Equity | Equitable | Optional Indicator

Indicator #4

Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education (Pioneer Ridge)

Last Year		This Year		
CB	100	100.00	--	100
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Equity, diversity, inclusion and anti-racism education will be completed by all active staff in 2024.

Process measure

- Number of active staff / Number of active staff who have completed all of their modules at year end.

Target for process measure

- Our target for this process measure is 100% of active staff will have completed their required EDI-R modules.

Lessons Learned

269 staff were assigned the Diversity, Equity and Inclusion module in Surge learning. 100% completion rate.

100% of all leadership team members completed Surge learning and the Ontario Health e-learning courses

Comment

Pioneer Ridge continues to work towards advancing equity, inclusion and diversity and addressing racism.

Experience | Patient-centred | Custom Indicator

	Last Year		This Year		
Indicator #1	**CB**	**80**	**NA**	**--**	**NA**
Overall Experience: Staff satisfaction Percentage of staff rating their satisfaction level at work as good, very good or excellent. (Pioneer Ridge)	**Performance (2024/25)**	**Target (2024/25)**	**Performance (2025/26)**	**Percentage Improvement (2025/26)**	**Target (2025/26)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

Offer staff appreciation initiatives/events to boost morale and improve staff satisfaction.

Process measure

- Total number of events % of staff rating satisfaction as Good, Very Good or Excellent

Target for process measure

- At least 6 events per year 80% staff satisfaction level

Lessons Learned

We have held staff appreciation events quarterly at a minimum. We did attempt to survey the staff after our events to gauge satisfaction levels, however we found that the response level was very low (less than 10%) and the staff who did complete the surveys, tended to be those with negative remarks.

Comment

We are going to continue with regular staff appreciation events. Even without survey results, we know that holding these regular events has a positive impact on satisfaction and wellbeing for our staff.

Results


Valentine's Day
BINGO IS HERE
Bingo cards are available from your manager, Nursing...yours will be on the floors (ONE per person)
Two Valentines pictures will be drawn a day (They will be scanned to your PERSONAL City of Thunder Bay email address. firstname.lastname@thunderbay.ca and the floor email address daily until Friday February 14, 2025)
Whoever gets two lines YELL BINGO and collect your prize from Jaime Rizzo, Admin Assistant (office is by the link, if not around leave a voicemail at 3497 with your name and floor please and thanks!)
Thanks to those who participate and lets have some fun!


LET ME TAKE A #SELFIE
Just for fun...take a selfie or group selfie and send it to jaime.rizzo@thunderbay.ca
Your picture may be posted in our newsletter or display board.
Please be sure to send your email with everyone's name in the picture as names will be added to a draw for a $50.00 Walmart Gift Card!

	Last Year		This Year		
Indicator #6 Resident and Family experience: involvement in decisions about palliative care (Pioneer Ridge)	**14.75** Performance (2024/25)	**30** Target (2024/25)	**30.00** Performance (2025/26)	**--** Percentage Improvement (2025/26)	**NA** Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Improve communication with families and residents and involve them in end of life conversations and goal setting earlier in the process.

Process measure

- Total number of deaths annually Number of referrals to Resident Counsellor Number of residents / families who request care conference

Target for process measure

- 30% referral rates with 50% of families requesting care conference

Lessons Learned

After implementing this change idea, the Resident Counsellor has noted that referral numbers have increased substantially. He also noted that most families decline the special care conference because staff are much better at contacting them earlier in the EOL process.

2024 30% referrals
Q1- 3 referrals / 1 meeting
Q2- 3 referrals / No meetings
Q3 – 4 referrals / 1 meeting
Q4 – 7 referrals / No meetings

Change Idea #2 ☑ Implemented ☐ Not Implemented

Improve referral process to Resident Counsellor when a resident is nearing end-of-life to facilitate earlier involvement and discussion re: supportive care, EOL goals etc.

