Continuous Quality Improvement Initiative Annual Report

Annual Schedule: May 2026

HOME NAME : Port Perry Place

People who participated in the evaluation of this report

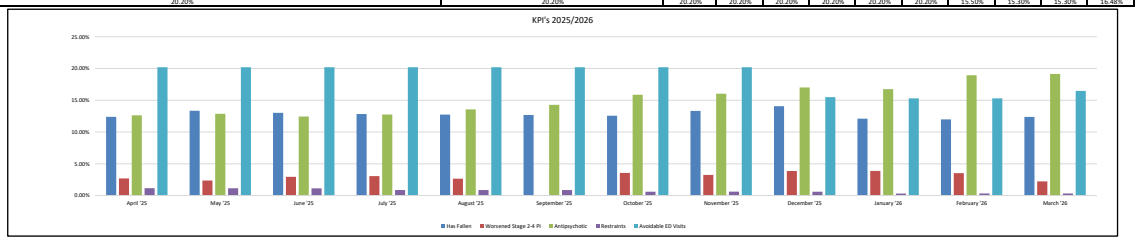
	Name and Designation	Date of Evaluation
Quality Improvement Lead	Lindsay Devlin - ED	**June 5/26**
Director of Care	Alana Mountaine - RN DOC	**June 5/26**
Executive Directive	Lindsay Devlin - ED	**June 5/26**
Nutrition Manager	Maggie Strong - FSM	**June 5/26**
Programs Manager	Leslie Kowalek - PM	**June 5/26**
Clinical Consultant	Moises Ruiz	**June 5/26**
Resident Council Representative	Peter Joyner	**June 5/26**
Family Council Representative	NIL	NIL
Medical Director	Amita Dayal	**June 5/26**
Other	Martha Moritz - RAI C	**June 5/26**
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
Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences".	**Change Idea:** To increase our goal from 86% (as compared to the previous year's 80%) to 90%. Engaging residents in meaningful conversations, care conferences, and forums that allow residents to express their opinions. Review "The Resident's Bill of Rights" more frequently, 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"; The program 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 townhalls •The ED reviewed the whistleblower policy with staff and during staff and family town hall meetings and attended a resident council meeting. **Change idea**: Review the complaint process with all new admissions and during annual care conferences, and the annual care conference with residents and SDMs •The complaint process was reviewed by the DOC 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	Review 3 resident rights at each resident council meeting. Family council was provided copies of Resident Bill of rights Whistle blower through surge and posted in the home. Quarterly review of whistleblower policy at res/family council meeting. Committee leads were successful in encouraging residents to participate in meaningful disscussions, Educational sessions were held to help promote comfortability and a safe enviroment for all residents to epress themselves, and the resident bill of rights were promoted and discussed a departmenal meetins and huddles. This topic was specifically covered in every resident council meeting and all members were provided the opportunity to express their concerns freely. **Outcome:** The home had 95.5% of residents surveyed in 2025, respond positively to " I can express my opinion without fear of consequences".
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: Residents who are prescribed antipsychotics for the management of Responsive expressions will have a quarterly review for the potential of reduction or discontinuation of medication. Utilization of tracking tool (antipsychotic)** •The interdisciplinary team met quarterly to review all residents on antipsychotics. The purpose of the meeting was to determine opportunities for antipsychotic deprescribing for each resident. The Deprescribing utilization tracking tool was utilized during these meetings. These meetings led to a gradual decrease in antipsychotic utilization in the home over the year. •BSO lead led the updating of care plans and medication reviews, every quarter and as required based on need. Families and residents, where possible, were included. **Change Idea: Development of plans of care, with nonpharmacological approach - identification of triggers and interventions** •BSO lead in collaboration with the interdisciplinary team and families, worked on resident-centred, non-pharmacological interventions to minimize triggers and overall personal expressions, i.e., engaging residents in meaningful activities.	BSO reviewed those Residents with responsive behaviors to ensure non-pharmacological interventions are in place to help manage behaviours and mitigate the need for antipsychotic medications Pharmacy and MD reviews antipsychotic use quartelty and as needed. NP/MD reducing previously prescribed antipsychotic medications where appropriate. **Outcome:** Current average is 18.13% as of April 2026. The home was not able to meet target for 2025-2026 of 15% due to an increase in the number of residents with personal expressions. For the current year, the interdisciplinary team will increase frequency of clinical reviews to ensure timely recommendations are implemented to safely decrease the use of antipsychotics.
Rate of ED visits for modified list of ambulatory care-sensitive conditions* per 100 long-term care residents.	**Change idea: Reduce avoidable hospital transfers with the support of the on-site Nurse practitioners. Staff education: Use of SBAR and Root cause analysis of transfers. Registered in-charge nurse to communicate with the physician and NP, a comprehensive resident assessment, to obtain direction before initiating an ER transfer** •Clinical consultant, DOC, 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 Clinical consultant 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 •NP focused education on timely measures to minimize acute episodes (i.e., vital signs monitoring of respiratory symptoms), interventions, and treatments. **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	The home continues to show a gradual reduction in avoidable/unnecessary ED transfers since Q1, 2024. Reg staff continue to use the SBAR tool to ensure timely and objective information is shared with the members of the interdisciplinary team to minimize or avoid unnecessary ED transfers. -Regular discussions are taking place between the Reg staff with the NP and MDs to ensure acute episodes are dealt with timely to reduce risk and possible unnecessary ED visits. The NP continues to do education on the spot with the reg staff on clinical assessments, including how to deal with medical acute episodes as appropriate -The home needs to focus more on re-educating residents and families on advanced care planning. **Outcome:** improved from 20 % in 2025 to 16.48% as of March 2026. SBAR training completed in 2025, NP in house, cause of transfers reviewed at quality meetings. The home remains below provinical benchmarking.
