SOUTHBRIDGE HEALTH CARE LP

Continuous Quality Improvement Initiative Annual Report

Annual Schedule: May 2026

HOME NAME : Southbridge Roseview

People who participated in the evaluation of this report		
	Name / Designation	**Date of Evaluation**
Quality Improvement Lead	Karlee Galusha - Executive Director	20-May-26
Director of Care	Cameron Robertson - Director of Care	20-May-26
Executive Directive	Karlee Galusha - Executive Director	20-May-26
Nutrition Manager	Elise Johnston - Food Service Manager	20-May-26
Programs Manager	Rylie Opas - Program Manager	20-May-26
Clinical Consultant		
Medical Director	Dr. John Coccumiglio - Medical Director	20-May-26
Resident Council Member	Debra Nadeau - Resident Council Member	25-May-26
Family Council Member	FAC: Rose Lauzon, Deb Legros, Amanda Anderson, Lenore Trodd	21-May-26
Nurse Practitioner	Tanner Dunn - Nurse Practitioner	20-May-26
Other	Kayla Seppanen RAI cordinator, Megan D'Amours Social Worker, Jeremy Hayden, Environmental Manager	20-May-26

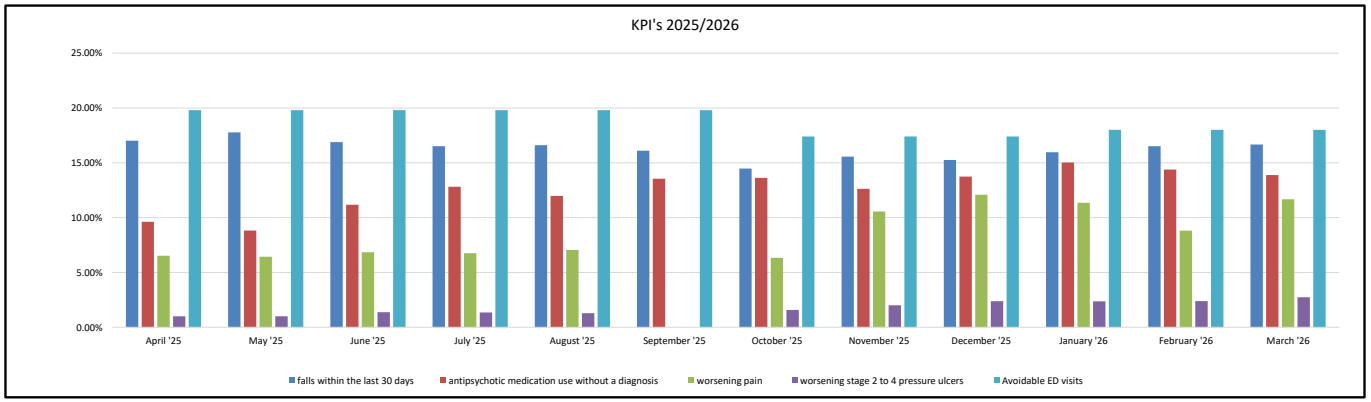
Summary of the Home's priority areas for quality improvement, objectives, policies, procedures and protocols from previous year (2025/2026): What actions were completed? Include dates and outcomes of actions.