Process measure

- # of residents with a PPS score of 30 or less # of referrals sent to resident counsellor

Target for process measure

- 30% of residents with a PPS score of 30 or less will have a referral sent to the RC.

Lessons Learned

After implementing this change idea, the Resident Counsellor has noted that referral numbers have increased substantially. He also noted that most families decline the special care conference because staff are much better at contacting them earlier in the EOL process.

Change Idea #3 ☑ **Implemented** ☐ **Not Implemented**

Improved understanding and accuracy of Palliative Performance Scale.

Process measure

- Number of registered staff (FT & PT) participating in education Number of direct care staff (FT & PT) participating in education

Target for process measure

- 100% of full time registered staff and direct care staff 60% of part-time registered and direct care

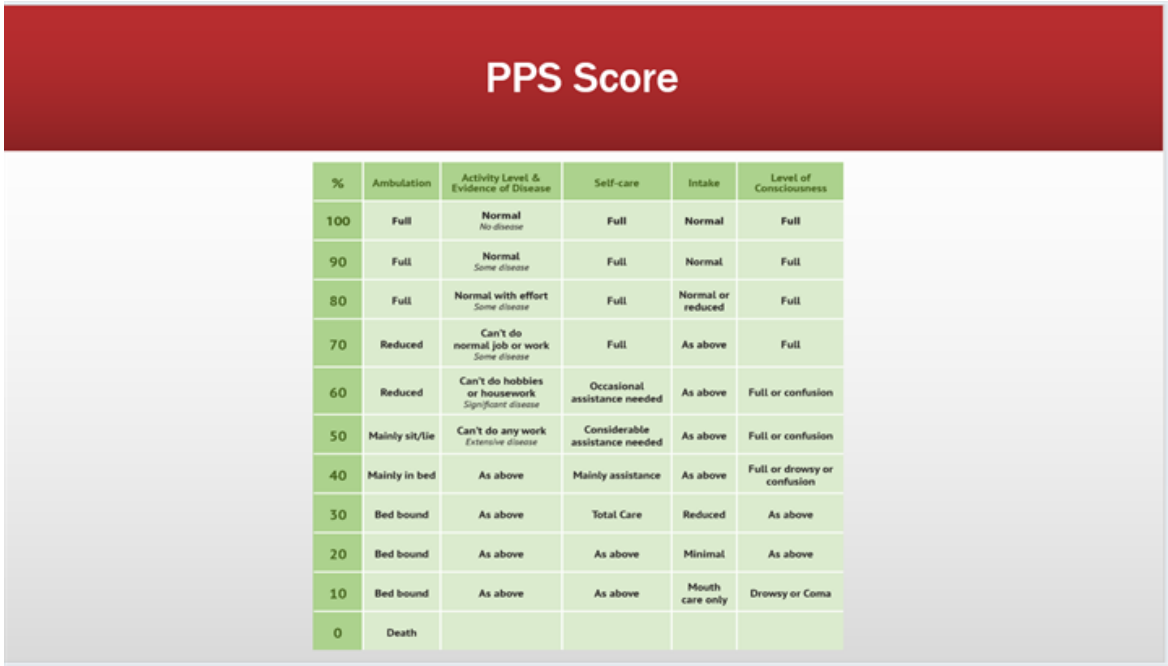
Lessons Learned

30 RPNs attended the PPS training.

Comment

Palliative Care continues to be a priority for our home. We will continue to focus on improving early communication with families and residents.

