SOUTHBRIDGE HEALTH CARE LP

Continuous Quality Improvement Initiative Annual Report

Annual Schedule: May 2026

HOME NAME : SOUTHBRIDGE CORNWALL

People who participated in the Evaluation of this report

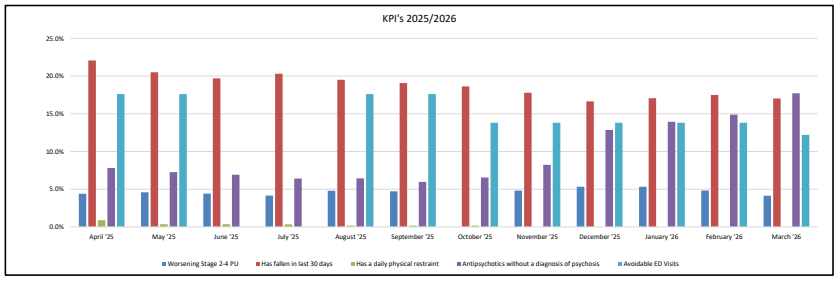
	Name and Designation	Date of Evaluation
Quality Improvement Lead	Director of Quality and Risk- Sinju Ninan	28-May-26
Director of Care	Cylin Galicia	28-May-26
Executive Directive	Rhonda Obiero	28-May-26
Nutrition Manager	Ria Sharma	28-May-26
Programs Manager	Ravneet Kaur	28-May-26
Clinical Consultant	Davina Dowdall	28-May-26
Resident Council Representative	Margaret Alguire	28-May-26
Family Council Representative	Dawn McKeown	28-May-26
Medical Director	Ashley Cook	28-May-26
Other	Kim Harrop Education Lead	28-May-26
Other	Tim Labelle, RAI Co-ordinator	28-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
Initiative #1: Rate of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents.	The home continued to strengthen it efforts to reduce avoidable ED visits through resident and family centered education, proactive clinical assessments and enhanced palliative care planning Interventions included; Providing ongoing education to families regarding the benefits of avoiding unnecessary ED tranfers and promoting alternative approahes to care with the home. Physician and NP reviewed resident and indentifed resident at risk for transfers, due to cinical and psychological, or behaviour concerns, and these reviewed where conducted with the interdisciplinary team. Developing and updating individualized care plans that identified early wardning signs for deterioration and outline treatment strategies to prevent hospital (avoidable) transfers. Implementating and promoting palliative care through education provided to staff, resident and families including end of life care planning and advance care discussions. Utilization of palliative care information brochures and handbooks	Improvement noticed during the 2025 with reduced avoidable ED tansfer Current performance 12.60% These interventions supported improved proactive care management, increased resident and family awareness of available care options within the home, strengthened interdisciplinary collaboration, and contributed to reducing avoidable ED transfers while promoting resident-centered and palliative approaches to care.
Initiative #2: Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education	The Home continued 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. Principles continued to be promoted through ongoing open communication between staff and management, supporting a safe environment for dialogue, feedback, and shared learning related to inclusion and workplace culture. The culture and diversity board remained active as a visible tool to reinforce awareness and encourage engagement among staff, residents, and visitors.	100% staff trained during 2025, These efforts helped sustain a culture of inclusivity, respect, and belonging within the Home. Ongoing education, communication, and engagement opportunities strengthened awareness of EDIA principles, supported positive workplace relationships, and reinforced the Home's commitment to providing equitable and person-centered care for all residents.
Initiative #3: Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences".	Add resident right #29 to standing agenda for discussion on monthly basis by program Manager during Resident Council meeting. Re-education and review to all staff on Resident Bill of Rights specifically #29 at department meetings monthly by department managers; Review of Concern process with resident and family with admission and care conferences Review of policy with staff during orientation and with monthly meeting. Review of policy with resident and family during admission and care conferences	Increase in satifaction noted with the 2025 survey These initiatives helped strengthen awareness and understanding of Resident Right #29 among residents, families, and staff. Regular education and discussion promoted a culture of openness, accountability, and respect, encouraging residents and families to voice concerns and participate in care-related decision-making. The Home continued to demonstrate its commitment to resident rights by fostering an
Initiative #4: Percentage of LTC home residents who fell in the 30 days leading up to their assessment	**Enhanced Equipment Audits and Environmental Safety:** Weekly and monthly audits were conducted by the Program Lead and Director of Quality to ensure all fall prevention equipment (e.g., bed alarms, mats, hip protectors) were functional, available, and appropriate to resident needs. **Strengthened Leadership Oversight and Accountability:** Ongoing review of fall data by leadership, with follow-up on corrective actions and reinforcement of staff accountability in post-fall management and documentation. **Staff Education and Reinforcement of Best Practices:** Education provided on high-risk residents, frequent fallers, and proper post-fall response, including consistent use of the Post-Fall Clinical Pathway. Implementation of the 4 P's (Pain, Positioning, Possessions, Prompted Toileting): Routine rounding practices reinforced to proactively address common fall risk factors. **Resident Monitoring and Interdisciplinary Follow-Up:** Utilization of the Falls tracker, to analize the reason for falls, trends. **Post-Fall Huddles and Continuous Quality Review:** Immediate post-fall huddles with the interdisciplinary team, to conduct for root cause analysis, with ongoing documentation audits to ensure compliance and continuous improvement. Collaboration with PT, and recreation team	Falls percentage reduce from 22.05% to 17% These initiatives contributed to a more proactive and coordinated approach to falls prevention and management. Enhanced monitoring, timely post-fall reviews, ongoing staff education, and interdisciplinary collaboration supported the identification of contributing factors and implementation of targeted interventions. The Home demonstrated ongoing commitment to resident safety through continuous quality improvement efforts, strengthened accountability, and individualized care strategies designed to reduce fall risks and improve resident outcomes.
Initiative #5: Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment	The home implemented a comprehensive, interdisciplinary approach to support the appropriate use of antipsychotic medications and promote person-centered, non-pharmalogical interventions for residents. 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. Comprehensive assessments were completed on residents admitted to the the home who were prescribed antipsychotic medications, this included a resview the indications for use, diagnosis. 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.	Current Performance 17.71% (which was increase from the previous year) These initiatives supported a more resident-centered approach to behavioural care by enhancing the assessment and management of responsive expressions and promoting the appropriate use of antipsychotic medications. Increased collaboration with external behavioural specialists, strengthened internal BSO processes, comprehensive resident assessments, and ongoing staff education contributed to improved identification of behavioural triggers, implementation of individualized non-pharmacological interventions, and enhanced quality of care for residents. Although, the Home did not meet the goal to decrease this indicator, the Home continue to implement a more proactive and collaborative approach.

