JOHN NOBLE HOME

LOVE, CARE AND DIGNITY

QUALITY IMPROVEMENT 2025-26
A YEAR IN GLANCE

OVERVIEW

The Quality Improvement Program is continually evolving and growing with a continue commitment to enhance the quality of life for those we serve by providing Love, Care and Dignity within a safe, home-like environment. The John Noble Home's Quality Improvement Plan will continue to focus on the priority indicators that are consistent with the priorities of the Ministry of Health, Ministry of Long-Term Care and Ontario Health. The Home is currently recruiting for a new member of the team to fill the position of Quality Improvement Coordinator, once hired they will build and grow the current vision of the Home.

PATIENT/CLIENT/RESIDENT EXPERIENCE

Resident and family input have remained a priority for the John Noble Home as we continue to implement best practice guidelines (BPG) as a Best Practice Spotlight Organization (BPSO). Having the opportunity to complete the BPG Person and Family Centered Care has impacted the culture of the Home at an administrative level as well. Family Council and Resident Council members sit on multiple committees such as the Infection Prevention and Control Team, Pain and Palliative Committee, Quality Improvement Team and have been able to participate with redeveloping these mandatory programs by providing insightful knowledge and resource. Jhon Noble Home is working on re-accreditation with Accreditation Canada in 2025/2026 that involves resident, family, and staff.

SAFETY

The Home is committed to achieving and maintaining the philosophy of a safe and healthy workplace and Home, for all its employees, residents, volunteers and visitors. The Home has a client safety plan which assists in ensuring compliance with the applicable laws and standards as well as safe work practices and procedures. The goal of the safety plan is to provide information that allows the Home to deliver services in the safest manner possible in a joint effort to reduce the possibility of adverse events resulting from unsafe practices and conditions. Areas of risk are recorded through the various committees within the Home, including the Quality Improvement Team, Risk Management, Infection Prevention and Control and the Joint Health and Safety Committee. Care and services are also evaluated, and any identified safety risks are corrected. Resident safety is then improved by coaching, mentoring, implementing organization-wide initiatives, promoting widespread learning, accessing evidence, implementing best practice guidelines and encouraging feedback while recognizing individuals for their input.

PALLIATIVE CARE

John Noble Home continues to have Goals of Care Discussion at 6-week post admission and annual Inter Disciplinary Care conference. New palliative care boxes were updated with stencil to provide as a meaningful keep’s sake for family. Palliative Care Series display was located at the front of the home and include Information changed every 3-4 weeks for families, staff and residents, the display included information on what advanced care planning is, the importance of being prepared, scenarios, informed consent, CPR vs. DNR, game for family and caregivers.

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 2024-25 is provided below:

Program	QI successes 2024-25	Planned improvements for 2025-26
Infection Prevention and Control	Improvement have been noted in all aspects of the program and continue to be evident by the management of outbreaks, staffs and family's involvement in IPAC such as PPE donning and doffing as well as hand hygiene clinics. Education for all staff, families and residents continues to be on going and revisions are made based on audit results. Additional IPAC Champions are being trained spring of 2025. The IPAC program continues to change and evolve. The IPAC policy and procedure manual has been reconstructed, evaluating the current policies which have been revised and many new polices added to meet the IPAC Standard. A rollout of the manual pertinent policies will start once the manual has been improved. The IPAC Lead is making attempts to include the members of Resident and Family Councils to assist in the IPAC program and education of families and visitors. The IPAC Lead has completed the IPAC program at Queen's University and this additional knowledge as well as the continued attendance and collaboration with outside resources will only continue to improve the program. The goal for the IPAC Lead is to obtain their LTC-CIP certification by May 2025.	• 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 • To meet all of the IPAC Standards as per the Sept 2025 document
Pain Management	Overall, the committee feels the Pain Management Program continues to work well	Pain Program Education • For PSWs

	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 February 11th to ensure program is running smoothly and identify new areas that may require improvement.	- POC pain button - Signs of pain - Assessing pain - Use of pain tools - Non-Pharmacological pain interventions • For Registered Staff - POC pain button - Signs of pain - Assessing pain - Use of Ax tools - Pharmacy component (how narcotics are titrated, long vs. short acting medications • BPSO Pain Champions - Training on Program and tools used - Identify WHO are Pain Champions are for the Home
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 behaviors, medication changes, any assessment results pertaining to mood/behaviors, care plan updates and referrals made to community partners. The Team is multidisciplinary and	• 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. • BSO Therapeutic Recreational position • JNH BSO Coach will be available to continue with education of 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 • To increase staff attendance at Quarterly Meetings to assist with dissemination of information to staff throughout the home.

