Equity | Equitable | Optional Indicator

	Last Year		This Year		
Indicator #3 Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education (Pioneer Ridge)	**100.00** Performance (2025/26)	**100** Target (2025/26)	**100.00** Performance (2026/27)	**0.00%** Percentage Improvement (2026/27)	**100** Target (2026/27)

Change Idea #1 ☑ Implemented ☐ Not Implemented ☐ In Progress

Regular and relevant mandatory education

Process measure

- Number of active staff (as of Dec. 31 2025) who have completed the required Surge modules

Target for process measure

- 100% of active staff will have completed all required modules

Lessons Learned

All of our staff and leadership team complete modules in Surge learning on hire and annually. In 2025 this included: Cultural Competence and Indigenous Cultural Safety, Indigenous Cultural Safety, Humility and Anti Racism, Cultural Safety & Strengths Based and Trauma Informed Practice, Diversity, Equity, and Inclusion in the Workplace and LGBTQ2+ Identities.

Change Idea #2 ☐ Implemented ☐ Not Implemented ☑ In Progress

Home policies and procedures are considerate and inclusive to all cultures. Staff are trained and knowledgeable in all procedures.

Process measure

- Number of current policies reviewed using an equity lens Number of current policies revised using an equity lens Number of new policies to address gaps Number of active staff who reviewed pertinent policies

Target for process measure

- 2 policies reviewed in 2025 1 new policy created in 2025 100% of active staff will review any pertinent policies

Lessons Learned

Through our policy reviews, we are embedding diversity, equity, inclusion, and anti-racism principles to strengthen equitable, person-centred care and support an inclusive environment for residents, families, and team members. This process is on-going.

Comment

We continue to strengthen our focus on diversity, equity and inclusion. We have begun incorporating Indigenous artwork throughout the home to create a more welcoming, culturally respectful environment that reflects the communities we serve. We also plan to explore additional opportunities to recognize and incorporate the cultures and traditions represented within our diverse workforce and resident population.

Results

Safety | Safe | Custom Indicator

Indicator #1

Number of resident whose behavioural symptoms improved from their previous assessment. (Pioneer Ridge)

Last Year		This Year		
18.00	20	NA	--	NA
Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

Change Idea #1 ☑ Implemented ☐ Not Implemented ☐ In Progress

Create a more home-like environment on Monarch Manor and move to an emotion based model of care.

Process measure

- Number of FT and PT staff working regularly on Monarch Manor who have completed the Butterfly training

Target for process measure

- 100% of FT and PT staff on Monarch Manor will have completed the training by December 2025

Lessons Learned

Successes:
Accredited as a Butterfly home by MCM
58% Reduction in behavioural expressions (243 in 2024 to 102 in 2025) reduction
Almost 90% reduction in the number of monthly physical expressions directed to staff (from 14 to 1)
Visible improvement in overall resident joy and staff & family satisfaction

Challenges:
Staff buy in - some staff were very resistant to change
Education - training is a vital piece in a change mgmt. project of this magnitude, and it was hard to schedule and accommodate staffing shortages, illnesses etc.

Change Idea #2 ☑ Implemented ☐ Not Implemented ☐ In Progress

Reduce risk of aggression/injury to staff or others by new residents with a high risk of aggressive behaviours

Process measure

- Number of new residents on Monarch Manor per quarter Number of new residents referred as high risk per quarter Number of aggressive incidents involving new residents per quarter Number of injuries to staff or others involving new residents per quarter

Target for process measure

- We will be collecting baseline data on this indicator Our target would be zero aggressive incidents or injuries involving new residents

