SOUTH BRIDGE

Continuous Quality Improvement Initiative Annual Report

Annual Schedule: May 2026

HOME NAME : Manoir Marochel

People who participated in the evaluation of this report

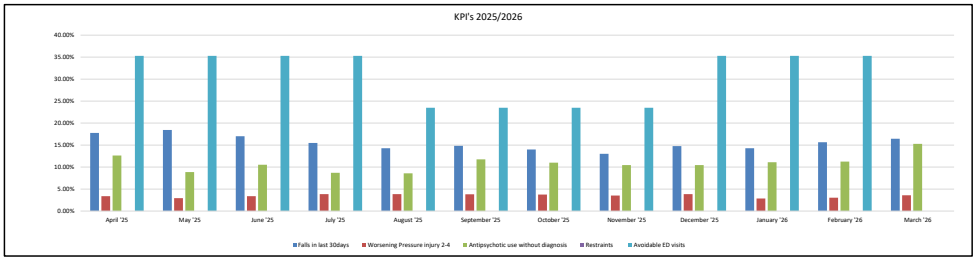
	Name and Designation	Date of Evaluation
Quality Improvement Lead	Khushi Arora	10-Jun-26
Director of Care	Khushi Arora	10-Jun-26
Executive Directive	Caroline Guimond	10-Jun-26
Nutrition Manager	Mathew Walker	10-Jun-26
Programs Manager	Martine Desouza	10-Jun-26
Clinical Consultant	Davina Dowdall - Senior CC	10-Jun-26
Resident Council Representative	Peter Frazier	10-Jun-26
Family Council Representative	NA	NA
Medical Director	Dr Gill	10-Jun-26
Other	Manpreet Kaur Saini RAI coordinator	10-Jun-26
Other	Rita Abou Chakra Clinical Consultant Tanya Adams Regional Director	10-Jun-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
Initiative # 1: Access & Flow The home aims to reduce the rate of potentially avoidable ED visits from a rate of 20% to 18%	**Methods implemented to Reduce ED visits** **Change idea #1 Use of SBAR communication tool** To support the reducation of avoidable Emergency Departement (ED visits), the interdisciplinary team implemented a mulitfacted approach focused on early intervention, staff education, enhanced communication, and continous quality improvements. Staff utilze SBAR communication with Physician and Nurse practitioner, this standard approach ensures relevant information is provided to the clear format -which provides timely assessments and decision making for treatment. **Change idea #2 Support early recognition of residents at risk for ED visits, by providing preventative care and early treatment for common conditions** Education/e-education provided on the use of SBAR communication tool Ongoing education with the clinical team of resident condition, diagnosis, external community partners, provided on-site education to clinical team Nurse practitioner was recruited to provided ehanced on site clinical assessments and management, enabling early diagnosis and treatment of acute and chronic conditions. **Change idea #3 During care conference discussion with resident and families regarding advanced care planning** Families were education about the role of availability of the Nurse Practitioner, helping to increase awareness of clinical services available within the home and supporting informed decision-making regarding resident care needs. Resident with history of frequent ED transfers were identified and reviewed through interdisciplinary team approach, with regular discussions focused on resident status, goals of care, and care planning to address health concerns. **Change idea #4 Director of Care, to review Hospital (ED) tracker for the common reason for transfers, review in Nursing practice meetints, to develop strategies to prevent further ED visits** DOC utilized hosptial tracker to monitor all resident transfers to ED, review and analyize for trends. This data/information was review with the Clinical team, as well as the development of education based on the conditions/reason to the ED transfor	Despite continued implementation and strengthening of existing interventions, the ED rate increased slightly to 35.30% compared to 35.29% in the previous year. This increase is recognized in the context of increasing resident complexity, higher acuity levels, and multiple comorbidities within the Home, which continue to impact clinical decision-making and transfer needs. In review of process indicators demonstrated sustained improvements, staff engagement in clinical education, and overall awareness of early deterioration and escalation processes. The implementation of standardized communication practices, enhanced clinical support through the Nurse Practitioner, proactive advance care planning, and ongoing monitoring of ED transfer data strengthened the home's ability to identify and manage resident health concerns early. Although these interventions improved clinical decision-making, increased access to on-site care, and supported a targeted reduction in avoidable Emergency Department visits, the Home is striving to continue to attain these goal while promoting resident-centered care.
