GFHC- HHCC 2026

Quality Improvement & Resident Safety Framework

Gibson Family Healthcare is committed to delivering safe, compassionate, and high-quality care that recognizes each resident as a whole person. Our approach integrates Trauma-Informed Care (TIC) principles with a Person-Centred Care Model to ensure residents feel safe, respected, empowered, and heard. This approach acknowledges that many individuals living in long-term care have experienced trauma throughout their lives, and seeks to prevent re-traumatization while promoting dignity, choice, trust, and meaningful relationships.

With a legacy of owning and operating a nursing home since 1965, the Gibson Family brings decades of experience and dedication to resident care. This commitment is reflected in our long-standing team members, many of whom have served for over 20 years. Their knowledge, compassion, and deep connection to residents are invaluable assets in continuously enhancing quality of life.

Helen Henderson Care Centre is dedicated to ongoing quality improvement by actively researching, evaluating, and implementing processes, programs, and services that enhance resident care. Our guiding philosophy is simple: *to do what provides our residents with a quality life*. To support this, we collect, analyze, and utilize data to inform decision-making and improve outcomes. As part of this evolution, we are progressively computerizing and automating key processes, prioritizing initiatives that align with our resident-focused philosophy. We also seek input from external organizations to strengthen and complement our internal quality improvement efforts.

Our quality improvement and Resident Safety framework is guided by provincial legislation and supported by key organizations including the Ministry of Health and Long-Term Care, the Canadian Council on Health Services Accreditation (CCHSA), CIHI (InterRAI), Health Quality Ontario, the Ontario Health Quality Council, and the Registered Nurses' Association of Ontario Best Practice Guidelines. Additional partners such as the Residents First program, Public Health Ontario, Ontario Health atHome and professional regulatory bodies contribute to our shared mandate of continuously improving care for residents, families, staff, volunteers, and the broader community.

Accreditation plays a vital role in our quality assurance processes. As a member of CCHSA, Helen Henderson Care Centre uses national and provincial standards to evaluate and enhance service delivery. This process not only supports continuous quality improvement but also provides recognition that our organization meets established benchmarks for excellence in care.

Through this integrated framework, Gibson Family Healthcare and Helen Henderson Care Centre remain dedicated to fostering a culture of safety, accountability, learning, and continuous improvement—ensuring the highest possible quality of life for every resident.

Section

A

What is the difference between Quality Assurance, Quality Control and Quality Improvement?

Quality Assurance (QA)

Quality assurance focuses on **ensuring that services meet predefined standards**.
It demonstrates that care provided fulfills **established requirements and criteria**.

Quality Control (QC)

Quality control focuses on **maintaining consistent performance standards**.
It uses monitoring methods to ensure services **continue to meet expected outcomes**.

Quality Improvement (QI)

Quality improvement focuses on **enhancing services over time**. When improvements are ongoing and repeated, this is known as **Continuous Quality Improvement (CQI)**.

Quality Improvement Plans (QIPs)

What is a QIP?

A Quality Improvement Plan (QIP) is a structured approach used to:

- Guide improvement efforts
- Communicate commitment to quality
- Support high-quality, resident-centred care

Why QIPs Matter

Helen Henderson Care Centre defines quality improvement as an organizational philosophy that seeks to meet and exceed the diverse needs and expectations of residents, families, and the community through a structured, evidence-informed approach to positive change. Grounded in Trauma-Informed and Person-Centred Care principles, and guided by a strong commitment to Diversity, Equity, and Inclusion (DEI), our approach ensures that every resident feels safe, respected, valued, and empowered.

We recognize that each resident brings unique life experiences, identities, cultures, and potential histories of trauma. Our quality improvement processes are designed to be inclusive, responsive, and respectful of these differences, ensuring equitable access to care and supporting dignity, choice, and meaningful participation in decision-making.

Our structured quality improvement process identifies areas for enhancement, determines effective methods for change, and establishes measurable outcomes to monitor progress across all aspects of care and service delivery. This includes evaluating both the quality of services and the outcomes experienced by residents, with a focus on safety, well-being, and quality of life.

Quality improvement at Helen Henderson Care Centre also reflects a culture of continuous learning and a commitment to achieving and sustaining standards of excellence. We actively seek opportunities to strengthen the services we provide to residents, families, staff, and the broader community, recognizing that the pursuit of quality is ongoing.

Key quality improvement concepts include:

- Understanding who our residents and communities are, with attention to their diverse backgrounds, lived experiences, and evolving needs
- Delivering care through a trauma-informed, person-centred lens that prioritizes safety, trust, collaboration, and empowerment
- Embedding equity and inclusion in all processes to ensure fair, respectful, and culturally responsive care
- Focusing on care and service delivery as interconnected processes that influence resident outcomes and experiences
- Using a scientific, data-driven approach that relies on accurate, reliable information, measurement, and analytical tools to understand variation and drive improvement

Helen Henderson Care Centre is committed to fostering a safe, respectful, and inclusive environment where every resident, family member, and team member feels valued, heard, and supported. In alignment with our vision and mission, we strive not only to sustain but to

meaningfully enhance quality of life by recognizing each person's unique experiences, strengths, and preferences.

To guide our progress, we identify a focused set of "critical few" objectives. These objectives reflect meaningful, measurable outcomes that support both individual well-being and organizational goals. Each objective clearly outlines who is involved, what actions will be taken, the anticipated impact, timelines, and how success will be evaluated.

Our outcome objectives are centred on the lived experiences of residents, focusing on the positive changes they experience as a result of our programs, services, and daily interactions. We recognize that quality of life is defined by the individual, and we continuously seek feedback to ensure care aligns with their values and goals.

We use a structured, reflective quality improvement process guided by provincial and national standards to monitor progress and continuously enhance care through learning, collaboration, and adaptation. In alignment with the Excellent Care for All Act (ECFAA), 2010, Helen Henderson Care Centre develops and publicly reports an annual Quality Improvement Plan (QIP) to advance quality, strengthen accountability, and ensure improvements reflect the needs and voices of those we serve.

Residents First is a provincial, partner-driven initiative that supports long-term care homes in Ontario in creating environments that enhance residents' quality of life while strengthening the sector's capacity for sustained quality improvement. As part of this initiative, Helen Henderson Care Centre incorporates three types of Quality Improvement Plans (QIPs), which help organize and share our quality improvement efforts for a variety of purposes and audiences.

A **topic specific QI plan** is a plan developed for each specific topic that Helen Henderson Care Centre team leaders want to improve. The Topic Specific QI Plan provides the framework for focused quality improvement work that includes:
• Specific and measurable aim statements
• Specific change ideas to be implemented
It also outlines each home's unique characteristics, to help the reader understand the QIP and its aims.

An **organizational QI plan** is developed to help Helen Henderson Care Centre plan our annual quality improvement initiatives. This plan is intended for internal use. It identifies:
• Priorities for strategic areas;
• Topics for improvement within each strategic area;

• Outcome and baseline measures for each improvement topic; and
• Long-term goals, aims/targets, timeframe, quality attributes, priorities and the team leader responsible.

An **implementation QI plan** is developed by our home leaders for use by the QI teams. It identifies the individuals who are accountable, process measures to be collected and evaluated, and timeframes and resources needed to implement the change ideas. Like the organizational QI plan, the implementation QI plan is also for internal use.

Approach to Quality Improvement Plans

The *5 Why's* is a simple brainstorming tool that we use to help us identify the root cause of any problem and is often used after an issue has been identified using another tool such as a "Fishbone" diagram or "Process Mapping". Once a general problem has been recognized ask "why" questions 5 times to drill down to the root causes. Asking the 5 "whys" allows us to move beyond obvious answers and reflect on less obvious causes or explanations.

The Residents First concept and format for Helen Henderson Care Centre's QIPs is based on the *Model for Improvement*. The Model for Improvement has two parts:

1. Three fundamental questions, which can be addressed in any order (see below)
2. The Plan–Do–Study–Act (PDSA) cycle, which tests changes in real-life work settings. The PDSA cycle guides us in determining if a change is an improvement.

The Model for Improvement's **first question**, "What are we trying to accomplish?" is reflected in all three types of QIPs. Helen Henderson Care Centre strives to set a clear and numeric aim for improvement to be accomplished within a specific time frame.

a) What are we trying to accomplish?
b) How will we know if a change is an improvement?
c) What changes can we make that will result in improvement?

The **second question**, "How will we know if a change is an improvement?" is also reflected in all three types of QIPs. The *Residents First* change packages provide outcome, process and balancing measures for a range of topics. Helen Henderson QI teams must collect these measures if we want to see whether improvement has occurred.

The **third question**, "What changes can we make that will result in improvement?" can help our QI teams tap into the innovation and creativity that exists within our home and beyond. Answers to this question are provided in all three types of QIPs.

The PDSA cycle helps our teams to plan the test change idea, observe the results and act on what is learned. The cycle is a "scientific method, used for action-oriented learning." It is important to continue to measure small, implemented changes and share these measurements with other teams and the staff. This kind of consistent feedback will ensure that QI teams are heading toward the desired aim.

When developing change strategies, our home incorporates the six change concepts listed in the *Residents First* change packages:

1. Recognition and assessment (e.g., risk assessment completed, early identification of concern areas);
2. Education and engagement (e.g., provide education to staff on the specific topic I identified) and evaluate the effectiveness of provided education;
3. Care planning
4. Improve workflow (e.g., streamline assessment tools, standardize care products)
5. Develop routine practices (e.g., quarterly med reviews)
6. Design systems to avoid mistakes

Priority Setting

A QIP is an important tool for identifying key priorities for improvement. Priorities help Helen Henderson Care Centre focus on what we want to accomplish. To do this we look at:

- **Impact:**

  The focus is on identifying the quality problem that is common, whether it has consequences for residents, if it has an impact on related areas, if there is a gap between the current and desired state, the costs to the organization etc.

- **Ease of implementation:**

  The focus is on a quality problem for which there is already a good change solution, measurement tools are available or in use and the successes achieved by other LTC homes are actionable by Helen Henderson staff.

- **Alignment:**

  The focus in this section helps us to ensure that the Helen Henderson's efforts are focused on a quality problem that is aligned with the provincial priorities, accountability agreements, public reporting and organizational strategic plans.

There is no simple answer to the question of how many priority topics a home should focus on but Health Quality Ontario (HQO) encourages us to focus on no more than 2 to 4 priority topics at a time.

Aim Setting

Teams set aims and team leaders oversee measurement collection, analysis and interpretation of data collected. A clear aim statement and a specific time frame within which Helen Henderson wants to reach that aim are essential to success. Teams are more likely to achieve their quality improvement aims when they set a stretch aim; an aim that is challenging yet achievable, rather than simply stating a vague or minimal aim, or no aim at all. Stretch aims can be inspirational. They can motivate staff and when accomplished, can engender confidence in the staff's ability to tackle the next major challenge.

The *Residents First* program offers some specific suggestions for stretch aims: a 50% relative reduction in falls, pressure ulcers, responsive behaviours and consistent PSW assignment topics; and a 25% relative reduction in ED visits and incontinence.

