# Implementation Plan Status Report for July - September 2025

St. Pat’s has an Implementation Plan for our Strategic Priorities that is aimed at advancing them in a systematic way spread over the lifetime of our 2022 – 2026 Strategic Framework. The Implementation Plan is updated annually based on the priorities and what is achievable. A Status Report of the 2025 Implementation Plan will be reviewed by the Board of Directors quarterly and is also posted in the Home as a communication tool for residents, staff and families. This Status Report is also posted on our website.

| Person-Directed Focus | Quality Improvement Initiatives | LEAD | SUPPORT/TEAM | OUTCOME TARGETED | ACTIONS | MEASURES | TARGET/GOAL | TIMELINE | ADJUSTED TIMELINE | CURRENT STATUS | STATUS REPORT Q1 | STATUS REPORT Q2 | STATUS REPORT Q3 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Resident Engagement and Contribution | **Person Directed Meal Service** | Paul | Quality Person-Directed Care Advisory Committee | SP1:ABC | 1) Create a team responsible for the overall project | Resident QOL survey | Increase satisfaction of the residents for the indicator: Food and Meals on the QOL survey for 2026 by 5%, from overall average of 56% to 61% | **Q2** | | **Completed** | Planning for this iniative to start. Reviewed with Resident Council and Leadership in finalizing the plan for initiation of the project and gathering team members. | Project team members chosen and meeting scheduled for July 30th . | |
| | | | | | 2) Create the philosophy of person directed meal service | | | | | **Started** | | To be started at the July 30th meeting. Meeting materials prepared for the meeting | The team has developed a draft philosophy that is pending review and approval by Leadership and the Residents' Council. |
| | | | | | 3) Using the QOL survey, add team members from each home that will be involved in the project for their area. | | | | | **Started** | | Will be starting on Carlow. Planning for Process mapping and additional members to be included. | This is still the plan, but delayed getting volunteers for Carlow, as the team conducted an additional SurveyMonkey survey focused on resident meal service, which has now been completed across all RHAs. |
| | | | | | 4) Process mapping on one of the home areas | | | | **Q4** | **Not Started - Timeline Adjusted** | | Timeline adjust for start date in August | Due to the teams decision to do additional targeted meal service surveys on all RHAs in addition to the QOL survey the process mapping as been moved to Q4. |
| | | | | | 5) Identifying gaps and barriers | | | | | | | Timeline adjust for start date in August | |
| | | | | | 6) Create an action plan | | | | | | | Timeline adjust for start date in August | |
| | | | | | 7) Implement plan with PDSA cycles | PDSA results | | **Q3** | **Q4** | **Not Started - Timeline Adjusted** | | | |
| | | | | | 8) Evaluate each cycle, adjust plan until cycle is effective | | | | | | | | |
| | | | | | 9) Discuss results with Resident Council and Family/Friends Council for feedback | | | | | | | | |
| | | | | | 10) Implement whole process with other home areas, one at at time. | | | **Q1 2026** | | **Not Yet Due** | | | |
| Resident Engagement and Contribution | **Person-Directed Recreation and Leisure** | Robert | Residents/BSO/Recreation/ QPDCAC | SP1:ABC | 1) Conduct process mapping with the interdisciplinary team | Residents, Staff & Family responses & comments | Increase satisfaction of the residents for the indicator: Activities on the QOL survey for 2025 by 5%, from overall average of 37% to 42% | **Q1** | | **Started** | Interdisciplinary team with residents and family met several times and process mapping and gap analysis completed. | | |
| | | | | | 2) Identify gaps and barriers | | | | | | | | |
| | | | | | 3) Develop action plan | QOL Survey Results | | **Q2** | | **Completed** | Interdisciplinary team with residents and family to develop an action plan. | | |
| | | | | | 4) Finalize the philosophy of person-directed recreation and leisure | | | | **Q3** | **Started** | | Philosophy is created in draft for approval at leadership in August | Input provided by Leadership and brought to Resident Council in Sept for feedback. Resident Council will provide feedback on Nov meeting. |
| | | | | | 5) Implement the plan using PDSA cycles in the RHA with the lowest score on the QOL survey | | | | **Q3** | **Started** | | PDSA Cycle started on July 1 on Cavan, Carlow and Waterford. | Ongoing |
| | | | | | 6) Evaluate each cycle and adjust the plan until it is effective | Residents & Residents Council Response, Audit, | | | | | | | Adjustments have occurred. |

