SOUTHBRIDGE HEALTH CARE LP

Continuous Quality Improvement Initiative Annual Report

Annual Schedule: May 2026

HOME NAME : Southbridge Lakehead

People who participated in the evaluation of this report

	Name and Designation	Date of Evaluation
Quality Improvement Lead	Hannah Boomhower - Director of Care	19-May-26
Director of Care	Hannah Boomhower - Director of Care	19-May-26
Executive Directive	Joanna Stavropoulos - Executive Director	19-May-26
Nutrition Manager	Arianne Eslana - Food Service Manager	19-May-26
Programs Manager	Caroline Cameron-Fikis - Program Manager	19-May-26
Clinical Consultant		
Medical Director	Dr. Ruby Klassen - Medical Director	19-May-26
Resident Council Representative	Beverly Succo - Resident Council President	25-May-26
Family Council Representative	No Active participants at this time	
Other	Kelechi Chukwu - Associate Director of Care	19-May-26
Other	Theresa Savard-Maki - Director Clinical Care	19-May-26

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

Quality Improvement Objective	Policies, procedures and protocols used to achieve quality improvement	Outcomes of Actions, including dates
Avoidable ED visits	**On-site Nurse practitioner / MD** The Home continue to provide preventative care and early treatment for common conditions leading to potentially avoidable ED visits by maximizing the current Medical Director and Nurse Practitioner. Staff monitor and communicate with the medical director and NP with any changes in health or exacerbations of current conditions for early identification of health issues. **SBAR communication statagies** SBAR education was completed last year and staff are encouraged to continue to use the SBAR focus documentation in the Progress Notes including communication with the MD/NP. **Registered in charge nurse to communicate and assess** Education was provided to all change nurses to ensure comprehensive resident assessment are completed prior to contacting the NP/MD to better determine appropriteness of ED transfer. **Preventative Care** Further education was provided to registered staff related to clinical assessments and common conditions leading to ED transfers. Early identification of common conditions such as UTI's has lead to early treatment. **Resident and Family focused centered care** The home completed conversations related to goals of care at all care conferences, on admission, annually and with changes in care. **DOC to review ED tracker** The DOC continues to monitor and evaluate all ED transfers as well and tracker them via the ED transfer tracker. All ED transfers are evaluated for effectiveness and to ensure all	The home has met and exceed their goal of 14%. Current Dec 2025 QI 12.2%. The home has exceeded provincial average of 22.3%. The home continues to implement change ideas, monitor progress and evaluate. The home completed SBAR education, as well as completing assessment training was completed in Dec 2025. The MD continues to provide on the stop education with registered staff during ED transfers as needed and identified.
% of staff that have completed diversity and inclusion training	**Improve overall dialogue of diversity, inclusion, equity and anti-racism in the workplace** The Home continues to embed equity, diversity, inclusion, and anti-racism principles into daily practice and organizational culture. The existing initiatives were sustained and further reinforced to ensure consistency across all departments and levels of leadership. **Increase diversity training** All staff and mangers completed SURGE online education related to diversity, inclusion, equity and anit-racism in the workplace. **Ongoing feedback** The management team continues to provide an open door policy and encourage feedback in order to address any concerns or issues at the moment. We also welcome all suggestions and ideas to further improve. **Include Cultural Diversity as part of CQI meetings** All CQI meetings now include a discussion related to diversity and further ideas for improvement, as well as evaluation of current actions	The home has met their goal of 100%. All staff and managers received training in 2025. The home continues to implement change ideas, monitor progress and evaluate. All staff completed SURGE education in 2025. Diversity and inclusion is discussed at CQI meeting monthly. The existing initiatives were sustained and further reinforced to ensure consistency across all departments and levels of leadership.

