

**PREVENTION OF ABUSE AND NEGLECT**

**Goal Statement:**

The goal of the Abuse and Neglect Prevention Program is to achieve and sustain an 80% reduction in critical incidents related to abuse and neglect compared to the 2022 baseline of six (6) residents. This equates to one (1) reportable incident in 2025. To achieve an 80% reduction from the 2022 baseline data of 6 critical incidents, which is equivalent to 1 or fewer than one critical incident in 2025.

Performance Measure Indicator: Number of Critical Incidents Involving alleged, suspected, or witnessed abuse and/or neglect reported to the Ministry through the Critical Incident System (CIS).

**Evaluation:**

In 2025, one (1) alleged incident of abuse involved resident-to-resident interaction. The incident was promptly identified, investigated, and reported in accordance with legislative and regulatory requirements, including immediate resident protection measures and internal follow-up. This outcome is consistent with 2024 (one <1> case) and demonstrates a sustained and significant

*Table 1: Year-to-Year Comparison of Data*

	<b>Number of Critical Incidents related to Resident Abuse</b>
2025	1
2024	1
2023	5
2022	6

*Table 2: Quarter-to-Quarter Comparison of Data for 2025*

	<b>Number of Critical Incidents related to Resident Abuse</b>
Q4	1
Q3	0
Q2	0
Q1	0

**Outcome & Effectiveness:**

The reduction from six (6) cases in 2022 to one (1) case in 2025 represents an 83% overall reduction, reflecting significant progress toward the stated goal. All incidents were managed in accordance with mandatory reporting obligations, internal investigation processes, and resident protection measures.

The Abuse and Neglect Prevention Program demonstrates sustained effectiveness, with a marked reduction in reportable incidents since the 2022 baseline. Continued focus on staff education, behavioural risk identification, and consistent application of policy will support ongoing compliance, resident safety, and quality improvement.

**Overall Evaluation:**

The Abuse and Neglect Prevention Program demonstrates sustained effectiveness and regulatory compliance, with a marked and maintained reduction in reportable incidents since the 2022 baseline. Continued focus on education, proactive behavioural risk management, and consistent policy application will support resident safety, dignity, and continuous quality improvement in 2026.

**Identified Gaps and Risk Factors:**

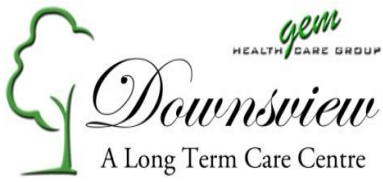
Ongoing review identified the following areas for improvement:

- Risk of normalization of responsive behaviours by staff due to increasing resident acuity.
- Increasing number of residents admitted to long-term care with complex behavioural and cognitive needs, increasing the risk of resident-to-resident incidents if not proactively managed.

**Change Ideas and Improvement Strategies:**

To address identified gaps and mitigate future risk, the following actions will be implemented;

- Continue to conduct regular interdisciplinary meetings with caregiving staff across all shifts to review Abuse and Neglect policies and procedures
- Reinforce zero-tolerance expectations
- Ongoing review and education on Residents' Bill of Rights
- Strengthen staff understanding of responsive behaviours, triggers, and early intervention strategies
- Continue to use Dementia Observation System (DOS) for residents with new or emerging responsive behaviours to support early identification, documentation, and individualized care planning



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- Reinforce education on timely reporting, documentation, and escalation processes for all suspected, witnessed, or alleged incidents

## REDUCTION OF EMERGENCY DEPARTMENT (ED) VISITS

### Goal Statement:

The aim of this quality improvement initiative is to sustain an Emergency Department (ED) visit rate of 8.26 per 100 residents or lower in 2025, in alignment with the Ministry of Long-Term Care's performance indicators and the home's Quality Improvement Plan (QIP).

### Evaluation and Monitoring:

The effectiveness of this quality improvement initiative is evaluated through **ongoing monitoring of ED visit rates**, calculated monthly as the number of ED transfers per 100 residents. The leadership team reviews data quarterly to identify trends, variations, and opportunities for improvement.

From **Q1 to Q3**, the home demonstrated **consistent performance below the annual target of 8.26 ED visits per 100 residents**. While monthly rates fluctuated between July and September, the overall trend indicates that ED transfers remain within acceptable limits and are responsive to implemented interventions. This reflects sustained progress toward reducing potentially avoidable ED visits and improving in-home clinical management.

