

Rapelje Lodge Continuous Quality Improvement Initiative Report

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Introduction

Rapelje Lodge is one of seven long-term care homes owned and operated by the Regional Municipality of Niagara. Located in the Welland community, it has 120 beds. Rapelje Lodge 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 it 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

Rapelje Lodge 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. Rapelje actively engages members of the Resident Council (RC) and Family Councils (FC) and in quarterly Professional Advisory and Continuous Quality Improvement (PAC-CQI) Committee meetings. The insights and experiences of the Resident and family councils, 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, Rapelje Lodge 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 Rapelje Lodge 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 Rapelje team will document the problem and identify opportunities for improvement.
- The Rapelje team will gather data to better understand the problem.
- The Rapelje team will review the problem statement and team composition needs.
- The Rapelje 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's needs, they would define an action plan in collaboration with residents and families.
- The team will be exploring and evaluating those opportunities.

- Rapelje Lodge 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 will support the initiative (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 the 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

Rapelje 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

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- 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

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-centered 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 Rapelje Lodge 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.

Rapelje Resident and Family/Caregiver Survey Results & 2026 Action Plan

Rapelje Lodge made significant progress during 2025-2026 across key areas, particularly in enhancing knowledge of pharmacy services, enhancements to dietary services, the quality of food & snacks, and the addition of a Nurse Practitioner. Regular Resident Council (RC) and Family Council (FC) 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-centred approach and a commitment to continuous improvement in care and quality of life. A full action plan is available upon request.

Resident & Family/Caregiver Survey Results 2025

Rapelje Lodge 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 88 responses, including 66 from residents and 22 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. Baseline data is being collected.

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 4.31 out of 5, Services 4.04 out of 5, Programs 4.21 out of 5, and Products 3.86 out of 5. 100.00% of families and 90.91% of residents rated this home as either Excellent or Good. The following are the results compiled for the family and resident surveys, and outline specific opportunities for improvement for our survey action plan. Please see survey results in Appendix A.

Three areas received lower satisfaction scores: enjoyable mealtimes, emotional & social support, and the comfort & quality of continence products. Results were shared with residents at the Residents' Council meeting on December 17 & January 21, 2026. Families received the results at family council on February 9, 2026. Results were also shared with residents and families through the Quality Board in January, via email on January 15, 2026, and through the Professional Advisory and Continuous Quality Improvement Committee (PAC) on January 22, 2026. Printed copies of the results were also made available at the main entrance and posted on the Quality Board in January.

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

Residents engaged in action planning on February 18, 2026, at residents' council. Families engaged in action planning on February 9, 2026, at family council. Families and residents were also encouraged to provide suggestions and engage in action planning through an engagement board located in the front lobby from January 16-February 18, 2026. Following consultation with residents and families, the leadership team further developed the action plan on February 18 & February 24, 2026. Residents and families engaged in the review of the proposed action plan, providing any feedback and adjustments they would like to see through residents' council on March 18, 2026, and through family council on March 16, 2026. The approved action plan was shared at PAC on April 22, 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:

- **Enjoyable Mealtimes:** Our aim is to improve our annual survey by reaching 4 out of 5 (our current rating is 3.47 out of 5) at our next survey by conducting an exploratory survey, providing education, trialing a breakfast show plate, trialing the use of a robotic arm to enhance autonomy during mealtimes, and splitting the nutrition and environmental services manager role into two.
- **Emotional & Social Support:** We aim to improve our annual survey result to 4.25 out of 5 (our current rating is 4.14 out of 5) by our next annual survey by implementing a family support group and increasing the number of families signed up for the WELBI family portal.
- **Comfort & Quality of Continence Products:** Our aim is to improve our annual survey result to a 4 out of 5 (our current rating is 3.86 out of 5) in our next annual survey by providing targeted education to staff and families, ensuring the number of MASD's remains the same or reduces.
- **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 residents, family council and the Quality Committee (refer to Appendix A). A comprehensive action plan is available in the home

