Continuous Quality Improvement Initiative Annual Report

Annual Schedule: May 2026

HOME NAME : Southbridge Kemptville

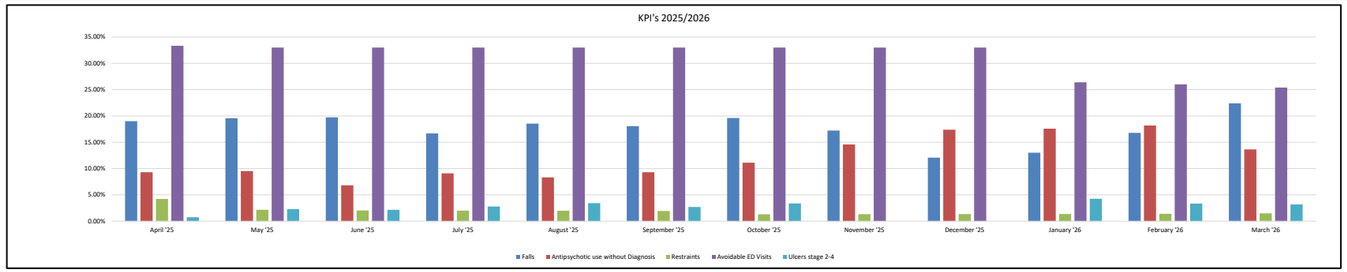
People who participated in the evaluation of this report		
	Name and Designation	**Date of Evaluation**
Quality Improvement Lead	Dustin Brown - ED	June 5 2026
Director of Care	Jennifer Black - DOC	June 5 2026
Executive Directive	Dustin Brown - ED	June 5 2026
Nutrition Manager	Sarah Graves - FSM	June 5 2026
Programs Manager	Jessica Hammond - Director Life Enrichment	June 5 2026
Clinical Consultant	Moises Ruiz	June 5 2026
Resident Council Representative	John Dodd	June 5 2026
Family Council Representative	Deborah Krause	June 5 2026
Medical Director	Dr. Greg Leonard	June 5 2026
Other	Dawn Blad - ADOC	June 5 2026
Other	Jane Johnston ADOC/Educator	June 5 2026

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
2024 Resident Satisfaction Survey: Top 5 Opportunities 1) I am satisfied with the temperature of my food and beverages. 76.13%. 2) I am satisfied with: The variety of spiritual care services 75.49% 3) I enjoy eating meals in the dining room. 74.60%. 4) I am satisfied with: The relevance of recreation program 73.25% 5) I am satisfied with the quality of: Laundry services for personal clothing 73.05%	The home maintains a policy that all residents receive meals at safe, palatable temperatures. To put this policy into practice, meals are only plated when the PSW requests the tray and confirms they are immediately ready to deliver it. For residents who require assistance with eating, plates are not sent to the dining unit until staff are available to provide that help. The leadership team reinforces this procedure through regular meal service audits. The goal is to increase satisfaction with food temperature from 76.13 percent. The home operates under a policy that every resident has the right to spiritual care that respects their individual faith. The procedure begins with identifying all faith traditions present within the resident population, followed by gathering direct feedback on spiritual needs and preferences. Based on this input, the home creates and promotes resources that explain available services. A communication protocol requires that the monthly newsletter list denominations and services offered, along with an invitation for ongoing feedback. The target is to raise satisfaction with spiritual care from 75.49 percent. A formal policy affirms that residents have the right to enjoy meals in a pleasant and dignified dining environment. To achieve this, all dining and nursing staff receive customer service education focused specifically on pleasurable dining. In addition, the leadership team collects formal feedback from residents and families about what makes an enjoyable dining atmosphere, which is reviewed quarterly to adjust practices. The home aims to increase satisfaction with the dining room experience from 74.60 percent. The home follows a policy requiring that all recreation programs be relevant, resident-centered, and responsive to feedback. The procedure involves gathering input at monthly Resident Council meetings, where residents share what they enjoy and what they would like to see offered. Resident suggestions are then used to shape upcoming programs. A standing protocol requires monthly program planning meetings, with resident feedback as the first agenda item. The goal is to raise satisfaction with recreation program relevance from 73.25 percent. A policy ensures that personal clothing is returned clean, undamaged, and within a reasonable timeframe. The procedure includes regular audits of laundry turnaround time and the delivery process, as well as training for all PSWs on correctly sorting soiled linen versus personal clothing. A protocol requires monthly laundry audits, a visual sorting guide posted in every soiled utility room, and training included in new hire orientation and annual education. The target is to increase satisfaction with laundry services from 73.05 percent.	