Vera M Davis Centre

Long Term Care Centre

Continuous Quality Improvement

Initiative Report

2025-2026

Peel Region

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Section 1: Introduction

1.1 Purpose

The purpose of this document is to summarize continuous quality improvement [CQI] initiatives conducted within Vera M Davis Centre Long-Term Care in the 2024-2025 year. It highlights our current commitments to CQI, the process of determining priority areas, committee support to CQI practice, as well as the implementation of and actions taken based off the Resident Experience Survey [RES] and the Family and Caregiver Experience Survey [FCES]. It also includes a comprehensive Quality Improvement Plan, using indicators from Health Quality Ontario as a guide. This document is intended to fulfill Ontario Regulation 246/22 s.168 of *the Fixing Long-Term Care Act* (2021). This report was completed on May 31, 2025.

1.2 Background

Peel Region's Long Term Care (LTC) Continuous Quality Improvement (CQI) Program is developed to facilitate continuous quality improvements at all levels in alignment with the organization.

The CQI program includes processes to monitor, review, and improve quality improvement initiatives and activities in the home for all areas of resident care, safety, satisfaction, and services.

The CQI program provides a framework with structured processes and quality improvement tools and techniques to apply consistently across the division.

The development of the program provides a basis to:

- Facilitate evidence-based decision making.
- Promote outcome measurement, and
- Create a culture of continuous improvement that includes active engagement and participation from all employees at every level of the division.

1.3 Seniors Services Strategic Plan 2024-2029

Peel Region's Seniors Services Strategic Plan is focused on addressing the needs of the growing seniors' population in Mississauga, Brampton, and Caledon. With a population exceeding 1.5 million that is expected to grow, Peel Region is committed to providing high-quality care and support for its seniors.

The 2024-2029 Strategic Plan outlines a comprehensive approach to delivering person-centred care, fostering a resilient and empowered workforce, and facilitating integrated care through purposeful collaborations.

Vision: Individuals receive person-centred, innovative, integrated care, and support that enhances their quality of life.

Mission: To provide compassionate, loving, and respectful care that is individualized for everyone we serve.

Strategic goals

Long Term Care and Seniors Services Development will focus efforts on advancing the following three goals:

- Cultivate a resilient and empowered workforce.
- Deliver person-centred care that honours individual needs and preferences.
- Facilitate integrated care through purposeful internal and external collaborations.

Section 2: Continuous Quality Improvement

2.1 Our approach to CQI

Continuous Quality Improvement (CQI) is an organizational philosophy that is strategic in an approach that:

- Aims to provide the best health care possible.
- Uses innovation to meet residents' needs and to exceed their expectations by using a structural process that identifies areas of improvement within an organization.
- Shifts the focus from applying interim solutions to reoccurring problems to critically assessing the current processes and practises in place. This provides a common understanding of the underlying causes of gaps in an effort to improve them.
- Encourages employees to seek opportunities for change and to try out ideas on a smaller scale before rolling them out to the entire organization. This ensures that the best possible solution is implemented for the current situation.

Organizational objectives, policies, procedures and protocols for the continuous quality improvement initiative are outlined in our CQI program manual (CQI 15-01) and this manual is reviewed/revised at least annually as necessary and are subject to the following legislation:

- *Fixing Long Term Care Homes Act, 2021 (FLTCA 2021)*
- *Ontario Regulation 246/22*
- *Annual Program and Departmental Evaluations*

2.2 The Quality Improvement Designate

Vera M Davis Centre is committed to ongoing and continuous quality improvement. This is achieved by having a designated lead for quality improvement who oversees and ensures adherence of the CQI Program in the home.

The designate works with the team to reflect on the practices, programs, and services to support specific quality improvement activities and initiatives.

CQI is a required standing agenda item at every Region of Peel LTC centre and at departmental leadership team meeting quarterly.

Name of Designated Lead for Quality Improvement Initiatives at Vera M Davis Centre: Fatima Mohammed

Position of the Designated Lead: Administrator

2.3 Process to identify the home's priority areas

In formulating Vera M Davis Centre's annual Quality Improvement Plan, we meticulously followed these steps to create a sustainable strategy:

- Assess and prioritize areas for improvement.
- Formulate improvement initiatives.
- Execute improvement initiatives.
- Monitor achievements and obstacles.
- Adjust strategies as necessary.

Data is consistently reviewed and analyzed throughout the year as part of the home's quality improvement program to track successes and identify areas of improvement. The sources of data and metrics reviewed include:

- Resident Experience Survey (RES) and Family and Caregiver Experience Survey (FCES)
- Analysis of complaints and critical incidents
- Review and analysis of performance indicators
- Engagement of residents, families, and caregivers through Residents and Family Councils and town halls
- Employee townhalls
- Daily Continuous Improvement Program (CIP)
- Educational needs assessment
- Accreditation
- Program Evaluations

- Residents' and Family Council Meetings
- Committees

Resident Experience Survey (RES) and Family and Caregiver Experience Survey (FCES)

- The RES and FCES surveys help us understand the experiences of residents, families, and caregivers.
- We encourage high survey participation and offer both electronic and paper versions.
- Volunteers assist residents with completing the survey, and when unavailable, families or designated individuals help.
- Survey results are summarized annually, both for individual homes and the entire division.
- We review and discuss results with employees, residents, families, and caregivers through formal and informal channels each year.
- The survey results help identify priority areas for quality improvement, and homes work to act on the feedback to improve services and programs.

