| Annual Program Evaluations 2024 | Department | Goals | Actionable items/change ideas (3-4) | Process Measures (how to follow up on the action that was done) | Accomplishments |
|---|---|---|---|---|---|
| Continence | | 1. 1/4ly Interdisciplinary Continence Care Meetings (Jessica & Nicole-Prevail) to discuss specific cases, challenges & ongoing improvement & obtain Medline Reports consistently | 1. Commitment to establish routine meetings Monitor documentation for new/ongoing challenges to be reviewed Actively engage interdisciplinary team Motivate Continence Care Committee & utilize resources (Jessica Armstrong) for Best Practice & review Medline Reports | 1. Evidence of 1/4ly Continence Care Meeting Minutes & Summary Report from Prevail Rep (Jessica/Nicole) | Quarterly meetings were held January 11, April 24, July 12 & September 17, 2024. On October 24, 2024, Nicole Elston came in for on the spot training for PSW staff.<br>Weekly review of surplus bags usage & adjust daily needs as indicated occurred on Wednesdays.<br>Monthly audits of Continence Product orders to ensure appropriate product sizes and amounts are obtained was completed at the end of the month as well as on an as needed basis.<br>Skin and wound meetings took place regularly on January 9, February 20, March 12, April 11, September 18, October 30, November 27 & December 12 . Any active skin concerns were reviewed with the listed parties during this meeting. In 2024 Sprucedale introduced the skin and wound app to track wounds in the home. Momo bed sense was started on November 26, 2024 to improve skin integrity.<br>The skin and wound app has been a helpful tool to track and help decrease skin impairments. Referrals are sent by registered staff to the dietitian and the skin and wound nurse if there are any concerns with deteriorating wounds. In November 2024, a skin and wound tracking sheet was created as a monitoring and communication tool for the skin and wound nurse, care plan nurse, dietitian as well as QI lead. This tool has had positive feedback during every skin and wound meeting.<br>Nanosalv education was in October 2024. This is a catalytic enzyme cream that helps speed wound healing. This cream has shown a positive effect specifically with MASD's and ulcers.<br>TruLu toilet monitoring system was implemented in early 2024. Unfortunately this diagnostic tool has shown minimal impact on care.<br>Education surrounding incontinence care was given to all staff on surge learning in August 2024 (Medical Mart Continence, MASD Dermatitis, Skin care - Remedy, Continence Care Management Program Annual Retraining |
| | | 2. Accurately capture Continence Care needs & products utilized at Sprucedale Care Centre-review at 1/4ly Care Conferences-according to RAI Schedule | 2. Weekly review of surplus bags usage & adjust daily needs as indicated<br>- Daily review of Continence Product referrals to ensure appropriate product and amount assigned to residents<br>- Monthly audit of Continence Product orders to ensure appropriate product sizes and amounts are obtained<br>- Monitor efficacy of Continence Products through Resident, staff & Family feedback during 1/4ly Care Conferences | 2. Consistent ordering & stock supply based on Resident care needs | |

| Annual Program Evaluations | Department | Goals | Actionable items/change ideas (3-4) | Process Measures (how to follow up on the action that was done) | Accomplishments |
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| | | 3. Improve skin integrity with appropriate use of appropriate products- review as needed and at 1/4ly meetings in collaboration with Skin & Wound Lead RN | 3.Weekly review Skin & Wound App trends in collaboration with Skin & Wound Lead RN<br>Observe feedback from Interdisciplinary team for specific concerns<br>Communicate with Resident & Family at 1/4ly Care Conferences condition of skin integrity<br>Engage Continence Care Committee at meetings to review concerns | 3. Decreased skin impairment as observed in Skin & Wound App in collaboration with Skin & Wound Lead RN | Continence Care Management Program Annual Retraining and Reflection : A Module for Direct Care Staff)<br>Launched REMEDY skin care line September 17 & 30th. Positive feedback from all home areas. |
| Emergency Department Transfers | Nursing | 1. Decrease number of non-essential emergency department transfers from 7 to 5, or 29% | 1. Decrease number of non-essential emergency department transfers by ongoing focused assessments, SBAR communication & early identification of health challenges/episodes in LTC. | 1. Utilize Insights via PCC to monitor frequency of Emergency Department Transfers | Sprucedale successfully met our goal for 2024. We decreased the number of non-essential emergency room transfers from 18.4% in January to 13.7 in April and 13.2% in July.<br>Change idea 1 - Decrease number of non-essential emergency department transfers by ongoing focused assessments, SBAR communication & early identification of health challenges/episodes in LTC: Education was given by the management team during the registered staff meetings |

