JOHN NOBLE HOME

LOVE, CARE AND DIGNITY

QUALITY IMPROVEMENT 2026-27
A YEAR IN GLANCE

OVERVIEW

The Quality Improvement Program continues to advance and mature, guided by an enduring commitment to enhancing the quality of life for all individuals served by the Home. This commitment is grounded in the principles of providing care with compassion, dignity, and respect within a safe, supportive, and home-like environment.

The John Noble Homes' Quality Improvement Plan will remain aligned with the priority indicators established by the Ministry of Health, the Ministry of Long-Term Care, and Ontario Health. By maintaining this alignment, the Home ensures that its quality initiatives are responsive to provincial expectations, grounded in evidence-based practice, and reflective of system-wide priorities designed to strengthen the long-term care sector.

PATIENT/CLIENT/RESIDENT EXPERIENCE

Resident and family input continues to be a central priority for the John Noble Home as we advance the implementation of Best Practice Guidelines (BPGs) through our designation as a Best Practice Spotlight Organization (BPSO). The completion of the Person- and Family-Centred Care BPG has contributed to meaningful cultural transformation within the Home, influencing practices at both the clinical and administrative levels. Members of the Family Council and Resident Council play an active and essential role in organizational governance and quality initiatives. Their participation on key committees including the Infection Prevention and Control Team, the Pain and Palliative Committee, and the Quality Improvement Team provides invaluable perspectives and lived experience. This collaborative engagement has supported the redevelopment of mandatory programs and strengthened the homes commitment to delivering person-centred, evidence-informed care. The John Noble Home is also preparing for re-accreditation with Accreditation Canada in 2025/2026. This process actively involves residents, families, and staff to ensure a comprehensive, inclusive, and collaborative approach to continuous quality improvement and organizational excellence.

SAFETY

The Home is committed to fostering and maintaining a safe and healthy environment for all employees, residents, volunteers, and visitors. A comprehensive client safety plan is in place to support compliance with applicable legislation, standards, and safe work practices. The purpose of this plan is to equip the Home with the information and processes needed to deliver services as safely as possible, reducing the likelihood of adverse events arising from unsafe conditions or practices.

Areas of potential risk are identified and monitored through several internal committees, including the Quality Improvement Team, Risk Management, Infection Prevention and Control, and the Joint Health and Safety Committee. Care and services are regularly evaluated, and any safety risks that are identified are promptly addressed and corrected.

Resident safety is further enhanced through ongoing coaching, mentoring, organization-wide initiatives, the promotion of shared learning, the use of evidence-based practices, and the implementation of best practice guidelines. Feedback is actively encouraged, and individuals are recognized for their contributions to improving safety across the Home.

PALLIATIVE CARE

The John Noble Home continues to prioritize Goals of Care discussions at both the six-week post-admission point and during the annual Interdisciplinary Care Conference. These discussions ensure that care plans remain aligned with residents values, wishes, and evolving clinical needs.

John Noble home has advanced several key initiatives to strengthen the quality and consistency of palliative and end-of-life care:

Launched the PoET Project to enhance our Palliative and End-of-Life Program, with a targeted focus on reducing avoidable emergency

room visits and ensuring residents receive care aligned with their goals and needs.

Modernizing Advance Care Planning: We are on track to complete the 2026 transition from traditional Consent forms to a new Individualized Summary format. This updated approach captures not only clinical care directives, but also each resident s personal wishes, beliefs, and values, ensuring more person-centered decision-making.

Building Staff Capacity: Eight Registered Staff have completed training in conducting Serious Illness Conversations with residents living with life-limiting conditions. We aim to expand this to 20 trained staff by 2026, further strengthening our ability to support residents and families with compassionate, meaningful dialogue.

Program evaluations

Annual program evaluations are conducted to assist in identifying gaps and prioritize initiatives for improvement ensuring quality of life and safety for residents. The list of program evaluation conducted in 2025-26 is provided below:

Program

1 Infection Prevention and Control

2 Pain Management
3 Responsive Behaviours and Antipsychotic Reduction
4 Palliative Care
5 Restorative Care
6 Continence Care
7 Skin and Wound Care
8 Falls Prevention and Restraints
9 Volunteer Program
10 Spiritual Care
11 Recreation Program
12 Dietary Services
13 Education, Training and Development
14 Joint Health and Safety

Program	QI successes 2025-26	Planned improvements for 2026-27
Infection Prevention and Control	The IPAC program continues to evolve. The Home has had several Ministry of Long-Term Care inspections in 2025. There have been several findings for staff not following PPE. The Home has also had a proactive inspection from the IPAC Hub, GEPH has completed an assessment of the vaccine fridge and immunization storage. A goal for 2025 was to complete the new policy and procedure manual, this entire manual will be ready for submission for review by the end of 2025. Annual Immunization audits have been completed to ensure residents remain update on all publicly funded vaccines. A new admission order set has been established, as well as updated caregiver package. The Home had 9 outbreaks in 2025,	• To continue to reduce risk through monitoring, audits and policy review IPAC Champions IPAC Lead All management, supervisors and staff. Proactive inspections from the IPAC Hub • To improve resident safety through education, early identification and risk interventions Registered staff will take the lead on this IPAC Champions IPAC Lead All management, supervisors and staff • Enhance community partnerships • To meet all of the IPAC Standards as per the Sept 2025 document

	89 days in outbreak, 3 deaths related to outbreak and 4 hospitalizations. Average outbreak lasting 16 days. The Home has prided itself on being able to stop transmission and have limited impact to activities of daily living during suspect and confirmed outbreaks. Recreation has done an excellent job on cohorting during the outbreaks. The Home continues to strategize and ensure interventions are in place to reduce infection but also while balancing the ethical framework for IPAC standards. All signage is being updated.	
Pain Management	Overall, the committee feels the Pain Management Program continues to work well however due to new staff education regarding the program should be the focus of this year's goals. The assessment tools are working well with no changes to the tools being used. BPSO GAP Analysis will be completed March 25, 2026 to ensure program is running smoothly and identify new areas that may require improvement.	• PSW Education on Pain Assessment Tools (BSO Pain screener, PainAD, Symptom Framework) • Nurse Education on Pain assessment tools (BSO Pain Screener, PainAD, Pain assessment in PCC, Care planning) • Complete a GAP analysis on our Pain BPG to identify gaps and create work plan to close gaps
Responsive Behaviours and Antipsychotic Reduction	• The home continues to ensure Responsive Behavior management is provided through a multidisciplinary approach. Risk Management Team Meetings are held weekly. Staff prepare for the meetings by completing a Risk Management Assessment prior to the meeting and come prepared to discuss the resident, including: behaviors experienced over the past week, effective strategies used to reduce	• To reduce risk to residents, staff and visitors with a multidisciplinary approach to responsive behavior management • To provide ongoing 1:1 service to residents whose behavior puts themselves or others at risk. • GPA training for frontline staff • To provide Education for staff related to Responsive Behaviours and Mental Health Diagnosis through in-services provided by the PRC and other community partners

