

*Annual Schedule: May 2026*
**HOME NAME : Errinrung LTC**
**People who participated in the evaluation of this report**

	Name and Designation	Date of Evaluation
Quality Improvement Lead	Krista Smith - DOC/RN	08-May-26
Director of Care	Krista Smith - DOC/RN	08-May-26
Executive Directive	Stacey Coe - RSSW	08-May-26
Nutrition Manager	Susan Elliott - FRM/ESS	08-May-26
Programs Manager	Hayley Elley - SSW	08-May-26
Clinical Consultant	Tiffany Gordon RN	08-May-26
Resident Council Representative	Gail Humphries	08-May-26
Family Council Representative	Heather Brassem	08-May-26
Medical Director	Naomi Kopp (nee Klages)	08-May-26
Other	Jorja Pendergast - BOM	08-May-26
Other	Lisa Davison - RAI/RPN	08-May-26

Summary of the Home's priority areas for quality improvement, objectives, policies, procedures and protocols from previous year (2025/2026): What actions were completed? Include actions.

Quality Improvement Objective	Policies, procedures and protocols used to achieve quality improvement	Outcomes of Actions, including
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**Initiative #1:Rate of ED visits for modified list of ambulatory care-sensitive conditions\* per 100 long-term care residents.**

Target: 12%

Change Ideas:

1. To reduce unnecessary hospital transfers, through the use of on-site Nurse practitioner; education to families; education to staff; Use of SBAR, Root cause analysis of transfers. Registered in charge nurse to communicate to physician and NP, a comprehensive resident assessment, to obtain direction prior to initiating an ER transfer. The home discussed unnecessary hospital transfers in all annual and 6-week care conferences. The home also implemented default SBAR charting within point click care to ensure all documentation was following proper format. SBAR education provided in monthly registered staff meetings.
2. Support early recognition of residents at risk for ED visits by providing preventive care and early treatment for common conditions leading potentially avoidable ED visits. The home reviews 24/7 report daily and meets Monday through Friday in the morning to discuss high risk areas within the home. This ensure prompt identification and preventative measures that can ultimately lead to avoidable ED visits. The home has a Nurse Practitioner on site 2 days a week to facilitate with early recognition.
3. Build capacity and improve overall clinical assessment to Registered Staff; through education of the most common transfers to ED. The home provided education to registered staff on the most common ED transfers in the fall of 2025. The home discuss what is considerate avoidable and what is considered unavoidable. The home also brought in a representative from Medigas to review respiratory assessments.
4. Development of IV program in the home. The home had all registered staff IV certified in February 2025. The home implemented IV hydration in December 2025 as a preventative ED transfer measure. Both Medical doctors are aware that the home can implement IV antibiotics and

Despite the continued implementation and interventions, the ED transfer rate increased to is reported in combination with Retirement continues to observe increasing resident compl multiple comorbidities, which continue to impa transfer requirements. The Home remains on ta of all planned change init