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| | | | 2. Ongoing communication with Resident & Family re: health status concerns or condition changes in order to make informed health related decisions | 2. Communication with Resident and Family at 1/4ly Care Conferences for ongoing feedback | on January 24, February 27, April 11, May 8, June 24, September 4 & November 13.<br>Change idea 2 - Ongoing communication with Resident & Family re: health status concerns or condition changes in order to make informed health related decisions: This is reviewed at the quarterly care conferences as well as on an as needed basis depending on acuity of the resident.<br>Change idea 3 - Utilization of Sprucedale Care Centre Resource Binder for ongoing support & clinical decision making: Implementation of resource binder will take place in 2025.<br>Change idea 4 - Interdisciplinary approach to Resident health challenges & goals: This is reviewed at the quarterly care conferences as well as on an as needed basis depending on acuity of the resident. |
| | | | 3. Utilization of Sprucedale Care Centre Resource Binder for ongoing support & clinical decision making | | |
| | | | 4. Interdisciplinary approach to Resident health challenges & goals | | |
| Annual Program Evaluations | Department | Goals | Actionable items/change ideas (3-4) | Process Measures (how to follow up on the action that was done) | Accomplishments |
| Emergency Drug Supply and Management | Nursing | 1. To reduce medication incidents from 72 incidents in 2023 to 54 medication incidents for 2024. | 1. DOC to review each medication incident with the individual Registered staff and provide education opportunities for improvement. | Monthly medication tracker and Silver Fox portal | We met our goal for 2024 to reduce the number of medication incidents. We have had 41 medication errors in 2024. In 2024, the DOC reviewed each medication incident with the registered staff and also provided education opportunities. The DOC continued to review the monthly tracker and the silver fox portal for patterns. These items were reviewed at our registered staff meetings. These meetings took place on January 24, February 27, April 11, May 8, June 24, September 4 & November 13. Education was also given by the management team during the registered staff meetings. |
| | | | 2. DOC to review monthly tracker and Silver Fox portal for patterns with Registered staff. | | |
| | | | 3. For Registered staff who have repeat med incidents will complete a medication administration practice reflection checklist. | | |
| | | | 4. Summary of medication incidents will be reviewed at the Registered staff meetings. | | |
| Annual Program Evaluations | Department | Goals | Actionable items/change ideas (3-4) | Process Measures (how to follow up on the action that was done) | Accomplishments |

| Falls Prevention | Nursing | 1. To decrease overall falls by approx 20% from 21.3% in Q2 2023 to 17.0% or less by Q2 2024. | 1. PT continues to track monthly falls with location and time of falls<br>2. focus on monitoring residents at times where falls have increased which is 6-10pm. BSO students to monitor high risk for fall residents during their shift by checking on these residents more frequently. Implement intentional rounds from 2000-2200hr<br>3. working with RNAO best practice falls and post fall assessment which includes post fall huddles.<br>4. continue to review falls monthly with falls meeting | % has fallen CIHI indicator for Q2 2024. | - PT reviews the risk management portal for falls from the previous month that occurred in the home within the first week of the following month. This information is forwarded to the DOC and QI Lead to discuss/review in the monthly falls prevention meetings.<br>- The BSO binder at reception is reviewed every evening shift by the BSO staff prior to starting their shift. This binder is updated on a weekly and PRN basis depending on the high risk observations by the BSO nurse. It was observed in the falls prevention meetings that this was effective.<br>- When completing a falls risk management on point click care the RNAO falls assessment is automatically generated. In this assessment there is a section for post fall huddles to be completed by the registered staff who opens the risk management.<br>- The falls monthly meetings took place January/February combined on February 2, March 17, April 4, June 27, July & August 8, September 12, October 17, November 17 & December 17, 2024. |