Review and Analysis of complaints and critical incidents

- The leadership team reviews and analyses all documented complaints and critical incidents at least once a month.
- We use the data we collect to identify one-time occurrences. We also use this data to pinpoint recurring and system trends to guide quality improvement and risk-management activities.
- We address any complaints we receive within 10 business days.

Review and analysis of performance indicators

- The leadership team and/or program leads reviews, analyzes, and compares service and program outcomes against set standards and historical performance. This helps us objectively measure the level of service provided.
- Performance indicators are recorded monthly, quarterly, and annually as appropriate. We regularly share these indicators with management and front-line employees at team meetings.
- We implement corrective actions and process improvements as required.

Engagement of resident and family councils and resident and family town halls

- We gather feedback from residents and families through satisfaction surveys, council meetings, town halls, and the Resident Voice program.

- These forums provide peer support, facilitate idea sharing, and keep participants informed.
- Regular engagement ensures that improvements align with the collective experiences of residents and families.
- The Resident Council meets monthly to discuss care preferences and expectations. Family Council meetings are held regularly to address concerns and expectations of residents, families, and caregivers.
- Updates on Quality Improvement plans are shared during these meetings, and feedback is documented in the minutes.
- Resident and family input is prioritized as our primary source of feedback.
- Council meetings are vital for gathering insights on improving care, encouraging active participation, and promoting ongoing communication.
- We collaborate closely with our Residents' Council and families to develop quality improvement strategies and keep all stakeholders informed about our plans and progress

Employee town halls

- Employees have several avenues to contribute to the CQI process, including divisional and home-level town hall meetings.
- The town hall is a forum for employees to have honest and open discussions with leadership to identify issues of concern related to work, processes, and ways to improve efficiencies.
- The employee perspective contributes to the development of viable solutions, and employees are empowered to identify CQI opportunities that will improve delivery of care and services.

Daily Continuous Improvement Program (CIP)

- The Daily CIP program was developed by SickKids Hospital and adapted to fit the needs of long term care.
- The program brings a small group of employees together to discuss challenges they experience in their day-to-day work.
- Recommendations are identified to improve the work and include longer-term opportunities and ‘quick wins’ that help make home operational processes more effective and sustainable.

Educational needs assessment

- An annual online survey for employees captures employees’ perspectives with regards to their education needs.

- Although this is a requirement of Ministry of Long-Term Care legislation, the survey is designed to identify areas of improvement in education to enhance employee knowledge and the transfer of knowledge to practice.
- The content of the survey varies from year-to-year, based on operational needs and current practice. This survey is used to plan employee education for the upcoming year.

Accreditation

- Vera M Davis Centre also demonstrates its commitment to continuously improve service quality and to focus on satisfaction through the Accreditation process.
- CARF® International is an independent accrediting body of health and human services.
- CARF-accredited service providers have applied CARF's comprehensive set of standards for quality to their business and service delivery practices.
- Vera M Davis Centre received a 3-year accreditation in 2023.

Program Evaluations

- Program evaluations are conducted annually to monitor the major programs of the home.
- Evaluations are completed by the program leads with interdisciplinary support.
- A thorough audit of the program using legislative and divisional requirements is conducted and the identified gaps and recommendations are used for continuous quality improvement.

Committees

Continuous Quality Improvement Committee:

- Our Continuous Quality Improvement (CQI) committee is a multidisciplinary team that includes external stakeholders. CQI meetings are held quarterly to monitor and report on quality-related issues, residents' quality of life, and the overall care and services provided in the home, using relevant data.
- These meetings aim to identify priority areas for improvement and make appropriate recommendations.
- These meetings serve as a forum to monitor and measure progress, identify necessary adjustments, and communicate outcomes for the home's key areas of quality improvement.
- Quality improvement initiatives are a key agenda item at CQI meetings, where the committee reviews the action plan, provides recommendations, and evaluates the effectiveness and sustainability of actions taken.

Other Committees:

Furthermore, the Centre also holds regular meetings through structured organizational committees, including but not limited to:

- The Centre Leadership Team (CLT)
- The Interdisciplinary Infection Prevention and Control Committee
- The Falls, Restraints and PASD Committee
- The Pain, Palliative and End of Life Care and Ethics Committee
- The Skin and Wound and Continence Care Committee
- The Responsive Behaviour and Purposeful Engagement Committee
- The Health Services Advisory Committee
- The Joint Occupational Health and Safety Committee
- The Restorative and Rehabilitative Care
- The Nutrition Care Committee

These interdisciplinary committees are in place to support the quality of care and services provided to residents. To ensure transparency, each committee displays the progress of improvement initiatives on information boards located in public areas of the home.

In support of continuous quality improvement, each committee:

Participates in reflective practice

- The home provides treatments and interventions to promote quality of care and services for residents.
- We make efforts to ensure the home provides strategies to maximize residents' independence, comfort, and dignity. This includes the use of equipment, supplies, devices, and assistive aids as applicable.

Reviews, tracks, and monitors progress

- All relevant indicators are reviewed to identify important trends.
- We audit and monitor resident care plans to evaluate outcomes and effectiveness. We also develop action plans to meet gaps in services and programs.

Plans, develops, implements, and evaluates

- We evaluate quality improvement initiatives as part of quarterly, annual, and ongoing reviews of the program.
- We evaluate and update programs annually in accordance with evidence-based practices or prevailing practices.

2.4 Home specific priority areas

We use a variety of information to guide our understanding of the areas in the home that require improvement. This includes using the Quality Improvement Plan indicators from Health Quality Ontario as well as using satisfaction surveys to better understand the resident, family, and caregiver experience. For the coming fiscal year 2025-26, Vera M Davis Centre priority areas for quality improvement as outlined in the Annual Quality Improvement Plan will address the four areas of focus below:

Timely and efficient transitions: Reduce the rate of potentially avoidable emergency department visits for long-term residents.

