Omni
Quality Living

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Omni Quality Living Continuous Quality Improvement Initiative Report 2026/27

Prepared in accordance with: *Fixing Long-Term Care Act, 2021* O. Reg. 246/22 – Section 168 Continuous Quality Improvement Initiative Requirements

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Omni Quality Living – Pleasant Meadow Manor

Continuous Quality Improvement Initiative Report

2026/27

OVERVIEW

At Omni Quality Living, people remain the driving force behind our mission. Since 1975, we have been committed to delivering compassionate, high-quality care, and as we move into our 51st year, we continue to shape the future of long-term care in Ontario with innovation, integrity, and a deep sense of purpose.

Quality is embedded in our culture. Our **Quality Matters** program guides our approach, ensuring that every resident receives care that is safe, timely, effective, and personalized. This framework supports continuous improvement and reinforces our commitment to evidence-based practices, routine evaluation, and industry-leading standards.

We recognize our role in supporting a health system that is sustainable, equitable, and focused on long-term wellness. Our work aligns with Ontario's vision for a value-based universal health care system—one that prioritizes prevention, improves outcomes, reduces hallway medicine, and strengthens access to high-quality care for all Ontarians.

Our **2026/27 Quality Improvement Plan** reflects provincial annual priorities as well as corporate priorities identified across Omni Quality Living. It aligns with regional and provincial strategies and fulfills the requirements of the **Continuous Quality Improvement Initiative Report (CQIIR)** under section 168 of O. Reg. 246/22 of the *Fixing Long-Term Care Act, 2021*.

This plan also supports broader provincial goals: enhancing the health care experience through an integrated, resident-centered continuum of care, and collaborating with partners to build an accountable, high-performing system that reduces disparities and improves outcomes across diverse populations.

Access and Flow

Improving access and flow across Ontario's health system continues to be a shared responsibility, and long-term care plays a vital role in ensuring residents receive the right care

in the right place. Omni Quality Living remains committed to strengthening system capacity and supporting smoother transitions for residents, families, and partners across the continuum of care.

- **Timely and Responsive Admissions**
  All applications for admission are reviewed promptly and responded to in accordance with the *Fixing Long-Term Care Act*. We remain committed to ensuring that individuals waiting for long-term care receive timely decisions and clear communication.
- **Efficient Bed Management**
  Available beds are reported to Ontario Health at Home without delay, and admissions are scheduled as soon as possible to support flow across hospitals, community settings, and long-term care.
- **Expanding Capacity Through Redevelopment**
  We continue to redevelop existing homes, often adding new beds and licenses—and to build new homes in communities across Ontario. These investments support provincial efforts to increase long-term care capacity and reduce pressure on hospitals.
- **Nurse Practitioner–Led Outreach**
  Nurse Practitioner outreach remains a key strategy in enhancing on-site clinical support, reducing avoidable transfers, and improving resident outcomes.
- **Reducing Unnecessary Emergency Department Transfers**
  We continue to strengthen in-home clinical capabilities, early intervention strategies, and staff education to minimize avoidable transfers to emergency departments.
- **Enhanced On-Site Diagnostics**
  Partnerships with local health agencies enable more facility-based services such as X-ray, ultrasound, and laboratory testing—improving access to timely diagnostics and reducing the need for off-site appointments.
- **Improving Transitions Through Technology**
  We continue to advance our use of digital tools to support safe, accurate, and efficient communication with external health partners.
- **Strengthening Medication Reconciliation**
  Many of our homes have adopted the pharmacist-led “Boomer Process” for first-time admissions, ensuring accurate medication reconciliation and safer transitions into long-term care.

Technology

Strengthening digital connectivity across the health system remains essential to improving access, flow, and resident safety. Omni Quality Living continues to expand the use of technology to support accurate, timely, and coordinated transitions of care.

- **Maximizing PointClickCare**

PointClickCare remains our core clinical information system. We continue to leverage its advanced capabilities, including analytics, dashboards, and real-time reporting—to support early identification of risk, improved care planning, and stronger communication across the continuum of care.