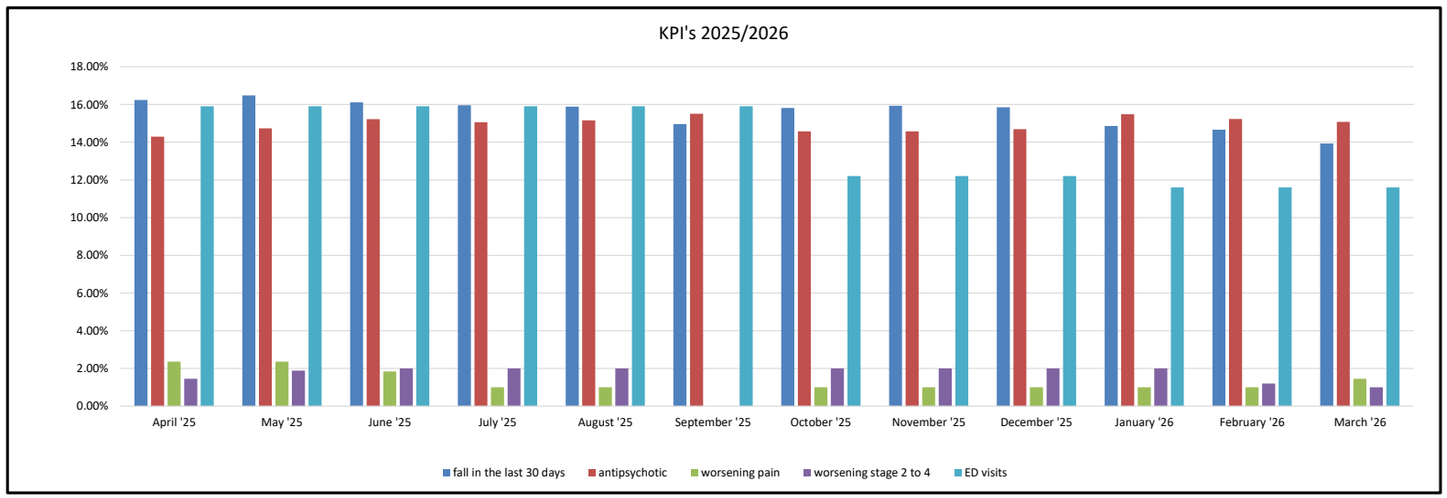
% of residents that responded positively to "I can express myself without fear of consequences	**Engaging residents in meaningful conversations** The home has engaged residents in meaningful conversations, through daily conversation and care conferences, that allow them to express their opinions. **Review "Resident's Bill of Rights"** A review of the "Resident's Bill of Rights" has occurred at residents' Council meetings monthly. With a focus on Resident Rights #29. "Every resident has the right to raise concerns or recommend changes in policies and services on behalf of themself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else" **Review of the Whistleblower policy** The home has reviewed the Whistleblower policy with Residents' Council, and continues to provide ongoing open conversations at each meeting. **Review the Concern process** The home has reviewed the complaint and concern process in the home with residents and families on admission and during annual care conference	The home has exceeded their goal of 85%. Current QI 2025 88.96%. The home remains below LTC division average of 92.15%. The home continues to implement change ideas, monitor progress and evaluate. Residents rights, whistleblowers policy and complaints process was reviewed a resident council in Jan 2025. They are also reviewed with each admission. This improvement reflects our commitment to actively engage families and residents in providing feedback, addressing concerns, and implementing targeted interventions to improve their over all experience.
% of residents with worsening stage 2 to 4 pressure ulcers	**Provide education and re-education on wound care** All registered staff have received education on wound assessment, the skin impairment checklist tool, and preventative wound care interventions. Our wound care champion completed Medline wound care education. We continue to assess all residents on a daily basis for skin impairments during care for early identification. The PURS scores are assessed and used to implement skin care interventions such as cream, turning wedges, repositioning for any resident identified as high risk for skin issues and concerns. The home continues to use and monitor wounds / impaired skin by using a skin and wound tracker. The tracker tool assists to ensure policies and procedures are being followed with all skin impairments. **Referral and consults** The home has utllized St.Joe's wound care clinic and a virual NSWOC NP for wound care consults to evaluate, assess recommend and provide suggestions. This has effectively assisted with better outcomes and effective wound healing **Monthly Wound Care Review** We continue to assess all residents on a daily basis for skin impairments during care for early identification. The PURS scores are assessed and used to implement skin care interventions such as cream, turning wedges, repositioning for any resident identified as high risk for skin issues and concerns. The home continues to use and monitor wounds / impaired skin by using a skin and wound tracker. The tracker tool assists to ensure policies and procedures are being followed with all skin impairments. All residents with pressure related injuries are discussed and reviewed with our quality meetings. Wounds continue to be reviewed for progressess and to ensure care plan interventions are effective.	The home did not met their goal of 1.5%. Current Dec 2025 QI 1.81%. Continues to exceed provincial average of 2.25 as well as corporate average of 2%. The home continues to implement change ideas, monitor progress and evaluate. Medline provided skin and wound care lead education in July 2025, as well as PSW training with preventative care. All skin impairments are tracker, assessed and evaluated at least monthly by the wound care lead.
% of residents that fell in the last 30 days	**Weekly Fall Huddles, collaboration, and injury prevention** The home is completing weekly falls huddles on each unit and include collaboration with the Falls committee and external partners. Environmental assessments, care plan interventions and FRS scores are taken into consideration with each fall, review of current falls interventions and additional interventions post fall. Each fall is reviewed with the ongoing huddles, MD/NP,PT, input and notifications to family. Input from family with notifications and care plan reviews is considered and evaluated. The home uses the falls tracker as a tool to monitor, evaluate and ensure policies are followed. PT has completed education to residents and families related to walker and w/c safety. FRS scores are reviewed on admission, quarterly and with significant change to ensure appropriate medication prescribed for prevention of bone density loss by the falls lead, MD and pharmacy consultant.	The home did not meet their goal of 15%. Current Dec 2025 QI 15.85%. The home continues to exceed provincial average of 16.2%, corporate goal is 15.5%. The homes continues to implement change ideas, monitor progress and evaluate. The home continues to complete weekly falls huddles, and review all falls. FRS scores are assessed on admission, quarterly and with significant change in condition, with noted impact to implementation of falls interventions and added fracture prevention medication.

