ST. JOSEPH'S Lifecare Centre BRANTFORD

CONTINUITY QUALITY IMPROVEMENT (CQI)INITIATIVE REPORT

2025-26

Chitra Jacob
Manager, Quality Innovation and Learning

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Introduction

St. Joseph's Lifecare Centre (SJLCB) is the largest Long Term Care Home in Brantford & Brant County comprising of 205 beds. We are inspired by the legacy of our founders, the Sisters of St. Joseph, who are dedicated to compassionate, person-centred care.

St. Joseph's Lifecare Centre Brantford is a member of St. Joseph's Health System, one of Canada's largest Catholic healthcare corporations serving more than two million Canadians. Through a system-wide commitment to caring for body, mind and spirit, we are living the legacy of the Sisters of St. Joseph. Together with our 10,000 healthcare workers, we'll achieve our shared mission of living the legacy through compassionate care, faith and discovery.

Quality Improvement 2023-24: A Year in Review is the result of the concerted effort of leaders at SJLCB committed to excellence and dedicated to quality care. The report is compliant with The Fixing Long-Term Care Act 2021(Sections 42 and 43) and Ontario Regulation 246/22 (Part III).

1. Continuous Quality Improvement (CQI)

Continuous Quality Improvement (CQI) is a structured, ongoing process aimed at enhancing the quality of care, services, and overall resident outcomes. It involves systematically identifying areas for improvement, setting measurable goals, implementing targeted interventions, and evaluating results.

St. Joseph's Lifecare Centre Brantford (SJLCB) is committed to safety and quality at all levels. The quality management system is guided by the six quality dimensions- **safe, timely, effective, efficient, equitable, and patient centered (STEEEP)**.

Operational data is reported to the CQI Committee, while organizational-level data is presented to the Quality, Mission and Ethics Committee (QME) of the Board.

The CQI Committee meets 6 times a year and reviews quality indicators, program evaluations, resident and family experience surveys, endorses annual Quality Improvement Plan (QIP) and QI Action Plan.

CQI Committee Membership

Manager Quality, Innovation and Learning, Chair, CQI Lead- Chitra Jacob
Director of Care, overall responsibility- Natalie Saville-Townsend
Administrator- Cindy Perrodou
Resident Council member(s)- Donna Black and Laura Jane Charlton
Family Council member- Michelle McInnis
Medical Director, Physician- Dr. Chandra Anokye
Clinical Manager(s)- Praveena Prasad Sheela Remany
Manager Infection Prevention and Control- Katrina Marques
Manager Facilities & Environmental Services **-** Andy Lipiec
Manager Life Enrichment- Shelley Murray
Manager Human Resources- Sandra Cook
Manager Nutrition Services- Candice Lawrence
Registered Dietician- TBD
Pharmacist- Claire Stewart (CareRx)
Registered Nurse/ Registered Practice Nurse- TBD
Personal Support Worker(s) – Nadia Williams and Heidi Dinsing

Clinical Practice and Learning Specialist, Stedman Community Hospice representative- Jose Lopes

2. Priority Areas, Objectives, Policies, and Procedures

Priority Areas for FY 2025-2026:

From Resident and Family Feedback survey

- Reduce falls
- Implement process to reduce missing laundry items
- Provide Diversity, Equity, Accessibility and Indigenous Reconciliation (IDEA-IR) to all staff
- Strengthening staff competency in developing care plans
- Implement training on continuous quality improvement (CQI) and mentorship program using resources using the provincial bodies- Ontario Association of Residents' Councils and Family Councils of Ontario for active members of the Resident Council and Family Council executives.
- Provide dementia care training to staff: Gentle Persuasive Approach (GPA)

Objectives:

- Reduce falls rate by 12%
- Deliver specialized dementia care training to 100% of care staff by Q4 2025.
- Diversity, Equity, Accessibility and Indigenous Reconciliation (IDEA-IR) by having 75% of staff complete training by March 31, 2026

Policies and Procedures:

- Falls reviewed at monthly Risk Rounds, post falls huddles, monthly reporting
- Staff training tracked via LMS with quarterly audits.
- Feedback from Resident and Family Councils

3. Process for Identifying Priority Areas

The CQI Committee met six times in 2024-25 to review:

- Program evaluations
- Accreditation follow-up
- Concerns and complaints
- Ministry inspection findings
- QIP (Quality Improvement Plan)
- Resident and Family Feeback Survey
- CIHI Your Health system report