Results



PPS Score

%	Ambulation	Activity Level & Evidence of Disease	Self-care	Intake	Level of Consciousness
100	Full	Normal *No disease*	Full	Normal	Full
90	Full	Normal *Some disease*	Full	Normal	Full
80	Full	Normal with effort *Some disease*	Full	Normal or reduced	Full
70	Reduced	Can't do normal job or work *Some disease*	Full	As above	Full
60	Reduced	Can't do hobbies or housework *Significant disease*	Occasional assistance needed	As above	Full or confusion
50	Mainly sit/lie	Can't do any work *Extensive disease*	Considerable assistance needed	As above	Full or confusion
40	Mainly in bed	As above	Mainly assistance	As above	Full or drowsy or confusion
30	Bed bound	As above	Total Care	Reduced	As above
20	Bed bound	As above	As above	Minimal	As above
10	Bed bound	As above	As above	Mouth care only	Drowsy or Coma
0	Death				

Indicator #5

Resident and Family experience: improved communication and partnership (Pioneer Ridge)

Last Year		This Year		
CB	**40**	**NA**	**--**	**NA**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Improved involvement and partnership with families and caregivers

Process measure

- Number of surveys distributed by mail / Number of surveys returned by mail Number of surveys sent by email / Number of surveys returned by email Number of surveys completed online / Number of surveys returned online Response rate % (Total surveys distributed vs. total surveys received)

Target for process measure

- 100% of resident designated POA or caregivers will receive a survey in 2024 40% survey response rate

Lessons Learned

198 surveys were sent by email
20 surveys were mailed
1 survey was given out at Care Conference

219 surveys total sent out, 35 surveys completed for a 16% response rate

Change Idea #2 ☑ **Implemented** ☐ **Not Implemented**

Improved communication with families and residents through educational sessions.

Process measure

- Number of sessions held quarterly Number of residents attending quarterly Number of families/caregivers attending quarterly Number of surveys returned per session % satisfaction rate

Target for process measure

- 1 session per quarter 15 caregivers per session/quarter 50% survey response rate 90% satisfaction

Lessons Learned

We have held one "Pioneer Talks" session per quarter
Falls/Restraint session - 9 attendees
Talks with Doc - 22 attendees
Alzheimer's Society Guest - 12 attendees
Butterfly Model - 30 attendees
The satisfaction surveys collected after each session demonstrate high satisfaction rates with the topic and discussion.

Comment

While the survey response rate was lower than we had hoped (16%) we have found the Pioneer Talks sessions to be very successful with a satisfaction rate of 98% and we will be continuing this initiative. We are continuously working to improve the response rate on our Family surveys.

Results

Safety | Safe | Optional Indicator

	Last Year		This Year		
Indicator #3 Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment (Pioneer Ridge)	**30.22** Performance (2024/25)	**19** Target (2024/25)	**31.63** Performance (2025/26)	**-4.67%** Percentage Improvement (2025/26)	**NA** Target (2025/26)

Change Idea #1 ☑ **Implemented** ☐ **Not Implemented**

Regular review of residents on antipsychotic medication

Process measure

- Number of residents reviewed by pharmacy monthly. Number of residents deemed inappropriate Number of residents reviewed by BSL team monthly. Number of residents deemed inappropriate Number of residents reviewed by Physician quarterly. Number of residents deemed inappropriate

Target for process measure

- 100% of residents with an antipsychotic medication will be reviewed monthly 100% of residents deemed inappropriate will have their medication reviewed by the Physician to determine if it can be discontinued

