SOUTHBRIDGE HEALTH CARE LP

Continuous Quality Improvement Initiative Annual Report

Annual Schedule: May 2026

HOME NAME : West Park

People who participated in the evaluation of this report

	Name and Designation	Date of Evaluation
Quality Improvement Lead	Julie Confient - RPN	May 27th 2026
Director of Care	Amanda Perry - RN	May 27th 2026
Executive Directive	Kennedy Clapp - RPN	May 27th 2026
Nutrition Manager	Maria Andrei - FSM	May 27th 2026
Programs Manager	Ashley Collee - Rec Manager	May 27th 2026
Clinical Consultant	Cindy Britton Clinical Consultant - RN	May 27th 2026
Resident Council Representative	John Deeker	May 27th 2026
Family Council Representative	n/a	n/a
Medical Director	Fiona Halliday	May 27th 2026
Other	Victoria Chaisson - RPN	May 27th 2026
Other		

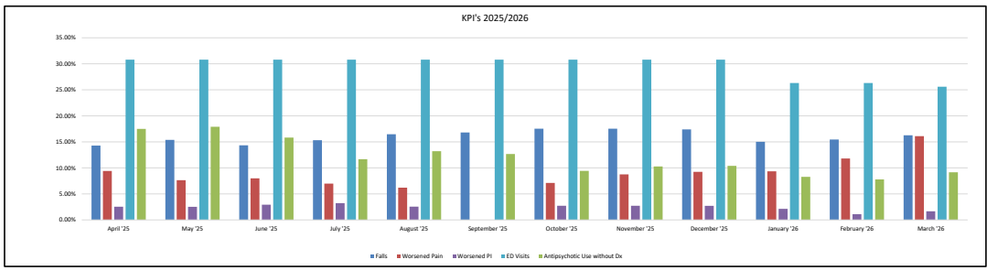
Summary of the Home's priority areas for quality improvement, objectives, policies, procedures and protocols from previous year (2025/2026): What actions were completed? Include dates and outcomes of actions.