<p><b>Initiative #2:Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education</b></p>	<p>Target: 100%</p> <p>Change Ideas:</p> <p>1) To mandate diversity training through Surge education or live events. Through onboarding, the home initiated diversity training, and completions of this topic annually with the rest of the staff. Errinrung LTC has also adopted the CLRI schedule of events related to diversity and inclusion.</p> <p>2) To include Cultural Diversity as part of PAC meetings. Cultural Diversity is discussed at each PAC meeting including a review of education and events that have occurred over the previous quarter. In October 2025 PAC meetings, we discussed that the home celebrated Christmas in New Zeland in July 2025, Canada Day, Indian Independence Day, Oktoberfest, National Beans Day with a Mexican-themed luncheon, and Canadian Thanksgiving; In January 2026 PAC meetings, we discussed that Diwali was celebrated as well as Christmas Tea. In April 2026 PAC meetings, we discussed that we celebrated Alzheimer's Awareness in January 2026, Black History Month in February 2026 with a wine and cheese trivia night, and International Women's Day Tea Party in March 2026.</p> <p>3) To include live events and activities within the home related to culture, diversity and inclusion. The home celebrated the following events: Truth and Reconciliation in September 2025; Community Engagement Day in September 2025; Veteran's Day in November 2025; The Five Days of Diwali in November 2025; Henna Tattoos in November 2025 to celebrate Indian Culture; Black History Programming and Recognition in February 2026, International Women's Day March 2026.</p> <p>4) To include both resident and staff in activities within the home related to culture, diversity and inclusion. Diwali was celebrated in November 2025. Staff wore traditional outfits and Indian sweets and snacks were served. Additionally staff participated with the residents in Henna Tattoos in</p>	<p>Current 100%</p> <p>The home has proven successful in maintaini percentage of staff (executive-level, mana completed relevant equity, diversity, inclusior</p>
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<p><b>Initiative #3:Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences".</b></p>	<p><b>Target: 94%</b>  <b>Change Ideas:</b>  1) Review resident rights at Resident Council. Every month, alternating Resident Rights are reviewed at each Resident Council Meeting.  2) Invite Residents to attend resident-focused education provided within the home. Resident's attended brief application training with staff in the Spring of 2025.  3) Social worker to complete wellness checks with residents. The home's social worker has provided visits to residents based on referrals. Documents conversations in progress notes. The Social Worker conducted MoCA Assessment and Depression screenings where applicable.</p>	<p style="text-align: right;">Current 93.55%</p> <p>While the home was just below target, they v satisfaction by 1.68% and all change ideas h home will continue with these intervention t improvement of this ini</p>
<p><b>Initiative #4:Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment</b></p>	<p>Target: 20.00  Change Ideas:  1) The MD, NP, BSO internal and external (including Psychogeriatric Team), with nursing staff will meet monthly to review newly admitted residents on antipsychotic medication for diagnosis and indication for use. The Home's NP, DOC, RSM and BSO meet monthly to review residents on antipsychotics and residents with expressive behaviours.  2) Reduce inappropriate use of antipsychotic medications. During three month medication reviews, inappropriate antipsychotics have been discontinued.  3) Development of plans of care, with non-pharmacological approach - identification of triggers and interventions. Resident specific interventions such as colours, music therapy and doll therapy. Pet therapy comes into the home two times a week.  4) Gentle Persuasive approaches (GPA) training/education - Establish GPA trainers, educators in the home. The home has one RN and PSW in the home who are GPA certified.</p>	<p style="text-align: right;">Current 16.67%</p> <p>Antipsychotics without a diagnosis are trending been implemented. The home will continue contribute to the ongoing improvem</p>

**Initiative #5: Percentage of LTC home residents who fell in the 30 days leading up to their assessment**

Target: 17%

Current 19.65%

While the Home remains above benchmark over the past year. The Home will continue to work and strive to be below benchmark

**Initiative #6:Percentage of LTC residents who develop  
worsening pressure injury stage 2-4**

**Target: 3.00**

Current: 1.64% Errinrung has made steady pr  
therefore we will continue with the interve

2024 Resident Satisfaction Survey: Top 5 Opportunities

1. I am satisfied with the quality of: Laundry services for personal clothing 72.06%
2. I am satisfied with the temperature of my food and beverages. 71.47%
3. I am satisfied with the quality of care from: Dietitian 68.18%
4. Overall, I am satisfied with the meal, beverage, and dining services. 66.18%
5. I am satisfied with the quality of care from: Social Worker/Social Service Worker 50.00%

1. To address concerns related to missing clothing, several steps were implemented to improve awareness, communication, and adherence to current practices. An item was added to the Residents' Council meeting agenda to gather further information and feedback from residents. The Missing Clothing Policy was also included in a staff meeting agenda to ensure the home consistently followed established procedures and to reinforce staff awareness and accountability. In addition, a designated Lost and Found system was utilized to support the recovery and return of misplaced items. Residents and their families were informed about the Lost and Found process and how to access it. A reminder was also communicated through the newsletter to reinforce the importance of labeling all new clothing to help prevent loss.