- **HealthConnex Integration**
  HealthConnex supports secure, streamlined information exchange between long-term care and acute care partners. Expanded use of this platform reduces delays, improves accuracy of shared information, and supports more efficient transitions.
- **Optimizing CHRIS**
  CHRIS remains essential for communication with Ontario Health at Home and community partners. Consistent use supports timely referrals, accurate documentation, and smoother transitions for residents entering or leaving long-term care.
- **Driving Compliance Through CHeCS**
  CHeCS transforms regulatory complexity into operational clarity. This mobile-first, AI-enabled platform standardizes compliance workflows, reduces incident logging time, manages staff training and certifications, and supports adherence to the *Fixing Long-Term Care Act*. By reducing administrative burden, CHeCS enables staff to focus more time on resident care.
- **Advancing Interoperability Through Amplify**
  All Omni homes continue to use Amplify to support safer transitions by connecting clinical data systems between long-term care and acute care. This integration reduces the risk of medication discrepancies, treatment errors, and information gaps during transfers.

Together, these digital tools strengthen our ability to deliver safe, coordinated, and efficient care while supporting broader provincial goals for a more connected and higher-performing health system.

Resident and Family Experience

A positive resident and family experience is central to high-quality long-term care. It reflects every interaction resident and family have within our homes—from daily care and communication to access to information and involvement in decision-making.

At Omni Quality Living, the voices of residents and families guide our quality improvement efforts. We are committed to creating an environment where each person's preferences, needs, and values shape the care they receive.

Resident Experience Survey

We partner with **Metrics at Work**, an independent organization that administers and analyzes our annual Resident Experience Survey. This survey focuses on two key indicators:

- How well residents feel staff listen to them.
- Whether residents feel they can express their opinions without fear of consequences

Survey results provide valuable insight into the lived experience of residents and families. Findings are used to identify opportunities for improvement, guide action planning, and celebrate strengths. Results are shared openly to promote transparency and accountability.

Our goal remains clear: to ensure every resident experiences compassionate, respectful, and individualized care, supported by strong partnerships with families and caregivers.

Provider Experience

A strong provider experience is essential to delivering exceptional resident care. At Omni Quality Living, we are committed to being a workplace where people feel respected, supported, and inspired—across all roles, generations, and career stages.

- **Recruitment, Retention, and Workforce Development**
  We actively recruit and retain qualified candidates while investing in the next generation of long-term care professionals. Our corporate education coordinator strengthens partnerships with colleges and universities, coordinates student placements, and supports preceptorship opportunities.
- **Success Through PREP LTC**
  The PREP LTC initiative has strengthened our ability to support students and new graduates by enhancing preceptor training, improving onboarding, and building confidence among staff who take on mentorship roles. This has contributed to stronger multigenerational teams and a more supportive learning environment.
- **Commitment to Learning and Growth**
  We offer bursaries for continuing education, certifications, and skills training, recognizing that investing in our people strengthens both care quality and job satisfaction.
- **Creating a Supportive Workplace**
  A positive provider experience includes moments of connection, recognition, and joy. Our homes regularly host appreciation events, celebrations, and team-building activities. Every employee also receives a holiday gift card as a gesture of gratitude for their dedication.

Safety

Safety is the foundation of high-quality care. At Omni Quality Living, we view safety as a whole-person commitment that includes physical, emotional, psychological, and social well-being.

Whole-Person Safety

Our approach is grounded in a biopsychosocial understanding of health. We focus on:

- **Physical safety:** Strong IPAC practices, fall prevention, medication safety, and safe clinical procedures.
- **Emotional and psychological safety:** Trauma-informed approaches, respectful communication, and environments free from fear or intimidation
- **Social safety:** Supporting meaningful relationships, reducing isolation, and fostering belonging.

A Culture of Staff Safety

A safe home depends on a safe workplace. We support staff through:

- Clear protocols and training
- Access to tools and technology that reduce risk.
- A culture of open reporting and psychological safety
- Respectful, inclusive environments that promote teamwork.

Learning and Continuous Improvement

We encourage open reporting of incidents and near misses and use this information to guide improvements. Digital tools support consistent documentation, timely communication, and effective follow-up.

Partnering With Residents and Families

Residents and families play an essential role in safety. Their insights help identify risks, improve communication, and strengthen care planning.

Palliative Care

Palliative care at Omni Quality Living is grounded in dignity, comfort, and whole-person support. Our approach enhances quality of life for residents living with progressive, life-limiting illnesses while providing meaningful guidance to families.

