly family connection meeting on January 26, 2026. On January 21, 2026, the survey results were shared with residents and families at the Professional Advisory and Continuous Quality Improvement Committee (PAC), and feedback was encouraged and welcomed. Printed copies of the results were also made available at the main entrance and posted on the Quality Board in January. On February 23, 2026, the home leadership team initiated further development of the action plan, discussing strategies for addressing the four identified areas in 2025 (guided and led by resident and family suggestions and feedback).

Residents and families were invited to review the proposed action plan and provide any feedback and adjustments they would like to see. Residents reviewed and approved the proposed action plan on March 16, 2026, at residents' council. Residents and families were also engaged in providing feedback on the proposed action plan from March 11-20, 2026, via an additional engagement board. Families reviewed and approved the action plan at the quarterly family connection meeting on April 9, 2026. The approved action plan was shared at PAC on April 15, 2026.

To address the areas with low satisfaction ratings from our 2025 survey, we have identified the following actions for improvement, to be completed in 2026:

1. **Enjoyable Mealtimes:** Our aim is to improve resident enjoyment during mealtimes, with a survey result of 4 out of 5 or higher in 2026 (currently we scored 3.91 out of 5). To meet this goal, we will install new blinds to meal service areas, remove background music as requested, conduct weekly meal service audits to determine areas of improvement and lastly, provide meal service education to frontline staff.
2. **Program Accessibility:** Our aim is to increase our annual survey rate to 4 out of 5 or higher by our next annual survey (currently we have scored 3.93 out of 5). Our team will trial the use of interventions during medium sized programs, change activity rooms to include kitchenettes, and solicit feedback monthly utilizing our recreation staff to identify any specific changes residents would like to see throughout the year to meet this goal.
3. **Enjoyable Programs:** Our aim is to improve our annual survey rate to 4 out of 5 or higher by our next annual survey (currently we scored 3.89 out of 5). The programs manager will conduct an exploratory survey to determine key areas for improvement, increase intergenerational programming by 10%, increase the number of volunteers to support our café, increase the number of family sign-ups for the WELBI portal,

and launch the DROM exercise program for residents. With these efforts, we anticipate that we will reach our goal.

The Resident and Family Council and the Professional Advisory and Quality Committee receive the current report and are regularly informed of progress regarding the action items during their meetings. Members can raise questions, provide input, and request changes as needed. An updated report and meeting minutes are posted in the Home, with copies available upon request.

The action plan will be reviewed and revised every quarter in collaboration with the resident council, family connection meetings, and the Quality Committee (refer to Appendix A). A comprehensive action plan is available in the home upon request.

Other Quality, Service, and Operational Improvements at Meadows for 2025

Meadows of Dorchester prioritized some other improvement initiatives that were not listed in our 2025 QIP or survey action plan. These initiatives are as follows:

- **Resident Room Drapery Refresh:** All existing room drapery in resident rooms were replaced, with residents participating in the selection of the drapes on Feb.24, 2025 date, and completion of Villa and Trillium in April 2025, and completion of Primrose and Spring Gardens in June 2025.
- **Safe & Secure Environment:** Several key areas related to safety and security were enhanced:
 - Securing the receiving bay (completed June 30, 2025), 2) Standardizing home keys (completed Aug. 31, 2025), 3) Addition of camera (Sept.1, 2025) and code access at the front vestibule (Nov.14, 2025), and 4) Cybersecurity instructions were added to all laptops and desktops (May.13, 2025).
- **Virtual Tour:** A virtual tour video of Meadows of Dorchester was created for inquiring and existing residents and families (completed Sept. 1, 2025).
- **Flooring/Painting Project:** New flooring in common areas, the staff lounge, and communication stations were installed (completed May 2025). An EASE assessment for dementia-friendly environments was conducted. Following this assessment, residents selected paint colors (from the EASE palette), and units received fresh new paint to enhance resident spaces and wayfinding. The entrance to Primrose was also repainted and refreshed (July 4, 2025).
- **New Pet:** The home welcomed a cat, named Freeway, in the summer of 2025 (Aug.18). A resident ambassador was selected to support Freeways transition into the home.

