



CONTINUOUS QUALITY IMPROVEMENT (CQI) INITIATIVE REPORT

2026

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Manager, Quality and Resident/Family Engagement

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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-centered 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 2026: 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 approximately 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 & Resident/Family Engagement, Chair, CQI lead
Director of Care, overall responsibility.

Administrator

Resident Council member(s)

Family Council member

Medical Director, Physician

Clinical Manager(s)

Manager Infection Prevention and Control

Manager Facilities & Environmental Services

Manager Life Enrichment

Manager Human Resources

Manager Nutrition Services

Registered Dietician

Pharmacist

Registered Nurse/ Registered Practice Nurse

Personal Support Worker(s)

Clinical Practice and Learning Specialist, Stedman Community Hospice representative

2. Priority Areas, Objectives, Policies, and Procedures

Priority Areas for 2026-2027:

From Resident and Family Feedback survey

- Increase the frequency of engaging residents to confirm feedback on their preferred bathing times and method.
- Improve laundry services.
- Offer more preferred recreational activities including the weekends
- Provide a safe home environment for reporting any concerns.

Objectives:

- Include in care conference agenda bathing and getting up preference 100% of the time
- Decrease the amount of missing laundry items.
- Increase attendance in recreational and social activities
- Increase reporting concerns

Policies and Procedures:

- Review the current missing-item tracking form, identify any gaps, and provide staff with reminders on correct documentation practices.
- Provide families with reminders about the required clothing-labelling procedures.
- Feedback from Resident and Family Councils

3. Process for Identifying Priority Areas

The CQI Committee met six times in 2025-26 to review:

- Program evaluations
- Accreditation follow-up
- Concerns and complaints
- Ministry inspection findings
- QIP (Quality Improvement Plan)
- Resident and Family Feedback 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 395 residents approached to be interviewed, 287 residents completed a survey: 81 from Guelph, 126 from Dundas, and 80 from Brantford. This represents an overall response rate of 73% of eligible residents.

Survey Results: Across the three LTCHs, 82% of residents rated the overall quality of care and services as "good" or "excellent". Furthermore, the majority of residents (91%) 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. Three new questions were incorporated into this year's surveys. One addresses personal property, while the other two focus on staff knowledge.

The questionnaire domains are as follows:

- | | |
|--|------------------------------------|
| • Overall (2 Questions) | • Choices (8 Questions) |
| • Dignity (1 Question) | • Hydration (1 Question) |
| • Recreation and Social Activities (5 Questions) | • Food Quality (2 Questions) |
| • Building and Environment (2 Questions) | • Snacks (2 Questions) |
| • Participation in Care Decisions (1 Question) | • Sufficient Staff (1 Question) |
| | • Oral Care/Hygiene (5 Questions) |
| | • Privacy (3 Questions) |
| | • Exercise of Rights (4 Questions) |

- Interaction with Others (4 Questions)
- Inappropriate Behaviour (3 Questions)
- Personal Property (6 Questions)
- Pain (1 Question)
- Personal Trust Accounts (3 Questions)
- Contenance 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 for 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	2025
Brantford	72.00%	92.00%	83.00%	93.00%	89.00%	89.00%	95.00%	95.00%	92.00%
Dundas	73.00%	84.00%	85.00%	87.00%	89.00%	82.00%	93.00%	90.00%	89.00%
Guelph	80.00%	91.00%	96.00%	91.00%	97.00%	83.00%	91.00%	80.00%	91.00%
All Facilities	75.00%	89.00%	88.00%	90.00%	92.00%	85.00%	93.00%	88.00%	91.00%

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	2025
Brantford	80.00%	40.00%	73.00%	95.00%	84.00%	76.00%	91.00%	91.00%	89.00%
Dundas	84.00%	75.00%	82.00%	86.00%	89.00%	82.00%	85.00%	79.00%	80.00%
Guelph	80.00%	40.00%	90.00%	94.00%	96.00%	84.00%	78.00%	78.00%	76.00%
All facilities	81.00%	52.00%	82.00%	92.00%	90.00%	81.00%	85.00%	83.00%	82.00%

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, 208 out of 1042 family members and significant visitors completed a survey. This represents an overall response rate of 20%.