	behaviors, medication changes, any assessment results pertaining to mood/behaviors, care plan updates and referrals made to community partners. The Team is multidisciplinary and includes members from nutrition, physiotherapy and recreation. • 2 JNH staff (BSO-TR and Manager of Resident Care) completed the GPA coach education. • GPA coach has collaborated with Alzheimer's society to educate JNH staff, 109 staff have compiled the education in 2025, education will continue in 2026 to achieve 100% compliance. • JNH will look into Teepa Snow educational coach in 2027 after GPA training is completed for all staff. • All new admissions to the Home are referred to BSO-TR and BSO mobile team for support during the transitional period. Responsive Behaviors Lead and Risk Management work closely with BSO staff to assist in ensuring sufficient supplies, staff buy in and use of any other resources with the goal of reducing responsive behaviors.	• To increase staff attendance at Quarterly Meetings to assist with dissemination of information to staff throughout the home.
Palliative Care	• Goals of Care conversations at 6-week post admit, annually, with decline in status and as needed. • Palliative/End-of-Life care plans including physical, emotional, psychosocial, social, cultural, and spiritual needs.	• Individualized Summary (replaces current Advance Care Planning form under PoET certification) • Serious Illness Conversations • Educate PSWs and Nurses on how to use the PPS to identify decline in residents. • Bereavement Huddles

	• Restorative/Physiotherapy assessments and programs. • End-of-Life orders by the NP/MD • Psychosocial support referrals to Resident Relations Coordinator • Specific end-of-life care plan and interventions • The Home obtained a 1-year certificate with the PoET Project. This does not directly impact the Palliative program itself but will assist us in identifying wishes early. • The Home also began working with the Palliative Care Consultant for our region to assist us in identifying and funding palliative care education.	
Restorative Care	• Trialing a Restorative Care Assessment Nurse. This has been successful in ensuring all residents are assessed thoroughly with each assessment and receive the care they need. • Enhance the PSW led programs to include: dining. The Restorative Care Nurse position has allowed more residents than ever to be put on PSW Led exercises. This ensures a restorative approach to care. 1. Trial a Restorative Care Assessment Nurse with goals to complete restorative assessments, evaluations, MDS restorative audits. 2. To ensure availability of assistive devices and equipment that Residents can safely use	• Develop communication tools (visual aids, communication books, picture books, white boards etc.) to restore communication for residents with impaired/altered communication or who speak a different language • Maintain PSW Led programming in the Home • Continue to ensure availability of assistive devices and aides

	and is in good working order determined by their assessed needs. 3. To educate direct care staff on home wide Restorative Approach to Care during routine care. This was done through PSW Practices, PSW Led Programs (added to care plan). 4. New RAI/MDS launching in 2025, educating staff on new ADL terminology for documenting ADLs in the most restorative approach.	
Continence Care	• New assignment of Continence Champions using BPSO trained champions: There is 1 or 2 Continence Champions on each home area. These champions are also on the Bladder/Bowel Management Program Committee (Continence Committee) • Education on continence products, application, and skin care to all PSWs • Conduct continence audits on each resident home area each month to determine compliance with the program • To further improve bladder and bowel function in residents who can improve, and to prevent deterioration whenever possible	• To further improvement in bladder and bowel function in residents who can improve, and to prevent deterioration whenever possible • Education on continence products, application, and skin care to all PSWs and Nurses • Increase number of Continence Audits on each resident home area each month to determine compliance with the program. • Provision and maintenance of commodes in use (Ensure all are in good working order; replacement parts) • Continence Program Information Sheet for Admission Packages
Skin and Wound Care	• Implement NEW Pressure Injury Best Practice Guidelines with BPSO • The new Pressure Injury Best Practice Guideline was implemented and completed in 2025. During the process of implementation, the policy was	• Full review of the 2025 Directives Additions to include: Steri-strips for lacerations (to avoid unnecessary ER visits or calls to on call) • Dressing/treatment review to ensure we are only ordering the products on the algorithms (and interchangeable dressings)

	updated and hired 2 nurses for a new Skin and Wound team. • Implement Skin and Wound Mobile APP: Begin with DC staff for 1 month and then spread to other units' month by month. Education to be provided on various dates for all registered staff during the roll out. • This was completed August 2025 with the implementation of the Skin and Wound Mobile App. All registered staff completed mandatory skin and wound education relating to the Home's skin and wound program as well as education on how to use the Skin and Wound App • In November 2025 the Skin and Wound Mobile App was upgraded to the ChartPic App. • To meet compliance with the completion of weekly wound assessments. • A trial Skin and Wound team was implemented over the past year that has shown great success in the assessment, management and healing of wounds in the Home. While the Home will always have goals to ensure compliance with the completion of weekly wound assessments, we are reaching higher levels of compliance with the Skin and Wound team and their audits.	• JNH/BPSO Skin and Wound Exhibition (to educate staff, res, families, and other BPSO homes on skin and wound best practices • To meet compliance with the completion of weekly wound assessments

	• Reviewed policies, screening tools, assessments, instruments, methods to reduce and manage skin and wound issues, monitoring outcomes, and referral process. • Discussed new goals for the program and set dates (see above). • Policies related to skin and wound were reviewed, discussed and revised.	
Falls Prevention and Restraints	• On annual review the program saw an improvement since implementing the new policy and procedure 3-I-10. Scott's Fall Risk Assessment is completed quarterly; HIGH RISK is implemented into care profiles along with HIGH RISK/UNSAFE ambulation. HIGH RISK UNSAFE Ambulation is considered for the falling leaves program. • Pain : Verbal / Non verbal signs of pain on movement or without • Peri-Needs : Need to use the toilet / change of incontinent products • Position : Need to be turned / repositioned or mobilized ? assess skin, provide care as needed • Possessions : does the resident have call bell, water, eye glasses, hearing aids, phone, tissue and mobility aid. • Environmental checks: Ensuring Resident's surrounding is clear of clutters • Education rounds – new process conducted	• To reduce the number of falls by following the RNAO Best Practice Guidelines for Preventing Falls and Reducing Injury related to Falls • Quarterly Falls & Restraints Committee meeting to review the MDS fracture risk score and implemented appropriate intervention to prevent fractures • RNAO Gap Analysis: Prevention of Falls and Fall Injuries in the Older Adult • On going evaluation of the Home's Falls Policy • The Committee continues to review the residents in house quarterly with lap belt usage as PASD. No restrains in use at present

