Continuous Quality Improvement Initiative Annual Report

Annual Schedule: May 2026

HOME NAME : Southbridge London East

People who participated in the evaluation of this report

	Name and Designation	Date of Evaluation
Quality Improvement Lead	Laurie Wheeler - Quality RN	May 26 2026
Director of Care	Sarah Hind- DOC	May 26 2026
Executive Directive	Courtney Lines - ED	May 26 2026
Nutrition Manager	Deb MacDonald - FSM/ Lise Wolyniuk RD	May 26 2026
Programs Manager	Brent Drost - PM	May 26 2026
Clinical Consultant	Julia Levreault/Mackenzie Thiessen	May 26 2026
Resident Council Representative	Rosa Campbell	May-26
Family Council Representative	N/A	N/A
Medical Director	Dr Crabbe	May 26 2026
Other	N/A	N/A
Other	Ava Hamelin	May-26

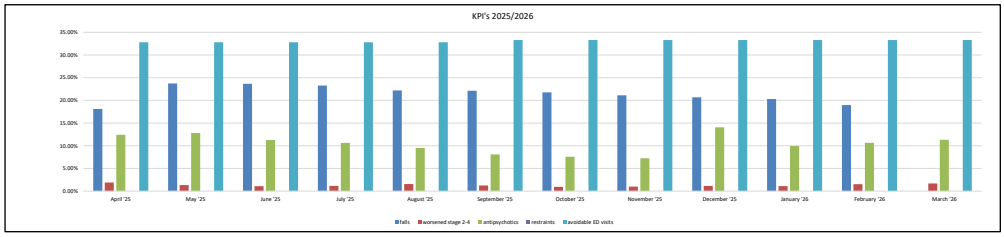
Summary of the Home's priority areas for quality improvement, objectives, policies, procedures and protocols from previous year (2025/2026): What actions were completed? Include dates and outcomes of actions.