	includes members from nutrition, physiotherapy and recreation. • The Edmond Protection and Consulting (EPC) services suspended by July 2024. Home utilizing our own PSW to cover shift 1:1 in mean time. • There has been a noticeable difference in the quality of services provided by PSW compared to EPC. John Noble Home staff find the PSW to be much more engaged with the resident's, ensuring that they are participating in activities (organized and self-directed), going outside for walks, conversing, etc.	
Palliative Care	The Palliative Care and End of Life Management Program was overhauled in 2024 where many changes were made to ensure compliance. It is the team's consensus this coming year to focus on Serious Illness Conversations and education to enhance the program.	• Serious Illness Conversations - SIC Guide - Practice Discussions • Bereavement Huddles for Staff • Resident Led End of Life Visits • Family/Caregiver Palliative Care Room - Determine a location for a room within the home
Restorative Care	• Direct Care staff received restorative training with annual lifts and transfer training last Sept. This included lift techniques, transfer techniques, positioning, and assistive devices. • Collaboration continues with Physiotherapy department to optimize goals for the program. Over the last year the team was able to rehabilitate 2 residents back to their maximum level of independence after falls with	• Trial a Restorative Care Assessment Nurse with goals to complete restorative assessments, evaluations, MDS restorative audits • To ensure availability of assistive devices and equipment that Resident's can safely use and is in good working order determined by their assessed needs • To educate direct care staff on home wide Restorative Approach to Care during routine care

	fracture. This is also due to the tight collaboration of the Physiotherapy and Restorative relationship. • Changes over the past year include: - Added a 2nd Restorative Care Aide to enhance and expand programming offered - New PSW led walking program added as an additional program to enhance restorative services and offer a more restorative approach to care to all residents not on the formal program - ADL assistance levels added to TASK buttons to allow PSWs to more easily see the most restorative approach to all residents. - Changes to the policy over the last year include: - Revised policy 3-F-30 to incorporate ALL types of mobility transfers to eliminate one policy per transfer technique. Now all types of transfer techniques are found under 1 policy.	• New RAI/MDS launching in 2025, educating staff on new ADL terminology for documenting ADLs in the most restorative approach
Continence Care	A review of the 2024 Resident Satisfaction result for incontinence: • Do you use incontinence products if so, does it meet your needs? Will update once results provided • 2. How would you rate the continence management within the	• New assignment of Continence 'champions' using BPSO trained champs • 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.

	home? Includes toileting, incontinence product changes and other assistance? 98% positive The Team is greatly satisfied with the results of the survey and the program itself.	• To further improvement in bladder and bowel function in residents who can improve, and to prevent deterioration whenever possible
Skin and Wound Care	• New Skin and Wound Directives (2024) with NEW Directives coming beginning of 2025 • New skinwound@jnh.ca referral email created in 2024 to alert the interdisciplinary team of new, stalled, infected, or worsened wounds • Changes to Pressure Injury Tracker to audit dates assessment notes were completed to strengthen compliance and lessen work load • Treatment carts now filled weekly on Fridays to ensure carts have equipment and treatments Working with BPSO to implement the new Pressure Injury Best Practice Guidelines for 2025.	• Implement NEW Pressure Injury Best Practice Guidelines with BPSO • 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. • To meet compliance with the completion of weekly wound assessments
Falls Prevention and Restraints	• 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.	• To reduce the number of falls by following the RNAO Best Practice Guidelines for Preventing Falls and Reducing Injury related to Falls • On going evaluation of the Home's new Falls Policy • The Committee continues to review the residents in house quarterly with lap belt usage however these are all family driven decisions and POAs are not receptive to reducing unless significant change in status.

	• 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 the new program criteria for falling leaves, an additional logo (x3) total / new one being the bedside, 4 P's task implemented into tasks. • 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 • The home continues to discuss falls at its morning huddle and collaborate as a multi-disciplinary team	
Volunteer Program	• All new volunteers and students completed their mandatory education. All the standards are covered in their required education. Education is done	• 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 surge learning. Education 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. Teepa Snow Education was offered again this year to our volunteers.	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.
Spiritual Care	• Megan G (Recreation Therapist) assists Director of Programs with Spiritual Care needs. April 1st 2024 Hours increased and have been allocated to provide spiritual programs. Megan G Completed her Certificate (April 2024) in Spiritual Care and provides spiritual programming on all home areas and spiritual visits as needed.	• The purpose of spiritual care is to develop and operate programs that meet the identified religious/spiritual needs for the residents, families and staff. • memorial tree to reflect those that we have lost in 2024 • Put together a Multi-Faith Spiritual Resources book shelf with include various Holy Texts
Recreation Program	• The following programs were added to the recreation schedule for 2024: - Additional Church Services with our community part - Community Bus Trips for each side of the home - Ride to the Rhythm - Horticulture on all home areas - Lunch outings returned • In 2024 the Recreation Department model changes were made.	• 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.

