

2026/2027 Gilmore Lodge

Continuous Quality Improvement Initiative Report

Designated Lead: Debbie Marks, Administrator
Fiscal Year End: March 31, 2027

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 representatives, and relevant internal oversight committees.

Table of Contents

Content	Pages
Overview	1
Our Approach to Continuous Quality Improvement	2
How We Identify Home's Priority Areas	3
Policies, Procedures and Protocols	3
How We Monitor Improvement and Identify Outcomes	5
2025/2026 Quality Improvement Accomplishments (reflections since last report)	6
Other Actions and Priorities Taken by the Home	9
2025/2026 Review of Resident and Family Surveys Action Plan	10
Resident and Family Survey Results and Action Plan 2026/2027	11
Upcoming Priorities: Areas for 2026/2027	12
Appendix A: Gilmore Lodge Resident and Family Experience Survey Results 2025 and Action Plan	14

Overview

Gilmore Lodge is one of the seven long-term care homes owned and operated by the Regional Municipality of Niagara. It has 160 beds and 21 specialty programs. The home is in pursuit of WELL Silver certification under the WELL Building Standard. The WELL Building Standard supports the health and well-being of residents and staff based on a holistic approach and is focused on enhancing people's health and well-being through the built environment. It is recognized as a best practice spotlight long-term care home and has been accredited from 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.

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.

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.

Our Approach to Continuous Quality Improvement

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. We will focus on providing the best quality to our residents and uphold our commitment to continuous quality improvement. Prioritizing improvement opportunities is a critical step in translating data into action.



How We Identify Home's Priority Areas

Gilmore 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. Gilmore Lodge actively engages members of the Resident Council and Family representatives in quarterly Professional Advisory and Continuous Quality Improvement (PAC-CQI) Committee meetings. The insights and experiences of the Resident Council and Family representatives 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 updates 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, essential incidents, complaints, infection control, and other key focus areas. This collaborative approach ensures that we consistently enhance the quality of care we provide.

Policies, Procedures and Protocols

Each year, Gilmore Lodge creates Quality Improvement Plans corresponding to 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 Gilmore Lodge works to sustain advancements in effective care, service delivery, and resident experience.

Our team will follow the PDSA cycle (Plan, Do, Study, Act). It's a simple tool for testing and enhancing ideas or processes. Start by planning a small change, then implement it on a limited scale. Analyze the results to see what happened and act on what you learned—either by adopting the change, adjusting it, or trying something new. It's a continuous cycle of improvement.

Identify/Diagnose the Problem

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

- Gilmore Lodge will document the problem and identify opportunities for improvement.
- Gilmore Lodge will gather data to understand the problem better.
- Gilmore Lodge will review the problem statement and team composition needs.
- Gilmore Lodge will analyze the problem and data available using QI methodologies to identify opportunities for improvement.



Create a Plan

- Once teams understand the underlying causes and align any resident's needs, they would define an action plan in collaboration with residents and families.
- The team will explore and evaluate those opportunities.
- Gilmore Lodge will identify how they plan to achieve desired results and document them under the PCC insights, Resident and Family 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 identify the team that will support the improvement activity.
- The team will determine if training is needed and include it as a task.

Set Improvement Aims

The aims set out 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.

Set and 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 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 whether the interventions or changes resulted in improvements. 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 Outcomes

Gilmore Lodge champions quality initiatives by leveraging the support of our Continuous Quality Improvement Advisors, who 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 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 council and family representatives committees and 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 of 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 in 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 representatives meetings (on request)
- Presentations at the Public Health and Social Services Committee
- Quarterly reports at the Quality Steering Committee

2025-26 Quality Improvement Accomplishments (reflections since last report)

1. Falls Prevention and Management

Gilmore Lodge continues to focus on preventing falls and managing risks through education on comprehensive falls assessments and RNAO clinical pathways for falls. Daily clinical rounds, weekly fall huddles and monthly quality meetings have contributed to reviewing individual falls, ensuring the appropriate interventions are utilized based on resident needs. The home has also worked to reduce injuries from falls through precautions such as non-pharmacological interventions, hip protectors, non-skid socks, bed and chair alarms, and fall mats, ensuring that when a fall does occur, there are measures to limit impacts on quality of life from post-fall injuries. A post fall huddle tool with a QR code to access the electronic falls interventions audit were attached to VS machine for easy access to staff. These efforts were based on trends in our falls data, resident and family input, and the clinical knowledge of our teams. As of first quarter of this year, falls indicator shows a 2.75% decrease, suggesting recent improvement.