Quality Improvement Objective	Policies, procedures and protocols used to achieve quality improvement	Outcomes of Actions, including dates
Rate of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents. Reduce the number of avoidable ED visits by 3.5% by March 2026	**Change idea: Discussion with resident and families, regarding Advance Care Planning:** Discussions were held at admission and annual care conferences and PRN with residents and families regarding Advanced Care planning consistently completed throughout the four quarters. Of the 53 ED visits this past year, 15 (28.3%) were initiated at family/resident request. **Change idea: Review of ED tracker**: A review of the ED tracker led the Leadership team to transition from monthly to weekly interdisciplinary review meetings. The change enabled more timely identification of residents at risk for ED transfers, allowing for earlier interventions and monitoring leading to a reduction in transfers over the last four quarters. **Change idea: Development of IV program in the home:** Eight Registered Staff are currently trained for the in-house IV program. Although no IV therapy needs were identified over the past four quarters, the program will expand this year to recruit new Registered staff and maintain competency through the home's IV training arm. **Change idea: Utilization of the PPS Palliative Performance Score to determine disease progression:** Care plans were consistently reviewed and updated over the past four quarters. The ET nurse made recommendations to the NP/MD to assist in solidifying diagnoses based on PPS scores. The Nurse Practitioner reviewed these scores to identify residents requiring palliative care	The Provincial Average for 2025/2026 was 22.3%%. The home's KPI for March 2025 was 30.8% with a goal of reducing the KPI by 3.5% by March 2026. By implementing the actions outlined, the Home has successfully surpassed the initial goal of a 3.55% reduction in Avoidable ED visits and achieved a reduction of 4.55% surpassing the original target by 1%. The Current KPI for March 2026 is 26.25%
Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education To maintain current performance of 100% by March 2026	**Change idea: Diversity training through Surge education or live events:** 100% of active staff completed Diversity training through surge learning over the last four quarters. **Change idea: Open Door policy:** The leadership team consistently maintained an open door policy throughout the year. Leadership remained committed to supporting the open communication, encouraging feedback, and advocating for regulatory compliance while fostering a culture of transparency and continuous improvement. **Change idea: Cultural Diversity Topic of the month:** Topic of the month was not fully implemented as planned, due to leadership changes during the year. A Diversity Program was established and became active in February 2026. The program continues to be updated monthly and includes educational materials, activities, and awareness initiatives for both staff and residents. This approach suports ongoing diversity, equity and inclusion efforts within the home. The home did include diversity topics throughout the homes activities but did not maintain the topics at the monthly mandatory program meetings, CQI meetings, huddles and departmental meetings. **Change idea: Cultural Board:** The Culture board was not implemented as planned in the change idea. The Culture board is now active and continues to be updated monthly.	100% of diversity training was completed by staff by December 2025. As of February 2026, the Diversity Program was implemented and the Culture board is now active and continues to be updated monthly. The effectiveness of the Open Door policy between leadership and staff is evidenced by the staff survey results of the October 2025 and based on the complaint process.
Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences".	**Change idea: Increase in Frequency of Review Resident Bill of Rights with a focus on Resident Rights #29 at Resident Council meetings:** There was an increase in reviewing the Bill of Rights in the past year at Resident Council meetings as evidence in the signed resident council minutes. **Change idea: Whistleblower Policy:** The Whistleblower Policy was added to all admission packages during the past year to ensure residents and families are informed of their rights ana available reporting mechanisms. In addition, a review of the policy during care conferences was initated in March 2026 and is now incorporated as part of the ongoing review process to promote awareness and understanding among residents and families. **Change idea: Complaint and Concern process:** is reviewed on admission, during annual Care Conferences, at the Resident Council meetings and as a standing agenda within leadership and staff meeting minutes. Communication sheet posted at the front entry to help aid families and residents to address any concerns.	The effectiveness of the Change ideas and maintaining an Open Door policy is evidenced by the survey results of the October 2025. Resident Satisfaction Survey which indicted that residents felt empowered to raise concerns and express their views without fear of negative repercussions. The goal for this indicator was to increase the Resident Satisfaction score from 85.71% in 2024 to 90.0% in 2025, representing a targeted improvement of 4.29%. The home exceeded this goal achieving a score of 97.92% which represents an overall increase of 12.21% from the previous year and surpasses the established target by 7.92% . The Family Satisfaction score was 90.92% from 87.24% in 2024. These results demonstrate the success of the home's efforts to promote open communication. By December 2025, 100% of staff completed education on the Whistleblower policy. In the past year the home received 16 complaints which was 22.5% compaired to 2024, 18 complaints which was 25.35%. This shows a decrease in complaints overall year to year.