	• The home continues to discuss falls at its morning huddle and collaborate as a multi-disciplinary team • QI incentive / Medical Director continues to review and decreasing antipsychotics within practice (QIP 2025-26) • The Committee continues to review the residents in house quarterly with lap belt usage as PASD. • Continue to summarize and approach falls reduction within the home as a multidisciplinary approach and foster ideas of research incentives that are clinically successful. On-going evaluation required to see if new policy is working and reflective in data. • 72-hour GCS monitoring implemented to increase close monitoring resident with unwitnessed fall. • 3-I-10 Falls Prevention and Management Program is revised to align the new InterRAI LTCF Assessment.	
Volunteer Program	• Our volunteers worked a total of 7,745 hours • 75 new volunteers/students joined and we onboarded. • Continued with partnerships with local high schools, colleges and universities. • All new volunteers and students completed their mandatory education. All the standards are covered in their required education. Education is done through surge learning. Education	• Recreation staff encourages volunteers to participate in programs offered to the residents. • Reviews on Fire Safety, Confidentiality, infection control and health and safety were reviewed through the Volunteer Times newsletter and the annual online education through surge learning. Confidentiality and IPAC education must be completed prior to starting their first shift.

	sessions were offered for those volunteers that needed assistance with completing their annual review, annual education sessions are now being completed online. • Director of Programs sent out newsletters updating the volunteers on what was happening at the home and encouraged them to follow our social media page and website for those that were not ready to return.	
Spiritual Care	Spiritual Care Survey was completed in 2025 with Findings: • 55% of participants say spiritual care is important to them • 19% of participants were extremely satisfied with Spiritual Care programs that are currently running • 65% of participants felt that there was enough Spiritual Care in the home with Sunday morning Service being most enjoyed • 50% of participants were not interested in participating in programs that were based on a different faith • 59% of participants felt that their faith/spiritual practice was well represented within the home • Recreation staff continue to ask at resident choice meetings if the residents feel their spiritual needs are being met? If any concerns noted the Recreationist will implement on their home area	• Referrals are given to Recreation from resident on admission during their assessment and or as needed, nursing department and families and is documented in Point Click Care • All spiritual programs are now being completed by the Recreationist on the home Spiritual volunteers/church affiliations provide virtual and in person services/support. While following current directives that were put in place throughout the year and to reflect the current ACT. Weekly Church Services were provided to each home area or in Noble Hall. Catholic Mass and Anglican Communion was provided in our Noble Hall monthly.

	calendar or pass along to Director of Programs to be sure service is being provided. • Recreation staff to continue to look at end of life requests on residents' personhoods to make sure all spiritual needs are being met at that time. Spiritual Care education will continue in 2025. Staff will enroll in Spiritual Care Generalist in Jan 2026, along with Director of Programs.	
Recreation Program	• Resident Satisfaction Survey completed • Family Council assists with input into programming • Resident Choice Meetings are held on each Resident Home Area this was being done and discussed in small groups or one to one setting. • The following programs were added to the recreation schedule for 2025: o Additional Church Services with our community partners. o Reintroducing intergenerational programs more consistency with schools, preschools etc. • successful added the Therapeutic Recreation Coordinator position.	• Recreation team continues to book through Sharpe Bus lines for monthly trips/outings. As well as local taxi services. • Therapeutic Recreation Coordinators working evenings and weekends to assist with additional programming.
Dietary Services	• RD notification of wounds per RQI nursing education related to referrals • Weight Monitoring: RD continues to work with Nursing staff to ensure weights are accurate	• Meet food budget • Improve/maintain cleanliness Achieved public health/MOH standards • Improve departmental communication Implement IPAD use on nourishment carts • Maintain resident satisfaction scores

	• Cook and Dietary Aide recruitment: Recruitment continues. Facilitating student placements and looking at other education opportunities for staff to help with recruitment. • Planning for new bed developments - additional 40 beds. New lines were approved, and hiring to back fill has started. Lines will be posted mid April.	Maintain scores above 80% on the annual survey • Prepare for the opening of the 40 new beds in 2026. Write work routines. Amend/create policies/procedures. • Investigate opportunities to enhance staff job skills. Funding was found but has ended. Nutrition will work with Finance in accessing the appropriate funds.
Education, Training and Development	•Education added on Cultural Competence, Diversity and Inclusion to all staff for 2025 • Health Care Consent Act module added to Registered staff. • New/updated video content assigned to cover mandatory education topics (Surge Learning has updated the Skin and Wound module) • Responsive Behaviour Committee looking at GPA training- based of response from evaluation • Ensuring all staff in a supervisory role complete the MOL 5 Steps to Health and Safety Awareness course •De-bundled WHMIS lesson per staff recommendation.	• To continue to reduce risk through meeting the Ministry of Health and Long-Term Care education requirements • To improve resident safety through education • Ensure compliance with all Training and Education Regulations (FLTCA 2021, ESA, OHSA, ADODA)
Joint Health and Safety	• The JHSC focuses on ensuring the Home meets all requirements of the Health and Safety Act. All reported incidents are tracked and discussed in an effort to identify trends and patterns. When trends and patterns are identified interventions are implemented. • Focus on PPE use and IPAC practices. Updated education and auditing of staff.	• To continue to meet the Ministry of Labours requirements • To continue to minimize risk of injury for employees via hazard elimination, substitution, engineering controls, administrative controls and PPE • To complete annual review of all Health and Safety policies • To ensure incidents of Workplace violence are properly reported, tracked and appropriate interventions are put in place.