Monthly ED utilization data are summarized in the table below, which demonstrates variation across the year, with higher utilization observed in December. This data will inform targeted analysis to identify contributing factors such as seasonal illness, acuity changes, or system pressures.

### Performance Measurement

- **Outcome Measure:** ED visit rate per 100 residents
- **Data Source:** PREVIEW ED tracking tool and transfer tracking logs
- **Frequency of Measurement:** Monthly, with quarterly review
- **Target:** ≤ 8.26 ED visits per 100 residents annually

*Table 3: Month-to-month ED visits*

	# of ED visits	Average# of residents per month	ED visit Rate per 100 residents by month
JAN	14	242	4.0
FEB	11	242	4.5
MAR	17	242	7.0
APR	9	241	3.8
MAY	15	239	6.27
JUNE	18	240	7.5
JULY	18	241	7.5
AUG	16	240	6.7
SEPT	16	238	6.7
OCT	17	242	7.0
NOV	16	240	6.6
DEC	28	241	11.6
	<b>16.5</b>	<b>241</b>	<b>6.7</b>

**Change Ideas and Improvement Actions:**

To further reduce potentially avoidable ED visits, the following evidence-informed change ideas have been implemented or are in progress:

**1. Enhanced Management of Skin Conditions**

To address ED transfers related to complex or unmanageable skin conditions, the home will partner with **Derm Café**, a service providing access to board-certified dermatologists through e-consults and in-person visits. This intervention is expected to:

- Improve timely access to specialist assessment
- Support early intervention and treatment
- Reduce the need for ED transfers related to dermatological issues

**2. Implementation of RNAO Best Practice Guidelines (BPGs)**

Effective **July 31, 2025**, the home adopted the **RNAO Delirium Best Practice Guideline** to strengthen assessment, prevention, and management of delirium for residents upon admission and during changes in condition. This initiative

supports early identification and in-home management, thereby reducing ED transfers associated with acute cognitive changes.

Additionally, gap analyses and policy reviews are underway to support the implementation of the **RNAO Falls Prevention and Pain Best Practice Guidelines**, with a planned implementation date of **April 1, 2026**. These guidelines are expected to further reduce ED visits by addressing two common contributors to hospital transfers.

**Sustainability and Next Steps:**

The leadership team will continue to:

- Monitor ED visit trends monthly
- Review high-risk transfers through interdisciplinary case reviews
- Align improvement actions with MLTC quality indicators and QIP priorities

Findings will be incorporated into ongoing quality improvement planning to ensure sustained performance and continuous improvement in resident care outcomes.

**INFECTION PREVENTION & CONTROL PROGRAM**

**Managing Urinary Tract Infections (UTIs)**

**Goal Statement:**

The aim of this initiative is to manage and reduce urinary tract infections (UTIs) and to maintain the percentage of residents with symptomatic, non-catheter-associated UTIs at 5% or below per quarter.

**Indicators**

**1. Outcome Indicator:**

- Number and percentage of residents diagnosed with symptomatic, non-catheter-associated UTIs, confirmed by urine culture and sensitivity.

**2. Process Indicators:**

- Appropriateness of urine culture and sensitivity testing prior to treatment.
- Reduction in unnecessary antibiotic prescribing, specifically antibiotic use for asymptomatic bacteriuria (presence of bacteria without clinical symptoms of UTI).

**Data Sources**

- Quarterly reports from LifeLabs Epidemiology Department
- Internal antimicrobial stewardship and surveillance records

**Performance Data and Results**

**Indicator A: Quarterly UTI Incidence**

*Table 3 – LifeLabs Data*

<b>QUARTER</b>	<b>NO. OF UTI CASES</b>	<b>INCIDENCE RATE</b>	<b>GOAL MET OR UNMET</b>
Q1 (Jan- Mar)	23	9.5%	No
Q2 (Apr-Jun)	10	4%	Yes
Q3 (Jul-Sep)	12	5%	No
Q4 (Oct-Dec)	10	5%	Yes

**Formula:**

- Average residents per quarter = 240
- Target threshold = 5% × 240 = 12 residents
- Quarterly cases must remain **below 12** to meet the goal
- Calculation: (Number of cases ÷ 240) × 100

**Indicator B: Year-to-Year Comparison of UTI Cases**

*Table 4:*

<b>QUARTER</b>	<b>2024</b>	<b>2025</b>
Q1 (Jan- Mar)	29	23
Q2 (Apr-Jun)	16	10
Q3 (Jul-Sep)	17	12
Q4 (Oct-Dec)	13	10
Total	75	55

**Evaluation:**

Overall performance demonstrates a **reduction in UTI cases from 2024 to 2025**, indicating improvement in infection prevention practices, surveillance, and antimicrobial stewardship. The majority of urine cultures submitted were **clinically appropriate**, and residents diagnosed with UTIs were treated according to culture and sensitivity results. Although the quarterly target was not met in Q1 and Q3, sustained improvement was observed in the latter half of the year.