Based on the action plan implemented throughout 2024, the home expects satisfaction to increase across all five priority areas by December 31st. For food temperature, satisfaction is expected to rise from 76% to 82-87%. Equipment repairs and plating protocols will ensure meals arrive hot and palatable. For spiritual care services, satisfaction is expected to increase from 75% to 80-85%. Identified faiths, resident feedback, and monthly newsletters will improve access and variety. For dining room experience, satisfaction is expected to rise from 75% to 80-85%. Customer service training and resident feedback will create a more pleasant atmosphere. For recreation programs, satisfaction is expected to increase from 73% to 78-83%. Monthly Resident Council input and planning meetings will ensure programs remain relevant and resident-centered.For laundry services, satisfaction is expected to rise from 73% to 78-83%. Audits and PSW training will improve turnaround time and proper sorting of personal clothing. Overall, the home expects an average increase of 5 to 10 percentage points across all areas, meeting the target satisfaction threshold of 80% by the end of 2024.
2024 Family Satisfaction Survey: Top 5 Opportunities: 1) Continence care products: Are comfortable. 75.97% 2) Continence care products fits properly 74.58% 3) The resident receives courteous service in the dining room. 74.34% 4) I am satisfied with the quality of care from the Dietitian 72.86% 5) I am satisfied with the timing and schedule of spiritual care services 70.59%	Continence Care Products – Comfort (75.97%): The Executive Director sought feedback from families at Town Hall and encouraged ongoing input. Continence Champions collected resident feedback on product comfort. The ADOC arranged a Prevail education session for families. Continence Care Products – Fit (74.58%): The Executive Director gathered family feedback at Town Hall. The ADOC arranged a Prevail education session for families. Courteous Service in the Dining Room (74.34%): The Food Service Manager and Leadership Team implemented new meal service processes. The Leadership Team conducts regular audits to ensure residents receive choice, fluids, seconds, and dessert. Quality of Care from the Dietitian (72.86%): The Executive Director collected family feedback to identify concerns. A Southbridge-employed dietitian now offers on-site services. The dietitian's bio, schedule, and contact information were shared with families, and the dietitian participates in care conferences for residents with complex needs. Timing of Spiritual Care Services (70.59%): The Executive Director, Chaplain, and Director of Life Enrichment gathered family feedback on preferred times through Town Halls, conversations, and surveys. The Chaplain organized the feedback and implemented schedule changes accordingly.	Based on the action plan implemented throughout 2024, the home expects satisfaction to increase across all five priority areas by December 31st. For continence care products, comfort and fit satisfaction are expected to rise from approximately 75% to 80-85%. Prevail education sessions and ongoing family feedback will improve product selection, dignity, and skin health. For courteous service in the dining room, satisfaction is expected to increase from 74% to 82-87%. New meal service processes and regular audits will ensure residents consistently receive choice, fluids, seconds, and dessert with respectful service. For quality of care from the Dietitian, satisfaction is expected to rise from 73% to 80-85%. An on-site dietitian, clear communication of contact information, and participation in care conferences will build family trust and improve nutritional outcomes. For timing of spiritual care services, satisfaction is expected to increase from 71% to 78-83%. Family feedback has been used to adjust schedules, leading to higher attendance and satisfaction. Overall, the home expects an average increase of 5 to 10 percentage points across all areas, meeting the target satisfaction threshold of 80% by the end of 2024.