1. *Aim* for the Theoretical Best
For certain indicators, there may be a theoretical best that Helen Henderson leaders may aim for, particularly in areas that measure defects, wait times or use of a best practice. For example, a theoretical best could be to aim for zero waste (e.g., defects, overproduction, unnecessary waiting, too much motion, etc.) or 100% adoption of a recommended clinical practice (e.g., Registered Nurses' Association of Ontario [RNAO] Best Practice Guidelines).

For some indicators, particularly those that are related to part of the disease process, it is not realistic to aim for a theoretical best, because these indicators can be reduced but not eliminated (e.g., responsive behaviours).

2. *Aim* to Cut a Defect or Waste in Half in the Current Planning Cycle
Residents First uses the RNAO Best Practice Guidelines to create recommendations for the relative percentage of reduction/improvement aims in change packages.

Examples:

- Reducing unfilled shifts by 75%, from 63 to 19 by September 2026; or
- Reducing medication errors by 90%, from 10 to 1 by October 2026

3. *Aim* for Best Achieved Elsewhere

Health Quality Ontario recently conducted an LTC benchmarking exercise that set quality indicator benchmarks to which homes can aspire. The process examined Ontario's performance, as well as that of other provinces and countries, on a selected number of quality indicators in order to determine benchmarks that represent high-quality care. Carveth teams can use them as targets for their own performance. Helen Henderson can also use HQO's LTC public reporting website to identify the best performers in Ontario and aim for similar results.

4. *Aim* for Performance Achieved by Peers

Another strategy is to aim for a particular rank or placement compared to other LTC homes. For example, a home that is already performing well might want to aim to be among the top 20 homes in the province. Data posted on HQO's LTC Public Reporting Website can help support this type of aim setting by allowing homes to compare their performance to others on certain quality indicators Helen Henderson Care Centre and our sister home Carveth Care Centre meet quarterly to review QI data which allows us to develop AIM statements which are process driven and allows the us to compare "like" data.

Baseline Measures and/or Dates

Baseline measurements are important both for setting aims and for calculating future/desired measures after improvement has been attained.

> For example, to calculate a 25% reduction for a relevant Residents First topic, team should use the following formula: *Baseline measure/4 = future state measure*
>
> If a home's baseline measure for the number of residents who fell is 27, then a 25% reduction would be *27/4 = 6.75 (i.e., rounded up = 7 residents who fell)*
>
> This figure represents roughly 25% of the baseline data, so in order to calculate the future measure we need to subtract 7 from 27, which will give us 20 (residents who fell). Thus, the aim statement will be: "Our QI aim is to reduce the number of residents who fell in our home by 25%, from 27 to 20, by December 2013."

Teams and Team leaders are encouraged to:

a) Set stretch aims, as provided in the Residents First change packages.
b) Engage frontline staff, residents and families in the aim-setting process.

c) Collect baseline data, if staff previously has not done so. Leaders need to set specific timeframes for baseline data collection, after which a stretch aim can be set.
d) Set a specific date on which to achieve the planned improvement.
e) Align the QIP with the organizational business plan. This will help leaders and staffs stay focused on the implementation of their QIP.

Change Ideas

Change ideas are important. They help teams develop a strategy for improvement, identify key evidence-based best practices to be implemented, anticipate common barriers to implementation and create a plan to address those barriers.
When identifying change ideas, teams and leaders should think of change strategies in three ways:

1. **What do our residents want?**

What do residents need, want and are required by regulation to have? Both residents and staff should be considered when identifying change ideas.

2. **What specific practices or activities will satisfy residents and fulfill their needs?**

This could include value-added steps in providing personalized care for residents, or certain treatments, drugs or tests/assessments that need to be given to certain types of residents and are often found in clinical practice guidelines.

3. **What changes can we all make (including frontline staff, residents and families) to ensure that best practices are tailored to residents' needs, and implemented and continually improved upon?**

To develop effective change ideas, teams and leaders must understand their current situation and collect baseline data. Teams should conduct their own internal root cause analysis using quality improvement tools (e.g., Fishbone [Ishikawa] and/or 5 Whys) to ensure that they are focusing on the appropriate areas. By looking into the root causes that affect or limit the consistent use of best practices, teams can gain a better understanding of the issues and be able to develop change ideas. Teams and leaders who want to use staff education as a change idea should answer the following questions:

- Do all relevant staff members attend the training program?
- If they attend, do they absorb the information?

- If they absorb the information, will they carry it out?
- If they learn a skill, how does the leader know they can perform the skill correctly?
- Do they carry out the activity well?
- Will they forget the skill over time?

Residents First highlights the importance of:

- Setting the right number of priority topics
- Setting clear stretch aims; setting stretch targets and having a defined strategy are key steps in the path towards improvement.
- Creating a prioritized, achievable list of change ideas.

Include change ideas related to system improvement, such as streamlined processes, standard work flow, reminders and creating systems to avoid mistakes. Avoid over-reliance on staff training as the sole strategy for improvement. Include more process measures to monitor whether change ideas are being implemented as intended.

Goals & Objectives

- Promote awareness and shared understanding to enhance each resident's quality of life, guided by their individual preferences, strengths, and lived experiences
- Collaboratively review insights from eight functional teams—Restorative Care, Falls Prevention, Enhanced Care, Ethics, Infection Control, Pain Management, Skin & Wound Care, and Continence Care—to identify opportunities for meaningful, person-centred improvements
- Ensure all areas of the home reflect evidence-informed, trauma-informed, and person-centred best practices
- Provide families with clear, compassionate, and accessible information upon admission to support a smooth, respectful transition and build trust in our care
- Foster a supportive, inclusive workplace culture through positive encouragement, recognition, and team-building initiatives
- Strengthen open, respectful, and transparent communication throughout the Home

MEASUREMENT

Creating a QI Measurement Plan

Identify how frequently data will be collected and reviewed (e.g., daily, weekly, monthly) to support timely understanding of how changes are impacting resident care and experience. Data collection should be frequent enough to allow teams to reflect, learn, and adapt in real time.

Information related to outcome, process, and balancing measures will be collected using a Measurement Plan template to support consistency and clarity.

Key measurement guidelines

- Select measures that align with team aims and reflect meaningful outcomes for residents
- Use existing data collection systems whenever possible to reduce burden and support sustainability
- Integrate measurement into daily routines to promote consistency and shared accountability
- Review and track measures regularly (e.g., monthly) to support ongoing learning and improvement

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Implementation

Each core focus team meets routinely to reflect on progress toward their goals, discussing both successes and challenges in a supportive, learning-focused environment. These discussions emphasize curiosity, shared learning, and continuous improvement.

Quarterly, results are shared with the QI Team to compare outcomes with partner homes and provincial benchmarks, helping to identify opportunities for growth and innovation.

All initiatives and improvements are communicated regularly with Residents' Council, Family Council, and staff to ensure transparency, inclusion, and shared ownership of changes across the Home.

As goals are achieved, teams will collaboratively determine next steps—whether to establish new aims or sustain current practices—based on resident experience, feedback, and alignment with provincial benchmarks.

QI METHODS & TOOLS

The tools described in this section are available as templates at the back of this binder and at www.hqontario.ca

Fishbone/Ishikawa/Cause & Effect Diagrams

The Fishbone Diagram, also known as an Ishikawa Diagram or Cause & Effect Diagram, is a simple tool that can be used to brainstorm and map out possible causes of a quality problem. A Fishbone Diagram is an important first step, because many QI teams jump into trying to fix one cause without assessing other possible causes.

Step-by-step instructions:

1. Put the name of the quality problem (the effect) in the box at the far right of the diagram.
2. To the left of this box, draw a central line (the spine) and from this central line draw diagonal lines (fish bones) representing different causes of the problem.

   For example, some teams use the five Ps (person/resident, providers/staff, policies, processes/procedures, and place/equipment); some use the six Ms (machine, method, materials, measurement, man and Mother Nature); and some use the four Ss (surroundings, suppliers, systems and skills). Pick groupings that make the most sense for the problem.
3. Ask the QI team members to identify different causes and list them along the appropriate diagonal line or grouping.
4. Team members may take any cause and draw a line and more branches off the line to describe other factors that contribute to the cause.

After deciding on the major groupings, allow plenty of opportunity for group creativity in identifying different causes. Encourage teams to consider all arms of the diagram and not to focus too much attention on only one or two categories of causes. This is brainstorming and it is best not to discuss the ideas during this part of the activity.

Once the Fishbone Diagram is complete, the QI team can start reviewing it to understand and analyze the cause(s) of the problem (or effect).

Five Whys

The Five Whys is a simple brain-storming tool that can help QI teams get to the root causes of a problem. For a problem you have identified (either using the Fishbone Diagram or Process Mapping), ask "why" questions to drill down to the root causes. This tool allows teams to move beyond obvious answers and reflect on less obvious explanations.

Step-by-step instructions

1. State the problem that has been identified to work on.
2. Start asking "whys" related to the problem and keep asking why in response to each suggested cause.
3. Ask as many "whys" as is needed in order to get insight at a level that can be addressed (asking five times is typical).

Guard against using the "Five Whys" questions on their own to avoid a narrow focus or bias.

Process Mapping

A Process Map, also known as a flowchart, outlines all the different steps in a process. Process Mapping helps our QI teams to identify problems that can be fixed. It is a fundamental tool that is very useful for all QI initiatives because it gives the team clear insight into its processes. If the team cannot agree on where the problems occur then data should be collected to support each argument.

It is recommended that QI teams start with a high-level Process Map (with five to 12 steps). The team may then choose to go into greater detail on any particular set of processes where problems are believed to be the greatest.

Step-by-step instructions

1. Assemble a group to work on the Process Map. Helen Henderson tries to include representatives of every category of staff who contributes significantly to the QI initiative being evaluated. This also includes including residents or users of the service.
2. Use a neutral team facilitator.
3. Agree on the start and end points that will be mapped.
4. Focus on mapping the steps or activities that account for 80% of what's happening. Don't waste time on the exceptions.
5. Map the actual — not the ideal — process.

6. Write each process identified on a post-it note and display it on a board. You may want to specify who does the process and where.

If key team members are not able to meet together to build the Process Map, try this alternative:

1. Post a board with processes partially mapped in a location staff pass through frequently e.g. staff room.
2. Invite staff to use post-it notes to add missing parts of the process. If someone disagrees with how part of a process is mapped, he/she can post an alternative set of processes below.
3. Leave the board up for a set period of time e.g., one day or one week.

There are several different types of Process Mapping:

Detailed — the most common kind of Process Map

The detailed Process Map maps processes in a sequential manner from start to finish

High-level — the fastest, simplest and least detailed Process Map

A high-level Process Map is the most basic of all. It lists the main steps in a process — usually 5to 12 of them. It is a great start and it is often followed by a high-low Process Map. This process map is good to evaluate care needs and services delivery.

High-low (also called **Top-down)** — adds depth to a high-level Process Map, but without detailed mapping .

To create a High-low Process Map It lists the main steps in a process — usually 5 to 12 of them and begins with the desired result the team is trying to achieve and works backwards.

Swim lane — shows what different functions/people do in a detailed Process Map

In a Swim lane Process Map, each “lane” is labeled with a care team member or location that is critical for the process to succeed. Do not forget to include the resident. Each step of the process is placed in the appropriate “Swim lane” according to who is handling it. A Swim lane Process Map allows the QI team to see how many “hand-offs” occur during the process from start to finish. Unnecessary hand-offs signal inefficiencies and an increased opportunity for mistakes to occur.