**Change Ideas and Tracking of Progress**

- **Staff Education and Coaching**
  - Ongoing education on personal care, perineal hygiene, and the appropriate use of continence products
  - Reinforcement of using **resident-specific equipment** (e.g., personal basins)
  - Toileting programs individualized to resident needs, with follow-up coaching by the Continence Lead
- **Clinical Assessment and Decision-Making**
  - Reinforcement of evidence-based UTI diagnostic criteria, including:
    - Acute dysuria

- OR two or more of the following:
  - Fever
  - New flank pain or suprapubic tenderness
  - New or increased urgency or frequency
  - Gross hematuria
- **Hydration Support**
  - Promotion of adequate hydration as a core prevention strategy, recognizing its impact on infection prevention, resident comfort, and functional independence

**Challenges and Barriers**

- **Communication Gaps**
  - Incomplete clinical assessments and interventions were not consistently communicated to physicians, resulting in antibiotic prescriptions without a confirmed UTI diagnosis
- **Resident Factors**
  - Responsive behaviours posed challenges in urine sample collection and hydration encouragement, leading to treatment for suspected UTIs without meeting diagnostic criteria

**Immunization Program Evaluation**

*Table 5 Immunization Table*

<b>VACCINATION COVERAGE</b>	<b>2024</b>	<b>2025</b>
<b>COVID-19</b>	<b>87% (210 residents)</b>	<b>82% (196 residents)</b>
<b>Influenza</b>	<b>82% (198 residents)</b>	<b>82% (197 residents)</b>
<b>RSV Vaccination</b>	<b>42% (100 residents)</b>	<b>74% (178 residents)</b>

**Evaluation:**

The goal of achieving **80% or greater vaccination coverage** for **COVID-19 and Influenza** was met. RSV vaccination, introduced in November 2023, demonstrated a **significant increase in uptake** in 2025. Additional doses are pending for approximately 50 residents, with consent already obtained.

**Change Ideas and Tracking of Progress:**

- **Immunization Education**
  - Continued education for residents, families, and staff regarding the benefits of vaccination
- **Routine Practices and Additional Precautions**
  - Reinforcement of hand hygiene through quarterly team huddles
  - Masking in clinical areas in accordance with MLTC directives
- **Surveillance and Early Identification**
  - Staff education on prompt reporting of new respiratory symptoms
  - Early isolation and implementation of additional precautions as indicated

**Challenges and Barriers:**

- **Vaccine Hesitancy**
  - Despite education, influenza vaccination uptake remains a challenge due to its non-mandatory status
- **Vaccine Misinformation**
  - Family members have access to websites that are not vetted

**FALL PREVENTION & MANAGEMENT PROGRAM**

**Reduction of Fall for Newly-Admitted Residents**

**Goal Statement:**

Reduce the fall rate among newly admitted residents by 2% each quarter in the current year.

**Evaluation:**

Our quality improvement objective is to achieve a minimum 2% in fall incidents among newly admitted residents each quarter.

For Q1: A reduction of at least 2% in falls among newly admitted residents was achieved, meeting the established target. Fall-risk assessments were completed on admission, and preventive interventions were implemented in accordance with the policy.

For Q2. A further reduction of less than 2% in fall incidents was achieved compared to Q1. Ongoing monitoring and adherence to individualized care plans supported continued progress.

For Q3: A significant increase in fall incidents was observed, rising from 9.5% in Q2 to 38.9% in Q3. This variance was associated with an increased number of newly admitted residents presenting with pre-existing fall histories and responsive behaviours, which significantly elevated fall risk. Despite standard preventative measures, resident acuity and behavioural complexity impacted outcomes during this period.

For Q4: Following the analysis of Q3 data and the implementation of targeted risk-mitigation strategies, the organization achieved a reduction of at least 2% in falls among newly admitted residents. Enhanced interdisciplinary interventions and increased monitoring contributed to improved outcomes.