% of residents receiving antipsychotic medication use without a DX	**Monthly Reviews of residents receiving antipsychotic medications** Monthly reviews of all residents receiving antipsychotic medication are completed with MD, NP, BSO and clinical managers / leads. Antipsychotic use continues to be reviewed and discussed at all CQI and PAC meetings. **New admission review** Any newly admitted residents are reviewed related to medications, medication alternates, and non medication interventions. The focus of the review is to take into consideration any reductions in antipsychotic medications.The home continues to complete quarterly medication reviews to assess management of Responsive expressions, interventions and the use of antipsychotic medications. **Care Plan Development** Resident care plans are developed with the multidisciplinary team, including RPN/PSW/BSO/MD/NP/Family/community partners. The focus of the care plan is to develop effective interventions with the focus on triggers / intervention with non pharmalogical approach.Care plans are reviewed quarterly, with significant change, new expressions, or new diagnosis. **Admission Conference** During admission conference, medications are reviewed with families, reason for the prescribing of antipsychotic medication, interventions effective in management of responsive expressions. Plan of care is reviewed and any suggestions or interventions that may have worked prior are taken into consideration	The home did not meet their goal of 14%. Current Dec 2025 QI 14.69%. The home has exceeded the provincial average of 22.3%. The home continues to implement change ideas, monitor progress and evaluate. Several residents have successfully had reduction or discontinuation of antipsychotics through the dose reduction initiative. Ongoing auditing and monitoring ensured accurate coding and documentation, supporting sustained improvement.
% of residents who have worseing pain during RAI look back period	**Through assessment** The home has conducted through assessments of the residents' goals, palliative care, and end of care. Through the completion of PPS assessments on admission, quarterly, and with significant changes the home has developed early identification of changes. Is able to address possible medication regiment changes, involve the interdisciplinary team, family and resident with care planning decisions. **Palliative care order sets** In collaboration with the MD/NP/Pharmarmacist and clinical team the home has developed and utilized a pallitive and end of life medication order set. The order set has been successful at address pain and comfort in the moment, providing timely management in health decline and the end of life process. The home has also implemented referral or collaboration with the pain management specialist. **Utilization of trackers** The home continues to use the PRN medication tracker to assist with changes in residents' pain and increased use of medication interventions. They are able to communicate to the MD and NP to have medication reassessed and updated to met the goals of the resident. All residents are assessed for pain, increased pain and intervention effectiveness on admission, re admission, quarterly, with significant change.	The home has met and exceed their goal of 8.5% Current QI Dec 2025 0.63% The home continues to implement change ideas, monitor progress and evaluate. PPS assessments continue to be completed on admission, quarterly, and with significant change in condition. Daily review of the PRN tracker is completed. Implementation of the palliative end of life order set has provided successful goals of care during end of life process
Top 5 resident satisfaction survey opportunities 2024 1) I am satisfied with the quality of:Laundry service for personal clothing = 79.74% 2) I am satisfied with:The variety of spiritual care and services = 75.89% 3) I have access to foot care when needed = 74.17% 4) I am satisfied with the temperature of my food and beverages = 71.11% 5) I am satisfied with the quality of care from: Social Worker/Social Service Worker = 55.77%	The home continues to promote open communication and responsiveness to residents and families through promoting a culture of open, transparent communication to all parties involved. Encouraging residents to voice concerns and provide feedback though multiple channels such as Resident Council, Satisfaction Surveys and direct conversation with the management and staff. The Management team continue to reinforce with the staff accountability to respond to concerns promptly, respectfully and professionally including addressing any raised concerns in a timely manner. The Home had implemented a linen inventory and ongoing tracking system to ensure adequate supply of linens at all times including increase par levels of linens to maintain and have backup of linens at all times. Education was completed to staff on proper linen handling and reporting shortages promptly. Spiritual care has been assessed with resident council involvement to determine requests for different spiritual care. The home has also implemented virtual spiritual care access, which is also offered at the bedside. Timely access to foot care services was identified and prioritized including streamlining of regular on-site foot care clinics every 6 weeks and as needed. Collaboration with the Home, residents and its families was the key of this service to be a success. The Home continues to monitor foot care access to ensure residents receive timely and appropriate care through referrals and working with the service provider to optimize scheduling and availability based on resident needs. There is a continued collaboration with the dietary team and Registered dietitian to review and respond to resident feedback such as the temperature of foods. The home has implemented auditing and training for all dietary staff to ensure food temperatures are within in optimal levels. The home successfully hired a social service worker in 2025 to assist with various needs assessments, and partnering with community organizations to ensure social assistance, consulting services and financial aide is available when required.	The goal of the resident satisfaction survey to gain a better understanding of residents goals and overall satisfaction of services. Our goal is always to provide the best possible care and services to the residents we server. In working collaboratively as a team the outcome of the 2025 satisfaction survey saw the following results. 1) I am satisfied with the quality of: Laundry services = 79.81% 2) I am satisfied with: The varity of spiritual care services = 78.95% 3) I have access to foot care when needed = 82.73% 4) I am satisfied with the temperature of my food and beverages = 80.80% 5) I am satisfied with the quality of care from: Social Worker = 85.0%