Method

The family questionnaire includes seventeen (17) domains comprising forty-one (41) questions, plus three (3) overall questions. Since last year's survey, six (6) new questions were introduced, including two (2) within a newly established domain. Additions were made across several existing domains: one question under *Interactions with Others* asked whether staff listen and take questions seriously; under *Personal Property*, a question was added regarding the cleanliness of the family member's wheelchair; and under *Participation in Care Plan*, a question explored how frequently respondents receive updates on their family member's health and care plan. A final question was added under *Overall Questions*, inquiring whether respondents were aware of the Family Council and, if not, how this information might be effectively shared with other family members.

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 2025, 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 June. 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	2018	2019	2021	2022	2023	2024	2025
Brantford	95.00%	99.00%	100.00%	88.00%	97.00%	96.00%	96.00%
Dundas	75.00%	82.00%	89.00%	82.00%	85.00%	92.00%	89.00%
Guelph	40.00%	90.00%	96.00%	84.00%	78.00%	95.00%	88.00%
All facilities	52.00%	82.00%	90.00%	81.00%	85.00%	94.00%	91.00%

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

**Overall Family Satisfaction
(Quality of Care)**

Comparator	2018	2019	2021	2022	2023	2024	2025
Brantford	97.00%	92.00%	93.00%	88.00%	95.00%	92.00%	91.00%
Dundas	96.00%	87.00%	93.00%	83.00%	84.00%	88.00%	86.00%
Guelph	88.00%	92.00%	85.00%	90.00%	86.00%	90.00%	87.00%
All facilities	94.00%	90.00%	90.00%	87.00%	88.00%	90.00%	88.00%

Based on "Good" or "Excellent" responses

Resident and Family Survey Action Plan

Identified Areas for Improvement	Action Plan
<p>Do you participate in choosing when to get up? Do you choose when and how to bathe?</p>	<ul style="list-style-type: none"> • Increase the frequency of engaging residents to confirm feedback on their preferred bathing times and method. • Add to care conference agenda to ask about bathing and getting up.
<p>Do you participate in any of the activity programs here? Do the organized activities meet your needs? Do you receive assistance with the things you like to do, such as supplies, batteries, books? Are there activities offered on weekends, including religious events? Are there activities available in the evenings?</p>	<ul style="list-style-type: none"> • Review monthly unit resident meetings minutes to find trends and identify new programs. • Create posters to emphasize unit meetings taking place and opportunity to voice recreation activities - likes/dislikes-being done monthly now. • Run an attendance report to identify individuals not attending activities (below 5 programs for 3 consecutive months) and following up to see if any feedback. • Complete two Program Satisfaction surveys per month. • Review all requests for supplies and utilize Helping Hands Funds and identify if there are any gaps in funds. • Improve staff model by hiring additional Recreation Therapists and will be scheduled throughout the 7-day week. • Improve staff model by hiring Spiritual Care Coordinator who will collaborate with community for additional religious services.
<p>Have you had any missing clothing or laundry? Have you had any belongings lost, damaged or taken without permission? Did you report the missing items?</p>	<ul style="list-style-type: none"> • Develop missing laundry process (to include starting at resident/family identifying missing items, to staff completing form and submitting either by paper or by maintenance portal, etc.) • Create Missing Laundry Database (to track data points such as date concern received, unit, brief description of missing item, date rectified, internal laundry, external etc.) • Add "labelling clothing reminders" and importance of reporting missing items to Family Newsletter and add process into admission checklist.
<p>Do you feel that you are provided with enough notice and communication when a transition in care occurs? Do you feel that you can speak up without fear of consequences?</p>	<ul style="list-style-type: none"> • Ensure Point Click Care is updated with who is the decision maker and ensure cognitively aware residents are always informed of notices. Review at nursing huddles and create/update consent notes. • Customer Service training for staff. • Clinical manager reviewing and recognizing with residents at each reported concerns the value of their reporting and that it's for learning and quality improvement initiatives vs reprisal.
<p>Have there been any concerns or problems with a roommate or any other resident? Did you report the problem to staff?</p>	<ul style="list-style-type: none"> • Review of priority list. • Increase registered staff competency and comfort level on follow-up on raised concerns. • Frontline staff education/reminders on how to have conversations with family members on bring forward concerns in the moment and the benefits.

