**ANNUAL EVALUATION**
**FISCAL YEAR 2025-2026**

**Program**: **Abuse and Neglect Program**
**Program Lead**: Mary Buhion, Director of Care
**Evaluation Date:** April 29, 2026
**Type of Evaluation:** Annual
**Reporting Period**: April 2025 – March 31, 2026 Fiscal Year

**Program Evaluation Attendance**

The program evaluation was conducted using an interdisciplinary team approach. Attendance reflected the involvement of individuals, as follows:
Present: Mary Buhion (DOC/Chair), Amin Makawi (Business Director), Dr. Matthew Runnalls (Medical Director), Umbreen Mir (Pharmacy Consultant), Sasan Tabibi (Physiotherapist), Roland Madrona (IPAC Lad), Araceli Balaoeg (Clinical Supervisor), Helen Filoteo (Clinical Coordinator), Anh Mai (RAI-Coordinator), Maru Espina (RAI-Coordinator/Notetaker), Christian Daguio (BSO Lead), Usoshe Bose (Registered Dietitian), Juliette James (Dietary Manager), Julie Mendis (Dietary Supervisor), Doris Nwosu (Director of Residents Program), Susan Williams (Registered Social Worker), Shawn Smith (RPN, Temporary Falls Lead), An Nguyen (Nurse Practitioner from North West Ontario)

Visitors: Beatrise Edelstein and Kathleen Kirk (Vice-President of Hennick Humber Hospital) and Kathleen Kirk (Manager of Hennick Humber Hospital)

Regrets: Robert Scott (Administrator) and Jessica Bandoo ((Nurse Practitioner from North West Ontario)

**Abuse and Neglect Prevention**

**Goal:** To achieve and sustain an **80% reduction** in critical incidents related to abuse and neglect compared to the 2022 baseline (6 residents).

**Performance Indicator:** Number of Critical Incidents (alleged, suspected, or witnessed) reported to the Ministry (MLTCC) via the Critical Incident System (CIS).

**Evaluation and Analysis**

*Table 1: 2025-2026 Quarter-to-Quarter Comparison*

| Quarter | Incidents Related to Resident Abuse |
|---|---|
| Q1 (Apr–Jun) | 1 |
| Q2 (Jul–Sep) | 0 |
| Q3 (Oct–Dec) | 0 |
| Q4 (Jan–Mar) | 0 |

*Table 2: A 5-Year-to Year Comparison (Fiscal Year)*

| Fiscal Year | Incidents Related to Resident Abuse |
|---|---|
| 2025–2026 | 1 |
| 2024–2025 | 1 |
| 2023–2024 | 5 |
| 2022–2023 | 5 |
| 2021–2022 (Baseline) | 5 |

During the fiscal year from April 2025 to March 2026, the facility reported a total of 10 critical incidents, with only one involving resident abuse and neglect. This sole incident, promptly reported to the MLTCC in the first quarter, reflects a marked improvement in safeguarding resident well-being. Importantly, there were zero incidents of abuse or

neglect in the subsequent quarters, underscoring the effectiveness of ongoing prevention and intervention strategies.

Trend analysis over the past five years reveals substantial progress. From April 2021 to March 2024, the facility consistently reported five incidents of abuse or neglect annually. However, this number dropped to just one incident in both 2024–2025 and 2025–2026. This sustained reduction signals the success of targeted quality improvement initiatives, comprehensive staff education, and strengthened prevention measures.

In summary, the data demonstrate sustained success in reducing critical incidents related to abuse and neglect. To maintain and accelerate this positive trajectory, the facility should continue robust monitoring of incident trends and prioritize ongoing staff education.

**Identified Gaps**

While our progress is significant, sustaining this positive trajectory demands continuous vigilance and proactive leadership. Two key challenges have been identified that require focused attention:

- Normalization of Responsive Behaviours: As resident acuity continues to rise, there is a risk that staff may become desensitized to challenging behaviours. It is essential to reinforce a culture of empathy, awareness, and immediate intervention to ensure every resident receives the attentive, compassionate care they deserve.
- Increasing Complexity of Resident Profiles: Recent admissions often present with complex cognitive and behavioural needs, which can elevate the risk of resident-to-resident incidents. Navigating this complexity requires ongoing staff training, specialized support, and early, individualized interventions to foster a safe and supportive environment for all.

**Change Ideas & Improvement Strategies**

We have implemented several targeted interventions to maintain this downward trend and proactively address identified risks:

Completed Staff Education

- January 2025: Duty to Protect & Responsive Behaviours (102 staff).
- May 2025: Bill of Rights, Privacy, & Zero Tolerance (19 Night Staff).
- June 2025: 100% Surge Learning completion for Abuse & Neglect education.
- October 2025: In-person education on Confidentiality & Personal Space (81 staff).

**ANNUAL EVALUATION**
**FISCAL YEAR 2025-2026**

## Ongoing Quality Actions

- Dementia Observation System (DOS): Continued use for early identification and individualized care for residents with emerging behaviours.
- Reporting Reinforcement: Ongoing education on timely documentation and escalation for all suspected incidents.
- Trigger Identification & Early Intervention: Strengthening staff understanding of early intervention for responsive behaviours and recognizing triggers.
- Specialized Dementia and Resident-Centred Care Education: On February 25 and 26, 2026, at least 13 front-line staff completed in-person education on the Living with Dementia Journey, and another 12 staff completed Resident-Centred Care training. These sessions were delivered on-site by two trainers from CLRI, who also provided financial support for back-fill coverage. Staff feedback was overwhelmingly positive, and there is high demand for further education. In response, additional sessions are scheduled for May 2026, with participants being identified from all departments to establish this as an ongoing initiative.
- BSO Team Engagement: Our Behavioural Supports Ontario (BSO) team plays an active role in assessing and responding to referrals. Our PSW, a BSO team member, flexibly adjusts her schedule to observe residents across shifts, including night shifts, and provides real-time assessment, guidance, and ongoing coaching to staff to manage challenging behaviours and support socially withdrawn residents.
- Our external BSO partners—including CAMH, GMHOT, and mBSS—are vital collaborators in assessing and identifying residents with responsive behaviours. A CAMH psychogeriatrician visits the Home monthly, and the GMHOT nurse and mBSS team provide regular on-site support. In addition, our doctors, nurse practitioners, and pharmacy consultant are actively engaged in ongoing medication reviews with the BSO team. This multidisciplinary collaboration ensures timely, resident-centred interventions and fosters a safer, more supportive, and compassionate environment for all.
- Strategic Staffing and Accommodation: We have strategically used high-intensity funding to support supplemental staffing and provide preferred accommodation for residents with significant responsive behaviours. Currently, three residents benefit from preferred accommodation, resulting in a noticeable reduction in incidents. Previously, shared accommodations triggered behaviours, such as the need for exclusive use of the washroom, that affected roommates. Since transitioning to preferred accommodation, these residents' behaviours have stabilized, creating a safer, more positive environment for everyone.

**ANNUAL EVALUATION**
**FISCAL YEAR 2025-2026**

**Goal Statement for FY 2026–2027: Abuse and Neglect Prevention Program:** From April 1, 2026, to March 31, 2027, achieve and sustain zero critical incidents of abuse and neglect reported to the Ministry (MLTCC) via CIS, compared to the 2022 baseline of five incidents. This will be achieved through ongoing staff education, enhanced early intervention and reporting, and continued multidisciplinary collaboration, with quarterly progress reviews by the interdisciplinary team.

**ANNUAL EVALUATION**
**FISCAL YEAR 2025-2026**

**Program: Reduction of Emergency Department (ED) visits**
**Program Lead**: Mary Buhion, Director of Care and Nurse Managers (Helen Filoteo, Araceli Balaoeg and Roland Madrona (Co-Leads)
**Type of Evaluation:** Annual
**Reporting Period:** April 1, 2025 to March 31, 2026
**Evaluation Date:** April 29, 2026

**Program Evaluation Attendance**

The program evaluation was conducted using an interdisciplinary team approach. Attendance reflected the involvement of individuals, as follows:

Present: Mary Buhion (DOC/Chair), Amin Makawi (Business Director), Dr. Matthew Runnalls (Medical Director), Umbreen Mir (Pharmacy Consultant), Sasan Tabibi (Physiotherapist), Roland Madrona (IPAC Lad), Araceli Balaoeg (Clinical Supervisor), Helen Filoteo (Clinical Coordinator), Anh Mai (RAI-Coordinator), Maru Espina (RAI-Coordinator/Notetaker), Christian Daguio (BSO Lead), Usoshe Bose (Registered Dietitian), Juliette James (Dietary Manager), Julie Mendis (Dietary Supervisor), Doris Nwosu (Director of Residents Program), Susan Williams (Registered Social Worker), Shawn Smith (RPN, Temporary Falls Lead), An Nguyen (Nurse Practitioner from North West Ontario)

Visitors: Beatrise Edelstein and Kathleen Kirk (Vice-President of Hennick Humber Hospital) and Kathleen Kirk (Manager of Hennick Humber Hospital)

Regrets: Robert Scott (Administrator) and Jessica Bandoo ((Nurse Practitioner from North West Ontario)

Attendance reflected the involvement of individuals, as follows:

**Goal:** 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).

**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

**Evaluation and Analysis**

*Table 3: Quarter-to-Quarter ED visits*

**ANNUAL EVALUATION**
**FISCAL YEAR 2025-2026**

| Quarter | Month | # of ED Visits | Avg. Resident Count | ED Rate (per 100) |
|---|---|---|---|---|
| **Q1** | APR – JUN | 42 | 240 | 5.83 |
| **Q2** | JUL – SEPT | 50 | 240 | 6.96 |
| **Q3** | OCT – DEC | 61 | 241 | 8.40 |
| **Q4** | JAN – MAR | 55 | 239 | 7.66 |
| **TOTAL** | **Annual Avg** | **17.33 (avg)** | **240** | **7.22** |

*Table 4: Month-to-month ED visits*

| | # of ED visits | Average# of residents per month | ED visit Rate per 100 residents by month |
|---|---|---|---|
| 2025 | | | |
| APR | 9 | 241 | 3.8 |
| MAY | 15 | 239 | 6.2 |
| 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 |
| 2026 | | | |
| JAN | 17 | 239 | 7.11 |
| FEB | 23 | 238 | 9.66 |
| MAR | 15 | 241 | 6.22 |

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.