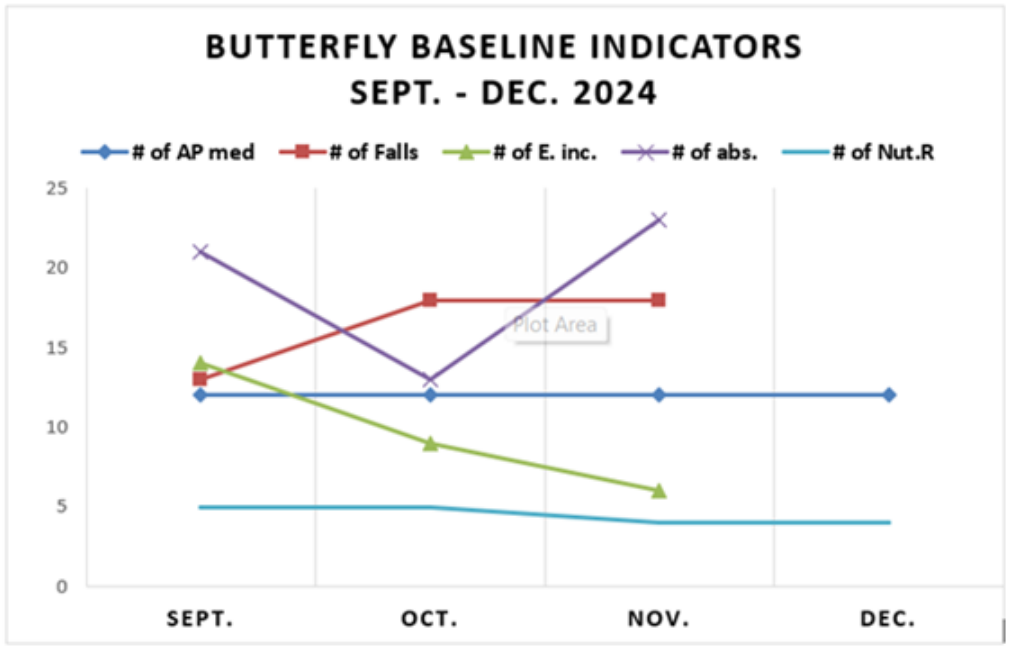
Lessons Learned

We are regularly reviewing the residents on antipsychotic medications. The Physician and the Phamrmacy are both regularly reviewing residents who are on antipsychotic medications to determine if they can be discontinued.

Comment

We are committed to minimizing the use of pharmacologic options in cases where they are of no benefit. We will continue to regularly review residents who are taking these medications. As we continue to implement our Butterfly model of care on Monarch Manor, we will be focusing on the reduction of medications and looking to more non-pharmacological options.

Results



Safety | Safe | Custom Indicator

	Last Year		This Year		
Indicator #2 Percentage of long-term care home residents in daily physical restraints over the last 7 days (Pioneer Ridge)	**13.90** Performance (2024/25)	**11** Target (2024/25)	**11.70** Performance (2025/26)	**--** Percentage Improvement (2025/26)	**NA** Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

We have identified that wheelchairs coming in to the home (new resident or new chair) have the seatbelts installed. Staff may inadvertently apply the seat belt to the resident because it is there (habit).

Process measure

- Number of new residents Number of restraint / seatbelt audits Number of referrals to Restorative Number of seatbelts secured with signage Number of incidents reported where seatbelt was applied in error

Target for process measure

- 100% of new residents will have a restraint and seatbelt audit in 2024 100% of referrals received by Restorative will be secured 0 incidents of restraint error due to missed seatbelt audit

Lessons Learned

100% of new admissions were reviewed for potential restraint use
Potential restraints (seatbelts) that were flagged as not required were tied off (made unusable)

Change Idea #2 ☑ Implemented ☐ Not Implemented

Reduce restraints through elimination of restraints no longer necessary.

Process measure

- # of residents with restraints # of restraint audits completed # of restraints discontinued

Target for process measure

- 100% of residents with a restraint will have an audit completed in 2024. 10% of restraints will be discontinued

Lessons Learned

100% of residents with an order for a restraint were audited in 2024 to determine if the restraint was necessary. Registered staff were reminded regularly to consider the appropriateness and need of restraints for their residents.

Change Idea #3 ☑ Implemented ☐ Not Implemented

Regular review of seatbelts in use on wheelchairs to prevent inappropriate restraint use

Process measure

- Total # of chair/bed/seatbelt audits weekly/monthly Total # of seatbelts audited Total # of seatbelt restraints removed Total # of seatbelts not in use, tagged "do not use"

Target for process measure

- 20% of seatbelt restraints that are audited will be removed 100% of seatbelts not in use and not required will be tagged "do not use"

Lessons Learned

Audits were completed as scheduled.

Comment

We have been very successful in reducing restraint use. We will continue to work on decreasing restraint use with the ultimate goal of achieving a zero restraint home.

Results