2. Antipsychotic Medication Reduction

Gilmore Lodge welcomed a new position onto the team, the responsive behaviours therapeutic advisor, which has been a great success for providing quick, responsive support with residents exhibiting responsive behaviours. Previously, the referral process would take a week or more. In addition to the direct support of residents, the therapeutic advisor conducts assessments that determine whether it is appropriate to utilize pharmacological interventions, which ensures care remains resident-centered and non-pharmacological interventions are considered first. The interdisciplinary team also gathers monthly to review antipsychotic use in the home and discontinue or titrate medication down when appropriate. These discussions occur as needed, to ensure the residents' prescribed medication list is optimized for the care they need. The home's usage remained below the regional and national average, indicating effective monitoring and deprescribing practices. Gilmore Lodge continues to explore other change ideas to reduce antipsychotic medication usage.



3. 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 was officially launched in the Nursing Department of Gilmore 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.

4. Diversity, Equity, and Inclusion (DEI)

Gilmore Lodge continues to support and promote inclusivity within the home. The DEI committee created a global staff origin map that highlights the countries of origin of team members, alongside a monthly DEI calendar recognizing cultural, heritage and awareness celebrations throughout the year. 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. Gilmore Lodge have 100% compliance with completing the 2025 Diversity, Equity, and Inclusion education incorporated in the Annual Mandatory professional Development. Gilmore Lodge has a DEI committee with 14 active members by the end of 2025 who facilitate the recognition of special events, holidays, festivals and celebrations occurring each month. Members of the committee update the displays in glass cabinets in the worship room and restorative rooms. The committee successfully organized 2 DEI based potlucks on May 21 and October 29, 2025 for staff and 1 fund raising event. The home also has an Indigenous Garden, located in the Point Abino Courtyard, it is accessible to residents and family.

5. Hospital Transfer Reduction and Recreation Engagement

Staff education focused on strategies to improve communication among registered staff, clinicians, residents and family was delivered by Nurse Practitioner on August 2025 to assist



key decision makers in choosing the best resident-centered option. Gilmore Lodge also utilized a delirium screening tool to identify residents experiencing signs of delirium or potential treatable infections. This strategy proved to be a successful method of assessing symptoms of underlying illness, which ultimately contributes to avoiding avoidable ED visits. Registered staff were provided with training based on identified gaps in documentation and SBAR-style documentation. The additional training ensured that staff were aware of how to document the details that the interdisciplinary team utilizes for decisions and conversations about ED transfer with family members. Objective findings and assessment tools, such as PPS, CHES, and PSI, were also used to inform conversations on goals of care when significant health declines occurred. These tools helped implement goals of care conversation before critical events, ensuring that residents' wishes are respected and implemented.

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, B-type natriuretic peptide (BNP) and Troponin tests, while the CLINITEK completes Urinalysis in about 1 minute.

6. Palliative Care

Gilmore Lodge maintains a resident-centered approach to palliative care, utilizing the palliative approaches to care assessment, which helps to ensure residents at end-of-life are addressed for comfort and support in their journey. While many residents are palliative but not end-of-life, we continue to use PoET discussions and daily clinical rounds to update the team about the resident's trajectory and experience. The team also utilizes comfort carts for families as they support their loved ones. The RNAO Clinical Pathway for Palliative and End-of-Life Care was implemented in Quarter 3, with education provided to registered staff by the Central Support Team. On October 2025, the home supported its first resident request for Medical Assistance in Dying (MAID), with the interdisciplinary team providing guidance and support to the residents, family, and staff throughout the process. The social worker continues to assist residents and families with discussions about goals of care and palliative/end-of-life wishes.