Resident-Centered and Culturally Responsive Care

Care plans reflect each resident’s physical, emotional, social, psychological, and spiritual needs. From admission, we complete additional assessments to support culturally appropriate advance care planning.

Support for Families

Families are essential partners. We provide education, emotional support, and practical guidance to help them navigate the palliative journey.

Holistic Comfort and Well-Being

Our teams focus on:

- Pain and symptom management
- Emotional and psychological support
- Social connection and belonging
- Spiritual care aligned with personal beliefs

Care in Place

Whenever possible, we provide palliative care within the home to reduce unnecessary hospital transfers and support comfort in familiar surroundings.

A Compassionate, Coordinated Experience

Our approach ensures personalized care, continuity, comprehensive support, and a focus on comfort, dignity, and peace.

Population Health

Long-term care plays a vital and often underrecognized role in improving population health. Omni Quality Living contributes to healthier communities by supporting older adults with complex needs, preventing avoidable hospital use, and promoting well-being across the continuum of care.

- **Supporting Aging Populations with Complex Needs**
  We provide stable, comprehensive, 24-hour care for individuals with chronic conditions, cognitive impairment, mobility challenges, and social vulnerabilities—reducing strain on hospitals and community services.
- **Promoting Wellness and Prevention**
  Our teams focus on early identification of health changes, chronic disease management, fall prevention, nutrition and hydration, and social engagement.
- **Reducing Health System Pressures**
  By providing high-quality care in place, we help reduce avoidable ED visits, unnecessary hospital admissions, ALC pressures, and harmful transitions.
- **Equity and Inclusion**

We support residents from diverse cultural, linguistic, and socioeconomic backgrounds and ensure care is respectful, inclusive, and aligned with individual values.

- **Strong System Partnerships**
  We collaborate with hospitals, primary care, Ontario Health Teams, community agencies, and specialized services to support coordinated care and improved transitions.
- **Data-Informed Decision-Making**
  We use clinical data, quality indicators, and resident experience feedback to guide improvement and target interventions.
- **Enhancing Quality of Life**
  Population health is about living well. We prioritize meaningful engagement, purposeful activities, social connection, and emotional well-being.

Alignment With the Fixing Long-Term Care Act and CQIIR Requirements

Omni Quality Living's 2026/27 Quality Improvement Plan fully aligns with the *Fixing Long-Term Care Act, 2021* and the **Continuous Quality Improvement Initiative Report** requirements under O. Reg. 246/22.

1. Systematic Approach to Continuous Quality Improvement

Our plan uses a standardized, evidence-informed framework supported by:

- Clinical indicators
- Resident experience surveys
- Safety reports
- Staff feedback

2. Annual Priorities and Targets

- Aligns with provincial priorities
- Includes home-level and corporate-level indicators
- Uses data from PCC, HealthConnex, CHRIS, CHeCS, and surveys
- Sets realistic, evidence-based targets

3. Resident, Family, and Caregiver Engagement

- Use independent Resident Experience Surveys
- Incorporate Resident and Family Council feedback
- Share results and action plans publicly
- Embed resident voice in care planning and safety initiatives

4. Staff Engagement and Provider Experience

- Strengthen workforce development
- Support multigenerational teams
- Promote psychological safety and open reporting
- Encourage staff participation in QI activities

5. Monitoring, Reporting, and Evaluation

- Use real-time data systems
- Conduct audits and interdisciplinary reviews
- Track trends in safety and outcomes
- Report progress to leadership, residents, families, and the public

6. Integration With the Broader Health System

- Strengthen partnerships with hospitals, OHTs, and community agencies
- Use digital platforms to improve transitions
- Support system flow and reduce avoidable transfers
- Contribute to population health and equity

7. Commitment to Resident Safety

- Use a biopsychosocial approach
- Strengthen IPAC, emergency preparedness, and violence prevention
- Encourage open reporting
- Implement technology-enabled safety systems

8. Public Transparency

- Share QI priorities and results openly
- Maintain clear, accessible documentation
- Demonstrate accountability through visible action

Access and Flow

Measure - Dimension: Efficient

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Rate of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents.	P	Rate per 100 residents / LTC home residents	CIHI CCRS, CIHI NACRS / October 1, 2024, to September 30, 2025 (Q3 to the end of the following Q2)	16.88	15.00	Achieve a target of 15% ow lower by providing registered staff education to keep residents in the home. We will also provide additional education to Power of Attorneys about the services and comfort measures we provide. We will ask for our Medical Director, Physicians, and Nurse Practitioner to provide education to POAs.	Campbellford Memorial Hospital, Peterborough Regional Health Centre, Peterborough Hospice, Ontario Health atHome Central East

Change Ideas

Change Idea #1 Decrease and improve on the current number of ED visits for modified list of ambulatory case-sensitive conditions. Utilize resident's physician or on-call physician if a resident is required to be sent to ED. Utilize our Nurse Practitioner through the NP STAT program to assist with specialized care.