Top 5 Family satisfaction survey opportunities 2024 1) I am aware of the spiritual care services offered in the home = 73.77% 2) I am satisfied with the variety of spiritual care services = 71.67% 3) I am satisfied with the quality of care from physiotherapist/Occupational therapist = 71.67% 4) Overall, I am satisfied with the continence care products = 71.67% 5) I am satisfied with the quality of care from: Social Worker/Social Service Worker = 62.50%	Implementation of plans to improved services in the Home is always the priority for resident comfort, dignity and satisfaction. Family's input is valuable to the Home to ensure essential services are completed in a timely manner and align with resident preferences. This also ensures staff accountability and quality in our service. For Spiritual Care services, the Home continues to coordinate with community spiritual leaders/ volunteers to expand their availability and promote services as per resident spiritual preference. Ongoing communication with the Resident Council are enhanced to continue to engage in dialogue with spiritual services items that can continue to improve quality of resident life at the Home. The home has also implemented virtual spiritual services to accommodate all needs and bedside visits. Similar with the Resident Satisfaction Survey, there is a continued collaboration with the physiotherapy team to review and respond to resident feedback such as incorporating new and reviewed planning and individualized care plans including support with ongoing improvements in our PT programs / care and resident/ family satisfaction. The Home continues to complete a regular individualized continence assessment and re-assessment with any change in resident condition. There are adequate stock of all sizes and proper staff training on proper sizing, fitting and application techniques completed. The Home continue to monitor and document issues and adjust products accordingly to ensure resident comfort and dignity is followed. The home successfully hired a Social service worker in 2025 to assist with various needs assessments, and partnering with community organizations to ensure social assistance, consulting services and financial aide is available when required.	The family satisfaction survey goal also guides the home in quality improvement from an alternate perception and further customer service. Guiding the home to further quality improvement goals from a multidisciplinary level. Our goal is always to meet or exceed the goals of everyone involved in our care and services. The 2025 satisfaction results from a family point of view are as follows. 1) I am aware of the spiritual care services offered in the home = 86.61% 2) I am satisfied with the variety of spiritual care services = 85.0% 3) I am satisfied with the quality of care from physiotherapist/Occupational Therapist = 84.4% 4) Overall I am satisfied with the continence care products = 80.0% 5) I am satisfied with the quality of care from: Social Worker/Social Service Worker = 85.75%