Other Actions and Priorities

The Gilmore Lodge team has made additional efforts to enhance the accommodation, care, services, and programs that contribute to the well-being of our residents and staff.



Accommodation

Gilmore Lodge remains committed to operating a home that supports the wellbeing of residents, staff, and all building occupants. Performance Verifiers (Inspectors) were on-site on July 2025 to conduct important assessments. The verification process helps ensure that our building is performing as intended—supporting air and water quality, lighting, thermal comfort, sound, and other key elements that contribute to a healthier environment. These evaluations are a routine part of ensuring our new home meets the highest standards of quality, safety, and comfort. Gilmore Lodge also completed emergency drills to improve preparedness and help staff respond in a coordinated way, which strengthens resident safety, staff confidence, and overall facility resilience. On March 2, 2026, the Resident and Family Self-Serve Laundry Rooms officially opened, offering a warm, home-like environment while enhancing choice and independence of residents at Gilmore Lodge.

Services

Several new positions were added to the home to support the enhanced care and operation of Gilmore Lodge, an Infectious Prevention and Control Manager on March 2025, a Responsive Behaviour Therapeutic Advisor (RBTA/BSO) in April 2025 and an additional Associate Director of Resident Care in quarter 1 of 2026. The nursing management team supported PSW and nursing student placements, providing hands-on clinical experience and mentorship throughout the year. The Central Support Team Student Lead coordinates onboarding and placement for students in partnership with local organizations. Some of the PSW students were hired at Gilmore upon completion of their education, supporting workforce sustainability and retention.

Programs

In February 2025, family members were introduced to the Welbi Family Portal, an innovative tool that provides families with real-time updates on activities and participation, fostering stronger family engagement and trust. It also improved transparency and seamless communication with family members through access to the Community Directory of contact information for key staff members.

Recreation programming at Gilmore Lodge continues to support resident engagement, quality of life, and community connection through a strong mix of outings, themed events, cultural programming, creative activities, and partnerships. Community outings and dining experiences were very well received, including walks to The Barrel Restaurant for lunch, a visit to the Butterfly Conservatory, the Niagara Parks Greenhouse, and outings such as the Fort Erie Racetrack and Green Acres Restaurant. Additional Service and Program Enhancements included expansion of the County Fair Café hours to include weekends, continued availability of the Hair Salon, and introduction of Spiritual & Religious Care Coordinator. Major celebrations included Father's Day, the home's 6-month anniversary, Canadian Multiculturalism Day, Pride Month programming, a Hawaiian theme day, a 50's Day event, and extensive holiday programming. Resident experience was further enhanced through live entertainment, pet therapy, intergenerational and community partnerships, and accessible shared spaces such as



the Town Square, Library, and County Fair Café. Strong support from staff, families, volunteers, and community partners has helped sustain high levels of engagement and connection. On December 18, 2025, the home celebrated its one year move-in anniversary with games and staff appreciation gifts to celebrate the special occasion.

2025/2026 Review of the Resident and Family Surveys Action Plan

Gilmore Lodge made significant progress during 2025-2026 across key areas, particularly in regard to incorporating family and resident feedback into home improvements and enhanced programming. Regular Resident Council (RC) and Family representatives' meetings throughout 2025 have been instrumental in enhancing collaboration between the homes management team and residents and their families. These meetings have provided a space to share updates, gather feedback, and implement action plans. Implementation of the Action Plan focused on increasing resident and family awareness, strengthening communication, and improving quality of care and service delivery. Staff were formally introduced at two Resident Council meetings. A Leadership Team meet-and-greet took place on October 3, 2025, and ongoing electronic displays and posted signage were used to share leadership contact information and program eligibility criteria with residents and families. Referrals were also taken as needed.

In 2025, several initiatives supported service improvement, including coordination of Niagara College OT/PT students, rollout of Meal Suite across Niagara Region LTC homes, implementation of the Just-in-Time Meal Survey, and launch of the Supplement Reduction Project. These efforts improved operational efficiency, enhanced the dining experience, strengthened responsiveness to resident feedback, and supported better nutritional care. The kitchen remodel, including the addition of two Convo-therm ovens, further improved in-home meal preparation and resident satisfaction.

