Equity | Equitable | Optional Indicator

	Last Year		This Year		
Indicator #7	**CB**	**100**	**94.76**	**--**	**100**
Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education (Au Chateau)	Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

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

One course will be added to Surge Learning platform for all staff to complete this year. The course will focus on Cultural Competence in Health Care and Truth & Reconciliation Commission of Canada.

Process measure

- percentage of staff who complete the course

Target for process measure

- 100% of active staff by the online education deadline set by the administration

Lessons Learned

We achieved several successes with this change idea, including increased staff awareness of the historical impacts outlined by the Truth and Reconciliation Commission of Canada and enhanced cultural sensitivity in resident□centred care. Completion rates for the module also represent a positive outcome.
Challenges remain, particularly the limited opportunity for debriefing or guided discussion after sensitive content when training is delivered exclusively online. Without reflection and practical application, learning may not consistently translate into behaviour change, and some staff may view online modules as compliance□focused rather than meaningful.
Going forward, the Home will explore additional ways to reinforce key concepts through follow□up activities and team discussions to support sustained learning and cultural safety.

Comment

For future improvement, the Home will move beyond one‐time training by implementing cultural competence education as an ongoing initiative rather than a single annual course. We also plan to expand training to include additional topics relevant to equity, diversity, and inclusion, and continue working toward embedding culturally respectful language within policies and documentation standards.

Experience | Patient-centred | Custom Indicator

	Last Year		This Year		
Indicator #1 Percentage of families who responded positively to the statement "My loved one can express their opinion without fear of consequences" (Au Chateau)	**60.50** Performance (2025/26)	**69.60** Target (2025/26)	**81.40** Performance (2026/27)	**--** Percentage Improvement (2026/27)	**NA** Target (2026/27)

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

We are transitioning our family survey from the SurveyMonkey platform to Google Forms and increasing the distribution frequency from once a year to four times a year to enhance family participation and response rates.

Process measure

- percentages of completed surveys that respond positively to the statement "my loved one can express their opinion without fear of consequences"

Target for process measure

- 69.6% of responses will have responded always or usually to the statement "my loved one can express their opinion without fear of consequences"

Lessons Learned

We achieved several successes related to this indicator over the past year. Family engagement strengthened significantly, with increased participation in the experience survey and greater openness during discussions within the Home. The transition to Google Forms proved highly effective, offering a more user‐friendly format and providing the survey in both English and French, which helped reduce barriers and support broader accessibility.
This change idea remains in progress, as only one survey cycle was completed during the reporting period, rather than the four cycles originally planned. Nonetheless, the initial results demonstrate strong potential, and the foundations established this year will support more frequent and structured survey distribution moving forward.

Comment

For this indicator, we analyzed the proportion of respondents who selected“Always” or “Usually” to the question: “Do you feel that your loved one can express his/her opinion without fear of consequences?” Results from both the French and English versions of the survey were included. The overall score represents the mean of the two survey groups. There were 60 French‐language respondents and 71 English‐language respondents, for a total of 131 participants.

Indicator #2

Percentage of family members who respond positively (9 or 10 out of 10) to the question "What number would you rate on how well the staff listen to your loved one?" (Au Chateau)

Last Year		This Year		
47.22	**54.35**	**47.20**	**--**	**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

We are transitioning our family survey from the SurveyMonkey platform to Google Forms and increasing the distribution frequency from once a year to four times a year to enhance family participation and response rates.

Process measure

- percentage of family members that responded positively (9/10 or 10/10) on the following question " What number would you rate on how well the staff listen to your loved ones?"

Target for process measure

- 54.35% of respondents will rate staff a 9 or 10/10 on how well they listen to their loved ones.

Lessons Learned

Although we did not meet our target from the previous year, we achieved several meaningful successes related to this indicator. Family engagement strengthened, demonstrated by increased participation in the survey and greater openness during discussions within the Home. The transition to Google Forms improved accessibility and ease of use, with the survey available in both English and French, supporting broader participation. This change initiative remains in progress, as only two survey cycle was completed during the reporting period rather than the four cycles outlined in the original change proposal.