Methods	Process measures	Target for process measure	Comments
Data is provided by Ontario Health atHome. Utilize the data for efficiency. Utilize Physicians and NP to train and educate registered staff to perform duties within their scope based on the needs of the home. Utilize Physicians and NP to provide POA education.	Daily review of ED visits in a multidisciplinary forum. Monthly and Quarterly review of the number of ED visits for modified list of ambulatory care-sensitive conditions.	Achieve a goal of 15% per or lower 100 residents.	Current performance data may be inaccurate and should be interpreted with caution.

Measure - Dimension: Efficient

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of registered staff shifts filled by agency staff	C	% / Staff	In house data collection / 2026	22.00	0.00	Average number of registered staff shifts filled with agency staff per month in 2025 was approximately 22%. We started 2025 with 42% of registered staff shifts being filled by agency staff and saw the decrease to approximately 15% by the end of 2025. We believe we will be able to achieve 0% usage by December 31, 2026.	Trent University, Fleming College, Ontario Health HFO, Ontario Health

Change Ideas

Change Idea #1 Enhance recruitment and retention. Collaborate with external collaborators to promote working at Pleasant Meadow Manor and a career in LTC. Utilize Ontario Health funding incentives for new or returning registered staff to LTC. Enhance onboarding to promote successful candidates.

Methods	Process measures	Target for process measure	Comments
Utilizing hiring partners. connecting with local universities and colleges. Promote placement opportunities in the home. Utilize Ontario Health incentives. Challenges include being located in a rural community with limited transportation options and limited housing options.	Reviewing job vacancies in the home and the amount of shifts filled by agency staff from month to month.	Average number of registered staff shifts filled with agency staff per month in 2025 was approximately 22%. Our target if to be at 0% usage by December 31, 2026.	Current LTC Beds-96. Current number of total staff-apx 125. Current performance data may be inaccurate and should be interpreted with caution.

Equity

Measure - Dimension: Equitable

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education	O	% / Staff	Local data collection / Most recent consecutive 12-month period	95.48	100.00	Education that was provided to staff was 95.48% complete by all staff in the home. Our target is 100% performance and believe this is achievable.	Surge Learning Inc., Peterborough OHT

Change Ideas

Change Idea #1 Omni Quality Living continues to be a strategic focus for the company and demonstrates passionate dedication to developing and enhancing our DEI program for all Omni homes. Pleasant Meadow Manor will encourage staff to participate in relevant equity, diversity, inclusion, and anti-racism education and bring ideas and feedback forward. Empower staff to bring forward any concerns they may have with our current DEI and anti-racism culture in the home. Develop a DEI committee and topic specific plan that would meet and be updated quarterly.

Methods	Process measures	Target for process measure	Comments
Provide DEI and anti-racism annual education and encourage staff completion. Post DEI and anti-racism calendar in the home and promote awareness of dates. Promote a DEI and anti-racism culture in the home. Monitor the DEI topic specific plan quarterly. Discuss any DEI and anti-racism concerns at a daily multidisciplinary report.	DEI survey completed in the home. Completion of DEI education on Surge Learning for 2026.	Our goal would be for our home to score 90% on feeling satisfied with our current DEI and anti-racism culture in the home. Our goal would also be to have 100% participation in the home for completing education completion.	# of LTC Beds - 96. Current performance data may be inaccurate and should be interpreted with caution.