4. Monitoring, Measurement, and Communication

Monitoring and Measurement

- QIP reporting to CQI and QME

- Risk Report
- Feedback from Residents and Family Councils
- Daily huddles
- Monthly Risk rounds- review of falls, worsening of wound, incidents, 1 on 1 resident monitoring, responsive behaviours etc.
- Critical incident review
- Post falls huddles
- Annual care conferences
- Action plans adjusted based on data trends

Communication

- Reports to Resident and Family Councils
- Leadership huddle
- Communication to staff via memo and department meetings
- Town Halls- quarterly and ad hoc

5. Resident and Family Satisfaction Survey

A. Resident Satisfaction Survey

The three St. Joseph's Health System (SJHS) Long-Term Care Homes (LTCHs) in Guelph, Brantford, and Dundas collectively implement the Long-Term Care (LTC) Resident Satisfaction Survey each year. This survey gives residents the opportunity to provide feedback on the quality of the care and services that they receive, and the collective approach allows the three sites to compare results between the homes.

Response rate: Of the 364 residents approached to be interviewed, 251 residents completed the survey: 89 from Guelph, 117 from Dundas, and 45 from Brantford. This represents an overall response rate of 66% of eligible residents.

Survey Results: Across the three LTCHs, 81% of residents rated the overall quality of care and services as "good" or "excellent". Furthermore, the majority of residents (88%) indicated that they would ("Yes") or would sometimes ("Yes Sometimes") recommend the Long-Term Care Homes to others.

Method

The resident survey includes nineteen (19) domains comprising fifty-eight (58) questions, including two (2) overall questions as well as four (4) questions relating to continence care products added by the three SJHS LTCHs.

The questionnaire domains are as follows:

- Overall (2 Questions)
- Dignity (1 Question)
- Recreation and Social Activities (5 Questions)
- Building and Environment (2 Questions)
- Choices (8 Questions)
- Hydration (1 Question)
- Food Quality (2 Questions)
- Snacks (2 Questions)
- Sufficient Staff (1 Question)
- Oral Care/Hygiene (5 Questions)
- Privacy (3 Questions)

- Participation in Care Decisions (1 Question)
- Interaction with Others (4 Questions)
- Inappropriate Behaviour (3 Questions)
- Personal Property (6 Questions)
- Pain (1 Question)
- Exercise of Rights (4 Questions)
- Personal Trust Accounts (3 Questions)
- Continence Care (4 Questions)

Procedure

Two summer student interviewers conducted the resident interviews in adherence to infection prevention and control practices. In addition to organization specific general orientation, further training and education about how to conduct interviews with LTC residents was provided to the student interviewers. This training covered topics such as:

- The Research Process
- Conducting a Structured Interview
- Privacy, Confidentiality, and Informed Consent
- Challenges Associated with Physically and Cognitively Impaired Populations, and
- Tools to Communicate with People with Aphasia.

Resident consent was obtained before each interaction, and all resident information was kept confidential within the completion and results of the survey.

Results

Overall Resident Satisfaction (Would You Recommend)

Comparator	2017	2018	2019	2020	2021	2022	2023	2024
Brantford	72.00%	92.00%	83.00%	93.00%	89.00%	89.00%	95.00%	95.00%
Dundas	73.00%	84.00%	85.00%	87.00%	89.00%	82.00%	93.00%	90.00%
Guelph	80.00%	91.00%	96.00%	91.00%	97.00%	83.00%	91.00%	80.00%
All Facilities	75.00%	89.00%	88.00%	90.00%	92.00%	85.00%	93.00%	88.00%

Based on "Yes" and "Yes Sometimes" responses

Annual Target is 80%

Overall Resident Satisfaction (Quality of Care)								
Comparator	2017	2018	2019	2020	2021	2022	2023	2024
Brantford	80.00%	40.00%	73.00%	95.00%	84.00%	76.00%	91.00%	91.00%
Dundas	84.00%	75.00%	82.00%	86.00%	89.00%	82.00%	85.00%	79.00%
Guelph	80.00%	40.00%	90.00%	94.00%	96.00%	84.00%	78.00%	78.00%
All facilities	81.00%	52.00%	82.00%	92.00%	90.00%	81.00%	85.00%	83.00%

Based on "Good" or "Excellent" responses

B. Family Satisfaction Survey

The three St. Joseph's Health System (SJHS) Long-Term Care Homes (LTCHs) in Guelph, Brantford, and Dundas collectively implement the Long-Term Care (LTC) Family Survey each year. This survey provides an opportunity for family members and significant visitors of residents in the LTC homes to provide feedback on the quality of the care and services provided to their loved one.