Quality Improvement Objective	Policies, procedures and protocols used to achieve quality improvement	Outcomes of Actions, including dates
% Avoidable ED visits	**To reduce unnecessary hospital transfers through the use of NP.** The home continues to maximize the use of the current Medical Director and Nurse Practistioner to provide preventative care and early treatment of common conditions that could lead to an ED visit. MD/NP provided education to our RN's in early recognition training of clinical assessments. All registered staff have also received training within the year related to palliative and end of life care as well as SBAR communication. **Root cause analysis** Root cause analysis is completed with all ED transfers to determine if early identification was used, complete communication accurate communication with family and MD prior to sending to the ED, tends, and if in home treatment options were used/communicated. Analyse is discussed at staff meetings, CQI and PAC meetings **Family education and communication** At Admission and during annual Care Conference the Home ensures that DNR and end of life discussed with the resident and family including informal education on hospital transfers which can severely impact our residents. **Palliative Performance Score** The home continues to perform PPS assessments on all residents on admission, quarterly, with significant change in condition and with diagnosis of a life altering disease. The PPS is monitor and evaluated to better determine decline and the need for further discussion related to care goals. The care plan is also evaluated for accurate reflection of the residents and family care goals and interventions	The home did not meet their goal of 17%. Current QI December 2025 17.41%. Exceeded provincial average of 22.30%. The home continues to implement and evaluate plan. Noted increase of ED transfers related to family and resident request. The home continues to implement change ideas, monitor and evaluate. Indicators demonstrated sustained improvements, particularly in SBAR utilization, staff engagement in clinical education,the use of PPS scores, root cause analysis, and family education of care goals.
% of staff and managers whom participates in diversity and inclusion training	**Improve Dialogue** The home has improved overall dialogue on diversity, inclusion, equity and anti-racism by having open conversation, reviewing at all staff meetings, and being sensitive to everyone's individual needs. The home continues to advocate " we are stronger together " **Education** All staff and mangers completed SURGE online education related to diversity, inclusion, equity and anit-racism in the workplace. **Open Door Policy** The management team continues to provide an open door policy and encourage feedback in order to address any concerns or issues at the moment. We also welcome all suggestions and ideas to further improve. **Meetings / Review** All CQI meetings now include a discussion related to diversity and further ideas for improvement, as well as evaluation of current actions.	The home has met and exceeded their goal of 98%. Current annual QI 2025 100%. The home continues to implement and evaluate plan. All staff completed SURGE education in 2025. Diversity and inclusion is discussed at CQI meeting monthly. The existing initiatives were sustained, such as open door policy and further reinforced to ensure consistency across all departments and levels of leadership.
% of residents to respond positively to "I can express myself without fear of consequences"	**Engaging Residents** The home has engaged residents in meaningful conversations, and care conferences, that allow them to express their opinions. A review of the "Resident's Bill of Rights" has occurred at residents' Council meetings monthly. With a focus 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" **Whistleblower Policy / Compliants process.** The home has reviewed the Whistleblower policy with Residents' Council and continues to review with care conference, council meetings and any concern brougth forward. The home has also reviewed the complaint and concern process in the home with residents and families on admission, during annual care conference. The Whistleblowers policy continues to be included in our resident admisiion package.	The home did not meet their goal of 98%. Current annual QI 2025 88.29%. Did not exceed provincial average of 92.15%. The home is committed to increasing satisfaction with the goal of residents responding positively to "I can express myself without fear of consequences" Our commitment to actively engaging families and residents in providing feedback, addressing concerns, and implementing targeted interventions to improve their over all experience.
	Education	