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| | | | | | 7) Discuss results with the Resident Council and Family/Friends Council for feedback | Residents co-created input & results/responses from Residents on Activity Pro satisfaction scale | | **Q4** | | **Started** | | | Will discuss adjustments at next residents council Nov 5th. |
| | | | | | 8) Implement the revised process in other RHAs, one at a time | Results/responses from Residents on Activity Pro satisfaction scale, Staff & Families Questionnaire, Audit and Residents Co-created input & Results & Activity Pro Results. | | **Q1 2026** | | **Not Yet Due** | | | |
| Staff Engagement | **Kindness Teamwork** | Monique | Leadership | SP1:C SP2:D | 1) Create content of education for teamwork with a kindness theme and get leadership team approval | QOL Survey Results | Increase satsifaction of the residents of the indicator: staff responsiveness by 5% from 61% to 66% in 2026 resident QOL survey | **Q1** | | **Started** | Education presentation was created and sessions booked. | Education sessions started and there has been positive feedback from staff. Slides and content have been revised based on feedback. | |
| | | | | | 2) Plan education times and schedule | | | **Q1** | | **Completed** | Education shedule and plan are completed. | | |
| | | | | | 3) Educate all staff including newly hired staff | | | **Q4** | | **Started** | ongoing | ongoing | ongoing |
| | | | | | 4) Create St. Pat's team charter from the sessions and post on every home area and work spaces, after a review with frontline staff on final version | | | **Q1 2026** | | **Started** | | | Information is being collated as the sessions are done. |
| Quality Person-Drected Care | **Quality Improvement** | Korry | Quality Person-Directed Care Advisory Committee | SP1:B SP2: ABC | 1) Review current policy and identify gaps for Quality Improvement Program | Inspection reports | Improve all findings from Ministry of Long Term Care inspections by 5% for 2026 from 20 to 19 | **Q2** | **Q3** | **Completed** | Policy review initiated | Onging review, need survey results to complete | A Person-Directed Quality Improvement and Risk Management Framework has been developed and was presented to QIRM in September.<br><br>Policy development to support the framework is currently underway. |
| | | | | | 2) Create a whole home audit program using GO Audit and Sodexo software, including the standardized process, timelines and resulting QI activities from the evaluation. | | | **Q3** | **Q4** | **Started** | | | Survey created to determine audit needs. |
| | | | | | 3) Educate and Implement the program with Leadership Team | | | **Q4** | | **Not Yet Due** | | | |
| | | | | | 4) Roll out the audit program to the staff | | | **Q1 2026** | | **Not Yet Due** | | | |

**Started**
**Not Started - Timeline Adjusted**
**Completed**
**On Hold**
**Not Yet Due**

**STRATEGIC PRIORITY 1: The best possible quality of life for every resident**

**Outcome A:** Our care is guided by residents' preferences and needs for physical, emotional, social, spiritual and psychological wellbeing.
**Outcome B**: Our flexible processes and ways of working accommodate different and changing needs.
**Outcome C:** Everyone in our St. Patrick's Home family has greater opportunities to engage with each other and with the larger community.