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| Annual Program Evaluations | Department | Goals | Actionable items/change ideas (3-4) | Process Measures (how to follow up on the action that was done) | Accomplishments |
| Infection Prevention and Control | Nursing/IPAC | 1. To reduce wound infections from 13 in 2023 by 20% (10) in 2024 2.<br>- To increase hand hygiene compliance from 86.4% in 2023 to 95% (10%) in 2024 | 1. Prevention- consult with skin and wound lead, continence lead, and Dietician (interdisciplinary approach)<br>2. Education for prevention and early identification by audit appropriate use of sling use in wheelchair, turning and repositioning, continence education<br>3. By June 2024 - Continue with RN Wound care lead to closely follow wounds in the home and consult with NSWOC as needed | Continued surveillance on PCC infection control portal Measure audit results monthly | -HH compliance: 194 total observations, increased from 86.4% in 2023 to 90.7% in 2024.<br>-Implemented new skin care line in Sept 2024. Continence education by Prevail provided in Oct 2024. Monthly skin and wound meetings were completed. NSWOC consult once a month and as needed for complex wounds. Medline provided education to registered staff June 2024. Sling audit completed in Dec 2024. IPAC reviewed the importance of the 4 moments of hand hygiene upon hire of new staff. |

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| | | | 4. Education for registered staff on wounds/dressing changes, complete by June 2024 | | |
| | | | 5. Complete regular hand hygiene audits on a monthly basis | | |
| | | | 6. Provide on the spot education for missed opportunities | | |
| | | | 7. Provide education/games for world hand hygiene day May 5th | | |
| | | | 8. Continue posting the results of hand hygiene audits in the home and send via one call to staff | | |
| | | | 9. Complete 16 hand hygiene audits per month | | |

| Annual Program Evaluations | Department | Goals | Actionable items/change ideas (3-4) | Process Measures (how to follow up on the action that was done) | Accomplishments |
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| Medical Services | Nursing | 1. We already meet 100% with care conference so our goal is to maintain current services and work within the interdisciplinary team with each resident having a quarterly care conference in 2024 to review care and satisfaction with services received. | 1. Annual care conferences are scheduled for the year by ADOC and put into the PCC calendar. RAI coordinator schedules the quarterly care conferences and puts them into the PCC calendar. | UDA are audited to ensure all are completed. | We successfully maintained our current services and work within the interdisciplinary team on a scheduled basis. We also introduced move-in surveys at week 1 and week 6 to monitor family/resident satisfaction with the move in process of the home.<br>- The annual & quarterly care conferences are scheduled by the RAI coordinator. The ADOC communicates these dates to the families via email or phone depending on preference.<br>- UDA's are audited in collaboration with the RAI coordinator and quality lead on a weekly basis throughout the year. |
| | | | 2. Annual/quarterly care conference reviews with families and residents | | |
| Annual Program Evaluations | Department | Goals | Actionable items/change ideas (3-4) | Process Measures (how to follow up on the action that was done) | Accomplishments |

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| Nursing and Personal Services Support | Nursing | 1. To have PSWs complete 100%of daily POC charting each shift by March 2024. 2. To implement Companion charting by April 1, 2024 | 1. DOC to audit POC charting three times a week. speak to PSW individually who are not completing their charting each shift. Utilize support of clinical support services to teach and implement PCC companion charting. Registered staff to audit charting completion 1hr prior to end of shift. | 100% of charting completed each shift. | 1. DOC to audit POC charting three times a week. Speak to PSW individually who are not completing their charting each shift. - Implemented February 2024<br>2. Utilize support of clinical support services to teach and implement PCC companion charting. - April 1, 2024<br>3. Registered staff to audit charting completion 1hr prior to end of shift. - Goal unmet<br>DOC and QI lead continued to follow up on a regular basis surrounding incomplete PSW documentation. PCC companion charting continues in the home. Registered staff were unable to regularly audit the companion charting; therefore the task was taken over by QI lead. |
| Annual Program Evaluations | Department | Goals | Actionable items/change ideas (3-4) | Process Measures (how to follow up on the action that was done) | Accomplishments |