2. To address dining and food service concerns, several actions were implemented to enhance the resident experience and gather meaningful feedback. An item was added to the Residents' Council meeting agenda to collect further input from residents. Regular dishes continued to be used during outbreak situations to maintain familiarity and comfort. Residents were informed that they could request staff to reheat their meals if they preferred their food to be warmer. To support this, a microwave was purchased for the South dining room to improve accessibility and service efficiency. Regular Food Committee meetings were also scheduled to provide residents with ongoing opportunities to share feedback and contribute to continuous improvement in dining services.

3. To improve awareness and communication regarding dietary services, several initiatives were implemented. An item was added to the Residents' Council meeting agenda to gather further information and feedback from residents. Efforts were made to ensure residents clearly understood who the Dietician was, including featuring them in a staff spotlight to enhance

**2025 Resident Satisfaction**

1. I am satisfied with the quality of: Laundry services 78.70% Improved
2. I am satisfied with the temperature of my food and beverages. Needs Improvement
3. I am satisfied with the quality of care from: Dietitian 68.18%
4. Overall, I am satisfied with the meal, beverage, and dining services. 72.32% Improved
5. I am satisfied with the quality of care from: Social Worker = 78.13% Improved

<p>2024 Family Satisfaction Survey: Top 5 Opportunities</p> <p>1. The resident can choose what time they go to bed. 77.97%</p> <p>2. I am satisfied with the timing and schedule of spiritual care services 75.00%</p> <p>3. I am satisfied with the variety of spiritual care services 72.50%</p> <p>4. I am aware of the spiritual care services offered in the home. 72.50%</p> <p>5. I am satisfied with the quality of care from doctors 71.43%</p>	<p>1. The concern has been added to the agenda for the next Family Council/Residents Council meeting to allow for further discussion and clarification. The importance of resident rights has been reviewed and reinforced with PSW staff during a staff meeting. In addition, resident care plans have been reviewed and updated as needed to ensure they accurately reflect each resident's individual bedtime preferences and support resident-centered care.</p> <p>2. The topic was added to the agenda for the next Family Council meeting to obtain further details and feedback. Available spiritual and religious services, along with the service schedule, were reviewed with Family Council members. Ongoing efforts to recruit and engage representatives from additional denominations continue to support the diverse spiritual needs of residents. The home's Chaplain has been featured in the monthly newsletter to increase awareness of available spiritual care services. Additionally, the reopening of the Chapel has been successfully completed, providing residents and families with an accessible space for worship, reflection, and</p>
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**2025 Family Satisfaction Survey**

1. The resident can choose what time they go to bed. 77.97%

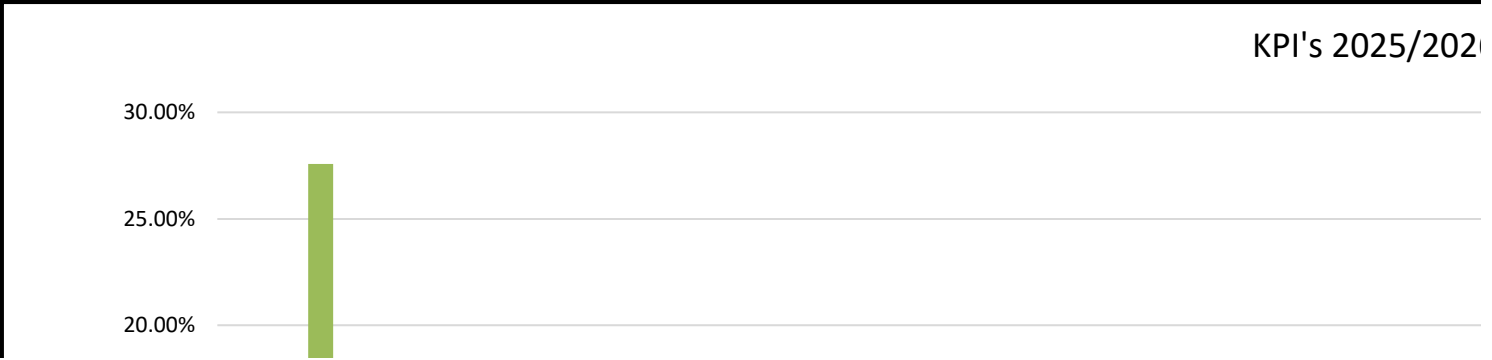
2. I am satisfied with the timing and schedule of spiritual care services 80.00% Improved