Initiative #2: Service and Excellence: Promote equity, inclusion, and person centered service by fostering a culturally aware, engaged, and responsive care environment for residents, families, and staff.	**Change Idea: Improve overall dialogue of diversity, inculsion, equity and anti-racismin the workplace** The home implemented several initiative to strengthen person-centered care. Staff completed Surge Learning education modules focused on diversity, equity, inclusion, and anti-racim. These learning opportunities enhanced awareness, encouraged respectful dialogue. **Change Idea: External organizatons to assist with education on equity, diversity, inclusion, and anti-racism** External organizations and community partners were invited to the home to provide educational sessions for staff and residents. **Change Idea: To include Cultural and Diveristy as part of of CQI meetings.** Programs and activities were developed and implemented throughout the home to celebrate cultural diveristy. This was reviewed as part of quarter CQI meetings. These activities, provided opportunities for residents to share their traditions, experiences and cultural backgrounds. **Additional Activities:** Enhance to communication and family engagemenet, the Recreation team distributed the monthly calendar to resident and families.	Current Performance- 100% of staff completed the required education The home demonstrates consistent and thoughtful efforts to embed EDI principles into practice, fostering a more inclusive and person-centered environment. The implementation of staff education, partnerships with external organizations, cultural programming, and ongoing CQI review processes has strengthened the home's commitment to equity, diversity, inclusion, and anti-racism. These initiatives have increased awareness, encouraged respectful and inclusive interactions, enhanced resident and family engagement, and promoted a culture that values and celebrates diversity throughout the home
Initiative #3 - Experience The home aims to increase the percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences" from 85.96% to 88%	**Change Idea: Review of the Resident Bill of Rights #29 -during resident council meeting, and family town hall meeting** The team included review of residents rights, with a focus on #29 to resident council meetings at the home, increasing awareness into the resident's rights and fostering therapeutic relationships. **Change Idea: Review of the Whistleblower policy with all staff during meetings, and resident council and family forum** The home's Whistleblower Policy was reviewed with residents and families upon admission, to ensure awareness of their right to voice concerns, reports issues and provide feedback. **Change Idea: Review the homes complaint process with resident and SDM's on and admission and during care conference** The Policy was reviewed in Resident council meetings, these ongoing discussions promoted transparency, accountability, and confidence in the homes commitment to responding to concerns respectfully and effectively **Change Idea: Educate staff on Person Centred Care** Education on person and family centered communication was provided to team members, to reinforce the importance of respecting resident choice, promoting dignity, and encouragaing meaningful participation in care and decision making. This education supported a culture where residents and families feel heard, valued and empowered to voice their opinions and concerns.	Current performance the home increase from 84.38% to 85%, this indicates the homes commitment to resident empowerment, transparent communication, and ensuring, resident feel comfortable expressing concerns. The question "What number would yo uuse to rate how well the staff listen to you" was not included in the 2025 satisfaction plan. Through ongoing education on resident rights, the Whistleblower Policy, the complaint process, and person-centred care principles, the home strengthened its commitment to resident advocacy, transparency, and meaningful engagement. These initiatives increased awareness of available supports and reporting processes, fostered open communication, and promoted a culture where residents and families feel respected, empowered, and actively involved in decisions affecting their care and quality of life.