| Pain and Palliative | Nursing | 1. To decrease the number of residents who have Pain by 20% from 10% in Q2 2023 to 8% by Q2 2024 | 1. To fully implement RNAO Pain clinical pathways by March 2024<br>2. To have 2 more registered staff with CAPCE by Dec. 2024.<br>3. Educate all registered staff and PSWs on new clinical pathway by March 29, 2024<br>4. Pain train the trainer education on Jan. 18, 2024 by PCC and RNAO<br>5. Utilizing RNAO best practice lead - Jessica Brennan for implementation<br>6. Resume monthly palliative care meetings | Q2 2024 CIHI stats will be decreased by 20% | 2 Alexas were purchased for the palliative program on October 15, 2024. A diffuser was purchased along with oils on October 22, 2024. The family council approved the purchase of memory boards on November 18, 2024. 12 palliative nightgowns purchased on October 22, 2024. The palliative committee created a brochure for end of life information on September 25/24. This brochure is located in the palliative care towers. Kate Faria will have completed the fundamentals of palliative care by February 13, 2025. 8 staff attended all in palliative care training on November 20, 2024. Activation will be completing the palliative care wishes forms upon admission and post them in front of the chart. |
| Annual Program Evaluations | Department | Goals | Actionable items/change ideas (3-4) | Process Measures (how to follow up on the action that was done) | Accomplishments |
| Prevention of Abuse and Neglect | Nursing | 1. To continue to have 0% abuse cases reported for 2024 | 1. ED will be delivering live education with all staff annually and upon orientation. To be completed Dec. 31, 2024<br>2. Continue to investigate any resident concerns immediately | 100% staff educated and monitored through surge learning and live events. No abuse cases reported | We had no substantiated abuse reports in 2024. |

| | | | 3. Ensure everyone is aware of the whistle blowing protection | | |
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| Annual Program Evaluations | Department | Goals | Actionable items/change ideas (3-4) | Process Measures (how to follow up on the action that was done) | Accomplishments |
| Responsive/Expressive Behaviours | Nursing | 1. To use RMI behaviours tools 100% of the time quarterly and as needed. | 1. Educate registered staff on RMI assessments | Through continuous auditing to ensure behaviour assessments are completed as indicated. | In 2024, the RMI tools were used 100% quarterly and as needed. The use of these tools were monitored on a monthly basis by the RAI coordinator and Quality Lead. In 2024, the BSO lead attended an education course called "Person Centered Language" on March 8, 2024. 3 staff received their “train the trainer” GPA certificate on October 3, 2024. 10 staff were trained in GPA training. Sprucedale's BSO student program continues to be an asset to the home in managing out responsive behaviours that are exhibited in the evenings. The QI lead attended the Collaborative project - self assessment meeting November 1, 2024. The QI Lead & RAI coordinator attended the Palliative care workshop June 26 - 27. Olivia Frockladge (BSO) continues to provide on the spot training for BSO support. Kaye C, RN attended and obtained a PIECES program certificate on September 30, 2024. Sandra S, RPN also attended and obtained a PIECES certificate on March 28, 2024. BSO (Olivia Frockladge) plans to meet on each unit monthly in the morning and afternoons BSO support throughout 2025. BSO boards to explain responsive behaviours in the conference rooms are updated once a month and as needed. BSO virtual meetings have resumed in December 2024 and will continue on a quarterly basis.<br>Working on life stories for the residents in the home. Goal for January 1, 2025. These will be located in the chart. 3 referrals were sent in 2024 to the BRT for residents with responsive behaviours in the home. Discharged 1 resident to the BSTU in 2024. |
| | | 2. BSO leads to attend one BSO related education course in 2024 | 2. Monthly audits to ensure assessments are being completed | | |
| | | | 3. Education around the referral process to the BSO team | | |
| | | | 4. Improve communication with BSO students | | |
| Annual Program Evaluations | Department | Goals | Actionable items/change ideas (3-4) | Process Measures (how to follow up on the action that was done) | Accomplishments |