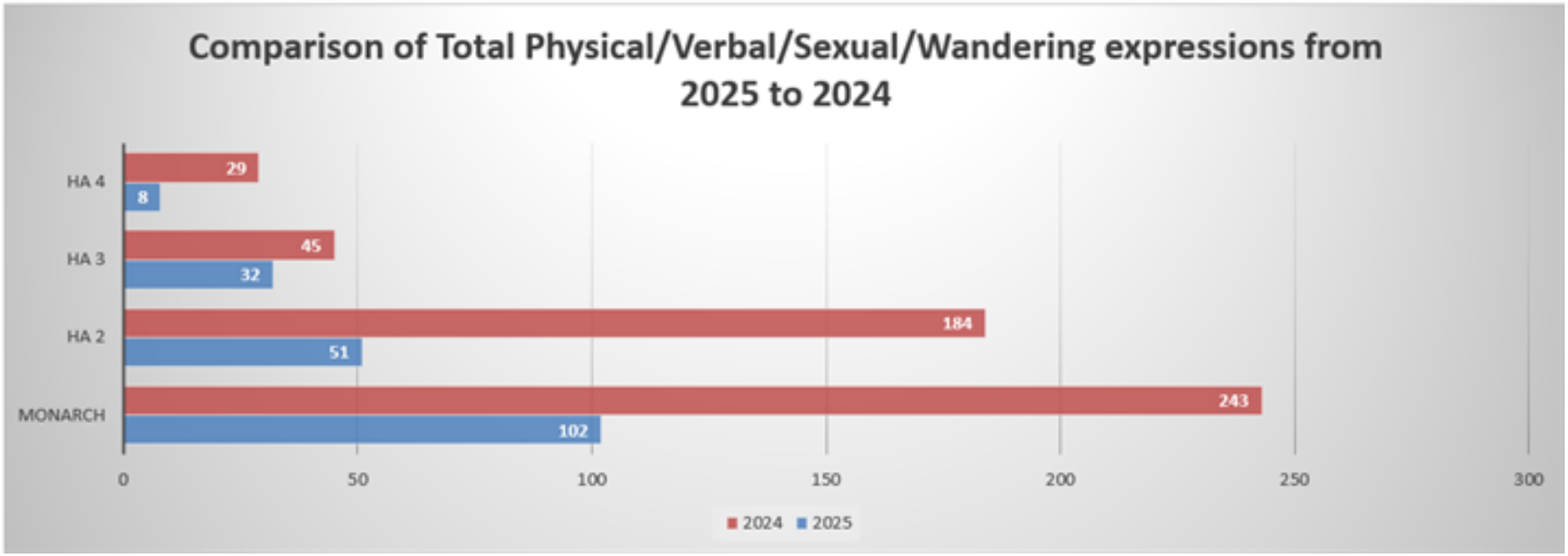
Lessons Learned

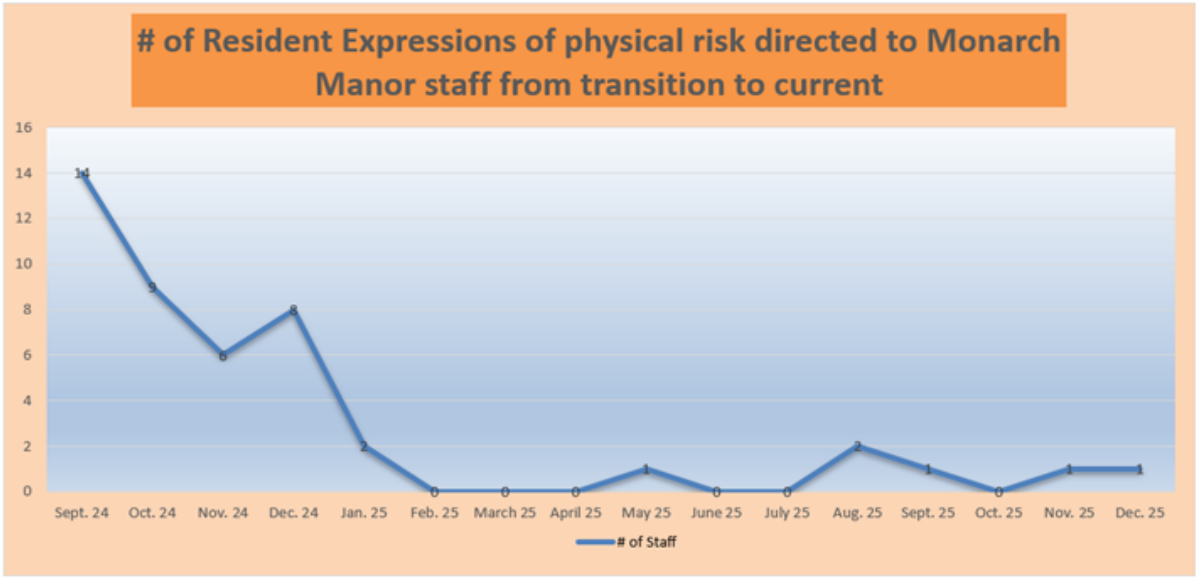
This new process of identifying residents with a potential risk of physical or sexually aggressive behaviours and assigning two staff to provide care for the initial few weeks as the resident settles into their new home was very successful.