Decrease of Potentially avoidable emergency department visits for long-term care residents	Change Idea: Reduce avoidable hospital transfers with the support of the on-site Nurse Practitioners and NLOT NP through the Ottawa Hospital. Staff education, Use of SBAR, and Root cause analysis of transfers. Registered in-charge nurse to communicate to physician and NP a comprehensive resident assessment to obtain direction before initiating an ER transfer •The Educator and NP provided education to the Reg staff on the process to ensure residents are properly assessed prior to contacting MD/NP for a potential transfer, including current status, i.e., pain, level of consciousness, etc. •The Educator provided education to all Registered staff on the application and use of the SBAR to enhance communication among all clinicians. •The DOC reviewed the monthly ED tracker with all the registered staff to provide clarity and highlight the most common reasons for ED transfers and interventions to reduce unnecessary ED transfers, including timely communication with MD/NP and appropriate communication with families. Change Idea : Build capacity and improve the overall clinical assessment of the Registered Staff through education on the most common reasons for transfers to the ED. •The NP provided on-the-spot education to the Registered staff on early recognition of acute symptoms and the most common reasons for avoidable ED transfers •Educator distributed a learning needs survey to all Reg. Staff. The survey results indicated the need for signs and symptoms of the most common medical reasons impacting the elderly, as well as physical assessment skills •NP focused education on timely measures to minimize acute episodes (i.e., vital signs monitoring of respiratory symptoms), interventions, and treatments. •The DOC reviewed the monthly ED tracker with all the registered staff to provide clarity and highlight the most common reasons for ED transfers and interventions to reduce unnecessary ED transfers, including timely communication with MD/NP and appropriate communication with families. Change Idea: Establish partnership/collaboration with the Paramedic LTC + program - provide in-home support, to avoid ED transfers. •The home was able to link with the program due to a lack of availability in the region. The home continues to work with the home's NP, and other external partners, such as a pain and symptom management consultant and a skin wound care specialist. Change Idea: Review the ED tracker by the Director of Care and the interdisciplinary team, to determine common reasons for transfer to the ED and interventions to prevent future avoidable transfers. •The DOC reviewed monthly the internal hospital tracking tool to analyze each transfer status with the interdisciplinary team and the NP NLOT from the Ottawa	Outcome: 2025 - 33.3% Date: Data released April 2026. The home was able to reduce unesscary transfers from 33.3% to 26% This is a decrease of 7%
Decrease the percentage of LTC home residents who fell in the 30 days leading up to their assessment	"Change Idea: Complete Weekly Fall Huddles for each unit with the interdisciplinary team. •The falls lead implemented weekly falls huddles with the interdisciplinary team to reviewed interventions to prevent /reduce the risk of falls. •Falls lead provided clarification and guidance to the staff during the fall huddles on fall prevention interventions and return demonstration in some situations to ensure a clear understanding of expectations.	Outcome: 2025 -22.22% Date: April 2026. The home was successful in decreasing falls from 22.22% to 17.61% per 4th qtr. April data 2026

	Change Idea: In collaboration with the The Falls committe , the falls lead and the interdisciplinary team will meet monthly to review residents determined to be at medium to high risk for falls. The team will review both non-clinical and clinical interventions. This review will also include the resident's plan of care, environmental assessment, Pharmacist/MD/NP for medication reviews, and PT for physio regimen. Residents and SDMs will be active participants in this process. •The falls lead, in collaboration with the interdisciplinary team, the falls committee members, POAs, and residents (as appropriate), met monthly to review residents determined to be medium and high risk for falls, their care plans, environmental assessments, and medication reviews, including POAs and residents as appropriate, to ensure all falls prevention interventions remain current and aligned with the residents' needs. Change idea: Re -introduce Purposeful rounding (4 Ps), for residents at medium and high risk for falls •Falls lead provided education to all nursing staff on the 4 P's. •Falls lead updated the care plans of the residents deemed medium to high risk for falls to reflect 4 P's interventions Change Idea: Resident list of FRS of 3 or greater, offer fracture prevention medication •Falls lead worked with the interdisciplinary team, residents (as applicable), and families to determine those residents with an FRS of 3 or greater to make recommendations for fracture prevention medication to NP/MD, i.e., Vitamin D, Calcium •Falls lead updated plans of care with fracture prevention regimen. "	
Improve the percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education	Change idea: Complete equity, diversity, inclusion, and anti-racism training for staff through Surge education and live events. •All staff completed their mandatory training on equity, diversity, inclusion, and anti-racism through surge learning •Five events were held on equity, diversity, and inclusion in the home throughout the year. Ie, Pride and Chinese New Year, black history month Change idea: All employees are to be trained in relevant equity, diversity, inclusion, and anti-racism in the year. •All departmental meetings included a standing agenda item to review topics on diversity, inclusion, equity, and anti-racism in the workplace, including CQI meetings. Change Idea: The home will partner with external stakeholders to assist the staff education on equity, diversity, inclusion, and anti-racism education. •The home was not able to roll out this change idea due to the lack of resources in the community. The homes continue to approach out-of-region options.	Outcome: 100%. Date: December 2025 - all staff were educated on equity, diversity, inclusion, and anti-racism education. Current performance 2026- 100%.
Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment	**Change Idea: The MD, NP, BSO internal and external (including the Psychogeriatric Team), and other members of the interdisciplinary team will meet monthly to review newly admitted and existing residents on antipsychotic medication for diagnosis and indication for use. This will also be a standing item in the CQI/PAC quarterly meeting agendas.** •The interdisciplinary team met monthly to review all residents on antipsychotics. The purpose of the meeting was to determine opportunities for antipsychotic deprescribing for each resident. •Both clinical and non-clinical approaches were reviewed to consider the safety and quality of life of residents. •The review included; Diagnoses, Medications Allergies, Diagnosis on File (Hallucination, Delusion, Schizophrenia, Huntington's,) Active Symptoms of Hallucination or Delusion, Antipsychotic used + dosage Indication Routine / PRN usage in last 3 months, BPSD in Past 3 Months, Description of (Behavioural psych symptom dementia), Sleep Assessment, Pre - CMAI Score, Pre - Cornell Score, Pain AD Score, Pre-post DOS Evaluation. •The outcomes of these reviews were shared quarterly with the CQI/PAC committee to evaluate and review progress and resident outcomes. **Change idea: Development of plans of care, with a non-pharmacological approach - identification of triggers and interventions.** •During the monthly Antipsychotic clinical reviews, the team suggested non-pharmacological (i.e., meaningful activities), trigger reduction interventions in collaboration with BSO and families before implementation and care plan update. •BSO monitored the education of staff on interventions and the effectiveness of new interventions. Change Idea: Residents who are prescribed antipsychotics for the purpose of management of Responsive expressions will have a quarterly review for the potential of reduction or discontinuation of medication. Utilization of tracking tool (antipsychotic) •The BSO lead of home, in collaboration with the interdisciplinary team, met monthly to review residents on antipsychotic therapy and personal	Outcome: 12.63% Date: April 2026 - Decreased to 12.39% per 4th qtr. average.
Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences".	Change Idea: Increase the home's goal from 83.2% in 2024 to 85%. Engaging residents in meaningful conversations during care conferences. Have forums that allow residents to express their opinions. Review "The Resident's Bill of Rights", at monthly residents' Council meetings with an emphasis on Resident Rights #29. "Every resident has the right to raise concerns or recommend changes in policies and services on behalf of themself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else"; •The activity manager reviewed the Resident Bill of Rights throughout the year with the resident council, with emphasis on #29, "Every resident has the right to raise concerns or recommend changes in policies and services on behalf of themself or others to the following persons and organizations without interference and without fear of coercion, discrimination, or reprisal, whether directed at the resident or anyone else". Change Idea: Review of the Whistleblower policy with all staff, at resident council, and family town halls. •The ED, in collaboration with the management team, reviewed the whistleblower policy with staff and during staff and family town hall meetings, and attended a resident council meeting. Change Idea: Review the home's complaint process with residents and SDMs on admission and during the annual care conferences. •The complaint process was reviewed by the Service Social worker during admission and annual care conferences. •During care conferences, residents and families were encouraged to bring any concerns forward to the Management team for a timely response. "Open door" philosophy was also reviewed	Outcome: 83.02%. Date: April 2026 - Increased to 86.49% per 2025 survey results