| Quality Improvement | Nursing | 1. Creation of Quality Improvement Lead position by May 2024<br>2. CQI meetings to be held Monthly | Hiring a QI lead will allow more opportunity and coordination for meetings and review of QIPS with this position will allow our Quality Indicators and initiatives to be communicated to family residents and staff. Prepare for new position In April October 25, 2024 Sprucedale Care Centre Sprucedale Care Centre Page 4 2024 when funding has been announced. CQI meeting schedule created now and has been shared with team members already. | We will have the position filled. by May 2024. To have 12 CQI meetings held for the year 2024 | - POC charting has greatly improved. 95% completion. 1-2 audits took place weekly; emails are sent out to staff with missing documentation.<br>- Physician order reference sheet has been completed last month and dispersed to the units<br>- Skin and wound tracker continues to be updated by QI Lead and Careplan nurse. This has been beneficial in increasing communication with skin and wound lead, keeping care plans up to date as well as dietitian.<br>- UDA completion for the rai scheduler and skin and wound continues to improve over the past few months<br>- A 6 week care conference information brochure is in the works. This will be beneficial when talking to families about wills, funeral arrangements and code status.<br>- Enhance Tub room décor to make a more home-like atmosphere - Committee meeting took place on November 18, 2024<br>-Hiring a QI lead gives us more opportunity and coordination for meetings and review of QIPS with this position will allow our Quality Indicators and initiatives to be communicated to family residents and staff. We prepared for a new position in April 2024. Quality Lead position was filled in August of 2024, by Kate Faria, RPN |
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| Annual Program Evaluations | Department | Goals | Actionable items/change ideas (3-4) | Process Measures (how to follow up on the action that was done) | Accomplishments |
| Restraint & PASD | Nursing | 1. To reduce PASD side rails use by 25% from 43 to 33 residents who by Dec. 2024 | 1. Process of attrition eliminate side rails on beds with all new admission<br>2. Education for staff and families on risk<br>3. Consult interdisciplinary team to eliminate current residents who have side rails<br>4. Continue to replace all beds that are not high-low beds | Monthly PASD tracking tool for each home area. | 1. Education is provided to families during the admission process; regarding the risks and benefits by DOC Jen Campbell.<br>2. Education to families regarding risk is initially provided upon admission to the home. During the quarterly care conferences the risks are again reviewed by the registered staff that is holding the care conference.<br>3. The interdisciplinary team is consulted on a quarterly and as needed basis to eliminate current residents who have side rails.<br>4. New high low beds are expected to arrive in early 2025. |
| Annual Program Evaluations | Department | Goals | Actionable items/change ideas (3-4) | Process Measures (how to follow up on the action that was done) | Accomplishments |

| Skin and Wound Management | Nursing | 1. To reduce the worsend Stage 2 to 4 pressure ulcer indicator by 20% from 4.8% in Q2 2023 to 3.8% or less by Q2 2024. | 1. All resident who have a sling left under them will be assessed by restorative for appropriateness.<br><br>2. Education to PSWs on how to properly remove and re-apply the sling<br><br>3. On the spot audits to determine if a resident has a sling left under them that shouldn't<br><br>4. List of residents who are assessed to have a sling left under them will be posted in each care conference room. Restorative will keep this list updated. | % Worsened Stage 2 to 4 Pressure ulcer Q2 CIHI indicator 2024. | We met our goal to reduce the worsened stage 2 to 4 pressure ulcers for Q2 2024. The QI score for Q2 2024 is 2.3% Residents who have a sling under them are assessed by the restorative team on admission and an as needed basis for appropriateness. The sling list for what residents may have a sling underneath them is posted in the conference room and updated monthly. Education was given to the PSW staff in December, 2024 on how to properly re-apply and remove slings from under residents. The residents who have slings left underneath them have been evaluated by restorative and do not meet the criteria to be removed. In 2024 Sprucedale introduced the skin and wound app to track wounds in the home. Momo bed sense was started on November 26, 2024 to improve skin integrity.<br>The skin and wound app has been a helpful tool to track and help decrease skin impairments. Referrals are sent by registered staff to the dietitian and the skin and wound nurse if there are any concerns with deteriorating wounds. In November 2024, a skin and wound tracking sheet was created as a monitoring and communication tool for the skin and wound nurse, care plan nurse, dietitian as well as QI lead. This tool has had positive feedback during every skin and wound meeting.