Overall, while monthly fall rates fluctuated over the 12-month period from April 2025 to March 2026, ED transfer rates remained within acceptable limits below 8.26, except for December 2025 and February 2026. Within this period, the fall rate peaked in December 2025 at 11.6 ED rate per 100 residents, followed by February 2026 at 9.66.

For December 2025, we attribute the increase in fall rate to 4 residents who were sent to the ED (no hospital admission) for injuries. Meanwhile, 2 residents were admitted to the hospital for pneumonia, and 1 resident was sent out twice for anemia. Also, four residents were sent out to the hospital twice in December.

In February 2026, Pneumonia had the highest hospital transfer rate, with 5 residents, 3 of whom were admitted and 2 who only reached the ER. This was followed by injury, after the fall, with 3 residents going to the ER without hospital admission. In February, 4 residents were sent to the hospital twice; 3 were admitted.

In general, the Home met the fiscal-year goal. The overall ED rate per 100 residents is 7.22, below the target of 8.22.

**Identified Gaps**

1. A significant proportion of emergency department (ED) visits from the nursing home are due to injuries resulting from resident falls.

   Change Ideas and Improvement Strategies: Conduct comprehensive fall risk assessments upon admission based on best practice guidelines for Admission Process and Fall Prevention and Management. Develop individualized care plans targeting fall prevention; Orient new residents to their environment and safety features; Ensure rooms are set up safely before arrival; Educate residents and families on fall prevention measures, and monitor closely during the first weeks and adjust interventions as needed
2. Insufficient Staff Training: Staff may not feel confident in assessing and managing complex medical issues, leading to a lower threshold for hospital transfers.

   Change Ideas and Improvement Strategies: Implement an assessment training course for staff, delivered by a third-party provider, to improve skills and confidence in managing complex medical issues and reduce unnecessary hospital transfers. Timeline by the 3rd quarter of 2026

3. Communication Gaps: Poor communication among nursing home staff, families, and physicians can lead to unnecessary ED visits, especially when advance care plans or resident preferences are unclear.

Change Ideas and Improvement Strategies: Standardized communication protocols to ensure all staff, families, and physicians are informed about resident care plans and preferences, reducing unnecessary ED visits; and provide re-education for nurses and PSWs on reviewing recent ED visits to identify communication gaps and prevent unnecessary transfers.

4. Families or residents are unwilling to update or change the level of care, which may result in care plans that do not reflect current needs and can lead to unnecessary ED visits.

   Change Ideas and Improvement Strategies: Address concerns and misconceptions through open communication; Provide clear, compassionate education on the benefits of updating care levels; and, when needed, collaborate with the Mt. Sinai Temmy Latner Centre to support families through compassionate conversations and expert guidance. Their involvement can help build trust, address concerns, and inspire residents and families to make informed decisions.

5. Family Expectations and Pressure: Families may request ED transfers out of concern or misunderstanding of the resident's condition, especially if they are not aware of the nursing home's capabilities.

   Change Ideas and Improvement Strategies: Provide families with clear information about the nursing home's capabilities and typical care processes. Hold regular meetings to review resident status, address concerns, and set realistic expectations. Engage trusted medical experts, such as the Mt. Sinai Temmy Latner Centre, to guide families through complex decisions and reassure them about on-site care.

6. Limited Access to Diagnostic Tools: Nursing homes may not have on-site diagnostics (e.g., X-rays, labs), making it difficult to rule out serious conditions without hospital resources.

   Change Idea and Improvement Strategies: Has begun advocacy by encouraging family members to write to the Ontario Health Team and MLTCC to request dedicated funding to support non-emergency mobile diagnostic services and accompaniment for residents, reducing the need for hospital transfers.

7. Regulatory and Legal Concerns: Concerns about liability or regulatory requirements may prompt staff to transfer residents to the ED as a precaution.

   Change Idea and Improvement Strategy: Foster a culture of open communication and support, so staff feel confident managing residents in place when appropriate.

## Additional Change Ideas and Improvement Actions

The program's success is supported by evidence-based strategies and a culture of innovation. Key initiatives include:

1. Best Practice Guidelines Implementation: Preparation for RNAO best-practice guidelines on Fall Prevention & Management and Pain Management, launching on April 1, 2026, is underway. Staff are receiving targeted education to address falls, a leading cause of ED transfers.
2. DermCafe Partnership: Collaboration with DermCafe, Canada's first national, publicly funded dermatology clinic, brought specialist care on-site. In Q4 2025-2026, 33 residents received assessments, reducing external referrals and ED transfers. A DermCafe dermatologist visited the Home twice in Q4 – on January 31 and March 28, 2026.
3. Enhance in-house resident assessment and treatment by leveraging the expertise of the NLOT team, who visit the Home twice weekly (Tuesdays and Thursdays) to work collaboratively with doctors and nurses. This proactive partnership enables early intervention and supports the treatment of residents in place whenever possible, reducing unnecessary ED transfers. This initiative aligns with the Ministry of Long-Term Care quality indicators and the Home's QIP, reflecting our commitment to excellence, innovation, and resident well-being.
4. Sustain use of the PREVIEW-ED tool to empower PSWs to report resident changes promptly, enabling early in-house intervention and reducing avoidable ED visits for conditions like pneumonia, dehydration, UTI, and CHF. Through monthly reporting to Hennich Humber Hospital and active participation in a collaborative community of practice hosted by Beatrise Edelstein and Kathleen Kirk with other long-term care homes, we review data, share best practices, and drive continuous improvement in resident care.
5. RNAO Clinical Pathways: Adoption of clinical pathways and best-practice guidelines for Delirium, Resident and Family Centred Care, and Admission Process on July 31, 2025, has strengthened early identification and in-home management of acute cognitive changes, reducing unnecessary transfers.
6. Non-Emergency Transportation Funding: Funding secured from August 2023 to March 2025 enabled timely access to non-urgent care, reducing avoidable ED transfers. Advocacy continues to secure ongoing support for transportation and accompaniment.

Through collaboration and a strong focus on resident-centred care, the Home has achieved and sustained its ED visit targets. Lessons learned during this period will inform future strategies, reinforcing our commitment to quality, safety, and resident well-being.

## Sustainability and Next Steps

The leadership team will sustain and build on these improvements by:

- Monitoring ED visit trends monthly.
- Reviewing high-risk transfers through interdisciplinary case reviews
- Aligning improvement actions with MLTC quality indicators and QIP priorities

Findings from this evaluation will guide ongoing quality improvement planning, ensuring continued excellence in resident care and fostering a culture of continuous learning and innovation.

**Goal Statement for 2026–2027:** By March 31, 2027, reduce and sustain the Emergency Department (ED) visit rate to 7.22 or fewer visits per 100 residents, through monthly data monitoring, targeted interventions, and interdisciplinary team collaboration, in alignment with the Ministry of Long-Term Care's quality indicators and the Home's QIP.

**ANNUAL EVALUATION**
**FISCAL YEAR 2025-2026**

**Program: Fall Prevention & Management Program**
**Program Lead** (Temporary): Mary Buhion, Roland Madrona and Shawn Smith, RPN
**Type of Evaluation**: Annual
**Reporting Period**: April 1, 2025 to March 31, 2026
**Evaluation Date**: April 29, 2026

**Program Evaluation Attendance**

The program evaluation was conducted using an interdisciplinary team approach. Attendance reflected the involvement of individuals, as follows:

Present: Mary Buhion (DOC/Chair), Amin Makawi (Business Director), Dr. Matthew Runnalls (Medical Director), Umbreen Mir (Pharmacy Consultant), Sasan Tabibi (Physiotherapist), Roland Madrona (IPAC Lad), Araceli Balaoeg (Clinical Supervisor), Helen Filoteo (Clinical Coordinator), Anh Mai (RAI-Coordinator), Maru Espina (RAI-Coordinator/Notetaker), Christian Daguio (BSO Lead), Usoshe Bose (Registered Dietitian), Juliette James (Dietary Manager), Julie Mendis (Dietary Supervisor), Doris Nwosu (Director of Residents Program), Susan Williams (Registered Social Worker), Shawn Smith (RPN, Temporary Falls Lead), An Nguyen (Nurse Practitioner from North West Ontario)

Visitors: Beatrise Edelstein and Kathleen Kirk (Vice-President of Hennick Humber Hospital) and Kathleen Kirk (Manager of Hennick Humber Hospital)

Regrets: Robert Scott (Administrator) and Jessica Bandoo ((Nurse Practitioner from North West Ontario)

## 1. Reduction of Falls for Newly-Admitted Residents

**Goal**: Reduce the fall rate among newly admitted residents by 2% each quarter during the 2025-2026 fiscal year.

**Evaluation and Analysis**

*Table 5: Quarterly Falls and Fall Rate Among New Admissions (2025–2026)*

| Quarter/Month | No. of Falls | No. of Admission | Fall Rate |
|---|---|---|---|
| Q1 (Apr-Jun 2025) | 2 | 21 | 9.5 |
| Q2 (Jul-Sep 2025) | 7 | 18 | 38.9 |
| Q3 (Oct-Dec 2025) | 5 | 14 | 35.7 |

| | | | |
|---|---|---|---|
| Q4 (Jan-Mar 2026) | 2 | 18 | 11.1 |

The first quarter demonstrated a strong start, with a fall rate of just 9.5%. This initial success reflected the team's commitment to onboarding new residents safely and proactively identifying risk factors.