Each type of Process Mapping frames the process a little differently. To decide which map to use, you need to understand how you need to visualize your process based on particular

needs during a project. Most times a high-level Process Map is all you need. You may opt to create detailed or swim lane Process Maps on subsets of the process only when you need them. Resist the desire to map all parts of your process in detail!

Analyzing your Process Map

Once the team has completed the Process Map, ask the following questions:

- Where are the bottlenecks? How can we address these?
- Are there inconsistencies in how things are done? What can be standardized?
- Can things be done:
  — In a different order?
  — In parallel?
  — By a different person with better or same quality, at lower or same cost?
- Can steps be located closer to each other to reduce travel?
- Does each step add value? If not, can it be eliminated?

Check Sheets

A Check Sheet is a simple data collection tool that can help a QI team identify the most important cause of a quality problem. It can also be used to gather information on the problem or different aspects of the problem. This tool is useful when the team has identified a number of causes or a number of problems or defects and wants to know which one is the most important.

Step-by-step instructions

1. Generate a list of the most common defects or causes. A typical list comprises of 6 to 10 defects or causes of a problem. Include an “other” category.
2. Create a Check Sheet.
3. Decide how to collect the data — eq. going forward in time or back in time, using chart audits or other documentation.
4. Pick a timeframe for collecting data. If you are collecting data going forward, try to keep the data collection timeframe short e.g. one to two weeks.
5. Identify who will collect the data e.g. the chart reviewer or service provider. Have them mark the appropriate place on the Check Sheet each time a defect or cause occurs. Provide specific instructions on how defects or causes are to be defined.
6. Plot the data on a Pareto Chart.

Pareto Charts

The Pareto Chart is a tool that helps teams see which causes or problems occur most frequently. The chart plots out the activities or areas that contribute most to poor quality. The Pareto Chart is based on the theory that a small number of causes will have the largest contribution to poor quality.

Step-by-step instructions

1. Place the data captured in the Check Sheet onto a table, in descending order. From this table, calculate the percentage frequency and cumulative frequency.
2. Plot this information as a bar chart, where each vertical bar represents a different cause or problem and the left vertical axis represents the number of causes and problems/defects.
3. Identify the bar where the cumulative frequency is high relative to the number of categories.
4. Look for a Pareto Effect where the first few categories account for most of the problems.

DEMONSTRATING IMPACT

Analyzing data over a period of time makes it easier to assess the impact of QI changes. A graphical display of results is very useful to show changes in measures across the life cycle of a project. Both run charts and control charts can achieve this.

Run charts are useful regardless of how much data you have collected. They are simple to produce and interpret and they are guided by simple rules. Control charts provide a more powerful way of analyzing your results, though they require more data for input and more sophistication to produce and interpret.

Run charts

Run charts should be set up at the start of a QI project and updated with new data as the project unfolds. A run chart is a graph that illustrates changes in quality over time. Measurements are taken at frequent points in time and connected with a line. This provides a graphical display of variation across time and helps a team to see if changes have led to improvement.

An annotated run chart has comments with arrows pointing to times when different ideas for improvement were tested. This helps explain any sudden changes in quality that may have occurred.

Step-by-step instructions

1. As the team gathers data, create a graph where the measure of quality is on the vertical axis and time is on the horizontal axis. Connect each data point with a line.
2. Show the target for improvement by drawing a horizontal line across the graph labeled “target.”
3. Show the median point of the data by drawing a horizontal line across the graph at the level where half the data points are above and half are below that line.
4. Make notes (annotate) on the run chart with comments to tell the story of the different improvements the team has tried.

QI teams recognize significant changes — hopefully, improvements — by carrying out two simple tests on the run chart:

1. Are there six or more consecutive points above the median?
2. Are there six consecutive points moving upward or downward?

If there is evidence of either of these rules in the chart, it indicates that a significant change has occurred within the process. Now QI team’s task is to maintain progress and continue to improve. Once a run chart has more than 11 points, consider turning it into a control chart.

Control charts

Control charts are like run charts but they have more statistical power to detect changes and improvements. Control charts are used for QI and also for performance monitoring e.g. dashboards or scorecards. Data may be presented in various forms:

- Percentages
- Rates
- Counts
- Individual values

Many kinds of control charts are available to work with different types of data but all control charts look similar and are interpreted in much the same way.

Control charts help QI teams understand the nature of the discrepancies (variations) of their processes. They may answer questions such as:

- Do we have a stable or in-control process with common cause discrepancies?
- Do we have an out-of-control process with special cause discrepancies?

• What does the discrepancy tell us about the level and range of performance of the process?

Variation is to be expected. Processes rarely produce the same measurements every time. It takes different times to get to work; golf scores vary; blood pressures fluctuate; staff routines are never identical; dining room waiting times vary from one resident to the next. The combination of small variations of a process adds up to common cause variation. Control charts can demonstrate whether a process is in control or not statistically speaking.

Common cause variation means that no one thing in particular is causing the result eq. when we travel to work all sorts of things contribute to how long it takes: traffic volumes vary; the number of red lights vary and the number of people making left-hand turns vary.

Sometimes variation in a process is due to a special cause eq. for example we are driving to work and have to take a long detour because of a water main break. Special cause variation can often be attributed to something unusual, rare or difficult to identify. If it isn't unusual or rare, it is probably common!

A control chart is a run chart with a line drawn at the average (or mean) and pairs of control limits. The control limits are calculated to show one, two and three standard deviation (SD) lines for the plotted data. Most control charts show three SD limits, commonly called the upper control limit (UCL) and lower control limit (LCL). A point beyond one of the three SD limits is evidence that a special cause probably occurred. The QI team's job is to figure out what the special cause might be.

We look at control charts to see if there is any evidence of special cause in the charted data. Special cause can be observed in several ways, using a number of rules. If we do not see evidence of special cause, it means our process is in statistical control. We then want to look at the average value and where the limits are. Looking at the average tells us whether the process is good or not on average. A process could be in control and still be a poor process — "some residents always get their meals late at this home!" It could also be that there are very wide limits around the average. Imagine that residents typically wait an average of 10 minutes to be served their dinner, but on some days the average wait time is

15, 20 or even 25 minutes. The overall average may be acceptable, but the variation around it may be unacceptable.

When we have special cause variation, we want to understand why. In the case of a QI project, the "why" may be because the team introduced a change and wanted to see a special cause signal that indicates they've made an improvement. In other situations, when we are monitoring a process, special cause may indicate something that we do not want to happen. For example, injuries due to falls may increase, risk assessments may be done too infrequently or resident satisfaction may be too low. In these instances, we want to investigate and find out what happened.

If trying to improve a process and but seeing a special cause for statistical variance, revisit tests of change using PDSA again. Control charts are ideally suited to monitoring improvement project outcomes and process measures and helping to determine whether a change is actually an improvement.

Current reporting on LTC quality shows that there is always ample room for improvement. Helen Henderson Care Centre is increasingly interested in influencing our success to strengthen existing QI activities and develop new QI projects. Our QI projects and activities strive to achieve slow, steady growth/improvement/progression. Helen Henderson Care Centre strives to utilize the fundamentals of the Model for Improvement and rapid cycle improvements, which help drive the new culture of Continuous QI. We strive to share methods and practical tips amongst teams in order to more readily analyze our current processes and identify opportunities for improvement.

Section

B

1. Health Quality Ontario - Quality Improvement Plan 2026/2027

Internal QI Team Goals

- Falls Team
- Restraint/Personal Assistive Safety Device Team
- Skin and Wound Care
- Continence Care
- IPAC
- Health & Safety
- Pain & Palliative Care Team

The internal team is involved with the HQO QIP

Departmental Goals

- Nursing Department
- Administration Department
- Environmental Services Department
- Recreation Department
- Dietary Department
- Retirement home

Equity

Measure - Dimension: Equitable

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of staff who have completed relevant Palliative/End of Life Education as it pertains to the Policy changes and Palliative Performance Scale.	C	% / Staff	Local data collection / most recent consecutive 12 month period	CB	CB	Education ensures the best working knowledge of Palliative Policy, imperative to quality Palliative and End of Life care.	

Change Ideas

Change Idea #1	Enhance PPS education, review and revised policy and procedure for Palliative/End-of Life.		
Methods	Process measures	Target for process measure	Comments
Educate via mini education sessions by Palliative Lead, knowledge board updated routinely, Palliative and End of life Care meetings, Bedside education by RN/RPN/NP.	percentage of staff completed relevant palliative education,	100% of registered staff completed education and implementing PPS effectively for optimal Palliative and End of Life care.	Education is ongoing and Keeping TIPC focused at the time of PPS assessments.
Change Idea #2	**Palliative Performance Scale developed for use in Point Click Care to enhance ability to track decline in residents more effectively.**		
Methods	Process measures	Target for process measure	Comments
internal audits, collaborate with Point Click Care, ADOC and Palliative care lead to align with current policy	PPS in PCC developed within 6 months, Audits completed regularly by Pain and Palliative Lead.	100% of Resident Palliative Performance Scales completed in Point Click Care by December 2026.	to enable HHCC to identify earlier when to initiate end of life care.

Safety

Measure - Dimension: Effective

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of organizational policies reviewed and revised to include explicit DEI, trauma-informed, and person-centred care language.	C	% / N/a	In house data collection / most recent consecutive 12 month period	CB	CB	All relevant policies that to include this DEI and Trauma informed person centred language at start of next QIP period.	

Change Ideas

Change Idea #1	Implementation of centralized policy management, to ensure staff have access to current, consistent policies across all departments reflective of DEI and Trauma Informed Person Centred Care. Quarterly review by Policy Review committee, which is comprised of Department Managers.		
Methods	Process measures	Target for process measure	Comments
All departments will review and upload updated policies to Surge Policy Pro on a quarterly basis to ensure policies remain current, accessible to staff, and aligned with regulatory requirements and best practices.	Percentage of departmental policies uploaded and reviewed in Surge Policy Pro.	100% of policies from all departments uploaded and reviewed quarterly, with full implementation completed by January 2026.	

Change Idea #2	% of policy reviews completed by agreed milestones (e.g., minimum quarterly checkpoints)		
Methods	Process measures	Target for process measure	Comments
Set quarterly review deadlines; assign accountable lead/manager for appropriate Policy Manuals. Reviewed during QI meetings to ensure completion, determine DEI & TIPC Language expectations	% of updates completed on schedule	to have 100% of all relevant policies includes DEI and TIPCC language.	This helps monitor progress throughout the year.
Change Idea #3	% of all relevant policies that currently include this language at start of QIP period		
Methods	Process measures	Target for process measure	Comments
Create policy review committee; develop DEI guidance template; conduct policy audits	(Number of policies updated with DEI + trauma-informed + person-centred language) ÷ (Total number of policies requiring review) × 100%	100% of policies to reflect DEI and TIPC language.	Dept managers to be responsible for Department specific polices to reflect DEI & TIPC Language.