- **Courtyard Gardens Project:** In conjunction with the residents' council, the courtyard gardens were refreshed with a new gazebo, fresh paint on courtyard chairs, and the installation of new planters (completed June 30, 2025).

Priority Areas 2026 - 2027

In 2026-2027, Meadows of Dorchester is aiming to implement the following initiatives:

Area of Focus	Performance	Change Ideas
Rate of ED visits for the modified list of ambulatory care-sensitive conditions* per 100 long-term care residents.	Current: 16.46% Target: 15.50%	• Share a handout on in-home medical resources with residents and families to enhance understanding of families/residents on what can be provided in-home. Provide brochures on core programs and other topics during associated referrals and place on units for quick access. • Create an educational training video and share associated resources for staff on the use of POCT machines, to enhance understanding and bolster in-home diagnostic testing. Ensure 100% of staff trained on POCT review training videos. • Consult frontline staff through feedback forms to determine gaps and opportunities for the use of POCT machines in-home and utilize an ED transfer tracking sheet to determine gaps and prevent unnecessary transfers, with feedback collected by June 30, 2026, and analyzed in Q3. Tracking to occur on an ongoing basis and reviewed quarterly. Additional actions based on feedback to occur in Q3/Q4. • Enhance goals of care conversations and provide at least four education sessions for day and afternoon shifts.
Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education.	Current: 100.00% Target: 100.00%	• Run at least one DEI-related activity/event opportunity per month for residents/families/staff. • Implement the RNAO DEI BPG. Utilize the CLRI assessment to determine gaps. • Conduct a policy review for cultural perspectives at EOL by December 31, 2026. • Enhance awareness and engagement of Indigenous history in Canada and Indigenous cultures through intentional activities of reflection during Red Dress Day and Truth and Reconciliation Day and implement a healing garden with support from residents and staff.

Area of Focus	Performance	Change Ideas
Percentage of residents responding positively to: "What number would you use to rate how well the staff listen to you?".	Collecting baseline	• Collaborate with PRC to deliver 12 education sessions across the year to enhance staff knowledge on various topics. • Provide at least 4 GPA sessions to frontline staff. • Implement family connection meetings to engage families. • Increase the number of family sign-ups for the WELBI family portal. Implement the DROM exercise program to enhance variety of regular programs
Percentage of residents responded positively to the statement: "I can express my opinion without fear of consequences".	Collecting baseline	• Create a "roles of the home" pamphlet for families, residents and staff to enhance understanding of who to come to for concerns. • Utilize unit tv screens to share information about the resident's bill of rights to increase understanding. Quiz staff at daily clinical rounds on bill of rights quarterly and share video at council meetings quarterly. • Provide partners in care (PIC) training to residents/families/staff. • Leadership team to attend a family connection meeting at least once in the year
Percentage of long-term care residents in daily physical restraints.	Current: 2.84% Target: 0.00%	Reach zero use by utilizing a pre-admission checklist conversation with new residents and families to articulate LTC culture of zero-restraints and associated risks of use.
Percentage of long-term care residents whose stage 2 to 4 pressure ulcer worsened.	Current: 6.70% Target: 2.30%	• Deliver at least two education sessions on skin & wound best practices to strengthen staff knowledge and application by December 31, 2026. • Implement a structured assessment process to differentiate MASD from fungal infections before initiating antifungal treatment. The focus will be on identifying and addressing the root causes of moisture-related skin breakdown and using in-house moisture management products as first-line treatment. Antifungal medications will only be initiated when a fungal infection is clinically suspected.

