

Linhaven Continuous Quality Improvement Initiative Report

Reporting Period: 2026–2027

Designated Lead: Denise Murphy, Administrator

Fiscal Year End: March 31, 2027

Prepared for: Public posting and internal quality improvement reporting

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.



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Overview

Linhaven is one of seven long-term care homes owned and operated by the Regional Municipality of Niagara. Located in the St. Catharines community, the home has 248 beds. As a Best Practice Spotlight Organization by the Registered Nurses' Association of Ontario (RNAO), and an organization accredited by Accreditation Canada, Linhaven is committed to maintaining high standards of quality and excellence in 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, and Partnership.

Legislative Alignment and Quality Improvement Framework

Niagara Region Long-Term Care Homes maintains a comprehensive Quality Improvement Program that guides continuous quality improvement activities across resident care, services, programs, goods, and accommodation. At Linhaven, this program provides the framework for monitoring, analyzing, evaluating, and improving performance in alignment with the Fixing Long-Term Care Act, 2021, Ontario Regulation 246/22, resident preferences, best practices, leading standards, Annual Program Evaluations, and Accreditation Canada standards.

Governance Element and Accountability

Table 1. Quality Improvement of Governance and Accountability

Governance Element	Accountability
Administrator/Designated Lead	Accountable for report completion, implementation oversight, and communication.
Leadership Team	Implement assigned initiatives, monitor progress, and address barriers.
Professional Advisory and Continuous Quality Improvement Committee	Reviews quality improvement data, priorities, progress, barriers, and recommendations for improvement.
Resident/Family Council	Provides recommendations and feedback for improvement opportunities.

How Home Priority Areas Are Identified

The identification of priority areas uses a whole-team approach. Annual priorities are informed by recommendations from the home's Continuous Quality Improvement Committee, leadership review, operational and clinical performance data, and feedback from residents and families.

Resident Council and Family Council feedback and suggestions are a key part of this process. Linhaven also collaborates with team members, volunteers, students, physicians, and the Public Health and Social Services Committee to identify opportunities for improvement and implement meaningful actions. This collaborative approach ensures that we consistently work towards enhancing the quality of care we provide.

Monitoring, Measurement, and Continuous Improvement

Linhaven uses a structured continuous quality improvement methodology to monitor and measure progress, including Plan-Do-Study-Act cycles (PDSA), SMART goal setting framework (Specific, Measurable, Attainable, Relevant, Timebound), defined performance indicators, and regular review of resident, family, staff, clinical, operational, and risk data. Project management tools.

The home's quality management processes review and analyze information from multiple sources, including:

- Home- and program-level performance indicators, including PCC insights and NQUIRE measures.
- Priority indicators outlined in annual quality improvement plans (Health Quality Ontario)
- Canadian Institute for Health Information indicators (CIHI).
- Resident and Family/Caregiver experience survey results.
- Critical incidents, near misses, inspection findings, complaint logs, RNAO, audits, infection prevention and control data, program evaluations, core programs, and other key focus areas.

Progress is reviewed throughout the year to assess success, identify opportunities for improvement, support decision-making, and implement adjustments where required.

Communication and Reporting of Outcomes

Updates on quality improvement initiatives and results are communicated through a range of mechanisms, including:

- Resident Council and Family Council meetings.
- Professional Advisory and Continuous Quality Improvement Committee meetings (PAC).
- Staff meetings and huddles.
- Posted on the Niagara Region website and the home's quality board.
- Public Health and Social Services Committee meetings.
- Cliniconex messages, email communications, and newsletters.
- Quarterly reporting to the Quality Steering Committee.

Quality Improvement Plans (QIPS) Linhaven Priority Areas

Our annual Quality Improvement Plan (QIP) reflects the outcome of this priority setting process and is developed in alignment with Health Quality Ontario's provincial priorities.

Table 2. Linhaven Priority Areas

Priority Areas	Priority Indicator(s)
Access and Flow	Reduce the number of potentially avoidable visits to the emergency department.
Equity	Improve on the percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education.
Safety	- Reduce the percentage of residents on antipsychotic medication without a diagnosis. - Reduce the percentage of LTC home residents who fell in the 30 days leading up to their assessment. - Reduce the percentage of worsened stage 2-4 pressure ulcers. - Reduce the percentage of daily physical restraints.
Experience	- Improve rating on how well staff listen to residents. - Improve rating on "I can express my opinion without fear of consequences."

Review of 2025–2026 Quality Improvement Accomplishments

The tables below summarize quality improvement initiatives undertaken during the reporting period, including change ideas/actions, completion dates, and outcomes and impact.