Comment

This indicator was measured using the mean score of respondents who selected 9/10 or 10/10 on the French and English surveys. As in the previous year, both response options were included to ensure an appropriate and consistent comparison over time. To support future improvement, we will continue to increase survey frequency, enhance accessibility and engagement through user-friendly formats, and regularly monitor and track results to identify trends and guide ongoing quality improvement efforts.

Experience | Patient-centred | Optional Indicator

	Last Year		This Year		
Indicator #5 Percentage of residents responding positively to: "What number would you use to rate how well the staff listen to you?" (Au Chateau)	**61.29** Performance (2025/26)	**70.50** Target (2025/26)	**54.17** Performance (2026/27)	**-11.62%** Percentage Improvement (2026/27)	**70** Target (2026/27)

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

To improve the percentage of residents responding positively to the question "What number would you use to rate how well the staff listen to you?", we will implement a structured approach to increase participation, accuracy, and engagement in survey responses. Key strategies include: Dividing the survey into smaller, more manageable sections and administering it at least four times per year to reduce fatigue and improve compliance. Engaging the Family Council and Resident Council to assist residents in completing the surveys, ensuring they understand the importance of their feedback in improving care. - Incorporating the Resident Council in the process by having members answer 1-2 survey questions at every meeting, with their responses included in the overall survey results. Addressing concerns about survey effectiveness by reinforcing how responses lead to meaningful changes, helping to reduce the stigma and skepticism around survey participation. Enhancing accessibility and comprehension by simplifying survey language, offering verbal or assisted response options, and ensuring residents maintain attention throughout the process. Making survey sessions informal, brief, and on-the-go to promote a comfortable and stress-free environment for participation. By adopting these approaches, we anticipate higher resident engagement, improved accuracy in responses, and a greater sense of empowerment among residents in shaping their care experience.

Process measure

- excel work sheet with answered questions-average percentage responses

Target for process measure

- 70.5% of resident who respond with a 9/10 or 10/10 for the question "What number would you use to rate how well the staff listen to you?"

Lessons Learned

We achieved improved accuracy in resident responses and supported more meaningful engagement by offering the survey in both English and French. This bilingual format helped ensure residents could participate in the language in which they are most comfortable, contributing to more reliable feedback and a better understanding of resident perspectives.
However, overall participation numbers did not significantly increase this year. Even with shorter, more frequent surveys, some residents may experience reduced interest over time, and maintaining consistent participation across the resident population remains challenging. Moving forward, we will continue exploring strategies to promote engagement while balancing survey frequency with residents' capacity and willingness to participate.

Comment

For this indicator, responses of 9/10 and 10/10 were considered positive results. By enhancing transparency, standardizing processes, and reinforcing staff communication practices, the Home can continue to improve resident engagement, support greater accuracy in survey responses, and strengthen a culture in which residents feel genuinely heard, respected, and comfortable expressing their perspectives.

Indicator #6

Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences". (Au Chateau)

Last Year		This Year		
84.38	**97.05**	**62.50**	**-25.93%**	**84**
Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

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

To improve the percentage of residents responding positively to the statement "I can express my opinion without fear of consequences." we will implement a structured approach to increase participation, accuracy, and engagement in survey responses. Key strategies include: Dividing the survey into smaller, more manageable sections and administering it at least four times per year to reduce fatigue and improve compliance. Engaging the Family Council and Resident Council to assist residents in completing the surveys, ensuring they understand the importance of their feedback in improving care. - Incorporating the Resident Council in the process by having members answer 1-2 survey questions at every meeting, with their responses included in the overall survey results. Addressing concerns about survey effectiveness by reinforcing how responses lead to meaningful changes, helping to reduce the stigma and skepticism around survey participation. Enhancing accessibility and comprehension by simplifying survey language, offering verbal or assisted response options, and ensuring residents maintain attention throughout the process. Making survey sessions informal, brief, and on-the-go to promote a comfortable and stress-free environment for participation. By adopting these approaches, we anticipate higher resident engagement, improved accuracy in responses, and a greater sense of empowerment among residents in shaping their care experience.