Initiative #5 - Safety The home aims to improve the percentage of residents who fell in the 30 days leading up to their assessment from a rate of 14.11% to 12%	**Change Idea: Post fall Huddles completed with the staff members on the floor. Montly collaboration with falls committee and external resources for the development of resident's plan of care.** Resident who experienced a fall were reviewed in-depth through a Post fall huddles and during monthly quality meeting. These interdisciplinary discussion focused on identifying contricating factors, evaluating the effectiveness of current interventins, and developing of additional prevention strategies to reduce falls. **Change Idea: Injury prevention, review of FRS, ensure appropriate medication precription for prevention of bone density loss** Pharmacist, conducted medication reviews for residents who experienced falls to identify medications that may contribute to falls. Recommendations, were incorporated into the resident plan of care, in collaboration with the physician. Environmental audits, completed of residents room and common areas, to address potential safety risk. Corrective actions were implemented. **Change Idea: Comprehensive post fall analysis in the development of resident plan of care** Comprehensive falls risk assessments completed during the admission process for resident with a history of falls, assessment findings were were used in the development of residents plan of care. **Additional Activities:** Falls Tracker was implemented to support the monitoring, analysis and trending of falls. This tool enabled the clincial team to identify patterns, evaluate interventions, and implement interventions, and review of the plan of care.	The implementation of post-fall huddles, comprehensive risk assessments, pharmacist-led medication reviews, environmental safety audits, and falls tracking enhanced the home's falls prevention program. Through interdisciplinary collaboration and ongoing evaluation of fall-related data, the home strengthened its ability to identify risk factors early, implement individualized interventions, and continuously improve resident safety outcomes. Although the home did not achieve the target of 12%, the current peformance is 16.45%, there was noted increase to the resident acuity and complexity of needs contributed to the outcome. The home continues to implement and monitor all planned interventions and remain committed to the quality improvment initiative. New change ideas have been planned as part of the 2026-2027 HQO QIP.
Initiative #6 - Safety The home aims to improve the percentage of residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment from a rate of 25.29% to 18%	**Change Idea: The MD, NP, BSO internal and external (including Psychogeriatric Team), with nursing staff will meet monthly to review newly admitted residents on antipsychotic medication for diagnosis and indication for use.** Comprehensive assessments were completed on residents admitted to the the home who were prescribed antipsychotic medications, this included a reaview the indications for use, diagnosis. **Change Idea: Use Gentle Persuasive training establish GPA trainers educators in the home.** Internal BSO team, was re-established to strengthen interdisciplinary collaboration, support staff education and provide ongoing oversight of residents exhibiting responsive expressions. Review/re-education on the process of the home's referral process in the home. **Change Idea: Monthly review in the quality meeting of residents who are prescribed antipsychotic medication- to include non-pharmacological interventions in their plans of care .** The home implemented a comprenhensive, interdisciplinary approach to support the appropriate use of antipsychotic medications and promote person-centered, non-pharmalogical interventions for residents. **Additional Activities:** External Behavioural supports (Royal) team was engaged to provide clinical expertise and support in the assessment and management of responsive expressions. The team collaborate with staff, residents and families in the development of individualized care plans, that determined and addressed the underlying reasons/causes of behavours and supported resident well being.	Through comprehensive medication reviews, enhanced behavioural support programs, GPA education, interdisciplinary quality reviews, and collaboration with external behavioural specialists, the home strengthened its approach to ensuring the appropriate use of antipsychotic medications. These initiatives promoted person-centered care, increased the use of non-pharmacological interventions, supported informed clinical decision-making, and improved the management of responsive expressions while enhancing resident quality of life and well-being. The home succusfully achieved and exceeded it's establihsed target for reducing the percentage of residents receiving antipsychotic medication without a diagnosis. Through ongoing interdisciplinary collaboration, comprehensive assessments, and implementation of non-pharmalogical interventions. Current performace 15.29%

