Interim Report for Continuous Quality Improvement Initiative 2025-2026

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

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(2) The below indicators were deemed high priority. In the fiscal year of March 2025 to April 2026 Bay Haven Identified 8 indicators to continue to work on.

a. Reducing the number of unplanned emergency room visits.
    i. In collaboration with primary physicians, nurse practitioners and the after hours on call physician rotation. Bay Haven endeavors to decrease the number of ER visits.
b. Decreasing the number of written notifications from the Ministry of Long-Term Care.
    i. Bay Haven to ensure that staff members are aware and adhering to fixing Long Term Care Act, 2021 and that best practices are implemented day to day.
c. Number of residents who within 14 days get an opportunity to discuss end of life wishes.
    i. Bay Haven to utilize RNAO/PointClickCare Clinical Pathways on admission and ongoing to ensure that best practice guidelines are being followed regarding end of life and palliative care.
d. Decrease the number of residents with unrelieved pain as per the resident satisfaction survey.
    i. Bay Haven to utilize the RNAO/PointClickCare Clinical Pathways Pain Management to screen, assess and evaluate pain. Staff to routinely assess for pain and provide pain management as ordered by clinicians.
e. Decrease number of missing items that has not been found.
    i. Bay Haven to implement a lost items sheet to monitor that items have gone missing and if it has been located. Staff on admission to ensure that all items are clearly labeled with resident's name.

f. Decrease in number of critical incidents that need to be reported to the Ministry of Long-Term Care.
    i. Bay Haven to ensure that residents who are at risk of a critical incident such as resident-to-resident violence or fall with injury have interventions clearly outlined in their plan of care.
g. Decrease number of days in outbreak.
    i. Bay Haven to ensure that best practice infection prevention and control interventions are implemented and being followed by all staff, utilizing audits, education, and training. Staff to quickly identify illness in residents and monitor for developing signs and symptoms.
h. Decrease fall related injuries.
    i. Ensure that on admission all residents are screened for risk of falls, all residents deemed risk for falls. Ensure residents care plan clearly outlines interventions to mitigate risk for falls. Ongoing assessments to be completed on residents. Residents who are at risk for falls will have interventions in their care plans.

(3) Areas of improvement were identified using the 2024 Resident Satisfaction Survey, the Ontario Health 2025/2026 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 2024/2025 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 2025/2026 were presented. Quarterly committee meetings provide opportunities to measure progress. Meetings are planned for May 2025, September 2025, and January 2026. 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.

(5) The Resident Satisfaction Survey was provided to Power of Attorneys (POA) on May 31st via e-mail. Hard copies were also made available in the front foyer, at the nursing station and in Kristi's office. On June 14th, a reminder e-mail was sent out to the same list of Power of Attorneys. The last day to submit surveys was July 1st, 2024. Residents were provided with hard copies on May 31st for completion and were collected until July 1st, 2024. 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 no later than July 31st, 2024. This provides access to residents, families, visitors, and staff. The results were presented to Residents Council on July 31st as per the meeting minutes. At the time, the Family Council was not fully established. The Survey for 2025 will be made available Monday June 2nd to POAs and Residents and can be submitted through until July 4th, 2025. 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.

(6) Collaboratively, Bay Haven identified a total of ten quality indicators that were improvement goals from April 2024 to March 2025. Bay Haven successfully reached 6 indicator goals, improved but did not meet goals in 2 indicator goals and worsened in 2 indicator goals, for an overall success rate of 80%. Results will be communicated to Management at the May 7th meeting, with staff at the CQI May 20th 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.