% of residents with worsening stage two to four pressure ulcers	All registered staff have received education on wound assessment, the skin impairment checklist, preventative wound care interventions and tools. We continue to assess all residents on a daily basis for skin impairments during care for early identification. All care staff also received education from Medline related to appropriate product use for preventative measures. **High risk identification** The home continues to utilize the Pressure ulcer rating scale on admission, quarterly and with significant change in condition to determine the residents pressure risk. The PURS scores are assessed and used to implement skin care interventions such as cream, turning wedges, repositioning, pressure receiving devices, and therapeutic surface used for any resident identified as high risk for skin issues and concerns. **Impaired Skin tracker** The home continues to use and monitor wounds / impaired skin integrity by using a skin and wound tracker. The tracker tool assists to ensure policies and procedures are being followed with all skin impairments. It was assists the home in evaluation of skin issues (improving or worsening)	The home did not meet their goal of 1%. Current QI December 2025 2.30%. Exceeded provincial average of 2.70%.The home continues to implement, monitor and evaluate. Medline provided skin and wound care lead education in July 2025, as well as PSW training with preventative care. All skin impairments are tracked, assessed and evaluated at least monthly by the wound care lead. Ongoing auditing and monitoring to ensure accurate coding and documentation, to support and sustain improvement.
% of residents that had a fall in the last 30 days	**Weekly meeting and Collaboration** The home is completing weekly falls huddles on each unit and include collaboration with the Falls committee and external partners. Environmental assessments, care plan interventions and FRS scores are taken into consideration with each fall, review of current falls interventions and additional interventions post fall. The home falls lead has completed education with all staff and continues to provide education on hire to new staff. Falls education includes prevention, monitoring, documentation, interventions, care planning, and family communication. The homes PT has completed education to residents and families related to walker and w/c safety. **Fracture Prevention** All residents are monitored and reviewed for possible fracture prevention medication intervention on admission, quarterly and with significant changes in condition. The home utilizes the FRS score form InterRAI to determine the fracture rsik of the residents individually. **Falls Analysis** Each fall is reviewed with the ongoing huddles, MD/NP, input and notifications to family. Input from family with notifications and care plan reviews is considered and evaluated. The home uses the falls tracker as a tool to monitor, evaluate and ensure policies are followed.	The home did not meet their goal of 15%. Current QI December 2025 15.24%. Exceeded provincial average of 16.2%. Falls indicator improved to 15.25% in Dec 2025 from 16.89% in Jan 2025, approaching the corporate benchmark of 15.50%, with a downward trend. Improved management of high-risk residents, with reduced frequency and impact of falls. Consistent implementation of interventions, and fracture prevention contributed to sustained improvement and enhanced resident safety.
% of residents receiving antipsychotic medication without a DX	**Monthly Review of residents receiving antipsychotic medication** Monthly reviews of all residents triggering antipsychotic medication QI are completed with NP, BSO and clinical managers / leads. Any newly admitted residents are reviewed related to medications, medication alternates, and non medication interventions. Antipsychotic use continues to be reviewed and discussed at all CQI and PAC meetings. **Antipsychotic Reducation** All residents receiving antipsychotic medication are assessed and evaluated at minimum of quarterly through medication reviews with the goal of reducing antipsychotic medications. The home also addresses antipsychotic medication use at care conference with residents and families. All efforts and interventions are considered and closely monitored for effectiveness. **Care plans** The home continues to use a multidsiplinary approach for plan of care development. All clinical staff, internal BSO, external BSO, MD, NP, families and clincal managers are all involved with the development, review and implmenation of the individuals plan of care. **Admission conference** During admission conference, medications are reviewed with families, reason for the prescribing of antipsychotic medication, interventions effective in management of responsive expressions.	The home has met and exceed their goal of 17.5% Current QI Dec 2025 13.74%. The home continues to implement and evaluate progress. Antipsychotic use without a diagnosis, reached 17.5% Dec 2025, with a continued downward trend to 14.44% in April 2026, successfully achieving below corporate benchmark. With the continued support of the MD, NP, family education and BSO interventions, the home continues to successfully discontinued antipsychotics through the dose reduction initiative. Ongoing auditing and monitoring ensured accurate coding and documentation, supporting sustained improvement.
% of residents with worsening pain during their RAI lookback period	**Through assessment of residents care needs and goals** The home has conducted through assessments of the residents' goals, palliative care, and end of care. Through the completion of PPS assessments on admission, quarterly, and with significant changes the home has developed early identification of changes. Is able to address possible medication regiment changes, involve the interdisciplinary team, family and resident with care planning decisions. **Establish Palliative Care / End of Life, medication order sets** The home has implemented, monitored and evaluated their palliative / end of life medication regime order set. This ensures comfort care is being provided in a timely manner, based on the goal of comfort and successful end of life experience. The home continues to review medication order sets and implement any changes noted. **Trackers / Monitoring** The home continues to use the PRN medication tracker to assist with changes in residents' pain and increased use of medication interventions. They are able to communicate to the MD and NP to have medication reassessed and updated to met the goals of the resident. The home has also implemented referral or collaboration with the pain management specialist. All residents are assessed for pain, increased pain and intervention effectiveness on admission, re admission, quarterly, with significant change.	The home did not meet their goal of 8.5% Current QI Dec 2025 13.74%. The home continues to see a downward trend and is now meeting their goal and benchmark April 2026 QI 8.21% The home continues to implement change ideas, monitor progress and evaluate. PPS assessments continue to be completed on admission, quarterly, and with significant change in condition. Daily review of the PRN tracker is completed. Implementation of the palliative end of life order set has provided successful goals of care during end of life process