Overall Evaluation: While the organization successfully met its quarterly reduction target in Q1, Q2, and Q4. The variance observed in Q3 reflects the impact of resident complexity and acuity rather than systemic non-compliance. Corrective actions were implemented, monitored, and demonstrated effectiveness.

*Table 6: Percentage of newly admitted residents who fell every quarter in 2025*

	2025			
	Oct. to Dec. Q4	July to Sept Q3	April to June Q2	Jan to March Q1
Number of New admissions that had falls in the first 30 days	5	7	2	1
Total Number of Admissions	14	18	21	8
Percentage of residents who had a fall incident	35.7	38.9	9.5%	12%
	3.2% reduction	29.4% increase in falls for newly-admitted residents	2.5% reduction of falls for newly admitted residents	13% reduction of falls for newly admitted residents

**Fracture Rate**

**Goal Statement:**

To maintain the fracture rate at or below 2.0 per 1000 occupied bed days.

**Evaluation:**

In 2025. The organization achieved a fracture rate of 1.092 per 1000 occupied bed days, exceeding the established target of 2.0. This represents a significant and sustained improvement when compared to prior years.

*Table 7: Comparison of Annual Fracture Rate per 1000 occupied beds*

	<b>NUMBER OF FRACTURES</b>	<b>AVERAGE NUMBER OF OCCUPIED BEDS</b>	<b>RATE PER 1000 OCCUPIED BEDS</b>
2025	8	7320	1.092
2024	20	7325	2.7
2023	15	7280	2.06
2022	16	6997	2.28

Table 8. Quarterly Fracture Rate per 1000 occupied beds

	<b>NUMBER OF FRACTURES</b>	<b>AVERAGE NUMBER OF OCCUPIED BEDS</b>	<b>RATE PER 1000 OCCUPIED BEDS</b>
Q4 October to December	<b>3</b>	<b>7404</b>	<b>0.13</b>
Q3 July to September	<b>1</b>	<b>7344</b>	<b>0.41</b>
Q2 April to June	<b>3</b>	<b>7281</b>	<b>0.41</b>
Q1 Jan to March	1	7252	0.13

The 2025 outcome reflects the lowest fracture rate achieved to date and demonstrates the effectiveness of current fracture-prevention strategies. The downward trend indicates improved risk identification, adherence to safety practices, and timely clinical interventions.

The fracture prevention program has demonstrated measurable effectiveness in reducing fracture rates below the organizational target. Continued monitoring, audit-driven practice reinforcement, and alignment with evidence-based guidelines will support sustained performance and further risk reduction.

**Change Ideas:**

In Q3, a pilot initiative involving random audits of safe transfer methods was trialled on one unit. Early findings supported improved staff adherence to safe transfer practices and informed plans for broader implementation.

Beginning in Q2, the organization will implement the following enhancements:

- Complete a minimum of five (5) safe transfer audits per floor per month to strengthen monitoring and compliance.
- Continue established initiatives, including:
  - Regular medication review to identify medications that may increase fracture risk
  - Ongoing use of the Fracture Order Set to support timely and standardized clinical management
- Implement the Registered Nurses Association of Ontario (RNAO) Best Practice Guideline: Fall Prevention and Management across the organization in April 2026/

We will continue applying change ideas and tracking progress through initiatives such as medication reviews, falls huddles, and maintaining the Fracture Order set upon admission and as needed. We have adopted the RNAO Clinical Pathways, and one of the best-practice guidelines we will incorporate into the 3-year program is the Fall Prevention and Management guideline.

## **RESTRAINT MINIMIZATION**

### **Goal Statement:**

To maintain no more than three residents on restraints per quarter in 2025 in compliance with the organization's commitment to least-restraint practices.

### **Evaluation:**

In 2025, the organization recorded a total of eight (8) residents who required restraints during the year, representing an improvement compared to ten (10) residents in 2024. Review of quarterly data confirms that in both 2024 and 2025, the organization consistently maintained at least three (3) or fewer than three (3) residents on restraints in each quarter, meeting the established performance target.

This outcome reflects sustained adherence to restraint minimization principles, appropriate use of clinical assessments, and ongoing efforts to implement alternative interventions before restraints are applied.

The restraint minimization program has been effective in maintaining restraint use below the organization's target on a quarterly basis.