Across the three SJHS LTCHs, 217 out of 822 family members and significant visitors completed a survey. This represents an overall response rate of 26%.

Method

The family questionnaire includes seventeen (17) domains comprising forty-one (41) questions, plus three (3) overall questions as well as three (3) questions relating to Continence Care products added by the three SJHS LTCHs.

The questionnaire domains are as follows:

- Choices (3 Questions)
- Recreation and Social Activities (1 Question)
- Privacy (4 Questions)
- Dignity (1 Question)
- Interaction with Others (3 Questions)
- Sufficient Staff (1 Question)
- Activities of Daily Living Assistance (3 Questions)
- Oral Health (2 Questions)
- Inappropriate Behaviour (4 Questions)
- Personal Property (4 Questions)
- Building and Environment (2 Questions)
- Exercise of Rights (4 Questions)
- Costs and Personal Funds (4 Questions)
- Notification of Change (4 Questions)
- Participation in Care Plan (1 Question)
- Overall Questions (3 Questions)
- Continence Care (3 Questions)

Procedure

In 2024, St. Joseph's Villa in Dundas and St. Joseph's Lifecare Centre mailed a letter regarding the LTC Family Satisfaction Survey to appropriate contacts in July. The letter provided information regarding the survey, the online survey link and information to request a paper copy of the survey if desired. Three weeks after the initial email was sent out a reminder was emailed out to the appropriate contacts at St. Joseph's Villa in Dundas and St. Joseph's Lifecare Centre in Brantford.

Results

Overall Family Satisfaction (Would You Recommend)

Comparator	2017	2018	2019	2021	2022	2023	2024
Brantford	77.00%	95.00%	99.00%	100.00%	88.00%	97.00%	96.00%
Dundas	84.00%	75.00%	82.00%	89.00%	82.00%	85.00%	92.00%
Guelph	80.00%	40.00%	90.00%	96.00%	84.00%	78.00%	95.00%
All facilities	81.00%	52.00%	82.00%	90.00%	81.00%	85.00%	94.00%

Based on "Yes" and "Yes Sometimes" responses (no annual target)

Overall Family Satisfaction (Quality of Care)

Comparator	2017	2018	2019	2021	2022	2023	2024
Brantford	77.00%	97.00%	92.00%	93.00%	88.00%	95.00%	92.00%
Dundas	73.00%	96.00%	87.00%	93.00%	83.00%	84.00%	88.00%
Guelph	77.00%	88.00%	92.00%	85.00%	90.00%	86.00%	90.00%
All facilities	72.00%	94.00%	90.00%	90.00%	87.00%	88.00%	90.00%

Based on "Good" or "Excellent" responses

Resident and Family Survey Action Plan

Identified Areas for Improvement	Key Actions	Improvements
Is there enough staff available to make sure that residents get the care and assistance they need without having to wait a long time?	Review of staffing mix by category & Sub-category – FT/PT Permanent, Casual etc. Review of hours to cover by **position** per day, per week, per month Scheduling Supervisor and Schedulers to spend minimum 4 hours on a unit to understand workflow, experience short staff impacts.	Job postings for summer recruitment have been initiated. Updates provided at Family Council monthly. Review of front-line job routines, as well as dining room protocol, provided education on updates.
Has your family member had any belongings item(s) damaged or taken without permission?	-Labelling of all items upon admission. -Provide families the stickers to apply on move in day or before hand if requested. -One location for all new items (gifts etc.) -Track all items on admission /newly added items.	Document missing items on each unit and track to determine severity and frequency, items found/not found with dates lost and date found, location found April 15, 2025 – reviewed the "Tell us how we are doing feedback card"-mailbox added to Reception Area ○ -reception to check for daily and provide to leadership for follow up -Labelling process and location to be initiated.
Does your family member have any chewing or eating problems, or mouth pain?	-Dental Hygienist to do assessment of residents as part of care plan -Ensure all families/residents aware of and apply for Canadian Dental Care Plan – Admissions Package, 6 Week Care Plan Review, Post throughout home, incl in Did You Know package	Plan appropriate strategies to improve – at point of admission, 6-week care plan review, and annual. Ensure families are aware of dental programs and access to them
Do you choose when and how to bathe?	Build into admissions, 6 weeks and annual conferences	Review of bath list process with ward clerk. Add to 6 week and annual care conference.
Has the staff addressed the concern(s) to your satisfaction? (Have there been any concerns or problems with a roommate or any other resident? Did you report the problem to staff?)	Complaints process, add to PCC for tracking, review policy.	Feedback form available at various locations to be able to report.

