SOUTHBRIDGE HEALTH CARE LP

Continuous Quality Improvement Initiative Annual Report

Annual Schedule: May 2026

HOME NAME : Kennedy Lodge

People who participated in the evaluation of this report

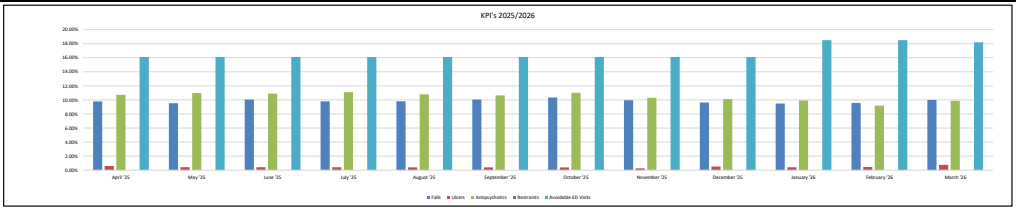
	Name and Designation	Date
Quality Improvement Lead	Olivia Gagliardi	May 20 2026
Director of Care	Jemmy Raval	May 20 2026
Executive Directive	Olivia Gagliardi	May 20 2026
Nutrition Manager	Francine Stewart	May 20 2026
Programs Manager	Sandra Morgan	May 20 2026
Clinical Consultant	Sarah Annesley	May 20 2026
Resident Council Representative	Afzal Jessa	May 20 2026
Family Council Representative	Ingrid Menezes	May 20 2026
Medical Director	Dr. Cyril Press	May 20 2026
Other	Evangeline Bautista	May 20 2026
Other	Adora Cunanmeng	May 20 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
Initiative #1 - "Communication from home leadership is clear and timely" 2024 Actual - 74.80% 2025 Target - 90%	**Newsletters are being sent out to families:** Newsletters are being regularly shared with residents and their families and are a valuable communication tool within long-term care home. They promote transparency, keep everyone informed, and strengthen trust between the care home, residents, and their loved ones. Overall, newsletters serve as an effective way to maintain open communication, support resident engagement, and build a positive, informed community within Kennedy Lodge. **Discussion with resident and family council about updates (if invited):** Engaging in discussions with Resident and Family Councils regarding updates, when invited, is an important practice that supports quality care in long-term care settings. These discussions create an opportunity for open dialogue, collaboration, and shared decision-making between the care home, residents, and their families. For residents, participating in or being represented through Resident Council discussions promotes a sense of autonomy, dignity, and inclusion. It ensures their voices are heard and their preferences, concerns, and suggestions are considered when making decisions that affect their daily lives. This engagement contributes to improved satisfaction, empowerment, and overall well-being. The commencement of regular email updates regarding the home is a valuable initiative that enhances communication and transparency within Kennedy Lodge. **Email updates commenced with updates regarding the home:** The commencement of regular email updates regarding the home is a valuable initiative that enhances communication and transparency at Kennedy Lodge. Overall, email communication strengthens partnerships between the home and families, improves transparency, and supports a more informed, engaged, and collaborative care environment—ultimately enhancing the quality of life for residents. **Additional Measures** - Kennedy Lodge is a multilingual long-term care home. The team translates important documentation to french and cantonese to increase our communication reach.	These initiatives have had a positive effect on the percentage of residents who are happy with the communication from Kennedy Lodge leadership, increasing from 74.80% in 2024 to 84.41% in 2025. While the home did not meet the target of 90%, we remain committed to timely communications with residents and families.
Initiative #2 - In my care conference, we discuss what's going well, what could be better, and how we can improve things. 2024 Actual - 78.20% 2025 Target - 80.90%	**Residents will be encouraged to attend their annual care conferences** **beginning February 19, 2025:** Encouraging residents to attend their annual care conferences is an important practice that promotes person-centered care and meaningful engagement within our home, Kennedy Lodge. For residents, participation in care conferences allows them to have a direct voice in decisions about their care. It supports their autonomy, dignity, and individuality by ensuring their preferences, goals, and concerns are heard and respected. Being involved in care planning can improve their sense of control, satisfaction, and overall well-being. For families, care conferences provide an opportunity to collaborate with the care team and gain a clear understanding of their loved one's care plan, progress, and any changes in needs. It encourages open communication, builds trust, and ensures that families are active partners in decision-making. This involvement often leads to greater confidence in the care being provided. Overall, resident participation in annual care conferences strengthens communication, promotes a person-centered approach, and supports better health outcomes by aligning care with the resident's values and needs. **There will be a 5% improvement in this indicator by December 2025:** Achieving a 5% improvement in this indicator by December 2025 reflects a commitment to continuous quality improvement at Kennedy Lodge. For residents, this improvement translates into enhanced quality of care, safety, and overall well-being. Whether the indicator relates to clinical outcomes, engagement, communication, or satisfaction, even a modest improvement can lead to better daily experiences, increased comfort, and improved health outcomes. It demonstrates that our home is actively working to meet residents' needs and improve their quality of life.	All residents are invited to attend their care conference. 100% of residents who agree are included in this meeting and are involved in their own plan of care. The home saw an increase in the percentages of residents who responded positively to the question about meaningful care conferences on the resident satisfaction survey, from 78.2% in 2024 to 80.9% in 2025. While the home did not reach the target of 83%, we remain committed to ensuring that residents have a meaningful experience when discussing their care needs.