### **Change Ideas:**

- Staff education was provided on the organization's Restraint and Least Restraint Policy (Surge Learning), with emphasis on risk assessment, documentation requirements, and the hierarchy of least-restrictive alternatives.
- Family health teaching (when needed) and engagement were strengthened in response to situations where family members requested the use of physical barriers or restraints. Health teaching focuses on available non-restraint alternatives to support resident safety and address clinical risks and potential harm associated with restraint. These discussions contributed to improved family understanding and supported shared decision-making aligned with least restraint principles.

*Table 9: Number of residents with Restraints every quarter. It also compares the data from 2024.*

	<b>TOTAL</b>	<b>Oct. to Dec. Q4</b>	<b>July to Sept. Q3</b>	<b>April to June Q2</b>	<b>January to March Q1</b>
2025	8	2	2	2	2
2024	10	2	2	3	3

**RESPONSIVE BEHAVIOUR MANAGEMENT PROGRAM**

**Antipsychotic Reduction Program**

**Goal Statement:**

To maintain the average number of 6 residents per year enrolled in the antipsychotic reduction program in order to prevent the inappropriate use of antipsychotic medications without a valid diagnosis, thereby reducing the risk of adverse effects and improving resident safety.

**Evaluation:**

For Q1, seven (7) residents were enrolled; four (4) residents were successfully deprescribed. For Q2 and Q3, eight (8) and six (6) residents were in the program, and five (5) and one (1) residents were safely deprescribed, respectively. For Q4, 6 residents are currently enrolled; to date, no residents have been deprescribed due to seasonal changes or increased responsive behavioural acuity.

Overall Evaluation: The organization maintained an average of 7 residents enrolled in the antipsychotic reduction program. The established annual target was achieved. Antipsychotic use was regularly reviewed, and deprescribing decisions were made based on clinical appropriateness, resident safety, and documented assessments. All deprescribing decisions were supported by interdisciplinary review, involvement of the substitute decision maker, and ongoing monitoring.

This evaluation includes drug utilization trends and patterns, including psychotropic drugs that place residents at risk. This approach aligns with Ministry expectations that antipsychotics be reduced only when clinically safe and appropriate.

*Table 10: Number of residents on Antipsychotic Reduction Program*

	Number of residents who are Active in the Antipsychotic Reduction Program	Number of residents who completed the Program	
Q4	6 residents	0	
Q3	6 residents	1	
Q2	8 residents	5	
Q1	7 residents	4	

**Risk Assessment and Clinical Considerations:**

- Reduced deprescribing in the latter half of the year reflects appropriate clinical caution in response to increased behavioural complexity
- Seasonal illness and delirium risk
- Resident safety considerations.

**Significant Gaps:**

- Limited availability of PRC to support the impacted staff education capacity
- Opportunities exist to improve the timely identification of residents suitable for deprescribing and enhance communication regarding changes in resident acuity and behaviours.

**Change Ideas:**

- Participation in ISMP Canada initiatives to strengthen safe medication practices and reduce antipsychotic use in October 2025.
- Implementation of RNAO’s Clinical Pathway and BPG for delirium screening
- Strengthen collaboration with the internal BSO team and external BSO partners
- Use of the High Intensity Support program for residents with complex behavior needs
- Continued education of staff on non-pharmacological interventions and responsive behaviours

**MEDICATION MANAGEMENT SYSTEM**

**Reduction of Medication Errors as Reported by Nurses**

**Goal Statement:**

To reduce the percentage of medication errors related to nursing practice by 10% on an annual basis, in support of resident safety and quality of care.

**Indicator**

Number of Medication Incident Reports (MIRs) related to nursing, as reported by registered nursing staff.

**Evaluation**

The program is evaluated annually. At this time, the goal has not been met. Data analysis indicates an overall 8% increase in medication incidents related to nursing practice between 2024 and 2025.

**Outcomes and Data Analysis**

*Table 11: Quarterly Comparison of MIRs Related to Nursing*

<b>QUARTER</b>	<b>2024</b>	<b>2025</b>
Q1 (Jan–Mar)	3	2
Q2 (Apr–Jun)	2	4
Q3 (Jul–Sept)	3	5
Q4 (Oct–Nov)	3	1
<b>TOTAL</b>	<b>11</b>	<b>12</b>

*Table 12: Quarterly Incidence Rate and Goal Status – 2025*

<b>QUARTER</b>	<b>RATE</b>	<b>GOAL STATUS</b>
Q1 (Jan–Mar)	33% increase	Unmet
Q2 (Apr–Jun)	100% increase	Unmet
Q3 (Jul–Sept)	25% increase	Unmet
Q4 (Oct–Nov)	80% increase	Met

While Q4 demonstrated improvement, overall annual data indicate an upward trend in reported medication incidents.

