SPRUCEDALE
CARE CENTRE

2025-2026 CONTINUOUS QUALITY IMPROVEMENT INITIATIVE REPORT

Quality Improvement Lead in the Home	**Kate Faria, RPN** - Quality Improvement Coordinator **Corrie VanHeeswyk** - Executive Director
Priority Areas for Quality Improvement	Sprucedale Care Centre is committed to continuous quality improvement and our interdisciplinary teams have been actively engaged to collaborate closely with the residents, their families, and external partners since the outset of 2025. Our Vision is to create a community of trust and fulfillment for our team members and residents. Quality improvement is the foundation of our home as it contributes to our core values of Kindness, Progressive, Integrity and Community. Our home has undertaken comprehensive initiatives aimed at enhancing performance across all departments and has formulated multiple quality improvement initiatives to effectively pursue the home's established goals and objectives encompassed in our Annual Program Evaluations, Home Operational Plan, Annual HQO Quality Improvement Plan (QIP), Resident Satisfaction & Team Survey Action Plans. Within the aforementioned plans, Sprucedale Care Centre has placed significant emphasis on the following key areas: ● ***Annual HQO Quality Improvement Plan (QIP)*** ○ Access: Reducing the percentage of potentially avoidable emergency department visits for residents ○ Resident Experience: A focus on improved communication; Do the residents feel they have a voice and are listened to by staff? Do the residents feel they can speak up without fear of consequences? ○ Equity: Provide education to all the staff about equity, diversity, inclusion, and anti-racism ○ Safety: Reduce the percentage of residents that have fallen ○ Reduce the percentage of residents without a diagnosis of psychosis who were given antipsychotic medications ○ Reduce the percentage of residents with worsening Stage 2 to 4 Pressure Ulcers ○ Reduce the percentage of Long-Term Care Residents whose mood from symptoms of depression worsened ● ***Resident Satisfaction Survey Action Plan*** ○ 1. "I can access my trust account when necessary" ○ 2. "I have enjoyable things to do in the evenings & on weekends"

	○ 3. “I have enough variety in my meals” ● ***Team Member Satisfaction Survey Action Plan*** ○ 1. When I do an excellent job, my accomplishments are recognized <u>Action Plan:</u> a. Present Connected with Kindness recognition program to Employees/ Residents and Families monthly to ensure familiarity with the program- On admission and New Hires. b. QR code has been framed with an explanation of the program and placed throughout the home. c. Shared Google Doc for ease of access to the survey type form. d. Executive Director to review with Managers weekly send out Ecards and/or an email of recognition of how important the person is for what they did ○ 2.: I see professional growth and career development opportunities for myself here. <u>Action Plan:</u> a. Increase employee engagement to ensure conversations are had at the time of Performance appraisals and touch points every year with employees by their direct supervisor. Improve Diversity, Equality and Inclusivity and belonging with one to one conversation with Staff b. Prepare teams now for possible future jobs, Examples such as leadership training. In-house opportunities such as PSW programs. c. Survey to ask team members what education opportunities they would like to see-(Educational Needs Assessment) d. Review Surge Learning to see if there are any opportunities for Online Events -Education Opportunities. ○ 3: Have you ever felt uncomfortable or excluded because of your background or identity? This was scored low however all comments were favorable, the company addresses these issues, and they are confident etc. I have created a one question survey monkey to ask staff yes or no question to support the misunderstanding. Question- I am confident that the company takes reports of discrimination seriously, scoring 88% doesn’t make sense with this question. 73% said they did not witness verbal or physical sexual in the workplace. Action steps are to gain more knowledge and interpretation of question ● ***Annual Program Evaluations and Goals for 2025*** **include improvement strategies targeting the following topic areas**; Continence & Bowel Management, Falls Prevention, Pain & Palliative Care, Responsive Behaviours, Restraint & PASD, Skin & Wound Care, Emergency Department Transfers, Restorative Care