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 •Live 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: All employees are to be trained in relevant equity, diversity, inclusion, and anti-racism in the year.** •All staff completed their mandatory training on equity, diversity, inclusion, and anti-racism through surge learning •Managers reviewed different topics on diversity, inclusion, equity, and anti-racism in the workplace during departmental meetings to provide meaningful opportunities for discussion and learning .	**Outcome:** 100% of all staff completed the 2025 relevant equity, diversity, inclusion, and anti-racism education. Posters displayed through out the home to create awareness of diversity - black history month, pride, cultural diversity, truth and reconciliation.
Percentage of long-term care residents whose stage 2 to 4 pressure ulcer worsened	Change idea : The interdisciplinary team will meet biweekly to review the skin and wound tracking tools to analyze pressure-related injuries in the home, completion of weekly skin assessments, and the need for referral to NP or NSWOC. Plans of care will also be reviewed to ensure interventions are aligned with current treatment, preventative measures, and best practices Interdiciplinary biweekly meetings took place throughout the year .During these metings , an indeepth analysis was conducated to review all wounds in the home . The Skin and wound care lead provided updates to the team regarding the compilation of weekly skin assessments and outcome of referrals to the NSWOC Care plans were updated as required. Family/residents were involved in the process . Change idea : Referrals to the NSWOC for the residents who fall into the 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. The skin and wound care lead of the home in collaboration wit the MD/NP , followed up with the NSWOC for timely consultations . All non healing wounds were reerred to the NSWOC for consults	By implementing these change ideas , the home was able to surpass the target performance of 8.5 % for 25-26. March 2025 : 16.12% March 2026 : 5.76 %
Percentage of long-term care residents whose pain has worsened	**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** For 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	By implementing these change ideas , the home was very close to meeting the target performance of 2.2 % for 25-26. March 2025 : 2.36% March 2026 : 2.22 % During the 25-26 year, the home inhereted residents with worsen wounds stage 2-4 with new admissions from the communicty and hospital settings.
Percentage of LTC home residents who fell in the 30 days leading up to their assessment	Change idea : Weekly meetings will take place with the interdisciplinary team to review. Medium and high-risk residents. Interventions are to be reviewed, and changes implemented as necessary. The falls lead , in collaboration with the interdiciplinary team , met weekly to review residents who were determined to be medium-high risk for falls . During the meetings, all aspects of care were revivwed , including , pain, mobility, vision, environmental factors, medications , etc . Families and residents were involved during the process . Change idea : The home will complete a Falls management-falls risk assessment for new admissions, after a change in rooms/setting, transfer, after a fall, any change in status, and after medication change for residents with a history of falls. The falls lead in collaboration with the nursing team completed fall resik assesments for all new admissions and during change in conditions . Care plans were updated accordingly based on resident's needs Change idea : The interdisciplinary team, in collaboration with SDM and the resident (as appropriate), will implement an individualized multi-factorial approach focusing on modifiable non-pharmacological and pharmacological factors. Intrinsic Risk Factors (e.g., demographic and biological). Extrinsic Risk Factors (e.g., behavioural, environmental, and medication-related). The interdiciplinary team reviewed both intrisic and extrinsic fatocrs that may influence on the level of risk for each resident perterning falls . This inititive assited the team in looking at all possible interventions required to minimize the risk for falls for the residents . Recomendations for interventions were made , families and residents participated in the process .	We continue to work with our NP, Pain consultant and Physio team to look at root causes, reduction of pain and pain management, as well as building physical capabilities for residents receving both PT, PTA and Restorative service falls huddles have continued to take place after each fall, this has allowed the team to review each event and formulate interventions to reduce risk of falls and injuries to residents -Medium and High risk residents have been reviewed by Falls Lead. Morse completed on admission, quarterly, and after a fall if not previously deemed high risk. **Outcome:** Average is 11.04% in April 2026. Home remains below provincial average
2024 Resident Satisfaction Survey: Top 5 Opportunities 1. I am satisfied with the quality of care from the variety of spiritual care services (2024 - 76.67%) 2. Continence care products are comfortable (2024 - 75.61%) 3. I am satisfied with the temperature of my food and beverages (2024 - 71.56%) 4. I have access to foot care when needed (2024 - 71.25%) 5. Overall, I am satisfied with the continence care products used in the home (2024 - 70.24%)	Spiritual Survey was complete on January 7, 2024 at Resident's Council. Spiritual services are offered monthly, church every Sunday, Chaplin's Chat monthly, Spirtiual word puzzle every Sunday and Reflective Mediation Every Monday. Meeting with Prevail rep reviewed and implemented resizing for the whole LTC done 1/7/24 ; worksheets updated on the units and audit forms available in PSW binder for submission of resizing. FSM monitors the temperature of the foods and beverages at meals and nourishment times. Footcare process reviewed to ensure those residents that have consented to footcare receive it. Footcare clinics held every 4-6wks in the home	Outcome: 1. I am satisfied with the quality of care from the variety of spiritual care services (2025 - 84.83%) 2. Continence care products are comfortable (2025 - 82.72%) 3. I am satisfied with the temperature of my food and beverages (2025 - 83.73%) 4. I have access to foot care when needed (2025 - 81.43%) 5. Overall, I am satisfied with the continence care products used in the home (2025 - 92.73%)