## Analysis of Medication Errors

The most common medication errors identified include:

1. Orders not carried out as prescribed, including:
  - Incorrect transcription
  - Orders not transcribed into the eMAR
2. Glucagon-related incidents
3. Administration to the wrong resident
4. Monitoring errors
5. Incorrect dosage
6. Medication omissions
7. Incorrect timing of administration

Findings suggest opportunities for improvement related to transcription accuracy, communication, monitoring, and adherence to medication administration standards.

## Change Ideas and Tracking of Progress

### System and Process Improvements

- **Medication Reconciliation:** Enhanced reconciliation processes during transitions of care (admission, transfer, discharge) to ensure accuracy and continuity.
- **Pharmacist Involvement:** Increased pharmacist review of medication orders, reconciliation, and staff education.
- **Independent Double-Checks:** Mandatory double-checks for high-alert medications, unusual dosages, and complex calculations.
- **Clear Communication:** Use of standardized terminology, elimination of unsafe abbreviations, and encouragement of clarification for unclear orders.

### Staff Education and Safety Culture

- **Ongoing Education:** Continued training on safe medication practices, new technologies, and evidence-based standards.
- **Non-Punitive Reporting:** Reinforcement of a just culture that encourages reporting of medication incidents without fear of reprisal, focusing on system-level improvement.
- **High-Risk Focus:** Increased attention to high-risk medications, polypharmacy, and transitions of care.

### Individual Practice Expectations (Nursing Staff)

- Minimize distractions during medication administration

- Adhere to the **rights of medication administration** (right resident, medication, dose, route, time)
- Clarify unclear or incomplete orders with prescribers or pharmacists
- Maintain knowledge of medications, including indications, effects, and potential adverse reactions

## **Conclusion**

The Medication Management Program continues to promote resident safety; however, the yearly goal to decrease medication errors by 10% has not been met. The observed rise in medication incidents underscores the need for stronger education, better monitoring, and ongoing system-level improvements. Continuous evaluation and quality improvement efforts will aim to reduce risks, enhance compliance, and support safe medication practices in line with Ministry of Long-Term Care standards.

**WEIGHT MANAGEMENT PROGRAM**

**Goal Statement**

To reduce the occurrence of weight variances by **5% annually** through improved accuracy of weight measurement, documentation, and consistency in weighing practices.

**Indicator**

Percentage of weight variances related to:

- Incorrect weight entry
- Inconsistent method of weighing

**Evaluation**

The program goal has been achieved. Data analysis showed a significant decrease in weight variances linked to both identified indicators. Weight variances from incorrect weight entry dropped by 22%, and those from inconsistent weighing methods decreased by 43%.

These results indicate improved compliance with established weight monitoring protocols and documentation practices.

**Findings and Data Analysis**

*Table 13: Annual Comparison of the Number of Incorrect Weight Entry & Inconsistent Method of Weighing*

<b>YEAR</b>	<b>NO. OF INCORRECT WEIGHT ENTRY</b>	<b>NO. OF INCONSISTENT METHOD OF WEIGHING</b>
2024	57	70
2025	42	44

*Table 14. Quarterly Comparison of the Number of Incorrect Weight Entry & Inconsistent Method of Weighing*

<b>QUARTER</b>	<b>INCORRECT WEIGHT ENTRY</b>	<b>INCONSISTENT METHOD OF WEIGHING</b>
Q1 (Jan–Mar)	15	7
Q2 (Apr–Jun)	15	8
Q3 (Jul–Sept)	12	16
Q4 (Oct–Nov)	0	13
<b>TOTAL</b>	<b>42</b>	<b>44</b>

## **Achievements**

- Registered staff consistently attend quarterly weight management meetings and demonstrate improved adherence to established weight monitoring protocols.
- Improved compliance has been observed with the appropriate use of weighing equipment, including reduced unnecessary weighing.
- Staff demonstrate receptiveness to feedback, contributing to sustained quality improvement.
- All units effectively utilize the Monthly Weight Master List to support accurate tracking, monitoring, and oversight of resident weights.
- Ongoing monitoring has supported increased consistency across units.

## **Challenges and Barriers**

Despite overall improvement, the following challenges were identified:

- Continued inconsistencies in weighing methods across units
- Use of multiple weighing scales without a documented clinical rationale
- Incomplete re-weighing and documentation when weight variances of **≥2.0 kg** are identified
- Inaccurate wheelchair weights
- Missing or duplicate weight entries
- Weights documented without appropriate physician orders

These gaps highlight the need for continued staff education, improved documentation practices, and enhanced monitoring to ensure compliance with Ministry expectations.