Initiative # 3 - "If I need help right away, I can get it." 2024 Actual - 79.10% 2025 Target - 85%	**Monthly call bell report to identify gaps in response time.** Monthly call bell audits are completed to quantitatively monitor response times, identify trends, and highlight areas requiring improvement. Audit results are reviewed with staff during monthly staff meetings, using collected data to reinforce expectations, track performance, and support accountability. This ongoing review process ensures that response time metrics remain a consistent focus, with less than 5 minutes of response time with staff actively engaged in improving timeliness and service delivery based on measurable outcomes. Proactive strategies such as purposeful rounding by staff and managers have been implemented to reduce call bell frequency and address resident needs in advance. Timely response expectations are reinforced across interdisciplinary team meetings and Resident Council, promoting shared accountability among staff and residents. In addition, PSW coverage protocols during breaks (through clear partner handoff) have strengthened continuity of care. These combined interventions have contributed to improved monitoring, more consistent coverage, and enhanced responsiveness, as reflected in overall staff awareness and adherence to call bell response expectations.	The home saw an increase in the number of residents who responded positively to the satisfaction survey question "If I need help, I can get it" from 79.10% in 2024 to 81.63% in 2025. While the home did not meet the target of 85% we continue to prioritize the call bell response time.
Initiative #4 - Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment target: 17.5% 2024 Actual - 13.43% 2025 Target - 12%	**All residents who do not have behaviours present but are prescribed antipsychotics are reviewed monthly.** Evidenced based tools like ADP and Cohen Mansfield test is completed to support our efforts in de-prescribing antipsychotics without a diagnosis. *Pharmacy provides monthly report for all residents who are using anti-psychotic.* All residents who do not have behaviours present but are prescribed antipsychotics are reviewed monthly. Kennedy Lodge has successfully discontinued antipsychotic usage for 6 residents in 2025. Ongoing auditing and monitoring ensured accurate coding and documentation, supporting sustained improvement. **ADP and Cohen Mansfield test is completed to support our efforts in de-prescribing antipsychotics without a diagnosis.** Antipsychotic reduction program for eligible residents and interdisciplinary team approach was utilized to identify residents suitable for dose reduction. Residents were carefully selected based on clinical judgement, including review of their current diagnosis, behaviours, and overall health status. Prior to initiation, residents underwent a Cohen-Mansfield Agitation Inventory observation assessment to confirm eligibility. Continuous auditing and monitoring of coding and documentation. This is to prevent errors and miscoding. This process was particularly important for avoiding misclassification of medications such as antidepression or anticonvulsants as antipsychotic. **Pharmacy provides monthly report for all residents who are using anti-psychotic.** In addition to close monitoring of the residents triggering the antipsychotic without a diagnosis of psychosis quality indicator, CarelRX provides monthly drug utilization reports that are reviewed and discusses during the committees for Continuing Quality Improvements and Professional Advisories. This ensures a multidisciplinary approach is paramount to the reduction program.	Through successful implementation of the change ideas, the home was able to reduce the percentage of residents receiving antipsychotic medications without a diagnoses of psychosis from 13.43% in 2024-2025 to 10.66% in 2025-2026. This far exceeds the target set, the corporate benchmark and the provincial averages. The home remains committed to antipsychotic reduction.
Initiative #5 - Percentage of LTC home residents who fell in the 30 days leading up to their assessment target is 15% and we are currently at 10.6% 2024 Actual - 9.24% 2025 Target - 8%	**Continue to implement falls screening and post fall huddles, continue to provide interventions as reflected in the care plan.** Continuing falls screening helps identify residents at risk early, allowing for timely preventative measures. Post-fall huddles enable the care team to quickly review incidents, identify causes, and adjust care to prevent recurrence. Ensuring interventions are consistently followed as per the care plan supports personalized, proactive care. Overall, this approach improves resident safety, reduces injuries, and reassures families that preventative and responsive measures are in place. **Continue to Provide Interventions as reflected in the care plan.