	Philosophy: Approaches & Nursing Restorative, Nursing & Personal Support Services, Medical Services, Emergency Drug Supply & Medication Management, Medical Equipment Calibration & Cleaning, Dietary Services, Nutrition & Hydration, Prevention of Abuse and Neglect, Staff Development, Staffing Plan, Health & Safety Networking, Emergency Plan, Resident's Council and Quality improvement ● ***Operational Plan*** ○ - Dr Marcou started using secure conversations January 31, 2025 - Dr Marshall is projected to start using secure conversations by February 28, 2025 - Education will be provided to registered staff at monthly staff meetings as well as upon hire and as needed - Enhance every tub room décor to make a more spa-like atmosphere through collaborative approach with all staff, managers, residents' council, family council - Collaboration with RNAO through clinical pathways for palliation and end of life -Education February 26, 2025 (2 sessions) & March 5, 2025 (1hr education sessions for PSW staff by Kindera Living) - 10-12 students through TRIOs college will be completing. 2 weeks of labs and placement hours at Sprucedale Care Centre - Sprucedale continues to implement placements opportunities for the following schools: Western University BScN Program, Anderson College- Personal Support Worker, Brescia College- Dieticians & Western Schulich School of Medicine. - Train interdisciplinary team champions from all departments. This was implemented partially last year. The goal is to increase the number of champions in the home. - Home expansion - 32 bed addition - Upgrade aged nurse call, phone system - Upgrade WIFI to reduce any weak spots - Signing in and out badges and phones - Increase the number of certified health and safety members on the health and safety team from 3-5 members & be actively participate in all health and safety meetings in 2025 - Upgrading the existing eye wash stations to include an upper flush - Implement QUIS - Implementing POET - Purchase of Cardeno Chairs - Purchase of high low beds (multipurpose/ bariatric ability) - purchase of Bariatric mattresses ● ***Strategic Plan*** ○ Sprucedale is new to the Kindera process of Strategic planning. We are currently in the planning phase and due to develop by December 2025.
Process to Identify Home Priority Areas	Beginning in January, our interdisciplinary team consisting of member representatives including Resident Council, family council, direct care team members PSW, RPN, RN, volunteers, leadership and external stakeholders gather to collaborate and complete our Annual Program Evaluations, Home Operational Plan, and HQO Quality Improvement Plans (QIPs). Together we identify and address gaps in practice and explore new initiatives to improve

	upon. During the completion of these evaluations and planning, we review and analyze multiple resources including; the previous year's goal targets, quarterly evaluations, meeting minutes from our various internal committees, quality indicator performance data, internal and external audits and reports, action plans and satisfaction survey results. With this information, the team collaboratively sets a list of goals as priorities to improve upon for the upcoming year.
Process of Monitoring & Measuring Quality Improvement Initiatives	It is one thing to set goals for improvement, although without action, monitoring, and measurement, it would be impossible to continue improving and celebrate our successes. Our team ensures that when our goals are identified, they are specific, measurable, achievable, relevant, and timebound. Vigorous audits are completed and relevant data is collected on priority areas across all departments and tracked monthly *(including critical incidents, complaints, focused audits, and results of varied assessments including the Resident Assessment Instrument (RAI), etc.)*. To identify if we are on target to meet our goals and are fostering quality-focused care, we monitor our progress in our quality indicator percentages and feedback from our team through satisfaction survey results and discussion in our internal committee meetings. To ensure all of our goals are monitored and measured, we compile a summary for each goal during relative care team or committee meetings and review them on a monthly or quarterly interval with the team. Input and feedback from our interdisciplinary team; inclusive of resident and family representatives, is encouraged during each review. Collaboratively we evaluate the current state and effectiveness of actionable items. Where needed, the team generates ideas for amendment to existing goals, interventions or targets *(ex; if we identify a goal is no longer attainable, intervention is no longer effective, etc.)*. The home prioritizes transparent communication, actively sharing successes, outcome measures, and quality improvement initiatives throughout the home. Updates on our performance and QIPs are shared regularly with Resident & Family Councils and additionally with team members at Town Halls or at the related care team or committee meetings.
SURVEY – Written Record	The Resident Satisfaction Survey was conducted during the month of September - October 2024 and completed either in person with each resident or mailed to family members of residents who were unable to provide feedback on their own. The survey results and related action plan were shared with the Residents Council on March 4, 2025 and with Family Council on February 20, 2025. These results were also posted on to the Resident Council Board in the center court for easy viewing access for all residents, family, visitors and team members. Survey results and related action plans were shared with the Team Members on January 16, 2025.
SURVEY ACTIONS - Written Record	Sprucedale's survey action plan was presented to the Residents Council, Family Council and Team Members and based on the feedback received, our home identified the following focus areas for improvement and implemented