<br>Nanosalv education was in October 2024. This is a catalytic enzyme cream that helps speed wound healing. This cream has shown a positive effect specifically with MASD's and ulcers.<br>Education surrounding incontinence care was given to all staff on surge learning in August 2024 (Medical Mart Continence, MASD Dermatitis, Skin care - Remedy, Continence Care Management Program Annual Retraining and Reflection : A Module for Direct Care Staff)<br>Sprucedale launched REMEDY skin care line September 17 & 30th. Positive feedback from all home areas.<br>We continued to use the NSWOC nurse on an as needed basis as well as meeting monthly with the dietitian.<br>Implemented a new skin and wound lead on October 16, 2024 and they attended 5 courses in 2024.<br>DOC submitted 3 high intensity workbooks to the ministry of health for 2024.<br>30 top slider sheets purchased to assist with positioning residents to reduce skin breakdown in December 2024. |
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| Annual Program Evaluations | Department | Goals | Actionable items/change ideas (3-4) | Process Measures (how to follow up on the action that was done) | Accomplishments |
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| Staffing Plan | Nursing | 1. To increase direct care hours from 3.15 to 3. 42 hours by March 31, 2024 | 1. Await nursing budget from RMI to add additional hours.<br>2. Look to see if part time or full time lines can be created.<br>3. Advertise on indeed for PSW positions.<br>4. Continue to interview and fill vacant nursing positions.<br>5. Continue to accept PSW students for placement hours. | Staff report to determine hours of direct care no vacant positions schedule always posted with all shifts filled | We averaged 3.93 hours for the last quarter of 2024. We continued to advertise on indeed for PSW's as well as continued interviews to fill vacant positions. We made the QP (PSW) shift full time on October 21, 2024. We changed the quality care aide position to a full time PSW position on October 21,2024. Quality lead position was filled in August 2024. Utilized the LTC prep student placement coordinating fund for 2024. We also continued to accept PSW student programs to recruit new staff. Sprucedale utilized PSW return of service for helping recruit staff. |
| Annual Program Evaluations | Department | Goals | Actionable items/change ideas (3-4) | Process Measures (how to follow up on the action that was done) | Accomplishments |
| Training & Orientation | Nursing | 1. Introduce the new RMI education process in Surge learning as previously we did annually. RMI does monthly. | 1. New education coordinator position.  Will know once ministry functing announced (APRIL 2024)<br>2. Audit monthly STAFF MONTHLY SURGE EDUCATION,ensure staff are completing 100% MONTHLY SURGE LEARNING AS GOAL STATED ABOVE. | By 3rd week of every month positive approach and remind staff by 3rd month, if still not complete by 6 month. written warning and by the 9th month they are booked off the floor until complete. | The education coordinator position was filled in August 2024. Sprucedale also utilized LTC prep PSW coordinator funds for all students.<br>This audit was completed by the QI lead. Any outstanding deficits were addressed via email to the staff who did not complete their surge learning. |
| Annual Program Evaluations | Department | Goals | Actionable items/change ideas (3-4) | Process Measures (how to follow up on the action that was done) | Accomplishments |
| CIS Quarterly Evaluation | Nursing | 1. To have 4 or less CI<br>2. Continue to ensure registered staff are aware of the reporting requirements<br>3. That CI's are completed as per MOH | 1. Continues with ensuring registered staff know the requirements of CI reporting in staff meetings and upon hire | 1. Registered staff being aware and communicating and concerns related to a CI | Completed. Given to RNs upon hire |

| Annual Program Evaluations | Department | Goals | Actionable items/change ideas (3-4) | Process Measures (how to follow up on the action that was done) | Accomplishments |
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| Recreation, Social and Spiritual Services | Programs | 1. To improve and increase male/men's programming by including a minimum of 1 men's program per month on the activity calendar | 1. Introduce programs to the calendar specific to men's programming ie: Men's breakfast, evening pubs, men's coffee break, reminiscing and/or games program | 1. Calendar will include at least 1 men's only program per month, survey the men after the program(s), complete program evaluations, discuss at Residents' Council | 1. Introduce programs to the calendar specific to men's programming ie: Men's breakfast, evening pubs, men's coffee break, reminiscing and/or games program. - February 2024<br>2. Plan & implement Volunteer Appreciation Special