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
Worsening Stage 2-4 PU	4.4%	4.6%	4.4%	4.2%	4.8%	4.7%	4.76%%	4.8%	5.3%	5.3%	4.8%	4.1%
Has fallen in last 30 days	22.1%	20.5%	19.7%	20.3%	19.5%	19.1%	18.6%	17.8%	16.6%	17.1%	17.5%	17.0%
Has a daily physical restraint	0.9%	0.4%	0.4%	0.3%	0.2%	0.2%	0.2%	0.0%	0.0%	0.0%	0.0%	0.0%
Antipsychotics without a diagnosis of psychosis	7.8%	7.3%	6.9%	6.4%	6.4%	6.0%	6.6%	8.2%	12.8%	13.9%	14.9%	17.7%
Avoidable ED Visits	17.6%	17.6%			17.6%	17.6%	13.8%	13.8%	13.8%	13.8%	13.8%	12.2%



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 1st to October 31st, 2025
Results of the Survey (*provide description of the results*):	Top 5 opportunities The timing and schedule of spiritual care services Satisfaction with the temperature of my food and beverages. Quality of care from Social Woker The variety of spiritual care services Updated regularly about any changes in the home.
How and when the results of the survey were communicated to the Residents and their Families (including Resident's Council, Family Council, and Staff)	Survey results were shared with resident Council in March meeting and attached to the minutes .Survey results has been sent to families via email and posted on the board where staff and families can read .