	corresponding action items aimed at enhancing the quality of life for both our residents and team members within the home. **Resident Satisfaction Survey Actions for Improvement:** Our home developed an action plan in late 2024 to address the following low-scoring survey items: **1. "I can access my trust account when necessary"** Action Plan: 1. Clarification in Future Surveys: In the upcoming survey, we will provide a more detailed explanation of the question regarding trust account access. This will help ensure that residents understand the context, especially since most of our residents do not have a trust account. This clarification aims to enhance the accuracy of survey responses. 2. Education for New Admissions: During the admission process, we will continue to inform both new residents and their families about the existence and utility of a trust account, if applicable. We will clearly explain how the trust account can be accessed and utilized during normal business hours, ensuring that both residents and their families feel confident in managing financial matters. Through this approach, we aim to improve understanding and satisfaction regarding trust account access. **2. "I have enjoyable things to do in the evenings & on weekends"** Action Plan: 1. During the Residents Council meeting held in March 2025, we addressed the topic of evening and weekend activities. Attendees expressed that they are not interested in additional evening programs and noted that weekend activities mirror those offered during the weekdays. No further suggestions for improvement were received. 2. For future surveys, we will conduct a thorough review of the questions, particularly regarding the availability and variety of evening and weekend programs. It is important to ensure that the questions effectively capture the residents' and families' satisfaction levels, which are currently reported as very high. **3. "I have enough variety in my meals"** Action Plan: 1.To ensure clarity and comprehension, the home will make certain that residents fully understand the survey question regarding meal variety by providing thorough explanations and any necessary additional information. 2. All residents are encouraged to participate in the Dining Enhancement Committee and the Resident Council. These platforms offer opportunities for residents to voice their dietary preferences and suggestions, ensuring that their opinions are actively considered and heard. **Staff Satisfaction Survey Actions for Improvement:** Our home developed an action plan in late 2024 to address the following low-scoring survey items: **1. "When I do an excellent job, my accomplishments are recognized"** Action Plan: 1. Present Connected with Kindness recognition program to Employees/ Residents and Families monthly to ensure familiarity with the program- On

	admission and New Hires. 2. QR code has been framed with an explanation of the program and placed throughout the home. 3. Shared Google Doc for ease of access to the survey type form. 4. Executive Director to review with Managers weekly send out Ecards/ and or an email of recognition. Of how important the person is for what they did **2. "I see professional growth and career development opportunities for myself here"** <u>Action Plan:</u> 1. Increase employee engagement to ensure conversations are had at the time of Performance appraisals and or touch points every year with employees by their direct supervisor. Improve Diversity, Equality and Inclusivity and belonging with one to one conversation with Staff 2. Prepare teams now for possible future jobs, Examples such as leadership training. In house opportunities such as PSW programs. 3. Survey to ask team members what education opportunities they would like to see-(Educational Needs Assessment) 4. Review Surge Learning to see if there are any opportunities for On Line Events -Education Opportunities. **3: "Have you ever felt uncomfortable or excluded because of your background or identity?"** This was scored low however all comments were favorable, the company addresses these issues, and they are confident etc. I have created a one question survey monkey to ask staff yes or no question to support the misunderstanding. Question - I am confident that the company takes reports of discrimination seriously, scoring 88% doesn't make sense with this question. 73% said they did not witness verbal or physical sexual in the workplace. Action steps are to gain more knowledge and interpretation of question The **Resident Council** provides a forum for residents to meet monthly to discuss topics of importance. The Residents Council plays a key role in the quality improvement program within our home. All proposed quality improvement initiatives are reviewed with the Resident Council and their input helps to formulate action plans that speak to the overall needs and preference of the residents. **Family Council** is a forum for resident's loved ones to meet and discuss topics of importance. The Residents Council plays a key role in the quality improvement program within our home and their collaboration and input helps to formulate action plans that speak to the overall needs and preference of the residents. Our **Interdisciplinary Quality Improvement Committee** that oversees all aspects of our Continuous Quality Improvement (CQI) Program and initiatives. The Committee identifies change ideas that are implemented in collaboration with its interdisciplinary team membership and meets on a quarterly basis to review performance indicators and progress towards quality improvement plans to seek feedback from key stakeholders including residents and families.
Report Completion DATE	**April 30, 2025**