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 list of program evaluations conducted in 2025-2026 is provided below:

	Program
1	Abuse and Neglect Prevention
2	Admissions, Transfers, Discharges (Information and Referral Services)
3	Recreational and Social Services
4	Religious & Spiritual Practices
5	Accommodation services (EVS, Linen)
6	Volunteer Services
7	Preventive Maintenance Program
8	Dietary Services & Hydration
9	Medical Services
10	Education, Training and Development
11	Responsive Behaviours
12	Infection Prevention and Control (+ Pandemic Plan)
13	End-of-Life/ Palliative Care
14	Restorative Care/Physiotherapy/OT
15	Restraints and PASD's
16	Staffing Care and Services (Staffing Plan)
17	Falls Prevention & Management
18	Continence Care and Bowel Management
19	Medication Management
20	Skin & Wound
21	Health and Safety and Wellness
22	Social Work
23	Facility Maintenance
24	Ethics
25	Equity, Diversity, Inclusion
26	Emergency Preparedness

Summary of Goals Identified for 2026-2027

Program	CQI successes 2025-26	Planned improvements for 2026-27
Prevention of Abuse and Neglect	<ul style="list-style-type: none"> Education to all staff – GPA certification with sustainability plan for all new hires Dementia Ability education initiated in Q4 Zero Tolerance enforced for incidents of staff to resident 	<ul style="list-style-type: none"> Decrease the number of incidents of resident-to-resident abuse, and staff-to-resident abuse that resulted in a critical incident due to injury or fear. Increase number of registered nurses as "Abuse Prevention Champions" Increase compliance with best practices in Point Click Care documentation by implementing initiatives
Information & Referral Services	<ul style="list-style-type: none"> Continued to update/change/lessen the paperwork required at admission - not fully achieved but ongoing process Digital Admission package - not achieved but ongoing process and remains a goal for this year Documented manager on PCC - not achieved but ongoing process and remains a goal for this year 	<ul style="list-style-type: none"> Increase compliance with accurate admission checklist documentation Increase resident and family satisfaction with the admission process Improve efficiency with the ADT Committee and documentation
Recreation Program	<ul style="list-style-type: none"> BSO Embedded Therapeutic advisor role filled. This role benefits responsive behaviours based on a referral process. A 7 day a week Behaviour support recreation therapist role created, screened and hired a role specific for the secure unit. This role will work 12-8pm, created and based on family and staff feedback of the needs of the unit. Residents provided feedback on a scale of 1-5. 1 representing "Awful", up to 5 representing "Fantastic". The satisfaction level displayed is the average of all feedback provided by residents during this time. 	<ul style="list-style-type: none"> Increase Recreation Therapy resident touchpoints. Increase Recreation Therapist conference attendance and/or written participation in Multidiscipline Care Conferences Increase Resident Satisfaction regarding residents feel they are heard and have a voice.
Religious & Spiritual Practices	<ul style="list-style-type: none"> Increased religious services 	<ul style="list-style-type: none"> Increase Community Member led Christian Inter faith-based Sunday Services Ensure all Catholic Residents who wish to receive Sacrament of the Sick are Anointed
Accommodation Services	<ul style="list-style-type: none"> Maintained a consistent high level of service, providing a safe, clean, sanitary, comfortable environment for all residents. Information exchanges and updates with residents and families are maintained through open lines of communication both informally and through Family Council meetings. 	<ul style="list-style-type: none"> All EVS staff complete department specific training (align with Global Workforce Survey Results). Auditing / Improvement of Resident daily room cleaning (align with Global Workforce Survey Results). Resident Personal Laundry – Decrease # of missing items per Quarter
Volunteer Services	<ul style="list-style-type: none"> Increased the number of volunteers in the home and offered ongoing opportunities for them to explore different roles. Maintained volunteer pool, ended the year 2025 with 33 active volunteers and 14 non-clinical students. We are currently sitting at 30 active volunteers and 13 non-clinical students. 	<ul style="list-style-type: none"> To increase Volunteer recognition for hours of service. To increase Volunteer knowledge and be trained in Emergency Preparedness.
Dietary Services	<ul style="list-style-type: none"> Food Service – 1) Simplify diets 2) Focused on ensuring residents receive the interventions needed to enjoy their desired quality of life 3) Continued open communication with both residents and families, including monthly food committee meetings and bi-annual residents council attendance. Clinical – 1) Continued to reduce weight loss 2) Reassessed need for altered textures 3) Improved tracking of interventions 	
Medical Services	<ul style="list-style-type: none"> Update annual physical form on PCC Hire second NP to help support existing medical services 	<ul style="list-style-type: none"> To recruit a permanent full-time Nurse Practitioner Increase certification compliance by having Medical Director complete the medical director certificate program
Education, Training and Development	<ul style="list-style-type: none"> Education is decentralized. Each department/program manager is responsible for the course content for their staff. 	<ul style="list-style-type: none"> Streamline annual surge training to under six hours, down from the current 16-hour baseline. To increase staff satisfaction of 80% or higher for general orientation Ensure 100% compliance with proper and timely department orientation among all staff