## **Change Ideas and Tracking Progress**

- Ongoing education will be provided through in-service sessions and targeted one-on-one coaching to reinforce correct weighing techniques and documentation standards.
- Emphasis will be placed on accurate identification, investigation, and documentation of weight changes.
- Continued auditing and monitoring will be implemented to track compliance and support sustained improvement.
- Findings will be reviewed regularly and incorporated into quality improvement initiatives as required.

## **Conclusion**

The Weight Management Program effectively supports accurate weight monitoring and adherence to Ministry of Long-Term Care requirements. The program has shown measurable improvements in reducing weight variances caused by incorrect documentation and inconsistent weighing practices. Ongoing education, monitoring, and



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quality improvement efforts will help sustain compliance and promote positive resident outcomes.

**PALLIATIVE CARE APPROACH & PAIN MANAGEMENT**

**Goal Statement:**

The goal of this program is to educate 40 staff members and families on the Palliative Approach to Care and End-of-Life (EoL) Support by the end of the calendar year.

**Performance Indicators**

Program performance is measured by the number of staff demonstrating interest and engagement in increasing their understanding of a Palliative Care Approach and End-of-Life Support.

**Evaluation:** The program has met its objective to train at least 40 individuals

**Identified Gaps:**

Gaps in knowledge and practice may persist, as education in palliative and end-of-life care requires ongoing reinforcement. To address these gaps, the program ensures that both new hires and existing staff receive appropriate training to support timely identification and implementation of a Palliative Approach to Care and End-of-Life Support.

**Change Ideas and Continuous Improvement**

The program will continue to collaborate with external partners to support the delivery of ongoing education and training for staff, families, residents, and loved ones. Efforts will also focus on ensuring that resources, guidance, and emotional support are readily accessible to individuals who require assistance or clarification regarding the transition to End-of-Life Care.

To strengthen program delivery, partnerships have been established with The Dorothy Ley Hospice **and** Ontario Health. These collaborations will support enhanced training opportunities for staff.

*Table 15. Quarterly Training*

	<b>No. of Trainings</b>
Q1 (Jan–Mar)	15
Q2 (Apr–Jun)	12
Q3 (Jul–Sept)	21
Q4 (Oct–Nov)	6
<b>TOTAL</b>	<b>54</b>

**Conclusion:**

The Palliative Care Approach and Pain Management program remains aligned with organizational and sector priorities. Continued emphasis on education, partnership development, and resource accessibility is expected to further enhance staff capacity and improve the quality of care provided to residents and families receiving palliative and end-of-life support.

## SKIN AND WOUND CARE PROGRAM

### Reduction of Internally Acquired Pressure Injuries

#### Goal Statement:

To reduce the percentage of residents with internally acquired pressure injuries **by 5%** annually.

#### Performance Indicator

Number of residents with new internally acquired pressure injuries, stratified by stage and monitored quarterly.

#### Evaluation:

For 2025, the Skin and Wound Care Program met and exceeded the established performance target. Compared to 2024, there was a **28.8% overall reduction** in internally acquired pressure injuries. This outcome demonstrates improved prevention strategies, enhanced staff compliance with assessment protocols, and more timely clinical interventions.

#### Q1 (January–March):

A 50% increase in internally acquired pressure injuries was observed compared to Q4 2024. This variance indicated a performance gap related to early identification and reporting. A focused review was completed, and targeted staff education and reinforcement of best practices were initiated to address contributing factors.

#### Q2 (April–June):

An 8.3% reduction in cases was achieved. This improvement reflects early effectiveness of corrective actions, including enhanced education and increased clinical oversight.

#### Q3 (July–September):

An increase in internally acquired pressure injuries was identified. Contributing factors included: Inconsistent completion of skin assessments, incomplete pressure injury staging and documentation, and delays in escalation of new skin concerns by PSWs to registered staff.

These findings highlighted the need for strengthened communication processes, documentation compliance, and closer monitoring.

#### Q4 (October–December):

A 50% reduction in internally acquired pressure injuries was achieved. This improvement reflects increased adherence to assessment schedules, consistent

documentation, and enhanced interdisciplinary communication following the implementation of earlier interventions.