Topic Source	GOAL	Change Ideas/Actions	Progress Update
Resident Satisfaction Survey	I can access my trust account when necessary	1.To ensure clarity and comprehension, the home will make certain that residents fully understand the survey question regarding meal variety by providing thorough explanations and any necessary additional information. 2. All residents are encouraged to participate in the Dining Enhancement Committee and the Resident Council. These platforms offer opportunities for residents to voice their dietary preferences and suggestions, ensuring that their opinions are actively considered and heard.	Interventions Ongoing
Resident Satisfaction Survey	I have enjoyable things to do in the evenings & on weekends	1. During the Residents Council meeting held in March 2025, we addressed the topic of evening and weekend activities. Attendees expressed that they are not interested in additional evening programs and noted that weekend activities mirror those offered during the weekdays. No further suggestions for improvement were received. 2. For future surveys, we will conduct a thorough review of the questions, particularly regarding the availability and variety of evening and weekend programs. It is important to ensure that the questions effectively capture the residents' and families' satisfaction	Interventions Ongoing

		levels, which are currently reported as very high.	
Resident Satisfaction Survey	I have enjoyable things to do in the evenings & on weekends	1.To ensure clarity and comprehension, the home will make certain that residents fully understand the survey question regarding meal variety by providing thorough explanations and any necessary additional information. 2. All residents are encouraged to participate in the Dining Enhancement Committee and the Resident Council. These platforms offer opportunities for residents to voice their dietary preferences and suggestions, ensuring that their opinions are actively considered and heard.	Interventions Ongoing
Staff Satisfaction Survey	When I do an excellent job, my accomplishments are recognized	1. Present Connected with Kindness recognition program to Employees/ Residents and Families monthly to ensure familiarity with the program- On admission and New Hires. 2. QR code has been framed with an explanation of the program and placed throughout the home. 3. Shared Google Doc for ease of access to the survey type form. 4. Executive Director to review with Managers weekly send out Ecards/ and or an email of recognition of how important the person is for what they did	Interventions Ongoing
Staff Satisfaction Survey	I see professional growth and career	1. Increase employee engagement to ensure	Interventions Ongoing

	development opportunities for myself here	conversations are had at the time of Performance appraisals and or touch points every year with employees by their direct supervisor. Improve Diversity, Equality and Inclusivity and belonging with one to one conversation with Staff 2. Prepare teams now for possible future jobs, Examples such as leadership training. In house opportunities Such as PSW programs. 3. Survey to ask team members what education opportunities they would like to see-(Educational Needs Assessment) 4. Review Surge Learning to see if there are any opportunities for On Line Events -Education Opportunities.	
HQO QIP & Falls Prevention Annual Program Evaluation	To reduce the CIHI "has fallen" indicator for Q2 2025 by 10% from 18.9% (Q2 2024) to 17% by Q2 2025 (September 30, 2025)	1. Analyze the MOMO bed sensor data monthly between January to December 2025. We will be able to analyze data for falls out of bed (for residents' on Cedar Grove; who are utilizing the bed alarm feature (MOMO bed sensor system) in 2025) 2. QI lead and RAI coordinator will track insights weekly on Fridays to review QI "has fallen indicator" for trends. Documented on insights tracker. 3. Continue to have monthly falls prevention meetings to analyze trends and decrease risk factors	Interventions Ongoing