**STRATEGIC PRIORITY 2: Consistent, person-directed, quality care and support**
**Outcome A**: We match our level of care to residents' individual needs and strive to always provide the best quality care possible.
**Outcome B**: Staff feel equipped and empowered to provide quality person-directed care.
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| Quality Person-Directed Clinical Care | **Improve Skin Integrity of Residents** | Jeena | Skin and Wound and Nutrition Team | SP2: A,C | 1) Provide all PSWs with wound prevention education delivered by Best Practice experts. | Inter-RAI inhouse data | To improve wound preventions by educating staff aimed at reducing the percentage of new internally acquired Stage 2-4 wounds among residents from 4.28% to 3.20% by the end of 2025. | **Q2** | | **Started** | Sessions held with our contracted NSWOC with Nursing staff in March on wound preventions. Comprehensive education focus on prevention of wounds embedded into mandatory education presentation. Mandatory sessions have started. | NSWOC plans to come in September to do Wound Care Education with Evening PSWs. Day shift was already completed in March 2025. | Plan has changed to our in-house SWAN nurses completing the Wound Care Education with our Evening PSWs. These evening sessions will occur in Q4. Day shift already completed in March 2025. |
| | | | | | 2) Embed skin and wound education into this year's Mandatory Education with emphasis on prevention. | | | **Q1** | | **Completed** | Education materials completed and being used at sessions. | | |
| | | | | | 3) Complete the education at Mandatory Education for all Nursing staff. | | | **Q4** | | **Started** | ongoing education | ongoing education | ongoing education |
| | | | | | 4) Follow up on audit results with staff, assisting them to be compliant with the MOLTC regulations and home policy on Skin and Wound care. | | To improve wound care for the residents by improving new wound audits by 25% from 50% to 75% by Dec.31, 2025 | **Q4** | | **Started** | ongoing education being done | ongoing education being done | ongoing education being done |
| Quality Person-Directed Clinical Care | **Reduction in Medication Errors** | Annik | Medication Safety Team | SP2: C | 1) Identify the gaps in the medication errors that are reported | CHIHI data on Med reporting site | Reduce Medication Errors by 5% from 120 incidents to 114 incidents by Dec. 31/2025 | **Q2** | | **Completed** | | Monique will update Jeena and Annik on the work done previously. Eight (8) FMEA's were completed in the previous medication project that will need reviewing to revitalize the project. | FMEAs were reviewed the Medication Management Committee in September 2025 and medication error gaps were identified and agreed upon. |
| | | | | | 2) Continue interventions from the process mapping that was completed previously, working on the FMEA's and resulting risks identified to create an action plan | | | **Q3** | | **Started** | | Monique plans to review identified area for action with Nursing Leads | Briefly discussed with Medication Management Committee in September 2025. Sub-committee meeting booked in Q4 to create detailed action plan. |
| | | | | | 3) Priorize the action plans and implement interventions as the team priorities. | | | **Q4** | | **Not Yet Due** | | | |
| | | | | | 4) Evaluation of the medication Administration process through a new process mapping to compare to previous one. | | | **Q1 2026** | | **Not Yet Due** | | | |
| Resident Safety | **Increase knowledge and support of the residents with the abuse and whistleblowing legislation** | Monique | Leadership Team | SP1: A SP2: A,C,D | 1) Create the materials to inform residents of the Human Resources process when a resident has a concern and how the Whistleblowing legislation is enforced. | Resident QOL survery results for 2025 | Increase satsifaction of the residents of the indicator: "I can express my opinion without fear of consequences" by 10% from 48.5% to 58.5% in 2025 and 12% to 70 % in 2026 resident QOL survey | **Q2** | | **Completed** | HR and SW collaborated to decide on materal for education sessions. | | |
| | | | | | 2) Plan meetings with residents on Cavan and Carlow to start the education by leadership team or delegates. | | | **Q2** | | **Completed** | | SW student Rayna Bonner created a Residents' Rights fact sheet, which she shares with Residents who participate in rights education. Rayna completed education with Residents who live on Cavan and Carlow. | |
| | | | | | 3) Plan meetings with residents on Dublin, Kerry and Waterford to complete the education by leadership team or delegates. | | | **Q3** | | **Started** | | | SW will begin to meet with Residents who live on Dublin, Kerry and Waterford. |
| | | | | | 4) Execute meetings and document feedback from residents to be provided to Leadership meetings monthly until all the residents are met with. | | | **Q4** | | **Not Yet Due** | | Waiting for feedback from session on 2nd floor | Feedback to be reviewed at August Leadership Meeting |
| | | | | | 5) Complete the 2025 Resident Quality of Life Survey and report results to Leadership and Resident Council | | | **Q4** | | **Not Yet Due** | | | |