2024 Family Satisfaction Survey: Top 5 Opportunities 1. Continence care products fit properly (2024- 77.65%) 2.Continence Care products: Are comfortable (2024 - 76.81%) 3. The resident enjoys eating meals in the dining room (2024 - 70.59%) 4. I am satisfied with the timing and schedule of Spiritual care services (2024 - 70.00%) 5. I am satisfied with the quality of care from: Social Worker/Social Service Worker (2024 - 68.93%)	Prevail did resizing and concerns reviewed with rep for the whole home on 1/7/2024 Pleasurable dining education provided to all staff through Surge Learning. Managers attend meals for their unit to ensure Pleasurable dining is compliant Activation department conducted a survey of spiritual care services wanted by residents. Activation department incorporated requested service into their monthly calendar. Social worker hired and present in the home 3 days/wk	Outcome: 1. Continence care products fit properly (2025 - 82.96%) 2.Continence Care products: Are comfortable (2025 - 82.96%) 3. The resident enjoys eating meals in the dining room (2025 - 82.87%) 4. I am satisfied with the timing and schedule of Spiritual care services (2025 - 78.83%) 5. I am satisfied with the quality of care from: Social Worker/ Social Service Worker (2025 - 79.83%)

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
Has Fallen	12.39%	13.35%	13.03%	12.83%	12.75%	12.68%	12.57%	13.33%	14.07%	12.11%	11.99%	12.38%
Worsened Stage 2-4 PI	2.69%	2.36%	2.94%	3.06%	2.65%	0.00%	3.56%	3.25%	3.86%	3.88%	3.52%	2.22%
Antipsychotic	12.63%	13%	12.44%	12.76%	13.57%	14.29%	15.87%	16%	17.02%	16.76%	18.95%	19.15%
Restraints	1.15%	1.14%	1.13%	0.87%	0.87%	0.86%	0.60%	0.61%	0.60%	0.31%	0.32%	0.32%
Avoidable ED Visits	20.20%	20.20%	20.20%	20.20%	20.20%	20.20%	20.20%	20.20%	15.50%	15.30%	15.30%	16.48%



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:	Oct-25
Results of the Survey (*provide description of the results*):	87.90% of residents and 83.53% of families would recommend this home to others. The 2025 resident and fmaily surveys were conducted from Oct 1-31, 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 survey.
How and when the results of the survey were communicated to the Residents and their Families (including Resident's Council, Family Council, and Staff)	Survey results were taken to resident (Jan 7, 2026) and family council (May 20, 2026) meetings for review and action plan review and updates. Staff were informed at department staff meetings and on the CQI board in the main hall of the home.