		4. Post fall huddles will occur and be documented with each fall to gain insight on route cause of the fall and update the care plan 5. Review all residents who have multiple falls each month for candidacy of nursing restorative program (walking program/active range of motion program) beginning February 2025	
HQO QIP & Emergency Department Transfer Annual Program Evaluation	To reduce the percentage of avoidable ED transfers by 10% from 15.2% to 13.5% by December 31, 2025	1. Complete application to NLOT by January 31, 2025. Work with the Nurse Led Outreach Team (NLOT) to educate all registered staff to reduce unnecessary emergency department visits and hospital admissions. Education will be surrounding diabetes, COPD, congestive heart failure & falls related injury assessments 2. To reduce potentially avoidable emergency department transfers; the DOC and/or Delegate will provide education and training on the SBAR (Situation, Background, Assessment & Recommendation) tool.	1. The NLOT application was completed before January 31, 2025. Education sessions surrounding the NLOT team were held on - Introduction: February 27, 2025 with Kendra Lindsay Butler & Erin Watson & McKellar (clinical manager of specialized services at St Joesephs Health Care), Dr Marcou, Jennifer Turnbull (DOC), Jennifer Campbell (ADOC) & Robyn VanderHoek (IPAC) - March 10, 2025 with Kendra McKellar (clinical manager of specialized services at St Joesephs Health Care) - March 20, 2025 with an NP, RN, Dr Marcou, Jennifer Turnbull (DOC), Jennifer Campbell (ADOC) & Robyn VanderHoek (IPAC) to discuss how communication will flow 2. This education was provided by the quality lead on March 11, 2025. The education was sent out to all Registered staff via email (one call)

		Education on the SBAR will be provided to 100% Registered staff by April 30, 2025. 3. Utilization of resource binder upon new registered hires between February and December 2025; to increase knowledge base of assessments (COPD, cough, infections, falls related injuries, PICC therapy, hypodermoclysis) 4. SBAR will be utilized and completed for each resident (for non-emergent transfers) prior to MD consult when considering treatment and possible hospital transfer. With use of the SBAR tool & MD consults; we will enhance communication. Registered staff will complete a SBAR tool prior to consulting a physician about treatment proposals for all non-emergent cases.	3. Intervention Ongoing 4. Intervention Ongoing
HQO QIP	Percentage of residents responding positively to: "What number would you use to rate how well the staff listen to you?"	1. Initiate the N Adv Can - RNAO Resident and Family-Centred Care assessment for every new resident who moves into the home 2. Initiate a minimum of 4 hours each month for QUIS observations for meaningful moments tracking for all departments in 2025 3. Initiate specialized	Interventions Ongoing

		musical programing (other than entertainment) to the home by February 28, 2025. This will include the Golden Grands Choir, intergenerational music programming, self directed music activities in the lounge & a variety show. 4. Director of Nutrition to attend the monthly resident council meetings/dining enhancement meetings to review any dining room and menu concerns. All concerns will be followed up within 1 week of the meeting.	
HQO QIP	Do residents feel they can speak up without fear of consequences?	1. Maintain a minimum of 3 representatives (1 per home area) as participants of resident council between January - December 2025. 2. Activation to review the "Whistle Blowing Protection Policy" during the Resident Council Meetings throughout the year. 3. 100% of staff will receive education on the "Whistle Blowing Protection Policy." 4. 100% of formal complaints will be followed up upon within a 10 day period	Interventions Ongoing
Responsive Behaviour Annual Program Evaluation	We will see a 5% improvement in the QI score for worsened mood from symptoms of depression from 20.8% to 19.8% for CIHI Q2 2025.	1. Host 1 GPA training session in the home per quarter (January, April, July and October). Targeting 10 nursing department staff per quarter by ADOC and delegate.	1. 1st training session was February 11th. 10 staff were in attendance 2nd training session is March 18. 7 staff are targeted to be in attendance

		2. Initiating self directed music activities in the lounge by May 30, 2025 to improve our CIHI worsened mood with symptoms of depression indicator 3. Every resident exhibiting a behavioural incident will have a responsive behaviour debrief tools completed each month 4. Implement new outdoor walking program to the activity calendar by April 2025 (weather permitting)	2. Intervention Ongoing 3. This was completed upon an identified behavioural risk. The responsive behaviour tool is completed if the LTCF ABS score is 3 or greater, quarterly if a resident has 1:1 care, quarterly if resident is under BSO care and with observations of escalating behaviour. January: 7 tools done / 7 behavioural incidents February: 13 tools done / 13 behavioural incident March: 4. Intervention Ongoing
Continence and Bowel Management Annual Program Evaluation	To improve our CIHI indicator for worsened bowel continence by 20% from 19.6% to 15.5% by Q2 2025	1. Audit bowel routines for residents who are triggering through RAI for worsened bowel incontinence quarterly through to September 2025 2. Create a spreadsheet/tracking sheet to show progress through each quarter. Creation will occur by January 31, 2025. 3. Utilize bowel diary sheet for tracking of bowel routines for triggered residents between February and September 2025.	Interventions Ongoing