Other Quality, Service, and Operational Improvements at Rapelje Lodge for 2025

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

- **Services:** Each unit received new washing machines in the flusher rooms, to ensure that washers in activity rooms can be primarily used by residents and families as they would like (Feb.5, 2025).
- **Town Square Fireplace:** As part of our ongoing enhancements to town square, the home installed a new fireplace (May.22, 2025) and added new decorations/furniture (Feb.5, 2025) to create a welcoming front entrance for all residents, families and visitors that enter the home.
- **Café Additions:** A new cookie oven (May.22, 2025) and slushy machine were added to the café. The smell of fresh cookies, and a nice cooling slushy treat has been a welcome addition to the home.
- **Virtual Reality Study:** The home introduced Rendeever, a cutting-edge virtual reality system that has brought joy, adventure and connection to Rapelje residents. In partnership with students from Brock University, our home has contributed to

research in this area (3yr study) and was featured on Niagara this week (Apr.1, 2025).

- **South Courtyard Renovation:** New accessible walkways, patio furniture, landscaping and a resident requested water feature were added to the south courtyard, creating a beautiful patio area for residents, families and staff to utilize (July 3, 2025).
- **Grand Piano:** A restored Steinway grand Piano was purchased for town square for everyone to enjoy. Recreation staff have utilized this piano to deliver music programs to residents, which has been well received (Aug.22, 2025).
- **Regional Award of Excellence:** Rapelje lodge received a Top award of excellence (Aug.22, 2025) for relationship building as a result of our response to a flood that occurred (Jan.22, 2025). Residents were safely transported away from the flood, with a grand welcome home (Jan.25, 2025) once the flood was addressed, including balloons, a welcome back cake, and staff applause.

Priority Areas 2026 - 2027

In 2026-2027, Rapelje Lodge 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: 25.97% Target: 23.30%	• 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. • Host 2 in-home potlucks for residents and staff to enjoy.

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. - Pilot OBI arm to enhance resident autonomy during meals, identifying the possibility of full implementation based on pilot results. - Create a new resident space to allow for more expansive programming, especially in relation to spiritual programs, council meetings, and family gatherings.
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 care partners (PIC) training to residents/families/staff. - Trial a monthly family support group, with topics based on family interest.
Percentage of long-term care residents in daily physical restraints.	Current: 0.50% Target: 0.00%	Continue to remain below the provincial average for restraint use in 2026 by ensuring the least restrictive type of restraint is considered or tried first.
Percentage of long-term care residents whose stage 2 to 4 pressure ulcers worsened.	Current: 6.57% Target: 4.29%	- Provide education to at least two staff members from wounds Niagara to enhance on-unit understanding of the principles of wound care. - Deliver at least two education sessions on skin & wound best practices to strengthen staff knowledge and application by December 31, 2026.

Area of Focus	Performance	Change Ideas
Percentage of LTC home residents who fell in the 30 days leading up to their assessment	Current: 18.14% Target: 16.20%	• 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 the 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. • Implement the PREVENT falls prevention project to support the reduction of hip fractures.
Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment.	Current: 8.51% Target: 6.00%	• 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 the home for the “MyPractice” report to enhance insight into prescribing patterns as it relates to antipsychotics. • Run quarterly 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: 18.40% Actual: 25.97%	- A standardized triage process for registered staff. - Develop and implement an education program for staff to enhance Emergency Department (ED) avoidance capacity, SBAR communication, and documentation principles. - Detect and report early changes in the resident's condition. Develop and implement decision-support resources for staff and families to guide hospital transfer decisions.	- Project abandoned June 3, 2025. - Initiated June 3, 2025. Education on Aug.6 & 7, 2025. - Initiated Jan. 1, 2025. - Project abandoned ; however, a newsletter was shared May 22, 2025	- Our team successfully implemented two out of four change ideas in 2025. We leveraged education to residents, families, and staff, facilitated the use of in-home resources where possible, and explored innovative approaches to ensure residents remain comfortably at home when appropriate. - We were 7.57% above our target; this is influenced by family/substitute decision-maker requests for transfers, which may in part reflect limited awareness of available in-home supports and impacts of unnecessary transfers.