Area of Focus	Performance	Change Ideas
Percentage of LTC home residents who fell in the 30 days leading up to their assessment	Current: 18.48% Target: 17.50%	• Deliver at least two education sessions on falls prevention best practices to strengthen staff knowledge and application by Q3. • Digitalize falls related audits to enhance process for timely follow-up of potential gaps in practice. • Evaluate the current use of the post-fall huddle tool and consult frontline staff on improvements to support consistent use and sustainability. Provide education based on changes or needs to reinforce efforts on the audit. • Improve sight lines on the units to create more open nurse stations and enhance detection/supervision of frequent fallers. Conduct regular floor mat audits and replace any torn or worn mats from home areas. Add contrasting paint behind toilets, beginning with the on-unit washroom.
Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment.	Current: 20.20% Target: 18.00%	• Provide nursing leadership education on risks/benefits of antipsychotic use and reduction approaches, at least twice in the year of 2026; ensure one education is delivered by June 30, 2026, 2026, and an additional education is offered by December 31, 2026. • Register at least one physician in home for the “MyPractice” report to enhance insight into prescribing patterns as it relates to antipsychotics. • Run bi-monthly committee; select 1–2 eligible residents per meeting for deprescribing review and planning (as appropriate) for the calendar year of 2026 and implement a new TOR by June 30, 2026. • Provide at least two education sessions to frontline staff on the use of non-pharmacological and pharmacological strategies.

Quality Improvement Accomplishments (reflections since last report)

Table 2: Results of 2025/2026 Health Quality Ontario (HQO) QIP & 2024-25 Survey Action Plan

Residents, families, and staff are invited to review the full progress report for Health Quality Ontario projects, located in-home at the Quality Board and upon request from the Administrator or Continuous Quality Improvement Advisor.

*CB=Collecting Baseline

Area of Focus	Performance	Change ideas	Date of Implementation	Outcomes and Impact
HQO: Rate of ED visits for the modified list of ambulatory care—sensitive conditions * per 100 long-term care residents.	Target: 19.00% Actual: 16.46%	- To successfully hire and integrate a Nurse Practitioner (NP) By the end of Quarter 1 2025, improving patient care, reducing unnecessary hospital transfers, and enhancing overall healthcare delivery in the facility. - To provide Education- Multiple sessions on SBAR, ED Avoidance, Principles of documentation to ensure larger captured audience. - To provide comprehensive education to families on avoiding unnecessary emergency department (ED) visits through newsletters and in-person education sessions. - Review how changes in resident status are monitored and communicated to providers in real time.	- NP was officially hired July 9, 2025. - Education occurred Aug.6 & 7, and Sept.7, 2025. - Project abandoned. - Initiated Jan.1, 2025	In 2025, our team successfully implemented three out of four change ideas, exceeding our performance goal by reducing avoidable Emergency Department (ED) transfers to 2.54% below our target. Key drivers—notably the hiring of a Nurse Practitioner (NP)—successfully enhanced in-home services and staff clinical skills. These efforts directly minimized unnecessary transfers, alleviated broader health system pressures, and prioritized resident comfort and experience.

Area of Focus	Performance	Change ideas	Date of Implementation	Outcomes and Impact
HQO: Percentage of staff who have completed relevant equity, diversity, inclusion, and anti-racism education .	Target: 100% Actual: 100%	• By the end of Q3 2025, Meadows will host two cultural showcases, each highlighting a different country of origin. These showcases will include an interactive world map for staff, residents, and families to engage with, learn about, and celebrate the unique aspects of each country. • Deliver DEI education through various channels. • Change our "chapel" to a more inclusive place for reflection, relaunching as a "Place of Worship". • Host 2 cultural celebratory events in the Home, engaging Residents and Staff.	• Showcases Jan. 29; Feb.1; Mar. 8; Mar.31; May. 1. International hallway installed Sept. 1, 2025. • Learning on indigenous topics occurred May. 5 & 7, and Sept. 17, 2025. • Launched Mar. 1, 2025. Additional resources added March 2025. • Celebrations on Jan. 29, May. 7 & 27; June 4; June 16-20; Aug. 13 & 15; Oct.22, 2025	• In 2025 we sustained a strong approach to DEI in the home by encouraging staff, residents, and families to participate in events, activities, and education throughout the year. We relaunched our chapel to a place of worship, with resources that help to embrace people of all cultures and religions. • We were able to meet our target measure, noting that education on DEI is embedded in our annual PD