Measure - Dimension: Safe

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment	O	% / LTC home residents	CIHI CCRS / July 1 to September 30, 2025 (Q2), as target quarter of rolling 4-quarter average	26.19	22.00	HHCC endeavors to reduce the current performance by 16%.	Providence Care Seniors Mental Health, Behavioural Support Services KFL&A

Change Ideas

Change Idea #1	Review medication use data from the home and from pharmacy providers (e.g., indications, new starts, PRNs, administration rates, summary of responsive behaviours, interventions)		
Methods	Process measures	Target for process measure	Comments
Our physicians and nurse practitioner and pharmacist will review all residents taking antipsychotics without a diagnosis of psychosis in an attempt to identify possible alternative therapies.	The number of residents currently taking antipsychotics without a diagnosis of psychosis vs. the number of residents taking antipsychotics without a diagnosis of psychosis after a full reassessment has been completed.	quarterly and annual reviews, reviews completed when Behaviours escalate as required	Suggestions for potential change will be forwarded to the SMH or BSO for further assessment and potential changes to treatment plan also involving the resident and/or their POA for personal care or anyone else the resident may request.
Change Idea #2	Educate staff on recognizing and understanding behavioural and psychological symptoms of dementia (BPSD) and non-pharmacological interventions.		
Methods	Process measures	Target for process measure	Comments
Increase staff completion of dementia education and Reinforce staff training on consistent documentation related to behaviours, triggers, and individualized interventions. Conduct ongoing audits of documentation and care plans to ensure individualized, person-centred interventions are implemented and monitored.	Education attendance records and training completion Resident care plan and documentation audits	100% of staff education completed related to BPSD and non pharmacological interventions and consistent documentation.	

Department: Nursing	**Goal #1**	**Goal #2**
Specific What exactly do you want to improve? Who is involved? Where will it take place? Why is this important?	Recruit and retain sufficient full-time and part-time Registered Practical Nurses (RPNs) to eliminate reliance on temporary staffing agencies. Recruitment efforts will include partnerships with local colleges for student placements (led by ADOC) and targeted outreach such as online ads and job fairs (led by the Marketing Manager).	Implement and fully integrate new pharmacy services by ensuring all registered staff, including nursing staff, Nurse Practitioners, and physicians, are trained in order entry and medication management processes, following the pharmacy provider's guidelines and transition procedures.
Measurable How will you track progress? What data will show improvement? Baseline and target?	• -Fill 100% of approved full-time and part-time RPN positions • -Reduce and ultimately eliminate use of agency RPN shifts • -Track number of applicants, interviews, hires, and student placements monthly	• -100% of registered staff complete initial and ongoing training on the new system • -Conduct monthly, quarterly, and annual audits of medication orders and processes • -Track and reduce medication errors, near misses, and order inconsistencies • - Monitor resident and family satisfaction through care conferences and survey results
Achievable Is the goal realistic given available resources? What barriers exist?	By focusing on new graduate RPNs, building relationships with local colleges, and increasing visibility through marketing efforts, the home can improve recruitment outcomes despite competition from hospitals and larger long-term care organizations and transportation barriers.	Allowing adequate time for training, ongoing support, and adjustment will help staff adapt to the new system. Challenges such as technical issues and resistance to change will be addressed through continuous education, troubleshooting support, and clear communication with the pharmacy provider and LTC Act Requirements
Relevant How does this align with organizational priorities or standards?	Consistent in-house RPN staffing supports continuity of care, improves resident outcomes, and strengthens person-centered care by having staff who are engaged and familiar with residents famillies/POA's/SDM's.	A successful transition will improve medication safety, streamline workflows, reduce errors, and enhance person-centered care, leading to better outcomes for residents.
Time-Bound What is the timeline? What milestones will be set?	Achieve full RPN staffing complement and eliminate agency reliance within 6 to 12 months, with regular progress reviews and adjustments to recruitment strategies as needed.	Complete the transition and achieve full implementation between July 2026 and July 2027, with quarterly reviews, ongoing audits, and annual evaluations to ensure sustained success.
Final SMART Goal Statement: "By [date], [unit/team] will [specific action] to improve [metric] from [baseline] to [target], as measured by [data source]."	Within 6 to 12 months, the home will recruit and retain enough full-time and part-time RPNs to fill 100% of staffing needs and eliminate reliance on agency staffing, using college partnerships, targeted marketing, and job fairs, with quarterly tracking of recruitment efforts to ensure consistent, person-centered care delivered by a stable and invested team and adjust recruitment efforts if unsuccessful.	Between July 2026 and July 2027, the home will successfully transition to new pharmacy services by ensuring 100% of registered staff are trained in the new order entry system, conducting regular audits and reviews, reducing medication errors and inconsistencies, and improving resident and family satisfaction, with ongoing education and quarterly evaluations to support safe, efficient, and person-centered care.

HHCC QI Team and Departmental Goals 2026

Department: Office Administration	**Goal #1**	**Goal #2**
Specific What exactly do you want to improve? Who is involved? Where will it take place? Why is this important?	Establish a consistent and streamlined onboarding process for all new hires and internal role changes (e.g., part-time to full-time, department transfers), ensuring completion of letters of offer, HR/payroll documentation, and onboarding checklists prior to the first shift.	The newly hired Office Assistant will be fully trained to perform the duties of the Office Manager, including payroll processes, scheduling systems (Staff Schedule Care, PointClickCare, Dayforce), benefits and pension administration (Manulife, NHRIPP), LTC file management, resident admissions and discharges, contract completion with residents/families/POAs, and adherence to Unifor and ONA union agreements. The assistant will also maintain up-to-date tour admission packages and provide reliable backup coverage for the Office Manager.
Measurable How will you track progress? What data will show improvement? Baseline and target?	• Achieve 100% completion of onboarding documentation before first shift • Ensure 100% use of a standardized onboarding checklist for all hires and transitions • Reduce onboarding delays or errors by 90% • Maintain backup onboarding coverage 100% of the time (office assistant or designate) • Audit onboarding compliance monthly	Demonstrate competency in: • Biweekly payroll processing and reconciliation • Monthly reporting and file management tasks • Quarterly audits and compliance checks • Annual/year-end payroll and fiscal responsibilities Successfully complete: • At least 2 supervised payroll cycles (biweekly) • 2 full resident admission and discharge processes independently • Updates to all admission/tour packages (reviewed quarterly) Accuracy target: 95–100% compliance with payroll, documentation, and union requirements Positive feedback from Office Manager and interdisciplinary team
Achievable Is the goal realistic given available resources? What barriers exist?	• Implement a mandatory onboarding checklist for all managers • Require completion of all documentation at time of hire • Assign office assistant as backup when office manager is unavailable • Provide clear expectations and accountability for all hiring managers • Monitor compliance and address gaps promptly	Training will be delivered through job shadowing, system-based instruction, and progressive responsibility over a 12-month period to account for varying duties (biweekly, monthly, quarterly, and annual tasks, including fiscal vs. calendar year differences and union-specific requirements).
Relevant How does this align with organizational priorities or standards?	Supports delivery of consistent, reliable, and respectful quality care by ensuring all staff are properly onboarded and prepared, aligning with the organization's vision: *"Our family caring for your family."*	This goal supports operational continuity, ensures accurate administrative and payroll processes, strengthens compliance with LTC regulations and union agreements, and promotes person-centered service for residents, families, SDMs, and staff.
Time-Bound What is the timeline? What milestones will be set?	• Immediate implementation • Ongoing monitoring at each hire or role change • Monthly audits of compliance • Full evaluation at **3 months**	• **0–3 months:** Orientation, system access, and basic administrative tasks • **3–6 months:** Participate in payroll cycles, admissions, and monthly duties with supervision • **6–9 months:** Increased independence in biweekly/monthly tasks; exposure to quarterly processes • **9–12 months:** Competency in most duties, including year-end preparation and full backup coverage for Office Manager
Final SMART Goal Statement: "By [date], [unit/team] will [specific action] to improve [metric] from [baseline] to [target], as measured by [data source]."	Within 3-6 months, the organization will implement a standardized onboarding process to ensure 100% of new hires and staff role changes have completed all required documentation, including letters of offer, HR/payroll forms, and onboarding checklists, prior to their first shift. This process will be consistently followed by all managers, with backup support from the office assistant when needed, and monitored through monthly audits to reduce onboarding delays and errors by 90%. This will support the delivery of consistent, reliable, and respectful quality care in alignment with the vision, *"Our family caring for your family."*	Within 12 months, the Office Assistant will be fully trained to independently perform core Office Manager duties, including biweekly payroll, monthly/quarterly/year-end processes, scheduling systems (Staff Schedule Care, PointClickCare, Dayforce), benefits and pension administration (Manulife, NHRIPP), LTC file management, and resident admissions/discharges with contract completion. Success will be measured by completing at least two full payroll cycles and two admissions/discharges independently, keeping admission/tour packages current, and demonstrating the ability to provide reliable backup coverage while adhering to Unifor and ONA collective agreements and supporting a consistent, person-centered, and inclusive environment.

Department: Environmental Service - Maintenance	
Specific What exactly do you want to improve? Who is involved? Where will it take place? Why is this important?	Improve the efficiency of room turnover by ensuring all vacated rooms are processed through the maintenance app and completed promptly by the maintenance team.
Measurable How will you track progress? What data will show improvement? Baseline and target?	Achieve a consistent turnaround time of **2 days (48 hours)** from when a room is vacated to when it is ready for occupancy, as tracked through work orders in the maintenance app.
Achievable Is the goal realistic given available resources? What barriers exist?	With the addition of a full-time maintenance staff member, the team has increased capacity to meet the 2-day turnaround target, while prioritizing room readiness over non-urgent tasks.
Relevant How does this align with organizational priorities or standards?	Timely room turnover is a top priority and directly supports operational efficiency, occupancy readiness, and overall service quality.
Time-Bound What is the timeline? What milestones will be set?	Effective immediately, all room turnovers will aim to be completed within **2 days**, with performance reviewed monthly. Seasonal challenges during summer months will be monitored and adjustments made as needed.
Final SMART Goal Statement: "By [date], [unit/team] will [specific action] to improve [metric] from [baseline] to [target], as measured by [data source]."	Effective immediately, the maintenance team will complete room turnovers within 2 days (48 hours) of vacancy, tracked through the maintenance app, achieving consistent compliance each month while prioritizing room readiness, even during seasonal workload fluctuations.