	• Implementing GPA training for all staff as a requirement of the Ministry. • JHSC meetings will be held on a semi-monthly basis with monthly incident reports communicated to committee members for review each month. Any critical incident requiring immediate action will be reported at the time they occur. • Policies updated to ensure compliance with Ministry of Labour • "All about Me" posters in resident rooms to notify staff of residents with behaviors or other risks in process.	• To improve tracking of employees who have recurring incidents reported by improving the communication of incidents with Department Mangers • Ensure compliance with all Health and Safety Regulation
Prevention of Abuse and Neglect	• RNAO Best Practice Guideline utilization through RNAO Best Practice Spotlight Organization designation process	• To continue to reduce risk through monitoring, audits and policy review • To improve resident safety through education, early identification and risk interventions • Enhance community partnerships • JNH GPA Coach • GPA education on regular basis for staff.

Quality Improvement Plan 2026-27

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)	15.17	13.20	John Noble Home will work toward achieving a 7.04% improvement and strive to remain below the provincial average.	

Change Ideas

Change Idea #1 Advance Care Planning & PoET Implementation

Methods	Process measures	Target for process measure	Comments
PoET Individualized Summary, completed on admission, at annual care conferences, and following a change in condition, to ensure resident goals, values, and preferences guide care. This will replace the existing Advance Care Planning form.	Percentage of residents with a completed Individualized Summary	100% of the residents will have completed Individualized Summary by March 31st 2027	

Change Idea #2 Strengthening the Palliative Care Program to enable timely recognition of changes in residents health status.

Methods	Process measures	Target for process measure	Comments
Palliative approaches to care by life and death matters including The Palliative Performance Scale (PPS) to be offered to PSW staff	Number of PSW's received Palliative care and The Palliative Performance Scale (PPS) education	20 PSW's will receive Palliative care education by December 31st 2025.	

Measure - Dimension: Equitable

Indicator #2	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	CB	CB	John Noble Home will work toward achieving a 100% of staff who have completed relevant equity, diversity, and inclusion education	

Change Ideas

Change Idea #1 **Equity, diversity, inclusion, and anti‐racism (EDIA) education.**

Methods	Process measures	Target for process measure	Comments
Diversity, Equity, and Inclusion in the Workplace (DEI) on Surge Learning	Percentage of staff completed Diversity, Equity, and Inclusion in the Workplace (DEI) on Surge Learning	100% staff completed Diversity, Equity, and Inclusion in the Workplace (DEI) on Surge Learning by 31st December 2026	

Change Idea #2 This Diversity, Equity, and Inclusion (DEI) Policy outlines the organization's commitment to creating and sustaining a workplace where all employees feel valued, respected, and empowered. We strive to foster an environment that embraces diverse perspectives and promotes fair and equitable opportunities for everyone.

Methods	Process measures	Target for process measure	Comments
Policies related Diversity, Equity, and Inclusion in the Workplace will include current legislation, regulatory requirements, and established best practices.	The Human Resources department will develop and maintain Diversity, Equity, and Inclusion (DEI) policies that reflect current legislation, regulatory requirements, and established best practices.	The Human Resources department will develop Diversity, Equity, and Inclusion (DEI) policies that reflect current legislation, regulatory requirements, and established best practices by June 2026.	

Measure - Dimension: Patient-centred

Indicator #3	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	86.44	91.00	John Noble Home will work toward achieving a 5.28 % improvement	

Change Ideas

Change Idea #1	Person Centred care gap analysis to identify priority education and practice opportunities that strengthen person-centred care delivery, high□quality care.		
Methods	Process measures	Target for process measure	Comments
Conduct a RNAO Person-Centred Care gap analysis	A Person Centred Care gap analysis will be conducted to assess current clinical practices, identify targeted educational needs, and strengthen person-centred care delivery.	A Person Centred Care gap analysis will be conducted by May 2026 to assess current clinical practices, identify targeted educational needs, and strengthen person-centred care delivery.	Total Surveys Initiated: 118

Change Idea #2	Improve resident centred care		
Methods	Process measures	Target for process measure	Comments
Improve resident centred care by ensuring each resident has an up-to-date "All About Me" Individualized Summary that captures what matters most to them to improve daily care delivery.	Percentage of residents with a completed "All About Me" Individualized Summary to be posted in their room.	100% of residents will have a current "All About Me" Individualized Summary completed and posted in their room by December 2026.	

Measure - Dimension: Patient-centred

Indicator #4	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	92.37	94.00	John Noble Home will work toward achieving a 1.76% improvement	

Change Ideas

Change Idea #1 Residents are constantly invited, supported, and encouraged to share their perspectives during care conferences, with clear reassurance that feedback can be expressed safely and without fear of negative consequences.

Methods	Process measures	Target for process measure	Comments
Ensure resident are invited for IDC, feedback shared during care conferences is documented in the IDC template and "All About Me" Individualized Summary.	Percentage of ICDs indicating that the resident was invited and feedback was documented in the most recent care conference.	80% of ICDs indicating that the resident was invited and feedback was documented in the most recent care conference by 31st March 2027	Total Surveys Initiated: 118

Change Idea #2 Focused education on Customer Service, Empathy, Resident Bill of Rights

Methods	Process measures	Target for process measure	Comments
Deliver focused education on Customer Service, Empathy, Resident Bill of Rights for all interdisciplinary staff.	Percentage staff who completion Customer Service, Empathy, Resident Bill of Rights education on Surge learning	90% staff will completion Customer Service, Empathy, Resident Bill of Rights education on Surge learning by December 2026	

Measure - Dimension: Safe

Indicator #5	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	19.13	18.00	John Noble Home will work toward achieving a 5.91% improvement and strive to remain below the provincial average.	

Change Ideas

Change Idea #1 To reduce the risk of fractures among residents by systematically reviewing MDS outcome scores and applying targeted prevention interventions.

Methods	Process measures	Target for process measure	Comments
Quarterly Falls & Restraints Committee meeting to review the MDS fracture risk score and implemented appropriate intervention to prevent fractures.	# of Falls & Restraints Committee meetings where fracture risk data are reviewed.	4 quarterly Falls & Restraints Committee meetings will review fracture risk data by 31st March 2027	

Change Idea #2 Prevention of Falls and Fall Injuries in the Older Adult gap analysis to reduce resident falls and fall related injuries by identifying gaps in current practices and implementing targeted improvements.