Process measure

- excel work sheet with answered questions-average percentage responses

Target for process measure

- 97.05% of resident who respond with a usually/ always response for the statement "I can express my opinion without fear of consequences".

Lessons Learned

Our successes for this change idea include improved resident engagement among those who participated, enhanced accessibility through a bilingual survey format, and stronger involvement from Resident and Family Councils in promoting feedback opportunities. These elements have contributed to more meaningful input and a clearer understanding of resident perspectives.
The primary challenge for this change idea has been maintaining consistency in survey administration, as the survey was not offered four times during the year as originally planned. Ensuring regular distribution remains an area for improvement to strengthen trend analysis and support more frequent resident feedback.

Comment

We combined the French and English survey results and calculated this year's performance using the mean of respondents who selected "Always" or "Most of the time." This approach aligns with previous methodology and supports consistency in year□over□year comparison.
Looking ahead, plans for future improvement include strengthening our culture of psychological safety by reinforcing the Home's zero□tolerance policy for retaliation and continuing to empower residents to express their views openly and confidently. Ongoing engagement with the Resident Council remains a key priority to support resident advocacy, encourage meaningful dialogue, and ensure residents' perspectives continue to inform quality improvement initiatives

Safety | Safe | Optional Indicator

Indicator #3

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

Last Year		This Year		
17.29	**15.55**	**23.20**	**-34.18%**	**17**
Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

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

We are transitioning to the RNAO Clinical Pathway, integrated within the PCC EHR, to enhance our assessment model. This updated approach includes a Falls Risk Assessment at admission, quarterly, and annually. Previously, our fall risk assessment was not part of the admission interview and was lengthy and complex, making it less efficient.

Process measure

- The effectiveness of the Falls Risk Assessment will be measured by tracking fall rates within 30 days of assessment. 1. Residents Who Do Not Fall – The percentage of residents who remain fall-free post-assessment, with a goal to increase this number. 2. Residents Who Do Fall – The percentage of residents who experience a fall within 30 days, aiming to reduce this rate through effective interventions. Data Collection & Analysis: Fall incidents will be tracked in PCC, with trends analyzed by the Clinical Leadership Team to assess pre- and post-assessment impact. A decline in falls will indicate successful risk assessment and intervention strategies.

Target for process measure

- Our target is to achieve a 10% annual reduction in falls as part of our ongoing efforts to improve resident safety and the effectiveness of our fall prevention strategies.

Lessons Learned

We have implemented the RNAO Clinical Pathways in several areas of practice, including the adoption of a new Falls Risk Assessment. As with any change, implementation required adjustment from the team; however, the transition has resulted in more consistent, accurate, and efficient completion of fall□risk assessments. The introduction of this evidence□based tool has significantly reduced the time required to complete assessments while supporting improved standardization and clinical decision□making.

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

introducing a new fall prevention tool, the personal alarm, while reducing the use of another fall prevention tool, the sensor pad in bed.

Process measure

- # of residents switched over to the new fall prevention tool

Target for process measure

- 10% reduction of residents with falls in the last 30 days

Lessons Learned

The introduction of the new fall□prevention personal alarm has presented some challenges, as many residents remove the device when it is clipped to their clothing. As a result, the bed□based sensor pad continues to be the most consistently used tool within the Home. We remain committed to gradually reducing reliance on sensor pads by continuing to introduce and trial the personal alarm with residents where appropriate, while monitoring effectiveness and identifying strategies to support improved tolerance and adoption

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

The change idea is the implementation of a dehydration screener tool for new admissions and post-fall assessments to identify residents at risk of dehydration and apply timely hydration interventions to reduce dehydration-related falls.