The Medical Services Program continued to support increasingly complex resident needs through stable prescriber coverage, interdisciplinary collaboration, improved communication using Secure Conversations in PointClickCare, and quarterly Professional Advisory Committee meetings. Overall, these activities demonstrate meaningful progress in implementing the Action Plan and improving resident centered experience, communication, and quality outcomes. A complete action plan is available upon request.

Resident & Family Survey Results and Action Plan 2026/2027

Gilmore Lodge conducted its annual Resident and Family 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, and we heard from 83 residents and 33 family members.

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 satisfaction was strong: 87.04% of all respondents rated the home as either Excellent or Good. This included an 86.21% satisfaction rate among families and 87.34% among residents. The survey result was shared with and reviewed by Leadership Team members on December 18, 2025. The information was posted at Quality Improvement Board on January 9, 2026, with electronic screen display stating the result is posted at the QI Board. On January 21, 2026, the "Action Plan Building" meeting was held with Resident Council members and on March 4, 2026, with family members. The following are the results compiled for the family and resident surveys. Please see the survey results in Appendix A.

Three areas received lower satisfaction scores: How enjoyable mealtimes are, experience with rehabilitation and physiotherapy services, and how well the activities and programs match what you enjoy.

The Resident Council and Family representatives 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 with the resident council and family representatives and the Quality Committee (refer to Appendix A). The comprehensive action plan is available at home.



Upcoming Priority Areas for 2026-2027

In 2026/2027 Gilmore Lodge is aiming to implement the following Initiatives.

Table 1: Gilmore Lodge initiatives

Area of Focus	Performance	Change ideas
Rate of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents	Current: CB Target: 5.20	- Promote early recognition & standardized response to change in resident's condition through these methods: - Easy access and sustainability of diagnostic tests available at the home: Bladder scanner and PoCT through having at least 2 registered staff per shift educated/trained on use of bladder scanner and PoCT. - Create of educational hand outs and training video that are easily accessible to staff to serve as a reference during afterhours for PoCT. - Proactive Identification & Risk Stratification using validated triggers/tools: monthly ED visit tracking and analysis - Reinforce SBAR-based escalation to physicians/NPs and utilization of PSW and Registered Staff communication tool - Distribute the updated Medical Resource Handout for residents/families - Proactive Advance Care Planning for new admissions and with significant change of status by this method: - Provide Serious illness conversation training for Registered Staff to improve Advanced Care Planning quality
Diversity, Equity & Inclusion	Current: 100 Target: 100	- To implement learning opportunities for staff with topics based on the 2026 Diversity, Equity, and Inclusion Spotlight Dates through these actions: - Increase awareness through education via Mandatory Annual Professional Development. - Hold 2 DEI based potluck showcasing traditional food from staff's country of origin to prompt conversation about different culture in a safe and welcoming environment. - Display DEI based visual presentations in common areas



Area of Focus	Performance	Change ideas
The percentage of residents responding positively to: "What number would you use to rate how well the staff listen to you?"	Current: CB Target: CB	- To implement the 2026 Resident and Family Satisfaction Survey Result Action Plan. - The team will collaborate with members of the Resident Council and Family members as well as the Professional Advisory Committee in planning, initiating and on-going review of outcome. - To provide staff education on Registered Nurses Association of Ontario (RNAO) Best Practice Guideline (BPG) on Person Centered Care. - RNAO BPG Champions to deliver education session/coaching on best practice communication techniques with front line staff, focusing on effectively navigating resident and family concerns.
Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences."	Current: CB Target: CB	- To heighten awareness of the Resident's Bill of Rights through education and open forum. - Leadership team representative will conduct an annual information session in a safe environment on Resident's Bill of Rights to refresh residents' knowledge. - Display the Residents' Bill of Rights on the electronic board for family/caregivers and visitors to view
Percentage of LTC home residents who fell in the 30 days leading up to their assessment.	Current: 20.55% Target: 18%	- Reduce the percentage of residents who fell in the last 30 days of their observation below the provincial average by the end of Q4 of 2026 by enhancing the RNAO BPG Champions Network. - Sustain an up-to-date list of RNAO BPG champions who will provide coaching sessions to front line staff in best practice guidelines for fall prevention. - Implement a multidisciplinary Falls reduction Initiative in partnership with internal partners to improve environmental and care-process changes. - Physiotherapy Department will provide in-unit short educational sessions on proper use of therapeutic surfaces, assistive aids and mobility devices. - Initiate pharmacy referrals to review medications and provide recommendations for residents with 2 or more falls in 30 days with no identified underlying contributors, such as infection or change in status.