Methods	Process measures	Target for process measure	Comments
RNAO Gap Analysis: Prevention of Falls and Fall Injuries in the Older Adult	A Prevention of Falls and Fall Injuries in the Older Adult gap analysis will be conducted to reduce resident falls and fall-related injuries by identifying gaps in current practices and implementing targeted improvements.	A Prevention of Falls and Fall Injuries in the Older Adult gap analysis will be conducted by May 2026 to reduce resident falls and fall-related injuries by identifying gaps in current practices and implementing targeted improvements by 31st March 2027.	

Measure - Dimension: Safe

Indicator #6	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	22.27	21.00	John Noble Home will work toward achieving a 5.70% improvement and strive to remain below the provincial average.	

Change Ideas

Change Idea #1	Implement Gentle Persuasive Approaches (GPA) training to enhance staff competency in managing responsive behaviours.		
Methods	Process measures	Target for process measure	Comments
Internal GPA coach and external coach to provide GPA in-services to improve resident care.	Percentage of staff who have completed GPA training	100% of staff will complete GPA training by end of December 2026	
Change Idea #2	To reduce the use of antipsychotic medications without an appropriate diagnosis by Review of resident receiving anti-psychotic during monthly antipsychotic reduction meeting.		
Methods	Process measures	Target for process measure	Comments
All residents on anti-psychotics without appropriate diagnosis will be reviewed at monthly antipsychotics reduction meeting and recommendations will be forwarded to MD.	percentage of residents who are taking antipsychotics without diagnosis will be reviewed.	100% of resident on antipsychotics without diagnosis will be reviewed by March 31st 2027	

Measure - Dimension: Safe

Indicator #7	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	2.78	2.17	John Noble Home will work toward achieving a 21.95% improvement and strive to remain below the provincial average.	

Change Ideas

Change Idea #1 Strengthen staff knowledge and clinical skills related to skin integrity and wound prevention through targeted education and training.

Methods	Process measures	Target for process measure	Comments
Direct care staff to receive Skin Health Education through Skin and wound Canada and on Surge learning.	Percentage of Direct care staff completed Skin Health Education Program through Skin and wound Canada and on Surge learning.	80% of Direct care staff will completed and in class Skin Health Education Program through Skin and wound Canada by December 31st 2026. 100% of Direct care staff will completed the skin and wound education on Surge learning.	

Change Idea #2 Enhance staff competency in skin and wound care through participation in the SWAN™ (Skin Wellness Associate Nurse) Program, supporting evidence‑based prevention, early identification, and management of skin breakdown and wounds.

Methods	Process measures	Target for process measure	Comments
Enroll eligible nurses (RPNs/ RNs) in the Skin and wound education Program	Skin and wound nurses (RPNs RNs) enrolled in the Skin and wound education Program by March 31,2027	2 Skin and wound nurses (RPNs RNs) will be enrolled in the Skin and wound education by March 31,2027	

Measure - Dimension: Safe

Indicator #8	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	0.91	0.50	John Noble Home will work toward achieving a 45.05% improvement and strive to remain below the provincial average.	

Change Ideas

Change Idea #1 Strengthen Staff Education on Least Restraints			
Methods	Process measures	Target for process measure	Comments
Provide annual and refresher education on: Risks associated with physical restraints Least-restraint philosophy Evidence-based alternatives	Percentage of staff to complete Restraints-Use of and Alternatives education on surge learning	100% of staff will complete Restraints-Use of and Alternatives education on surge learning by December 31st 2026	

Resident and Family/caregivers experience

JNH maintains a strong commitment to person- and family-centred care through active and structured engagement with both residents and their family members. The Home has an established Resident Council and Family Form, both committee meets monthly to provide ongoing feedback related to quality of care, food services, home operations, and overall quality of life. These Councils play a critical role in ensuring that resident and family voices remain central to decision-making processes.

Executive members from both Councils participate directly on the Home's Continuous Quality Improvement (CQI) Committee. This operational quality and safety committee is responsible for monitoring performance, identifying opportunities for improvement, and reducing disparities in care. Through this representation, residents and families contribute to co-designing improvements and strengthening the Home's quality and safety culture.

In addition to CQI participation, JNH ensures resident and family engagement in the development of its Quality Improvement Plan (QIP). Representatives from both Councils sit on the QIP Working Group, where they help shape improvement priorities and guide the refinement of initiatives from year to year.

Resident and family perspectives also inform ongoing performance monitoring through the administration of standardized Long-Term Care Resident Satisfaction Surveys. These surveys provide residents and families with formal opportunities to express their views on the quality of care and services provided. By using consistent survey tools and methods across the three Long-Term Care Homes (LTCHs) within the organization, JNH is able to compare performance, identify trends, share learnings, and collaborate on joint quality improvement initiatives.

Overall, this integrated approach to resident and family engagement supports a culture of transparency, continuous learning, and shared responsibility for quality and safety across the organization.

Resident survey

The John Noble Home conducts an annual Resident Satisfaction Survey to provide residents with the opportunity to share feedback on the quality of care and services they receive. Using a collective approach across the three sites allows for meaningful comparison of results between homes.

The 2025 survey process was formally approved by the Resident Council in July 2025 and by the Family Form in August 2025. Data collection took place between September and October 2025.

Survey results were presented to the Resident Council on November 20, 2025, followed by the presentation of the action plan and Quality Improvement Plans (QIPs) on February 24, 2026. As requested by the Family Form, both the survey results and the action plan will be presented to the Family Council on February 17, 2026.