Key Perfomance 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
fall in the last 30 days	16.24%	16.48%	16.11%	15.96%	15.89%	14.96%	15.81%	15.93%	15.85%	14.86%	14.66%	13.93%
antipsychotic	14.29%	14.73%	15%	15.06%	15.16%	15.51%	14.57%	14.57%	14.69%	15%	15%	15%
worsening pain	2.36%	2%	1.84%	1.00%	1.00%	N/A	1.00%	1%	1.00%	1.00%	1.00%	1.45%
worsening stage 2 to 4	1%	2%	2%	2%	2%	N/A	2%	2%	2%	2%	1%	1%
ED visits	15.90%	15.90%	15.90%	15.90%	15.90%	15.90%	12.20%	12.20%	12.20%	11.60%	11.60%	11.60%



How Annual Quality Initiatives Are Selected

The continuous quality improvement initiative is aligned with our mission to provide quality care and services through innovation and excellence. The home has a Continuous Quality Improvement Committee comprised of interdisciplinary representatives that are the home's quality and safety culture champions. An analysis of quality indicator performance with provincial benchmarks for quality indicators is completed. Quality indicators below benchmarks and that hold high value on resident quality of life and safety are selected as a part of the annual quality initiative. Emergent issues internally are reviewed for trends and inccorporated into initiative planning. The quality initiative is developed with the voice of our residents/families/POA's/SDM's through participation in our annual resident and family satisfaction survey and as members of our continuous quality improvement committee. The program on continuous quality improvement follows our policies based on evidence based best practice.

Summary of Resident and Family Satisfaction Survey for Previous Fiscal Year

Date Resident/Family Survey Completed for 2024/25 year:	October 1 to October 31, 2025
Results of the Survey (*provide description of the results*):	88.91% of the residents and 88.91% of family members would recommend this home to others.The 2025 resident and family surveys were conducted from October 1st to October 31st, 2025. For participation, the numerator represents the number of residents and family members that completed a survey. The denominator represents the number of residents and family members that were eligible to complete the surveys. Resident top 5 opportunities Overall, I am satisfied with laundry, cleaning, and maintenance services.79.37% I am satisfied with: The variety of spiritual care services.78.95% I am satisfied with: The timing and schedule of spiritual care services78.95% I enjoy eating meals in the dining room.77.46% I am satisfied with the quality of: Maintenance of the physical building and outdoor spaces76.95% Family top 5 opportunities Overall, I am satisfied with the quality of care from: Nursing staff80.55% I am satisfied with the quality of care from: Personal support staff80.55% My feedback on the residents' goals and plan of care is considered and adopted.80.41% I am satisfied with the quality of care from: Administration/Office Staff80.11% Continence care products: Fit properly80.00%
How and when the results of the survey were communicated to the Residents and their Families (including Resident's Council, Family Council, and Staff)	Resident and Family statisfaction survey was reviewed with Resident's Council on February 25, 2026. At this time, the home does not have a Family Council or advisory committee and are actively seeking members. Resident and Family Satisfaction survey was posted on CQI board on February 1, 2026. CQI program evaluation is posted publically on our information board located in the main lobby of Southbridge Lakehead. Satifaction survey results have been reviewed with staff during regular staff meeting.