Percentage of Long Term Care residents who developed worsening pressure injury stage 2-4	**Change idea: Education on wound care assessment and management:** Education was provided by the Enterostomal Therapy (ET) Nurse during wound care round throughout the year. In addition, the Medline Consultant provided education to frontline staff regarding skin assessment, wound managment, and the appropriate use of skin care products. Two in-house education sessions facilitated by medline were conducted on March 3, 2025 and August 14, 2025. In November 2025, a new Wound Care lead was appointed and began providing ongoing education and support to frontline staff related to wound assessments, documentation, treatment interventions, and bes practices in wound care management. The Wound Care Lead is currently enrolled in the SWAN (Skin and Wound Awareness Nurse) Program to further enhance wound care knowledge and leadership within the home. **Change idea: Referral to ET Nurse:** Referrals to the Enterostomal Therapy (ET) Nurse continued throughout the year and have been sustained over the past four quarters. The ET Nurse provided ongoing support and mentorship to the Wound Care Lead, assisting with wound assessments, treatment recommendations, and care planning. Referrals continue to be made as required through the ET Nurse referral process. In addition, the ET nurse conducts scheduled on-site visits every six weeks to support wound care management, review resident outcomes and provide clinical guidance and education to staff. **Change idea: Monthly Review at Quality Meetings of Resident's with Pressure related injuries:** Residents with pressure-related injuries were line listed in the Skin and Wound tracker and reviewed monthly at the Quality Committee Meetings. The reviewes included an evaluation of each resident's care plan, wound progression and healing status. The interdisciplinary team discussed factors contributing to wound healing or lack of improvement with implementation of additional preventative measures, updating care plans, referrals to outside resources i.e. ET nurse. **Change idea: Audit of pressure relief devices:** Pressure relieving devices continue to be utilized and monitored in accordance with the manufacturer's instructions. PURS review audits are conducted monthly; however resident compliance with offloading and repositioning interventions are not alway 100%. Audit results are reviewed monthly prior to Quality Committee meetings and discussed with the interdisciplinary team to evaluate the effectiveness of current interventions and identify areas for improvement. These discussions support ongoing efforts to prevent Pressure related injuries and ensure that the equipment is used appropriately and effectively in accordance with the manufacturer's	In December 2025, the home's Key Performance Indicator (KPI) was 2.7%, with a goal of reducing the rate by 0.5% to 2.2.% by March 2026. By March 2026, the home exceeded this goal, achieving a rate of 1.65%, representing a reduction of 1.05%. The home also performed below the Corporate benchmark of 2.5%. The implemented change ideas were successful in improving the KPI throughout the year.
Percentage of LTC home residents who fell in the 30 days leading up to their assessment	**Change idea: Create activity bins for engagement:** The initiative to create individual activity bins for resident engagement was started; however, infection Prevention and Control (IPAC) concerns were identified based on existing policies and procedures. As a result, the original plan was modified. A master activity bin was developed and is maintained and cleaned by the Recreation department after each use, and in accordance with IPAC practices. In addition, an activity board utilizing disposable materials was implemented to provide opportunities for meaningful engagement while supporting compliance with IPAC policies and procedures. The resident's can participate in activities while maintaining a safe environment. The data does not line up with a decrease in falls however it does show resident engagement increasing as per welbi program lookback. **Change idea: Purposeful rounding:** Rounding practices were sustained throughout the four quarters as per the policy. Monthly Quality Committee meeting minutes identified high risk fall timeframes, which were reviewed by leadership and communicated to frotnline staff to support enhanced rounding and fall preventioin efforts during peak risk periods. A new Falls Lead was appointed within the last two quarters and continues to provide ongoing education to frontline staff regarding fall prevention stragegies, high risk fall times and resident specific interventions. The Falls Lead is responsible for maintaining the Falls Tracker, analyzing trends and outcomes and sharing findings with the interdisciplinary team. In addition, the Falls Lead has implemented monthly falls huddles,The policy related to rounding were sustained throughout the four quarters. Monthly quality minutes outline the high falls time frames which leadership then heightens rounding including front line staff. New falls lead has started within the last two quarters and continues to educate frontline staff regarding high falls times. Falls lead updates the tracker and analysis the results. Falls Lead has implemented monthly huddles and as needed to review incidents, identify areas for improvement and reinforce best practices. Universal falls precautions remain in place for all residents to support a proactive approach to fall prevention, resident safety and outcomes. **Change Idea: Admission process:** During the Admission Process, a review is completed with the resident and family of the resident's fall history, risk factors and effective intervention.. The RAI Coordinator completes a Face sheet which is distributed to the interdisciplinary team prior to admission to promote awareness of identified risks for care planning. This process enables the team to implement appropriate falls prevention interventions aupon admission and helsp to ensure a	The home's KPI for April 2025 was 14.34% which was below the Corporate benchmark of 15%. The goal was to continue to maintain below the Corporate benchmark. However throughout the remainder of the year, the KPI increased, reaching 17.53% in December 2025 and 16.26% in March 2026. Although there was a slight improvement between December 2025 and March 2026, the home remained above the Corporate benchmark by March 2026. With the appointment of a new Falls Lead in the last two quarters and a continued focus on fall prevention strategies, the home's goal is to achieve and sustain the Corporate benchmark while enhancing resident safety and and reducing fall related risks to improve resident outcomes.
Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment	**Change idea: Monthly review of resident's prescribed antipsychotic medication:** Monthly review for supporting diagnosis and indication for use are conducted by the Leadership team in collaboration with the Nurse Practitioner. The home continues to hold regular antipsychotic review meetings to suppor the ongoing reduction efforts where clinically appropriate and to ensure appropriate prescribing practics are maintained. The interdisciplinary team remains active n supporting residents through the Behavioural Supports Ontario (BSO) team and the Geriatric Psychiatry team for residents with complex behavioural needs. The team assists in identifying individual strategies to optimize care and reduce the reliance on antipsychotic medications. The Nurse Practitioner continues to audit new admissions to support appropriate prescribing practices including tapering discontinuation and deprescribing where clinically indicated. Referrals to Geriatric Psychiatry are mde when tapering is not recommended or unsuccessful. **Change idea: Quarterly Review of resident's prescribed antipsychotics medication:** Residents who are prescribed antipsychotic medications for the management of responsive behaviours had and continue to have a quarterly review to assess the ongoing need for the medication. The review focuses on evaluating the potential for dose reduction or discontinuation , where clinically appropriate. Home continues to identify triggering residents that qualify for reduction or discontinuation of antipsychotic medication. Audit of symptoms continues based on the criteria surrounding antipsychotics. Tapering continues to be discussed and implemented at the home's monthly antipsychotic meetings. **Change idea: Gentle Persuasive approaches (GPA) coaches:** The training opportunities for the internal GPA coach were limited during the last four quarters due to oerpational challenges, including leadership changeover, staff unavailability and limited session availability. As a result, formal internal coach training was not initally completed as planned. Despite the challeges, GPA was successfully rolled out in the second quarter with support from the Psychogeriatric Resource Consultant (PRC) and in collaboration witha sister home's GPA coach. This ensured that foundational education and support strategies were still implemented within the home. The home currently has a certified and trained GPA coach who is able to coordinate and schedule future GPA education sessions for staff. This will support ongoing capacity building, consistent use of GPA techniques and improve strategies for residents exhibiting responsive behaviour. **Change Idea: Antipsychotic Trackers:** A tracking system is maintained and reviewed monthly by leadership as part of the monitoring and drill through exercises to ensure ongoing analysis and evaluations related to antipsychotic use.	The home's antipsychotic use without a diagnosis KPI was 21.12% in April 2025 and demonstrated a steady decline throughout the remainder of the year. By March 2026 , the KPI had decreased to 9.15% representing an overall reduction of 11.97%. The implemented change ideas were successful in reducing antipsychotic use without a diagnosis and contributed to significant improvements in resident outcomes. The home not only achieved but substantially exceeded the Corporate benchmark of 17.5% demonstrating the effectiveness of ongoing medication reviews, interdisciplinary collaboration and resident centred approaches to care.
Precentage of LTC residents that develop worsening pain	**Change idea: End o f Life and Palliative Care program:** Palliative care conferences were held to support residents and families in developing end of life care plans and goals of care discussions. A palliative care cart was implemented June 2025 to provide comfort items and resources for families, to enhance the support avaialbale during end of life care. A reclinder chair was also provided to improve family comfort. Palliative care education was conducted on October 2025 and Novemeber 2025 and presented by the Director of Care and Assistant Director of Care to all departments. The Nurse Practitioner continues to complete the comprehensive pain assessments for resident's receiving palliative care. **Change idea: Utilization of Pain tracker:** The utilization of the pain tracker continues to be sustained within the home and is reinforced during morning report discussions. The Pain tracker serves as a trigger tool to ensure timely completion of assessments and supports early identification of resident' experiencing pain or discomfort. When concerns are identified, appropriate referrals are made to the Nurse Practitioner for further assessment , to guide interventions and care planning and addresses a timely response to resident's changing needs. **Change Idea: Adjuvant and nonpharmacological interventions:** Non pharmacological interventions have been incorporated into the resident care plan as part of the home's pain management approach. However, the effectiveness and acceptance of these interventions vary, and they are not sonsistently well received by some residents, which presents a challenge in providing alternative therapies for pain management. The interdisciplinary team continues to promote an offer non pharmacological strategies.	The Worsened Pain KPI was 9.48% in April 2025, 8.33% in June 2025. In the fourth quarter, there was a notable increase, with the KPI rising to 16.1% by March 2026. The Corporate goal was 8.5% which the home did not consistently meet during the latter part of the year. The escalation observed in the fourth quarter coincided with the roll out of a new process in July 2025, which may have impacted the home's ability to achieve the Corporate target as well as a change in leadership in the RAI Coordinator role . The home is currently reviewing the KPI data, with a focus on routine medication administration practices in relation to pain score promtpting to better understand contributing factors and identify opportunities for improvement in pain manageent and documentation accuracy.