Initiative # 7 - Safety Percentage of LTC residents who develop worsening pressure injury stage 2-4 Target 2.5%	**Change Idea #1: Provide education and re-education on wound care assessment and management. Education to be provided by NSWOC** A collaborative approach was used to provide education to the registered staff, personal support workers and the management team with regards to wound care management. The DIMES approach was reviewed with consultantion of our medline team while the homes Long Term Care Consultant provied education on our policies related to Wound and Pain Management. Additional one to one education was also provided to the registered staff by the homes Wound Care Lead with a focus on ensuring that dressing changes were adhered too as per the directions received from the NSWOC. **Change Idea #2: Monthly review in Quality meeting of resident with Pressure related injuries, review of care plan, progression/lack of healing of pressure injury, review of the PURS.** The home implemented a weekly comprehensive review of residents with pressure related injuries and implemented strategies focused on reducing the risk through ongoing collaboration, education, and monitoring. A new skin and wound lead was hired for the home. Their responsibilities included updating and reviewing resident(s) plan of care, monitoring pressure injuries by completing weekly assessments and reporting wound progression, changes and or concerns to POA/SDM and to the interdisciplinary team and sending referrals to the homes NSWOC as needed. The interdisciplinary team met monthly for their quality meeting and evaluated the effectiveness of current practices. Wound Care Binders implemented on all units with a focus on current treatments and the supplies needed to manage resident(s) wounds. A weekly Wound Supply Inventory is completed to ensure that the dressing needed for each resident(s) are available. The NSWOC Referral Process was reviewed with the Clinical team and changes were made to improve the referral process and provide timely manner assessments. **Change Idea#3: ROHO education, Implement ROHO champions' team** With the support of our service provider Consel Aid, education was completed with the staff on the use, maintanence and monitoring of resident(s) that use ROHO Cushion daily.	The home did not achieve its goal of 2.5% as our current performance is 3.51% however through the implemention of the homes change ideas and the comprehensive review of the wound management program which included providing staff with education on the skin and wound management program the home has strengthened its approach in managing pressure related injuries ensuring that resident(s) plan of care is reviewed and changes implemented are appropriate. These initiatives promoted person-centered care, supported informed clinical decision-making, and improved the management of skin and wound while enhancing resident quality of life and well-being.
2024 Top 5 opportunites from Resident Satisfaction Survey I am satisfied with the quality of laundry services for personal clothing (73.33%) I am satisfied with the variety of spiritual care services (71.88%) I am satisfied with the timing of spiritual care services, provided in the home (71.18%) I have access to hair dressor services, as required (70.19%) I am satisfied with the quality care of the Social worker/Social service worker (30.50%)	I am satisfied with the quality of laundry services for personal clothing Review of the laundry process, with resident and family Review/education of the policy with nursing and laundry departments Completion of audits, regarding laundry services Review with resident related to laundry services I am satified with the variety of spiritual care services Recreation manager completed survey with resident for type of spiritual care services Recreation manager reached out to community partners to provide services in the home I am satisfied with the timing of spiritual care services, provided in the home Recreation manager completed suvery with resident for preferred timing for spiritual care services I have access to hair dressor services, as required Communication with resident and families, when servies are provided Establish process for male resident to attend barber (service available in the same building)	**2025 Resident Satisfaction Survey Results:** Laundry services, increased from 73.33% to 79.81% Access to hairdressor, increased from 70.19% to 79.81% Timing of spiritual care services, 71.81% to 81.94% I am satisfied with the quality of social worker increased from 30.%0% to 79.24% I am satisfied with variety spiritual services, 80.32%
2024 Top 5 opportunites from the Family Satisfaction Survey 1. Pleasurable dining service for residents (77.86%) 2. I am satisfied with the Registered dietician (75%) 3. I am satisfied with the timing of the recreation programs (75%) 4. I am satisfied with the variety of spiritual services, available (71.86%) 5. Resident has access to hairdressor, when needed (70%)	1. The interdisciplinary team provided, education on pleasurable dining, and customer services. Audits completed during meal service, reviewed in Resident council (interventions and action plans). 2 Ongoing recruitment for regular on-site Dietician - FSM, facilitated virtual assessments 3. Recreation team conducted surveys for timing of the recreation programs, Resident council review of the monthly calendar 4. Recreation manager, reached out to the community partners, to provide spiritual services, completed survey with residents preferred time, and type of spiritual programs	**2025 Family Satisfaction Survey Results:** Resident access to hairdressor increased to 79.81% I am satisfied with timing of recreational program increased to 89.95% Iam satisfied with variety of spiritual care services, increased to 82.22% I am satisfied with the timing of recreational programming increased to 81.51% Pleasurable dining increase to to 84.44%