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%	59.74%	83.80%	82.00%	81.48%	12.30%	80.49%	Encourage all residents to participate in survey's annually. Have voluteers assist resident in completion of survey's annually
Would you recommend	89.00%	88.91%	87.00%	85.93%	89.00%	88.91%	13.50%	65.00%	Show case the home with positivity. Advertise events, improvement and programs. Increased staff training related to customer service, non abuse, GPA, and resident bill of rights.
If I have a concern, I feel comfortable raising it with the staff and leadership	87.00%	86.64%	87.00%	85.00%	91.00%	90.11%	81.98%	80.74%	Open door policy, advertise if you have a complaint poster. Review complaints policy and whistleblowers policy at admission and annual care conference

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

Avoidable ED visits	1) Education and re-education will be provided to registered staff on the continued use of SBAR tool and support standardize communication between clinicians. 2) Educate residents and families about the benefits of and approaches to preventing ED visits. The home's attending NP/MD will review and collaborate with the registered staff on residents who are at high risk for transfer to ED, based on clinical and psychological; 3) The MD on site will provide education theoretically and at bedside. 4) Utilization internal hospital tracking tool and analyze each transfer status. ED transfer audit will be completed and reviewed monthly by nursing leadership (DOC, ADOC). Reports will be reviewed at quarterly PAC meetings 5) Care plan for residents with responsive expression - indication of triggers and interventions	12.2% Dec 2025
% of staff and management completed diversity and inclusion training	1) Training and/or education through Surge education or live events; 2) Introduce diversity and inclusion as part of the new employee onboarding process; 3) Celebrate culture and diversity events; educational opportunities 4) Monthly quality meeting standing agenda- review the number of programs, education completed	100% Dec 2025
% of Residents that answered positively to " I can express myself without fear of consequences"	1) Continue to discuss resident right #29 on monthly basis, during Resident Council meeting 2)Re-education and review with all staff Resident Bill of Rights specifically #29 at department meetings monthly 3)Review of whistleblower policy with resident and family on admission and care conferences	88.28% Dec 2025
% of residents with worsening stage 2 to 4 pressure areas	1) Arrange education for Registered staff and PSW, with Medline consultant and NSWOC 2) Develop a list of resident who PURS is 3 or greater, review plan of care, for the appropriate pressure relieving devices, review of surfaces in place 3) Utilization of skin and wound tracking tool, to analysis the pressure related injuries in the home - and the development of plan of care	1.81% Dec 2025
% of residents that have fallen in the last 30 days	1) Complete a weekly meeting with unit staff regarding ideas to help prevent risk of falls or injury related to falls; 2) to increase training and/or education of Falls program; 3) Resident list of FRS of 3 or greater, offer fracture prevention medication 4) Education and re-education provided to registered staff on the completion of post fall analysis	15.02% Dec 2025
2025 Resident Satisfaction Survey Top 5 opportunities 2025 1)Overall, I am satisfied with laundry, cleaning, and maintenance services.□ 2)I am satisfied with: The variety of spiritual care services.□ 3)I am satisfied with: The timing and schedule of spiritual care services□ 4)I enjoy eating meals in the dining room. 5)I am satisfied with the quality of: Maintenance of the physical building and outdoor spaces□	1) The home will continue to utilize the policy that is currently in place when labeling clothing and ensuring all clothes are returned to the proper residents within 24 hours. The home will continue to train all staff and new staff to adhere to Southbridge policies. The home will continue to utilize the maintenance care app and prioritize tasks to be completed. All staff are encouraged to use the app that is provided on the IPADS in all home areas. The Maintenance Care app is tracked to ensure all tasks are completed in a timely manner. 2)Recreation will conduct a survey with Residents and family to find out what they would like regarding spiritual programs. We will complete this by June of this year. Access community contacts working with Tammy Squitti (Mental Health Counsellor). We will increase our Indigenous programs with drumming, smudging and other cultural programs addressing the spiritual component. 3)Residents Council will be asked for feedback regarding spiritual services on how we can increase and the scheduling of church/spiritual programs 4)The Food Service Department will ensure meals are served at the proper temperature, with attention to taste, variety, and visual presentation. The Food Service Department and Recreation Dept will maintain clean and inviting dining areas, including table settings, seasonal decorations, and centerpieces to create a welcoming atmosphere. The home will introduce soft background music during mealtimes, while adjusting lighting, ventilation, and noise levels to create a more comfortable and enjoyable dining environment. The Manager will train dining staff to provide friendly and attentive service. 5)The home is currently waiting for quotes to paint all the home areas. This includes the spas, hallways, and resident lounge areas. All lounge areas will be getting new tint on the windows and blinds. The home has plans to clean up all the chipped paint on the front of the building in the spring and has bought paint for touch ups. The home was approved for Ministry funding to widen the patio door to the roof top patio, so bariatric wheelchairs have access. The council room door will be widened as well. This will allow bariatric wheelchairs to have access to more programming and care conferences held in the council room.	2025 Resident Satisfaction Survey Result: 1) 79.37% 2) 78.95% 3) 78.95% 4) 77.46% 5) 76.95%