The 2024 Resident Satisfaction Surveys The Resident's Top 5 areas of Opportunities are: 1.Communication from home leadership is clear and timely (75.90%) 2.My concerns are addressed in a timely manner (75.89%) 3.Overall, I am satisfied with communication from home leadership (72.62%) 4.Continence care products are available when I need them (70.65%) 5.Iam satisfied with the quality of care from: Social Worker/Social Service Worker (53.33%)	1. A clear, concise monthly newsletter has been developed and distributed to outline changes, upcoming events, and important updates, ensuring that the language used is simple and accessible for all residents. In addition, leadership and staff have been provided with communication training focused on active listening, clarity in conveying information, and maintaining a compassionate and transparent approach in all interactions. 2. All staff have been re-trained on the resident complaint process through weekly huddles and Surge blasts to reinforce understanding and consistency in practice. Additionally, focus groups have been established outside of Residents' Council to provide residents with opportunities to share their experiences, identify areas for improvement, and suggest solutions directly to leadership. 3. Focus groups outside of Residents' Council were created allowing residents to discuss their experiences, identify areas for improvement, and suggest solutions directly to leadership 4. Surveys and one-on-one conversations have been conducted with residents to determine their preferences for continence care products, ensuring that preferred products are readily available. Additional training has been provided to staff on the proper use and timely distribution of continence care products to support residents' comfort and dignity. Communication has been reinforced to all frontline staff regarding the availability of back-up stock located in Kennedy's office. PSWs have also continued to complete their audits to maintain accountability and monitor ongoing compliance. 5. Residents have been informed when their social work referrals have been submitted, ensuring transparency and awareness of next steps. Communication has also been provided regarding the social worker's schedule to support accessibility and planning. This information has been included in the quarterly newsletter to keep residents and families informed. Additionally, Residents' Council discussions have incorporated education on the role of the social worker, including whether residents are receiving social work services, with the Social Worker, Brooke, invited to attend and engage directly with residents.	**The 2025 Resident Satisfaction Surveys Results** 1.Communication and Concerns: Communication from home leadership is clear and timely (84.70%) (Improved) 2.My concerns are addressed in a timely manner (80.91%) (Improved) 3.Overall, I am satisfied with communication from home leadership (87.29%) (Improved) 4.Continence care products are available when I need them (98.90%) (Improved) 5.Iam satisfied with the quality of care from: Social Worker/Social Service Worker (95.17%) (Improved)
The 2024 Family Satisfaction Surveys **The Families Top 5 areas of Opportunities are:** 1. I am satisfied with the quality of care from the doctors (75.00%) 2. The resident has input into spiritual care programs (73.88%) 3. The resident has input into the recreation programs available (70.76%) 4. The resident has access to footcare when needed (69.73%) 5. The resident has access to a hairdresser when needed (60.82%)	1. As Resident issues arose, MDC's were arranged with participation of the Physician in a timely manner allowing for an increase in communication with the POA's/families. POA's were and continue to be encouraged to plan visits around Physician scheduled days. 2. Home provided opportunities for focus groups setting with residents to gather their preferences for spiritual care programs, including religious services, meditation, or other spiritual activities. 3. The Home continued to encourage resident participation in organizing and/or leading activity programs. Recruitment for Family volunteers continued through the admission process, surveys, and meaningful conversations 4. The home communicated access to foot care services through the family newletters ahead of scheduled foot care clinic days, which encouraged families to be present with the resident during the treatment. On admission, residents and families are made aware of the regular schedule. Based on the Foot Care Nurse's assessment, external Referrals to chiropodists and podiatrists continued for complex cases in support of the Nurse Practitioner. BSO continued to support the service. 5. The Recreation Manager ensured family members were made aware of the hairdresser's schedule and how to make appointments through additional signage, newsletters and email blasts.	**The 2025 Family Satisfaction Surveys Results:** 1. I am satisfied with the quality of care from the doctors (97.92%) (Improved) 2. The resident has input into spiritual care programs (83.82%) (Improved) 3. The resident has input into the recreation programs available (86.21%) (Improved) 4. The resident has access to footcare when needed (90.00%) (Improved) 5. The resident has access to a hairdresser when needed (89.06%) (Improved)