During the second quarter, the fall rate increased significantly to 38.9%. Possible reason for a spike in the number of falls for July to September are:

- Disruption in Routines: Changes in daily schedules or activity patterns during summer can create confusion or disorientation for new residents.
- Environmental Factors: Hotter weather can lead to fatigue or dizziness, which may contribute to falls.
- Staffing Changes: Staff vacations are more common in summer, possibly resulting in less experienced or temporary staff caring for new residents.
- Increased Activity: Residents may participate in more outdoor or group activities during summer, exposing them to unfamiliar settings and hazards.

This spike served as a crucial learning opportunity, highlighting the need for stronger support systems and prompting a reassessment of our fall-prevention strategies for newly admitted residents. In the third quarter, we observed a modest decrease to 35.7%. This change signalled the early positive impact of our targeted interventions and underscored our resolve to continuously improve resident safety.

By the fourth quarter, our dedication and adaptability yielded remarkable results: the fall rate dropped dramatically to 11.1%. Achieving a 24.6% reduction from the previous quarter is a testament to the team's effectiveness, resilience, and unwavering commitment to excellence in resident care.

Despite the challenges faced in Q2, our sustained and collaborative efforts culminated in a significant 24.6% reduction in falls by Q4. The implementation of rapid-cycle improvements and consistent quarterly reviews empowered us to respond proactively to emerging trends, reinforcing a culture of safety and continuous improvement throughout the year.

**Goal Statement for FY 2026 - 2027:** From April 1, 2026 to March 31, 2027, reduce and maintain the fall rate among newly admitted residents within their first 30 days of admission to **5% or less each quarter** by continuing targeted fall-prevention interventions, enhancing staff training, and conducting quarterly data reviews to monitor progress and make timely adjustments.

**2. Fracture Rate**

**ANNUAL EVALUATION**
**FISCAL YEAR 2025-2026**

**Goal:** Maintain the fracture rate at or below 2.0 per 1000 occupied bed days every quarter for FY 2025 to 2026.

**Evaluation and Analysis**

*Table 6: Quarterly Falls and Fall Rate Among New Admissions (2025–2026)*

| QUARTER | NO. OF FRACTURES | BED DAYS | FRACTURE RATE BY 1000 occupied beds |
|---|---|---|---|
| Q4 | 4 | 7191 | 0.55 / 1000 |
| Q3 | 3 | 7404 | 0.41 / 1000 |
| Q2 | 1 | 7344 | 0.13 / 1000 |
| Q1 | 3 | 7281 | 0.14 / 1000 |

During the 2025–2026 fiscal year, the Home consistently maintained a fracture rate well below the established benchmark of 2.0 per 1,000 occupied bed-days.

Quarterly rates ranged from 0.13 to 0.55 per 1000, resulting in an annual average of 0.38 per 1000. This performance reflects the effectiveness of risk mitigation strategies, timely clinical interventions, and ongoing monitoring.
The data demonstrates a strong commitment to resident safety and continuous quality improvement, with each quarter's rate substantially below the threshold. Continued focus on preventative measures and staff education is recommended to sustain these positive outcomes.

**Goal Statement for 2026–2027:** From April 1, 2026 to March 31, 2027, maintain the facility's fracture rate at or below 1.0 per 1000 occupied bed days by implementing evidence-based fall prevention strategies and conducting quarterly reviews of incident data to ensure ongoing progress.

**Change Ideas and Improvement Strategies**

- Launch of the Falls Prevention and Management Program Clinical Pathway, including comprehensive education for all staff and ongoing reinforcement of best practices.
- Gap analysis and subsequent updates to policies and procedures, with the introduction of "falls huddles" after every incident to drive learning and improvement.
- Expansion of safe transfer audits: While initial monthly targets were challenging, we pivoted to a quarterly audit strategy with a goal of at least 24 audits across all units each quarter, ensuring rigorous monitoring and compliance.
- Integration of the Delirium, Admission Process, and Resident-Centred Care best practice guidelines, including assignment of an admission nurse to closely review fall risk and coordinate with residents and families.

- Continuation of multidisciplinary interventions: Quarterly medication reviews, use of a fracture order set, physiotherapy and restorative activities, annual vision checks, and environmental safety audits.
- Adoption of RNAO Clinical Pathways to ensure alignment with the latest evidence-based standards.

**Identified Gaps**

- History of Falls: Recognized as the strongest predictor; enhanced monitoring and tailored care plans for high-risk individuals.
- Chronic Conditions: Diabetes, arthritis, stroke, and cognitive impairment/dementia require coordinated medical and nursing management.
- Sensory Impairments: Ongoing screening and adaptations for vision and hearing deficits.
- Environmental Transitions: Proactive orientation and support for new admissions to mitigate confusion and risk.
- Nutritional Deficiencies: Targeted nutrition assessments and interventions, including Vitamin D supplementation.
- Polypharmacy: Regular pharmacist-led medication reviews to minimize medication-related fall risk.

**Goal Statement for FY 2026–2027:** From April 1, 2026 to March 31, 2027, maintain the fracture rate at or below 1.0 per 1000 occupied bed days each quarter by implementing evidence-based fall prevention strategies, conducting quarterly incident data reviews, and continuously strengthening staff education and multidisciplinary interventions.

**ANNUAL EVALUATION**
**FISCAL YEAR 2025-2026**

**Program: Restraint Minimization Program**
**Type of Evaluation:** Annual
**Evaluation Date:** April 29. 2026
**Reporting Period:** April 1, 2025 to March 31, 2026

**Program Evaluation Attendance**

The program evaluation was conducted using an interdisciplinary team approach. Attendance reflected the involvement of individuals, as follows:

Present: Mary Buhion (DOC/Chair), Amin Makawi (Business Director), Dr. Matthew Runnalls (Medical Director), Umbreen Mir (Pharmacy Consultant), Sasan Tabibi (Physiotherapist), Roland Madrona (IPAC Lad), Araceli Balaoeg (Clinical Supervisor), Helen Filoteo (Clinical Coordinator), Anh Mai (RAI-Coordinator), Maru Espina (RAI-Coordinator/Notetaker), Christian Daguio (BSO Lead), Usoshe Bose (Registered Dietitian), Juliette James (Dietary Manager), Julie Mendis (Dietary Supervisor), Doris Nwosu (Director of Residents Program), Susan Williams (Registered Social Worker), Shawn Smith (RPN, Temporary Falls Lead), An Nguyen (Nurse Practitioner from North West Ontario)

Visitors: Beatrise Edelstein and Kathleen Kirk (Vice-President of Hennick Humber Hospital) and Kathleen Kirk (Manager of Hennick Humber Hospital)

Regrets: Robert Scott (Administrator) and Jessica Bandoo ((Nurse Practitioner from North West Ontario)

**Least Restraint**

**Goal:** 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:**

*Table 7: Number of residents with Restraints every quarter. It also compares the data from 2024.*

| | Jan to March 2026 Q4 | Oct. to Dec. 2025 Q3 | July to Sept. 2025 Q2 | April to June 2025 Q1 |
|---|---|---|---|---|
| 2025 | 2 | 2 | 2 | 2 |

The data show a consistent trend, with only 2 residents restrained in each quarter (Q1–Q4). This stability indicates effective adherence to restraint-minimization policies and an

ongoing commitment to resident autonomy and safety. Compared with the previous year (2024), the number of residents with restraints has remained unchanged, reflecting sustained success in maintaining low restraint use. The consistently low numbers demonstrate the facility's strong culture of least restraint, effective staff training, and ongoing review of restraint alternatives.

Continued monitoring, staff education, and individualized care planning remain essential to ensure restraint is used only as a last resort and in accordance with regulatory standards. Sustaining these results supports both resident rights and best practice in care.

**Change Ideas**

- Staff education on the organization's Restraint and Least Restraint Policy (Surge Learning) emphasized risk assessment, documentation requirements, and the hierarchy of least-restrictive alternatives. By June 2025, 100% of employees achieved compliance.
- 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.

**Goal Statement for FY 2026–2027:** From April 1, 2026 to March 31, 2027, maintain the number of residents with physical restraints at no more than 2 per quarter, achieving 100% compliance with the organization's Restraint and Least Restraint Policy, and ensuring that all restraint use is supported by documented risk assessment and consideration of least-restrictive alternatives.