Response Rate

156 residents approached to be interviewed,

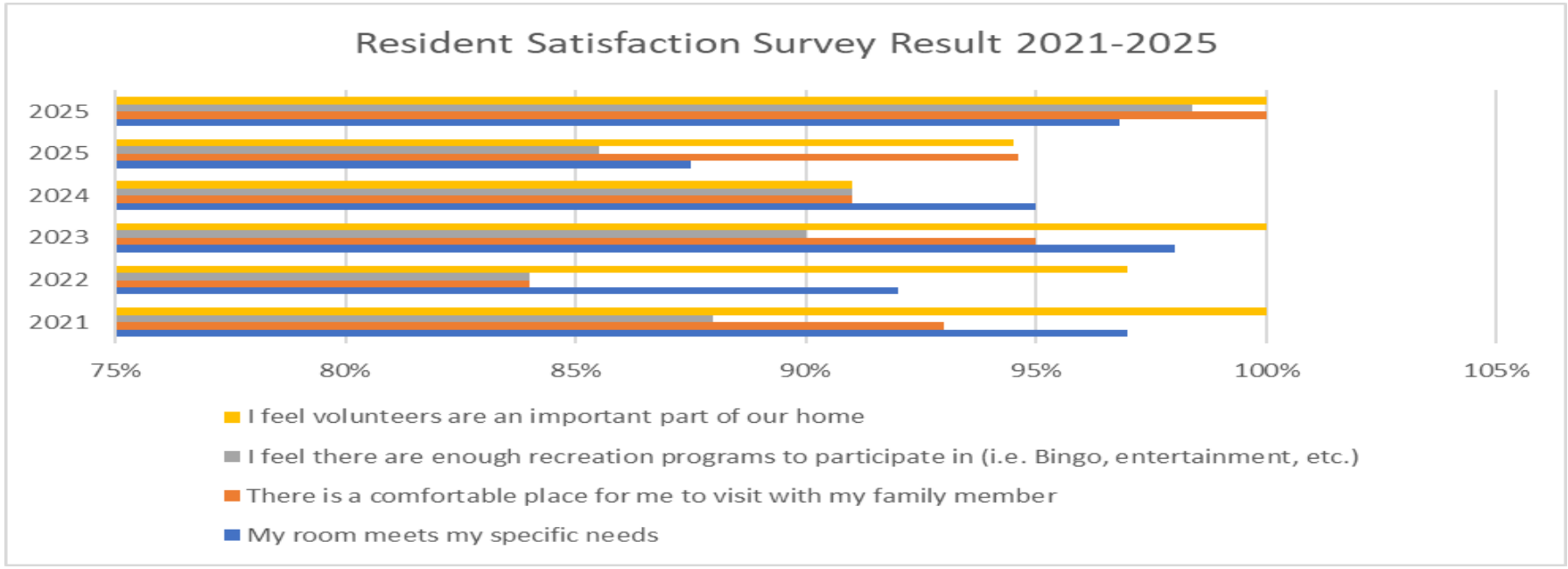
No of Resident who were eligible to complete Survey: 118