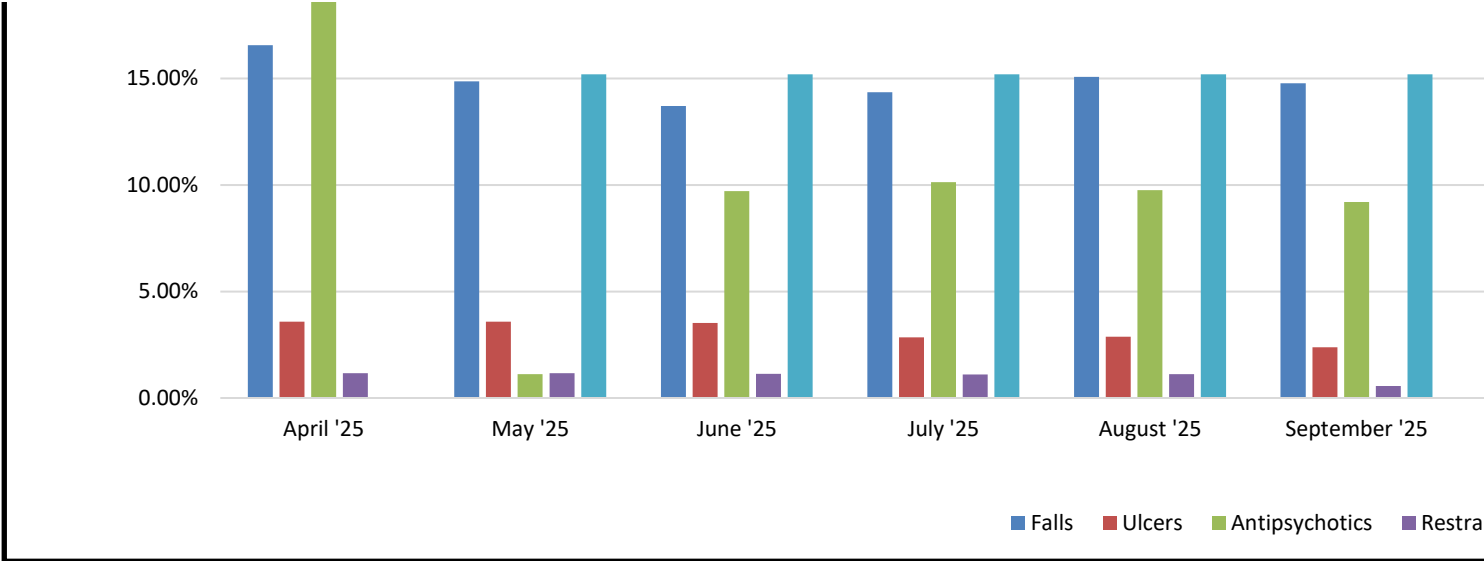
3. I am satisfied with the variety of spiritual care services 72.50% Improved

4. I am aware of the spiritual care services offered in the home. 72.50% Improved

5. I am satisfied with the quality of care from doctors 71.43%

Key Performance Indicators			
KPI	April '25	May '25	June '25
Falls	16.57%	14.86%	13.71%
Ulcers	3.59%	3.59%	3.53%
Antipsychotics	27.57%	1.12%	9.72%
Restraints	1.17%	1.17%	1.14%
Avoidable ED Visits	ND	15.20%	15.20%