** The home enhanced audits for equipment and environmental safety, ensuring weekly and monthly audits were conducted by the program lead and physiotherapist to ensure all fall prevention equipment, (e.g. bed alarms, fall mats, hip protectors) were functional, available, and appropriate to resident need. **Additional Measures** *Strengthen Leadership and Over sign Accountability* - ongoing review of fall data by fall program lead with follow up on corrective actions and reinforcement of staff accountability in post fall management and documentation. *Resident monitoring and interdisciplinary follow up* - use of fall risk assessment tool, (e.g. MORSE fall risk scale) to identify high risk residents with interdisciplinary care conferences conducting following recurrent falls to update care plans. Fall analysis was completed for all staff to review and sign off at the end of the month and during our interdisciplinary meetings.	Falls management quality indicator improved 8.33% which was below the corporate benchmark of 15% with sustained downward trend. Improve med management of high risk resident with reduced frequency and impact of falls. There was consistent implementation of layered interventions, contributed to sustained improvement and enhanced resident safety.
2024 Resident Satisfaction Survey Top 5 Opportunities #1. "Communication from home leadership (Administrator, Executive Director, and Managers) is clear and timely" 2024 Actual - 74.8% #2 - "In my care conference, we discuss what's going well, what could be better and how we can improve things" 2024 Actual - 78.2% #3 - "If I need help right away, I can get it" 2024 Actual - 79.1% #4 - "I feel my goals and wishes are heard and considered in my care." 2024 Actual - 79.7% #5 - "There is someone I can talk to about my medications." 2024 Actual 80.3%	#1. "Communication from home leadership (Administrator, Executive Director, and Managers) is clear and timely" - This indicator was included as an initiative #1 in the 2025-2026 QIP and results of the change ideas are discussed above. #2 - "In my care conference, we discuss what's going well, what could be better and how we can improve things" - This indicator was included as an initiative #2 in the 2025-2026 QIP and results of the change ideas are discussed above. #3 - "If I need help right away, I can get it" - This indicator was included as an initiative #3 in the 2025-2026 QIP and results of the change ideas are discussed above. #4 - "I feel my goals and wishes are heard and considered in my care." - As part of the improvements made to care conferences, residents were invited to attend and share personal goals and wishes. Attendance from residents increased with reminders of meeting times. #5 - "There is someone I can talk to about my medications." - In addition to improvements made to care conferences, where a physician is present to discuss medications, the home hired a nurse practitioner full-time for the unit. Physicians are also available on the units, each day of the week and are happy to attend to any questions that the residents may have regarding their medications.	2025 Satisfaction Survey Results #1 84.41% #2 80.9% #3 81.63% #4 89.75% #5 88.40%
2024 Family Satisfaction Survey Top 5 Opportunities #1 - I am satisfied with the food and beverages served to residents. 2024 Actual - 82.5% #2 - I am satisfied with the variety of food and beverage options for residents. 2024 Actual - 82.5% #3 - I am satisfied with the quality of laundry services for personal clothing and linens; 2024 Actual - 83.3% #4 - Communication from home leadership (Administrator, Executive Director, and Managers) is clear and timely. 2024 Actual - 83.5% #5 - I am satisfied with the quality of maintenance of the physical building and outdoor spaces 2024 Actual - 84.6%	#1 - I am satisfied with the food and beverages served to residents. - As part of the resident food council, residents were offered food tastings and input into the seasonal menu changes. #2 - I am satisfied with the variety of food and beverage options for residents. - Residents are invited to attend monthly food council meetings where they have input into the menu. Changes are made at the request of the residents. Kennedy Lodge has a multi cultural resident population and incorporates food choices into cultural celebrations. #3 - I am satisfied with the quality of laundry services for personal clothing and linens; - As part of the transition to Southbridge, new policies and procedures were implemented. The home maintained the satisfaction above 80%, and has incorporated new change ideas as part of the 2025 satisfaction action plan. #4 - Communication from home leadership (Administrator, Executive Director, and Managers) is clear and timely. - This indicator was included as an initiative #1 in the 2025-2026 QIP and results of the change ideas are discussed above. #5 - I am satisfied with the quality of maintenance of the physical building and outdoor spaces - In 2025, Kennedy Lodge hosted a gardening day to plant new flowers in the residents outdoor garden. This area was used by residents/families as a safe place to wander. The home implemented daily manage by walkabout audits that included the outdoor spaces, allowing for improved resolution to any identified problems.	2025 Satisfaction Survey Results #1 90.81% #2 90.83% #3 80.09% #4 80.70% #5 81.21%

