SOUTHBRIDGE HEALTH CARE LP

Continuous Quality Improvement Initiative Annual Report

Annual Schedule: May 2026

HOME NAME : The Palace

People who participated in the evaluation of this report

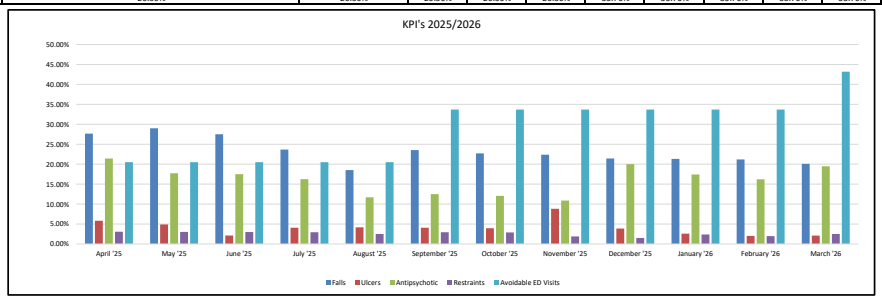
	Name and Designation	Date of Evaluation
Quality Improvement Lead	Diane Dupuis	June 12 ,2026
Director of Care	Johanne Wensink	June 12 ,2026
Executive Directive	Diane Dupuis	June 12 ,2026
Nutrition Manager	Amber Ogilvie	June 12 ,2026
Programs Manager	Julie Roy	June 12 ,2026
Clinical Consultant	Nicola Lachapelle	June 12 ,2026
Medical Director	Dr. Gill	June 12 ,2026
Resident Council Member	Micheline Doth	June 12 ,2026
Family Council Member	Kathy Pelaschuk	June 12 ,2026
RAI Coordinator/ ADOC	Kemote Poyser	June 12 ,2026
Quality Improvement Nurses	Gurwinder Kaur, Cheryl Miller	June 12 ,2026