**How Annual Quality Initiatives Are Selected**

The continuous quality improvement initiative is aligned with our mission to provide quality care and services through innovation and excellence. The home has a Continuous Quality Improvement Committee comprised of interdisciplinary representatives that are the home’s quality and safety culture champions. An analysis of quality indicator performance with provincial benchmarks for quality indicators is completed. Quality indicators below benchmarks and that hold high value on resident quality of life and safety are selected as a part of the annual quality initiative. Emergent issues internally are reviewed for trends and incorporated into initiative planning. The quality initiative is developed with the voice of our residents/families/POA's/SDM's through participation in our annual resident and family satisfaction survey and as members of our continuous quality improvement committee. The program on continuous quality improvement follows our policies based on evidence based best practice.

**Summary of Resident and Family Satisfaction Survey for Previous Fiscal Year**

Date Resident/Family Survey Completed for 2024/25 year:	Surveys were conducted between October 1 and October 31, 2025
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Results of the Survey ( <i>provide description of the results</i> ):	83.93% of the residents and 87.21% of family members would recommend this home to others; The Overall Satisfaction Resident Rate in 2025 is 83.11% under the 2024 of 85.30 previously%. For Family Satisfaction Overall Survey in 2025 is 84.69, also slightly below the 2024 rate of 84.30%. To note, there was a significant increase in both the resident and family participants for 2025 verses 2024.
How and when the results of the survey were communicated to the Residents and their Families (including Resident's Council, Family Council, and Staff)	Results of the survey were shared with both families and residents during both resident and family council. The homes programs Manager reviewed with each council to ensure understanding and to address any questions related to results and or the delivery of the survey. The results of the survey were share with resident council on February 18th, 2026 and reviewed monthly. The results of the survey were shared with family council on March 19th, 2026.

Client & Family Satisfaction	Resident Survey		
	2026 Target	2025 (Actual)	2024 (Actual)
<i>Survey Participation</i>	100.00%	100.00%	56.67%
<i>Would you recommend</i>	100.00%	83.93%	87.50%
<i>If I have a concern, I feel comfortable raising it with the staff and leadership</i>	100.00%	95.89%	91.67%

Summary of quality initiatives for 2026/27: Provide a summary of the initiatives for this year including current performance, target and change ideas.		
<b>Initiative</b>	<b>Target/Change Idea</b>	<b>Current Performance</b>

<p><b>Initiative #1: Rate of ED visits for modified list of ambulatory care-sensitive conditions* per 100 long-term care residents.</b></p>	<p><b>Target: 26.00</b>  <b>Change Ideas:</b></p> <ol style="list-style-type: none"> <li>1. Use of SBAR - Registered in charge nurse to communicate to physician and NP, a comprehensive resident assessment, to obtain direction prior to initiating an ER transfer.</li> <li>2. Build capacity and improve overall clinical assessment skills of registered staff, through education supported by NP.</li> <li>3. Implementation of more fulsome education for UTI, Shortness of Breath, and Congestive Heart Failure and Respiratory Assessments.</li> <li>4. During care conferences, discussion with resident and families, regarding advance care planning (Resident and Family focused centered care).</li> </ol>	<p>April 2026: 36.5%</p>
<p><b>Initiative #2: Percentage of LTC residents who develop worsening pressure injury stage 2-4</b></p>	<p><b>Target: 2.00</b>  <b>Change Ideas:</b></p> <ol style="list-style-type: none"> <li>1. To reduce the percentage of residents who develop or experience worsening pressure injury.</li> <li>2. Home to collaborate with NSWOC to provide in home and virtual consults on residents with stage 2 or greater pressure ulcers.</li> <li>3. Prompt identification, assessment, and documentation of new and worsening pressure injuries.</li> </ol>	<p>April 2026: 1.64%</p>
<p><b>Initiative #3: Percentage of long term care residents who develop worsening pain.</b></p>	<p><b>Target: 5.00</b>  <b>Change Ideas:</b></p> <ol style="list-style-type: none"> <li>1. Enhancement of the end of life and palliative care program</li> <li>2. Utilization of pain tracker to monitor the use of PRN analgesics</li> <li>3. Provide education on the non-pharmacological interventions and approaches.</li> </ol>	<p>April 2026: 4.88%</p>