Event/Advertise for new volunteers at schools, newsletters, churches, Sprucedale Friends Facebook page & Just ask Strathroy. - this occurs on a 1/4ly basis<br>3. As well as the usual annual special events, introduce 4 new for the year such as<br>Mardi Gras February 12, 2024, Leap year dance Feb 29, 2024, Harvest fest October 25, 2024, Family Xmas photos November 2024, Family affair dinners June 10 & November 2024 & Volunteer appreciation April 18, 2024<br>Through the actionable items Sprucedale met our goal for recreation, social and spiritual services for 2024. We met our goal to improve male programming; we included men's breakfast, evening pubs, men's coffee break as well as reminiscing and/or games program. We met our goal by recruiting 4 new volunteers and were able to successfully retain them for a minimum of a year. We planned & implemented Volunteer Appreciation Special Event/Advertisement for new volunteers at schools, newsletters, churches, Sprucedale Friends Facebook page & Just ask Strathroy. We successfully introduced 4 new special events over the course of 2024. In addition to the special events we also introduced 4 new programs for the year. These included Leap year dance, Carnival, intergenerational day, Family Xmas photos, family affair dinners & volunteer appreciation |
| | | 2. To further develop our volunteer services team by recruiting 4 new volunteers and retaining them for a minimum of 1 year. | 2. Plan & implement Volunteer Appreciation Special Event/Advertise for new volunteers at schools, newsletters, churches, Sprucedale Friends Facebook page & Just ask Strathroy. | 2. An increase and retention of volunteers & services at the home | |
| | | 3. To introduce 4 new special events over the course of 2024 | 3. As well as the usual annual special events, introduce 4 new for the year such as Mardi Gras, Luau, Leap year dance, Carnival, intergenerational day, Family Xmas photos, family affair dinners, volunteer appreciation, variety show | 3. 4 new special events will be offered throughout the year, program evaluations will be completed, discussion and evaluation will be discussed at Residents' Council | |
| Annual Program Evaluations | Department | Goals | Actionable items/change ideas (3-4) | Process Measures (how to follow up on the action that was done) | Accomplishments |

<table>
<tr><td>Resident Council Annual Evaluation</td><td>Programs/ Recreation</td><td>1. Implement the required RMI (ORCA) content in to the Council Agenda</td><td>1. Stats from previous month's activity calendar will be shared with the Council and added to the Agenda, evaluate 1 program per month, include required ORCA content in monthly agenda ie: IPAC, Emergency info etc, trend & analyze complaints 1/4ly.</td><td>1. Information will be added to the minutes and posted in the home, a new agenda format will be initiated in accordance with the suggestions of ORCA</td><td>We implemented the required RMI (ORCA) content in the council agenda in January 2024. We had meetings on each unit during an outbreak. This increased the number of meetings for 2024. During an outbreak; we had 3 council meetings and then the meeting minutes would be combined. We divided the dining enhancement and resident council meetings into separate meetings and gave them more time for each section. Once the meetings were divided the residents felt less rushed. The residents do not like the numbers/STATS included in the meetings. They report this causes confusion.</td></tr>
<tr><th>Annual Program Evaluations</th><th>Department</th><th>Goals</th><th>Actionable items/change ideas (3-4)</th><th>Process Measures (how to follow up on the action that was done)</th><th>Accomplishments</th></tr>
<tr><td rowspan="2">Restorative Phlolophy and Approaches</td><td rowspan="2">Programs/ Recreation</td><td>1. To improve on the Hallwalkers program</td><td>1. Ensure Hallwalkers Programs takes place 3 times per week, keep list of participants up to date and available for all staff, list program on activity calendar, implement program into staff's daily routine.</td><td>1. Increased resident participation in Hallwalkers program, Residents will become stronger and improve gait and distance, monthly Welbi reports</td><td rowspan="2">In 2024, the hall walkers program showed more consistency. The hallwalkers program takes place on Mondays, Tuesday and Thursdays. The lists of the residents who are on the hallwalkers program are kept in the conference room and were updated on an as needed basis. Nursing staff reviewed these lists prior to starting their shift to help ensure those residents were available for the walking program that day. Deep cleaning was on June 25, 2024. A schedule was implemented for the night shift to implement regular mobility equipment cleaning. The CIHI has fallen indicator for Q2 2024 is 18.9% Our indicator for Q2 2023 was 21.3%; therefore we met our goal of reducing falls by 10% for 2024.</td></tr>