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| Resident Cultural Safety and Inclusion | **EDIA-R ICS** | Monique | EDIA-R ICS Team | SP1: A, SP2:C,D | 1) Create Action plan from the evaluation of best practices that was completed in 2024. | CLRI EDI-AR assessment | 15% of staff who have not previously received EDIA-R education will complete an EDIA-R education session by March 31, 2026. | **Q1** | | **Completed** | The 2 impact areas that the Home was strong in were Service and Resident & Family engagement. The 2 impact areas that the Home requires improvement are Education & Training and Planning & Policy. Action planning is based on these areas. | | |
| | | | | | 2) Follow the Promising Practice action plan with the priorities from the team evaluation<br>A) Create EDI education for Mandatory and Orientation for all staff.<br>B) Provide specific sessions for staff on various topics included in EDI education so the staff attending have a variety of interests to be educated.<br>C) Evaluations of EDI-AR by staff included in the home wide Employee Survey | The number of sessions provided to staff who have previously not participated in sessions in the last 3 years. | | **Q1 2026** | | **Started** | | 2A) Mandatory education is completed and sessions are ongoing. 45% of staff are educated. B) Action starting in Q3. C) Company selected for the employee survey. | 2A) Mandatory session is completed. Orientation session is in process.<br>2B) EDI specific topics have started on TV in the lobby and email communication by the committee to all staff.<br>2C) EDI questions will be included in employee survey. |
| | | | | | 3) Review the Health Care Calls To Action and create an action plan related to this mandate. | The number of sessions provided to staff who have previously not participated in sessions in the last 3 years. | 15% of staff and leadership who have not received Indigenous Cultural Safety education in the past 3 years will complete the 5 ICS courses available on the Cancer Care Ontario website, by March 31, 2026. | **Q1 2026** | | **Not Yet Due** | | | |
| | | | | | 4) Provide the resources required for 15% of staff to complete the 5 ICS courses available and recommended on the Cancer Care site. | | | | | | | | |
| | | | | | 5) Provide the resources for more frontline staff to attend the full day education at Wabano | | | | | | | | |
| | | | | | 6) Investigate the opportunity for collaboration with Wabano or Odawa . | | | | | | | | |
| Resident Experience | **Move in Experience** | David/ Annik | Quality Person-Directed Care Advisory Committee | SP2: C | 1) Review the survey created in 2024 and implement the survey in the admission package. | The number of surveys completed monthly | 75% of the Residents/Family that move in complete the survey | **Q2** | | **Completed** | | Survey has been completed and ready to be integrated into the admission package | |
| | | | | | 2) Review survey results quarterly at Leadership Team | | | **Q4** | | **Not Yet Due** | | | |
| | | | | | 3) Provide education on Admission experience using the book, "RECIPE for Empathy: Six Strategies for Turning your Familes into Fans" utilizing the Acronym RECIPE. Teaching relational interactions rather than transactional interactions. | The number of education sessions completed monthly | To decrease the number of written formal complaints by 5% | **Q4** | | **Started** | Education materials completed and integrated in the Kindness Teamwork education and sessions have started. | We continue to provide this education at Mandatory Kindness sessions- 45% of staff completed. | We continue to provide this education at Mandatory Kindness sessions- 72% of staff completed. |
| | | | | | 4) Utilize the RNAO Best Practice resources in Person Directed Resident and Family Admission assessment, integrated into the new Clinincal Guidelines and the InterRai assessment tools. | The number of required assessments completed on admission | 100% of assessments completed | **Q3** | | **Started** | April 1st the new Assessments became live. The team needs to review the resources available and ensure they are being put into practice. | We continue to utilize this assessment. 59% of the residents admitted has had this assessment initated. Nursing Leads will continue to follow up. | We continue to utilize this assessment. 84% of the residents admitted has had this assessment initated. Nursing Leads will continue to follow up |
| | | | | | 5) Engage new residents and families at a Meet and Greet event with the Leadership Team, Resident Council Rep and Family Council Rep on a Bi-Monthly basis or after 6 admissions. | The number of Meet and Greet attendees at each event | 75% of the Residents/Family attend the Meet and Greet | **Q3** | **Q4** | **On Hold** | | | |

**Started**
**Not Started - Timeline Adjusted**
**Completed**
**On Hold**
**Not Yet Due**

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| Resident Community Involvement | **Ontario Association of Resident Council Representation** | David | Resident Council | SP3: A | 1) Support residents on Residents' Council and communicate the events and opportunities that are availble through OARC monthly. | Residents will receive the OARC newsletter | Residents Council will have at least one resident participate in OARC programs. | **Q4** | | **Started** | Our Resident Council President is actively involved in OARC. Monique has been involved in the committee with OARC and submitted St. Pat's resident volunteers that sit with palliative residents for the toolkit. | Our President of Resident Council passed away and a new President of Resident Council was elected. The current President is not yet part of OARC. OARC published a lovely tribute to the Past President and donated money to the Residents in his memory. | Our current President is actively reviewing information about OARC membership and is in the process of deciding whether to participate in OARC activities. |
| | | | | | 2) The home will pay for the OARC membership annually | | | **Q1** | | **Completed** | Invoice paid. | | |
| | | | | | 3) Monique to participate in the Resident Engagement toolkit that will be a guideline to residents having real input into the home in which they live and implement some strategies in the toolkit once available. | St. Patrick's Home engagement ideas are integrated into the OARC toolkit. | Resident Council will have the opportunity to initiate a program from the toolkit or a similar opportunity of their wishes facilitated by the President and CEO | **Q4** | | **Started** | Completed toolkit is not yet available for release yet to the sector. | Toolkit is still ongoing and has not yet been released. | Toolkit is still ongoing and has not yet been released. |
| Advocacy for LTC Residents' Voice | **Membership on External Committees** | Monique | Leadership | SP3: A,B | Leadership team members will continue to look for opportunities to join an external committee that advocates for seniors and vulnerable people in congregate living settings. | The number of committees that a St. Patrick's team member is a associated. | The Leadership team will be associated with a minimum of 4 external committees | **Q4** | | **Completed** | Korry and Monique sit on Person Centered Care Community of Practice and on Eastern Ontario LTC Senior Leadership & Community Partner Quarterly Meeting. Monique is also on the OHE Digital Health Advisory committee, the Ontario Health East LTC Advisory Committee and the COP for Administrators with CHAC. Tracey works with another CHSO organization to provide HR support, sits on the CHAC COP for HHR and the Advantage EDI knowledge exchange committee. | In addition to Q1 status update, Stephen has been on COP for Mission and Spiritual Care and Tracey is on a COP for EDIAR. | Monique is on the NFP Advisory Group with Advantge Ontario as well as Person Centred Care Advisory Committee. |
| Advocacy for Vulnerable Seniors | **Explore opportunities in joining a Ontario Health Team** | Monique | Leadership | SP3: B | Monique to explore the opportunities and risks associated with joining an Ontario Health Team and bring the information to the Leadership Team for feedback. A recommendation will then be brought to the Board with the analysis of the information gathered. | Research on this topic | The Board will decide on whether the home should join an OHT and ensure resident council is in agreement | **Q3** | | **Started** | Research on OHTs has been started . | Monique has reached out to a local OHT for information and is waiting to hear back from them. | Monique spoke with the Lead and there is no cost to the home to join the OHT. OHT lead is providing information and coming for a tour. Provided a memo to the Board in September and more information is required. |