**ANNUAL EVALUATION**
**FISCAL YEAR 2025-2026**

**Program**: **Infection Prevention and Control**
**Program Lead**: Roland Madrona
**Evaluation Date:** April 29, 2026
**Type of Evaluation:** Annual
**Reporting Period**: April 2025 – March 31, 2026 Fiscal Year

**Program Evaluation Attendance**

The program evaluation was conducted using an interdisciplinary team approach. Attendance reflected the involvement of individuals, as follows:

Attendance reflected the involvement of individuals, as follows:
Present: Mary Buhion (DOC/Chair), Amin Makawi (Business Director), Dr. Matthew Runnalls (Medical Director), Umbreen Mir (Pharmacy Consultant), Sasan Tabibi (Physiotherapist), Roland Madrona (IPAC Lad), Araceli Balaoeg (Clinical Supervisor), Helen Filoteo (Clinical Coordinator), Anh Mai (RAI-Coordinator), Maru Espina (RAI-Coordinator/Notetaker), Christian Daguio (BSO Lead), Usoshe Bose (Registered Dietitian), Juliette James (Dietary Manager), Julie Mendis (Dietary Supervisor), Doris Nwosu (Director of Residents Program), Susan Williams (Registered Social Worker), Shawn Smith (RPN, Temporary Falls Lead), An Nguyen (Nurse Practitioner from North West Ontario)

Visitors: Beatrise Edelstein and Kathleen Kirk (Vice-President of Hennick Humber Hospital) and Kathleen Kirk (Manager of Hennick Humber Hospital)

Regrets: Robert Scott (Administrator) and Jessica Bandoo ((Nurse Practitioner from North West Ontario)

## 1. Managing Urinary Tract Infections (UTIs)

**Goal:** Maintain the percentage of residents with symptomatic, non-catheter-associated UTIs at 5% or below per quarter.

**Evaluation and Analysis**

The program demonstrated marked improvement in the second half of the fiscal year, successfully meeting the target threshold in both Q3 and Q4.

While the total annual cases increased slightly from 44 to 47, a notable improvement was observed in Q4: incidence fell from 10% (2025) to 3% (2026), a 7% decrease. This Q4-over-Q4 progress highlights the effectiveness of enhanced surveillance and antimicrobial stewardship interventions implemented in the latter half of the year. Sustained efforts in

these areas are recommended to continue driving down UTI incidence and to maintain performance at or below the target threshold.

*Table 8: UTI Quarterly Incidence Rate and Goal Status Report(Target: ≤ 5%)*

| Quarter | No. of Cases | Incidence Rate | Goal Met |
|---|---|---|---|
| Q1 (Apr-Jun) | 14 | 6% | No |
| Q2 (Jul-Sep) | 14 | 6% | No |
| Q3 (Oct-Dec) | 12 | 5% | **Yes** |
| Q4 (Jan-Mar) | 7 | 3% | **Yes** |

**Note:** Calculations based on an average occupancy of 240 residents. Target threshold is ≤ 12 cases per quarter.

*Table 9: Quarterly [Case Type] Counts by Fiscal Year (2024–2025 vs 2025–2026)*

| Quarter | 2024 - 2025 | 2025 - 2026 |
|---|---|---|
| Q1 | 08 | 14 |
| Q2 | 07 | 14 |
| Q3 | 06 | 12 |
| Q4 | 23 | 07 |

**ANNUAL EVALUATION**
**FISCAL YEAR 2025-2026**

| Quarter | 2024 - 2025 | 2025 - 2026 |
|---|---|---|
| Total | 44 | 47 |

**Identified Gaps**

- **Communication:** Incomplete clinical assessments occasionally led to "asymptomatic" antibiotic prescriptions.
- **Resident Factors:** Cognitive impairments and responsive behaviors made sample collection and hydration encouragement difficult.
-

**Change Ideas and Improvement Strategies**

Staff Education & Clinical Practice

- Hygiene & Care: Ongoing coaching on perineal hygiene and the use of resident-specific equipment (e.g., personal basins).
- Diagnostic Integrity: Reinforcement of evidence-based criteria (e.g., acute dysuria or fever + flank pain) to ensure cultures are only submitted when symptomatic.
- Hydration: Promotion of hydration as a primary prevention tool for infection and functional independence.

**Goal Statement for FY 2026-2027:** Reduce the percentage of residents with symptomatic, non-catheter-associated UTIs to 4% or below in each quarter of the 2026–2027 fiscal year by implementing targeted prevention strategies and ongoing staff education.

2. **Immunization Program Evaluation**

The facility successfully met the 80% target for both COVID-19 and Influenza for residents. Notably, RSV vaccination saw a massive surge in uptake.

*Table 10: Vaccination Coverage Comparison*

| Vaccine Type | 2024 Coverage | 2025 Coverage | Status |
|---|---|---|---|
| COVID-19 | 87% (210) | 82% (196) | Goal Met |

**ANNUAL EVALUATION**
**FISCAL YEAR 2025-2026**

| Vaccine Type | 2024 Coverage | 2025 Coverage | Status |
|---|---|---|---|
| **Influenza (Resident)** | 82% (198) | 82% (197) | Goal Met |
| **RSV Vaccination** | 42% (100) | **74% (178)** | Significant Increase |
| **Influenza (Staff)** | 26% | 30% | Area for Growth |

The facility demonstrated strong performance in resident vaccination coverage for both COVID-19 and Influenza during the reporting period. In FY 2025, the COVID-19 vaccination rate among residents was 82% (196 individuals), exceeding the facility's target of 80%, though this was a slight decrease from the previous year's 87% (210 individuals).

Similarly, Influenza vaccination coverage among residents remained at 82% (197 individuals), sustaining the high level achieved in 2024 and successfully meeting the established goal.

A particularly notable improvement was observed in RSV vaccine uptake among residents. Coverage surged from 42% (100 individuals) in 2024 to 74% (178 individuals) in 2025, indicating effective outreach and increased acceptance of the vaccine.

However, staff Influenza vaccination rates remain an area for improvement. Staff coverage increased modestly from 26% to 30%, still falling short of desired benchmarks. Continued emphasis on staff education and targeted interventions is recommended to further enhance staff vaccination rates.

Overall, the facility has consistently met vaccination goals for residents and made substantial progress in RSV vaccination. Focused efforts should now be directed towards improving staff Influenza vaccination rates to ensure comprehensive protection within the facility.

**Identified Gaps**

- Staff Uptake: Problem: Only 30% of staff are vaccinated since it's non-mandatory.

  Change Ideas:
  - Increase on-site vaccination opportunities.
  - Offer incentives and public recognition.
  - Provide targeted education about vaccine benefits.

  - Encourage leadership to model vaccination.
  - Consider stronger policies to encourage uptake.
- Misinformation: *Problem:* Families are influenced by unverified online sources, leading to vaccine hesitancy.

  Change Ideas:
  - Distribute clear, evidence-based information.
  - Direct families to reputable health resources.
  - Hold Q&A sessions to address concerns.
  - Monitor and address common myths proactively.

**Goal Statement for FY 2026–2027:** Increase staff influenza vaccination rate from 30% to at least 50% by the end of 2027 through enhanced education, on-site clinics, incentives, and targeted communication initiatives.

**ANNUAL EVALUATION**
**FISCAL YEAR 2025-2026**

**Program**: **Medication Management Program**
**Program Lead**: Helen Filoteo, RN
**Evaluation Date:** April 29, 2026
**Type of Evaluation:** Annual
**Reporting Period**: April 2025 – March 31, 2026 Fiscal Year

**Program Evaluation Attendance**

The program evaluation was conducted using an interdisciplinary team approach. Attendance reflected the involvement of individuals, as follows:

Present: Mary Buhion (DOC/Chair), Amin Makawi (Business Director), Dr. Matthew Runnalls (Medical Director), Umbreen Mir (Pharmacy Consultant), Sasan Tabibi (Physiotherapist), Roland Madrona (IPAC Lad), Araceli Balaoeg (Clinical Supervisor), Helen Filoteo (Clinical Coordinator), Anh Mai (RAI-Coordinator), Maru Espina (RAI-Coordinator/Notetaker), Christian Daguio (BSO Lead), Usoshe Bose (Registered Dietitian), Juliette James (Dietary Manager), Julie Mendis (Dietary Supervisor), Doris Nwosu (Director of Residents Program), Susan Williams (Registered Social Worker), Shawn Smith (RPN, Temporary Falls Lead), An Nguyen (Nurse Practitioner from North West Ontario)

Visitors: Beatrise Edelstein and Kathleen Kirk (Vice-President of Hennick Humber Hospital) and Kathleen Kirk (Manager of Hennick Humber Hospital)

Regrets: Robert Scott (Administrator) and Jessica Bandoo ((Nurse Practitioner from North West Ontario)

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

**Goal:** 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.

**ANNUAL EVALUATION**
**FISCAL YEAR 2025-2026**

**Evaluation and Analysis**

*Table 11: Quarterly Incidence Rate and Goal Status for FY 2025 – 2026*

| QUARTER | RATE | GOAL STATUS |
|---|---|---|
| Q1 (Apr–Jun) | 100% increase | Unmet |
| Q2 (Jul–Sept) | 66% increase | Unmet |
| Q3 (Oct–Nov) | 66% decrease | Met |
| Q4 (Jan-Mar) | No change | Unmet |

In 2025, quarterly incidence rates for medication incidents varied notably. The first two quarters saw significant increases compared with the previous year, with Q1 up 100% and Q2 up 66%; neither quarter met the reduction goals. In Q3, there was a marked improvement—a 66% decrease in incidents—indicating successful interventions and goal achievement. However, Q4 saw no change in the incident rate compared with the prior year, and the goal was unmet.