Patient, client, and resident experience: Focus on increasing satisfaction rates among residents who agree with the following statements:
"Staff listen to me"
"I can express my opinion without fear of consequences"
"My problem was resolved to my satisfaction"
"I have access to activities that meet my interests"

Safe and effective care: Reduce the percentage of long-term care residents (without a diagnosis of psychosis) who are given antipsychotic medication.
Reduce the number of falls of long-term care residents (who fell in the 30 days leading up to their assessment).

Equity: Implement Best Practice Spotlight Organizations (BPSO) Best practice Guideline (BPG) on Promoting 2SLGBTQI+ Health Equity

2.5 Process to measure and monitor progress

- The process of monitoring and evaluating successes and areas for improvement at Vera M Davis Centre involves identifying, tracking, communicating, monitoring, and implementing necessary changes to continually enhance the quality of resident care and service.
- Quality management at our Centre is a comprehensive, ongoing self-assessment system. Through our CQI process, we monitor, track, analyze, and assess priority areas.
- Our assessments encompass processes, quality reports, resident & family satisfaction, trend analysis, and outcomes to pinpoint areas needing enhancement. We collaborate closely with

our Residents' Council and Family Council to devise quality improvement strategies and ensure all stakeholders are informed of our plans and outcomes of the actions.

- We conduct a thorough review of the LTC performance indicators established in consultation with various stakeholders, the LTC divisional leadership team, and specific employee peer groups. The purpose of these indicators is a consistent approach to monitoring care and service delivery through measurement and evaluation practices. These indicators give employee peer groups and the whole division the opportunity to monitor, analyze, and track progress. We then set targets for indicators based on past data or industry benchmarks (or both).

The processes we use to study and monitor progress and implement adjustments include:

An annual review of quality indicators and associated targets:

- This includes the responsible employee peer groups, external stakeholders, and Divisional CQI Committee reviewing the indicators for relevance.

An ongoing review of specific data by each department:

- We use data to identify important trends and improvement opportunities. We then use this information to inform program planning decisions for each department.
- Significant variances or high-risk trends are brought forward to the Administrator for decision-making.

Conducting root cause analyses:

- It's important that any area or issue identified as needing improvement be evaluated to determine its root cause.
- We use Root Cause Analysis tools and techniques for this purpose.

Action plan development:

- Once priority areas for quality improvement are identified, the Continuous Quality Improvement (CQI) Specialist helps to develop action plans that are shared with the home's employees.
- The home ensures action plans are implemented and sustained. Follow up on any outstanding concerns happens in a timely manner.

Communication of results and action plan outcomes:

- We communicate survey results for the Resident Experience Survey (RES) and the Family and Caregiver Experience Survey (FCES) to residents, families, and caregivers, and we receive feedback through the Resident's Council and Family Council.

- We also communicate action plans informed by these surveys to residents and families to gather their feedback and suggestions.

Program evaluation:

- Programs are evaluated annually using relevant evaluation tools and quality improvement methodology.
- This includes ensuring that program goals are SMART (specific, measurable, achievable, realistic, and have a start and end date).

Section 3: Experience Surveys

3.1 Introduction

The Resident Experience Survey and Family and Caregiver Experience Survey are important data sources used to understand the resident, family, and caregiver experience. We use formal and informal channels to review and discuss survey results every year with employees, residents, families, and caregivers. The survey results guide the identification of the home's priority areas for quality improvement. Homes make every reasonable effort to act on survey results to improve how programs and services are delivered.

The Resident Experience survey was conducted from September 16, 2024, to October 11, 2024, while the Family and Caregiver Experience Survey took place between June 24, 2024, and July 19, 2024. Resident surveys were administered in-house with the assistance of volunteers, while family and caregiver surveys were distributed both by mail as paper copies and via email with a SurveyMonkey link for online completion. Paper surveys were later entered into SurveyMonkey, and the results were compiled. The results of both surveys were analyzed and shared in a data dashboard.

The Family and Caregiver Experience Survey results were available to staff on October 29, 2024, and the Resident Experience Survey results were available on January 21, 2025. Results of resident experience survey was shared with our Resident Council on February 10, 2025, and Family Councils on February 26, 2025. Results of family and caregiver experience survey was also shared with our Resident Council on January 16, 2025, and Family Councils on October 16, 2024. During these sessions, collaborative dialogue took place and additional change ideas were discussed with staff. Survey results

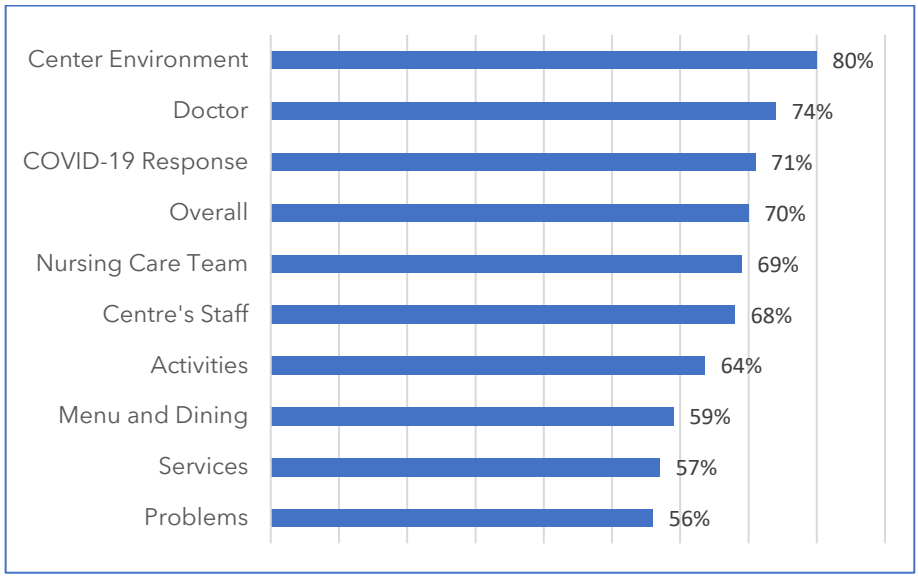
were also posted on the communication board at the home on October 29, 2024 (FCES) and January 21, 2025 (RES).