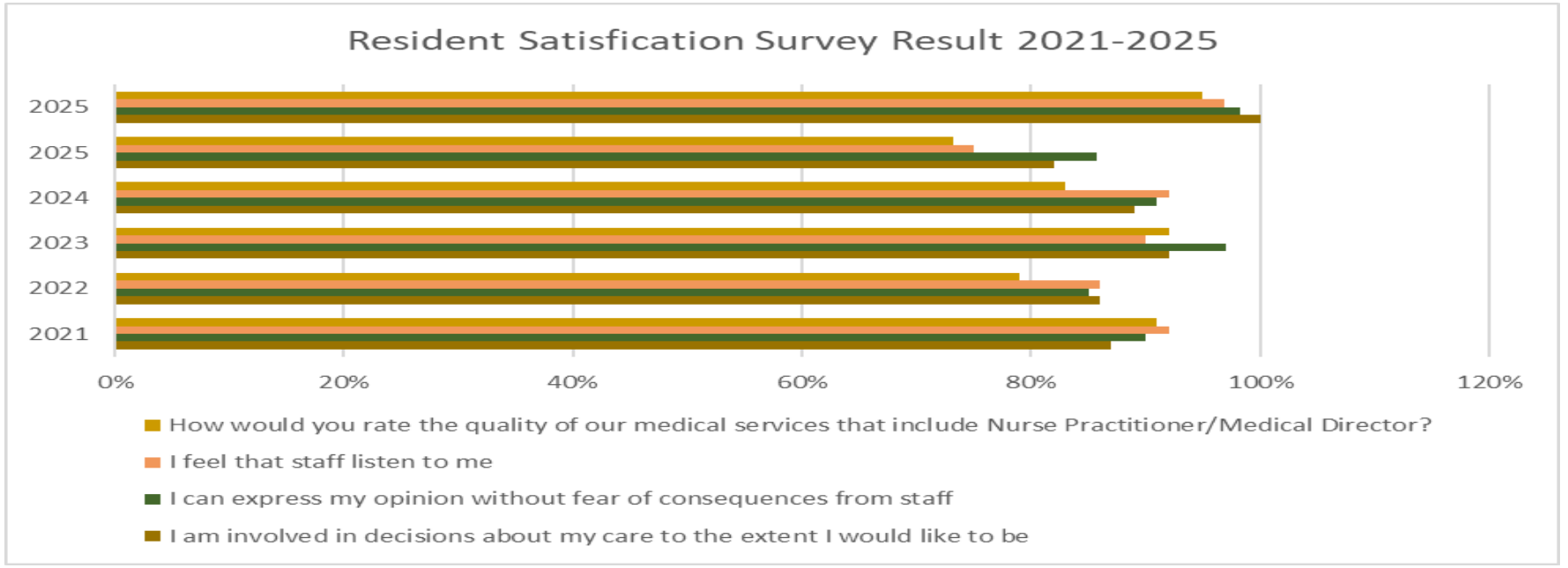
No of resident completed the Survey: 56

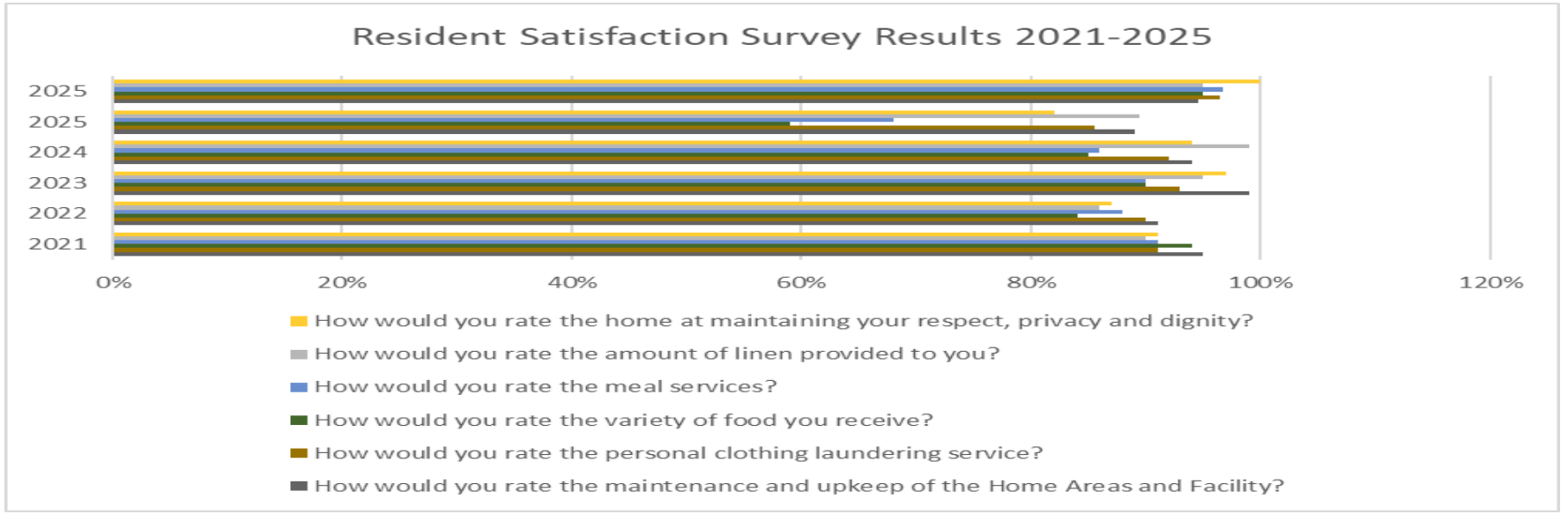
No of POA/SDM completed the Survey: 62

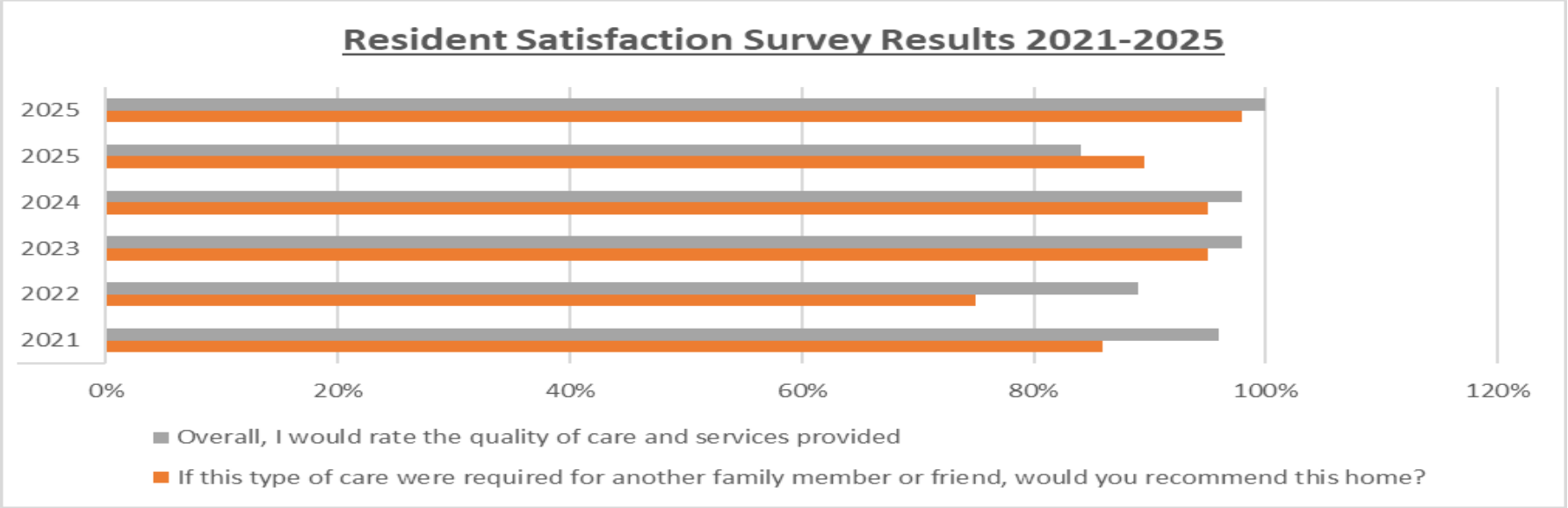
Overall quality of care and services:

84% of residents rated the overall quality of care and services as “good” or “very good” or “excellent”. Furthermore, the majority of residents (90%) indicated that they would (“Yes”) or would sometimes (“Yes Sometimes”) recommend the LTCH to others.




Resident Satisfication Survey Result 2021-2025
2025
2025
2024
2023
2022
2021
0%
20%
40%
60%
80%
100%
120%
How would you rate the quality of our medical services that include Nurse Practitioner/Medical Director?
I feel that staff listen to me
I can express my opinion without fear of consequences from staff
I am involved in decisions about my care to the extent I would like to be


Resident Satisfaction Survey Results 2021-2025
2025
2025
2024
2023
2022
2021
0%
20%
40%
60%
80%
100%
120%
How would you rate the home at maintaining your respect, privacy and dignity?
How would you rate the amount of linen provided to you?
How would you rate the meal services?
How would you rate the variety of food you receive?
How would you rate the personal clothing laundering service?
How would you rate the maintenance and upkeep of the Home Areas and Facility?



Action Plan

Q5: I am involved in decisions about my care to the extent I would like to be
Q6: I can express my opinion without fear of consequences from staff
Q7: I feel that the staff listen to me

- Person-centred care gap analysis to identify priority education and practice opportunities that strengthen person-centred care delivery, high-quality care.
- Improve resident-centred care by ensuring each resident has an up-to-date “All About Me” Individualized Summary that captures what matters most to them to improve daily care delivery.
- Residents are constantly invited, supported, and encouraged to share their perspectives during care conferences, with clear reassurance that feedback can be expressed safely and without fear of negative consequences.
- Focused education on Customer Service, Empathy, Resident Bill of Rights
- PSW practice sessions have been increased from monthly to twice a month to reinforce
    - the importance of staff introducing themselves before providing care. This fundamental, person-centered approach helps establish trust, respect, and a sense of safety for residents.
    - Resident care practices emphasize the importance of oral hygiene, peri care, and proper skin care to prevent skin breakdown.

    - respect, dignity, privacy and confidentiality.
- Nursing managers will be present on the home areas twice a week to monitor and improve the flow of care over the next two quarters.
- GPA (Gentle Persuasive Approaches) training for all staff by end of November 2026
- PSW break times have been reviewed, and staffing will be arranged to ensure that three staff members remain on the floor at all times to support resident care, this approach is currently being trialed for the evening shift and will be introduced to the day shift if it proves effective.

Q12: How would you rate the variety of food you receive?
Q13: How would you rate meal services?