2024 Top 5 Resident satisfaction survey opportunities I enjoy eating meals in the dining room = 81.77% If I need help right away, I can get it = 80.95% Continence care products fit properly = 79.33% I am satisfied with the quality of: laundry service for personal clothing = 77.86% I am satisfied with the quality of care from: Physiotherapist/Occupational Therapist = 76.06%	The home continues to promote open communication and responsiveness to residents and families through promoting a culture of open, transparent communication to all parties involved. Encouraging residents to voice concerns and provide feedback though multiple channels such as Resident Council, Satisfaction Surveys and direct conversation with the management and staff. The Management team continue to reinforce with the staff accountability to respond to concerns promptly, respectfully and professionally including addressing any raised concerns in a timely manner. In collaboration with resident's council the Home implemented soft music in the dining room during service, and increased staffing levels in order to serve residents in a timely manner. The home also implemented auditing of dining room service and resident pleasurable dining room satisfaction. During the 2025 year personal support staffing levels were increased to ensure resident needs were being met as per their requests and preferences. This increase saw one full staff member added to each home area complement. The Home continues to complete a regular individualized continence assessment and re-assessment with any change in resident condition. There are adequate stock of all sizes and proper staff training on proper sizing, fitting and application techniques completed. The Home continue to monitor and document issues and adjust products accordingly to ensure resident comfort and dignity is followed. The Home has implemented a linen inventory and ongoing tracking system to ensure adequate supply of linens at all times including increase par levels of linens to maintain and have backup of linens at all times. Education was completed to staff on proper handling of resident personal laundry and reporting missing items promptly. Continued collaboration with the physiotherapy team to review and respond to resident feedback such as incorporating new and reviewed planning and individualized care plans including support with ongoing improvements in our PT programs / care and resident/ family satisfaction.	The goal of the resident satisfaction survey is to gain a better understanding of resident's goals and overall satisfaction of services. Our goal is always to provide the best possible care and services to the residents we server. In working collaboratively as a team, the outcome of the 2025 satisfaction survey saw the following results. I enjoy eating meals in the dining room = 80.65% If I need help right away, I can get it = 88.54% Continence care products fit properly = 82.84% I am satisfied with the quality of: laundry service for personal clothing = 90.91% I am satisfied with the quality of care from: Physiotherapist/Occupational Therapist = 89.90%
2025 Top 5 Family satisfaction survey opportunities I am satisfied with: The variety of spiritual care services = 73.65% Continence care products keeps resident dry = 72.45% Continence care products fit properly = 72.00% I am satisfied with: The timing and schedule of spiritual care programs = 71.62% I am satisfied with the quality of: laundry service for personal clothing = 70.88%	Implementation of plans to improved services in the Home is always the priority for resident comfort, dignity and satisfaction. Family's input is valuable to the Home to ensure essential services are completed in a timely manner and align with resident preferences. This also ensures staff accountability and quality in our service. For Spiritual Care services, the Home continues to coordinate with community spiritual leaders/ volunteers to expand their availability and promote services as per resident spiritual preference. Ongoing communication with the Resident Council are enhanced to continue to engage in dialogue with spiritual services items that can continue to improve quality of resident life at the Home. The home has also implemented virtual spiritual services to accommodate all needs and bedside visits including virtual options. Similar with the Resident Satisfaction Survey, the Home continues to complete a regular individualized continence assessment and re-assessment with any change in resident condition. There are adequate stock of all sizes and proper staff training on proper sizing, fitting and application techniques completed. The Home continue to monitor and document issues and adjust products accordingly to ensure resident comfort and dignity is followed. The Home has implemented a linen inventory and ongoing tracking system to ensure adequate supply of linens at all times including increase par levels of linens to maintain and have backup of linens at all times. Education was completed to staff on proper handling of resident personal laundry and reporting missing items promptly.	The family satisfaction survey goal also guides the home in quality improvement from an alternate perception and further customer service. Guiding the home to further quality improvement goals from a multidisciplinary level. Our goal is always to meet or exceed the goals of everyone involved in our care and services. The 2025 satisfaction results from a family point of view are as follows. I am satisfied with: The variety of spiritual care services = 85.35% Continence care products keeps resident dry = 90.47% Continence care products fit properly = 85.61% I am satisfied with: The timing and schedule of spiritual care programs = 86.72% I am satisfied with the quality of: laundry service for personal clothing = 88.62%

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 within the last 30 days	17.02%	17.77%	16.89%	16.52%	16.61%	16.10%	14.48%	15.56%	15.26%	15.97%	16.52%	16.67%
antipsychotic medication use without a diagnosis	9.62%	8.82%	11%	12.82%	11.98%	13.55%	13.62%	12.63%	13.74%	15%	14%	14%
worsening pain	6.52%	6%	6.84%	6.76%	7.05%	N/A	6.33%	11%	12.09%	11.35%	8.81%	11.67%
worsening stage 2 to 4 pressure ulcers	1%	1%	1%	1%	1%	N/A	2%	2%	2%	2%	2%	3%
Avoidable ED visits	19.80%	19.80%	19.80%	19.80%	19.80%	19.80%	17.40%	17.40%	17.40%	18.00%	18.00%	18.00%