	• 37.5 Therapeutic Recreation Coordinators days, evenings and weekends • 29.5 x 5 Recreation Assistants on the additional 6 home areas Monday – Thurs 900-3/ Fri 930-330 • 29.5 x 2 Recreation Aide positions that provided 4x a week evening programs on each side of the home as well as Saturdays 9-4 x 2 and Sundays 9-4 x 2.	
Dietary Services	• Discussion and change to policy • Resident council continued to choose to say with 2 chooses at meals during the menu review in January • Change in Pharmacy ordering to online, this includes diet orders • Diet order policy changed to include fluid texture order. • Staff meeting held most months on both shifts. Annual Surge Learning completed by all staff. • Staff Talks reviewed monthly at meeting d posted in the kitchen for staff to review and sign off on.	Financial • l. Meet raw food budget (< or actual department budget) - Review food purchases monthly. - Adjust menu items as needed as product availability changes. o Review Complete notifications on contract increases. Food Service • Improve/maintain cleanliness of department and serveries (achieve average audit score > 90% on cleaning audit) o Complete sanitation audits and review at monthly meetings. - Based on results, revise cleaning schedules as necessary. - Achieve Public Health/MOH/IPAC standards. Technology • Improve communication by implementing Meal Suite on the IPADS for Nursing to use on snack carts. - Provide education to the nursing staff on expectations of snack service and how to use Meal Suite for snack service.

		- Monitor compliance through snack audits. Resident Satisfaction • Improve resident satisfaction with the variety of food on the resident survey (maintain total score on Resident annual survey -above 80%) - Solicit input from Residents through the Resident Food Committee, Resident's Council, Care Conferences and individual meetings in menu development. - Follow Dietitians of Canada menu planning guidelines. Growth • Prepare a food service plan for the opening of 40 new beds in 2026. - Write new job descriptions, work schedules, cleaning schedules/checklists, orientation plan etc. - Prepare new policies and procedures as required. - Work with the multidisciplinary team to meet the MOH time lines for opening the new beds. • Investigate opportunities to enhance staff job skills. - Research and implement training opportunities that will enhance existing staff skills. i.e. Dietary Aide to Cook
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.	• To continue to reduce risk through meeting the Ministry of Health and Long-Term Care education requirements • To improve resident safety through education

	• 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.	• Ensure compliance with all Training and Education Regulations (FLTCA 2021, ESA, OHSA, ADODA)
Joint Health and Safety	• Focus on PPE use and IPAC practices. Updated policies around the handling of soiled linen. • All staff have been N95 Mask Fit tested • JHSC meetings will be held via Zoom 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 • Reviewed Abestoes Management Policies and updated based on the findings from Ministry of Labour	• To continue to minimize risk of injury for employees via hazard elimination, substitution, engineering controls, administrative controls and PPE • To ensure incidents of Workplace violence are properly reported, tracked and appropriate interventions are put in place. • To improve tracking of employees who have recurring incidents reported by improving the communication of incidents with Department Mangers
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 2025-26

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.	O	Rate per 100 residents / LTC home residents	CIHI CCRS, CIHI NACRS / Oct 1, 2023, to Sep 30, 2024 (Q3 to the end of the following Q2)	12.95	12.00	John Noble Home will work towards achieving a 7.34% improvement and move towards the provincial average.	

Change Idea #1 Improve utilization of the SBAR (tool) with transfer checklist		
Methods	Process measures	Target for process measure
Re-education of registered staff on using the SBAR (tool) with transfer checklist prior to calling the physician and families. Education session to be completed during inservice/departmental meetings and add to nursing orientation for new registered staff	Percentage of registered staff who have completed re-education on the use of SBAR (tool) with transfer checklist.	80% of the registered staff to be re-educated on the use of SBAR (tool) with transfer checklist by October 30,2025.