Quality Improvement Objective	Policies, procedures and protocols used to achieve quality improvement	Outcomes of Actions, including dates
Initiative #1 - 'Initiative #1 - Rate of ED visits for modified list of ambulatory care-sensitive conditions* per 100 long-term care residents. Target: 15.4	The home has a full time nurse practitioner on site who is available to respond to resident medical needs, alonside the physicians. In class education provided to all registered staff about how to use the SBAR tool to document and inform NP or MD of medical concerns with residents. Education provided to residents, families, and SDMs/POA's on the benefits and approaches to preventing ED visits during admission, care conferences, goals of care conversations, upon change in status and additionally as needed. Nurses, NP, and MD explain to residents and families what care and medical interventions can be provided in the home, what would be different in hospital, and whether it is appropriate or in line with resident goals of care. Utilize the community paramedic program to support assessment and treatment of residents in the home. Community paramedicine program is being utilized - contacted by home staff to come in for point of care lab testing, assessments to prevent hospital transfers for residents who are not experiencing a medical emergency. NP referrals - Q1 2025 - 713 , Q2 2025 - 681 , Q3 - 617, Q4 -578 for a total number of 2589 for the year. Community Paramedic program was launched during Q1 of 2025. In Q1 - there were 7 requests and 3 were activated. Q2 there were 4 requests and 4 were activated and there was new POC test with full CBC testing. Q3 there were 4 requests and 2 were activated and 2 resulted in 2 ER visits. Additionally, the data for ED visits was reported for Chelsey Park Long Term Care and Retirement home. The Long Term care home has now separated and moved into a new building with new name, and ED visit reporting will now be captured separately.	Current Performance: 32.79% (March 2026) - needs improvement Previous Performance: 28.91 (March 2025) The home demonstrates a strong commitment to resident-centered care, education, and ED avoidance strategies. Continued focus on optimizing program utilization and data tracking will further strengthen outcomes.
Initiative #2 -'Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education. Target: 100% completion by December 31, 2025.	Training and education offered through Surge Learning platform and is mandatory. All staff required to complete the online modules to learn about equity, diversity, inclusion, and anti-racism in order to provide culturally competent and safe care to residents. The home is committed to celebrate culture and diversity events. The home organizes multiple cultural events throughout the year such as Diwali celebration, Christmas, and Easter events. Monthly quality meetings standing agenda: EDI initiatives discussed each month during monthly quality meetings to ensure that the home is making an effort to create a culturally safe and diverse environment.	100% completed for all staff by December 31, 2025 The home demonstrates consistent efforts to support an inclusive, culturally safe environment through education and meaningful engagement initiatives.
Initiative #3 - 'Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences". Target: 90%	The Resident Bill of Rights is read out to the council at the beginning of each resident council meeting to ensure that residents are aware of their rights. Resident Right #29 added to standing agenda of Resident council Meetings monthly. Reviewed at each meeting so that residents are aware of their right. Re-educated all staff on residents bill of rights and whistle blower protection. Staff have been educated on hire, annually, and additionally as needed the entirety of the bill of rights and the corporate whistleblower policy to ensure that resident rights are respected and any violation of those rights are promptly reported and followed up on.	Outcome: 93.21% (Improved) Date: Oct 1-31, 2025 The home continue monitoring staff compliance and resident understanding to ensure practices are consistently upheld. The home also demonstrates a proactive and thorough approach to promoting and safeguarding resident rights through education, transparency, and ongoing engagement.
Initiative #4 - Percentage of LTC home residents who fell in the 30 days leading up to their assessment. Target 15.40	The home continues to hold weekly falls huddles with the interdisciplinary team and led by the falls program lead. Residents at high risk for falls are reviewed to ensure all interventions are appropriate and up to date. Complete weekly unit staff meeting to reveiw falls and interventions. Falls champion nurse reviews falls from the last week with home area staff to discuss interventions and identified patterns/trends to reduce falls. Established documentation/charting down individual home areas to increase staff presence. Home has wall mounted ipads along each home area hallway, staff are required to document at these ipads to maintain visibility and accessability to the residents. Fall and fracture prevention and assessment education was done on 27th Nov/ 2025 for all registered staff.	Performance: 19.63 for the rolling quarter Dec 2025 - Needs improvement The Home will continue to have a proactive and well-coordinated approach to fall prevention, supported by education, staff teamwork and improved documentation practices
Initiative #5 - Percentage of LTC residents who were prescribed an antipsychotic without a diagnosis of psychosis. Target: 16	Monthly interdisciplinary meetings to review residents who are taking antipsychotics and determine if they are effective and appropriate, create plan to taper off if determined to be inappropriate. Analytics reviewed quarterly at PAC Meetings. BSO Nursing team implement non-pharmacological interventions prior to exploring antipsychotics and in attempt to reduce antipsychotic use. Nursing working with NP and physicians to address antipsychotic use and de-prescribe as appropriate. BSO and NP participated in monthly quality meeting. Residents who trigger as inappropriate antipsychotic use discussed and analytics reviewed for effectiveness. RAI auditing for coding completed each month to determine appropriatness of coding. GPA training on 8th April/ 2025, BSO/ VTN training 3rd September/ 2025 and DLT training on personality disorder on Dec 1st 2025. External referral BRT- 12 and Geri- Psychiatrist- 11.	Current Performance: 7.91% (March 2026) - Improved The Home will continue monitoring outcomes of deprescribing efforts and ensure consistent documentation and follow-up of intervention effectiveness. The Home will also continue to demonstrates a comprehensive, data-informed, and collaborative approach to appropriate antipsychotic use, prioritizing safer alternatives and continuous quality improvement.
Initiative #6 - Percentage of Residents Who Have Developed Worsening Pain. Target 2.85	Enhance end of life palliative program - The home participated in Community of Practice March 10 2025, June 10 2025, Sept 9 with discussion on pain and palliative care. Participated in quality forum Jan 30, Feb 4, Feb 28 palliative forum provided an overview of the program, cart, pamphlets, CoP, poster and story. March 11, May 20. May 2 facility wide palliative care education from head office. Utilize the pain tracker to monitor prn analgesic use continues. Education provided on new pain assessment and tracker Jan 16 2025. Admission screen resident for diagnosis to support use of pain relieving medication and/or interventions prior to admission to the home. New admission overview shared at morning meeting the day prior to admission for nursing to be prepared with interventions when they arrive. Complete resident assessment of pain and palliative score outcome on admission and as needed. Identify residents who are declining through reading morning report (24 hour summary and discussion with RNs), new diagnosis of pain, change of analgesic medication. Pain is discussed at quarterly quality improvement meetings (completed April 23, 2026) and PAC meeting (April 30, 2026).	Residents with worsening pain (May 2026) - 4.94% - Needs improvement The Home will continue to evaluate consistency in pain assessment documentation and monitor outcomes of interventions to further strengthen care delivery. The home will also continue to have a coordinated proactive approach to palliation and end-of-life care, supported by education, structured processes, and continuous quality improvement
Initiative #7 - Percentage of Residents who Develop a Worsening Pressure Injury Stage 2-4. Target: 2.5	Education provided by wound care nurse on wound care assessments. Skin and Wound education provided to all home staff in September 2025. April 17th 2025 ROHO education for all staff. June 12, 2025 the new skin issue checklist was implemented in the home. Wounds Canada Skin Health program that 2 PSWs attended March 2025. June 11, 2025 Medline education. August 21, 2026 2 staff attended Medline wound care education in Woodstock September 23-26, 2025 skin and wound whole home education done by Corporate Education Consultant. Educate wound care champion on wound care referral process with wound specialist. Referrals were completed to Southbridge ET Nurse, visits monthly to attend referrals for certain wounds. Established ROHO champions - one restorative aide was trained off site as the ROHO champion. PT remains a resource for ROHO knowledge and training Medline education provided on skin care line February 26, 2026. Medline did education on skin, wound and continence products as part of orientation for the new home. Southbridge ET comes monthly to see specific referrals. Continue to use wound care IPAD to take pictures of wounds that are then uploaded in the MISC tab in PCC and weekly wound assessments are tracked by wound care champion to ensure completion. Skin and Wound tracker is maintained by skin and wound champion.	Residents with worsening Stage 2-4 pressure ulcers (May 2026) - 1.91% improved The Home had a comprehensive wound care program supported by extensive staff education, specialized training, and strong collaboration with external experts (ET Nurse, Medline). Implementation of tools such as the skin issue checklist, wound tracking systems, and wound care iPads enhances assessment accuracy and documentation. Designation of wound and ROHO champions strengthens leadership and consistency in practice. The home demonstrates a highly organized, education-driven, and collaborative approach to skin and wound care, with strong systems in place to support quality and continuous improvement.
2024 Resident Satisfaction Survey: Top 5 Opportunities 1. I am satisfied with the laundry services for personal clothing 73.21% 2. I am satisfied with the quality of care from Physio therapist/occupational therapist 73.05% 3. Overall, I am satisfied with the continence care products used in the home. 71.64% 4. I am satisfied with the temperature of my food and beverages. 71.63% 5. I have a good choice of continence care products. 71.59%	Additional laundry shift added at the new home, making laundry services 24/7. Personal clothing missing form filled out by nursing and followed up by Environmental Services Manager, providing updates to residents/families. Physio attends care conferences when available or provides details to be reviewed. No concern related to physiotherapist or occupational therapist or ADP were identified through the 2025/26 complaint log. Physio document resident participation and refusals in exercise programs to support ongoing monitoring and engagement. New continence care product, FitRight, implemented in April 2026. Food temperatures are a standing agenda on Food Advisory Meeting. The larger dining rooms in the new home have improved meal service flow and reduced delays between meal service and consumption. Ongoing food temperature audits and follow-up as needed.	2025 Resident Satisfaction Survey Results: 1. 84.20% 2. 82.91% 3. 83.92% 4. 82.00% 5. 86.50% The survey revealed our top opportunities for improvement within the home. The actions mentioned, such as implementing an additional laundry shift, physiotherapist attendance at care conferences, continence product change, and increased food temperature audits have all contributed to the increase in resident satisfaction in each of the identified opportunity categories.