6. Program evaluations

Annual program evaluations are conducted in a cyclical manner to assist in identifying gaps and prioritize initiatives for improvement ensuring quality of life and safety for residents. The program evaluation template is enclosed in Appendix E. The list of program evaluations conducted in 2024-25 is provided below:

	Program	Date of evaluation
1	Abuse and Neglect	16-Aug-23
2	Information and Referral Services	18-Oct-23
3	Recreational and Social Services	20-Mar-24
4	Religious & Spiritual Practices	20-Mar-24
5	Accommodation services (EVS, Linen, Maintenance)	20-Mar-24
6	Volunteer Services	20-Mar-24
7	Preventive Maintenance Program	15-May-24
8	Dietary Services & Hydration	15-May-24
9	Medical Services	15-May-24
10	Education, Training and Development	15-May-24
11	Responsive Behaviours	17-Jul-24
12	Infection Prevention and Control (+ Pandemic Plan)	17-Jul-24
13	Palliative Care	17-Jul-24
14	Restorative Care/Physiotherapy/OT	17-Jul-24
15	Restraints and PASD's	17-Jul-24
16	Staffing Care and Services (Staffing Plan)	18-Sep-24
17	Falls Prevention & Management	18-Sep-24
18	Continence Care and Bowel Management	18-Sep-24
19	Medication Management	20-Nov-24
20	Skin & Wound	20-Nov-24

Summary of Goals Identified for 2025-26

Program	CQI successes 2024-25	Planned improvements for 2025-26
Prevention of Abuse and Neglect	Frequent and ongoing communication with individual residents and families regarding any challenges or new recommendations identified in risk rounds, huddles, or from referrals/consults	- Goal to reduce the number of incidents in each quarter - Compliance of 100% for online education in Surge Learning - Continue to promote zero tolerance for Abuse
Information & Referral Services	Digital admission package sent directly to family prior to admission Updated the "Getting to know you" forms currently in use during admission – with feedback from families and residents - to better capture information that is important to the resident and family, to ensure we can provide access to the right services for individual residents Family satisfaction with admission process, opportunity to address questions or concerns and give feedback	• Continue to update/change/lessen the paperwork required at admission • Improve Satisfaction Feedback rates (>75%) • Digital admission package (fillable forms) that can be sent directly to family prior to admission to reduce the stress/time of admission day process and - Document manager on PCC (digitalize signing forms)
Recreation Program	Total Offerings from January 1st, 2024-December 31st, 2024 – 5280 (↓10%)	Recruit a BSO-embedded Recreation Therapist to strengthen the Level 1 team, supporting behavior management and fostering a multidisciplinary approach to interventions.
Religious & Spiritual Practices	Total spiritual group programs offered in 2024- 361 (↑6.2% compared to 2023)	Seek feedback on services of choice through various listed resources from Families and Residents. Work with spiritual care team at Hospice to build a list of spiritual connections in the community to utilize per resident/family requests.
Accommodation Services	Ongoing audits of housekeeping checklists. Maintenance Care reports. Staff training through Surge and BAS.	To maintain a consistent high level of service, providing a safe, clean, sanitary, comfortable environment for all residents. Information exchange and updates with residents and families are maintained through open lines of communication both informally and through Family Council meetings.
Volunteer Services	A volunteer distribution list has been established to ensure volunteers receive timely updates and key messages from the Lifecare Centre. Total hours for the year 10826.50 Total Visits 1819 # Active Volunteers/Non-clinical students = 80	Increase the number of volunteers in the home and offer ongoing opportunities for them to explore different roles.
Preventive Maintenance Program	Added PM job tasks and run reports Add Lifting equipment and Bed Audits to Maintenance portal for tracking purposes Added BP machines to bi-annual – Calibration and PM service reminder in Maintenance care portal	Change ARJO services from bronze service package to all inclusive Gold package Review Maintenance Portal tasks related to bed repairs and lift equipment repairs 2x a year. PM programs ensure all vital infrastructure equipment is appropriately maintained an operating at peak performance.
Dietary Services	Current stats for April are (targets): High risk 4%(3%), pureed 14.5%(10%), minced 11.5%(20%), thick fluids 5.5%(4%), supplements 10.5%(6%), total undesirable weight loss 15/7.5%(4-7%). Only 4 of the weight loss are new and the remainder are residents that lost weight and have since stabilized with interventions.	Food Service – 1) Simplify diets 2) Focus on ensuring residents receive the interventions needed to enjoy their desired quality of life 3) Continue open communication with both residents and families, including monthly food committee meetings and bi-annual residents council attendance. Clinical – 1) To continue to reduce weight loss 2) Reassess need for altered textures 3) Improve tracking of interventions
Medical Services	Annual physicals – 2023: 29 with in progress/errors (13%); 7 incomplete (3%)	• Update annual physical form on PCC • Hire second NP to help support existing medical services
Education, Training and Development	General orientation completion rate 2024: 74.1% Department specific completion rate 2024 – 75.7%	Education is decentralized. Each department/program manager is responsible for the course content for their staff.