Area of Focus	Performance	Change ideas	Date of Implementation	Outcomes and Impact
HQO: Percentage of residents responding positively to: "What number would you use to rate how well the staff listen to you?"	CB Most recent consecutive 12-month period survey in-house data,	- At the start of Q2, monthly updates will be provided on the resident action plan activities and progress, addressing the concerns identified in the survey results. - By the end of the next quarter, leverage existing communication tools (e.g., email, newsletters, and meetings) to share streamlined processes with staff, families and residents. - Engage Residents in choice for home improvements. - Education for the normalization of pain and its impacts on residents' quality of life	- Reviewed at residents' council Jan. 20; Feb. 24; Mar. 17; June 23; July 21; Sept. 15; Oct.20 (last meeting, all items were completed, so no additional updates needed). - Reviewed at PAC Apr.16; July 16; Oct. 15, 2025 - Shared via newsletter Feb., May-Oct. 2025. - May, June & September newsletters. - Residents' council Jan. 20; Feb. 24; Mar. 17; Apr.28; May 26; June 23; July 21; Aug. 18; Sept. 15; Oct. 20, 2025. - Education occurred Apr. 29 & Sept. 4, 2025.	- We completed all four projects in this priority area, strengthening how we spotlight resident voice through a person-centred care approach and ongoing collaboration with the Residents' Council. We utilized the expertise of external partners to further support staff knowledge on the normalization of pain. - Note changes to our survey this year resulted in collection of baseline and more accurate comparison to occur for 2026-27.

Area of Focus	Performance	Change ideas	Date of Implementation	Outcomes and Impact
HQO: Percentage of residents responded positively to the statement : "I can express my opinion without fear of consequences".	CB	- Respect residents' values, preferences, needs and suggestions in enhancing daily living. - Increase participation in meal dining feedback experience. - Engage Resident(s) in recruitment of a new Nurse Practitioner. - Utilizing the monthly Resident Council forum, we will solicit suggestions for improvements.	- Food council meetings Jan. 20; Feb. 24; Mar. 17; Apr. 28; May 26; June 23; July 21; Sept.15, 2025. Meal Suite launch Sept. 29, 2025. - Initiated Jan.1, 2025. 212% increase in surveys collected. - Interview of selected candidate with resident June 9, 2025. - Improvements identified during council Jan. 20; Feb. 24; Apr. 28; May 26; June 23; July 21; Aug. 18; Sept. 15; Oct.20, 2025.	- We completed all four projects in this priority area, enabling us to enhance communication and solicit feedback directly from residents, ensuring a person-centred approach. Our greatest asset is our partnership with residents and families. By involving residents in decision-making, residents are empowered to enhance their home, which also positively impacts mood, fulfillment, and overall satisfaction. - Note changes to our survey this year resulted in collection of baseline and more accurate comparison to occur for 2026-27.

Area of Focus	Performance	Change ideas	Date of Implementation	Outcomes and Impact
HQO: Percentage of LTC home residents who fell in the 30 days leading up to their assessment	Target: 18.40% Actual: 18.48%	• Provide universal fall precautions education to 100% of staff within the next 9 months, with follow-up assessments to ensure understanding and implementation of protocols. • Assign designated staff to review and verify fall prevention interventions in resident care plans weekly, ensuring 100% of care plans are checked for accuracy and implementation over the next 6 months. • Conduct trend analysis meetings to review frequent fallers and identify trends in their falls, followed by the development of resident-centered prevention strategies. • Educate families and visitors on ways they can assist in preventing resident falls, such as reducing clutter and communicating with staff before leaving.	• Annual PD Mar. 31, 2025. Education creation May 2025. Facilitator training July 2025. Delivery of additional training paused. • Initiated Jan. 1, 2025. • Initiated Jan. 1, 2025. • March & September newsletter	• We completed all four projects in this priority area. Our greatest strength lies in our collaborative, interdisciplinary approach in reducing falls. Our team has processes in place to continuously review falls trends, interventions, and potential risks, and these projects enhanced our efforts. • We had a rate of 0.08% higher than our goal; however our falls rate continues to trend down in 2026.