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 LTC Residents: Decrease of ED transfers **2024: Actual 33.7%** **2025 Target: 28.00%**	**Change Idea: Decrease avoidable ED transfers to 28% by December 31, 2026.** -The clinical team increased the usage of SBAR documentation through education provided to Registered staff. -The team developed an IV program and completed education on managing IVs. -Ongoing discussion with Residents and Families occured about their ongoing wishes for hospital transfer, as well as PPS scores completed quarterly, allowed for the clinical team to have more information on when to transfer.	At the end of 2026 the Avoidable ED rate was at 43.20%. There were successes with increased education, however this will be a strong area of focus moving into 2026.
Initiative #2 Improve overall dialogue on equity, diversity, inclusion, and anti-racism education- **2024 Actual: 100%** **2025 Target 100%**	**Change Idea: Improve education and comfort within the staff on the topics of equity, diversity, inclusion and anti-racism by December 31, 2025.** - Education was held online was on equity, diversity, inclusion, anti-racism with daily review in the risk management meetings - Development of a diversity committee comprised of residents, families and staff to improve inclusion was not acheived in 2025.	100% of staff have completed their training for anti-racism. While a Diversity committee was not formed in 2025, it was a topic of discussion in both Daily Risk Management meetings and Family/ Resident Councils.
Initiative #3 Resident can express opinions without fear of consequence **2024 Actual 90%** **2025 Target 92.73%**	**Change Idea: The Home will provided more resident-centered wholistic care through regular wellness checks by a Social Worker. 100% of residents will have wellness checks by March 31 2026.** -There was a review of the complaints and whisteblower policy with residents and families held at every Resident council in 2025.	Work on this Initiative is ongoing into 2026 with a goal to continue to increase resident satisfaction due to a score of 85.34% on the 2025 satisfaction survey.
Initiative #4 Residents who have fallen in the past 30 days **2024 Actual 25.45%** **2025 Target 17%**	**Change Idea: To reduce to 17% the number of residents who have fallen in the previous 30 days by the end of 2025.** -There has been the Implementation of weekly team huddles -Monthly collaboration with interdisciplinary team to review resident who have fallen -Injury prevention, review resident FRS, and implementation of bone density replacement	Both the Pharmacist and Doctor have been assisting with medication reviews to increase the usage of bone density medications. Weekly fall huddles have been occurring resulting in a drop in the KPI from 25.45% to 21.33%
Initiative #5 % of LTC Residents without psychosis who were given Antipsychotic Medication in the 7 days preceding their resident assessment **2024 Actual 21.43%** **2025 Target 19.7%**	**Change Idea: The home will reduce the usage of anti-psychotics without a diagnosis of psychosis in the home to bellow MLTC Benchmark of 19.7% by the end of 2025.** -During the admission of residents to the home on antipsychotic medication, there was a review with family for the indication/reason for the medication -Monthly collobration occured with the interdisciplinary team, to review resident responsive expressions, and the use of anti-psychotic medication -Referrals were placed to the psycho-geriatic team	The KPI has dropped from 21.43% to 19.47%, the Clinical Team is still making progress on the appropriate usage of Anti-psychotics in the home.
Initiative #6 Percentage of LTC residents who develop worsening pressure injury stage 2-4 **2024 Actual 5.6%** **2025 Target 2%**	**Change Idea: The reduction to 2% of stage 2-4 pressure ulcers within the home before December 31, 2025.** -There was a review of PURS that are 3 or greater, which resulted in a review of the plan of care, and referrals to appropriate interdisciplinary team - NSWOC referrals were submitted both for in home and virtual consults. - Education -to Registered staff and PSW, on Pressure related injuries	Improvement resulting in a reduction to 2.58% was seen in 2025, with this being a selected ongoing area of opportunity in 2026.
2024 Resident Satisfaction Survey **1) Noise is an appropriate level during the day 80.0%** **2) I have access to footcare when needed 78.13%** **3) Continence care products fit properly 77.63%** **4) I am satisfied with the temperature of my food and beverages 73%** **5) Continence care products are comfortable 72.3%**	1) Noise is an appropriate level during the day - The staff worked on reducing noise during shift change, and reducing TV noise when not in usage. 2) I have access to footcare when needed 78.13% -The schedule for footcare has be posted ahead of time and offered over many days so multiple attempts can be made to fit all residents in 3) Continence care products fit properly 77.63% - All residents were assessed quarterly and as needed for product fit, and appropriateness for size 4) I am satisfied with the temperature of my food and beverages 73% -Staff worked on getting food to independent residents when it is ready, and delivering food to residents who need assistance when a staff member is available to assist them 5) Continence care products are comfortable 72.3% -All residents were assessed quarterly and as needed for product fit, and appropriateness for size	2025 Resident Satisfaction Results 1)80.0% 2)82.29% 3)82.95% 4)86.92% 5)80.68%
2024 Family Satisfaction Survey **1) The resident can choose what time they go to bed 81.06%** **2) I am satisfied with the variety of recreation programs 80.81%** **3) The residents can choose what time they get up in the morning 80.30%** **4) The resident has input into the recreation programs available 79.17%** **5) I have an opportunity to provide input on food and beverage options 74.22%**	1) The resident can choose what time they go to bed - Ideal bedtimes were reviewed with residents and added to their plan of care, then shared with clinical staff 2) I am satisfied with the variety of recreation programs - The recreation department did follow up with residents on which programs they enjoyed and which are less enjoyable, as well as asking for ideas for new events. The schedule was customized based on the requests of the residents in the home. 3) The residents can choose what time they get up in the morning -Ideal wake times were reviewed with residents and added to their plan of care, then shared with clinical staff 4) The resident has input into the recreation programs available -The recreation department did follow up with residents on which programs they enjoyed and which are less enjoyable, as well as asking for ideas for new events. The schedule wascustomized based on the requests of the residents in the home. 5) I have an opportunity to provide input on food and beverage options - The food service manager did seek feedback on the menu, and bring suggestions back to the dietician for possible implimentation into the menu plan	2025 Family Satisfaction Results 1)90.56% 2)85.14% 3)90.56% 4)90.71% 5)90.11%