Experience

Measure - Dimension: Patient-centred

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of residents responding positively to: "What number would you use to rate how well the staff listen to you?"	O	% / LTC home residents	In house data, NHCAHPS survey / Most recent consecutive 12-month period	92.50	100.00	Resident Experience Survey was 92.8%. This is an increase from the previous year. Target of 100% is what we strive to achieve. The absolute target is 100%.	Metrics@Work

Change Ideas

Change Idea #1	Encourage residents to participate in the home's Resident Council to bring ideas or concerns forward. Empower staff to bring any resident idea or concern forward so that managers and staff can collaborate towards a resolution for the resident. Ensure that all resident and Family Council are answered within 10 days and that all items are addressed. Present resolution to the resident which had the idea or concern. Provide assistance to residents on the use of the devices in which to complete the Resident Experience Survey.

Methods	Process measures	Target for process measure	Comments
Annual Resident Experience Survey, quarterly Quality Improvement meeting, monthly Resident Council meeting, daily multidisciplinary meeting. Gentle Persuasive Approach training along with Dementia training through Ontario Health in our home.	Metrics@Work 2026 survey results for the question: "What number would you use to rate how well staff listen to you?"	Our goal is to improve from 92.8% in 2025 to 100% in 2026.	Total Surveys Initiated: 80 Total Survey Initiated=80 # of LTCH beds=96 Current performance data may be inaccurate and should be interpreted with caution.

Measure - Dimension: Patient-centred

Indicator #5	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences".	O	% / LTC home residents	In house data, interRAI survey / Most recent consecutive 12-month period	88.75	100.00	Resident Experience Survey was 88.5% in 2025. Target of 100% is what we strive to achieve. The absolute target is 100%.	

Change Ideas

Change Idea #1 Encourage residents to participate in the home's Resident Council to bring ideas or concerns forward. Provide assistance to residents on the use of the devices in which to complete the Resident Experience Survey. Empower staff to bring any resident idea or concern forward so that managers and staff can collaborate towards a resolution for the resident. Present resolution to the resident which had the idea or concern. Education and communicate to staff our change ideas and to maintain professionalism and display a high level of customer service standard.

Methods	Process measures	Target for process measure	Comments
Annual Resident Experience Survey, quarterly Quality Improvement meeting, monthly Resident Council meeting, daily multidisciplinary meeting. Gentle Persuasive Approach training along with Dementia training through Ontario Health in our home.	Metrics@Work 2026 survey results for the question: "I can express my opinion without fear of consequences."	Our goal is to improve from 88.5% in 2025 to 100% in 2026.	Total Surveys Initiated: 80 Total Survey Initiated=80 # of LTCH beds=96 Current performance data may be inaccurate and should be interpreted with caution.

Safety

Measure - Dimension: Safe

Indicator #6	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of LTC home residents who fell in the 30 days leading up to their assessment	O	% / LTC home residents	CIHI CCRS / July 1 to September 30, 2025 (Q2), as target quarter of rolling 4-quarter average	18.78	15.00	Utilize the home's falls prevention program as guidance to decrease the number of residents who fell in the 30 days leading up to their assessment by 18.78% to 15%.	Achieva Health

Change Ideas

Change Idea #1	Provide direction to all nursing staff of new resident's assistive devices for mobility upon admission. Provide education to all nursing staff on accurate documentation and reporting on mobility and post fall requirements. Post fall huddles, and daily QI huddles occur to keep clear and open communication between shifts, to target and observe high risk fallers, and to increase supports such as programming (fun and fitness) or our PT program such as our walking program and strength programs. Follow policy and procedure regarding quarterly assessment and care plan review and communicate changes immediately.

Methods	Process measures	Target for process measure	Comments
Data collected and reviewed in the home each month by the Falls team and Quality Improvement team. Residents with falls are tracked daily by multidisciplinary team report.	Our resident population in QI Q4 2024 - Q3 2025 had a percentage of 15.09% of has fallen. Our goal is to below 15%. We have observed an increase in the new admission demographic being more frail and at a higher risk for falls including an increase in cognitive impairment. Measures are completed and reviewed at monthly Falls Prevention team meeting along with monthly and quarterly Quality Improvement team meetings.	The target is to decrease in residents who fell in the 30 days leading up to their assessment from 18.78% in 2025 to 15% in 2026.	# of LTCH beds=96. Current performance data may be inaccurate and should be interpreted with caution.