Process measure

- Our process measure for this change idea focuses on tracking the implementation and impact of the dehydration screener tool on fall reduction. Specifically, we aim to achieve a 5% reduction in the number of residents who have fallen in the last 30 days due to dehydration-related causes. To monitor progress, we will: Measure baseline data: Record the number of residents who have fallen in the last 30 days before implementing the dehydration screener. Track implementation: Ensure the dehydration screener is consistently used for new admissions and post-fall assessments. Evaluate outcomes: Compare the number of falls over time to assess whether early identification and hydration interventions are reducing dehydration-related falls. By analyzing these factors, we can determine the effectiveness of this intervention and make adjustments as needed to further enhance resident safety.

Target for process measure

- Our goal for the process measure is to achieve a 5% reduction in the number of residents who have experienced a fall in the last 30 days.

Lessons Learned

This change idea was partially implemented through the introduction of a dehydration screening tool for all new admissions. In addition, dehydration risk is now identified through the RNAO Post□Fall Assessment, which prompts Registered Nurses to initiate timely hydration interventions when risk factors are detected.
The change initiative remains in progress, as we continue working toward earlier identification of residents at risk of dehydration before a fall occurs, with the goal of reducing dehydration□related falls proactively. Ongoing efforts will focus on expanding routine screening, strengthening early□intervention practices, and integrating hydration monitoring more consistently into daily care.

Comment

There are several factors that may explain why the percentage of long□term care residents who experienced a fall within 30 days of their assessment is higher this year compared to last year. We continue to see an increase in the frailty and clinical complexity of new admissions, many of whom enter long□term care with multiple comorbidities, mobility limitations, and cognitive impairment. We also note a rise in admissions among older adults aged 85 and above a group that is inherently at higher risk for falls due to age□related changes in balance, strength, and endurance.
For future improvement, the Home will conduct a more detailed analysis of resident□level data to better identify those at highest risk for falls. This will include reviewing the location and timing of falls to identify potential environmental contributors, and examining staffing patterns to determine whether any trends correlate with the occurrence of falls. These insights will inform targeted interventions and support continued enhancement of our fall prevention strategies.

Indicator #4

Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment (Au Chateau)

Last Year		This Year		
32.08	**28.87**	**31.58**	**1.56%**	**30.50**
Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

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

Support staff training in Positive Approach to Care (PAC) lead by NEBSO external partners. Increase our trained staff pool by 10% yearly.

Process measure

- # of staff successfully trained in PAC

Target for process measure

- increase our staff pool by 10% yearly

Lessons Learned

With this change idea in progress, we have seen improvements in staff confidence and competence, particularly through increased use of PAC (Positive Approach to Care) communication strategies, de□escalation techniques, and validation approaches. Strengthening these skills supports non□pharmacological interventions and contributes to a reduction in the use of as□needed antipsychotic medications. Staff are also demonstrating improved recognition of triggers and early signs of escalating behaviours, allowing for more timely and person□centred responses.
Key challenges include scheduling constraints and operational pressures, which make it difficult to consistently release staff for training while maintaining safe staffing levels. Balancing shift coverage with training opportunities remains an ongoing priority as we continue to expand staff participation in this initiative.

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

showcase our in depth quarterly analysis of each resident taking antipsychotic medication without the diagnosis of psychosis. Our Monitoring of Antipsychotics Usage in Dementia (MAUD) has been used since 2015. It has significantly reduced the use of such medication to treat dementia and dementia related behaviours.

Process measure

- the number of residents having medication reduced or removed as a result of our MAUD analysis the number of antipsychotic medication used regularly and prn as per Care Rx available data for our facility.

Target for process measure

- Maintain a low % of residents with dementia using antipsychotic medication to treat their dementia related BPSD.