		4. Audit companion documentation daily for specific residents that have bowel tracking in place for 7 days.	
Dietary Services, Nutrition & Hydration Annual Program Evaluation	Improve the PRECEPTIX resident satisfaction for "I enjoy meal times" by 10% from 73% in 2024 to 80% in 2025	1. Dining enhancement meetings to continue monthly. 2. Feedback from resident council about menu/dining room concerns will be reviewed with the director of nutrition on a monthly basis by the activation team. 3. Food samples/taste testings for residents will occur within 2 weeks of the new menu change (spring/April menu) - helping to introduce variety 4. Renovation to the dining rooms (between March and July 2025) will provide more pleasurable environment	Interventions Ongoing
Emergency Drug Supply & Medication management Annual Program Evaluation	To review our admission order set to ensure all orders are individualized and appropriate for each resident by June 30, 2025 and to reduce our medication incidents from 41-36 for 2025.	1. Collaborate with the silver fox consulting pharmacist to finalize the admission order set by April 30, 2025 2. Present reduction to the admission order set to the medical director for approval by May 15, 2025 3. Educate all registered staff surrounding all of the changes to the admission order set by June 30, 2025. 4. Discontinue generalized (admission protocol and medical directives) APMDs by June 30, 2025	Interventions Ongoing

Emergency Plan Annual Evaluation	100% compliance for all eye wash stations to be up to code by April 30, 2025	1. Executive director will validate & allocate financial support for eye wash station upgrades by February 1, 2025. 2. Visual eye wash station signage will be in place at the location of the eye wash station by March 31, 2025 3. Education to be provided to all active staff via email (one call) by July 1, 2025. This will include how to operate the station, SDS and cleaning information 4. New upper flush hardware installation will have taken place by April 30, 2025	1. Executive director validated and allocated financial support for upgraded eye wash stations on January 31, 2025 2. Visual eye was signage was in place by March 31, 2025 3. Intervention Ongoing 4. Intervention Ongoing
Health & Safety Networking Annual Evaluation	Increase the number of certified health and safety members on the health and safety team from 3-5 members & be actively participate in all health and safety meetings in 2025	1. Two new worker representatives will complete health and safety certification by November 1, 2025 2. Two existing worker representatives will complete recertification for health and safety by June 1, 2025 3. Recruit members for each department (dietary, PSW, RPN/RN, activation, environmental) to attend the monthly the health and safety team meetings by April 30, 2025 4. Advertise/create posters to gain interest for joining the health and safety team between February and April 2025	1. 1 new worker representative as of March 11, 205 2. Refresher course is April 29, 2025 3. March 11, 2025 1 PSW recruited 4. 4 posters were created and posted in the conference rooms, staff room door and health and safety board

Infection Prevention & Control Annual Evaluation	To increase our hand hygiene compliance from 90.7% to 95% by December 2025.	1. All new staff and students will receive hand hygiene education between February and December 2025 2. 16 random hand hygiene audits will take place every month by IPAC or delegate 3. Surge learning IPAC education will be 100% completed by all staff before December 2025. 4. Email communication (Nuiz) for monthly hand hygiene audit results will be shared with all staff to be included with how well the home is doing with hand hygiene (creating awareness).	Interventions Ongoing
Medical Equipment Calibration & Cleaning Annual Program Evaluation	Maintaining the current cleaning schedule and calibrations as per manufacture's guidelines.	1. keep list equipment that requires cleaning and calibration 2. review instructions for current and any new equipment coming into the home 3. ensure all equipment is regularly maintained as per schedule in manufactures guide 4. Add any new equipment coming into the home into the cleaning and calibration schedule where applicable	Interventions Ongoing
Medical Services Annual Evaluation	Our goal for 2025 is to enhance non-emergency communication between registered staff and physicians via secure conversations.	1. Both physicians will be updated on how to use "secure conversations" 2. Education will be provided to registered staff at monthly staff meetings as well as upon	1. Dr Marcou - January 2025 Dr Marshall - February 2025 2. Intervention Ongoing