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%	96.33%	100.00%	98.17%	100%	82.48%	34.19%	29.45%	Collaborate with the Resident and Family Council to enhance survey engagement. The program department will continue to support residents and families in completing the survey.
Would you recommend	100%	91.94%	76.41%	86.19%	100%	89.91%	72.16%	68.29%	Strengthen the admission process and wellness checks through collaboration with the Resident Support Coordinator (RSC). Staff education will focus on promoting compassionate, person-centered care. Resident concerns will be regularly reviewed to support continuous quality improvement and enhance overall quality of life in the home.
If I have a concern, I feel comfortable raising it with the staff and leadership	90%	87.86%	80.83%	88.97%	90%	84.57%	89.25%	73.02%	Ensure the home's complaint process is clearly reviewed with residents and families during admission and reinforced during care conferences to support awareness and trust. Review the home's whistleblower policy with staff during monthly meetings to reinforce awareness, reporting expectations, and a culture of transparency. Encourage staff to actively engage residents in meaningful conversation during care to promote dignity, emotional well-being, and person-centered interactions.

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**
To reduce the number of ED visit and maintain below the provincial average. Target 12%	**Change idea #1** **Use of SBAR -Registered nurse to communicate with the physician and NP, a comprehensive assessment, to obtain direction prior to ED transfer** -Education to registered staff on the continued use of the SBAR tool **Change idea #2 Support early recognition of residents at risk for ED visits, by providing preventive care and early treatment for common conditions leading potentially avoidable ED visits.** Homes, attending NP/MD will review and collaborate with the registered staff on residents who are high risk for transfers to ED, based on clincial and psychological status, Development of care plans Provide education with registered staff, clinical conditions **Change idea #3 Education on palliative approach and end of life for staff, residents and families** Completion of Palliative performance scale assessment, Provide education to families, resident and staff on palliative care approach Utilizaton of information brochure Utilization of community partners to assist with education	January 2026 - 12.2%
Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education 100% target was achieved in the last year and will continue to keep the target 100	**Change idea #1 To increase diversity training through Surge education or live events;** Home, review the number staff who have completed the education Community partners to provide education at the home to staff and residents **Change idea #2 To include Cultural Diversity as part of CQI meetings** Standing agenda, on CQI meeting to review number of programs, education sessions held in the home Review any request for education **Change idea #3 Cultural assessment on admission, (language, faith, gender preference for care, family roles)** All admissions to the home to will have a cultural assessment	December 2025 - 100%
The home will implement measure to increase the satisfaction of the residents.	To increase our goal from 87.53 as compared to previous year to 90%. Engaging residents in meaningful conversations, and care conferences, that allow them to express their opinions. Review ""Resident's Bill of Rights"" more frequently, 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 and zero tolerance to abuse policy with staff, resident and family Review the Concern process in the home on admission and during annual care conference	October 2025 - 87.5%
Percentage of long-term care residents whose stage 2 to 4 pressure ulcer worsened The home will implement measures to be equal or below the cooperate benchmark of 2%	**Change idea #1 To reduce the percentage of resident who develop, or experience worsening pressure injury** Utilization of the Skin and wound tracker, to analize the pressure related injuries in the home, assist with the development of plan of care **Change idea #2 Home to collaborate with NSWOC to provide in home and virtual consults** Registered staff to complete rounds with NSWOC, to enhance knowledge on wound care management Virtual consults -assist with review and changes to treatment plan to support wound healing **Change idea #3 During admission process, complete comprehensive review of resident status, and risk level for alteration in skin, and develop plan of care** Comprehensive review during admission process, and assessments to develop a plan of care for treatment and preventation	2025-2026 Q3 - 3.85%
Percentage of LTC home residents who fell in the 30 days leading up to their assessment The home will implement measures to be equal or below the cooperate benchmark of 15% Target	**Change idea #1 To facilitate a Weekly Fall Huddles on each unit; with the interdisciplinary team** Weekly interdisciplinary team huddles on resident home areas, to review plan of care, to mitigate risk, of fall or injuries related to falls, (updating of plan care) **Change idea #2Establish/re-establish the restorative care program in the home (provide education on how residents quality for the program)** Identify lead for the restorative program, provide education on how resident qualify for the program, and how success is measured Monthly review at the Quality meeting of resident on the program and how the resident is progressing **Change idea #3 During admission process, review with resident and history of falls, and interventions implemented** Comprehensive review with families and resident during admission process, for development of the plan of care	2025-2026 Q3 - 17.5%
The home will reduce the use of antipsychotic medication without the diagnosis of psychosis by utilizing antipsychotic reduction tool	**Change idea #1 Residents who are prescribed antipsychotics for the purpose of management of Responsive expressions, will have a quarterly review, for the potential of reduction or the discontinuation of medication.** Utilization of tracking tool (antipsychotic)-this will allow for tracking of resident on anti-psychotic, reason/indication, de-prescribing, (number of resident who had medication decreased/de-prescribed) **Change idea #2 Gentle Persuasive approaches (GPA) training/education** - establish GPA trainers, educators in the home, (provide on site education on GPA to assist with the development of plans of care for non pharmalogical approaches **Change idea #3 Development of plans of care, with non pharmacological approach**-	2025-2026 Q3 - 18.21%