Change Idea #2 To avoid unnecessary or unwanted transfer to acut care hospital		
Methods	Process measures	Target for process measure
QI Coordinator to work with PoET (Prevention of Error-Based Transfer) program team.	Implementing PoET (Prevention of Error-Based Transfer) program at John Nobel Home to reduse emergency room visits.	PoET (Prevention of Error-Based Transfer) program will be implemnted at John Nobel Home by December 2025 to reduse emergency room visits.

Change Idea #3 IV insertion and administration of IV medication		
Methods	Process measures	Target for process measure
IV insertion and administration education to registered staff to avoid unnecessary or unwanted transfer to acute care hospital	Percentage of registered staff who have completed education on IV insertion and administration	80% of registered staff will be educated on IV insertion and administration

Measure - Dimension: Patient-centred

Indicator #2	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	CB	CB	Target based on improvement over previous year's survey and trends	

Change Idea #1	Tracking of number of resident's and responses each time the question is asked at Resident Choice Meeting on each home area and in Resident satisfaction survey.		
Methods	Process measures	Target for process measure	Comments
Number of resident responses at the Resident Choice meeting is tracked and concerns will be reviewed by leasdership team.	% of concerns reviewed by leadership team.	100% of concerns will be reviewed by leadership team.	

Change Idea #2	Eudcate Resident Bill of Rights to all staff via Surge learning		
Methods	Process measures	Target for process measure	Comments
All staff will be eudcated on Resident Bill of Rights through anuual Surge learning module and through general staff orientation for new staff	% of staff completed eudcated on Resident Bill of Rights through Surge learning module.	100% of staff to completed eudcated on Resident Bill of Rights through Surge learning module.	

Measure - Dimension: Safe

Indicator #3	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 Sep 30, 2024 (Q2), as target quarter of rolling 4-quarter average	15.47	15.00	John Noble Home will work towards achieving a 3% to move towards the provincial average for falls.	

Change Idea #1 Re-educate registered staff on post-fall huddles		
Methods	Process measures	Target for process measure
The nursing leadership team will provide education to registered staff on conducting and completing thorough post-fall huddles.	Percentage of registered staff who completed re-education on post-fall huddles.	100% of registered staff will be re-educated by the end of 2025.

Change Idea #2 Re-educate PSW staffs on 4P's (Peri-needs, Position, Possession, Pain)		
Methods	Process measures	Target for process measure
The Nursing Programs Coordinator will provide education to PSWs on conducting and completing thorough 4P's (Peri-needs, Position, Possession, Pain).	% of PSWs educated on 4P's (Peri-needs, Position, Possession, Pain) % of PSWs utilizing 4P's as per Plan of Care.	100 % of PSWs will be educated on 4P's (Peri-needs, Position, Possession, Pain) and 100 % of PSWs will utilizing 4P's as per Plan of Care.

Change Idea #3 Utilizing MDS outcome score data to analyze residents Fracture risk and implement appropriate interventions.		
Methods	Process measures	Target for process measure
Quaterly Falls & Restraints Committee meeting to review the fracture risk data and implemented approprate intervention to prevent fractures.	# of Falls & Restraints Committee meetings where fracture risk data are reviewed.	All quaterly Falls & Restraints Committee meetings will review fracture risk data.

Measure - Dimension: Safe

Indicator #4	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 Sep 30, 2024 (Q2), as target quarter of rolling 4-quarter average	19.70	18.70	John Noble Home will work towards achieving a 5% improvement and move towards the provincial average.	

Change Idea #1 Review of resident receiving anti-psychotic without appropriate diagnosis		
Methods	Process measures	Target for process measure
All residents on anti-psychotics without appropriate diagnosis will be reviewed at monthly antipsychotics reduction meeting and recommendations will be forwared to MD.	% of residents who are taking antipsychotics without diagnosis will be reviewed.	100% of resident on antipsychotics without diagnosis will be reviewed.

Change Idea #2 Implement Gentle Persuasive Approaches (GPA) training to enhance staff competency in managing responsive behaviors		
Methods	Process measures	Target for process measure
Internal GPA coach to provide GPA in-services to improve resident care.	Percentage of frontline staff who have completed GPA training	30% of frontline will complete GPA training by end of December 2025

Measure - Dimension: Safe

Indicator #5	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of long-term care home residents who had a pressure ulcer that worsened to a stage 2, 3 or 4	C	% / LTC home residents	CIHI CCRS / July 1 to Sep 30, 2024 (Q2), as target quarter of rolling 4-quarter average	2.80	2.60	John Noble Home will work towards achieving a 7% improvement and move towards the provincial average.	