<tr><td>2. To ensure regular cleaning and upkeep of resident mobility equipment</td><td>2. Ensure maintenance binders are available to all staff for referral, weekly communication with the mobility vendor (Action Health Care), communicate with ADP authorizer for any mobility equipment needs, schedule deep steam clean of mobility equipment with Action Health Care twice annually (every 6 months)</td><td>2. Documentation of cleaning & repair schedule of all mobility equipment, checking mobility repair binder on a weekly basis, equipment will be in better working condition</td></tr>
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| | | 3. To reduce resident falls by 10% | 3. Results from improved Hallwalkers program, collaborate with the Nursing Dept. during fall prevention meetings, update the falling star program to alert staff at risk residents, review the bi-hourly (afternoons 6:00 pm-10:00 pm) fall rate per home area | 3. PT will provide monthly report of falls with emphasis on bi-hourly fall rate & possible interventions to reduce future risk of falls. | |
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| Annual Program Evaluations | Department | Goals | Actionable items/change ideas (3-4) | Process Measures (how to follow up on the action that was done) | Accomplishments |
| Dietary Services, nutrirtion and hydration | Dietary | 1. PSW Staff education for correct POC intake documentation, completed accurately and fully. | 1. Educate staff through eating assistance provided by Orange Lily | 1. Review the residents fluid intake quarterly according to PCC to reference the increases in fluid amts. | Changed water glass back to 200 ml since the residents did not like the 250 ml glasses. August 2024<br>Orange lilly came 13th of November for educational purposes (Kelsey Sobkowich only)<br>Responsive groups new menus were implemented in October 2024 |
| | | 2. Changed water glass back to 200 ml since the residents did not like the 250 ml glasses. | 2. Changed water glass back to 200 ml since the residents did not like the 250 ml glasses. | 2. Review POC to ensure complete and accurate recording. | |
| | | 3. Resident Satisfaction Survey measured 73% commented that they enjoy meal times. | 3.We have implemented the new Responsive's menus Nov 2023 and I am making changes after every dining support meeting as to what the residents are requesting. Ongoing updates and changes as per residents. | | |
| Annual Program Evaluations | Department | Goals | Actionable items/change ideas (3-4) | Process Measures (how to follow up on the action that was done) | Accomplishments |
| Emergency Plan | Environmental | 1. To increase our relationships with the community, and to increase knowledge with the RMI processes | 1. To join the Community emergency management committee, Joining the excellence program with RMI | Will measure through outcomes at the end of this year | The man (Don McLean) who runs the program is on leave. He is expected to return at the end of the year and will follow up with Sprucedale in January 2025. Jason Chabot (fire prevention office/emergency services in Starthroy) was utilized in the interim. Emergency plans were listed on Surge learning for all staff to review on a yearly basis. 6 Emergency drills were run per month. We have gained substantial knowledge about the RMI process through the year 2024. |

| Annual Program Evaluations | Department | Goals | Actionable items/change ideas (3-4) | Process Measures (how to follow up on the action that was done) | Accomplishments |
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| Health and Safety Networking | Environmental | 1. Increase knowledge and networking | 1. Joining the Emergency Management committee locally for Strathroy.<br>2. Eye wash stations to be completed in all areas. (20 min upward flush) permanent.<br>3. Join RMI Excellence program | To increase knowledge and process for 2024 | 1.Joining the Emergency Management committee locally for Strathroy. Unfortunately this is delayed by community partner<br>2. Eye wash stations to be completed in all areas. (20 min upward flush) permanent. - This was installed in the Kitchen in June 2024<br>3. Join RMI Excellence program - Unfortunately this is delayed by community partner<br>- addition of brighter lights in the parking lot out back - Completed July 19, 2024<br>-Stairs to lower level updated July 19/24<br>-Eye wash station on lower level June 2024<br>-Signs to remind staff to lock doors Completed May 2024<br>-New convex mirror Completed Maple May 2024<br>-Lifts, slings, shower chair to be purchased before March 31, 2024 (Completed February 2024) |
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