Department: Retirement Lodge	#1	#2
Specific What exactly do you want to improve? Who is involved? Where will it take place? Why is this important?	Increase and maintain occupancy levels in the lodge by improving lead generation (calls and tours) and conversion of prospective residents into move-ins, led by the Lodge Manager and Marketing Manager.	Recruit and retain sufficient full-time and part-time Registered Practical Nurses (RPNs) to eliminate reliance on temporary staffing agencies. Recruitment efforts will include partnerships with local colleges for student placements (led by ADOC) and targeted outreach such as online ads and job fairs (led by the Marketing Manager).
Measurable How will you track progress? What data will show improvement? Baseline and target?	Achieve and sustain 90% occupancy, tracked monthly using a reporting sheet that includes number of calls, tours conducted, successful move-ins, and missed opportunities (residents who did not move in).	-Fill 100% of approved full-time and part-time RPN positions -Reduce and ultimately eliminate use of agency RPN shifts -Track number of applicants, interviews, hires, and student placements monthly
Achievable Is the goal realistic given available resources? What barriers exist?	This goal is realistic with consistent monitoring and adjustments to marketing and outreach efforts, though competition from other retirement homes in the area may present challenges.	By focusing on new graduate RPNs, building relationships with local colleges, and increasing visibility through marketing efforts, the home can improve recruitment outcomes despite competition from hospitals and larger long-term care organizations and transportation barriers.
Relevant How does this align with organizational priorities or standards?	Maintaining high occupancy is critical to maximizing revenue and ensuring the lodge operates at optimal capacity.	Consistent in-house RPN staffing supports continuity of care, improves resident outcomes, and strengthens person-centered care by having staff who are engaged and familiar with residents.
Time-Bound What is the timeline? What milestones will be set?	Reach 90% occupancy within 6 to 12 months, with monthly reviews to assess progress and adjust advertising or outreach strategies as needed.	Achieve full RPN staffing complement and eliminate agency reliance within 6 to 12 months, with monthly progress reviews and adjustments to recruitment strategies as needed.
Final SMART Goal Statement: "By [date], [unit/team] will [specific action] to improve [metric] from [baseline] to [target], as measured by [data source]."	Within 6 to 12 months, the Lodge Manager and Marketing Manager will increase and maintain lodge occupancy to 90% by tracking monthly calls, tours, move-ins, and lost opportunities, and adjusting marketing efforts as needed to stay competitive and support revenue goals.	Within 6 to 12 months, the home will recruit and retain enough full-time and part-time RPNs to fill 100% of staffing needs and eliminate reliance on agency staffing, using college partnerships, targeted marketing, and job fairs, with monthly tracking of recruitment efforts to ensure consistent, person-centered care delivered by a stable and invested team.

Department: Nutrition Services	
Specific What exactly do you want to improve? Who is involved? Where will it take place? Why is this important?	Improve communication and accuracy of resident diet textures across all meal service providers (dietitian, FSNM, nurses, PSWs, dietary aides) at the point of service, while strengthening education for staff, residents, and families to promote safe, person-centred dining and prevent aspiration.
Measurable How will you track progress? What data will show improvement? Baseline and target?	• Achieve 100% accuracy of diet textures at meal service (verified through audits) • Ensure 100% of diet changes are updated on diet rosters within 24 hours • Maintain 100% staff completion of diet education (Surge training) at orientation and annually • Conduct point-of-service education at all three meals daily • Provide education sessions for residents and families at least twice per year and at time of admission • Monitor and reduce diet-related incidents (e.g., aspiration, errors) by 20%
Achievable Is the goal realistic given available resources? What barriers exist?	• Post updated diet rosters at serveries and point-of-service locations • FSNM to provide ongoing meal-time education and oversight • Dietitian and SLP to communicate diet changes promptly • Use shift communication and huddles to reinforce updates • Incorporate education into resident council (monthly) and family council (quarterly) meetings
Relevant How does this align with organizational priorities or standards?	Supports resident safety, prevents aspiration, and promotes dignity through person-centred care and proper nutrition practices.
Time-Bound What is the timeline? What milestones will be set?	• Immediate implementation • Daily monitoring at meal service • Monthly review through audits and resident council feedback • Quarterly evaluation aligned with family council meetings • Full evaluation at **3 months**
Final SMART Goal Statement: "By [date], [unit/team] will [specific action] to improve [metric] from [baseline] to [target], as measured by [data source]."	Within 3 months, the team will ensure accurate and consistent communication of resident diet textures at all points of meal service by maintaining up-to-date diet rosters, providing daily point-of-service education, and achieving full staff compliance with required diet training. This will result in 100% accuracy in diet texture delivery, timely communication of all diet changes within 24 hours, and a 20% reduction in diet-related incidents such as aspiration, while promoting person-centred care, safety, and dignity through ongoing education for staff, residents, and families at meal services, resident council, and family council meetings

HHCC QI Team and Departmental Goals 2026

Department: Recreation	#1	#2
Specific What exactly do you want to improve? Who is involved? Where will it take place? Why is this important?	Increase overall resident participation in scheduled recreation programs through enhanced programming, one-to-one engagement, and improved scheduling, involving the recreation team, volunteers, families, and residents.	Increase meaningful involvement of families and community partners in resident life by enhancing participation in programs, events, care conferences, and celebrations through improved communication and outreach led by the recreation team.
Measurable How will you track progress? What data will show improvement? Baseline and target?	• Achieve a 20% increase in documented attendance using the Activity Pro attendance tracking system • Monitor resident engagement and satisfaction through surveys • Review participation trends during monthly program planning meetings	• Achieve a 20% increase in family and community participation in scheduled programs, events, and care conferences • Track participation monthly • Review progress quarterly by the Recreation Manager
Achievable Is the goal realistic given available resources? What barriers exist?	By offering varied and meaningful programming, increasing individualized engagement, and coordinating schedules more effectively, the team can realistically improve participation levels.	Through consistent implementation of family-focused events, expanded community partnerships, and improved communication strategies (newsletters, emails, and direct invitations), increased engagement is attainable.
Relevant How does this align with organizational priorities or standards?	Improving participation supports residents' quality of life, reduces loneliness and boredom, and enhances emotional well-being and social connection.	Stronger family and community involvement enhances resident well-being, fosters connection, and improves overall quality of life
Time-Bound What is the timeline? What milestones will be set?	Achieve a 20% increase in participation within 12 months, with ongoing monthly monitoring and adjustments to programming as needed.	Achieve the 20% increase by January 1, 2027, with ongoing monthly tracking and quarterly evaluations to adjust strategies as needed.
Final SMART Goal Statement: "By [date], [unit/team] will [specific action] to improve [metric] from [baseline] to [target], as measured by [data source]."	*Within one year, the recreation team will increase resident participation in scheduled programs by 20%, as measured through Activity Pro attendance tracking, by implementing varied programming, one-to-one engagement, and improved scheduling, while monitoring progress through monthly planning meetings and resident engagement surveys to enhance quality of life and social well-being.*	By January 1, 2027, the recreation team will increase family and community engagement by 20% in programs, events, and care conferences through enhanced communication, outreach initiatives, and partnership development, with participation tracked monthly and reviewed quarterly to support improved resident well-being and quality of life.

QI Team: Falls Team		
Specific What exactly do you want to improve? Who is involved? Where will it take place? Why is this important?	The Falls/Activation Lead will ensure monthly "Falling Stars" falls reports are obtained, reviewed, and distributed at the beginning of each month to support resident safety and quality improvement. If data is unavailable in the shared drive, follow-up will be completed with the Falls Lead and Physio Therapist to obtain required data.	The Falls Team Lead and Activation Lead will monitor and track the number of residents on the "Falling Stars" program by reviewing monthly data uploaded to the shared drive. They will analyze trends, compare monthly data, and follow up on data completion to ensure accuracy and consistency in reporting.
Measurable How will you track progress? What data will show improvement? Baseline and target?	• 100% of monthly falls reports reviewed and distributed each month • Follow-up completed for any missing data within the same reporting month • Documentation of falls data tracking and follow-up actions maintained monthly • Increased activity supports provided during identified high falls-risk periods	• Monthly review of Falling Stars program data completed • Monthly and quarterly trend comparisons documented • 100% follow-up on missing or incomplete data • Reduction in number of residents on the Falling Stars program, measured through monthly data trends
Achievable Is the goal realistic given available resources? What barriers exist?	This goal will be achieved through established monthly reporting processes, collaboration with the Activation Lead, and consistent tracking systems within existing documentation tools and shared drives.	This goal will be achieved through established monthly data uploads, shared drive tracking systems, and collaboration between the Falls Team Lead and Activation Lead to ensure data is complete, accurate, and usable for trend analysis.
Relevant How does this align with organizational priorities or standards?	This goal supports resident safety, falls prevention strategies, and continuous quality improvement by ensuring timely access to accurate data and supporting individualized goals of care.	This goal supports falls prevention, improves resident safety, strengthens care planning, and allows for identification of patterns that inform interventions to reduce falls and improve outcomes
Time-Bound What is the timeline? What milestones will be set?	This is an ongoing monthly requirement, with all reporting, follow-up, and tracking completed by the end of each month.	Ongoing monthly and quarterly monitoring, with a target review period ending December 2026 to evaluate reduction trends in the number of residents on the Falling Stars program.
Final SMART Goal Statement: "By [date], [unit/team] will [specific action] to improve [metric] from [baseline] to [target], as measured by [data source]."	The Falls Lead & Activation Lead will ensure that monthly "Falling Stars" falls reports are obtained, reviewed, and distributed at the beginning of each month. If required data is not available in the shared drive, timely follow-up will be completed with the Activation Lead to ensure all information is collected and finalized by the end of the month. The Lead will support increased activity programming during high falls-risk periods and maintain consistent tracking and documentation of falls data on an ongoing monthly basis. This process will be completed with 100% monthly compliance to support resident safety, accurate monitoring, and optimization of individualized goals of care.	The Falls Team Lead and Activation Lead will monitor residents on the "Falling Stars" program by reviewing and comparing monthly shared drive data to ensure completeness and accuracy. They will track monthly and quarterly trends, follow up on missing data, and use findings to identify fall patterns and improve care routines. By December 2026, the goal is to reduce the number of residents on the program, as measured through consistent monthly data analysis and documented outcomes.

QI Team: Restraints/PASD's	
Specific What exactly do you want to improve? Who is involved? Where will it take place? Why is this important?	Resident will have initial assessment for need to wear or need for application of 'specific type' of PASD to assist with safety ADL. This will be approved and ordered by doctor and consent obtained from POA. Alarm will be applied as per its policy and procedure. Documentation will be done according to HHCC policy.
Measurable How will you track progress? What data will show improvement? Baseline and target?	Resident will wear alarm 100% of time where and when indicated, alone in room, in wheelchair or in bed or if known to be a wanderer. There will be focus on repositioning and providing comfort when any PASD is in use. Staff will monitor and measure compliance. Ongoing assessment and reassessment documentation will take place including when there is any changes to the residents' health.
Achievable Is the goal realistic given available resources? What barriers exist?	All staff will be trained to use and troubleshoot PASD Device assigned to the resident. Resources to assist to achieve project goal of 100% use will be done by creating a routine usage and reviewing questions or concerns from staff to staff on daily basis and PASD Lead monthly review and staff meetings as needed.
Relevant How does this align with organizational priorities or standards?	Project goal is relevant to all involved as it established the sense of security for residents and families (POA) by alerting staff when resident is at potential risk. This will reduce risks of falls and allowing resident to remains safe with ADLs and independent longer.
Time-Bound What is the timeline? What milestones will be set?	Consistent wearing or application of PASD once need is identified as early as upon their admission and reassessed prn and quarterly.
Final SMART Goal Statement: "By [date], [unit/team] will [specific action] to improve [metric] from [baseline] to [target], as measured by [data source]."	Effective immediately, 100% of residents identified as requiring a PASD will receive assessment, physician approval, POA consent, and proper device application, and will wear the device at all indicated times. Compliance will be monitored daily, documented per HHCC policy, supported through staff training and routine communication, and reviewed monthly with reassessments conducted quarterly or as needed to ensure ongoing resident safety.