Resident Satisfaction Survey-Top 5 Opportunities for improvement	I am satisfied with: The timing and schedule of spiritual care services. Prepare agenda, include a dedicated segment on the timing of spiritual care services Gather feed back, schedule spiritual care services, review with the residents I am satisfied with the temperature of my food and beverages. Conduct a comprehensive review of current food and beverages service, Re-education on temperature control , regular quality checks, enhance serving practices I am satisfied with the quality of care from: Social Woker. Recruit social works, (the home secured a social worker) I am satisfied with:The variety of spiritual care services. Resident council engagement, Recuitment of engagement	2025 Satisfaction Results 1. 81.16% 2. 80.34% 3. 79.85% 4. 79.81% 5. 77.65%
Family Satisfaction Survey-Top 5 Opportunities for improvement	I am satisfied with the quality of care from: Dietitian. Enhance communication about dietary services, (focus groups) Collaborate with interdisciplinary team Continue to actively recruit for on site Clinical dietician My concerns are addressed in a timely manner. I am satisfied wiht the Quality of - my concerns are addressed in timely manner DOC/ADOC, DQR/RSC respond to email within one business day POA/resident, with concerns, immediate touch point, weekly touch points Education on resident centered care The resident's care conference is a meaningful discussion that focuses on what's working well, what can be improved, and potential solutions. Review and revise attenadance for care conferences Review format of Care conferences Ensure time is alloted for family feedback discussion I am satisfied with: The timing and schedule of spiritual care services. Resident council engagment, data collection, survery and comply feedback, and analize	2025 Satisfaction Results 1. 80.75% 2. 80.54% 3. 80.33% 4. 80.20% 5. 80.09%

Process for ensuring quality initiatives are met

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

Participants of Evaluation Name and Signatures:	*Print out a completed copy – obtain signatures and file.*	Date Signed:
Quality Improvement Lead	Sinju Mariam Ninan	28-May-26
Executive Director	Rhonda Obiero	28-May-26
Director of Care	Cylin Galicia	28-May-26
Nutrition Manager	Ria Sharma	28-May-26
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