Key Perfomance Indicators

KPI	April '25	May '25	June '25	July '25	August '25	September '25	October '25	November '25	December '25	January '26	February '26	March '26
Falls	14.29%	15.38%	14.34%	15.32%	16.47%	16.80%	17.53%	17.53%	17.39%	15.01%	15.45%	16.26%
Worsened Pain	9.40%	7.63%	7.98%	6.98%	6.19%	NR	7.10%	8.74%	9.24%	9.34%	11.80%	16.10%
Worsened PI	2.54%	2.52%	2.92%	3.23%	2.55%	NR	2.72%	2.72%	2.70%	2.13%	1.10%	1.65%
Antipsychotic Use without Dx	17.50%	17.90%	15.82%	11.66%	13.21%	12.66%	9.43%	10.26%	10.39%	8.28%	7.79%	9.15%
ED Visits	30.80%	30.80%	30.80%	30.80%	30.80%	30.80%	30.80%	30.80%	30.80%	26.30%	26.30%	25.60%



How Annual Quality Initiatives Are Selected

The continuous quality improvement initiative is aligned with our mission to provide quality care and services through innovation and excellence. The home has a Continuous Quality Improvement Committee comprised of interdisciplinary representatives that are the home's quality and safety culture champions. An analysis of quality indicator performance with provincial benchmarks for quality indicators is completed. Quality indicators below benchmarks and that hold high value on resident quality of life and safety are selected as a part of the annual quality initiative. Emergent issues internally are reviewed for trends and incorporated into initiative planning. The quality initiative is developed with the voice of our residents/families/POA's/SDM's through participation in our annual resident and family satisfaction survey and as members of our continuous quality improvement committee. The program on continuous quality improvement follows our policies based on evidence based best practice.

Summary of Resident and Family Satisfaction Survey for Previous Fiscal Year

Date Resident/ Family Survey Completed for 2024/25	Surveys were conducted from October 1st to October 31st, 2025.
Results of the Survey (*provide description of the results*):	80.83% of the residents and 84.90% of the family members would recommend this home to others; The Overall Satisfaction resident rate in 2025 is 88.61% above the 2024 of 85.36%. For family satisfaction overall survey in 2025 is 87.81%, which was also above the 2024 rate of 83.73%.
How and when the results of the survey were communicated to the Residents and their Families (including Resident's Council, Family Council, and Staff)	The results of the Resident and Family Satisfaction survey was communicated to Residents during Council Meetings as of March 2026. Survey results were posted at front lobby on the QI board & Communication board for families and visitors and during tours the quality board and communication board is discussed.

Client & Family Satisfaction	Resident Survey				Family Survey				Improvement Initiatives for 2026
	2026 Target	2025 (Actual)	2024 (Actual)	2023 (Actual)	2026 Target	2025 (Actual)	2024 (Actual)	2023 (Actual)	
Survey Participation	90.00%	88.61%	100.00%	76.00%	100.00%	87.81%	100.00%	25.49%	1) promote give aways & incentive to gain buy in for completing surveys 2) post QR board at front entrance to promote filling out surveys
Would you recommend	82.00%	80.83%	90.00%	83.75%	90.00%	84.90%	90.00%	84.44%	1) Advocate for google reviews based on feedback received from families. 2) create a new admission process to create a better experience for residents being admitted.
If I have a concern, I feel comfortable raising it with the staff and leadership	92.00%	90.92%	90.00%	88.42%	100.00%	91.67%	90.00%	92.31%	monthly basis by program Manager during Resident Council meeting. Re-education and review to all staff on Resident Bill of Rights specifically #29 at department meetings monthly by department managers. 2) 100% of admissions packages will include the resident bill of rights. 3) Review of reporting policies with resident and family during care conferences.

Summary of quality initiatives for 2026/27: Provide a summary of the initiatives for this year including current performance, target and change ideas.