QI Team: Skin and Wound Care	#1	#2
Specific What exactly do you want to improve? Who is involved? Where will it take place? Why is this important?	Implement and standardize the use of the Levine method for wound swabbing (C&S) by training all registered staff and reinforcing consistent practice at the bedside and during monthly wound care meetings.	Enhance long-term care nursing staff knowledge and skills in selecting and applying appropriate dressings for residents with skin tears through education led by the Wound Lead, incorporating best practice guidelines and hands-on training.
Measurable How will you track progress? What data will show improvement? Baseline and target?	• Achieve 100% training completion for all registered staff (tracked via sign-off sheet after video completion) • Ensure availability of laminated step guides and QR codes on all treatment carts • Complete a 4–12 week competency checklist for each staff member • Monitor and demonstrate a reduction in wound infection rates and improved accuracy of culture results	• 90% of nursing staff will correctly identify and demonstrate the use of at least three appropriate skin tear dressings during a post-training skills assessment • Track completion of education through the SURGE Learning Platform • Monitor wound dressing order types to assess appropriate product selection trends
Achievable Is the goal realistic given available resources? What barriers exist?	With structured education, hands-on practice, and accessible resources, staff can transition to the Levine method. Barriers such as resistance to change from previous practices will be addressed through ongoing support and reinforcement.	This will be supported through one in-service education session, hands-on demonstrations, and accessible resources such as laminated quick-reference dressing guides in treatment carts.
Relevant How does this align with organizational priorities or standards?	Consistent use of the Levine method improves the accuracy of wound culture results, leading to better diagnosis, treatment decisions, and outcomes for residents with acute and chronic wounds.	Improving staff competency in skin tear management enhances resident skin integrity, promotes faster healing, and reduces the risk of infection and complications in a vulnerable long-term care population.
Time-Bound What is the timeline? What milestones will be set?	Complete staff training and competency validation within 4–12 weeks, with ongoing monitoring and reinforcement through monthly wound meetings.	Complete all education, training, and competency assessments by September 2026, with ongoing monitoring of practice and outcomes.
Final SMART Goal Statement: "By [date], [unit/team] will [specific action] to improve [metric] from [baseline] to [target], as measured by [data source]."	Within 4–12 weeks, 100% of registered staff will be trained and demonstrate competency in the Levine method for wound swabbing, supported by bedside education, monthly wound meetings, and accessible resources, with compliance tracked and outcomes measured through improved culture accuracy and reduced wound infection rates.	By September 2026, the Wound Lead will deliver education and hands-on training to ensure that at least 90% of nursing staff can correctly identify and demonstrate the use of three appropriate skin tear dressings, supported by the SURGE Learning Platform, best practice guidelines, and point-of-care resources, resulting in improved skin integrity and reduced complications for residents.

QI Team: Continence April 2026	
Specific What exactly do you want to improve? Who is involved? Where will it take place? Why is this important?	Improve continence care practices by eliminating double product application, ensuring correct sizing of incontinent products, reducing leakage associated with Medline products, preventing skin breakdown, and enhancing resident comfort through proper stocking and use of appropriately sized products in resident rooms.
Measurable How will you track progress? What data will show improvement? Baseline and target?	• Achieve 100% compliance with single-product application (no double layering) • Decrease reported leakage incidents • Maintain daily stocking compliance at 95–100% in resident rooms • Conduct weekly product usage reviews and track trends • Complete shift-change huddles daily with PSWs and team leads
Achievable Is the goal realistic given available resources? What barriers exist?	• Daily stocking of correctly sized continence products in resident rooms and storage areas • Accurate ordering based on updated supply lists • Staff education and reinforcement during shift-change huddles • Weekly review meetings with the DOC to monitor usage and address gaps
Relevant How does this align with organizational priorities or standards?	Supports optimal, person-centered resident care by promoting dignity, comfort, and skin integrity, while also improving resource utilization and reducing unnecessary product waste.
Time-Bound What is the timeline? What milestones will be set?	• Implementation begins immediately • Weekly monitoring and review with DOC • Quarterly evaluation with Medline representative • Full goal evaluation at 3 months, with adjustments as needed
Final SMART Goal Statement: "By [date], [unit/team] will [specific action] to improve [metric] from [baseline] to [target], as measured by [data source]."	Within 3 months, the team will optimize continence care practices by eliminating double product application, ensuring the use of correctly sized incontinent products, and maintaining consistent daily stocking in resident rooms, decrease leakage incidents , prevent skin breakdown, and improve resident comfort and dignity. Progress will be monitored through daily shift huddles with PSWs and team leads, weekly product usage reviews with the DOC, accurate supply ordering, and quarterly evaluations with the Medline representative.

HHCC QI Team and Departmental Goals 2026

QI Team: IPAC	
Specific What exactly do you want to improve? Who is involved? Where will it take place? Why is this important?	Improve hand hygiene compliance rates in 6 months this will decrease the risk for infection for elderly and immunocompromised residents.
Measurable How will you track progress? What data will show improvement? Baseline and target?	Hand hygiene audits will take place on a daily basis with point of care corrections/education. Surge education will also be provided and recorded.
Achievable Is the goal realistic given available resources? What barriers exist?	Hand sanitizer is available throughout the Home, at the front entrance, at each nursing station, each lift cart, within each resident's room. Hand washing stations are available in break rooms, clean and soiled utility room, laundry room, activity rooms and kitchen and serveries.
Relevant How does this align with organizational priorities or standards?	Maintaining high standards of hand hygiene is an essential strategy for improving resident health outcomes enhancing quality of care and reducing infection rates
Time-Bound What is the timeline? What milestones will be set?	In the next two months the average hand hygiene compliance will increase by 20% they will then be maintained at that rate for the next 12 months
Final SMART Goal Statement: "By [date], [unit/team] will [specific action] to improve [metric] from [baseline] to [target], as measured by [data source]."	By July 31st 2026 staff will increase hand hygiene compliance from 68% to 88% then maintained through the next 12months Apr 2027 through education audits and reminders as measured by daily hand hygiene audits

QI Team: Health & Safety	
Specific What exactly do you want to improve? Who is involved? Where will it take place? Why is this important?	Join and actively participate in the Wilkens Health and Safety Solutions group, while developing strong communication and rapport with new healthcare team representatives. Focus on delivering consistent safety reporting, education, and guidance to support a safe workplace and eligibility for WSIB rebates.
Measurable How will you track progress? What data will show improvement? Baseline and target?	• Successfully join and attend safety group meetings within 1 month • Establish regular communication with all key representatives (e.g., monthly check-ins) • Implement consistent safety reporting processes (e.g., monthly reports, incident tracking) • Deliver or coordinate ongoing safety education sessions (e.g., quarterly training) • Track progress toward WSIB rebate eligibility requirements
Achievable Is the goal realistic given available resources? What barriers exist?	Leverage onboarding support from the new safety group, existing knowledge of workplace safety standards, and collaboration with team members to gradually implement systems and build relationships.
Relevant How does this align with organizational priorities or standards?	Supports organizational goals of maintaining a safe workplace, improving compliance, strengthening team communication, and maximizing financial benefits through WSIB rebates.
Time-Bound What is the timeline? What milestones will be set?	• 1 month: Join the safety group and begin onboarding • 3–6 months: Establish communication channels and consistent reporting practices • 12 months: Fully implement health and safety plans, education programs, and WSIB-aligned processes
Final SMART Goal Statement: "By [date], [unit/team] will [specific action] to improve [metric] from [baseline] to [target], as measured by [data source]."	Within 12 months, join Wilkens Health and Safety Solutions (within 1 month), build strong relationships with healthcare team representatives (within 3–6 months), and implement consistent safety reporting, education, and WSIB-aligned safety plans to provide ongoing guidance and maintain a safe, compliant workplace while supporting rebate eligibility.

Section

C

Internal QI Team Goals

Provision of Quality Resident Care

The provision of compassionate, inclusive, and person-centred care that honours the diverse needs, identities, and lived experiences of our residents. To support each resident in achieving their highest possible quality of life, we are committed to providing responsive services and supports that address physical, emotional, social, cultural, and spiritual well-being.

In evaluating the services we provide, we are guided by the following principles:

Being a Learning Organization
The team engages in ongoing reflection and learning to understand and respond to the evolving needs of the residents it serves. This includes regularly assessing service needs while considering the social determinants of health, health status, strengths, capacities, and potential risks, with attention to equity and inclusion.

When planning, designing, and adapting services, the team collaboratively establishes goals, objectives, and desired outcomes that are measurable, meaningful, and aligned with Helen Henderson Care Centre's mission and values. Indicators are selected to monitor progress in ways that reflect resident experience, safety, and well-being.

The team regularly reviews service outcomes—including resident experience, feedback, concerns, and both positive and unintended impacts—to inform continuous improvement. Benchmarking with similar programs and organizations supports shared learning and accountability.

Achieving Wellness
In partnership with residents, families, and community organizations, the team works to promote health, prevent illness, and support overall well-being. This includes identifying and addressing barriers to care, particularly for individuals and groups who may experience increased vulnerability or inequity.

The team strives to recognize health concerns early, provide accessible education, and support residents and communities in making informed choices that align with their values, preferences, and goals. Information is shared in ways that are inclusive, culturally sensitive, and accessible to all.

Being Responsive
Services are coordinated, inclusive, and adaptable to ensure continuity and responsiveness to each resident's needs and preferences.

The team collaborates with other providers and sectors by fostering respectful partnerships, sharing information appropriately and confidentially, and supporting smooth transitions across services. Efforts are made to reduce barriers and ensure equitable access to care.

When services cannot be provided, the team communicates openly and compassionately with residents and families, explains the reasons, and supports connection to alternative, appropriate resources. All referrals and service gaps are documented and used to inform future planning and system improvement.

Addressing Residents' Needs

The team determines the most appropriate approach to assessment by considering each resident's unique context, including age, health status, urgency, language, culture, identity, and personal preferences, as well as previous care experiences.

Assessments are strengths-based, holistic, and culturally responsive, recognizing each resident's abilities, needs, and potential risks. Areas of assessment may include medical history, current health status, mental and emotional well-being, functional abilities, communication needs, nutrition, social supports, cultural and spiritual needs, safety, identity, and personal goals.

The team values and incorporates each resident's voice, including their perceptions of their needs, quality of life, and desired outcomes. Access to safe, timely, and appropriate diagnostic services is supported.

Empowering Residents

The team ensures residents and families receive clear, accessible, and inclusive information about available services and supports.

Residents and families are provided with timely, accurate information regarding:
• how and when services will be provided
• opportunities for choice, participation, and shared decision-making
• potential benefits, limitations, and outcomes of care options
• risks and side effects of treatments
• costs and available alternatives, where applicable
• access to financial supports, if needed
• availability of counselling, advocacy, and peer supports
• community-based programs and resources

Informed consent is obtained through respectful, transparent, and ongoing dialogue. The team actively upholds and promotes the rights, dignity, and autonomy of residents and families.

Processes are in place to support staff in addressing ethical concerns through education, resources, and inclusive dialogue that respects diverse perspectives.

The team maintains a fair, accessible, and responsive process for addressing concerns and complaints, ensuring residents and families feel safe to share feedback without fear of reprisal.