Despite Q3 improvements, the annual trend indicates persistent challenges in consistently reducing medication incidents, particularly in the first half of the year. This underscores the need for ongoing staff training, process review, and targeted interventions to ensure sustained progress.

The Medication Management Program remains central to resident safety. Although the goal of reducing medication errors by 10% was not met this year, these ideas for change provide a positive path forward. With a focus on targeted education, proactive communication, and ongoing system improvements, we are committed to continuous quality improvement, regulatory compliance, and the highest standards of safe medication practices.

**Goal Statement for FY 2026-2026**: Achieve a 15% overall reduction in medication incidents compared to 2025 and meet quarterly reduction targets of 3% in all four quarters.

*Table 12: Quarterly Comparison of MIRs Related to Nursing between 2024 and 2025*

| QUARTER | 2024 | 2025 |
|---|---|---|
| Q1 (Apr–Jun) | 2 | 4 |

**ANNUAL EVALUATION**
**FISCAL YEAR 2025-2026**

| | | |
|---|---|---|
| Q2 (Jul–Sept) | 3 | 5 |
| Q3 (Oct–Dec) | 3 | 1 |
| Q4 (Jan-Mar) | 2 | 2 |
| **TOTAL** | **10** | **12** |

**Evaluation and Analysis**

In 2025, the total number of medication incident reports (MIRs) related to nursing increased to 12, compared to 10 in 2024. Increases were seen in Q1 (from 2 to 4) and Q2 (from 3 to 5), while Q3 showed improvement (from 3 to 1), and Q4 remained unchanged (2 incidents each year). The improvement was only seen in Q3.

The rise in incidents in the first half of 2025 suggests potential gaps in staff training, communication, or medication management processes. The significant decrease in Q3 indicates that targeted interventions during this period were effective. However, maintaining these improvements year-round remains a challenge.

**Identified Gaps**
The most frequent medication errors included:

- Orders not carried out or incorrectly transcribed
- Errors in glucagon administration
- Medication given to the wrong resident
- Inadequate clinical monitoring (e.g., failure to check blood pressure before administration)
- Incorrect dosages
- Missed doses (e.g., Ativan BID omitted, identified during narcotic count)
- Incorrect timing of medication administration

These issues highlight the need for improved transcription accuracy, stronger interdisciplinary communication, and enhanced clinical monitoring. Consistent adherence to medication administration protocols is crucial for resident safety and regulatory compliance.

**Change Ideas**

- Enhance Staff Training: Provide regular education on accurate order transcription, safe medication administration, and the importance of clinical monitoring.
- Implement Double-Check Systems: Require two-person verification for high-risk medications and order transcription.
- Strengthen Communication: Foster interdisciplinary huddles and clear handoff protocols to ensure accurate relay of medication orders and changes.

**ANNUAL EVALUATION**
**FISCAL YEAR 2025-2026**

- Audit and Feedback: Conduct routine audits of medication administration and provide timely, constructive feedback to staff.
- Strengthen Medication Reconciliation: Review all medications at admission, readmission, and care transitions; Involve pharmacists to check orders and educate staff and flag frequent PRN use for review.
- Independent Double-Check: Carefully follow administration parameters.
- Use of clear communication: Use standardized language and avoid abbreviations, and clarify any unclear orders with a physician, pharmacist, or colleague.
- Enhance staff education and promote a safety culture: Provide ongoing training and reinforce safe practices; teach and support students on correct procedures; and promote a culture where reporting errors is safe and encouraged.
- Focus on High-Risk Areas: Pay extra attention to residents on multiple or high-risk medications, and ensure residents eat before administering medications like insulin.
- Staff to minimize distractions: Reduce interruptions during medication rounds to prevent errors.
- Verify Medication Rights: Always confirm the right resident, medication, dose, and time, and use system alerts and organize medications to avoid mix-ups
- Clarify Orders: Ask questions if orders are unclear—no assumptions.
- Staying Informed: Know the purpose and effects of each medication and review any changes after time off.

**ANNUAL EVALUATION**
**FISCAL YEAR 2025-2026**

**Program: Pain Management**
**Program Lead**: Helen Filoteo, RN and Maru Espina, RPN
**Evaluation Date**: 29 April 2026
**Evaluation Period**: April 1, 2025 to March 31, 2026
**Type of Evaluation:** Annual

**Program Evaluation Attendance**

The program evaluation was conducted using an interdisciplinary team approach. Attendance reflected the involvement of individuals, as follows:

Attendance reflected the involvement of individuals, as follows:
Present: Mary Buhion (DOC/Chair), Amin Makawi (Business Director), Dr. Matthew Runnalls (Medical Director), Umbreen Mir (Pharmacy Consultant), Sasan Tabibi (Physiotherapist), Roland Madrona (IPAC Lad), Araceli Balaoeg (Clinical Supervisor), Helen Filoteo (Clinical Coordinator), Anh Mai (RAI-Coordinator), Maru Espina (RAI-Coordinator/Notetaker), Christian Daguio (BSO Lead), Usoshe Bose (Registered Dietitian), Juliette James (Dietary Manager), Julie Mendis (Dietary Supervisor), Doris Nwosu (Director of Residents Program), Susan Williams (Registered Social Worker), Shawn Smith (RPN, Temporary Falls Lead), An Nguyen (Nurse Practitioner from North West Ontario)

Visitors: Beatrise Edelstein and Kathleen Kirk (Vice-President of Hennick Humber Hospital) and Kathleen Kirk (Manager of Hennick Humber Hospital)

Regrets: Robert Scott (Administrator) and Jessica Bandoo ((Nurse Practitioner from North West Ontario)

**Goal**: Reduce the number of long-stay residents experiencing severe pain. Our goal is to maintain the percentage of residents reporting pain at or below 2%. Data collected during the FY 2025-2026 will serve as our benchmark for ongoing evaluation and continuous improvement.

**ANNUAL EVALUATION**
**FISCAL YEAR 2025-2026**

## Evaluation and Analysis

*Table 13: Summary of quarterly data on the prevalence of severe pain among residents, relative to the average census.*

| QUARTER | NO. OF RESIDENTS EXPERIENCING SEVERE PAIN | AVERAGE RESIDENT COUNT | PERCENTAGE OF RESIDENTS WHO ARE EXPERIENCING SEVERE PAIN |
|---|---|---|---|
| Q1 | 5 | 240 | 2.0% |
| Q2 | 6 | 240 | 2.5% |
| Q3 | 5 | 241 | 2.7% |
| Q4 | 4 | 239 | 1.7% |

- The percentage of residents experiencing severe pain ranged from 1.7% (Q4) to 2.7% (Q3) over the year.
- The highest percentage was observed in Q3, followed by a notable decrease in Q4.
- While the average resident count remained stable across quarters, the number of residents with severe pain fluctuated slightly.
- The data suggests some improvement in pain management in Q4, possibly due to adjustments in care or interventions.

While the overall prevalence of severe pain among residents is relatively low, ongoing gaps in pain assessment and communication highlight areas for targeted improvement. Implementing these change ideas can help ensure timely and effective pain management, contributing to improved quality of life for residents.

**Identified Gaps:**

- There is inconsistency in pain reassessment after medication administration, which may result in unaddressed pain if initial interventions are ineffective.
- Communication highlights areas for targeted improvement

**Change Ideas:**

- The pain management policy was reviewed and updated, with the revised policy adopted on April 1. This update integrates evidence-based practices from RNAO's Clinical Pathway program, ensuring that all aspects of pain assessment, intervention, and follow-up are aligned with current clinical guidelines and best practices. This alignment promotes standardized, high-quality pain management for all residents.

**ANNUAL EVALUATION**
**FISCAL YEAR 2025-2026**

- To further standardize pain assessment and management procedures, the Home will formally launch the RNAO Clinical Pathway on Pain Management guidelines on April 1, 2026.
- Additionally, the Home has been admitted as a Best-Practice Spotlight Organization, with Pain Management and Fall Management selected as the initial best practice guidelines for implementation in the upcoming quarters. These initiatives collectively support the delivery of consistent, high-quality care for all residents.
- Re-education regarding the updated pain management policy was initiated in March and will continue as an ongoing initiative to ensure staff are consistently informed and compliant with best practices.
- Targeted education for PSWs on recognizing non-verbal indicators of pain will start in April and will be maintained as a continuous effort, supporting early identification and timely intervention for residents experiencing pain
- Reassess pain after administering medication to ensure efficacy and adjust treatment plans as needed.
- Implement scheduled, long-acting pain management regimens for residents with ongoing pain, reducing dependence on PRN (as-needed) medications and promoting more consistent and effective pain control.
- Enhance communication protocols by establishing clear expectations and regular reminders for Personal Support Workers (PSWs) to immediately report any observed signs or resident complaints of pain to clinical staff. This will facilitate prompt assessment and intervention, supporting better pain management outcomes for residents.
- .A targeted change idea to reduce pain for residents with contractures is to continue referring eligible individuals for Botox treatment to address spasticity. This intervention aims to decrease pain and improve comfort and function for affected residents.
- Regular medication reviews to ensure optimal pain management by identifying gaps or areas for improvement. Both interventions aim to decrease pain and enhance comfort and function for affected residents.
- Continue to incorporate non-pharmacologic interventions, such as physiotherapy, stretching exercises, heat or cold therapy and positioning supports.