Initiative	Target/Change idea	Current Performance
Rate of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents.	**Change idea #1]** To reduce unnecessary hospital transfers, using on-site Nurse practitioner. **Change idea #2)** Build capacity and improve overall clinical assessment skills of Registered Staff; through education supported by Nurse Practitioner. **Change idea #3) Utilization of the PPS Palliative Performance Score assessment to determine disease progression.** **Change idea #4]** Implementation of the Nursing PLEDGE Initiative program to build capacity and improve overall clinical assessment skills of Registered Staff by supporting mentorship of nurses, enhancing quality of care and workforce stability. Target: 22.25%	January 2026: 26.25%
Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education	**Change idea #1] To improve overall dialogue of diversity, inclusion, equity and anti-racism in the workplace** **Change idea #2)** Sustaining a culture board, of the cultures of the resident and team members in the home Target: 100.0%	December 2025: 100%
Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences".	**Change idea #1)** To increase our goal by 2% from 90% in 2025 to 92% in 2026. In 2025 our percentage was 97.92% which surpassed our goal of 90% as compared to previous year that was 86%. **Change idea #2)** Bill of rights included in admission package **Change idea #3)** Engaging residents & families in meaningful conversations during care conferences Target: 90.0%	October 2025: 86.67%
Percentage of LTC home residents who fell in the 30 days leading up to their assessment	**Change idea #1]** To reduce the number of falls in the home **Change idea #2)** To facilitate a monthly Huddles on each unit; with the interdisciplinary team **Change idea #3)** Purposeful rounding, for resident at high risk for falls Target: 15.0%	September 2025 : 16.39%
Percentage of LTC residents who develop worsening pain	**Change idea #1]** Utilization of pain tracker, to monitor the use of prn analgesic **Change idea #2)** Admission, comprehensive assessment of pain, and how this has been managed previously, and the goal for pain management **Change idea #3)** Provide non-pharmacological interventions in the plan Target: 8.0%	December 2025: 9.29%
Precentage of LTC residents whose stage 2 to 4 pressure ulcer worsened	**Change Idea #1]** Conducting audit of resident surface (bed/w/c), for the appropriate surface for pressure relieving. **Change idea #2)** Skin and Wound lead attending accredited wound care lead education. **Change idea #3)** Quarterly education on Identification and documentation of skin integrity Target: 2.0%	September 2025: 2.21%
2025 Family Satisfaction Survey, Top 5 areas of Opportunities are: 1. I am satisfied with the quality of laundry services for personal clothing (81.48%) 2. I am satisfied with the quality of laundry services for linen (81.48%) 3. I am satisfied with the timing and schedule of recreation programs (80.88%) 4. I am satisfied with the variety of spiritual care services (80.77%). 5. I am satisfied with the timing and schedule of spiritual care services (80.77%)	**Action Plan for improvement:** 1. Provide families within newsletters with clear labeling routines. Offer monthly reminders within newsletters to encourage families to purge clothing inventories. Improve communication by residents and families by sending timely notifications of any items that are damaged or missing. 2. Spot audits for linen cleanliness and conditions. Ensure replacement of worn linens and communicate changes to families, staff and residents. Establish a linen committee into the continence committee. Implement a linen tracker for up-keeping. 3. Send families a Monthly recreation email or printed calendar. Offer programs at family-friendly times so they can join when visiting. 4. Survey families on their loved one's spiritual background and needs. Bring in diverse spiritual and cultural leaders to reflect resident and family backgrounds. Add non-faith spiritual options such as meditation, music reflection, and storytelling. 5. Avoid scheduling conflicts with meals, therapies, and popular recreation activities. Post a calendar on program activity board	**2025 Family Satisfaction Survey Results:** 1. (81.48%) 2. (81.48%) 3. (80.88%) 4. (80.77%). 5. (80.77%)
2025 Resident Satifaction Survey, Top 5 areas of Opportunities are: 1. I trust the staff in my home (83.33%). 2. I am satisfied with the variety of spiritual care services (83.33%). 3. Staff take the time to chat with me (81.97%). 4. My concerns are addressed in a timely manner (80.91%). 5. Overall, I am satisfied with the meal, beverage and dining services (80.83%)	**Action Plan for Improvement:** 1.Use consistent staff assignments so residents see the same caregivers. Train staff on clear communication and explaining care steps. Leadership completes weekly rounds to check in with residents. 2. Survey residents on spiritual preferences. Bring in community faith leaders and volunteers. (pastors). Create/refresh a quiet multifaith reflection space. 3. Require staff to have one meaningful conversation per shift with each assigned resident. Train on active listening and engagement. Integrate social moments into ADLs. 4. Implement a simple concern-tracking process. Always close the loop: tell residents what was done. 5. Hold monthly menu feedback. Improve dining room atmosphere (music, décor, seating). Establish food committee. MBWA food tasting including time frames	**2025 Resident Satisfaction Survey Results:** 1. (83.33%). 2. (83.33%). 3. (81.97%). 4. (80.91%). 5. (80.83%)

Process for ensuring quality initiatives are met
Our quality improvement plan (QIP) is developed as a part of our annual planning cycle, with submission to Health Quality Ontario. The continuous quality team implements small change ideas using a Plan Do Study Act cycle to analyze for effectiveness. Quality indicator performance and progress towards initiatives are reviewed monthly and reported to the continuous quality committee quarterly.

Participants of Evaluation Name and Signatures:	*Print out a completed copy - obtain signatures and file.*	Date Signed:
Quality Improvement Lead	Julie Confiant	**27-May-26**
Executive Director	Kennedy Clapp	27-May-26
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