Setting Goals
The team collaborates with residents and families to establish meaningful, individualized goals that reflect their preferences, strengths, cultural values, and desired quality of life. Consideration is given to physical, emotional, mental, and social needs, as well as safety and informed choice.

Goals and expected outcomes are documented in a clear, accessible format that residents and families can understand and engage with.

The integrated care plan outlines roles and responsibilities, how and when services will be provided, and how the team will support residents in achieving and maintaining well-being, independence, and quality of life. Timelines are developed collaboratively, and progress is regularly reviewed. Education, emotional support, and transition planning are provided as needed.

Delivering Services
The team provides safe, respectful, equitable, and effective care.

Services are delivered and documented in alignment with current legislation, professional standards, ethical guidelines, and Helen Henderson Care Centre's policies, with a commitment to culturally safe and trauma-informed practice.

The team takes proactive steps to promote safety and prevent harm, including identifying and addressing risks, supporting residents with diverse needs, and providing education to residents and families on safety and prevention.

Section

D

Risk Management and Resident Safety Framework

The Risk Management Plan is an overarching, conceptual framework that guides the development of a program for risk management and resident safety initiatives and activities. The Plan supports Helen Henderson Care Centre's philosophy that resident safety and risk management is everyone's responsibility. Teamwork and participation among management, service providers, volunteers, families and staff are essential for an efficient and effective resident safety and risk management program. The program will be implemented through the coordination of multiple organizational functions and the activities of multiple departments.

Helen Henderson Care Center supports the establishment of a 'just' culture that emphasizes implementing evidence-based best practices, learning from error, and providing constructive feedback. In a just culture, unsafe conditions and hazards are readily and proactively identified, medical or resident care errors are reported and analyzed, mistakes are openly discussed and disclosed, and suggestions for systemic improvements are welcomed. Individuals are still held accountable for compliance with resident safety and risk management practices. As such, if evaluation and investigation of an error or event reveal reckless behavior or willful violation of policies, disciplinary actions can be taken.

Helen Henderson's Risk Management Plan stimulates the development, review, and revision of the organization's practices and protocols in light of identified risks and chosen loss prevention and reduction strategies. Principles of the Plan provide the foundation for developing key policies and procedures for day-to-day risk management activities, including:

- Staff and Resident Incident reports
- Event investigation, root-cause analysis, and follow-up
- Complaint resolution
- Confidentiality and release of information
- Individual Prospective Analysis
- Service provider and staff education, competency validation, and credentialing requirements
- Reporting and management of sentinel events, adverse events and near misses
- Trend analysis of events, near misses, and claims
- Claims Management
- Resident and Family Education and In-services
- Routine Occupational Health and Safety Inspections
- Joint Occupational Health & Safety Concerns
- In-house Quality Improvement Teams (falls, skin & wound, pain, enhanced care, infection control, restorative care, continence etc...)

A **Just and Trusting Safety Culture** is an environment where everyone—residents, families, staff, physicians, and volunteers—feels safe, respected, and supported to speak openly about safety concerns, errors, and near misses without fear of blame or punishment. It reflects a shared commitment to learning, accountability, and continuous improvement, grounded in trauma-informed, person-centred, and equity-focused principles.

In this culture, safety is understood as both physical and psychological. Relationships are built on trust, transparency, and mutual respect. Individuals are encouraged to report concerns and share their experiences, knowing their voices will be heard, valued, and used to improve care. The focus is on understanding *what happened and why*, rather than assigning blame, recognizing that most errors arise from system and process gaps rather than individual intent.

A just and trusting culture also recognizes the impact that harm—whether experienced by residents, families, or care providers—can have, and responds with compassion, support, and openness. It promotes fairness by distinguishing between human error, at-risk

behaviour, and reckless behaviour, and responding in ways that are supportive, educational, and accountable.

This approach strengthens teamwork, fosters psychological safety, and supports equitable care by encouraging diverse perspectives, reducing fear, and addressing systemic barriers that may impact safety outcomes.

A commitment that Helen Henderson Care Centre will be open and transparent. Helen Henderson Care Centre will be guided by its responsibility to inform the public and other stakeholders of safety issues where there is real or perceived risk to the health of the individual or where a safety issue may adversely impact public confidence in the healthcare system. This commitment will be undertaken following all of the Organization's legal obligations to protect the privacy of the resident, staff, physicians and volunteers.

A commitment that Helen Henderson Care Centre will:

a) be fair and transparent in assessing system and process failures;
b) not discipline staff, physicians, and volunteers for harm that occurs as a result of unforeseen events;
c) analyze and learn from all reported harm and near misses; and
d) improve safety throughout Helen Henderson Care Centre.

Through this commitment, Helen Henderson Care Centre fosters a culture where learning is continuous, accountability is balanced with compassion, and everyone works together to create a safer, more responsive, and person-centred environment.

RESIDENT SAFETY FRAMEWORK PRINCIPLES

Helen Henderson Care Centre and its staff, physicians, and volunteers are guided by the following:

Ethical and Moral Responsibility
The disclosure of harm and safety risks is a core component of trauma-informed, person-centred care and therapeutic relationships.

We are committed to openness, honesty, and transparency with residents and families when harm has occurred or may have occurred. Disclosure is conducted with compassion, cultural sensitivity, and respect for each person's lived experience, identity, and preferences.

A trauma-informed approach recognizes the emotional impact of harm and prioritizes safety, dignity, choice, and clear, inclusive communication, ensuring residents and families feel heard and supported.

Health Professional Standards

We uphold professional standards while fostering a Just and Trusting Safety Culture that emphasizes fairness, inclusion, and psychological safety.

Care providers involved in harm or near-harm events are supported in a respectful, non-punitive manner. This includes:

- fair and non-discriminatory treatment when reporting or involved in events;
- access to emotional and professional supports;
- encouragement to seek guidance from professional or regulatory bodies; and
- clear expectations for competence, accountability, and respectful conduct.

This approach focuses on learning and system improvement rather than blame, while maintaining fair and consistent accountability.

Expectations and Competencies

- accountability for professional behaviour within a supportive, learning-focused environment; and
- recognition that intentional unsafe actions (e.g., substance misuse, deliberate policy violations) are not tolerated and will be addressed appropriately.

Through these principles, Helen Henderson Care Centre promotes a culture of transparency, trust, inclusion, and continuous learning—where residents, families, and care providers are supported, respected, and actively engaged in improving safety and quality of care.

Governing Body Leadership

The success of Helen Henderson Care Centre's Resident Safety and Risk Management Program requires top-level commitment and support.

The Gibson family is committed to promoting the safety of all residents, visitors, employees, volunteers, and other individuals involved in organization operations. The Resident Safety and Risk Management Program is designed to reduce system-related errors and potentially unsafe conditions by implementing continuous improvement strategies to support an organizational culture of safety. The Gibson Family empowers the organizations leadership and management teams with the responsibility for implementing performance improvement and risk management strategies. Identified areas of risk and/or trends are shared at minimum with the Governing Body during quarterly collaborative meetings between sister-homes (owners are present at these meetings)

DEFINITIONS

Resident Safety incident: An event or circumstance which could have resulted, or did result, in unnecessary harm to a resident

Harm: an unexpected or normally avoidable outcome that negatively affects a resident's health and/or quality of life, and occurs or has occurred during the course of receiving health care or services from Helen Henderson Care Centre

Harmful incident: A resident safety incident that resulted in harm to the resident. Replace "adverse event" and" sentinel event"

No Harm incident: A resident's safety incident which reached a resident but no discernible harm resulted.

Nearly Harmed: Is defined as a situation where there was a high likelihood (greater than 25%) an adverse event would occur and a resident would have been harmed but the potential for harm was recognized and a successful action was taken which prevented actual harm. Replaces 'close calls', 'near misses' or 'near hits'.

Risk analysis: Determination of the causes, potential probability, and potential harm of an identified risk and alternatives for dealing with the risk. Examples of risk analysis techniques include failure mode and effects analysis, systems analysis, root-cause analysis, and tracking and trending of adverse events and near misses, among others.

Risk assessment: Activities undertaken in order to identify potential risks and unsafe conditions inherent in the organization or within targeted systems or processes.

Risk avoidance: Avoidance of engaging in practices or of hazards that expose the organization to liability.

Risk identification: The process used to identify situations, policies, or practices that could result in the risk of resident harm and/or financial loss. Sources of information include proactive risk assessments, adverse event reports, past accreditation or licensing surveys, medical records, clinical and risk management research, walk-through inspections, safety and quality improvement committee reports, insurance company claim reports, risk analysis methods such as failure mode and effects analysis and systems analysis, and informal communication with healthcare providers.

Risk management: Clinical and administrative activities undertaken to identify, evaluate, prevent, and control the risk of injury to residents, staff, visitors, volunteers, and others and to reduce the risk of loss to the organization itself. Activities include the process of making and carrying out decisions that will prevent or minimize clinical, resident, staff and operational risks.

Root-cause analysis: A process for identifying the basic or causal factor(s) that underlie the occurrence or possible occurrence of an adverse event.

Unsafe and/or hazardous condition: Any set of circumstances (exclusive of a resident's own disease process or condition) that significantly increases the likelihood of a serious adverse outcome for a patient or of a loss due to an accident or injury to a visitor, employee, volunteer, or other individual.

Disclosure: Disclosure is the process used by health professionals to inform a resident/POA/SDM of a specific harm event and the implications of that event, if any, for the course of the resident's care. It is grounded in trauma-informed, person-centred, and equitable care, and supports a Just and Trusting Safety Culture where all individuals feel safe, respected, and supported to engage in open, honest communication.

Claims management: Activities undertaken to exert control over potential or filed claims against the organization and/or its providers. These activities include identifying potential claims early, notifying the organization's liability insurance carrier and/or defense counsel of potential claims and lawsuits, evaluating liability and associated costs, identifying and mitigating potential damages, assisting with the defense of claims by scheduling individuals for deposition, providing documents or answers to written interrogatories, implementing alternate dispute-resolution tactics, and investigating adverse events or incidents.

THE INCIDENT/EVENT:

The following tools are to be used as source documents to assist in the identification of harmful, nearly harmful and no harm events.

- all inspection reports received from all agencies eq. public health, MOHLTC, fire inspections, elevator, ventilation, WHMIS etc.
- health and safety inspection reports and audits
- fire safety and maintenance checks
- resident and employee incident reports eq. aggressive behaviours, elopements, injuries etc.
- medication incident reports
- maintenance repair reports
- staff observation and reporting
- staff meetings
- written and/or verbal concerns from residents, families, visitors and staff
- preventative maintenance program
- care specific team meetings eq. continence care, professional advisory, wound care, PIECES, pain, falls etc.
- unusual occurrence reports
- RQI audits

- infection control surveillance
- disaster planning report
- credentialing and audits of standards of practice for all contracted services
- police checks on all new employees and volunteers
- verification of completion of orientation for all new employees and volunteers

The QI team will:

a) review the results of all internal and external risk management activities to identify areas presenting an immediate threat and areas requiring improvement to manage potential threat eq. falls management, elopement, aggressive behaviours, infection control, emergency readiness, WSIB etc.;
b) ensure resources are available for counseling of residents, families, staff and witnesses as required;
c) co-ordinate a review team to evaluate the system/process deficiencies that resulted in the occurrence of the event. The team will be responsible for further recommendations to the Administrator to ensure that approved remedial actions are implemented and evaluated on an ongoing basis;
d) ensure that all follow-up action plans are completed.