		hire and as needed 3. Ongoing support with updates when moving forward with "secure chat." 4. teaching the registered staff how to move the conversations from secure conversations to the resident's chart during registered staff meetings.	3. Intervention Ongoing 4. Intervention Ongoing
Nursing & Personal Support Services Annual Evaluation	To have 100% of companion charting completed every shift for 2025.	1. Utilize education lead (Alison Benoit) twice weekly to audit companion charting and speak to staff who have not completed their charting. 2. Quality lead will audit companion charting 1-2x weekly document on POC spreadsheet and sheet will be shared with DOC and education lead. 3. Education on how to document on companion will be provided through surge learning by February 1, 2025	Interventions Ongoing
Pain & Palliative Annual Evaluation	To reduce the CIHI "has pain" indicator by 20% from 5.0% Q2 2024 to 4.0% by Q2 2025	1. 1 registered staff will be CAPCE trained by April 30, 2025 and 1 registered staff by July 30, 2025 2. 100% of Nursing Staff (RNs, RPNs) will receive Pain Management education via Surge Learning by April 30, 2025	1. Intervention Ongoing 2. Education was provided to staff via videos on Surge learning for March-April 2025. This education included: MODULE 1 The Pain Experience: A Module for Direct Care Staff by Surge Learning, MODULE 2 Pain Assessment and Management: A Module for Registered Staff by Surge - Learning, MODULE 3 Pharmacological Pain Management: A Module for

			Registered Staff by Surge Learning & RCS G-60 Pain Management 31 registered staff (100%) received this education by April 30, 2025
		3. 1 registered staff to attend the fundamentals of pain and palliation by August 31, 2025	3. Next course April 8
		4. Implement the RNAO Palliation and EOL clinical pathway on March 27, 2025	4. RNAO palliation and EOL clinical pathway went live March 27, 2025
Prevention of Abuse & Neglect Annual Program Evaluation	We would like to continue 0% of substantiated abuse cases throughout 2025.	1. Host 1 GPA training session in the home per quarter (January, April, July and October). Targeting 10 nursing department staff per quarter by ADOC and delegate.	1. 1st training session was February 11th. 10 staff were in attendance 2nd training session is March 18. 7 staff are targeted to be in attendance
		2. Topic discussion on abuse and neglect will be delivered via townhall on March 31, 2025	2. A Townhall meeting was delivered to all staff by the Executive Director Corrie VanHeesky on March 19, 2025 with the topic of abuse and neglect.
		3. 100% of surge learning education surrounding abuse and neglect will be completed by all staff by January 31, 2025	3. 30.4% (55 of 181) completed RCS P-20Whistleblower Policy by January 31, 2025 27.1% (49 of 181) completed RCS P10 Abuse and Neglect Policy by January 31, 2025 Above 50% for both courses for all Staff by March 20, 2025
		4. All formal complaints received will be reviewed and follow up upon within a 10 day period, from January - December 31, 2025 by the DOC and Executive director	4. Intervention Ongoing
Quality Improvement Annual Evaluation	The QI program will have 100% compliance	1. Annual program evaluation tracking sheet	Interventions Ongoing

	for timeline of auditing, quarterly evaluations in 2025	to be updated on a monthly basis by QI Lead. This will occur after every quality team meetings throughout 2025. 2. Open discussion regarding annual program evaluations progress on interventions and action plans will occur at every quality team meeting. This will be documented in the meeting minutes. 3. QI lead will audit the QRMs in surge learning on a by the second week of every month with completion of scheduled audits by the 15th of the month 4. Quarterly interdisciplinary committees (IPAC, medication management and QI) will be held 4x in 2025 with meeting minutes documented	
Recreation, Social & Spiritual Services Annual Program Evaluation	Initiate specialized musical programing (other than entertainment) to the home by November 1, 2025	1. Implement intergenerational music programming partnering with local schools and community music programs by May 30, 2025 (recreation staff are going to invite schools & community music partners between February and April 2025) 2. Implementing a Sprucedale Golden Grands Choir. This includes musical talents living at Sprucedale by July 31, 2025 3. Initiating self directed music activities in the	1. OLI (kindergarten class) is coming once a month since January 2025. Laurie is working to finalize arrangements with the strawbubs program Starting April 2025, we doing a biography program with the students from North Meadows 2. Golden Grands Choir was started on January 20, 2025. The Choir plan to practice on a weekly basis on Thursday at 3:30 3. Intervention Ongoing