Change Idea #1 Improve Registered staff knowledge on identification and staging of pressure injuries and use of approprate dressing

Methods	Process measures	Target for process measure
Provide education for Registered staff on correct staging of pressure injuries and use of approprate dressing	% of Registered staff educated on correct staging of pressure injuries and use of approprate dressing	100% of Registered staff will be educated on correct staging of pressure injuries and use of approprate dressing

Change Idea #2 Implementation of comprehensive, structured and validated wound assessment tool.

Methods	Process measures	Target for process measure
Provide education for Registered staff on new skin and wound assessment tool	% of Registered staff educated on new skin and wound assessment tool	100% of Registered staff wiil be educated on new skin and wound assessment tool

Resident and Family/caregivers experience

JNH has an active Resident and a Family Council that meets monthly providing feedback on aspects of care, food choices and quality of life. The executive members of both the Councils sit on Continuous Quality Improvement (CQI) Committee, our operational quality and safety committee that aims at reducing disparities and co-designing improvements. We also have resident and family representation on our QIP working group, that helps shape our improvement efforts year after year.

(LTC) Resident Satisfaction Surveys. These surveys give residents and their family members the opportunity to provide their view on the quality of care and services provided. This ongoing collaboration involves the use of common standardized survey tools and methods, and allows for comparison of performance across the three LTCHs, and subsequently, shared learning and partnering on quality improvement initiatives.

Resident survey

John Noble home Resident Satisfaction Survey completed each year. This survey gives residents the opportunity to provide feedback on the quality of the care and services that they receive, and the collective approach allows the three sites to compare results between the homes. The Survey was approved by Resident council in April 2024 meeting and Family council in May 2024 meeting. The data was collected between September and October 2024. The survey results were presented to Resident council on February 19th 2025 and the action plan and QIPs were presented on March 19th 2025. The survey results and action plan will be presented to Family council on April 15th 2025 as per Family council request.