The survey results helped to inform many of the initiatives highlighted in this report and associated Quality Improvement Work Plans submitted to Ontario Health.

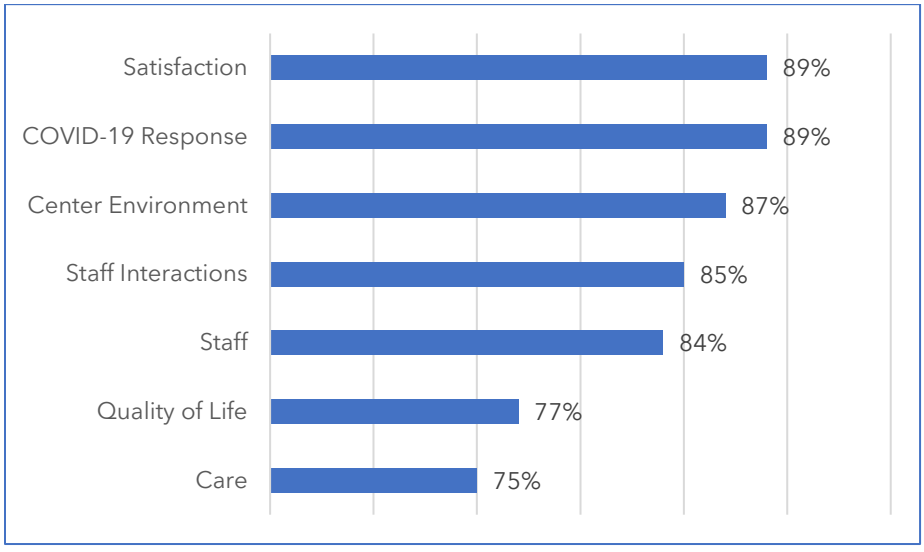
3.2 Survey Results

2024 overall results for Vera M Davis Centre are as follows:

Results from 2024 Resident Experience Survey



Results from 2024 Family and Caregiver Experience Survey



3.3 Residents', Family and Caregiver Experience Survey Results Action Plan

The analysis of our 2024 Experience Surveys results indicated overall satisfaction with the accommodation, care, services, programs, and goods provided to our residents. Additionally, it highlighted specific areas where targeted improvement efforts are needed to further enhance the resident experience.

Area	Key actions	Target date for completion	Status and outcomes of actions
Dietary	The brand of mashed potato used in the home to be replaced by another brand for improving texture and flavor.	February 2025	Completed in February 2025. The mashed potato brand was replaced.
Dietary	National food day celebration has been introduced as an ongoing celebration which allows the residents to taste different food items across the world. The items that are well received will then be added to the permanent menu.	April 2025	Completed in April 2025. National food day has been introduced and will continue throughout the year.
Customer communication	Emotion-based care model is being introduced in Nursing Station 1 in addition to the Butterfly model in Nursing Station 2. This would ensure emotion-based care to be introduced in both the stations.	February 2025	Completed in February 2025. The emotion-based care model has been introduced in the home area.

Housekeeping	a. Enhanced cleaning to be put in place during the construction activities b. New equipment to be purchased to improve floor deep cleaning and refinishing	February 2025	Completed in February 2025. a. Enhanced cleaning has been put in place. b. New equipment has been purchased to improve deep cleaning and refinishing.
Safety	a. New access control system to be placed. b. Roam alert system to be modified to increase safety. c. Introduce fire safety improvements.	February 2025	Completed in February 2025. a. New access control system introduced. b. Roam alert system has been modified. c. Fire safety improvements completed.
Maintenance	a. New HVAC system to be installed and to be customized as per resident's preferences. b. New lighting to be installed for improving light quality and control. c. Door vinyl to be customized to make the environment feel more like home. d. Free-swing doors closers to be installed to support resident's independence.	February 2025	Completed in February 2025. a. New HVAC system has been installed. b. New lighting has been installed. c. Door vinyl has been customized. d. Free-swing door closers have been installed.

Maintenance	a. Repainting of room walls. b. Closet door replacement.	December 2025	Pending a. Repainting of room walls. b. Closet door replacement.
Exercise	Introduction of chair yoga once per month.	February 2025	Completed in February 2025. Chair yoga has been introduced.
Spiritual services	a. Pastoral services to be organized each week. b. Rosary program to be organized each week.	February 2025	Completed in February 2025. a. Pastoral services are organized each week. b. Rosary program is being held each week.
Intellectual programs	a. Implementing cyber security program to raise awareness about cyber security. b. Introduction of new intellectual programs by each activation staff.	March 2025	Completed in March 2025. a. Cyber security program held. b. New intellectual programs have been introduced.

Section 4: Quality Improvement Plan

4.1 Quality Improvement Narrative

Peel Region's Long Term Care homes are committed to providing high quality care to our residents. This demonstrates we have met rigorous quality standards and hold an ongoing commitment to quality improvement.