- Menu has improved, resident choice lunches are added, the Resident Council has been engaged in the menu planning process to ensure that resident preferences and feedback are reflected in meal offerings.
- Feedback and Input from the Resident Council meetings and Resident Choice meetings is regularly reviewed, with appropriate adjustments implemented to address identified needs, preferences, and areas for improvement.
- Dietary supplies are being ordered through local suppliers to support the community and to benefit from fresher ingredients, faster delivery, and stronger local partnerships.

Q2: There is a comfortable place for me to visit with my family member

- The recreational area is scheduled to reopen following the completion of the new construction project, ensuring the space is fully prepared for resident use.

Successes: 2025-26

- The John Noble Home has implemented the Prevention of Error- Based Transfers (PoET) project, an ethics-driven quality improvement initiative designed to align organizational habits, practices, and policies with the requirements of Ontario s Health Care Consent Act. This initiative supports residents, staff, physicians, and substitute decision-makers in ensuring that all care decisions adhere to provincial standards for consent, capacity, and substitute decision-making. Through PoET, long-term care homes collaborate to co-design and implement meaningful changes that promote sustained cultural transformation, ensuring that care decisions reflect residents' individual wishes, values, and beliefs while remaining aligned with clinically appropriate treatment options.
- John Noble Home is proud to be among the 405 long-term care homes in Ontario that have successfully transitioned to the interrail LTCF resident assessment system. The transition was completed on October 1, 2025.

- In 2025, John Noble Home successfully implemented Point Click Cares' Skin and Wound APP, enhancing visibility into wound progression and supporting more accurate, reliable monitoring of treatment outcomes. This implementation strengthens bedside nursing workflows and reduces documentation demands. Updated dashboards now offer clearer visuals to help staff quickly identify concerns and act confidently.
    - Skin & Wound Program: Program Enhancements and Clinical Improvements
    - Updated Clinical Directives & Algorithms
    - Refreshed all Skin and Wound Directives and treatment algorithms to reflect best practices and ensure consistent, evidence-based care.
    - Established a Dedicated Skin & Wound Team
    - Introduced new RN and RPN positions focused on documentation audits, complex wound assessments, and ongoing staff education to strengthen clinical oversight.
    - Streamlined Documentation with ChartPic App
    - Implemented the ChartPic application to support efficient, accurate documentation, including standardized wound photography.
- In March 2025, the Home successfully hosted a Best Practice Spotlight Organization (BPSO) Open House to increase awareness and deepen staff understanding of previously implemented Best Practice Guidelines (BPGs). The event saw strong engagement, with participation from over 90 staff members across departments. Throughout the session, teams reviewed key processes, procedures, and evidence-based best practices, reinforcing consistent application of BPGs throughout the Home. The Open House contributed to improved staff confidence, alignment, and readiness for ongoing and future BPG sustainability initiatives.
- In 2024, the Home expanded its clinical capabilities by initiating inhouse intravenous (IV) therapy for residents returning from hospital
- who required IV antibiotics. Elastomeric pumps were utilized to administer these medications safely and effectively. This advancement enables residents who require IV medications to receive treatment within the Home, thereby reducing unnecessary emergency department visits and hospital stays. In 2025, Registered staff received re-education and training on the use of the CADD pump to support continued safe IV administration.
- In addition, the Homes pharmacy partner has an online physician ordering portal designed to eliminate errors associated with handwritten orders and to facilitate immediate communication between prescribers and pharmacy services. Quarterly medication reviews are also conducted through this online platform, further enhancing accuracy, efficiency, and resident safety.
- To strengthen our Hand Hygiene awareness efforts, we partnered with HUB to implement several engaging initiatives across all units, See Something, Say Something Posters: Posters were placed on each unit to remind staff, residents, and visitors to speak up and support safe hand hygiene practices.
- Photo Contest Best Group Picture: Units participated in a fun, organization-wide photo contest showcasing teamwork and creativity while promoting proper hand hygiene. The theme focused on Hand Hygiene and the Clean Hands, Warm Hearts campaign, encouraging

staff engagement and awareness. These activities helped reinforce consistent hand hygiene practices, increased visibility of the campaign, and boosted staff participation in infection prevention efforts.

- The Health Connex platform provides a centralized, web-based solution that replaces inefficient paper-based data collection and manual reporting. It significantly reduces time spent on documentation by pulling information directly from Point Click Care
- (PCC). Key features include: Real-Time Infection Tracking
    - Live monitoring of both resident and employee infection cases to support timely decision-making
    - Automatically generates reports for infection tests, infection case frequency, days of therapy, and immunization compliance. Customizable Visual Floor Maps
    - Interactive floor maps that display active infections, symptoms, and unit-specific trends.
    - AI-driven automation for tracking and trending metrics required for regulatory inspection reports.
    - My Audit Platform: A digital audit tool for electronically collecting data related to Hand Hygiene, PPE use, Health & Safety, and other compliance requirements.

Quality Improvement Priorities: 2026-27

- Implementing PoET (Prevention of Error Based Transfer) program at John Nobel Home to reduce emergency room visits.
- Gentle Persuasive Approaches (GPA) training to enhance staff competency in managing responsive behaviors

Quality Improvement Team 2025
Quality Improvement Coordinator: Usha Gunasekaran (Chair)
Executive Assistant/Staff Education: Jessica Tanchak
Administrator: Anna Gora
Director of Care: Amandeep Gill
Medical Doctor: Dr Legere
Resident Care Coordinators: Farisai
Nursing Programs Coordinator: Melissa Gregory
Admission/RAI Coordinator: Jennifer Donn
Physiotherapist: Kinjal Shah
Director of Financial: Sheppard Julie
Human Resources: Maria Howard
Director of Support Services: Jeremy Williamson
Support Services Supervisor: Jaime Askes

Director of Environmental Maintenance: Edward Owen
Director of Programs: Karli Cass
Day & Stay Manager: Lisa Clarkson
Social Service Worker: Kim McDermott
Pharmacy Consultant: Kero Moussa, Mina Abdelsayed
Registered Nursing Staff: Tanvir Khaira RN
Personal Support Worker: Helena Moniz
Resident Council: Peter Dawson
Family Council: Family Council Rep

Conclusion

John Noble Home remains committed to continuous quality improvement and continue to work in collaboration with stakeholders to improve the quality of care and services offered for our residents. Quality Improvement 2026-27: A Year in glance reflects on the achievements and successes of the past year and highlights of our commitments for 2026-27.