

CONTINUOUS QUALITY IMPROVEMENT ANNUAL REPORT

April 1, 2025 to March 31, 2026

At Foyer Richelieu Welland, continuous quality improvement (CQI) is an ongoing commitment to enhancing the quality of care, safety, and quality of life for our residents. Through collaboration with residents, families, staff, physicians, volunteers, and community partners, we strive to foster a culture of learning, innovation, and continuous improvement.

Foyer Richelieu continues to be dedicated to continuous quality improvement and improving our resident experience. Our foundational goal is to promote our residents to live and belong with wellness and joy, to immerse them in the French culture and Catholic faith and to provide person centered, holistic care to all who live here. We continue to focus on risk reduction in areas such as falls, worsening behaviors, infection prevention and control, social isolation and unplanned weight loss.

Foyer Richelieu remains committed to protecting our residents and continuing to cultivate our core values of respect, mutual aid and inclusion. Our quality improvement focuses for 2026 will continue to be driven in the areas of risk reduction, resident satisfaction and inclusion providing high-quality, person-centered care while emphasizing wellness, culture, and faith.

A Year of Transition

The 2025 calendar year represented a significant period of transition for our Home. As one of the early adopters of the transition from the interRAI Long-Term Care Facility (LTCF) assessment system, considerable organizational resources were dedicated to implementing new assessment processes, staff education, system configuration, and ensuring a smooth transition while maintaining high-quality resident care.

In addition, the Home successfully relocated to the new long-term care facility in October 2025. This milestone involved extensive planning, operational changes, staff orientation, and the implementation of new workflows to support residents, families, and team members throughout the move.

These two major initiatives significantly impacted the availability and comparability of standardized quality indicator data during the year.

Focus on Process Improvement

Recognizing the limitations associated with system conversion and the temporary disruption of provincial quality indicator reporting, the Home prioritized strengthening key clinical and operational processes throughout 2025. Rather than focusing solely on outcome performance measures, quality improvement initiatives emphasized establishing consistent practices, improving documentation, enhancing communication, and standardizing care delivery.

Where provincial indicator data was unavailable or incomplete due to the RAI LTCF conversion, the Home implemented manual tracking and auditing processes to monitor quality and identify opportunities for improvement. This approach allowed leadership teams to continue evaluating performance and responding proactively to identified risks while provincial reporting systems stabilized.

Quality Improvement Initiatives

During 2025, quality improvement activities focused on strengthening foundational processes across several key areas, including:

- Falls prevention through enhanced risk assessments, post-fall reviews, and interdisciplinary follow-up.
- Skin and wound management, including routine auditing of assessments, measurements, treatment documentation, and prevention strategies.
- Medication management through medication incident reviews, documentation audits, and medication safety education.
- Responsive behaviour management by strengthening interdisciplinary care planning and reviewing behaviour support interventions.
- Pain assessment and management through improved assessment practices and monitoring of reassessments.
- Infection Prevention and Control (IPAC), including surveillance processes, outbreak preparedness, and staff education.
- Resident nutrition and hydration assessment through ongoing monitoring of weight changes, nutritional risk, and dining experience initiatives.
- Staff education and competency development to support the implementation of new clinical processes associated with the interRAI LTCF transition, the new home and changes to legislation.
- Safe relocation planning and transition activities to support residents and staff during the move to the new Home.

Monitoring Quality

Throughout the year, leadership teams conducted regular audits, chart reviews, environmental rounds, and interdisciplinary quality meetings to monitor compliance with best practices and legislative requirements. Findings were reviewed by the Continuous Quality Improvement Committee and shared with leadership, Board members, staff, residents, and families to support continuous learning and accountability.

During the 2025-2026 reporting year, Foyer Richelieu identified and advanced a number of Quality Improvement Plan (QIP) priorities aimed at enhancing resident outcomes, strengthening quality and safety, and supporting continuous quality improvement across the Home. The following initiatives were selected as a key areas of focus for the year:

Mandatory Long Term Care Indicators

Potentially avoidable emergency department visits for long term care residents

Number of emergency department (ED) visits for a modified list of ambulatory care-sensitive conditions per 100 long-term care

It was determined that 21.05% of our ED visits were avoidable. The provincial average is 21.66%. Our Homes percentage did rise as compared to the previous year and the influx of new admissions as we transitioned into the new homes is believed to have contributed to this increase.

Resident experience: Having a voice

The percentage of residents that responded positively (a response on 9 or 10) to the question "What number would you use to rate how well the staff listen to you?"

88.33% of resident responded positively (Target was 67.33%). This is a 51.45% improvement.

Resident experience: Being able to speak up about the home

The percentage of residents who responded positively to the following statement: "I can express my opinion without fear of consequences."

100% of residents responded positively (Target was 85.00%). This is a 35.41% improvement



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Appropriate prescribing: Potentially inappropriate antipsychotic use in long-term care.

The percentage of LTC home residents without psychosis who were given antipsychotic medication in the seven days preceding their resident assessment.

Currently 19.68% (Target was 20.39). This is an improvement of 12.10%

Percentage of all staff who have completed relevant equity, diversity, inclusion, and antiracism education.

100% of the staff completed this education. This education will be completed annually.