Overview

The Region of Peel's Long Term Care homes are committed to providing high quality care to our residents. We recently launched our Seniors Services Strategic Plan 2024-2029, built on input gathered from residents, clients, families, caregivers, staff, and partners. Our vision is that individuals receive person-centred, innovative, integrated care, and support that enhances their quality of life. This has included meeting the *Fixing Long Term Care Act* (FLTCA) regulations and through Peel Region's corporate quality improvement strategy to support with quality improvement methodology, risk management, and quality management planning.

Quality improvement initiatives in 2024 we are most proud of include:

Advanced Diagnostic Equipment: In LTC homes, residents often face hospital transfers due to changes in their health, and homes lack the tools to detect or diagnose these issues early. The Province of Ontario provided new Local Priority Funding to enable us to secure diagnostic equipment and training to give our nursing and medical care team vital information to support resident care. Based on using the new diagnostic equipment, early results have shown improvements in providing care to residents in their own home, resulting in internally diverted hospital transfers. We plan to continue to monitor the outcomes of this initiative through the support of our nursing care team.

Increasing Family Survey Completion Rate: Vera M Davis Centre relies on feedback from families to improve service delivery and plan programs. However, response rates to completing the voluntary surveys have been historically low. A new process was implemented involving follow-up phone calls and incentives which has increased survey response rates from 36% to 67%. These methods will be incorporated in future annual family experience surveys to ensure these valuable insights inform our service.

Internal Quality Review (IQR): In 2024, we re-introduced comprehensive internal quality audits conducted by our centralized team across our LTC homes which had been on hold since the COVID-19 pandemic. These audits are a crucial component of our internal quality review, emphasizing a proactive approach to evaluating our care programs in addition to the home-level auditing processes. Beyond aligning with our policies and protocols, this process ensures compliance with required legislation while driving continuous quality improvement. Based on auditing programs, trends and opportunities for improvement were identified for critical areas related to infection prevention, falls, management, skin and wound care, abuse prevention, nutrition, and facility services program. Davis Centre developed

specific action plans for targeted initiatives based on the findings to enhance performance and resident outcomes.

Butterfly Accreditation: Davis Centre was accredited with butterfly home area accreditation of Nursing Station 2. The butterfly accreditation status affirms that the home has been working to provide and sustain emotion-based care to our residents.

Performance measures are used to assess how we are doing with achieving our goals. The performance measures outlined in the Quality Improvement Plans are well-aligned with the "Quintuple Aim" framework adopted corporately at the Region of Peel. The Quintuple Aim provides a framework for addressing system-level challenges as we advance healthcare in Peel Region. This framework focuses on improving value for money, enhancing client and resident experience, enhancing employee experience, improving population health outcomes, and advancing health equity.

In addition, we are a CARF® International accredited organization. This demonstrates we have met rigorous quality standards and hold an ongoing commitment to quality improvement.

Access and Flow

In 2024, our LTC division introduced diagnostic equipment to all five centers to enhance resident care, improve efficiency and contribute to better health outcomes for our residents.

These devices are meant for early detection of some medical conditions such as pneumonia, acute changes due to congestive heart failure, and urinary tract infections etc., providing our clinical team with tools to intervene promptly and treat the condition while resident remain in the comfort of their home. This equipment also helps in identifying and monitoring some chronic conditions when there is an acute change in residents' condition and allows the practitioner to adjust treatment as needed. Having these devices onsite also improve efficiency by reducing the need for residents to go to emergency department or external medical facilities for diagnostic tests. We will enhance resident experience and care by treating conditions identified through our in-house diagnostic equipment and reduce the complications that can occur in seniors due to hospitalization. Overall, the use of these devices will also enhance collaboration among healthcare providers to achieve best possible care to our residents in a timely manner.

By March 31, 2024, all five long-term care centers successfully introduced four advanced diagnostic devices: e-POC, CRP analyzer, hemoglobin meter, and urinalysis machine. A core team of nurses, including Nurse Practitioners and clinical leaders, received comprehensive training on these devices, along with venipuncture techniques required for e-POC use. Subsequently, this core team has trained additional nurses across the centers, ensuring widespread proficiency in utilizing these tools.

The core group focuses on tracking progress, sharing tailored resources to address the unique needs of each home, and developing sustainable processes to ensure ongoing improvement and success across all homes. Our nurse practitioners have received specialized education and training in wound suturing, enhancing our capacity to address specific wound care needs of residents within our homes and reducing the need for emergency department transfers.

Davis Centre was also able to secure One-Time Funding from Ontario Health Central Region for bariatric equipment and wound care training in February/March 2024. This will ensure timely access to care by admitting residents with complex care needs and avoid hospital transfers.

Equity and Indigenous Health

Peel's Long Term Care (LTC) homes are continuing to prioritize the use of data to address health inequities in their programs and services for residents. This work was piloted in one home and efforts will extend to the remaining four in 2025, aiming to enhance the quality, scope, completeness and use of health equity data collection. To apply a health equity lens to Continuous Quality Improvement (CQI) work, activities included a comprehensive literature review to identify best practices, a current state assessment of data collection processes, and summarizing findings to highlight gaps and develop recommendations for improvement and future decision making. Further work in 2025 will include determining the most effective methods for analyzing sociodemographic data and integrating it into daily practice. This approach aims to improve health outcomes and address health inequities in a meaningful and sustainable way. In the process of identifying and piloting health equity metrics within our LTC homes, there is an opportunity to recognize and support Indigenous people, contributing to a better understanding of the Indigenous culture.