Key Performance Indicators												
KPI	April '25	May '25	June '25	July '25	August '25	September '25	October '25	November '25	December '25	January '26	February '26	March '26
Falls in last 30days	17.77%	18.44%	17.01%	15.48%	14.29%	14.83%	14.00%	13.03%	14.77%	14.29%	15.65%	16.45%
Worsening Pressure injury 2-4	3.39%	2.93%	3%	3.85%	3.85%	3.81%	3.75%	3.52%	3.85%	3%	3%	4%
Antipsychotic use without diagnosis	12.64%	9%	10.53%	8.70%	8.57%	11.76%	11.00%	10%	10.45%	11.11%	11.25%	15.29%
Restraints	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Avoidable ED visits	35.29%	35.29%	35.29%	35.29%	23.50%	23.50%	23.50%	23.50%	35.30%	35.30%	35.30%	38.20%%



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

Summary of Resident and Family Satisfaction Survey for Previous Fiscal Year	
Date Resident/Family Survey Completed for 2024/25 year:	Oct-25
Results of the Survey (*provide description of the results*):	79.61% of the residents and 69.98% of family members would recommend this home to others; The Overall Satisfaction Resident Rate in 2025 is 86.08% over the 2024 of 85.36%. For Family Satisfaction Overall Survey in 2025 is 86%, also above the 2024 rate of 83.74%.
How and when the results of the survey were communicated to the Residents and their Families (including Resident's Council, Family Council, and Staff)	The 2025 resident and family surveys were conducted from October 1st to October 31st, 2025. The Resident Council was in person meeting on February 25, 2026

Client & Family Satisfaction	Resident Survey				Family Survey				Improvement Initiatives for 2026
	2026 Target	2025 (Actual)	2024 (Actual)	2023 (Actual)	2026 Target	2025 (Actual)	2024 (Actual)	2023 (Actual)	
Survey Participation	100.00%	100.00%	66.67%	70.00%	100.00%	88.24%	23.44%	40.63%	Encourage all families and residents to give honest feedback on their surveys to show the areas of opportunity and where the successes are occuring. Activity staff will continue to engage with residents to promote partipation and assist them with completion of the survey on IPADs, families have been offered a options to complete the survey.
Would you recommend	90.00%	79.62%	80.96%	79.21%	90.00%	70.71%	80.71%	69.89%	Improvements to the exterior/interior esthetics of the home, to make the home more appealing and beautiful. Regular meetings with residents and families to address concerns as promptly as possible. Addition of reception desk near from entrance to help guide visitors and families when they arrive in the home.
If I have a concern, I feel comfortable raising it with the staff and leadership	90.00%	86.80%	87.04%	87.27%	90.00%	82.90%	88.63%	89.52%	Reinforce open-door policies for managers, and the need to be visible in the home as an expectation at hire. Review of resident and family concerns at the daily risk management huddle.

Summary of quality initiatives for 2026/27: Provide a summary of the initiatives for this year including current performance, target and change ideas.		
Initiative	**Target/Change Idea**	**Current Performance**
Indicator #1 - *Access & Flow* The home aims to reduce the rate of potentially avoidable ED visits from a rate of 35.29% to 30.29%	**Change idea #1:** To reduce unneccessary hospital transfers, through the use of onsite Nurse Practitioner **Change idea #2:** Build capacity and improve overall clinical assessment skills of Registered staff and PSW; through education supported by NP. **Change idea #3** : Use of SBAR; Registered staff to communicate with Physician and NP, a comprehensive resident assessment, to obtain direction prior to initiating an ED transfer	Homes current performance as of March 2026 is 35.29%
Indicator #2 - *Equity* The home aims to ensure that 100% of staff have completed relevant equity, diversity, inclusion, and anti-racism education	**Change idea #1:** To increase diversity training through Surge education, to develop safe cultural. **Change idea #2:** Cultural assessment on admission (language, faith, gender preference for care).	Homes current performance as of July 2026, is 85.8%
Indicator #3 - *Experience* The home aims to increase the percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences" from 85% to 90%	**Change idea # 1** To increase our goal from 85.58% to 90%. Engaging residents in meaningful conversations, and care conferences, that allow them to express their opinions.	Homes current performance, is 91.82% as per the 2025 resident survey results