Table 3. Access and Flow – Emergency Department (ED) Avoidance

Indicator / Priority Area	Change Ideas / Actions	Completion Date	Outcomes and Impact
Emergency Department Avoidance (ED)	"Change in condition" case scenario education for staff.	February 4, 2025.	4 situations were reviewed. Improved critical thinking and promoted teamwork.
Emergency Department Avoidance (ED)	SBAR/SBOR structured communication tool staff training.	May 29, 2025.	32 staff received training. Enhanced communication, clarity, and timely care.
Emergency Department Avoidance (ED)	ED avoidance training - Infection control, falls, and palliative care.	September 3, 2025.	Reviewed 3 priority areas related to ED visits during unit rounds across all shifts.
Emergency Department Avoidance (ED)	Palliative vs end-of-life visual review for staff.	July 30, 2025.	Developed to support informed conversations with residents and families.

Table 4. Equity – Diversity, Equity, and Inclusion (DEI)

Indicator / Priority Area	Change Ideas / Actions	Completion Date	Outcomes and Impact
Diversity, Equity, and Inclusion (DEI)	Cultural appreciation and education initiatives for staff and residents.	September 17, 2025	A food-based event with activities. Supported reflection, engagement, and learning.
Diversity, Equity, and Inclusion (DEI)	DEI promotional opportunities using dates of significance.	July 9, 2025.	100% of staff had access to DEI activities monthly (e.g., displays, interactive elements)
Diversity, Equity, and Inclusion (DEI)	DEI Toolkit basket was developed, including activities, and resources.	June 25, 2025.	Improved access to DEI resources in the home and promoted engagement.
Diversity, Equity, and Inclusion (DEI)	Accessibility for Ontarians with Disabilities Act (AODA) training.	June 4, 2025	From a user's perspective. 88 staff attended sessions improving awareness.

Table 5. Safety – Antipsychotic Reduction and Fall Prevention

Indicator / Priority Area	Change Ideas / Actions	Completion Date	Outcomes and Impact
Antipsychotic Reduction	Dementia, delirium, and depression education for staff.	March 31, 2025.	100% of staff completed training as part of the annual professional development.
Antipsychotic Reduction	Review responsive behavior policy with nursing staff.	October 10, 2025	Held a code white week with activities and a mock drill. Improved teams' readiness.
Antipsychotic Reduction	Appropriate Usage of Antipsychotics process improvement trial (AUA)	November 15, 2025.	Process was trialed with 4 residents, with sustainability considerations under review.
Antipsychotic Reduction	Medication room organization and standardization.	November 21, 2025.	Launched across all 8 units. Improved organization and defined responsibilities.
Fall Prevention	Deliver fall prevention education at resident council meetings.	March 3 & Nov 14, 2025	11 residents attended the first session and 14 the second. Increased awareness.

Indicator / Priority Area	Change Ideas / Actions	Completion Date	Outcomes and Impact
Fall Prevention	Conduct a night-time fall prevention audit and provide staff education.	March 27, Nov 14, 2025	2 audits were held on units. 149 staff received education. Reinforced compliance.
Fall Prevention	Develop a “post fall huddle” tool for staff.	July 2, 2025	The tool was attached to all blood pressure machines, and education was provided.
Fall Prevention	Enhance CAPS fall intervention review.	April 3, 2025	Early adopters. Staff training was provided prior to launch Enhanced compliance.

Table 6. Resident Experience – Feeling Heard and Fear Without Consequences

Indicator / Priority Area	Change Ideas / Actions	Completion Date	Outcomes and Impact
Feeling Heard	Launch interRAI Long Term Care Facilities (LTCF) assessment.	April 1, 2025	Early adopters. Standardized comprehensive personal assessment for long term care.
Feeling Heard	Smoking education for home and code of conduct review.	April 24, 2025.	Education was provided to the home. Smoking code of conduct reviewed.
Feeling Heard	Provide more variety at breakfast.	March 30, 2025.	Brunch program added, fruit daily, rotation of yogurt and starch, beverage cart.
Feeling Heard	Enhance building interior appearance with paint and furniture.	June 23, 2025.	The front of the home was painted, as well as a fireplace, and washrooms.
Fear Without Consequences	Pocket size visual on resident’s bill of rights.	July 27 September 14, 2025	Distributed during Resident Council celebration event. Also, in newspaper and email.
Fear Without Consequences	Welcome note to resident council minutes.	September 8, 2025	Refreshed names and contact lists, hair salon information, updated banking hours, etc.
Fear Without Consequences	Rename suggestion box and create standardized suggestion forms.	Abandoned project	Project was not implemented. Home chose to keep the existing names of the boxes.

Other Quality, Service, and Operational Improvements

Linhaven also undertook other actions and priorities to improve accommodation, care, services, programs, and goods throughout the year.