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 inccorporated 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:	October 1 to October 31, 2025
Results of survey results (provide describtion of results:)	89.9% of the residents and 97.74% of family members would recommend this home to others.The 2025 resident and family surveys were conducted from October 1st to October 31st, 2025. For participation, the numerator represents the number of residents and family members that completed a survey. The denominator represents the number of residents and family members that were eligible to complete the surveys. Resident top 5 opportunities I am updated regularly about any changes in the home.80.80% I enjoy eating meals in the dining room.80.65% Overall, I am satisfied with communication from home leadership.80.19% I am satisfied with the quality of care from: Personal support staff80.06% Staff take the time to chat with me.77.68% Family top 5 opportunities I am satisfied with the quality of: Maintenance of the physical building and outdoor spaces84.89% I am satisfied with the quality of: Cleaning services throughout the home86.75% I am satisfied The timing and schedule of spiritual care services86.72% I am satisfied with the quality of: Cleaning within the resident's room 86.38% I am satisfied The variety of spiritual care services.85.35%
How and when the results of the survey were communicated to the Residents and their Families (including Resident's Council, Family Council, and Staff)	Southbridge Roseview reviewed and posted their family / resident satisfaction survey results on the public display borad in the main lobby on March 31, 2026. The satisfaction survey results were reviewed with the resident council on Feburary 19, 2026, and the family advisory commitee on May 21, 2026. The survey and results were also reviewed with staff during routine staff meetings. A copy of the annual CQI program evaulation has been posted on the public display board in the main lobby.

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	84.00%	84.31%	79.45%	100.00%	89.00%	87.74%	33.97%	62.33%	Continue to advertise the annual satisaftion survey. Have volunteers assist with resident satisfaction surveys. Send family communication eary and frequently, during survey
Would you recommend	90.00%	89.90%	92.14%	84.41%	98.00%	97.74%	80.00%	74.68%	Continue to advertise the home, send newsletters on "what's new" and what is going on in the home. Active communication with residents and families
If I have a concern, I feel comfortable raising it with the staff and leadership	89.00%	88.29%	97.69%	82.60%	97.00%	96.64%	86.96%	77.60%	Continue open door policy. Ensure residents and families have the opportunity to express their oppinion during care conference, manager walk abouts and promote open door policy

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.	1)Education and re-education will be provided to registered staff on the continued use of SBAR tool and support standardize communication between clinicians. 2) Educate residents and families about the benefits of and approaches to preventing ED visits. The home's attending NP/MD will review and collaborate with the registered staff on residents who are at high risk for transfer to ED, based on clinical and psychological; 3) Nurse Practitioner on site will provide education theoretically and at bedside. 4) Utilization internal hospital tracking tool and analyze each transfer status. ED transfer audit will be completed and reviewed monthly by nursing leadership (DOC, ADOC). Reports will be reviewed at quarterly PAC meetings; and standing agenda in nursing practice meeting	17.41% December 2025

Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education	1)Training and/or education through Surge education or live events; 2) Introduce diversity and inclusion as part of the new employee onboarding process; 3) Celebrate culture and diversity events; educational opportunities 4) Monthly quality meeting standing agenda- review the number of programs, education completed	100% December 2025
Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences".	1)Add resident right #29 to standing agenda for discussion on monthly basis by program Manager during Resident Council meeting. 2)Re-education and review to all staff on Resident Bill of Rights specifically #29 at department meetings monthly by department managers; Review of policy with resident and family with admission and care conferences	88.29% December 2025
Percentage of long-term care residents whose stage 2 to 4 pressure ulcer worsened	1) Arrange education for Registered staff and PSW, with Medline consultant and NSWOC 2) Develop a list of resident who PURS is 3 or greater, review plan of care, for the appropriate pressure relieving devices, review of surfaces in place 3) Utilization of skin and wound tracking tool, to analysis the pressure related injuries in the home - and the development of plan of care	2.3% December 2025
Percentage of LTC home residents who fell in the 30 days leading up to their assessment	1) Complete a weekly meeting with unit staff regarding ideas to help prevent risk of falls or injury related to falls; 2) increase training and/or education of Falls program; 3) Resident list of FRS of 3 or greater, offer fracture prevention medication 4) Education and re-education provided to registered staff on the completion of post fall analysis	15.24% December 2025
Top 5 Resident satisfaction survey opportunities 2025 1)I am updated regularly about any changes in the home. 2)I enjoy eating meals in the dining room. 3)Overall, I am satisfied with communication from home leadership. 4)I am satisfied with the quality of care from: Personal support staff 5)Staff take the time to chat with me.	1)Nursing management continue to send communications to residents via the Resident Council board and meetings Continue to invite residents to their Care Conference meetings to provide updates. Nursing leadership to provide updates to care staff at PSW and Registered staff meetings to inform the residents on their home areas. Increase leadership presence on home areas to meet new and current residents to provide opportunities to ask questions. 2)Reduce any unnecessary loud sounds while meal service is occurring (Google Chrome, Music) Prioritize porting of certain residents to dining room before meal service starts (behavioural residents, residents who require staff for feeding) Have multiple departments to assist during meal times (nursing, dietary, programs) 3)Leadership members to introduce themselves at new comers tea. Nursing leadership to continue to send updates of home changes to families via email. Utilize window boxes on home areas to provide updates to the home. Utilize Roseview new letter to all home areas Provide updates to residents and families during Care Conferences 4)Increase PSW education on Zero Tolerance for Resident Abuse and Neglect Policy on hire, annual, and as needed 5)All new hires to be assigned to GPA training Increase live events of common resident concerns to increase awareness Increase staffing ratios (4 staff per home area plus float PSW, and RN staff) Increase staffing ratios (4 staff per home area plus float PSW, and RN staff) . Increase 1:1 program activities with program staff Implement buddy charting.	The Homes results in 2025 1) 80.80% 2) 80.65% 3) 80.19% 4) 80.06% 5) 77.68%
Top 5 family satisfaction survey opportunities 2025 1)I am satisfied with the quality of: Maintenance of the physical building and outdoor spaces 2)I am satisfied with the quality of: Cleaning services throughout the home 3)I am satisfied The timing and schedule of spiritual care services 4)I am satisfied with the quality of: Cleaning within the resident's room 5)I am satisfied The variety of spiritual care services.	1)Have hired new maintenance staff to assist with maintenance care tasks All leadership to complete daily manager walk-abouts and input found maintenance concerns into Maintenance Care and QRM Encourage Families to bring forward any concerns with Environmental Service Manager. Keep in touch with families through various channels such as family council meetings to address and identify areas of improvement. 2)Increased cleaning staff ratios for home areas, one for every unit to increase cleaning needs of the home. All leadership to complete daily manager walk-abouts and input found home area cleanliness concerns into Maintenance Care and QRM Encourage Families to bring forward any concerns with the Environmental Service Manager. 3)Increase spiritual activities on the resident home areas (ex. Hyme sings, bible studies). Schedule spiritual services (Hyme sings) for the evenings. Look into possibility of other methods of recording the service for others to watch later (ex. Video recording, live stream service, online searches, YouTube). 4)Increased cleaning staff ratios for home areas, one for every unit to increase cleaning needs of the home. All leadership to complete daily manager walk-abouts and input found home area cleanliness concerns into Maintenance Care and QRM Encourage Families to bring forward any concerns with the Environmental Service Manager and Nursing Managers regarding care staff. Keep in touch with families through various channels such as family council meetings to address and identify areas of improvement. Improve education for PSW and Registered staff to ensure resident rooms are clean and tidy after care is provided. 5)Bring results to family advisory meeting to determine what other services should be offered other than what is currently being offered in the home. Complete lunch and learn with families for idea sharing Inquiry to families to determine their definition of spirituality and what that looks like for the residents	The Homes 2025 results 1) 84.89% 2) 86.75% 3) 86.72% 4) 86.72% 5) 85.35%

Process for ensuring quailty 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:**

CQI Lead	Karlee Galusha	**20-May-26**
Executive Director	Karlee Galusha	20-May-26
Director of Care	Cameron Robertson	20-May-26
Clinical Consultant		
Medical Director	Dr. John Coccumiglio	20-May-26
Resident Council Member	Debra Nadeau	25-May-26
Family Council Member	Rose Lauzon, Deb Legros, Amanda Anderson, Lenore Trodd	21-May-26