Family top 5 opportunities 2025 1)Overall, I am satisfied with the quality of care from: Nursing staff 2)I am staified with the quality of care from: Personal support staff 3)My feedback on residents' goals and plan of care is considered and adopted 4)I am satisfied with the quality of care from: Administration/Office Staff 5)Continence care products: Fit properly	*1)The nursing managers continue to provide external services brought in to complete GPA with all staff in the home.* The nursing department along with Care Rx continues to provide educational oportunties to all registered staff related to medication mangement 2) The nursing managers continue to provide external services brought in to complete GPA with all staff in the home. The home continues to onboard new staff and increase the number of PSW's on the care floors in order to allow more time for direct care to be provided. 3)The home continues to involve both the residents and their loved ones in IDTC meetings. Residents and families are encouraged to bring forward any changes they would like to have implemented. Residents and families are encouraged to speak with the staff of the care units in absence of a nursing manager to express their wishes. 4)Managers of the home continue to extend the "open door" policy and encourage the residents and loved ones to express themselves openly. The Business Office will ensure that someone is always available to distribute money as needed to residents during business hours. As well as keeping an open line of communication with families/POA regarding finances. Office manager is working closely with PGT, ODSP and Indigenous Services to assist residents with finances. 5) Southbridge is transitioning to Medline continence products on April 27, 2026. Education will be provided to staff prior to the new product launch date, as well as on-going education as required. All residents will be individually sized for the new product to ensure proper fit. Communication will be mailed out to families regarding the change, and information posted in the home.	The homes score 2025 1) 80.55% 2) 80.55% 3) 80.41% 4) 80.11% 5) 80.00%

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

Participants of Evaluation Name and Signatures:	***Print out a completed copy - obtain signatures and file.***	**Date Signed:**
Quality Improvement Lead	Hannah Boomhower	**19-May-26**
Executive Director	Joanna Stavropoulos	19-May-26
Director of Care	Hannah Boomhower	19-May-26
Nutrition Manager	Arianne Eslana - Food Service Manager	19-May-26
Programs Manager	Caroline Cameron- Fikis - Program Manager	19-May-26
Medical Director	Dr. Ruby Klassen	19-May-26
Clinical Consultant		
Resident Council Member	Beverly Succo	25-May-26
Family Council Member	The home does not have an established council at this time.	N/A