Table 7. Other Improvements

Area	Actions
Accommodations	May 31, 2025, enhanced code red drill report tracking metric.
Care	- May 3, 2025, Registered Practical Nurse attended Resident Council meeting and October 14, 2025, for fall education. - On February 26 and March 5, 2025, pain and behavior training occurred. 33 staff attended these sessions.
Services	By November 30, 2025, the home implemented an annual medical service performance review.
Programs	- February 12, 2025, Welbi Family portal went live. - On May 14, 2025, 8 VICAIR Pressure Relief Cushions were trialed and introduced in the home.
Goods	July 31, 2025, streamlined labelled supplements for nutrition care and hydration.

Review of the 2025–2026 Resident and Family Experience Survey Action Plan

Each year, Linhaven conducts a Resident and Family Experience Survey to measure experience with the home and the care, services, programs, and goods provided. This section summarizes progress made on prior-year action items.

Below are when and how findings were shared with residents, families, and staff.

- Survey period: November 18 to December 8, 2024.
- Action plan input: Feedback to inform Action Plan development was sought from Family Council on January 28, 2025, and Resident Council on January 21, 2025.
- Communication of results: On February 13, 2025, survey results were shared with residents, families, and staff, and were posted on the Quality Board in Ontario Square.
- Council review: Survey results were reviewed with Resident Council February 18, 2025, at which time the action plan was approved. On March 27, 2025, the Manager of Program Evaluation and Continuous Quality Improvement and the Data Analyst met with Family Council and reviewed survey. April 24, 2025, Administrator and Nutrition Manager attended Family Council meeting and discussed the process of forming an Action Plan. In addition, discussed the Action item progress.

Table 8. 2025-2026 Resident and Family Experience Survey Action Plan

Area of Focus	Actions Taken	Target Date	Completion/Outcome
Maintenance of Grounds	Create information regarding smoking areas and receptables for home. Review “Smoking Code of Conduct” with current smokers.	March 31, 2025	Completed on April 2, 2025. Education regarding the home's designated smoking areas was distributed via email. Smoking Code of Conduct was also reviewed with current smokers.
Maintenance of Building	Repaint building interiors to enhance appearance.	June 30, 2025	Completed June 23, 2025. Resident areas were repainted, and new furniture was added.
Food and Snack Quality	Provide residents with a larger variety of breakfast options.	June 30, 2025	Completed March 30, 2025. Brunch program added, fruit daily, rotation of starch and yogurt, etc.

2026–2027 Resident and Family Experience Results and Action Plan

A new Resident and Family Experience Survey was used in 2025 to better support family and resident feedback collection. The survey was approved by Family Council on August 5, 2025, and by Resident Council on August 18, 2025.

The Resident and Family Experience Survey was available from September 22, 2025, to October 17, 2025. A total of 79 responses were received from residents, and 53 from family members. Survey results are provided in Appendix A. Overall, 84.00% of resident responses and 91.30% of family responses indicated a Good or Excellent overall rating of the home (86.78% combined score).

Feedback from the Resident and Family Council identified four areas for focusing which were: Care, Dietary, Recreation, and Physiotherapy and Rehabilitation. The following actions have been identified to address these areas.

Table 9. 2026-2027 Resident and Family Satisfaction Survey Action Plan

Area of Focus	Action Items	Target Date
Care	1. Staff empathy, communication, and customer service training.	June 30, 2026
Dietary	1. Display menus on units. 2. Dietary feedback box.	April 30, 2026 April 30, 2026
Recreation	1. Focus group – residents, families, and staff. 2. Role review. 3. Evening/weekend coverage audit.	July 31, 2026

Area of Focus	Action Items	Target Date
Physiotherapy and Rehabilitation	1. Physiotherapy program review poster. 2. Staff seating and cushion training.	April 30, 2026 September 30, 2026

Below are the when and how findings were shared with residents, families, and staff.

- Survey period: September 22 to October 17, 2025.
- Action plan input: Feedback to inform Action Plan development was sought from Resident Council on March 10, 2026, at which time the action plan was approved. Family Council feedback on proposed action items was reviewed on March 6, 2026, and accepted for inclusion in the action plan.
- Communication results: January 16, 2026, results were shared with residents, families and staff via email and was posted on the home's quality board January 22, 2026.
- Council review: Results of survey were reviewed by Resident Council on March 10, 2026. The results were sent to Family Council on January 16, 2026, and were reviewed independently.

2026-2027 Priority Improvement Areas

The following annual quality improvement priorities are planned for the upcoming year.

Details of the Quality Improvement Plan (QIP) are available on the home's quality board and on Health Quality Ontario's website.

Table 10. 2026-2027 Priority Improvement Areas

Area of Focus	Current Performance	Change Ideas
Emergency Department Avoidance (ED)	Current performance: 17.55% (CIHI Data) Target: 16.67% (CIHI Data)	1. By July 30, 2026, the home will complete and document a review of 2 communication materials. 2. By June 30, 2026, create an educational training video and supporting resources for Point-of-Care (POCt) machines and ensure 80% of relevant staff receive training. 3. By May 31, 2026, the Nurse Practitioner will provide ED avoidance training to 30 front-line staff (including at least 2 representatives from each home area). 4. Between September 14 and September 30, 2026, the home will deliver targeted palliative care education, ensuring each shift in every home area receives education.