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	9.78%	9.52%	10.04%	9.79%	9.80%	10.05%	10.34%	9.95%	9.62%	9.48%	9.55%	9.99%
Ulcers	0.60%	0.43%	0.43%	0.42%	0.41%	0.40%	0.40%	0.26%	0.52%	0.42%	0.46%	0.70%
Antipsychotics	10.72%	10.88%	11%	10.79%	10.63%	11.00%	10.29%	10.10%	9.91%	9.19%	9.87%	
Restraints	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Avoidable ED Visits	16.10%	16.10%	16.10%	16.10%	16.10%	16.10%	16.10%	16.10%	16.10%	16.10%	16.10%	16.10%



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:	October 1st to October 31st, 2025
Results of the Survey (*provide description of the results*):	In the 2025 resident satisfaction survey, 87.08% of residents have an overall satisfaction level, this is slightly higher than the corporate average of 86.08%. Comparatively, 87.29% of families are satisfied with Kennedy Lodge, overall. This is slightly higher than the corporate average of 86.0% This is a similar response to the 2024 survey where 87.4% of Residents and 88.8% of Family would recommend this home to others.
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 reviewed by CQI committee: April 16, 2026 Survey results were shared and discussed with Resident Council: March 31, 2026 A copy of the survey results was provided to Resident Council: March 31, 2026 A copy of the survey results was shared and provided with Family Council: February 11, 2026

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%	100.00%	100.00%	100.00%	72.50%	100.00%	80.60%	The Home will continue to promote participation in the Resident and Family Satisfaction Survey through multiple communication channels, including the Newsletter, Care Conferences, email communications, notice boards, and Resident/Family Council Meetings, to ensure broad engagement and awareness. The home aims to translate the satisfaction survey to Cantonese again this year, in order to accommodate the high population of residents and families who speak Cantonese as a first language.
Would you recommend	90.00%	86.74%	87.40%	80.20%	90.00%	82.77%	88.80%	91.10%	To support improvement in the likelihood of residents and families recommending Kennedy Lodge as a place to live, the Home will continue to focus on enhancing the quality of resident programs and services. Staff will be expected to consistently uphold the Home's Mission, Vision, and Values in daily practice and interactions with residents and families. Positive engagement and communication will be actively encouraged to strengthen relationships and overall satisfaction. The Home will also continue to highlight ongoing quality improvement initiatives and care outcomes through newsletters and Resident Council meetings, including updates and success on quality indicators, staffing levels, and care improvements. In addition, "Would you recommend this Home?" will remain a standing discussion item at Resident Council meetings, with follow-up completed on feedback and recommendations provided.
If I have a concern, I feel comfortable raising it with the staff and leadership	99.00%	92.92%	80.90%	75.00%	100.00%	98.95%	92.50%	93.60%	The Home remains committed to fostering an environment where residents and families feel safe and comfortable raising concerns. In alignment with the Home's HQJ-QIP improvement initiatives, the following strategies will continue: 1. Ongoing review and reinforcement of the Complaints and Concerns process upon admission, during annual care conferences, and through staff education and training sessions. 2. Continued engagement of residents in meaningful discussions during care conferences to encourage open expression of opinions, concerns, and suggestions. 3. Regular review of the Residents' Bill of Rights at Resident Council meetings, with emphasis on Resident Rights #29, which supports the right to raise concerns or recommend changes without fear of discrimination or reprisal. 4. Timely follow-up, discussion, and resolution of resident concerns raised through Resident Council Meetings. These ongoing initiatives aim to strengthen resident voice, improve communication, and support continuous quality improvement within the Home.