Response Rate

156 residents approached to be interviewed,

No of Resident who were eligible to complete Survey: 76

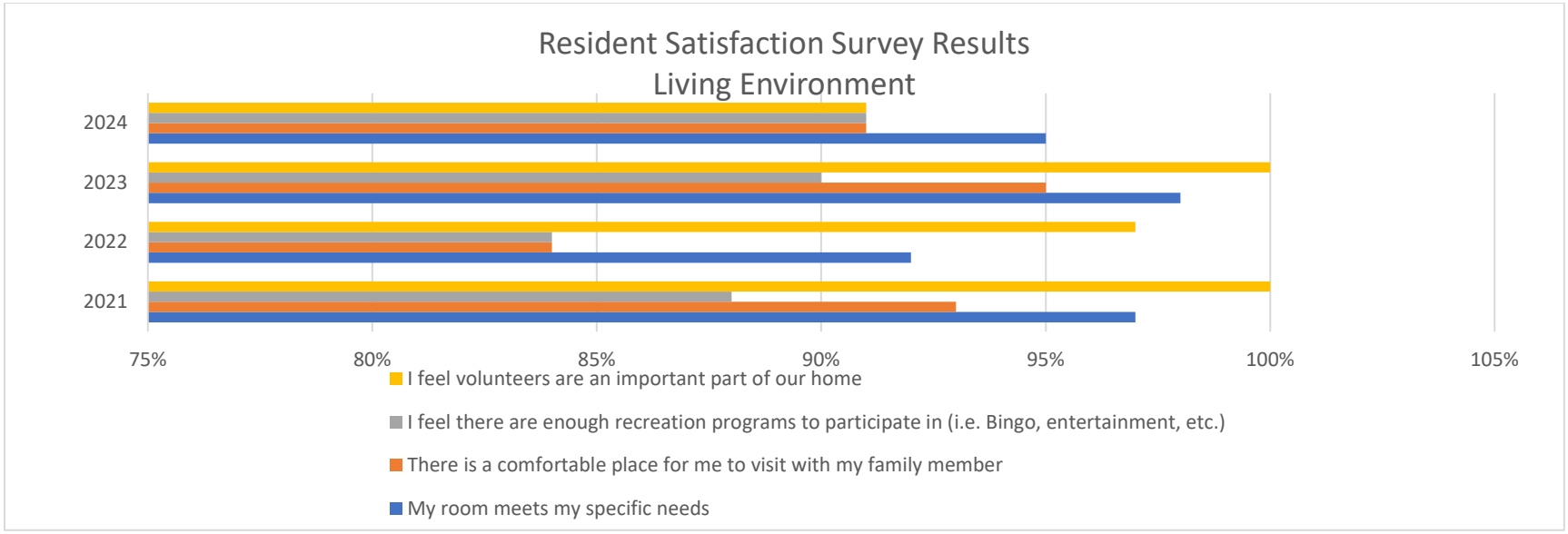
No of resident completed the Survey: 59

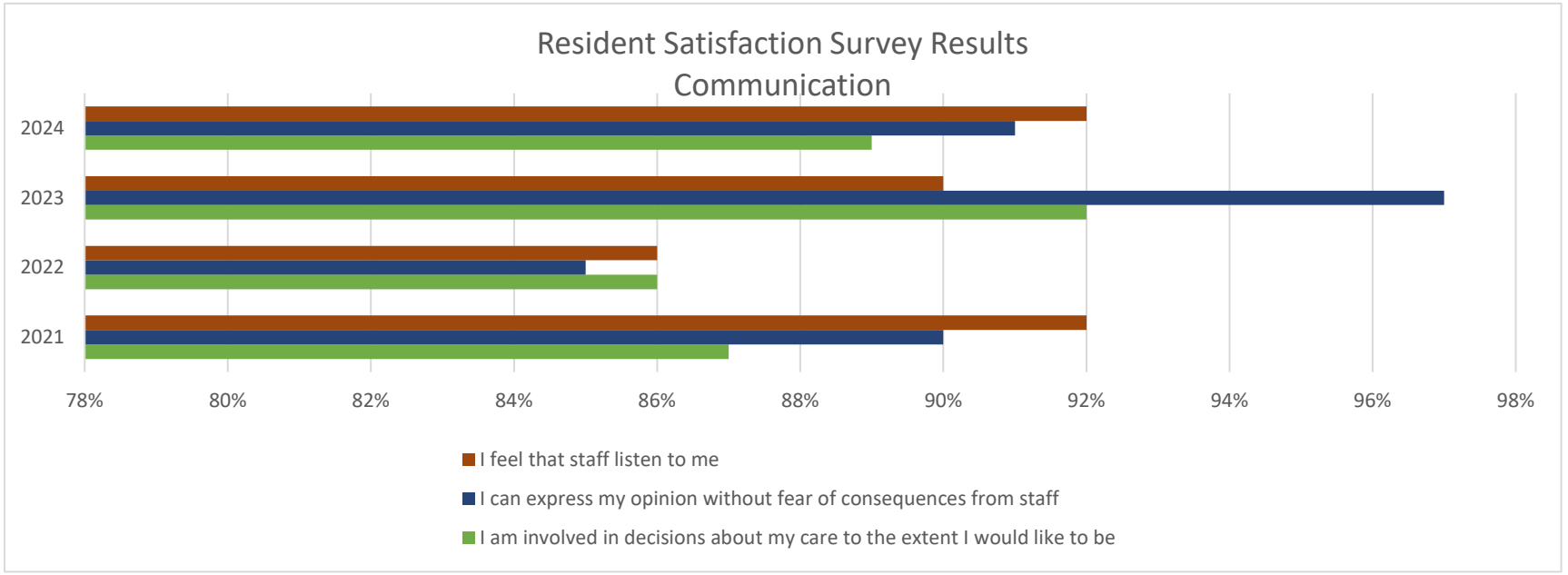
No of Surveys send out to family members: 78