Indicator #4 - *Safety* The home aims to improve the percentage of residents who fell in the 30 days leading up to their assessment from a rate of 14.11% to 12%	**Change idea #1:** Re-establish of the restorative care program, with education provided to staff and resident on How resident's qualify for the program **Change idea #2:** Facilitate a Weekly huddles on each unit with the interdisciplinary team members. **Change idea #3:** Reducation of falls, in the home; completion of comprehensive assessment on admission and post fall	Homes current performanceas of April 2026 is 16.31%
Indicator #5 - *Safety* The home aims to improve the percentage of residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment from a rate of 11.59% to 10%	**Change idea #1:**The MD, NP, BSO internal and external (including Psychogeriatric Team), with nursing staff will meet monthly to review newly admitted residents on antipsychotic medication for diagnosis and indication for use. This is standing item in CQI/PAC quarterly meeting agenda **Change idea #2:** During admission conference, review with families, reason for prescribing of antipsychotics, intervention effective in management of responsive expressions (with admission from another LTC, obtain care plan, consult with the BSO if in place to review reason)	Homes current performance as of April 2026 is 19.61%
Indicator #6 - *Safety* The home aims to reduce the percentage of residents whose stage 2 to 4 pressure ulcer worsened from 3.36% to 2.30%	**Change idea #1:** To decrease the percentage of worsening pressure injuries (consultation with NSWOC in home consult and virtually **Change idea #2 :** Develop list of resident's with PURS 3 or greater, to update the plan of care, to preventive measures **Change idea #3:** Education provided to the PSW for early recognition of alteration in skin	Home current Performance as of April 2026 is 3.51%
2025 Top 5 Opportunities Resident Satisfaction Survey 1. I have access to hairdressor 2. I am satisfied with; Laundry services for personal items 3. I am satisfied with; Cleaning services 4. I have access to the foot care services when required 5. I am satisifed with the temperature of my food and beverages	1. I have access to hairdressor Communication in family communication, post to when the hairdressor will be in the home Provide residents with notices when the hairdressor will be in the home 2. I am satisfied with: Laundry services for personal items In-depth review of the laundry process, responsibilities to of PSW and laundry aides Review of the labelling process in the home Review of the Missing personal item process with families and staff 3. I am satisfied with the quality of: Cleaning services throughout the home Complete the QIRMHL- Resident Room cleaning and QIRMHL- Resident room Sanitation audit for the housekeeper weekly We will be increasing the number of on-the-spot housekeeping checks completed throughout the week. 4. I have access to foot care when required. Review the foot care process Communicate with resident, to when the foot care clinics are occurring 5. I am satisfied with the temperature of my food and beverages. Root Cause Review: FSM/FSS will complete a kitchen production audit to assess production timing, holding practices, and workflow. Temperature Controls: During floor audits, FSM/FSS will ensure hot foods are kept in steamers (not pans) and cold foods are held using proper ice-bath methods at proper temperature and correct at the point of service Audit using QRM-DS- food production audit and Daily management Dietary audit.	**2025 Resident Satisfaction Survey Results:** 1. I have access to hairdressor Current performance 79.81% (Target 85%) 2. I am satisfied with; Laundry services for personal items Current preformance 79.81% (Target 90%) 3. I am satisfied with; Cleaning services Current preformance 79.41% (Target 85%) 4. I have access to the foot care services when required Current performance 78.33% (Target 85%) 5. I am satisfied with the temperature of my food and beverages Current preformance 76.76% (Target 90%)
2025 Top 5 Opportunities - Family Satisfaction Survey 1.Continenece Care- 2.Access to foot care when required 3.Iam satsfied with the the relevance of recreation programs 4.I am satisfied wiht the variety of recreastion programs 5.I am satisfied with the quality of care from the Administration/Office staff	1. Contienence care Re-education to be completed with clinical team on proper sizing of incontinent products Documentation in process Process of the related to when a change of product is required Weeky audits to be completed, 2. Access to foot care when needed -communication to families, foot care schedule, when services may be changed and the reason to why -review of foot care services, during admission and care conferences 3. I am satisfied with the relevance of recreation programs Program manager will add the monthly calendar of activies to the monthly newletter Audit related to the programming offered, and surveries to family and resident input 4. I am satisifed with the variety of recreation programs -Program manager will add the full monthly calendar in the family communication newsletter -Provide educatoini related to how programs support cognitive stimulation, physical mobility, social engagment and wellbeing, spiritual wellness -Monthly survery and review the results of the survey with families and residents 5 I am satisfied with the Administration/office staff -Management team to read and sign complaint policy -Office doors to remain open -increase visibility by being present on the resident home areas	**2025 Family Satisfaction Survey Results:** 1.Continenece Care-Current performance 79.24% (Target is 85%) 2.Access to foot care when required Current preformance is 79% (Target 85%) 3.Iam satsfied with the the relevance of recreation programs Current performance 79% (Target 85%) 4.I am satisfied wiht the variety of recreastion programs Current preformance 79% (Target 85%) 5.I am satisfied with the quality of care from the Administration/Office staff 78.14% (Target 90%)

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	Khushi Arora	**10-Jun-26**
Director of Care	Khushi Arora	10-Jun-26
Executive Directive	Caroline Guimond	10-Jun-26
Nutrition Manager	Mathew Walker	10-Jun-26
Programs Manager	Martine Desouza	10-Jun-26
Clinical Consultant	Davina Dowdall	10-Jun-26