		lounge by May 30, 2025 4. Variety show will take place in September 2025	 4. Intervention Ongoing
Resident Council Annual Program Evaluation	To maintain our three representatives for resident council for 2025.	1. If we are short a member this will be brought up at the resident council meeting. 2. Invite the representatives to each resident council meeting 3. Personally invite new admissions to the resident council meetings if a vacant position becomes available 4. Keep a binder in their rooms with the meeting minutes as well as dining enhancements	Interventions Ongoing
Restraint & PASDs Annual Program Evaluation	Our goal is to reduce our 1/4 upper side rails PASD's from 39 to 30 by November 1, 2025	1. 29 new high low beds (without rails) have been ordered and are awaiting arrival by April 30, 2025. 2. A PASD informative brochure will be given at all new residents on admission and reviewed at the 6 week care conferences by the registered staff. 3. 1 audit for PASD side rails will take place monthly by the first Friday of the month by the care plan nurse. 4. Surge education for PASDs to be completed by all staff by April 1, 2025. QI will audit this by April 30, 2025. Any staff with outstanding courses will be contacted Via email to complete.	1. Intervention Ongoing 2. As of March 2025, upper 1/4 bed rails are not being offered. Education/information is still available in the admission package 3. Intervention Ongoing 4. Intervention Ongoing
Restorative Care Philosophy Annual	The restorative program will launch an outdoor	1. Volunteer coordinator to recruit volunteers for	1. 7 volunteers have been selected from Mount

Program Evaluation	walking program for our residents from the months of April to October 2025. (Day of the week and frequency during those weeks are weather dependent.)	the outdoor walking program. This will also increase community involvement (through recruitment, social media etc) 2. Implement new outdoor walking program to the activity calendar by April 2025 (weather permitting) 3. Any feedback from residents that the program is promoting physical movement, cognitive stimulation and social interactions at the resident council meeting. 4. Any feedback from the volunteers will be reviewed at the resident council meetings.	Brydges 2. Intervention Ongoing 3. Intervention Ongoing 4. Intervention Ongoing
Skin & Wound Management Annual Program Evaluation	To reduce the Worsened Stage 2 to 4 Pressure Ulcer CIHI indicator by 10% from 2.3% to 2% or less by Q2 2025	1. The Referral to Nutrition Services (for residents with new or deteriorating wounds) will be assessed and responded to within a 7 day period by the dietician. 2. Skin and Wound education courses from Wounds Canada will be completed by the skin and wound lead, 5 registered staff and 20 PSWs from March to November 2025 3. QI lead/Delegate to assess MOMO bedsensor reports to analyze and audit turning and repositioning schedules on Cedar Grove monthly from January to December	Interventions Ongoing

		2025 4. Replace 33 mattresses (to therapeutic mattresses) by April 202	
Staffing Plan Annual Program Evaluation	To maintain and establish affinitions with community colleges and universities to recruit PSW's and registered staff. This is in anticipation for increased requirements of the addition of 32 beds in 2025.	1. To continue to accept clinical placements through community colleges and universities 2. Start a contract with TRIOs college to offer a hybrid PSW program. Theory will be online. Labs will be at Sprucedale; along with their placement hours. Program will start March 24, 2025 3. Continue to advertise postings on “indeed.” 4. Utilizing Sai from KL for recruitment.	Interventions Ongoing
Training & Orientation Annual Program Evaluation	All new employees will have the orientation package (including surge learning) complete in 2025.	1. Education lead to run an education summary report on surge with every new hire/student to ensure all items are completed prior to starting. 2. General orientation checklist will be returned after the first orientation day. 3. The department orientation checklist will be completed and handed in by their last orientation shift to their supervisor. 4. All department heads will be educated on the expectations surrounding the orientation package.	1. Intervention Ongoing 2. Intervention Ongoing 3. Intervention Ongoing 4. Completed January 14, 2025