Comment

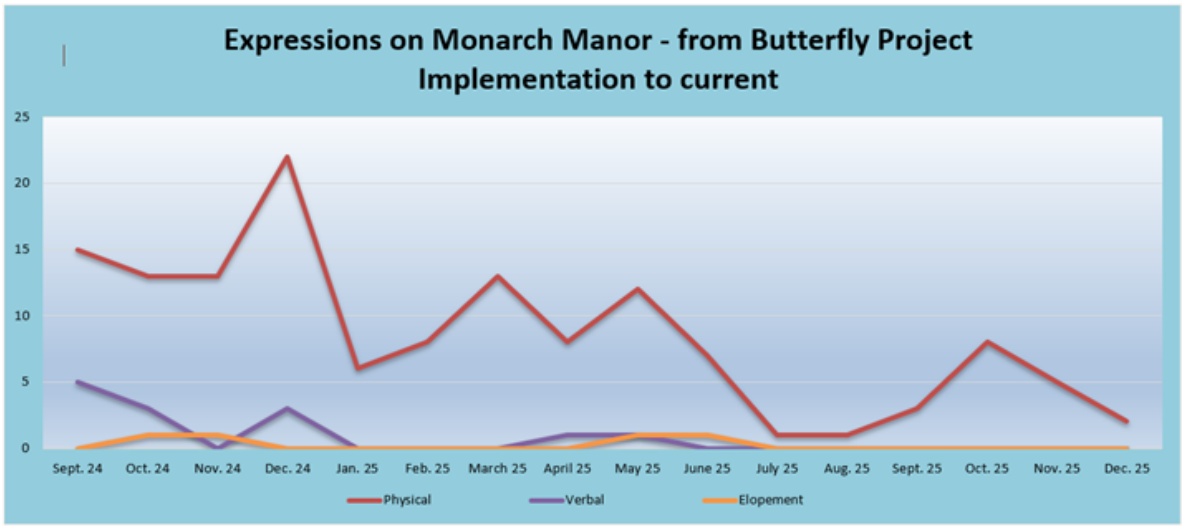
The indicator that we chose to report on in last year's QIP is not easily obtained, as it required a lot of chart reviews. Instead we have decided to report on improved behavioural symptoms through reduction expressions as well as physical risk directed toward staff in our 2026 QIP, which allows us to report on specific home area data as opposed to whole home data. We are continuing with Butterfly education for staff throughout the home and we are planning to transform another home area (currently known as Plaza 4) to a Butterfly unit in 2026/27! Work is already underway!

Results


Comparison of Total Physical/Verbal/Sexual/Wandering expressions from 2025 to 2024
HA 4
HA 3
HA 2
MONARCH
29
8
45
32
184
51
243
102
0
50
100
150
200
250
300
2024
2025



# of Staff injuries on Monarch Manor has decreased significantly from transition



Incidents of physical, verbal expressions of risk and elopement from initial transformation to current date.

Report Accessed: March 24, 2026

Indicator #4

Reduction in Overall Resident Infection Rate (Pioneer Ridge)

Last Year		This Year		
7.90	**5**	**7.65**	**--**	**NA**
Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

Change Idea #1 ☑ Implemented ☐ Not Implemented ☐ In Progress

Increased IPAC-related auditing

Process measure

- Number of HH audits per month Number of PPE audits per month Number of role-specific audits per department per month

Target for process measure

- 40 HH and PPE audits (total) per month 1 role specific audit per department per month

Lessons Learned

We exceeded our annual target of hand hygiene audits (640 completed vs. target of 540)

In November 2025, our audit % dropped significantly from 92% to 0% - this outlier data point is due to the unexpected absence of our IPAC lead. While we have a casual IPAC coordinator for backfill, there were some delays and gaps with coverage. Although no audits were submitted/tracked for November, this does not mean none were completed. It is highly plausible that they could have been submitted but not received, or misplaced by the oncoming casual staff member.

