Interim Report for Continuous Quality Improvement Initiative 2026-2027

As per Ontario Regulations 246/22 section 168.

168. (1) Every licensee of a long-term care home shall prepare a report on the continuous quality improvement initiative for the home for each fiscal year no later than three months after the end of the fiscal year and, subject to section 271, shall publish a copy of each report on its website.

(1) Designated Co- Leads:

Scott Strandholt, Administrator scott@bayhaven.com

Kristi Molenhuis, BScN RN, Director of Nursing kmolenhuis@bayhaven.com

(2) The below indicators were deemed high priority. In the fiscal year of March 2026 to April 2027 Bay Haven Identified 8 indicators to work on.

a. **Percent of residents responding positively to: "What number would you use to rate how well the staff listen to you?**
    i. Bay Haven wants residents and Power of Attorneys (POA) or Substitute decision Maker (SDM) to feel that staff are actively listening to their concerns.
b. **Percent of residents who responded positively to the statement "I can express my opinion without fear of consequences".**
    i. Bay Haven residents, POA/SDM should feel that they can express any opinions/or concerns without fear of consequence as per our Whistle Blower Protection Policy.
c. **Percentage of long-term care residents in daily physical restraints.**
    i. Bay Haven has a policy of least restraint, Staff to adhere to policy. Bay Haven will ensure that all staff are educated on this policy during their orientation process and re-education annually.
d. **Percentage of long-term care residents whose stage 2 to 4 pressure ulcer worsened.**
    i. Bay haven utilizes Artificial Intelligence (AI) to monitor all wounds to detect microscopic changes in the wound size. Bay Haven policy has goal of improving all wounds that are deemed "healable".

e. **Percentage of LTC home residents who fell in the 30 days leading up to their assessment.**
    i. Bay Haven wishes to reduce the incidents of falls and fall related injuries utilizing our "falls Prevention Policy".
f. **Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment.**
    i. Bay Haven wishes to reduce the number of residents who use antipsychotic medications without a corresponding diagnosis. Bay Haven to partner with external pharmacy.
g. **Number of days in confirmed outbreak.**
    i. Utilizing ne electronic auditing system Bay Haven wishes to reduce the number of days that we spend in confirmed outbreaks. Bay Haven recognizes the need for proficient Infection Prevention and Control (IPAC) measures to reduce the number of outbreaks, and decrease the amount of time that we are in outbreak. Will continue to work with external partners.
h. **Number of recreational programs classified as an 'environmental" program under the dominions of recreation therapy.**
    i. Bay haven wishes to increase the amount of recreational programs at Bay Haven that are deemed environmental. We have contingency plans in place for programs to occur inside, if the weather in inclement.

(3) Areas of improvement were identified using the 2025 Resident Satisfaction Survey, the Ontario Health 2026/2027 QIP technical indicators, Bay Haven's Resident's Council (meets monthly), Bay Haven's Suggestion Program (ongoing), Bay Haven's Continuous Quality Improvement Committee (CQI) (meets quarterly), Professional Advisory Committee (PAC) (meets quarterly) and each departments recommendation (meets monthly). Quality Improvement committee meetings are open to all staff, residents and families to join and\or participate. Meeting agendas and minutes are posted on the committee board in the home. Archived agendas and minutes are available in co-leads office. Continuous Quality Improvement (CQI) indicators, planning and discussions are also brought foreword during Resident Council meetings for resident input.

(4) Department's identified lead person(s) will monitor implemented changes, progress, and recommend/develop education and resources. Audits have been developed for department leads to quantify data. Information collected by department leads will be provided to the designated lead, who will update the Quality Improvement Plan.
The quality improvement leads will continually through the year collect data needed for the quality improvement data indicators, for the QIA submission in PointClickCare (PCC), NQuire Data, and Committee Meeting information. It will be up to the department managers to ensure that the change indicators are communicated and implemented in their departments. Kristi Molenhuis, who is the co lead of the CQI will communicate the results of the QIP from 2025/2026 to staff via committee meetings, residents via residents' council, management via management meeting, families via family council and external

partners via PAC meetings. It is at these same meetings that the change ideas for the 2026/2027 were presented. Quarterly committee meetings provide opportunities to measure progress. Meetings are planned for May 2026, September 2026, and January 2027. Communication of outcomes and processes will be outlined in the meeting minutes posted on the committee board. All staff and residents are invited to join these committee meetings. At these meetings the success and or failures of the QIP will be communicated. It is also discussed at the PAC Meetings where the interdisciplinary team is made aware of expected changes, and outcomes. PAC is scheduled for April 2026, October 2026, and 2027 dates are pending.

(5) The Resident Satisfaction Survey was provided to Power of Attorneys (POA) on June 2nd, 2025, via e-mail. Hard copies were also made available in the front foyer, at the nursing station and in Kristi's office. On June 23rd a reminder e-mail was sent out to the same list of Power of Attorneys. The last day to submit surveys was August 29th, 2025. Residents were provided with hard copies for completion. Residents who needed assistance in filling out the survey were provided assistance from Recreation Department Staff and/or POAs. Residents were provided with a condensed version of the survey as not to overwhelm them, this increased survey completion by residents this year. The results of the survey were tabulated and published. The results were posted at the Nursing Station Information Board, the Resident Information Board in the Retirement Home. This provides access to residents, families, visitors and staff. The results were presented to Residents Council in December 2025 as per the meeting minutes. The Survey for 2026 will be made available June 1st, 2026 to POAs and Residents and can be submitted through until July 31st, 2026. The Continuing Quality Improvement Lead is responsible to ensure that the 2025 Satisfaction Survey compares and tracts indicators of interest. Results will be posted once data is tabulated and the report is generated. Copies of the survey will be available in the front foyer, and in Kristi's office, and for Reinterment home copies to be located in the Nursing Station. Residents who are able, will be provided with a volunteer to assist with filling out the survey if they so choose. Retirement home residents will be provided with surveys in their mailboxes. Family members, substitute decision makers and power of attorneys will be provided with e mails of the survey if they have provided their e-mail addresses. Results will be shared in the manner that was outlined above.

(6) Collaboratively, Bay Haven identified a total of 8 quality indicators that were improvement goals from April 2025 to March 2026. Bay Haven successfully reached 7 indicator goals, improved but did not meet goals in 1 indicator goals and worsened in 0 indicator goals, for an overall success rate of 88%. Results will be communicated to PAC Meeting in April, Management at the May Leadership meeting, with staff at the CQI Committee Meeting in May meeting and with resident council May 27th. We will discuss where we were successful, what interventions were implemented, and where we were not able to meet our goals and why. At this time will also be opportunities for other members of staff and residents to communicate why they feel that goals were not met. Results to be posted on the Resident information board across from the Nursing Station, and with the agenda minutes from the meetings.