		Plan for next fiscal: • Managers to review course load and provide suggestions to add/remove content • Encourage 100% completion rate for courses that are mandated and program specific • Ensure course content are tailored per program requirements
Responsive Behaviours and Anti-Psychotic Reduction	Reduction in responsive behaviours. Increased education for staff on responsive behaviours provided through multi opportunities to assist with different learning styles in the care team.	Create strategies and interventions using a multi-disciplinary approach including caregivers to ensure all persons in the resident's circle of care feel supported. Provide additional POC trainings for PSW's for improving documentation and triggering individualized needs of residents such as pain documentation.
Infection Prevention and Control	Education was provided to registered staff on the IPC module in Point click care. N95 mask fit testing continues for new staff and for those that require updating – every 2 years as per legislation. TEMI robot was brought in as a trial to assist with recreational programming.	To have a part time ICP (Infection control practitioner) in place to assist IPAC manager. Education provided to family and resident council on hand hygiene – monitor hand hygiene compliance for staff and visitors.
Palliative Care	- Comfort care rounds completed on all units, palliative care conferences - Completion of participation in SPA-LTC research project - Education modules updated - Information pamphlets for family and residents now live Advanced Care Planning section now built into post-admit conference on PCC EMR	- Continue to empower **all** staff to develop a palliative approach to care to support residents at all stages of their journey - Incorporate PPS score into PCC EMR - Reinstate Pain and Palliative Care Committee
Restorative Care/Nursing Rehabilitation	% of resident population on Nursing Rehab this year to date (RUGS summary Report on PCC) – 9% NEW assessment – e.g. As of June 28th – 45 old Bed Safety assessments not complete and 1 new bed entrapment assessment completed. - Restorative can run Maintenance Care Portal Reports for accreditation and CQI purposes.	Arrange to have revised Policy on bed safety/entrapment presented to resident's and family council. - Input nursing equipment (bed frames, Blood Pressure machines, Patient safety Lifts) into Maintenance care Portal for long term tracking of each equipment.
Staffing Care and Services (Staffing Plan)	• Implementation of General Orientation Program • Implement biannual performance appraisals/performance enablement process • Conduct focus groups with front-line staff based off of the Worklife Pulse survey to gain more information on employee satisfaction, concerns and suggestions. Develop action plan • Reduce overall voluntary and unavoidable turnover (on-going)	• Implement Talent Management Policy • Implement Attendance Management Policy and Program • Review interview structure and guides to hire staff that meet our mission and values • Reduce overall voluntary and unavoidable turnover (on-going)
Falls Prevention & Management	• Transfer and Lift education completed by Physio and Restorative February 2024 • Reimplementation of biweekly fall huddles begun in January 2024	• Continue to decrease falls rate and potential injuries. • Utilize falls funding to manage all appropriate fall interventions, to ensure reduction in falls and injuries. • Reinstate Fall audits by restorative and physio team. • Continue to involve with residents/families at Multidisciplinary care conferences and on ongoing basis • Implement Post fall huddle
Continence Care and Bowel Management	TENA portraits are being completed on the computer. Random TENA audits completed to see if residents are in the correct product.	• Address individual needs and preferences with respect to continence of the bladder and bowel and bowel management. • Initiate best practice, appropriate strategies, and interventions. • Promote learning about best practice continence care. • Monitor and evaluate resident outcomes and product effectiveness. Product review done yearly with staff. • Continue with TENA assessments. • Maintain good skin care and no related skin issues due to continence products.