**Goal Statement for FY 2026–2027**: By March 31, 2027, reduce the percentage of long-stay residents experiencing moderate to severe pain to 1.5% or lower, as measured by standardized pain assessment tools, with progress tracked and reviewed quarterly

**ANNUAL EVALUATION**
**FISCAL YEAR 2025-2026**

**Program**: **Skin and Wound and Continence Programs**
**Program Lead:** Araceli, Balaoeg, RN
**Evaluation Date:** April 29, 2026
**Type of Evaluation:** Annual
**Reporting Period**: April 2025 – March 31, 2026 Fiscal Year

**Program Evaluation Attendance**

The program evaluation was conducted using an interdisciplinary team approach. Attendance reflected the involvement of individuals, as follows:

Attendance reflected the involvement of individuals, as follows:
Present: Mary Buhion (DOC/Chair), Amin Makawi (Business Director), Dr. Matthew Runnalls (Medical Director), Umbreen Mir (Pharmacy Consultant), Sasan Tabibi (Physiotherapist), Roland Madrona (IPAC Lad), Araceli Balaoeg (Clinical Supervisor), Helen Filoteo (Clinical Coordinator), Anh Mai (RAI-Coordinator), Maru Espina (RAI-Coordinator/Notetaker), Christian Daguio (BSO Lead), Usoshe Bose (Registered Dietitian), Juliette James (Dietary Manager), Julie Mendis (Dietary Supervisor), Doris Nwosu (Director of Residents Program), Susan Williams (Registered Social Worker), Shawn Smith (RPN, Temporary Falls Lead), An Nguyen (Nurse Practitioner from North West Ontario)

Visitors: Beatrise Edelstein and Kathleen Kirk (Vice-President of Hennick Humber Hospital) and Kathleen Kirk (Manager of Hennick Humber Hospital)

Regrets: Robert Scott (Administrator) and Jessica Bandoo ((Nurse Practitioner from North West Ontario)

## 1. Reduction of Internally Acquired Pressure Injuries

**Goal:** Reduce the percentage of residents with internally acquired pressure ulcers by 5% from the previous fiscal year.

**Indicator:**
Number of residents with newly acquired pressure ulcers from internal causes.

*Table 14: Quarterly Breakdown of Internally Acquired Pressure Ulcers by Stage – 2025*

| QUARTER 2025 | PU – 1 | PU – 2 | PU – 3 | PU – 4 | PU – X | DTI | Total |
|---|---|---|---|---|---|---|---|
| Q1 (Apr-Jun) | 2 | 8 | 0 | 0 | 0 | 1 | 11 |
| Q2 (Jul-Sep) | 3 | 11 | 1 | 0 | 0 | 1 | 16 |
| Q3 (Oct-Dec) | 3 | 5 | 0 | 0 | 0 | 0 | 8 |
| Q4 (Jan-Mar) 2026 | 1 | 4 | 0 | 0 | 0 | 2 | 7 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| TOTAL | 9 | 28 | 1 | | | 4 | 42 |

*Table 15: Quarterly Breakdown of Internally Acquired Pressure Ulcers by Stage – 2024*

| QUARTER 2024 | PU – 1 | PU – 2 | PU – 3 | PU – 4 | PU – X | DTI | Total |
|---|---|---|---|---|---|---|---|
| Q1 (Apr-Jun) | 1 | 7 | | | 1 | 1 | 10 |
| Q2 (Jul-Sep) | 7 | 15 | | | | 2 | 24 |
| Q3 (Oct-Dec) | | 4 | 1 | | | 3 | 8 |
| Q4 (Jan-Mar) 2025 | 1 | 10 | | | | 1 | 12 |
| TOTAL | 9 | 36 | 1 | | 1 | 7 | 54 |

**Evaluation and Analysis:**

The goal was met, with a 22.2% reduction in newly acquired pressure ulcers internally acquired, from 54 cases in 2024 to 42 in 2025.

- Stage 2 pressure ulcers remained the most common type in both years (36 in 2024; 28 in 2025).
- Quarter 2 consistently had the highest number of new cases, indicating a seasonal or operational risk factor.
- Deep Tissue Injuries (DTI) and Stage 1 cases showed slight reductions.
- Stage 3 and higher severity ulcers remained low in both years, reflecting some success in early detection and intervention.

The significant overall reduction demonstrates effective prevention strategies and increased staff vigilance. However, the persistence of high numbers in Stage 2 ulcers and the spike in Quarter 2 suggest areas for targeted improvement, such as enhanced skin assessments, turning schedules, and nutrition interventions during higher-risk periods.

While the annual goal was exceeded, continued focus on preventing Stage 2 ulcers and addressing Quarter 2 spikes will further improve resident outcomes and quality of care.

**Goal Statement for FY 2026-2027:** Achieve an additional 5% reduction in the number of residents with new internally acquired pressure ulcers compared to 2025, with focused interventions to further decrease Stage 2 ulcers and address peak incidence in Quarter 2.

## 2. Reduction of Rashes

**Goal:** To reduce the percentage of residents with rashes by 5% annually.

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

*Table 16: Residents with New Rashes Requiring Prescribed Medication*

| Quarter | Residents with New Rashes Requiring Prescribed Medication |
|---|---|
| Q1 (Apr-Jun) | 52 |
| Q2 (Jul-Sep) | 60 |
| Q3 (Oct-Dec) | 29 |
| Q4 (Jan-Mar) 2026 | 36 |

Since no comparable data were available for 2024, 2025 has been established as the baseline year for tracking the reduction of residents with new rashes requiring prescription medication. In 2025, Quarter 2 recorded the highest number of cases, highlighting a period of increased risk. Possible reasons for the spike in rashes during Quarter 2 (July–September) may include: Hotter, more humid weather increases sweating and skin irritation, seasonal allergies leading to more skin reactions, increased outdoor activities exposing residents to plants, insects, or allergens, higher prevalence of heat-related conditions such as heat rash, changes in clothing (e.g., lighter, more skin-exposing fabrics) or less frequent clothing changes, and potential lapses in routine skin care during summer vacations or staffing changes. These factors can contribute to increased skin breakdown, irritation, and rashes during this period.\
Data collected this year will be used as a reference point for measuring progress and evaluating the effectiveness of interventions in 2026 and beyond.

### Identified Gaps

- Inconsistent adherence to required weekly wound reassessment schedules.
  Change Ideas: Continue to implement a calendar to schedule and monitor weekly wound reassessments, conduct regular audits to check compliance and provide feedback, and remind staff of the importance of timely reassessment through education and team meetings.

- Incomplete registered staff assessments, including missing documentation of wound location and staging.
  Change Ideas: Assign experienced staff or wound care champions to mentor and support others in accurate assessment and documentation, and implement regular audits of wound assessment records and give feedback to staff on omissions.

- Delayed Identification and Reporting: Staff may not recognize early signs of skin breakdown or rashes, and delays in reporting changes to the nursing or clinical team.

  Change Ideas: Provide regular training and visual guides for all staff on recognizing early signs of skin breakdown and rashes; Will Implement a standardized daily skin check protocol for PSWs, with clear documentation steps. Timeline Q2 FY 2026-2027; Reinforce a "Report Early, Treat Early" culture by encouraging immediate communication of any skin changes to nursing or clinical staff; and monitor and audit reporting practices, providing feedback and support to ensure timely escalation of concerns.

- Knowledge deficit
  Change Idea: About 40 PSWs will receive focused education on skin and wound care before December 31. Additionally, nurses will complete training on comprehensive skin and wound assessment by year's end.

- Suboptimal Repositioning Practices:
  Change Ideas: Document every repositioning event in the resident's record and audit compliance regularly, and continue using visual cues or reminders (e.g., repositioning clocks, charts) to prompt staff during each shift.

- Communication Breakdowns: Poor handover of skin/wound/continence issues during shift changes and lack of interdisciplinary collaboration and communication

  Change Idea: Standardize shift-to-shift handover using a dedicated section for skin, wound, and continence updates (e.g., in a handover sheet or electronic record).

**Change Ideas (Additional)**

- 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."

**ANNUAL EVALUATION**
**FISCAL YEAR 2025-2026**

- Continue collaboration 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 on 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.
- Hydration and Nutrition Support: Enhance dietary and fluid intake monitoring, and involve dietitians in developing nutritional plans for at-risk residents to support skin health.
- Data-Driven Reviews: Regularly review incident data and trends with the interdisciplinary team to identify patterns and adjust interventions proactively
- Skin Integrity Champions: In Q3 of 2025, 12 PSWs volunteered as "TENA Champions" (2 PSWs on each unit to model best practices, mentor peers, and serve as resources for early skin issue identification.
- Enhanced Skin Assessment Tools: On November 30, 2025, we adopted the new assessment tool introduced by PCC as a standardized, user-friendly checklist for nurses.
- Daily Skin Checks: Incorporate daily head-to-toe skin inspections into routine care, especially for high-risk residents, and document findings in the health record.
- Moisture Management: Continued use of Calmoseptine (not covered by ODB) barrier creams and timely incontinence care to minimize skin breakdown due to moisture.

**Goal for Statement for FY 2026-2027:** Achieve a 5% reduction in the number of residents with new rashes requiring prescription medication compared to the 2025 baseline, with a focus on improved documentation, timely intervention, and staff education—especially during high-risk periods such as Quarter 2.