Measure - Dimension: Safe

Indicator #7	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	35.48	20.00	The provincial average in QI Q3 2025 was 20%. Our goal is to be below the provincial average and achieve 20% or lower, which will be a decline of approximately 15.5%. In the last quarter we began a trend downward.	Ontario Health atHome Central East, Peterborough PASE Clinic, Behavioural Support Ontario, Ontario Health East

Change Ideas

Change Idea #1 Provide education to all nursing staff on the completion of DOS documentation and review by registered staff. Provide education to all nursing staff on the importance of accurate documentation, reporting, and communication of resident behaviors and successful interventions. Follow policy and procedure regarding quarterly assessment and review. Review resident diagnosis of resident's were were given antipsychotic medication with the physicians of the home.

Methods	Process measures	Target for process measure	Comments
Data collected in the home each month by the Quality Improvement Team and reviewed. BSO Team Lead submission of metrics to BSO Ontario.	Quality Improvement Team meeting each month and quarterly meeting each quarter. Daily review of antipsychotic medication changes at multidisciplinary team meeting.	Our target will be less than 20% of residents without psychosis who are given antipsychotic medication in their look back period for assessment.	Current performance data may be inaccurate and should be interpreted with caution.

Measure - Dimension: Safe

Indicator #8	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of long-term care residents whose stage 2 to 4 pressure ulcer worsened	O	% / LTC home residents	CIHI CCRS / July 1 to September 30, 2025 (Q2), as reporting quarter for the rolling 4-quarter average	5.29	2.50	Utilize the home's healthy living, healthy skin program as guidance to decrease the percentage of residents in the home whose stage 2 to 4 pressure ulcer worsened to 2.5% or lower.	Peterborough Regional Health Centre, Ontario Health atHome Central East

Change Ideas

Change Idea #1 Register a RN in the home in the NSWOCC program and a RPN in the home to the SWAN program to have a RN and RPN skin and wound champion in the home. Ensure the Skin and Wound Lead in the home is identified to the staff of the home so that they can bring skin and wounds forward to the lead for additional intervention. Provide further intervention to any wound that is not improving or worsens.

Methods	Process measures	Target for process measure	Comments
Utilize the healthy living, healthy skin program to guide on the procedures to follow in the home. Ensure the skin and Wound Lead is monitoring pressure ulcer progress in the home. Contact NP STAT for further intervention along with contacting the skin and wound clinic at PRHC if wounds are not improving or worsening. Research and apply for the NSWOCC and SWAN courses.	Daily communication at the home's multidisciplinary report. Weekly clinically appropriate assessment tool. Monthly skin and wound team meeting. Monthly and quarterly Quality Improvement team meetings.	The target is to decrease in residents whose stage 2 to 4 pressure ulcer worsened from 5.29% in 2025 to 2.5% in 2026.	# of LTCH beds=96 Current performance data may be inaccurate and should be interpreted with caution.

Measure - Dimension: Safe

Indicator #9	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of long-term care residents in daily physical restraints	O	% / LTC home residents	CIHI CCRS / July 1 to September 30, 2025 (Q2), as target quarter of rolling 4-quarter average	0.00	0.00	We strive to have 0% of residents in daily physical restraints as we have maintained a low number of restraints or 0% of residents in daily physical restraints in previous years.	CIHI, Ontario Health atHome East

Change Ideas

Change Idea #1 Educate POA/SDMs on the risk of daily physical restraints and alternative interventions. Connect POA/SDMs with NP STAT or BSO Lead for education on alternative interventions. Ensure that residents are not in bed too early and encourage activities after dinner and prior to going to bed.

Methods	Process measures	Target for process measure	Comments
Quality Improvement Team monthly and quarterly meetings. Multidisciplinary daily report. Falls team.	Quality Improvement monthly and quarterly data from CIHI.	Our goal is to maintain 0% residents in daily physical restraints in the home.	# of LTCH beds=96 Current performance data may be inaccurate and should be interpreted with caution.

Access and Flow | Efficient | Optional Indicator

Indicator #7

Rate of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents. (Pleasant Meadow Manor)

Last Year		This Year		
15.31	**10**	**16.88**	**-10.25%**	**15**
Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

Change Idea #1 ☐ Implemented ☐ Not Implemented ☑ In Progress

Decrease and improve on the current number of ED visits for modified list of ambulatory case-sensitive conditions. Utilize resident's physician or on-call physician if a resident is required to be sent to ED. Utilize our Nurse Practitioner to assist with specialized care.