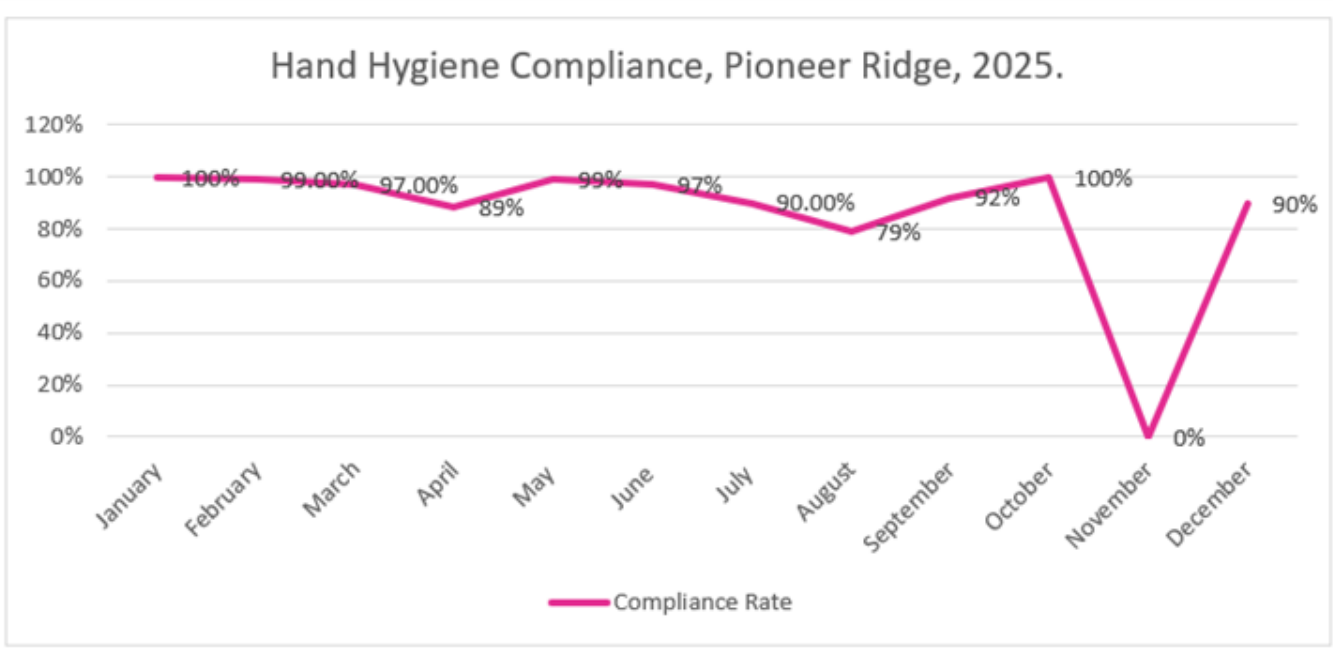
In the accompanying graph (Infection Frequency Rate, 2025) our 2024 data is represented by the thick yellow line, and our 2025 data by the thick pink line. Although we did not meet our target of 5% overall infection rate in 2025, we did start to trend downwards (as represented by the thin pink line) in the second half of 2025, versus the upward trend noted toward the end of 2024.

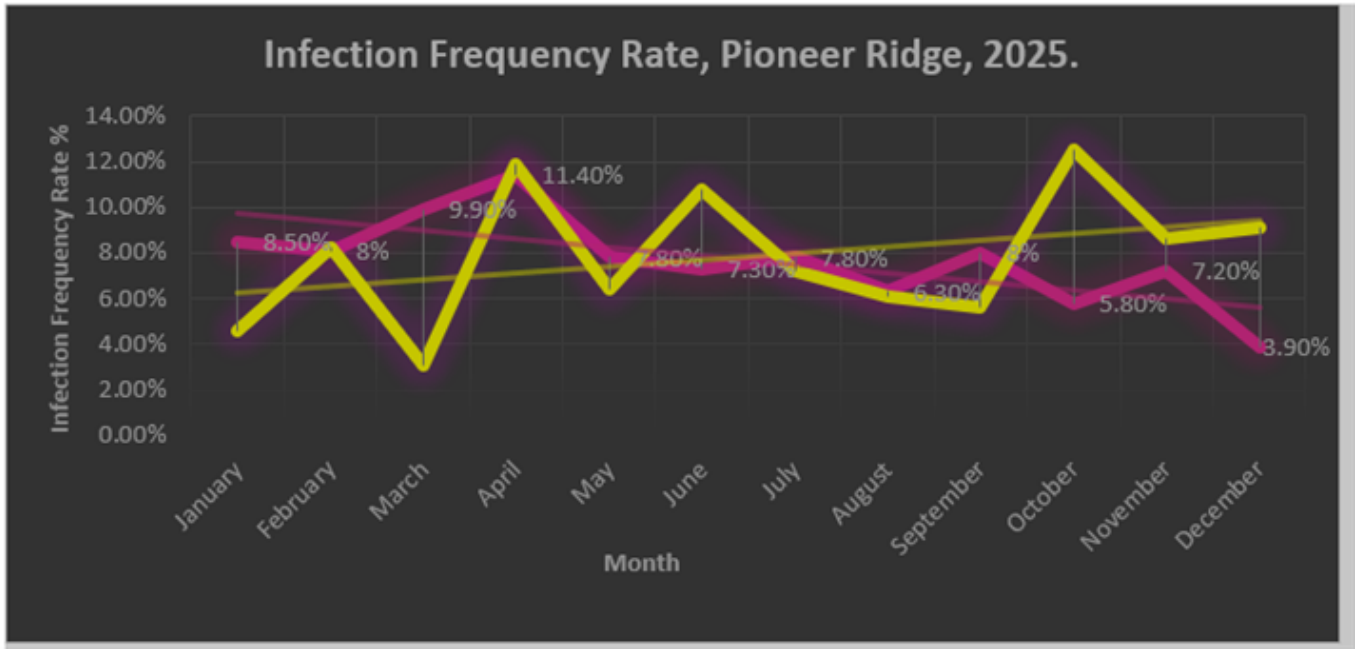
In 2025, Q4 represents our lowest quarterly infection rate at 5.6%.