The home reviews risk management activities at minimum quarterly and as needed based on reports brought forward. Identified risk activities and outcomes (e.g., staff incident reports, resident incident reports, team summaries and trends) are shared regularly to the relevant internal committee structures and identified trends to the Gibson Family annually and if necessary quarterly. Identified risks are incorporated into the home's operational plans goals and objectives as well as often overlap with the Home's continuous quality improvement initiatives.

The next few pages outlines how we determine risks and what procedures go along with identifying and troubleshooting risks. In addition, you will see a form that is used for each department where we have identified key risk areas to monitor ongoing. Risks are identified through QI and carried forward to the Health & Safety Team.

What is a Risk Assessment?
A Risk Assessment is a thorough look at your workplace to identify things, situations, processes that may cause harm, particularly to people.

- identifies hazards within - then
- analyze or evaluate the risk associated with the hazard - then
- determine appropriate ways to eliminate or control the hazard.

Purpose of a Risk Assessment
Employers in each workplace have a general duty to ensure the safety and health of workers in every aspect related to their work. The purpose of carrying out a risk assessment is to enable the employer to take the measures necessary for the safety and health protection of workers. These measures include:

- prevention of occupational risks.
- providing information to workers.
- providing training to workers.
- providing the organization and the means to implement the necessary measures.

What is the Goal of a Risk Assessment?
The goal of a risk assessment is to remove a hazard or reduce the level of the risk by adding precautions or control measures. By doing so you create a safer and healthier workplace.

The Resident Safety and Risk Management Program goals and objectives are to:

- Continuously improve resident safety and minimize and/or prevent the occurrence of errors, events, and system breakdowns leading to harm to residents, staff, volunteers, visitors, and others through proactive risk management and resident safety activities.
- Minimize adverse effects of errors, events, and system breakdowns when they do occur.
- Minimize losses to the organization overall by proactively identifying, analyzing, preventing, and controlling potential clinical, and operational risks.
- Facilitate compliance with regulatory, legal, and accrediting agency requirements (e.g., LTCHA, RHA, OH&S, Ministry of Labour)
- Protect human and intangible resources (e.g., reputation).

How do you do a Risk Assessment?

Assessments should be done by individuals who have a good working knowledge of the workplace. To do an assessment, you should:

- identify the hazard.
- evaluate the likelihood of an injury or illness.
- its severity.
- consider and review all available health & safety information (ie. MSDS, equipment information etc.).
- identify actions necessary to eliminate or control the risk.
- monitor and evaluate to ensure the risk is eliminated or controlled.
- keep all records.

How are the Hazards Identified? How do you know if a Hazard is Serious (Poses a Risk)?

Hazards are identified through workplace inspections. Each hazard should be studied to determine its level of risk such as:

- layout of the building.
- past experience (workers, etc.).
- previous injuries / illness.
- workers involved.

How do you Rank or Prioritize the Risks?

Ranking or prioritizing hazards is one way to help determine which hazard is the most serious and thus which hazard to control first. Prioritizing is usually established by considering the employee exposure and the potential for accident, injury or illness. The following factors play an important role:

- number of worker exposed.
- frequency of exposure.
- degree of harm from the exposure.
- probability of occurrence.

Definition of Risk Level:

Low: No additional controls are required. Ensure controls are maintained and reviewed and documented.

Medium: Consideration should be as to whether the risk can be lowered to an expectable level. Ensure controls are maintained and reviewed and documented.

High: Substantial efforts are made to reduce the risk. Risk reduction measures should be implemented urgently within a defined time period. Ensure controls are maintained and reviewed and documented.

What are Methods of Hazard Control?
Once you have established your top priorities, you then decide on ways to control the hazard. Hazard controls are often grouped into the following categories:

- eliminate.
- engineering controls.
- administrative controls.
- personal protective equipment.

Why is it Important to Review and Monitor your Assessment?
It is important to know if your risk assessment was complete and accurate. It is also essential to be sure that changes in the workplace have not introduced new hazards or changed hazards that were once ranked as lower priority to a higher priority.

What Documentation should be done for a Risk Assessment?
Keeping records of your assessment and any control actions taken is very important. The level of documentation or any record keeping will depend on:

- level of risk involved.
- legislative requirements.

Your records should show that you:

- conducted a good hazard review,
- determined the risks of those hazards,
- implemented control measures suitable for the risk,
- reviewed and monitored all hazards in the workplace.

On the next page you will see a blank copy of our Risk Assessment Form. This form is utilized in all aspects of the home, including all departments. Once filled out, the completed forms are presented to both the Health & Safety Team as well as the Quality improvement team to brainstorm and put in place any necessary changes. From there, regular follow-ups are conducted to ensure progress. If no improved results are visible then we look at other options and start from scratch.

HELEN HENDERSON CARE CENTRE

RISK ASSESSMENT

NAME OF ASSESSOR: _____ **POSITION:** _____

AREA ASSESSED: _____ **DATE:** _____

RISK	HAZARD	RATING LOW/MODERATE/HIGH	CONTROLS	NEW RATING	REVIEW DATE

SCOPE AND FUNCTIONS OF THE PROGRAM

HHCCs Resident Safety and Risk Management Program covers all departments and services including the Home's environmental, nursing and administrative departments as well as residents, families, volunteers and service providers.

Functional Interfaces

Functional interfaces with the resident safety and risk management program include the following:

- Preventative Maintenance for building, grounds and equipment
- Claims management (both WSIB and potential liability claims)
- Legislative compliance (i.e. Long-term Care Home's Act and the Retirement Homes Regulatory Authority…)
- Credentialing of service providers, staff and student placements
- Emergency Disaster Plan and management
- Safe Return to work plans and strategies
- Resident and Staff incident reporting and investigation
- Finance/billing (Management of Outstanding Receivables and Bad Debt accounts)
- Human resources (recruitment & retention)
- Information technology
- Contracts
- Marketing/advertising/public relations
- Dietary services
- Resident and family education and orientation
- Resident/Family satisfaction
- Pharmacy Services
- Continuous Quality Improvement
- Safety and security
- Recreational and Activation Programs
- Volunteers
- Skin and Wound Care
- Ethics/Palliative Care
- Pain Management
- Falls Prevention
- Infection control
- Enhanced Care
- Continence Care
- Health & Safety

Risk Management Program Functions

Risk management functional responsibilities include:

a) Developing systems for and overseeing the reporting of adverse events, near misses, and potentially unsafe conditions. Reporting responsibilities may include internal reporting as well as external reporting to regulatory, governmental, or voluntary agencies. This includes the development and implementation of incident-reporting policies and procedures.
b) Ensuring the collection and analysis of data to monitor the performance of processes that involve risk or that may result in serious adverse events.
c) Overseeing the organizational Resident Safety and Risk Management Plan.

This Plan may utilize and include, but is not limited to, the following:

- In-house team reports and minutes
- Event, incident, or near miss reports
- Medical record/Resident Chart reviews
- Monitoring systems/policies and procedures for effectiveness and efficiencies
- Resident/Family suggestions and complaints
- Physician and other medical professionals' input (Professional Advisory Committee)
- Results of failure mode and effects analysis/ Prospective Analysis of high risk processes
- Root-cause analyses of sentinel events

d) Analyzing data collected on adverse events, near misses, and potentially unsafe conditions; providing feedback to residents, families and staff; and using this information to facilitate systems improvements to reduce the probability of occurrence of future related events. Root-cause analysis and systems analysis can be used to identify causes and contributing factors in the occurrence of such incidents.

e) Facilitating and ensuring the implementation of resident safety initiatives such as improved tracking systems for preventive screenings and diagnostic tests, medication safety systems, and falls prevention programs.

f) Facilitating and ensuring staff participation in educational programs on resident safety and risk management.

g) Facilitating a culture of safety in the organization that embodies an atmosphere of mutual trust in which all staff members can talk freely about safety problems and potential solutions without fear of retribution.

h) Proactively advising the organization on strategies to reduce unsafe situations and improve the overall environmental safety of residents, visitors, staff, and volunteers.

i) Reducing the probability of events that may result in losses to the physical plant and equipment (e.g., preventative maintenance, fire safety prevention).

j) Preventing and minimizing the risk of liability to the organization, and protecting the financial, human, and other tangible and intangible assets of the organization.

k) Decreasing the likelihood of claims and lawsuits by developing transparent communication with staff, residents and families. This includes communicating and disclosing errors and events that occur in the course of resident care with a plan to manage any adverse effects, complications or reoccurrence.

l) Supporting quality assessment and improvement programs throughout the organization.

m) Implementing programs that fulfill regulatory, legal, and accreditation requirements.

n) Monitoring the effectiveness and performance of risk management and resident safety actions. Performance monitoring data may include:

- Culture of safety surveys

- Incident Report trend analysis
- Ongoing risk assessment information
- Residents and/or family's perceptions of how well the organization meets their needs and expectations; overall satisfaction
- Quality performance data

o) Developing and monitoring effective handoff processes for continuity of resident care.

MONITORING AND CONTINUOUS IMPROVEMENT

The Home reviews risk management activities at minimum annually and as needed based on reports brought forward. Identified risk activities and outcomes (e.g., staff incident reports, resident incident reports, team summaries and trends) are shared regularly to the relevant internal committee structures and identified trends to the Gibson Family annually and if necessary quarterly. Identified risks are incorporated into the Home's operational plans goals and objectives as well as often overlap with the Home's continuous quality improvement initiatives.

Risk Reduction

Risk reduction includes the safe, effective, and equitable use of medications to support each resident's health, dignity, and quality of life. Medication practices are person-centred and responsive to individual needs, preferences, and lived experiences.

The team follows processes to ensure medications are reviewed for accuracy, prepared and administered safely and in a timely manner, and stored and disposed of securely. Potential risks and adverse effects are proactively monitored and addressed, with a focus on learning and system improvement. Support is available after-hours and during emergencies to ensure continuity and safety.

Residents and families are supported with compassionate, culturally responsive emotional care and counselling to promote well-being, dignity, and coping. This includes support with complex health decisions and experiences such as advance care planning, serious illness, and grief and bereavement.

Achieving Positive Outcomes

In partnership with residents and families, the team monitors progress toward goals using both qualitative and quantitative measures, ensuring care reflects what matters most to each individual.

Progress is documented, and goals are regularly reviewed and adjusted collaboratively. Barriers to achieving goals are identified and addressed with a focus on equity, inclusion, and removing systemic challenges that may impact outcomes.

Maintaining Continuity

Continuity of care is supported through inclusive, collaborative planning for transitions and ongoing needs. Residents and families are active partners in planning transitions, discharge, and follow-up care.

Clear, accessible information is provided to residents, families, and care partners on how and when to re-access services, ensuring a seamless and supportive care experience.

Helen Henderson Care Centre recognizes that quality improvement is an ongoing journey. Guided by trauma-informed, person-centred, and DEI principles, and supported by a Just and Trusting Safety Culture, we are committed to continuous learning and improvement.

Our approach focuses on steady, meaningful progress, collaboration across teams, and shared learning to better understand current practices and identify opportunities to enhance safety, equity, and quality of life for all residents.