Responsive Behaviors and Montessori

Develop a program to monitor and address changes in quarterly depression rating scores, aggressive behavior scores and participation scores. This would include actionable items based on score trends.

This QIP was abandoned due to the increased focus on supporting residents in the transition to the new Home and will be completed in the 2027-28 QIP cycle

Ethics and Palliative Care

Maintain a rate of 100% for all complaints being responded to within 10 days.

100% of complaints were reviewed and responded to within 10 days.

Achieve a rate of 95% of residents responded positively to "Would you recommend this LTC to others".

87% of residents would recommend the FRW to others

Falls Prevention and Restraint Reduction

Maintain the percentage of residents who fell during in the 30 days preceding their resident assessment below 20%

Currently at 22.24 (Target was 20.84). This is still a 1.84% improvement from the previous year.

Infection Prevention and Control

Maintain the hand hygiene failure rate at 10%

Hand hygiene failure rate was 6.18%. There was a total of 582 hand hygiene audits completed

Skin and Wound

Develop a suite of strategies to monitor and address increases in the quarterly Pressure Ulcer Risk Scoring.

SSKIN bundle was implemented which involves assessing surfaces such as mattresses and cushions, skin inspections, keep residents moving with exercise and re-positioning, incontinence management, and nutrition and hydration management.

Medication Management

Reduce the drug utilization rate per resident from 13 medications per resident to 10 medications per resident.

Not achieved. Current DUR is 12. All appropriate de-prescribing was considered. The influx of new admissions into the Home accounted for the slow progress related to this plan

Nutrition and Hydration Committee

To maintain the percentage of unplanned weight loss at 5.5% by implementing resident specific care planning related to the etiology of the weight loss.

The percentage of unplanned weight loss was 9.7% with the greatest increases noted in November, December 2025 and January 2026. This percentage has stabilized in February 2026

To improve the resident meal taste satisfaction percentage from 62% to 68%

Percentage of resident very satisfied was 62%. The percentage of resident satisfied was 26% and the percentage of residents not satisfied was 12%

Satisfaction Survey Results

At Foyer Richelieu, resident and family satisfaction surveys are completed annually. Achieving a high level of satisfaction among residents and families is a priority and the CQI committee uses this feedback to identify and support areas of improvement at the home. This year the questionnaire de satisfaction was completed in August prior to the move into the new home.

- 87% of residents and families would recommend Foyer Richelieu to others
- 89% of residents feel that staff listened to them
- 100% of residents believe they can express their opinions without fear of consequence
- 90% overall satisfaction rate

There were many informal quality improvement activities that Foyer Richelieu initiated. There are as follows:

- Residents are asked tableside for their preferred beverages at each meal
- Coffee and tea are provided prior to meal service upon resident request
- A prayer is offered before meals in accordance with resident preferences and spiritual practices
- Special meals and themed menus are provided on holidays and special occasions (e.g., Valentine's Day) to enhance the dining experience
- Menu items are adjusted based on resident preferences (e.g., providing homemade mashed potatoes at supper when requested)
- Selected food items are prepared one day in advance when appropriate to support production flow and ensure meals are delivered to residents in a timely manner
- Salads are consistently available at lunch and supper to support resident choice and meal variety
- Informal resident feedback is gathered during and after meals to support continuous improvement
- Efforts are made to create a pleasant and respectful dining environment that promotes social interaction and enjoyment of meals
- Weekly skin integrity audits implemented to monitor skin breakdown trends and healing progress
- Post fall huddles were implemented to establish real time root fall causes
- PointClickCare documentation quality audits completed to ensure adherence to protocols
- Late entry monitoring to ensure timely documentation
- Care plan accuracy reviews implemented to ensure care being provided is accurate and appropriate for each resident
- MAR/TAR/POC completion monitoring to ensure documentation is complete
- Call bell response time observations to ensure timely assistance is being provided
- Responsive behavior case discussions and rounds re-established
- HH audit reminders mid month to all departments to determine if this improves number of audits completed to lower incidences of infections within the facility.
- HH audit tool updated in June 2025 to reflect all departments
- HH audits compiled monthly and executive summary shared with nursing and all department managers outlining areas that require improvement.
- Skin/wound duotang created for each RHA to ensure that all registered staff adhering to wound care policy/procedures to improve resident wound care throughout facility
- Review of infection tool to determine areas that require focused attention in education when UTIs are increasing in frequency.
- Outbreak management binder provided in each RHA to ensure that residents are isolated promptly and reduce risk of transmission
- IPAC lead invited to attend monthly resident committee meetings in 2025. Resident concerns related to nursing department brought forward to DOC to improve resident care within facility.

- Weekly communication to nursing staff following skin/wound reports to ensure policy/procedures are followed to reduce incidences of worsening wounds of residents.

Looking Ahead

As provincial quality indicator reporting becomes fully established following the interRAI LTCF transition, the Home will continue to integrate standardized performance data with its existing quality monitoring processes. In 2026, quality improvement efforts will focus on evaluating resident outcomes, sustaining process improvements implemented during the transition year, and using available data to identify new opportunities for enhancing resident care and services.

We thank our residents, families, staff, physicians, volunteers, Board of Directors, and community partners for their commitment and resilience throughout this transformational year. Together, we remain dedicated to providing safe, compassionate, person-centred care while continually striving for excellence.

Designated Lead for the CQI Initiative

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