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%	• Training for all staff on DEI. • Enhance the current DEI committee within the home. • Spotlight 2 DEI celebrations within the home for all to join in. • Involve residents and families in DEI initiatives.	• Annual PD completed Mar.31, 2025. Ongoing signage shared for cultural celebrations. • DEI meetings occurred monthly. DEI board was implemented on June 27, 2025. • Jan.29; Mar. 4; Mar.17; Apr.18; May 5; June 25; July 1; July 20; Sept.10, 2025. • Initiated Jan. 1, 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 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	- Engaging residents and their families in the goal-setting process to identify and document personalized, short-term goals that reflect the residents' desires and needs, with a focus on fostering collaboration and enhancing resident satisfaction in care planning. - Implementing an "open door policy" for the management team to foster transparent communication, allowing staff to approach management with concerns, ideas, or feedback, and promoting an inclusive and approachable work environment. - Evaluating Staff Responsiveness to Resident Preferences Through the Implementation of a Pleasurable Dining Experience. - Through Resident Council and one-to-one meetings with residents, identify gaps and improvements to ensure we are listening and responding to residents' needs.	- Initiated June 22, 2025. - Initiated Jan.1, 2025. - Half walls removed Dec.17, 2024. Mealsuite launched Sept.29, 2025. - Initiated Jan.1, 2025	- We completed all four projects in this priority area. Our goal was to strengthen partnerships and collaboration within the home by utilizing daily feedback from surveys, conversations, and formal meetings to drive continuous improvement. - 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	• Creating a display featuring the photos and role descriptions of the management teams to help residents to identify the appropriate person for feedback • Enable communication channels where residents and families can bring their concerns • Provide an anonymous way for Residents to give input to departments. • ICC's to give opportunity to express opinions and concerns in a safe space.	• Project abandoned. • Pharmacy rep. attended FC Apr.28, and RC July 24, 2025. Newsletter shared May 22, 2025. • Initiated Jan.1, 2025. • Initiated June 10, 2025.	• We fully completed three out of four projects in this priority area. Our focus was to enhance processes that allow residents and families to provide feedback comfortably. • 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: 18.00% Actual: 18.14%	- Audit of Falls Prevention Interventions to Evaluate and Enhance Effectiveness. - Falls prevention tips/education for families. - Implementing Hourly Rounding as a Strategy to Reduce Falls in Long-Term Care Homes. - Identifying Trends in Fall Incidents to Enhance Prevention Strategies and completion of a timely comprehensive assessment	- Implemented July 31, education July 15-30, 2025. - Initiated Apr.29, 2025. - Project abandoned. - Initiated Jan.1, 2025.	- We completed three out of four projects in this priority area. Our team focused on refining processes in identifying trends, providing education, and implementing interventions for residents at risk of falls. - We had a rate of 0.14% higher than our goal. As we progress into 2026, our focus remains on education and identifying innovative methods to address falls effectively in our homes.
HQO: Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment	Target: 8.50% Actual: 8.51%	- Review and optimize the use of antipsychotic medications in residents without a diagnosis of psychosis. - A systematic review of residents in each home area will be conducted by the RBTA. - Implement a standardized tracking sheet to document the titration process and other medication changes for residents undergoing antipsychotic reduction to ensure accurate monitoring and informed decision-making. - Develop a process on the antipsychotic medication review for newly admitted residents.	- Initiated May 27, 2025. - Initiated June 25, 2025. - Project abandoned. - Initiated May 27, 2025	- We completed three out of four projects in this priority area. Our team is dedicated to maintaining resident safety and comfort by addressing the risks of inappropriate antipsychotic use through a strong interdisciplinary approach and partnership with ISMP. - We had a rate of 0.01% higher than our goal. We will continue our reduction efforts and continue our collaboration with pharmacy and ISMP, while exploring ways to enhance physician engagement