Percentage of LTC residents who develop worsening pain	"Change idea: Utilization of the pain tracker, to monitor the use of prn analgesic •The home utilized the PRN analgesic tracker to ensure residents on PRN analgesics are assessed and monitored for pain effectiveness. Change Idea: For all new admissions, the home's pain lead will monitor the completion of a comprehensive pain assessment as per policy. The comprehensive assessment will include the resident's previous history of pharmacological and non-pharmacological pain management interventions to better address the resident's pain needs. •All new admissions were assessed with a comprehensive pain assessment. The Pain lead monitored this process •The assessment captured pre-existing history of pain, previous pain therapy, both pharmacological and non-pharmacological therapies, and their effectiveness in controlling pain. •As required, the pain and symptom management consultant was involved to ensure the matter expert makes recommendations. Change Idea: Enhancement of the end-of-life palliative care program •The Pain and Palliative care specialist provided education on end-of-life care and advanced care planning. •Goals of Care are reviewed with residents and families during all care conferences to ensure the home honors the resident's /POA's wishes. •Comfort Care rounds were rolled out	The home was be to surpass the target of 8.50% . As of March 2026 ; the home achieved 8.15 % . The home made a great improvement from March 2025 to March 2026 . March 2025 : 13.24% March 2026 : 8.15 %
Percentage of LTC residents who develop worsening pressure injury stage 2-4	Change Idea: Roll out education on wound care management and assessment and skin care . Education to be provided by NSWOC (during wound care rounds), Medline consultant. •NSWOC provided on the spot education during wound care rounds to the Reg. staff and PSW's throughout the year. •Medline held 2 educational sessions on skin and wound care throughout the year. •Home's educator held education session throughout the year on the fundamentals of skin and wound care, including Southbridge Wound care management policy Change idea: Monthly review in the Quality meeting of residents with Pressure related wounds. •The skin and wound care lead reviewed skin and wound care tracker on a weekly basis to ensure compliance with Southbridge policy and best practices. Trends were reviewed. •During skin and wound care clinical reviews, the skin and wound care lead in collaboration with the interdisciplinary team, made recommendations for new interventions / treatments. Care plans were updated. Families and Residents (where possible) were included in the process Change idea: Referral to NSWOC for in home and virtual consults. •The Skin and wound care lead in collaboration with the interdisciplinary team, referred residents with non healing and complex wounds to the NSWOC. •NSWOC made virtual consults and in person every 6 weeks •NSWOC made recommendations for treatment and relevant interventions .	The home was not able to meet the target of 2.50% , however; there as a significant improvement from March 2025 compared to March 2026. March 2025 : 3.72% March 2026 : 2.56% . The home had some new admisisons with worsen stage 2-4 coming from bth, hospital and the community . The action items in place for 25-26 were very succeful .

Key Performance 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	19.00%	19.57%	19.73%	16.67%	18.54%	18.06%	19.61%	17.22%	12.08%	13.01%	16.78%	22.39%
Antipsychotic use without Diagnosis	9.30%	9.52%	7%	9.09%	8.33%	9.30%	11.11%	14.58%	17.39%	18%	18%	14%
Restraints	4.23%	2%	2.04%	2.00%	1.99%	1.94%	1.31%	1%	1.34%	1.37%	1.40%	1.49%
Avoidable ED Visits	33%	33%	33%	33%	33%	33%	33%	33%	33%	26%	26%	25%
Ulcers stage 2-4	0.74%	2.29%	2.16%	2.78%	3.42%	2.70%	3.37%	0.00%	0.00%	4.26%	3.33%	3.17%



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 year:	Sep-25
Results of the Survey (*provide description of the results*):	Family - 5 opportunities - My concerns are addressed in a timely manner. (80.11%). Continence care products: Fit properly. (80.23%). The resident enjoys eating meals in the dining room. (80.65%). Continence care products: Are comfortable. (80.81%). am satisfied with the quality of: Laundry services for personal clothing. (80.95%) Resident 5 opportunities - I am updated regularly about any changes in the home. (78.95%). I am satisfied with: The variety of spiritual care services. (77.92%). I am satisfied with: The timing and schedule of spiritual care services. (77.85%). I enjoy eating meals in the dining room. (77.72%). Maintenance of the physical building and outdoor spaces. (79.01%)
How and when the results of the survey were communicated to the Residents and their Families (including Resident's Council, Family Council, and Staff)	Distributed through resident council, family council, and quality board meeting. Presented to both councils on March 10, 2026. During resident councils it was presented by the Activity Manager. For Family council it was sent to president Deborah Krause via email who shared it to the rest of Family Council.