Peel LTC is committed to advancing health equity by integrating inclusive person-centred care into all aspects of service delivery. Through the implementation of the Registered Nurses' Association of Ontario's Best Practice Guideline, Promoting 2SLGBTQI+ Health Equity, we are supporting safe, welcoming environments for 2SLGBTQI+ individuals across our Homes. Policies, procedures,

assessments, and tools have been updated to support inclusive language and preferences, ensuring equitable care practices and service delivery that honours the individual needs and preferences of those we serve in alignment with our strategic goals.

In parallel, Peel Region is committed to advancing truth and reconciliation with Indigenous peoples. Staff underwent mandatory Indigenous Cultural Awareness training, achieving 100% completion. New employees must complete relevant training modules within their first month of onboarding. Ongoing promotion of Indigenous cultural awareness is facilitated through the Employee Ambassador program, encouraging participation in Truth and Reconciliation Events and raising awareness about available Indigenous resources. Land acknowledgments are continuously being improved to meaningfully integrate into meetings and training sessions, and inclusive leadership training has become a core competency for People Leaders.

Patient/Client/Resident Experience

We use ongoing opportunities to engage residents and their families to support improvements that reflect the collective voice and experiences of those living in the home.

Resident and Family Experience Surveys: The Resident and Family/Caregiver Experience Surveys provide crucial insights into their experiences. We annually review and discuss survey findings via formal and informal channels with stakeholders. These results inform priority areas for quality improvement efforts. Homes diligently act on survey feedback to enhance program and service delivery.

Resident/Family Councils and Resident/Family Town Halls: We receive feedback from residents and families through council meetings, town halls, and the resident voice program. These venues also provide peer-to-peer support and the opportunity to share information, discuss potential program ideas, and stay informed.

CQI Committee Meetings: Davis Centre has a CQI committee in place that utilizes an interdisciplinary approach to evaluate sources of data and discuss, plan, and prioritize quality improvement initiatives. Inclusion of representatives from both residents and families in CQI committee meetings has provided rich discussions and a diverse, lived-experience perspective that was previously missing from the work. They have made valued contributions that have encouraged the group to pause and re-evaluate previous assumptions about what might be priorities for residents and families. They have also supported the

development and review of this year's Quality Improvement Plan submission. There have been a number of positive outcomes from their participation. This fosters a new approach to quality planning that is co-created and co-led with families and residents rather than professionally driven.

Resident and Family Information Night: At this meeting, quality improvement results are shared with residents and families. They are also given the opportunity to provide feedback on improvement ideas and engage in quality-of-care conversations.

4.1.1 Provider Experience

Employee wellbeing and a positive workplace culture are central to delivering high-quality care to residents and clients. Staffing shortages, challenging workloads, and cumulative exposure to stressful events during the pandemic have highlighted the importance of enhancing measures to support psychological health and wellbeing of employees. Activities aimed to support employee wellbeing at Peel include:

Employee Engagement Pulse Survey: The employee engagement pulse survey is an important tool that gathers point in time employee feedback on their well-being to identify gaps, opportunities, and themes to enhance psychological health and safety in our workplace. Customized engagement tactics for boosting response rates for LTC employees included utilizing Employee Ambassadors, engaging employees on modified duties to support with uptake, providing additional iPads/laptops, hosting "coffee breaks", and creating targeted posters and communications. Support from culture & wellness advisors and business coordinators was crucial, alongside corporate strategies such as prize draws and QR codes linking to the survey.

Health Services Culture and Wellbeing Advisory Group: Formed in early 2022, this advisory group identified the following immediate priorities: leadership development, raising awareness and engagement with wellbeing initiatives, and promoting diversity, equity and inclusion tools and resources.

Mental Health & Wellbeing Education: In 2024, Seniors Services employees received mental health and wellness education from the Your Health Space program which is a part of the Canadian Mental Health Association. The Wellness Moments Program offers in-person, 15-minute micro-learning huddles designed for health care employees, by health care employees. These sessions addressed the needs that were identified by our employees, such as strategies for managing stress in the workplace, combatting

burnout, remaining emotionally connected through empathic strain, fostering meaningful relationships at work, etc. Operational team members took part in interactive webinars and in-person sessions also focused on mental health and wellness. Leaders took part in a "Fostering Well-Being Through Leadership Series" which was facilitated virtually and encouraged leaders to reflect on their own psychological well-being, identify their role in promoting psychological safety within the organization, and feel more confident supporting the psychological health of those they lead through the application of practical, evidence-informed strategies.

Huddle Tools: Bimonthly huddles tools are developed to support our leaders with having conversations with their employees on the topic of mental health, wellness and culture. These short, one-page tools support our leaders in normalizing conversations about mental health and diversity, equity and inclusion, having meaningful discussions with their teams, and engaging in team-building activities. The tools contain key messages to leaders, team members, discussion questions, activity ideas, resources, and a list of respective observances.

Wellness Resources Roadshow: In early 2024, a Wellness Resources Roadshow took place at each of the homes in the form of 10–15-minute huddles and drop-in sessions for night shift team members. These huddles were held in-person in partnership with our Human Resources team who provided information on health and wellness information and resources that are available at no cost to employees. A postcard was provided to employees for reference with QR codes linking to each of the available services, for ease of accessibility.

Creating a Culture of Belonging Workshops: The Ontario Centre for Learning, Research, and Innovation (CLRI) in LTC has offered sessions to LTC homes across the province focused on Creating a Culture of Belonging. There are currently 6 employees from Davis Centre registered for these sessions which will conclude at the end of February 2025. Next steps will include a focus group with session participants to support with developing a plan to cascade these learnings to all seniors services employees.