<p><b>Initiative #4: Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences".</b></p>	<p><b>Target: 95%</b>  <b>Change Ideas:</b>  <b>1. Engaging residents in meaningful conversations and care conferences that allow them to express their opinions. Review "Resident's Bill of Rights" more frequently, at Residents' Council meeting monthly. With a focus on Resident Rights #29. "Every resident has the right to raise concerns or recommend changes in policies and services on behalf of themselves or others to the following persons and organizations without interference and without fear of coercion, discrimination, or reprisal, whether directed at the resident."</b>  <b>2. Review of the Zero Tolerance of Abuse and Whistleblower policy.</b>  <b>3. Educate families on the concern process in the home.</b></p>	<p>October 2025: 93.55%  All change ideas have been implemented. The home will continue with these interventions to contribute to the ongoing improvement of this initiative.</p>
<p><b>Initiative #5: Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education</b></p>	<p><b>Target: 100%</b>  <b>Change Ideas:</b>  1. To increase diversity training through surge education or live events and introduce diversity and inclusion as part of the new employee onboarding process.  2. Creation of a culture board, of the cultures of the residents and team members in the home. Increased cultural recognition in the home.  3. Cultural assessment on admission (language, faith, gender preference for care, family roles)</p>	<p>April 2026: 100%  Programming has included cultural diversity within the home. New program manager recently started. Mandatory training included on new hire onboarding and annually for existing staff.</p>

<p><b>2025 Resident Satisfaction Survey:</b>  <b>Top 5 Opportunities:</b>  1. I have an opportunity to provide input on food and beverage options.  2. The resident receives courteous service in the dining room.  3. Continence care products: Are available when the resident needs them.  4. I am satisfied with: The timing and schedule of spiritual care services  5. I am satisfied with the quality of care from: Social Worker/Social Service Worker</p>	<p><b>The top 5 areas of improvement that were identified with the Resident Satisfaction survey included:</b></p> <ol style="list-style-type: none"> <li>1. Seek clarity on how we can improve resident contribution to food and beverage choices at resident council and food committee. Implement changes based on resident feedback. Offer additional condiments to residents in caddies on tables.</li> <li>2. Seek clarity on how we can improve courtesy in the dining room. Implement changes based on resident feedback. Review the home's pleasurable dining policy with the staff during staff meetings.</li> <li>3. Implementation of a new Continence Care Program. Provide Education to resident and staff regarding how products are distributed and how to request more.</li> <li>4. Collect further details and information related to specific concerns. Review the Calendar with Residents Council with a focus on Spiritual Care and request any timing adjustments. Implements changes based on resident feedback. Encourage participation in PAC</li> <li>5. Complete an annual review with the service provider to provide feedback. Collect further details and information related to specific concerns from the resident council. Provide residents with information on the role of social worker through the monthly newsletter.</li> </ol>	<p><b>2025 Resident Satisfaction Survey Results:</b></p> <ol style="list-style-type: none"> <li>1. 80.16%</li> <li>2. 80.15%</li> <li>3. 80.00%</li> <li>4. 80.00%</li> <li>5. 79.05%</li> </ol>
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**2025 Family Satisfaction Survey: Top 5 Opportunities**