Area of Focus	Current Performance	Change Ideas
Diversity, Equity, and Inclusion (DEI)	Current performance 100.00% (PD Training) Target: 100.00% (PD Training)	1. By October 31, 2026, introduce at least 3 new culturally or religiously significant items or observances to programs. 2. By February 28, 2026, complete 2 enhancements to the religious/spiritual spaces to support an inclusive environment. 3. By November 30, 2026, incorporate at least 2 cultural perspectives on End-Of-Life (EOL) care into relevant policies and procedures. 4. By April 30, 2026, deliver at least one End-Of-Life (EOL) care cultural practice education to at least 20 staff participants.
Resident Experience – Feeling Heard	Collecting Baseline (CB) Target: 69.00% (Experience Survey)	1. By June 30, 2026, we will provide empathy, communication, and customer service training to front-line staff. 2. By April 30, 2026, ensure 90% of Resident Home Areas (RHAs) maintain a visibly displayed daily menu. 3. By July 31, 2026, complete 3 defined Recreation activities. 4. By September 30, 2026, complete at a minimum of 2 seating and cushion trainings.
Resident Experience – Fear Without Consequences	Collecting Baseline (CB) Target: 92.00% ((Experience Survey)	1. By July 31, 2026, embed a 5–10-minute Residents Bill of Right's video into a minimum of 2 staff meetings. 2. By November 30, 2026, have at least 3 leadership team members attend at least one Resident and/or Family Council meeting. 3. By September 30, 2026, create a "Roles of the Home" document highlighting at least 3 departments. 4. By July 31, 2026, provide a minimum of 2 Partners in care training (PIC) to staff.
Fall Prevention	Current performance 16.47% (CIHI Data) Target: 15.64% (CIHI Data)	1. By September 30, 2026, decrease the number of injuries sustained from falls by 5% by utilizing staff lead to deliver one fall-prevention education to front-line staff. 2. By November 30, 2026, increase the percentage of staff trained in the Registered Nurses' Association of Ontario (RNAO) by 20%. 3. By December 31, 2026, implement electronic fall audits ensuring at least 80% of responsible staff for auditing are trained. 4. By April 30, 2026, fall prevention strategies will be reviewed at resident council with resident feedback.

Area of Focus	Current Performance	Change Ideas
Antipsychotic Reduction	Current performance: 24.59% (CIHI Data) Target: 22.13% (CIHI Data)	1. By December 31, 2026, reduce indicator to 22% by achieving at least 65% nursing staff attendance at nonpharmacological approached education. 2. By June 30, 2026, develop and pilot a medication room cleanliness audit tool built on last year's project. 3. Reduce inappropriate usage to 22% by June 30, 2026, by establishing an interdisciplinary Antipsychotic Reduction Committee supported by an approved Terms of Reference document (TOR). 4. By December 31, 2026, create a nonpharmacological tool list on all units with Responsive Behavior Therapeutic Advisor (RBTAs).
Pressure Ulcers	Current performance 5.16% (CIHI Data) Target: 5.06% (CIHI Data)	1. By August 31, 2026, the Nurse Practitioner will provide and document evidence informed skin and wound training to a minimum of 15 front-line staff. 2. By May 31, have 100% completion of Registered Dietitian referrals to residents with new or worsening stage 2 pressure injury.
Restraints	Current performance 1.91% (CIHI Data) Target: 1.56% (CIHI Data)	1. By August 31, 2026, the home will develop and document 2 structured least-restraint education sessions to front-line staff to reinforce least-restraint practices.

Appendix A – Resident and Family Experience Survey Results

Domain	How would you rate your experience with...	Combined	Resident	Family
Care	Quality of care provided by the care team	4.36	4.34	4.39
Care	How your choices and preferences are respected in your care	4.28	4.25	4.32
Care	Support provided for your activities of daily living and routines	4.36	4.32	4.4
Care	How safe you feel living in this home	4.55	4.62	4.42
Services	How enjoyable mealtimes are	3.88	3.84	3.93
Services	Cleanliness and maintenance of the home	4.29	4.46	4.00
Services	Emotional and social support provided	4.29	4.25	4.36
Programs	How well the activities and programs match what you enjoy	4.17	4.22	4.09
Programs	How accessible programs and activities are for you	4.35	4.46	4.18
Programs	Experience with the rehabilitation and physiotherapy services	3.93	4.24	3.44
Goods	Comfort and quality of the continence products provided	4.29	4.27	4.32