In addition, employees have a variety of avenues that allow them to identify opportunities to improve their experience in the workplace including peer groups, communities of practice, surveys, town hall meetings, and accessing mental health and wellness resources and services.

Safety

Ensuring resident safety constitutes a fundamental aspect of Peel Region's Continuous Quality Improvement Program. It permeates our care team discussions during care conferences and huddles, reinforced by corporate and long-term care policies and procedures. Our resident safety strategy encompasses preventive measures and thorough post-incident follow-up and management. The subsequent examples showcase initiatives aimed at supporting resident safety and incident management.

Standardized Documentation: Improved communication enhances resident safety. Davis Centre implemented structured SBAR documentation, facilitating clearer and concise communication among care teams. All staff are trained on SBAR techniques.

Post Falls Assessment Tool: This tool allows for a comprehensive analysis of the contributing factors that may have led to the fall. The purpose of the tool is to support transparency, learning, and identify areas for improvement.

4P's (Pain, Position, Possession, Personal assistance) intervention: All staff members are trained to adhere to the 4P's guidelines when interacting with residents. They assess whether residents are experiencing Pain (by asking or observing signs), need assistance with Position (by asking or observing signs), are seeking a Possession (by asking or observing signs), or require Personal assistance (by asking or observing signs). Implementing the 4P's approach helps minimize falls and enhances the overall care and safety of residents.

Follow-up on medication errors: There is a robust process that follows any medication errors including the completion of a medication error report and a follow-up meeting with the in-home clinical, medical, and pharmacy team.

Review and analysis of complaints and critical incidents: The leadership team reviews and analyses all documented complaints and critical incidents at least once a month. We use the data to identify recurring and system trends to guide quality improvement and risk-management activities.

Access cards: At Davis Centre, the staff, volunteers and caregivers are provided with access card for entry in and out of the home. This access card ensures the safety and wellbeing of our resident's, and it prevents unauthorized access in the building.

Increased range of roam alert: The roam alerts are often used for the safety and wellbeing of our residents who have declined cognition and who have repeated habit of eloping from the home. At Davis Centre, the range of roam alert was increased to ensure that such residents could be provided increased safety by preventing them from unauthorized elopement.

Resident safety remains a top priority for our home. We continue to explore additional processes and changes that may enhance resident safety. We strive to build a just culture where staff feel comfortable coming forward and where we learn collaboratively from errors or incidents and implement action plans to mitigate risk.

Population Health Approach

Peel Region's seniors' population is experiencing unprecedented growth, with a projected 61% increase between 2016 to 2025 - outpacing the provincial growth rate of 45%. As this demographic shift unfolds, the demand for complex care, particularly for individuals with dementia, continues to rise. Over the past five years (2019 to 2023), Peel Regional Paramedic Services (PRPS) reported a 23% increase in responses to seniors with a diagnosis of dementia – an underestimation given the number of undiagnosed individuals.

Recognizing the growing need to support seniors in the Peel community living with dementia and their families, and understanding the benefits of equipping first responders with the tools to support during emergency situations, Peel Region Long Term Care (LTC) Division forged a vital partnership with PRPS, Peel Regional Police, and Caledon OPP. Together we launched an innovative, emotion-based dementia training initiative for first responders, aimed at improving interactions and de-escalating emergency situations involving people living with dementia.

In 2023, a pilot dementia training program was conducted with 40 first responders. The goal of the training was to enhance the participants' knowledge of dementia and increase their confidence in interacting with and supporting people living with dementia and their families or caregivers during calls in the community. Based on feedback gathered, in 2024, PRPS endorsed spreading this training to 780 road medics throughout their department as part of their annual mandatory training.

This training has strengthened relationships across the continuum of care, integrating emergency services, community programs (including Adult Day Services), and long term care to create a seamless support system for individuals living with dementia. Each service is interconnected and fosters an understanding of how best to support people in our communities who are living with dementia, their

families, and their caregivers using emotion-based, person-centred care strategies. As a leader in implementing emotion-based dementia care in our LTC homes since 2017, our journey in providing emotion-based care continues to evolve as we look for new ways to support partners with strategies to improve the wellbeing of people living with dementia.

Palliative Care

An interdisciplinary care team provides integrated, person-centered, and holistic care to address the physical, emotional, psychological, social, cultural, and spiritual needs of residents in alignment with their expectations. This approach ensures early identification of residents who may benefit from palliative care, enabling timely assessment of their current and future needs, preferences, and the involvement of Substitute Decision Makers (SDMs), family members, and designated caregivers. Care planning and collaboration focus on addressing these needs and expectations. Advance care planning and individualized discussions occur at admission, during care conferences (admission, annual, or situational, such as significant health changes), using tools like the Individualized Summary. This tool guides healthcare practitioners, including physicians, nurse practitioners, and staff (RN, RPN, SW), to explore residents' wishes, values, and beliefs upon admission. Additionally, in 2024, we identified the opportunity to provide more equitable end-of-life practices and developed family-led death care policies with input from diverse stakeholders, including residents' and family councils, and end-of-life doulas. Goals of care, end-of-life preferences, and values are documented in the resident's electronic health record (EHR) to ensure care aligns with their current needs and expressed wishes.

At Davis Centre, we have started preparing palliative care awareness space for residents, SDM, caregivers, volunteers and staff. This space includes a range of resources that may raise awareness among stakeholders and may provide them with an opportunity to explore palliative care for their loved ones. The main purpose of this exercise is to ensure safety and comfort for our residents and to provide the stakeholders with all the available options for this.