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	108 residents with proper CPS score - 100% 108/108	100.00%	100.00%	82.33%	100.00%	100.00%	90.00%	75.85%	**1. Communication & Updates** Resident communication boards on each unit Monthly resident newsletter (activities, menus, home news) Verbal updates during morning rounds for non-readers **2. Spiritual Care** Annual resident interest survey (5 residents/unit) Chaplain attends Residents' Council every 2 months Offer major services on multiple days (not just Sundays) Bi-weekly spiritual care updates to families **3. Dining Experience**
Would you recommend	89.80%	85.00%	85%%	81.04%	100.00%	85.00%	85.00%	76.00%	**1. Concern Resolution** Complaint Tracking log with 48-hour follow-up Designated manager per unit for resolution updates Clear flowchart of concern resolution process for families **2. Continence Care Products (Fit & Comfort)** Product fit assessment for all residents (switch products Feb/March) Trial two alternative brands/sizes Trial rather breathable product lines for comfort
If I have a concern, I feel comfortable raising it with the staff and leadership	89.49% - looking to increase by 3% next year	86.49%	80.00%	80.00%	100.00%	85.00%	80.00%	80.00%	1. Continue education to all staff and residents regarding open door policy and whistleblowing. Also education residents regarding that their concerns will be held in confidence. 2. Management to continue to attend and educate at residents council about bringing concerns forward.

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 : Continue to reduce avoidable hospital transfers by 3% for the upcoming year. Registered staff will continue to be educated regarding use of the SBAR tool, assessment skills and support of NP and MDs to keep residents in the home. SIM labs with collaboration with NP NLOT program will be offered to nurses to improve situation skills. Education will be offered as needed. Change idea : Enhance goals of care conversations and family engagement Conduct early and ongoing goals of care discussions: Initiate conversations with residents and families upon admission and at regular intervals (quarterly, with significant change, and annually). Use structured communication tools Conduct early and ongoing goals of care discussions: Initiate conversations with residents and families upon admission and at regular intervals (quarterly, with significant change, and annually). Use structured communication tools Change idea : Education for Families	March 2026: 26.42 %

Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment	Change idea : The MD, NP, BSO internal and external (including the Psychogeriatric Team), and other members of the interdisciplinary team will meet monthly to review newly admitted and existing residents on antipsychotic medication for diagnosis and indication for use. This will also be a standing item in the CQI/PAC quarterly meeting agendas.Monthly meetings with the interdisciplinary team with a focus on Antipsychotic use and interventions for the reduction/tapering of antipsychotic medication usage. Review data during CQI and PAC meetings. Monthly meetings with the interdisciplinary team with a focus on Antipsychotic use and interventions for the reduction/tapering of antipsychotic medication usage. Review data during CQI and PAC meetings. Change idea : Development of plans of care, with non-pharmacological approach - identification of triggers and interventions. Review of the plan of care for non-pharmacological approaches, and triggers leading to Personal expressions. Target : 9.5%	March 2026: 10.60%
Percentage of LTC home residents who fell in the 30 days leading up to their assessment	Change idea : Falls committee continues to meet monthly and as needed to identify frequent fallers, and residents at high risk for falls. Completed in person with clinical team at falls meetings. Resident data will be discussed and analysised. . Change idea : Continual education on Purposeful rounding (4 P's) Education via in -person, huddles, online training platforms, to all direct care staff - PSWs and nurses. Target : 17.5%	March 2026: 19.62%