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	27.66%	29.00%	27.50%	23.65%	18.52%	23.53%	22.71%	22.38%	21.43%	21.33%	21.18%	20.10%
Ulcers	5.82%	4.89%	2.13%	4.08%	4.17%	4.06%	3.94%	8.82%	3.86%	2.58%	2.01%	2.10%
Antipsychotic	21.43%	17.72%	17.50%	16.25%	11.69%	12.50%	12.05%	10.87%	20.00%	17.43%	16.22%	19.47%
Restraints	3%	3.02%	2.99%	2.94%	2.50%	2.93%	2.88%	1.90%	1.50%	2.37%	1.97%	2.51%
Avoidable ED Visits	20.50%	20.50%	20.50%	20.50%	20.50%	33.70%	33.70%	33.70%	33.70%	33.70%	33.70%	43.20%



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:	September/ October 2025
Results of the Survey (*provide description of the results*):	The participation rate for 2025 was 100% for residents, and 85.42% for Families which was an improvement form 2024 at 78.57%. Overall Residents and families were satisfied with the quality of care from Personal Support Staff (84.40% Palace, 88.31% Corporate) and Administration (85% Palace, 85.94% Corporate). Residents expressed being satisfied with choosing what time they get up (91.51% Palace, 91.92% Corporate) and go to bed (93.96% Palace, 93.96% Corporate), or being able to access a hairdresser (93.48% Palace, 85.85% Corporate) or a nurse to talk about their medications(91.0% Palace, 91.06 Corporate). There are areas of opportunity with the noise level with the home(80% Palace, 86.45% Corporate), overall communication(78% Palace, 83.61% Corporate), the spiritual program(85% Palace, 88.23% Corporate), and being able to access a social worker (79.89% Palace, 76.72% Corporate).
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 of the Resident and Family satisfaction survey were sent via email to all Family contacts shared at multiple Resident Council meetings as well as Family Town Halls/ Council meetings. Copies of the surveys are also available to residents and staff in their Resident Council meeting binder.

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%	86.21%	100.00%	100.00%	85.42%	78.57%	62.90%	Survey participation increased in 2025 due to increased family and resident engagement. Residents had easy access and assistance to complete the survey removing barriers. Ongoing work in 2026 will be to improve ease of access for families, as well as reminders to complete.
Would you recommend	100.00%	82.96%	87.00%	82.63%	100.00%	88.95%	76.00%	80.50%	Family recommendations increased in 2025, while residents dropped from 2024 statistics. Management will continue to work into 2026 creating an atmosphere of positivity, engagement, and creating a desirable place to live for our residents. Areas of opportunity identified in the Satisfaction Survey will be reviewed, and plans created to promote scores, improving the overall would to recommend score.
If I have a concern, I feel comfortable raising it with the staff and leadership	100.00%	85.91%	88.00%	83.60%	100.00%	89.38%	89.77%	83.60%	Scores remained stable from 2024 to 2025, reflecting a stable management team. Ongoing promotion for management to be engaged with both families and residents will happen in 2026. Being present at activities, on the units, and engaging with Residents will promote positive communication and relationships.