Responsive Behaviours and Anti-Psychotic Reduction	<ul style="list-style-type: none"> Created strategies and interventions using a multi-disciplinary approach including caregivers to ensure all persons in the resident's circle of care feel supported. Provided additional POC training for PSW's for improving documentation and triggering individualized needs of residents such as pain documentation. 	<ul style="list-style-type: none"> Increase compliance with residents receiving one-on-one support have an individualized plan of care for support. Increase staff knowledge on person-centered care and GPA certification.
Infection Prevention and Control	<ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> To increase hand hygiene compliance rates to 75% compliance rate. Increase N95 mask fit testing to 100% compliance rate. Increase resident/family membership on IPAC committee – could be full time or ad hoc that wants to help with special events
Palliative Care	<ul style="list-style-type: none"> Continued to empower all staff to develop a palliative approach to care to support residents at all stages of their journey. Incorporated PPS score into PCC EMR Reinstated Pain and Palliative Care Committee 	<ul style="list-style-type: none"> To increase nurse assessments/determination if resident is at end of life and implement end-of-life orders. To increase compliance with Palliative/End-of-Life Management Committee under FLTCA. Increase accuracy and documentation on End-of-Life assessments.
Restorative Care/Nursing Rehabilitation	<ul style="list-style-type: none"> Arranged revised Policy on bed safety/entrapment presented to residents and family council. <ul style="list-style-type: none"> Inputted nursing equipment (bed frames, Blood Pressure machines, Patient safety Lifts) into Maintenance care Portal for long term tracking of each equipment. 	<ul style="list-style-type: none"> Improve documentation within Restorative Program Increase the number of residents using their own personal adaptive equipment, specifically to wheelchairs
Staffing Care and Services (Staffing Plan)	<ul style="list-style-type: none"> Implemented Talent Management Policy Implemented Attendance Management Policy and Program Reviewed interview structure and guides to hire staff that meet our mission and values. Reduced overall voluntary and unavoidable turnover (on-going) 	<ul style="list-style-type: none"> To decrease overall vacancy rates. To decrease overall absenteeism rate. To decrease cost of agency staffing (separate from purchasing services).
Falls Prevention & Management	<ul style="list-style-type: none"> Continued to decrease falls rate and potential injuries. Utilized falls funding to manage all appropriate fall interventions, ensuring reduction in falls and injuries. Reinstated Fall audits by restorative and physio team. Continued to involve with residents/families at Multidisciplinary care conferences and on ongoing basis. Implemented Post fall huddle 	<ul style="list-style-type: none"> Increase completion of root cause analysis of any resident who has more than one fall related to the same underlying cause. Increase compliance with care plans being updated with fall interventions for all residents in the last 30 days. Increase completion of “consent progress notes” related to falls.
Continence Care and Bowel Management	<ul style="list-style-type: none"> Addressed individual needs and preferences with respect to continence of the bladder and bowel and bowel management. Initiated best practice, appropriate strategies, and interventions. Promoted learning about best practice continence care. Monitored and evaluate resident outcomes and product effectiveness. Product review done yearly with staff. Continued with TENA assessments. 	<ul style="list-style-type: none"> Increase compliance with resident admission/ongoing assessments for continence products. Increase Care Plan accuracy to reflect correct continence product. Increase resident/family knowledge on Tena product/program.