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	100.00%	100.00%	90.57%	100.00%	75.00%	62.20%	25.00%	42.50%	Family council will have a president that can assist with driving participation for the 2026 survey. We will be hold a table at the front lobby during survey time frame to inform families of the survey and to assist with submitting if they can. Management will actively participate with this process. Engaging residents in meaningful conversations, care conferences, have forums that allow residents to express their opinions. Review "The Resident's Bill of Rights" more frequently, 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 Engaging residents in meaningful conversations, care conferences, have forums that allow residents to express their opinions. Review "The Resident's Bill of Rights" more frequently, 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. Ensure any concerns brought forward are dealt with in a timely manner.
Would you recommend	90.00%	87.90%	75.00%	74.76%	90.00%	83.53%	80.10%	83.75%	
If I have a concern, I feel comfortable raising it with the staff and leadership	96.00%	95.50%	87.66%	77.62%	95.00%	91.52%	88.68%	85.63%	

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 : Maintain current avoidable ED visit target by utilizing the onsite NP and other external collaborators and the clinical consultant and Director of Care!! Nursing team to alert the Nurse practitioner and other external collaborators when changes noted in resident status to allow for prompt assessment and managing acute episodes in house Change idea : Build capacity in Nursing team by ongoing education on the use of SBAR tool and early detection of signs and symptoms of the most common causes of hospital transfers from 2025 to ensure effective assessment and prompt interventions. Provide training to staff on use of SBAR and early detection of signs and symptoms of the most common causes of hospital transfers from 2025 Target : 15.25%	March 2026: 15.25%
Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education	Change idea : The home will continue to conduct mandatory training on equity, diversity, inclusion, and anti-racism through the year for all staff.!! completion of Surge learning Modules Change idea : Home will host at minimum 2 events to celebrate equity, diversity, inclusion and provide another venue to educate staff on anti-racism.!! Communication boards will be reflective of specific events to engage staff, residents and families Target : 100%	March 2026 : 100%
Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences".	"Change idea : The home will continue to encourage residents to express their opinion at Resident council and care conferences.!! Encourage residents to attend and participate in both Resident council and Care conferences. Change idea : Review the complaint process with all new admissions and during annual care conferences with residents and SDMs.!! During admission and annual care conferences, the social worker will review the complaint process with the residents and/or SDMs and documented in the ""CONFERENCE - Interdisciplinary Team Care Conference (IDTC)"" assessment." Target : 95.50%	March 2026: 95.65%
Percentage of LTC home residents who fell in the 30 days leading up to their assessment. Goal 12%	Change idea : Complete Weekly Fall Huddles for each unit with the interdisciplinary team.!! Complete a weekly huddle with unit staff regarding ideas to help prevent risks of falls or injury related to falls. Change idea : In collaboration with the Falls committee, the Falls lead, and the interdisciplinary team, residents who are determined to be medium to high-risk and have recently sustained a fall will be reviewed for 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.!! Completion of the Monthly clinical falls review meetings. Change idea : Resident list of FRS of 3 or greater, offering fracture and injury prevention alternatives, both pharmacological and non-pharmacological.!! Education provided to registered staff on fracture and injury prevention. Involve restorative care lead .	March 2026: 12.17%
Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment	Change idea #1 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. Change idea #2 Residents who are prescribed antipsychotics for the 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 and the nursing team will ensure that residents who receive antipsychotics for responsive expressions with have their medication, and plan of care reviewed, quarterly by the interdisciplinary team (including resident and family)	March 2026: 11.84%

Percentage of long-term care residents whose stage 2 to 4 pressure ulcer worsened - goal of 2.0%	Change Idea #1 Roll out education on wound care management and assessment, and skin care. Education to be provided by NSWOC (during wound care rounds), DOC to arrange education for Registered staff and PSW, with NSWOC/Medline Change idea #2 Monthly review in the Quality meeting of 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 Change idea #3 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 : 2 %	March 2026: 3.15%
Percentage of long-term care residents in daily physical restraints	Change idea : The home will continue to have zero Residents utilizing daily physical restraints.!! Continue to provide education to Staff, Families and residents on alternate options to restraints and the risks associated with restraint use. Target : 1.14%	March 2026: 1.14%