<p><b>The top 5 areas of improvement that were identified with the Family Satisfaction survey included:</b></p> <ol style="list-style-type: none"> <li>1. Seek clarity on how we can improve family contribution to food and beverage choices at family council. Implement changes based on family council feedback. Ensure FSM attends each admission and care conference and asks for input on resident preferences.</li> <li>2. Seek clarity on how we can improve courtesy in the dining room. Implement changes based on resident feedback · Review the home’s pleasurable dining policy with the staff during staff meetings</li> <li>3. Heightened focus on program evaluations related to spiritual care. Seek clarity on how we can improve courtesy in the dining room. Implement changes based on resident feedback.</li> <li>4. Collect further details and information related to specific concerns. Review the Calendar with Family Council with a focus on Spiritual Care and request any timing adjustment.</li> <li>5. Complete an annual review with the service provider to provide feedback. Collect further details and information related to specific concerns from the resident council. Provide residents with information on the role of social worker through the monthly newsletter.</li> </ol>	<p><b>2025 Family Satisfaction Survey Results:</b></p> <ol style="list-style-type: none"> <li>1. 80.16%</li> <li>2. 80.15%</li> <li>3. 80.00%</li> <li>4. 80.00%</li> <li>5. 79.05%</li> </ol>
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**Process for ensuring quality initiatives are met**

Our quality improvement plan (QIP) is developed as a part of our annual planning cycle, with submission to Health Quality Ontario. The continuous quality team implements small change ideas using a Plan Do Study Act cycle to analyze for effectiveness. Quality indicator performance and progress towards initiatives are reviewed monthly and reported to the continuous quality committee quarterly.

Participants of Evaluation Name and Signatures:	<i>Print out a completed copy - obtain signatures and file.</i>	Date Signed:
Quality Improvement Lead	Krista Smith	
Executive Director	Stacey Coe	

	Director of Care	Krista Smith	
	Nutrition Manager	Susan Elliot	
	Programs Manager	Haley Elly	
	Clinical Consultant	Tiffany Gordon	
	Resident Council Representative	Gail Humphries	
	Family Council Representative	Heather Brassem	
	Medical Director	Naomi Kopp (nee Klages)	

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ding dates

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t Home figures. The Home  
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ct clinical decision-making and  
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tiatives.

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were successful in increasing  
have been implemented. The  
to contribute to the ongoing  
initiative.

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with these intervention to  
ent of this initiative

k, they have seen a decrease  
th the following interventions  
mark shortly.

Progress within this indicator,  
initiatives in place currently.