The Prevention of Error-Based Transfers (PoET) program is a provincially led initiative designed to help long-term care facilities align their decision-making practices with the Ontario Healthcare Consent Act. This program aims to reduce unnecessary hospital transfers, safeguard resident autonomy by ensuring care aligns with their wishes, values and beliefs, and maintain compliance with consent-related requirements outlined in the *Fixed Long Term Care Act* (FLTCA). In 2024, Davis Centre's registered staff successfully renewed their certification for the PoET program.

4.2 Quality Improvement Workplan

Peel Region's Long Term Care homes are committed to providing high quality care to our residents. This has included meeting the FLTCA regulations and hiring CQI Specialists for each of our homes in 2024 to support with quality improvement methodology, risk management, and quality management planning.

The Quality Improvement Plan is an organization-owned document that sets to establish the home's plan for quality improvement over the coming year. This includes documenting the set of quality commitments we make to our residents, families, and staff related to quality-of-care issues identified at the home.

The following table breaks down priority areas identified for the year 2024/25. Vera M Davis Centre' Quality Improvement Initiatives align with annual submissions of Quality Improvement Plans.

Area	Key actions	Target date for completion	Status and outcomes of Actions
Rate of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents.	a. Improve the use of diagnostic equipment to avoid common reasons for ED transfers. b. Maintain partnerships with mobile diagnostic services (lab tests) to avoid hospital trips for routine investigations.	August 2025	In progress Diagnostic devices are being used for avoiding ED transfers and work is in progress to improve diagnostic services turnaround time.
	PDSA Initiative Phase 2: Decrease ED transfer rate by monitoring the implemented change ideas from phase 1.	December 2025	In progress PDSA phase 2 has been initiated.

	Use of a tracking tool to report, analyze, and identify trends in all ED transfers to support improvement in the indicator.	April 2025	Completed on 22 April 2025. Training has been provided to staff and the tool is currently being used for recording all transfers.
	Ensure SBAR tool is used in PCC for communication between nursing and clinicians prior to hospital transfer.	July 2025	In progress It is still under process. Staff have been trained last year and they are reminded to complete the SBAR tool after each transfer.
	Enhance the Palliative Care Program.	December 2025	In progress Required documentations and reference materials have been prepared. Staff education and family council education has been provided. Residents are approached as and when deemed fit.
Percentage of staff completing 2SLGBTQI+ training in alignment with BPSO BPG implementation.	Implement BPSO BPG: Promoting 2SLGBTQI+ Health Equity.	December 2025	In progress Home has assigned champions to promote 2SLGBTQI+ work. Documents are being reviewed and revised. Home is organizing events for raising awareness among residents and staff. Training is expected to be completed by all staff November 2025.

Percentage of residents responding positively to: "What number would you use to rate how well the staff listen to you?"	Staff Education on Customer Service	December 2025	Pending It is still under planning phase.
	Staff Education on Resident Bill of Rights	November 2025	In progress We are aiming to train all staff by November 2025.
Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences".	Empower residents' voices	February 2025	Completed. The residents were informed at the Resident Council meeting that they will be approached on quarterly basis to record any concerns.
Percentage of residents who responded positively to the statement: "My problem was resolved to my satisfaction"	Raising awareness among staff regarding dealing with resident and family complaints.	October 2025	Pending The development of education material is still under process.
	Increase residents' awareness of the complaint review process.	August 2025	Pending Home is expected to review the complaint process with residents before August 2025.
Percentage of residents who responded positively to, "I have access to	Develop and implement strategies to expand the availability and variety of activities to meet resident's needs, ability and interests.	August 2025	In Progress New activities are being added in the home.

activities that meet my interests"			
Percentage of LTC home residents who fell in the 30 days leading up to their assessment	PDSA Initiative (Phase 2) - Decrease the percentage of falls through analysis of falls data and adjustment of strategies as necessary.	December 2025	In progress PDSA phase 2 has been initiated.
Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment	Establish the Anti-psychotic subcommittee.	April 2025	Completed The Anti-psychotic subcommittee has been established in the home.
	Implement evidence-based interventions, monitor medication practices, and provide targeted education to interdisciplinary teams.	August 2025	In Progress The interventions are being implemented and the educations is being provided.

Section 5: Communication Plan

Quality Improvement is communicated utilizing different strategies that are tailored to the specific improvement initiative and outcomes. These include, but are not limited to:

- Postings on the information/quality board
- Direct e-mails to staff and families
- Newsletters
- Website
- Informal presentations/huddles
- Presentations at staff meetings
- Presentations at Residents' Council meetings
- Presentations at Family Council meetings (on request)
- Presentations at various Committee meetings

Residents: The action plans from quality improvement initiatives and the 2024 experience surveys were reviewed at the Resident Council Meeting in March 2025. No changes or additions were made. Information was shared with residents through the Resident Council meeting minutes, and residents are also encouraged to share suggestions at any time, not just during the annual survey.

Families: The same action plans were shared with the Family Council in February 2025, with no changes or additions proposed. Details were provided to families through the Family Council meeting minutes and family members are also encouraged to offer suggestions anytime.

Progress on quality improvement initiatives and action plans to address key areas from the satisfaction surveys will be shared quarterly at the Resident and Family Council Meetings starting May 2025.

Staff: Updates were shared with staff via CLT and CQI meetings, where action plan development was discussed regularly. The updates on the action plan will be shared in CLT and CQI meetings starting May 2025. Ongoing updates regarding plan implementation will be posted on the quality board on quarterly basis starting May 2025.