Area of Focus	Performance	Change ideas
LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment.	Current: 11.93% Target: 10%	1. Reduce the CIHI “Potentially Inappropriate Use of Antipsychotics in Long-Term Care” indicator to 5% percent from the baseline percentage of January 1st, 2026, for each home, while maintaining or decreasing the monthly number of responsive behavior incidents among residents whose antipsychotics were titrated down. a. Pharmacist and Nurse Practitioner–led education sessions to strengthen registered staff’s knowledge and understanding on the potential harms associated with inappropriate antipsychotic medication use. b. RBTA-led discussions with frontline staff on non-pharmacologic interventions and correct utilization of available resources/tools to de-escalate behaviors. c. Distribute a resource handout to front line staff on items designed support individuals with behavioral symptoms. d. Establish the Appropriate Use of Antipsychotics Committee with Terms of Reference. e. Increase physician's engagement on change ideas for quality improvement in managing behavioral and psychological symptoms of dementia starting with registration in HQO's My Practice. Send letter to all MD in LTC home with information about My Practice and with request to register.

*CB=Collecting Baseline

Gilmore Lodge Resident & Family Survey Results 2025

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.



Appendix A – Gilmore Lodge Resident, Family and Caregiver Survey Results 2025

	Question Short	Resident	Family	Combined
Care	Quality of care provided by the care team	4.10	4.21	4.13
Care	How your choices and preferences are respected in your care	3.95	4.00	3.96
Care	Support provided for your activities of daily living and routines	3.96	3.94	3.96
Care	How safe you feel living in this home	4.16	4.35	4.21
Services	How enjoyable mealtimes are	3.66	3.80	3.70
Services	Cleanliness and maintenance of the home	4.32	4.19	4.28
Services	Emotional and social support provided	3.99	4.13	4.03
Programs	How well the activities and programs match what you enjoy	3.96	3.85	3.93
Programs	How accessible are programs and activities for you	3.99	3.89	3.96
Programs	Experience with the rehabilitation and physiotherapy services	3.87	3.48	3.77
Goods	Comfort and quality of the continence products provided	4.04	4.14	4.07
Reportable	Do residents feel they can speak up without fear of consequences?			75.90%
Reportable	Do residents feel they have a voice and are listened to by staff?			46.25%
Overall	What is your overall rating of the home as a place to live?	87.34%	86.21%	87.04%

* Results shown under Reportable Questions represent the highest positive responses for these questions: “Always” or “Most of the time” for whether residents feel they can speak up without fear of consequences, and scores of 9 or 10 for whether residents feel they have a voice and are listened to by staff.