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
Indicator #1 - Rate of ED visits for modified list of ambulatory care	(1) To reduce unnecessary hospital transfers, through the use of on-site Nurse Practitioner. (2) Completion of PPS assessments and implementation of use and education for residents and/or families on palliative approach and end of life. (3) Utilization of information brochure and discussions upon admission and during care conferences, and Utilization of home-level hospital tracking tool and document each transfer status. ED transfer tracking tool will be reviewed to identify trends and action accordingly. This will be added as a standing agenda item at monthly nursing staff meetings and reported back to the professional advisory committee with attending physicians and nurse practitioner quarterly. **Target - 18.0%**	January 2026 - 18.48%
Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education	(1) celebrate culture and diversity events and recognize the cultural events/holidays throughout the year. Quarterly quality improvement meetings will have cultural diversity and events as a standing agenda item for discussion. (2)Training and education through Surge education and live events. (3) The spiritual assessment will be used as a tool to plan activities/events that celebrate cultural diversity in alignment with resident preferences **Target - 100%**	December 2026 - 100%
Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences".	(1) review the concern/complaint process in the home upon admission and at care conferences annually. (2) A renewed approach to reviewing Resident Bill of Rights #29 will be incorporated into meetings this year. (3) Create more awareness about the resident bill of rights within the home. With the involvement of our residents, a video will be created highlighting all the resident bill of rights. This multilingual video will represent the diverse culture of the residents, families and staff at Kennedy Lodge. It will play on loop in our front lobby. **Target - 97%**	October 2025 - 95%
Percentage of LTC home residents who fell in the 30 days leading up to their assessment	(1) to reduce the number of falls at Kennedy Lodge through focus on the root cause analysis of the fall. Staff will be re/educated to conduct a post fall huddle after each fall, through completion of the comprehensive post-fall assessment. From this analysis, staff will determine new interventions to prevent future falls. These interventions will be included in the plan of care. (2) A renewed focus on injury prevention, through review of MORSE falls risk and fracture risk scale (FRS) to ensure residents bone health medications are appropriate. (3) Kennedy Lodge will continue to implement a program that supports purposeful rounding for all residents identified at high risk for falls. **Target - 9.5%**	2025-2026 Q3 - 9.9%
Percentage of long-term care residents whose stage 2 to 4 pressure ulcer worsened	(1) Prompt identification and documentation of worsening pressure injuries, including a notification to the Skin and Wound Champion, as needed. (2) Expand the role of the PSW Coordinator to include leadership as a Pressure Injury Prevention Champion, with a focused responsibility on optimizing resident pressure redistribution surfaces. (3) Registered Dietician review of nutritional hydration status of residents with impaired skin integrity. **Target - 1%**	2025-2026 Q3 - 1.53%
2025 Resident Satisfaction Survey Top 5 Opportunities	**#1 - I am satisfied with the quality of Laundry Services for personal clothing** - Digital photo inventory: upon admission, take a quick photo of the resident's initial wardrobe and upload it under Misc Tab on PCC. This will provide a baseline for what "belongs" in their room and make it easier for laundry staff to return items that lose their tags or have never been tagged. - Purchase hamper dedicated specifically for laundry labelling services to keep accountability on labelled, new clothes and keeping them separate from other laundered items already bagged. **#2 - I enjoy eating meals in the dining room** - 15 minutes before meals, play soft, era-appropriate music. This will help in transitioning to social and dinner experience time. - Walk abouts on units and constant reminders in Town Halls/PSW Meetings and Registered Staff Meetings monthly reminding PSWs to serve course by course, removing finished/dirty plates before the next course. - Do a deeper dive/questionnaire for the next Food Committee to identify the areas of improvement (get residents input). **#3 - I am satisfied with the timing and schedule of spiritual care services** - Improve Visibility on program schedules. Will highlight and identify spiritual care programs on calendars and newsletter. • Review timing of spiritual and religious programs to ensure they are offered on various days and time • Implement small group programs religious monthly program with multifaith pastor once per month. **#4 - I am aware of the spiritual care services offered at home.