Lessons Learned

Since its implementation in 2015, MAUD has provided robust quarterly oversight of antipsychotic prescribing practices for residents living with dementia but without psychosis. This process has supported safer prescribing practices, strengthened deprescribing efforts, and contributed to improved resident outcomes. To sustain these successes and address ongoing challenges, we continue to conduct quarterly resident reviews and reinforce deprescribing pathways, medication monitoring, and interdisciplinary communication.

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

weekly review of RAPS identified residents that do not meet the criteria for antipsychotic medication use to determine and confirm proper diagnosis.

Process measure

- Identification of residents who are wrongfully triggered.

Target for process measure

- reduction of 10% of triggered RAPS that identify residents with use of antipsychotic medication without a diagnosis of psychosis.

Lessons Learned

The review of RAPS is designed to identify residents who are prescribed antipsychotics without a confirmed diagnosis of psychosis. These weekly reviews help inform clinical decision‐making and support the reduction of inappropriate or prolonged antipsychotic use. This process strengthens medication safety, promotes adherence to best practices, and ensures that antipsychotic prescribing is aligned with residents' clinical needs.
Ongoing challenges include ensuring consistent and comprehensive behavioural data collection to support review decisions, as well as balancing deprescribing efforts with the need to manage behavioural risks effectively. Continued focus on documentation quality, interdisciplinary communication, and non‐pharmacological strategies will support the success of this change initiative

Change Idea #4 ☐ Implemented ☐ Not Implemented ☑ In Progress

To reduce the percentage of long-term care (LTC) residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment, the following change idea is proposed: Provide Front-Line Staff with a List of Upcoming Resident Assessments: Staff will be given a list of residents whose assessments are approaching, which will encourage them to focus on documenting activities of daily living (ADL) and behaviors relevant to the resident's care. This allows for accurate tracking of the resident's condition and ensures that decisions regarding the use of antipsychotic medication are based on clear, up-to-date documentation.

Process measure

- The process will be measured by the percentage of residents with complete documentation for ADLs and behaviors within the specified timeframe. This will be tracked weekly, with the POC audit happening mid-week and at the end of the week. Results will be reviewed during weekly or bi-weekly meetings to track improvement and address challenges. This process measure will help assess whether the change idea is leading to timely and accurate documentation, and whether it is working as planned to reduce the unnecessary use of antipsychotic medication.

Target for process measure

- The target for the process measure is to achieve a 10% annual reduction in the use of antipsychotic medication among residents without a diagnosis of psychosis. This will be accomplished by improving the documentation of ADLs and behaviors, ensuring that decisions regarding the use of antipsychotic medications are based on comprehensive and accurate resident assessments. Progress will be monitored through weekly audits of documentation completeness, with the aim of aligning better care practices with the reduction target.

Lessons Learned

This action plan has successfully supported MAUD quarterly reviews, strengthened audit readiness, and demonstrated consistent monitoring of residents without psychosis who are receiving antipsychotics. These efforts contribute to safer prescribing practices and reinforce a proactive approach to medication oversight.
At the same time, staff may perceive this change initiative as an added workload, which can increase the risk of rushed documentation rather than meaningful behavioural observation. Operational pressures, competing priorities, and periods of higher acuity may also impact the timely review of lists and documentation. Acknowledging these challenges allows us to continue refining processes, streamline workflows, and support staff in completing thorough assessments that inform safe and appropriate deprescribing decisions

Comment

We observed a slight decline in the percentage of long□term care residents without psychosis who received an antipsychotic medication in the seven days prior to their assessment. Several strategies have contributed to this progress, including quarterly medication reviews, increased use of non□pharmacological interventions, enhanced staff education and training, and ongoing engagement with residents and families regarding care approaches.
With these strategies in place, we remain committed to further improving this indicator. Continued emphasis on deprescribing pathways, behavioural assessment quality, interdisciplinary collaboration, and early identification of triggers will support additional reductions in antipsychotic use among residents without psychosis. Our focus moving forward will be to sustain positive trends and strengthen safe, evidence□informed medication practices across the Home.