Percentage of long-term care residents whose stage 2 to 4 pressure ulcer worsened	Change idea : Roll out education on wound care management and assessment and skin care . Education to be provided by NSWOC (during wound care rounds), Medline consultant. DOC and Educator to arrange education for Registered staff and PSW, with NSWOC/Medline as required. Change idea : Monthly review in the Quality meeting of current residents with Pressure related wounds. Utilization of skin and wound tracking tools to analyze pressure-related injuries in the home, the development of the plan of care, and appropriate prescribed wound and skin care products. Consultation with current Skin and Wound lead and ADOC overseeing skin and wound. Change idea : Referral to NSWOC for in home and virtual consults. Referrals to the NSWOC for the residents who fall into following categories: Wounds That Fail to Heal: Non-healing wounds: If a wound doesn't show signs of healing after 4-6 weeks of appropriate basic care (cleansing, protection, edema control, and antibiotics), it's a strong indicator for referral. Wounds with complications: Wounds with a large necrotic burden, unhealthy peri wound tissue, or those that are recurrent should be evaluated by a wound care specialist. Wounds with exposed tissue: Any wound with exposed bone, tendon, joint capsule, or significant tunneling warrants referral. Chronic wounds: Wounds that persist for more than 6 to 12 weeks, even with appropriate care, should be referred. Target : 1.90%	March 2026: 2.10%
Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences".	Chnage idea : Continue to increase % of this indicator. Current is 86.49%. Looking to improve to by 3%. Recreation to hold monthly resident council meetings where residents can voice concerns and address issues with DOC or ED present. Specific resident rights are discussed and reviewed at each meeting. Identify acute urgent concerns and direct them to the correct avenue for action. Implemented support measures through social work, care conferences and recreation. Change idea : Review of the Whistleblower policy with all staff, at resident council and family town halls. Education for staff to be rolled out via Surge learning. The program manager will review the whistleblowing policy annually with the resident council. The Executive Director will review the whistleblowing policy annually during family town hall meetings. Target : 86.49%	March 2026 : 86.49%
Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education	Change idea : Continue to meet 100% training completion as Mandatory education. Continue to explore external partnerships to enhance training as needed. Continue with online training platform SURGE with DEI education, annual events and in person training. DEI training as needed, if required more then mandatory requirements. Change idea : All employees to be trained in relevant equity, diversity, inclusion, and anti-racism in the year. Include equity, diversity, inclusion, and anti-racism as part of the home's departmental committees' standing agendas. The goal is to maintain a consistent forum to review applicable topics, thus increasing the understanding and knowledge of the staff. Target : 100%	December 2025 : 100 %
Percentage of long-term care residents in daily physical restraints	Change idea : Introduce and Promote Alternatives to Physical Restraints Equipment Trial: Introduce a range of restraint alternative devices. Evidence-based options include: Mitts, diversional items based on residents background and likes, use of bed and pad alarms and PASDs. Change idea : Implement, Person-Centered Assessments to address underlying causes of responsive behaviors which have may have led to restraint use. Pain and Discomfort Checks: Implement a standardized protocol for assessing pain, hunger, thirst, toileting needs, or discomfort whenever a resident shows signs of agitation or restlessness. Many behaviors are expressions of unmet needs . Integrate restraint case review into existing falls prevention meetings Update the purpose of the falls prevention Meeting to include reducing the use of physical restraints as a core objective. Add restraint review as a standing agenda item for every meeting, ensuring it is never overlooked. Target : 2.80%	March 2026: 3.24%

Top 5 opportunities for Family Satisfaction Survey 2025	**Action Plan**	**Status**
My concerns are addressed in a timely manner - 80.11%	1.Use Complaint Tracking log to ensure follow-up within 48 hours if required. 2. Designate a manager to oversee each unit to communicate resolution updates. 3. Provide families with a clear flowchart of the concern resolution process.	Ongoing as complaint tracker is used throughout year. ED/DOC oversees complaint tracker and updates as needed. Complaint algorithm posted in home on mandatory board
Continence care products: Fit properly. - 80.81%	1. Conduct a product fit assessment for all residents using incontinence products. (Switching products Feb/March). 2. Trial two alternative product brands/sizes based on resident comfort and feedback. 3. Educate nursing staff on proper fit assessment and adjustment during care.	Completed March/April 2026. Assessment done if required by continence lead