**ANNUAL EVALUATION**
**FISCAL YEAR 2025-2026**

**Program: Weight Management Program**
**Program Lead**: Usoshi Bose, RD and Julie Mendis, FSS
**Evaluation Date:** April 29, 2026
**Type of Evaluation:** Annual
**Reporting Period**: April 2025 – March 31, 2026 Fiscal Year

**Program Evaluation Attendance**

The program evaluation was conducted using an interdisciplinary team approach. Attendance reflected the involvement of individuals, as follows:

Attendance reflected the involvement of individuals, as follows:
Present: Mary Buhion (DOC/Chair), Amin Makawi (Business Director), Dr. Matthew Runnalls (Medical Director), Umbreen Mir (Pharmacy Consultant), Sasan Tabibi (Physiotherapist), Roland Madrona (IPAC Lad), Araceli Balaoeg (Clinical Supervisor), Helen Filoteo (Clinical Coordinator), Anh Mai (RAI-Coordinator), Maru Espina (RAI-Coordinator/Notetaker), Christian Daguio (BSO Lead), Usoshe Bose (Registered Dietitian), Juliette James (Dietary Manager), Julie Mendis (Dietary Supervisor), Doris Nwosu (Director of Residents Program), Susan Williams (Registered Social Worker), Shawn Smith (RPN, Temporary Falls Lead), An Nguyen (Nurse Practitioner from North West Ontario)

Visitors: Beatrise Edelstein and Kathleen Kirk (Vice-President of Hennick Humber Hospital) and Kathleen Kirk (Manager of Hennick Humber Hospital)

Regrets: Robert Scott (Administrator) and Jessica Bandoo ((Nurse Practitioner from North West Ontario)

**Reduction of Weight Variances**

**Goal**: To reduce the occurrence of weight variances by 5% every year.

**Indicator:** Percentage of weight variances due to incorrect weight entry and inconsistent method of weighing.

**Evaluation and Analysis**.

**ANNUAL EVALUATION**
**FISCAL YEAR 2025-2026**

*Table Name 17: Quarterly Weight Variance by Fiscal YearQuarterly Weight Variance by Fiscal Year*

| Factors | 2024-25 | 2025-26 | % Change | |
|---|---|---|---|---|
| 1. Incorrect Weight Entry | **65** | **41** | **36.9 % ↓** | **Met** |
| 2. Inconsistent method of weighing | **55** | **49** | **10.9 % ↓** | **Met** |

**Incorrect Weight Entry**

In the 2024–25 fiscal year, incidents of weight variance caused by incorrect weight entries reached a total of 65 cases. The quarterly breakdown revealed a striking peak in Q3 with 30 cases, while Q2 saw a notably low count of just 2 cases.

By the following fiscal year, 2025–26, the total number of cases dropped considerably to 41—a reduction of 36.9%. The quarterly figures in 2025–26 were more evenly distributed, and notably, Q3 reported zero cases. This substantial decline suggests that targeted interventions, such as enhanced staff training, improved data verification protocols, or stricter adherence to weighing procedures, were successful. The achievement of the annual reduction goal in this category reflects the effectiveness of these measures and demonstrates progress toward more accurate weight recording.

**Inconsistent Method of Weighing:** Weight variances due to inconsistent weighing methods totaled 55 cases in 2024–25, with Q3 again the highest at 19 cases.

In 2025–26, the total decreased to 49 cases, a 10.9% reduction. The quarterly results in 2025–26 showed moderate, stable counts across all quarters, indicating less variability and more consistent practice. Although the decrease was less dramatic than for incorrect weight entries, it still signifies meaningful progress. The reduction goal for this factor was also met, suggesting that efforts to standardize weighing methods—such as procedure reviews and equipment calibration. Educational sessions, which were timed during quarterly meetings and attended by registered nursing staff, have positively influenced outcomes.

The data demonstrate improvement in both key areas: incorrect weight entry and inconsistent weighing methods. The most notable progress was in reducing errors from incorrect weight entries, highlighting the impact of targeted corrective actions. While

consistency in weighing methods has improved, ongoing efforts to further refine these processes are recommended. Sustained attention to staff education, procedural standardization, and regular audits will likely continue to reduce weight variance, ensuring greater accuracy and reliability in the weighing process.

*Table 18: Comparison of the Number of Weight Variances due to Incorrect Weight Entry and Inconsistent Weighing Methods (2024-2025 and 2025-2026) broken down by Quarter*

| Indicators | 2024-25 (fiscal year) | | | | | 2025-26 (fiscal year) | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Q1 | Q2 | Q3 | Q4 | TOTAL | Q1 | Q2 | Q3 | Q4 | TOTAL |
| 1. Incorrect Weight Entry | 18 | 2 | 30 | 15 | **65** | 15 | 12 | 0 | 14 | **41** |
| 2.Inconsistent Method of weighing | 11 | 18 | 19 | 7 | **55** | 8 | 16 | 13 | 12 | **49** |

**Incorrect Weight Entry:** During the 2024–25 fiscal year, variances from incorrect weight entries totalled 65 cases, with the highest number in Q3 (30 cases) and the lowest in Q2 (2 cases). In 2025–26, this number decreased substantially to 41 cases, marking a 36.9% reduction.

The quarterly distribution showed improvement, with no cases reported in Q3 and relatively balanced figures in the other quarters. This significant decrease indicates that targeted interventions or process improvements implemented to address incorrect weight entry have been effective, and the annual reduction goal for this category was met.

**Inconsistent Method of Weighing:** For variances arising from inconsistent weighing methods, the total in 2024–25 was 55 cases, with Q3 recording the highest incidence (19 cases). In 2025–26, the total fell to 49 cases, a 10.9% reduction.

Although the decrease is less pronounced than the reduction in incorrect weight entries, the downward trend still demonstrates progress. Each quarter in 2025–26 saw moderate case counts, with no extreme fluctuations. The goal to reduce cases in this category was also met.

Both indicators improved from 2024–25 to 2025–26, with a particularly notable reduction in incorrect weight entries. The data suggest that interventions have had a positive impact, especially in reducing data entry errors. Continued focus on standardizing weighing methods may yield further improvements in the coming year.

**ANNUAL EVALUATION**
**FISCAL YEAR 2025-2026**

**Goal Statement for FY 2026–2027:**

The goal for the next fiscal year is to expand the Weight Management Program focusing mainly on significant weight loss related to weight variances as one of the indicators. We will be using the provincial benchmark on unintentional weight loss as comparative data.

**ANNUAL EVALUATION**
**FISCAL YEAR 2025-2026**

**Program**: **Restorative Care Program**
**Program Leads**: Anh Mai, RPN
**Evaluation Date:** April 29, 2026
**Type of Evaluation:** Annual
**Reporting Period**: April 2025 – March 31, 2026 Fiscal Year

**Program Evaluation Attendance**
The program evaluation was conducted using an interdisciplinary team approach. Attendance reflected the involvement of individuals, as follows:

Attendance reflected the involvement of individuals, as follows:
Present: Mary Buhion (DOC/Chair), Amin Makawi (Business Director), Dr. Matthew Runnalls (Medical Director), Umbreen Mir (Pharmacy Consultant), Sasan Tabibi (Physiotherapist), Roland Madrona (IPAC Lad), Araceli Balaoeg (Clinical Supervisor), Helen Filoteo (Clinical Coordinator), Anh Mai (RAI-Coordinator), Maru Espina (RAI-Coordinator/Notetaker), Christian Daguio (BSO Lead), Usoshe Bose (Registered Dietitian), Juliette James (Dietary Manager), Julie Mendis (Dietary Supervisor), Doris Nwosu (Director of Residents Program), Susan Williams (Registered Social Worker), Shawn Smith (RPN, Temporary Falls Lead), An Nguyen (Nurse Practitioner from North West Ontario)

Visitors: Beatrise Edelstein and Kathleen Kirk (Vice-President of Hennick Humber Hospital) and Kathleen Kirk (Manager of Hennick Humber Hospital)

Regrets: Robert Scott (Administrator) and Jessica Bandoo ((Nurse Practitioner from North West Ontario)

Goal: At least 5% of the residents, who are eligible, will be in the program in a quarterly basis

*Table 19: Residents in Restorative Care Program*

| Quarters | No. of Residents in the Program | Average Resident Count | % of Residents in the Program |
|---|---|---|---|
| Q1 | 18 | 240 | 7.5 % |
| Q2 | 15 | 240 | 6.2% |
| Q3 | 12 | 241 | 5.0% |
| Q4 | 19 | 239 | 8.0% |

**Evaluation and Analysis**

- The program met or surpassed the target of 5% participation each quarter, demonstrating effective identification and enrollment of eligible residents.

- Participation rates were highest in Q4, indicating a positive trend and responsiveness to ongoing efforts.

**Identified Gaps:**

- A knowledge deficit among Personal Support Workers (PSWs) regarding program eligibility criteria was noted, particularly in understanding which residents have reached full potential and are not at risk for decline.

**Change Ideas:**

- A re-education initiative focused on restorative referral and program eligibility is scheduled to commence in Q3 FY 2026 to address knowledge gaps and reinforce best practices among staff.