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**n Result:**

Services for personal clothing =

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Food and beverages = 66.96%

nt

Dietitian = 75.89% Improved

erage, and dining services =

|

Social Worker/Social Service

roved

**Key Results:**

3 to bed = 87.42% Improved

use of spiritual care services =

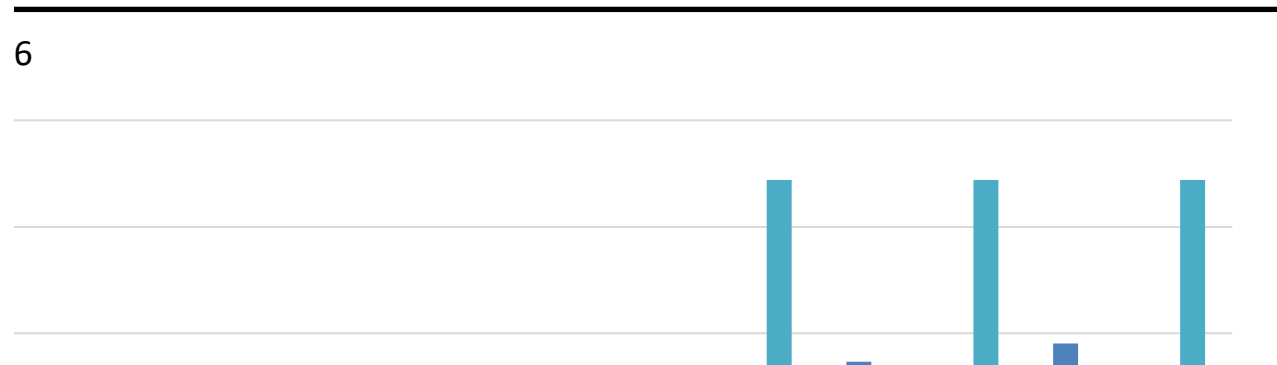
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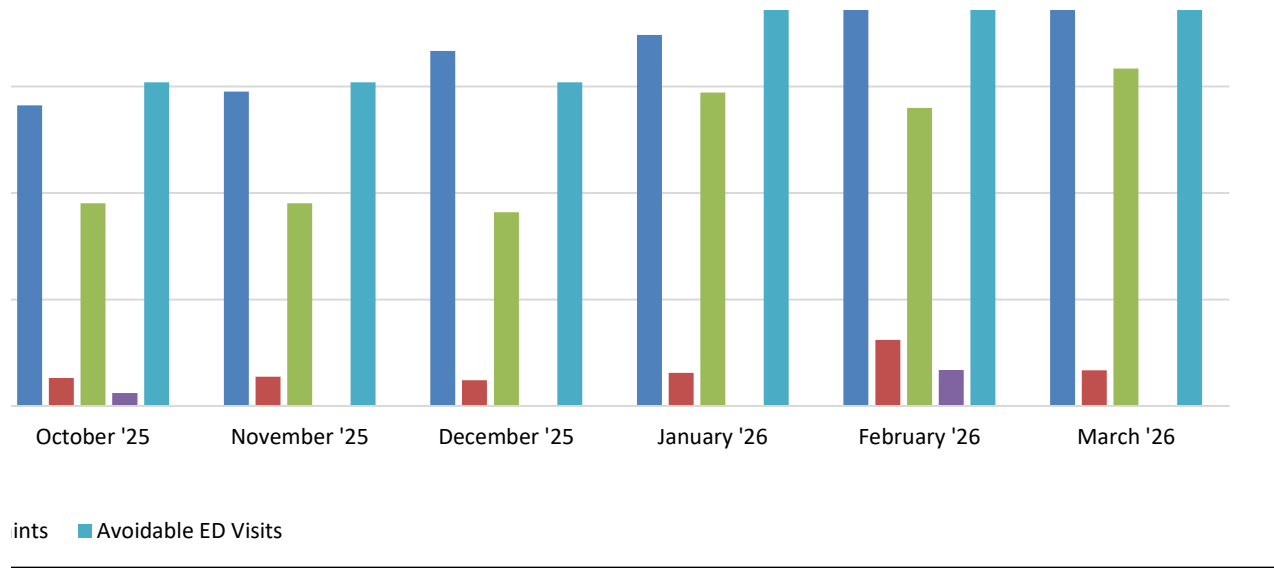
spiritual care services = 88.57%

provided in the home = 83.09%

consultations with doctors = 85.51% Improved

July '25	August '25	September '25	October '25	November '25	December '25	January '26	February '26	March '26
14.36%	15.08%	14.77%	14.11%	14.76%	16.67%	17.42%	18.67%	19.53%
2.84%	2.87%	2.38%	1.32%	1.38%	1.21%	1.55%	3.10%	1.67%
10.13%	9.76%	9.20%	9.52%	9.52%	9.09%	14.71%	14.00%	15.84%
1.10%	1.12%	0.57%	0.61%	0.00%	0.00%	0.00%	1.69%	0.00%
15.20%	15.20%	15.20%	15.20%	15.20%	15.20%	27.20%	27.20%	27.20%





	Family Survey				Improvement Initiatives for 2026
2023 (Actual)	2026 Target	2025 (Actual)	2024 (Actual)	2023 (Actual)	
60.00%	100.00%	90.00%	34.00%	20.00%	Designated staff will support all residents willing to complete a survey with privacy. Survey access online will be sent to all family members. Satisfaction survey will be advertised at the main home.
93.33%	100.00%	87.21%	84.38%	87.00%	Action plan to be created for the lowest scoring areas on the survey. Action plan will be shared with family and resident council.
92.00%	100.00%	84.85%	91.98%	88.00%	Continue to follow quality improvement plan from 2025/26, including sharing whistle blower policy around the home and at resident and family council.