Process measure

- Daily review of ED visits in a multidisciplinary forum. Monthly and Quarterly review of the number of ED visits for modified list of ambulatory care-sensitive conditions.

Target for process measure

- Achieve a goal of under 10% per 100 residents.

Lessons Learned

The change ideas must be implemented and maintained to be effective. Our goal will be to maintain improve the current performance.

POAs changing their view about Advanced Directives at the end stage of life and sending their loved ones to hospital.

Comment

We were not able to achieve a goal of 10% and are pivoting our target to 15% for the 2026/2027 QIP to trend towards improvement while implementing our change idea.

Equity | Equitable | Optional Indicator

	Last Year		This Year		
Indicator #6 Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education (Pleasant Meadow Manor)	**99.19** Performance (2025/26)	**100** Target (2025/26)	**95.48** Performance (2026/27)	**-3.74%** Percentage Improvement (2026/27)	**100** Target (2026/27)

Change Idea #1 ☐ Implemented ☐ Not Implemented ☑ In Progress

Omni Quality Living continues to be a strategic focus for the company and demonstrates passionate dedication to developing and enhancing our DEI program for all Omni homes. Pleasant Meadow Manor will encourage staff to participate in relevant equity, diversity, inclusion, and anti-racism education and bring ideas and feedback forward. Empower staff to bring forward any concerns they may have with our current DEI and anti-racism culture in the home. Develop a DEI topic specific plan that would be updated quarterly.

Process measure

- DEI survey completed in the home. Completion of DEI education on Surge Learning for 2025.

Target for process measure

- Our goal would be for our home to score 90% on feeling satisfied with our current DEI and anti-racism culture in the home. Our goal would also be to have 100% participation in the home for completing education completion.

Lessons Learned

We were very close to our goal last year, but there was a discrepancy a few staff members that did not complete 1 course. Further review will be completed prior to the end of 2026 to ensure 100% performance.

Comment

# of LTCH Beds-96.
Maintain a target of 100% for 2026/2027.

Experience | Patient-centred | Optional Indicator

	Last Year		This Year		
Indicator #4	**93.10**	**100**	**92.50**	**-0.64%**	**100**
Percentage of residents responding positively to: "What number would you use to rate how well the staff listen to you?" (Pleasant Meadow Manor)	Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

Change Idea #1 ☐ Implemented ☐ Not Implemented ☑ In Progress

Encourage residents to participate in the home's Resident Council to bring ideas or concerns forward. Provide assistance to residents on the use of the devices in which to complete the Resident Experience Survey. Empower staff to bring any resident idea or concern forward so that managers and staff can collaborate towards a resolution for the resident. Present resolution to the resident which had the idea or concern.

Process measure

- Metrics@Work 2025 survey results for the question: "What number would you use to rate how well staff listen to you?"

Target for process measure

- Our goal is to improve from NUMBER% in 2024 to 100% in 2025.

Lessons Learned

Continue to coach and mentor staff on good quality customer service skills and taking the time to listen to the residents of the home.

Comment

Although we were not able to achieve our target of 100%, it was also a challenge to see our performance decrease from less than 1% from the year before. We will maintain our target of 100%

Indicator #5

Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences". (Pleasant Meadow Manor)

Last Year		This Year		
87.93	**100**	**88.75**	**0.93%**	**100**
Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

Change Idea #1 ☐ Implemented ☐ Not Implemented ☑ In Progress

Encourage residents to participate in the home's Resident Council to bring ideas or concerns forward. Provide assistance to residents on the use of the devices in which to complete the Resident Experience Survey. Empower staff to bring any resident idea or concern forward so that managers and staff can collaborate towards a resolution for the resident. Present resolution to the resident which had the idea or concern. Education and communicate to staff our change ideas and to maintain professionalism and display a high level of customer service standard.

Process measure

- Metrics@Work 2025 survey results for the question: "I can express my opinion without fear of consequences."

Target for process measure

- Our goal is to improve from 82% in 2024 to 100% in 2025.

Lessons Learned

Continue to coach and mentor staff on good quality customer service skills and taking the time to listen to the residents of the home.