2024 Family Satisfaction Survey: Top 5 Opportunities	New spiritual assessment tool implemented at the end of 2025 to identify needs and preferences. The timing of the Celebration of Life services was adjusted to the evening, providing families with greater opportunity to attend and participate. A new dietitian joined the home in Oct 2025. No concerns regarding dietitian services have been identified through resident or family feedback. Dining services have improved with the new home as the spaces are larger, brighter and provide a more welcoming environment. Physio attends care conferences when available or provides details to be reviewed. No concern related to physiotherapist or occupational therapist or ADP were identified through the 2025/26 complaint log. Physio document resident participation and refusals in exercise programs to support ongoing monitoring and engagement.	2025 Family Satisfaction Survey Results: 1. 86.30% 2. 85.93% 3. 85.31% 4. 85.00% 5. 85.43% Similar to the resident satisfaction survey, the home's action to address the opportunities for improvement identified were successfully implemented and did contribute to an increase in family satisfaction in each category identified.
1. I am satisfied with: the timing and schedule of spiritual care services 79.79%		
2. I am satisfied with the quality of care from the dietitian 79.77%		
3.I am satisfied with the variety of spiritual care services 79.70%		
4. The resident enjoys eating meals in the dining room. 78.94%		
5. I am satisfied with the quality of care from physiotherapist / occupational therapist		