Area of focus	Performance	Change ideas	Date of Implementation	Outcomes and Impact
HQO: Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment	Target: 19.00% Actual: 20.20%	- Establish a formal titration process within 3 months. - Provide staff education and training on the medication review process. - The BSO therapeutic advisor will identify residents eligible for non-pharmacological strategies to reduce their current antipsychotic usage. - Ongoing education on how to properly identify hallucinations and delusions to personal support workers	- Project abandoned July 29, 2025. - Project abandoned Aug. 5, 2025. - Initiated Jan. 1, 2025. - Education occurred Jan. 30; Feb. 11; Feb. 27; May 14; July 29; Aug. 13, 2025.	- We completed two out of four projects in this priority area. Despite ongoing efforts, inappropriate antipsychotic use in our home continues to trend upwards. We aim to enhance the availability of in-home resources and education to advance non-pharmacological approaches - We had a rate of 1.20% higher than our goal. Key barriers associated with this indicator include increasing complexity of new residents, awaiting the onboarding of our NP late Q3, and lastly, the need for family education on appropriate antipsychotic use, and its associated risks.
Survey: Physician Services	Previous score: 78.8% 2025 score (recategorized as quality of care): 4.16 / 5	Leverage newsletters as an effective communication tool to streamline processes such as MD visits, appointment bookings, and updates related to SMHO (Seniors Mental Health Outreach), ensuring consistent and clear engagement with recipients.	- Shared in the February newsletter. - Reviewed at PAC meetings on Jan.15; Apr. 16; July 16; Oct.15, 2025.	- Vaccine clinic information, denture support and the hear again clinic, UTI program and new LTC rates information was shared in newsletters. - Note changes to our survey this year resulted in collection of baseline and more accurate comparison to occur for 2026-27.

Area of focus	Performance	Change ideas	Date of Implementation	Outcomes and Impact
Survey: Food & Snack Quality	Previous 74.3% 2025 score (recategorized as enjoyable mealtime): 3.91 / 5	Encourage resident participation by conducting a survey to collect feedback at dining room tables. Our goal is to have at least 30% of residents participate within the next three months.	Initiated January 1, 2025. Updates shared at PAC meetings on Jan.15; Apr. 16; July 16; Oct.15, 2025.	- In Q2, we had a notable but temporary increase in survey collections as a result of additional support from staff on modified duties. In Q3, we noticed a slight increase in surveys as a result of PSW routines incorporating feedback collection. Survey results for 2025 show over 100% increase in survey feedback collection compared to 2024. - Note changes to our survey this year resulted in collection of baseline and more accurate comparison to occur for 2026-27.
Survey: Rehabilitation and Physiotherapy	Previous: 80.8% 2025 score: 3.91 / 5	Include a dedicated section in the monthly newsletter to communicate key physiotherapy parameters, such as recommended exercises and tips. The goal is to reach at least 80% of residents and their families within the next quarter. Additionally, gather feedback from families and residents to assess the effectiveness of this initiative by the end of the third quarter.	- Completed in the April, May, June/July, September, October, and November monthly newsletters. - Shared at PAC meeting for feedback on Oct. 15, 2025	- The home shared a 5-part series on the physiotherapy program throughout Q2 and Q3, with the final edition in the September Meadows Muse. Additional information on in-home physiotherapy has been posted outside of the physiotherapy room. - Note changes to our survey this year resulted in collection of baseline and more accurate comparison to occur for 2026-27.

Appendix A: Meadows Experience Survey Results 2025

Question Category	Question Short	Resident	Family	Combined
Care	Quality of care provided by the care team	4.09	4.28	4.16
Care	How your choices and preferences are respected in your care	4.03	4.23	4.11
Care	Support provided for your activities of daily living and routines	4.05	4.10	4.07
Care	How safe you feel living in this home	4.29	4.31	4.30
Services	How enjoyable mealtimes are	3.84	4.02	3.91
Services	Cleanliness and maintenance of the home	4.41	4.38	4.40
Services	Emotional and social support provided	4.05	4.07	4.06
Programs	How well the activities and programs match what you enjoy	3.86	3.93	3.89
Programs	How accessible programs and activities are for you	3.95	3.90	3.93
Programs	Experience with the rehabilitation and physiotherapy services	3.95	3.85	3.91
Goods	Comfort and quality of the continence products provided	4.09	4.08	4.08
Reportable	Do residents feel they can speak up without fear of consequences?	N/A	N/A.	52.94%
Reportable	Do residents feel they have a voice and are listened to by staff?	N/A	N/A	49.25%
Overall	What is your overall rating of the home as a place to live?	94.12%	85.37%	90.83%