Medication Management	-Completed 2024 MSSA in October 2024 with increased involvement from interdisciplinary team and scored improved from previous years. -Mandatory Education session completed on Medication Management with written testing in September to RN/RPN. -Continued eMAR/eTAR support for issues as they arise as noted by registered staff. -Continued support from Pharmacist with the Automated Dispensing Cabinet for our emergency supply box. -Improved accessibility of the electronic medication incident reporting platform.	Reducing medication incidents relating to high alert incidents, such as narcotics. To have a better communication system in place to inform residents and families about any updates surrounding the medication management program To involve registered staff during the yearly medication management assessment (MSSA) and improving their knowledge around medication management and best practice standards–Through RNAO best practice clinical pathway.
Skin and Wound Care	• SmartZone education on PCC regarding skin and wound care module was shared by previous Director of Care with all registered staff. • Arrangement was made with a nurse to go around to the different home areas through couple of weeks to do some hands-on training for anyone that needs additional support. • The home has provided increased education opportunities to registered staff on the essentials of wound care in 2023 for increased skills and knowledge in product selections, assessment, documentation, and ongoing evaluation.	• Education for all staff on optimal wound care, following Best Practice Guidelines. • Registered staff education focusing on updating Care plan • Registered staff to be educated on Wound care App. • Have increased education for PSW's to help support skin and wound care. • Restorative team to provide education on ROHO cushion (ex. check for enough air) • Auditing of Skin and Wound Care Assessment completion • Skin and Wound Care committee meetings to be held monthly • Plan to have more PSW champions in the committee.

7. Quality Improvement Plan 2025-26

QIP 2024-25 Successes

2024-25 has been a remarkable year for SJLCB achieving 42% improvement in avoidable Emergency Department visits and 10% improvement in Resident Experience. The indicator *Do residents feel they can speak up without fear of consequences?* has been added to the annual Resident Experience survey in 2024. SJLCB was invited to present at the Ontario Health QIP LTC Spotlight series in December 2024 to share avoidable ED visit insights and learnings with peers.

1. Priority issue: **Equity** (LTC and Hospice)
   % of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and antiracism education

Priority Issue	**Indicator**	**Planned Improvement initiatives (Change Ideas)**	**Current performance**	**Target for process measure** (how will you know you are successful)
Equity	% of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and antiracism education	1)Implement Inclusion, Diversity, Equity, Accessibility and Indigenous Reconciliation (IDEA-IR) training in the workplace for all employees	EDI Training for Leaders- 86%	Build awareness around Inclusion, Diversity, Equity, Accessibility and Indigenous Reconciliation (IDEA-IR) by having 75% of staff complete set training by March 31, 2026.
		2)Implement Ontario Health Equity, Inclusion, Diversity and Anti-Racism Framework		Complete baseline benchmarking by December 31, 2025.
Experience	Custom indicator To improve skill, knowledge, impact, engagement, and leadership development of Family and Resident Councils by implementing a training & mentorship program to build capacity and be healthcare quality improvement leaders by December 30, 2025.	To Improve skill, knowledge, impact, engagement, and leadership of Resident Council	-	100% of RC members who actively attend RC completed training on OARC resources by March 31, 2026 100% of RC members who actively attend RC completed CQI training by December 30, 2025.
		To Improve skill, knowledge, impact, engagement, and		100% of FC Executive members completed training on Family Councils Ontario by March 31, 2026

		leadership of Family Council		100% of FC Executive members completed CQI training by December 30, 2025.
Safety	% of long-term care residents who fell in the last 30 days	Assessment of resident care plans to ensure that appropriate toileting routines and care plans are in place		We are aiming to complete reviews on selected resident care plans reviews by December 31, 2025.
		All residents who have more than 3 falls within a month will have a medication review completed		100% of residents identified as having a high fall risk will have a quarterly medication review completed by the pharmacist with a special focus of deprescribing medication associated with falls when medically appropriate.

8. Report distribution

Resident Council - June 2025

Family Council - June 2025

Publication - June 2025