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	18.10%	23.72%	23.65%	23.26%	22.19%	22.12%	21.76%	21.11%	20.67%	20.31%	18.97%	18.52%%
worsened stage 2-4	1.90%	1.34%	1%	1.15%	1.56%	1.24%	0.95%	1.00%	1.13%	1.11%	1.53%	1.68%
antipsychotics	12.40%	13%	11.26%	10.62%	9.52%	8.09%	7.58%	7.23%	14.06%	9.94%	10.64%	11.31%
restraints	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
avoidable ED visits	32.80%	32.80%	32.80%	32.80%	32.80%	33.30%	33.30%	33.30%	33.30%	33.30%	33.30%	33.30%



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:	October 1 - October 31, 2025
Results of the Survey (*provide description of the results*):	Resident and Family Satisfaction surveys were conducted in October 2025 and largely reflected both resident and family overall satisfaction with the care and services provided by our home. Participation increased significantly from the previous year, with resident participation rising by 32% and family participation increasing by 27%. Overall satisfaction was 85% among both residents and families, consistent with the previous year's results. Residents expressed satisfaction with expressing their opinions without fear of consequences, laundry and housekeeping services. Residents expressed opportunity for improvement in the home for noise at night, courtesy in the dining room, spiritual care and recreation services. Action plans have been developed and implemented to address these areas and support ongoing quality improvement.
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 results and action plans were posted in the home in February on the Quality Improvement board, as well as in the Family Communication binder. The results were also shared and reviewed at Residents' Council on February 23, 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	95.00%	95.33%	63.00%	64.40%	90.00%	55.56%	27.82%	18.49%	Designated staff will support all residents willing to complete a survey with privacy. Survey access online will be sent to all family members. Satisfaction survey will be advertised at the main home entrance and supported by reception for any required assistance.
Would you recommend	95.00%	82.94%	76.00%	79.80%	90.00%	85.93%	76.41%	68.40%	Action plan is completed to make improvements to the areas residents and families identified as lowest scoring on the survey. These are imbedded in the quality initiatives for 2026/27. Survey for 2026 will be based off the new home, where previously identified areas for improvement may no longer be applicable.
If I have a concern, I feel comfortable raising it with the staff and leadership	95.00%	90.92%	83.00%	75.20%	95.00%	95.00%	86.39%	73.60%	Reviewing Whistleblower policy at Residents' Council and posted in home. Discuss with residents and families on admission, included in admission family handbook.

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
Rate of ED visits for modified list of ambulatory care-sensitive conditions* per 100 long-term care residents.	**Change Ideas:** 1) Use of on-site Nurse Practitioner 2) Build capacity and improve overall clinical assessment skills of registered staff; supported by education from NP, clinical consultants, and Nurse PLEDGE program. 3) DOC to review ED tracker and analyze most common reasons for transfer, review at nursing meetings to develop strategies to prevent further transfers. 4) Implement IV program in the home. 5) Educate staff, residents, and families on palliative approach, end of life care, and goals of care. 6) Utilize community paramedics services	Q4 2024/25 - Q3 2025/26 - 33.3% Target: 22.7%
Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education	**Change Ideas:** 1) To improve overall dialogue of diversity, inclusion, equity and anti-racism in the workplace. 2) To increase diversity training through Surge education. 3) To facilitate ongoing feedback or open door policy with the management team. 4) Cultural assessment on admission, (language, faith, gender preference for care, family roles). 5) Include cultural diversity as part of CQI meetings. All new hires complete course prior to orientation shift in the home	Current Performance Jan-April 2026: 89.4% completion Target 100%
Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences".	**Change Ideas:** 1) To increase our goal from 90% to 95%. 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"; 2) Review of the Whistleblower policy 3) Review the Concern process in the home on admission and during annual care conference 4) Social worker, completing wellness checks with residents	2025 Satisfaction Survey Result: 93.21% Target: 95%
Percentage of long-term care residents whose stage 2 to 4 pressure ulcer worsened	**Change Ideas:** 1) To reduce the percentage of resident who develop, or experience worsening pressure injury 2) Home to collaborate with NSWOC/ET nurse to provide in home and virtual consults 3) Conducting audit of resident surface (bed/w/c), for the appropriate surface for pressure relieving 4) RD review of nutritional and hydration status of residents 5) During admission process, complete comprehensive review of resident status, and risk level for alteration in skin, and develop plan of care 6) Identification of resident at risk for alteration in skin 7) Prompt identification and documentation of worsening pressure injuries	March 2026 Results: 1.68% Target: 2.0%
Percentage of LTC home residents who fell in the 30 days leading up to their assessment	**Change Ideas:** 1) Strengthen weekly falls huddles by utilizing a formalized meeting template and ensuring all department are present. 2)Establish a process of communication to all staff in the home are aware of what resident are high risk for falls. 3) Integrate review of FRS into weekly falls huddles to ensure appropriate medications are prescribed to prevent bone density loss and fractures 4) Collaborate with recreation team to implement activities to engage residents 5) Utilize internal falls tracking tool, analyze fall data and review at monthly nursing meetings to develop strategies to prevent falls in the future. 6) Provide leadership with root cause analysis training to help support anlaysation of fall.	March 2026 Results: 18.52% Target: 15%