*Table 16. Quarterly Comparison of Internally Acquired Pressure Injuries*

	<b>Pressure Ulcer Stage 1</b>	<b>Pressure Ulcer Stage 2</b>	<b>Pressure Ulcer Stage 3</b>	<b>Pressure Ulcer Stage 4</b>	<b>Unstageable Pressure Ulcer</b>	<b>Deep Tissue Injury</b>
Q1	1	10	0	0	0	1
Q2	2	8	0	0	0	1
Q3	3	11	1	0	0	1
Q4	3	5	0	0	0	0

*Table 17. Annual Comparison of Internally Acquired Pressure Injuries*

<b>QUARTER</b>	<b>2024</b>	<b>2025</b>
Q1 (Jan- Mar)	24	12
Q2 (Apr-Jun)	10	11
Q3 (Jul-Sep)	24	16
Q4 (Oct-Dec)	8	8

### **Reduction of Rashes**

#### **Goal Statement:**

To reduce the percentage of residents experiencing new rashes requiring prescription treatment by 5% annually.

#### **Performance Indicator:**

Number of residents with new rashes requiring prescription medication, compared year over year.

*Table 18 Quarterly Comparison*

<b>QUARTER</b>	<b>NO. OF RESIDENTS WITH RASHES &amp; HAVE PRESCRIBED MEDICATIONS</b>
Q1	52
Q2	52
Q3	60
Q4	29

**Evaluation:**

As no comparable data were available for 2024, 2025 serves as the baseline year for this indicator. Results from this year will be used for future comparative evaluation beginning in 2026.

Q1 and Q2 (January – March and April – June)

No change was observed between Q1 and Q2, indicating stable performance during the baseline year.

Q3 (July-September)

A 15.38% increase was observed from Q2 to Q3. This increase was associated with inconsistent reporting and delayed documentation of skin changes, resulting in delayed clinical intervention.

Q4 (October-December)

An 51.7% reduction was achieved from Q3 to Q4, suggesting that reinforced education and reporting expectations are supporting improved identification and management of skin conditions.

**Reduction of Worsening Pressure Injury**

**Goal Statement:**

To reduce the percentage of residents with worsening pressure injuries from Stage 2 to Stage 3 or greater by 5% annually.

**Performance Indicator:**

Number of residents whose pressure injuries progressed from Stage 2 to Stage 3 or higher, compared year over year.

**Evaluation:**

No overall change was observed year over year. While improvement was not achieved, performance remained stable, establishing a consistent baseline for continued quality improvement.

Q1 (January-March)

A 33.3% reduction compared to Q4 2024, indicating early success in prevention and timely intervention.

**Q2 (April-June)**

A further 50% reduction, demonstrating strong compliance with monitoring, reassessment, and escalation processes.

**Q3 (July-September)**

A 50% increase, indicating reduced effectiveness of prevention strategies and highlighting the need for reinforced monitoring and timely reassessment.

**Q4 (October-December)**

A 33.3% reduction from Q3 to Q4, reflecting improved outcomes following strengthened monitoring and earlier intervention.

*Table 19. Quarterly Comparison of Worsening Pressure Injuries*

	<b>Pressure Ulcer Stage 1</b>	<b>Pressure Ulcer Stage 2</b>	<b>Pressure Ulcer Stage 3</b>
Q1	0	3	1
Q2	0	1	1
Q3	1	2	0
Q4	0	2	0

*Table 20. Annual Comparison of Worsening Pressure Injuries*

	<b>2024</b>	<b>2025</b>
Q1	1	4
Q2	3	2
Q3	1	3
Q4	6	2

**Identified Gaps and Opportunities for Improvement:**

- Inconsistent documentation and reporting of new skin issues by PSWs
- Incomplete registered staff assessments, including missing wound location and staging
- Inconsistent adherence to required weekly wound reassessment schedules

**Change Ideas and Monitoring Plan:**

- Implement quarterly mandatory re-education for PSWs on early detection and prevention of pressure injuries and rashes, reinforcing the principle of “Report Early, Treat Early.”

- Collaborate with DermCafé to support timely dermatological assessment through e-consults and on-site visits for complex or persistent skin conditions.
- **Continue** weekly Wound Nurse Coordinator rounds for Stage 3 and higher pressure injuries, with follow-up of worsening Stage 2 injuries and non-healing skin tears.
- Maintain collaboration with Humber River Hospital – NLOT and OwnHealth, including NP consultation, staff education, vascular referrals, and ongoing implementation of evidence-based change strategies.