** - Residents are offered a variety of spiritual and religious programs that support emotional well-being, reflection, comfort; connection and faith. Programs are offered 7 days per week from 9:30 a.m. to 7:00 p.m. All residents are offered the opportunity to participate. Programs such as tai chi, Yoga, cozy corner quiet reflection, 1-1 emotional support, programs that support person centered meaning and purpose. Plus, our religious programs such as church visits, church services on teams, Buddhist monthly visits - To further improve awareness and understanding of spiritual programming, the programs department will be hosting our annual open house and will focus on spiritual activities. This will help to educate residents and families on the difference between religious and spiritual programs. **#5 - Overall, I am satisfied with the meals, beverages, and dining services -** - Do a deeper dive/questionnaire for the next Food Committee to identify the areas of improvement (get residents' input). - Continue to perform quality checks on the food monthly. - Monitor temperature through quality checks, ensuring lids are on properly. Food is served at servery under temperature-controlled heating.	2025 Resident Satisfaction Survey Result: #1 - 78.82% #2 - 77.50% #3 - 76.58% #4 - 76.54% #5 - 75.73%
2025 Family Satisfaction Survey Top 5 Opportunities	**#1 - I am satisfied with: The relevance of recreation programs** - Residents' programs are developed based on residents' interests, ability, and feedback. To improve family satisfaction with relevance of the recreation programs, the recreation department will enhance communication with families by clearly identifying program's goal and care domains, physical, cognitive, social emotional and spiritual though newsletter, Kennedy highlights. Education will be provided to families to help them better understand how programs are designed to meet the individual's needs, abilities, and interests. Programs are chosen by residents though residents' choice quarterly meeting families are welcome to attend and participate in programming however residents have the final say in what they wish to be on the calendar. Will develop recreation program legend understanding our activities (e.g.) **#2 - Communication from home leadership is clear and timely.** - Getting accurate email addresses upon admission and checking with family members thereafter at care conferences to confirm if they'd like to be on our communication email list. - Improve on the "open door policy" for all management so family and resident inquiries are addressed as soon as possible, and a response is received in real-time. **#3 - I am satisfied with the quality of care from PSWs** - The Goal: Make the "invisible" work of PSWs visible to families. - Whenever possible, assign the same PSWs to the same residents. Familiarity breeds trust and allows staff to notice subtle changes in health faster. - Two fun facts (with consent of staff) under the WOW employee board. - Handoff communication checks: families can be briefed if they happen to be visiting. A quick "Hi, I'm Bob, I've been with your mom today; she had a great lunch, and we've managed to get her walking to the window," builds immense confidence. All through customer service training. - To minimize call-bell time by auditing via QRM walkabouts. **#4 - I am satisfied with the quality of laundry services for personal clothing.** - Digital photo inventory: upon admission, take a quick photo of the resident's initial wardrobe and upload it under Misc Tab on PCC. This will provide a baseline for what "belongs" in their room and make it easier for laundry staff to return items that lose their tags or have never been tagged. - Have a "label only" laundry hamper so we can trace bags of clothes that need to be labelled and not just left out isolated. **#5 - The resident has access to a hairdresser when needed - 79.50%:** The goal: to ensure Tuesdays are optimized appropriately as the hairdresser is only on-site one day a week, creating a "bottleneck" issue. • If the hairdresser is fully booked, keep a formal waitlist. If a resident refuses their appointment on Tuesday morning, the hairdresser will immediately go to the next person on the list. This ensures 100% capacity on that one precious day. • Consult with Ruby the Hairdresser to increase her salon hours or create a "by appointment" schedule for weekends.	2025 Family Satisfaction Survey Results: #1 - 79.39% #2 - 80.70% #3 - 80.63% #4 - 80.09% #5 - 79.50%

Process for ensuring quality initiatives are met

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

Participants of Evaluation Name and Signatures:	*Print out a completed copy - obtain signatures and file.*	Date Signed:
Quality Improvement Lead	Olivia Gagliardi	**20-May-26**
Executive Director	Olivia Gagliardi	**20-May-26**
Director of Care	Jemmy Raval	**20-May-26**
Nutrition Manager	Francine Stewart	**20-May-26**
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Family Council Representative	Afzal Jessa	**20-May-26**
Medical Director	Dr. Cyril Press	**20-May-26**
Other	Evangeline Bautista, ADOC	**20-May-26**
Other	Adora Curammeng, IPAC Lead	**20-May-26**