Comment

Although we were not able to achieve our target of 100%, it was positive to see our performance increase from the year before. We will maintain our target of 100%

Safety | Safe | Optional Indicator

Indicator #2

Percentage of LTC home residents who fell in the 30 days leading up to their assessment (Pleasant Meadow Manor)

Last Year		This Year		
15.09	**12.50**	**18.78**	**-24.45%**	**15**
Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

Change Idea #1 ☐ Implemented ☐ Not Implemented ☑ In Progress

Provide direction to all nursing staff of new resident's assistive devices for mobility upon admission. Provide education to all nursing staff on accurate documentation and reporting on mobility and post fall requirements. Post fall huddles, and daily QI huddles occur to keep clear and open communication between shifts, to target and observe high risk fallers, and to increase supports such as programming (fun and fitness) or our PT program such as our walking program and strength programs. Follow policy and procedure regarding quarterly assessment and care plan review.

Process measure

- Our resident population in QI Q4 2023 - Q3 2024 had a percentage of 15.09% of has fallen. Our goal is to below 12.5%. We have recently admitted 32 residents into new beds between September 2024 - February 2025. Many of these residents could be at high risk for falls upon admission to our home. Measures will be daily multidisciplinary report, monthly falls team meeting and monthly Quality Improvement team meetings.

Target for process measure

- Our goal is to be at less than 12.5% of resident who have fallen in the 30 days leading up to their assessment in each quarter of 2024.

Lessons Learned

We did not meet our goal of 12.5%. We will pivot to a target of 155% for the 2026/2027 due to the change in demographic of residents to LTC. More residents are being admitted to LTC with an increase in cognitive impairment and at a higher risk for falls.

We will continue to utilize these change ideas to strive for improvement in 2026/2027.

Comment

Continue with previous change ideas along with improve in communication with care plan monitoring and changes to staff.

	Last Year		This Year		
Indicator #3	**33.51**	**20**	**35.48**	**-5.88%**	**20**
Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment (Pleasant Meadow Manor)	**Performance (2025/26)**	**Target (2025/26)**	**Performance (2026/27)**	**Percentage Improvement (2026/27)**	**Target (2026/27)**

Change Idea #1 ☐ Implemented ☐ Not Implemented ☑ In Progress

#1) Provide education to all nursing staff on the completion of DOS documentation and review by registered staff. Provide education to all nursing staff on the importance of accurate documentation, reporting, and communication of resident behaviors and successful interventions. Follow policy and procedure regarding quarterly assessment and review. Review resident diagnosis of resident's were were given antipsychotic medication with the physicians of the home.

Process measure

- Quality Improvement Team meeting each month and quarterly meeting each quarter. Daily review of antipsychotic medication changes at multidisciplinary team meeting.

Target for process measure

- Our target will be less than 20% of residents without psychosis who are given antipsychotic medication in their look back period for assessment.

Lessons Learned

A challenge we faced with this indicator was an increase of admissions from hospital that were admitted without psychosis who were on a current prescription of antipsychotic medication.

Another challenge is when a resident that is on an anti-psychotic medication due to psychoses does not have an incident of psychoses in the lookback period it will count against the metric.

Comment

Although we did not meet our target and had a negative performance, our target will remain to decrease the performance to 20%.

Safety | Safe | Custom Indicator

Indicator #1

Infection Prevention and Control - Hand Hygiene Compliance (Pleasant Meadow Manor)

Last Year		This Year		
88.20	**95**	**92.50**	**--**	**NA**
Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

Change Idea #1 ☑ Implemented ☐ Not Implemented ☐ In Progress

Ensuring 100% staff compliance on annual education on Surge Learning on the four moments of hand hygiene. Provide in person education with return demonstration on the four moments of hand hygiene using both ABHR and soap and water. Provide the education and return demonstration in September prior to the fall and winter months. Respiratory viruses tends to increase in the fall and winter months. Utilize Peterborough IPAC Hub as an educational resource for staff on a quarterly basis. Assign all managers to complete hand hygiene audits each day, on a rotating basis to maintain consistency in the auditing and coaching process.

Process measure

- Analyze hand hygiene compliance on the monthly basis in the IPAC committee monthly meeting.

Target for process measure

- Our target will be 95% for the calendar year, including achieving 95% compliance on a monthly basis.

Lessons Learned

Performance improvement by 4.3%.

This change idea was implemented but is always in progress. HH and IPAC education must continue so that staff and residents continue to understand the importance and prevention measures it provides.

Comment

Performance improvement by 4.3%.

Continue with change ideas and education while onboarding new staff along with monthly education while auditing.