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
Initiative #1 - Rate of ED visits for modified list of ambulatory care-sensitive conditions * per 100 long-term care residents Goal: Reduce from 33.65% to 28%	**Change Idea 1)** To reduce unnecessary hospital transfers through root cause analysis of transfers **Change Idea 2)** Registered Nurse in Charge to communicate to physicia, a comprehensive resident assessment and to obtain direction from the GP prior to initiating an ER transfer **Change Idea 3)** Review IV education for use in the home to avoid a hospital transfer	January 2026 - 33.65%
Initiative #2- Percentage of staff who have completed relevant equity, diversity, inclusion and anti-racism education. Goal: Maintain at 100%	**Change Idea 1)** To improve overall dialogue of diversity, inclusion, equity, and anti-racism in the workplace **Change Idea 2)** To include diversity in team huddles **Change Idea 3)** To include diversity as part of CQI meetings	December 2025 - 100%
Initiative #3- Percentage of residents who responded positively to the statement "I can express my opinion without fear of consequences" Goal: Increase from 90.16% to 92.67%	**Change Idea 1)** To increase our goal from current percentage 85.34% by 2% this year **Change Idea 2)** Review the concern process in the home on admission and during annual care conferences **Change Idea 3)** Social worker visits	October 2025- 90.16%
Initiative #4- Percentage of LTC home residents who fell in the 30 days leading up to their assessment. Goal: Reduce from 23.36% to 20%	**Change Idea 1)** To re-educate staff at huddles about Purposeful rounds, when residents are in bed keep the doors open and curtains pulled back to monitor for safety; transfer high fall risk residents into their wheelchairs when awake **Change Idea 2)** Implement a buddy system while charting, PSWs sit with residents with high risks for falls **Change Idea 3)** Plan calming activities or residents targeting evening and sundowning (colouring, puzzles)	2025-2026 Q3 - 23.36%
Initiative # 5 - Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment. Goal: Decrease from 11.63% to 10%	**Change Idea 1)** Re-education of all staff on Gentire Persuasive Approach (GPA) training/education - establish GPA trainers, educators in the home **Change Idea 2)** Re-educate on the use of Behaviour Note heading for responsive expressions documentation in the progress notes; remind registered staff to chart on responsive expressions, to not normaize behaviours as they occur **Change Idea 3)** Implement the Southbridge Antipsychotic Reduction Program	2025-2026 Q3 - 10%
Initiative # 6- Percentage of LTC residents who develop worsening pressure injury stage 2-4% Goal: Reduce from 3.85% to 3%.	**Change Idea 1)** RD review of nutritional status of residents **Change Idea 2)** Increased use of the Re-education of staff on care and use of pressure releleving surfaces (ie. no incontinence pad on top of the air mattress) **Change Idea 3)** Monthly reivew of residents with pressure injuries at Quality Meetings, reivew of the plan of care	2025-2026 Q3 - 3.85%
2025 Resident Satisfaction Survey 1) I trust the staff in my home 2) Noise is at an appropriate level during the day 3) I am satisfied with the care of the social service worker 4) I am satisfied with the timing and schedule of spiritual care services 5) Communication from home leadership is clear and timely	**1) I trust the staff in my home** -The PSW's will continue to be educated on their approach, and ensuring they introduce themselves when entering a room. **2) Noise is at an appropriate level during the day** -Each department will be mindful to help reduce noise ex. Scraping plates, using manual pill crushers, and answering call bells promptly. **3) I am satisfied with the care of the social service worker** -Within the newsletter there will be the contact information for the Social worker, which is a fairly new position within the home, so sharing her contact information will be important to new and long term residents. **4) I am satisfied with the timing and schedule of spiritual care services** -The programs manager will ask Residents about which spiritual events they would like to attend so they can be reminded when these events are occurring. **5) Communication from home leadership is clear and timely** - The ED will continue to send family communications as required during outbreak and quarterly.	2025 Resident Survey Results 1) 80.0% 2) 80% 3) 79.89% 4) 79.35% 5) 78%
2025 Family Satisfaction Survey 1) Continence care products are comfortable 2) Overall I am satisfied with the recreation and the spiritual care services 3) I am satisfied with the quality of cleaning within the resident's room 4) I am satisfied with the quality of care from Social Service Worker 5) The resident has input into the recreation programs available. Spiritual care services.	**1) Continence care products are comfortable** -The home will successfully transition to using Medline products with the support of Medline Corp **2) Overall I am satisfied with the recreation and the spiritual care services** - The programs manager and activity aids will work together to complete a program evaluation to help identify the activities that are the most enjoyable and what need to be updated. **3) I am satisfied with the quality of cleaning within the resident's room** - The home will implement home wide cleaning audits. **4) I am satisfied with the quality of care from Social Service Worker** - With the start of a new social worker, the home will share updates via the newsletter on a monthly basis. **5) The resident has input into the recreation programs available. Spiritual care services.** - The activity team will take feedback from Resident and Family councils to keep the activities current and relevant to resident needs and wants.	2025 Family Satisfaction Results 1)82.05% 2)81.76% 3)81.71% 4)80.66% 5)80.71%

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	Diane Dupuis	**June 12 2026**
Executive Director	Diane Dupuis	June 12 2026
Director of Care	Johanne Wensink	June 12 2026
Medical Director	Dr. Gill	June 12 2026
Clinical Consultant	Nicola Lachapelle	June 12 2026
Resident Council Member	Micheline Doth	June 12 2026
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