Area of focus	Performance	Change ideas	Date of Implementation	Outcomes and Impact
Survey: Pharmacy Services	Previous 76.5% 2025 score (recategorized as quality of care): 4.33 / 5	- The Administrator will send out detailed information about Pharmacy Services, including a summary of the services contact information for questions or concerns to families and residents. - Pharmacy Representative to attend a Family Council and Resident Council Meeting in 2025 to provide an update on services and answer any questions.	- Implemented May 22, 2025. - FC May 26 and RC July 24, 2025.	- The administrator shared information on pharmacy services via newsletter including the ODB program, policies on medications/supplements, and drug coverage. The pharmacy representative addressed additional questions live, contributing to better understanding of pharmacy services in the home. - Note changes to our survey this year resulted in collection of baseline and more accurate comparison to occur for 2026-27.
Survey: Dietary services	Previous 76.8% 2025 score (recategorized as enjoyable mealtimes): 3.47 / 5	- By June 30th deliver Pleasurable Dining Experience (music/noise) & Staff Expectations During Mealtimes (Talking, Start Times, Portering times) education to at least 50% of staff members. - Remove all half walls by January 30th, 2025, in dining areas to create more space and easier access. - Trial of Harvest Tables in House 200 & 300 in Activity Rooms. Families or Recreation Staff with Residents can gather and enjoy a meal together.	- Screens installed July 21. Education provided Sept. 8, 9, 15, 16, 17, 18, 19. Full implementation of Mealsuites on Sept. 29, 2025. - Removed Dec. 17, 2024. - Update shared Feb. 5, 2025, to announce. RC May 22 and FC Feb. 10, 2025.	- Pleasurable dining experience initiatives were slightly delayed, however once implemented, residents were able to enjoy the benefits of enhance systems related to meal services. The removal of half walls created space for residents to enter and exit the dining room more comfortably, and the addition of harvest tables was well received. - 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: Quality of Food & Snacks	Previous: 77.8% 2025 score (recategorized as enjoyable mealtimes): 3.47 / 5	- Drip Coffee Makers to be purchased and installed in each Servery. This will replace the “wet” coffee system. These new coffee makers will enhance the coffee plus add the lovely aroma of percolated coffee. - New Rationale Oven to be purchased and installed. Will enable air frying plus more options for home-made food items. - Resident Council to trial food – food shows. NES Manager to attend 2 food shows this year and have Suppliers provide samples of new items. Have Residents try new products. In addition – the new menu system being introduced in April 2025, will get feedback from residents and have them involved in product selection.	- Announced Feb.5 upon implementation. - Installed Jan-Feb 2025. Announced upon implementation Feb. 5, 2025. - Food shows attended Feb.26 and Mar. 26, 2025. New snack menu approved May 22, 2025.	- New equipment, food, and snack items from food shows have enhanced the variety of options available to residents and supported an improved dining experience. These changes contribute to increased enjoyment and an enhanced sensory experience, including improved coffee aroma. - Note changes to our survey this year resulted in the collection of baseline and a more accurate comparison to occur for 2026-27.
Survey: Physician Services	Previous 79.6% 2025 score (recategorized as quality of care): 4.33 / 5	To fill Nurse Practitioner Vacancy April 1 st , 2025, to increase Physician Services to 85% satisfaction.	Role filled Mar. 17, 2025.	- The Nurse Practitioner has enhanced the availability of on-site prescriber support and clinical presence available to residents and families. - Changes to our survey this year resulted in the collection of baselines.

Appendix A: Rapelje Lodge Satisfaction Survey Results 2025

Question Category	Question Short	Resident	Family	Combined
Care	Quality of care provided by the care team	4.29	4.45	4.33
Care	How your choices and preferences are respected in your care	4.20	4.45	4.26
Care	Support provided for your activities of daily living and routines	4.17	4.35	4.21
Care	How safe you feel living in this home	4.34	4.67	4.42
Services	How enjoyable mealtimes are	3.32	4.00	3.47
Services	Cleanliness and maintenance of the home	4.45	4.67	4.51
Services	Emotional and social support provided	4.08	4.35	4.14
Programs	How well the activities and programs match what you enjoy	4.15	4.47	4.22
Programs	How accessible programs and activities are for you	4.23	4.32	4.25
Programs	Experience with the rehabilitation and physiotherapy services	4.11	4.29	4.16
Goods	Comfort and quality of the continence products provided	3.70	4.38	3.86
Reportable	Do residents feel they can speak up without fear of consequences?	N/A	N/A.	
Reportable	Do residents feel they have a voice and are listened to by staff?	N/A	N/A	
Overall	What is your overall rating of the home as a place to live?	90.91%	100.00%	93.10%