**ANNUAL EVALUATION**
**FISCAL YEAR 2025-2026**

**Goal for Next Year (FY 2026-2027):**

Maintain or improve quarterly participation, ensuring that at least 5% of eligible residents are enrolled in the Restorative Care Program each quarter. Monitor the impact of the re-education program on staff knowledge and resident participation, with the aim of sustaining or increasing program enrollment while ensuring appropriate eligibility.

**ANNUAL EVALUATION**
**FISCAL YEAR 2025-2026**

**Program**: **Behaviour Management Program**
**Program Lead**: Christian Daguio, RPN
**Evaluation Date:** April 29, 2026
**Type of Evaluation:** Annual
**Reporting Period**: April 2025 – March 31, 2026 Fiscal Year

**Program Evaluation Attendance**

The program evaluation was conducted using an interdisciplinary team approach. Attendance reflected the involvement of individuals, as follows:

Attendance reflected the involvement of individuals, as follows:
Present: Mary Buhion (DOC/Chair), Amin Makawi (Business Director), Dr. Matthew Runnalls (Medical Director), Umbreen Mir (Pharmacy Consultant), Sasan Tabibi (Physiotherapist), Roland Madrona (IPAC Lad), Araceli Balaoeg (Clinical Supervisor), Helen Filoteo (Clinical Coordinator), Anh Mai (RAI-Coordinator), Maru Espina (RAI-Coordinator/Notetaker), Christian Daguio (BSO Lead), Usoshe Bose (Registered Dietitian), Juliette James (Dietary Manager), Julie Mendis (Dietary Supervisor), Doris Nwosu (Director of Residents Program), Susan Williams (Registered Social Worker), Shawn Smith (RPN, Temporary Falls Lead), An Nguyen (Nurse Practitioner from North West Ontario)

Visitors: Beatrise Edelstein and Kathleen Kirk (Vice-President of Hennick Humber Hospital) and Kathleen Kirk (Manager of Hennick Humber Hospital)

Regrets: Robert Scott (Administrator) and Jessica Bandoo ((Nurse Practitioner from North West Ontario)

**Antipsychotic Reduction**

**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 and Analysis

*Table 20: Number of residents on Antipsychotic Reduction Program*

| | Number of residents who are Active in the Antipsychotic Reduction Program | Number of residents who were safely deprescribed |
|---|---|---|
| | | |
| Q1 | 3 residents | 6 |
| Q2 | 6 residents | 8 |
| Q3 | 6 residents | 1 |
| Q4 | 8 residents | 2 |

- The highest number of active participants was in Q4 (8 residents) enrolled in the Antipsychotic Reduction Program, achieving the established annual target.
- The greatest number of safe deprescriptions occurred in Q2 (8 residents), and these residents have been admitted for more than 2 years.
- There was a notable decrease in successful deprescriptions in Q3 and Q4, despite an increase in active participation. This is related to the complexity of the newer residents admitted to the Home.

The data reveal several important trends in the Antipsychotic Reduction Program throughout the year. There was a clear increase in the number of active participants, particularly rising from Q1 (3 residents) to Q4 (8 residents). Despite this growth, the number of residents who were safely deprescribed peaked in Q2 (8 residents) and declined significantly in Q3 (1 resident) and Q4 (2 residents).

This pattern suggests that while efforts to enroll more residents in the program were successful, achieving safe deprescribing outcomes became more challenging as participation increased. As the program progressed, remaining participants may have presented with more complex needs, making safe deprescribing more difficult. Antipsychotic use was regularly reviewed by the interdisciplinary team, pharmacy, and external psychiatric teams. Deprescribing decisions were made based on clinical appropriateness, resident safety, and documented assessments. 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.

**ANNUAL EVALUATION**
**FISCAL YEAR 2025-2026**

Overall, the analysis indicates the importance of ongoing evaluation of program strategies, targeted support for residents with complex needs, and adaptive resource planning to maintain and improve positive outcomes as participation grows.

**Risk Assessment and Clinical Considerations:**

- Allowing ample time for possible behaviour changes related to medication titration.
- Seasonal changes, illness, and delirium risk.
- Resident safety considerations.

**Significant Gaps:**

- Opportunities exist to improve the timely identification of residents by the interdisciplinary team, suitable for deprescribing.
- Possible improvement in communication regarding changes in resident behaviours.

**Change Ideas:**

- The new PRC assigned to assist DV will affect staff education capacity.
- Continued staff education on non-pharmacological interventions and responsive behaviours from the Mobile Behavioural Services.
- Participation in ISMP Canada's quality initiative on Antipsychotic Reduction, which ended in March 2026. Resources from ISMP Canada helped streamline resident identification, data collection, and medication titration timelines.
- Implementation of RNAO's Clinical Pathway and BPG for delirium screening.
- Use of the High Intensity Support program for residents with complex behavioural needs.
- A significant increase in the number of residents engaged in the program, as per the Medical Director's s
- At the midpoint of Q3, a review of antipsychotic medications for deprescribing was conducted for residents who were newly admitted and were taking antipsychotic medications. The number of residents enrolled in the deprescribing program rose from 6 in Q3 to 8 in Q4. This will be an ongoing change idea.

**Goal Statement for FY 2026-2027:** By the end of the next fiscal year, increase the number of residents who are safely deprescribed antipsychotic medications by at least 20% compared to this year (from 17 to at least 21 residents). Progress will be tracked monthly and reported quarterly to ensure transparency and accountability.

**ANNUAL EVALUATION**
**FISCAL YEAR 2025-2026**

**Program**: **Palliative Care Approach**
**Program Lead**: Susan Williams. RSW
**Evaluation Date:** April 29, 2026
**Type of Evaluation:** Annual
**Reporting Period**: April 2025 – March 31, 2026 Fiscal Year

**Program Evaluation Attendance**
The program evaluation was conducted using an interdisciplinary team approach. Attendance reflected the involvement of individuals, as follows:

Attendance reflected the involvement of individuals, as follows:
Present: Mary Buhion (DOC/Chair), Amin Makawi (Business Director), Dr. Matthew Runnalls (Medical Director), Umbreen Mir (Pharmacy Consultant), Sasan Tabibi (Physiotherapist), Roland Madrona (IPAC Lad), Araceli Balaoeg (Clinical Supervisor), Helen Filoteo (Clinical Coordinator), Anh Mai (RAI-Coordinator), Maru Espina (RAI-Coordinator/Notetaker), Christian Daguio (BSO Lead), Usoshe Bose (Registered Dietitian), Juliette James (Dietary Manager), Julie Mendis (Dietary Supervisor), Doris Nwosu (Director of Residents Program), Susan Williams (Registered Social Worker), Shawn Smith (RPN, Temporary Falls Lead), An Nguyen (Nurse Practitioner from North West Ontario)

Visitors: Beatrise Edelstein and Kathleen Kirk (Vice-President of Hennick Humber Hospital) and Kathleen Kirk (Manager of Hennick Humber Hospital)

Regrets: Robert Scott (Administrator) and Jessica Bandoo ((Nurse Practitioner from North West Ontario)

**Goal Statement:** To educate 40 staff and families on the Palliative Approach to Care and End-of-Life Support, and to make palliative care and end-of-life resources available to everyone.

**Indicators:**

- Number of staff and families with demonstrated interest in understanding a Palliative Care Approach and End-of-Life Support.
- Number of participants who completed training sessions.

**Evaluation and Analysis:** An annual evaluation was completed at the end of March 2026 to determine if the program reached its goal. The following table summarizes the number of staff and families who attended training sessions throughout the year:

**ANNUAL EVALUATION**
**FISCAL YEAR 2025-2026**

*Table 21: Table of Education done every quarter*

| QUARTERS | INDICATOR | # TRAININGS CONDUCTED | OUTCOMES |
|---|---|---|---|
| Q4 | # of staff and families who received education | 54 | |
| Q3 | # of staff and families who received education | 5 | |
| Q2 | # of staff and families who received education | 24 | |
| Q1 | # of staff and families who received education | 15 | |
| | | 98 | Goal met |

- Across four quarters, a total of 98 staff and families received education on the Palliative Approach to Care and End-of-Life Support.
- The training goal for the fiscal year was achieved and exceeded, indicating strong program reach and engagement.

The Palliative Approach to Care Program exceeded its annual target for education and engagement. The ongoing commitment to staff development, family support, and respectful end-of-life practices will further strengthen the program in the coming year.

The program successfully met its annual objective, providing essential education to staff and families and strengthening the culture of palliative

**Identified Gaps:**

- Ensuring that new hires and all current staff receive proper and ongoing training remains a priority.

**Change Ideas Implemented:**

- Continued partnership with external agencies (Dorothy Ley Hospice, Ontario Health) to facilitate ongoing training for staff, families, residents, and loved ones.
- Implementation of the Train-the-Trainer strategy to build internal capacity.

- Issuing certificates of completion for some trainees.
- Introduction of the Honour Guard Program to respectfully recognize residents who have passed on by honoring their life through music and ceremony.

**Next Steps (FY 2026-2027):**

- **Goal:** To educate at least 50 staff and families on the Palliative Approach to Care and End-of-Life Support by March 31, 2027.
- Continue offering education to new hires and current staff.
- Expand family and resident involvement in training.
- Maintain and strengthen partnerships with external agencies.
- Continue evaluating and adapting the program based on feedback and emerging needs.

Goal Statement for 2026 to 2027: To increase the number of staff and family members trained in the Palliative Approach to Care and End-of-Life Support from 40 to 50 by March 31, 2027.