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| **Started** | **STRATEGIC PRIORITY 3: A purposeful partner in the health system** |
| **Not Started - Timeline Adjusted** | |
| **Completed** | **Outcome A:** All of us involved in St. Patrick's Home - residents, families, friends, volunteers and staff - share an understanding of critical health system gaps, identify opportunities and present a strong, collective voice for positive change. |
| **On Hold** | **Outcome B:** We strive to foster greater coordination and connection among health and social service partners, engaging effectively and drawing on our day-to-day understanding of long-term care realities. |
| **Not Yet Due** | |

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| Community engagement and Advocacy for Vulnerable Seniors | Affordable Housing Project | Monique | Cheryl H and Board | Affordable Housing for Seniors with 133 units | 1) Put out Contractor tender package to pre-approved proponents | The building is viable to build and operate | To have Board Approval to start buiding once Financing is approved. | Q1 | Q2 | Completed | Waiting for CCLC to come to an agreed lease with St. Pat's for 2857 Riverside Dr. Waitng for CHMC to provide our funding agreement and once this is completed the HAF agreement will be completed. Due to the Federal Election CMHC is in a blackout and cannot hold meetings. | The finalization of the lease with CCLC is still pending. CMHC has conditionally approved the financing. The preferred proponent is holding until September. | The preferred GC and BTY are coordinatin to confirm an extension of the contract award to March 2026 and what the associated costs will be. |
| | | | | | 2) Obtain a lease from CCLC for 50+ years | | | Q1 | Q2 | Completed | Ongoing | Ongoing | Lease completed on July 24th, 2025 |
| | | | | | 3) Ensure building permits and plan is in order prior to building | | | Q3 | | Started | | Building permit cheque has been issued and the Housing Coordinator will bring to the City. | The finalizing of the Building Permit is still in process. |
| | | | | | 4) Secure Financing from CMHC and approvals from Infastructure Ontario and approval from Board. | | | Q2 | Q3 | Started | | Financing has been approved from CMHC and waiting for the final terms and conditions to be sent to us. | Financing has been approved from CMHC and waiting for the final terms and conditions to be sent to us. |
| | | | | | 5) To plan a ceromonial ground breaking public event tied in with the LTC Homes Annual Public engagement event | | | Q3 | | Started | | Plans are in the planning phase without at date until lease and building permit completed. | Plans are in the planning phase without at date until building permit, financing agreement and GC contract are finalized. |
| | | | | | 6) Leadership team with Housing development Coordinator to work on an operational plan for the building. | Risk assessment and workplan | To complete a work plan for operationalizing the Building by the end of 2025 | Q4 | | On Hold | On hold until financing is secured as well as a lease. | Still on hold until financing is secured as well as a lease. | Still on hold until financing is secured. |

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| Started | **STRATEGIC PRIORITY 4: Supportive affordable housing and services to met community needs** |
| Not Started - Timeline Adjusted | **Outcome A:** Plans to expand housing and services that defer or provide an alternative to long-term care have broad support throughout the St. Patrick's community. |
| Completed | **Outcome B**: We develop our expanded campus thoughtfully, minimizing disruptions and creating new benefits for our home and the broader community. |
| On Hold | **Outcome C:** We secure the funding needed to fulfill our housing plans and provide associated supports. |
| Not Yet Due | |