TOP 5 OPPORTUNITIES **Resident satisfaction survey 2025**	**ACTION PLAN**	**Results**
I can find a private place to visit with when I have visitors.	Review private resident space areas at Resident Council, care conferences, in newsletter and tour packages. Create and share a poster that advertises the private places for residents to visit with family.	I can find a private place to visit with when I have visitors = 81/94%
I have access to foot care when needed.	Ensure there are two full days of footcare services every 6 weeks for residents to receive footcare who have signed consent. Ensure Footcare dates are posted for residents/families. Share dates at Resident council meetings	I have access to foot care when needed = 81.43%
I am satisfied with the quality of care from: Dietitian	Resident Council requests for Registered Dietitian to attend a Resident Council Meeting for introduction and services available. Review of Registered Dietitian services at admission and ensure RD meets resident/family in person within 14 days of admission. Registered Dietitian to provide introduction and summary of registered Dietitian role, scope of practice and schedule when they are in the home. This information is to be sent out in the Resident and Family newsletter bi-annually	I am satisfied with the quality of care from: Dietitian = 80.53%
I am satisfied with the quality of: Laundry services for personal clothing	ESM review personal clothing laundry process including washing and delivery guidelines, with Laundry Aids. Post guidelines for reference. Initiate monthly auditing of clothing delivery accuracy, location concerns. Implement a lost clothing cart program for Resident Home Area's for easy identification by staff, residents and family to return items quarterly. Track missing Laundry reporting forms; overall # per month, reviewed to determine trends monthly. Create action plans as required.	I am satisfied with the quality of: Laundry services for personal clothing = 80.2%
I am satisfied with the quality of care from: Social Worker/Social Service Worker	Social Service Worker onboarded in August 2025, as a new part time role/position in the home. Residents Council to invite Social Service Worker to attend Residents Council Meeting to introduce role and scope of practice and scheduled times in the home. Social Service Worker to visit each resident to develop case load to determine frequency of visits to address resident's needs.	I am satisfied with the quality of care from: Social Worker/Social Service Worker = 73.3%

TOP 5 OPPORTUNITIES **Family satisfaction survey 2025**	**ACTION PLAN**	**Results**
I am satisfied with the quality of: Cleaning within the resident's room.	Environmental Services Manager to complete resident room cleaning audits biannually. ESM to review the Housekeeper Aid cleaning checklist for task assignment and completion. Implement an action plan to declutter resident rooms as required. Leadership team completed Manager by Walkabout to observe residents' rooms for cleanliness daily. ESM to review and train Housekeeper Aid on job routines and assignments and educate on cleaning routines, processes and products.	I am satisfied with the quality of: Cleaning within the resident's room = 80.95%
The resident has access to foot care when needed.	Educate residents on admission of the footcare provision in the home schedules. Include footcare schedule in the monthly Family Newsletters. Residents will be encouraged to discuss foot-care preferences during care conferences.	The resident has access to foot care when needed = 80.54%
I am satisfied with the quality of care from: Social Worker/Social Service Worker.	Social Service Worker onboarded in August 2025, as a new part time role/position in the home. Family Council to invite Social Service Worker to attend Family Council meeting to introduce role and scope of practice and scheduled times in the home. Social Service Worker to visit each resident to develop case load to determine frequency of visits to address resident's needs.	I am satisfied with the quality of care from: Social Worker/Social Service Worker = 79.83%
I am satisfied with: The timing and schedule of spiritual care services. 78.83%	Review of spiritual services timing with residents and Residents Council to determine timing preferences. Family Council notified residents of preferences. Revisit spiritual volunteers to address any individual requests for time changes. Offer virtual sessions as available. Recruit and Develop 1:1 spiritual volunteers to meet resident's needs.	I am satisfied with: The timing and schedule of spiritual care services = 78.83%
I am satisfied with: The variety of spiritual care services.	Spiritual assessment completed on admission to collect feedback from residents on their spiritual needs and preferences. Create and promote resources that promote available spiritual care services and how to access them. Communicate the variety of denominations and services available for each denomination in the newsletter and ask for feedback. Ensure all resident faiths are represented with services in the home.	I am satisfied with: The variety of spiritual care services = 77.56%

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 & complete/ copy - obtain signatures and file*	Date Signed
Quality Improvement Lead	Lindsay Devlin	**June 5/26**
Executive Director	Lindsay Devlin	**June 5/26**
Director of Care	Alana Mountaine	**June 5/26**
Nutrition Manager	Maggie Strong	**June 5/26**
Programs Manager	Leslie Kowalek	**June 5/26**
Clinical Consultant	Moises Ruiz	**June 5/26**
Resident Council Representative	Peter Joyner	**June 5/26**
Family Council Representative	N/A	**N/A**
Medical Director	Amita Dayal	**June 5/26**
Other		
Other		