Resident Family and Caregiver Experience Survey Action Plan

Area / Question	Current Performance	Action items	Target completion date	Responsible person	Role of Resident Family Representatives	Status	How actions taken were communicated	Outcomes of the Actions that were taken
How enjoyable mealtimes are	Resident 3.66 Family: 3.80	- Implement a Mealtime Service Standard Work checklist for Dietary + Nursing/PSW support: - Pre-meal set-up completed 15 minutes before service (tables, condiments, adaptive utensils, thickener, hand hygiene supplies, seating plan). - Assign clear service roles (e.g., Tray Runner, Beverage Lead, Assist-with-Feeding Lead, Call-Bell Response during meal). - Introduce a “Ready-to-Serve” huddle at meal start or at shift report (2 minutes): confirm diet changes, allergies, isolation trays, and staffing coverage. - Conduct temperature audits as per Public Health and as outlined in internal policy to ensure appropriate level of thermal condition upon serving food. Add mandatory temperature checks per meal service: - At plating / prior to leaving kitchen - Reduce heat loss during transport/service: - Keep lids/coverings on until point-of-service. - Reduce non-urgent interruptions (routine calls/visits) during meal service windows. 10.Assign one staff member to manage call bells and interruptions so dining staff can focus on service.	Target start: April 1, 2026 Full Completion by: December 31, 2026	P. Stevens, Nutrition Manager PSW and Registered Staff Registered Staff Dietary Aid Dietary Aid Reg. Staff	Reviewed and approved by resident council members and family members Residents participate in daily meal survey to provide feedback on quality of food with specific comments. Family members report observations during mealtimes that warrants inquiry or action to leadership team members	- Implementation phase in Progress P. Stevens accepted a new role as EVS Manager and K. Swift transitioned as the new Nutrition Manager-effective April 13, 2026. - Planning stage. In progress	January 21, 2026, "Action Plan Building" meeting with Resident Council members March 4, 2026, meeting with family members	Q1 2026 meal Satisfaction Survey Result: 78.5%

Area / Question	Current Performance	Action items	Target completion date	Responsible person	Role of Resident Family Representatives	Status	How actions taken were communicated	Outcomes of the Actions that were taken
Emotional and Social Support Provided	Resident: 3.99 Family: 4.13	1.Create a plain-language “Community Supports Menu” (one-page) with: • Transportation options (municipal/regional transit supports where applicable, accessible taxis, volunteer driver programs, community agency options) • Social/peer programs (seniors’ centres, cultural/faith-based groups, library programs, recreation/community engagement) • Support navigation contacts (home staff point-of-contact; key community agencies) 2. Deliver information through 3 channels: • Admission Day/Admission ICC (Resident/Family welcome package) • Monthly “What’s available this month” bulletin (posted in electronic board) • Quarterly info session (15–20 minutes) co-hosted with a community partner (virtual or in-person)	Target start: May 1, 2026 Full Completion by: December 31, 2026	D. Marks, Administrator A. Zamora, CQI Advisor A. Todd, Program Manager M. Male, Office Lead Admission Nurse E. Riel, Social Worker A. Zamora, CQI Advisor	Reviewed and approved by resident council members and family members Provide feedback on the initiative at Quarterly PAC Meetings	1. Plan in place, pending Implementation 2. Plan in place, pending Implementation	January 21, 2026, "Action Plan Building" meeting with Resident Council members Mar 4, 2026, meeting with family members	

Area / Question	Current Performance	Action items	Target completion date	Responsible person	Role of Resident Family Representatives	Status	How actions taken were communicated	Outcomes of the Actions that were taken
Quality of Care Provided by the Team	Resident:4.10 Family: 4.21	- Reinforce “Acknowledge First” standard work. If staff can’t immediately provide care, they must acknowledge the resident and give an estimated time to return. - Establish a Call Bell “Zone Ownership” model (each shift). Assign staff to zones/rooms with clear primary/backup coverage. - Create a buddy system for breaks, transfers, and peak times. Huddle at start of shift will cover staffing, high-need residents, planned rounds, who covers what. 4. Provide brief staff coaching on: - Dementia-responsive approaches - Trauma-informed communication - De-escalation when residents are anxious about waiting or rushing	Target start: June 1, 2026 Full Completion by: December 31, 2026	L. Urtuna, DRC E. Sager, ADRC P. Cervoni, ADRC PSWs M. Napper, RBTA	Reviewed and approved by resident council members and family members Provide feedback on the initiative at Quarterly PAC Meetings	1. Plan in place, pending Implementation 2 and 3. Evaluation of Registered Staff and Personal Support Worker job routines in progress 4. Education provided: 6 education-related action items outlined	January 21, 2026, "Action Plan Building" meeting with Resident Council members Mar 4, 2026 meeting with family members	4. A new task in POC for residents on 1:1 staffing support or for specific residents who display physical expression of risk initiated by RBTA.