<p>Medication Management</p>	<ul style="list-style-type: none"> • Reduced medication incidents relating to high alert incidents, such as narcotics. • Better communication system in place to inform residents and families about any updates surrounding the medication management program. • Involved 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. 	<ul style="list-style-type: none"> • Reducing medication incidents relating to high alert incidents. • Increase resident/family satisfaction with their own involvement of medication management program. • Increase resident/family involvement/initiatives in Medication Management.
<p>Skin and Wound Care</p>	<ul style="list-style-type: none"> • Educated 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. • Increased education for PSW's to help support skin and wound care. • Restorative team provided education on ROHO cushions (ex. check for enough air) • Audited of Skin and Wound Care Assessment completion. • Skin and Wound Care committee meetings held monthly. • Increased PSW champions in the committee. 	<ul style="list-style-type: none"> • Compliance with Skin and Wound Committee Development. • Root cause analysis on all Stage 3+ Pressure Injuries • Increasing resident/SDM knowledge of skin and wound interventions

7. Quality Improvement Plan

QIP 2025-26 Successes

Priority Issue	Indicator	Planned Improvement initiatives (Change Ideas)	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	Build awareness around Inclusion, Diversity, Equity, Accessibility and Indigenous Reconciliation (IDEA-IR) by having 75% of staff complete set training by March 31, 2026. Performance: 91.2%
		2) Implement Ontario Health Equity, Inclusion, Diversity and Anti-Racism Framework	Complete baseline benchmarking by December 31, 2025. Performance: Completed Framework
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 Performance: 100% 100% of RC members who actively attend RC completed CQI training by December 30, 2025. Performance: 100%
		To Improve skill, knowledge, impact, engagement, and leadership of Family Council	100% of FC Executive members completed training on Family Councils Ontario by March 31, 2026 Performance: 100% 100% of FC Executive members completed CQI training by December 30, 2025. Performance: 100%

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. Performance: 5 audits/month
		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. Performance: 100%

QIP 2026-2027

Target	<ul style="list-style-type: none"> Decrease avoidable emergency departments visits/transfers to ≤7.8% for LTC residents. Current SJLC Performance: 2024/25 is 8.7% 	<ul style="list-style-type: none"> Decrease LTC residents falls in the last 30 days to ≤22.2%. Current SJLC Performance: 2024/25 is 24.7% 	<ul style="list-style-type: none"> 75 % of leaders who have completed Just Culture training. 	<ul style="list-style-type: none"> Achieve resident satisfaction on feeling residents can speak up without fear of consequences to ≥80% (Last year was 75%) Achieving resident satisfaction on feeling residents have a voice and are listened to by staff ≥85% (Last year was 88%)
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8. Report distribution

Resident Council - May 2026

Family Council - May 2026

Publication - May 2026