2025 Resident Satisfaction Survey: Top 5 Opportunities 1. I am satisfied with the relevance of recreation programs 2. Overall, I am satisfied with the recreation and spiritual care services 3. I am satisfied with the variety of spiritual care services 4. I am treated with courtesy in the dining room 5. Noise is at an appropriate level during the night	**Action Plan:** 1. I am satisfied with the relevance of recreation programs - 78.92% Complete Resident Program Evaluation after the implementation of each new program and twice monthly on existing programs to assess resident satisfaction Review Resident Program Evaluation to determine if program is relevant or requires adaptation Implement a monthly program for resident program suggestions Incorporate resident program suggestions into upcoming monthly calendars 2. Overall, I am satisfied with the recreation and spiritual care services - 79.38% Complete Resident Program Evaluation after the implementation of each new program and twice monthly on existing programs to assess resident satisfaction Review Resident program evaluation to determine if program is relevant or requires adaptation Offer a balance of physical, social, emotional, intellectual and spiritual programs into monthly calendars 3. I am satisfied with the variety of spiritual care services - 79.91% Complete Resident Program Evaluation on spiritual programs to assess resident satisfaction Offer group and individualized spiritual support based on resident preferences identified on Spiritual and Religious assessments Establish partnerships with community faith groups to support diverse spiritual needs 4. I am treated with courtesy in the dining room - 80% Provide education to dietary aides and PSWs on expectations for respectful, resident-centered interactions during dining service Monitor dining room practices weekly through leadership observations and follow-up with staff as required 5. Noise is at an appropriate level during the night - 80% Ask Residents' Council what the concerns are related to noise Conduct night audits to identify sources of noise Review audit findings and eliminate avoidable noise (equipment, routines, processes).	2025 Resident Satisfaction Survey Results: 1. 78.92% 2. 79.38% 3. 79.91% 4. 80% 5. 80%
2025 Family Satisfaction Survey: Top 5 Opportunities 1. Overall, I am satisfied with the meal, beverage, and dining services 2. The resident has access to foot care when needed 3. I am satisfied with the quality of care from: Social Worker / Social Service Worker 4. feedback on the residents' goals and plan of care is considered and adopted 5. The resident has access to a hairdresser when needed	**Action Plan:** 1. Overall, I am satisfied with the meal, beverage, and dining services Invite Family Council members to attend a meal service Review feedback from Family Council on their dining experience, creating action plans based on the feedback Share menu updates with families through newsletters 2. The resident has access to foot care when needed Offer Family Council an information session on the foot care processes (what is offered from PSW staff vs. foot care paid service) Add foot care dates to family newsletter Bring the unfunded services form to all care conferences to provide family an opportunity annually to have the footcare process reviewed and sign up if interested 3. I am satisfied with the quality of care from: Social Worker / Social Service Worker Increase hours of the Social Worker to full-time in January Social Worker to attend all care conferences Share a summary of available social work services with Family Council Ask Family Council for a list of services they feel the Social Worker could assist them with in addition to current services 4. feedback on the residents' goals and plan of care is considered and adopted Printed copy of care plan to be provided at care conferences Incorporate family input in resident care plans Communicate updates on resident care plans with family 5. The resident has access to a hairdresser when needed Review access to hairdressing services with families during admission and care conferences Share information with families on available hairdressing services, scheduling process and associated costs through the family newsletter Communicate any changes or updates with families through newsletter and posters	2025 Family Satisfaction Survey Results: 1. 75.99% 2. 79.22% 3. 79.50% 4. 79.55% 5. 79.55%

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	Sarah Hind	May 26 2026
Executive Director	Courtnev Lines	May 26 2026
Director of Care	Sarah Hind	May 26 2026
Nutrition Manager	Deb MacDonald FSM/Lise Wolvniuk RD	May 26 2026
Programs Manager	Brent Drost	May 26 2026
Clinical Consultant	Julia Levreault/Mackenzie Thiessen	May 26 2026
Resident Council Representative	Rosa Carnobell	May 26 2026
Family Council Representative	N/A	N/A
Medical Director	Dr. Crabbe	May 26 2026
Other	Ava Hamelin, SW	May 26 2026
Other	N/A	N/A