Comment

We have identified a gap in PPE audits, specifically donning and doffing. We plan to target this in 2026. We are planning to increase auditing of PPE use along with hand hygiene as well as providing additional education with the goal of continued reduction in infections.

Results





Safety | Safe | Optional Indicator

Indicator #2

Percentage of LTC home residents who fell in the 30 days leading up to their assessment (Pioneer Ridge)

Last Year		This Year		
14.74	**12**	**12.50**	**15.20%**	**9**
Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

Change Idea #1 ☑ Implemented ☐ Not Implemented ☐ In Progress

Regular and relevant online and in-person education and training on falls prevention to all staff

Process measure

- Number of total active staff (as of Dec.31, 2025) who have completed the online course(s) Number of in person sessions offered on falls prevention topic Number of Registered Staff attending in person session Number of Front Line Staff (PSW,HSS,TR) attending in person session

Target for process measure

- 100% of total active staff will have completed the required online courses 1 in-person education topic in 2025 (may have multiple sessions) 75% of FT and PT Registered Staff 75% of FT and PT Front Line Staff

Lessons Learned

Falls Prevention requires repetitive and ongoing education, with a focus on completing a Point of Care Risk Assessment before every interaction.

Hosted a "Fall Prevention Week" using best practices to create interactive participation and chances to be entered into a draw for fun prizes. Activities included:
- Bingo with common fall prevention strategies;
- Spin the wheel with fall related quiz questions;
- Point of care risk assessment activity with an unsafe wheelchair (staff had to identify what was wrong)

Change Idea #2 ☑ Implemented ☐ Not Implemented ☐ In Progress

Improved monitoring, review and analysis of falls stats/trends

Process measure

- Number of Registered Staff trained to use the incident reporting module in PCC

Target for process measure

- 100% of FT and PT Staff will be trained

Lessons Learned

Lesson learned: Incidents need to be reviewed frequently by designate (either Director of Care or Clinical Manager or other) to ensure timely review and identification of potential omissions of pertinent information.

Change Idea #3 ☑ Implemented ☐ Not Implemented ☐ In Progress

Improved monitoring, review and analysis of falls stats/trends

Process measure

- Number of resident falls assessed monthly for potential preventative interventions, decreasing risk of injuries, determine cause of fall and review current interventions in place. Number of Fall Committee Meetings

Target for process measure

- 100% of resident falls assessed each month 12 Fall Committee Meetings in 2025

Lessons Learned

Successes: We began using the electronic risk management module and reporting available to us in Point Click Care which reduces paper (easily misplaced or lost) to better review and track trends. The Best Practice Clinician is able to share the data from these reports easily with staff and residents/families.

Comment

Our Nursing Restorative department created and delivered education on Safe Lifts and Transfers to all of the staff on RHA3, with the goal of reducing and preventing falls. Education included a booklet with knowledge check questions to be completed prior to the training. We also updated our Falls policy and procedure in 2025 to include clarity on completing a point of care risk assessment prior to all resident interactions. For 2026/27, we plan to continue this training throughout the remaining home areas and the training booklet they created has been added to Surge learning for all new hires.

Results


FALL PREVENTION - WEEK 1
HOW TO PARTICIPATE
WET FLOOR
Find the Injured Gnome somewhere in the Home and bring to NRS Office. Your name will be placed in a ballot box to win 1 of 3 prizes.
Between Spooky Season and Christmas comes Falls Prevention Season - join us in celebrating
Falls Prevention Week 1 Activity November 3-7


NOVEMBER IS FALLS PREVENTION MONTH
Nov 3-7
Find the Injured Gnome
Nov 10-14
Fall Prevention BINGO
Nov 17-21
Spin the Wheel - Falls Prevention Style
Stay Tuned for Further Details each week!
Prizes to be Won!
Nov 24-28
Point of Risk Assessment Activity
Nov 18
Pioneer Talks for Caregivers and Residents
BPSO
RNAO BEST PRACTICE SPOTLIGHT ORGANIZATION