The resident enjoys eating meals in the dining room - 80.65%	1.Offer alternative dining options(e.g., room service, smaller dining nooks) for residents who dislike the main dining room, if possible. 2. Involve families in meal planning through quarterly feedback sessions. 3. Improve dining room accessibility and comfort for residents with mobility aids. Strategic entry of residents. 4.FSM to attend resident council, visible in dining rooms, present at care conferences other options, and host food committee meeting.	Completed March/April 2026. FSM attended residents council. Continue to incorporate families and residents in meal planning

Continence care products: Are comfortable. - 80.23%	1. Trial softer, breathable product lines for residents reporting discomfort. 2. Implement a skin integrity check protocol during product changes. 3. Educate staff on product selection based on individual resident needs and skin sensitivity.	Completed March/April 2026 - will be ongoing as needed basis per resident/family request
I am satisfied with the quality of: Laundry services for personal clothing. - 80.95%	1. Implement a laundry tracking sheet for families to note special instructions.2. Audit laundry processes monthly for consistency and quality	Ongoing - laundry audit needs to be completed with new ESM starting June 8, 2026
Top 5 opportunities for Resident Satisfaction Survey 2025	**Action Plan**	**Status**
I am updated regularly about any changes in the home - 78.95%	1. Implement a Resident Communication Board in each unit for routine updates.2. Establish a Monthly resident newsletter with updates on activities, menu changes, and home news. 3. Train staff to provide verbal updates during morning rounds for residents who may not read notices.	Completed and Ongoing. Activity Manager sends out monthly newsletter and communication updates as needed
I am satisfied with the variety of spiritual care services - 77.92%	1.Conduct a computer-generated resident interest survey for 5 residents to complete per unit on an annual basis. 2.Every 2 months, the Chaplain will attend Residents' Council for feedback. 3.Chaplain will advertise spiritual activities/programming in monthly newsletter to residents (and bi-weekly newsletter to families	Completed March/April 2026. Sprtiual activites are now highlighted in blue on acitivty calendars. Chaplain has attended residents council
I am satisfied with the timing and schedule of spiritual care - 77.85%	1.Chaplain will attend Residents' Council twice per year to survey the residents about timing and scheduling of spiritual care services.2.Continue to offer major spiritual services on multiple days of the week (not Sundays only). 3.Communicate the updated schedule clearly via newsletter, communication board, and activity calendars.	Completed. Chaplain attended residents council in April 2026. Updated schedule will continue to be put out per monthly communication
I enjoy eating meals in the dining room - 77.72%	1.Survey residents to identify what they would like to enhance their dining experience.2.Education with dietary, psw and activity staff to encourage socialization amongst residents and staff. Discuss updates in home with residents. FSM to meet with PSWs to discuss routines in dining room. 3.Gather resident feedback on dining preferences via monthly food committee meetings and residents council. FSM to attend resident council and get input.	FSM met with PSWs and attended resident council in March/April 2026. Continue to gather feedback as needed to enhance experience in dining room
Maintenance of the physical building and outdoor spaces - 79.01%	1. Implement a maintenance tracking log in common areas to show reported issues and repair status.2. Increase routine inspections of outdoor spaces and common areas. 3. Assign a staff member to provide updates on maintenance progress during resident council.	Completed March/April 2026. Tracking log updated in HOOP. Repairs and maintenance for whole building posted in maintenance office. Ongoing repairs and upkeep of building to happen throughout summer 2026

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 commitee quarterly.

Participants of Evaluation Name and Signatures:	*Print out a completed copy - obtain signatures and file.*	Date Signed:
Quality Improvement Lead	Dustin Brown	**June 5/26**
Executive Director	Dustin Brown	**June 5/26**
Director of Care	Jennifer Black	**June 5/26**
Nutrition Manager	Sarah Graves	**June 5/26**
Programs Manager	Jessica Hammond	**June 5/26**
Clinical Consultant	Moises Ruiz	**June 5/26**
Resident Council Representative	John Dodd	**June 5/26**
Family Council Representative	Deborah Krause	**June 5/26**
Medical Director	Dr. Greg Leonard	**June 5/26**
Other		
Other		