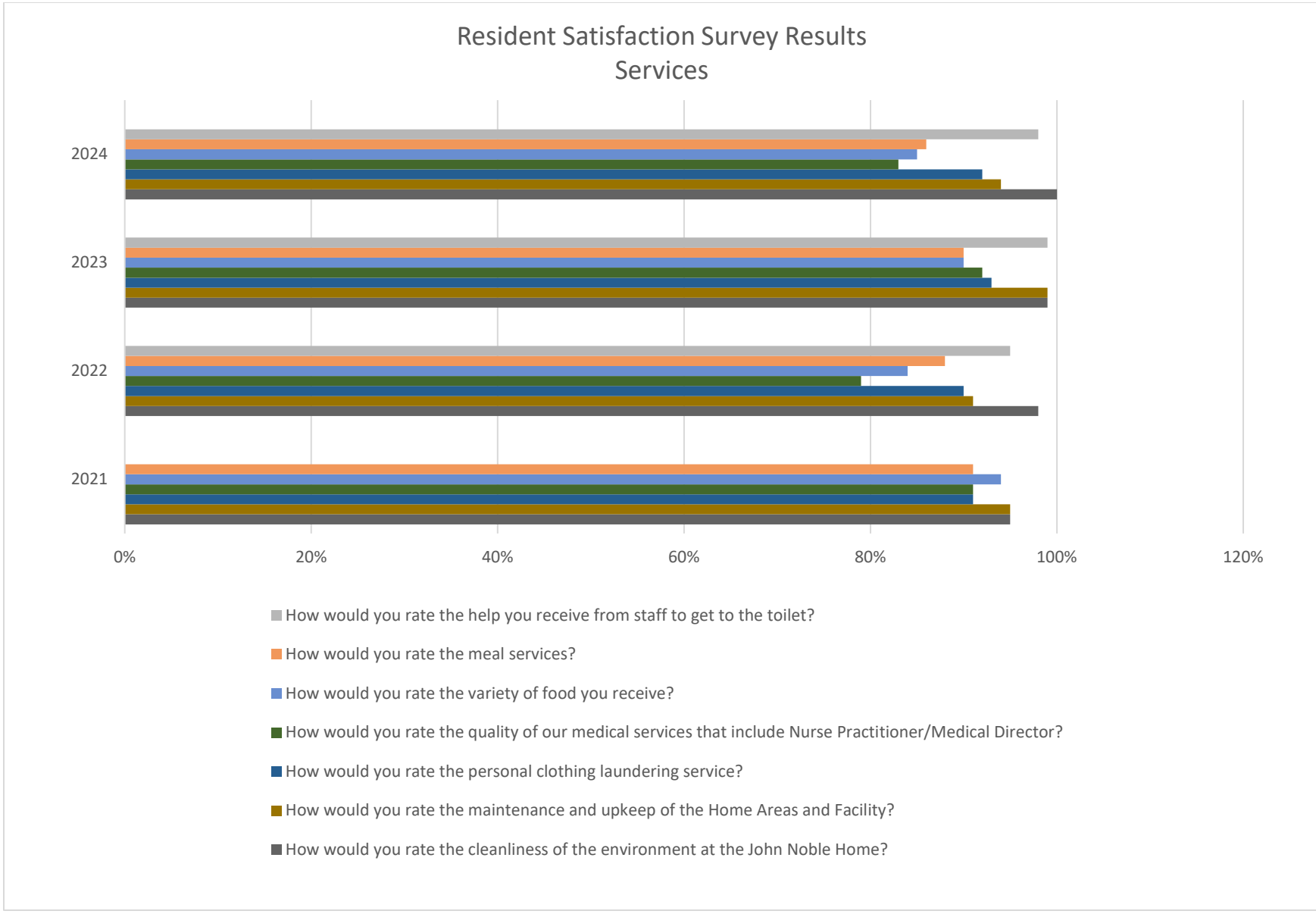
No of Surveys received: 26

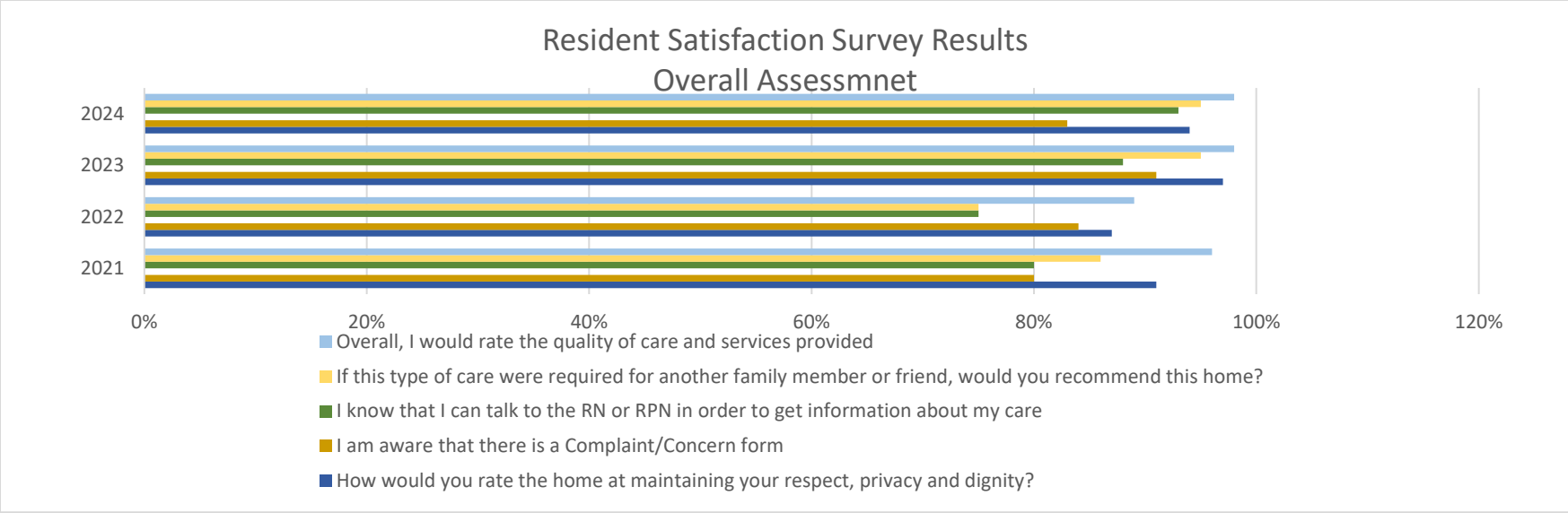
Overall quality of care and services:

98% of residents rated the overall quality of care and services as “good” or “very good” or “excellent”. Furthermore, the majority of residents (95%) indicated that they would (“Yes”) or would sometimes (“Yes Sometimes”) recommend the LTCH to others.


Resident Satisfaction Survey Results
Living Environment
2024
2023
2022
2021
75%
80%
85%
90%
95%
100%
105%
I feel volunteers are an important part of our home
I feel there are enough recreation programs to participate in (i.e. Bingo, entertainment, etc.)
There is a comfortable place for me to visit with my family member
My room meets my specific needs


Resident Satisfaction Survey Results
Communication
2024
2023
2022
2021
78%
80%
82%
84%
86%
88%
90%
92%
94%
96%
98%
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
Services
2024
2023
2022
2021
0%
20%
40%
60%
80%
100%
120%
How would you rate the help you receive from staff to get to the toilet?
How would you rate the meal services?
How would you rate the variety of food you receive?
How would you rate the quality of our medical services that include Nurse Practitioner/Medical Director?
How would you rate the personal clothing laundering service?
How would you rate the maintenance and upkeep of the Home Areas and Facility?
How would you rate the cleanliness of the environment at the John Noble Home?



2024 Resident Satisfaction Survey Action Plan

Feedback	Action	Process
I know that I can talk to the RN or RPN in order to get information about my care	• Education new Registered staff • Continue to decrease use of agency staff • Robust on boarding process and staff retention	• Register staff orientation to be reviewed and updated
Do you know where to go if you have a concern?	• Improve communication with residents and family	• To create a contact list for each department to help Resident and families • New admission package to be reviewed
What number would use to rate how well the staff listen to you?	• Included in QIPs 2025/2026	• Resident choice meeting to be utilised to get response for the question • Educated Resident Bill of Rights to all staff via surge learning.

Successes: 2024-25

- The John Noble Home has implemented project AMPLFI with Barnt Community Health Care System, it allows us to receive and send residents health information between Jhon Noble Home and Barnt community, this helps use to improve resident care.
- In 2024 IV administration was started in home for resident who returned from hospital who required IV antibiotic. Elastomeric pump was used for IV medication administration. Residents of the home who require other medications to be delivered via IV to potentially receive treatment within the home avoiding ED visit or Hospital stays.
- New Pharmacy was introduced late 2024 with physician ordering online portal that allows use to eliminate errors related to written orders and promote instant communication with pharmacy. Three-month medication review is completed online.
- In 2024 we re-educated the Registered staff on the use of the CADD pump for IV administration.
- Completed 2024 ISMP in November 2024 with increased involvement from interdisciplinary team and scored improved from previous years.
- New pharmacy electronic medication incident reporting platform was launched in December 2024 medication incidents, with platform links located on each nursing
- Online ordering system implemented in December 2025 to improve for better patient safety

Quality Improvement Priorities: 2025-26

- Establish interdisciplinary post falls huddles
- 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
- Implementation of comprehensive, structured and validated wound assessment tool

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: Raquel Diez
Human Resources: Maria Howard
Director of Support Services/ RD: Barb Midgley
Support Services Supervisor: Jeremy Williamson
Director of Environmental Maintenance: Edward Owen
Director of Programs: Karli Cass
Day & Stay Manager: Lisa Clarkson
Social Service Worker: Tina Praass
Pharmacy Consultant: Namita Kalra
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 2025-26: A Year in glance reflects on the achievements and successes of the past year and highlights our commitments for 2025-26.